Public Health
Department
Alameda County Health
COMMUNITY HEALTH SERVICES DIVISION
2024-2025 COMMUNITY IMPACT REPORT

CONTENTS

I. INTRODUCTION 3

II. ACCOMPLISHMENTS 6

- HEALTHY COMMUNITIES, SYSTEMS & ENVIRONMENTS 7
- COMMUNITY HEALTH PROMOTION & PREVENTION 14
- HEALTH NAVIGATION & CHRONIC DISEASE SUPPORTS 22

III. PROGRAMS 27

- ASTHMA 28
- CARE PARTNERS 30
- HEALTHY BRAIN INITIATIVE 32
- HEALTHY NAIL SALON PROGRAM 34
- NUTRITION SERVICES 36
- OFFICE OF DENTAL HEALTH 39
- OLDER ADULTS HEALTHY RESULTS 41
- TOBACCO CONTROL 43
- WOMEN, INFANTS AND CHILDREN (WIC) 45

I. INTRODUCTION

The Community Health Services Division is centered on chronic disease prevention and mitigation programs that reach across the life course, from early childhood through youth resiliency and healthy aging. This diverse array of programs is united by the effort to create healthier communities, to empower residents to eat and exercise in ways that support optimal health, and to assist residents with better managing their health. Health equity remains our North Star.

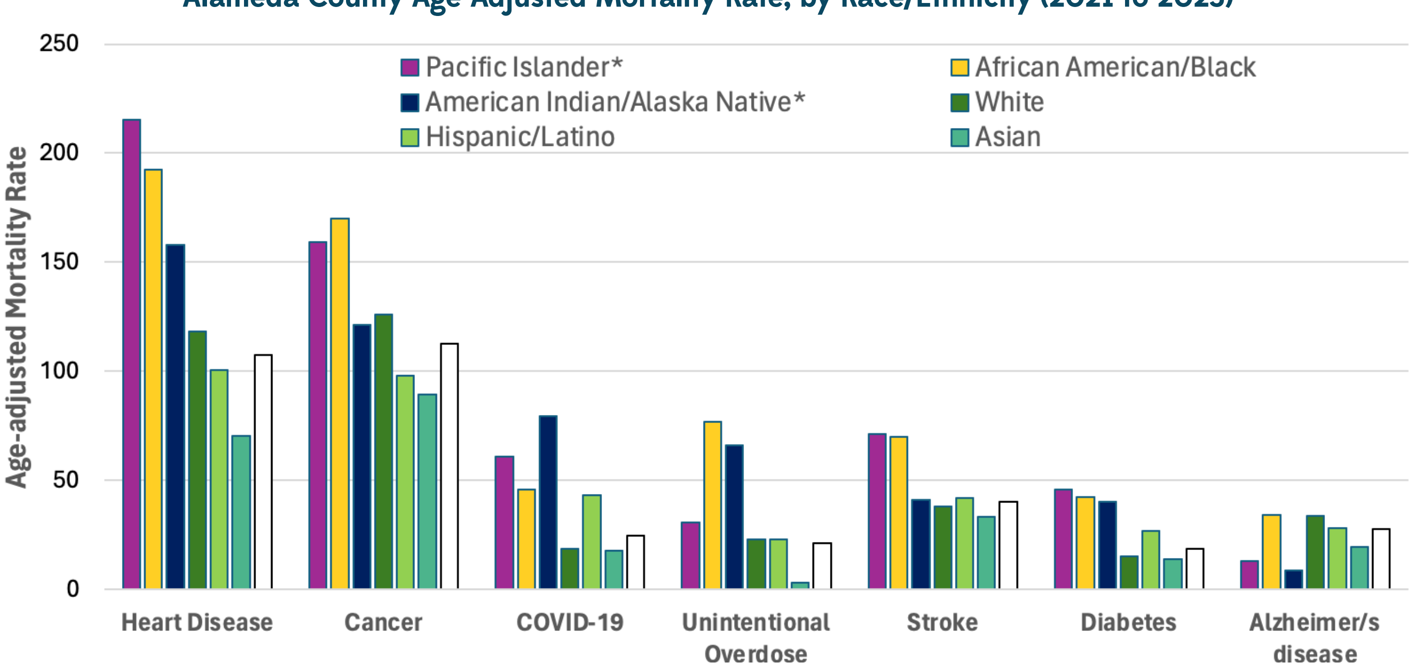
Chronic diseases—including cancer, heart disease, diabetes, and Alzheimer's and related dementias—remain leading causes of death in Alameda County, in California, and in the nation. This is especially true starting in middle age, often reflecting lack of access to healthy foods and exercise opportunities earlier in life. Many more people live with the disabling effects of chronic diseases, including asthma and dental concerns, that make them miss school or work or limit their participation in the community.

Alameda County Leading Cause of Mortality Overall and a Young Age

	<1	1–17	18–29	30–44	45–64	65–74	75+	Total Deaths
1	Perinatal conditions	Homocide	Unintentional drug overdose	Unintentional drug overdose	Cancer	Cancer	Heart disease	Cancer
	146	43	263	636	2,326	2,999	6,498	11,144
2	Congenital anomalies	Suicide	Homocide	Heart disease	Heart disease	Heart disease	Cancer	Heart disease
	61	29	227	262	1,689	2,007	5,485	10,510
3	Sudden infant death syndrome (SIDS)	Cancer	Unintentional motor vehicle crash (MVC)	Cancer	Unintentional drug overdose	Stroke	Stroke	Stroke
	23	27	153	256	747	569	2,915	3,960
4	Symptoms, signs, and abnormal clinical and laboratory findings, not elsewhere classified	Unintentional motor vehicle crash (MVC)	Suicide	Homocide	Diabetes melitis	Diabetes melitis	Alzheimers disease	Alzheimers disease
	17	27	131	253	477	440	2,620	2,798
5	All other external causes and injuries*	All other external causes and injuries*	All other external causes and injuries*	Suicide	Chronic liver disease and cirrhosis	COVID-19	COVID-19	COVID-19
	15	22	71	213	436	438	1,283	2,189

Source: Alameda County vital statistics files, 2020–2024.
* Injury other than homocide, suicide, unintentional motor vehicle crash and unintentional overdose

Unfortunately, we see a striking pattern of concentrated inequities affecting African American/Black and Pacific Islander people across nearly every leading causes of death.



Ultimately, these disparities affect all of us, in reduced community health, increased healthcare costs, and lost productivity. One way to quantify just a portion of these costs is illustrated in this table:

2023 Alameda County Resident Emergency Dept and Hospitalizations Summary

	Hospital charges	Number of hospitalizations
Cardiovascular disease, except stroke	$2,080,385,426	12,882
Cancer	$1,194,804,998	5,548
Stroke	$630,813,749	3,828
Diabetes	$381,466,355	4,444
Asthma	$31,020,226	534
TOTAL	**$4,318,490,754**	**27,236**

Source: CAPE analysis of Alameda County HCAI data from the California Community Burden of Disease Engine

While poor nutrition, lack of exercise, and exposure to tobacco and environmental toxins are often singled out as the key drivers of chronic disease, these are not just the result of individual choices. They are driven by structural factors shaped by public and organizational policies. These policies, in turn, support or prevent access to fresh foods and social supports that shape our health, including education, quality health care, meaningful career choices and safe places to live, work and play.

Each CHS program addresses chronic disease on multiple levels, seeking to change systems and policies that drive health; to empower residents to choose healthier behaviors in terms of diet, exercise, and tobacco use; and to support individuals and families in navigating complex health and social systems. This Annual Report highlights CHS's accomplishments across three large strategies:

Healthy Communities, Systems & Environments

Community Health Promotion & Prevention

Health Navigation & Chronic Disease Supports

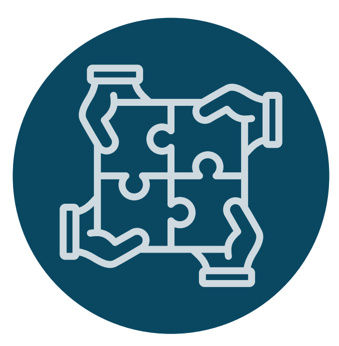
The next three chapters highlight the results of CHS programs organized within each of these three strategies, or levels of change.

THE ROAD AHEAD

Looking ahead, we will strive to meet this moment, a time when many of our most vulnerable residents are facing cuts and changes to federally funded, vital public benefits. We will continue to partner with community champions, promotoras, peer educators, and community-based organizations to find creative solutions to support residents' nutrition security, maintain their health coverage, and link them to needed services.

In the year ahead, CHS anticipates expanding collaborations across programs to achieve greater collective impact for our community. Starting in fall 2025, we are standing up a Community Engagement unit to build outreach capacity across our program areas, allowing more holistic outreach to community members. In recognition of the impact of cancer as the leading cause of death in our county, and in partnership with the Public Health Commission and others, we are launching the next phase of our Cancer Initiative, which is completing a community needs assessment. At the same time, we are welcoming two new programs that have been incubated elsewhere in AC Health and the County: the Recipe4Health "food as medicine" program and the Office of Violence Prevention. They will add depth and connection to existing work within CHS focused on nutrition security and on youth resiliency.

II. ACCOMPLISHMENTS



Healthy Communities, Systems & Environments

Community Health Promotion & Prevention

Health Navigation & Chronic Disease Supports

ACCOMPLISHMENTS: HEALTHY COMMUNITIES, SYSTEMS & ENVIRONMENTS

Creating and sustaining equitable improvements in population health requires creating the conditions and environments that support optimum health. This section highlights how CHS programs are building healthy communities by changing policies, systems and environmental factors that support improved health outcomes. CHS programs have worked with elected leaders, schools, small businesses, and have brought together strategic partners to improve coordination of services and change the environments that influence health among priority populations.

ASTHMA

This year Asthma Start's social workers joined a multi-disciplinary committee through RAMP (Regional Asthma Management & Prevention, a Public Health Institute Initiative) to create Integrated Pest Management guidelines (IPM). The guidelines will help asthma remediation providers identify and address pest issues during in-home environmental asthma trigger assessments, and in turn, build client capacity for sustainable and less-toxic household pest management. Asthma Start's social worker shared years of experience in the field, working with both clients and property owners and later presented at a RAMP Asthma Home Visitors Webinar—attended by asthma educators throughout California—where these guidelines were introduced. The guidelines covered how to:

» Provide an overview of what IPM is and why this healthier, more sustainable approach is important to use when addressing pests as part of Asthma Remediation.

» Build provider capacity to identify pests and signs of pests during an in-home environmental asthma trigger assessment.

» Build provider capacity to educate clients/families about what they can do to prevent and manage pests.

» Help providers identify sources of pest problems that could potentially be addressed through Asthma Remediation (e.g. exposed food and trash, plumbing leaks, cracks and crevices).;

» Describe the types of supplies and services that the Asthma Remediation program may provide to address pests.

> "The repairs in the home and the air purifier helped everyone in the home."

CARE PARTNERS

Alameda County's chronic-conditions/end-of-life care landscape is often fragmented, leaving many older adults and their caregivers uncertain about where to turn for support. To address this, Care Partners facilitates the **Palliative Care & Hospice Providers Coalition** to foster connection, knowledge-sharing, and cross-sector collaboration to build a more coordinated and informed system of care that highlights and scales promising practices. Out of 94 members, key partners include Stanford, Alameda Health System, hospice and palliative care agencies, community- and faith-based organizations, and federally qualified health clinics.

HEALTHY BRAIN INITIATIVE

The Healthy Brain Initiative (HBI) made significant strides in their top priority of improving systems of care for older adults by training health and social service providers and family caregivers to address the unique needs of the growing number of adults with Alzheimer's Disease and Related Dementias (ADRD).

HBI completed trainings with the following service providers this year:

- 335 informal caregivers and/or community members
- 202 housing services providers
- 147 first responders
- 33 health care providers of complex case management and palliative care services at Alameda Health System
- 23 staff members at City of Berkeley including two senior centers, social services and Meals on Wheels
- Seven staff from five older adult mental health services CBOs who were taught to train other staff at their organizations to administer the mini-cog screening for ADRD

Using a "train the trainers" approach, HBI will continue to support dissemination of these trainings to create a more responsive system of care for the County's older adults.

HBI also made progress incorporating the needs of people with ADRD into Alameda County's Emergency Planning and Preparedness efforts. During the fall of 2024, HBI, together with Quality Improvement and Accreditation (QIA), developed and launched the Alameda County Access and Functional Needs (AFN) Advisory Committee. Two public-facing committee co-chairs were appointed to lead this group: Elsie Kusel, Prevention, Preparedness, Education and Training, Alameda County EMS Agency; and Ron Halog, Emergency Preparedness Coordinator, ILRSCC (Independent Living Resources of Solano & Contra Costa Counties). Both are well-known and respected among emergency planning stakeholders as well as community partners supporting people with AFN.

As of June 30, 2025, the Alameda County Access and Functional Needs (AFN) Advisory Committee included 48 people from 33 cities, county agencies and community-based organizations. This group is actively implementing three priorities:

1. Review of existing city and county Emergency Operations Plans (EOPs) for AFN inclusion
2. Action-oriented projects, such as tabletop and full-scale exercises, to test recommendations
3. Invite additional members to represent Alameda County's diversity

As a result of an AFN Advisory Committee presentation to the Alameda County Emergency Managers' Association (EMA), two staff from the Alameda County Sheriff's Office of Emergency Services (ACSO-OES) joined the AFN Advisory Committee. This is an important step forward as the ACSO-OES is responsible for the county's Emergency Operations Plan.

HEALTHY NAIL SALON

The Alameda County Healthy Nail Salon Program (HNSP) continued to lead efforts to protect workers and consumers from exposure to harmful chemicals in Alameda County's more than 400 nail salons. This program advocates for long-term, systemic changes in occupational health and safety salon policies. HNSP certified two new nail salons this year, bringing the total to 18 Salons that are now certified. These salons adopted multiple health-protective strategies, including:

- Replacing high-risk products with less toxic alternatives
- Installing ventilation systems and using masks/gloves
- Conducting regular staff safety training
- Implementing cleaning and product storage protocols

HNSP centers its work in racial equity and language justice, with a focus on Vietnamese-speaking workers (which comprise over 80% of the nail salon workforce) and small business owners. The two new nail salons received ventilation units from HNSP, which significantly helps to reduce chemical exposure of nail workers and the customers in the salon.

HNSP also played a central role in developing policy guidelines for the Healthy Nail Salon Certification program. Through their participation in the Healthy Nail Salon Program Workgroup HNSP contributed to regional conversations about legislation, health equity and immigrant worker justice, lifting community voices in planning and policy development. These guidelines are now informing other county and state-level programs.

NUTRITION SERVICES

Nutrition Services' equity-centered policies, systems and environmental (PSE) change work embeds health into structures that shape daily life for our Alameda County communities. These structures provide the foundation for long-term prevention of chronic diseases such as heart disease, diabetes and cancer.

⊕ Transforming schools and housing sites into spaces that nourish health

» 70 school gardens maintained or revitalized with Oakland and San Lorenzo Unified School Districts promoting nutrition education and hands-on learning

» Two new gardens installed at affordable housing sites for families and seniors bringing fresh food steps from home

» One food pantry reinstated at East Oakland Boxing Association expanding food access through our Measure A-funded partner

⊕ Centering wellness in community life

» 13 walking groups are thriving! Where older adults are integrating physical activity and social connection

» 1,350 farmers market vouchers distributed connecting families with local, seasonal produce while supporting regional food systems through a Measure A funded partner

> "The community loves that cut-up fruits (watermelon, cantaloupe, etc.), sandwiches.... and boxes of strawberries are available because of the new refrigerator."
> –Owner, General Market in West Oakland

⊕ Refrigeration in retail to support healthy choices

Thanks to the California Department of Agriculture Refrigeration Grant, four Healthy Retail Program partners—Jalos, Wah Fey, General, and Dallaq—installed energy-efficient refrigeration in the fall of 2024. These upgrades:

» Made space for fresh fruits, veggies, and frozen meats

» Helped 100% of stores report increased sales of healthier food options

» Strengthened neighborhood economies by making fresh food an accessible and local choice.

⊕ Systems change on the horizon, our long-term investment in community health will include

» 30 fruit trees planted at San Lorenzo High School embedding fresh food access into the school landscape.

» 70 fruit trees distributed to families in East and West Oakland rooting nutrition directly in community and at homes.

OFFICE OF DENTAL HEALTH

The Office of Dental Health launched a new five-year Oral Health Strategic Plan for Alameda County. In their role as Chief Health Strategist, ODH convened a committee of over 30 community leaders, health professionals, and advocates to plan and, most important, commit to jointly implement this 5 year plan to improve oral health for all Alameda County residents. Participants formed strong partnerships and demonstrated a commitment to identifying essential goals, including improving access to care, expanding the workforce, and advocating for meaningful policy changes.

Implementation of the strategic plan is already taking place through several robust advisory committees and workgroups, including: the Strategic Planning Steering Committee, workgroups focused on special needs, early childhood, and homelessness. These engagements ensure that population-specific trends and barriers are continuously monitored, addressed and guided in how services can be improved and expanded.

⊕ Perinatal Dental Demonstration Project

The Perinatal Dental Demonstration Project (PDDP) tested and refined integrated strategies to drive sustainable system change in perinatal oral healthcare. This year the project's main activities included providing interdisciplinary workforce training, tailored patient education, and implementing a closed-loop referral process that ensures oral health assessments and connections to care occur where individuals already receive services. Through these innovative efforts, PDDP is generating models and evidence for integrating oral health into broader

maternal and child health programs, laying the groundwork for scalable, sustainable change that closes care gaps and improves health outcomes.

⊕ Oral Health & Fluoride Varnish Application Training

The Office of Dental Health partnered with Alameda Alliance for Health to create a recorded video for medical providers on oral health and fluoride varnish application training. This resource will be available for providers to watch, allowing them to incorporate oral health assessments and fluoride varnish applications into their practice.

⊕ Advocacy and Mobilization

The Kindergarten Oral Health Assessment (KOHA) requirement (AB 1433) enables schools to identify children with untreated dental issues proactively and helps parents find a dental home for their children. In early 2024, ODH established the KOHA committee, comprising a diverse group of dedicated stakeholders, educators, and advocates. The ODH aims to mobilize partners, capitalize on their collective expertise, leverage existing resources, and expand additional resources. Guided by the shared goal that every child in Alameda County starts school with good oral health, the committee's strategies focused on increasing parent involvement in KOHA, improving school data submission, organizing onsite assessment events at priority schools, and connecting students with necessary dental care.

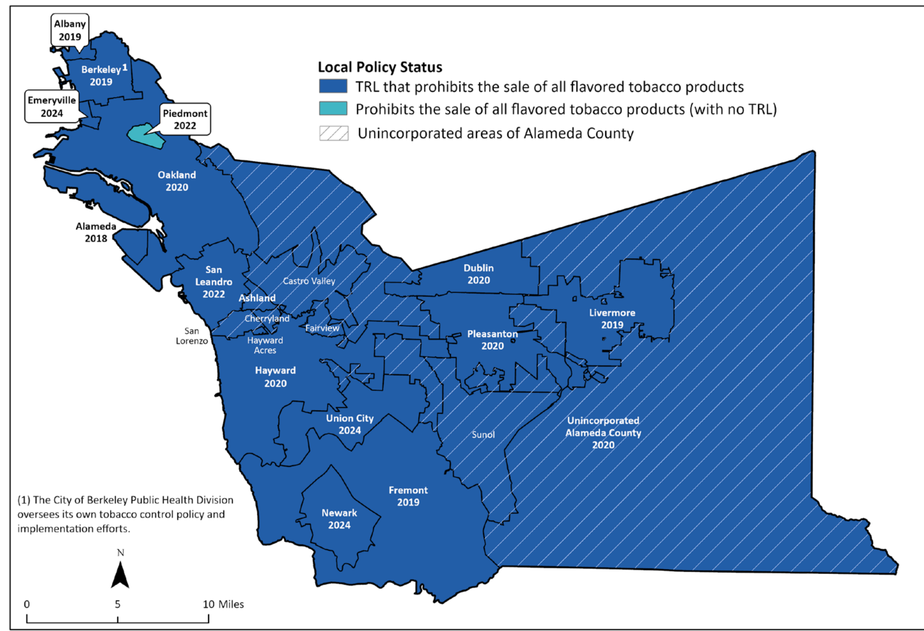
Moreover, the Public Health Commission dispatched a formal letter to the Superintendents of 18 school districts in Alameda County, urging them to promote and encourage active participation in the KOHA mandate. This initiative aims to enhance

community engagement and foster a collaborative approach to public health within the educational sector.

TOBACCO CONTROL PROGRAM

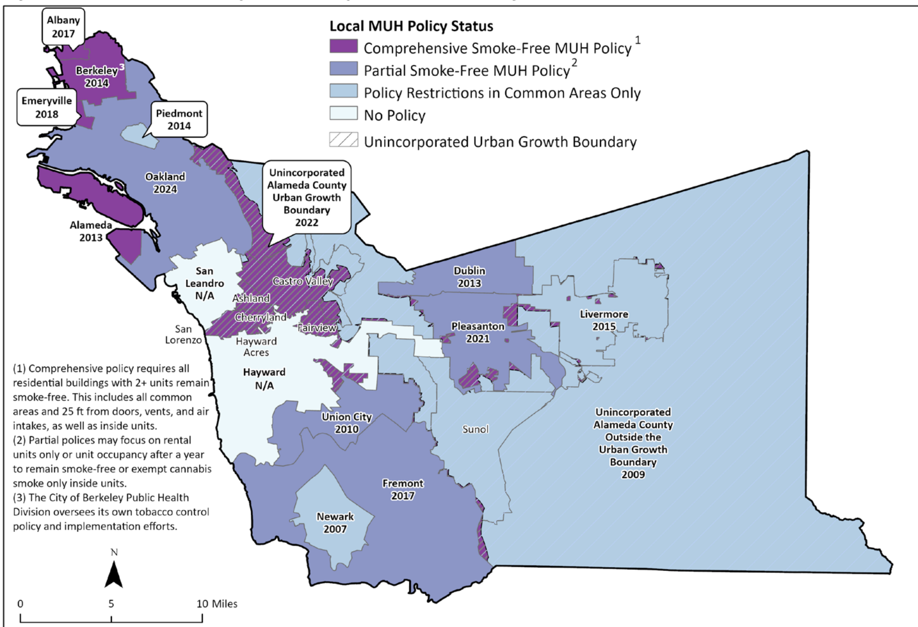
Following extensive policy education on tobacco control among residents in Newark and Oakland, the Newark City Council adopted a new tobacco retail licensing policy that included multiple provisions to hold retailers accountable for following local, state and federal tobacco sales laws aimed at reducing youth access to tobacco products. As of October 2024, all jurisdictions in Alameda County (15 of 15) have strong local laws to regulate tobacco retailers.

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



In Oakland, a coalition of partners and residents spoke up at City Council meetings about the harms of drifting smoke in multi-unit housing. In response, the City Council voted to protect all multi-unit housing residents (181,000 people) from secondhand tobacco smoke in their homes.

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



In fall 2024, the California legislature passed AB 3218 which requires that the Office of the Attorney General post a list of unflavored tobacco products that are legal for sale in California by December 31, 2025. A statewide list would simplify enforcement and create a level playing field for all retailers. The Tobacco Control Program staff recognized that this would have a huge positive impact on the health of Alameda County and California residents and that accurate information would be essential for the creation of an effective list. Program staff identified 1,800 ambiguously labeled tobacco products for which accurate information would help the Attorney General's Office in their efforts. The Program repeatedly solicited colleagues across the state to help with product research, and as a result secured participation from Sonoma, Contra Costa and Los Angeles Counties as well as many local volunteers. TCP staff trained over 30 volunteers on how to perform and document online research and will be able to submit the results of all their research to the Attorney General's Office in fall 2025.

WIC

Regional Breastfeeding Liaison Program

The Alameda County WIC Regional Breastfeeding Liaison (RBL) program promotes and supports breastfeeding in Alameda County through collaborative systems change to improve access to services, advance quality of care, and address disparities in infant feeding outcomes.

The RBL program is facilitating ongoing collaboration and quality improvement among the Medi-Cal Managed Care Plans (MCP) and all seven WIC local agencies through the new Department of Health Care Services (DHCS) MOUs between MCPs and WIC to provide high-quality, accessible, and cost-effective health care for all WIC eligible families.

Recent data shows that more than 95% of mothers in Alameda County intend prenatally to breastfeed and 71% of mothers to breastfeed exclusively. Close to 94% of newborns breastfeed at birth, with 78.6% of infants exclusively breastfeeding. However, this is not equal for all families as the data shows.

Lack of anticipatory guidance and support was identified by all birthing hospitals as significantly contributing to high rates of medically unnecessary supplementation at birth, causing two-thirds of families to not meet their goals of exclusive breastfeeding, and contributing to early cessation of breastfeeding.

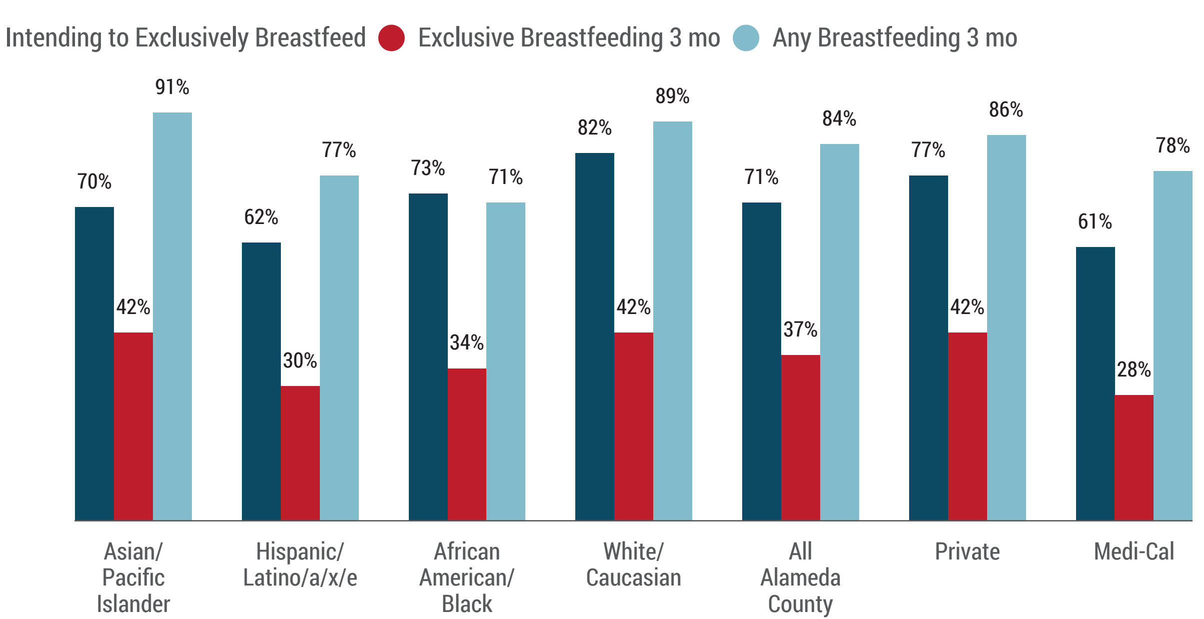
The RBL program partnered with community partners including the Fatherhood Initiative, to host a series of Parent Listening Sessions to learn more about the needs and experiences of families. Results of these groups will be shared with the Alameda County Breastfeeding Coalition, WIC programs and health care providers across Alameda County to support improvements in education and care for all families.

In June, the WIC RBL program sponsored an all-day conference for over 135 educators and care providers from more than 30 programs across Alameda County for training, resource sharing and networking in support of families. The day included a panel of parents—three moms and three dads—who shared their experiences of care and what they needed from care providers.

The conference also included keynote expert speakers and resources from Medi-Cal Managed Care Plans and a Prenatal Lactation Education and Postpartum Breastfeeding Guide with links for multi-lingual resources to share with families

- 87% of participants said they will use what parents shared to change the support they offer—like really include dads!
- 81% said they will use in educating families) and much more.

Breastfeeding at Three Months Compared to Prenatal Intention to Breastfeed Exclusively, Ranked Closest to Furthest from Maternal Goals (2019–2021)



COMMUNITY COALITIONS AND COUNCILS

CHS programs work closely with community partners and residents to prioritize and advance health goals. Community coalitions, councils, advisory bodies, and workgroups bring together a diverse array of stakeholders—including local organizations, businesses, government agencies, and community members—to tackle common issues and achieve shared goals. Many CHS Division programs leverage these groups as a core strategy to drive systemic and policy changes. The following list highlights the depth of community engagement in our work.

* Convener or Lead for this group

CARE PARTNERS

- Palliative Care & Hospice Providers Coalition*
- Alameda County Age-Friendly Council, Embracing Aging subcommittee
- Adult Protective Services Multi-disciplinary Team
- Senior Injury Prevention Program
- Area Agency on Aging Roundtable

HEALTHY BRAIN INITIATIVE

- Alameda County Age Friendly Council
  - Data Sub-Committee
  - Embracing Aging Sub-Committee (HBI Advisory Board)
- Access and Functional Needs Committee for Alameda County*

HEALTHY NAIL SALON

- California Healthy Nail Salon Collaborative
- Vietnamese American Community Center of the East Bay
- Alameda County Green Business Program

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 Community Impact Framework, Local Advisory Council
- CalFresh Healthy Living Pilot Community Consultant Pilot FFY 2025–2026
- 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
- Roots Diabetes 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
- Oral Health Strategic Planning Committee*

OLDER ADULTS HEALTHY RESULTS

- 2024 Adult Protective Services Multi-disciplinary Team Meeting
- Senior Injury Prevention Program Meeting (CBOs + County Agencies)
- Older Adult Provider Meeting (ACBH + CBOs)
- Palliative Care & Hospice Providers Coalition

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 community-based organizations and 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.

CARE PARTNERS

HBI training presentation material "Dementia Essentials"

Care Partners delivered empowering Advance Care Planning conversations that raise awareness on healthcare documentation and ownership. The culturally diverse team hosted 12 in-person Advance Care Planning workshops in multiple languages to 145 low-income older adults in residential facilities and to 105 County staff and community partners.

Partnering with the **Healthy Brain Initiative,** Care Partners delivered 12 dementia awareness and caregiver education training courses between April to June 2025, reaching 191 participants from racially, linguistically, and professionally diverse backgrounds. Fostering inclusive and high-impact learning environments around brain health, the courses focused on Alzheimer's Disease and Related Dementias, early detection, cultural stigma, and caregiver support.

Care Partners conducted monthly online trainings to 5,017 (contains duplicates) IHSS Care Providers and Recipients on a variety of topics, such as effective communication, fall prevention, food safety and self-care. These educational forums were designed to help vulnerable populations achieve equitable access to resources and improved health outcomes.

Care Partners also participated in 32 community outreach events–15 of them in high-risk zip codes—and provided program introductions to approximately 4,400 individuals. Additional outreach efforts included giving short presentations to 8,698 IHSS Care Providers in 232 IHSS daily orientation sessions. Like all other services, these outreach presentations were provided in English, Spanish, Vietnamese, and Chinese languages.

HEALTHY BRAIN INITIATIVE

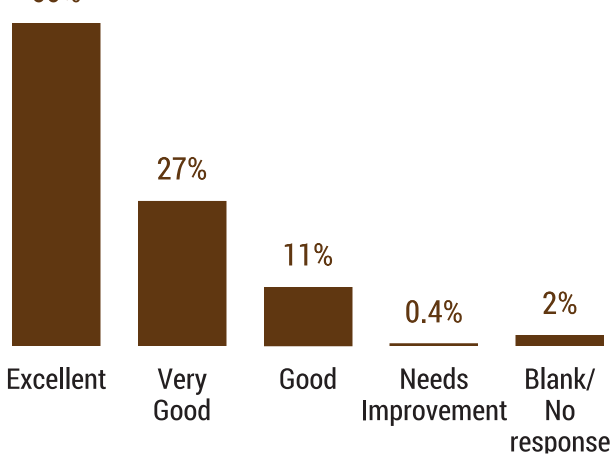
One of HBI's main goals is to provide Alzheimer's Disease and Related Dementias (ADRD) Trainings for informal/family caregivers, health care professionals, community-based organization (CBO) service providers, County staff, and others who support people living with dementia and their caregivers. Trainings are focused on the "4Ms" of geriatrics (mobility, mentation, what matters, and medication), with particular attention to ADRD.

By June 30, 2025, HBI had provided 63 ADRD training sessions to over 1,000 people across Alameda County. That is more than triple the goal in the CDPH-funded project plan to provide 20 trainings before that date. Trainings were conducted by six subject matter expert (SME) partners:

- ACPHD Care Partners
- Alzheimer's Association
- Grimsich Consulting
- Roots Community Health
- Sage Dementia Consulting
- University of California, San Francisco (UCSF)

To assure that HBI trainings were adapted to meet the culturally diverse needs of residents, HBI partnered ACPHD's **Care Partners** team, which provided more than 10 culturally-tailored trainings to African American and Chinese communities. Trainings were offered in multiple languages and delivered by staff members that align with the communities they serve. Care Partners has now integrated ADRD into their existing model of care and will continue to provide ADRD training, outreach and resource dissemination.

Overall Satisfaction: HBI Trainings (n=236)



Trainings reached a wide range of participants by age and race/ethnicity.

- Among the 173 participants that Care Partners reached in more than 10 trainings, nearly 48% identified as Asian and 47% as Black or African American. 38% of participants preferred Cantonese or Mandarin.
- The Alzheimer's Association presented trainings in Spanish to 30% of participants in its 10 trainings.

- Roots Community Health provided all of its 10 trainings to African American and Latinx community members in East Oakland.

Trainings were well received across the board. Among participants who completed the training evaluation, nearly 87% rated the trainings as "Excellent" or "Very Good."

Nearly two-thirds of training participants (59%) who completed the evaluation survey were adults age 55 and older. It is significant that 41% were under age 55, and 25% were young adults ages 25-44, as many people provide care for their parents and grandparents with ADRD.

Care Partners took this further by allowing plenty of time for questions and intentionally creating space for participants to connect with each other to talk about their experiences as caregivers, family members and friends of loved ones showing symptoms of cognitive decline and dementia. After one such training, a Care Partners team member shared this:

> *"A powerful moment came when a participant tearfully shared the heavy grief of caregiving through a loved one's dementia diagnosis and short prognosis. Her vulnerability moved the group, leading to an outpouring of empathy, support, and healing hugs. The session created a safe and supportive space for participants to grieve, reflect, and connect—many for the first time in such a setting.*
>
> *As a result, one participant asked to be connected to the HBI program for future sessions, and shared*

plans to initiate a family meeting with their loved one's primary care provider. Their goal: to establish a plan of care and begin the journey of caregiving with early guidance and support."

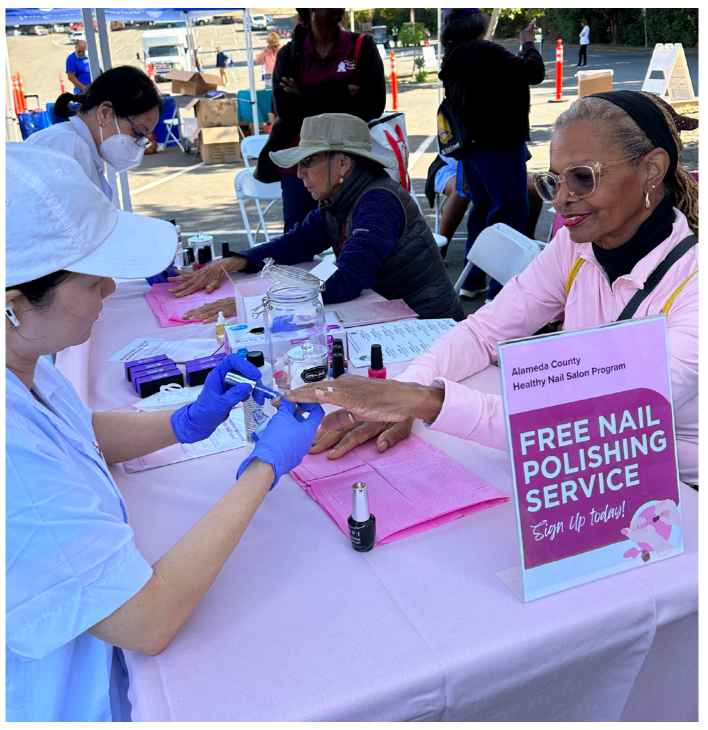
It is moments like these that begin to break through the stigma and fear surrounding ADRD. Overcoming these barriers will increase the likelihood that training participants seek needed support from their communities and health care providers, and that providers include cognitive screenings in their services.

HEALTHY NAIL SALON

HNSP centers community voices, leadership development, and collaboration in its health promotion activities. Knowing that messages from trusted colleagues are among the most effective, HNSP worked hard to educate and engage Salon owners in the program. Program staff conducted personalized visits to more than 120 nail salons to build relationships and introduce them to the program.

Sustainable Change

HNSP conducted one-year follow-up site visits and surveys with 20 certified salons to assess the sustainability of safety practices. Over 90% continued to use safer products and maintained safer ventilation one-year post-certification.



Health Fairs and Community Events

The program ran its first-ever Mobile Healthy Nail Salon at the Healthy Living Festival in September 2024, serving more than 80 seniors with safe nail care services and on-site education about chemical exposure and salon safety. HNSP also educated over 900 community members on chemical exposure, choosing certified salons, and personal protection strategies through participation in wellness events with senior centers and cultural organizations.

"It was really nice to see [the Healthy Nail Salon pop-up] at the festival. The staff were kind and patient, and I appreciated that you took the time to be here. I never realized how much salon products can affect workers' health. Now I know what to look for when choosing a salon or products for myself."

—Healthy Living Festival participant

Multilingual Educational Materials

Developed and distributed more than 2,000 brochures, posters, and shopping guides in Vietnamese and English to local salons, community centers, and events. The materials were designed to be visually engaging and easy to understand.

Consumer Behavior Change

Through education at health fairs and outreach events, consumers learned to identify Healthy Nail Salons, ask informed questions, and advocate for safer service environments.

"I always knew nail products had some chemicals, but I didn't really know what they were or how they could affect people. The nail workers have to work with these every day—that's really concerning. Thank you for sharing this, it's so important. I'm glad you're doing this work and helping us understand what's safer to use."

NUTRITION SERVICES

Nutrition Services (NS) leads community-centered health education across Alameda County, offering tools and resources that support residents in eating well, staying active, and making informed choices for lifelong wellness. Our strategies center resident leadership, build capacity, and create opportunities for shared learning.

⊕ Resident Leaders in Action

At Nutrition Services, resident leaders are key partners in promoting health and advancing equity. Since January 2025, 57 Community Health Champions, Diabetes Peer Educators, and Community Advisors have supported programs with their lived experience, cultural knowledge, and commitment to communities.

- Nutrition Services participated in 33 community health events.
  - 32 of these (97%) included resident leaders working alongside staff.
  - 26 events (79%) were led entirely by resident champions.
- 15 resident leaders taught or co-taught Cooking for Health Academy, supported diabetes education efforts, and contributed to Oakland's Making Moves walk and roll initiative.

By working together, we deliver relevant health education and support lasting change in the communities we serve.

New partnerships with Dublin Senior Center, Monarch Housing, Thea Bowman and Percy Abrams Senior Housing, Hamilton Senior Housing, Kenneth Aitken Senior and Community Center (Castro Valley), Hayward Public Library, and Cherryland Elementary School allowed the program to expand into new neighborhoods. These were in addition to our ongoing collaborations with trusted sites like Alameda's Mastick Senior Center, San Leandro and Emeryville Senior Centers, Acts Full Gospel and Glad Tidings Churches, and multiple senior housing communities.

⊕ Rethink Your Drink: Healthy Beverage Promotion

Nutrition Services, in partnership with community organizations, implemented the statewide Rethink Your Drink: The Not So Sweet Side campaign to encourage healthier beverage choices and raise awareness about the health impacts of sugar-sweetened beverages (SSBs) such as soda, fruit juices, sports and energy drinks. Regular consumption of SSBs is linked to a higher risk of type 2 diabetes, obesity, tooth decay, and heart disease. As part of the campaign, NS:

- Created and shared a social media toolkit for community partners,
- Led tabling events with water bottles and educational materials,
- Extended the campaign through the summer months in partnership with Oakland Parks and Recreation, delivering interactive education at eight park and recreation centers, reaching hundreds of children.
- Showcased youth-created artwork from schools, recreation centers, and HOPE Collaborative's youth advisory board at the Alameda County Fair, spreading the message about the benefits of drinking water to thousands

This work highlights NS creative partnerships, youth voice, and culturally relevant messaging about healthier beverage consumption in communities across Alameda County.

Happy Heart Campaign: Know Your Numbers. Eat More Whole Foods. Eat Less Processed Foods

The Happy Heart (HH) campaign promotes heart health through community education focused on reducing processed food intake, increasing whole foods, and encouraging regular blood pressure monitoring especially in communities disproportionately impacted by heart disease and hypertension. This second year marked significant growth:

- HH events increased by 130%, from 22 to 53 events.
- Partner engagement rose by 59%, with 54 organizations joining the campaign.
- 1,354 residents were reached in just one month.
- 25 billboards were placed strategically throughout Oakland, Hayward, and unincorporated areas, where rates of hypertension are highest.

Community surveys provided valuable insight into behavior change intentions. These results show that the HH campaign helped raise awareness and motivated action toward healthier habits.

- 79% of 129 respondents planned to monitor their blood pressure.
- 66% intended to increase their fruit and vegetable intake.
- 60% aimed to reduce processed food consumption.

COMMUNITY SPOTLIGHT

Collaboration with El Tímpano's Civic Engagement Initiative:

- 4,141 subscribers received heart health messaging via SMS.
- A culturally relevant Mam-language video posted on Facebook reached over 2,600 unique viewers and received 3,100+ views.
- With an average 15-second watch time, the video demonstrated meaningful engagement in a hard-to-reach community.

> "This level of engagement is truly exciting, especially within the realm of sponsored messaging. It's clear that the content focused on heart health really resonated with our community… this outreach has been a great success and really builds the case for making the Happy Heart Campaign a consistent, year-round effort."
>
> –Strategic Partnerships Manager, El Tímpano

Cooking for Health Academy

Cooking for Health Academy (C4HA) is a six-class series designed for adults with limited time or financial resources to learn how to prepare nutritious, budget-friendly meals. In 2025, C4HA reached 247 participants across 10 sites, with classes offered in both English and Spanish, in person and virtually. Of those enrolled, 174 participants (70%) completed the full series and graduated, and 111 (45%) earned their California Food Handler Certification—an achievement that builds food safety awareness and opens doors to employment opportunities. In a strong display of community leadership, nine graduates returned as Community Champions, co-facilitating or assisting with classes.

Complementing the C4HA, Nutrition Services produced and distributed 45,000 annual Harvest of the Month calendars featuring simple recipes, culturally relevant nutrition tips translated into four languages and local farmers market information.

⊕ Bingocize®: Movement, Connection, and Health for Older Adults

Bingocize® promotes increased exercise, strength-building, and intentional movement—meeting older adults where they are in a supportive and engaging environment. Bingocize classes were held across Oakland, Union City, Ashland, and Newark, creating opportunities for older adults to build strength, increase mobility, and connect with peers in a fun, health-promoting setting.

Program Impact (based on 96 participant surveys):

» 34% improvement in the number of days participants exercised for at least 30 minutes.

» 53% improvement in strength training participation.

» 68% improvement in making small, purposeful changes to be more physically active.

Compared to last year, strength training and intentional movement outcomes improved by 10% and 12%, respectively, showing progress in promoting physical activity and behavior change.

⊕ Oakland Making Moves: Advancing Health with Community Power

Oakland Making Moves (OMM) promotes health equity by encouraging physical activity through community-informed walks and rolls at 13 affordable family and senior housing sites. Designed with and for residents, OMM participants support each other to shape and sustain a safe and welcoming walking and rolling community. New partnerships this year include St. Mary's Community Center and Sylvester Rutledge Manor, a CCH site.

By the Numbers: Community Accomplishments

46	9	4	8	7
regular walks and rolls joined and led by residents	Walking and Rolling Encouragement events uplifting the importance of safe and continued walking to healthy places	partner meetings to support resident priorities	healthy living activities that promote strength, movement, and joy	quarterly special events bridging walking and rolling and cultural celebrations, including Lunar New Year

OFFICE OF DENTAL HEALTH

⊕ Oral Health Trainings

The Office of Dental Health (ODH) provided ten comprehensive oral health trainings for 348 staff at partnering organizations. These training sessions are designed to elevate awareness of oral health issues, equip participants with effective strategies for preventing dental diseases, and offer essential resources that guide families in locating suitable dental providers.

⊕ Education and Awareness

This year ODH attended 24 community events and engaged with 4,626 members throughout Alameda County, providing them with essential oral health resources, dental hygiene products, and offered effective dental care coordination.

Children's Dental Health Month

In February, ODH provided oral health education to 1,197 elementary school students and 86 teachers across multiple school districts. These interactive sessions inspired young minds to instill healthy dental habits from an early age, fostering a lifetime of optimal oral health.

School-Based/Linked

ODH successfully delivered vital preventive dental services to 751 third-grade students in 11 elementary schools within the Berkeley Unified School District (BUSD) and two schools in the Livermore Valley Joint Unified School District (LVJUSD). This included: dental screenings for 281 students; fluoride varnish applied to 236 students, professional teeth cleanings were performed for 85 students, and protective dental sealants were placed on 58 students.

To improve Kindergarten Oral Health Assessment participation, ODH collaborated with Oakland Unified School District to pilot onsite dental screening events at two elementary schools. Fluoride varnish applications were offered for participants to help reduce their risk of developing tooth decay.

WIC Dental Days

ODH collaborated with five WIC sites throughout Alameda County to provide essential dental screenings for 176 young children, which included applying fluoride varnish to 174 children and referring 139 children for personalized dental care coordination, helping them connect with a dental home. This year ODH extended its commitment to maternal health by serving 42 pregnant and postpartum clients with similar dental services, promoting overall wellness for both mothers and their children.

WOMEN INFANTS AND CHILDREN (WIC)

WIC Participation

In the last fiscal year, WIC served a total of 21,613 unduplicated participants. Our caseload is spread across the county, with 5 clinics—Hayward is our largest site and Livermore is our newest and the smallest site to date. Close to 70% of WIC benefits were redeemed, totaling more than $15,603,000 spent at local grocery stores.

Nutrition Education

Nutrition Education is a core WIC activity. Our funder requires a certain number of nutrition education contacts for each individual enrolled in WIC. Topics range from Picky Eating to Oral Health, from Prenatal Nutrition to Understanding Your Baby Cues, Trimester and checks. In 2024, WIC staff provided 70,069 nutrition education contacts to WIC families. Here's to a healthier Alameda County!

Farmers Market 2024

Every year, WIC provides families with $30 checks to buy fruits and vegetables at local farmer's market. WIC staff distributed 2,500 checks, worth $75,000, to WIC families. Distribution sites include various farmers markets and WIC locations. Families enjoy being at the market and able to shop right after receiving the Farmers market checks!

⊕ Partnership Between Bay Area Community Health (BACH) and WIC

A collaboration of getting referrals from BACH was implemented to help promote WIC at the health center. WIC participants can access BACH services, including and most importantly getting started on their prenatal care early. In the course of 12 months, BACH referred 168 newly pregnant women to WIC, of which 118 or 70.2%, were successfully enrolled in WIC. Some were already current WIC participants and some declined the referral.

⊕ Pregnancy Day

Pregnancy Day started as a pilot project at our Eastmont location. It was so successful that it was implemented at our 4 large sites: Fremont, Hayward, Telegraph, and Eastmont. We offer prenatal nutrition and breastfeeding classes on our Pregnancy Days. We invite all our pregnant participants to join us, with refreshments and gifts. At our last event in Fremont, May 2025, one of the participants approached our staff and expressed her gratitude in bringing the pregnant mothers together. She said, "It's great WIC does this so we can learn from each other." We had a total of 10 Pregnancy Days, classes offered in both English and Spanish, with 219 pregnant women in attendance.

⊕ Outreach

This year WIC staff participated in over 150 health fairs and events! Reaching hundreds of people, promoting the WIC Program and other resources, available to the community. Outreach and resource events continue to adapt with careful planning and follow-through for our county's most economically disadvantaged, racial and ethnic minorities, the uninsured, low-income children, elderly, homeless, members with HIV & other chronic health conditions, including mental illness.

⊕ Celebrating World Breastfeeding Week and WIC's 50th Birthday

In 2024, WIC achieved a huge milestone, celebrating it's 50th birthday by having a picnic at the park! Together with other county programs and non-profit organizations, over 300 families joined our festivities at Kennedy Park.

ACCOMPLISHMENTS: HEALTH NAVIGATION & CHRONIC DISEASE SUPPORTS

Health navigation and care coordination are services that help individuals understand and access the healthcare system more effectively. 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.

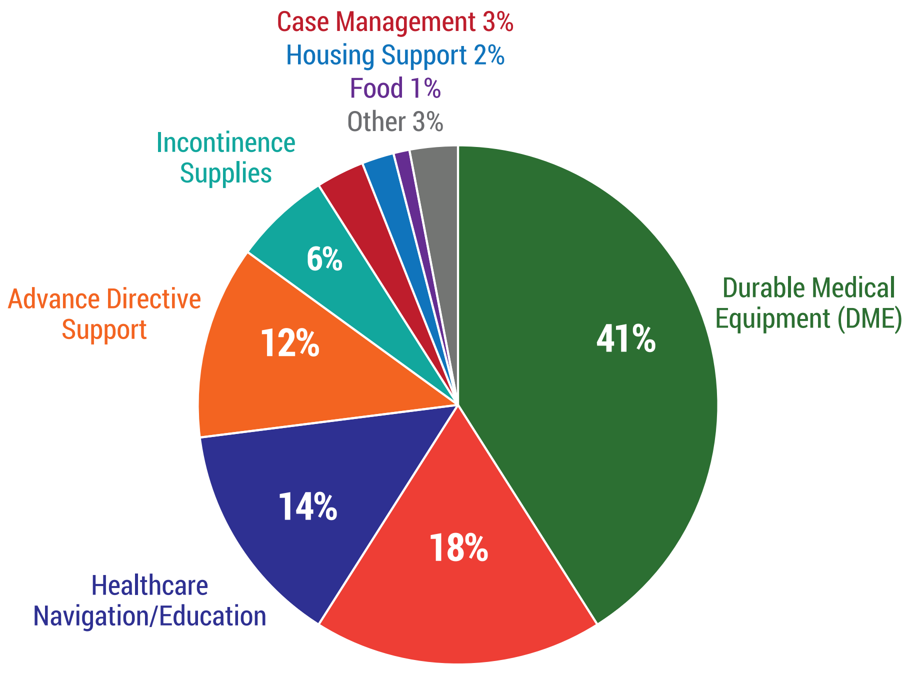
ASTHMA

The Asthma Program provided care navigation and asthma remediation services to children—and for the first time, adults—living with poorly controlled asthma. Between July 2024 and June 2025, the programs served 339 client families. Of these, 285 were Asthma Start clients (<18 years), and 54 (>18 years) were Adult Program clients. 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. Clients 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.

FIRST VISIT		LAST VISIT		INCREASE
27%	of adults scored in the well-controlled category in the Asthma Control Test.	73%	of adults scored in the well-controlled category in the Asthma Control Test.	73%
62%	of children scored in the well-controlled category in the Asthma Control Test.	93%	of children scored in the well-controlled category in the Asthma Control Test.	50%
55%	of adults scored 70% or above on the Asthma Knowledge Test at their first visit.	100%	of adults scored 70% or higher on Asthma Knowledge Test at the last visit.	81%
52%	of children scored 70% or above on the Asthma Knowledge Test at their first visit.	97%	of children scored 70% or above on the Asthma Knowledge Test at their last visit.	87%

CARE PARTNERS

Through culturally and linguistically competent home visits and telephone contacts, Care Partners assisted 1,294 individuals with social determinants of health. The graph highlights the program's light-touch service interventions on the clients' unmet social or health needs. These efforts not only improve individual outcomes, but they also strengthen trust in Alameda County's public health system.



"I am writing to express my deepest gratitude for your generous gift of a shower chair for my 92-year-old mom. It has made a huge difference in her daily life, more than I can say.

Your gift helps me as her caregiver, too. What used to be a stressful and physically demanding task for both of us is now calm and manageable.

Seeing how relieved and happy she is has been wonderful for our whole family. This chair is more than just equipment; it has truly improved our quality of life."

HEALTHY BRAIN INITIATIVE

Responding to community feedback, HBI supported those doing health navigation by developing an easily digestible, two-page resource list for family caregivers and people who have been recently diagnosed with ADRD. The Care Partners team beta-tested the list with service providers and community members, and received glowing feedback.

> "This is a fantastic resource—it's beautifully organized and incredibly helpful for families navigating dementia care. I know that many families living with dementia will find this guide invaluable in connecting with the right support systems."

HBI also researched and evaluated existing cognitive screening tools for use both within and outside of a health care setting. Based on these results, HBI recommends UCSF's Brain Health Toolkit for ease of use and accessibility across cultures, for outside of the healthcare setting. For use within a primary care setting, HBI selected the Cognitive Health Assessment, developed by UCSF and Dementia Care Aware, for early detection and care planning.

NUTRITION SERVICES

Diabetes Self-Management Education (DSME)

Diabetes is the 8th leading cause of death in Alameda County, and the 5th leading cause of death among adults between the ages of 55–74. Over 11% of adults in the County are currently living with diabetes, and rates are increasing among younger people.

The DSME program is an eight-week, evidence-based, highly successful program that offers culturally responsive education and support for individuals living with diabetes and prediabetes across the County. In 2025, a second Registered Dietitian and a consultant Dietitian joined the team, expanding the program's reach and instructional capacity. This year's reach and outcomes:

- 13 DSME classes were delivered to 145 participants, an 18% increase in classes and a 38% increase in participants from the previous year.
- Classes were offered in English, Spanish, and Chinese, making the program more inclusive and accessible.
- A new Monday evening Zoom Support Group was launched to meet the needs of working adults and caregivers.
- In total, the program facilitated 38 diabetes support groups (in-person and virtual), reaching 354 participants.
- An additional 10 diabetes presentations reached 261 residents, and 3 hypertension presentations served 35 participants.

DSME Class Results:

- 90.5% improved their A1c or maintained a healthy A1c below 7.0%
- 78% improved or maintained blood pressure under 130/80, aligned with 2024 ADA Standards of Care
- 64.5% lost or maintained their weight
- 93% rated the classes 5 or 6 out of 6 for overall quality

Nutrition services continue to address disparities in diabetes outcomes by raising awareness and focusing resources on communities that experience the worst outcomes.

OLDER ADULTS HEALTHY RESULTS

Older Adults Healthy Results provided intensive home-visiting nurse case management for 120 older adult clients (60+) who have trouble managing complex health conditions due to psychosocial challenges. This represents a 30% increase in cases compared to last year. OAHR works with clients for 6 to 12 months during which time we assess all aspects of our clients' health and wellbeing including:

» Medical status

» Cognitive and mental health needs

» Family supports

» Home safety and accessibility

» Nutrition, food and financial security

» Caregiving and functional requirements

» Advance care planning

We identify areas of risk and work to reduce those risks so that our clients can stay living at home and enjoy an improved quality-of-life. We visit our clients regularly in their homes, follow-up with frequent phone calls to family members, healthcare and social services providers, and anyone else involved in our clients' care. Many of our clients have sensory and cognitive challenges that prevent them from successfully using phones or screens so we help them navigate a complex safety net healthcare system. We help them find and train caregivers, set up transportation services so they are able to get to medical appointments, and we follow-up after these appointments to help our clients understand their treatment plans and make sure they are taking their medications safely, as directed.

Part of this support includes coordinating with their healthcare providers so that their providers understand their patients' needs, limitations, and priorities. We do all this in multiple languages using telephonic and on-site interpreters. Our goal at the time of case closure is to have in place services and supports that are sustainable for the long-term so that our clients can remain as independent as possible for as long as possible.

CASE MANAGEMENT ACTIVITIES	
Cases	120
Consultations	204
Full time employees	3 nurses
Face-to-face encounters	594
Total encounters	1,516

FALL PREVENTION	
At-risk clients who received an individualized fall prevention interventions to reduce risk	94%
QUALITY-OF-LIFE	
Clients' quality-of-life goals that were met or partially met	92%
LIVING AT HOME	
Clients who remained living safely in their home at the time of reassessment and/or case closure	90%

OFFICE OF DENTAL HEALTH

The Office of Dental Health (ODH) successfully delivered Dental Care Coordination services to 774 young children, arranging a total of 825 appointments, which resulted in a commendable show rate of 66%. In addition to these routine services, ODH staff provided crucial support to 96 clients facing urgent dental issues, ensuring that their immediate needs were addressed promptly.

Additionally, Family Support Care Coordinators played an essential role in assisting 430 pregnant and postpartum clients, scheduling a total of 285 appointments. This resulted in 63% attendance rate, highlighting the commitment to supporting the oral health of mothers and their children during this significant time in their lives.

This year the ODH outreach team spoke with over 5,600 people by attending local events and health fairs. During these brief encounters the team provided oral health resources and dental hygiene kits to community members, and connected clients with dental care services through care coordination efforts.

⊕ Perinatal Dental Demonstration Project

This project raised awareness about the importance and safety of dental care during pregnancy among health professionals, dental providers, and community members.

A key achievement of the project was establishing a closed-loop referral process that connects pregnant and postpartum patients referred from Alameda Health System Women's Clinics, WIC and other community partners to appropriate dental care through ODH's care coordination team. These partnerships improve access to dental care and promote equity for pregnant and postpartum populations.

WIC

⊕ Depression Screening at WIC

In 2024, WIC staff conducted over 2,300 screenings, of which 7.7% tested positively for depression, with 42 (23.2%) successfully referred to the Starting Out Strong Program in Family Health Services.

TOTAL: 2,365	
Positive for Depression	
181	7.7%
Referrals to Starting Out Strong in FHS	
42	23.2%

More than 1 in 10 women develop a mental illness during pregnancy or within the first year after having a baby, and if left untreated these illnesses can have a devastating impact on women and their families. In the most serious cases, perinatal mental illness can be life threatening: suicide is one of the leading causes of death for women during pregnancy and one year after birth (Maternal Mental Health press release, 2014). In collaboration with Family Health Services, WIC offers the PHQ-9 depression screening to all pregnant and postpartum women. This partnership started in 2012 and continues to be a great collaboration between divisions!

III. PROGRAMS

During the fiscal year 2024–2025, 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)**

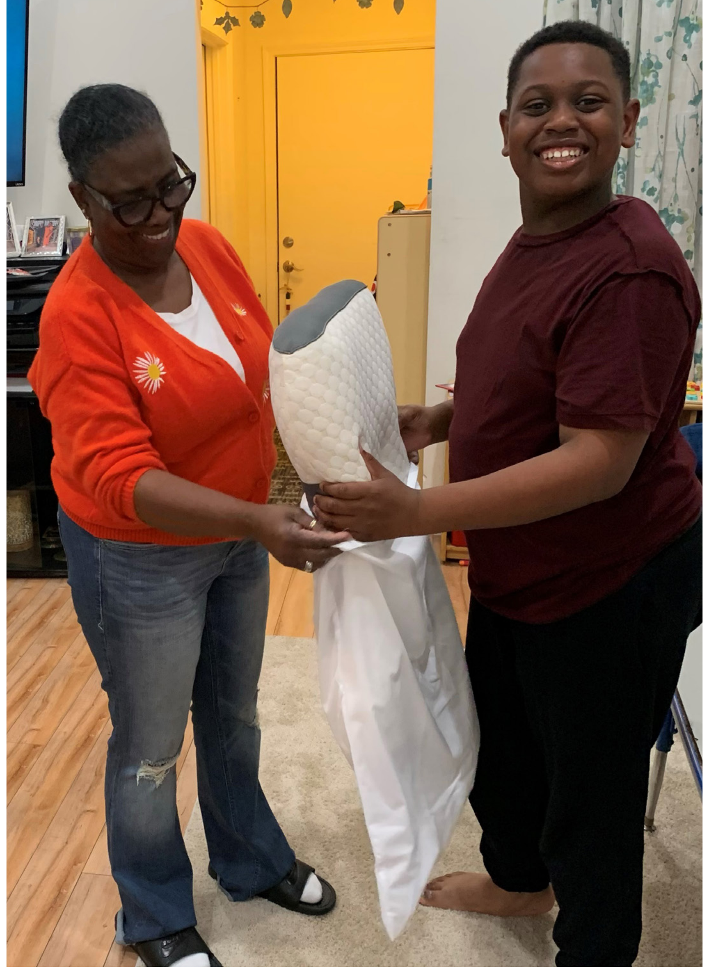
The following sections provide a detailed description of the services offered by each active program, the populations they serve, and a snapshot of plans for the coming fiscal year.

ASTHMA

WHAT WE DO

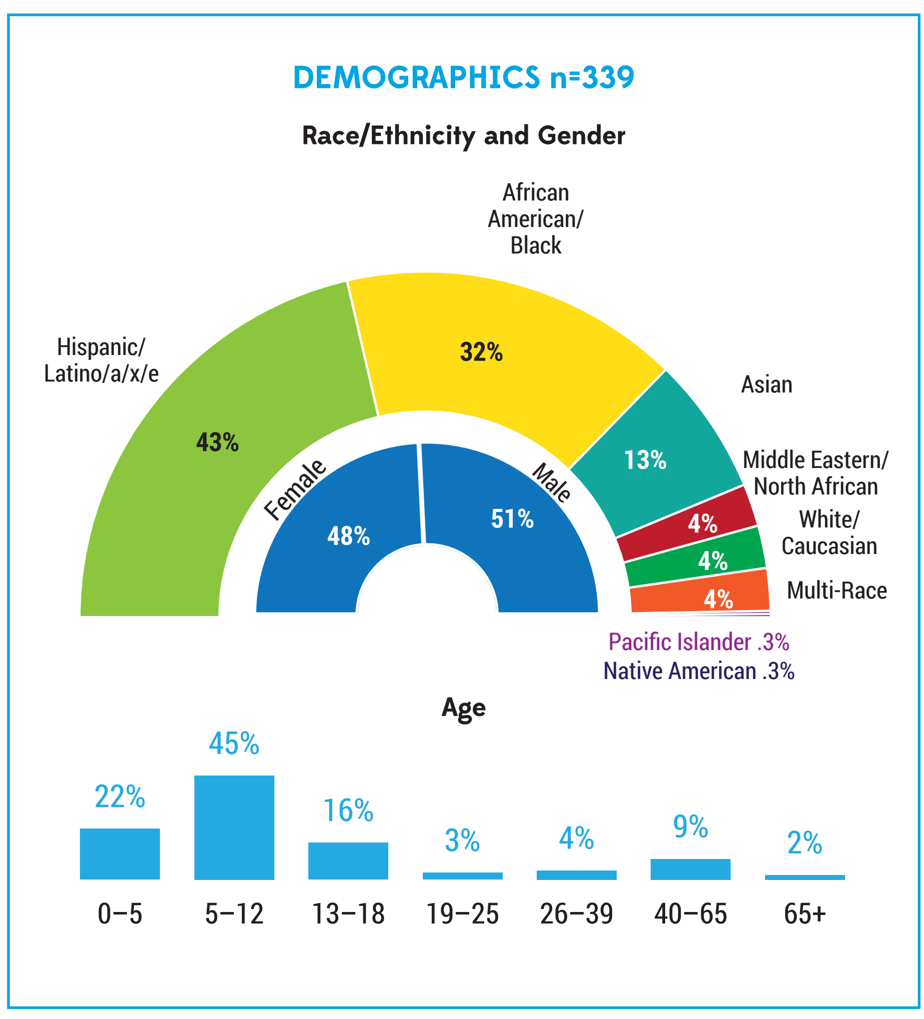
The Asthma Program provides comprehensive, in-home case management to people living with poorly controlled asthma throughout Alameda County. Asthma Start, the award-winning, research validated pediatric program, provides services to youth throughout the County. Children who have been to the emergency 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, air purifiers, 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.

This year marks the end of our first year after launching our Adult Asthma Program which serves clients ages 18–80+. Central to the success of the program was the partnership with the County's Public Health Nursing Division's Front Door Unit. The initial engagement that the Front Door staff conducted proved beneficial by helping clients become better aware of their health after participating in the Department's Universal Intake Assessment, this is the first touch point for adults referred to asthma services prior to entering our program.



POPULATIONS SERVED

The Asthma Program serves children, youth, young adults, and adults throughout Alameda County. Between July 2024 and June 2025, we served 339 client families. Of these, 285 were Asthma Start clients (<18 years), and 54 (>18 years) were Adult Program clients.



THE ROAD AHEAD

- Expand the 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.
- Expand the partnership with the Nursing Division's Front Door program and the Alameda Alliance for Health to serve the adult Medi-Cal population, including assessing the program's referral system and the effectiveness of Enhanced Case Management (ECM) referrals.
- Continue partnership with UC Berkeley's School of Public Health through an EPA initiative to provide educational services and environmental resources for Medi-Cal parents of children with uncontrolled asthma.

CARE PARTNERS

WHAT WE DO

Care Partners (CP) aims to: 1) help older adults and people with disabilities in Alameda County to stay safely at home with an improved quality of life; 2) help reduce suffering and build client knowledge, skillsets, and empowerment to improve health outcomes; and 3) eradicate inequities in access to quality healthcare and social services.

As a non-medical, holistic, equity-focused and language-specific care coordination program that provides engagement, information, education, resources and advocacy, Care Partners core strategies consist of:

» Conducting biopsychosocial assessments, identifying issues related to the social determinants of health, and providing closed-loop care coordination services with appropriate information, resources and referrals on clients' unmet needs

» Increasing awareness of Advance Care Planning to help county residents prepare for an emergency when they can't advocate for themselves

» Participating in community outreach events to promote awareness of program services and available resources

» Providing monthly trainings on illness prevention and wellness promotion topics for IHSS Care Providers to enhance their caregiving skills

» Building sustainable partnerships with health systems, community based organizations and internal County partners to assist clients to access available health and social supports

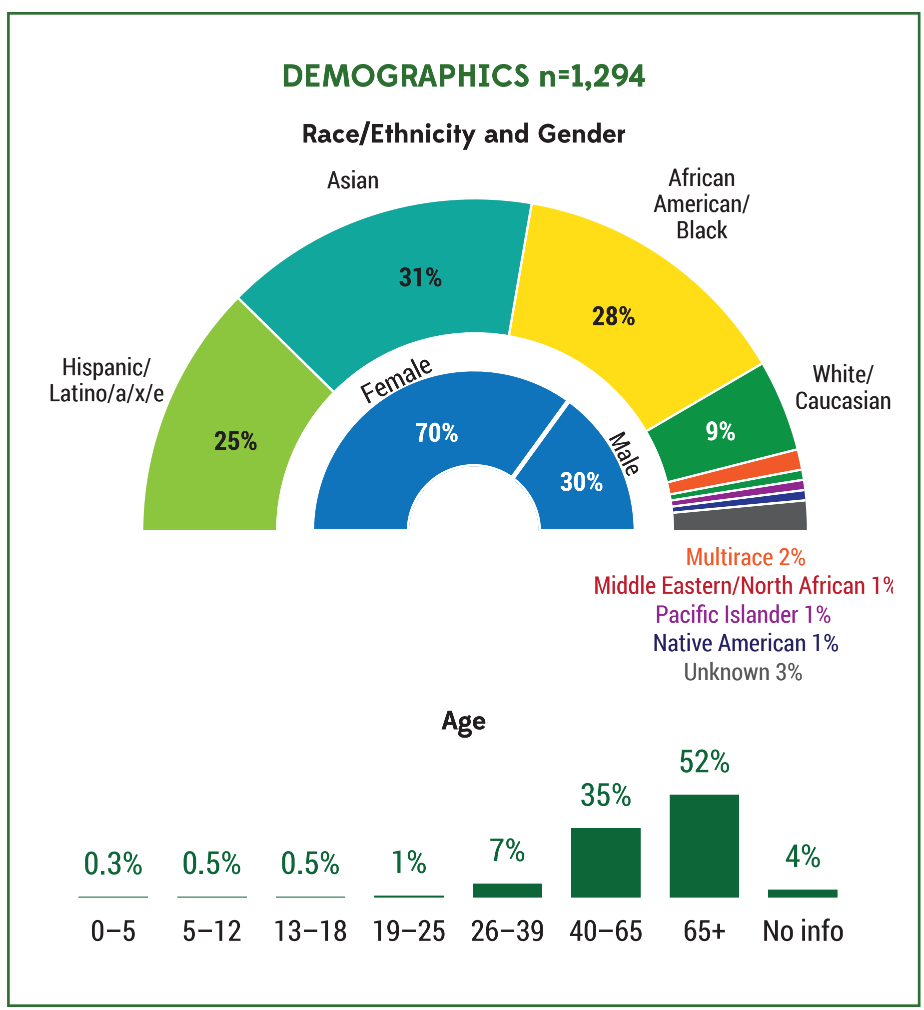
» Recruiting and developing linguistically and culturally competent team members and future leaders.

» At the September 25, 2024, Agency All Staff Conference, Care Partners showcased a program poster and led a workshop on Advance Care Planning for 70+ agency staff.

POPULATIONS SERVED

The main population that's eligible for Care Partners services is In-Home Supportive Services (IHSS) Recipients and Care Providers, and low-income older adults, and/or people living with disabilities.

Care Partners reached over 20,372 Alameda County residents through outreach events, daily IHSS orientations, training classes, and in-service presentations. They provided individual support to 1,294 clients, described in the demographic charts.



THE ROAD AHEAD

- Engage and reach more men as clients and caregivers.
- Utilize new databases to streamline client services, data collection and reporting.
- Evaluate cost savings for clients resulting from care coordination efforts.

HEALTHY BRAIN INITIATIVE

BACKGROUND

The Alameda County 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). It was developed in consultation with the Alameda County Age-Friendly Council, particularly its Embracing Aging (EA) Committee that is focused on training for older adults. The EA Committee, which is comprised of subject matter experts in older adult training and services, has supported HBI's strategic planning and implementation on an ongoing basis. .

WHAT WE DO

HBI takes a systems-level approach in its focus on training across systems that reach people living with dementia and their caregivers. HBI is focused on the social determinants of health (SDOH) across populations with greater prevalence and health impacts from ADRD. Along those lines, HBI prioritizes training for caregivers and service providers serving the African American, Pacific Islander and American Indian/Alaska Native populations where prevalence, Emergency Room visits, hospitalizations and mortality rates are highest.

This approach also informs HBI's work with ACPHD's Quality Improvement and Accreditation (QIA) Division to include people with Access and Functional Needs (AFN) in emergency planning and preparedness. The goal of the AFN is to ensure that emergency plans are prepared to meet the needs of people living with dementia and their caregivers. The Alameda County AFN Advisory Committee, launched by HBI and QIA in October 2024, includes more than 48 people from 33 cities, county agencies and community-based organizations.

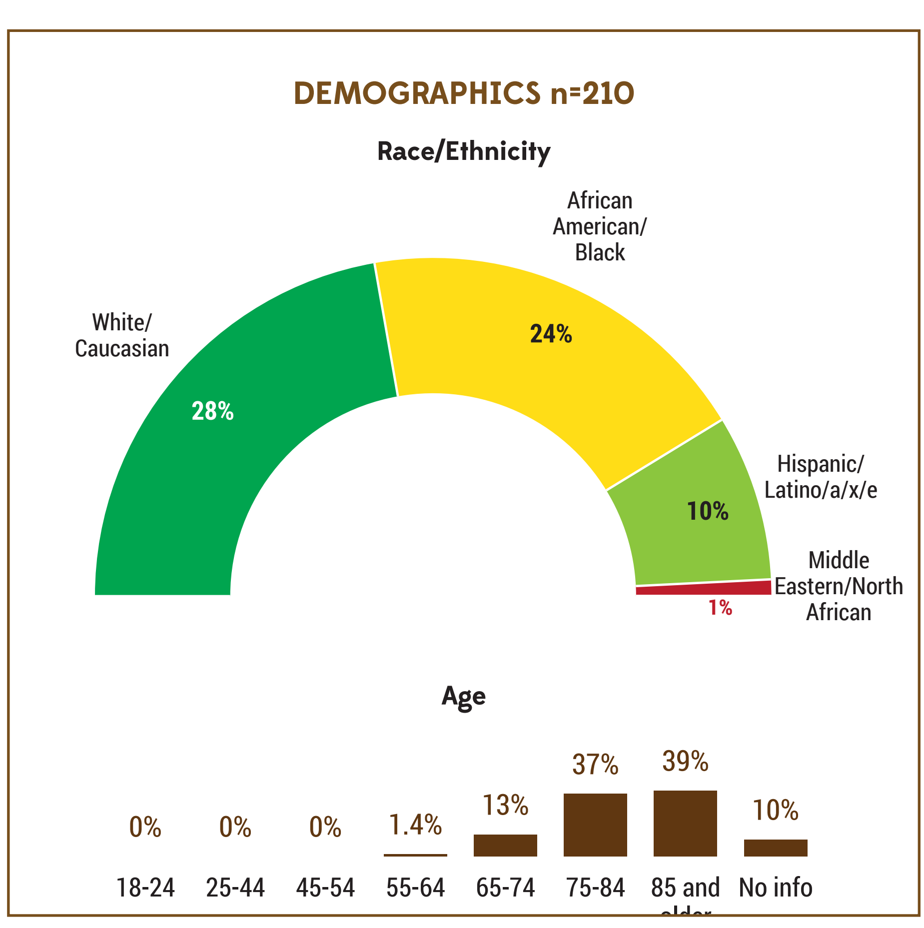
CBOs	Cities	State & County Agencies & Programs
» Center for Independent Living » Regional Center of the East Bay » Community Resources for Independent Living (CRIL) » East Bay Paratransit » East Bay Innovations (EBI) » ILRSCC (Independent Living Sources of Solano and Contra Costa Counties) » Down Syndrome Connection of the Bay Area (DSCBA) » Alzheimer's Associations » Family Resource Navigators » Centers for Elders Independence (CEI) (PACE) » On Lok (PACE) » CityServe of the Tri-Valley » Nelson | Nygaard	» City of Oakland » Oakland Fire Department » City of Oakland Emergency Management » City of Berkeley » City of Hayward » City of San Leandro	» Alameda County Sheriff's Office-Office of Emergency Services (OES) » EMS-Health Emergency Preparedness and Response (HEPR) » SSA-Disaster Preparedness and Emergnecy Management (DEPM) » EMS-Senior Injury Prevention Program (SIPP) » ACPHD-Health Equity, Policy, Planning (HEPP) » ACPHD-Dept of Communicable Disease Control and Prevention (DCDCP) » ACPHD-FHS-California Children's Services » ACPHD-Quality Improvement and Accreditation (QIA) » ACPHD-Healthy Brain Initiative » ACPHD-Public Health Nursing » State Council on Developmental Disabilities (SCDD) » ACH Housing and Homelessness Services » DA Victim Witness Program » General Service Agency

HBI's Strategic Plan is grounded in health equity and a community-driven planning process, basing its conclusions upon extensive local quantitative data provided by the CAPE unit as well as key informant interviews and listening sessions with a total of 98 people, including community members living with dementia and their caregivers as well as the programs and service providers that support them. HBI works closely with internal and external partners across Alameda County to ensure that the Strategic Plan findings continue to inform program implementation.

The work would not be possible without the deep and longstanding partnership of the Alameda County Age-Friendly Council, which PHD co-convenes with Alameda County Social Services Agency (SSA) and the Council's Embracing Aging workgroup that has served as HBI's Community Advisory Coalition.

POPULATIONS SERVED

The HBI program trained 1,757 people in 2025, including nearly 700 informal caregivers, over 200 housing providers, and nearly 300 first responders. Demographic data was collected on 210 program participants, described in the charts below.



THE ROAD AHEAD

- Continue five SME contractors to provide 40 additional HBI trainings through December 31, 2025.
- Collaborate with QIA to expand the AFN Advisory Committee.
- Finalize and distribute the Spanish-language version of the HBI Resource List.
- Complete an evaluation of HBI's work through June 30, 2025, for distribution to community partners and stakeholders.

HEALTHY NAIL SALON PROGRAM

BACKGROUND

The Alameda County Healthy Nail Salon Program (HNSP) aims to protect the health and well-being of nail salon workers, owners, and consumers by promoting safer workplace practices and reducing exposure to toxic chemicals commonly found in nail care products. California has the largest number of nail salon businesses and nail technicians in the country, and Alameda County has over 400 nail salons. The program advances health equity by supporting immigrant and low-wage workers—many of whom are women of color—through culturally and linguistically appropriate education, technical assistance, and policy advocacy. HNSP is part of a broader movement across California to improve occupational health in the beauty industry and uplift the voices of vulnerable workers.

Promoting safer products and practices

Reducing harmful chemical exposure

Empowering workers through education and leadership

Recognizing salons that prioritize health and safety

Increasing customer awareness

WHAT WE DO

HNSP implements a combination of direct services, education, and community engagement strategies to achieve its goals:

Healthy Nail Salon Certification

The program recognizes salons that meet specific health and safety standards, including the use of safer nail products, proper ventilation, worker training, and personal protective equipment. Certified salons are promoted to the public as safer places to work and receive services.

Workforce Education & Outreach

HNSP conducts culturally and linguistically tailored outreach and education in Vietnamese and English. Workers and owners receive training on workplace safety, chemical hazards, and workers' rights.

Technical Assistance

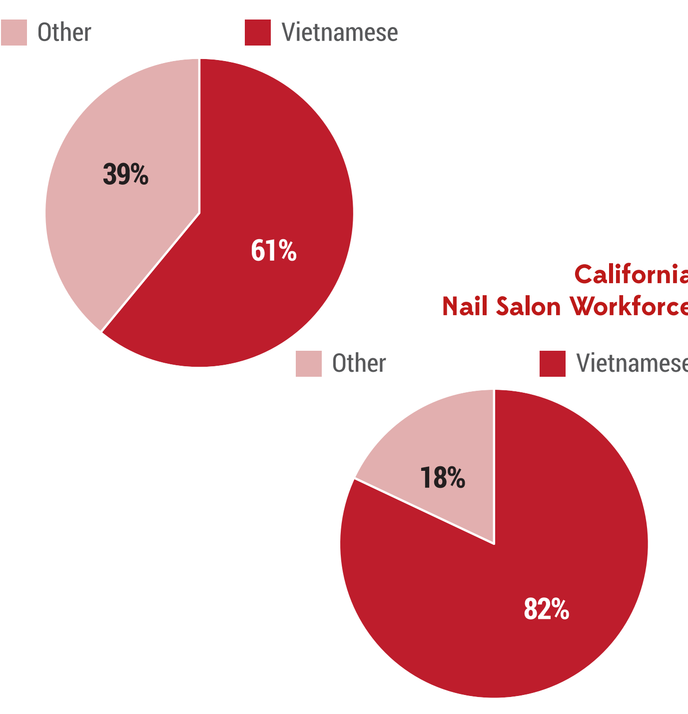
Salons receive personalized support in meeting certification criteria, selecting safer products, and implementing protective practices.

POPULATIONS SERVED

The program primarily serves nail salon workers and owners in Alameda County, with a special focus on immigrant and refugee communities, particularly the Vietnamese American population, who make up a significant portion of the local nail salon workforce (estimated to be over 80%). Consumers also benefit from the program's efforts through increased awareness of safer salons and healthier practices.

Vietnamese American Population in the Nail Salon Industry

U.S. Nail Salon Workforce



Sources: UCLA Center for the Study of Women (2018), CA Healthy Nail Salon Collaborative (2023)

Community Partnerships & Policy Engagement

The program works closely with local and statewide partners, including the California Healthy Nail Salon Collaborative, public health agencies, and other counties to share best practices and advocate for systemic changes in the nail care industry. HNSP continued to enhance their Referral Network by building bridges with local organizations such as Vietnamese American Community Center of the East Bay, Alameda County Green Business Program, and other programs within the CHS division to connect workers with health-related services.

Public Awareness Campaigns

Through events, social media, and community workshops, HNSP raises awareness among consumers about the importance of choosing certified healthy salons and understanding the health impacts of toxic chemical exposure.

THE ROAD AHEAD

- **Expand Certification Program:** Increase the number of certified salons across Alameda County, particularly in underserved cities such as Fremont, Hayward, and San Leandro, by streamlining the certification process and offering more hands-on support to salon owners.
- **Expand Consumer Awareness through Community Workshops:** HNSP will launch a series of consumer-focused workshops to educate the public, especially seniors, youth, and frequent nail salon clients—about safer nail care practices and how to identify certified salons.
- **Integrate Nail Salon Safety into Broader Health Equity Efforts:** Position nail salon worker health as a key element in immigrant worker justice and environmental justice frameworks. Advocate for greater recognition of nail salon safety within countywide efforts related to occupational health, indoor air quality, and small business resilience.

NUTRITION SERVICES

OUR MISSION: Alameda County Nutrition Services is dedicated to advancing health and racial equity within our communities. Guided by our commitment to inclusivity, belonging, and justice, we closely collaborate with like-minded partners towards the vision that Alameda County thrives.

OUR VISION: We envision that all people live in safe, connected neighborhoods that offer fresh, affordable foods, choose active healthy lifestyles and are engaged in their communities.

WHAT WE DO

Nutrition Services has six distinct programs that address nutritional needs of individuals and families, as well as improve healthy food access in local neighborhoods. These include:

Bingocize for Older Adults

An evidence-based healthy living, interactive, physical activity and nutrition program through the game of bingo! This is a 6-to-8-week series.

Cooking for Health Academy

A series of six, two-hour sessions focusing on nutrition education, food safety and culinary skills to promote healthy eating. Participants can graduate with a California food handler certification.

Diabetes Education Program

American Diabetes Association diabetes self-management education, two-hour classes for eight weeks and support groups for adults who are living with pre-diabetes or Type 2 diabetes.

Early Childhood Education

Support for preschool students, their families, and staff to create, pass and implement nutrition and physical activity policies and best practices.

Healthy Retail Program

Local grocery store owners work towards lasting environmental changes to promote increased access to quality fruit and vegetables. Currently 20 stores participate across the County.

Oakland Making Moves

A walking and rolling program to healthy places from affordable housing site partners. Includes quarterly events that encourage safe transportation. Resident advisors help lead the way.

OUR APPROACH

Policy, Systems and Environmental (PSE) Change: The Nutrition Services Program is dedicated to creating and implementing sustainable PSE strategies, that lay the foundation for equitable health outcomes.

ACCOMPLISHMENTS

Local Leadership in Action: Oakland Making Moves (OMM): At SAHA (Satellite Affordable Housing Associates) sites in Oakland, Jesse, a local Community Advisor, created a public health video leading outreach at Monarch and St. Andrews Manor. At Madison Apartments (EBALDC), resident-led walk audits sparked the creation of a safety committee and Sadie, a young adult Community Advisor also developed a “video map” to guide a safe walking route to a local farmer market. OMM demonstrates local voices impacting lasting, neighborhood-level change.

Statewide Recognition, Local Roots: Oakland Unified School District (OUSD), a long-time partner in advancing health equity, was recognized by the California Department of Public Health (CDPH) for best practices in nutrition education and physical activity and CDPH’s public relations team visited OUSD to spotlight its new Center and Wellness Director. OUSD’s sustained collaboration with Nutrition Services has led to lasting environmental changes from school gardens to expanded wellness initiatives reflecting the power of local action with statewide impact. Also, two CalFresh Healthy Living (CFHL) posters were selected for presentation at the statewide forum.

National Recognition: Centering Community in Active Transportation. Nutrition Services was invited by the Hayward Area Recreation and Park District to co-present at the National Safe Routes to Schools Partnership. The presentation highlighted community engagement in the San Lorenzo Creekway project,

focusing on non-infrastructure strategies that elevate resident voice, safety, accessibility, and youth involvement.

In the Community—In Person and Online: Nutrition Services connects with the community through fun, engaging activities that make healthy living more accessible. Our special Food Fridays feature Harvest of the Month recipes in English and Spanish, making it easy for families to try new fruits and vegetables at home. We also offer one-time nutrition and diabetes workshops giving a "taste of Nutrition Services" in Chinese, Spanish, and English, meeting people where they are. By translating newsletters and educational materials into multiple languages, we ensure everyone can access helpful health information. These small but meaningful efforts are designed to spark lasting habits and healthier communities.

Centering Equity in Diabetes Education: We're expanding diabetes education and support for communities most impacted by health inequities—including Pacific Islander, African American, and Native American residents. By strengthening outreach and partnerships, we're working to close gaps in care and create lasting health improvements.

Supporting Food Access Through Policy: Nutrition Services is exploring how to uplift community food and nutrition priorities in Alameda County's Community Development Agency's Environmental Justice Element. Our goal is to ensure that residents most affected by environmental and health injustices help shape solutions that support a healthier, more equitable future.

Investing in Our Youngest Learners: The future is young—and we're building it together. In response to needs identified by the County Nutrition Action Partnership (CNAP), five early childhood, family childcare sites received monetary support for physical activity equipment, family wellness events, and nutrition education. This small but meaningful project is just the beginning—we look forward to sharing its impact.

OUR PARTNERSHIPS

Rooted in community! We work with organizations across Alameda County such as the County Nutrition Action Partnership (CNAP) that includes UC Cooperative Extension, early education providers, clinics, school districts, city agencies, and the Bay Area Nutrition Action and Physical Activity Council (BANPAC) to advance shared health goals. Community residents are also at the core of our work, serving as community health champions, community advisors, and peer educators. Together, we're building a healthier, more equitable and connected Alameda County where all can thrive.

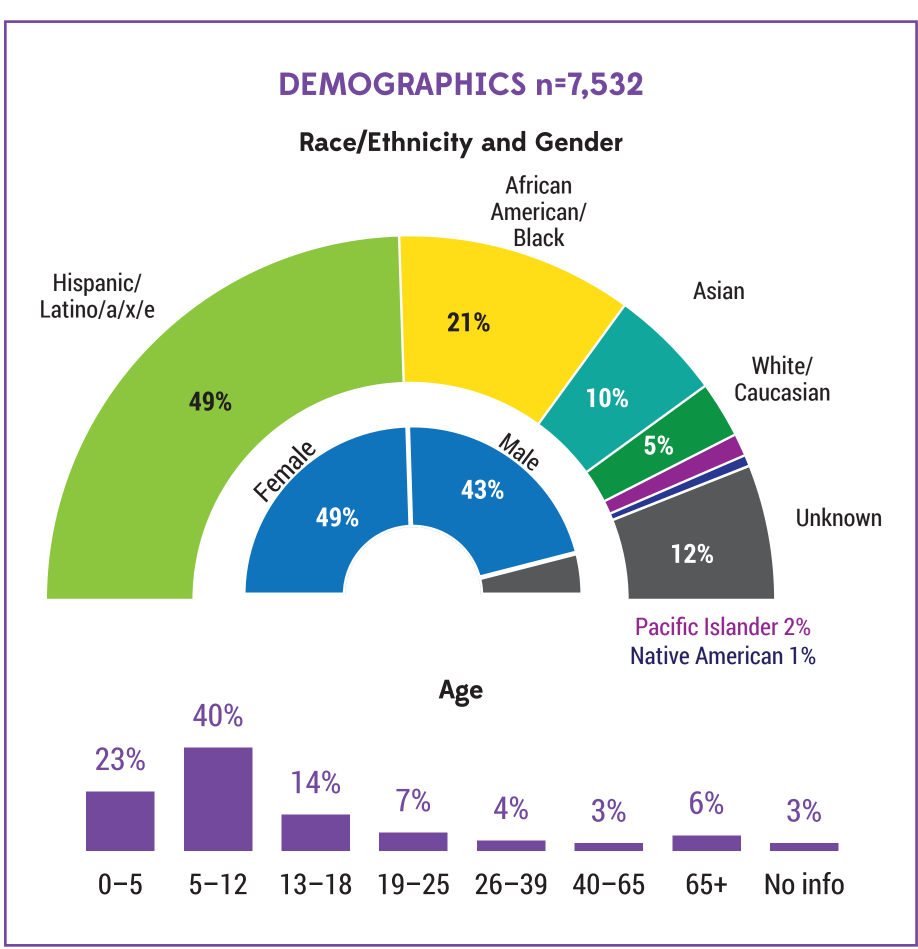
PARTNER SPOTLIGHT: OAKLAND UNIFIED SCHOOL DISTRICT

Nutrition Services has partnered with OUSD for over 20 years to educate and excite youth in learning about healthy eating, gardening and the environment.

- Over **66 schools maintain instructional gardens and integrate the Harvest of the Month (HOM) program** that encourages students to grow and eat a variety of produce from the gardens and their school produce bar. Highlights of HOM is featured in a video highlighting CDPH's SNAP-Ed program.
- The OUSD Center Garden **expanded the growing of plant starts/seedlings** for all school gardens.
- SNAP-Ed's Leaders in Eating and Activity Practices (LEAP) Awards were given to 22 OUSD Schools, including 2 gold, 2 silver, and 1 bronze.
- **The Market Off West produce stand managed by 12 high school interns** provides fresh fruits and veggies grown in the OUSD Center's instructional garden and school gardens at no cost to the community.
- A Summer Garden Steward program was created to maintain gardens and increase access to healthy food during the summer months at **33 school gardens where 60 varieties and 2,137 pounds of produce were harvested and distributed.**

POPULATIONS SERVED

Nutrition Services impacted over 25,973 Alameda County residents this year through educational programs, counseling, outreach events, and policy, systems and environmental changes. Demographic information was collected for 7,532 program participants, described in the graphs below.



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

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

WHAT WE DO

The Office of Dental Health includes seven distinct programs, all of which are guided by the Oral Health Committee of the Alameda County Public Health Commission, along with three workgroups focused on Early Childhood, Homelessness, and Special Needs Dentistry. The Oral Health Committee is comprised of subject matter experts, dental providers and residents in Alameda County. This Committee, along with the three Workgroups work continuously to improve coordination and accountability in relation to our current Oral Health Strategic Plan, ensuring that we effectively meet the needs of our community.

Dental Care Coordination Program

Since we launched our dental care coordination model in the early 2000s, ODH has significantly improved access to and utilization of dental services for Medi-Cal eligible clients aged 0-20 years, including at-risk pregnant populations. Our compassionate care coordinators engage families in meaningful conversations about the importance of dental care, assist them in scheduling appointments, and help establish a reliable dental home. This approach fosters continuity of care, enabling families to prioritize and receive essential dental services.

Perinatal Dental Demonstration Project (PDDP)

In March 2023, the Office of Oral Health at the California Department of Public Health provided funding to ODH for a transformative three-year initiative known as PDDP. This project aims to significantly improve access to dental care for pregnant and postpartum individuals in Alameda County, addressing their unique dental health needs during and after pregnancy.

School-Based Dental Sealant Program

ODH provides essential preventive dental services to 3rd-grade students in 11 elementary schools across the Berkeley Unified School District (BUSD) and two schools in the Livermore Valley Joint Unified School District (LVJUSD). Our comprehensive offerings include engaging oral health education, thorough dental screenings, fluoride varnish applications, professional teeth cleaning, the application of protective dental sealants, and referrals for further care, ensuring that students not only receive the necessary care but also cultivate lifelong oral health habits.

Kindergarten Oral Health Assessment (KOHA)

The kindergarten dental assessment requirement (AB 1433) enables schools to proactively identify children with untreated dental issues while assisting parents in securing a dental home for their children. This forward-thinking approach greatly contributes to children's health and supports their academic success. Early 2024, ODH established a dedicated KOHA Committee to unite partners and resources, enhancing participation and reporting in the KOHA program and ensuring its continued effectiveness and reach within the community.

Women, Infants, & Children (WIC) Dental Days

ODH collaborates with five WIC sites across Alameda County to offer dental screenings, fluoride varnish treatments, anticipatory guidance, and personalized dental care coordination for young children, as well as for pregnant and postpartum clients. This ongoing partnership, which began in 2006, is dedicated to helping all clients establish a dental home, creating a supportive environment for healthy development.

Outreach and Education

ODH actively enhances community well-being by participating in health fairs and various events throughout the year. We engage with residents of all ages by distributing valuable oral health education

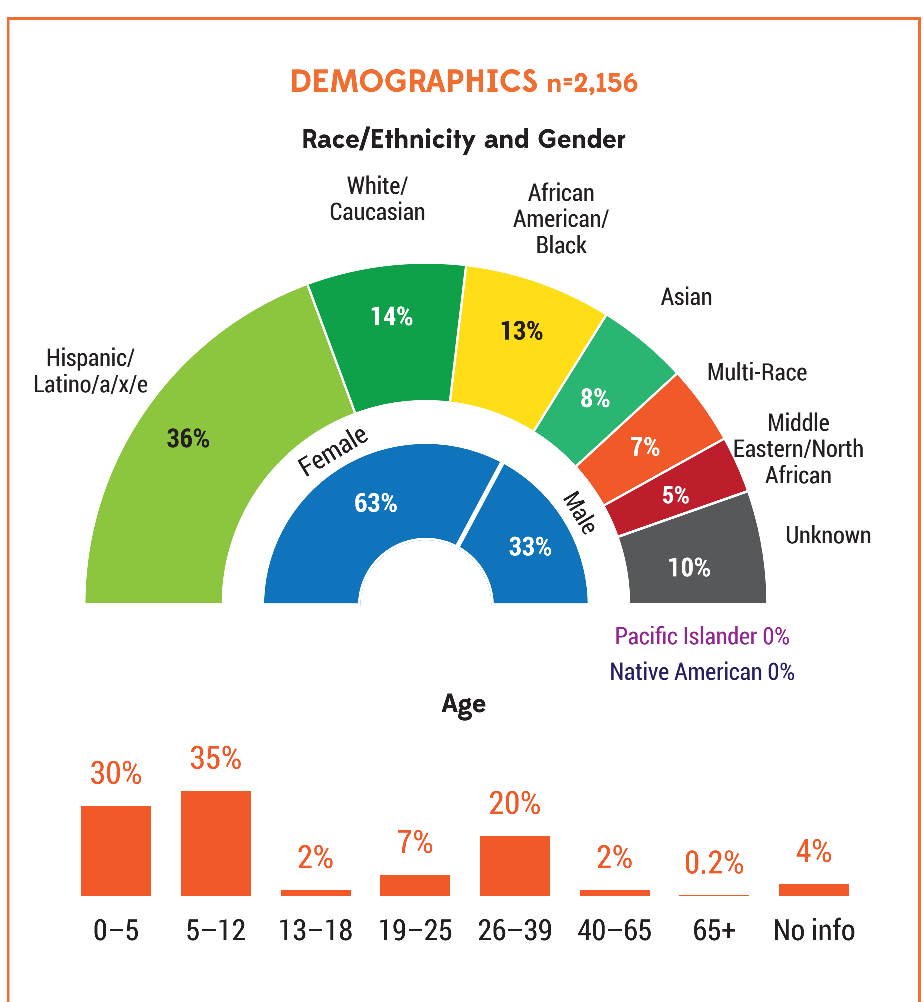
materials and dental kits, empowering everyone to maintain good oral hygiene. Our dedicated team also provides engaging oral health presentations, either in-person or online, to community organizations, ensuring that vital information reaches those who can benefit most, thereby fostering a culture of health awareness and preventive care.

Community of Practice

Our goal is to foster a strong and supportive network of dentists committed to providing equitable access to dental care. By raising awareness of the barriers faced by Medi-Cal enrollees, we can effectively address the ongoing issue of under-participation by providers in the Medi-Cal Dental Program. Through this initiative, we aim to enhance the clinical skills of dental providers, equipping them to deliver high-quality care to young children aged 0-5 years, setting the stage for lasting oral health.

POPULATION SERVED

While ODH reached over 11,158 residents and health providers through their capacity building, education, and outreach activities, the demographic data below is based on the 2,156 individual clients they served.



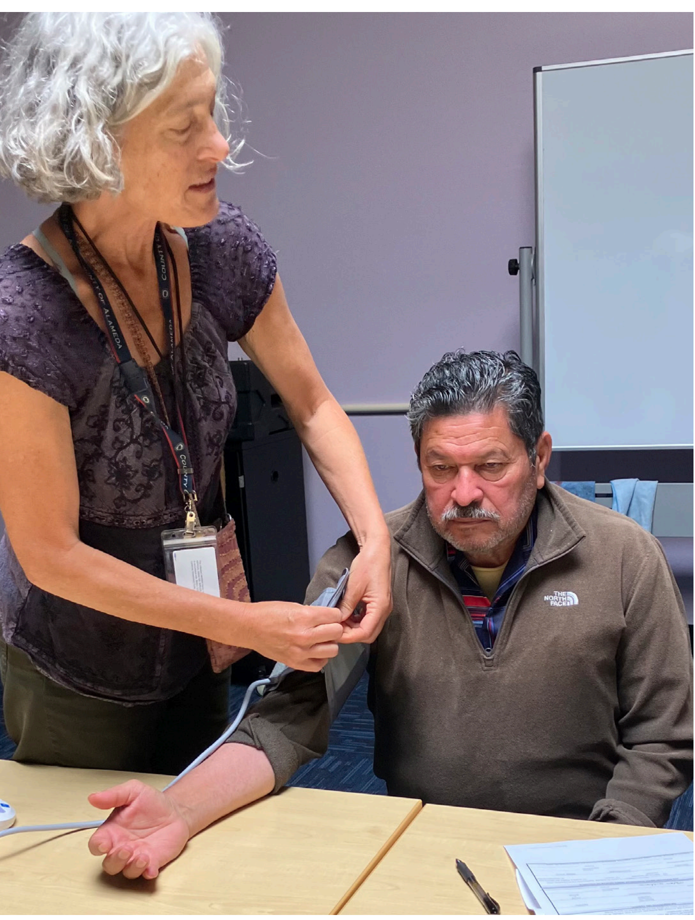
THE ROAD AHEAD

- Collaborate with school districts to improve Kindergarten Oral Health Assessment (KOHA) participation
- Empower partner organizations to utilize Community Health Workers (CHW) Medi-Cal benefit to improve access to dental care.
- Publish, disseminate and implement the Oral Health Strategic Plan 2025–2030.

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 our older adult communities and lead to premature functional decline.



OOAHR'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, we provide 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 our 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 Our services are free to all Alameda County residents who qualify based on income, medical complexity, and functional status.

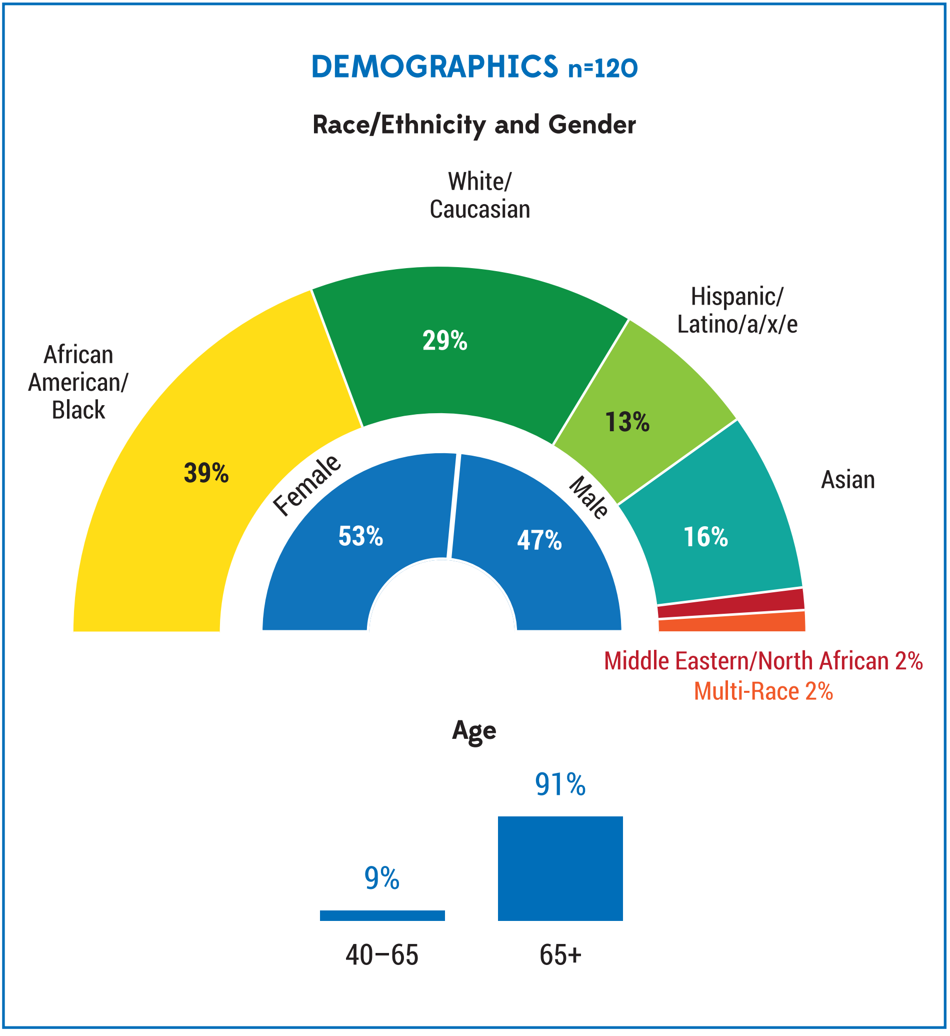
OAHR services are free to all Alameda County residents who qualify based on income, medical complexity, and functional status.

POPULATION SERVED

Many of our 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 we received became clients. Our services are free to all Alameda County residents who qualify based on income, medical complexity, and functional status.

Many of the clients we take care of are:

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



OAHR's caseload includes clients who speak English, Spanish, Cantonese, Mandarin, Korean, Amharic, Vietnamese, Arabic, Bisayan/Filipino, Khmer, Tongan, and Hindi. 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

- → Develop OAHR's niche alongside CalAIM; fill in gaps in care and reach clients who may fall through the cracks of larger managed-care systems.
- → Explore braided care management delivery pathways in order to maximize funding and ensure that OAHR nurse case management continues to be a referral option for safety net providers and their highest risk patients.
- → Continue to expand OAHR's reach across the County by forging strategic partnerships with healthcare and social services providers.
- → Further develop knowledge of Medi-Cal eligibility requirements amidst a changing health benefits landscape.

TOBACCO CONTROL

OVERVIEW

The Tobacco Control Program seeks to de-normalize tobacco products and their use through multi-level strategies that include upstream local policy development. The Program focuses policy work on two core areas:

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 holds 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 (ex. 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, increase health risks for medically vulnerable residents as well as for 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.

WHAT WE DO

The Tobacco Control Program provides 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, Oakland and the urban communities of the Unincorporated areas (Castro Valley, San Lorenzo, Ashland, Cherryland, Fairview, and Hayward Acres), the Program 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

The Program receives complaints if a retailer is suspected of 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.

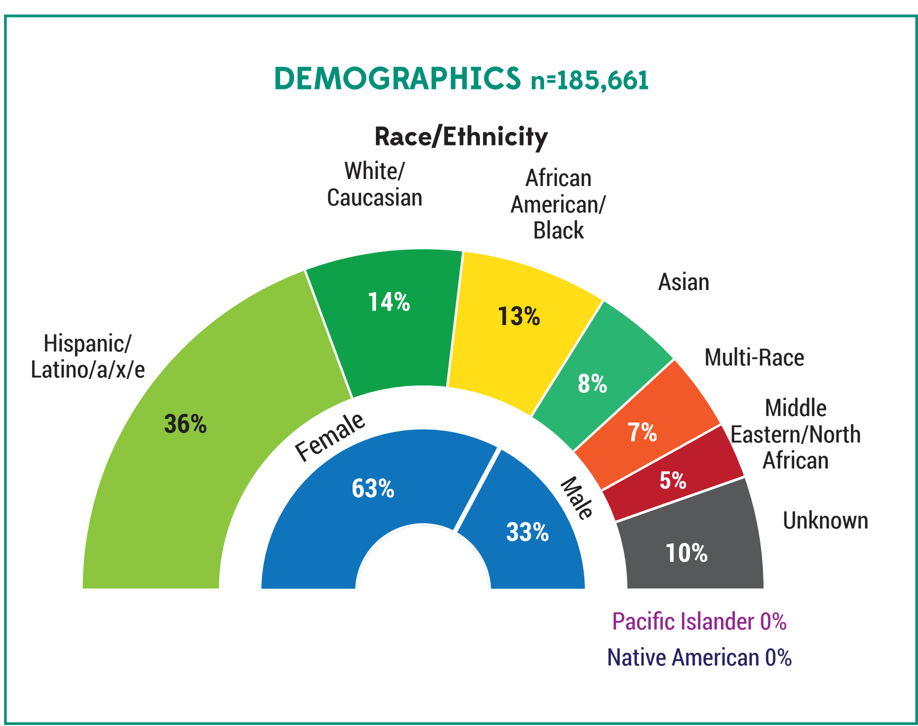
Resources for Tobacco Treatment and Cessation

The Tobacco Control Program links residents to existing resources for tobacco cessation.

- Kickitca.org Statewide phone and text-based tobacco treatment counseling in multiple languages
- Tobaccofreealamedacounty.org Provides local listings of no-cost tobacco treatment classes

POPULATION SERVED

The Tobacco Control Program supported jurisdictions to pass policies that protected over 185,600 adults and youth. Demographic information is from the jurisdictions covered.



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, we have several programs to serve the community:

WIC Regional Breastfeeding Liaison (RBL) Program

The 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.

Local Vendor Liaison (LVL) Program

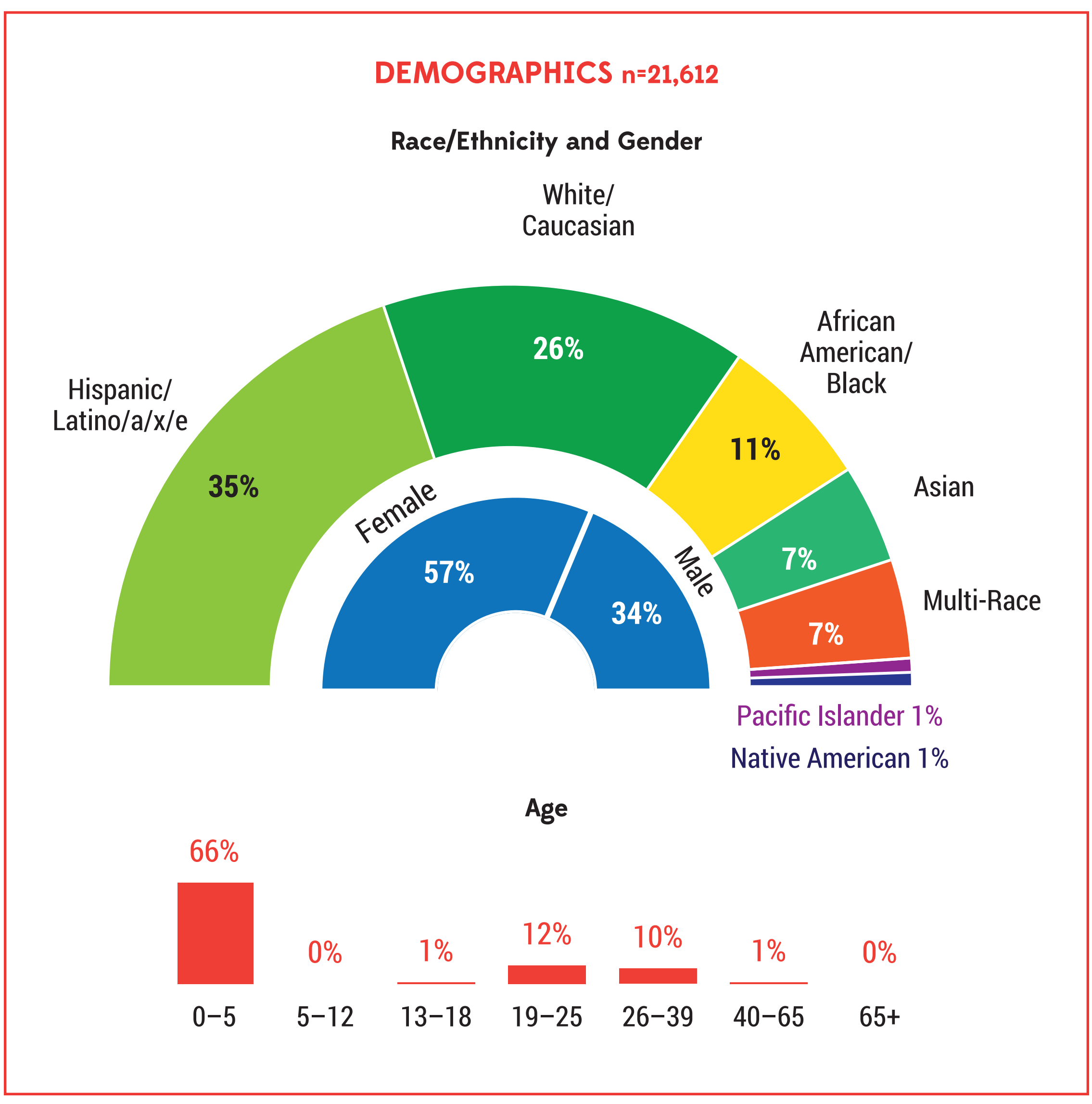
The LVL Program was established in 2008 to educate and support vendors during the implementation of new WIC foods. Since then, the role of LVLs has evolved and designated LVL staff provide WIC Authorized Vendors with technical assistance on program requirements and updates, conduct store surveys, and serve as local resources playing a critical role to support vendors in their success in providing healthy foods to WIC families. LVLs help improve vendor program participation and resolve customer service issues in order to create positive shopping experiences for both vendors and WIC families.

Breastfeeding Peer Counseling (BFPC) Program

BFPC connects pregnant moms with other trained and skilled moms who share similar demographics. Since 2003 BFPC has trained over 40 peer counselors. The moms build relationships and provide support by phone, in office, and in support group settings. By providing BFPC services, WIC continues to increase accessibility to support while helping moms navigate through common transitions in infant feeding and development for the duration of breastfeeding. In addition to educating and mentoring staff, our BFPC program has provided extended personalized support to more than 11,000 pregnant and breastfeeding families. Our peer counselors continue to evolve, one getting her doula certificate, two graduates of the Grow Our Own Lactation Consultant Program (GOO) and two who are currently enrolled with GOO. With their WIC experience, they will be eligible to sit for the IBCLC board exam after completing course requirements. Hoping to see future Lactation Consultants working with Alameda County WIC!

POPULATION SERVED

WIC serves infant, children ages 1–5, pregnant and postpartum women.



THE ROAD AHEAD

- Work with USDA and CDPH/WIC to implement the food package changes approved by USDA in 2024.
- These changes will be implemented in April of 2026.
- Along with the transition, staff training and participant education will be a top priority as we transition to the new WIC foods.

COMMUNITY HEALTH SERVICES DIVISION

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acphd.org/about/our-organization/community-health-services-division