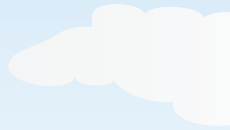




**Public Health
Department**

Alameda County Health



COMMUNITY HEALTH SERVICES DIVISION 2023-2024 ANNUAL REPORT



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I. INTRODUCTION

In fiscal year 2023–2024, the Community Health Services (CHS) Division moved forward with bold new campaigns and initiatives, as well as further refinements to our existing programs and services. Within the larger Public Health Department, CHS is focused on strategic approaches to address chronic disease—which continues to be the leading cause of death and disability, both nationally and in Alameda County. CHS offers a comprehensive array of programs, services, and initiatives to prevent and mitigate chronic disease, especially among populations who experience disparities in health outcomes.

We recognize that persistent disparities among our communities are most often driven by structural and institutional factors, including the effects of racism and discrimination and stigma tied to race, ethnicity, gender identity and expression, sexual orientation, and ability. Histories of discrimination, segregation, and disinvestment also contribute to many of the structural drivers of inequity, including differences in access to culturally and linguistically appropriate health care; insurance coverage and public benefits; healthy, fresh food; affordable, safe housing options; high-quality education and childcare; living wage and safe employment opportunities; transportation and public transit connections; and safe, livable, and accessible neighborhoods with clean air and safe green spaces and walking routes.

We operate within the context of Public Health 3.0, which calls on each local health department to serve as the chief health strategist for its jurisdiction. As such, we work closely with many community coalitions, advisory bodies, and workgroups to understand community needs and shape and refine systems to better meet them.

CHS STRATEGIES

Our work in CHS employs a spectrum of prevention strategies:

Healthy Communities, Systems & Environments



We engage in upstream approaches that change policies, systems, and neighborhoods to create communities where people can live their healthiest lives. Examples include our advocacy to ban smoking in multi-unit housing; our efforts to increase corner stores' uptake of more produce and fewer sugar-sweetened or alcoholic drinks; and our certification of nail salons that provide less-toxic alternative products and better ventilation to protect their workers and their clients.

Community Health Promotion & Prevention



Community outreach and health education efforts aim to prevent chronic disease through healthy nutrition and physical activity. We also seek to increase health literacy among residents so that they are better aware of steps they can take to manage and improve their own health—from monitoring their blood pressure to regular cancer screenings to advocating with their medical providers.

Health Navigation & Chronic Disease Supports



We partner with residents who are living with chronic conditions or caring for others with chronic illnesses to improve their quality of life and their health, through case management, patient navigation, and disease self-management education.

In keeping with Department, Agency, and County-wide priorities, CHS continues to center equity in all our programs. We work closely with the Community Assessment, Planning, and Evaluation (CAPE) and the Health Equity, Policy, and Planning (HEPP) units to ensure that our strategies and priorities are based on the most current data available and focus on those populations experiencing the greatest inequities. This data-driven approach informs CHS program planning and quality improvement efforts.



VISION, VALUES AND PROGRAMS

DIVISION VISION:

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

CHS MANAGERS' SHARED VALUES:

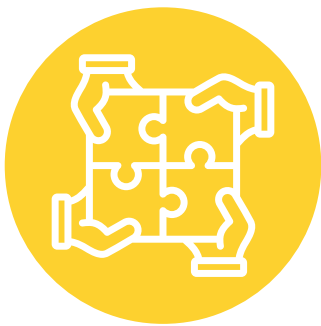


CHS PROGRAMS:

- ✓ ASTHMA
- ✓ CARE PARTNERS
- ✓ HEALTHY BRAIN INITIATIVE
- ✓ HEALTHY NAIL SALON PROGRAM
- ✓ NUTRITION SERVICES
(includes Diabetes Program and Healthy Retail)
- ✓ OFFICE OF DENTAL HEALTH
- ✓ OLDER ADULTS HEALTHY RESULTS
- ✓ TOBACCO CONTROL
- ✓ WOMEN, INFANTS AND CHILDREN (WIC)

This report highlights the CHS program accomplishments from fiscal year 2023–2024 as they relate to each of the major strategies listed on page 3, followed by a more detailed description of each CHS program.

II. ACCOMPLISHMENTS



**Healthy
Communities,
Systems &
Environments**



**Community
Health Promotion
& Prevention**



**Health
Navigation &
Chronic Disease
Supports**

ACCOMPLISHMENTS: HEALTHY COMMUNITIES, SYSTEMS & ENVIRONMENTS



Implementing and sustaining equitable improvements in population health necessitates creating conditions and environments that support optimal health for everyone. This section explores how Community Health Services (CHS) programs are fostering healthier communities by reshaping policies, systems, and environmental factors to enhance health outcomes. CHS programs collaborate with elected officials, schools, small businesses, and strategic partners to better coordinate services and transform environments that impact the health of priority populations. Through a diverse array of targeted programs, CHS is actively working to build and sustain these vital community health improvements.

STRATEGIES FOR BUILDING HEALTHY COMMUNITIES, SYSTEMS, AND ENVIRONMENTS:

- » **Public Health Policy Development** focuses on identifying health priorities, setting goals, and creating guidelines and regulations to promote health and prevent disease.
- » **Systems Change** includes integrating health promotion and prevention strategies into healthcare settings, schools, workplaces, and communities. Systems change efforts often aim to improve access to healthcare services, enhance the quality of care, and address disparities in health outcomes.
- » **Advocacy and Mobilization** efforts may involve grassroots organizing, coalition building, media campaigns, and engagement with policymakers to promote policies that support public health goals.
- » **Monitoring and Evaluation** involves collecting and analyzing data on health outcomes, healthcare utilization, policy implementation, and population trends to inform decision-making and policy adjustments.

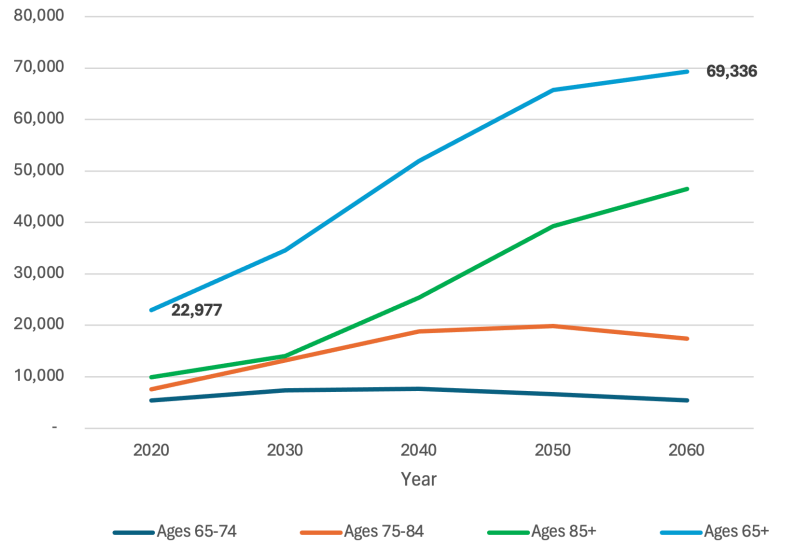
THE ASTHMA PROGRAM has recently been officially recognized as a CalAIM provider by Alameda Alliance for Health, a health plan within California's Medi-Cal program. CalAIM is an initiative aimed at enhancing and innovating Medi-Cal services across the state, with a focus on improving care delivery and coordination for Medi-Cal beneficiaries. With this new status, the program can now receive direct referrals from CalAIM and secure authorization for their services through the health plan. Additionally, this recognition enables the program to incorporate home modifications into their Medi-Cal-funded programming. These modifications are designed to enhance clients' living conditions, ensuring their homes are safe and supportive for effective asthma management.



THE HEALTHY BRAIN INITIATIVE has been actively involved in assessing and addressing Alzheimer’s disease and related dementias (ADRD) across the County’s diverse communities. Staff collaborated with the Alameda County Public Health Department’s Community Assessment, Planning, and Evaluation (CAPE) team to compile a comprehensive Community Needs Assessment. The program also worked with CAPE to analyze qualitative data from key informant interviews, focus groups, and listening sessions with community members and service providers. The findings were shared with internal and external partners for feedback, and the Strategic Plan was submitted to California Department of Public Health on June 30, 2024.

Plan priorities include: 1) Training health, social service providers and family care givers on addressing the unique needs of the growing number of older adults with ADRD, and 2) Incorporating the needs of adults with ADRD into emergency plans at the city and county levels in Alameda County.

Projected Number of People Living with Alzheimer’s Disease, Related Disorders, or Senile Dementia, Alameda County



THE HEALTHY NAIL SALON PROGRAM has made significant progress in improving working conditions in nail salons. By equipping qualified salons with advanced ventilation units featuring adjustable arms, they can effectively target the specific areas where chemicals are used, particularly during artificial nail services. This exhaust ventilation system has the potential to cut chemical exposure for both workers and customers by at least 50%. Additionally, the program has reached over 150 nail salons across the County, providing vital information on toxic cancer-causing chemicals, guidance on safer nail products, and other safety protocols. Three new salons achieved Healthy Nail Salon Certification in 2023–2024, switching to products with less harmful chemicals and receiving personal protective equipment, including nitrile gloves, goggles, and N-95 masks.

The program continues to work closely with other Counties’ Healthy Nail Salon Program (HNSP) coordinators, the State-level Healthy Nail Salon Program (Department of Toxic Substances Control), and the California Healthy Nail Salon Collaborative to share experiences, information, updated legislation, and together make key policy decisions to create a healthier and safer salon environment for both workers and customers.

Alameda County’s HNS staff attended to the Health Is Beauty workshop hosted by Santa Clara County’s HNSP, which focused on workplace violence prevention (nail salon setting) and California Safe Cosmetics Program. Guest speakers were from Santa Clara County’s HNSP, CA Healthy Nail Salon Collaborative, and CA Department of Public Health.



CA Department of Public Health, Alameda County’s HNSP, San Francisco’s HNSP, Santa Clara’s HNSP, and CA Healthy Nail Salon Collaborative.

NUTRITION SERVICES (NS) has a variety of programs focused on making healthy foods more accessible in local neighborhoods. The Healthy Retail program has engaged over 9,000 community members through a variety of retail activities. These included distributing \$5 produce coupons, setting up Harvest of the Month bulletin boards with recipes at select stores, offering education and taste tests at Healthy Snack and Rethink Your Drink events, and providing nutrition labeling and shopping tips to Children’s Hospital medical residents for sharing with their clients. They have also supported stores in removing and replacing alcohol and beer signs with healthy food items.

In December 2023, Alameda County was notified of funding for four refrigeration units that were given to General, Dallaq, Wah Fay, and Jalos local markets. Three other partner stores, Rancho, A&G, and Model Mart were awarded new freezer/refrigerator units with the help of Green Biz, for a total of seven Alameda County partner stores.

Former refrigeration recipient Royal Market now has produce delivered weekly and reports sales have increased with the help of two refrigeration units located at the front of the store.

NS has also concentrated on developing and implementing health and wellness policies in schools, working with the Oakland Unified School District (OUSD) and San Lorenzo Unified School District (SLZUSD). This effort has led to initiatives such as “Harvest of the Month” taste tests at all OUSD schools and the creation of school gardens in SLZUSD.

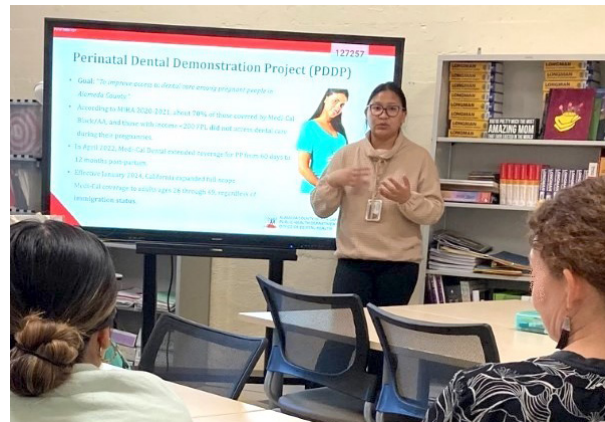
OUSD has introduced a revised health and wellness policy this school year that emphasizes a whole-child approach and aims to eliminate inequities. This policy has significantly increased students’ access to locally sourced, seasonal produce through educational taste tests and opportunities to grow produce in school gardens, thanks to the expansion of the Harvest of the Month program. Additionally, OUSD has expanded salad bars to over 75 schools, integrating these with nutrition education and school garden programs under the Harvest of the Month initiative.

The OUSD Harvest of the Month program has garnered recognition from the California Department of Public Health (CDPH) and will be featured in a video showcasing exceptional programs and success stories.

Nutrition Services has also impacted environmental sustainability. Gardens were sustained and continue to grow at Satellite Affordable Housing Associates (SAHA) sites even after CalFresh Healthy Living Funding ceased. SAHA secured funding and resources to support the 21 edible gardens that were installed in partnership with Nutrition Services. Persimmon trees were planted at 20 OUSD school sites. SLZUSD had a produce stand at an elementary school and a food pantry was established at the new Family Resource Center.



THE OFFICE OF DENTAL HEALTH (ODH) has made significant strides in integrating medical and dental practice and building workforce capacity. As part of the Perinatal Dental Demonstration Project, ODH has focused on transforming dental care for pregnant and postpartum individuals and their babies. This past year, ODH launched an initiative to integrate dental care as a standard component of prenatal services. By training prenatal care providers, ODH is raising awareness of the critical role dental care plays during pregnancy and its positive impact on children’s oral health. The training is tailored specifically for prenatal care staff and includes strategies for addressing oral health needs of pregnant individuals and infants. Additionally, ODH is collaborating with Women’s Health Clinics to establish a streamlined referral process, ensuring patients are connected to dental services and that utilization is monitored.



In a statewide effort to ensure that all children receive an oral health assessment before starting school, ODH, in collaboration with a dedicated group of stakeholders, established the Kindergarten Oral Health Assessment (KOHA) Committee. ODH staff have compiled baseline data on school district and student participation rates in oral health assessments. This data is guiding the committee in developing strategies to effectively engage schools and school districts to boost participation and impact. The committee plans to launch its campaign this fall.

ODH has enhanced its education and mobilization efforts through the Alameda County Community of Practice (COP). This year, the COP organized a series of Continuing Education training courses in collaboration with the Alameda County Dental Society, benefiting 228 dental professionals. The training covered essential topics such as oral health care during pregnancy, special needs dentistry, and behavioral management of young children in dental settings. Additionally, the COP provided Maternal Oral Health and Fluoride Varnish Application training to six medical clinics and 45 medical professionals. This private and public partnership is unique and the first of its kind aimed to increase the knowledge and confidence of general dentists to treat ODH priority populations.



THE WIC REGIONAL BREASTFEEDING LIAISON (RBL) PROGRAM

collaborated with La Clínica de La Raza San Antonio to pilot an evidence-based infant feeding assessment and care coordination initiative. This program, designed to promote breastfeeding through provider training, has supported hundreds of breastfeeding families in their critical early days, significantly improving both breastfeeding outcomes and the quality of care. Due to its success, this model is now being replicated across healthcare settings throughout Alameda County. Additionally, RBL worked with hospitals and clinics to streamline messaging and enrollment procedures for WIC. By co-creating and distributing a multilingual brochure in five languages, the initiative has led to over 1,400 new enrollments this year.

This past year RBL supported Alta Bates Baby Friendly designation with effective technical assistance for the Baby Friendly Taskforce and Baby Friendly Education Committee.

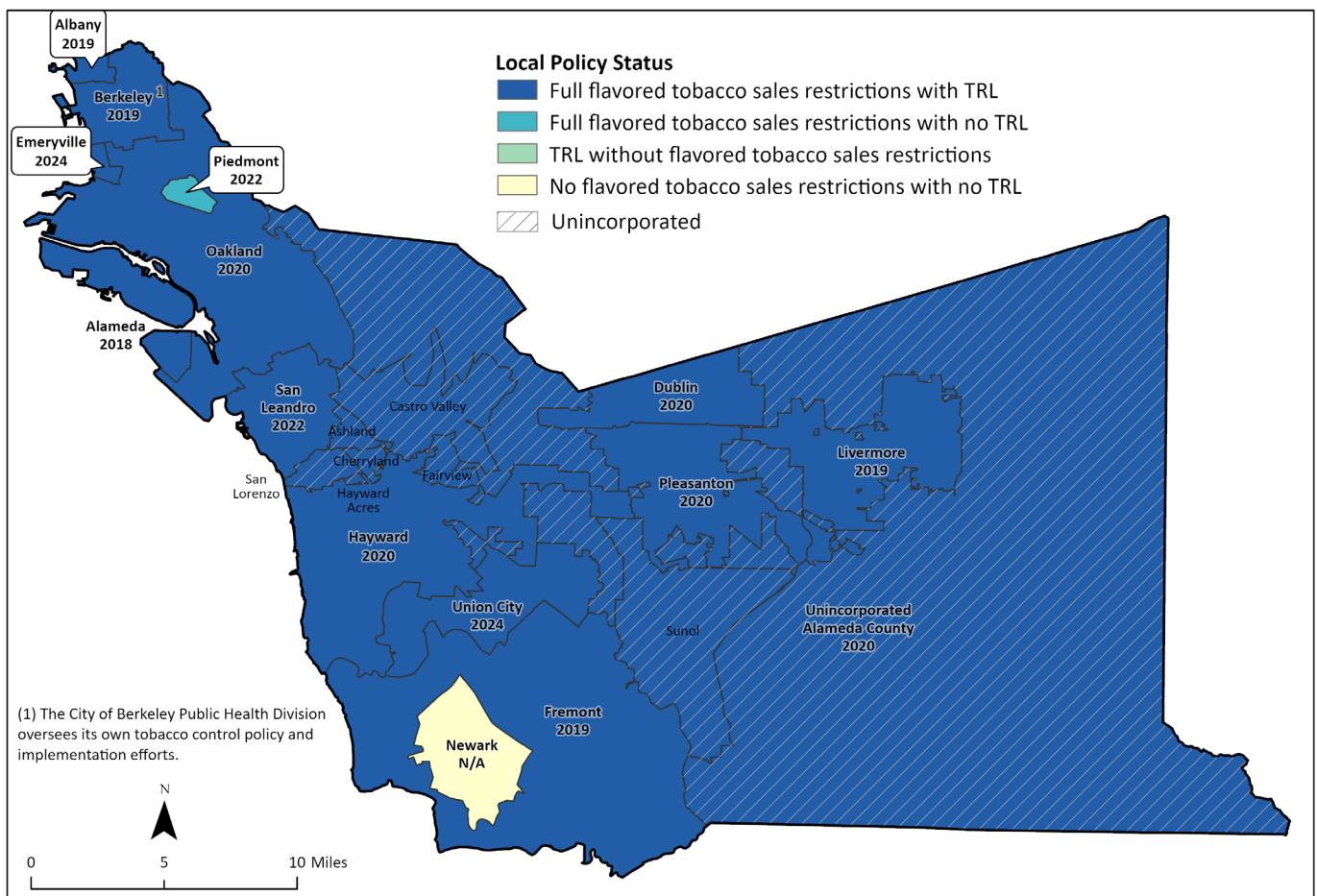
“ RBL is an invaluable help in our journey to Baby Friendly, and has helped us to connect with our WIC teams in Alameda County to improve our partnership to meet patient needs... ”

THE TOBACCO CONTROL PROGRAM (TCP) concentrated on advancing policy development, advocacy, and mobilization this year. Partnering with concerned residents and community-based organizations, TCP has delivered comprehensive education on tobacco control policies in Emeryville and Union City.

In Emeryville, these efforts culminated in the City Council adopting a new tobacco retail licensing policy. This policy includes several key provisions designed to hold retailers accountable for adhering to local, state, and federal tobacco sales laws and to reduce youth access to tobacco products.

Additionally, TCP continued to organize the Alameda County Tobacco Retail Enforcement Network (ACTREN) on a quarterly basis. ACTREN facilitates the sharing of information, best practices, and cross-jurisdictional partnerships among tobacco retail enforcement agencies throughout Alameda County. This network has expanded to include participants from various Bay Area and Southern California counties, enhancing collaboration and support. Through ACTREN, the program has also provided crucial assistance to enforcement officials in addressing ambiguously labeled tobacco products.

LOCAL TOBACCO RETAIL LICENSING ORDINANCES (TRL) WITH YEAR OF ADOPTION



Source: Alameda County Public Health Department Tobacco Control Program, updated April 2024.

CHS PARTICIPATION IN COMMUNITY COALITIONS

CHS could not achieve its goals without the active engagement of a diverse array of stakeholders—including local organizations, businesses, government agencies, and community members. CHS programs convene as well as participate in a broad range of coalitions, work groups, task forces and councils to tackle common issues and achieve shared goals.

CARE PARTNERS

- » Palliative Care & Hospice Providers Coalition
- » Alameda County Age Friendly Council
 - Embracing Aging Sub-Committee
- » 2024 Adult Protective Services Multi-disciplinary Team Meeting
- » Senior Injury Prevention Program Meeting (CBOs & County Agencies)
- » Older Adult Provider Meeting (ACBH & CBOs)
- » Roundtable Meeting (AAA & CBOs)

HEALTHY BRAIN INITIATIVE

- » Alameda County Age Friendly Council
 - Data Sub-Committee
 - Embracing Aging Sub-Committee—serves as HBI Advisory Board
- » Alameda County Access and Functional Needs Advisory Committee

HEALTHY NAIL SALON

- » California Healthy Nail Salon Collaborative

NUTRITION SERVICES

- » Alameda County Nutrition Action Partnership (CNAP)
- » Bay Area Nutrition and Physical Activity Collaborative (BANPAC)
- » Alameda County Diabetes Community Advisory Council
- » CalFresh Healthy Living Equity Strategic Framework, Local Advisory Council, Stewardship Committee
 - CalFresh Healthy Living Pilot Cohort FFY 2023–2024
 - San Lorenzo Unified Health and Wellness Committee Member
 - Hoover Neighborhood Senior Advocates via Oakland Making Moves, Active Transportation Program
 - Health and Human Resource Education Center Advisory Board

OFFICE OF DENTAL HEALTH

- » Community of Practice Coalition (COP)—workforce training for health providers.
- » Oral Health Committee of the Alameda County Public Health Commission
- » Early Childhood Workgroup
- » Homelessness Workgroup
- » Special Health Needs Dentistry Workgroup
- » Kindergarten Oral Health Assessment Committee

TOBACCO CONTROL

- » Alameda County Tobacco Retail Enforcement Network (ACTREN)
- » Alameda County Tobacco Control Coalition—policy advocacy

WIC

- » Alameda County Breastfeeding Coalition
 - Latina Chicana Lactation Task Force (LatCH)
 - Asian Southeast Asian Pacific Islander Taskforce (ASAP)
- » Regional Breastfeeding Liaison Steering Committee
- » California Breastfeeding Coalition
- » Fremont Resource Center Resources and Benefits Sub-Committee
- » Fremont Resource Center Executive Council
- » Bay Region WIC Directors
- » Breastfeeding Cultural Outreach Task Force (BCOT)

ACCOMPLISHMENTS: COMMUNITY HEALTH PROMOTION & PREVENTION



Community Health Promotion and Prevention is a vital aspect of CHS services, focusing on proactive strategies to enhance health and prevent disease within communities. CHS collaborates with County residents at all stages of life to actively involve them in identifying health priorities, planning effective interventions, and implementing strategic initiatives. The goals are to provide valuable information and resources that empower individuals and communities to make informed health decisions, promote positive health behaviors, and foster environments that support and encourage healthy choices.

STRATEGIES FOR COMMUNITY HEALTH PROMOTION AND PREVENTION:

- » **Empowerment and Participation:** Community health promotion emphasizes the active participation of community members in identifying health priorities, planning interventions, and implementing strategies. Empowerment involves building community capacity, fostering leadership, and promoting ownership of health initiatives to ensure sustainability and effectiveness.
- » **Education and Awareness:** Education is a cornerstone of community health promotion. Health education campaigns may focus on topics such as nutrition, physical activity, chronic disease prevention, mental health awareness, substance abuse prevention, and sexual health.
- » **Health Behavior Change:** Community health promotion aims to promote positive health behaviors and prevent risky behaviors through targeted interventions. This may include implementing programs to encourage smoking cessation, increase physical activity levels, improve diet quality, promote safe sexual practices, and reduce substance abuse.

THE WIC PROGRAM provided breastfeeding support and peer counselling, through regular check-ins to 5,100 parents to ensure breastfeeding mothers achieve their infant feeding goals. WIC counselors provided nutrition education to 71,800 unduplicated participants via phone, video, and in-person appointments. They provided participants with \$14 million worth of WIC benefits that were spent at local grocery stores, and issued \$112,500 of Farmers' Market vouchers enabling participants to purchase seasonal fresh fruits and vegetables.

They also collaborated with the Office of Dental Health offering dental screenings on site at four WIC locations and helped WIC participants acquire formula during this year's formula shortage. Additionally, through a partnership with Family Health Services Division (FHS), WIC screened 3,170 people for maternal depression.



THE OFFICE OF DENTAL HEALTH (ODH) carried out a range of educational and prevention oriented clinical activities throughout the community and in schools. They engaged over 5,661 community residents through 28 outreach events. They provided presentations and trainings on oral health to 21 organizations serving ODH priority populations, in addition to a CE course on dental care during pregnancy with the local Dental Society. They offered 13 oral health education workshops to community members and trained 122 parents of young children and pregnant individuals. They also conducted oral health education for 754 elementary school and high school students at Parenting Teens Program sites.



The ODH Clinical Program provided various preventive and diagnostic services including conducting dental screenings for 261 students, applying fluoride varnish to 220 students, placing dental sealants on the permanent molars of 65 students, performing teeth cleanings for 105 students, and applying fluoride varnish to 109 infants' and children's teeth to prevent early tooth decay. They also provided anticipatory guidance and oral health education to 120 parents of young children and conducted dental assessments and provided fluoride varnish applications to 33 pregnant and postpartum clients. During National Oral Health Month, ODH provided oral health education to 742 elementary school students across four school districts and 12 high school Parenting Teens Program sites, and gave 10 Oral Health presentations and participated in 12 outreach events conducted at Early Childcare Centers and elementary schools.

HEALTHY BRAIN INITIATIVE (HBI) staff actively collaborated with both internal and external partners across Alameda County to ensure that their Strategic Plan reflects the needs and experiences of individuals living with dementia and their caregivers, as well as the organizations that support them. As part of this effort, HBI organized four listening sessions with community members who care for loved ones with Alzheimer's disease and related dementias (ADRD), and conducted 15 key informant interviews with County and community partners. Additionally, HBI worked with the California Department of Public Health to successfully launch the state's Alzheimer's awareness media campaign, TakeOnAlz, which was attended by representatives from 15 agencies, received extensive media coverage and was featured in multiple news stories.



Lisa Gonzales, Communications & Prevention Lead, California Department of Public Health Alzheimer's Disease Program; Claudia Landau, PhD, MD, Chief of Geriatrics and Palliative Care Emeritus and consultant to Alameda Health System; Jessie Spivey, Director of Elder Services, Oakland LGBTQ Community Center; Jenny Wang, MPH, MPP, Director, Community Health Services Division, ACPHD; Taunuu Ve'e, Co-Chair/Co-Founder, Regional Pacific Islander Taskforce and Director, Taulama for Tongans; David K. Johnson, PhD, Professor in Neurology, UC Davis School of Medicine, Director, California Alzheimer's Disease Center-East Bay, and Principal Investigator, The Good Life Program for Healthy Aging; Nalleli Albarran-Cruz, Senior Manager of Senior Wellness, The Unity Council; Mercel Amin, Senior Manager of Community Outreach and Engagement, Alzheimer's Association of Northern California/Nevada Chapter (East Bay)

NUTRITION SERVICES has led a variety of disease- and population-specific health education initiatives throughout the County.

The Happy Heart Campaign (HH) launched a comprehensive set of educational and outreach strategies to enhance heart health awareness and combat hypertension. Over the past year, the Campaign hosted 22 events, collaborated with 34 partners, and reached 1,015 residents. It provided event materials, virtual education, multilingual resources, and a simplified nutrition label guide. To promote regular self-testing, 350 free wrist monitors and blood pressure logs were distributed. HH utilized billboards, dedicated website pages, social media challenges, posters, and flyers to ensure that health behavior messages effectively reached the target audience.



Cooking for Health Academy (C4HA) is a six-class series designed for adults with limited time or financial resources to learn how to prepare budget-friendly, nutritious meals. C4HA saw a 50% increase in enrollment compared to last year, with 170 participants this year. Of these, 123 graduated, 83 (67%) earned their California Food Handler Certification, and five former graduates acted as Community Champions, serving as co-educators or assistants. Classes were offered in Spanish and English, both in person and virtually.



Bingocize combines Bingo with nutrition education and physical activity in an evidence-based program. It promotes increased exercise, age-appropriate strength workouts, and intentional movement. This year, participation grew by 25%, from 144 to 180 older adults. The program is available to low-income residents, those at senior centers, and individuals in affordable senior housing.

Oakland Making Moves (OMM) encourages physical activity through purposeful walks/rolls supporting residents of 13 affordable family and senior housing sites in their efforts to sustain a safe and welcoming environment. Program activities are funded by California Transportation Commission through September 30, 2025. Like the Healthy Retail Program, OMM has been met with challenges especially around safety in neighborhoods with concerns ranging from drug dealing and residents witnessing violence in broad daylight to inclement weather. Acting on walk audit findings, staff offer safe alternatives such as Bingo with physical activity or walking within the housing site to the garden.



The Diabetes Self-Management Education (DSME) Program

forged new partnerships with various community and faith-based organizations this year. Through these collaborations, the program delivered nine diabetes presentations to 239 participants and four hypertension presentations to 71 participants across the County. The program also conducted 11 DSME classes, which benefited 105 individuals managing diabetes or prediabetes. It also facilitated 36 diabetes support groups, both in-person and virtual, reaching a total of 371 participants throughout Alameda County. This year the program passed all audit requirements by the American Diabetes Association and gained their program recognition through 2026. The curriculum was translated into Spanish and Chinese, with plans to add more languages in the future.



Additionally, through dedicated County nutrition funding, contracted community-based partner organizations: prepared and distributed 4,300 meals cooked by Resident Leaders and delivered to community sites; offered 42 free six-week-long Cooking Matters classes, benefiting 625 low-income adults, children, teens, and families; conducted food demonstrations at six farmers' markets; and distributed \$1,356 in VeggieRx vouchers to 339 households.



CARE PARTNERS applies a health equity lens and approach to its diverse health promotion training and educational forums, empowering vulnerable populations to achieve equitable access to resources and improved health outcomes. This year, Care Partners hosted 14 in-person Advance Care Planning workshops to help older adults in Senior Centers and residential facilities to become aware of and create advanced health care plans, including developing directives for their future palliative, supportive, and hospice care. These workshops, delivered in languages including Spanish, Cantonese and others, reached 324 chronically ill and older adults, as well as staff from Social Services Agency, Public Health and other agencies throughout the County. They also offered monthly trainings on a variety of

wellness promotion and illness prevention topics, increasing knowledge and skills for 660 IHSS Recipients and Care Providers.

Care Partners outreach efforts included participation in 33 community health fairs and events where they had direct conversations with over 3,103 community residents, providing information on the program, rights to care, and available resources. Additional outreach efforts included giving short (10–15 min.) presentations in 182 IHSS daily orientation sessions and 90 Public Authority trainings. Presentations were given in English, Spanish, Vietnamese, and Chinese languages.

HEALTHY NAIL SALON program staff distributes informative handouts about choosing safer chemicals and practices, a list of recognized healthy nail salons in the County, and the impact of toxic chemicals on health during outreach and local health fair events. More than 75 nail technicians and 100 Alameda County staff have been trained in English and Vietnamese to protect themselves while working directly with chemicals, to choose healthier nail products and personal protective equipment, and to continue applying safer practices to maintain their wellbeing. The program also partnered with District 3 to participate in District 3's public events to meet more residents and raise awareness about toxic chemicals in nail products by distributing safety guidelines flyers and in-person training.



ACCOMPLISHMENTS: HEALTH NAVIGATION & CHRONIC DISEASE SUPPORTS



CHS Health Navigators assist individuals in overcoming various challenges by guiding them through the complexities of the healthcare system to ensure they access timely and appropriate care. CHS also offers comprehensive support for populations managing chronic diseases including disease management, patient education, self-management support, care coordination, and emotional and psychological support.

HEALTH NAVIGATION

Health navigation and care coordination are services that help individuals understand and access the healthcare system more effectively. Health navigators/care coordinators guide patients through the complexities of healthcare services, ensuring they receive timely and appropriate care.

Key functions include:

- » Information and Guidance
- » Coordination of Care
- » Connection to Resources
- » Advocacy for Needed Services
- » Client Education

CHRONIC DISEASE SUPPORT

Chronic disease support refers to the ongoing care and management provided to individuals with chronic illnesses, aiming to improve their quality of life, manage symptoms, and prevent complications.

Key strategies include:

- » Disease Management
- » Patient Education
- » Self-Management Support
- » Care Coordination
- » Emotional and Psychological Support

THE OFFICE OF DENTAL HEALTH enrolled 811 children and youth in care coordination, facilitating a total of 1033 dental appointments. Over 220 children aged 0-5, and 392 pregnant and postpartum individuals were enrolled in care coordination. Of the 226 pregnant and postpartum individuals that were scheduled appointments, 141 completed their first appointments for a show-up rate of 62%.



THE ASTHMA PROGRAM provided care navigation and asthma remediation services to children—and for the first time, adults—living with poorly controlled asthma. The longstanding pediatric Asthma Start program served 335 children and their families this year. Some of this work included developing individualized action plans to assist families in controlling their children’s asthma, collaborating with schools and day care providers to ensure that asthma medication is available for every child with asthma at the site, collaborating with medical providers at local hospitals and clinics to support quality care, and assisting families in accessing housing, employment, and health insurance. Participants also learned about asthma triggers, how to manage their child’s asthma, and how to administer medication. They received needed supplies, including HEPA vacuums and mattress covers and, when needed, were able to have minor home repairs conducted that assist with mitigating their asthma.

The program yielded impressive results. This year, prior to enrollment, 10% of the children served by Asthma Start had been hospitalized within the past 12 months. During their time in the program, this figure dropped to only 2%. Similarly, while 55% of the children had visited the Emergency Department in the year before joining the program, only 19% needed to visit the Emergency Department while participating. Furthermore, the Asthma Control Test, a validated assessment tool, revealed that 58% of the children initially had poorly controlled asthma. By the end of the program, this percentage decreased significantly, with only 10% of the children still having poorly controlled asthma.

The Adult Asthma Remediation program launched in February 2024, so program outcome data is not yet available for the adult participants in what is usually a 4-6 month intervention.

PRE-INTERVENTION		POST-INTERVENTION	
10%	of the children had been hospitalized 12 months before entering program.	2%	had been hospitalized while in the program.
55%	of the children had been in the Emergency Department 12 months before entering program.	19%	had been in the Emergency Department while in the program.
58%	of the children according to the Asthma Control Test (a validated test) were not in control of their asthma.	10%	would be considered not in control.
39%	scored 80% or higher on Asthma Knowledge test.	96%	scored 80% or higher on Asthma Knowledge test.

NUTRITION SERVICES’ Diabetes Self Management Education (DSME) program assisted over 476 individuals with managing their diabetes. As a result of participating in DSME classes: 90% improved their Hemoglobin A1c or maintained a reading under 7.0%, a key measure of well controlled blood sugar; 63% improved their blood pressure or maintained a BP under 140/90; and 75% lost weight or maintained their weight.

Quotes from DSME Class Participants:

“ I like how the class was geared to the needs of our group. ”

“ Great instructor, communicates clearly, reassuring, informative, and good at responding to questions. ”

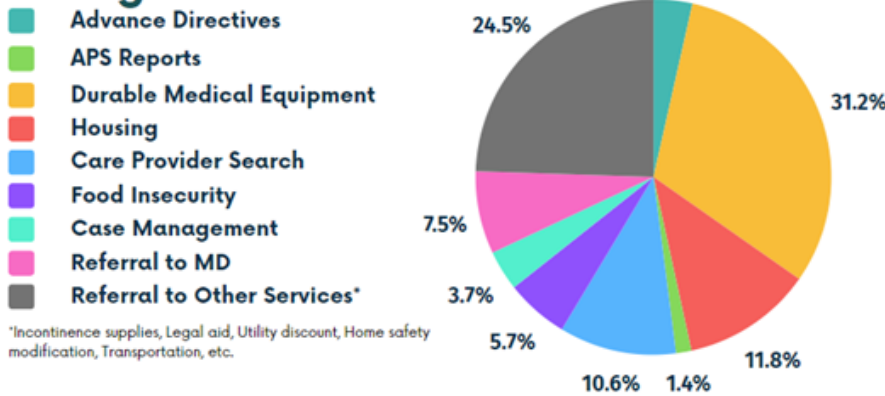
“ Enjoyed class! Instructors respected students at the level they were at. Appreciated the wholistic approach and specifically the medication chapter. ”

CARE PARTNERS, a multi-disciplinary team, connected 1,124 older adults with a specific focus on adults who speak languages other than English, to needed resources including health care, in home support services, durable medical equipment, adult protective services, adult care facilities, housing, and food resources among others. Over 99% of clients who completed Satisfaction Surveys “strongly agreed” that Care Partners’ compassionate and culturally responsive services increased their access to care, support, and resources.



Care Partners’ advocacy enabled this client to receive motorized transportation.

Care Partners Client Care Coordination Categories



OLDER ADULTS HEALTHY RESULTS provided intensive “high touch” home-visiting nurse case management for 101 older adult clients (60+) who have trouble managing complex health conditions due to psychosocial challenges. This comprehensive care includes interpreting information from various sources, prioritizing self-management strategies, navigating interactions with clinicians and healthcare systems, enhancing medication understanding, and helping patients integrate and act on different care recommendations.

CASE MANAGEMENT ACTIVITIES	
Cases	91
Consultations	85
Full time employees	2.5 nurses
Face-to-face encounters	380
Total encounters	1,270

FALL PREVENTION	
At-risk clients who received an individualized fall prevention interventions to reduce risk	96%
QUALITY-OF-LIFE	
Clients’ quality-of-life goals that were met or partially met	96%
LIVING AT HOME	
Clients who remained living safely in their home at the time of reassessment and/or case closure	94%

III. PROGRAMS

During the fiscal year 2023–2024, the CHS Division managed nine active programs:

- ✓ **ASTHMA**
- ✓ **CARE PARTNERS**
- ✓ **HEALTHY BRAIN INITIATIVE**
- ✓ **HEALTHY NAIL SALON PROGRAM**
- ✓ **NUTRITION SERVICES (includes Diabetes Program and Healthy Retail)**
- ✓ **OFFICE OF DENTAL HEALTH**
- ✓ **OLDER ADULTS HEALTHY RESULTS**
- ✓ **TOBACCO CONTROL**
- ✓ **WOMEN, INFANTS AND CHILDREN (WIC)**

The following sections provide a detailed description of the services offered by each active program, the populations they serve, and a snapshot of plans for the coming fiscal year.

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, the award-winning, research validated pediatric program, provides services to youth throughout the County. 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. Asthma Program 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.



New floor installed in home to reduce asthma triggers.

“ I loved the program. The info and supplies such as the air purifier were very helpful. Grateful for the program. ”



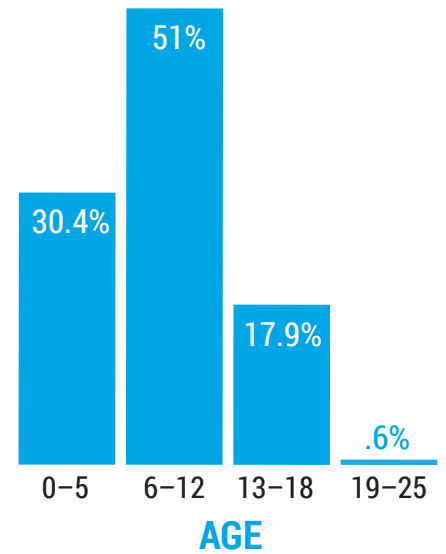
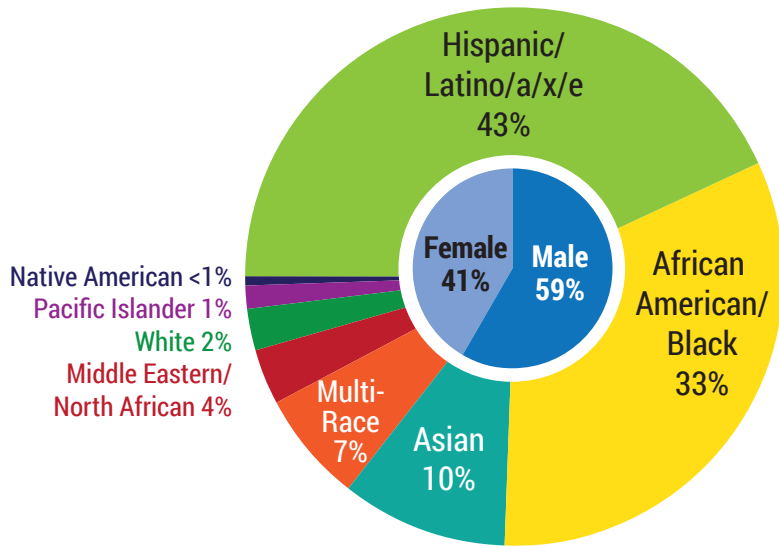
“ The air purifier was very helpful. My neighbor has a cat and the air purifier helps with those smells. Alexa was very informative and friendly and kind. ”

This year, the Asthma Program launched the Adult Asthma Program to serve adults aged 19–80+ years. They have partnered with the County's Public Health Nursing Division to serve as the first point of contact for the adults via the Division's Front Door program. This partnership allows skilled nursing staff to identify co-morbidities and other needs that the adult may have before embarking on asthma remediation. For adults who are Medi-Cal eligible, they too will have at their disposal a lifetime allotment of funds that can be applied to mitigation and remediation measures for the homes.

“ I had a very good experience in the program, and I learned a lot from the asthma worker. ”

POPULATIONS SERVED

The Asthma program serves children, youth, young adults, and adults throughout Alameda County. Between July 2023 and June 2024, they served 335 client families. Of these, 166 were carried over from last fiscal year and 169 clients opened new cases this fiscal year. (Adult clients are not reflected in the charts below.)



“ I felt respected, and I appreciate the simple way the worker explained things. ”

“ My worker was very helpful. We hope that the program continues to help more clients in need. ”

“ My worker helped me a lot, calmed me a lot, and gave me information. ”

THE ROAD AHEAD

- Expand the Asthma Program’s reach and shorten client waiting times by deploying a team of Asthma Specialists to interface with medical providers, schools, and families, and conduct outreach to underserved communities.
- Increase health promotion and awareness campaigns through new branding, participation in health fairs and events, and supporting new partnerships with community based organizations and Alameda County Health’s departments.
- The Adult Asthma Program will expand its relationship with the Alameda County Public Health Department’s Nursing Division’s Front Door program and the Alameda Alliance for Health to serve the adult Medi-Cal population through CalAIM.
- The Asthma Start Program will partner with UC Berkeley’s School of Public Health to provide educational services and environmental resources for Medi-Cal parents of children with uncontrolled asthma.

CARE PARTNERS

WHAT WE DO

Care Partners (CP) applies a racial equity lens to deliver holistic, supportive services using a non-medical, culturally competent and language-specific approach. CP seeks to eradicate inequities in access to quality healthcare and social services among the County’s older adult populations and their caregivers. CP serves In-Home Supportive Services (IHSS) Recipients and Care Providers, and low-income older adults, and/or people living with disabilities.

Through home or remote visits, CP conducts biopsychosocial assessments, identifies issues related to the social determinants of health, and provides care coordination services with appropriate information, resources and referrals on clients’ unmet needs. CP’s educational training and emotional support are designed to help reduce suffering and build client knowledge, skillsets, and empowerment to live their best quality of life. CP intentionally recruits and develops linguistically and culturally competent team members, including university student interns, CalWorks employees, Pathways fellows, and community champions to improve care delivery and contribute to workforce diversity in their culture/ language specific communities.

CP also participates in community outreach events to promote awareness of program services, available



resources, and Advance Care Planning to help community members document the kind of care they want and ensure their medical wishes are known in case they cannot speak on their own behalf.

The Care Partners program maintains a [website](#) that includes a program introduction, resources and Advance Care Planning information.

BUILDING SUSTAINABLE PARTNERSHIPS

To build relationships, reach more clients, and collaborate to help mutual clients get connected to needed resources, CP works with: **Health Systems**, such as Highland, Stanford, and Kaiser; **Internal County programs**, such as IHSS, Adult Protective Services, Workforce & Benefits Administration, and the Area Agency on Aging; and **Community Based Organizations**, such as Food Bank and DayBreak Adult Care.

Referrals stemming from these relationships allow CP to support many older individuals to access both health and social supports that are available.

CLIENT REFERRALS RECEIVED	
Health Systems/Medical providers	23
Internal County programs	256
Community Based Organizations	21

CP also convenes and facilitates the Palliative Care and Hospice Provider Coalition. This forum allows these organizations to share resources, information, and collaborate with health providers and health systems, as well as to create access to care options for elders who are facing the ends of their lives.

CP engages Veteran community champions and community men’s groups to reach more men.

TRAINING AND EDUCATION

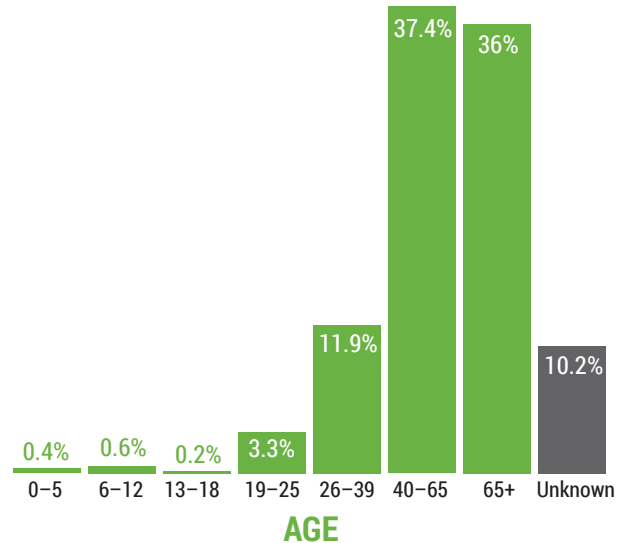
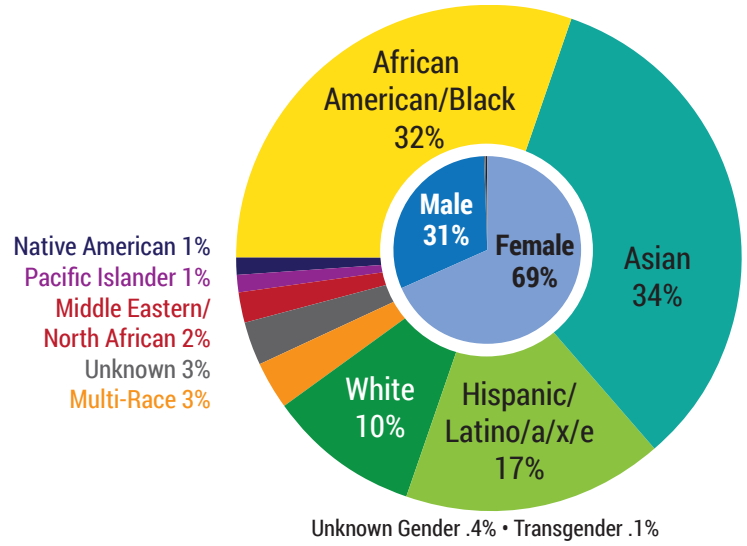
CP provides education and conducts trainings on a variety of topics for IHSS care providers who need support and training to enhance their caregiving skills:

- ✓ Loneliness, Isolation and Friendly Visitor Program
- ✓ Capacitación Digital Nivel Básico/Basic Digital Training (Spanish)
- ✓ Doula: Companionship, Comfort and Guidance to Those Facing a Terminal Illness or Death
- ✓ Tips For IHSS Care Providers Who Care for People With Complex Needs
- ✓ 提前護理計劃 (Advance Care Directive—Cantonese)
- ✓ Holiday Self-Care and Free Resources
- ✓ Financial Literacy: It's Not How Much Money You Make, It's What You Keep!

Classes are given regularly through IHSS training forums, as well as in residential facilities and senior centers on request.



POPULATIONS SERVED



THE ROAD AHEAD

- Create new training opportunities for students.
- Implement new client database.
- Design and adopt an evaluation strategy to assess the impact of CP model on quality of life for older adults.
- Secure sustainable funding to meet the growing demand for CP services.

HEALTHY BRAIN INITIATIVE

BACKGROUND

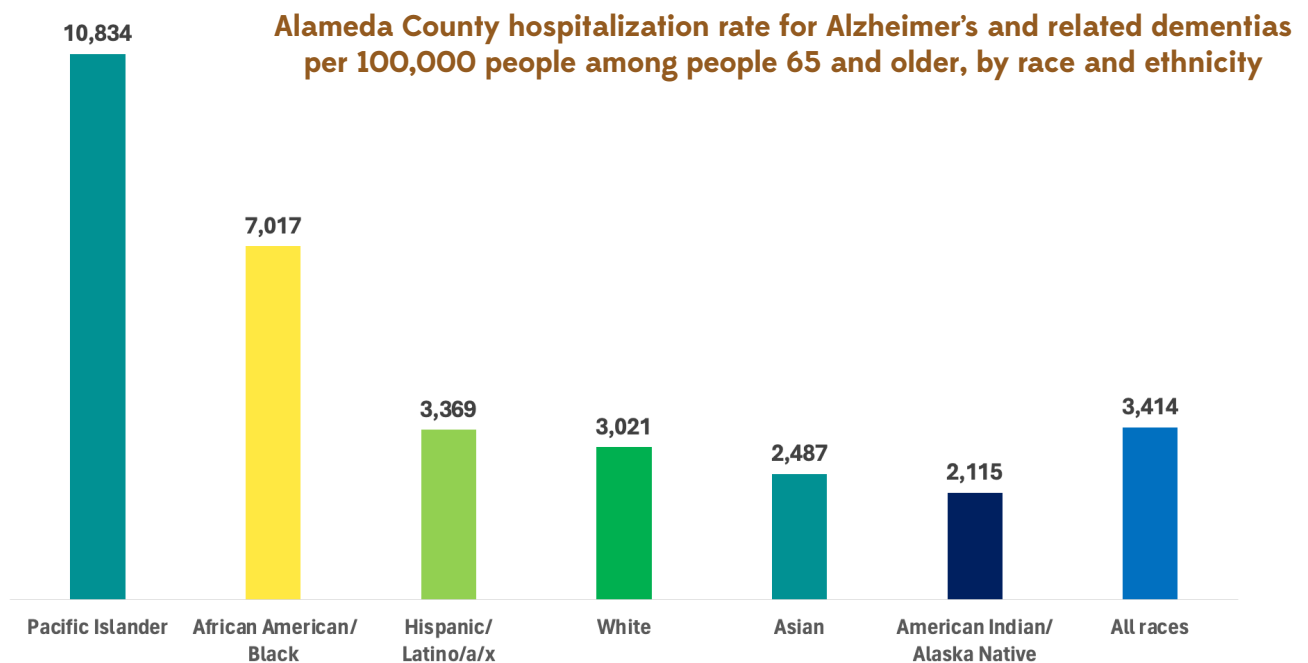
Alzheimer’s Disease and Related Dementias (ADRD) are chronic diseases that deeply affect Alameda County residents, and prevalence is rapidly increasing. ADRD was the third leading cause of death among people ages 65 and older in Alameda County in 2021. This age group is the fastest growing age group in the County and comprises nearly 16% of the total population. There is a 12.1% prevalence of Alzheimer’s Disease in this age group, with approximately 31,000 people living with the disease today. The number of people aged 65 and over with ADRD in Alameda County is estimated to nearly triple to close to 90,000 by 2060.

Although ADRD affects Alameda County residents of all races/ethnicities, there are stark disparities in prevalence and health outcomes. According to data analyzed by the Alameda County Public Health Department’s Community Assessment, Planning, and Evaluation (CAPE) Unit, there are disproportionate impacts in the Black, Pacific Islander and American Indian/Alaska Native populations, including higher prevalence, emergency department visits, hospitalizations and mortality as compared with overall County rates. There are also disproportionate health impacts in low-income neighborhoods.

WHAT WE DO

The Healthy Brain Initiative (HBI) seeks to create a better coordinated, aligned, and equity-focused system of care for those at-risk for or living with Alzheimer’s Disease and Related Dementias (ADRD). Funded by the California Department of Public Health (CDPH) Alzheimer’s Disease Program (ADP) and working in partnership with Alameda County’s Age Friendly Council, the Embracing Aging/HBI Workgroup was formed. This group considered and selected the following priorities from among the recommended Action Steps (Components) in The Healthy Brain Initiative Road Map developed by the Alzheimer’s Association and the Centers for Disease Control and Prevention:

- 1. Community Needs Assessment, Surveillance, Evaluation:** The Community Needs Assessment and Strategic Plan for ADRD were completed by June 2024. Ongoing surveillance and evaluation will be built into priority action steps.
- 2. Community Advisory Coalition:** The Age-Friendly Council’s Embracing Aging/HBI workgroup serves as HBI’s Community Advisory Coalition, bringing expertise and guidance to the work.

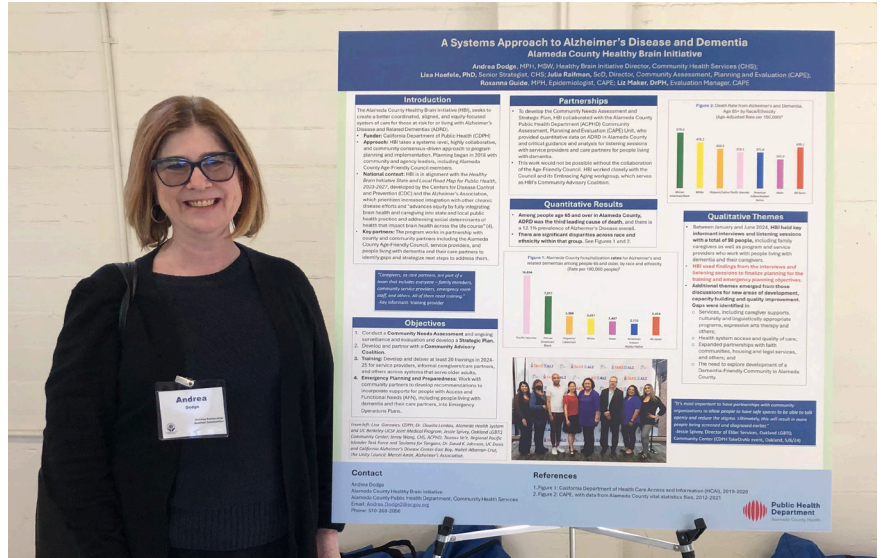


3. ADRD Trainings for Providers:

HBI will expand the Alameda County Embracing Aging Training Initiative to include up to 20 trainings for health care professionals, community-based organization (CBO) service providers, other stakeholders, and County staff focused on the “4Ms” of geriatrics (mobility, mentation, what matters, and medication), with particular attention to ADRD.

4. Emergency Planning and Preparedness:

HBI will work with Alameda County and its 14 cities to ensure that emergency plans at all levels address the specific needs of people with dementia and their caregivers.



After the program was launched and HBI conducted key informant interviews, focus groups, and listening sessions with community members and service providers, additional themes emerged for new areas of development, capacity building, and quality improvement, as follows:

- ✔ Address critical gaps in caregiver supports and respite slots, and generally increase system capacity for services
- ✔ Widely increase access to culturally and linguistically appropriate services
- ✔ Expand training and cognitive screenings for primary health care providers
- ✔ Increase case management and support for patient navigation
- ✔ Expand housing and legal services for people with dementia and their caregivers
- ✔ Develop age-friendly shelters

THE ROAD AHEAD

- Ensure that Alameda County’s Emergency Operations Plan is up-to-date and support at least two to five agencies or jurisdictions to adopt and integrate recommendations that ensure inclusion of ADRD individuals into their emergency protocols, guidelines, and/or formal emergency plans.
- Continue to work with County and community partners to implement ADRD trainings for providers and support local emergency plans to incorporate the needs of people with dementia and their caregivers.
- The program will also continue to work with the community to develop strategies to address the additional gaps identified after HBI was launched.

HEALTHY NAIL SALON PROGRAM

BACKGROUND

California has the largest number of nail salon businesses and nail technicians in the country. In Alameda County, there are over 400 nail salons. According to a study by the California Healthy Nail Salon Collaborative in 2015, an estimated 80% of nail salon workers in California, and in Alameda County, are Vietnamese immigrants. The Alameda County Public Health Department partners with the California Healthy Nail Salon Collaborative to implement the Healthy Nail Salon program to ensure the safety of nail salon owners, staff, and customers.

WHAT WE DO

The [Healthy Nail Salon Program](#) (HNS) is a free, voluntary program that educates and supports nail salon owners and workers in choosing less toxic products and creating a safer and healthier working environment. The program provides bilingual training and guidance (English and Vietnamese) about safe practices and safer nail care products. The training is open to any nail technicians who want to learn more about health and safety guidance in a nail salon setting. All nail salons in Alameda County are eligible for the training.

Once a salon's staff completes the training, a site visit is conducted to assess all the products used in the salon and review safety procedures and the ventilation system. If needed, recommendations are made to improve the working environment, and qualified nail salons are provided with a specialized ventilation unit and other personal protective equipment to reduce chemical exposure during any nail services. After a follow-up visit, if the salon meets all of the program criteria, they become formally recognized as a Healthy Nail Salon.



THE ROAD AHEAD

- HNS plans to increase the number of recognized nail salons in Alameda County each year and to be able to provide the training to more nail staff.
- In the next year HNS will bring up to three mobile healthy nail salons that could travel to large health fairs in Alameda County to demonstrate safer practices and the use of safer products and to encourage residents to urge their regular salons to get certified as healthy nail salons.
- HNS will work on additional publicity for the program, which includes possible outdoor media in selected areas and targeted ads and articles in Vietnamese media.

NUTRITION SERVICES

WHAT WE DO

The Alameda County [Nutrition Services](#) (NS) program advances health and racial equity by providing healthy eating and physical activity supports, including diabetes education to reduce chronic disease and improve long-term health. NS does this through implementing County staffed programs and services and through committed community partnerships that ideally lead to sustainable policy, systems, and environmental (PSE) change. NS envisions that all people live in safe, connected neighborhoods that offer fresh, affordable foods, are choosing active healthy lifestyles, and are engaged in their communities. NS serves children ages 3–5 to older adults throughout the County. ACNS and partners service CalFresh-eligible households and underserved, under-resourced geographic communities. Programs and services are held on site and virtually in classrooms and in community throughout the County.

PROGRAMS

ACNS provides educational, fun, and interactive ways to teach healthy eating and physical activity for **Early Childhood Education (ECE)** students through their families and staff. Partners such as Community Association for Preschool Education, Inc. (CAPE, Inc.) and Room to Bloom connected NS with about 200 families and staff who experienced healthy snack demonstrations, Healthy Heart resources and materials, and Rethink Your Drink Day information on reducing sugar sweetened beverage consumption. Also, their partner CoCoKids shared ECE resources for families in both Alameda County and sister county, Contra Costa, via organizations through the CNAP collaborative.

Bingocize is an evidence-based program combining Bingo with physical activity and nutrition education encouraging increased time spent exercising,

NS Youth and School Programming is accomplished through partner school districts and their health and wellness policies and local recreation and community center programs that expand experiences in nutrition, cooking, gardening, physical activity, and healthy messaging. Their CalFresh funding supports Oakland Unified School District and San Lorenzo Unified School District, and summer brings Rethink Your Drink programming in partnership with non-profit, Fam D.N.A, to eight Oakland Recreation and Park Centers reaching hundreds of school aged children each summer.

Adult and Older Adult Programs Cooking for Health Academy (C4HA) provides nutrition knowledge, food safety awareness, and cooking techniques. Interactive classes educate and encourage participants to increase fruit and vegetable intake and decrease sugar sweetened beverage consumption. The C4HA offers cooking skills through a United States Department of Agriculture (USDA) approved, community informed, hands-on, engaging curriculum. Each class includes:

- ✓ The importance of healthy eating
- ✓ Nutrition education
- ✓ Shopping for fresh produce
- ✓ Safe food preparation
- ✓ Culinary skill techniques
- ✓ A practice session and recipe tasting



strengthening workouts, and intentional movement. Bilingual English/Chinese classes reached 201 older adults, including low-income residents, residents at senior centers, and those living in 10 affordable senior housing sites.

Diabetes Self-Management Education (DSME) provides classes, support groups, presentations, and informational newsletters to County residents. The program focuses on individuals aged 18 and over diagnosed with prediabetes and type 2 diabetes.

NS and partners provide healthy messaging, community resources, and technical assistance. Alameda County Community Foodbank (ACCFB) provides nutrition and/or physical activity workshops at 10 Member Agency sites for staff, volunteers, and community members; reviews and revises wellness policies, training, and nutrition education materials for volunteers and staff at four Member Agency sites; and dives deeper with assessment, coaching, and technical assistance at a minimum of three Member Agency sites that are working to adopt nutrition and wellness improvements that lead to policy, system, or environmental (PSE) changes.

NS staff host special educational events—both in person and virtually. This year brought 17 Foodie Friday online sessions featuring healthy recipes. And NS staff, partners, and community champions hosted the annual Rethink Your Drink campaign at 17 sites with materials about the impact of sugar sweetened beverages.

COMMUNITY CHAMPIONS

NS could not do this work without the active involvement of communities! Community Champions, residents who have graduated from NS programs, are trained and support or co-lead programs alongside staff. They represent the communities in which they live and lead. Champions have been active in the Cooking for Health Academy, the Diabetes Program, Oakland Making Moves, community health fairs, and more. ACNS also works with short term volunteers and interns on special projects. 20+ Community Champions, volunteers and interns have worked with NS this year.

This year, Champions:

- ✔ Co-led the inaugural Happy Heart Campaign
- ✔ Presented Food Waste Reduction strategies to 18 County Nutrition Action Partnership member organizations
- ✔ Shared personal stories of experience living with pre-diabetes or diabetes with support group participants
- ✔ Led regular walking/rolling groups from senior affordable housing sites to healthy destinations such as Lake Merritt, local museums and more.
- ✔ Participated/staffed in over 20 community health fairs

POPULATION SERVED



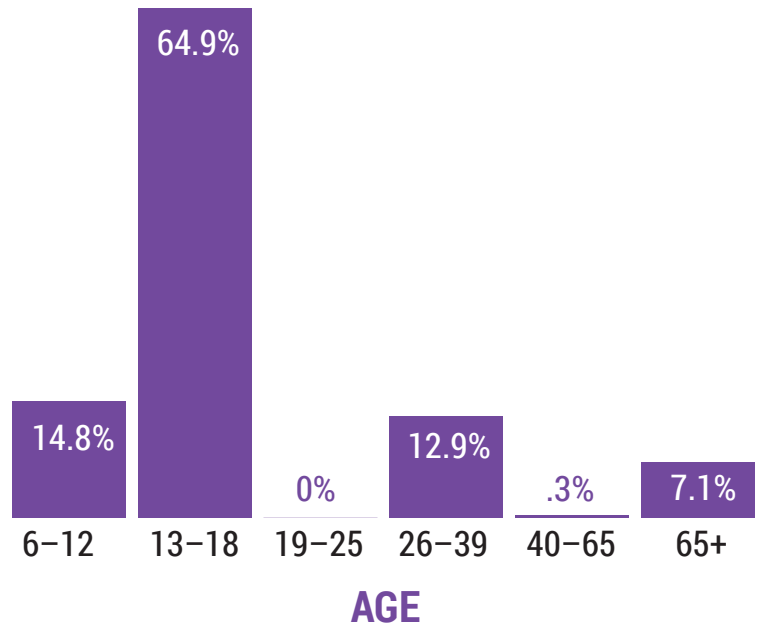
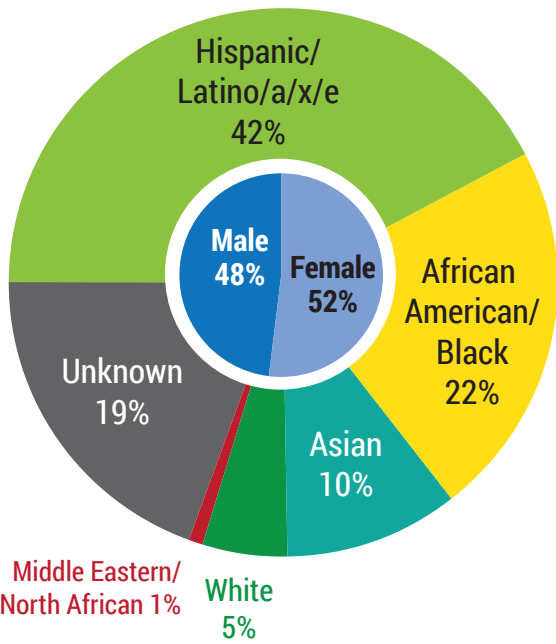
**MY FAVORITE PART ABOUT BEING A
“ RETHINK YOUR DRINK CHAMPION IS...**

... reaching out to and educating the community about nutritional health and the resource options our County provides.

—R. GREENWELL

... cuando los niños se sorprenden de la cantidad de azúcar que contiene las bebidas (when children are surprised by the amount of sugar in drinks).

—N. CASTILLO



THE ROAD AHEAD

- Commit to health and racial equity by enhancing community participation in programmatic decision making.
- Commit to exploration and bridging of direct health education to creating sustainable and equitable organizational, policy, systems and/or environmental changes.
- Increase the number of participants who start and graduate from the DSME classes and have completed pre and post clinical measures.

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

CARE COORDINATION

ODH offers dental care coordination, which focuses on increasing access to oral health through the utilization of preventative dental care. The priority population groups of this program are children, youth (ages 0–20 years), and perinatal individuals who are Medi-Cal eligible. ODH Family Support Care Coordinators (FSCC) work with clients referred by internal program partners (WIC, Asthma, DCDCP, etc.) and various external community agencies (Early Childcare Programs—Early Head Start, Head Start, and Alameda Health System Wellness Clinics). Once referrals are received, FSCCs assess the level of dental care each client needs. The services rendered can range from providing oral health education to scheduling dental appointments and linking clients to any other necessary resources. The partnerships and connections ODH has established in the community have contributed to dental care coordination that better serves priority populations in Alameda County.

SCHOOL-BASED DENTAL SEALANT PROGRAM

To improve access to care and reduce the prevalence of tooth decay, ODH provides preventive dental services at 14 elementary schools in three school districts. These services include dental screening, fluoride varnish applications, teeth cleaning, dental sealants, and oral health education. Dental care coordination is provided for students with urgent dental care needs.

WIC DENTAL DAYS

ODH collaborates with WIC sites to provide preventive dental services. This program aims to help connect children, pregnant, and postpartum clients to a dental home. Clients receive oral health education, dental screening, and a fluoride varnish application. Dental care coordination is provided to all clients needing help in establishing a dental home.

PERINATAL DENTAL DEMONSTRATION PROJECT

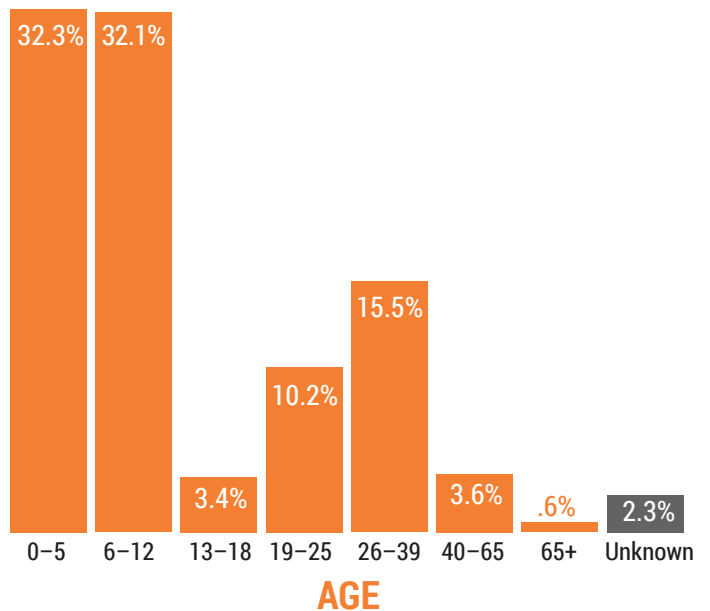
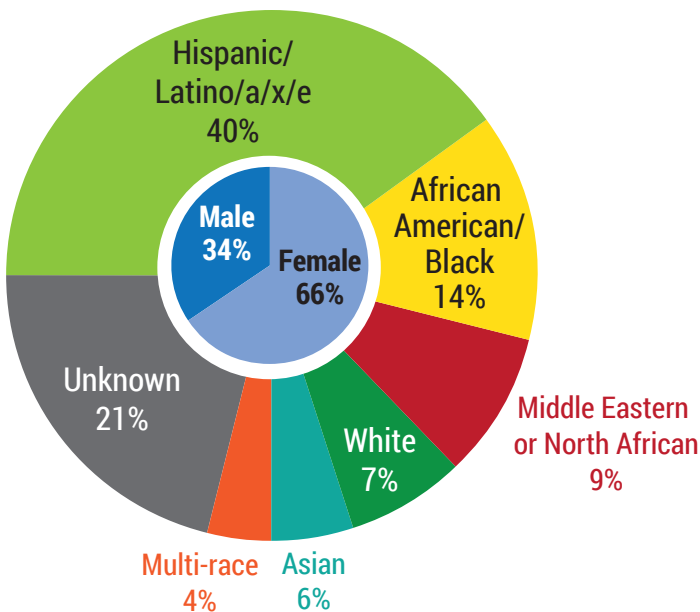
The project aims to improve access to dental care for pregnant and postpartum people in Alameda County. The program is working with organizations that serve this population to enhance the awareness about safety and importance of dental care for pregnant individuals and their infants. Through improving and expanding the existing ODH care coordination program, ODH assists Medi-Cal eligible pregnant and postpartum individuals in scheduling dental appointments and tracks their appointment attendance.

ODH works closely with and is guided by organizations serving priority populations in Alameda County. The Advisory Committee, the Oral Health Committee of the Public Health Commission, meets once every quarter to support the strategic plan objectives. ODH has also formed workgroups that include local organizations and community members that understand the unique oral health needs of priority populations:

- ✔ Early Childhood Oral Health Workgroup: children 0–5 and pregnant/postpartum individuals
- ✔ Oral Health for Homeless Children and Families
- ✔ Special Needs Dentistry Workgroup: individuals with special health care needs



POPULATION SERVED



THE ROAD AHEAD

- ODH will expand its program to provide preventive dental services and oral health education to elementary schools.
- ODH will strengthen collaborations with Alameda County’s three local dental societies to offer Kindergarten Oral Health Assessment (KOHA) dental screenings at additional schools.
- Continue to collaborate with WIC to assist clients in establishing a dental home and increase awareness on the importance of dental visits/checkups for prevention of dental disease among new parents and parents of children 0–5 years old.

OLDER ADULTS HEALTHY RESULTS

WHAT WE DO

Older Adults Healthy Results (OAHR) 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, facilitating healthcare access, and linking isolated clients to culturally appropriate and available resources, OAHR combats intersecting systems of ageism and racism that negatively impact 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



To accomplish this, OAHR provides comprehensive home-based nurse case management, including:

- ✓ Care coordination with healthcare providers
- ✓ Referrals and linkage to services and supports
- ✓ Caregiver stabilization, training, and support
- ✓ Healthcare navigation
- ✓ Advocate for patient-focused treatment that aligns with OAHR's clients' priorities and capabilities
- ✓ Fall prevention
- ✓ Maximize health benefits
- ✓ Health education
- ✓ Medication review
- ✓ Ensure that planned interventions, benefits, or services are in place, appropriate, and effective

OAHR services are free to all Alameda County residents who qualify based on income, medical complexity, and functional status.

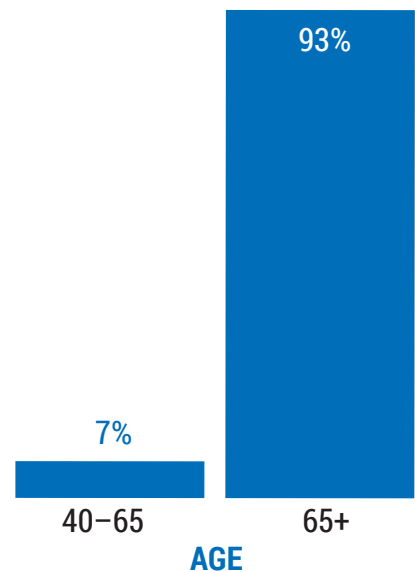
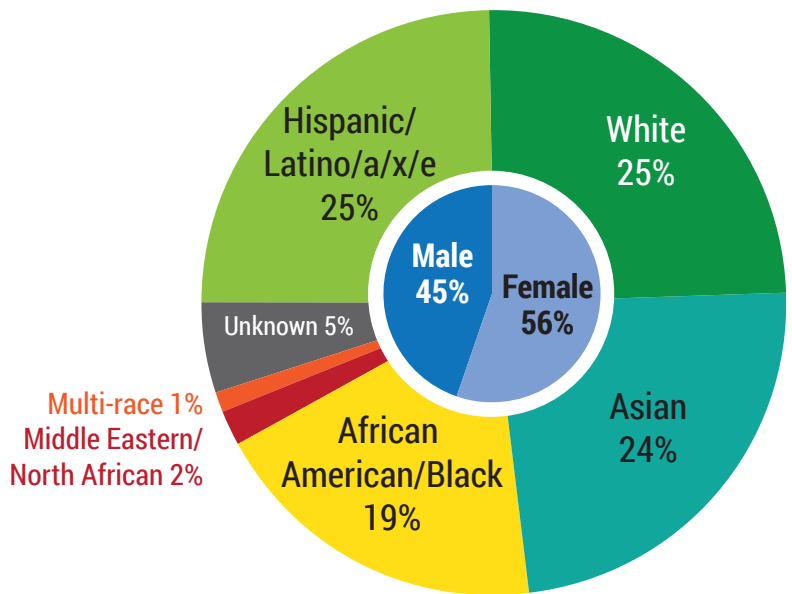
POPULATION SERVED

Many of OAHR’s clients require in-person services provided by trained nurses who understand the complex interplay of medical and psychosocial needs. This year, **80% of the referrals OAHR received became clients.**

Many of the clients OAHR takes 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

OAHR’s 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 assured the clear and accurate communication necessary for high quality, equitable service.



THE ROAD AHEAD

- Further develop knowledge of Medi-Cal eligibility requirements amidst a changing health benefits landscape.
- Forge strategic partnerships with experts and advocacy agencies to help clients gain access to long-term services and supports like caregiving and respite services.
- Find OAHR’s niche alongside CalAIM; fill in gaps in care and reach clients who may fall through the cracks of larger managed-care systems.
- Continue to expand OAHR’s reach across the County.

TOBACCO CONTROL

OVERVIEW

The [Tobacco Control Program \(TCP\)](#) seeks to de-normalize tobacco products and their use through multi-level strategies that includes upstream local policy development. TCP focuses policy work on two core areas—tobacco retail and smoke-free protections.

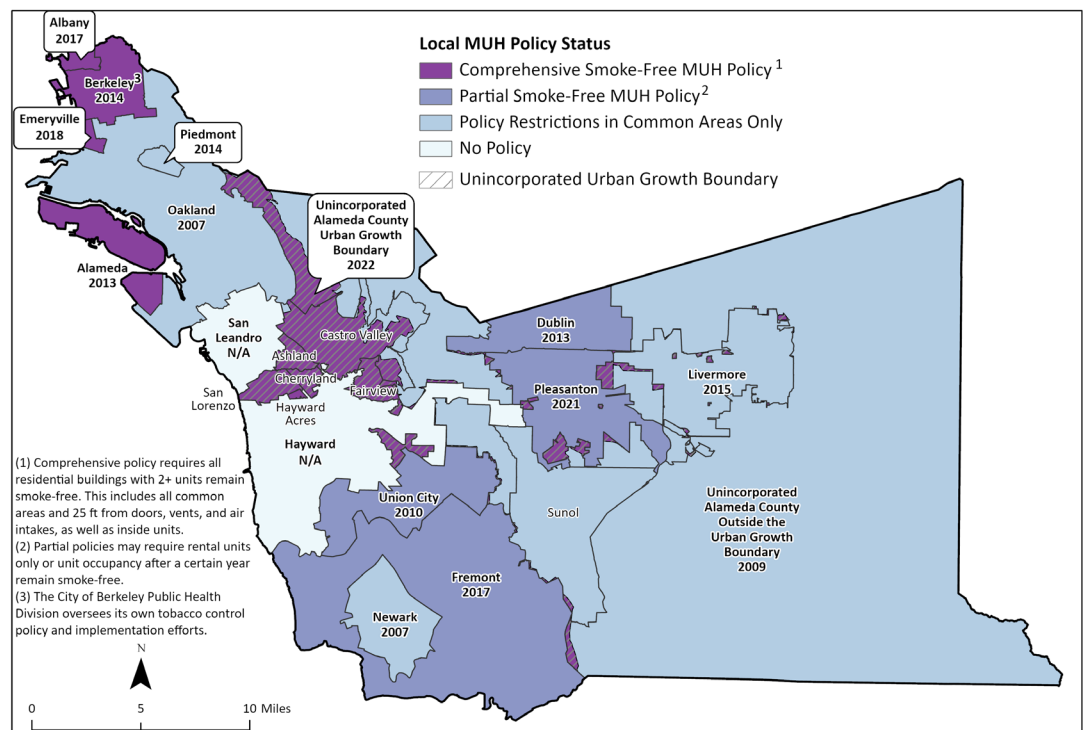
THE TOBACCO RETAIL ENVIRONMENT

Local jurisdictions can pass ordinances that require tobacco retailers in their community to obtain a license to sell tobacco products; this helps hold businesses accountable to follow all local, state, and federal tobacco sales laws. The local jurisdiction can also set standards for those retailers such as prohibiting the sale of all flavored tobacco products or vape products, setting a minimum price and package size for tobacco products, prohibiting the sale of tobacco in pharmacies, and limiting the density of tobacco retail locations near youth-sensitive areas (e.g., schools/parks) or other tobacco retailers. Local jurisdictions can also create a graduated penalty structure that includes significant fines on the business owner, license suspension, and even license revocation for repeated violations. These local laws serve to limit tobacco access among youth and maximize health protections for other groups that the tobacco industry disproportionately targets.

SMOKE-FREE PROTECTIONS

Drifting secondhand smoke continues to impact the health of many residents in Alameda County. The most common place for people to be exposed to secondhand smoke is now the home, particularly in multi-unit housing settings. Smoke-free multi-unit housing policies prohibit all types of smoking in housing complexes. Smoking in multi-unit housing can travel through the building—under doors, through electrical outlets, along plumbing pipes, and through shared ventilation. Secondhand smoke exposure can cause asthma attacks and increase health risks for medically vulnerable residents, including seniors and young children. Thirdhand smoke is the harmful residue of smoke on walls, surfaces, and furniture—and it can also impact the health of residents.

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



Source: Alameda County Public Health Department Tobacco Control Program, updated October 2022.

WHAT WE DO

TCP is available to provide community education around tobacco control issues, as well as technical assistance to support local jurisdictions adopting or implementing tobacco control laws.

✔ SMOKE-FREE MULTI-UNIT HOUSING COMPLAINTS

For the jurisdictions of Emeryville, City of Alameda, and the urban communities of the Unincorporated areas (Castro Valley, San Lorenzo, Ashland, Cherryland, Fairview, and Hayward Acres), TCP will verify smoking complaints in multi-unit housing and send out warning letters to alleged violators. If the smoking continues after three warning letters, then the complaint is forwarded to the relevant code enforcement agency for enforcement and fines. To make a complaint, visit acphd.org/tobacco-control/smoke-free-multi-unit-housing.

✔ TOBACCO SALES VIOLATIONS COMPLAINTS

TCP receives complaints if a resident suspects a retailer is illegally selling flavored tobacco products or selling to underage persons. Complaints about tobacco retailers violating tobacco sales laws are forwarded to the relevant enforcement agency.

✔ TOBACCO CONTROL COALITION

The Alameda County Tobacco Control Coalition is a diverse, grassroots coalition of educators, professionals, and community members that work to prevent, reduce, and limit tobacco use in Alameda County through education, advocacy, and policy. The Coalition is committed to the de-normalization of tobacco use in Alameda County. More information on the Alameda County Tobacco Control Coalition can be found at tobaccofreealamedacounty.org.

✔ RESOURCES FOR TOBACCO TREATMENT AND CESSATION

The Tobacco Control Program does not provide direct services to clients. TCP does link residents to existing resources for tobacco cessation:

[Kickitca.org](https://kickitca.org) Statewide phone and text-based tobacco treatment counseling in multiple languages

[Tobaccofreealamedacounty.org](https://tobaccofreealamedacounty.org)

Local listings of no-cost tobacco treatment classes.

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 in local jurisdictions.
- Engage Newark residents in exploring a potential tobacco retail licensing ordinance to reduce youth access to tobacco.

WOMEN, INFANTS AND CHILDREN (WIC)

WHAT WE DO

WIC, officially called [Supplemental Nutrition Program for Women, Infants, and Children](#), is a nutrition education program for pregnant and postpartum women, infants, and children under the age of five. WIC provides nutrition education and breastfeeding support as well as food benefits to reduce infant mortality, lower incidence of anemia and obesity, and promote healthy eating. Within WIC, there are several other programs to serve the community:

The WIC Regional Breastfeeding Liaison (RBL) Program contributes to community health by facilitating inclusive and effective collaborations to strengthen the continuum of quality breastfeeding care for all WIC eligible families. This work includes resource development and promotion; education of clinicians, health care providers, and health educators; and technical assistance to hospitals, health centers, and community organizations. Evaluation surveys from community coalition leaders and RBL program partnerships show that 100% report improved coordination of care for WIC participants.

Partnering with the community and Alameda County Public Health Department's Community Assessment, Planning, and Evaluation (CAPE) epidemiologists, RBL facilitated special data reports on South Asian, Asian American, and Native Hawaiian and Pacific Islander populations to better understand their unique community risks, potential needs, and opportunities. RBL also assists the development of a growing series of Latina Chicana (LatCh) breastfeeding education videos and the promotion of the flyers with QR codes



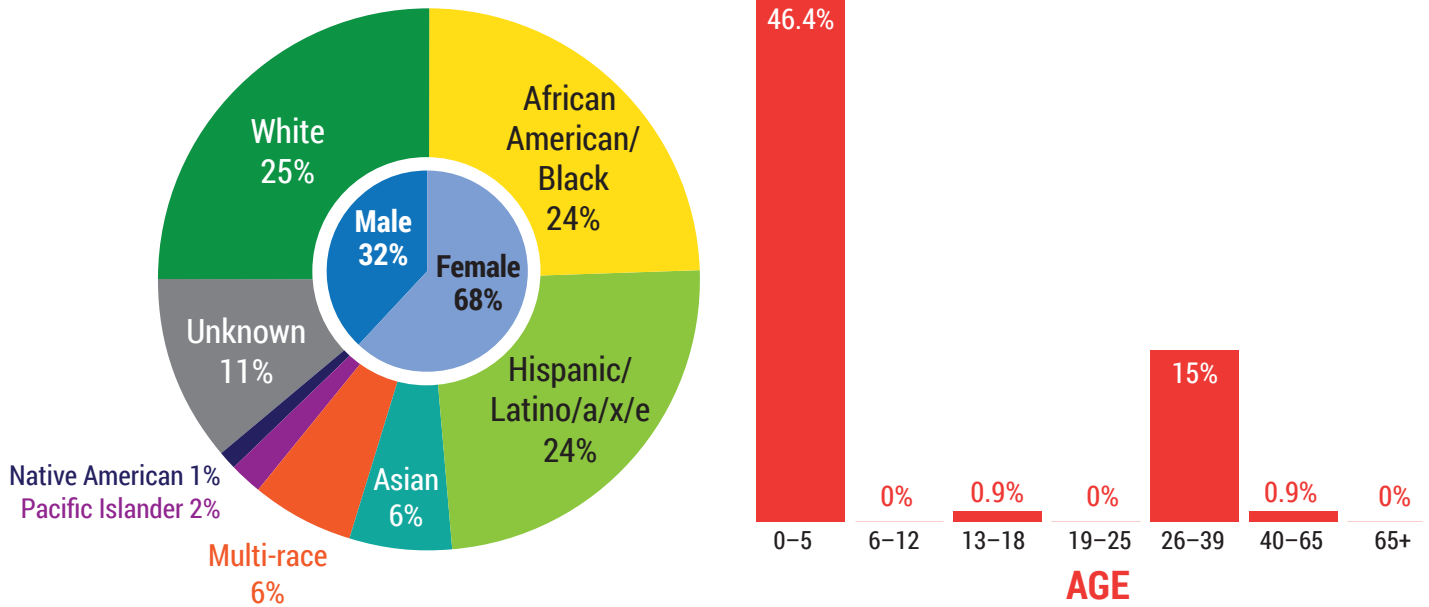
through the Child Health and Disability Prevention Program (CHDP), Comprehensive Perinatal Services Program (CPSP), health centers, and hospitals.

The Local Vendor Liaison (LVL) Program was established in April 2008. The goal was to educate and support vendors during the implementation of new WIC foods. Since then, the role of LVLs has evolved to provide WIC Authorized Vendors with technical assistance on program requirements and updates, and to conduct store surveys. WIC local agencies have designated one or more staff as an LVL to provide technical assistance and reinforce education for WIC Authorized Vendors. LVLs serve as a local resource to WIC Authorized Vendors and play a critical role to support vendors in their success in providing healthy foods to WIC families. The efforts of LVL staff help to quickly resolve vendor program participation and customer service issues to create a positive shopping experience for both the vendor and WIC family.

The Breastfeeding Peer Counseling (BFPC) Program utilizes peers to encourage and support WIC mothers to breastfeed their infants via a mother-to-mother connection. The goal of the program is to increase the initiation, exclusivity, and duration of breastfeeding with the support of Peer Counselors (PCs) in WIC local agencies. Alameda County has six PCs and two board-certified Lactation Consultants.

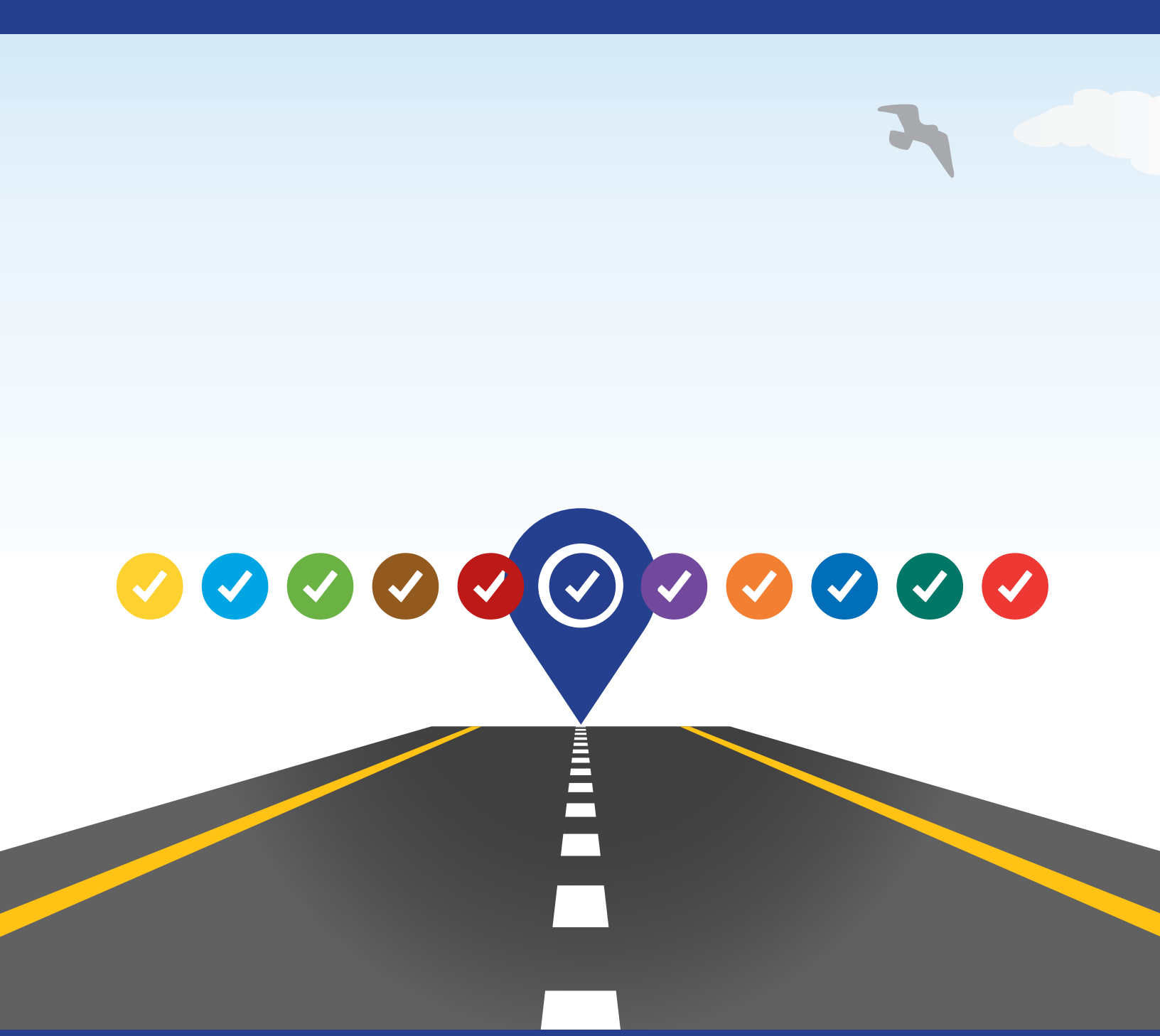


POPULATION SERVED



THE ROAD AHEAD

- Work with USDA and CDPH/WIC to implement the food package changes approved by USDA in 2024.
- Provide staff training and participant education to support transitioning to the new WIC foods.
- Make available the convenience of online shopping to all WIC participants; though there is no specific date, this is definitely coming in the future.
- Developmental screenings for babies as young as 6 months to children ages 1–4 years will be restarted following pandemic closures. Staff will be retrained to complete these in the year ahead.



Public Health Department

Alameda County Health

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