



ALAMEDA COUNTY HEALTH CARE SERVICES AGENCY
PUBLIC HEALTH DEPARTMENT

Community Health Improvement Plan

2023-2025

January 2024





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Introduction

The Alameda County Public Health Department's (ACPHD) Community Health Improvement Plan (CHIP) articulates the long-term, system-wide, effort to improve the Health of Alameda County's communities. The CHIP is an action-oriented plan that addresses the most significant health issues identified through an extensive assessment of local socio-economic and health status data. It relies upon the assessment to define coordinated, measurable health improvement strategies that leverage participation from across the public health system to ensure everyone in Alameda County, no matter who they are, where they live, how much money they make, or the color of their skin, leads a healthy, fulfilling, and productive life.

The CHIP is grounded in assessment findings and the resulting prioritization processes that shaped Alameda County's 2022-2025 Community Health Needs Assessment (CHNA¹). The CHNA convened stakeholders, including residents, community-based organization staff and members, public sector

representatives, and business owners, in focus groups and listening sessions. Information from stakeholders and population-level health status data emphasized the leading causes of death and the disproportionate burden of chronic disease by race and ethnicity. This gave rise to community health improvement priorities for those who live, work and play in Alameda County.

The community health improvement priorities are linked to increased access to high-quality, culturally relevant health care, conditions that foster economic security and wealth generation, and the promotion of peaceful homes and communities. This document covers the CHIP background processes and details the resulting goals, desired outcomes, timelines, and how ACPHD and its partners will measure collective progress. The CHIP Project Manager is Gabriela Castillo.

Introduction to Frameworks

The Alameda County Public Health Department follows evidence-based practices to support the quality of program implementation, delivery, and outcomes. These include following specific procedures and strategies that have proven to guide quality work. These procedures and strategies are known as frameworks or models based on systematic research and application in the public health sector. For the purposes of the CHIP, ACPHD used three frameworks to guide the development, processes, and outcomes of the CHIP.

Chief Health Strategist Approach

The “Chief Health Strategist” approach, first adopted in 2016 by the US Department of Health and Human Services, allows public health leaders to serve as chief architects across their jurisdiction, empowering leaders to align health systems transformation and population health activities². A demonstration of ACPHD’s commitment to the Chief Health Strategist role is evidenced by an accreditation conferred by the Public Health Accreditation Board (PHAB). The CHIP integrates PHAB’s standards of practices and guides an approach that continuously demonstrates accountability to the

communities served, reaffirms the credibility and quality of the Department’s work, and guides efforts to strengthen the public health infrastructure in partnership with an array of stakeholders throughout the public health system.

Chief health strategists craft programs, policies, or service interventions using population data rather than relying on a specific individual or undefined group’s health status or socio-economic conditions. A population-level approach ensures systemic activities attend to the social determinants of health, fostering



conditions whereby equity is advanced, and health is improved at the individual and community levels.

The ACPHD's Community Health Improvement Plan embodies the Chief Health Strategist competencies, as shown in Figure 1 below. Each competency is directly addressed or emphasized at different stages of the CHIP process. Alameda County's CHIP began with the mandate to deploy strategies and interventions that will combat the leading causes of death. During the CHIP implementation phase, specific Chief Health Strategist competencies are emphasized, including: (1) collaborating with the community,

(2) promoting health, (3) improving data, and (4) updating organizational practices. The remaining competencies, federal partnerships and collaboration with clinical care, typically require written agreements that guide activities, ensuring resources, personnel, and processes are well-resourced. These agreements are anticipated products to be developed and will inform the next CHIP iteration in 2026.



Figure 1: Chief Health Strategist Competencies Essential Public Health Services Framework



Essential Public Health Services

In keeping with PHAB Standards and Measures, ACPHD incorporated the 10 Essential Public Health Services (EPHS)³, (Figure 2) (Figure 2), describing the public health activities that health departments should undertake. The EPHS serves as a framework for carrying out the public health mission and aligning it with current and future

public health best practices. The EPHS framework was updated in 2020; it now aims to be more inclusive of all people and voices in communities. The update elevates equity and prevention by setting standards for State, Local, and Tribal Health Departments that remove systemic barriers contributing to health inequities. Further details on the framework are in the appendix.

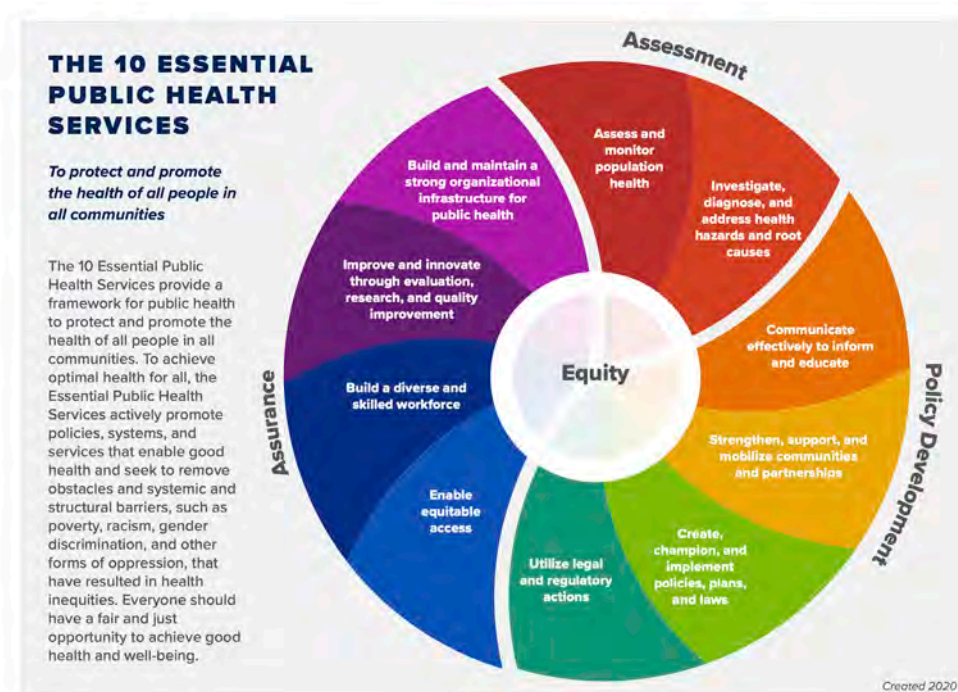


Figure 2: The Essential Public Health Services Framework

Foundational Public Health Services Framework

The Foundational Public Health Services (FPHS⁴) (Figure 3) complements the Essential Services framework. The FPHS framework outlines which programs, policies, and services State, Local, and Tribal Health Department should provide in their communities. The two elements of the framework are Foundational Programs and Foundational Capabilities. When the elements are combined, the framework defines the minimum skills, capacities, and programs that comprise the governmental public health infrastructure and details the responsibilities and vital role of governmental public health for a jurisdiction.

Alameda County's CHIP priorities emphasize FPHS program areas inside the Public Health Department, including Communicable Disease Control, Chronic Disease and Injury Prevention, Maternal Child and Family Health, and Access to and Linkage to Clinical

Care Environmental Health programming is in our sister Department, the Environmental Health Department, and is not included in this CHIP iteration. Over time, the CHIP implementation will address each of the eight FPHS capabilities. In the first phase, four capabilities are addressed to emphasize equity and guide measurement of the CHIP's impact: (1) Community Partnership Development, (2) Policy Development and Support, (3) Accountability and Performance Management, and (4) Equity. The remaining capabilities, Assessment and Surveillance, Emergency Preparedness and Response, Organizational Competencies, and Communications, are addressed in other plans (Community Health Needs Assessment, Emergency Operations Plan, and Strategic Plan) that guide the Public Health Department's work. There are more details on the FPHS framework in the appendix.



Foundational Public Health Services

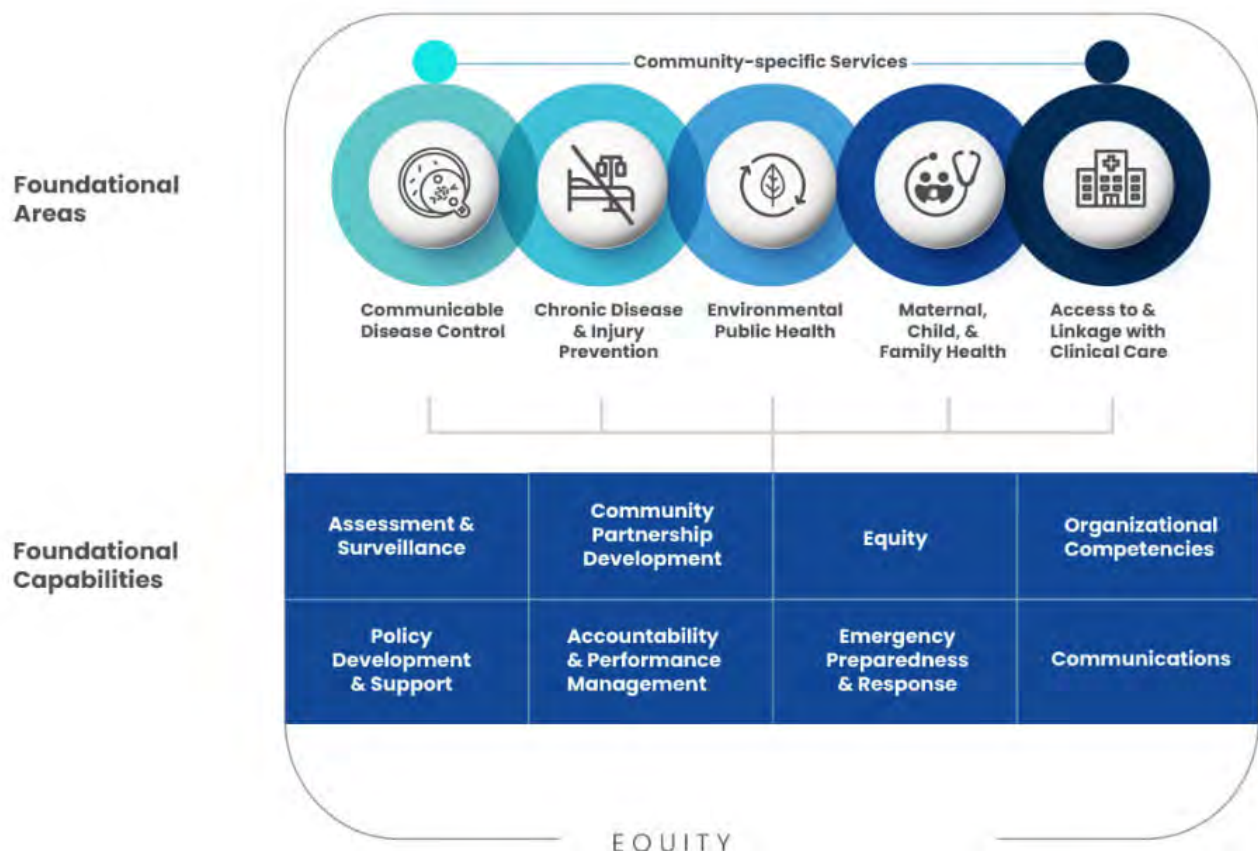


Figure 3: Foundational Public Health Services



Community Health Improvement Plan Development Process

Stakeholders





The Alameda County Public Health Department's Community Health Improvement Plan serves as a roadmap to collaboratively address prioritized health needs across Alameda County. ACPHD has a long history of collaborating with partners to improve health. The 2023 – 2025 CHIP expresses the Department's continuous commitment to meaningful engagement to spark and sustain community health improvement. Alameda County's CHIP is staffed by the Quality Improvement and Accreditation Division in ACPHD's Office of the Director.

Internal and external strategies guide Alameda County's CHIP planning and implementation processes. Typically, ACPHD convenes a cadre of residents, community-based organizations, and public sector representatives to define the

CHIP's implementation process. Convening external community partners in recent years proved challenging due to COVID-19 prevention measures and the significant emergency response workload of the ACPHD staff. To ensure the process did not stall, a strategy was enacted to advance the CHIP launch because the CHNA process involved several external stakeholders. CHNA results are reliable and made clear the community-based groups and partners aligned with CHIP work. Since it was not feasible to do extensive outreach to partners, the plan called for "in-reach" by engaging the ACPHD's programs with an extensive group of pre-existing community-based partners and programs. These external partners will eventually define the CHIP work and the benchmarks to measure success and meaning.



Selected Priority Areas



Figure 4: The three Community Health Improvement Plan priority areas.

In 2022, the CHIP Steering Committee reviewed the CHNA findings and identified three overarching priority areas for the community health improvement plan. The priorities are:



Health, dental, and behavioral care access and delivery that is high quality, comprehensive, affordable, and culturally and linguistically appropriate.



Economic security and opportunity that supports the ability of all residents, regardless of race or ethnicity or place of residence, to be able to pay for their basic needs (including housing, food, transportation, health care, and childcare) and build wealth.



Promoting peaceful families and communities by ensuring neighborhood safety through violence prevention and promoting community resilience in the face of disasters and emergencies.

Please see [Alameda County's Community Health Needs Assessment \(CHNA\)](#)⁵ to better understand the priority areas and how they were selected.



Setting Objectives

The CHIP planning committee reviewed national, state, and local plans to align strategies and outcomes with population-level efforts. The plans reviewed include [Healthy People 2030](#), the [National Prevention Strategy](#), [Let's Get Healthy California](#), [Alameda County Vision 2026](#), and ACPHD's 2021 [Leading Causes of Death Report](#). The focus areas for these plans overlap with the CHIP's goals and provide targets for improvement.

A list of the specific objectives with respective plans is shown below in figure 5.

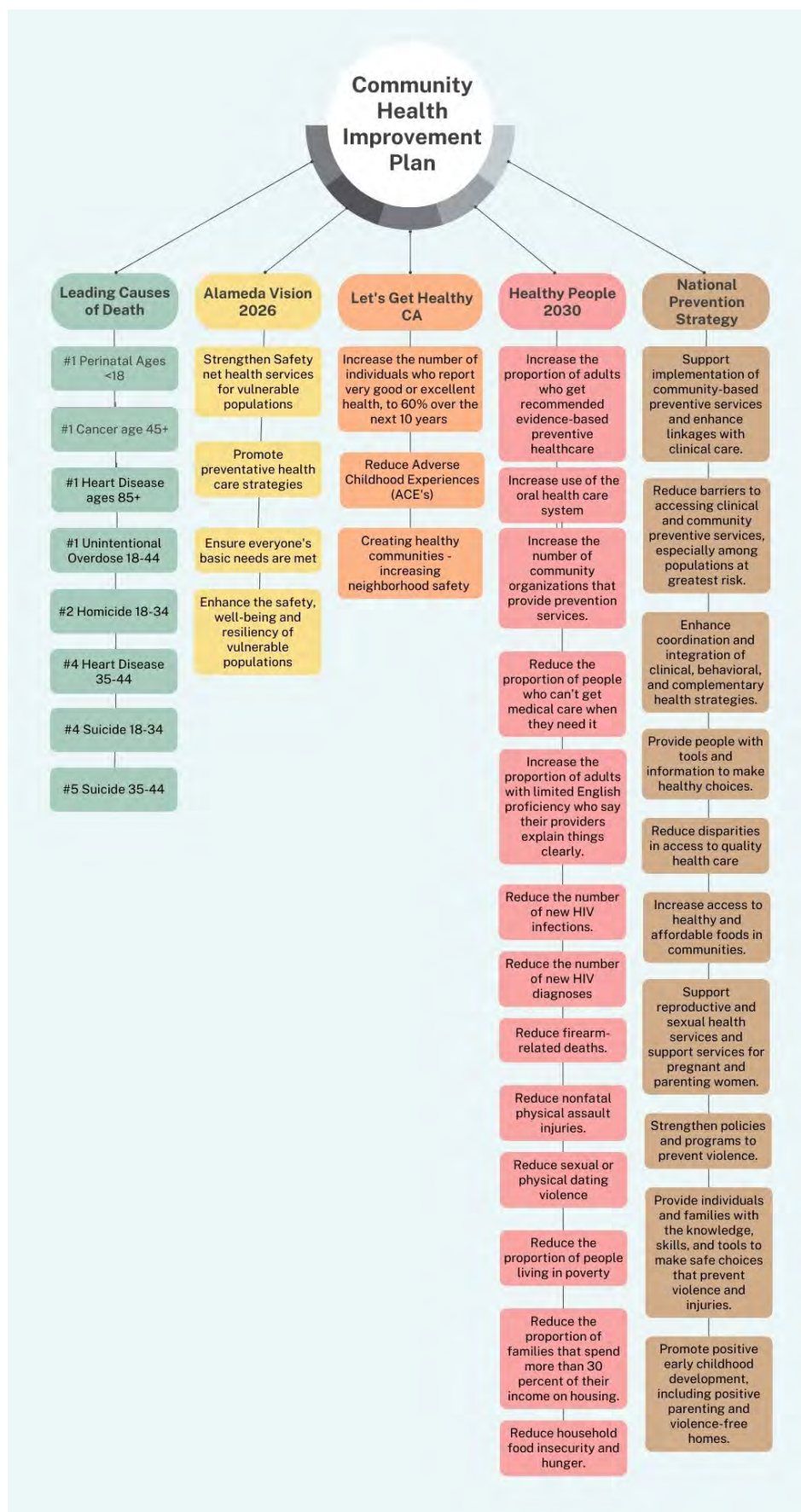


Figure 5: Plans and their respective objectives that were taken into consideration for the Community Health Improvement Plan. Updated September 2023.

Alignment with Federal, State and Local Public Health Plans

The Department reviewed several federal, state, and local Public Health plans to select objectives. Using the Public Health Accreditation Board's standards, a set of criteria was developed to ensure alignment with our health priorities. Revised plans included the National Prevention Strategy, Let's Get Healthy CA, Alameda Vision 2026, California's Department of Public Health (CA's DPH) Violence Prevention Initiative, and Healthy People 2030. These external public health reports provided data sources and information on population-level health that informed our objectives. Additionally, the planning team narrowed in on objectives that underscored equity and addressed health disparities in the most impacted communities of Alameda County.

More details about the plans used are outlined below.

National Prevention Strategy

Part of the Affordable Care Act, the [strategy](#) comes from the National Prevention, Health Promotion, and Public Health Council, which is made up of the 17 directors of federal departments, agencies, and offices that promote prevention and wellness. The strategy's goal is to move the US healthcare system

from just caring for the sick to a focus on wellness. Its priorities are preventing tobacco use, drug abuse, and excessive alcohol use, healthy eating and active living, injury- and violence-free living, reproductive and sexual Health, and mental and emotional well-being.

Let's Get Healthy CA

[This statewide initiative](#) aims to make California the healthiest state in the nation through an assessment of Californians' Health and a plan for improvement across several conditions and factors. The initiative focuses on creating healthy childhoods and optimal

physical and mental Health at all stages of life, allowing older adults to maintain dignity and independence, realigning the health system around health and not sickness, creating healthier communities, and lowering the cost of care.

Alameda Vision 2026

[Vision 2026](#) was established in 2016 and set the County's goals for the next decade. The plan establishes a vision for safe and livable communities, a healthy environment, thriving population, safe and livable communities, and prosperous and vibrant economies.

These will be achieved through goals that include healthcare and employment for all, crime-free County, and eliminating homelessness, poverty, and hunger.

CA DPH Violence Prevention Initiative – External

[This initiative from the California Department of Public Health](#) aims to make California's communities safer and healthier by reducing violence. The initiative takes a public health approach to violence prevention through using government policies to improve public Health and by preventing violence.

Taking a public health approach means viewing violence as preventable, as other health harms are. This means violence should be defined and monitored through data analysis, risk and protective factors should be identified, prevention strategies should be developed and tested, and effective practices should be shared broadly.

Healthy People 2023

[Healthy People 2030](#) works to ensure more people have medical, dental, and prescription drug insurance coverage. People who are racial/ethnic minorities, less educated, and have a lower income are less likely to be insured.

Economic stability is another Healthy People 2030 initiative. Living in poverty harms Health. Healthy People 2030 notes that people need employment and career programs, and those who

are parents need high-quality childcare to find and keep jobs. Government policies that help people pay for food, housing, health care, and education can reduce poverty and improve health and well-being.

Healthy People 2030 notes the problems physical, sexual, and gun violence, can cause. Violence can be particularly harmful to children and lead to life-long problems.



Signature Pilot Programs

In the summer of 2023, the CHIP planning team engaged ACPHD leadership in a process for selecting the internal programs that will contribute to addressing the three priority areas, naming them the CHIP Signature Pilot Programs as part of the first cohort for the year 2023-2024.

By summer 2023, the CHIP Planning Team developed the following criteria to vet potential ACPHD programs to participate in the CHIP implementation process. Selected ACPHD programs, projects or activities must:

1

Be **data-driven** and have **data collection**. There should be an existing process to collect population-level data and have existing data agreements with external stakeholders. These programs or efforts should use recognized metrics to measure effort (such as Healthy People 2030, National Prevention Strategy, etc.).



2

Have **active external partnerships**. These partnerships should have at least two of the following:

- Shared aim, vision, or agenda.
- Written decision-making agreement.
- Membership definition.
- Regular meetings that are documented.
- Leadership from those affected by the issue.
- Authority and weight to convene stakeholders.

3

Have **population-level approaches**. Existing programmatic activities that advance systemic change a.k.a. “move the needle” through either a defined policy agenda or health promotion campaign. Program design is informed by its population-level impact. Public data sharing & communication practices related to population-level health exist.



4

Be **Equity** centered. Existing programmatic activities that use disaggregated data on race to

- Inform activities.
- Lead or contribute to power-building strategies.
- Address, or mitigate or undo “isms” and/or inequities.
- Promote equitable access.

The selected CHIP Signature Pilot Programs are detailed in this section.

Table 1. CHIP Signature Programs by Divisions

Division	Program
Community Health Services	Women, Infant and Children (WIC)
Division of Communicable Disease Control & Prevention	Immunization Sexual and Reproductive Health
Family Health Services	EmbraceHer
Office of the Director	Office of Violence Prevention
Public Health Nursing	The Front Door

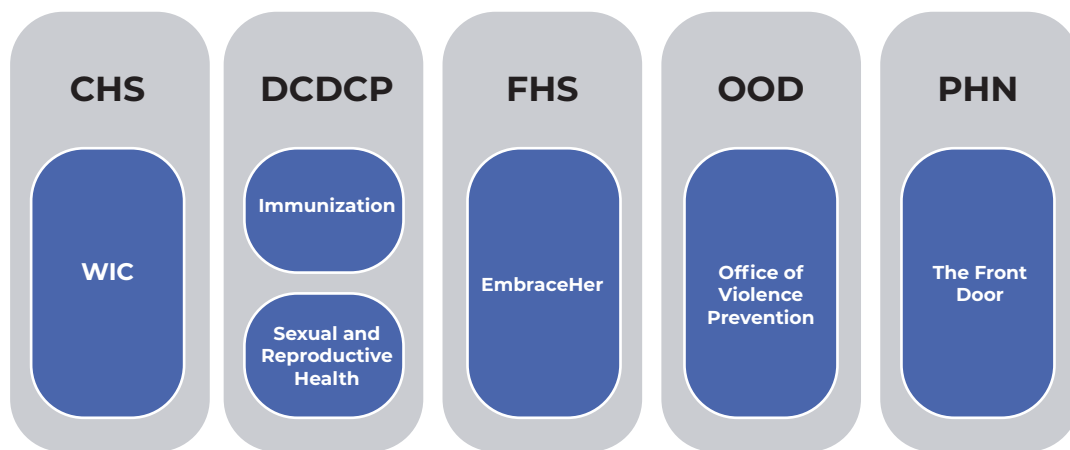


Figure 6: ACPHD's selected Signature Pilot Programs per Division. Updated August 2023.

Women Infants and Children (WIC)

WIC is a program within the Community Health Services (CHS) Division of ACPHD. WIC's intended impact is to safeguard the Health of low-income women, infants

and children up to age 5 who are at nutrition risk by providing nutritious foods to supplement diets, information on healthy eating , and referrals to health care.



Figure 7: Women, Infants, and Children (WIC) program staff.

EmbraceHer Program

EmbraceHer is a program of the Family Health Services (FHS) Division. The EmbraceHer team provides co-facilitation, care coordination, support, and referral services to all BElovedBIRTH Black Centering participants. Below are some images of the program participants. BElovedBIRTH Black Centering is a program of Alameda Health System and Alameda County Public Health Department. It is a revolutionary new 'by us for us' group perinatal care program, designed to honor

and celebrate Black birthing people, while preventing racism from harming Black birthing people's health in pregnancy and beyond. Launched at the height of the COVID-19 pandemic in 2020, and grounded in the birth justice movement, BElovedBIRTH Black Centering provides a holistic and comprehensive "Gold Package of Black Love". BElovedBIRTH Black Centering is the future of Black birthing solutions!



Figure 8: EmbraceHer program clients stretching.

Sexual and Reproductive Health Section

The Sexual & Reproductive Health Section is part of the Division of Communicable Disease Control and Prevention (DCDCP) of ACPHD. The section aims to achieve sexual and reproductive health equity throughout Alameda County by dismantling systemic barriers and eradicating the disparities in access, information, and outcomes related to sexual Health. Prioritizing the needs of

our most impacted community members (e.g., youth, men who have sex with men, transgender persons, persons with substance use disorder, and persons experiencing homelessness), through research, education, advocacy, and community partnership, we aim to promote, protect, and enhance the sexual and reproductive well-being of our community members.



Figure 9: ACPHD's Sexual and Reproductive Health Section staff at a community event.

Immunization Program

The Immunization Program is part of the Division of Communicable Disease Control and Prevention (DCDCP) of ACPHD. The immunization program's mission is to provide access to vaccines and vaccine education for all vaccine-preventable diseases to Alameda County residents. The program uses equity-focused community outreach to specifically make these resources available to vulnerable residents who have

been discriminated against and often marginalized due to racism, sexual orientation, disability, economic status, education, etc. The program also collaborates with local healthcare providers, community leaders, and health advocates to promote routine vaccine administration rates to ensure our County stays ahead of disease outbreaks such as COVID-19 and seasonal flu.



Figure 10: ACPHD's Immunization Program Staff at a vaccination site.

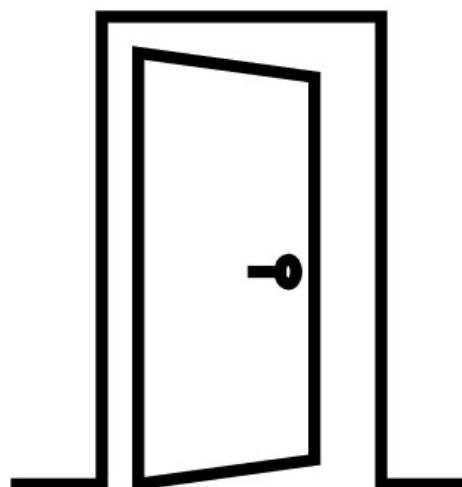
Office of Violence Prevention

The Office of Violence Prevention (OVP) is a program in the Office of the Director within ACPHD. The Office of Violence Prevention works to ensure a better understanding of the scope of violence across Alameda County and the communities disproportionately impacted by the experience of trauma. In carrying out this work, the Alameda County Public Health Department will help to improve community discourse about factors that contribute to violence and foster conversations

and action planning to implement strategies that promote resilience among individuals, families, and communities. The OVP will take on the role of Chief Health Strategist to implement a cross-sector approach that focuses on upstream policy change, empathy training, neighborhood reclamation, midstream hospital-based violence intervention and trauma-informed care, and downstream restorative justice programming and community healing practices.

Front Door Program

The Front Door Program is a new program in the Public Health's Nursing (PHN) Division within ACPHD that will serve as a resource and central referral unit for individuals, families, providers, communities, and organizations. The "Front Door" objective is to bridge that gap of knowledge and access, by directing individuals in need, to supportive, useful, and appropriate services, through care coordination and connection to services.





Signature Project Staff

The following staff lead the CHIP Signature Program.

Table 2. CHIP Signature Program Lead Staff

Signature Program Division & Name	Lead Staff	Title
Public Health Nursing:		
Front Door	Shannon Benson	Senior Program Specialist
Community Health Services:		
WIC	Kathleen Willkom	WIC Program Director
	Candice Poon	Senior Nutritionist
Office of the Director:		
Office of Violence Prevention	Kristen Clopton	Violence Prevention Manager
	Michael Huff	Program Services Coordinator
Family Health Services:		
EmbraceHer	Dana Cruz Santana	MPCAH Coordinator & Healthy Start Director
	Danielle Davis	Interim Program Manager
Division of Communicable Disease Control and Prevention:		
Sexual and Reproductive Health	Curtis Moore	Interim Section Director, HIV/STD/HCV
	Eileen Dunne	STD/HIV Controller
Immunization	Kaeb Menker	Director of Immunization
	Mark Johnson	Operations Manager



Implementation Process

The CHIP process is to be rolled out in two phases over two years beginning in fall 2023. The following graphic describes the process.



Figure 11: ACPHD's CHIP implementation process timeline. Revised September 2023.

The Signature Pilot Programs, referencing the first cohort of programs contributing to the CHIP, launched in the fall of 2023 and will be ongoing with the addition of a second cohort estimated to

be in Summer 2024. Signature Programs will work on a CHIP program portfolio highlighting program activities, best practices, and strategies on addressing the CHIP priorities.

Community of Practice

ACPHD is committed to the role of Chief Health Strategist and will work to incubate a community of practice with the Signature Pilot Programs and their community-based partners. The CHIP Planning team's intention is to convene a group of people who come

together to build and share knowledge and skills to develop networks and provide recognition. Additionally, the community of practice will build momentum and desire for change for the CHIP's priority areas.



Figure 12: Community of Practice Framework



Planned Convening Timeline

ACPHD plans to follow the following timeline to continue developing its CHIP. Updates will be made as we continue developing this process.

Table 3. CHIP Convening Timeline

Meeting	Agenda	Date
Workgroup Convening #1	Introduce programs and program leads. Understand program impacts. And review programs' evolution into Public health 3.0.	October 2023
Workgroup Convening #2	Review CHIP concept project and Technical Assistance.	February 2024
Workgroup Convening #3	Data review and progress	April 2024
Workgroup Convening #4	Data review and progress	June 2024
Workgroup Convening #5	Data review and progress	August 2024
Workgroup Convening #6	Data review and progress	October 2024



Community Stakeholders and Centering Equity

ACPHD understands that the public health system is made up of more than just clinics and hospitals, but rather, all sectors that impact health. This includes community sectors such as schools, housing and food security entities, transportation agencies, workforce development organizations, employers, and health care, mental health care and oral health care providers. In developing the CHIP, ACPHD

focused on programs and partners that reflected where our communities live, work, worship, and play. ACPHD values the work of community-based partners and all that they bring to the table. The community-based partners invited to be part of the community stakeholders will be carefully considered using criteria that promote the voices of all communities living in Alameda County.



Evaluation Plan

“Evaluation” refers to various activities that provide evidence about what a program or strategy did and how well it achieved its aims⁶. Evaluations are designed to answer predetermined questions and are carried out over a discrete time frame. They often require additional data beyond what is normally collected for regular performance tracking.



Figure 13: The Centers for Disease Control and Prevention Program Performance and Evaluation Office uses the continuous program improvement cycle.

The CHIP evaluation will implement two types of evaluations described below.

The first type of evaluation, a **Formative Evaluation**, will seek to answer questions about how the different programs are designed and carried out. The evaluation will aim to clarify a program's or strategy's plans and to make improvements early on. Some of the questions this evaluation will address include:

- 1 What are the goals and objectives of the program or strategy?
- 2 What population is the intervention intended to serve?
- 3 Are the activities appropriate for the identified goals and population?
- 4 What is the intervention's expected impact? Is there sufficient evidence to support this prediction?
- 5 Are the data being collected sufficient to document implementation and outcomes?
- 6 Is the implementation timeline achievable?
- 7 Are there opportunities to apply more multidisciplinary approaches?
- 8 Are the right partners involved in the project implementation?
- 9 Can we rely more on the expertise of community members to fill knowledge gaps?



The second type of evaluation for the CHIP is a **summative or impact evaluation**. The summative evaluations will examine the programs' ability to perform the chief health strategist competencies and elevate impact. Some of the questions this evaluation will seek to address include:

1

Have the programs developed effective strategies to promote health and well-being?

2

Have the programs improved their ability to collect, analyze, and use data for improvement?

3

Have the programs collaborated with a broad array of partners, including neighborhood-level and non-health sectors?

4

Have the programs updated organizational practices through innovation and evaluation efforts?

The evaluation methods and tools will be developed in partnership with the signature program staff to ensure reliability and relevance. Evaluation data will be collected periodically, and evaluation summaries will be reviewed quarterly with the signature programs to adjust as needed.



Conclusion

The ACPHD thanks our collaborators and partners in the development and implementation of the Community Health Improvement Plan. As we continue developing this process, this live document will live on our website at www.acphd.org and will provide updates periodically. For further information, please contact the Quality Improvement and Accreditation Division at QIA@acgov.org.

Footnotes

1. Alameda County Public Health Department, Community Health Needs Assessment can be accessed here: <https://acphd.org/chip/chna/>
2. DeSalvo KB, Wang YC, Harris A, Auerbach J, Koo D, O'Carroll P. Public Health 3.0: A Call to Action for Public Health to Meet the Challenges of the 21st Century. *Prev Chronic Dis* 2017;14:17001
3. <https://www.cdc.gov/publichealthgateway/publichealthservices/essentialhealthservices.html>
4. <https://phaboard.org/center-for-innovation/public-health-frameworks/the-foundational-public-health-services/>
5. [Alameda County Public Health Department Website](#). Accessed January 5, 2024
6. Tatian, Peter A. 2016. [Performance Measurement to Evaluation](#). Washington, DC: Urban Institute
7. US Census Bureau, QuickFacts for Alameda County and California, <https://www.census.gov/quickfacts/fact/table/CA,alamedacountycalifornia/PST045221>, accessed November 30, 2022.
8. Alameda County Public Health, California Comprehensive Birth & Death Files, 2016–2020.
9. American Community Survey, 2015–2019.
10. Alameda County Public Health, California Comprehensive Birth & Death Files, 2016–2020.
11. American Community Survey, 2015–2019.

Footnotes

12. Alameda County Public Health, CalREDIE and CAIR, November 2021.

13. Alameda County Public Health, California Comprehensive Birth & Death Files, 2016–2020.

14. Ibid.

15. Alameda County Public Health, California Comprehensive Birth & Death Files, 2016–2020.

16. Ibid.

17. <https://www.managementcenter.org/resources/smartie-goals-worksheet/>



Appendix

Alameda County Public Health Essential Public Health Services

The Department follows the 10 Essential Public Health Services model. These services are the following:

1. Assess and monitor population health status, factors that influence Health, and community needs and assets.
2. Investigate, diagnose, and address health problems and hazards affecting the population.
3. Communicate effectively to inform and educate people about Health, factors that influence it, and how to improve it.
4. Strengthen, support, and mobilize communities and partnerships to improve Health.
5. Create, champion, and implement policies, plans, and laws that impact Health.
6. Utilize legal and regulatory actions designed to improve and protect the public's Health.
7. Assure an effective system that enables equitable access to the individual services and care needed to be healthy.
8. Build and support a diverse and skilled public health workforce.
9. Improve and innovate public health functions through ongoing evaluation and research and continuous quality improvement.
10. Build and maintain a strong organizational infrastructure for public Health.



Foundational Public Health Services

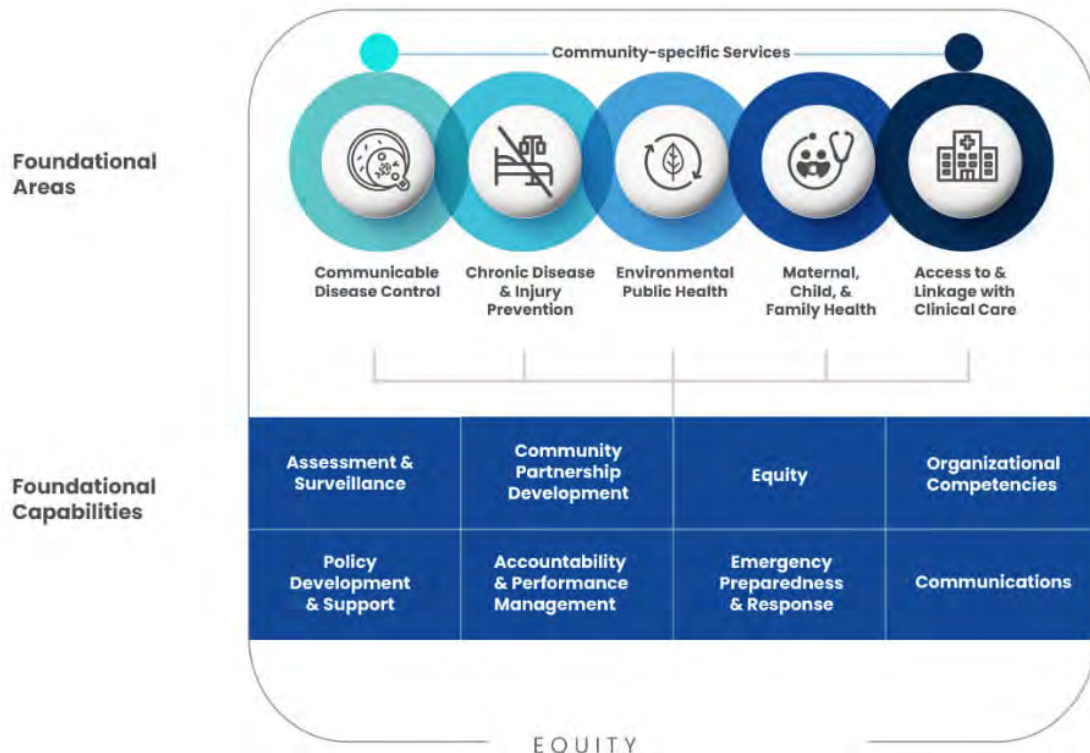


Figure 14: Image of the Foundational Public Health Services Framework alongside the Foundational Capabilities.

Alameda County Public Health Department's work is also informed by the FPHS.

The Foundational Areas include:

1. Communicable Disease Control
2. Chronic Disease & Injury Prevention
3. Environmental Public Health
4. Maternal Child and Family Health
5. Access to & Linkage with Clinical Care

Foundational Capabilities include:

1. Assessment & Surveillance
2. Community Partnership Development
3. Equity
4. Organizational Competencies
5. Policy Development & Support
6. Accountability & Performance Management
7. Emergency Preparedness & Response
8. Communications

Community Health Needs Assessment (CHNA)

The process to develop the CHIP priority areas began with the data collection and input provided through the CHNA. These assessments are due to a mandate established by the Affordable Care Act that requires hospitals to assess and prioritize the needs of their service areas to maintain nonprofit status.

The ACPHD's assessment was conducted in partnership with hospitals serving Alameda County residents. Conducting a comprehensive community needs assessment is an essential public health function and should be updated at least every three to five years. In addition, the Public Health Accreditation Board (PHAB) outlines a set of processes that inform the CHIP, which include the following:

- At least two priorities are addressed that resulted from the CHNA.
- Each priority must have objectives and strategies that address these priorities.
- At least two strategies need to be policy-related.

- The plan must have clear roles and responsibilities for every partner involved in this process.
- Departments must partner with community stakeholders to drive the work.
- Departments must consider alignment with other public health plans.

ACPHD joined Kaiser Permanente, Stanford Health Care, John Muir Health, Sutter Health, UCSF Benioff Children's Hospitals, and other organizations in the planning, implementation, and completion of the CHNA.

The CHNA collected primary data through key respondent interviews with individuals and through focus groups of residents. To identify issues that most impact the Community's health, local public health experts, community leaders with expertise on local health needs, and individuals

with knowledge and/or lived experience of racial health inequities were recruited to participate in focus groups or key respondent interviews. ACPHD's Community Planning and Assessment Unit (CAPE) provided secondary data on relevant morbidity and mortality trends. These data were augmented by Kaiser Permanente's data platform.

The ACPHD staff and key stakeholders identified three priority areas from the CHNA that are the focus of this CHIP:

1. Health and Behavioral Care Access and Delivery.
2. Economic Security and Opportunity.
3. Promoting Peaceful Families and Communities.

1. Health and Behavioral Care Access and Delivery

Community respondents emphasized that limited English speakers had long waits for clinical and mental health services in their native languages. Respondents also said that transgender people struggled to find accepting services. Key respondents reported barriers to accessing care, such as transportation, the cost of insurance, and the cost of health care.

Issues appeared throughout the County. Oakland, the County's largest city and one of the country's most diverse, has fewer uninsured residents compared with other areas of the state, but Oakland has lower Medi-Cal enrollment rates than the state and the nation despite a higher poverty rate than the state.⁷ Significant disparities exist: two Oakland neighborhoods with higher

Hispanic populations have higher rates of uninsured children compared with Oakland in general.

Infant mortality rates are 200 percent worse for Multiracial infants and 165 percent worse for Black infants than for the city.⁸

San Leandro, the County's fifth-largest city, has higher rates of insured populations compared with California.⁹ Other measures, such as infant mortality,¹⁰ are on par with Alameda County. But again, disparities exist. Black residents experience higher rates of infant mortality than San Leandro generally. COVID-19 death rates were highest among Multiracial and Black residents compared with all other racial and ethnic groups. The

ZIP code with the highest proportion of Hispanic residents had the highest rate of uninsured, both for the total population and for children.¹¹ Pacific Islander residents had the highest rate of COVID-19 cases across Fremont, while white residents had the highest death rates.¹²

Behavioral Health, which includes mental health and trauma, as well as consequences such as substance use, ranked high as a health need in Livermore, in the County's east. Key respondents mentioned a particular need to address substance use within the unhoused Community.

Objectives Summary

Objectives for this area target preventive care, including cancer screening and reducing HIV transmission; reducing disparities; increasing access to healthy foods; reducing the number of adults and children who have a major depressive episode; and ensuring people's basic needs are met.

2. Economic Security and Opportunity

Income and employment are significant issues for Alameda County residents. Education generally correlates with income, making statistics that differ by race/ethnicity concerning. Smaller proportions of Alameda County's Black, Latinx, Native American, and Pacific Islander 11th graders meet or exceed grade-level English language arts standards compared with California 11th graders overall. Also, a smaller percentage of Black, Latinx, and Pacific Islander 11th graders meet or exceed math standards. Much smaller proportions

of Alameda County's Black and Pacific Islander high school graduates completed college-preparatory courses compared with high school graduates statewide. The high school drop-out rate is particularly high among Alameda County's Latinx youth compared with all California youth.

In some Oakland neighborhoods, poverty rates are alarmingly high: 22 to 24 percent. Oakland youth have higher rates of being neither in school nor working than the state.

Objectives Summary

Objectives selected include reducing food insecurity and hunger, reducing the proportion of people living in poverty, improving education and employment opportunities, and providing quality, affordable housing.

3. Promoting Peaceful Families and Communities

Community safety issues, including gun violence, premature death by injury, and pedestrian accident death, present major health barriers in Oakland, especially for Black populations.¹³ San Leandro experiences rates of injury death 11 percent higher than Alameda County as a whole,¹⁴ with Black residents experiencing the highest rates of motor vehicle crash death of all ethnic groups in San Leandro.¹⁵

Native Hawaiian / other Pacific Islander residents experience injury death rates higher than San Leandro overall.¹⁶

In Livermore, key respondents discussed a lack of safe outdoor spaces to exercise and recreate as primary concerns about community safety. Several focus group participants believed that many community parks had become

places of illicit activities, specifically alcohol and drug use, that made their neighborhoods less safe. While many community safety statistics are better in the Tri-Valley than the state, the rate of violent crimes is higher.

Respondents throughout the County shared that during the COVID-19 pandemic, domestic violence increased with additional stress, and residents were trapped in the house with their abuser. Also, they spoke about the increase in anti-Asian hate crimes, which caused trauma and left residents afraid to leave their homes.

Objectives Summary

Area objectives selected include reducing firearm-related deaths and assault injuries, promoting healthy decision-making, providing equitable and effective crime reduction strategies, and ensuring the reentry community has opportunities to become contributing and productive members of society.

Community Health Improvement Plan Planning Team

The planning process began with internal programs and leadership reviewing findings from the CHNA and prioritizing focus areas for community health improvement. The prioritization process was driven by the mandate to amplify existing work, create opportunities for expanded partnerships, and promote data-driven innovations that addressed the leading causes of death. Next, the planning team convened with internal stakeholders to define the implementation process, including strategy identification, associated SMARTIE¹⁷ objectives, and evaluation activities. Before the formal CHIP launch, the last step was to apply strategy, SMARTIE objectives, and evaluation – to identify and invite internal programs that can significantly contribute to the priority areas.

ACPHD staff and team members within the Quality Improvement and Accreditation Division established the CHIP planning process. Members include:

- **Kimi Watkins-Tartt**
Director of ACPHD
- **George Ayala**
Deputy Director of ACPHD
- **Evette Brandon**
Quality Improvement and Accreditation Director
- **Carolina Guzman**
Quality Improvement Manager
- **Gabriela Castillo**
Project Manager
- **Sadaf Siddiq**
Health Program Planner
- **Margaret Crecy**
Health Program Planner
- **Kristin Clopton**
Violence Prevention Manager
- **Tram Nguyen**
Health Equity, Policy & Planning
Interim Deputy Director
- **Sandi Galvez**
Health Equity, Policy & Planning
Director

In line with the Foundational Capabilities, upcoming implementation activities are wholly defined by the CHIP partners and what emerges as the work begins. Full implementation begins with deepened and expanded Community Partnership Development. This stage is critical as the process has remained primarily internal based on the constraints described in Community Health Improvement Plan Development Section. The next stages are guided by the FPHS framework and are anticipated to follow a sequence that elevates equity, then Policy Development and Support, with Accountability and Performance Management, closely tied to the evaluation process, as the last implementation stage for the initial cohort.

The Signature Pilot Programs, comprised of ACPHD staff, and their community-based organization partners, will:

- Define a focus and lead three workgroups aligned with the CHIP priority areas.
- Finalize SMARTIE objectives and propose benchmarks for success.
- Identify additional community stakeholders to support implementation.
- Recommend incentives, including technical assistance, mini-grants, and other supports to incentivize participation.



Proposed Population Outcomes by Priority Areas

Health and Behavioral Care Access and Delivery Objectives

Healthy People 2030:

- AHS08 – Increase the proportion of adults who get recommended evidence-based preventive health care.
- OH08 – Increase the number of community organizations that provide prevention services.
- ECBPD07 - Increase the number of community organizations that provide prevention services.
- Increase the proportion of adults who get screened for cancer.
- AHS04 – Reduce the proportion of people who cannot get medical care they need it.
- AHS06 – Reduce the proportion of people who cannot get prescription medicines when they need them.
- HC/HITD11 - Increase the proportion of adults with limited English proficiency who say their providers explain things clearly.
- HIV03 – Reduce the number of new HIV diagnoses.
- HIV01 – Reduce the number of new HIV infections.

National Prevention Strategy:

- Support implementation of community-based preventive services and enhance linkages with clinical care.
- Reduce barriers to accessing clinical and Community preventive services, especially among populations at greatest risk.
- Enhance coordination and integration of clinical, behavioral, and complementary health strategies.
- Provide people with tools and information to make healthy choices.
- Reduce disparities in access to quality health care.
- Increase access to healthy and affordable foods in communities.
- Support policies and programs that promote breastfeeding.
- Support reproductive and sexual health services and support services for pregnant and parenting women.
- Provide individuals and families with the support necessary to maintain positive mental well-being.

Let's Get Healthy CA

- Increase the number of individuals who report very good, or excellent health to 60% over the next ten years.
- Reduce the number of adults and adolescents who experience a major depressive episode.
- Reduce Adverse Childhood Experiences (ACEs).

Alameda Vision 2026

- Ensure that all Alameda County residents live in Healthy Communities.
- Strengthen safety net health services for vulnerable populations.
- Promote preventative health care strategies.
- Ensure everyone's basic needs are met.

Economic Security and Opportunity Objectives

Healthy People 2030:

- SDOH01 - Reduce the proportion of people living in poverty.
- SDOH02 - Increase employment in working-age people.
- SDOH04 - Reduce the proportion of families that spend more than 30 percent of their income on housing.
- NWS01 – Reduce household food insecurity and hunger.

National Prevention Strategy

- Design and promote affordable, accessible, safe, and healthy housing.
- Improve education and employment opportunities.

Let's Get Healthy CA

- Creating healthy communities – Reduce Poverty.
- Creating healthy communities – Reduce unemployment.

Alameda Vision 2026

- Provide quality housing that is affordable to all residents.
- Increase the availability of housing to meet the needs of County residents.



Promoting Peaceful Families and Communities Objectives

Healthy People 2030:

- IVP13 – Reduce firearm-related deaths.
- IVP10 – Reduce nonfatal physical assault injuries.
- IVP18- Reduce sexual or physical dating violence.
- LGBT01 - Increase the number of national surveys that collect data on lesbian, gay, and bisexual populations.

National Prevention Strategy

- Design and promote affordable, accessible, safe, and healthy housing.
- Promote positive social interactions and support healthy decision-making.
- Create environments that empower young people not to drink or use other drugs.
- Strengthen policies and programs to prevent violence.
- Provide individuals and families with the knowledge, skills, and tools to make safe choices that prevent violence and injuries.
- Promote positive early childhood development, including positive parenting and violence-free homes.



Let's Get Healthy CA

- Creating Healthy Communities – Increasing neighborhood safety.

Alameda Vision 2026

- Ensure that all Alameda County residents live in Healthy Communities.
- Enhance the safety, well-being and resiliency of vulnerable populations.
- Provide equitable and effective crime reduction strategies.
- Provide the reentry community with the opportunities to become contributing and productive members of society.



ALAMEDA COUNTY HEALTH CARE SERVICES AGENCY
PUBLIC HEALTH DEPARTMENT

For further information about
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