Center for Health Equity
ACTION PLAN
2018-2024 Update & Extension

Letter from the Department of Public Health Leadership

As we enter 2024, after a once-in-a-century pandemic emergency, political strife, and an international disregard for human rights, we are presented with the question "How do we continue to center health equity and racial justice in our work". But before we can answer that we must look back and determine what has worked and what must be shifted.

Unfortunately, the color of your skin, where you live, where you were born, how you express your gender, who you love, and how much money you make continues to predict your health status or life expectancy. We have, however, learned over the last 5 years that we can make progress toward addressing health and social inequities by building and strengthening partnerships, using data to drive solutions, developing equitable policies and systems, and creating an infrastructure to address equity and racial justice.

This document provides an overview of the challenges and opportunities faced over the last 5 years as we worked to address health outcomes in infant mortality rates, sexually transmitted infection rates, and poor health due to exposure to toxic emissions as well as led the emergency response to the COVID-19 pandemic. While the data will show that inequities continue to exist, we have had successes in the services offered and how Public Health operates. It also provides a peek into the work moving forward to achieve equity. Lessons learned during the COVID-19 pandemic are being applied to other areas of focus.

We confirm our commitment to achieving equity by creating measurable strategies that 1) Provide access to useful and inclusive health equity data; 2) Support policy and systems change for the equitable distribution of opportunities and resources; 3) Build partnerships that truly share power and respect community perspective; and 4) Strengthen organizational readiness and capacity to adopt a just culture and achieve health equity.

I want to thank all our partners who have been critical to our success. We have listened and learned from you. We have made shifts in how we operate because of your feedback and experience. This document is as much a testament to Public Health's work as it is to the work of all our partners.

Thank you for joining us in building this movement for health equity. Together we can make LA County a community where everyone has what they need to attain their optimal health and well-being.

Sincerely,

Dr. Barbara Ferrer
Director
Los Angeles County Department of Public Health

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I. Introduction

For the County of Los Angeles Department of Public Health (Public Health), health equity is achieved when everyone has a fair and just opportunity to attain their optimal health and well-being. To achieve this, we must focus our efforts on those who are most impacted to close the gaps while improving outcomes for all. This is to ensure that all people have access to the goods, services, resources, and power they need to be healthy and well—especially people who have experienced socioeconomic disadvantage, historical injustice, and other avoidable and unjust systemic inequities that are socially produced and often associated with social categories of race, gender, ethnicity, social position, sexual orientation, and disability.

The Center for Health Equity (CHE) Action Plan 2018-2023

The original Action Plan was created to reflect shared commitments from the Departments of Health Services, Mental Health, and Public Health to reduce and eliminate health inequities among LA County residents. Since then, each Department has embarked on its organizational journey to implement policies and practices that ensure fair and just health outcomes tailored to their operational and workforce need[i]. The Departments continue collaborating on projects and efforts where there is programmatic alignment and opportunity to streamline services and access to community resources, such as language justice, mortality prevention among people experiencing homelessness, and career pathways for community health workers.

This latest edition of the CHE Action Plan (Action Plan) represents Public Health's commitment and progress toward achieving equity through a set of key organizational priorities centered on institutional change and eliminating inequities in health outcomes related to Infant and Maternal Mortality, Sexually Transmitted Infections (STIs), and Environmental Justice. Furthermore, the Action Plan frames Language Justice as a cross-cutting factor and outlines 4 equity priorities that showcase how Public Health is advancing equity:

- Providing access to useful and inclusive health equity data[ii].
- Supporting policy and systems change for the equitable distribution of opportunities and resources.
- Building partnerships that truly share power and respect community perspective and autonomy.
- Strengthening organizational readiness and capacity to adopt a just culture and advance health equity.

Equity Framework

The following framework (Graphic 1) was created to guide the design or enhancement of Public Health programs and administrative changes aimed at achieving health equity in Los Angeles County. It was developed based on Public Health's collective work to address health inequities and the components are promoted through Departmental policies and protocols, partnerships, and community investments. The framework is also used to assess how the objectives and equity priorities laid out in the Action Plan have progressed our work toward achieving equity.

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[i] LA County Department of Mental Health - ARDI (Anti-Racism, Diversity, Inclusion Division https://dmh.lacounty.gov/ardi/; LA County Department of Health Services - Equity, Diversity, Inclusion, and Antiracism Initiative https://dhs.lacounty.gov/who-we-are/work-or-partner-with-us/equity-diversity-inclusion-and-antiracism-initiative/

[ii] The Centers for Medicare & Medicaid Services (CMS) "defines health equity data as the combination of quantitative and qualitative elements that enable the examination of health differences between populations and their causes." LaShawn McIver L. Centers for Medicare & Medicaid Services. "The Path Forward: Improving Data to Advance Health Equity Solutions." November 2022. https://www.cms.gov/blog/path-forward-improving-data-advance-health-equity-solutions

Graphic 1: LA County Department of Public Health Equity Framework

Graphic 2: LA County Department of Public Health Shared Health Equity Priorities and Strategies

Priorities	Strategies
1. Provide access to useful and inclusive health equity data 2. Support policy and systems change for the equitable distribution of opportunities and resources. 3. Build partnerships that truly share power and respect community perspective and autonomy 4. Strengthen organizational readiness and capacity to adopt a just culture and advance Health Equity	1. Increasing organizational competency and capacity to engage in sustained equity work to achieve equity. 2. Communicating in ways that amplify community voices and authentic narratives[iii] to drive action and policy towards achieving equity. 3. Supporting/building community capacity to engage in efforts that eliminate inequities. 4. Forging partnerships to enhance and promote efforts that result in equitable health outcomes. 5. Aligning resources to work that eliminates inequities.

Report Structure

During the last 5 years, implementation of the Action Plan activities was either accelerated, paused, or modified. Section II of this report provides a high-level overview of progress made toward achieving items in the initial action plan, highlights challenges and barriers encountered during implementation, and offers some details on the path forward. Due to a variety of issues outlined in this report, the Center for Health Equity (CHE) was unable to engage in the scheduled strategic planning for the next Action Plan. As a result, the current plan was extended through 2024 and, as of the publication of this report, the planning process for the next iteration has begun. Section III provides an overview of the extension plan and next steps.

[iii] Narratives are stories and messages from the community that transform views and beliefs about a particular issue to drive actions and policies toward achieving health equity.

II. Accomplishments, Struggles, and Path Forward

To effectively address the persistent disparities in health and the social inequities that cause and maintain them, a prolonged focus on confronting the legacy impacts of discriminatory and racist policies and systems and community mistrust in government institutions is required. A 5-year period is just not enough time to develop the roadmap, set up the infrastructure, build the partnerships, change narratives, and align the resources to start addressing inequities. This task was further delayed and complicated during a period of local, national, and global emergencies caused by the COVID-19 pandemic, which required a restructure of the Department's operations in response to a public health emergency that lasted through 2023 and is still partially in operation today. As implementation of the Action Plan began, the intent had been to be flexible, learn from the process, listen to partners, make course corrections when needed, provide periodic brief reports, and present a mid-term report to update the action plan as appropriate. However, Public Health had to make a major shift in focus to rapidly address the ever-changing status of the COVID-19 pandemic.

At the peak of the pandemic, over 70% of the workforce was dedicated to implementing a comprehensive, multi-pronged emergency response to both prevent and control the spread of COVID-19 in the County and address the disproportionate rates of infections, hospitalizations, and deaths observed among already overburdened racial/ethnic groups (primarily African American and Latinx), older adults, individuals living with disability, essential workers, healthcare workers, and other vulnerable and under-resourced groups. The response included leveraging existing and building new partnerships to establish community-centered COVD-19 testing and vaccination efforts, coordinate infection control strategies, including conducting outbreak investigation and contract tracing, provide services to the school systems and worker centers, create protocols and supports for Skilled Nursing Facilities, support evaluation for and access to COVID-19 treatment thru newly established public health telehealth services, launch a call center to answer questions from the public, deliver accessible and accurate information and messages to counter false narratives and scare tactics (misinformation and disinformation), and distribute free personal protective equipment (PPE), test kits, and other resources.

The pandemic shined a light on key inequities that caused outcomes to be most devastating for Black, Indigenous, and People of Color (BIPOC) communities. Furthermore, local, state, and national incidents had jurisdictions grappling with how to center equity in all aspects of the work. Before 2018, Public Health's CHE was one of the few offices dedicated to looking at how to achieve health equity. Today almost every LA County (County) agency has an equity division and plan or is looking to build one. The County also launched the Anti-Racism, Diversity, and Inclusion (ARDI) Initiative[iv]. Additionally, Public Health actively sits in countywide spaces to develop an aligned framework for addressing policies and practices that create more equitable outcomes, such as contracting, community engagement, and participatory budgeting. As a result, reducing infant and maternal mortality, eliminating sexually transmitted diseases, addressing environmental hazards, and emergency preparedness have often been elevated as County priorities.

Much has occurred in the last 5 years, requiring shifts in interventions outlined in the Action Plan. This section provides a high-level overview of the challenges and opportunities faced and the plans for moving forward:

1) **What Does the Data Tell Us:** Improvements made, where inequities still exist, and where applicable, what got worse.
2) **What We Accomplished:** Key activities that addressed one or more of the Strategies outlined in the Equity Framework and set the foundation for addressing the objectives and priorities.
3) **Areas for Collective Improvement:** The challenges in addition to COVID-19 that made it difficult to make any major progress in addressing the objectives and strategic priorities.
4) **The Path Forward:** Key activities the Department will execute over the next year.

[iv] Los Angeles County Chief Executive Office, Anti-Racism, Diversity, and Inclusion (ARDI) Initiative. https://ceo.lacounty.gov/ardi/

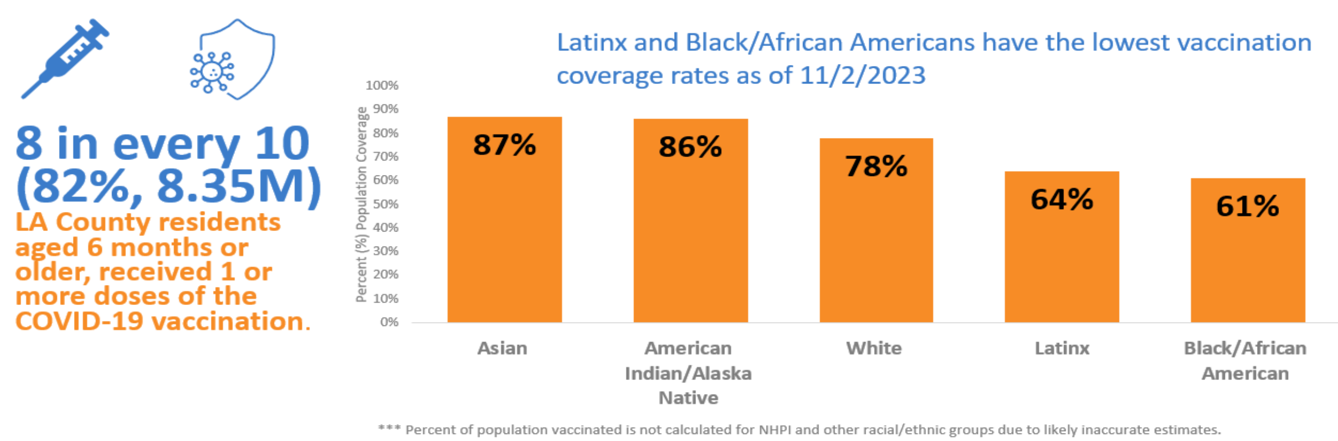
Mitigating COVID-19 Inequities in Racial/Ethnic Groups, Vulnerable Populations and Communities.[v]

Historically, communities disproportionately affected by poor health outcomes include Black/African American, Hispanic/Latinx, Asian American (AA), Native Hawaiian and Pacific Islander (NHPI), and American Indian/Alaska Native (AI/AN) communities, as well as undocumented populations, frontline low-wage workers, people experiencing homelessness (PEH), LGBTQIA+, and justice-involved populations. These persistent disparities are primarily the result of longstanding inequities in an array of social determinants, including access to living wage jobs, educational disparities, and limited access to health care, affordable housing, nutritious foods, and availability of disposable income as well as experiences with racism and other forms of discrimination. Similar patterns were documented for COVID-19 outcomes. Closing gaps from the impact of COVID-19, while improving health outcomes for all, required both targeted and tailored approaches for specific communities.

What Does the Data Tell Us

The data in graphic 3 shows that as of late 2023, though COVID-19 vaccination coverage (individuals 6 months or older who received 1 or more doses) was high in the overall LA County population (82%, 8.35 million), we still see disparities for Black/African Americans and Hispanic/Latinx individuals who have the lowest vaccination coverage (61% and 64% respectively) compared to members of other racial/ethnic groups. Asians had the highest coverage at 87%. Reasons for this disparity could be due to general vaccine hesitancy among and a lack of easy access to vaccines for Black/African Americans and Latinx individuals, which would highlight a need for a particular need for more tailored outreach and engagement to these racial/ethnic groups in the County. Calculations were not done for Native Hawaiian/Pacific Islander, Multi-Race, and Other categories due to likely inaccurate estimates due to their smaller sub-population group size. Data for vaccination coverage are available at *http://publichealth.lacounty.gov/media/Coronavirus/vaccine/vaccine-dashboard.htm*. The racial and ethnic groups presented are based on the best available data collection and were not able to be disaggregated further within each racial and ethnic group, hence sub-population disparities may likely exist.

Graphic 3: COVID-19 Vaccination Coverage by Race/Ethnicity in Los Angeles County as of 11/2/2023.



Date Source for Vaccination Coverage: *Los Angeles County Department of Public Health COVID-19 Vaccination Dashboard http://publichealth.lacounty.gov/media/coronavirus/vaccine/vaccine-dashboard.htm – accessed 11/2/2023.*

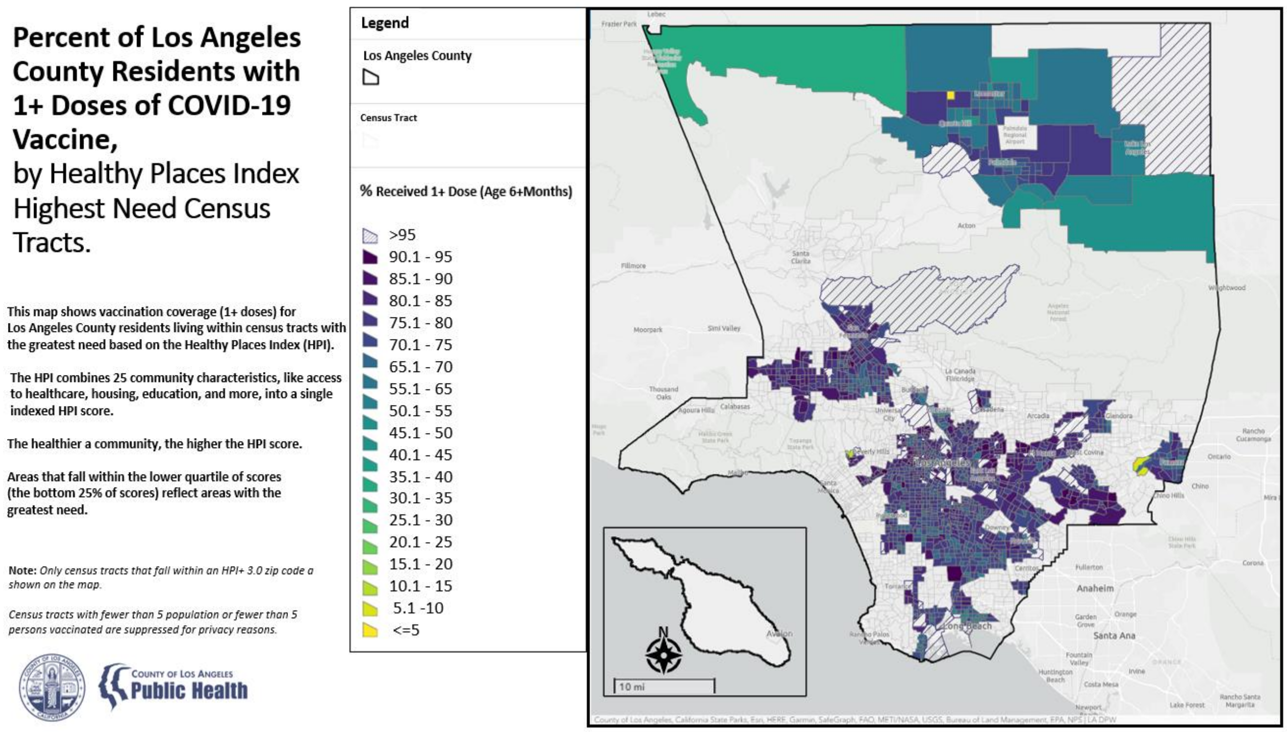
Data source for population estimates used on calculating coverage: *County of Los Angeles, Internal Services Department, Information Technology Service, Urban Research-GIS Section, Population and Poverty Estimates of Los Angeles County Tract-City Splits by Age, Sex and Race-Ethnicity for July 1, 2019, Los Angeles, CA, April 2020. The estimate of population with age of less than 1 year (by month of age) was based on Los Angeles County Annual Birth Data File 2018 and 2019, assembled from California Department of Public Health Vital Records Data. Office of Health Assessment and Epidemiology, Los Angeles County Department of Public Health.*

[v] This is not a full account of the Public Health COVID-19 response. More can be found at http://publichealth.lacounty.gov/media/coronavirus/docs/Manatt_Report_COVIDResponseInterimReview_Dec2022.pdf

Below in graphic 4 is a map showing vaccination coverage (1+ doses) for Los Angeles County residents living within census tracts with the greatest need based on the Healthy Places Index (HPI Plus 3.0)[vi]. The HPI combines 25 community characteristics, like access to healthcare, housing, education, and more, into a single indexed HPI score. The healthier a community, the higher the HPI score. Areas that fall within the lower quartile of scores (the bottom 25% of scores) reflect areas with the greatest need.

Vaccination coverage varied by census tract and was more skewed toward higher coverage (>75%) in higher concentrated areas of population and need. There were only a few census tracts with <15% population coverage for one or more doses.

<u>Graphic 4</u>: Percent of Los Angeles County Residents with 1+ Dose of COVID-19 Vaccine, by Healthy Places Index High-Need Census Tract as of 9/10/23.



__Note:__ Areas with >95% coverage have no upper bound (e.g., 100%) due to the calculation of vaccination coverage being based on a cumulative numerator count and a point in time denominator. In some census tracts, there were more people vaccinated compared to the point in time census tract denominator count for that tract, which would produce a >100% coverage estimate. These tracts are highlighted in the hashed purple stripes. Map modified from data map provided by Los Angeles County Department of Public Health, Vaccine Preventable Disease Control Program (VPDC).

What We Accomplished

<u>Increased Organizational Capacity</u>

- From the onset of the COVID-19 Pandemic, the Department provided data, organized in different ways, readily accessible and available to the public. This began initially by collaborating with the Departments of Health Services and Medical Examiner-Coroner to create the Los Angeles County COVID-19 Racial, Ethnic & Socioeconomic Data & Strategies Report[vii]. This report summarizes what was known at the time about the

[vi] HPI Plus data census tracts acquired from the Public Health Alliance of Southern California (https://www.healthyplacesindex.org/) and provided by Los Angeles County Department of Public Health, Vaccine Preventable Disease Control Program.

[vii] *The Los Angeles County COVID-19 Racial, Ethnic & Socioeconomic Data & Strategies Report*. Los Angeles County Department of Public Health, Chief Science Office April 2020 http://publichealth.lacounty.gov/docs/RacialEthnicSocioeconomicDataCOVID19.pdf

racial/ethnic and socioeconomic characteristics of those who had been tested, diagnosed, and required hospitalization for COVID-19 as well as proposed strategies to address COVID-19 inequities among highly impacted populations. To inform their strategies and ongoing efforts, community stakeholders had access to data through the development of various dashboards[viii] to highlight progress made.

- Several efforts, informed by a group of community stakeholders, were launched to create an equitable distribution of COVID-19 vaccines including through local Vaccine Sites, Mobile Vaccine Teams, and In-home vaccination. These efforts connected to people where they were in communities, in skilled nursing facilities, in their own homes, and in numerous other places to ensure easy access to the vaccines.
- The Public Health Call Center was initially created to connect COVID-19 positive individuals to a case interviewer and determine their eligibility for services, such as temporary housing and food delivery services, to support them during isolation and prevent further spread. The Call Center then expanded to include the Nurse Triage Line to assist with scheduling vaccine appointments, coordinating rides to vaccination appointments, and serve as a hub for information, resources, and referrals.
- The Public Health Councils program was established to increase understanding and adherence to legally enforceable directives in business sectors disproportionately impacted by COVID-19 (e.g., garment manufacturing, food manufacturing, warehousing and logistics, restaurants, and grocery stores). This is the first program in the nation to directly fund worker centers to conduct outreach to low-wage workers and support them in forming Public Health Councils—committees where workers can come together to identify Health Officer Order violations and discuss strategies for increasing compliance at the worksite.

Supporting/building community capacity

- Critical to the pandemic response was making targeted investments, such as the COVID-19 Community Equity Fund, Public Health Councils, and the Community Health Worker Outreach Initiative, to support community- and faith-based organizations to do what they do best: connect with residents, provide much-needed community services, engage in policy and practice changes, and share vital information on risks and opportunities for improved information sharing and health outcomes. These investments ensured that community partners had the resources to keep their doors open and continue to provide much-needed services, and that their staff had the knowledge and understanding needed to respond to questions and concerns about this deadly disease.
- Addressing the needs of vulnerable populations, such as essential workers, those in skilled nursing facilities/congregate living settings, people experiencing homelessness, incarcerated populations, and educational intuitions, required comprehensive and multi-sector approaches. Strategies included funding to support local entities already serving these populations, health officer orders and emergency ordinances to implement, support, and ensure compliance with necessary pandemic response activities, provision of education, detailed infection control guidance, and technical assistance to sector institutions, distribution of free PPE, public dashboards for all to monitor the situation through relevant data, and easily accessible testing and vaccination sites.

Amplify Community Voices

- Public Health, with stakeholder input, strived to develop and as needed, modify response strategies, craft tailored communications with an equity narrative, use community-preferred communication channels and spokespeople to foster trust, and provide timely, responsive, and accurate information. Elevating and listening to community perspectives and experiences builds stronger and more effective public health practices. It is also the backbone of both our pandemic response and equitable public health practice. Public Health deployed a variety of in-language strategies to communicate and engage with diverse communities

[viii] Los Angeles County Department of Public Health LA County COVID-19 Data Dashboards http://www.publichealth.lacounty.gov/media/Coronavirus/data/index.htm

across the County. This work also included reaching a bilingual audience and multigenerational households with varying degrees of comfort with English and specific preferences for media outlets they use for information and communication. Strategies included press conferences specifically for ethnic media outlets, partnerships with prominent community figures, updating key messages and printed materials for community partners, online resources, paid/earned media, targeted social media, phone lines and other phone-based strategies, media briefings, podcasts, and promotion of new and existing programs and services.

Forged Partnerships

- Starting in December 2020 in preparation for the new COVID-19 vaccine, Public Health engaged over 150 external stakeholders and partners to provide actionable recommendations to center equity in COVID-19 vaccine distribution and related communication through the COVID-19 Vaccine Equity Committee.
- The Department's ability to connect with the public and quickly deploy information, vaccines and other resources was highly dependent on a vast network of partners. This network included an array of local clinics, Community Based Organizations (CBOs), Faith Based Organizations (FBOs), health plans, ethnic media outlets, the business sector and other municipalities and government agencies.

Aligning Resources

- Funding received from Federal and State jurisdictions ensured that Public Health had funding for the rapidly evolving response and related needs of the community through a robust and flexible set of strategies as those listed above. Most importantly funding was used to establish a broader net of partners to support with COVID-19 outreach and education. Without their support, efforts to reach the community would have been unsuccessful.

DPH Programs – COVID-19

Funds Received:
~$2Billion in multi-year Federal, state and local grants acquired.

Vaccine Sites:
500 Mobile Vaccination Sites,
1,300 Fixed Vaccination Sites by May 2022.

Call Centers:
446,095 Calls processed in Sept. 2020 – Aug. 2023.
62,057 Appointments facilitated Feb. 2021 – Aug. 2023.

Communications:
More than **20 social media campaigns** since Oct. 2021.
960 Residents reached with more than **20K views/likes,**
180K impressions, 29K engagements and **19K likes.**

Public Health Councils (PHC):
Since Apr. 2021, **96 PHCs** formed with **41,408 workers** and **1,844 employers receiving** COVID-19 and Health Officer Order education.

Outreach & Education:
Since Apr. 2021, CBOs provided over **23 million engagements** with COVID-19 information, resource links, testing assistance, vaccine appointments and access to therapeutics.

Older Populations:
1.4 Million residents aged 65+ years or older received 1+ doses of the COVID-19 vaccine.

Skilled Nursing Facilities:
Over **2.1 million tests provided** to Skilled Nursing Facilities and congregate living facilities to support infection control and compliance with Health Officer Orders.

Personal Protective Equipment (PPE):
Over **100 million pieces of PPE** distributed between Mar. 2020 – Oct. 2021.

Antigen Tests:
Over **14 million Antigen Tests** distributed as of Jun. 2022.

Areas for Collective Improvement

<u>Mistrust</u>

Underlying mistrust of government and health-related institutions was high throughout the pandemic, especially within the Black/African American and Latinx communities. Residents have elevated the deeply problematic history between medical, public health, and governmental entities and community members of color and personal experiences with bias exhibited by clinical providers as reasons for not seeking services from Public Health or other County entities.

Governmental and public health entities' sense of urgency to vaccinate residents to limit community spread and impact of COVID-19 has led some community members to recall examples of historical unethical studies and practices by public health institutions and government entities that have directly fostered their mistrust in these organizations. The legacy of these unethical acts has led to mistrust in institutions leading the COVID-19 emergency response and life-saving services, including vaccination. Furthermore, among immigrant populations, many fled their home countries due to long-term war or civil unrest. Some have experienced multiple traumatic events (i.e., imprisonment, sexual assault, ethnic cleansing, and violence),[1] sometimes at the hands of their country's government. While the use of tailored strategies through CBOs and FBOs helped, countering the mistrust was a heavy lift, even for those trusted community entities. As timed past and the COVID-19 case counts and hospitalizations decreased and public attention on the risks of COVID-19 began to shift and lessen, our community partners struggled to change opinions.

<u>Misinformation and Disinformation</u>

With the abundance of health information available today, it can be hard to tell what is true or not. False or misleading information can lead people to make decisions that could have dangerous consequences for their health. Thus, we all need easy access to trusted sources of information to stay safe and healthy.[ix]

The longstanding mistrust of government and health entities continues to breed rampant misinformation (information that is false, inaccurate, or misleading according to the best available evidence at the time) and fuel disinformation (misinformation used to serve a malicious purpose, such as to trick people into believing something for financial gain or political advantage). Coupled with the growing number of places people go to for information, it is easier for misinformation and disinformation to spread at a never-before-seen speed and scale, especially on social media, online sites, and search engines.

> *"Health misinformation is a serious threat to public health. It can cause confusion, sow mistrust, harm people's health, and undermine public health efforts."*
> *—Dr. Vivek H. Murthy*
> *Surgeon General of the United States*

Misinformation is often based on a lack of or flawed understanding of clinical information (e.g., vaccines change your DNA) or the best available evidence at the time, disinformation was aimed at exacerbating mistrust (e.g., vaccines insert microchips for tracking purposes) and undermining efforts. For example, during the COVID-19 pandemic misinformation and disinformation caused people to decline COVID-19 vaccines, reject public health measures such as masking and physical distancing, and use unproven treatments.

Throughout the COVID-19 pandemic, many found it challenging to stay up to date on the evolving scientific knowledge and understanding of COVID-19 as an illness and how to prevent and treat it. In addition, the ever-changing and sometimes conflicting updates to federal, state, and local requirements and recommendations

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[ix] Health Misinformation — Current Priorities of the U.S. Surgeon General https://www.hhs.gov/surgeongeneral/priorities/health-misinformation/index.html#understand

also proved confusing and difficult to track for many, especially those who were already struggling with other, often more pressing, basic needs, such as housing and employment. While guidance and interventions were based on data and messages delivered by recognizable messengers through trusted communication channels, the overarching misinformation and disinformation that targeted these communities and at times shared by influential public figures spread quickly, making it hard to counter.

Path Forward

Public Health will continue its efforts to monitor and respond to the ongoing spread and ever-changing impact of COVID-19 while continuing to build the capacity to address health inequities and be prepared to address future pandemics and emergencies. As such Public Health will strive to:

1) Continue to tailor investments in COVID-19 education, testing, vaccinations, and therapeutics to maintain necessary disease prevention and control strategies after the lifting of emergency declarations and commercialization of vaccination and treatment options.
2) Continue ongoing surveillance to monitor and track disparities and inequities in health outcomes.
3) Sustain community partnerships and ongoing investments and engagement in the community infrastructure. Specifically, Public Health is sustaining its Community Health Worker Initiative and building out Community Public Health teams.
4) Sustained capacity in various response efforts launched during COVID such as Mobile Vaccine Teams which will expand services beyond COVID to include other vaccines and the Public Health COVID Call Center, which became a blueprint for the forthcoming Public Health Call Center to help residents get information and connected to additional Public Health services and beyond.

Reduce the Gap in Black/White Infant Mortality

Before 2022, the rate of infant deaths in the United States had been falling for two decades while gaps between Black/African Americans, American Indian/Alaska Natives, and other racial/ethnic groups persisted. Newly released national data show that the rate has now increased by nearly 3% between 2021 and 2022 (5.44 to 5.60 per 1,000 live births respectively)[x], and persistent disparities by race/ethnicity, income, and geographic location continue. Drawing upon the logic that the health of an infant is linked to the health of the individual to whom they are born, the health of the pregnant woman/person is an important factor. The rate of maternal deaths is on the rise and similar disparities exist. For Black mothers in particular, the lifetime of exposure to racism and its correlates put them at elevated risk for infant and maternal mortality, and other adverse health outcomes.

What Does the Data Tell Us

Infant Mortality is an important indicator for the overall health of any population and is defined as the death of an infant before the first birthday. The leading causes of infant deaths include congenital anomalies, birth defects, preterm birth, low birthweight, and sudden unexpected infant death, which includes sudden infant death syndrome. California has one of the lowest infant mortality rates (per 1,000 live births) in the nation, but significant disparities persist based on race/ethnicity, geography, and socio-economic status.

Pregnancy-related mortality ratio (PRMR) is an important health indicator of maternal health. It is defined as the number of deaths while pregnant or within one year of the end of pregnancy from causes related to or aggravated by the pregnancy or its management (per 100,000 live births) - excluding deaths from suicide, homicide, drug overdose, or most other injuries. Maternal mortality is the death of a woman during pregnancy,

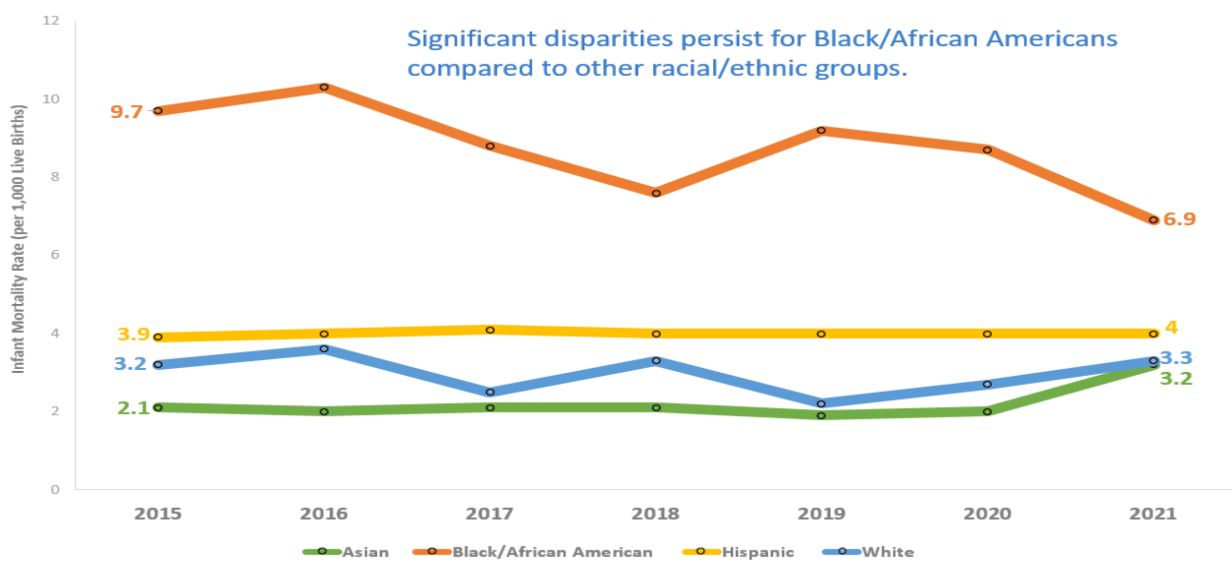
[x] Driscoll AK, Ely, DM. Quarterly provisional estimates for infant mortality, 2021-Quarter 2, 2023. National Center for Health Statistics, National Vital Statistics System, Vital Statistics Rapid Release Program. 2023.

at delivery, or within 42 days after delivery or termination of pregnancy from any cause related to or aggravated by the pregnancy or its management but not from unintentional or incidental causes[xi].

At the root of racial disparities—in premature birth, infant mortality, and maternal mortality—is not the behavior of Black individuals, but rather the afront of generational oppression and structural and interpersonal racism, the toxic stress-inducing experience of which takes a physiological toll on a Black woman's body. The harm of racism is amplified by economic oppression experienced by Black individuals, and both implicit and overt bias in our healthcare system is seen in repeated accounts of Black women/birthing people being unheard when they express concerns. It is important to note that this inequity has impacted Black women of all socio-economic backgrounds and education levels.

In 2021, in Los Angeles County, there were 21,188 white, 52,743 Hispanic, and 7,508 Black births. While infant mortality rates (shown in graphic 5 below) are declining overall, the Black/White gap persisted during the Action Plan period, with the mortality rate for babies born to Black mothers remaining at twice that of babies born to White mothers.

Graphic 5: Infant Mortality Rate (infant deaths/1,000 live births) by Mother's Race/Ethnicity and Year, Los Angeles County 2015-2021.

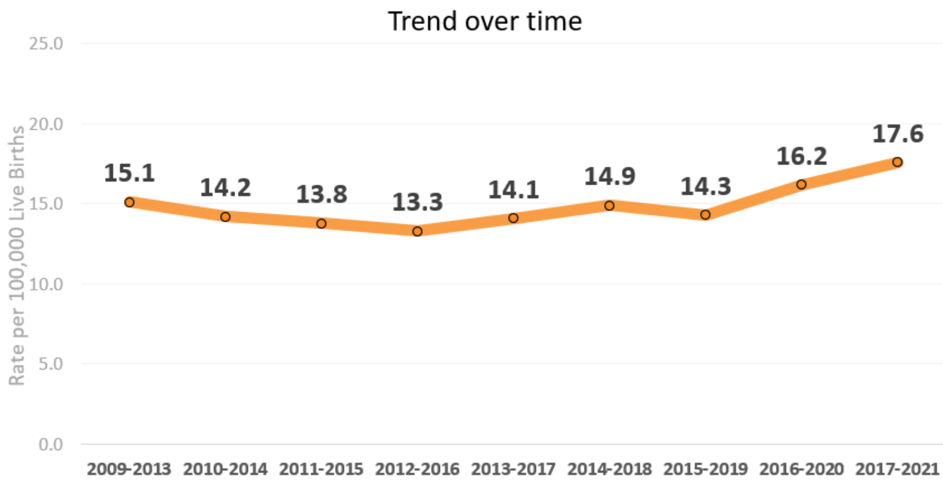


Notes: Infant Mortality rate is defined as the number of deaths to infants within the first year of life per 1,000 live births. Data not shown for Native Americans, Pacific Islanders, Other and Unknown races. Data Source: 2015-17 California Department of Public Health, Birth and Death Statistical Master Files. 2018-2021 birth and death records downloaded from the Vital Record Business Intelligence System (VRBIS). Data provided by Los Angeles County Department of Public Health, Maternal Child & Adolescent Health Program.

The PRMR (5-year rolling average) for Los Angeles County is on the rise for 2016-2021 with a rate ratio of 17.6 per 100,000 Live Births.

[xi] Trends in maternal mortality 2000 to 2020: estimates by WHO, UNICEF, UNFPA, World Bank Group and UNDESA/Population Division. Geneva: World Health Organization; 2023. License: CC BY-NC-SA 3.0 IGO. 9789240068759-eng.pdf (who.int)

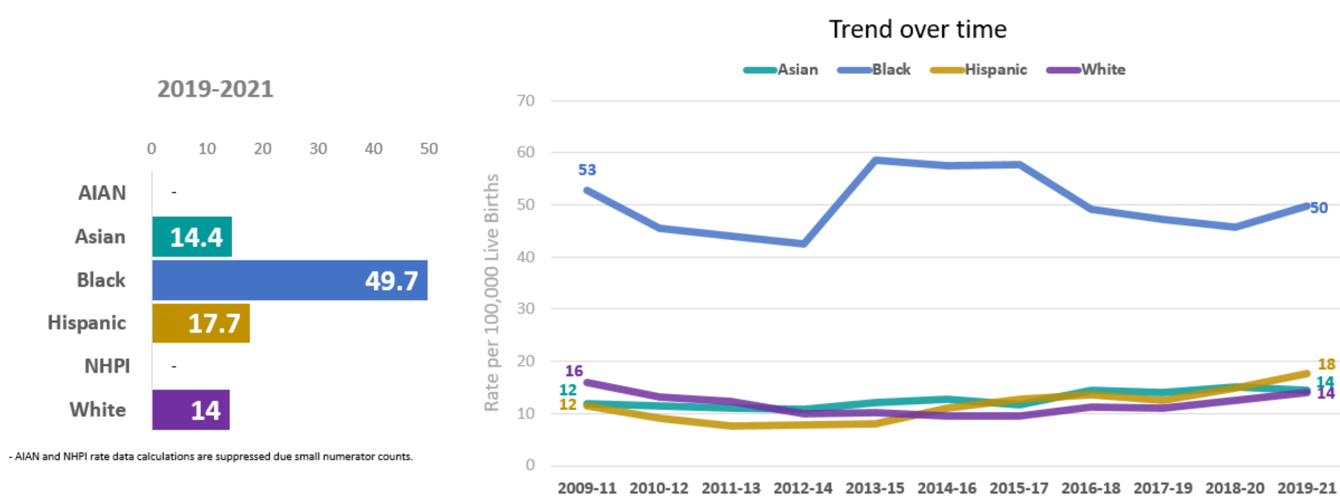
Graphic 6a: Pregnancy-Related Mortality Ratio (5-year Rolling Averages), Los Angeles County 2009-2021.



California Department of Public Health, Birth Statistical Master File, 2009–2017: Compiled from information on birth certificates, including demographic information related to the infant and parents, as well as medical data related to the birth. California Department of Public Health, California Comprehensive Master Birth File, 2018–2021: Compiled from information on birth certificates, including demographic information related to the infant and parents, as well as medical data related to the birth. Beginning in 2018, the California Comprehensive Master Birth File replaced the Birth Statistical Master File. California Department of Public Health, California Pregnancy Mortality Surveillance System Data, 2009–2021: Compiled from information on vital statistics and administrative data (California Department of Public Health: Birth Statistical Master File, 2009–2017, California Comprehensive Master Birth File, 2018–2021, California Fetal Death Statistical Master File, 2009–2021, Death Statistical Master File, 2008–2013, California Comprehensive Master Death File, 2014–2021; California Department of Health Care Access and Information, formerly the Office of Statewide Health Planning and Development: Patient Discharge Data, 2009–2021, Emergency Department Data, 2009–2021 and Ambulatory Surgery Data, 2009–2021), Coroner/Medical Examiner investigations, autopsy and toxicology reports, hospital discharge summary, medical records and expert committee case review results.. https://www.cdph.ca.gov/Programs/CFH/DMCAH/surveillance/Pages/Pregnancy-Related-Mortality.aspx.

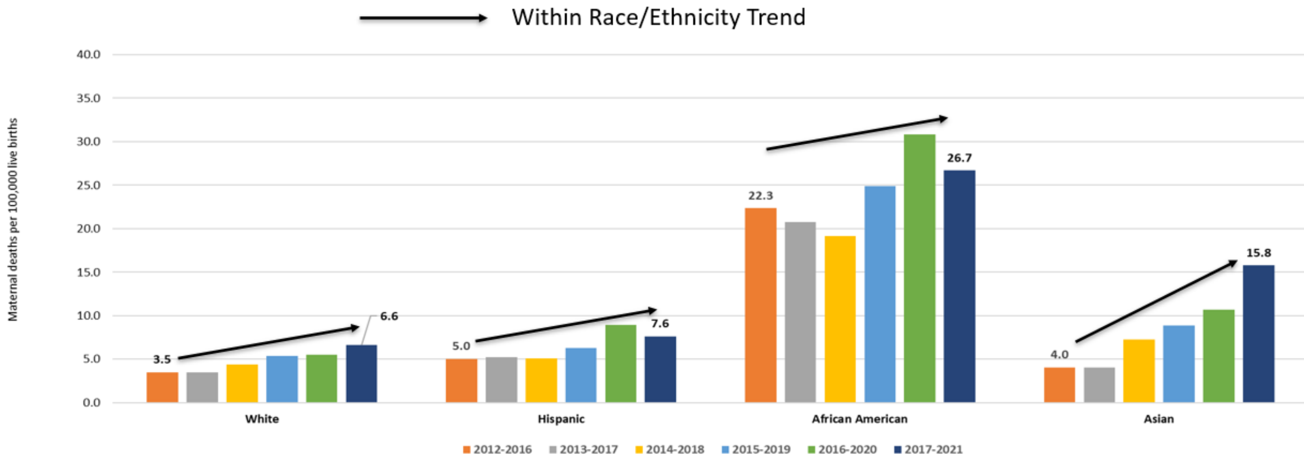
California Department of Public Health data on race/ethnicity shows the PRMR for Black mothers in California is over 3 times that of white mothers and as remained consistently higher than other racial/ethnic groups.

Graphic 6b: Pregnancy-Related Mortality Ratio (3-year Rolling Average) by Race/Ethnicity, California 2009-2021.



California Department of Public Health, California Department of Public Health, Center for Family Health, Maternal, Child and Adolescent Health Division, Pregnancy-Related Mortality Dashboard, Last accessed May 2, 2024. https://www.cdph.ca.gov/Programs/CFH/DMCAH/surveillance/Pages/Pregnancy-Related-Mortality.aspx

Graphic 7: Maternal Mortality Ratio (5-year Rolling Average) by Race/Ethnicity, Los Angeles County 5-year Moving Averages, 2012-2021.



Revised 05/01/2024: Maternal Mortality Ratio (MMR) estimates revised to exclude ICD-10 codes 096-097, these estimates supersede all previous versions of MMR data released by the Los Angeles County Department of Public Health Maternal, Child, and Adolescent Health Division.
Note: *Maternal deaths included to calculate MMR are defined by WHO as "the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes". Included in these deaths are ICD-10 codes A34, O00-O95, and O98-O99. Data not shown for American Indian/Alaska Natives, Native Hawaiian/Pacific Islander, Other and Unknown races due to small cell sizes and unstable estimates.*

Data Sources: California Department of Public Health (CDPH), Birth Statistical master File, 2012-2017 & California Integrated Vital Records System, 2018-2021. California Department of Public Health Death Statistical Master File, 2011-2013 & California Integrated Vital Records System, 2014-2021.More information on MMR and other measures of maternal health are available at https://www.cdph.ca.gov/Programs/CFH/DMCAH/Pages/Health-Topics/Maternal-Mortality.aspx .

Deaths during pregnancy, childbirth, or postpartum are tragic events, and the Public Health community-driven African American Infant and Maternal Mortality (AAIMM) Prevention Initiative[xii] is working to reduce these events and to close the glaring racial gap that currently exists between Black mothers and mothers of other races due to systemic racism and other social factors that are at the root of the problem. AAIMM is working to catalyze community action to address these root causes of inequality in Black/white birth outcomes and promote effective, culturally supportive health and social services for African American/Black families.

What We Accomplished

What, in 2018, was a budding, unstaffed project has now become the Los Angeles County African American Infant and Maternal Mortality Prevention Initiative (AAIMM). It is a coalition led by community members with lived experience in partnership with the Department of Public Health, First 5 LA, community organizations, health care providers, funders, and other County departments. AAIMM is united under one purpose: to address the unacceptably high rates of Black infant and maternal deaths countywide and ensure healthy and joyous births for Black families in LA County. The initiative is guided by a countywide Steering Committee (SC) and includes Community Action Teams (CATs) in four county regions and myriad direct service, awareness-building, and systems-change programs. AAIMM has received national recognition by receiving the 2023 Robert Wood Johnson Foundation (RWJF) Culture of Health Prize[xiii]. The prize celebrates communities across the country where people and organizations are collaborating to build positive solutions to barriers that have created unequal opportunities for health and wellbeing.

[xii] The Los Angeles County African American Infant and Maternal Mortality (AAIMM) Prevention Initiative https://www.blackinfantsandfamilies.org/about
[xiii] Los Angeles County, California 2023 RWJF Culture of Health Prize Winner https://www.rwjf.org/content/rwjf-web/us/en/grants/grantee-stories/2023/2023-winner-los-angeles-county-ca.html

FUNDING

- Received six grants totaling more than **$5 million annually** to support the work of AAIMM

DOULA SERVICES

- **700 Black pregnant women** received support from Black doulas
- Living wages for doulas and extensive continuing educational opportunities were provided for Black birth workers countywide

COMMUNICATIONS

- **110 Million impressions** through www.blackinfantsandfamilies.org and outdoor and social media campaigns.

COMMUNITY CAPACITY BUILDING TRAININGS

- **500 people reached** through community capacity building trainings

COMMUNITY INVESTMENTS

Since 2020, the LA Partnership for Early Childhood Development has secured a total of **$2.96 million in private philanthropic funding** toward AAIMM.

<u>Increase organizational capacity</u>

Over the last 5 years, six grants totaling more than $5 million annually have been secured by Public Health to support the work of AAIMM, with substantial additional investment and in-kind support from First 5 LA and the LA Partnership for Early Childhood Investment. Community partners have also received numerous grants to contribute to their work.

In Los Angeles County,

Birth Justice Is Black-Led and Joyful —and It Takes a Village!

Top Left: AAIMM is a coalition of the LA County Dept. of Public Health, First 5 LA, community organizations, mental and healthcare providers, funders and community members.
Top Right: A breastfeeding mother in AAIMM's Safe Space Breast/Chestfeeding Tent at the Taste of Soul Family Festival in Los Angeles.
Bottom Left: Participants at the Black Women for Wellness Breast Health and Art Event share dialogue about environmental justice, health and community.
Bottom Right: Fatherhood coordinator for AAIMM, hosts a meetup for Black fathers in Compton, California.

The SC and CATs contributed to the creation of programs that were based on community knowledge and feedback. This includes AAIMM's fatherhood program, the AAIMM Village Fund, and the AAIMM Doula Program, which the increased grant funding also made possible. The combined community-government capacity of AAIMM enabled it to promote racial equity in perinatal health at the local, state, and federal levels. The CATs were critical in helping to design plans for new programs, including a Guaranteed Basic Income initiative that will support hundreds of high-risk pregnant Los Angeles families and a Black mother-driven policy workgroup. AAIMM has also used funds to provide training for staff around racial equity, effective collaboration, and communication.

Supporting/building community capacity

Over the last 5 years, the AAIMM Initiative has advanced a counter-narrative to shift perceptions about the cause of birth outcome inequality and thus, the appropriate solutions. AAIMM developed core messaging focused on addressing racial harm and activating a village of support for Black individuals. AAIMM has built a community infrastructure that redefines the cause of birth outcome disparity as systemic inequity and then engages community leaders by:

- Sharing the facts on infant mortality with community organizations and providing training on organizational development including grant writing, collective impact, and leading effective collaboration to help put that knowledge to work. AAIMM recently launched the 2023 Community Capacity Building training at no cost to the LA County AAIMM network. Public Health also provided training to both community organizations and individuals on opportunities and resources to better serve clients, including Earned Income Tax Credit, Paid Family Leave, maternal mental health, doula care, and the new Medi-Cal doula benefit. Over 500 people have received training through AAIMM.

- Providing direct funding to Black woman-led community organizations via contracting and stipends for time allocated to AAIMM activities. The AAIMM Village Fund[xiv] was developed to provide small grants to community agencies and individuals who contribute to community well-being and to engage the leaders of those businesses as AAIMM ambassadors.

- Administering the AAIMM Doula Program, which has provided over 700 Black pregnant women with doula support from Black doulas. The AAIMM Doula program further promotes the availability of doula care by offering living wages for doulas and providing continuing education opportunities for Black birth workers countywide. AAIMM makes doula care available to African American families regardless of birth outcome, serving those who terminate pregnancy or experience fetal, infant, or maternal losses.

- Linking to Cherished Futures for Black Moms and Babies Hospital Learning Community via direct funding and support for AAIMM leaders who serve as Community Advisors to participant hospitals, ensuring that Black residents have a seat at the table with hospital executives to identify and implement strategies to reduce racial inequities in health care service.

- Supporting the launch of the Charles Drew University of Science and Medicine's Black Maternal Health Center of Excellence through the promotion of the model and direct funding.

Areas for Collective Improvement

Community/Public Partnership

AAIMM proudly refers to itself as a "collaborative of collaboratives" and navigates on an ongoing basis authentic power sharing within a county-community partnership and the challenges of maintaining momentum and solidarity. Until recently, there was only one full-time Black County employee dedicated to AAIMM, including

[xiv] African American Infant and Maternal Mortality Prevention Initiative Village Fund Website https://villagefundla.org/

those leading the Community Action Teams. AAIMM will continue to participate in opportunities to review hiring practices and staffing contracts and leverage funding to assure representation and fairness.

Global Pandemic and Racial Unrest

The AAIMM Initiative was heavily impacted by the COVID-19 pandemic, due to the reassignment of critical Public Health staff to COVID response, departmentwide delays in procurement and contracting, and implementation of prevention policies, such as hospital restrictions on patient visitation and on large in-person gatherings that limited transmission. This created barriers to AAIMM efforts to assure in-person labor support for Black birthing people and growth of the AAIMM network through large, in-person meetings in SPAs and countywide.

Soon after the COVID-19 pandemic began, the AAIMM community was devastated and traumatized by the unjust murders of George Floyd and Breonna Taylor by police officers, and Ahmaud Arbery by civilians. These events were felt personally and deeply among the community and exacerbated by COVID-19-related deaths and severe illness in the Black community. This season of trauma, which also brought a debate over the Public Health's vaccine requirements and national setbacks to reproductive justice, put into the spotlight our work and its root causes. Many of the AAIMM doulas chose to leave Public Health and the program had to be rebuilt at an incredibly challenging time. The murders, social unrest, and pandemic policies were forceful reminders to the need to engage in an ongoing examination of policies and practices that sustain social inequality. Additionally, the importance of acknowledgment when employing and engaging people with lived experience, that they endure the very disparities and root causes they are working to address. The vaccine debate was a lesson about the ongoing need to build trust through shared decision-making and transparency as AAIMM moves forward.

Need for Specific Mental Health Expertise and Compassion Response

Across AAIMM programs, the demand for culturally affirming mental health support exceeds provider capacity. Public Health collaborates with the Department of Mental Health, mental health collectives, and private practices to refer families with the greatest need but wait times can be long. The need is most palpable among families experiencing pregnancy, infant, or maternal loss and for whom AAIMM wishes to offer mental healthcare and wraparound support (i.e., legal & financial assistance, meal preparation, childcare, and advocacy.

Path Forward

Over the next year, the AAIMM team will continue to sustain and expand the work including:

- Building infrastructure to sustain and expand the AAIMM Doula Program with a maintained commitment to quality, culturally congruent care and living wages.
- Designing and implementing a countywide Guaranteed Income program for pregnant persons most impacted by perinatal health disparities
- Expanding funding provided via the AAIMM Village Fund to additional community-based programs providing stress reduction and support to Black pregnant and childrearing families.
- Sustaining and enhancing efforts to address implicit bias and institutional racism in clinical settings.
- Increasing hiring and revising the structure of AAIMM toward better community-county balance.
- Convening a Policy and Advocacy Mother Board, a committee comprised of Black pregnant and newly parenting persons who will set policy priorities for AAIMM.
- Seeking funding for and implementing a Compassion Response, wraparound support for AAIMM network families who experience a late pregnancy, infant, or maternal loss.

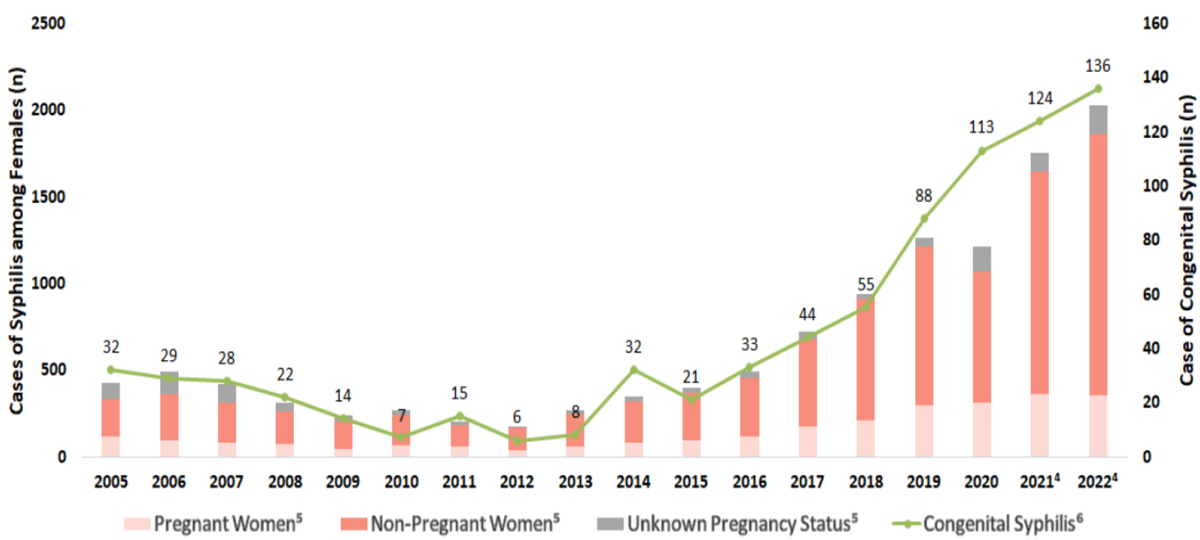
Reduce Disproportionate Rates of Sexually Transmitted Infections (STIs) and Eliminate Congenital Syphilis

A case of congenital syphilis (CS) is reported when a pregnant person with untreated syphilis infection passes the infection to their baby during pregnancy. When untreated, CS can cause serious illness, including causing a baby to be born early, have low birth weight, or develop birth defects, blindness, and hearing loss. Congenital syphilis can also lead to stillbirth (death of a fetus after 20 weeks of pregnancy) or infant death (death of a baby after it is born). While the ultimate result we want to see is to the elimination of congenital syphilis, the current trend trajectory suggests that reducing the rates of syphilis should be the first focus and intermediate result we try to achieve to safeguard lives.

What Does the Data Tell Us

Syphilis rates in LAC are rising at levels not seen in over 30 years, including a consistent rise in morbidity among males (particularly men who have sex with men), a nearly 1000% increase in female cases, and a 2000% increase in congenital syphilis (CS) cases since 2012 (please see graph below). In Los Angeles County (LAC) in 2022, there were 124 infants diagnosed with CS and 13 syphilitic stillbirths. Data continues to show that syphilis infection increases the risk of HIV transmission and is frequently associated with methamphetamine use disorder.

Graphic 8: Number of Female Syphilis and Congenital Syphilis Cases, Los Angeles County 2005-2022

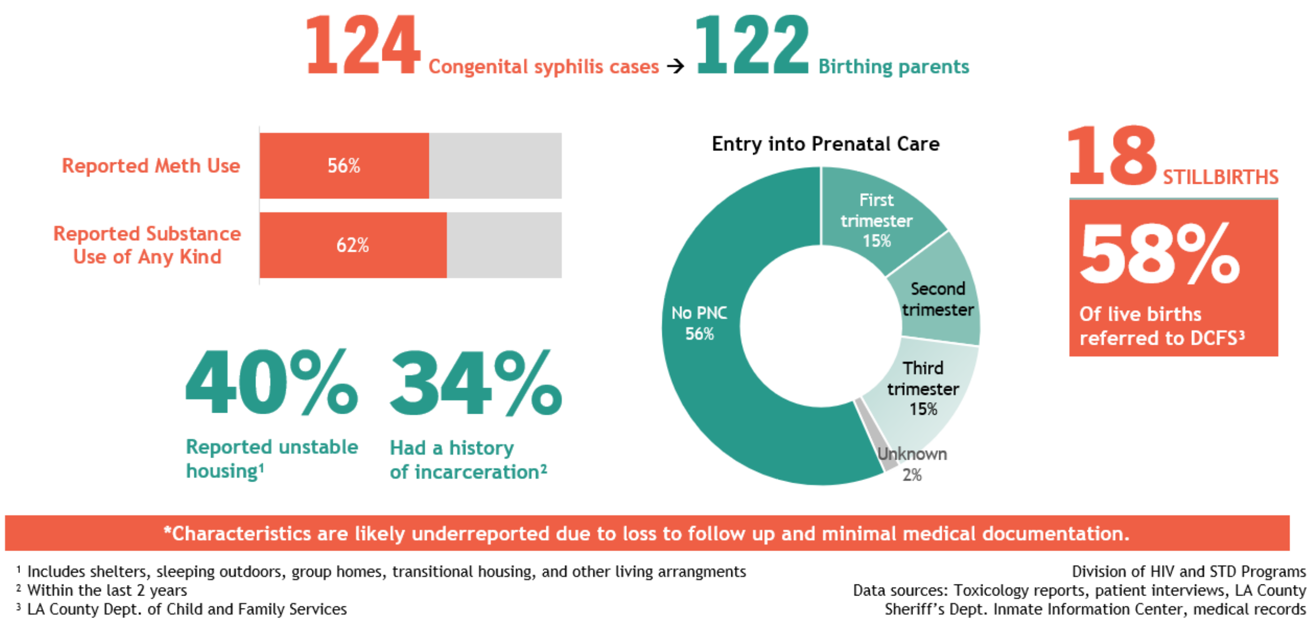


Source: 2005-2022 data are from STD CaseWatch as of 08/20/2023 and exclude cases from Long Beach and Pasadena.

The effects of congenital syphilis (CS) cases are increasingly concentrated in the most vulnerable groups in Los Angeles County, particularly African American and Latina women of reproductive age suffering from concurrent substance use disorder, mental health challenges, and experiencing homelessness. Among women, African Americans and Latinas have the highest rates of syphilis in LAC. While the rate of syphilis is higher among African American women compared to Latinas, more cases occur among Latinas than any other group of women, as they make up a larger proportion of the LAC population. In 2021, among the pregnant women tied to a congenital syphilis case, 61% were Latina, 16% were African American, 16% were White, and 4% were other[xv].

[xv] Source: DHSP 2021 STD Surveillance Snapshot- http://publichealth.lacounty.gov/dhsp/Reports/STD/2021_STD_Snapshot_LAC_Only_04.03.23_Final.pdf

Graphic 9: Congenital Syphilis Cases by Birthing Parent Characteristics*, Los Angeles County, 2021.



What We Accomplished

After more than a decade of sharing these troubling trends, the Division of HIV and STD Programs (DHSP) has more broadly increased awareness of this public health crisis across a range of stakeholders, policy leaders, and healthcare delivery partners. In addition, DHSP deployed a range of strategies to combat the increasing rates of congenital syphilis (CS) in Los Angeles County. Below are three key initiatives aimed at addressing the inequities tied to this public health issue.

Increased Organizational Capacity

To enhance Public Health's congenital syphilis (CS) response, a *CS Specialized Investigation Team (SIT)* was created, consisting of Public Health Investigators (PHIs) and Public Health Nurses (PHNs), to provide enhanced case investigation and support for complex cases. These cases require a multi-disciplinary team approach that includes PHIs, PHNs, social workers, and, on occasion, a Public Health physician who can deliver street-based medical care.

- Cases include women of childbearing age (WCBA) and persons who may be pregnant that could not be located for syphilis treatment as part of a previous investigation.
- The team locates high-priority clients and offers more intensive interventions to ensure prompt syphilis treatment and to reduce the risk of congenital syphilis to newborns. This initiative predominately serves low-income women of color facing homelessness and multiple co-occurring conditions such as substance use disorder and untreated mental illness.
- Clients are also linked to other medical and supportive services, including prenatal medical care, treatment for substance use disorder, and housing.
- Furthermore, the CS SIT coordinates with multiple public-sector and private-sector service delivery partners to provide additional support services.

This enhanced case investigation strategy for women of childbearing age with syphilis actively supports and builds community capacity by identifying and addressing healthcare access barriers, promoting culturally sensitive care, providing education and empowerment, using data to develop and implement strategies, and fostering collaboration. This approach aligns with equity strategies that ensure that all members of the community have a fair and just opportunity to attain their highest level of health.

Supporting/Building Community Capacity

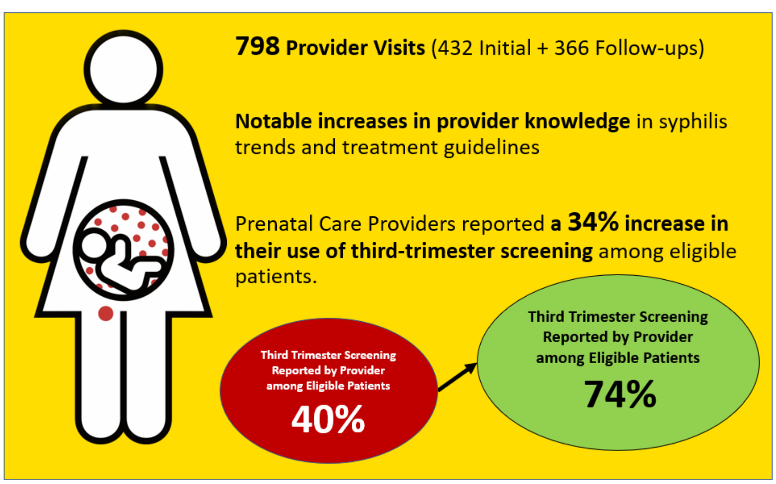
In response to a rise in congenital syphilis cases, Public Health developed a *Syphilis in Women Action Toolkit*[xvi] that includes clinical resources for healthcare providers and educational materials for patients. The Toolkit was used as a foundation for an intensive *Public Health Detailing Campaign* that was launched to raise provider awareness about the trends in syphilis in women and disseminate key recommendations to positively turn the curve in the trends. The campaign began in May 2018 and ran for 8 weeks.

Public Health Detailers delivered 4 key recommendations: 1) screen all women of reproductive age for syphilis at least once, 2) screen all pregnant women for syphilis during the first trimester or at their initial prenatal visit, 3) Re-screen pregnant women for syphilis early in the third trimester (28-32 weeks) and again at delivery, and 4) stage syphilis correctly to treat syphilis. Public Health will continue to support this intervention as resources become available.

This Public Health Detailing Campaign serves as a critical link between medical expertise and community capacity-building as well as significantly increasing organization capacity. By empowering healthcare professionals with knowledge, resources, and the ability to advocate for change, this approach supports the reduction of syphilis and, thus, congenital syphilis rates, ultimately improving the health and well-being of the community.

Forging Partnerships

Expanded Syphilis Screening Efforts with Community Providers: Expanding access to syphilis screening is critical to improving the identification of undiagnosed, infectious syphilis cases, treating those cases, and identifying contacts to prevent the forward transmission of this bacterial STI. However, the actions needed in response to and impacts of the COVID-19 pandemic decreased the number of available syphilis testing sites and in-person visits for syphilis screening, diagnosis, and treatment. Public Health continues to meet with prenatal care providers and hospitals that have reported a CS case to offer and provide technical assistance, review the expanded screening recommendations, and review missed opportunities to prevent CS.



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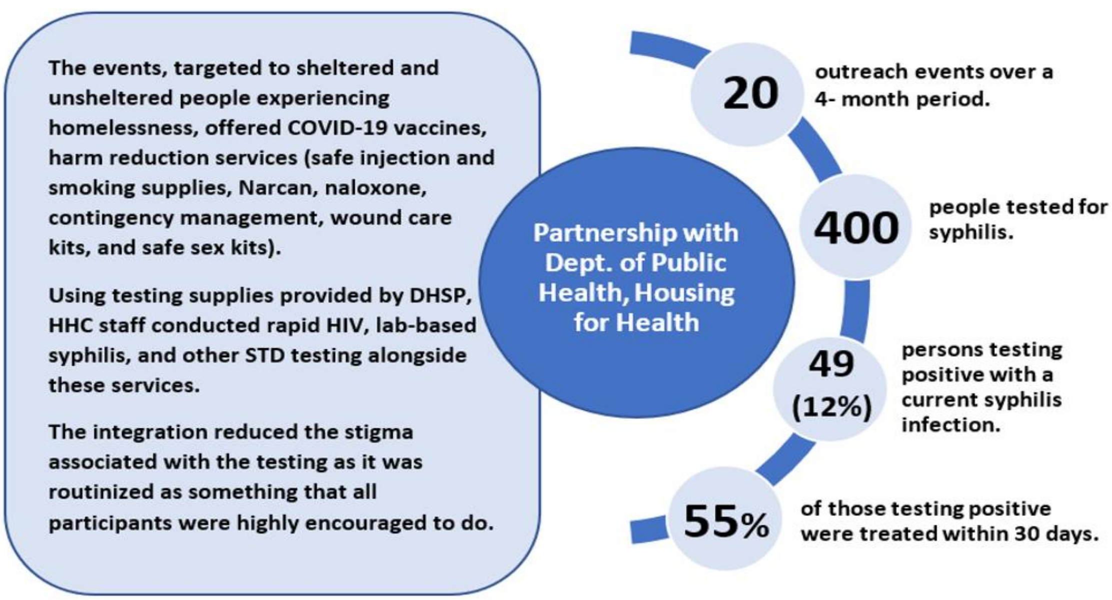
xvi Los Angeles County Department of Public Health, Division of HIV and STD Prevention Programs ***Syphilis in Women Action Toolkit*** http://publichealth.lacounty.gov/dhsp/SyphilisInWomen-ActionKit.htm

Public Health has also continued to support outreach efforts with local housing partner organizations (e.g., Department of Health Services Housing for Health COVID-19 Response Team and Los Angeles Community Action Network) to deliver services in the Downtown Skid Row area. To enhance outreach services, Public Health refurbished a mobile testing unit and re-trained field services staff returning from their COVID-19 assignment. Services focused on persons experiencing homelessness and women of reproductive age. In addition to routine laboratory-based HIV and STI testing, Public Health offered rapid point-of-care testing for syphilis HIV, gonorrhea, and chlamydia. In 2023, Public Health added Hepatitis C testing and streamlined workflows to provide more responsive “test and treat” approaches to treat presumptive cases of STIs more rapidly or treat persons with reactive STI results on the same visit to optimize treatment effectiveness.

In addition, *Public Health’s POWER (Prevention and Outreach for Women at Elevated Risk for HIV and Syphilis)* project launched a pilot program with a CBO, Bienestar Human Services (Bienestar), at their Pomona-based Engagement and Overdose Prevention Hub (previously referred to as a Syringe Service Program). Following intensive training and mentorship by Public Health, the CBO staff began conducting rapid HIV and syphilis testing, as well as laboratory-based three-site testing for gonorrhea and chlamydia for clients served, with a focus on women, at the Engagement and Overdose Prevention Hubs.

The expansion of access to syphilis screening through community-based providers and projects is an important strategy for strengthening community capacity. It greatly improves access to care, facilitates early detection and treatment, allows for effective contact tracing, prioritizes cultural competence, empowers local communities, yields crucial data, and optimizes resource allocation. Expanding syphilis screening among non-traditional partners and programs serves a central role in curbing congenital syphilis rates which creates healthier communities.



Areas for Collective Improvement

While Public Health has begun to make notable progress with certain initiatives, there still exist several challenges in addressing congenital syphilis rates.

Improving 1st and 3rd Trimester Syphilis Screening of Pregnant Persons

California has signaled that 1st and 3rd trimester syphilis screening is needed to reduce the incidence of congenital syphilis but there is not a statewide systematic mechanism to measure compliance, nor is there a clear consequence if screening rates remain low. There is a need for policy solutions to address these gaps.

Addressing Multiple Morbidities

Among the most troubling STI-related increases over the last decade have been those tied to congenital syphilis. Among those diagnosed with syphilis, the use of methamphetamines plays a prominent risk factor. As presented in Graphic 9 and more specifically, a review of the maternal characteristics tied to 124 congenital syphilis cases reported in 2021 revealed that 34% of mothers had a history of incarceration, 40% were unstably housed, 56% were using methamphetamine and 62% reported substance use of any kind. A review of prenatal care patterns among the same group of pregnant persons revealed that 15% entered prenatal care in the first trimester, 12% in the second trimester, 15% in the third trimester, and 56% received no prenatal care (prenatal care access could not be confirmed for 2% of the 124 cases). These data highlight the importance of syphilis awareness and client engagement across all sectors of providers serving pregnant persons, and syphilis screening compliance across multiple trimesters of pregnancy. Furthermore, the continued expansion of interventions designed to link pregnant persons to pre-natal care (including persons with substance use disorder, mental illness, and experiencing homelessness) remains critical.

Path Forward

In the ongoing battle against congenital syphilis, Public Health is dedicated to the continued support and implementation of a range of strategies. As such, Public Health plans to

- Continue to collaborate with community clinics and organizations to expand the accessibility of syphilis screening services for women of childbearing age.
- Continue public health visits with healthcare providers, equipping them with valuable knowledge about syphilis resources and comprehensive STI screening protocols tailored to the needs of women of childbearing age.
- Launch a syphilis prevention campaign. This initiative intends to heighten awareness and enhance efforts surrounding syphilis prevention, screening, and treatment, with a focus on populations that are at heightened risk for sexually transmitted infections (STIs).

Reduce Exposures to Environmental Hazards that Disproportionately Affect Low-Income Communities and Communities of Color

Environmental Justice is the just treatment and meaningful involvement of all people regardless of race, color, national origin, or income, in decision-making and other activities that affect human health and the environment so that all people:

- are fully protected from disproportionate and adverse human health and environmental effects, and hazards, including those related to climate change, the cumulative impacts of environmental and other burdens, and the legacy of racism and other structural and systemic barriers; and
- have equitable access to a healthy, sustainable, and resilient environment in which to live, play, work, learn, grow, worship, and engage in cultural and subsistence practices.[xvii]

[xvii] The United States Environmental Protection Agency. Environmental Justice. [Online: https://www.epa.gov/environmentaljustice].

It recognizes that the health of a community largely depends on its conditions and the fair distribution of environmental benefits and burdens.

In LA County, those disproportionately burdened by pollution, other toxic hazards, and poor land use are low-income communities and communities of color. Public Health focuses on developing policies and supporting regulations and practices aimed at reducing emissions of harmful toxins from heavy industry and other local sources, with a focus on protecting healing in vulnerable communities.

What Does the Data Tell Us

Low-income and communities of color already burdened with social and health inequities resulting from past and present policies and practices influenced by prejudice, discrimination, and systematic racism, are oftentimes the same communities live in areas disproportionately burdened by increased exposure to environmental and climate hazards, unhealthy land uses, psychological stressors, and historical traumas, all of which drive health disparities.

As stated in the American Public Health Association's policy on *Addressing Environmental Justice to Achieve Health Equity*, "It is therefore no surprise that exposure to deleterious land uses and infrastructure has been linked to increased cancer and respiratory illness and a decreased overall sense of well-being,[xviii,xix] as well as exacerbation of comorbid conditions such as diabetes, obesity, cardiovascular disease, neurological and psychiatric disorders, and impaired maternal and child health.[xx,xix,xxi] Infants and children are especially vulnerable to adverse environmental health outcomes because of their unique biological vulnerabilities and age-related patterns of exposure.[xxii]"

A recent study[xxiii] found that there are 5576 active and idle wells in Los Angeles County. The presence of active or inactive (i.e., postproduction) oil and gas wells in neighborhoods has been shown to contribute to ongoing pollution.[xxiv,xxv] Approximately 500,000 residents live in the most pollution-burdened census blocks (above 90th percentile statewide) in LA County and within 1 kilometer of at least one active or idle oil well. Residents living in the most pollution-burdened census blocks (above 90th percentile) are more than 4 times as likely (adjusted OR=4.15) to live within 1 kilometer of an oil well compared to residents living in the least pollution-burdened census blocks (35th percentile or lower).

Pollution Burden represents the potential exposures to pollutants and the adverse environmental conditions caused by pollution. CalEnviroScreen is a screening tool developed by the California Office of Environmental

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[xviii] Environmental Justice Health Alliance for Chemical Policy Reform. Life at the fence line: understanding cumulative health hazards in environmental justice communities. Available at: https://new.comingcleaninc.org. Accessed December 30, 2019.

[xix] Wilson SM, Hutson M, Mujahid M. How planning and zoning contribute to inequitable development, neighborhood health, and environmental injustice. Environ Justice. 2008;1:1–6.

[xxxx] Gee GC, Payne-Sturges DC. Environmental health disparities: a framework integrating psychosocial and environmental concepts. Environ Health Perspect. 2004;112:1645–1653.

[xxi] Thurston GD, Kipen H, Annesi-Maesano I, et al. A joint ERS/ATS policy statement: what constitutes an adverse health effect of air pollution? An analytical framework. Eur Respir J. 2017;49:1600419.

[xxii] Children's Health Protection Advisory Committee. Social Determinants of Health. Washington, D.C.: U.S. Environmental Protection Agency; 2013.

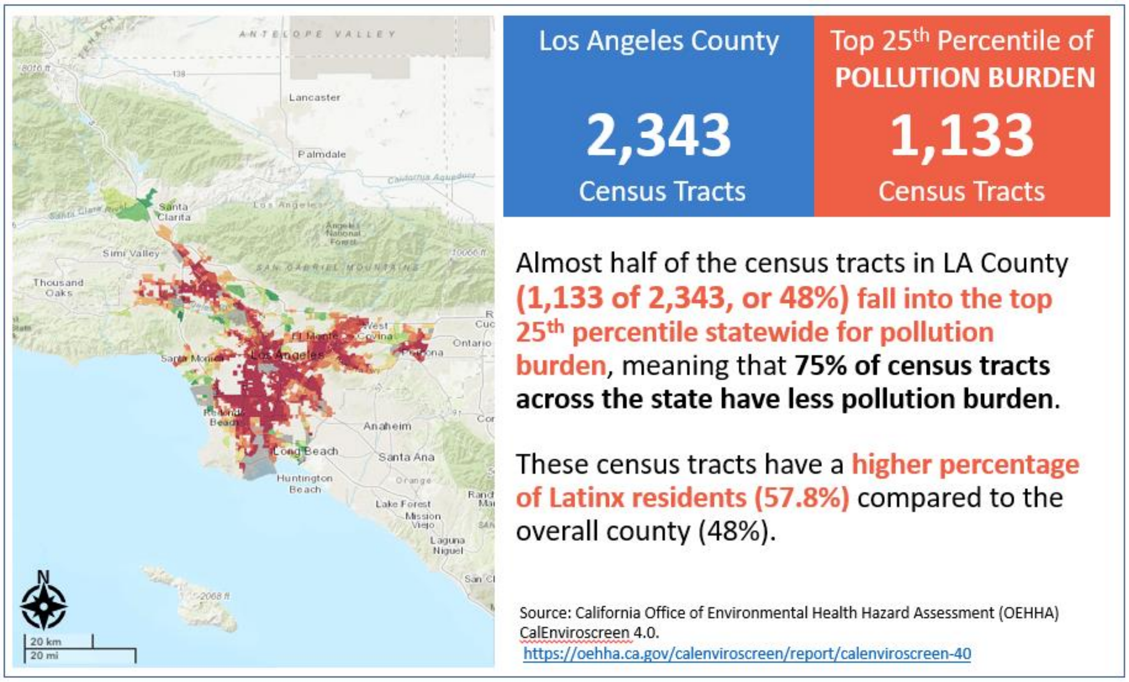
[xxiii] Marissa Chan, Bhavna Shamasunder, Jill E. Johnston, "Social and Environmental Stressors of Urban Oil and Gas Facilities in Los Angeles County, California, 2020", *American Journal of Public Health* 113, no. 11 (November 1, 2023): pp. 1182-1190. https://ajph.aphapublications.org/doi/10.2105/AJPH.2023.307360

[xxiv] Gonzalez DJX, Francis CK, Shaw GM, Cullen MR, Baiocchi M, Burke M. Upstream oil and gas production and ambient air pollution in California. Sci Total Environ. 2022;806:150298.

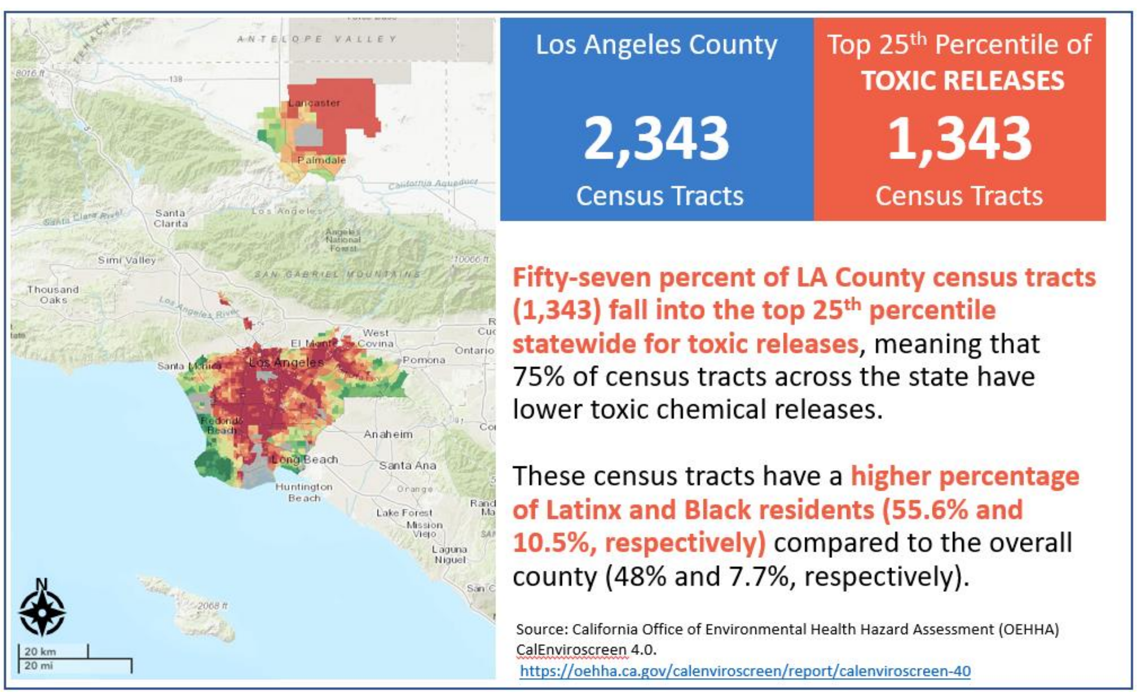
[xxv] Lebel ED, Lu HS, Vielstädte L, Kang M, Banner P, Fischer ML, et al. Methane emissions from abandoned oil and gas wells in California. Environ Sci Technol. 2020;54:14617–26.

Health Hazard Assessment (OEHHA) that can be used to help identify California communities that are disproportionately burdened by multiple sources of pollution. This tool, now in its fourth version, helps Public Health programs identify and target the most burdened LA County communities for increased environmental justice efforts that can help achieve health equity, decrease disease burden, and save lives.

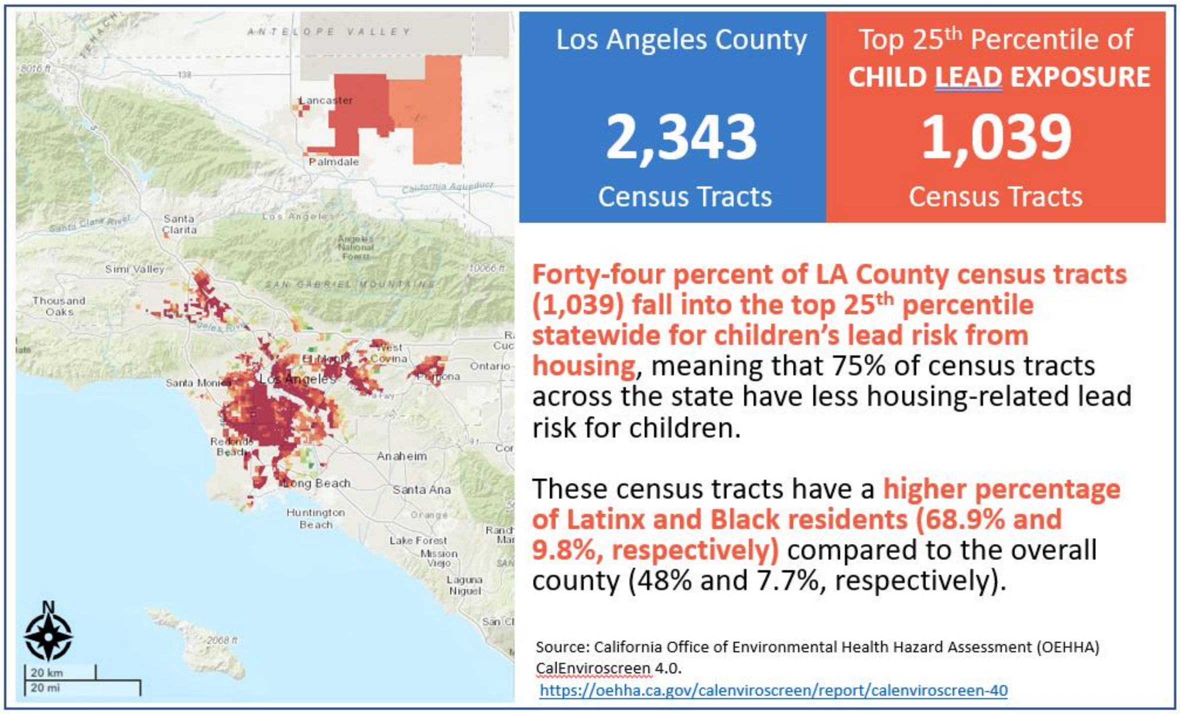
Graphic 10: Census Tracts with the Highest Pollution Burden, Los Angeles County, CalEnviroScreen 4.0 Environmental Hazard Assessment



Graphic 11: Census Tracts with the Highest Toxic Release Burden, Los Angeles County, CalEnviroScreen 4.0 Environmental Hazard Assessment



Graphic 12: Census Tracts with the Highest Child Lead Exposure Risk from Housing, Los Angeles County, CalEnviroScreen 4.0 Environmental Hazard Assessment

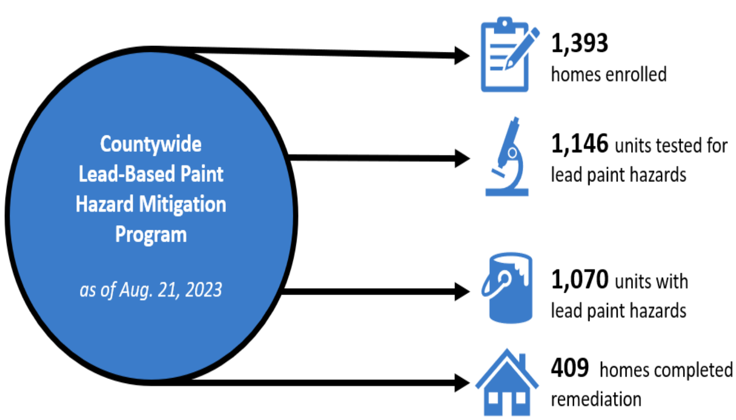


What We Accomplished

In recognition that the same communities burdened by exposure to, and the adverse conditions caused by environmental pollution are also disproportionately at risk from climate threats, the County formed a new Office of Environmental Justice and Climate Health (OEJCH) by passing a motion on April 5, 2022 that updated the Board priority from "Environmental Oversight and Monitoring" to "Environmental Justice and Climate Health." The directive called for the development of a Strategic Plan for the OEJCH, along with broad stakeholder engagement to develop the plan. Five key functions have been laid out, including community engagement, interagency coordination, policy areas of focus, data capabilities, and communications. A consultant has been engaged to support the development of the Strategic Plan, and stakeholder engagement is under way.

Align resources to work that eliminates inequities.

In 2019 Los Angeles County was awarded approximately $134 million as part of a landmark 20-year litigation against three major paint companies. Funds were earmarked for lead-based paint hazard remediation services throughout the County. The Board of Supervisors approved a motion to use the funds for the *Countywide Lead-Based Paint Hazard Mitigation Program - Lead Free Homes LA*, along with Board priorities for community engagement and targeted hiring within the program. To implement this program Public Health conducted:



- A pilot project with funds from a modest earlier settlement was conducted in the Fall of 2018 to jump start the lead paint hazard remediation services. Ten homes were recruited for the mitigation of lead paint hazards, offering a chance to gather qualitative evaluation data from a select group of homeowners. This data aimed to guide the expansion of remediation efforts to a countywide scale.
- Focus groups with homeowners, renters, and landlords/property managers of small buildings that assessed resident/owner understanding of personal risk of lead exposure and poisoning, understanding of remediation, and reactions to the first iteration of plans for the Countywide lead-paint hazard remediation program. Stakeholders provided input on Program outreach and applications and helped to formulate the Program name: Lead Free Homes LA (https://www.leadfreehomesla.com/).
- Key informant interviews with community leaders, professionals, and residents with first-hand knowledge of their communities. Interviewees provided recommendations on how to gain community trust in the program, trusted leaders that can help communicate program importance, and how to create transparency in the Program process.
- Community stakeholder meetings which were an opportunity to gather input on potential outreach partners, nontraditional outreach strategies, and resident engagement concerns. This feedback was used to develop a communications plan and outreach and recruitment roadmap that included ways to build community trust and program validity.

The program launch was delayed from April 2020 to July 2021 due to the emergency response to the COVID-19 pandemic. Program staff used the time to finalize program planning, including contracting with local CBOs and Cities for community outreach and enrollment in five focus areas, developing outreach materials, launching education/awareness campaigns, and reviewing and implementing findings from stakeholder engagement and a pilot program evaluation report, and securing agreements with service providers for lead-paint hazard assessment and clearance, relocation services, and construction services to conduct the lead-paint hazard remediation.

With persisting pandemic safety precautions and considerations, such as families working or schooling from home, program rollout was slower than initially anticipated to reduce disruptions to participating families. Moving forward Lead-Free Homes LA aims to remediate approximately 400 homes per year.

Forge partnerships

The Inglewood Oil Field, the largest urban oil field in the U.S., operates under the 2008 adopted Baldwin Hills Community Standards District (CSD), which establishes additional regulations for oil and gas production activities in the field. In 2011, the County entered into a Settlement Agreement with the operator and five litigants which further regulates the oil field and includes a requirement that Public Health complete a ***Baldwin Hills Health Assessment and Environmental Justice Study*** every 5-7 years. The first assessment was completed in 2012.

To address community concerns about the limitation of the first assessment, in early 2018, OEJCH, the Baldwin Hills Community Advisory Committee (CAP), and the community around the Field worked together to determine the scope for the second assessment. Public Health proposed a process, with which the CAP agreed, to (1) provide the community via the CAP with independent expert input on the scope of the assessment and (2) allow more community ownership of the decision-making into what the health assessment should cover. As a result, the following was achieved:

- A scoping phase was initiated utilizing a Steering Committee (SC) of community representatives, three independent experts selected by the CAP, and two Public Health representatives, to build trust between stakeholders. The SC met between October 2019 and January 2020 and engaged in a collaborative decision-making process to review other studies, learn about environmental justice and redlining in the

Inglewood Oil Field communities, prioritize health impacts and population groups, and provide input into the selection of the final design.[xxvi]

- Public Health wholly adopted the SC's recommendations, which were (1) study birth outcomes to determine whether those living closer to the oil field were at higher risk of negative birth outcomes than those living farther away; and (2) conduct a household survey with a biometric measure (lung function) to determine whether those living closer to the oil field were at higher risk of short- and long-term health impacts compared to those living farther away. Public Health secured researchers from UCLA to conduct the assessment in May 2021.
- UCLA established an advisory group, self-named as the Community Health Assessment Advisory Panel (CHAAP), to review and comment on all assessment plans, protocols, and materials. The CHAAP has provided input into survey and research questions, recruitment materials and strategies, study awareness-raising activities and data collection sites, and other facets of the assessment. The collaboration between the CHAAP and the researchers has added value to the work, tailoring materials to the community and ensuring alignment with the community's questions about their health. Results of the health assessment are expected by June 30, 2024.

Amplify Community Voices

Ecobat (formerly known as Quemetco) is a battery recycling plant in the City of Industry. According to the Department of Toxic Substance Control (DTSC) and South Coast Air Quality Management District (SCAQMD), operations at the plant may have released harmful levels of lead and arsenic into the surrounding communities of Hacienda Heights, La Puente, and Avocado Heights. Exposure to high levels of lead and arsenic may cause significant health risks. In response to this potential contamination, Public Health staff conducted door-to-door community outreach and held resource fairs on September 21, 2019, and on March 7, 2020, to residents of Hacienda Heights and Avocado Heights.

As part of the door-to-door outreach conducted to provide information about the Ecobat investigation, share potential health risks, and refer residents to the resource fairs for additional information and resources, a confidential survey was also administered to understand the level of residents' awareness and concerns related to Ecobat and share the results with community stakeholders. Additionally, 125 residents surveyed expressed that they would have the soil in their home tested for lead if another testing opportunity was offered. This information was shared with DTSC for follow up. Furthermore, 165 follow up calls and 18 home visits by Public Health Nurses were conducted to address survey respondents' health concerns. Public Health also partnered with over 20 public agencies to distribute information and resources to residents at both resource fairs, including free blood lead testing by EH Public Health Nurses. Additionally, a partnership was established with Intrinsik, Ecobat's environmental consultant, to cover the laboratory costs for testing the blood samples through an agreement with Quest laboratories.

[xxvi] The Final Report from the scoping phase can be found at https://planning.lacounty.gov/wp-content/uploads/2022/10/bh_steering-committee-planning-facilitation-summary-report.pdf.

Ecobat (formerly known as Quemetco) Investigation Outreach

Door-to-Door Community Survey	Free Blood Lead Testing
287 Completed	**264** Individuals
Contacted for Follow-up	**Visited and Provided Education**
165 Residents	**18** Homes

Areas for Collective Improvement

COVID-19 impact.

The emergency response to the COVID pandemic created delays in rolling out Lead Free Homes LA implementation as well as other efforts due to the redirection of staff and department resources to the emergency response. However, as noted above the team was able to make progress in designing the program, developing partnerships, and creating resources. The project is now on track.

Unfunded efforts

The Baldwin Hills Health Assessment and Environmental Justice Study is an unfunded mandate for Public Health. It took a significant number of months to identify funding for the scoping and implementation phases. The contracting process took longer than anticipated due to the impact of the emergency response to COVID-19 on staffing resources and contracting processes. Further, to be responsive to community wishes regarding the design of the assessment, community engagement was extensive and time-consuming, deferring the start of the second assessment.

Top Left: LEAD- Free Home LA outreach event.

Top Right: BHSC member Erica Blyther presents the history of environmental racism and the implications for the communities surrounding the Inglewood Oil Field.

Bottom Left: Quemetco Resource Fair

Path Forward

In the coming year, Public Health looks forward to

- In the process of hiring a director and finalizing the strategic plan for the full launch of the Office of Environmental Justice and Climate Health in partnership with the community.
- Completing the Baldwin Hills Health Assessment and Environmental Justice Study by June 30, 2024, working with the CHAAP to contextualize the results, and sharing the findings with the community.
- Continuing to expand the Lead-Free Homes LA Program and work with regional partners to mitigate environmental burdens across Los Angeles County.

Improving Language Access for Diverse Communities

Language barriers can be a significant deterrent to achieving optimal health and well-being. People who don't speak English well are less likely to seek health care or receive much needed health information on which to make an informed decision. This can lead to delay of preventative care and treatment, including missed health screenings for chronic disease and cancers. Language isolation is also linked to poor mental health.

Linguistic Isolation is defined as the percentage of households in which no one over the age of 14 speaks only English at home or speaks English "very well" as a second language.

"If you are linguistically isolated, you're very likely to be isolated socially, and we know social isolation contributes to mortality …" — Kerstin Emerson, Researcher and Associate Professor, Institute of Gerontology, College of Public Health, Univ of Georgia.

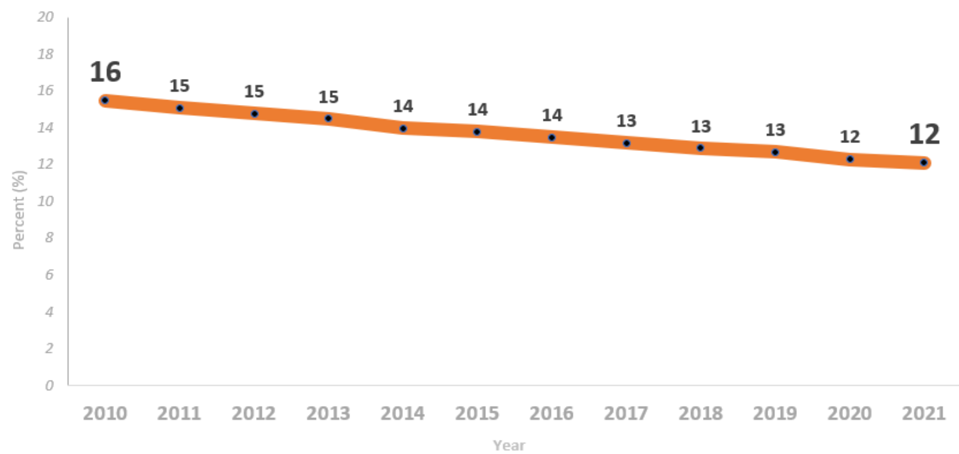
What Does the Data Tell Us:

Graphic 13: Los Angeles County Residents Who Speak a Language Other than English at Home.

Source: ***1.*** *2021 U.S. Census Bureau, 2017-2021 American Community Survey 5-Year Estimates, table S1601.* ***2.*** *2021 U.S. Census Bureau, 2017-2021 American Community Survey 5-Year Estimates, Table S1603*

Though levels of linguistic isolation have decreased over time (from around 15.5% in 2010 to 12% in 2021), there are still significant geographic disparities across the county.

Graphic 14: Proportion of Linguistically Isolated Households in Los Angeles County, 2010-2021.



Source: *American Community Survey, 5-year estimates: 2006-10 ~ 2011-15: Table B16002; 2012-16 ~ 2020-21: Table C16002 Note: 5-year estimates are an average of the preceding 5 years.*

What We Accomplished

Increased Organizational Capacity

Seeing the need to translate materials more quickly into multiple languages during the pandemic, Public Health set up a translation team to help with the existing process of working with external vendors. Updated information and guidance were placed in multiple languages on the COVID-19 website, distributed through social media, and shared with partners who could more effectively engage with community residents. This translation team is being sustained while the Department establishes an improved system of translation and interpretation beyond COVID-19.

To inform this effort, Public Health has convened a workgroup of community partners since 2022 to inform language access efforts. Additionally, an internal online portal has been developed that simplifies the process for requesting services for translation and interpretation by Public Health programs. This new system allows the Department to track language request trends, budgets, vendor performance, and more.

Forging Partnerships

Public Health became a lead partner in Language Justice efforts in the County and regionally. The Center for Health Equity is:

- Working with DHS and DMH to identify needed changes for Public Health's Language Access Services Master Agreement (LASMA) and develop a pilot performance survey to garner feedback on the quality of services provided by the translation and interpretation vendors secured through the LASMA. The survey will collect important data that will be used to recommend changes to the LASMA.
- Serving as a co-chair for the LA County Language Access Task Force. This is a board initiative led by the Office of Immigrant Affairs, which will bring together all county departments to discuss any language access issues we are collectively facing. Key issues that will be on the agenda include language access plans, threshold languages, and bilingual certifications.
- Co-chairing a regional language access workgroup comprised of public health departments from the Southern California region. This workgroup is focused on collaborating on important regional language access issues related to staff training and policy development.

Areas for Collective Improvement

There were several starts and shifts to get this work off the ground.

- In April 2018, the Institute for Cultural and Linguistic Inclusion and Responsiveness (ICLIR) launched to create culturally and linguistically appropriate pathways that address gaps in service delivery and advance the Health Agency's ability to meet the needs of Los Angeles County communities. Unfortunately, the effort was paused during the pandemic.
- In 2022, it was determined that some of this work would be advanced in the Alliance for Health Integration (AHI) work plan under the objective "Deliver culturally and linguistically appropriate care and communications to all patients, clients, customers, and community members." To meet this objective AHI formed a workgroup of representatives from the three County Health Departments to focus on increasing the quality of language access services (interpretation and translation) provided through the Master Agreement by gathering feedback from Health Department staff on vendor performance. However, in 2023, there was a reorganization with AHI, and now Public Health is leading the workgroup.

Path Forward

Public Health will continue to work with DHS and DMH to assess and propose changes to the Language Access Services Master Agreement based on a discussion with Public Health Contracts and Grants determined allowable parameters. These changes strive to create a more equitable vendor process that will allow community-based vendors to apply and provide the County with translation and interpretation services. Once the revised LASMA is done, the team will begin to outreach to potential new CBOS and vendors that can support language, including sign language, needs.

Internally, the Center for Health Equity is currently assessing the feasibility of continuing an in-house Language Justice Unit and will be collecting and analyzing data to strengthen the language service offered by Public Health. The team is also 1) looking to expand beyond language to include the accessibility and cultural appropriateness of information being shared, 2) developing glossaries and communications style guides to culturally tailor materials, and 3) streamlining language services within the Public Health clinics.

Building an Infrastructure to Foster a Culture that Supports and Upholds Health Equity

Fostering and maintaining a culture that can achieve, support, and uphold health equity is not a one-time event, training, statement, or check of a box on a form or survey. It requires a change in understanding of how health disparities develop, an alignment of and change in policies, practices, processes, and partnerships, and an infrastructure and systems to implement, support and maintain work to achieve health equity. During the last 5 years, amid a global pandemic emergency, Public Health continued to align resources, to strengthen organizational capacity, forge partnerships, amplify community voices and build community capacity to eliminate inequities.

What Does the Data Tell Us:

Several health equity issues continue to require improved public health infrastructure and community collaboration to close equity gaps and mitigate health impacts for all Los Angeles County residents.

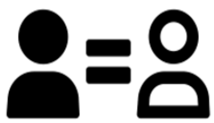
Persistent Public Health Challenges

Life Expectancy[1]:

- On average a typical LA County resident is expected to live to at least **79** years of age.
- **However, Black residents have a 14-year gap in life expectancy compared to Asians and an 8-year gap compared to white residents.**
- Also, Life Expectancy **can vary up to 11 years depending on where residents live (SPAs)** in the County.

At Risk for Major Depression[2]:

- In 2018, **13%** of LA County adults (18+ years old) were at risk for major depression.
- The prevalence among **adults with a disability was 3 times that of adults without a disability** (**27.2% vs 8.3%** respectively).



Perceived Healthcare Discrimination[2]:

- In 2018, **4%** of LA County adults (18+ years old) had a worse experience compared to people of races other than their own, when seeking healthcare in the past year.
- The prevalence among **Black adults was more than 5 times that of white adults** (**10.9% vs 2.1%** respectively).
- And the prevalence among **lower income adults living below 100% Federal Poverty Level (FPL) was almost 2 times that of those in the 300+% FPL**.

Perceived Neighborhood Safety[2]:

- In 2018, **85%** of LA County adults (18+ years old) perceived their neighborhood to be safe from crime.
- The prevalence among **lower educated adults with less than a high school degree was significantly less compared to those with a college or post graduate degree** (**78% vs 91%** respectively).
- Similarly, the prevalence among those with lower income (0-99% FPL) had significantly lower neighborhood safety perception compared to those living at 300+% FPL (**79% vs 92%** respectively).

Children with Special Health Care Needs[3]:

- In 2018, **15%** of LA County children (0-17 years old) met the criteria for having special health care needs.
- The prevalence among **Black children was almost 2 times that of Asian and Latinx children** (**25.3% vs 12.7%** respectively).

Children Read to Daily by Family in a Typical Week[3]:

- In 2018, **52%** of LA County children (0-5 years old) were read to daily by family in a typical week.
- The prevalence among **Latinx children (46%) was the lowest compared to children of other racial/ethnic groups (67% Black/African American; 65% White; and 52% Asian).**

Suicide Attempts and Deaths[4]:

- In 2020, Suicide among all ages was
  - the **8th leading cause of death** among Los Angeles County residents with **829 deaths (7.6 per 100,000 residents)**.
  - **A third (270, 33%)** of suicide deaths in Los Angeles **involved a firearm.**
  - **There were 3,399 non-fatal suicide attempts** treated in California hospitals/emergency departments.
- Among Youth (ages 10-24 years old), Suicide was
  - the **3rd leading cause of youth death** among Los Angeles County residents with **102 deaths (5.3 per 100,000 residents).**
  - **19 youth suicide deaths involved a firearm.**
  - **There were 1,502 non-fatal suicide attempts** treated in California hospitals/emergency departments.

Accidental Fentanyl Overdose Deaths[5]:

- In 2022, **fentanyl surpassed methamphetamine** to become the most common drug type listed as a cause of death in accidental drug overdose deaths in Los Angeles County.
  - Fentanyl accounted for more than half **(59%) of all alcohol and drug related overdose deaths.**
  - The **male overdose death rate was more than 4 times that of females in the county (32.3 vs 7.0 per 100,000 population).**
  - **Whites (n=735, 38%) and Latinxs (n=707, 37%) accounted for the largest proportions of fentanyl overdose deaths**, followed by Blacks (n=396, 21%) and Asians (n=41, 2%).
  - However, **Black/African Americans had the highest overdose death rate**, which was **18 times higher** than the rate among Asians (**49.5 vs 2.7 per 100,000 population**).

Source:

1. Los Angeles County Annual Death File 2021, assembled from California Department of Public Health Vital Records Data. Office of Health Assessment and Epidemiology, Los Angeles County Department of Public Health, June 2023. July 1, 2021, Provisional Population Estimates, prepared by Hedderson Demographic Services for Los Angeles County Internal Services Department, released October 2022.

2. 2018 Los Angeles County Health Survey; Office of Health Assessment and Epidemiology, Los Angeles County Department of Public Health.

3. 2018 Los Angeles County Health Child Survey; Office of Health Assessment and Epidemiology, Los Angeles County Department of Public Health.

4. 2020 Provisional Mortality Data from Office of Health Assessment and Epidemiology (data subject to change), Centers for Disease Control CDC Wonder and California Department of Health Care Access and Information.

5. Data Report: Fentanyl Overdoses in Los Angeles County. Health Outcomes and Data Analytics Branch, Substance Abuse Prevention and Control, Los Angeles County Department of Public Health, November 2023.

What We Accomplished

DPH Programs – Strategic Priorities

Funding:

Between 2021 – 2023, **$88Million** non-COVID brought into the County.

Community Profile Data Portal:

Between 2018 - 2023:

66,973 users have viewed the CCHP websites.

- Around **82% (54,980)** were unique users.
- There was a total of **32,711 PDF data documents** and **9,020 excel tables** viewed.

Positive Youth Development (PYD) Initiative:

Almost **10,000** served between 2019-2023.

Heart Heroes:

27 major partnerships developed.

Over 440,000 trained specifically on Hands Only CPR.

Equity-Related Policies:

96 Public Health Equity-Related policies updated.

Community Vendors:

78 Community Engagement Master Agreements completed.

Used for **23** solicitations (12 DPH and 11 DPR)

Provide useful and inclusive data.

Public Health is responsible for collecting, analyzing, and making accessible data that reflects the health of the population and the social factors or inequities affecting health within LA County. It also strives to highlight the varying ways communities are impacted, the root causes of health disparities, and the intersectionality of issues that affect health and well-being. The Department continues to increase its competency and capacity to improve data collection and ensure that stakeholders have access to the most up-to-date data.

- In 2018, the City and Community Health Profiles[xxvii] series was developed to provide local-level data for a broad array of indicators known to impact community health and well-being. In total, 86 unique geographic places in Los Angeles County have been profiled in this series.
- Public Health has been developing Standards of Practice (SOPs) for the collection and reporting of data on several demographic characteristics. An extensive process was completed for the SOP on sexual orientation and gender identity (SOGI). The SOP on race/ethnicity is being updated and the SOP on individuals living with disabilities has been finalized. These SOPs have been informed with feedback from a broad sector of community stakeholders.

Support Policy and Systems Change

Public Health engaged in several efforts to strengthen the infrastructure, increase funding, and improve practices to reduce gaps in health outcomes such as:

- Efforts to establish the California Health Equity and Racial Justice Fund, which would have allocated $75 million to support community-based organizations to reduce health disparities and address the public health impacts of systemic racism. Unfortunately, this did not make it into the final adopted California 2022-2023 budget, though advocates continue to look at ways to support funding for community-based prevention efforts.
- Public Health was able to secure several significant investments to support the local public health workforce, infrastructure, and data systems from the Centers for Disease Control and Prevention and another from the California Department of Public Health. The investments allowed Public Health to maintain stable, permanently allocated positions to ensure our readiness to tackle emerging public health issues. The funding is supporting several Public Health programs/efforts including but not limited to Communicable Disease Control and Management, Language Access, and Community Public Health Teams. While the funding and timeframe of these investments vary, 2021-2023 alone was approximately $88 Million.
- Building on work being done to address gun and community violence, including the successful passage of Assembly Bill 1929 to make community-based violence prevention programs a covered Medi-Cal benefit. Public Health has also spearheaded a countywide collaborative that developed a 40-point Gun Violence Prevention Platform[xxviii] focusing on prevention, intervention, and healing strategies.
- Sustained and expanded funding for the Black Infant Health (BIH) Program, namely $50 million in ongoing funding, to augment resources in the Home Visiting Program and the BIH Program. In FY 2022-23 Los Angeles County received $1,071,050 for BIH Expansion.
- Increased funding for the prevention and treatment of sexually transmitted infections (STIs), particularly syphilis and congenital syphilis. From a California State budget proposal of $57 million in one-time funding, LA County received $3.97 million to support a package of initiatives and strategies to reduce

[xxvii] Los Angeles County Department of Public Health City and Community Health Profiles Website http://publichealth.lacounty.gov/ohae/cchp/index.htm.

[xxviii] Los Angeles County Office of Violence Prevention Gun Violence Prevention Platform http://www.publichealth.lacounty.gov/ovp/GunViolencePreventionPlatform.htm

syphilis, congenital syphilis, and viral hepatitis and expand harm reduction and condom access programs.

- Advocating for the successful passage of Assembly Bill (AB) 2473 to enhance the training requirements for registered and certified substance use disorder counselors across California to promote high-quality and effective services. Public Health sits on the Executive Board of the County Behavioral Health Directors Association (CBHDA) and has been a vocal leader in ensuring that substance use priorities are elevated in a wide range of state behavioral health policies including payment reform, overdose prevention efforts, harm reduction, access to care standards, etc.

Build Public, Private, and Community Partnerships

- Public Health's ***Positive Youth Development (PYD) Initiative*** aims to promote positive outcomes for young people by providing opportunities that build on strengths and empower the next generation of change-makers to reach their full potential. Using the PYD framework and incorporating evidence-based best practices with a strong emphasis on trauma-informed care, partnerships have been developed with youth and other community stakeholders to inform and implement Public Health solutions that improve the health and well-being of youth in Los Angeles County.
  - Since the inception of the ***Youth Advisory Council*** in 2019, over 100 youth have received training as Youth Ambassadors within local health offices and advisors to Public Health programs and community partners.
  - ***Friday Night Live (FNL)/Club Live (CL), & FNL Kids*** builds partnerships for positive, healthy youth development, and engages youth as active leaders, mentors, and promotes strategies to reduce access to and availability of alcohol and other drugs. Within select middle and high schools, youth-adult partnership activities include educating policy-making officials, providing safe social outlets for youth, and hosting training and conferences on topics from leadership to social factors that contribute to substance abuse.
  - In collaboration with the LA County Department of Parks and Recreation (DPR), the ***Our Social Places and Opportunities for Teens (SPOT)*** program provides substance use prevention education and positive youth development through recreational programs for teens in grades 7-12. The design is informed by research literature on positive youth development. Our SPOT empowers participants through life skills training, mentorship, youth development, and peer support. Within this tailored and safe space, youth receive mentorship from DPR staff including opportunities to build leadership skills through various drug-free activities and community-based projects.
  - ***Student Well Being Centers (WBC)*** is a network of 39 school-based centers to provide students with direct access to confidential sexual health, mental health, and substance use counseling and support. This collaboration between Public Health, the Los Angeles County Office of Education (LACOE), the Los Angeles Unified School District (LAUSD), and Planned Parenthood provides on-campus services that allow students to access care without having to risk truancy or confide in third parties. Through WBC, the ***Peer Health Advocate (PHA) program*** students train to be leaders on their campus to address issues of concern to themselves and their peers. They engage in leadership skills training and design and implement activities that educate others and promote a safer, healthier school climate and positive peer norms. To support their mental health, they receive tools and the opportunity to act constructively and with others to change the conditions that cause them significant stress. PHAs gain an enhanced sense of agency as they experience themselves making a difference and helping to raise the voices of youth to decision-makers.
  - As part of the **Public Health Ambassador Program**, students and parents are trained on how to address the negative impacts of the COVID-19 pandemic on community health, specifically supporting the K-12 sector in Los Angeles County communities that have been most adversely

impacted. They are provided information and resources delivered by County Subject Matter Experts addressing the "how-to" in closing the health, academic, mental health, and drug use and addiction gaps associated with poor health outcomes. Ambassador training encourages peer-to-peer education among participants through the active dissemination of accurate information within their schools and local communities.

- Heart disease is the leading cause of death in Los Angeles County and the nation. Approximately 90% of cardiac arrests outside of a hospital setting will lead to death, if not given CPR immediately. Furthermore, Black and Latinx persons experiencing a cardiac arrest at home or in a public location are less likely than White persons to receive bystander CPR, regardless of the racial or ethnic makeup or the income level of the neighborhood where the cardiac arrest occurs.[xxix] In early 2023, Public Health launched the ***Heart Heroes Initiative***[xxx] to change this disparity. Several partner agencies and organizations in Los Angeles County have joined the Department of Public Health to train 500,000 Angelenos in Hands-Only/Bystander Cardiopulmonary Resuscitation (CPR) by the end of 2023. Trainings are being brought to places where folks gather, including sporting events, entertainment venues, places of worship, college and school campuses, worksites, malls, and other places throughout LA County communities. To date over 503,840 individuals have been trained.

Above: Heart Heroes training Team with Dr. Ferrer and Dodgers Manager Dave Roberts on a game day at Dodgers stadium, where baseball fans were offered training in hands-only CPR.
Right: Dodgers mascot showing correct placement of hands for providing CPR.

[xxix] R.A. Garcia, J.A. Spertus, S. Girotra, B.K. Nallamothu, K.F. Kennedy, B.F. McNally, K. Breathett, M. Del Rios, C. Sasson, and P.S. Chan Racial and Ethnic Differences in Bystander CPR for Witnessed Cardiac Arrest. New England Journal of Medicine October 27, 2022
[xxx] Los Angeles County Heart Heroes Website http://publichealth.lacounty.gov/media/heart/

Strengthen Organizational Readiness and Capacity

- In 2019, Public Health established a standard on how to create and update Department policies which requires using an Equity and Just Culture framework. Prior to the COVID-19 pandemic, from February 2019–January 2020, the Public Health Policy Workgroup reviewed, revised, and finalized thirty-four (34) Public Health policies. The Workgroup formally reconvened in late 2022, is assessing policies, and continues to support workforce members assigned with updating policies and standards of practices.

- In 2019, the Office of Planning worked closely with Contracts and Grants to develop the ***Community Engagement Master Agreement*** which creates a pool of vendors that meet contracting requirements. The Board approved the Master Agreement for Community Engagement on January 22, 2020, and it is open to all Departments in the County.

Areas for Collective Improvement

COVID-19 Pandemic

As noted in the opening of Section II, the pandemic emergency response was a huge factor in Public Health's ability to move the needle in many of the above issues. Staff and resources were devoted to supporting residents who were becoming ill and dying at high rates across the county in many vulnerable communities and populations. It was difficult to focus on much beyond the COVID-19 emergency response. However, programs did their best to keep the issues at the forefront and work with partners to balance the need to address COVID with the need to address other issues that were being exacerbated by COVID. As the emergency declarations for the pandemic have been lifted, the Department has been quickly shifting its focus and resources back to other community needs and strengthening the infrastructure in areas like staffing, protocols, and technology to ensure that future pandemics and emergencies do not create any more shifts in focus.

Overarching County Processes

To amplify the impact of the strategic priorities, other institutions must adopt similar strategies to address inequities and apply them to their own areas of responsibility, control, and influence. Furthermore, issues related to data sharing, budgeting, contracting, and HR require centralized coordination and countywide shifts in standards and practices. Many of the countywide efforts that are set to address these issues were paused or delayed during the response to the COVID-19 pandemic. As these efforts continue or re-start, the Department will continue participating to encourage the use of an equitable lens used with a public health focus.

Path Forward

Public Health will continue to sit in countywide spaces such as those led by the Counties Anti-Racism, Diversity, and Inclusion Initiative and collaborate with other agencies to reduce inequities and close the gaps while improving health for all. The following are some of the efforts that will move forward to strengthen the Public Health infrastructure:

- Building a Data Network to support the Department's commitment that data be collected, analyzed, and shared in ways that value lived experiences, is disaggregated to include the county's most historically underrepresented communities, and presented in a manner that allows communities and partners to use data to inspire policy change and action across sectors.
- Learning about and implementing equitable practices in contracting with community stakeholders to connect, coordinate, and collaborate on efforts that advance equitable opportunities and reduce inequities in health outcomes.
- Further expand an Equity Learning Series to provide the Public Health workforce with opportunities to build their capacity to apply equity principles.

III. Next Steps

As noted earlier, it was decided to extend this plan through December 2024. The extension plan, in the attachment, represents a list of continuing priorities and key actions to address the overarching Equity Goal, Objectives, and Strategic Priorities. Some are an extension of actions laid out in the original plan while others were developed based on a changing landscape, in response to emerging issues/new funding, or best practices to address ongoing needs.

In addition to the Center for Health Equity Action Plan, Public Health also develops a Community Health Improvement Plan (CHIP). This community-driven multi-year plan is developed in partnership with the Community Prevention and Population Health Task Force with involvement from multiple stakeholders. The purpose of CHIP is to provide an action-oriented plan that spurs collaboration across sectors on priority community public health issues. Both the CHIP and the CHE Action Plan engage community stakeholders to identify priorities that address inequities as well as are informed by the Community Health Assessment Data.

To avoid duplication in efforts and center equity in our work moving forward, it has been determined that the Center for Health Equity's Action Plan and the Community Health Improvement Plan will be consolidated into an overarching plan for Public Health beginning with the 2025-2029 plan. Preparation of the CHIP is currently being led by the Office of Planning, Integration, and Engagement, specifically the Planning Unit. Both teams are currently planning the process for this consolidated plan.

Updates on the current extension plan and the process for the 2025-2029 plan will be shared through various Public Health channels, including the Center for Health Equity electronic newsletter.

Appendix

A. 2018-2023 Progress Update

Objective 1: Reduce the Gap in Black/White Infant Mortality

Aim	Action	Status
1. Create Collaborative Structures to Support Progress at Local and County Levels	1. By December 31, 2018, convene a broad inclusive countywide Perinatal Health Equity Coalition to guide and support implementation of the County's Five-Year African American Infant Mortality Plan. The coalition will select at least one initiative to prioritize implementation by June 30, 2019.	Complete
	2. By June 30, 2019, convene Perinatal Equity Action Teams in two LA County areas with the highest Black/African American infant mortality rates. Each team will develop a local action plan for the four-year period starting with one strategy listed under strategy 2-4 that can be enacted during Year 1.	Complete
	3. By June 30, 2019, identify at least two new sources of funding to support collaborative Perinatal Equity efforts at county and/or local levels.	Complete
2. Reduce Women's Exposure to Socially Mediated Stress.	1. By June 30, 2019, implement community education campaigns aimed at building awareness of black-white inequality in birth outcomes and the causal role of racism as a source of stress among black women.	Complete
	2. By June 30, 2019, partner with at least two delivery hospitals and/or managed care organizations to develop a plan for implicit bias training of maternity staff. Complete training by December 2019.	Complete
	3. By June 30, 2019, ensure effective screening for interpersonal violence in County clinics.	Completed
	4. By June 30, 2020, provide anti-racism and reproductive justice training to at least 200 County employees.	Complete
	5. By June 30, 2020, select and initiate at least one campaign to address social conditions that affect black infant health, in each priority community. Potential areas of focus include housing availability, access to healthy food, paid family leave, and uptake of the Earned Income Tax Credit.	Complete
3. Block the Pathway from Social Stress to Physiological Stress	1. By June 30, 2019, assure staff in Department of Public Health (DPH)-funded home visiting programs are trained to help women recognize the signs of chronic stress and that all programs have protocols for referral to social supports and self-care when signs of stress or social isolation are present.	Complete
	2. By December 31, 2019, complete a plan to increase diversity in the expanding perinatal home visitation workforce.	Complete
	3. By December 31, 2019, assure tobacco use screening and referrals to cessation programs in all County-run clinics for women.	In Progress
	4. By June 30, 2020, train DPH-funded home visitors and Comprehensive Perinatal Health Workers across the county on at least one evidence-based, preventive mental health intervention, such as Motivational Interviewing or Problem-Solving Education.	Complete

Aim	Action	Status
4. Intervene as Early as Possible Before Stress Has Taken a Toll on Health.	1. By June 30, 2019, pilot a new model of home visiting for women at high risk due to substance abuse, homelessness and/or mental illness. Serve at least 150 women from preconception through parenting in Year 1.	Complete
	2. By June 30, 2020, train at least 50 prenatal and pediatric clinic staff regarding Help Me Grow, an enhanced service coordination system for children with special health care needs.	In Progress
	3. By June 30, 2020, assure adoption of protocols standardizing the use of progesterone to avert preterm birth and low-dose baby aspirin to avert pre-eclampsia leading to preterm birth among women at risk.	Complete
	4. By December 31, 2020, implement One Key Question© (OKQ) screening and appropriate follow up in County-run clinical settings that serve individuals of reproductive age.	Complete

Objective 2: Reduce Disproportionate Rates of Sexually Transmitted Infections (STIs) and Eliminate Congenital Syphilis

Aim	Action	Status
1. Detect STIs early in populations at risk. These include youth 12 to 24 years old, women of childbearing age, men who have sex with men, transgender individuals, and incarcerated individuals	1. By June 30, 2019, develop and promote audience-specific and STI-specific awareness and action messages for target populations, primary care and specialty medical providers, family planning centers, medical associations, and health plans.	Complete
	2. By December 31, 2019, build and/or maintain capacity for STI screening and testing at clinics that serve individuals living with, or at high risk for, HIV infection.	Complete
	3. By June 30, 2020, promote and ensure health plan and payor coverage for STI screening and testing services are consistent with current STI screening recommendations for populations at risk for STIs. These include three site (e.g., rectal, and pharyngeal) testing for gonorrhea and chlamydia for men who have sex with men and transgender individuals, repeat CT screening 3 to 4 months after treatment, and third-trimester syphilis screening for pregnant women.	Partially Complete
	4. By December 31, 2020, ensure that commercial health plans, public and private primary care and specialty care providers, family planning centers, and public and private healthcare delivery providers track and improve their adherence to STI screening and testing recommendations based on age, gender, race and ethnicity, sexual orientation, and pregnancy status.	Not Completed
	5. By December 31, 2021, strengthen health care provider skills related to taking comprehensive sexual health histories and educating, screening, testing, and treating populations at risk for STIs.	Complete and ongoing
2. Treat patients and their partners and stop the spread of STIs	1. By December 31, 2019, promote and ensure health plan coverage for STI treatment in accordance with current STI screening recommendations.	Partially Complete
	2. By June 30, 2020, assess and address the factors that influence the increasingly limited use of condoms among youth and men who have sex with men and recommend actions to reverse these trends.	Not Complete
	3. By June 30, 2020, assess and address the structural, operational, and behavioral issues that negatively impact the prompt treatment of STIs, including among youth, women of childbearing age and men who have sex with men.	Partially Complete
	4. By December 31, 2020, assess and address structural, operational, and administrative issues that impact the full use of patient delivered partner therapy (PDPT) for chlamydia and gonorrhea.	Ongoing

Aim	Action	Status
1. Educate consumers and community to increase awareness and empower people to make decisions that protect health	1. By June 30, 2019, develop and promote audience-specific and STI-specific awareness and action messages to improve STI prevention, screening, and treatment for populations at risk for STIs.	Ongoing
	2. By June 30, 2020, develop a plan for improving STI awareness among youth, promoting youth engagement in sexual health- related efforts and improving STI screening, diagnosis, and treatment rates.	Partially Complete
	3. By December 31, 2020, support community engagement and social marketing efforts to improve STI awareness, safer sexual health practices and consumption of sexual health services among men who have sex with men, transgender individuals, and women of childbearing age.	Ongoing
	4. By December 31, 2020, develop a plan to support a sexual health component for youth-specific programs designed to empower youth and promote positive youth engagement and development; efforts will target communities with high rates of STIs among youth.	Ongoing
2. Ensure health care providers appropriately prevent and treat STIs	1. By December 31, 2019, assess and identify structural, operational, and administrative issues impacting health plan billing and payment for STI screening diagnosis and treatment services.	Not Complete
	2. By December 31, 2019, partner with key stakeholders to develop a plan to increase funding for STI prevention and control efforts, including the appropriation of categorical STD funding and a more streamlined health plan billing and payment system.	Partially Complete and ongoing
	3. By June 30, 2021, begin working with health plans and payors to ensure coverage and promote extra-genital screening for gonorrhea and chlamydia and more frequent STI screening based on sub-populations consistent with current STI recommendations.	Partially Complete
	4. By June 30, 2019, issue a requirement under Health Officer authority that all pregnant women be screened for syphilis during the 1st and 3rd trimester (between weeks 28 and 32) of pregnancy and develop a systematic mechanism to track compliance.	Not Complete

Objective 3: Reduce Exposures to Environmental Hazards that Disproportionately Affect Low-Income Communities and Communities of Color

Aim	Action	Status
1. Strengthen the county's environmental health prevention efforts.	1. By December 31, 2018, engage and partner with community members in priority areas (i.e., communities that are burdened with multiple pollution sources) to support efforts to address environmental hazards in or near residential areas.	Complete
	2. By December 31, 2019, promote timely and effective enforcement of existing regulations in communities most burdened with many sources of pollution by strengthening the enforcement authority of Public Health Directives.	Complete
	3. By December 31, 2020, develop and support policy approaches that focus on environmental health protection and risk reduction.	Complete
2. Increase capacity to monitor and evaluate environmental and	1. By December 31, 2019, expand monitoring, assessment, and reporting of health conditions in priority communities, defined as residential communities with elevated exposures to hazardous toxins.	Complete
	2. By December 31, 2019, expand monitoring of environmental conditions in priority communities to ensure compliance with existing environmental laws and assess conditions in areas with high pollution burden.	Complete

Aim	Action	Status
health conditions in priority communities to support both prevention and response efforts		
3. Ensure the county is adequately prepared to respond to environmental emergencies.	1. By June 30, 2019, revise Health Agency environmental emergency plans, and develop field operation manuals and standard operating procedures to enhance Health Agency coordination and training to achieve effective environmental response and recovery.	In progress
	2. By June 30, 2019, build sustainable response operations with the flexibility to shift to emergency models of operation when threats emerge.	Complete

Objective 4: Strengthen Health Neighborhood Coalitions to Improve Care Integration Across Clinical and Community Settings and Improve Resident Outcomes

Aim	Action	Status
Strengthen and expand health neighborhoods to improve service delivery and address social determinants of health	1. By June 30, 2019, develop a framework that improves health by addressing unmet community needs in partnership with each Health Neighborhood Coalition.	Complete
	2. By December 30, 2019, coalitions identify priorities and desired outcomes.	Complete & Ongoing
	3. By December 30, 2019, identify resources for each coalition to support improved coordination and integration of services for residents with complex health needs.	Complete & Ongoing

Objective 5: Launch ICLIR to Ensure the Needs of Diverse Communities and Patient Populations are Met.

An update on this effort is provided in Section 2 of the main report.

Strategic Priority 1: Provide useful and inclusive data.

Aim	Action	Status
1. Ensure health agency data and reports represent all communities and reflect their experiences	1. By June 30, 2019, convene an ad-hoc, cross-sector Data Advisory Board comprised of organizations and residents from communities in LA County with disproportionately poor health outcomes to provide guidance on Health Agency measures, data and reports.	Complete
	2. By December 31, 2019, share tools and guidelines for Health Agency staff to increase the use of personal vignettes and storytelling in data reports and presentations.	In progress
	3. By December 31, 2019, share best practices within the Health Agency for disaggregating data to help ensure programs better report data on underserved communities, including Asian Pacific Islander and LGBTQ+ communities.	Complete
	4. By June 30, 2020, provide Health Agency programs with technical assistance to include root causes of health inequities in data reports.	Complete

Aim	Action	Status
	5. By December 31, 2020, develop toolkits and deliver technical assistance to communities and Health Agency programs to increase community-based participatory	Not Complete
2. Give communities access to the data they need to advance their Priorities	1. By June 30, 2019, provide support to community organizations to prioritize and tailor data to better address their local needs.	Complete
	2. By December 31, 2019, obtain community feedback on their data needs and the Department of Public Health's data dissemination efforts to improve the way DPH provides and presents data for policy, systems, and practice changes.	Complete
	3. By June 30, 2020, conduct presentations on the Department of Public Health City and Community Health profiles in at least 30 high-need communities to share cross-sector data on health, social, economic, and environmental outcomes. Reports are accessible at: http://publichealth.lacounty.gov/ohae/cchp/healthProfilePDF.htm.	Complete
	4. By December 31, 2021, develop a community-informed data-sharing mechanism to provide community partners with health, social, environmental, and economic data in ways they can use in decision-making.	Complete
3. Share and apply data to inform decision-making	1. By June 30, 2019, assess the health and equity impacts of proposed cannabis regulations to ensure more equitable policy implementation.	Complete
	2. By December 31, 2019, collaborate with the Data Advisory Board to identify 3 topics for health assessments of cross-sector policies.	Complete
	3. By December 31, 2020, partner with Health Agency programs to develop talking points, fact sheets, and presentations that summarize reports shared with decision-makers, advocates, and community organizations.	Complete
	4. By December 31, 2021, participate in a data exchange that allows for the sharing of de-identified data across county departments and community partners to identify underlying factors contributing to disproportionality in outcomes; this information can be used to support advocacy efforts for change.	In progress

Strategic Priority 2: Support Policy and Systems Change

Aim	Action	Status
1. Apply a health equity lens to policy-making	1. By June 30, 2020, share training about "Health in All Policies" to help Health Agency staff and partners apply a health lens to policy change efforts across sectors.	Not complete
	2. By June 30, 2020, develop a health equity analysis toolkit and template that Health Agency staff and community partners can use to evaluate potential equity impacts of proposed local, state and federal policy.	Complete
2. Ensure that health agency and partners work together	1. By December 31, 2018, create a robust process that involves grassroots organizations in DPH's annual policy prioritization process to identify local and state policy priorities.	Complete
	2. By December 31, 2019, support grassroot organizations and other community efforts leading social justice campaigns by connecting partners to Health Agency programs, sharing resources, and providing technical support.	Complete

Aim	Action	Status
towards policies that support equity	3. By December 31, 2019, support at least 3 local and state policies across sectors that will increase resources for the communities and groups in LA County experiencing the highest burden of inequities.	Complete
	4. By December 31, 2020, co-sponsor at least two countywide policy forums to highlight community-driven priorities, connect partners, and promote collaboration across sectors.	Complete

Strategic Priority 3: Support Public, Private and Community Partnerships

Aim	Action	Status
1. Share decision-making power with communities	1. By June 30, 2019, establish a DPH Youth Advisory Council to integrate youth voices into the Department of Public Health policies, practices, and initiatives.	Complete
	2. By June 30, 2019, pilot a training for Health Agency staff and community partners on facilitation skills and leading effective collaborations to increase shared decision-making around Center for Health Equity focus area initiatives.	Complete
	3. By December 31, 2019, create a platform on the Center for Health Equity website for community residents and organizations to learn about opportunities to provide input on government resource allocation and policy decisions.	Complete
	4. By June 30, 2020, release a set of tools to support meaningful community engagement and support Health Agency partnerships that embrace shared leadership.	In Progress
	5. By December 31, 2022, host a series of listening sessions to review progress on focus area objectives and discuss adding new areas of focus.	Not started
	6. By June 30, 2023, initiate at least one participatory budgeting project.	Not started
2. Ensure that all cross-sector partners understand and work to address health equity	1. By June 30, 2019, actively participate in five cross-sector County initiatives to identify and address health inequities.	Complete
	2. By December 31, 2019, partner with the philanthropic sector to plan a series of events focused on increasing funding for underserved communities.	Complete
3. Clearly communicate and make easily accessible health equity information and messaging	3. By December 31, 2018, compile and share health equity-related news, funding, job opportunities, and local events at least monthly via the Center for Health Equity Listserv.	Complete
	4. By June 30, 2020, develop and share a multi-media toolkit with the community to amplify health equity messaging and advance community priorities.	Complete

Strategic Priority 4: Strengthen Organizational Readiness and Capacity

Aim	Action	Status
1. Ensure underserved communities have equitable access to county jobs and contracts	1. By June 30, 2019, draft a framework for assessing departmental policies using an equity and "just culture" frame to ensure policies and practices are equitable and just.	Complete
	2. By December 31, 2019, develop recommendations to simplify applications and contracting based on feedback from stakeholders to increase investment in underserved communities.	Complete
	3. By June 30, 2020, offer targeted trainings for organizations serving historically underserved communities on how to successfully obtain grants and County contracts.	Not started
	4. By June 30, 2020, develop partnerships with schools and communities to support entry into public service careers for under-represented communities.	In progress
	5. By June 30, 2021, increase the number of historically underrepresented vendors who obtain contracts by 15% at DPH.	Ongoing
	6. By June 30, 2021, implement policies and procedures that support recruitment, retention, and promotion of individuals of historically under-represented communities, including residents with differing abilities.	In progress
2. Enable health agency staff to have the capacity to support diverse communities	1. By December 31, 2018, offer at least two implicit bias trainings for Health Agency employees to improve customer service.	Ongoing
	2. By June 30, 2019, establish a health equity team of at least 20 Health Agency staff to champion health equity policies, practices, and programs.	In progress
	3. By June 30, 2019, create a resource library on the CHE website related to cultural competency, language justice, disability rights and health equity.	Complete
	4. By December 31, 2019, implement a Health Agency workforce training curriculum to increase understanding and practice of health equity concepts, and share with community partners.	In progress
	5. By June 30, 2020, use feedback from customer/patient satisfaction surveys to improve the quality of culturally and linguistically appropriate services (and by June 30, 2022, increase by 25% the number of residents who report culturally sensitive and linguistically appropriate services).	In progress
3. Ensure linguistically appropriate materials and services are available to all communities	1. By December 31, 2019, implement a policy to ensure materials and community events are provided in the preferred language of community members and accessible to residents with differing abilities.	In progress
	2. By December 31, 2021, propose policies and procedures to ensure accessibility and quality of staff interpretation and translation skills and services.	In progress

B. 2023-2024 Extension Plan

Objective 1: Reduce the Gap in Black/White Infant Mortality

Strategies	Key Actions	Measurable Outcomes	Responsible Parties
1. Create Collaborative Structures to Support Progress at Local and County Levels	By June 2024, implement the AAIMM Policy & Advocacy Workgroup with a community-led MotherBoard to draft an AAIMM policy agenda.	By June 2024, Policy & Advocacy Workgroup has identified two policy changes for which AAIMM will advocate.	• LA County Department of Public Health • AAIMM Steering Committee and Community Action Teams
	By June 2024, finalize a plan to restructure AAIMM to elevate community voice as an equal partner alongside DPH.	By June 2024, AAIMM will have a finalized structural plan.	
2. Reduce Women's Exposure to Socially Mediated Stress.	By December 2024, via the African American Infant and Maternal Mortality (AAIMM) Village Fund, at least thirty additional community-based programs will be funded to provide stress-reducing services and support to Black pregnant and childrearing families	By December 2024, 30 additional agencies will receive funding through the AAIMM Village Fund. 90% of families receiving services through Village Fund grantees report that the services were helpful.	• DPH Division of Maternal, Child, & Adolescent Health (MCAH) • LA Partnership for Early Childhood Investment (PECI) • First 5 LA
	By December 2024, design, implement, and enroll eligible individuals in a countywide Guaranteed Income (GI) program for pregnant persons most impacted by perinatal health disparities.	By December 2024, 400 people will be enrolled and receiving GI payments.	• MCAH • CEO Poverty Alleviation Initiative
3. Block the Pathway from Social Stress to Physiological Stress.	By June 30, 2024, assure AAIMM doulas, home visitors, and Community Action Team partner organizations are trained to help women recognize the signs of chronic stress and that all programs have protocols for referral to social supports and self-care when signs of stress or social isolation are present.	By June 2024, fifty doulas and home visitors will be trained on maternal mental health and trauma-informed care. 90% of training participants will report confidence in recognizing signs of stress and referring appropriately. By September 2024, the DPH Division of Maternal, Child, and Adolescent Health (MCAH) will have a division-wide protocol for referral in place.	• MCAH • Los Angeles Best Babies Network
	By December 31, 2024, implement a plan to increase diversity in the expanding perinatal home visitation workforce, with particular attention to the Antelope Valley.	By April 2024, require documentation of Diversity & Inclusion hiring policies from DPH home visiting contractors. By December 2024, there will be a 25% increase in the number of culturally aligned birthworkers in the Antelope Valley.	• MCAH • PECI • Charles Drew University (CDU) • CA Black Women's Health Project

Strategies	Key Actions	Measurable Outcomes	Responsible Parties
	By June 2024, build systems to sustain and expand the AAIMM Doula Program with a maintained commitment to quality, culturally congruent care and living wages.	By March 2024, have contracts in place with at least two managed care plans to bill Medi-Cal for doula services. By December 2024, 90% of clients report satisfaction with services received	• MCAH • Managed care plans
4. Intervene as Early as Possible When Stress Has Taken a Toll on Health.	By December 2024, pilot at least two new models of home visiting for women at risk of adverse birth outcomes, with a focus on Black women.	By December 2024, complete pilot studies and finalize plans for permanent implementation of effective models.	• LA County Department of Public Health • LA County Department of Mental Health • LA County Department of Public Social Services
	By December 2024, establish Help Me Grow partnerships with at least three Black-parent-led organizations that address the unique needs of Black families raising children with special needs.	By December 2024, Help Me Grow has established three partnerships.	• MCAH • Pritzker Foundation • First 5 LA
	By December 2024, MCAH will promote clinical interventions to prevent preterm birth and pre-eclampsia, including low-dose aspirin and preconceptional health.	By June 2024, ten training sessions will have been offered to healthcare providers and community-based organizations regarding low-dose aspirin and preconceptional health. By December 2024, DPH will have endorsement from three clinical organizations to include pregnancy intent screening as standard of care.	• DPH Health Promotion Bureau, MCAH (AAIMM, CPSP) • Essential Access Health

Objective 2: Reduce Disproportionate Rates of Sexually Transmitted Infections (STIs) and Eliminate Congenital Syphilis

Strategies	Key Actions	Measurable Outcomes	Responsible Parties
1. Detect STIs early in populations at risk. These include youth 12 to 24 years old, women of childbearing age, men who have sex with men, transgender individuals, and incarcerated individuals	By December 2024, promote and ensure health plan and payor coverage for STI screening and testing services are consistent with current STI screening recommendations for populations at risk for STIs. These include three-site (e.g., genital, rectal, and pharyngeal) testing for gonorrhea and chlamydia for men who have sex with men and transgender individuals, repeat CT screening 3 to 4 months after treatment, and first and third-trimester syphilis screening for pregnant women.	By December 2024, conduct at least 3 meetings with health plans to discuss increasing coverage to align with current STI screening recommendations will have been held.	• LA County Department of Public Health leadership and Disease Control Bureau and Division of HIV and STD Programs Leadership • Board of Supervisors (BOS) • CA Department of Public Health, Educations, Health

Strategies	Key Actions	Measurable Outcomes	Responsible Parties
	By December 2024, conduct public health visits and educational events with healthcare providers, equipping them with valuable knowledge about syphilis resources and comprehensive STD screening protocols tailored to the needs of women of childbearing age	By December 2024, of the Division of HIV & STD Programs (DHSP) will host a CME event and/or trainings that include congenital syphilis prevention and best practices. By December 2024, Division of HIV & STD Programs (DHSP) will conduct at least 1 Provider Visitation campaign. (Completed)	Care Services and Mental Health • Health Plans operating in LAC
2. Screen, diagnose and treat patients and their partners to stop reinfection, forward transmission and spread of STIs	By December 2024, expand utilization of Patient Delivered Partner Therapy (PDPT).	By December 2024, the number of PDPT interventions per year will have increased from the previous year by 5%.	Same as above
	By December 2024, support and/or collaborate with community clinics and organizations to expand the accessibility of syphilis screening services for women of childbearing age.	By December 2024, at least 5 additional community partners will be providing syphilis screening for women of childbearing age.	
3. Educate consumers and community to increase awareness and empower people to make decisions that protect health	By December 2024, develop and promote audience-specific and STI-specific awareness and action messages to improve STI prevention, screening, and treatment for populations at risk for STIs	By December 2024, launch at least one syphilis prevention-focused social marketing campaign to heighten awareness and enhance efforts surrounding syphilis prevention, screening, and treatment, with a focus on populations that are at heightened risk for sexually transmitted infections (STIs).	Same as above
4. Ensure health care providers appropriately prevent and treat STIs	By December 2024, partner with key stakeholders to enhance strategies for managing STD prevention and control efforts.	By December 2024, at least 4 meetings will be held with key stakeholders to discuss streamlining services, data collection efforts, diversifying revenue streams, and policy discussions for STI prevention and control efforts.	Same as above

Objective 3: Reduce Exposures to Environmental Hazards that Disproportionately Affect Low-Income Communities and Communities of Color

Strategies	Key Actions	Measurable Outcomes	Responsible Parties
1. Strengthen the County's Environmental Health Prevention Efforts	By December 2024, support the implementation of the Green Zones Ordinance to address the pollution burden of multiple industrial uses near sensitive uses.	Through December 2024, participate in monthly Industrial Use Task Force (DRP) meetings, this is the implementation workgroup for Greenzones).	• LA County Department of Public Health • Environmental Health Division: Land Use Program and Office of Environmental

Strategies	Key Actions	Measurable Outcomes	Responsible Parties
			Justice & Climate Health (EJCH) • LA County Department of Regional Planning (DRP) and other IUTF partners (DPW, Fire Health HazMat) • Chief Sustainability Office
	By December 2024, work with CARB, SCAQMD, and local community groups on the implementation of Community Emissions Reduction Programs and Community Air Monitoring Systems required under AB 617 (legislation that aims to address disproportionate air quality burdens impacting disadvantaged communities)	By December 2024, continue participation in AB 617 meetings and provide technical assistance to CBOs implementing programs.	• AB-617 Community Emission Reduction Programs led by the local air district SCAQM • Office of EJCH; • funded community-based organizations.
	By June 2024, Build internal infrastructure for the Office of Environmental Justice and Climate Health	Develop a Strategic Plan and hire a permanent director for the Office of EJCH by June 2024.	Office of EJCH
	By December 2024, enroll new participants in the "Lead-Free Homes LA Program" to eliminate lead paint hazards in homes throughout LA County.	By December 2024, remediate lead paint hazards in 200 homes throughout LA County.	• Office of EJCH • LACDA
2. Assess Environmental and Health Conditions to Support Both Prevention and Response Efforts	By June 2024, complete a Health Assessment and Environmental Justice Study to evaluate the potential impact of Inglewood Oil Field operations on community health outcomes.	By June 2024, complete analysis of the impact of distance from the oil field on 2000-2019 birth outcomes to mothers living within 1.5 miles of the oil field. By 2024, Complete collection, and analysis of household survey data to examine the association of distance from the oil field with short-term health outcomes and lung function among residents living within 1.5 miles of the Inglewood Oil Field.	• Office of EJCH • UCLA • Baldwin Hills Community Advisory Panel • Baldwin Hills CHAAP
3. Engage, Collaborate, and Partner with Community Members and	By June 2024, conduct a strategic planning process to define the mission and activities of the new Office of Environmental Justice and Climate Health through engagement meetings, soliciting community review of documents, developing community-informed objectives	By June 2024, Office of Environmental Justice and Climate Health Strategic Plan completed and published an Office web page By December 2024, participate in a minimum of 10 workgroup meetings related to EJ and climate.	• Office of EJCH • Center for Health Equity (CHE)

Strategies	Key Actions	Measurable Outcomes	Responsible Parties
Community-Based Organizations	By December 2024, participate in workgroups related to EJ and climate, focused on generating community-driven strategies	By December 2024, create a separate Office of EJCH website.	
	By December 2024, update and maintain information for the public on our program webpage, including the development of informational materials for communities; media requests; and other awareness building.		
4. Increase survival rates for out-of-hospital cardiac arrests by increasing the number of people trained to perform bystander/Hands-Only cardiopulmonary resuscitation (CPR)	Through partnerships, increase the number of people trained to provide Hands-Only CPR (HOCPR) by offering training at places where people gather, including places of worship, community events, schools, adult education centers, worksites, sporting events, malls, and other locations.	Train 500,000 Los Angeles County residents and workers in Hands-Only CPR (HOCPR) by December 31, 2023, to increase the number of people in LA County communities who can perform this lifesaving skill.	• Emergency Preparedness and Response Division (ERPD) and other DPH programs (CFS, CHE, PIE) • Other County and City Departments • American Heart Association • CA Community Foundation • LA Sports Teams and Entertainment Venues • LA County businesses, Community Based Organizations, • K-12 Schools (especially middle & high schools) • Colleges, Universities, and other Institutes of Higher Education
	Leverage strong working relationships built over the past three-plus years, including working with 1) Sports teams, Entertainment venues, and Business Partners; 2) Organizers of Community Events and Activities; 3) Community and Faith-Based Organizations; and 4) the Education Sector.		
	Ensure coordinated, campaign-related communication with all Heart Heroes 2023 partners.		

Strategic Priority #1: Provide useful and inclusive data

Aims	Key Actions	Measurable Outcomes	Responsible Parties
1. Advance Equitable Data Policy and Analysis	By June 2024, transition from the current DPH Data workgroup to a broader Data Network that can support all DPH programs.	By June 2024, have a Network established including purpose, criteria, membership, and expectations defined.	CHE and OHAE

Aims	Key Actions	Measurable Outcomes	Responsible Parties
2. Ensure that data is representative and reflective of all communities and their experiences	By December 2024, develop 3 data communication toolkits for Public Health Staff and community partners, such as data visualization, approaches to using qualitative data, and community-based participatory research (CBPR) practices.	By June 2024, develop 3 toolkit modules as a resource for DPH program staff who disseminate data reports/presentations to the community By December 2024, deliver technical assistance to communities and DPH programs to support the utilization of toolkits.	CHE
3. Ensure Public Health Data and Reports Represent All Communities and Reflect Their Experiences	By June 2024 develop a standard of practice (SOP) for the collection and reporting of data regarding people's disability status	By June 2024, disseminate the SOP throughout DPH programs to improve data collection regarding people with disabilities and incorporate data collection regarding disability status in at least one DPH database/system	OHAE

Strategic Priority 2: Support Policy and Systems Change

Aims	Key Actions	Measurable Outcomes	Responsible Parties
1. Strengthen Public Health's Language Justice & Cultural Responsiveness	By June 30, 2024, convene an internal Public Health Language Justice Workgroup to develop and implement a language justice action plan, which includes the development of a streamlined process for language translation/interpretation	By June 30, 2024, increase the number of CBO applicants as language justice vendors by 25%.	CHE, Equity Champions Language Justice Workgroup, and internal Public Health Workgroup.
		By June 30, 2024, implement a Public Health Language Justice Policy and share it with other County agencies	
2. Ensure Underserved Communities Have Equitable Access to County Contracts	By December 2024, in collaboration with Public Health Contracts and Grant convene an Equitable Contracting Workgroup and engage key Public Health programs (i.e., SAPC & DHSP) to develop recommendations and best practices and inform the Countywide Equitable Contracting process.	By June 2024, launch a Public Health Equitable Contracting workgroup with a minimum of three representatives per Bureau and the Executive Team.	CHE, Office of PIE, and Grants & Contracts Unit
		By December 2024, develop a work plan and implementation timeframe.	CHE, Office of PIE, and Grants & Contracts Unit

Strategic Priority 3: Support Public, Private and Community Partnerships

Aims	Key Actions	Measurable Outcomes	Responsible Parties
	By June 2024, support the County's Anti-Racism, Diversity, and Inclusion Initiative including the	By June 2024, implement Equity Action Plan	CHE

1. Ensure Public Health representation on County-wide efforts	development of a draft Equity Action Plan to support ARDI effort and informed by the findings of the GARE Racial Equity workforce engagement survey.	By June 2024, successfully respond to a minimum of 75% of all ARDI requests.	CHE
	By December 2023, collaborate with DHS and DMH to implement CHW Action Plan and evaluation process to strengthen our CHW Workforce and CHW infrastructure	By June 2024, Implement an interdepartmental CHW Action Plan	CHE
3. Share Decision-Making Power with Communities	By November 2024, implement a robust community stakeholder engagement process for the 2025-2030 Equity Action Plan which will include reviewing data and progress on focus area objectives & strategic priorities and discussing new areas of focus, priorities, action items, and metrics.	By March 2024, engage a minimum of 1000 community stakeholders in the process	CHE and Office of Planning, Integration & Engagement (OPIE)
		By November 2024, have a complete Equity Action Plan	CHE & OPIE
4. Community Public Health Teams (CPHTs) will consist of coordinated, place-based, and community-driven health practitioners who will work together with community members to reduce gaps in health outcomes and improve the conditions essential for overall health and well-being in high-need communities throughout LAC.	By November 2024, full implementation of CPHT initiative.	By October 2023, all CPHTs launched • Establish CPHT leadership group (leads from each of the 10 CPHTs) to guide the pilot • Develop and deploy a process for service coordination. By November 2024, conduct preliminary community coordination activities • In partnership with community members, initiate household assessments in each CPHT community • Initiate community convenings to identify community-level health priorities • Develop Community Action Plan	OPIE - CEU Contracted fiscal sponsor CPHT teams once onboarded

Strategic Priority 4: Strengthen Organizational Readiness and Capacity

Aims	Key Actions	Measurable Outcomes	Responsible Parties
1. Expand Partnerships to Inform How Public Health Addresses Equity	By June 2024, the department will have established a plan to promote gender-inclusive and affirming services and programs.	By June 2024, develop an ad hoc committee to develop an implementation strategy for a minimum of two recommendations.	CHE

Aims	Key Actions	Measurable Outcomes	Responsible Parties
3. Identify and Address Equity, Racial Justice and Anti-Racism through Departmental policies, procedures, and practices	By December 2024, in coordination with OVP continue to oversee the DPH Violence and Racism workgroup and implement at least three components of their action plan to foster a culture of anti-racism and inclusion	By December 2024, work with DPH Leadership to Implement recommendations to strengthen HR Practices and organizational culture.	CHE, Violence and Racism Workgroup
	By June 2024, utilize the Department's process for assessing departmental policies through an equity and "just culture" frame to review and modify policies and practices to ensure they are equitable and just.	By June 2024, review and propose modifications for at least 5 DPH policies, practices, and/or procedures	Executive Office
4. Build the capacity of the Public Health workforce to apply equity principles	By June 2024, expand and strengthen the Public Health Equity Learning Series to build the capacity of the Public Health Workforce to apply principles of health equity during internal County practices, policy development, program design, and service delivery.	By June 2024, implement a minimum of three components of the Equity Learning Series.	CHE and Office of Development and Training (ODT)
		By December 2024, 80% of the workforce participated in Equity Learning Series activities	CHE, ODT
5. Ensure Underserved Communities Have Equitable Access to County Jobs and Contracts Through Cross-Sector Partnerships	By December 2023, establish Academic Health Department (AHD) Planning and Steering Committees, consisting of internal and external partners, to guide the department as it facilitates collaborative affiliations with academic institutions in LA County.	By December 2023, AHD Steering Committees established	Office of Planning, Integration, and Engagement
	By June 2024, explore the viability of establishing a paid internship program in which LAC DPH and academic institution(s) provide hands-on, project-based professional experience and training that will improve the public health workforce's ability to improve health outcomes of LA County residents with a focus on disproportionately impacted communities.	By June 2024, identify paid internship opportunities that can support AHD efforts through project-based professional experience	Office of Planning, Integration, and Engagement
	By June 2025, convene strategic meetings with DPH staff, philanthropic partners, and academic leaders to build a shared understanding of priority public health workforce competencies and needs and develop a plan with academic institutions to enhance training programs accordingly.	By June 2025, develop a plan with academic institutions to enhance training programs accordingly.	Office of Planning, Integration, and Engagement