

ALAMEDA COUNTY
**COMMUNITY
HEALTH
SERVICES**
DIVISION

2022–2023 ANNUAL REPORT



ALAMEDA COUNTY HEALTH CARE SERVICES AGENCY
PUBLIC HEALTH DEPARTMENT

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INTRODUCTION

In the three years since the last CHS Annual Accomplishments report was produced, Alameda County, and the rest of the world, experienced the deadliest and longest lasting pandemic in more than a century. Throughout this extraordinary time, the Community Health Services Division, together with every other Division in the Public Health Department, made significant contributions—and sacrifices—to address this emergency by altering program priorities, redirecting staff resources, and changing workplace policies and procedures. Of CHS's more than 120 staff, over 90% were deployed to the response at one point or another over the three years. While some of the Division's programs were closed entirely (Older Adults Healthy Results, Project New Start, Alcohol and Other Drug Prevention, Office of Urban Male Health) others were required to maintain some basic levels of essential services while parts of their staff were deployed to the emergency response (Tobacco Control, Nutrition Services, Office of Dental Health, Asthma Start, WIC).

The 2022–23 fiscal year saw the return of most staff to their regular programs within CHS. However, significant changes in both funding and program leadership over the past three years led to some reorganization within the Division. In 2020–2022, the Division became the new home for the Older Adults Healthy Results program, the Care Partners program, and the Healthy Nail Salon program. In 2022–2023 the Diabetes Prevention program was moved under the umbrella of Nutrition Services; the Office of Urban Male health was transferred to the Department Office of the Director; and Asthma became a stand-alone program. Project New Start and the [Alcohol and Other Drug Prevention](#) programs entered into a planning phase, setting up new contracts and refreshing relationships with community partners in preparation for re-starting services for youth in the next fiscal year.

The COVID-19 Pandemic

In January 2020, the first confirmed case of SARS-CoV-2 was introduced to the United States. On February 28, 2020, Alameda County reported the first two positive cases of COVID-19. On March 17, with 33 confirmed cases, Alameda County joined five Bay Area counties to issue the Nation's first "shelter in place" orders directing people to stay in their homes and allowing only essential businesses to remain open. By June 30, 2020, 6,223 Alameda County residents had tested positive for COVID-19, and 145 had died.

Early in 2021, the COVID vaccine became available for mass distribution.

In 2022 vaccine distribution grew to reach 84% of the County population, testing became widely available through clinics and at home, and new treatments became available. For nearly three years, Alameda County functioned under public health emergency declarations from both the State and Federal governments. While COVID is still present in the population, vaccines, treatments, home testing and widespread use of PPE have lessened the most severe impacts of this disease.

In 2023, both the State and Federal governments declared an end to the public health emergency (February 28 and May 11, respectively).

VISION, VALUES AND PRIORITIES

Throughout this time and the changes it brought about, CHS staff and leadership remained committed to the vision, values and priorities that were established in 2019:

Division Vision:

We all work efficiently together for quality and results that advance health and racial equity in Alameda County.

CHS Managers' Shared Values:



Division Priorities:

1.

Use Results Based Accountability for Quality Improvement

2.

Communicate program successes regularly

3.

Build capacity to reduce racial inequities in Alameda County

DIVISION-WIDE ACCOMPLISHMENTS

Focus on Racial Equity

Program Directors, together with the Interim Division Director, committed this year to focusing on building the Division’s capacity to address racial equity by planning a series of trainings. In collaboration with the Workforce Development team, a six-part racial equity training series was developed and made available to the entire Department. CHS Program teams followed up on these trainings with smaller group discussions and commitment to action.

Personnel

CHS successfully navigated through a number of key leadership transitions that occurred prior to the start of the fiscal year, including the retirement of three Program Directors and the Division Director. To adjust to these changes, programs were re-designed, several positions were reclassified, and new opportunities emerged to fill these key roles and gaps. As they were throughout the emergency response, CHS staff proved to be resilient, committed, and willing to step up to the challenges and opportunities that were presented to maintain the high quality of services expected by our communities.

THE ROAD AHEAD

- Support re-opening programs that were partially or fully closed during the COVID emergency response.
- Continue to build capacity among staff and supervisors to address racial inequities and build internal competencies.
- Explore, plan, and launch new or expanded program models to address chronic disease prevention and mitigation, starting with asthma remediation for adults and a program to address Alzheimer’s Disease and Related Dementias.
- Explore building a Division-wide infrastructure that aligns with current community needs, programs, and equity goals.

The remainder of this report highlights key accomplishments of Community Health Services Division programs during the fiscal year July 2022–June 2023.

ASTHMA

WHAT WE DO

The [Asthma](#) program provides comprehensive, in-home case management to people living with poorly controlled asthma throughout Alameda County. Asthma Start, our award-winning, research validated pediatric program, provided services to 324 families last year. Children who have been to the emergency room or hospital, as well as those with other signs of poorly or uncontrolled asthma, are referred to the program by hospitals, medical providers, schools, and Alameda Alliance for Health. Our clients' families learn about asthma triggers, how to manage their child's asthma, and how to administer medication. They also receive needed supplies—including HEPA vacuums and mattress covers—and may receive minor home repairs that assist with mitigating their asthma. Case managers also link families to other services and health insurance, as needed.






“ I learned a lot, and just today I taught one of the things I learned from my [case] worker to a friend of mine with asthma. The information I learned from the program was very helpful. ”



ACCOMPLISHMENTS

This year we expanded our program in two ways:

- ✓ Through an innovative partnership with the Bay Area Air Quality Management District, we now provide air purifiers to our Medi-Cal and moderate to severe asthma clients, with a focus on those living in areas with high pollution and poor air quality. Air purifiers continue to show benefits to our families especially during fire season.
- ✓ Asthma Start became an Asthma Remediation Community Support provider through Alameda Alliance for Health under the California Advancing & Innovating Medi-Cal (CalAIM). This new work allows us to receive direct CalAIM referrals and obtain authorization for services from the health plan. The asthma remediation widens our scope of work and now provides the program with the ability to provide home modifications that are necessary to ensure the health, welfare, and safety of our clients.

PRE-INTERVENTION		POST-INTERVENTION
11% of the children had been hospitalized 12 months before entering program.		Only 4% had been hospitalized while in the program.
42% of the children had been in the Emergency Department 12 months before entering program.		Only 17% had been in the Emergency Department while in the program.
45% of the children according to the Asthma Control Test (a validated test) were not in control of their asthma.		Only 7% would be considered not in control.

“

It is a great program! I benefited from their services, and I think more people should be aware of this program.

”



“

The program was good. Supplies were helpful, and I think the social worker calling to check in was helpful.

”

“

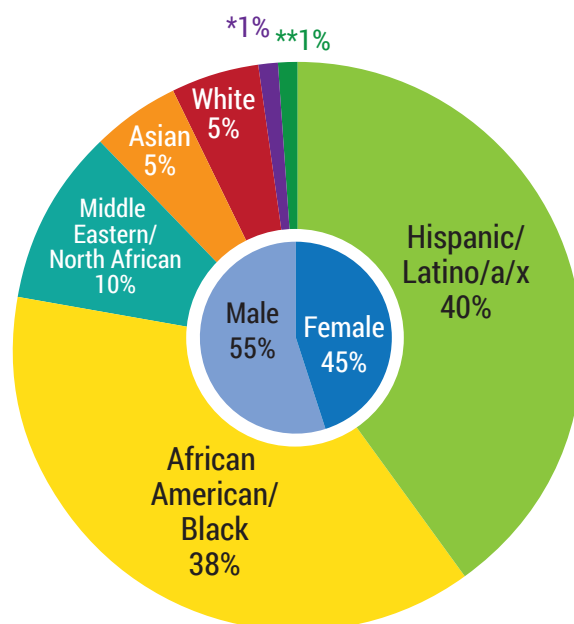
I had a wonderful experience with the program. Staff was very helpful and informative. Before the program, my kid had several ER visits.

”

THE ROAD AHEAD

- In 2024, the Asthma program plans expand to serve adults with asthma, in partnership with the Public Health Nursing Program's Front Door Care Team.
- Adult asthma remediation services, also funded under CalAIM, will start client services with a Universal Intake Process that will allow for a deeper dive into accessing health needs to address social determinants of health and will connect our Asthma Coordinators with nurses and community health workers.

POPULATION SERVED



*Native Hawaiian &/or Other Pacific Islander

**American Indian &/or Alaskan Native

CARE PARTNERS

WHAT WE DO

The [Care Partners](#) program provides culturally competent care coordination services to In-Home Supportive Services (IHSS) Recipients, Care Providers, and members in their Circle of Care, as well as low-income disabled and older adults, to improve their quality of life at home. We use a health equity approach to address the unmet needs of Alameda County older adults through home and remote visits. We link them to social services, wellness promotion and illness prevention education. We support our clients navigating the complex healthcare system and connecting them to the kind of care they want with Advance Care Planning support. We host Advance Care Planning workshops in facilities throughout the County. We implement a strategic systems approach to reach out to the public and community partners, attending community outreach events and networking.


Using a “light touch” approach, the Care Partners program addresses all of the top ten concerns of older adults as represented in a Countywide survey of 3,725 residents aged 55 and older.¹

“You answered everything. I really appreciate you. I will pass all the info to others who need the support and services. I’m now a Care Partner! Oh, and you were on time! Thanks.”

ACCOMPLISHMENTS

Care Partners individual-, group-, and systems-level accomplishments range from providing care coordination services and education to our clients to partnering with County as well as community providers to broaden outreach and service delivery. Our robust outreach includes IHSS Daily Orientation, Public Authority trainings, community outreach events and Advance Care Planning workshops, and meet and greet meetings with community partners in which we get the word out on Care Partners services and Advance Care Planning.


Introduced Program Services and Increased Awareness of Advance Care Planning to...


6,441
IHSS (new)
Care
Providers
through
virtual and
in-person
IHSS Daily
Orientation.


4,884
IHSS Care
Providers
and
Recipients
attended
106 Public
Authority
trainings.


2,178
people
through
11
community
outreach
events.


146
people
through
6 Advance
Care
Planning
workshops
in senior
residential
facilities.

 **27** partnerships with community/fair-based organizations, county partners, or other service providers including healthcare systems.

Client Cases


70%+

761 referral cases received.
536 clients successfully connected and linked to community resources, care and services based on their unmet needs.

Additional Accomplishments

- ✓ Partnered with the Office of HIV to develop an Advance Care Planning train-the-trainer model and improve digital access for Alameda County older adults living with HIV.
- ✓ Distributed 62 iPads to older adults through partnership with California Department of Aging’s Connections, Health, Aging and Technology (CHAT) project.
- ✓ Provided four, two-hour trainings on topics related to illness prevention and wellness promotion for IHSS Care Providers and Recipients.
- ✓ Selected for the Alameda County Food Bank’s FY24 CalFresh Partnerships Program.

¹ https://agefriendly.acgov.org/agefriendly-assets/docs/Age%20Friendly%20Efforts/Alameda_County_Area_Plan_Final.pdf



“I have a lot more confidence that the numbers you have given me will come through with something as opposed to just nothing. You’ve been most helpful with the numbers I’ve called. You are very knowledgeable with what you do.”

“The slides, feedback, and discussion in today’s training was great. This session provided much needed information with effective presenters and active participation from the attendees.”

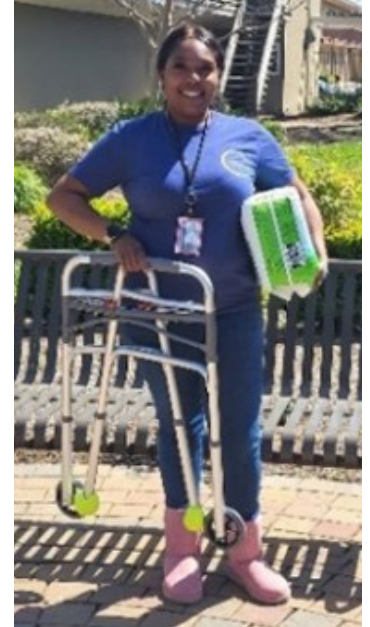
Reducing Racial/Ethnic Health Disparities

We provide culturally-relevant whole person coordinated care, which includes Goals of Care conversations, advocacy, and linkages to health care and/or community resources to increase our clients’ access to the social determinants of health. Also, we raise awareness about the importance of Advance Directive (AD) form completion as a health equity strategy, particularly among people of color. With AD, we empower our clients to get the care they want and restore their trust in the healthcare system.

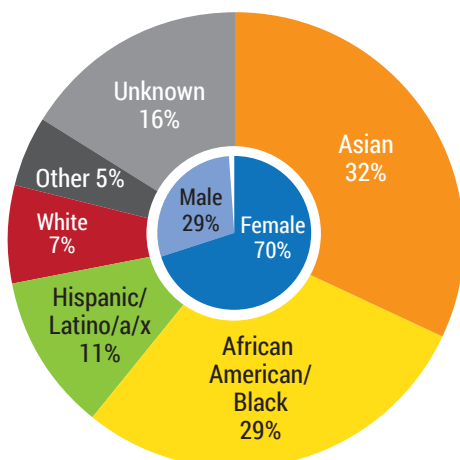
“Thank you for all your support, Care Partners. You all are important to me in understanding all the benefits you provided. You all are all awesome, and I’m grateful for you all.”

During the COVID emergency response many of the services were transformed into a “virtual visit” model. These practices proved so successful that they were continued after the emergency declarations ended, including:

- » Provide education to clients on vaccination updates, mandates, and physical distancing;
- » Link clients to free testing and vaccines, including linking homebound elders to in-home vaccine services;
- » Increase client access to digital resources, connecting them to their medical providers and preventing isolation.



POPULATION SERVED



THE ROAD AHEAD

- Expand community-based services for older adults with chronic conditions and people with disabilities through broader collaboration with service providers, including alternative healthcare providers.
- Broaden the reach of CalFresh enrollment efforts among older adults in Alameda County.
- Connect eligible non-English speaking older adults to government benefits and programs that will improve their wellbeing.
- Expand the Community Outreach Worker team through collaboration with CalWORKs to expose future leaders to Alameda County departments and programs.



ACCOMPLISHMENTS



15

Nail salons
certified
within the
County since
July 2021.



More than

100

nail salons have received
additional guidance on safer and
healthier nail care products and
practices in nail salon settings
through the program's weekly
outreach efforts.



More than

60

nail workers trained and
certified.

Over

80%

are Vietnamese immigrant women.



7

ventilation
units
distributed to
qualified nail
salons.

The Healthy Nail Salon staff participated in a Vietnamese-language talk show hosted by a representative from the California Healthy Nail Salon Collaborative on April 8, 2023, to promote the program and to raise awareness of toxic chemicals and safer alternatives. The talk show was on KTSF 26 and now is available on YouTube at youtu.be/SHR1b6cy3L8.

Alameda County's Healthy Nail Salon program collaborated and formed strong partnerships with several other counties, including San Francisco, San Mateo, and Santa Clara, and the State Department of Public Health, as well as the California Healthy Nail Salon Collaborative.

THE ROAD AHEAD

- As we continue to grow the program, we will increase the number of certified nail salons in the County by at least five per year.
- We will explore a collaboration with the Alameda County Green Business Program to recruit more nail salons for both programs and to help those salons already in the Healthy Nail Salon program become recognized as Green Businesses.

NUTRITION SERVICES

WHAT WE DO

The [Nutrition Services](#) program advances health and racial equity by promoting healthy eating and physical activity opportunities and by providing positive, meaningful healthy messaging to reduce chronic disease and improve long-term health. We do this through committed community partnerships and combined efforts leading to sustainable policy, systems, and environmental (PSE) change. In addition, we offer two seasonal healthy messaging campaigns to raise awareness and connect communities to resources about the benefits of drinking water and healthy snacking.

This year, we continued to adapt our offerings to be safe, comfortable, and accessible as community needs shifted due to COVID. As disaster service workers, 80% of nutrition services staff returned from COVID deployment, yet we maintained connected to our communities. We turned to social media for healthy messaging including short Harvest of the Month recipe reels; we turned to Zoom to offer online workshops and classes if they couldn't be in person; in-person classes were held in outdoor/indoor spaces for ventilation and safety as restrictions were lifted, and we used WhatsApp, text, and traditional phone calls to stay in touch with participants.

In July 2022, our menu of programs and services expanded to include the Diabetes Prevention program. This brought our public health nutritionists, nutrition assistants, and administrative and managerial team together to expand Diabetes program offerings and plan for continued growth.

ACCOMPLISHMENTS

Cooking for Health Academy (C4HA)

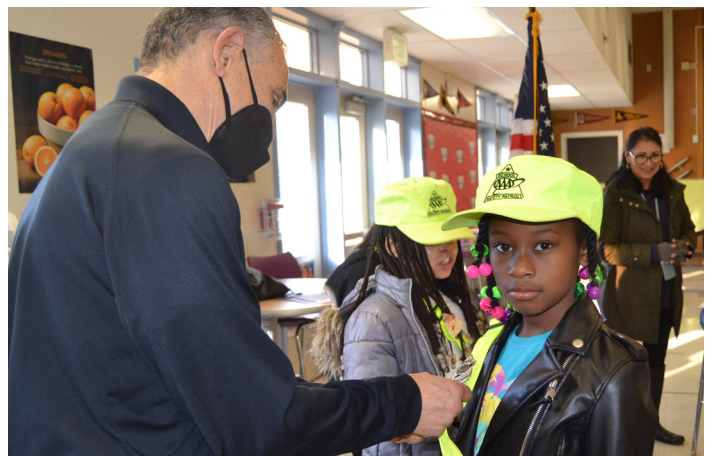
The C4HA is a comprehensive, six-class series designed for adults of all ages who may have limited time and/or funds to learn and practice ways to provide healthful meals for themselves and their families. Each class strives to increase participants' nutrition knowledge, as well as their cooking and food safety skills.

This year, 84 adults participated in five series of

classes. Of these, 55 graduated and 39 obtained their California Food Handler Certification, and three Resident Champions served as co-educators.

Participants in these classes typically report an increase in consumption of a wider variety of both fruits and vegetables. Participants also experienced less food insecurity as they did not run out of food by the end of the month as often. Also, participants reported an increase in reading the Nutrition Facts food label on food packaging.

Active Transportation Program (ATP) and Safe Routes Partnership



Nutrition Services has partnered with the City of Oakland Department of Transportation, the Oakland Unified School District (OUSD), and the nonprofit partner Transform for over ten years to cultivate a culture of traffic and pedestrian safety, in addition to building public health and youth leadership in and around school neighborhoods.

This year, Active and Safe Oakland supported families who came back strong as they walked and rolled safely to schools. Priority schools included those located in “disadvantage communities” designated by the California Transportation Commission through the U.S. Department of Transportation.

- ✓ 280 3rd–8th grade students led 14 Automobile Association of America (AAA) Oakland School Safety Patrols at OUSD elementary and middle schools
- ✓ Three Safety Patrol Awards were granted from AAA Northern California, Nevada, and Utah region.

Early Childhood Education (ECE) Support

Nutrition Services supports ECE sites to create, pass and implement nutrition and physical activity policies and best practices.

It also provides teachers a chance to learn fun and interactive ways to teach healthy eating habits. The program reaches preschool students, their families, and staff. With this year's partner sites, 13 staff and 87 students experienced the Discover MyPlate program and has committed to reviewing their wellness policies.



Older Adult Program and Support



Bingocize is an evidence-based program combining Bingo with nutrition education and physical activity. The program encourages increased time spent exercising, strengthening workouts, and intentional movement. Bilingual English/Chinese classes reached 144 older adult participants, including low-income residents, residents at senior centers, and those living in six affordable senior housing sites.

School and Youth Partnerships

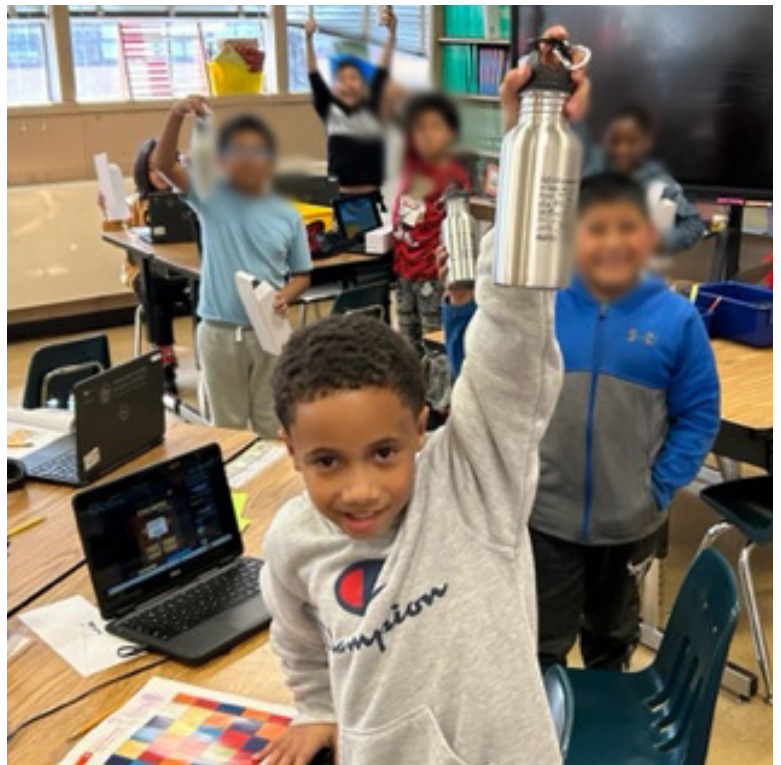
Alameda County Nutrition Services (ACNS) partners with schools, local recreation and community centers, and community-based organizations to expand youth experiences in nutrition, cooking, gardening, and healthy messaging. These strategies have led to effective policy, systems, and environmental changes.

- ✓ One school district provided local and seasonal produce served as part of school meals, grown in school gardens, and tasted in cafeterias, classrooms, afterschool programs, gardens, and more. Hands-on garden learning takes place at school sites.
- ✓ Another school district featured youth and adult promotores(as) where high school youth promotores(as) learned ways to live a healthy life and share learnings with their peers.
- ✓ Summer programs at local recreation centers included a special Rethink Your Drink day with fresh fruit infused water and water games! Nutrition Services presented Rethink Your Drink at eight sites.

Rethink Your Drink Month of Action in May

We bring the state Rethink Your Drink campaign to Alameda County to encourage choosing healthy beverage options, raise awareness and ways to identify sugary drinks, and make the connection between sugar sweetened drinks and impact on one's health. Rethink Your Drink also invites local change towards improved access, affordability, and desirability of healthy beverages. May celebrated:

- ✓ 22,000 water bottles distributed throughout two school districts thanks to a grant from the Wilma Chan Legacy Fund
- ✓ 2,158 reached at live events.
- ✓ 30-day social media campaign
- ✓ 28 live events and two billboards.
- ✓ 14 champions tabled at community events.



Nutrition Services promotes healthy messaging. Staff and champions participate in community organized events and were at 22 events this year. Nutrition education, physical activity, and recipes were also shared via 40,000 Harvest of the Month calendars distributed throughout the county that includes nutrition tips translated in four languages.

- ✓ 6,900 residents were reached (estimate).
- ✓ 20 days of social media healthy messaging.
- ✓ 47+ sites and partners including 20 County Nutrition Action Partnership organizations, eight Healthy Retail program stores, seven Oakland Park and Recreation Centers, six schools, three churches, and three senior public housing sites.
- ✓ Eight champions hosted local events.
- ✓ Two proclamations by the City of Oakland and the Alameda County Board of Supervisors



- Bring a new Active Transportation Program, “Oakland Making Moves,” to 13 affordable housing sites encouraging safe walking, rolling, and wellness to healthy neighborhood places led by youth, adult, and older adult residents.
- Celebrate ethnic foods by offering a community reviewed, multicultural cookbook with taste-tested recipes in partnership with Alameda Alliance for Health.
- Partner with five locally-based organizations in priority communities to provide nutrition education, physical activity, and policy, systems and environmental change to youth and the broader community.

A donut chart illustrating the distribution of race/ethnicity and gender among respondents. The chart is divided into seven segments representing different racial and ethnic groups, with a central circle showing the gender distribution.

Race/Ethnicity	Percentage
Hispanic/Latino/a/x	30%
African American/Black	25%
Asian	12%
White	8%
Other/Unknown/Mixed Race	21%
*2%	2%
**2%	2%

Gender Distribution (Center):

Gender	Percentage
Male	40%
Female	60%

**American Indian &/or Alaskan Native

NUTRITION SERVICES: DIABETES

“

Originally, I wanted to know the specific foods to avoid, and now I realize I can eat a variety of foods and make adjustments.

”

WHAT WE DO

The Alameda County Public Health Department [Diabetes](#) program is recognized by the American Diabetes Association and provides diabetes self-management classes, support groups, and informational newsletters to improve the health of residents 18 years and over diagnosed with pre-diabetes and type 2 diabetes.

This year brought changes to the program location, program partners, and the delivery format. The Diabetes program moved from Eastmont Mall to Telegraph Avenue in Oakland to become part of the broader Nutrition Services program. This move has yielded improved coordination, information exchange, and peer support between nutritionists in both programs and support from nutrition assistants and administrative staff.

ACCOMPLISHMENTS

This year we developed new partnerships with the county Social Services Agency's In-Home Support Services, Tri-Valley City Serve in Pleasanton, and Emeryville Senior Center to provide Healthy Living with Diabetes presentations and cooking demonstrations for over 110 clients and staff of those organizations.

The program also delivered Diabetes Self-Management Education (DSME) classes to 61 residents with diabetes or pre-diabetes and held 39 diabetes support groups (in-person and virtual) that served over 370 participants throughout Alameda County.



“

The class was the best that I have attended. I loved that it explained how the pancreas works and so much more.

”

As a result of participating in DSME classes:

- ✓ 94% improved their Hemoglobin A1c or maintained a reading under 7.0%, a key measure of well-controlled blood sugar;
- ✓ 80% improved their blood pressure or maintained a BP under 140/90;
- ✓ 79% lost weight or maintained their weight.

Diabetes Newsletter New Look

The Diabetes program produces a monthly newsletter that is mailed to over 400 Alameda County residents. This year, the newsletter got a makeover and features Harvest of the Month highlights, articles, recipes, and upcoming classes and support groups.

THE ROAD AHEAD

- Increase outreach through health fairs and community contacts with the program's peer educator volunteers and through new partnerships to improve participation in classes.
- Provide training opportunities for peer-educators in partnership with Project Dulce.
- Increase access to physical activity and healthy food and cooking classes and looking forward to adding Spanish language classes working with the Nutrition Services Team.

NUTRITION SERVICES: HEALTHY RETAIL

“The coupons are getting customers to ask for more variety and to buy produce instead of soda and chips. Customers appreciate that they have received something free and want to return the favor by coming back.

—Akram Dallaq, Dallaq's store owner

”

WHAT WE DO

The [Healthy Retail](#) program offers small store owners effective interventions promoting fresh produce and healthier food options that increase food access to residents in underserved neighborhoods. The team provides nutrition education to customers and owners alike with incentives to display and promote Harvest of the Month, Healthy Snack Day, and Rethink Your Drink. The Healthy Retail program uses a variety of strategies to advance health and racial equity. Key to these strategies are collaborations with store owners of different cultural backgrounds to offer diverse fruits, vegetables, healthy snacks, and water. We work primarily with small, neighborhood stores in areas far from supermarkets. This work includes supporting small store owners to remove unhealthy advertisements and increase health messaging to create a welcoming environment for residents. In-store or virtual events that include culturally-relevant cooking demonstrations, fruit-infused water taste tests, and healthy snack options have proven effective in bringing more residents into the store. Finally,

collaborating with neighborhood groups/associations such as the Yemeni Grocer's Association and Children's Hospital have helped to increase overall awareness of the importance of making healthy foods accessible in neighborhoods with otherwise limited access to fresh fruits and vegetables.

ACCOMPLISHMENTS

- ✓ Recognized as a Promising Practice by the National Association of County and City Health Officials.
- ✓ Engaged and supported 23 stores, a 155% increase from 2018.
- ✓ Reached over 9,000 community members through retail activities that included: receiving \$5 produce coupons; displaying Harvest of the Month bulletin boards with recipes at selected stores; receiving education and taste tests at Healthy Snack and Rethink Your Drink events; and Children's Hospital medical residents received education on nutrition labeling and shopping healthfully to share with their clients.
- ✓ Eight resident champions hosted Healthy Snack Day and Rethink Your Drink events at eight stores.
- ✓ With store owners, co-designed the Produce Coupon Pilot Initiative offering coupons to residents living near partner stores to purchase fresh produce.



THE ROAD AHEAD

- Explore working with community Healthy Retail Champions to play an active role in promoting health and wellness in neighborhood stores.
- Support local health initiatives by working with community-based organizations to improve the food system to ensure residents have access to affordable, healthy foods.
- Increase the number of stores with healthy options in the unincorporated area of Alameda County in partnership with All In Alameda County.

OFFICE OF DENTAL HEALTH

WHAT WE DO

The [Office of Dental Health](#) (ODH) works to improve the oral health of Alameda County residents by:

- » Connecting residents to dental care
- » Providing preventive dental services at schools and WIC sites
- » Building capacity of dental and medical providers
- » Expanding the oral health workforce
- » Collaborating with community partners

ACCOMPLISHMENTS

School-based Dental Sealant Program

- ✓ Provided preventive dental services at 11 elementary schools in Berkeley Unified School District and two schools in Livermore Valley Joint Unified School District.
- ✓ Delivered oral education through group presentations to 721 students.
- ✓ Conducted dental screenings for 357 students
- ✓ Applied fluoride varnish on teeth to prevent tooth decay for 302 students.
- ✓ Placed dental sealants on permanent molars of 107 students to protect the chewing surfaces of these teeth from tooth decay.
- ✓ Performed teeth cleaning for 131 students.
- ✓ Collaborated with UCSF Dental Public Health Residency Program and Oakland Unified School District to successfully pilot a first-of-its-kind toothbrushing program in three early childcare classrooms.

“A wonderful collaboration for our third-grade students... who otherwise would not have gotten care or received free sealants to prevent future decay and problems. This has allowed students to remain in school and thrive.

—Catherine Arthur, RN, PHN, MSN, Livermore Valley Joint Unified School District, Credentialed School Nurse



National Oral Health Month (February 2023)

- ✓ Provided oral health education to 579 elementary school students across four school districts
- ✓ Conducted 13 oral health presentations and five outreach events at Early Childcare Centers and Elementary schools

WIC Dental Days

- ✓ Provided anticipatory guidance and oral health education to 283 parents.
- ✓ Performed oral health assessments for, and applied fluoride varnish to 211 children.
- ✓ Referred 193 children for dental care coordination.

Care Coordination

- ✓ 651 children and youth were enrolled in care coordination and saw a dentist for a total of 1,137 appointments. Of these, 473 were for children age 0–5 years.
- ✓ 28 pregnant people were referred and enrolled in care coordination to establish a dental home.

“Thank you so much again for everything. I got my tooth fixed last Thursday, and it's been well so far. I think I will have a follow up appointment with the dentist sometime this week.”

“ I am very grateful for your help. My child was able to have his dental emergency taken care of very soon. Your reminder texts and calls helped me remember to take my son to his appointments. Thank you very much!

”

Medical Dental Integration and Workforce Capacity Building

- ✓ Conducted six CE training courses with UCSF for 357 dental professionals
- ✓ Provided oral health and fluoride varnish application training to five medical clinics, and 86 medical professionals

“ Great presentation. My younger daughter was using a pacifier till age 6. Should’ve had this CE before...

—Dentist attendee of the CE course, “Oral Habits in Children and How to Treat Them” (April 8, 2023)

”



“ Great presentation. Useful tips and strategies to help us talk to patients about tobacco cessation.

—Dentist attendee of the CE course, “Practical Strategies for Implementing Tobacco Cessation in Dental Settings” (February 22, 2023)

”



Community Engagement

- ✓ Reached out to 2,201 residents through community events.
- ✓ Distributed 3,624 dental outreach materials through outreach events, oral health presentations, internal and external partnerships

State Pregnancy Demonstration Project

- ✓ Launched the Pregnancy Demonstration Project in collaboration with State Office of Oral Health
- ✓ Conducted an environmental scan to assess existing services provided to pregnant people in the County and identify current policies and programs enabling those services

THE ROAD AHEAD

- Expand the School-Based Dental program to other school districts
- Expand the scope of preventive services to include pregnant and post-partum clients
- Develop an assessment report to identify barriers to care for pregnant people
- Establish a new contract to continue the Community of Practice program
- Provide trainings to Head Start for toothbrushing program

OLDER ADULTS HEALTHY RESULTS

“

I've always been healthy and self-reliant. Never expected to need public assistance. Even when I was in the hospital and my friends and family shared [that] they didn't expect me to pull through, I was able to recover and have the determination to keep going. Though it is hard to accept help, I need it now, and my [OAHR] case manager makes it so much easier.

”

WHAT WE DO

The [Older Adults Healthy Results](#) (OAHR) program provides intensive home-visiting nurse case management to older adults 60+ who are having trouble managing complex health conditions due to psychosocial challenges. The heavy burden of chronic disease in the OAHR client population reflects larger societal trends that disproportionately impact communities of color and recent immigrants. By developing care plans that prioritize client values, facilitate healthcare access, and link isolated clients to available resources, OAHR combats intersecting systems of ageism and racism that negatively impact our older adult communities and lead to premature functional decline.

OAHR's primary goals are to:

- » Keep people living at home as long and as safely as possible
- » Improve function and support independence
- » Strengthen services that support health and wellbeing
- » Improve quality-of-life

WHO WE SERVE

Many of our clients are unable to use safety net services that rely heavily on telephonic means of communication and service delivery. They require in-person services provided by trained nurses who understand the complex interplay of medical and psychosocial needs. Our services are free to all Alameda County residents who qualify based on income, medical complexity, and functional status.

Many of the clients we take care of are:

- » Very low income
- » Extremely socially isolated
- » Medically fragile
- » Struggling with cognitive, hearing, and/or visual impairments
- » Facing language and cultural barriers
- » Experiencing premature onset of chronic disease and functional decline influenced by social determinants of health
- » At high risk of nursing home placement

“

Can everyone get their own nurse? I mean someone like you who REALLY listens and CARES. My daughter had a stroke and I want her to have a nurse to help her like you have helped me.

”

Our caseload includes clients who speak English, Spanish, Cantonese, Mandarin, ASL, Vietnamese, Korean, Tagalog, and Japanese. OAHR utilizes both on-site and telephonic interpreters so that all referred clients are ensured the clear and accurate communication necessary for high quality, equitable service.



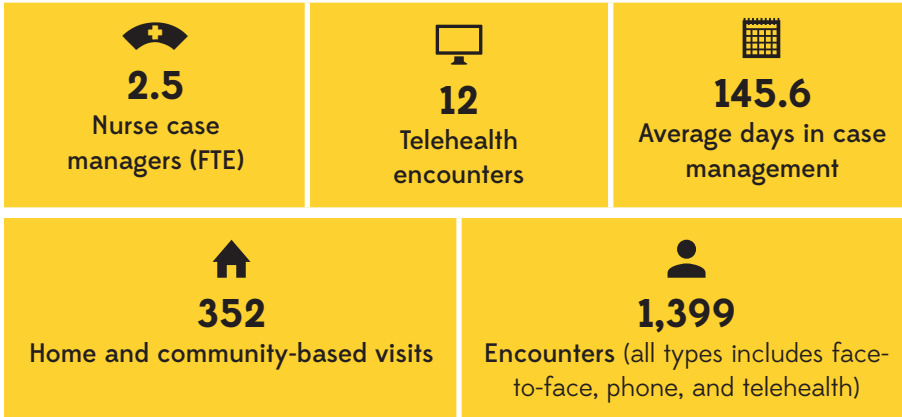
“

So thankful for being connected to public benefits and services—CalFresh, Medi-Cal, IHSS and having a CM [case manager] who understands me (language and culturally).

”

ACCOMPLISHMENTS

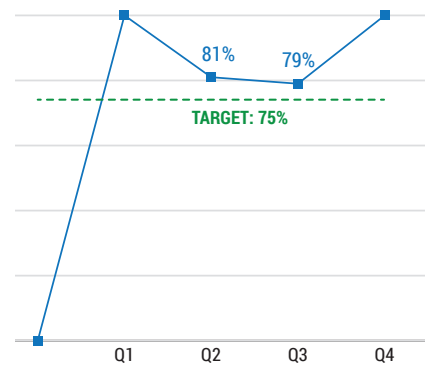
- ✓ Restarted OAHHR services after a two-year closure due to full-time deployment of public health nurses to the COVID response.
- ✓ Provided intensive, “high touch” services:



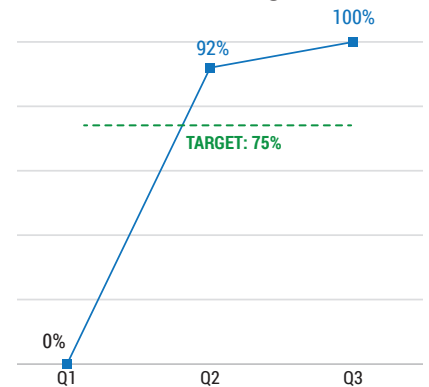
- ✓ Provided in-service presentations to all Social Service Agency, In-Home Social Service (IHSS) units to reach the County’s 25,000 IHSS clients.
- ✓ Provided over 15 in-service presentations to partnering CBOs who provide senior services to our target population.
- ✓ Expanded language capacity and cultural competency by adding a bilingual, Cantonese speaking nurse and a bilingual Spanish speaking Community Health Outreach Worker (CHOW) to the team.
- ✓ Rebuilt a robust referral network across healthcare and community safety net providers.
- ✓ Implemented data tracking in Community Health Record for improved care coordination.



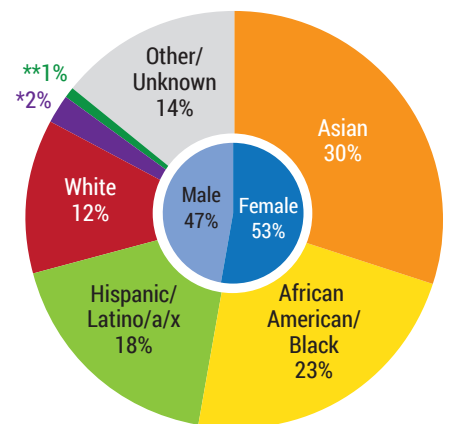
Percent who reduced fall risk after intervention



Percent who met or partially met quality of life goals



POPULATION SERVED



*Native Hawaiian &/or Other Pacific Islander

**American Indian &/or Alaskan Native

THE ROAD AHEAD

- Continue to expand our reach across the County.
- Outreach to agencies that serve Spanish speakers to reach more Hispanic/Latino/a/x elders.
- Improve communication with healthcare partners by gaining access to electronic health records systems.
- Find our niche alongside CalAIM; fill in gaps in care and reach clients who may fall through the cracks of larger managed care driven systems.

TOBACCO CONTROL

MISSION

Advancing health and racial equity by reducing tobacco use and exposure through effective policy solutions and community partnerships.

WHAT WE DO

The [Tobacco Control](#) program promotes community health by reducing exposure to second and thirdhand smoke, and preventing residents, primarily youth, from wanting to start smoking in the first place. This past year we focused on two key strategies:

- » Education about advancement and enforcement of policies that reduce youth access to flavored tobacco products; and
- » Creating smokefree, multi-unit housing.

FLAVORED TOBACCO

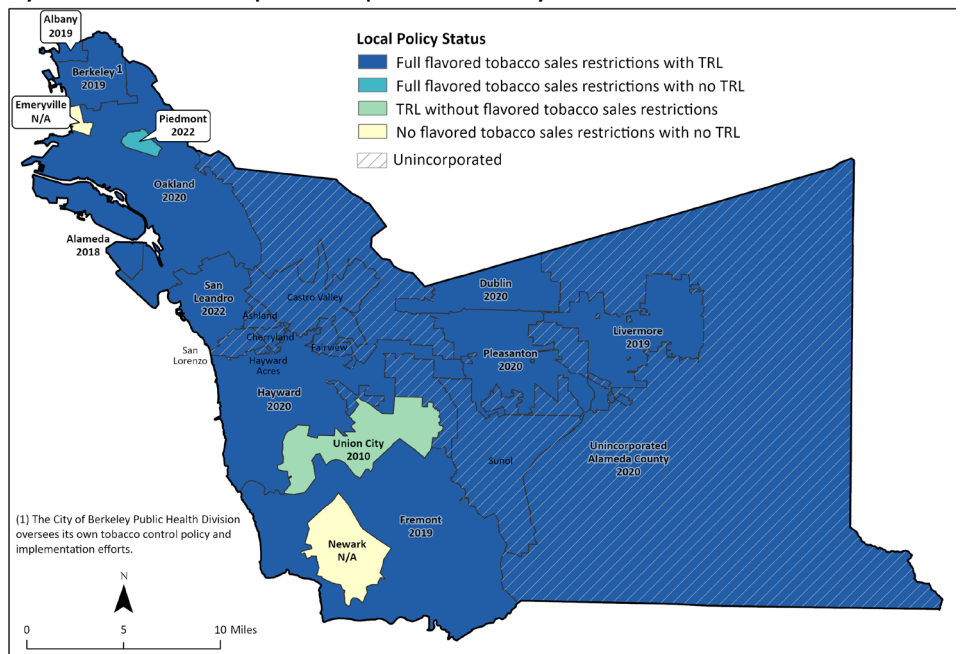
The Problem: The tobacco industry continues to seek ways to circumvent state and local laws that prohibit the sale of flavored tobacco products by introducing new ambiguously labeled products.

ACCOMPLISHMENTS

- ✓ Developed a flavored tobacco product identification protocol that includes a smell test in an effort to provide accurate technical assistance (TA) to enforcement officials. This “first in the state” protocol is serving as a model for other counties.
- ✓ Convened quarterly workgroup meetings to support tobacco retail enforcement officials in all 15 jurisdictions, plus provided over 160 hours of policy implementation TA to enforcement agencies.
- ✓ Provided educational materials on new statewide flavored tobacco law to enforcement officials across the County to support compliance by all 1,300 tobacco retailers.
- ✓ Created a model Flavored Tobacco Product Research Database that was then implemented by the California Tobacco Prevention Program.



Flavored Tobacco Sales Restrictions & Tobacco Retail Licensing (TRL) Policy Status By Jurisdiction with Adoption Year | Alameda County



SMOKE-FREE MULTI-UNIT HOUSING

The Problem: Drifting secondhand smoke in multi-unit housing (residential buildings with two or more units) impacts the health of **all** residents in the building. This smoke disproportionately affects young children, seniors, and those with severe medical conditions. Thirdhand smoke, the smoke that remains behind on clothing, carpet, walls, and in the air, also impacts residents of multi-unit housing long after the secondhand smoke clears. Low-income communities of color are more likely to live in multi-unit housing and be exposed to drifting smoke in their homes. Residents in multi-unit housing often have limited resources to address secondhand smoke issues.

ACCOMPLISHMENTS

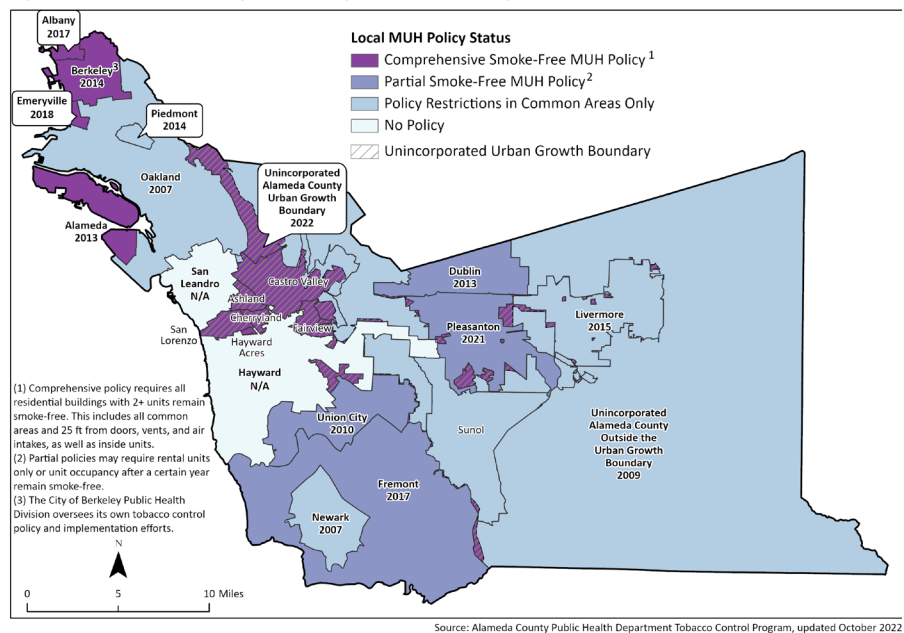
Implemented the Alameda County Unincorporated Area's Smoke-free Multi-Unit Housing Ordinance, which went into effect on July 1, 2022, in partnership with Code Enforcement. The ordinance covers the communities of Ashland, Cherryland, Fairview, Hayward Acres, San Lorenzo, and Castro Valley. In total:

 55,224 homes educated on the new law	 50 complaints received from residents	 87 warning letters sent
---	--	--

 20 cases resolved	 0 people evicted for smoking violations	 6 cases forwarded to Code Enforcement for fines
---	--	--

In addition, 25 complaints from the City of Hayward and six complaints from the City of San Leandro were received from these two jurisdictions without a smoke-free multi-unit housing ordinance.

Smoke-Free Multi-Unit Housing (MUH) Policy Status By Jurisdiction with Adoption Year | Alameda County







SMOKE FREE

To protect residents from secondhand smoke, smoking is prohibited in multi-unit residences in the Unincorporated Areas of Alameda County starting on **July 1, 2022**.

Con el fin de cuidar la salud de los fumadores pasivos, fumar en las residencias de unidades múltiples de las áreas no incorporadas del condado de Alameda estará prohibido a partir del **1 de julio de 2022**.

The law applies to multi-unit residences in Unincorporated Areas of the County: including Ashland, Cherryland, Fairview, Castro Valley, and San Lorenzo. (Ordinance No. O-2022-5.)

A multi-unit residence is housing with two or more units, including apartments, townhomes, condominium complexes, senior and assisted living facilities, long-term health care facilities, and hotels and motels.

A multi-unit residence does not include single-family homes with an accessory dwelling unit or junior accessory dwelling unit and mobile homes in a mobile home park.

This means no one is allowed to smoke:
Esto significa que a nadie se le permite fumar:

1) Inside their unit
Dentro de su unidad

2) On ANY balconies, patios, porches & decks
En NINGUNA balcon, patio, porche o terraza

3) In ANY indoor common areas*
En NINGUNA área común interior*

4) In ANY outdoor common areas*
En NINGUNA área común exterior*

- La ley se implementará en residencias de unidades múltiples en áreas no incorporadas del condado. Las áreas donde se implementará la ley son: Ashland, Cherryland, Fairview, Castro Valley y San Lorenzo. (Ordenanza N° O-2022-5.)
- Una residencia de unidades múltiples es una vivienda que posee dos o más unidades, es decir, apartamentos, casas adosadas, complejos de condominios, instalaciones para la asistencia de personas mayores, instalaciones de asistencia médica a largo plazo, hoteles y moteles.
- No se considerarán residencias de unidades múltiples a las viviendas unifamiliares con una unidad de alojamiento auxiliar o con una unidad de alojamiento auxiliar pequeña, ni tampoco las casas rodantes que permanecen en un estacionamiento de casas móviles...

THE ROAD AHEAD

- Outreach to Hayward residents to ensure that their voices are heard as Hayward City Council gathers information for drafting a proposed Smoke-free Multi-Unit Housing Ordinance
- Continue conversations with stakeholders to determine how a possible ban on the sale of all commercial tobacco products might be passed and implemented
- Engage residents in south Alameda County to strengthen tobacco retail policies to protect vulnerable populations.

WOMEN, INFANTS AND CHILDREN (WIC)

WHAT WE DO

The [WIC](#) program provides nutrition education, breastfeeding support, and referrals to needed services provided by other community organizations for pregnant people and families with young children. Research has shown that the WIC program plays an important role in improving birth outcomes and containing health care costs. The United States Department of Agriculture (USDA) published a series of reports that prenatal WIC participation for low-income women resulted in:

- » Longer pregnancies
- » Fewer premature births
- » Lower incidence of moderately low and very low birth weight infants
- » Fewer infant deaths
- » A greater likelihood of receiving prenatal care

In addition, the USDA reported that every dollar (\$1.00) spent on prenatal participation in WIC reduced health care costs by \$1.77 to \$3.13 within the first 60 days after birth.

Alameda County WIC has two additional programs that support new parents and their infants' nutritional needs:

Breastfeeding Peer Counseling (BFPC) Program

BFPC is a veteran program that has existed since 2003, at the forefront of Breastfeeding Promotion. It has created policies, promotions, and protocols that have advanced breastfeeding in a positive direction for two decades. Our BFPC program is funded by USDA, through the California Department of Public Health (CDPH). Peer counselors provide breastfeeding support and encouragement to pregnant and new parents, regularly check in with parents to see how breastfeeding is going, and help parents understand their baby's cues (i.e., sleep, hunger, cry). The BFPC program supports breastfeeding mothers to achieve their infant feeding goals.

Regional Breastfeeding Liaison (RBL) Program

Support hospitals, community health centers, healthcare providers, childcare programs, and other community partners to ensure quality breastfeeding care for all.



“

I am thankful to WIC for helping us during these difficult times.

”



Thanks for all your help and support Allana I'm bigger

Super sweet and cute 🥰💕

And you are so very welcome!

ACCOMPLISHMENTS

- ✓ 21,201 unduplicated participants were served this fiscal year via phone, video, and in-person appointments.
- ✓ \$14,415,565 worth of WIC benefits were spent at local grocery stores.
- ✓ Issued \$75,000 worth of Farmers' Market vouchers for seasonal fresh fruits and vegetables.
- ✓ Collaborated with Help A Mother Out to distribute 524,300 diapers.
- ✓ Collaborated with the Office of Dental Health and offered dental screenings on site at four WIC locations.
- ✓ Offered formula flexibilities during the formula shortage; participants were able to purchase non-contract WIC formulas.
- ✓ With a grant from CDPH, WIC was able to expand services to purchase 9,950 books for distribution to children ages 0–5 years on WIC.
- ✓ 93% of WIC participants surveyed are satisfied with the services they received from WIC staff.

BFPC Accomplishments

- ✓ Hired and trained three new peer counselors
- ✓ Provided breastfeeding support to over 2,700 new parents
- ✓ Issued and ordered breast pumps to moms in need
- ✓ Conducted lactation consults to WIC parents

“

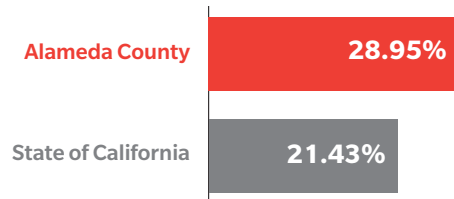
WIC has been amazing and extremely helpful.

”

THE ROAD AHEAD

- Resuming depression screenings for pregnant and postpartum women as well as developmental screenings for children ages 6 months to 5 years old.
- Expanding access to WIC services in the Tri-Valley area.
- Addressing client participation barriers and adjusting to new technology that can be used by WIC staff will be our immediate focus.
- Continuing to strive for the best participant outcomes, quality work, and customer service.
- Creating new and strengthening existing partnerships with community organizations and other Public Health Department programs will continue to be a focus of the WIC program.

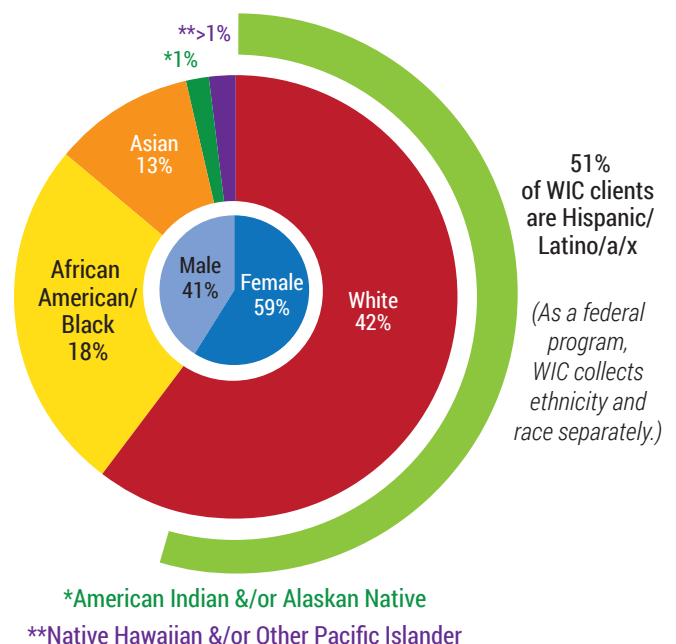
BREASTFEEDING RATES

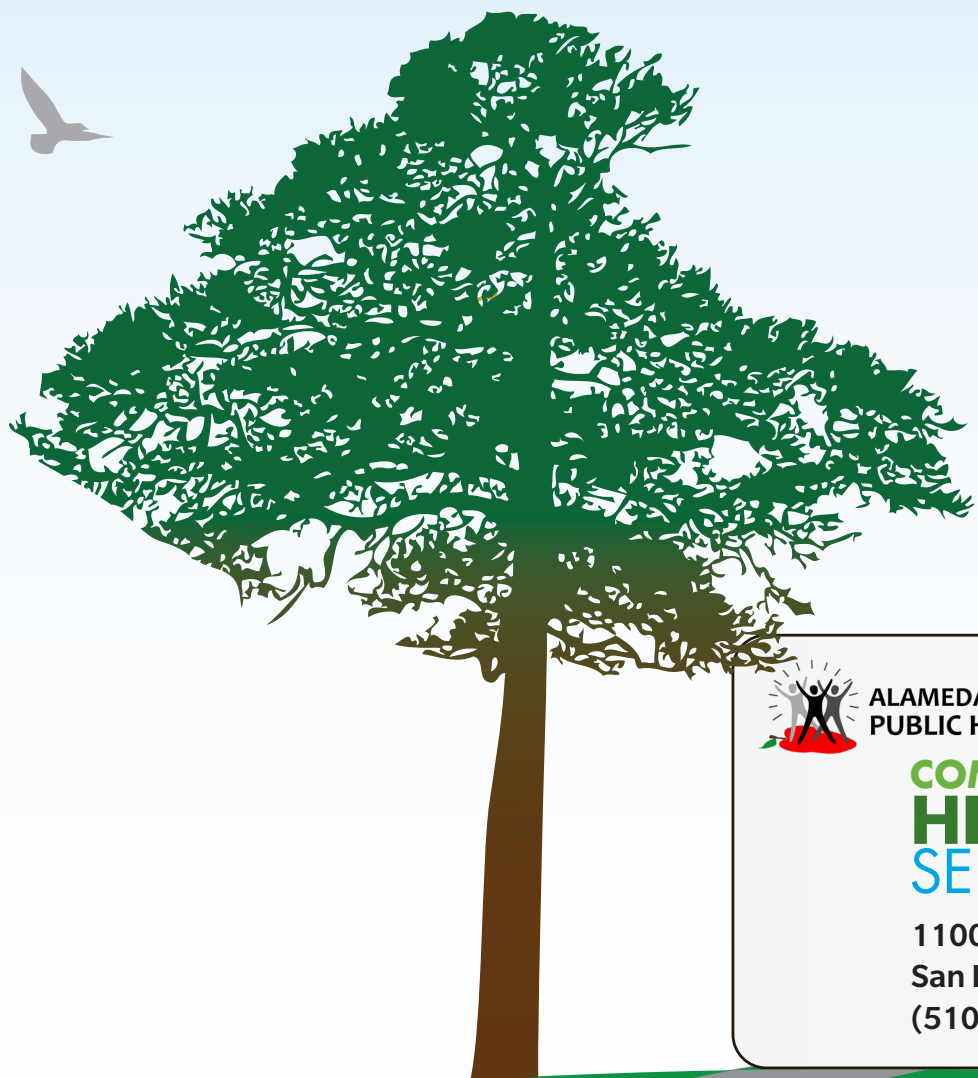


RBL Accomplishments

- ✓ Trained over 260 Hospital Care Providers on California Model Hospital Policy requirements providing technical assistance to all perinatal hospitals in Alameda County.
- ✓ Trained over 250 Health Care Providers in essential infant feeding assessment and breastfeeding counseling skills.
- ✓ Led development of and training in new Epic Electronic Health Record Infant Feeding Assessment with all community health centers, providing guidance within the patient chart for assessing breastfeeding, care plan management, and referrals.
- ✓ Designed and implemented a new WIC Enrollment brochure to facilitate enrollment in all local WIC agencies.
- ✓ Serves as the Alameda County Breastfeeding Coordinator, supporting shared leadership in the County Breastfeeding Coalition activities, such as inclusive professional development mentorship and creation of social media toolkits and the county breastfeeding website ACBreastfeeds.org.

POPULATION SERVED





ALAMEDA COUNTY HEALTH CARE SERVICES AGENCY
PUBLIC HEALTH DEPARTMENT

COMMUNITY
HEALTH
SERVICES

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