# Community Health Equity Improvement Plan for Los Angeles County

**2024-2029**

County of Los Angeles Public Health

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# Letter from Public Health Leadership

Dear Community Members and Partners,

I am pleased to introduce the new Community Health Equity Improvement Plan (CHEIP) for Los Angeles County, which can be used as a roadmap to guide our collective efforts, initiatives, and investments along our journey to foster thriving communities that support the health of our residents.

The CHEIP was developed in collaboration with many community partners, and it outlines strategies to improve health outcomes in several key public health focus areas: Black/African American infant and maternal health, sexually transmitted infections, environmental justice, and violence prevention in our communities. While the strategies and initiatives in this plan reflect a subset of current public health initiatives, it offers a set of priorities that we can collectively focus on to advance our efforts to improve the conditions that foster healthy residents and healthy communities. Additionally, this plan builds upon an Equity Framework that focuses on strengthening partnerships, using data to drive solutions, developing equitable policies and systems, and updating an infrastructure to achieve health equity and justice.

While pursuing health equity and improving health outcomes are monumental tasks, they remain a priority for the Los Angeles County of Public Health (Public Health). However, Public Health alone cannot bring about the desired results. The partners that lead and support this work are more important than ever in making strides to achieve these goals. To that end, Public Health is committed to collaborating with partners and is also eager to engage new partners with unique perspectives to support healthier and safer communities across Los Angeles County. Collectively, your involvement and support are crucial in helping us move forward.

We want to thank all partners for their ongoing dedication to improve the health of our communities and to advance the movement for health equity.

We look forward to strengthening our collaborative efforts and welcoming new partners on this journey together.

Sincerely,

Dr. Barbara Ferrer
Director

# Executive Summary

**What is the Community Health Equity Improvement Plan (CHEIP)?**

The new Community Health Equity Improvement Plan for Los Angeles County 2024-2029 is a shared plan between the Los Angeles County Department of Public Health (Public Health), partners, and stakeholders to advance health equity and foster healthy, thriving communities. The CHEIP, developed in collaboration with a diverse range of partners, consolidates two plans, the Community Health Improvement Plan (CHIP) and Center for Health Equity's Action Plan (Equity Action Plan), into one overarching plan. During its development, Public Health worked closely with community partners and stakeholders to review the most current data available and identify strategies that would make a collective impact on some of the most pressing public health issues in Los Angeles (LA) County. This CHEIP reflects the population health issues that continue to be of high priority and reinforces the importance of partnering and aligning efforts to achieve equity and promote health collectively.

**CHEIP Focus Areas**

The CHEIP focuses on four key areas: Black/African American infant and maternal mortality, sexually transmitted infections (STIs) and congenital syphilis, environmental justice, and violence prevention.

Each Focus Area section in the CHEIP includes an overview of the issue, strategies to be collectively implemented, and actions that can be taken to support existing efforts and help change the trajectory of each issue.


**Equity as a Foundation for the CHEIP**

Health equity is achieved when everyone has a fair and just opportunity to attain their optimal health and well-being. To achieve this, the CHEIP builds on an Equity Framework established to guide the design or enhancement of programs and processes. Strategies in the CHEIP are organized according to the following County of Los Angeles Department of Public Health Equity Framework Priorities:

- Provide access to **useful and inclusive health equity data**,
- Support **policy and systems change** for the equitable distribution of opportunities and resources,
- **Build partnerships** that truly share power and respect community autonomy, and
- Strengthen **organizational readiness and capacity** to adopt a just culture and advance health equity.

**Get Involved!**

Public Health deeply values collaborating with others and recognizes the critical role that partners play in leading and advancing the work of protecting and improving the health of LA County residents. While the CHEIP's strategies reflect several significant efforts, it is not an exhaustive plan of the work happening in LA County. Rather, the CHEIP offers a collective starting point for the selected focus areas and recognizes that the efforts of other organizations, agencies, stakeholders, and community members also advance equity and improve health outcomes. Thus, each section in the CHEIP offers additional "Collaborative Actions" that can be taken to support or complement the work identified in the CHEIP. As Public Health and partners implement the CHEIP, we hope to expand and update the plan with additional opportunities to further advance the collective impact on the targeted health priorities. We hope this plan will inspire meaningful collaborations across the county.

## Summary of CHEIP Focus Areas, Equity Framework Priorities, and Strategies

**Focus Area 1 Result Statement:**
All Black/African American babies and mothers/birthing people in Los Angeles County enjoy healthy and joyous births and thrive well beyond baby's first birthday.

| Equity Framework Priority | Strategy |
|---|---|
| **Useful and Inclusive Data** | **Strategy 1:** By June 2025, launch and maintain a publicly accessible data dashboard of maternal and infant mortality and associated data disaggregated by race/ethnicity. |
| **Policy and Systems Change** | **Strategy 2**: By June 2026, evaluate the implementation of an economic stabilizing initiative, such as the Guaranteed Income program, that serves a minimum of 400 pregnant persons impacted by perinatal health disparities. |
| | **Strategy 3**: By June 2027, expand the AAIMM Doula Program into at least three health related systems to improve access to culturally affirming and supportive maternal care. |
| **Building Partnerships** | **Strategy 4**: By June 2027, fund at least 10 community organizations to provide stress-reducing services and support for Black pregnant and parenting families through the AAIMM Village Fund. |
| **Organizational Readiness and Capacity** | **Strategy 5**: By December 2025, strengthen the ability of Community Action Teams to identify local needs and develop and implement at least one new strategy in response to local needs assessment implemented to address disproportionality in Black/African American infant and maternal mortality. |
| | **Strategy 6**: By June 2026, finalize a three-to-five-year strategic plan through shared decision-making in the AAIMM Steering Committee. |

**Focus Area 2 Result Statement:**
Everyone in Los Angeles County, including future generations, is protected from sexually transmitted infections and congenital syphilis.

| Equity Framework Priority | Strategy |
|---|---|
| **Useful and Inclusive Data** | **Strategy 1:** By December 2024 and ongoing, regularly disseminate up-to-date, user-friendly HIV and STI data, ensuring accessibility and interactivity, to empower and inform the community. |
| **Policy and Systems Change** | **Strategy 2:** By December 2027, improve adherence to California law and LA County guidelines that mandate syphilis screenings for all pregnant women during their initial prenatal visit, with additional screenings recommended in the third trimester (28-32 weeks) and at the time of delivery. |
| | **Strategy 3:** By December 2025, increase STI screening and testing rates among populations at elevated risk for STIs by strengthening community awareness and understanding of STIs. |
| **Building Partnerships** | **Strategy 4:** By January 2025, establish a partnership council to use routinely solicit community input and feedback to identify actions and activities that will improve STI prevention and control efforts. |
| **Organizational Readiness and Capacity** | **Strategy 5:** By December 2025, establish a comprehensive program to regularly provide targeted training for public health investigators (PHIs), community-embedded disease intervention specialists (CEDIS), and front-line clinic staff. |

**Focus Area 3 Result Statement:**
Those living in the most highly pollution-burdened communities in Los Angeles County enjoy healthy lives safe from toxic exposures and the negative effects of climate change.

| Equity Framework Priority | Strategy |
|---|---|
| **Useful and Inclusive Data** | **Strategy 1:** By December 2025, post data on a publicly accessible platform that shares environmental, climate, and related health conditions, informed by strategic planning stakeholder input. |
| | **Strategy 2:** By December 2025 and annually thereafter, ensure the Office of Environmental Justice and Climate Health (OEJCH) program webpage provides up-to-date, relevant information for the public, based on input gathered from strategic planning stakeholder engagement. |
| **Policy and Systems Change** | **Strategy 3:** By December 2025, develop an initial policy agenda on priority environmental justice and climate health issues that identifies at least 3 policies to pursue. |
| **Building Partnerships** | **Strategy 4:** By December 2027, reduce the risk of lead poisoning from lead paint in 2000 homes throughout LA County through remediation of lead paint hazards. |
| | **Strategy 5:** By December 2025 and annually thereafter, provide training and develop maps for each of the hyper-local health teams, Community Public Health Teams (CPHT), to build knowledge and awareness of local environmental and climate justice issues in the initial pilot communities. |
| | **Strategy 6:** By June 2026, partner with environmental justice and climate health organizations in LA County to support and convene spaces for symposiums for environmental justice and climate health topics. |
| **Organizational Readiness and Capacity** | **Strategy 7:** By January 2027, implement the collaboratively developed OEJCH strategic plan to reduce health disparities due to environmental exposures in communities overburdened by pollution exposure and climate impacts. |

**Focus Area 4 Result Statement:**
All families and communities in Los Angeles County live free of violence and thrive in a culture of peace.

| Equity Framework Priority | Strategy |
|---|---|
| **Useful and Inclusive Data** | **Strategy 1:** By June 2025, create a centralized open data portal with metrics to evaluate progress on Office of Violence Prevention strategic plan goals and objectives. |
| **Policy and Systems Change** | **Strategy 2:** By January 2026, establish a Sexual Assault Council to improve coordination across county systems and service providers to improve services to survivors of sexual assault and invest in prevention programs. |
| | **Strategy 3:** By July 2026, expand initiatives and services to address gender-based violence across the lifespan by strengthening inter-agency collaboration. |
| | **Strategy 4:** By June 2027 expand place-based community-driven public safety efforts through the Trauma Prevention Initiative, including Street Outreach and Community Violence Intervention, Hospital Violence Intervention, and Community Action for Peace networks by: 1) increasing investment in nine communities, and 2) building infrastructure for peer violence intervention training and county services alignment. |

| **Focus Area 4 Result Statement:** All families and communities in Los Angeles County live free of violence and thrive in a culture of peace. | |
|---|---|
| **Building Partnerships**<br>**Organizational Readiness and Capacity** | **Strategy 5:** By June 2025, implement a comprehensive plan to promote firearm safety through community education and awareness, policy change, and peer approaches. |
| | **Strategy 6:** By June 2026, implement trauma-informed systems and practice change among County departments and community partners to promote healing and wellbeing and to support the unique needs of local communities. |
| | **Strategy 7:** By June 2026, develop a coordinated communications strategy to promote a shared understanding of violence and violence as a public health issue. |
| | **Strategy 8:** By June 2025, implement local efforts to prevent suicide and suicidal behavior among populations demonstrated to be at increased risk including youth, communities of color, veterans, and firearm owners. |

# I. Overview

The County of Los Angeles Department of Public Health (Public Health), in collaboration with partners, is pleased to introduce the new Community Health Equity Improvement Plan (CHEIP) for 2024-2029. This CHEIP consolidates two plans that were previously developed as separate efforts: a Community Health Improvement Plan (CHIP) and the Center for Health Equity Action Plan.

### Background

The previous CHIP was a shared plan between Public Health, partners, and community stakeholders that outlined a collective effort to improve community health. Through a robust engagement process, the CHIP was developed with stakeholder input and offered a shared vision and approach for creating healthy and vibrant communities. Public Health began working with the Community Prevention and Population Health Task Force[1] (Task Force), which is a collection of external stakeholders established to provide recommendations regarding equity, health, and community well-being for LA County, to identify potential focus areas in the new CHIP. Public Health began working with the Task Force in 2018, but before this process was completed, Public Health shifted its focus to respond to the COVID-19 Pandemic, thus postponing the development and release of a new CHIP.

Not long before the development of a new CHIP was underway, Public Health also established a new Center for Health Equity (CHE) in 2017 to advance racial, social, economic, and environmental justice in partnership with committed County partners, local organizations, and community members. Soon after CHE was established, a six-year Action Plan (2018-2023) was developed and has since been extended to the end of 2024. The Action Plan outlined collective goals that were developed based on extensive community feedback gathered during listening sessions and community forums.

The extended Action Plan represents Public Health's commitment to achieving equity with a continued focus on reducing infant and maternal mortality, sexually transmitted infections (STIs), and exposure to environmental hazards. Additionally, the extended Action Plan continues to build on four equity priorities, which are now solidified into Public Health's Equity Framework:

- Provide access to **useful and inclusive health equity data**.
- Support **policy and systems change** for the equitable distribution of opportunities and resources.
- **Build partnerships** that truly share power and respect community autonomy.
- Strengthen **organizational readiness and capacity** to adopt a just culture and advance health equity.

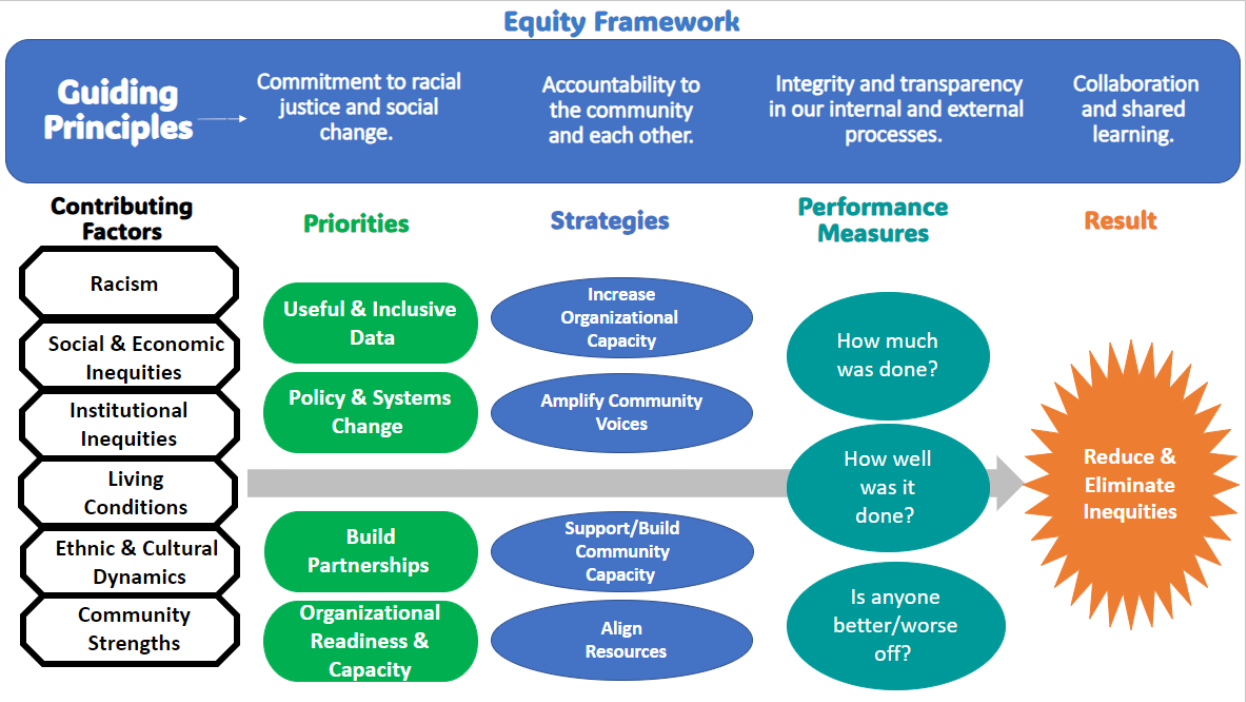
Both the original CHE Action Plan and extended Action Plan can be found here:
http://publichealth.lacounty.gov/centerforhealthequity/ActionPlan.html

Given that both plans are developed with community partners to address public health priorities and reduce health disparities, Public Health determined that it made more sense to consolidate them into one overarching plan. Additionally, Public Health engaged the Task Force in the development of the new plan to inform its design and content of key elements. This new CHEIP reflects the issues that continue to be of high priority in Los Angeles (LA) County and reflects a set of strategies that reinforce the importance of sharing power with our communities and aligning efforts to advance equity together.

## Equity as a Foundation for the CHEIP

Health equity is achieved when everyone has a fair and just opportunity to attain their optimal health and well-being. To achieve this, Public Health utilizes an Equity Framework to guide the design or enhancement of programs, services, and processes. (See Figure 1). The Equity Framework was developed based on Public Health's collective work to address inequities and informed by collaborations with community partners. It identifies **guiding principles** that serve as foundational standards for the work, **contributing factors** to consider in planning, a set of **priorities** that help organize our collective efforts to achieve a positive impact, a set of **strategies** to advance those priorities, and a set of questions for developing **performance measures** to assess and make improvements towards achieving the desired **result**, condition of well-being**.**

**Figure 1: County of Los Angeles Department of Public Health Equity Framework**




## CHEIP Focus Areas

Prior to consolidating the plans, the CHIP and CHE Action Plan each identified areas of public health focus. Given the persistent disparities and concerning health outcomes, community stakeholders and Public Health collectively chose to continue efforts to advance equity in the following Focus Areas:

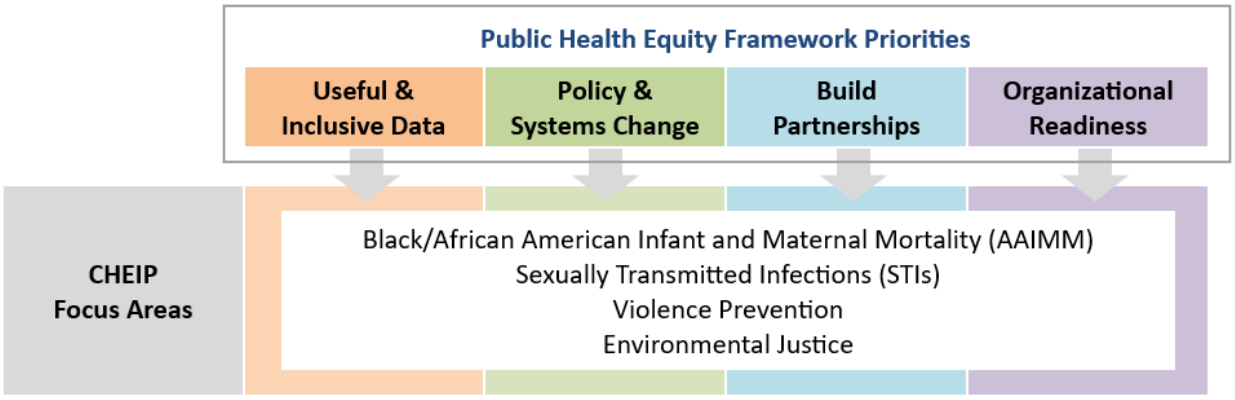
- Black/African American Infant and Maternal Mortality
- Sexually Transmitted Diseases and Congenital Syphilis
- Violence Prevention
- Environmental Justice

To further inform the CHEIP's development, Public Health and partners utilized data from Public Health's Community Health Assessment (CHA) which, due to LA County's large size, the complexity of issues, and numerous partners, is a compilation of several cornerstone data sources including the Community Health Profiles (CHP)[2], the Los Angeles County Health Survey (LACHS)[3], and program-specific data. To

develop the stated desired results and strategies, the focus area teams relied on the most current available data. Additionally, the most recent LACHS and CHP data are shared throughout this document along with our intent of how to incorporate it in future iterations of the CHEIP.

The CHEIP highlights four focus areas which include: an overview of the issue including root causes and current data trends, an outline of key strategies that Public Health and partners will collectively implement, and actions for community stakeholders to help change the trajectory of each issue. The strategies in the CHEIP are organized according to the Equity Framework Priorities (see Figure 2).

**Figure 2: Applying the Equity Framework in the CHEIP**




## Health Equity: What the Data Says

The 2023 LACHS, which collected information from 9,372 adults (18+ years old) and 7,391 children (<18 years old), shows that many LA County residents face challenges and stressors across several Social Determinants of Health (SDOH)[4] which are the conditions and environments where people are born, live, learn, work, play, worship, and age that can affect their health and quality of life. Recent assessments of SDOH indicators find:

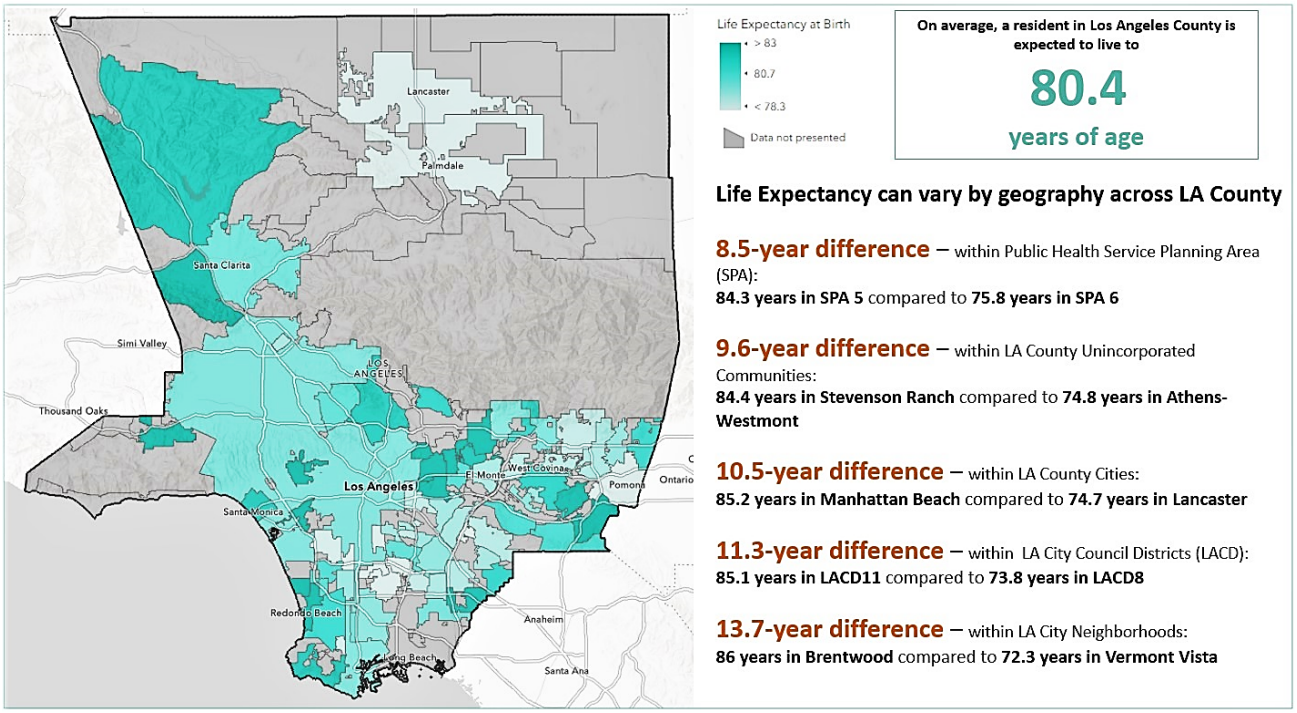
- **More than half (54%)** of households were housing burdened (pay more than 30% of their income on mortgage or rent).
- **One in four (25%)** of all households and **nearly a third (30%)** of households with children experienced food insecurity.
- **One in four (25%)** adults reported difficulty accessing needed medical care, and **one in five (21%)** reported not having a regular source of health care.
- **More than a third (37%)** of children were reported to have experienced difficulty accessing needed childcare.
- **More than a third (36%)** of adults reported having anxiety or stress about climate change.
- **Nearly one half (49%)** of LA County adults reported experiencing discrimination at least once a year.
- **Only 74%** of adults (18+ years old) perceived their neighborhood to be safe from crime.

The data also show that there are persistent health and socioeconomic inequities in LA County. A few sub-groups disproportionately experience a higher burden of unfavorable outcomes compared to the overall LA County average and other counterparts. These sub-groups include individuals who identify as Black/African American, Latinx, American Indian or Alaskan Native, Native Hawaiian or Pacific Islander,

Transgender males, Transgender females, Gender non-conforming individuals, those living under 200% Federal Poverty Level (annual income less than $55,500 for a family of 2 adults and 2 dependents), and those with lower educational attainment (a high school diploma or less). See the appendix in this document for more data and information about specific indicators assessed in the 2023 LACHS.

Geography is also a determining factor when it comes to negative health and socio-economic factors. Communities with historic disinvestments, burdened by racist policymaking and barriers to accessing needed resources, experience the worst health outcomes and mortality rates. Adults in LA County Service Planning Areas 1, 4, and 6 (Antelope Valley, Metropolitan Los Angeles, and South Los Angeles, respectively) tend to have the most highly impacted communities. See Figure 3 for the differences in life expectancy across geography.

**Figure 3: Life Expectancy at Birth for Los Angeles County Cities and Unincorporated Communities in 2022.**




*Source: Los Angeles County Health Profiles: https://ph-lacounty.hub.arcgis.com/pages/chp. Los Angeles County Department of Public Health, Office of Health Assessment and Epidemiology, Epidemiology Unit.*

Everyone deserves the opportunity to achieve optimal health, longevity, and wellbeing. Unfortunately, data from multiple sources continue to highlight persistent health inequities and outcomes that are experienced mostly by people of color. These outcomes are compounded by factors such as age, race/ethnicity, gender identity, sexual orientation, other characteristics like disability status, economic class, language barriers, place/geography, and other factors that influence interpersonal and institutional discrimination. The 2023 LACHS data will be further analyzed by Public Health and shared with community partners to apply or further refine the CHEIP's strategies for greater impact.

## CHEIP Implementation and Tracking

Public Health collaborated with partners to develop the CHEIP and will continue working through these valued partnerships to collectively implement the plan, track its progress, and adjust or revise the plan as needed each year.

To develop a meaningful plan, specific programs within Public Health, which include the Maternal Child and Adolescent Health Division, the Division of HIV and STD Programs, the Office of Environmental Justice and Climate Health, and the Office of Violence Prevention, engaged with their respective network of community partners, stakeholders, and subject matter experts to inform each CHEIP Focus Area section. During this process, Public Health and partners also identified roles to support the plan's collective implementation. A brief description of the community engagement process and partner roles are included in the corresponding CHEIP Focus Area sections. Individual names and agencies are not specified in this document as Public Health works with a multitude of diverse partners that vary widely in levels of engagement and will evolve over time. Instead, this plan collectively acknowledges the contributions of partners and coalitions by groups.

To track implementation and impact, each CHEIP Focus Area section has several components: a **Results Statement** that identifies a desired condition; a **Measurable Goal** and corresponding **Population Indicators** to help assess progress and any collective impact toward the desired result; and a set of **Strategies** that Public Health and partners can do to work towards the desired result. Additionally, for each Focus Area, Appendix B outlines a set of **Workplan Activities** to operationalize the strategies and **Performance Measures** to help assess the performance and impact of the strategies implemented. Currently, these performance measures are considered developmental and will be adjusted as the plan's implementation is more established.

As implementation progresses, each Public Health program will facilitate the reporting process annually with partners by utilizing a performance management software program. This software program, currently used by Public Health, will help Public Health and partners regularly share updates on indicators and performance measures. Progress on CHEIP implementation will be routinely reviewed and adjusted, as needed. These reviews will allow Public Health and partners to uplift successes, identify barriers and seek opportunities for improvement.

Public Health also anticipates revising the plan to incorporate community and stakeholder input and/or adjust to emerging issues or lessons learned as implementation progresses. For example, Public Health and partners plan to host community convenings around the issue of Environmental Justice. These engagement efforts, in turn, may suggest updates or revisions to CHEIP strategies. Public Health also anticipates new findings from community input from an upcoming initiative called the Community Public Health Teams[5] (CPHT). This place-based, hyper localized public health initiative, launched in partnership with a set of community-based organizations and health care partners, may identify new assets, emerging issues, or a need for additional partners or strategies as the CPHTs conduct local household and community assessments in key neighborhoods across LA County. As findings from these efforts or new reports, such as from the 2023 LACHS, add to the growing body of local health data, Public Health will engage partners and community members to assess progress, new developments and update the CHEIP. Further, Public Health will soon launch a CHEIP website where additional input can be collected and updates on the plan can be shared broadly.

## Call to Action

Public Health deeply values collaborating with others and recognizes the critical role that partners play in driving and supporting the collective work of protecting and promoting the health of LA County residents. The focus areas and strategies outlined in the CHEIP reflect several significant efforts that Public Health is working on in partnership with others, but it is not an exhaustive plan of the work that is happening in LA County. The CHEIP offers a collective starting point for the selected focus areas but also recognizes that many organizations, agencies, community residents, and workers contribute to the effort to eliminate health disparities and improve health outcomes for all residents. Thus, each section of the CHEIP offers additional "Collaborative Actions" that agencies, organizations, stakeholders, or community members can take to move towards the desired results identified in the CHEIP. Additionally, Public Health continues to work with partners to collectively advocate for resources that strengthen the broader public health system and improve the public health infrastructure. Specifically, Public Health seeks sustained investments to bolster a chronically underfunded system and support an equitable distribution of resources and opportunities needed for optimal health and well-being.

## Closing

Fully countering decades of disinvestment, the legacy impacts of discriminatory policies and systems, deep mistrust in government institutions requires, and a recent global COVID-19 pandemic that further exacerbated long-standing inequities in health outcomes requires intentional focus. In each focus area section, the CHEIP represents a collective effort to reverse health inequities by modifying the roadmap, updating community infrastructure, cultivating and strengthening partnerships, aligning resources, and changing the dominant narratives of individualism to that of interdependence and collective impact.

# II. FOCUS AREA: Black/African American Infant and Maternal Health

### What the Data Says About the Issue

Infant mortality or death is an important indicator for the overall health and well-being of any population and is defined as the death of an infant before their first birthday. Important determinants of infant health operate even before a child is conceived. Before and during pregnancy, the socioeconomic and physical environments in which we are born, live, play, and work shape our general health, nutrition, lifestyle, and exposure to harm, all of which have an even more immediate influence on infant health. Once children are born, their healthy physical and psychosocial development continues to be subject to a variety of influences.[6] In California, the leading causes of infant deaths include birth defects (92.9 per 100,000), sudden unexpected infant death (54.9 per 100,000), preterm births/low birthweight (48.2 per 100,000), and maternal complications (29.5 per 100,000)[7].

Before 2022, the overall rate of infant deaths in the United States had been falling for two decades across all populations. However, Black/African American infants continued to bear the burden of disparate, higher rates of infant mortality than other racial/ethnic groups. Between 2021 and 2022, newly released data showed that the national infant mortality rate (per 1,000 live births) increased by nearly 3% across all groups (5.44 to 5.60 per 1,000 live births respectively)[8] with marked disparities seen in Black infant mortality. The root causes of these inequities are a complex intersection of the impact of stress associated with racism and multigenerational trauma, systemic oppression, and injustices that have been leveled against Black individuals and continues to this day in the form of structural and interpersonal harm associated with maltreatment and discrimination. California has one of the lowest infant mortality rates in the nation, but significant inequities in birth outcomes persist, impacting Black births at the greatest rates.

In 2021, in LA County, there were 21,188 White, 52,743 Hispanic, and 7,508 Black births, and the infant mortality rate was 3.97 per 1,000 live births. Though the mortality rate for babies born to Black mothers is declining compared to recent years, in 2021 the rate was 6.9 per 1,000 live births and remains more than twice that of babies born to White mothers (3.3 per 1,000 live births) (Figure 4).

As infant health is linked to the health of the individual to whom they are born, maternal health is an important factor in infant health at birth and survival. It is also shaped by the same determinants that influence infant health. Pregnancy-Related Mortality Ratio (PRMR) is an indicator of maternal health. It is defined as the number of deaths per 100,000 live births among pregnant individuals and those within one year after pregnancy, due to causes related to or worsened by the pregnancy or its management.

In LA County, the pregnancy-related mortality ratio (5-year rolling average) is on the rise with an increased rate ratio for 2017-2021 of 17.6 per 100,000 live births compared to 16.3 per 100,000 live births for 2015-2019, and 16.2 per 100,000 live births for 2016-2020 (Figure 5). In California, the pregnancy-related mortality ratio (PRMR) for Black/African American mothers is over three times that of White mothers and remains consistently higher than other racial/ethnic groups (Figure 6). Maternal Mortality Ratio is an additional indicator of maternal health. It is defined as the number of deaths per 100,000 live births of pregnant individuals during pregnancy, during childbirth, or within 42 days after childbirth or termination of pregnancy from any cause related to or worsened by the pregnancy or its management, but not from accidental or incidental causes[9]. Black mothers consistently experience the highest maternal mortality ratios (Figure 7).

At the root of racial disparities in premature birth, infant mortality, and maternal mortality is not the behavior of Black/African American individuals, but rather the effect of generational oppression, structural and interpersonal racism, which takes a physiological toll on a Black/African American woman's body. The lifetime of exposure to racism and its correlates puts Black/African American mothers at elevated risk for pregnancy and infant loss as well as maternal mortality. It is important to note that this inequity has impacted Black/African American women of all socio-economic backgrounds and education levels. The harm of racism is amplified by economic oppression and by both implicit and overt bias in our health care system, as seen in repeated accounts of Black/African American women/birthing people being unheard when they express concerns.[10]

Deaths during pregnancy, childbirth, or postpartum are tragic events. The African American Infant and Maternal Mortality Prevention Initiative (AAIMM)[11], a community-led and Public Health-administered initiative, is working to reduce these events and to close the glaring racial gaps in infant and maternal mortality by addressing systemic racism and other social factors at the root of the problem.

### DPH and Partner Actions

The African American Infant and Maternal Mortality Prevention Initiative (AAIMM) is a coalition of the Department of Public Health in partnership with First 5 LA, the LA County Department of Health Services, the LA County Department of Mental Health, community organizations, mental and health care providers, funders, and community members. Since the onset of the AAIMM Initiative, the coalition instituted a shared leadership and decision-making approach among members to build trust and prioritize and implement strategies to address the unacceptably high rates of Black infant and maternal deaths countywide; the coalition meets regularly to develop, implement, and review strategies highlighted in this section of the CHEIP and catalyze community action to ensure the healthy and joyous births for all Black families in LA County.

The table below outlines a set of strategies and the partners that will guide the plan's implementation. Refer to Appendix B for additional information, including time-framed work plan activities and developmental performance measures.

| |
|---|
| **Results Statement:**<br>All Black/African American babies and mothers/birthing people in Los Angeles County enjoy healthy and joyous births and thrive well beyond baby's first birthday. |
| **Measurable Goal:**<br>In five years, reduce the gap by 50% in Infant Mortality Rates (IMR) between White and Black/African American babies by reducing the Black/African American IMR. |

| **Population Indicators** | Los Angeles County |
|---|---|
| **2021 Infant mortality rate (per 1,000 live births)**<br>*Data source: 2015-2017 California Department of Public Health, Birth and Death Statistical Master Files. California Department of Public Health, California Comprehensive Birth/Death File (Dynamic) for Los Angeles County, 2018-2021. Data extracted (4/2020, 7/2021, 7/2021, 7/2022). Prepared by Los Angeles County Department of Public Health, Maternal Child and Adolescent Health (MCAH) Program.* | **3.9** |
| **2021 Black/African American infant mortality rate (per 1,000 Black/African American live births)**<br>*Data source: Los Angeles County Department of Public Health, Maternal Child and Adolescent Health (MCAH) Program as of 2021* | **6.9** |

## Focus Area Strategies and Partners

Refer to Appendix B to see work plan activities and developmental performance measures.

### Useful and Inclusive Data

**Strategy 1:**
By June 2025, launch and maintain a publicly accessible data dashboard of maternal and infant mortality and associated data disaggregated by race and ethnicity.

**Partners**
- AAIMM Data & Evaluation workgroup - advisors
- Public Health - data platform development lead

### Policy and Systems Change

**Strategy 2:**
By June 2026, evaluate the implementation of an economic stabilizing initiative, such as the Guaranteed Income program, that serves a minimum of 400 pregnant persons impacted by perinatal health disparities.

**Partners**
- AAIMM Community Action Teams – program lead and Members (individuals/organizations)
- AAIMM Village Fund Recipients – outreach collaborators
- Abundant Birth Project participating counties (Alameda, Contra Costa, Los Angeles, Riverside)
- AAIMM Steering Committee Members
- Internal/External LA County Partners
- Pregnant Women/Birthing Persons and Partners who are now parents, inclusive of those who have experienced perinatal loss

### Building Partnerships

**Strategy 3:**
By June 2027, expand the AAIMM Doula Program into at least three health related systems to improve access to culturally affirming and supportive maternal care.

**Partners**
- AAIMM – lead advisors, advocates
- Doula professionals – advisors, advocates
- Public Health - lead contract collaborators

**Strategy 4:**
By June 2027, fund at least 10 community organizations to provide stress-reducing services and support for Black/African American pregnant and parenting families through the AAIMM Village Fund.

- AAIMM – lead
- Private Philanthropy – funder
- Public funders – funder
- AAIMM Village Fund Recipients – program & service leads, advisors

### Organizational Readiness

**Strategy 5:**
By December 2025, strengthen the ability of Community Action Teams to identify local needs and develop and implement at least one new strategy in response to local needs assessment implemented to address disproportionality in Black/African American infant and maternal mortality.

**Partners**
- Organizations & community members in Service Planning Areas 1, 2, 3, 6 & 8 – collaborators, advisors
- AAIMM Community Action Teams – lead

| | |
|---|---|
| **Strategy 6:**<br>By June 2026, finalize a three-to-five-year strategic plan through shared decision-making in the AAIMM Steering Committee. | • AAIMM Steering Committee – lead<br>• AAIMM Community Action Teams - contributors |

## Collaborative Actions

Reducing the gap in Black/African American infant and maternal mortality rates requires a multi-sector and multi-faceted approach to address the factors that contribute to disparate health outcomes. Below are actions that can be taken to better understand and address factors contributing to the disproportionality in birth outcomes.

1. **Advocate for Policy and Systems Changes**
   Support policies and practices that prioritize maternal and infant health equity, address systemic racism and discrimination, and improve access to and utilization of healthcare, stable housing, and other supports for Black/African American individuals and families. Examples include support for guaranteed income programs for pregnant persons, the expansion of midwifery care and doula support services, access to high-quality prenatal, perinatal, and postnatal care, home visitation services, efforts to expand income and housing security, and connection to supportive resources and programs.

2. **Contribute to Inclusive Research and Data**
   Add to the body of data of maternal and infant mortality and associated data disaggregated by race and ethnicity to better understand the root causes of racial disparities in maternal and infant health outcomes and better identify effective interventions to address them within and beyond your own institution.

3. **Engage in Community-Driven Priorities**
   Participate alongside communities and community members in the development and implementation of strategies and initiatives to support and celebrate Black/African American pregnant and parenting families. Examples include supporting the convening, priorities, plans, and projects of the AAIMM Steering Committee and local Community Action Teams.

4. **Promote Community-Based Programs and Social Support Services**
   Promote, fund, and/or support programs that offer education (e.g., group prenatal classes, financial well-being, stress management techniques, breastfeeding support), counseling (mental health, nutrition), resources, assistance with accessing healthcare, or other social support services (e.g., Fatherhood engagement) for Black/African American pregnant women and parenting families.

5. **Advance Organizational Transformation**
   Increase education, awareness, and visibility of Black/African American infant and maternal mortality as a public health issue. Dismantle narratives that blame individual Black/African American women; instead, name racism and work for systems change. Support service-oriented organizations and agencies in increasing organizational readiness and capacity to better understand and meet the unique needs and experiences of Black/African American residents. For example, adopt intentional values to address equity or offer trainings to the workforce on issues such as cultural awareness, implicit bias, and discrimination.

# III. FOCUS AREA: Sexually Transmitted Infections and Congenital Syphilis

### What the Data Says About the Issue

Over the past decade, LA County has witnessed a significant surge in rates of sexually transmitted infections (STIs) such as syphilis, gonorrhea, and chlamydia—a concerning trend mirrored on a national scale. These infections disproportionately impact low-income groups, communities of color, and gay, bisexual, and transgender communities.

In LA County, syphilis rates are rising at levels not seen in over 30 years, including a consistent rise in infections among males, particularly men who have sex with men (MSM). The overall rate of primary and secondary syphilis among MSM in 2022 was 354 per 100,000. While almost half of MSM cases were Latinx (49%), Black/African American MSM had the highest rate (610 per 100,000) of primary and secondary syphilis compared to other racial/ethnic groups (Figure 8a). As syphilis rates among men have surged, there has been a corresponding increase in cases among women. This trend highlights the connection of STI transmission, where higher infection rates among men, including MSM, can lead to increased syphilis rates among women through sexual contact. There has been a nearly 12-fold increase in cases among females of childbearing age (15-44 years old), and an almost 23-fold increase in congenital syphilis cases since 2012. In LA County in 2022, there were 136 infants diagnosed with congenital syphilis including 13 syphilitic stillbirths (Figure 8b).

Congenital syphilis (CS) occurs when a pregnant person with untreated syphilis infection passes the infection to their baby during pregnancy. CS can have major health impacts on the baby. How CS affects the baby's health depends on how long the pregnant person had syphilis and if — or when — they got treatment for the infection. When untreated, CS can lead to a miscarriage (losing the baby during pregnancy), premature birth (being born early), stillbirth (death of a fetus after 20 weeks of pregnancy), or infant death (death of a baby shortly after it is born). Babies born with CS can have serious illnesses, including having low birth weight or developing birth defects, blindness, and hearing loss.

CS cases are increasingly reported in the most vulnerable groups in LA County, particularly Black/African American and Latina women of reproductive age experiencing substance use disorder, mental health challenges, and homelessness at the same time. Among women, Blacks/African Americans and Latinas have the highest rates of syphilis in LA County. While the rate of syphilis is higher among Black/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 LA County population. In 2022, among the pregnant women who had babies with congenital syphilis 64% were Latina, 19% were Black/African American, 11% were White, and 6% were of other/unknown race/ethnicity[12]. Figure 9 has more details on Congenital Syphilis cases by birthing parent characteristics.

In addition to these STIs, human immunodeficiency virus (HIV) transmission remains a critical concern among Latinx and Black/African American individuals, cis-women (women who identify with the gender they were assigned at birth), men who have sex with men (MSM), and transgender individuals (a person whose gender identity is different from the gender they were assigned at birth), further exacerbating the health disparities faced by these groups. Data also continues to show that syphilis infection increases the risk of HIV transmission and is associated with methamphetamine use disorder. Efforts to control and prevent the spread of HIV, alongside other STIs, are crucial in safeguarding the health and well-being of these communities.

## DPH Actions and Partners

The strategies outlined in this section were shaped through a continuous process of meetings and forums with strategic partners. To ensure an equity-focused approach, Public Health engaged a wide array of partners, including county leaders, service providers, prevention and treatment experts, health plan leaders, schools and education partners, federally qualified health centers, community clinics/agencies, and community advocates. Additionally, diverse populations in areas with high STI rates were engaged through a formal community engagement process, led by the WeCanStopSTDsLA Coalition, to address health justice and equity and reduce the impact of STDs on vulnerable communities. Public Health also established internal workgroups, such as the Los Angeles County STD Workgroup and the STD Metrics and Milestones Workgroup, to coordinate these efforts and finalize measures.

The table below outlines a set of strategies and the partners that will guide the plan's implementation. Refer to Appendix B for additional information, including time-framed work plan activities and developmental performance measures.

**Results Statement:**
Everyone in Los Angeles County, including future generations, is protected from sexually transmitted infections and congenital syphilis.

**Measurable Goal:**
The rate of primary and secondary syphilis will decrease among African American and Latinx men who have sex with men (MSM) by 20% in five years.

| **Population Indicators** | Los Angeles County |
|---|---|
| **2022 Rate of Primary & Secondary syphilis in MSM (rate per 100,000 persons)**<br>*Data source: LA County Public Health, Division of HIV and STD Programs. These data do not include Long Beach and Pasadena.* | **Overall: 354**<br>*Black/African American: 610*<br>*Latinx: 353* |
| **2023 Rate of congenital syphilis (per 100,000 live births)**<br>*Data Source: LA County Public Health, Division of HIV and STD Programs. These data do not include Long Beach and Pasadena.* | **153** |

## Focus Area Strategies and Partners

Refer to Appendix B to see work plan activities and developmental performance measures.

### Useful and Inclusive Data

**Strategy 1:**
By December 2024 and ongoing, regularly disseminate up-to-date, user-friendly HIV and STI data, ensuring accessibility and interactivity to empower and inform the community.

**Partners:**
- Community members – advisors
- Community Clinics – collaborators, contributors
- Health Plans – collaborators
- Providers – contributors, advisors
- Public Health – data Lead

### Policy and Systems Change

**Strategy 2:**
By December 2027, improve adherence to California law and LA County guidelines that mandate syphilis screenings for all pregnant people during their initial prenatal visit, with additional screenings recommended in the third trimester (28-32 weeks) and at the time of delivery.

**Partners:**
- CA Dept. of Health Care Services – monitor, ensure compliance
- CA Dept. of Public Health – monitor, ensure compliance
- Health Care Delivery Systems and Birthing Hospitals – collaborators, contributors
- Community Clinics – collaborators, contributors
- Public Health – outreach, content development, technical assistance, training

**Strategy 3:**
By December 2025, increase STI screening and testing rates among populations at elevated risk for STIs by strengthening community awareness and understanding of STIs.

**Partners:**
- Media partners – content distribution lead
- Community members – lead advisors
- Public Health – campaign management lead

### Building Partnerships

**Strategy 4:**
By January 2025, establish a partnership council to routinely solicit community input and feedback to identify actions and activities that will improve STI prevention and control efforts.

**Partners:**
- FQHC – advisors, collaborators
- Health Plans – funders, collaborators
- Community leaders – advisors, collaborators
- Local Health Organizations – advisors, collaborators
- Public Health – convenors, subject matter experts
- Academic partners – subject matter experts
- Consumers – advisors, collaborators

### Organizational Readiness

**Strategy 5:**
By December 2025, establish a comprehensive program to regularly provide targeted training for public health investigators (PHIs), community-embedded disease intervention specialists (CEDIS), and front-line clinic staff.

**Partners:**
- Subject Matter Experts – content contributors
- HIV & STI workforce – collaborators, ambassadors
- Public Health – collaborators, curriculum & training management

## Collaborative Actions

Addressing the disproportionate rates of sexually transmitted infections (STIs) and congenital syphilis requires a multifaceted approach. Here are additional actions to support the reduction of these disparities:

1. **Increase Syphilis Screening**
   Implement robust screening and treatment for syphilis for at-risk populations, including women of reproductive age and pregnant women. For example, screen all women ages 15 to 44 years for syphilis at least once and more often based on risk, birthing hospitals to confirm syphilis status of all women and newborns prior to discharge, and expand opportunities to pair syphilis testing with homeless service provision.

2. **Raise STI Awareness**
   Increase education and awareness of STIs, including syphilis, among those at highest risk. Include a stigma reduction campaign to combat the stigma associated with STIs, which can act as a barrier to testing, treatment, and disclosure. Messages should include the importance of incorporating testing as part of a routine to healthcare.

3. **Utilize Enhanced Care Models for Women Experiencing Increased Vulnerability**
   Utilize enhanced models to meet the needs of women challenged with multiple co-morbidities, such as substance use disorder and homelessness as a critical syphilis intervention. For example, to enhance coordination of field outreach and testing efforts to highly impacted populations, explore models such as "MAMA'S Neighborhood[13]" program focused on assisting pregnant women experiencing medical challenges, behavioral health conditions, or complex life circumstances.

4. **Strengthen Organizational Readiness to Provide Culturally Competent Care**
   Increase the capacity of the workforce to provide culturally competent and linguistically appropriate STI prevention. Address language barriers, cultural norms, and socio-economic factors may impact access to care and health outcomes.

5. **Combat the Spread of HIV and STI Infections**
   Implement sexual health education sessions or campaigns, become a condom distribution site, and actively work to dismantle the stigma and discrimination faced by individuals and communities at elevated risk for HIV and STIs in faith-based organizations, cities, local organizations and businesses. Local community agencies and providers can provide and facilitate access to prevention programs, testing, and treatment services, and support partner services (e.g., partner elicitation and notification) for populations at elevated risk for HIV and STIs.

# IV. FOCUS AREA: Environmental Justice

### What the Data Says About the Issue

Air pollution and particulate matter pose serious threats to public health. Fine particles ($PM_{2.5}$) pose the greatest health risk. These fine particles can get deep into lungs, and some may even get into the bloodstream. Breathing polluted air can lead to various health issues, including worsening asthma, increased hospitalizations, and premature deaths from and worsening of underlying heart and lung diseases. Toxic chemicals released from vehicles, factories, and other industries can also contribute to the development of cancer.

Environmental Justice is the fair treatment and meaningful involvement of all people regardless of race, color, national origin, or income, with respect to the development, implementation, and enforcement of environmental laws, regulations, and policies[15]. It recognizes that the health of a community largely depends on its conditions and the fair distribution of environmental benefits and protection from environmental burden. In LA County, those disproportionately burdened by poor land use, climate hazards, and exposure to pollution and other toxic environmental hazards include low-income communities and communities of color, often the same groups already burdened with social and health inequities.

CalEnviroScreen is a screening tool developed by the California Office of Environmental Health Hazard Assessment (OEHHA) that can be used to help identify communities that are disproportionately burdened by multiple sources of pollution. This tool, now in its fourth version, will help Public Health programs identify and target the most burdened LA County communities for increased environmental justice efforts that can improve health equity and save lives.

### Pollution Burden and Particulate Matter (PM2.5)

According to CalEnviroScreen 4.0, approximately 500,000 LA County residents live in the most pollution-burdened census blocks (above 90$^{th}$ percentile statewide). Figures 10a–10b show maps that clearly illustrate the burden and impact on LA County communities from exposure to multiple sources of pollution. Particulate Matter (PM2.5) is a mixture of particles from chemicals, dust, soot and metals from vehicles, factories, wood burning, and other activities that can travel deep into human lungs and lead to serious health issues including heart and lung disease. See figure 10b for PM2.5 percentile levels in LA County. See figure 10b for more details.

- **Almost half** of the census tracts in LA County **(48%)** fall into the top 25$^{th}$ statewide percentile for pollution burden. These pollution-burdened census tracts have a higher percentage of LA County's Latinx residents (58%) compared to the overall county Latinx population (48%). See figure 10a for more details.

### Toxic Releases

Figures 11a-11b show maps of facilities that make or use environmentally toxic chemicals in their industrial processes and can release these chemicals into the air. The US Environmental Protection Agency (EPA) provides data on the number facilities and the amount of releases for over 500 toxic chemicals for large facilities. These chemicals are sometimes detected in the air of nearby communities and people living in these nearby communities may breathe contaminated air regularly or if contaminants are released during an accident[14]. Figure 11b shows the concentration of Toxic Release

Inventory (TRI) Facilities in Los Angeles County. Many of these facilities are clustered in marginalized communities in southern and eastern Los Angeles County.

- **60% of LA County census tracts** fall in the top 25% statewide percentile for toxic releases. These impacted census tracts have a higher percentage of Latinx and Black/African American residents (56% and 11% respectively) compared to the overall county (48% and 8% respectively). See Figure 11a for more details.

### Lead Exposure

In addition to the disproportionate burden of exposure to multiple sources of pollution and toxic releases across some LA County communities, environmental lead hazards also persist in LA County. Figure 12 shows a map of household lead risks for children in Los Angeles County. Young children are considered most at risk and susceptive to lead exposure, which can cause a wide range of problems including lifelong damaging effects including brain and cognitive developmental issues in children, blood, kidney and endocrine toxicity, and reproductive issues in males and females. Further, lead poisoning does not impact all children equally. Children living in poverty, children enrolled in Medicaid, children living in older housing, and Black/African American children are found to have higher levels of lead exposure. Geographic disparities also exist.

- **Almost half (44%)** of LA County census tracts fall in the top 25$^{th}$ statewide percentile for children's lead risk from housing. Most of these census tract houses are located in southern and eastern Los Angeles County communities with higher percentages of Latinx and Black/African American residents (69% and 10% respectively). See Figure 12 for more details.

LA County is home to some of the most environmentally challenged areas affected by exposure to multiple sources of pollution, harmful toxins, and other conditions that disproportionately threaten the health of our most vulnerable communities. In response, Public Health will focus on promoting strategic policies and programs that prevent environmental threats, build climate resilience, and advance environmental justice to reduce health disparities among some of the county's most impacted communities.

### DPH Actions and Partners

The strategies identified in this plan were developed through two extensive partner engagement processes. The Office of Environmental Justice and Climate Health (OEJCH) is currently in the process of finalizing a program strategic plan, which includes a robust community engagement process to solicit ideas from internal and external stakeholders and community members. Prior to engaging with the community, a Stakeholder Engagement Framework was created and included key informant interviews with Public Health leadership and key program staff as well as external interviews and focus groups with key County department and Community-Based Organization (CBO) partners. Wider community and stakeholder engagement was conducted through a CBO partnership model where CBOs, with representation in each Supervisorial District in LA County, conducted public outreach activities and solicited input on the program strategic plan by hosting public workshops to gather feedback from community members.

Additionally, before the development of the program strategic plan, OEJCH also launched the Lead-Free Homes LA program which provides lead paint hazard remediation services to eligible homeowners,

property owners, and tenants across LA County[15]. This program was developed with input from community members and stakeholders through various engagement activities:

- focus groups were conducted, in English and Spanish, among homeowners, renters, and landlords
- formative research was conducted to gauge reactions among community members to a new program intended to assess and remediate lead-based paint hazards in homes throughout LA County and to understand any questions or concerns from each demographic
- key informant interviews were conducted with professionals working in non-profit organizations that focus on housing development, tenant unions, and community outreach initiatives and specialize in work surrounding low-income families and children.

The results and strategies highlighted in this focus area's section outline early developmental strategies. As Public Health continues to gather community input and further strengthens its relationships with stakeholders, Public Health will collaborate with its partners to update and revise strategies identified for this CHEIP focus area.

The table below outlines a set of strategies and the partners that will guide the plan's implementation. Refer to Appendix B for additional information, including time-framed work plan activities and developmental performance measures.

| |
|---|
| **Results Statement:**<br>Those living in the most highly pollution-burdened communities in Los Angeles County enjoy healthy lives safe from toxic exposures and the negative effects of climate change. |
| **Measurable Goal:**<br>In five years, find and fix the sources of lead exposure for at least 25% of children with a blood lead level of 3.5 µg/dL or higher who live in the most polluted communities of Los Angeles County*. |

*These are communities ranked in the top 25% using the California Communities Environmental Health Screening Tool (CalEnviroScreen 4.0).

| **Population Indicators** | Los Angeles County |
|---|---|
| **Children under 6 years of age with blood lead levels at or above 3.5 mcg/dL living in communities with high rates of pollution burden in 2022.**<br>*Data Source: Los Angeles County Department of Public Health, Office of Environmental Justice, Lead Program 2022 RASSCLE Surveillance database archive as of 7/3/2023* | **503 (35%) of 1438 total in Los Angeles County** |

## Focus Area Strategies and Partners

Refer to Appendix B to see work plan activities and developmental performance measures.

### Useful and Inclusive Data

| | |
|---|---|
| **Strategy 1:**<br>By December 2025, post data on a publicly accessible platform that shares environmental, climate, and related health conditions, informed by strategic planning stakeholder input. | **Partners:**<br>• Subject Matter Experts – advisors, contributors<br>• Community Organizations – advisors<br>• Public Health – data platform development |
| **Strategy 2:**<br>By December 2025 and annually thereafter, ensure the Office of Environmental Justice and Climate Health (OEJCH) program webpage provides up-to-date, relevant information for the public, based on input gathered from strategic planning stakeholder engagement. | • Community members – advisors<br>• Community organizations – advisors<br>• Data Reporting organizations – contributors<br>• Public Health – data platform development & maintenance |

### Policy and Systems Change

| | |
|---|---|
| **Strategy 3:**<br>By December 2025, develop an initial policy agenda on priority environmental justice and climate health issues that identifies at least 3 policies to pursue. | **Partners:**<br>• Community members – advisors<br>• Community organizations - advisors<br>• Data Reporting organizations – contributors<br>• Public Health – policy analysis and policy agenda development |

### Building Partnerships

| | |
|---|---|
| **Strategy 4:**<br>By December 2027, reduce the risk of lead poisoning from lead paint in 2000 homes throughout LA County through remediation of lead paint hazards. | **Partners:**<br>• Community Organizations – outreach, recruitment, enrollment, collaboration<br>• Housing Authorities – program implementation, collaboration<br>• Public Health – program oversight |
| **Strategy 5:**<br>By December 2025 and annually thereafter, provide training and develop maps for each of the hyper-local health teams, Community Public Health Teams (CPHTs), to build knowledge and awareness of local environmental and climate justice issues in the initial pilot communities. | • Community Public Health Teams – lead contributors, collaborators<br>• Public Health – environmental justice mapping development |
| **Strategy 6:**<br>By June 2026, partner with environmental justice and climate health organizations in LA County to support and convene spaces for symposiums for environmental justice and climate health topics. | • Health-focused stakeholders – advisors, collaborators<br>• Regulators – advisors, collaborators<br>• NGOs/CBOs – advisors, collaborators |

ORGANIZATIONAL READINESS

**Strategy 7:**
By January 2027, implement the collaboratively-developed OEJCH strategic plan to reduce health disparities due to environmental exposures in communities overburdened by pollution exposure and climate impacts.

**Partners:**
- CBOs, government/non-government agencies, regulators, academic partners/researchers, community members, & other jurisdictions – collaborators, advisors
- Public Health – implementation lead

## Collaborative Actions

**1. Contribute to Data and Monitoring**
Share data to understand environmental conditions that negatively influence the health of LA County communities, and the effectiveness of interventions to improve health. Examples include conducting community-based participatory research, supporting residents to track health symptoms, and lifting up community narratives and storytelling to contextualize the quantitative data.

**2. Actively Engage in Policy Development, Implementation and Enforcement**
Engage with a wide range of stakeholders including policymakers, regulatory agencies, non-profit organizations, and residents to move environmental justice and climate health research toward meaningful policy change. Identify and center environmental justice communities in all levels of policy work. Advocate for policies that address frontline community conditions, including exposure to cumulative environmental pollution. Advocate for policies that advance good health by protecting vulnerable populations from exposure to and/or reduce exposure to pollutants that drive health disparities. For example, policies that strengthen enforcement of existing environmental regulations, address unfair distribution of harmful pollution, and prioritize sustainable development practices for EJ communities.

**3. Engage in Community-Driven Priorities and Programs**
Empower communities and residents by actively engaging with them in planning, prioritizing, and implementing strategies, as well as decision-making processes related to environmental justice and climate health. For example, develop strategic partnerships and participate in existing collaboratives focused on environmental justice and climate health issues and priorities/needs.

**4. Build Community Capacity to Address Environmental Conditions Locally**
Educate disproportionately impacted communities on the cumulative impacts and the land use and other decision-making processes that perpetuate exposure to multiple pollution sources in environmental justice communities. For example, build capacity of communities to participate in and influence decision-making processes, organize around polluting sites, and utilize regulatory agency complaint systems to gain the attention of local, state, and federal regulatory agencies to help ensure existing environmental rules are enforced; advocate for interagency coordination to address problematic sites.

# V. FOCUS AREA: Violence Prevention

### What the Data Says About the Issue

The American Public Health Association recognizes violence as a health issue, based on an understanding of violent behavior as arising from contextual, biological, environmental, systemic, and social stressors. Preventing violence is crucial for achieving positive results on health in the short and long term.

Violence affects everyone in LA County whether it is directly experienced, witnessed, or shared via newsfeed. Two key indicators of violence – deaths and medical visits, show the widespread extent of violence in the county. In 2019, suicide and homicide were respectively the 4th and 7th leading causes of premature death[16] in the county. They are consistent leading causes for the prior 10 years, but these indicators are the tip of the iceberg. For every person who dies from intimate partner violence, sexual violence, suicide, child abuse, elder abuse, gang violence, gun violence or hate violence or who suffers non-fatal injuries that require medical treatment and/or long-term physical or mental health care, there are many more incidents of violence or threats of violence that go unreported and uncounted. The data below provide a brief overview of recent data regarding homicide, firearm death, suicide, and gender-based violence.

#### Homicide Rates

During 2021, 275 Black residents of LA County died by homicide,[17] which is one-third of the 816 total homicides among county residents. As Blacks account for less than 8% of the county's population,[18] this reflects a disproportionately high homicide rate for Black residents (33.4 deaths per 100,000) compared to an overall county rate (8.1 per 100,000).[19] Rates for other racial ethnic groups (Figure 13) were also much lower with the next highest homicide rate seen among Latinx individuals (8.8 per 100,000) followed by Whites (2.7 per 100,000). Similar disparities are seen throughout California and the nation. In 2021, the homicide rate among Black California residents was 4.8 times higher than the overall state homicide rate; nationwide, the Black homicide rate was 4.4 times higher than the national homicide rate.[20] (Figure 14).

When further examining homicide rates, disparities are also seen among males and females and across all age groups. In LA County, homicide rates are far higher for males than females for both the Black and overall population. During 2021, males accounted for 88% (n=242) of homicides among the Black population and 87% (n=706) of the homicides among the overall county population. Among males, the Black homicide rate was 4.4 times higher than the county rate, while among females, the Black homicide rate was 3.7 times higher than the county rate. Similar patterns across age groups are seen for the Black and overall populations, with homicide rates highest among 25-44-year-olds (Figure 15). However, for each age group, the homicide rate among the Black population is 3 to 4 times higher than the homicide rate for the county overall. These disparities in homicide rates can be closely linked to our country's long history of racism and the current, ongoing marginalization, discrimination, and disinvestment that limits the opportunities and resources available to communities of color throughout LA County.

#### Firearm Mortality

During 2022, 836 Los Angeles County residents died from firearm injuries, for an age-adjusted mortality rate of 8.2 firearm deaths per 100,000 people. This is similar to the California rate of 8.6 firearm deaths per 100,000 people but substantially less than the US rate of 14.2 firearm deaths per 100,000 people.

Firearm mortality increased dramatically in the US, California, and LA County after the start of the COVID-19 pandemic (Figure 16).[21, 22] In the US, firearm mortality rates increased 23% from 2019 (11.9 per 100,000 people) to 2021 (14.6 per 100,000 people) and in California, firearm mortality rates increased 25% during the same period (from 7.2 to 9.0 deaths per 100,000 people). However, in LA County, firearm mortality rates increased by 46% from 2019 (6.3 per 100,000 people) to 2021 (9.2 per 100,000 people).

In LA County during 2022, most firearm deaths were homicides (60%), with suicides accounting for 37%.[20] This is quite different from the US overall, where 56% of firearm deaths were suicides and 41% were homicides.[21] Other firearm deaths including unintentional shootings, legal intervention (shootings by law enforcement officers), and deaths where the intent could not be determined make up the remainder of firearm deaths in both LA County and in the US.

Demographic patterns of firearm deaths are quite different for victims of firearm homicide and firearm suicides, except regarding gender. Males accounted for almost all firearm homicides (91%) and firearm suicides (92%) during 2022.[21] That same year, the average age of firearm homicide victims (33.8 years) was much lower than that of firearm suicide victims (51.1 years). Over half (58%) of all firearm homicide victims were under the age of 35, while 43% of firearm suicide victims were 55 years or older.[21] Patterns of firearm homicide (Figure 17) and firearm suicide (Figure 18) also varied by race/ethnicity.[20] For firearm homicides, mortality rates were highest among Blacks, followed by Latino/Latinx individuals, and Whites. For firearm suicides, rates were highest among Whites, followed by Blacks and Latino/Latinx individuals. We are unable to report rates for Asians, Native Hawaiians and Pacific Islanders, American Indians and Alaska Natives, and other racial and ethnic groups because of small numbers and the concern of confidentiality.

### Suicide Rates

Suicide is a leading cause of death in the United States (US) and in LA County. Since 2014 at least 800 LA County residents have died by suicide each year,[23] with preliminary data from 2022 showing that 828 LA County residents died by suicide.[24] Additionally, since 2009, every year more LA County residents have died by suicide than by homicide. While the suicide rate in LA County is lower than rates in California and the US overall (Figure 19), this is still far too many deaths.[25]

Suicides impact all populations. However, there are substantial differences in suicide rates by gender and race/ethnicity with mortality rates highest among males (12.6 per 100,000) and Whites (11.6 per 100,000) compared to a county overall suicide rate (7.8 per 100,000).

When looking at suicide rates by age group, elevated rates are seen among older age groups.[26] The highest rate was among 65+ year olds (11.3 per 100,000) compared to those under 20 years old (1.4 per 100,000). The rate jumps significantly higher for adults 20+ years old to 9.5 per 100,000 (Figure 20). There are also geographic differences (Figure 21) in suicide rates within LA County, with the highest rates in the Antelope Valley (Service Planning Area 1) and Metropolitan Los Angeles (Service Planning Area 4) and the lowest in South Los Angeles (Service Planning Area 6).[27]

In LA County during 2022, firearms (n=313) and suffocation/hanging (n=292) were the most common methods of suicide, accounting for nearly three quarters of all suicide deaths. Poisoning, including drug overdoses (n=91) was the next most common method. Some differences in suicide rates may be

partially related to the prevalence of firearm ownership and/or the strength of gun laws within the local, state, and national populations. Firearms are an extremely lethal means of suicide; suicide attempts with a gun are fatal 90% of the time, while attempts with other methods are fatal 4% of the time.[28] In LA County during 2022, 38% of suicide victims died from firearm injuries,[29] which is similar to California. Nationally, however, 55% of all suicide victims died from a firearm injury.[30]

Finally, it is important to note that suicide is one part of a complex spectrum of suicidal behaviors impacting LA County residents. The demographic patterns of individuals experiencing nonfatal suicide attempts and other suicidal ideation and behaviors is different from that of victims of suicide. While suicide is more common among older age groups, youth aged 10-24 are hospitalized for non-fatal suicide attempts at a rate two times higher than 55+ year olds and are treated in emergency departments for non-fatal suicide attempts at a rate 10 times higher than 55+ year olds.[31]

## Gender-based Violence

Many forms of gender-based violence impact LA County residents. These include rape and sexual assault, intimate partner violence, hate crimes, and human trafficking. Many of these forms of violence are substantially underreported in our existing data systems, so the data presented here should be interpreted with caution.

### *Intimate partner violence*

Data from the 2023 LACHS shows that females report higher levels of all forms of intimate partner violence than males. Additionally, individuals identifying as gender non-binary/non-conforming/Queer are even more likely to report experiencing intimate partner violence. Data on transgender males and transgender females could not be reported due to small numbers and confidentiality.[32] See Figure 22 for data on adults experiencing different forms of violence by an intimate partner.

Gender differences by type of violence were greatest for unwanted sex; females reported experiencing unwanted sex by an intimate partner over 5 times as often as males, while gender non-binary/non-conforming/Queer individuals reported experiencing unwanted sex by an intimate partner more than 20 times as often as males.

While there were consistent statistically significant differences by gender identity in reported intimate partner violence, survey results by age group and race/ethnicity were less consistent with fewer clear differences. Asians were less likely than all other racial/ethnic groups to report ever experiencing physical violence, stalking, and being called names, insulted, humiliated, or intimidated by an intimate partner. Asians were also less likely than all other racial/ethnic groups to report an intimate partner ever trying to control them. Individuals who identified as multi-racial were more likely than all other racial/ethnic groups to report experiencing unwanted sex and being called names, insulted, humiliated, or intimidated by an intimate partner.

It is important to note that the data shared above is self-reported survey data. Due to stigma in different populations, different groups may be more or less likely to report incidents of intimate partner violence. The comparisons reported here between different populations may be driven by differences in reporting in addition to actual differences in experiencing intimate partner violence.

### *Rape/sexual assault*

Between 2015 and 2022, an average of over 4,000 rapes and attempted rapes were reported to law enforcement agencies in LA County each year.[33] See Figure 23 for more details on the number of rapes

reported in Los Angeles County. According to the National Crime Victimization Survey, in 2022 only 21.4% of rapes/sexual assaults were reported to law enforcement.[34] If we apply this to the number of reported rapes/attempted rapes in LA County during 2022, we estimate there may be more than 18,000 rapes/attempted rapes countywide that year. However, there are likely additional geographic and demographic disparities not reflected in this simple estimation.

### DPH Actions and Partners

The strategies identified in this section were informed by a continuous process of community engagement. The Office of Violence Prevention (OVP) engaged its County Leadership Committee and Community Partnership Council and conducted regional listening sessions and review of best practices to inform the 2020-2024 strategic plan priorities. The current priorities build on the work completed to date from the early implementation of the program strategic plan and are informed by input from OVP's Regional Violence Prevention Councils, Trauma Prevention Initiative Community Action for Peace networks, and County Board of Supervisors priorities based on recent motions. Additionally, OVP seeks input from other County departments from multiple sectors working on violence prevention and intervention, community leaders, survivors of violence from across the county, and communities most impacted by violent crime. OVP is in the process of conducting community engagement efforts to inform the 2025-2030 strategic plan. This collaborative process will also help update this CHEIP focus area as needed to reflect new or updated efforts in LA County.

The table below outlines a set of strategies and the partners that will guide the plan's implementation. Refer to Appendix B for additional information, including time-framed work plan activities and developmental performance measures.

**Results Statement:**
All families and communities in Los Angeles County live free of violence and thrive in a culture of peace.

**Measurable Goals:**
1. Reduce the gap in homicide rates between African Americans and the Los Angeles County average by 20% in five years.
2. Reduce the number of adult women and gender diverse/expansive people who report ever experiencing physical violence by an intimate partner by 10% in five years.

| **Population Indicators** | Los Angeles County |
|---|---|
| **Gap in homicide rates between African Americans and the LA County average homicide rate in 2021.**<br>*Data Source: Los Angeles County Department of Public Health Office of Violence Prevention. Linked Mortality Data File, OHAE* | **Rate Gap: 25.3 per 100,000**<br>***(LA County 8.1 per 100,000***<br>***Black/African American 33.4 per 100,000)*** |
| **Number of assault-related trauma hospital visits in 2021**<br>*Data Source: Los Angeles County Department of Public Health Office of Violence Prevention* | **5,090** |
| **2021 Suicide Rate among Los Angeles County Residents**<br>*Data Source: Los Angeles County Department of Public Health Office of Violence Prevention. Linked Mortality Data File, OHAE* | **7.8 per 100,000** |
| **Estimated number of females, transgender females, and gender non-binary/con-confirming/queer individuals who reported ever experiencing physical violence by an intimate partner.**<br>*Data Source: 2023 Los Angeles County Health Survey Data* | **448,000** |

## Focus Area Strategies and Partners

Refer to Appendix B to see work plan activities and developmental performance measures.

### Useful and Inclusive Data

| | |
|---|---|
| **Strategy 1:**<br>By June 2025, create a centralized open data portal with metrics to evaluate progress on OVP strategic plan goals and objectives. | **Partners**<br>• County departments – data providers, advisors<br>• Community organizations – advisors, collaborators<br>• Public Health – Data portal development lead |

### Policy and Systems Change

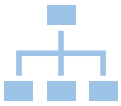
| | |
|---|---|
| **Strategy 2:**<br>By January 2026, establish a Sexual Assault Council to improve coordination across county systems and service providers to improve services to survivors of sexual assault and invest in prevention programs. | **Partners**<br>• Sexual Assault Council – lead strategic plan development<br>• Community Based Organizations – council members, advisors<br>• Health Care Organizations – contributors<br>• Mental Health Providers – council members, advisors<br>• Law Enforcement – council members, advisors<br>• Survivors – advisors, members<br>• Advocates – advisors, members<br>• Public Health – lead convenor |

### Building Partnerships

| | |
|---|---|
| **Strategy 3:**<br>By July 2026, expand initiatives and services to address gender-based violence across the lifespan by strengthening inter-agency collaboration. | **Partners**<br>• Community organizations – lead prevention programming<br>• County partners – coordination and policy development<br>• Public Health – lead training development & coordination |
| **Strategy 4:**<br>By June 2027, expand place-based community-driven public safety efforts through the Trauma Prevention Initiative (TPI), including Street Outreach and Community Violence Intervention (CVI), Hospital Violence Intervention (HVIP), and Community Action for Peace networks by 1) increasing investment in nine communities, and 2) building infrastructure for peer violence intervention training and county services alignment. | • Trauma Prevention Initiative network partners – TPI programming lead<br>• LA County Parks and Recreation – park programming lead<br>• County departments – collaborators, referral partners<br>• Community leaders – advisors<br>• Survivors of violence/Advocates – advisors<br>• Public Health – convenors, fiscal lead |

| | |
|---|---|
| **Strategy 5:**<br>By June 2025, implement a comprehensive plan to promote firearm safety through community education and awareness, policy change, and peer approaches. | • Regional Violence Prevention Coalitions – lead convenors in each region<br>• Trauma Prevention Initiative networks – advisors<br>• County departments – advisors, strategy implementation<br>• Community leaders – advisors, policy contributors<br>• Survivors of violence/Advocates – advisors, trained peers, policy contributors<br>• Public Health – data and webpage lead, gun safety locks coordination |

## Organizational Readiness



| | |
|---|---|
| **Strategy 6:**<br>By June 2026, implement trauma-informed systems and practice change among County departments and community partners to promote healing and wellbeing and to support the unique needs of local communities. | **Partners**<br>• Trauma Prevention Initiative Community Action for Peace networks – collaborators<br>• County departments – collaborators<br>• Public Health – lead capacity development & coordination |
| **Strategy 7:**<br>By June 2026, develop a coordinated communications strategy to promote a shared understanding of violence and violence as a public health issue. | • County Leadership Committee – advisors<br>• Community Partnership Council – advisors<br>• LA County Medical Association – collaborator, media campaign contributor<br>• LA Care Health Plan – collaborator, media campaign contributor<br>• Public Health – lead communications management |
| **Strategy 8:**<br>By June 2025, implement local efforts to prevent suicide and suicidal behavior among populations demonstrated to be at increased risk including youth, communities of color, veterans, and firearm owners. | • California Department of Public Health – advisors and collaborators<br>• Local suicide prevention organizations – advisors, contributors, collaborators<br>• Veteran organizations – collaborators, coordinators, advisors<br>• Youth focused organizations – collaborators, advisors, and contributors<br>• Public Health – lead convenor, program management<br>• County Departments – advisors, collaborators<br>• School Districts, advisors, collaborators |

## Collaborative Actions

It takes all of us working together to prevent violence and to support emotional, social and economic well-being for all. Below are additional strategies to take to eliminate violence in LA County and foster a culture of peace.

1. **Contribute to Inclusive Research and Data**
   - Identify and share data to address gaps in data and deepen the understanding of multiple forms of violence, including gun violence, suicide, hate violence, domestic violence, sexual violence and human trafficking.
   - Support efforts to collect qualitative data to gain a deeper understanding of the circumstances of violence and the impact of healing-informed and community-centered practices like peer approaches and storytelling to amplify the voices of those affected by violence and supporting community-based participatory research.

2. **Advocate for Policy and Systems Changes**
   - Support and implement policies and practices that advance trauma-informed approaches, healing practices, and reduce elements of racism and bias. Additionally, support processes where survivors and community members, including youth, can inform and participate in the development of such policies and practices.
   - Support and implement policies and practices that make funding more accessible to grassroots community-based organizations to help advance equity, including partnering with fiscal agencies, streamlining, and simplifying contract requirements, examining county insurance requirements, in addition to funding technical assistance initiatives that build the capacity of grassroots organizations.

3. **Engage and Support Community-Driven Programs and Priorities**
   - Support the development of programs such as holistic and culturally relevant youth centers that offer resources and services, build youth leadership, and advance the arts, healing, and restorative justice; and support existing community-based and trauma-informed initiatives such as the county's Trauma Prevention Initiative and Parks After Dark and city initiatives such as the Gang Reduction Youth Development Program, particularly in communities with high levels of violence.
   - Engage with community-based organizations and partners in regional violence prevention coalitions and community action for peace networks to support local leadership and collaboration, create shared knowledge on root causes of violence, a public health approach, trauma and healing, racism, and historical oppression as part of local prevention plans.
   - Align initiatives that support the health, healing, and well-being of communities in communities impacted by violence, such as the Trauma Prevention Initiative communities, to build a holistic, place-based approach tailored to the needs and assets of each community. Identify additional resources and partnerships to distribute free gun safety locks across the county.

4. **Invest in Organization Transformation Initiatives:**
   - Invest in trauma-informed systems change including trainings for the workforce at all levels, training for youth and organizations working with youth, and aligning organizational

practices and policies that support staff, provide resources, and address vicarious trauma and compassion fatigue.

- Invest in programs and initiatives by providing resources and offering flexible funding that enables quick responses, encourages new and creative strategies, and the ability to adapt to the latest social circumstances and political and physical environments.
- Provide resources and dedicated, ongoing funding to sustain and expand programs such as Parks After Dark, Summer Night Lights, Crisis Response, Street Outreach and Hospital Violence Intervention Programs (HVIPs) in trauma centers in communities where there are high levels of violence.
- Invest in coordinated communications campaign to support violence as a public health issue that is preventable and develop common messaging and innovative ways to engage diverse stakeholders impacted by violence.

## Conclusion

Throughout this plan, strategies and additional actions have been highlighted to show how LA County can make an impact on reducing infant and maternal mortality, STIs and congenital syphilis, exposure to environmental hazards, and violence. For each of these focus areas, the data has illustrated the current state of the issue and the desired results to achieve. These results cannot be achieved working in silos. Change requires the collective will and commitment of Public Health and partners. We hope this plan offers a roadmap of sorts that can be collectively used for reducing health inequities by addressing root causes of disproportionality in health outcomes.

# Acknowledgements

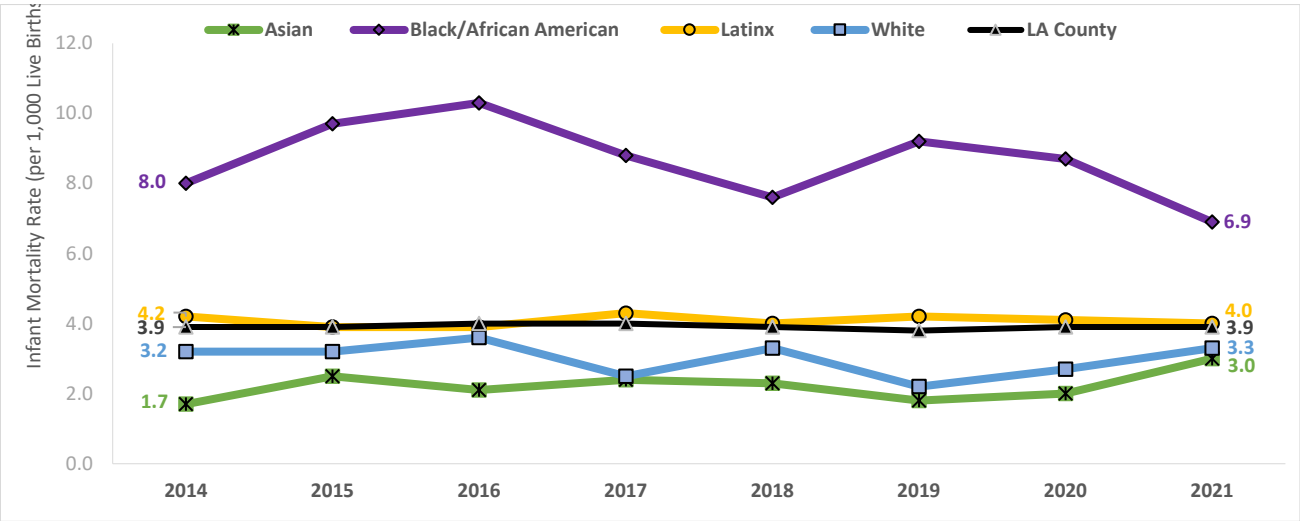
Public Health would like to give a special thanks all the individual and collective partners who have come together for the betterment of Los Angeles to take part in strategies that will make a positive difference in the lives of Los Angeles residents.

Thank you also to the staff in Office of Violence Prevention, Office of Environmental Justice and Climate Health, Division of HIV & STD Programs, and Maternal Child and Adolescent Health Programs within the Department of Public Health for leading these collaborative efforts for the department, and the Office of Health Assessment & Epidemiology, Quality Improvement & Accreditation Program, and Government Affairs for your review and support.

# Appendix A – Focus Area-Specific Graphs

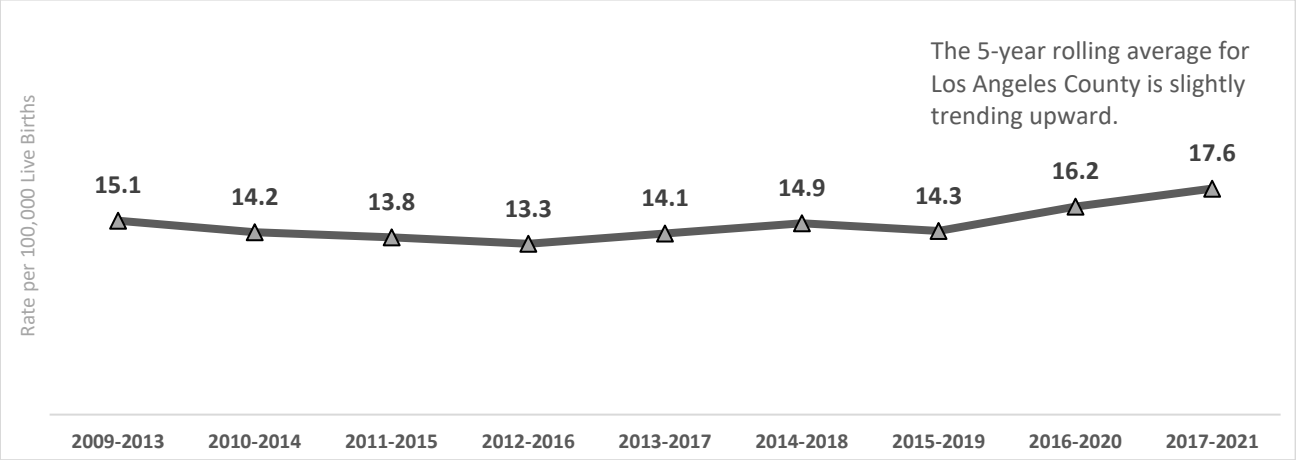
## Focus Area – Black/African American Infant and Maternal Health

**Figure 4: Infant Mortality Rate (infant deaths/1,000 live births) by Mother's Race/Ethnicity and Year, Los Angeles County 2014-2021.**



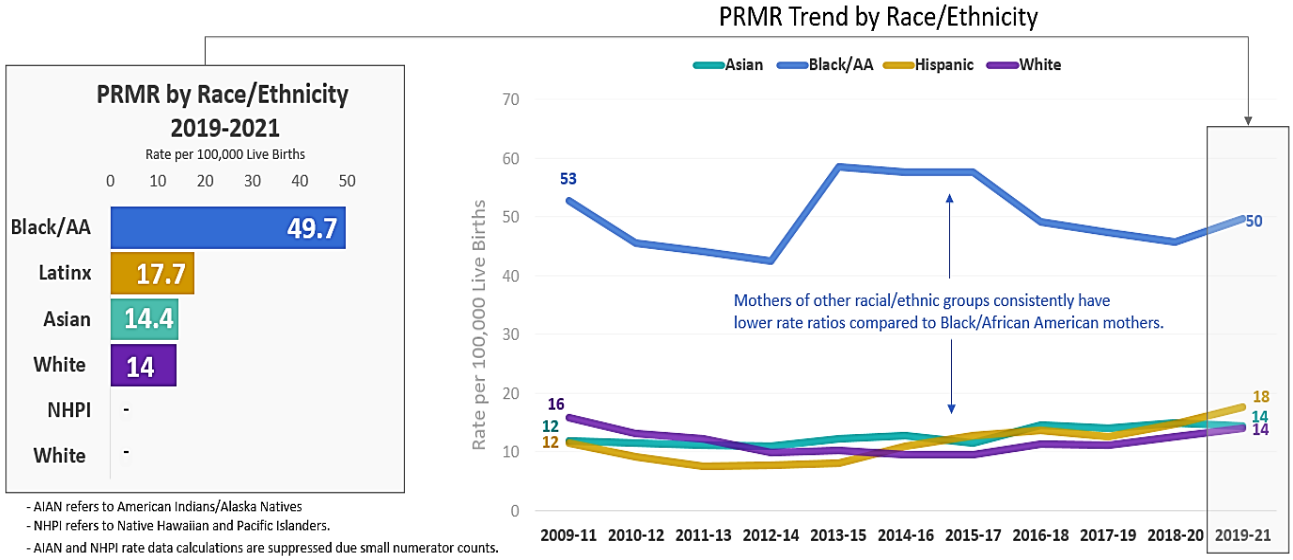

*Notes: Infant Mortality rate is defined as the number of deaths to infants within the first year of life per 1,000 live births. Data not shown for Native Americans, Pacific Islanders, Other and Unknown races. Data Source: 2014-17 California Department of Public Health, Birth and Death Statistical Master 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.*

**Figure 5: Pregnancy-Related Mortality Ratio (5-year Rolling Averages), Los Angeles County 2009-2021**



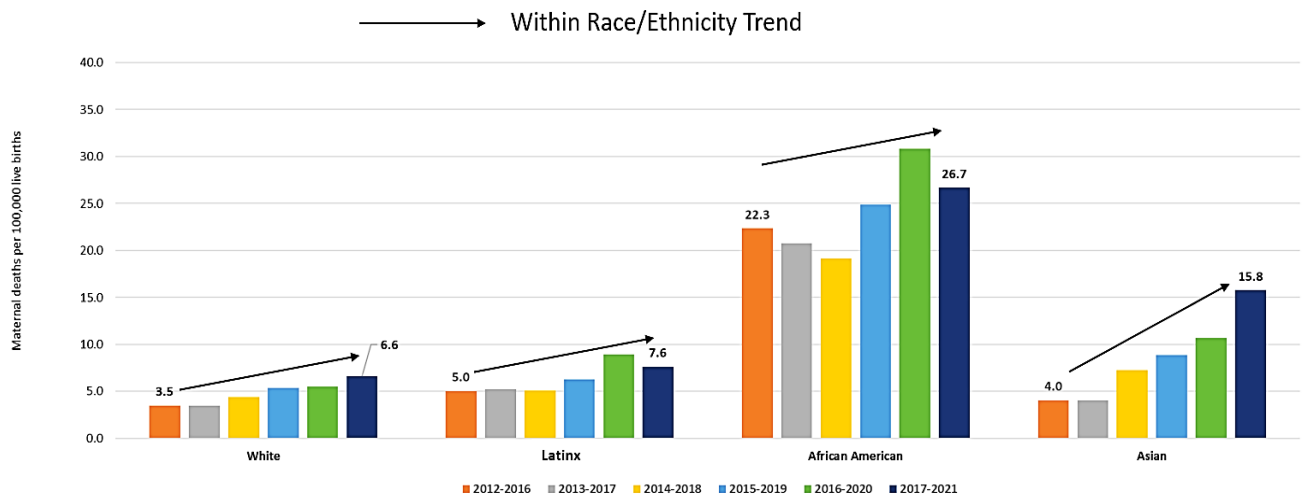

*California Department of Public Health, Birth Statistical Master File, 2009–2017: Compiled from information on birth certificates, including demographic information related to the infant and parents, as well as medical data related to the birth. California Department of Public Health, California Comprehensive 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.*

**Figure 6: 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*

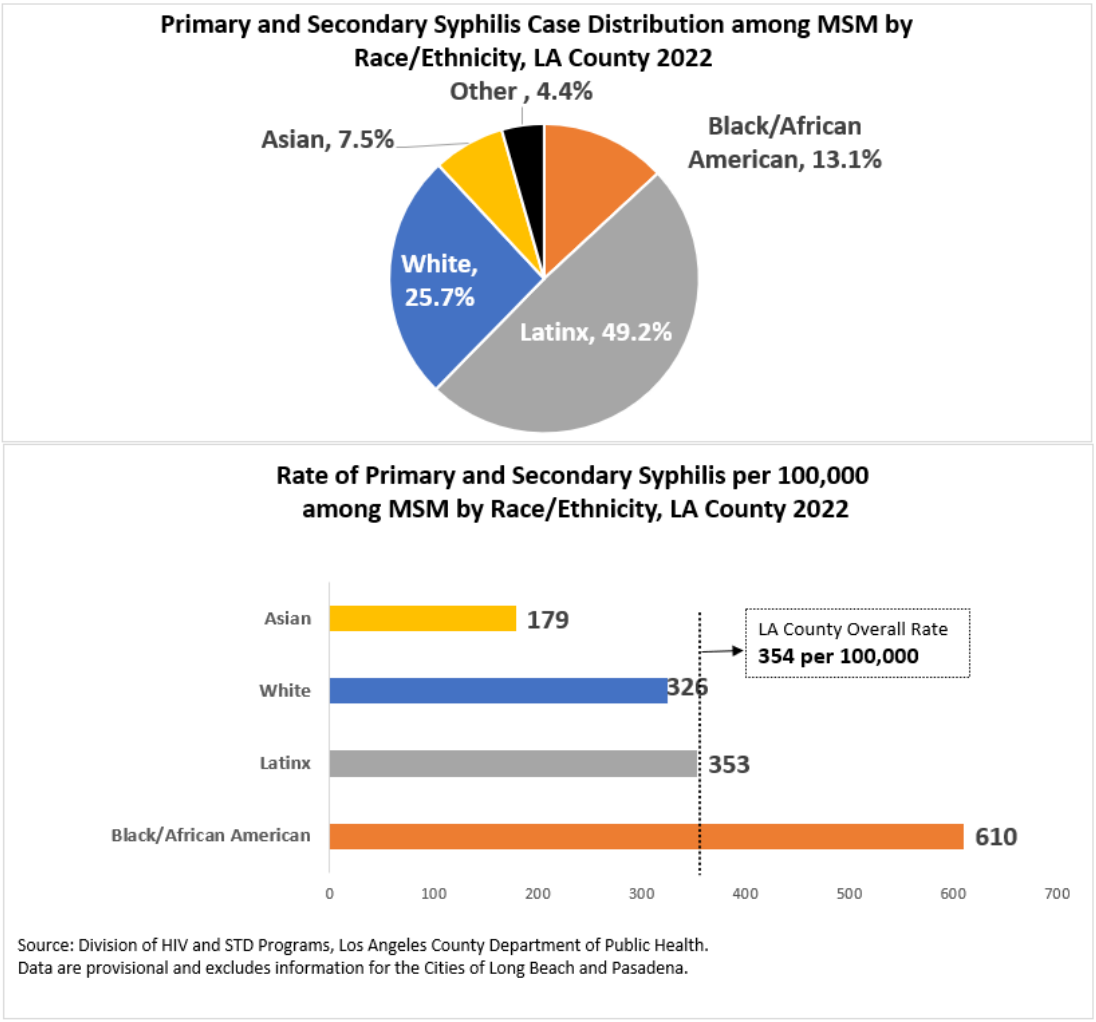
**Figure 7: Maternal Mortality Ratio (5-year Rolling Average) by Race/Ethnicity, Los Angeles County 5-year Moving Averages, 2012-2021**




*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 Indians/Alaska Natives, Native Hawaiians/Pacific Islanders, 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 .*

## Focus Area Sexually Transmitted Infections and Congenital Syphilis

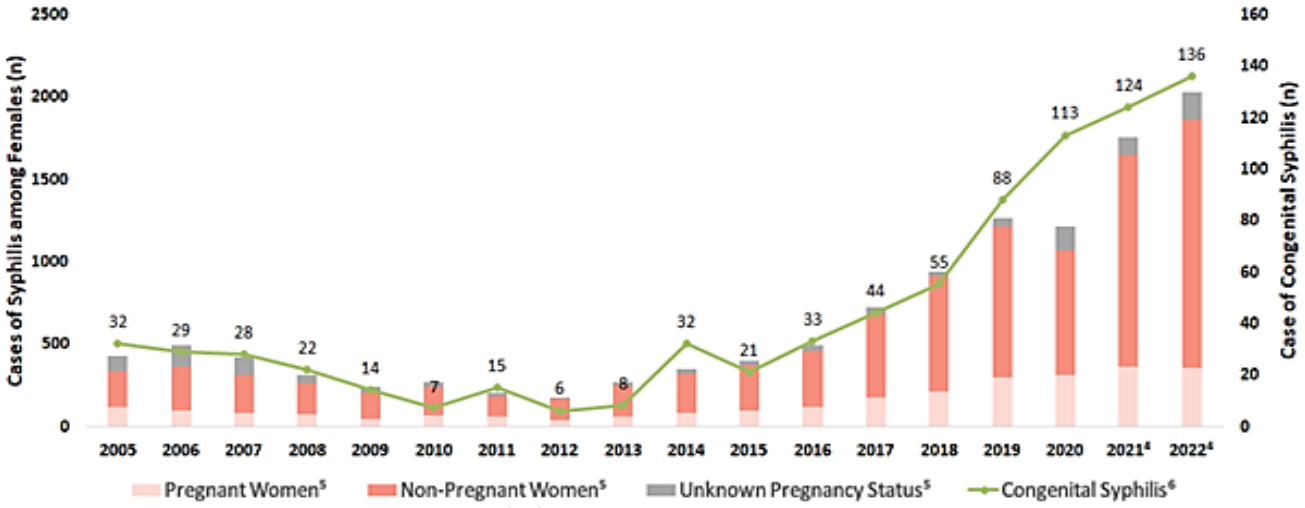
**Figure 8a: Primary and Secondary Syphilis Case Distribution and Rates per 100,000 among MSM by Race/Ethnicity, Los Angeles County 2022.**




Note that there are multiple limitations to the MSM rates provided:

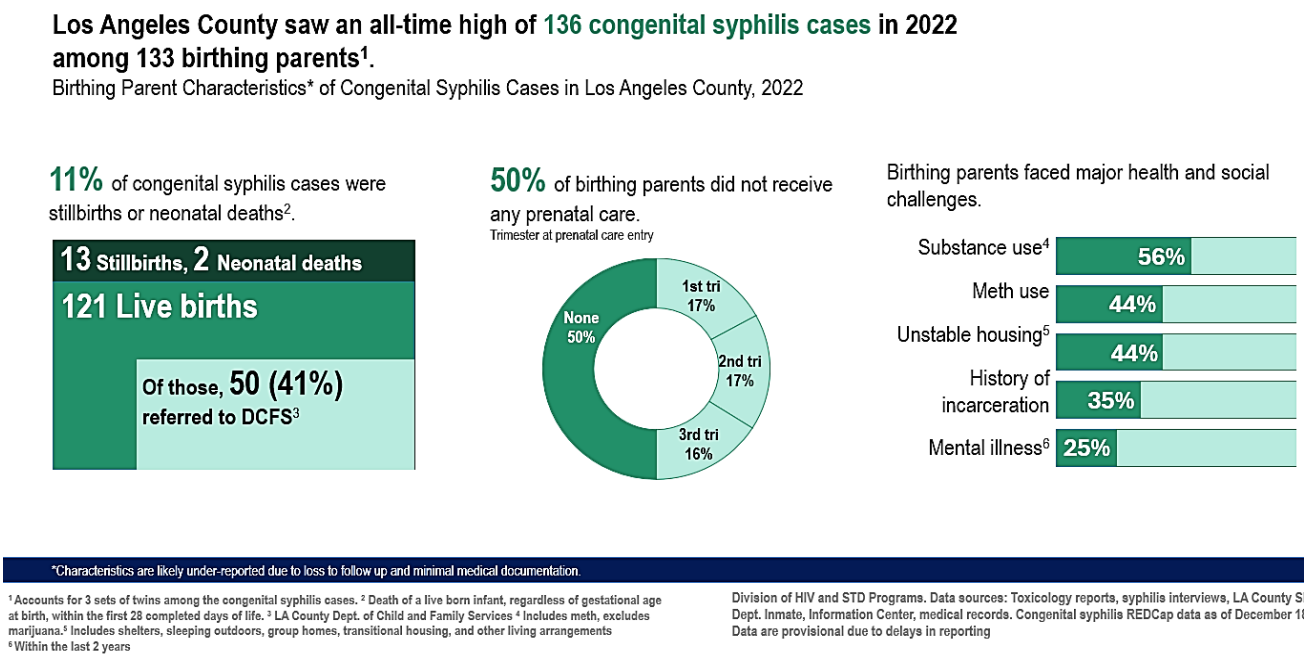
1. 2022 population estimates are provisional. 2. MSM denominators are not available through Census data. 3. MSM denominators were estimated based on Grey et al. (2016) which estimated 6.9% of LA County male population to be MSM. 4. MSM denominators by race/ethnicity were estimated based on 6.9% of racial/ethnic breakdown of male population. 5. 17% of sexual behavior data are missing for males.

**Figure 8b: 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. Los Angeles County Department of Public Health, Division of HIV and STD Programs.

**Figure 9: Congenital Syphilis Cases by Birthing Parent Characteristics*, Los Angeles County, 2022.**



## Focus Area Environmental Justice

For more information and mapping please visit the CalEnviroscreen website at https://oehha.ca.gov/calenviroscreen/report/calenviroscreen-40.

**Figure 10a: CalEnviroScreen 4.0 Environmental Hazard Assessment for the Highest Pollution-Burdened Los Angeles County Census Tracts that fall in the Top 25th Percentile of Statewide Pollution Burden.**

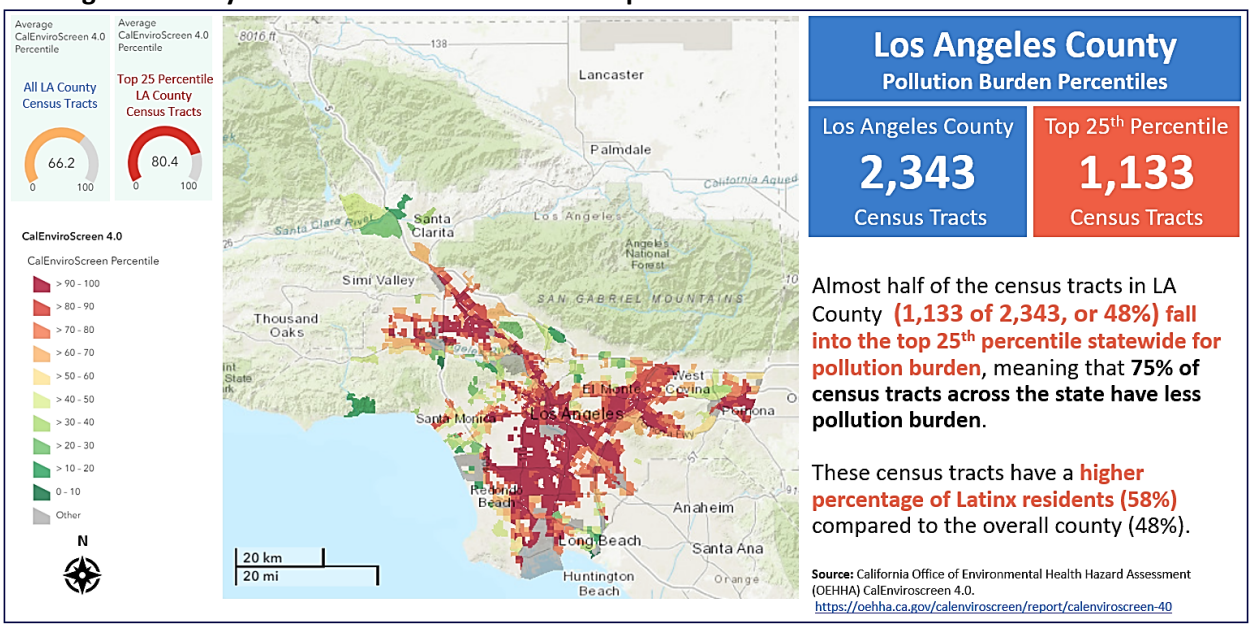



**Figure 10b: CalEnviroScreen 4.0 Particulate Matter percentiles for All Los Angeles County Census Tracts**

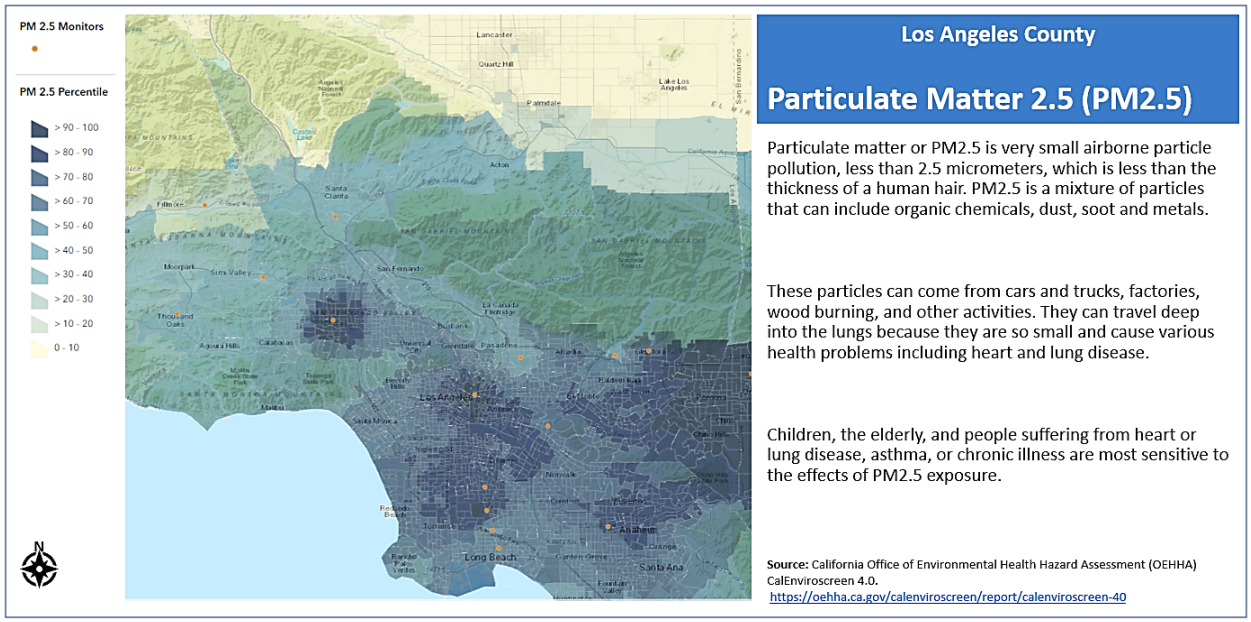


**Figure 11a: CalEnviroScreen 4.0 Environmental Hazard Assessment for the Highest Toxic Release Burdened Los Angeles County Census Tracts that fall in the Top 25th Percentile of Statewide Toxic Release Burden.**

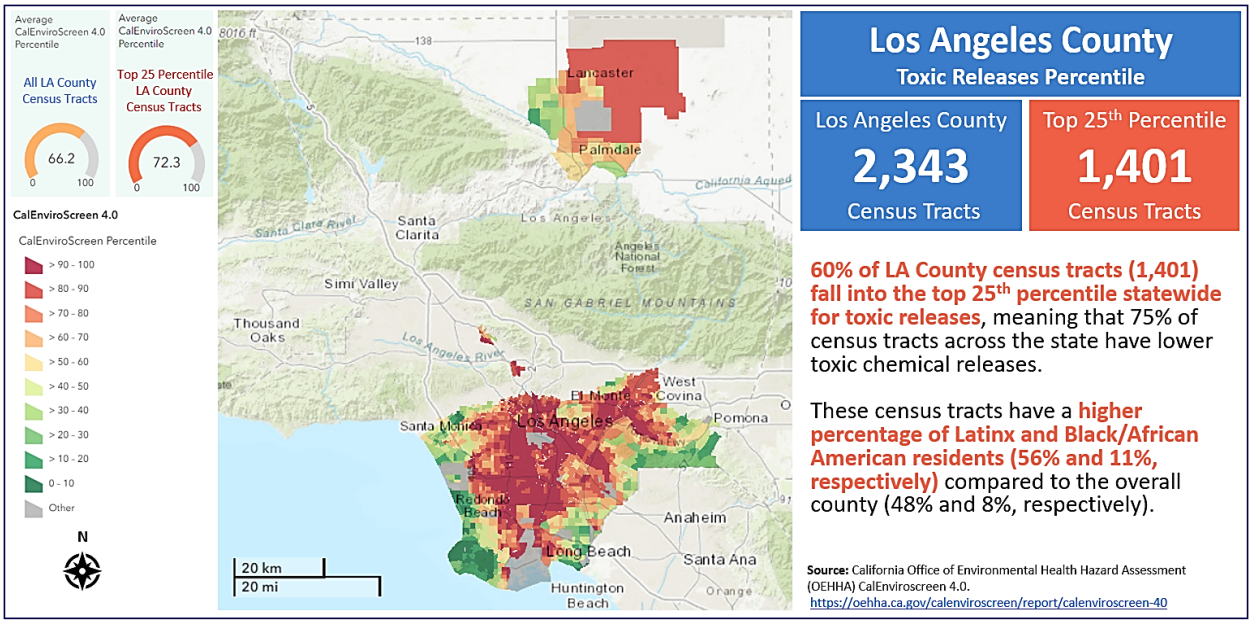



**Figure 11b: CalEnviroScreen 4.0 Toxic Releases from Facilities in Los Angeles County Census Tracts**

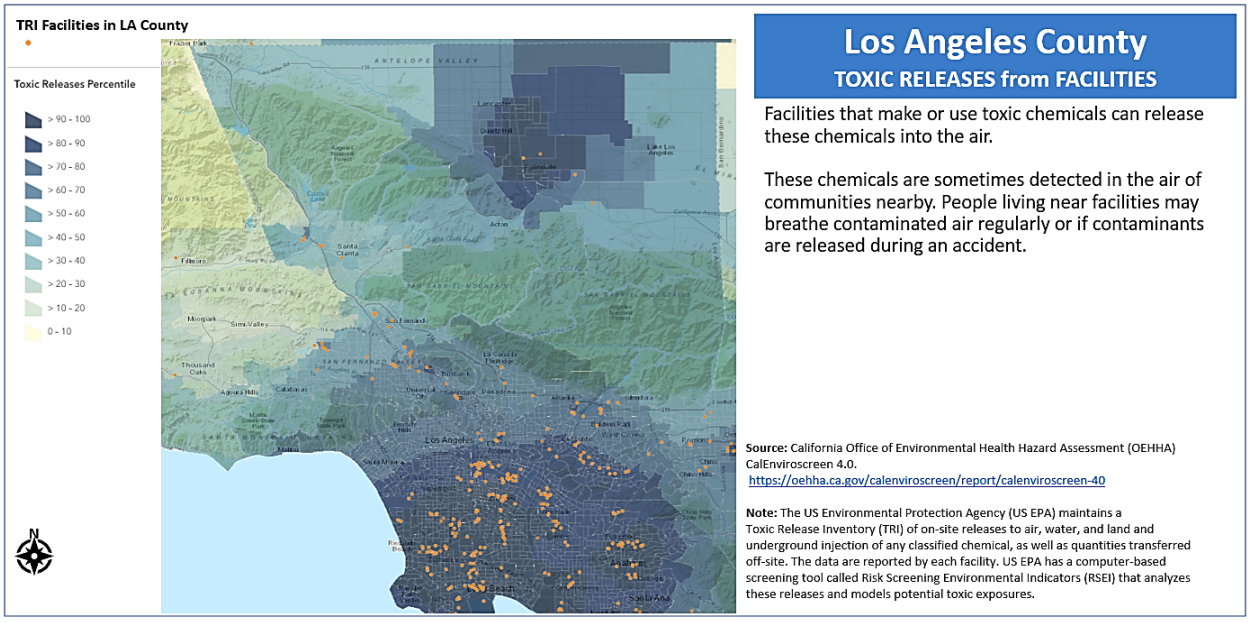
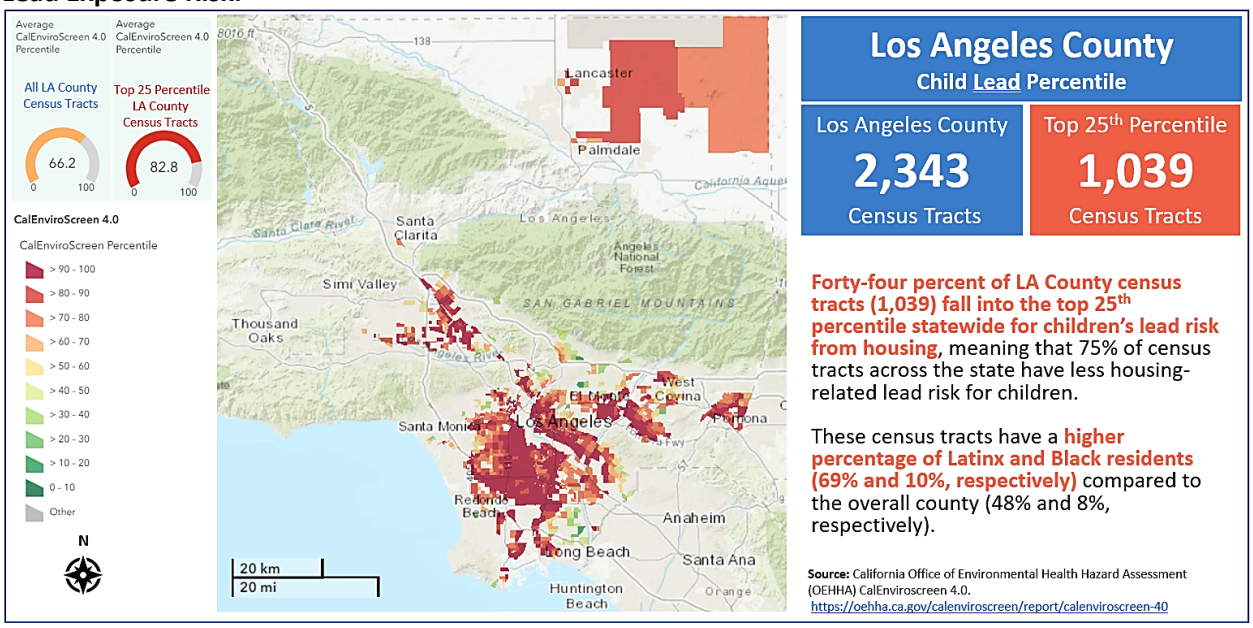
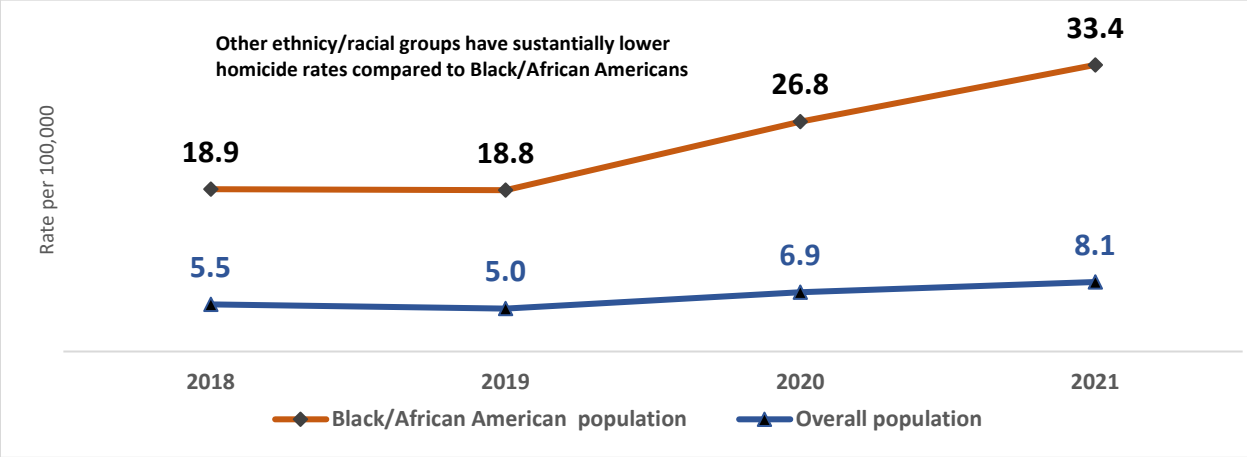


**Figure 12: CalEnviroScreen 4.0 Environmental Hazard Assessment for the Highest Child Lead Exposure Risk from Housing in Los Angeles County Census Tracts that fall in Top 25th Percentile of Statewide Lead Exposure Risk.**



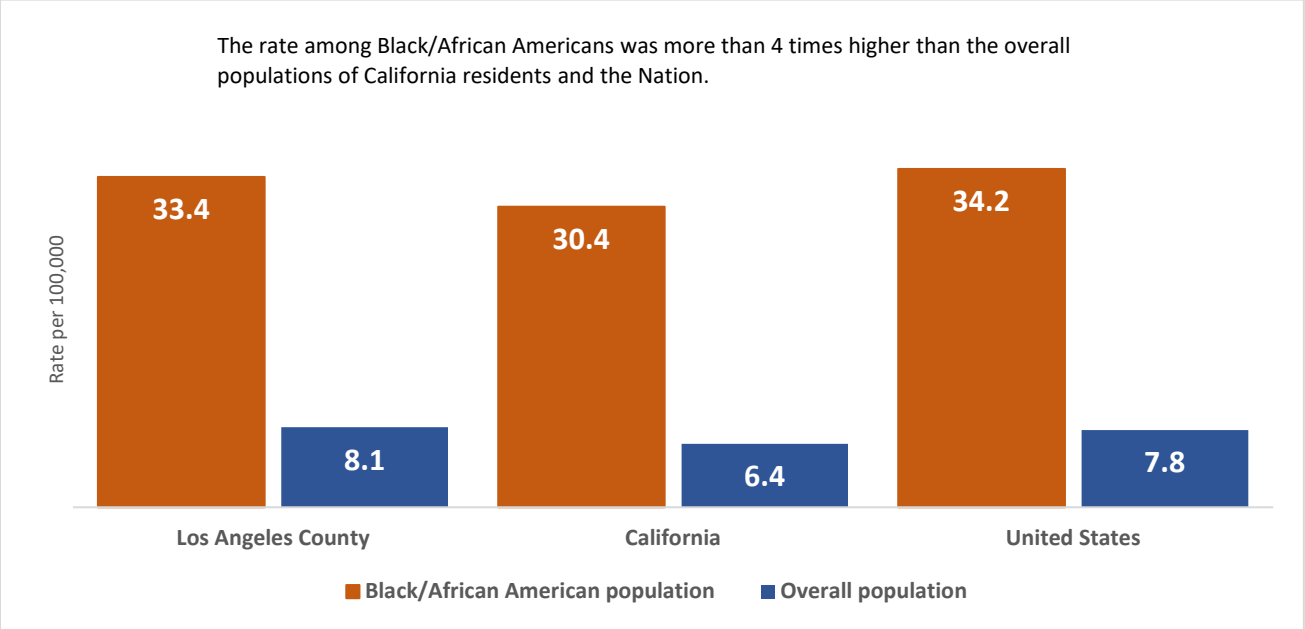

## Focus Area Violence Prevention

**Figure 13: Homicide Rates for the Black Population and the Overall Population by Year, LA County, 2018-2021.**



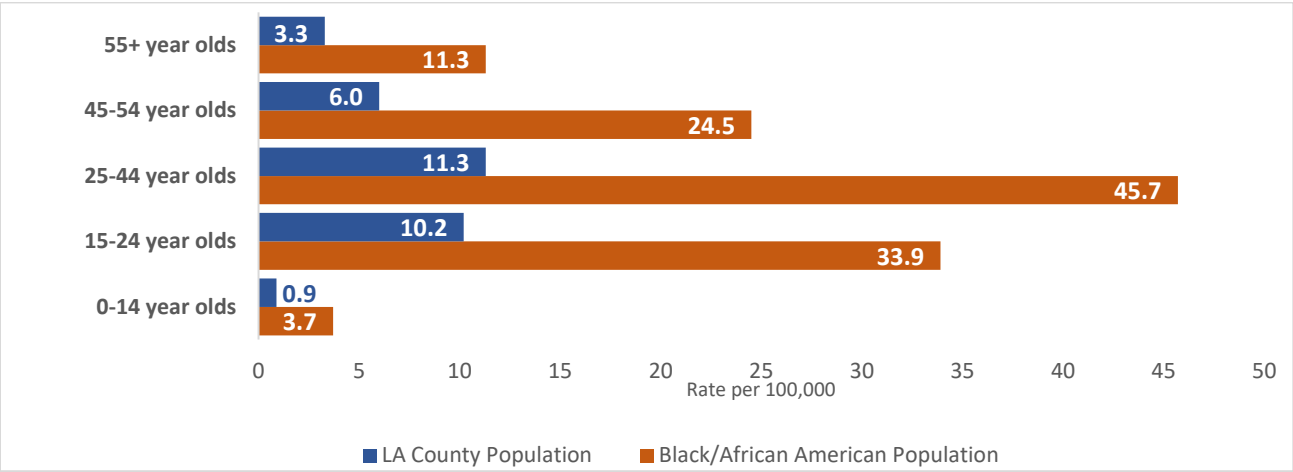

*Source: Los Angeles County Department of Public Health, Office of Violence Prevention. Los Angeles County Annual 2021 Data File, assembled from California Department of Public Health Vital Records Data. Office of Health Assessment & Epidemiology, Los Angeles County Department of Public Health. Population estimates from County of Los Angeles, Internal Services Department, Information Technology Service, Urban Research-GIS Section.*

**Figure 14: Homicide Rates for the Black Population and the Overall Population During 2021 in Los Angeles County, California, and the United States**



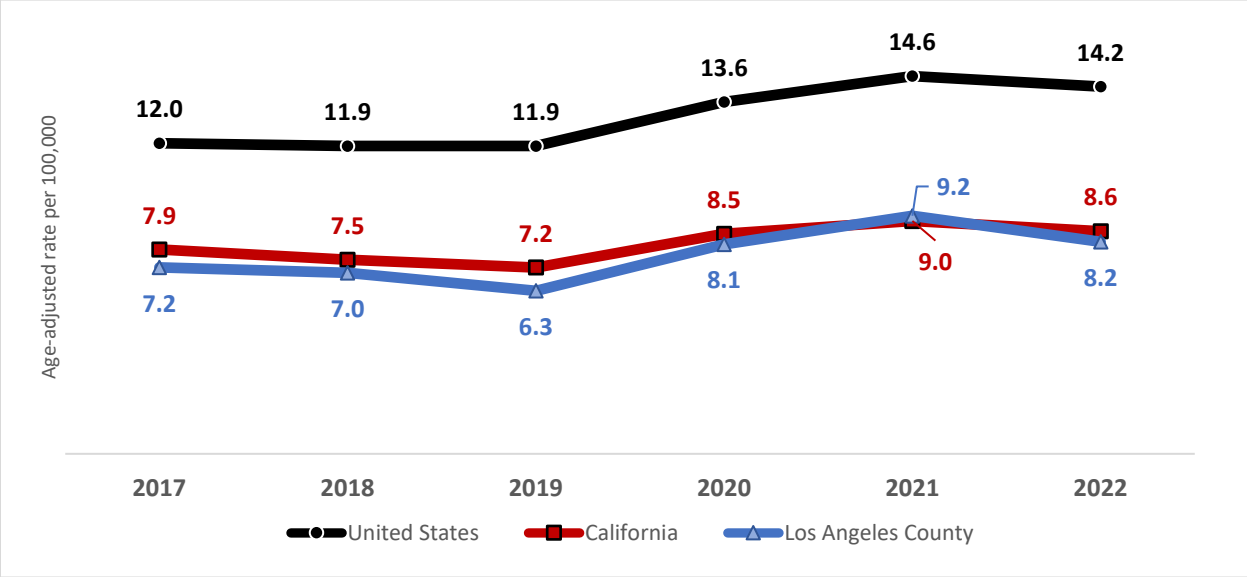

*Source: Los Angeles County Department of Public Health, Office of Violence Prevention. Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Mortality 2018-2021 on CDC WONDER Online Database, released in 2021. Data are from the Multiple Cause of Death Files, 2018-2021, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/ucd-icd10-expanded.html on Mar 29, 2024 5:11:24 PM*

**Figure 15: Homicide Rates for the Black Population and the Overall Population by Age Group, LA County, 2018-2021**



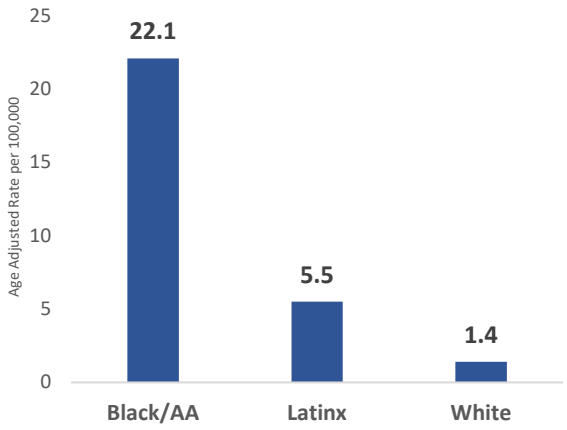

*Source: Los Angeles County Department of Public Health, Office of Violence Prevention. Los Angeles County Annual 2021 Data File, assembled from California Department of Public Health Vital Records Data. Office of Health Assessment & Epidemiology, Los Angeles County Department of Public Health. Population estimates from County of Los Angeles, Internal Services Department, Information Technology Service, Urban Research-GIS Section.*

**Figure 16: Overall Firearm Mortality Rates for the United States, California, and Los Angeles County, 2017-2022**



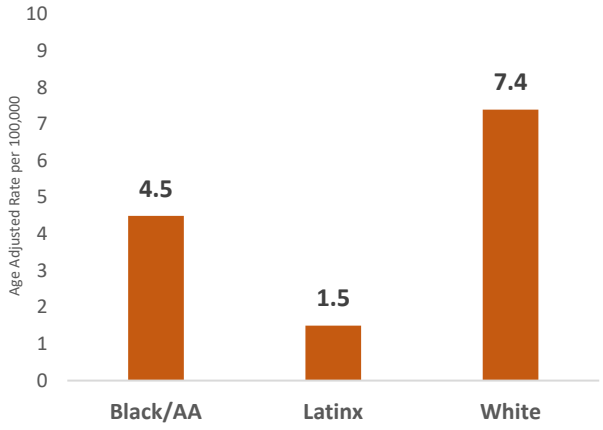

*Source: Los Angeles County Department of Public Health, Office of Violence Prevention. Los Angeles County 2022 Data File (Provisional), assembled from California Department of Public Health Vital Records Data. Office of Health Assessment & Epidemiology, Los Angeles County Department of Public Health. Population estimates from County of Los Angeles, Internal Services Department, Information Technology Service, Urban Research-GIS Section. CDC, NCHS. National Vital Statistics System, Data on CDC WONDER Online Database, released in 2021. Data are from the Multiple Cause of Death Files, 1999-2020, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program.*

**Figure 17. Firearm Homicide Rates by Race/Ethnicity, Los Angeles County Residents, 2022 (N = 500)***




* Rates are not reported for Asians, Native Hawaiians and Pacific Islanders, American Indians and Alaska Natives, and other groups because of small numbers.

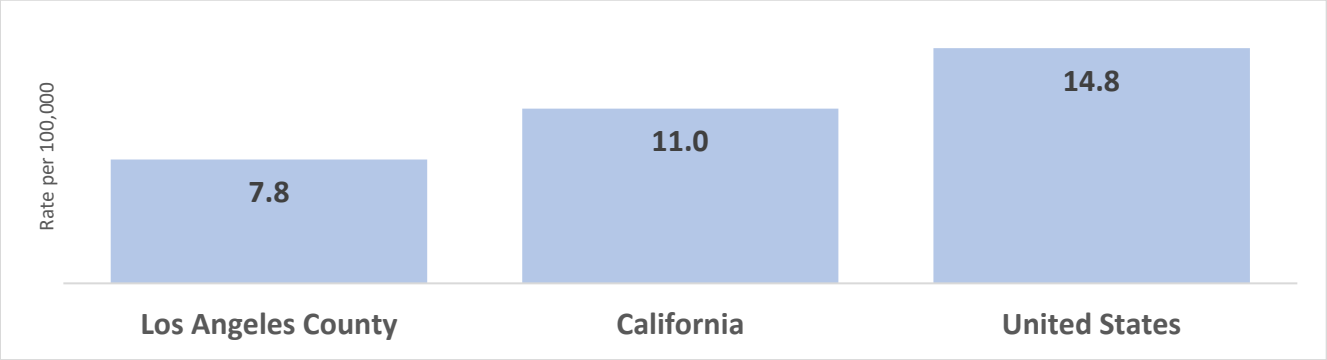
**Figure 18. Firearm Suicide Rates by Race/Ethnicity, Los Angeles County Residents, 2022 (N= 313)***




* Rates are not reported for Asians, Native Hawaiians and Pacific Islanders, American Indians and Alaska Natives, and other groups because of small numbers.

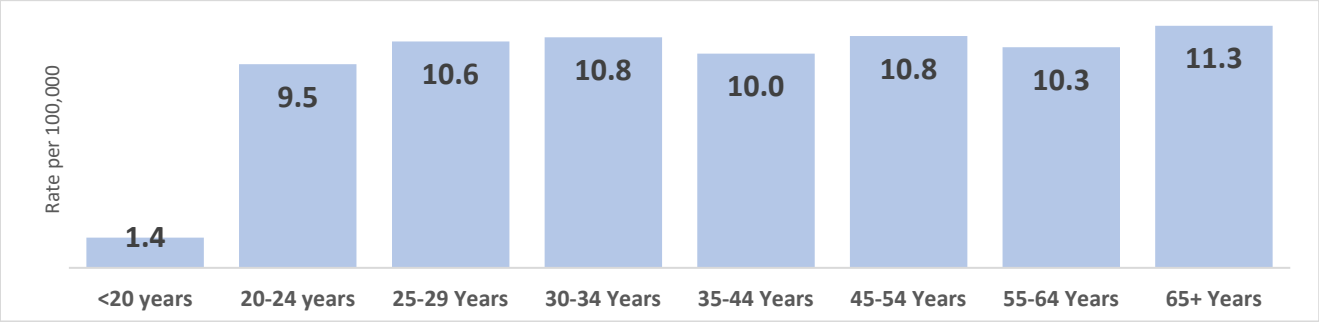
*Source: Los Angeles County Department of Public Health, Office of Violence Prevention. Los Angeles County 2022 Data File (Provisional), assembled from California Department of Public Health Vital Records Data. Office of Health Assessment & Epidemiology, Los Angeles County Department of Public Health. Population estimates from County of Los Angeles, Internal Services Department, Information Technology Service, Urban Research-GIS Section.*

**Figure 19: Suicide Rates During 2022 for Residents of Los Angeles County, California, and the United States**



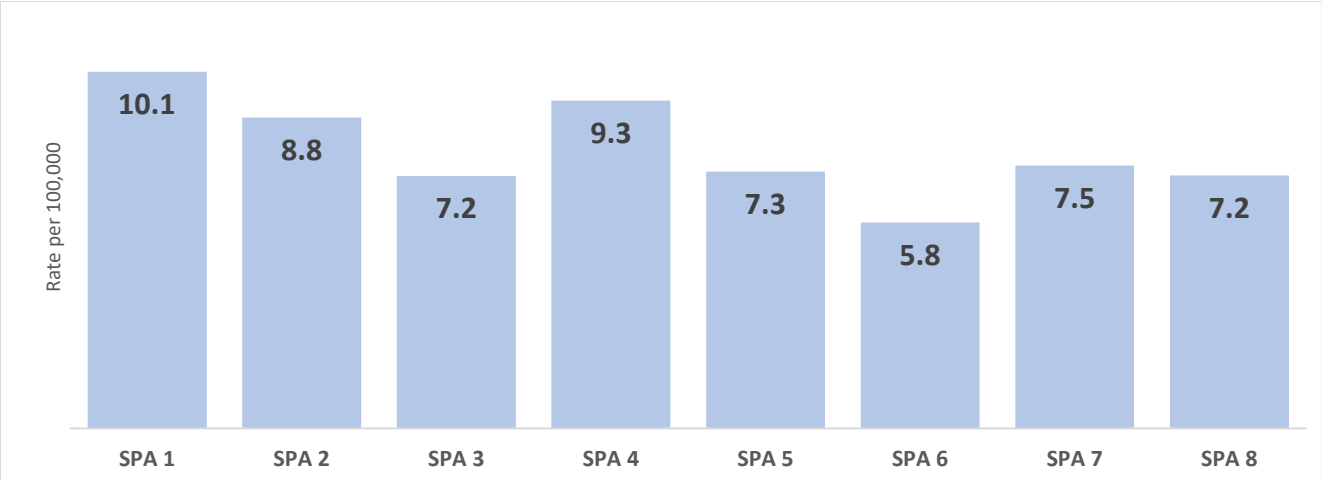

*Source: Los Angeles County Department of Public Health, Office of Violence Prevention. Los Angeles County Annual 2022 (Provisional) Data File, assembled from California Department of Public Health Vital Records Data. Office of Health Assessment & Epidemiology, Los Angeles County Department of Public Health. Population estimates from County of Los Angeles, Internal Services Department, Information Technology Service, Urban Research-GIS Section.*

**Figure 20: Suicide Rates by Age Group, Los Angeles County Residents, 2022**



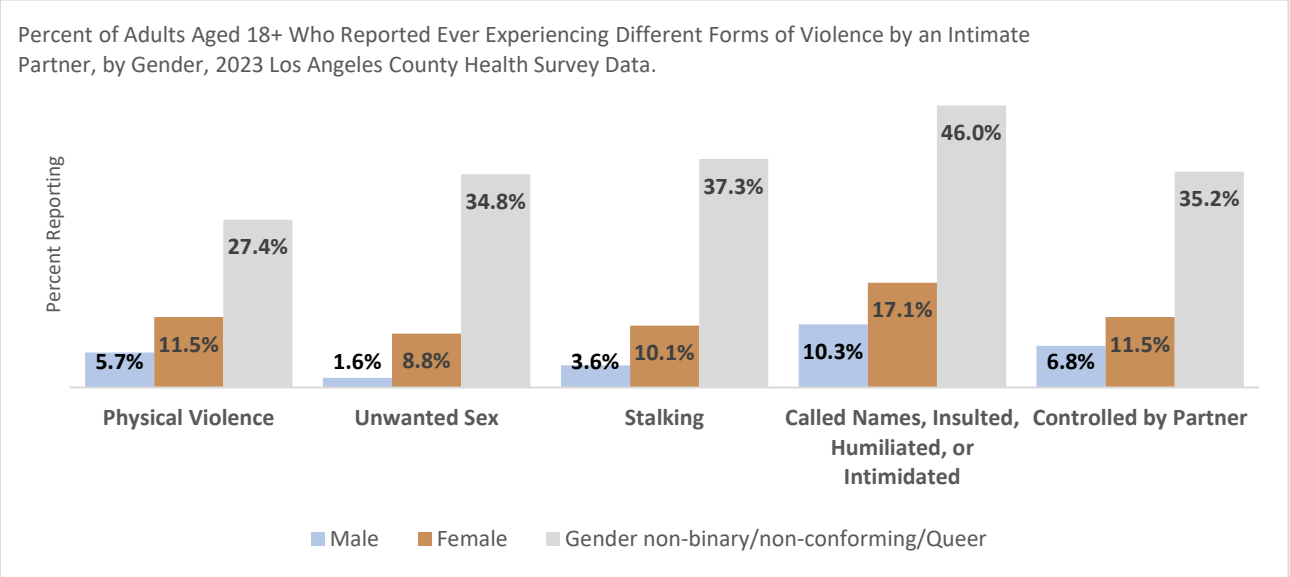

*Source: Los Angeles County Department of Public Health, Office of Violence Prevention. Los Angeles County Annual 2022 (Provisional) Data File, assembled from California Department of Public Health Vital Records Data. Office of Health Assessment & Epidemiology, Los Angeles County Department of Public Health. Population estimates from County of Los Angeles, Internal Services Department, Information Technology Service, Urban Research-GIS Section.*

**Figure 21: Suicide Rates by Service Planning Area, Los Angeles County Residents, 2022**



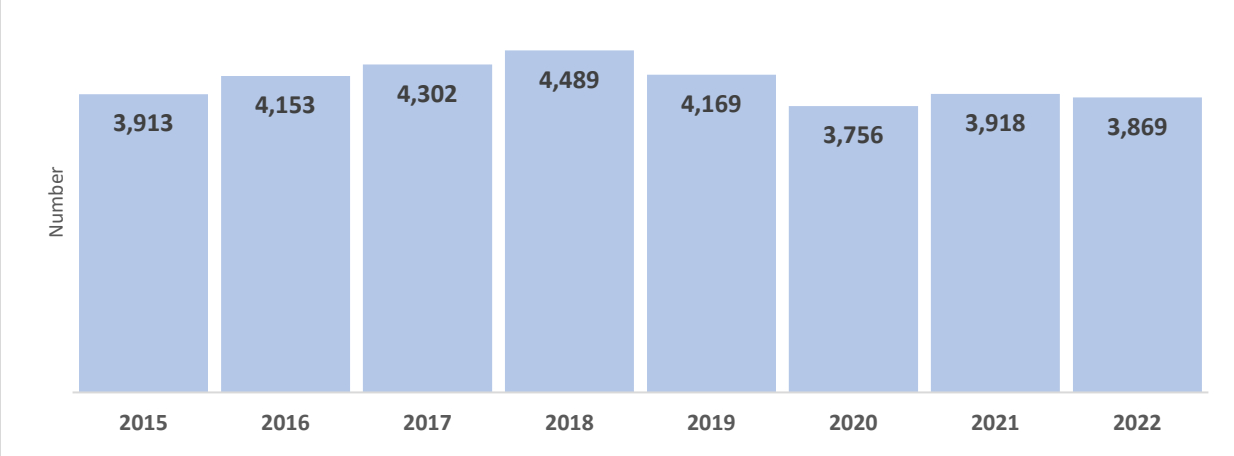

*Source: Los Angeles County Department of Public Health, Office of Violence Prevention. Los Angeles County Annual 2022 (Provisional) Data File, assembled from California Department of Public Health Vital Records Data. Office of Health Assessment & Epidemiology, Los Angeles County Department of Public Health. Population estimates from County of Los Angeles, Internal Services Department, Information Technology Service, Urban Research-GIS Section.*

**Figure 22: Adults Experiencing Violence by an Intimate Partner, by Gender, 2023 Los Angeles County Health Survey Data**




*Source: Los Angeles County Health Survey, Los Angeles County Department of Public Health, Office of Health Assessment and Epidemiology. Percent of Adults Who Reported Ever Experiencing a) Physical Violence; b) Unwanted Sex; c) Stalking; or d) Being Called Names, Insulted, Humiliated, or Intimidated by an Intimate Partner; or e) Having an Intimate Partner Try to Control Them. Source: 2023 Los Angeles County Health Survey; Office of Health Assessment and Epidemiology, Los Angeles County Department of Public Health.*

**Figure 23: Number of Rapes/Reported Rapes in LA County, 2015-2022**




*Source: Los Angeles County Department of Public Health, Office of Violence Prevention. California Department of Justice, Crimes and Clearances data.*

# Appendix B – Focus Area Strategies, Work Plan Activities, Performance Measures & Partners

## FOCUS AREA: BLACK INFANT AND MATERNAL HEALTH

**Results Statement:** All Black/African American babies and mothers/birthing people in Los Angeles County enjoy healthy and joyous births and thrive well beyond baby's first birthday.

**Measurable Goal:** In five years, reduce the gap by 50% in Infant Mortality Rates (IMR) between White and Black/African American babies by reducing the Black/African American IMR.

<table>
<tr><th colspan="2">USEFUL and INCLUSIVE HEALTH EQUITY DATA</th></tr>
<tr><td rowspan="3">Strategy 1:<br>By June 2025, launch and maintain a publicly accessible data dashboard of maternal and infant mortality and associated data disaggregated by race and ethnicity.</td><td>Work Plan Activities:<br>1.1 By October 2024, develop a protocol for dashboard data collection and management.<br>1.2 By May 2025, distribute survey to 10 AAIMM external community partners to assess dashboard utility, accessibility, and inclusiveness.<br>1.3 By May 2026, Public Health implements recommendations for dashboard improvement from AAIMM community partners.<br>1.4 By December 2026, present data dashboard at five (5) community events after implementation.</td></tr>
<tr><td>Performance Measures (under development):<br>• Engage stakeholders to solicit input that informs the development of the dashboard<br>• Visits to the data dashboard site increase by 5% each month for the first six months after implementation</td></tr>
<tr><td>Partners:<br>• AAIMM Data & Evaluation workgroup – advisors<br>• Public Health – data platform development lead</td></tr>
</table>

<table>
<tr><th colspan="2">POLICY AND SYSTEMS CHANGE</th></tr>
<tr><td>Strategy 2:<br>By June 2026, evaluate the implementation of an economic stabilizing initiative, such as the Guaranteed Income program, that serves a minimum of 400 pregnant persons impacted by perinatal health disparities.</td><td>Work Plan Activities:<br>2.1 By January 2025, AAIMM Community Action Teams and Public Health conduct targeted outreach to promote the Abundant Birth Project (ABP) Guaranteed Income program among community members, Village Fund grantees, providers, partnering organizations and their networks that service Black/African American pregnant/parenting women/birthing persons, fathers, partners, and infants.<br>2.2 By January 2025, Public Health collaborates with AAIMM Village Fund grantees to conduct targeted outreach to priority populations/communities and geographies and provide technical assistance with application completion for potentially eligible ABP participants.</td></tr>
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| | **2.3** By January 2025, Public Health offers 1-1 coaching sessions and online and in-person meetings to program participants to increase access to education, information, services, and resources needed to improve health/wellness for Black/African American moms, infants, and family units.<br>**2.4** By January 2026, participate in the statewide evaluation of ABP with four California counties to review the efficacy and outcomes of ABP for program participants, project improvements, and sustainability.<br>**2.5** By June 2026, seek additional funding for the ongoing implementation and sustainability of the ABP beyond the pilot term to ensure vital support to expectant mothers and families, particularly those at the highest risk of disparate pregnancy/birthing outcomes. |
| | **Performance Measures** (under development):<br>• Number of Abundant Birth Coaching sessions<br>• Number of persons served by the Guaranteed Income program |
| | **Partners:**<br>• AAIMM Community Action Teams – Program lead and members (Individuals/Organizations)<br>• AAIMM Village Fund CBOs – outreach collaborators<br>• Abundant Birth Project participating counties (Alameda, Contra Costa, Los Angeles, Riverside)<br>• AAIMM Steering Committee Members<br>• Internal/External LA County partners<br>• Pregnant Women/Birthing Persons and Partners who are now parents, inclusive of those who have experienced perinatal loss |
| **Strategy 3:**<br>By June 2027, expand the AAIMM Doula Program into at least three health related systems to improve access to culturally affirming and supportive maternal care. | **Work Plan Activities:**<br>**3.1** By March 2025, seek contracts between the AAIMM Doula Program and health plans to receive Medi-Cal reimbursement for doula services.<br>**3.2** By December 2025, promote program services with physicians, health plans, and community partners.<br>**3.3** By December 2026, advocate for doulas as an evidence-informed home visiting model for funding. |
| | **Performance Measures** (under development):<br>• Number of health plans where the Doula program is billing for Medi-Cal reimbursement for services<br>• Percentage of health plans with AAIMM doula service contracts secured |
| | **Partners:**<br>• AAIMM Community Action Teams– Lead advisors and advocates<br>• Doula professionals – advisors and advocates<br>• Public Health – Co-lead contract collaborators |

| BUILDING PARTNERSHIPS | |
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| **Strategy 4:**<br>By June 2027, fund at least 10 community organizations to provide stress-reducing services and support for Black/African American pregnant and parenting families through the AAIMM Village Fund. | **Work Plan Activities:**<br>**4.1** By December 2024 and semi-annually thereafter, select AAIMM Village Fund grantees through a collaborative decision-making process.<br>**4.2** By June 2025 and quarterly thereafter, provide capacity building trainings for grantees via the Village Fund learning collaborative.<br>**4.3** By December 2025, promote the AAIMM Village Fund to expand pool of potential grantees and pool of funders.<br>**4.4** By June 2026, determine metrics for Village Fund grantee services to include on AAIMM data dashboard. |
| | **Performance Measures** (under development):<br>• Percent increase in the pool of grantees<br>• Amount of funding invested in Village Fund |
| | **Partners:**<br>• AAIMM- Lead<br>• Private Philanthropy – Funder<br>• Public Funders – Funder<br>• Village Fund grantees – Program/service leads, advisors |

| ORGANIZATIONAL READINESS | |
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| **Strategy 5:**<br>By December 2025, strengthen the ability of Community Action Teams to identify local needs and develop and implement at least one strategy to in response to local needs assessment implemented to address disproportionality in Black/African American infant and maternal mortality. | **Work Plan Activities:**<br>**5.1** By December 2025, conduct a community landscape assessment including membership gaps and zip codes where Black/African American women/birthing people give birth in LA County.<br>**5.2** By December 2026, conduct up to 24 signature activities and campaigns with the AAIMM CAT and/or partner organizations to uplift Black/African American birth equity.<br>**5.3** By June 2027, provide 20 capacity building trainings to the AAIMM CAT members, community partners and interested individuals.<br>**5.4** By December 2028, conduct 100 community events/activations in response to landscape analysis findings and elevate community voices. |
| | **Performance Measures** (under development):<br>• Number of community events/activations implemented as a result of landscape assessment |
| | **Partners:**<br>• Organizations and community members in Service Planning Areas 1, 2, 3, 6 & 8 – Collaborators and advisors<br>• AAIMM CATs – Lead |

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| **Strategy 6:**<br>By June 2026, finalize a three-to-five-year strategic plan through shared decision-making in the AAIMM Steering Committee. | **Work Plan Activities:**<br>**6.1** By December 2026, provide programmatic updates to the AAIMM Steering Committee on the existing strategic plan to identify ongoing gaps in services.<br>**6.2** By June 2027, prepare a list of priorities and garner feedback from AAIMM Community Action Teams to select priorities for the three-to-five-year plan.<br>**6.3** By December 2027, finalize the three-to-five-year AAIMM Strategic Plan. |
| | **Performance Measures** (under development):<br>• Feedback collected from community and stakeholders regarding priorities selected for the AAIMM strategic plan |
| | **Partners:**<br>• AAIMM steering committee – Lead<br>• AAIMM CAT – contributors |

## FOCUS AREA: SEXUALLY TRANSMITTED INFECTIONS AND CONGENITAL SYPHILIS

**Results Statement:** Everyone in Los Angeles County, including future generations, is protected from sexually transmitted infections and congenital syphilis.

**Measurable Goal:** The rate of primary and secondary syphilis will decrease among African American and Latinx men who have sex with men (MSM) by 20% in five years.

<table>
<tr><td colspan="2">USEFUL AND INCLUSIVE DATA</td></tr>
<tr><td rowspan="3">Strategy 1:<br>By December 2024 and ongoing, regularly disseminate up-to-date, user-friendly HIV and STI data, ensuring accessibility and interactivity to empower and inform the community.</td><td>Work Plan Activities:<br>1.1. By December 2024, update user-friendly, accessible data reports to meet the diverse needs of stakeholders.<br>1.2. By December 2025, engage community members and establish user feedback mechanisms for continuous data improvement.<br>1.3. By December 2025, integrate relevant health equity indicators, demographics, and geographic information into HIV and STI data reports to ensure healthcare providers in LA County benefit from a unified approach to reviewing their respective data.<br>1.4. By December 2025, establish protocols for regular data dissemination to ensure timely access to critical health information and enable stakeholders to make informed decisions on STI programming and services.</td></tr>
<tr><td>Performance Measures (under development):<br>• Percent of STI reports that include demographics<br>• Percent of STI reports that include geographic information maps</td></tr>
<tr><td>Partners:<br>• Community members – advisors<br>• Community Clinics – collaborators and contributors<br>• Health Plans – collaborators<br>• Providers – contributors and advisors<br>• Public Health – Data Lead</td></tr>
</table>

<table>
<tr><td colspan="2">POLICY AND SYSTEMS CHANGE</td></tr>
<tr><td>Strategy 2:<br>By December 2027, improve adherence to California law and LA County guidelines that</td><td>Work Plan Activities:<br>2.1 By December 2025, in partnership with the California Department of Health Care Services (DHCS) and California Department of Public Health (CDPH), develop and implement a monitoring system tied to syphilis screening among pregnant persons in California.</td></tr>
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| mandate syphilis screenings for all pregnant people during their initial prenatal visit, with additional screenings recommended in the third trimester (28-32 weeks) and at the time of delivery. | **2.2** By December 2027, develop and conduct outreach sessions incorporating public health visits to educate healthcare providers and clinic staff about syphilis screening guidelines for people who can become pregnant or of reproductive potential. |
| | **Performance Measures** (under development):<br>• Number of providers visited<br>• Percent increase in provider self-reported knowledge of recent LAC syphilis trends and screening guidelines at a follow-up visit |
| | **Partners:**<br>• California Department of Health Care Services – monitor, ensure compliance<br>• California Department of Public Health – monitor, ensure compliance<br>• Health Care Delivery Systems and Birthing Hospitals – collaborators and contributors<br>• Community Clinics – collaborators and contributors<br>• Public Health – outreach, content development, technical assistance, training |
| **Strategy 3:**<br>By December 2025, increase STI screening and testing rates among populations at elevated risk for STIs by strengthening community awareness and understanding of STIs. | **Work Plan Activities:**<br>**3.1** By March 2025, conduct focus groups, key informant interviews, and community feedback sessions to inform the development of targets STI prevention campaigns.<br>**3.2** By September 2025, implement a minimum of two (2) prevention campaigns across diverse media platforms, aiming to heighten awareness regarding STI prevention and control strategies, including the advantages of doxycycline post-exposure prophylaxis (DoxyPEP) and syphilis prevention.<br>**3.3** September 2025, measure the impact of prevention campaigns by analyzing the impact of the campaigns' call to action, shifts in community awareness, attitudes, and behaviors about STI prevention strategies. |
| | **Performance Measures** (under development):<br>• Percent of STI prevention campaigns incorporating both focus groups and community feedback sessions during their development phase to ensure that each campaign actively engages and resonates with the target audience and community stakeholder<br>• Number of STI prevention and control campaigns incorporating out-of-home and digital assets, as well as leveraging social marketing strategies for enhanced reach and effectiveness |
| | **Partners:**<br>• Media partners – content distribution lead<br>• Community members – lead advisors<br>• Public Health – campaign management lead |

| BUILDING PARTNERSHIPS | |
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| **Strategy 4:**<br>By January 2025, establish a partnership council to routinely solicit community input and feedback to identify actions and activities that will improve STI prevention and control efforts. | **Work Plan Activities:**<br>**4.1** By December 2024, host a series of four community forums with local health organizations and community leaders of diverse representation and expertise to solicit feedback on STI prevention and treatment policies.<br>**4.2** By December 2024, gather feedback from community partners to create more responsive STI prevention and control programming and influence the improvement of Public Health solicitation documents. |
| | **Performance Measures** (under development):<br>• Number of convenings of the HIV & STD Prevention Advisory Board to inform the development and evolution of local HIV and STD prevention and control efforts. |
| | **Partners:**<br>• FQHC – advisors, collaborators<br>• Health Plans – funders, collaborators<br>• Community leaders – advisors, collaborators<br>• Local Health Organizations – advisors, collaborators<br>• Public Health – Convenors, subject matter experts<br>• Academic partners – subject matter experts<br>• Consumers – advisors, collaborators |

| ORGANIZATIONAL READINESS | |
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| **Strategy 5:**<br>By December 2025, establish a comprehensive program to regularly provide targeted training for public health investigators (PHIs), community-embedded disease intervention specialists (CEDIS), and front-line clinic staff. | **Work Plan Activities:**<br>**5.1** By December 2026, establish a structured continuous professional development plan for PHIs, CEDIS, community partners, and community and Public Health clinic staff, ensuring ongoing education and skill enhancement.<br>**5.2** By December 2027, implement a cultural sensitivity training program designed to create an inclusive and respectful environment for frontline community clinic and partner staff and Public Health Clinic staff. This program will specifically address the unique needs of LGBTQ+ individuals, including transgender individuals, and substance users creating an environment that is both inclusive and respectful.<br>**5.3** By December 2029, incorporate regular updates on emerging STI trends, technological advancements, and cultural sensitivity training to maintain a high level of preparedness and adaptability within the team. |
| | **Performance Measures** (under development):<br>• PHI training framework developed<br>• Updated tailored HIV and STI prevention and control curriculum for PHIs and CEDIS |
| | **Partners:**<br>• Subject Matter Experts – content contributors<br>• HIV and STI workforce – collaborators and ambassadors<br>• Public Health – collaborators, curriculum and training management |

## FOCUS AREA: ENVIRONMENTAL JUSTICE

**Results Statement:** Those living in the most highly pollution-burdened communities in Los Angeles County enjoy healthy lives safe from toxic exposures and the negative effects of climate change.

**Measurable Goal:** In five years, find and fix the sources of lead exposure for at least 25% of children with a blood lead level of 3.5 µg/dL or higher who live in the most polluted communities of Los Angeles County*.

*These are communities ranked in the top 25% using the California Communities Environmental Health Screening Tool (CalEnviroScreen 4.0).

<table>
<tr><th colspan="2">USEFUL AND INCLUSIVE DATA</th></tr>
<tr><td rowspan="3">Strategy 1:<br>By December 2025, post data on a publicly accessible platform that shares environmental, climate, and related health conditions, informed by strategic planning stakeholder input.</td><td>Work Plan Activities:<br>1.1 By June 2025, map environmental justice indicators, excessive heat indicators, pollution burden indicators, and health impacts indicators for internal use.<br>1.2 By December 2025, and annually thereafter, publish annual health impacts and trend data for selected health outcomes related to excessive heat.<br>1.3 By December 2025, and annually thereafter, publish selected pollution burden indicators and trend data in Environmental Justice communities and across LA County.</td></tr>
<tr><td>Performance Measures (under development):<br>• Percentage of selected Indicators that are mapped<br>• Number of annual data reports published</td></tr>
<tr><td>Partners:<br>• Subject Matter Experts – advisors and contributors<br>• Community Organizations – advisors<br>• Public Health – Data platform development</td></tr>
<tr><td rowspan="3">Strategy 2:<br>By December 2025 and annually thereafter, ensure the Office of Environmental Justice and Climate Health (OEJCH) program webpage provides up-to-date, relevant information for the public, based on input gathered from strategic planning stakeholder engagement.</td><td>Work Plan Activities:<br>2.1 By June 2025, determine content to be updated on the publicly accessible OEJCH webpage based on stakeholder input.<br>2.2 By December 2025 and annually thereafter, update information for the publicly accessible OEJCH webpage, including the development of informational materials for communities; media requests; and other educational materials.</td></tr>
<tr><td>Performance Measures:<br>• Annual review completed with stakeholder input<br>• Number of visits to webpage</td></tr>
<tr><td>Partners:<br>• Community members – advisors</td></tr>
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| | • Community organizations – advisors<br>• Data Reporting organizations – contributors<br>• Public Health – Data platform development and maintenance |

| POLICY AND SYSTEMS CHANGE | |
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| **Strategy 3:**<br>By December 2025, develop an initial policy agenda on priority environmental justice and climate health issues that identifies at least 3 policies to pursue. | **Work Plan Activities:**<br>**3.1** By June 2025, conduct a landscape scan of environmental justice and climate health policy developments locally, statewide, and nationally to inform the development of successful policies locally.<br>**3.2** By December 2025, develop an initial policy agenda on priority environmental justice and climate health issues based on the landscape scan. |
| | **Performance Measures** (under development):<br>• Policy agenda developed |
| | **Partners:**<br>• Community members – advisors<br>• Community organizations – advisors<br>• Data Reporting organizations – contributors<br>• Public Health – Policy analysis and policy agenda development |

| BUILDING PARTNERSHIPS | |
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| **Strategy 4:**<br>By December 2027, reduce the risk of lead poisoning from lead paint in 2000 homes throughout LA County through remediation of lead paint hazards. | **Work Plan Activities:**<br>**4.1** By December 2025, conduct outreach and recruitment of homes with community partners through direct mailings, phone banking, door-knocking, community events, and distribution of materials through established networks of local stakeholders and organizations serving the target populations.<br>**4.2** By December 2027, enroll new participants in the "Lead-Free Homes LA Program" to eliminate lead paint hazards in homes throughout LA County. |
| | **Performance Measures** (under development):<br>• Number of homes per year in which lead paint hazards have been remediated |
| | **Partners:**<br>• Community Organizations – outreach, recruitment, enrollment, and collaboration<br>• Housing Authorities – program implementation and collaboration<br>• Public Health –program oversight of the Lead-Free Homes LA program |

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| **Strategy 5:**<br>By December 2025 and annually thereafter, provide training and develop maps for each of the hyper-local health teams, Community Public Health Teams (CPHTs), to build knowledge and awareness of local environmental and climate justice issues in the initial pilot communities. | **Work Plan Activities:**<br>**5.1** By June 2025, provide training for Public Health and Community Health Worker staff engaged in CPHTs on Environmental Justice and Climate Health issues.<br>**5.2** By June 2025, and annually thereafter, map environmental, climate, and health indicators across CPHT communities.<br>**5.3** By December 2025, and annually thereafter, share map of environmental, climate and health indicators with CPHTs |
| | **Performance Measures** (under development):<br>• Percent of initial pilot communities for which a CPHT staff training is held<br>• Percent of initial pilot communities for which a map showing environmental justice and climate indicators is created |
| | **Partners:**<br>• Community Public Health Teams – lead contributors, collaborators<br>• Public Health – environmental justice mapping development |
| **Strategy 6:**<br>By June 2026, partner with environmental justice and climate health organizations in LA County to support and convene spaces for symposiums for environmental justice and climate health topics. | **Work Plan Activities:**<br>**6.1** By December 2025, connect with environmental justice and climate stakeholders to identify partners that express interest/enthusiasm for convening symposiums on environmental justice and climate health.<br>**6.2** By May 2026, convene one symposium on environmental justice and climate health. |
| | **Performance Measures** (under development):<br>• Number of interested partners identified to collaborate on an environmental justice and climate health symposium |
| | **Partners:**<br>• Health focused stakeholders – advisors, collaborators<br>• Regulators – advisors, collaborators<br>• NGOs/CBOs – advisors, collaborators |

| ORGANIZATIONAL READINESS | |
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| **Strategy 7:**<br>By January 2027, implement the collaboratively-developed OEJCH strategic plan to reduce health disparities due to environmental exposures in communities overburdened by pollution exposure and climate impacts. | **Work Plan Activities:**<br>**7.1** By January 2027, implement Strategic Plan actions.<br>**7.2** By January 2028, evaluate Strategic Plan. |
| | **Performance Measures** (under development):<br>• Percent of strategic plan actions initiated |
| | **Partners:**<br>• Partners (CBOs, government and non-government agencies, regulators, academic partners/researchers, community members, other jurisdictions) – collaborators, advisors<br>• Public Health – Implementation lead |

## FOCUS AREA: VIOLENCE PREVENTION

**Results Statement:** All families and communities in Los Angeles County live free of violence and thrive in a culture of peace.

**Measurable Goal:**

1. Reduce the gap in homicide rates between African Americans and the Los Angeles County average by 20% in five years.
2. Reduce the number of adult women and gender diverse/expansive people who report ever experiencing physical violence by an intimate partner by 10% in five years.

| USEFUL AND INCLUSIVE DATA | |
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| **Strategy 1:**<br>By June 2025, create a centralized open data portal with metrics to evaluate progress on OVP strategic plan goals and objectives. | **Work Plan Activities:**<br>**1.1** By December 2024, Public Health collaborates with partners to determine datal portal components and determine strategic plan metrics to evaluate.<br>**1.2** By June 2025, Public Health releases data visualizations showing trends and demographics of firearms deaths and non-fatal injuries. |
| | **Performance Measures** (under development):<br>• Number of dashboard views on website<br>• Number of projects where data dashboards are used as resource |
| | **Partners:**<br>• County departments – data providers, advisors<br>• Community organizations – advisors, collaborators<br>• Public Health – Data portal development lead |

| POLICY AND SYSTEMS CHANGE | |
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| **Strategy 2:**<br>By January 2026, establish a Sexual Assault Council to improve coordination across county systems and service providers to improve services to survivors of sexual assault and invest in prevention programs. | **Work Plan Activities:**<br>**2.1** By October 2024, assess capacity and willingness of potential partners to establish a council.<br>**2.2** By June 2025, establish a Sexual Assault Council that brings together a diverse group of stakeholders (including sexual assault service and advocacy service providers, community organizations, survivors, health care organizations, mental health providers, and law enforcement) to develop a common vision and strategic plan for addressing and preventing sexual assault including increasing access to services for victims and survivors.<br>**2.3** By a date to be determined by the Council, develop a strategic plan, through the Sexual Assault Council, to improve policy, practice, and systems change to support survivors of sexual assault. |
| | **Performance Measures** (under development):<br>• Sexual Assault Council established<br>• Strategic plan developed |

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| | **Partners:**<br>• Sexual Assault Council – lead strategic plan development<br>• Community Based Organizations – council members, advisors<br>• Health Care Organizations<br>• Mental Health Providers – council members, advisors<br>• Law Enforcement – council members, advisors<br>• Survivors – advisors, members<br>• Advocates – advisors, members<br>• Public Health – lead convenor |

| BUILDING PARTNERSHIPS | |
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| **Strategy 3:**<br>By July 2026, Expand initiatives and services to address gender-based violence (GBV) across the lifespan by strengthening inter-agency collaboration. | **Work Plan Activities:**<br>**3.1** By July 2025, complete a GBV environmental scan to understand the current landscape of county and community efforts to address GBV.<br>**3.2** By July 2025, identify and engage departments and organizations and partners that address and respond to GBV.<br>**3.3** By July 2026, fund community-based organizations to implement GBV prevention programming. |
| | **Performance Measures** (under development):<br>• Percent of county programs/initiatives that integrated addressing/preventing gender-based violence as a component of their work<br>• Number of partnerships with CBOs focused on addressing/preventing GBV |
| | **Partners:**<br>• Community organizations – lead prevention programming<br>• County partners – coordination and policy development<br>• Public Health – lead training development and coordination |
| **Strategy 4:**<br>By June 2027, expand place-based community-driven public safety efforts through the Trauma Prevention Initiative (TPI), including Street Outreach and Community Violence Intervention (CVI), Hospital Violence Intervention (HVIP), and Community Action | **Work Plan Activities:**<br>**4.1** By December 2024, confirm additional county funding for TPI including mental health services for HVIP clients and case managers, HVIP for Antelope Valley and Hawaiian Gardens/Norwalk, Peer to Peer Violence Prevention Training Academy and community engagement.<br>**4.2** By June 2025, complete first year of pilot Peer to Peer Academy with ARPA funding and draft recommendations for ongoing academy.<br>**4.3** By December 2025, establish a Memoranda of Understanding (MOU) to coordinate referrals with Department of Youth Development Youth Networks and Diversion programs and Parks and Recreation to provide technical guidance for expanded park safe passages program.<br>**4.4** By June 2026, develop plan for coordination with two additional initiatives in TPI communities. |

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| for Peace networks by: 1) increasing investment in nine communities, and 2) building infrastructure for peer violence intervention training and county services alignment. | **4.5** By June 2027, establish a strategic plan for regional coordination among cities for implementing Community Violence Intervention (CVI). |
| | **Performance Measures** (under development):<br>• Percent of stakeholders reporting improved connections<br>• Number of referrals between county initiatives |
| | **Partners:**<br>• Trauma Prevention Initiative network partners – TPI programming lead<br>• LA County Parks and Recreation – Park programming lead<br>• County departments – collaborators, referral partners<br>• Community leaders – advisors<br>• Survivors of violence/Advocates - advisors<br>• Public Health – convenors, fiscal lead |
| **Strategy 5:**<br>By June 2025, implement a comprehensive plan to promote firearm safety through community education and awareness, policy change, and peer approaches. | **Work Plan Activities:**<br>**5.1** By September 2024, Public Health collaborates with community and County department partners to distribute gun safety locks countywide through county hospitals, clinics, libraries, and OVP contracted agencies.<br>**5.2** By September 2024, Public Health creates a webpage on gun safety; including information on Gun Violence Restraining Orders (GVROs), how to obtain a gun safety lock, and other resources to prevent gun violence.<br>**5.3** By June 2025, coordinate with Regional Violence Prevention Coalitions established in each of the County's Service Planning Areas (SPAs) to implement priority strategies in the Gun Violence Prevention Plan. |
| | **Performance Measures** (under development):<br>• Number of community members connected to GVRO resources<br>• Number of gun safety locks distributed<br>• Number of RVPC's implementing gun violence prevention projects |
| | **Partners:**<br>• Regional Violence Prevention Coalitions – lead convenors in each region<br>• Trauma Prevention Initiative networks - advisors<br>• County departments – advisors, strategy implementation<br>• Community leaders – advisors, policy contributors<br>• Survivors of violence/Advocates - advisors, trained peers, policy contributors<br>• Public Health – data and webpage lead, gun safety locks coordination |

<table>
<tr><th colspan="2">ORGANIZATIONAL READINESS</th></tr>
<tr><td rowspan="3">Strategy 6:<br>By June 2026, implement trauma-informed systems and practice change among County departments and community partners to promote healing and wellbeing and to support the unique needs of local communities.</td><td>Work Plan Activities:<br>6.1 By June 2025, conduct Gang and GBV training for TPI agencies and OVP staff.<br>6.2 By June 2026, provide trauma-informed systems change training and technical assistance to support two (2) new county departments.</td></tr>
<tr><td>Performance Measures (under development):<br>• Number of County staff trained<br>• Number of community stakeholders trained</td></tr>
<tr><td>Partners:<br>• Trauma Prevention Initiative Community Action for Peace networks - collaborators<br>• County departments – collaborators<br>• Public Health – lead capacity development & coordination</td></tr>
<tr><td rowspan="3">Strategy 7:<br>By June 2026, develop a coordinated communications strategy to promote a shared understanding of violence and violence as a public health issue.</td><td>Work Plan Activities:<br>7.1 By June 2024, work with LA County Medical Association (LACMA) and LA Care Health Plan to develop and implement a digital billboard campaign.<br>7.2 By June 2025, facilitate discussion with County Leadership Committee (CLC) and Community Partnership Council (CPC) regarding coordinated communications.<br>7.3 By June 2026, develop a communications workplan with CLC and CPC.</td></tr>
<tr><td>Performance Measures (under development):<br>• Communications workplan finalized and approved<br>• Development of a gun safety billboard campaign in partnership with LACMA and LA Care Health Plan</td></tr>
<tr><td>Partners:<br>• County Leadership Committee – advisors<br>• Community Partnership Council – advisors<br>• LA County Medical Association – collaborator, media campaign contributor<br>• LA Care Health Plan – collaborator, media campaign contributor<br>• Public Health – lead communications management</td></tr>
<tr><td rowspan="2">Strategy 8:<br>By June 2025, implement local efforts to prevent suicide and suicidal behavior among populations demonstrated to be at increased risk including</td><td>Work Plan Activities:<br>8.1 By June 2024, conduct first review of a veteran suicide death as part of the Veteran Suicide Review Team.<br>8.2 By June 2025, implement California Department of Public Health funded Youth Suicide Prevention Pilot Program.<br>8.3 By June 2025, develop outreach materials and host trainings on gun violence restraining orders, including how they can be used in suicide prevention.</td></tr>
<tr><td>Performance Measures (under development):</td></tr>
</table>

| | |
|---|---|
| youth, communities of color, veterans, and firearm owners. | • Number trainings/events where OVP distributed suicide prevention resources and materials |
| | **Partners:**<br>• California Department of Public Health – advisors and collaborators<br>• Local suicide prevention organizations – advisors, contributors, collaborators<br>• Veteran organizations – collaborators, coordinators, advisors<br>• Youth-focused organizations – collaborators, advisors, and contributors<br>• Public Health – lead convenor and program management<br>• County Departments – advisors, collaborators<br>• School Districts - advisors, collaborators |

# Appendix C – Health Equity: What the Data Says

Everyone in Los Angeles County should have a fair and just opportunity to achieve optimal health, longevity, and wellbeing to live their best lives and contribute positively to our society. Unfortunately, due to the legacy impacts of historical and systemic injustices, as well as the persistence of institutional and structural racism and bias in society, data from multiple sources highlight persistent health inequities and disparities, experienced mostly by people of color. The challenges people face can be compounded because they experience discrimination and bias based on multiple aspects of who they are, like their race, age, ability, socioeconomic status, language, nationality, and sexual orientation or gender identity or expression.


Persistent health and socioeconomic inequities in Los Angeles County are linked to the Social Determinants of Health (SDOH),[35] which are the conditions and environments where people are born, live, learn, work, play, worship, and age that can affect their health and quality of life. Below is a snapshot of Los Angeles County data by each of the five SDOH domains (as listed to the right) with a focus on the inequities in health outcomes and socio-economic inequalities based mostly in **race/ethnicity, education level, income, gender identity, disability status, and geography**.

The following data comes from the **2023 Los Angeles County Health Survey (LACHS),[36]** which is a periodic, population-based survey conducted by Public Health since 1997. The survey collects information from adults and children in the county on health status, health conditions, health behaviors, social determinants of health, and other topics relevant to community health. (See end for notes on the data)

## Economic Stability

Everyone in Los Angeles County should earn a livable income allowing them to meet their basic healthcare and other essential needs. However, the poverty rate in Los Angeles County is 14% (compared to 10% in the United States) and particularly alarming, is the child poverty rate of 18%.[37] Poverty intersects with many important indicators of health such as access to health care, food security, access to quality and affordable housing, exposure to stress, environmental hazard exposures and educational attainment as you will see throughout the following charts.

**Housing affordability:**

US Census American Community Survey (ACS) 2022 1-year estimate data show that housing costs and the cost of rent are at elevated levels. The 2018-2022 owner-occupied housing unit rate was 36.6%, the median cost of a home in LA County was $822,600, and the median monthly owner cost with a mortgage was $3,235. The median gross rent in Los Angeles County was more than $1,805/month and more than a third (39%) of occupied rental units pay more than $2,000/month. This is much higher than in other areas of the country.

Persistent health and socioeconomic inequities in Los Angeles County are linked to the Social Determinants of Health (SDOH),[38] which are the conditions and environments where people are born, live, learn, work, play, worship, and age that can affect their health and quality of life. Below is a snapshot of Los Angeles County data by each of the five SDOH domains (as listed to the right) with a focus on the inequities in health outcomes and socio-economic inequalities based mostly in **race/ethnicity, education level, income, gender identity, disability status, and geography**.

The following data comes from the **2023 Los Angeles County Health Survey (LACHS),[39]** which is a periodic, population-based survey conducted by Public Health since 1997. The survey collects information from adults and children in the county on health status, health conditions, health behaviors, social determinants of health, and other topics relevant to community health. (See end for notes on the data)

Based on the 2023 LACHS, an estimated 16% of LA County households experienced a delay or an inability to afford to pay their mortgage or rent in the past two years. Glaring disparities were seen based on race/ethnicity, education, income, gender identity, and disability status of residents living in these households. For example, Households with Native Hawaiian or Pacific Islander (NHPI) individuals had the highest prevalence (35%) of experiencing housing unaffordability compared to only 5% of households with US-born Asians. That's a 7-fold difference. Household education and income levels were inversely related with housing unaffordability. More than 1 in 5 (22%) of those with less than high school education experienced a delay or inability to pay their mortgage or rent in the past two years compared to only 9% of those with college/postgraduate degrees. Similarly, the prevalence of those who delayed or were unable to pay their mortgage or rent was almost 1/3 (31%) among those living below the poverty level (0-99% FPL) compared to only 7% of high-income adult households (300+% FPL). Adults with disabilities had higher prevalence (23%) compared to those without a disability (13%) for having to delay or were unable to afford to pay their mortgage or rent in the past two years. Geographic disparities were also seen, as nearly 1/4 (24%) of households in South SPA6 compared to only 11% of adults living households in West SPA5 had a delay or were unable to afford to pay mortgage or rent in the past two years. See Figure 24 below.

**Housing Burden:**
Being housing burdened is when individuals pay more than 30% of their household income on mortgage or rent. If they pay more than 50% of their household income on mortgage or rent, then they are considered severely housing burdened. In 2023, more than half (54%) of all households in LA County (an estimated 1,798,000 households) were housing-burdened, while 23% of households were severely housing-burdened (an estimated 748,000 households). Seven in 10 (70%) foreign-born Latinx adults were housing burdened compared to only 35% of US-born Asian adults. Similarly, 68% of Transgender Male adults and 67% of Gender non-binary/non-conforming/Queer adults were housing burdened. Nearly 2/3 (64%) of adults with less than a high school education, were housing burdened compared to less than half (44%) of adults with college/postgraduate degrees. Nearly¾ (73%) of adults with income levels between 100-199% FPL were housing burdened compared to only 39% of those at 300+% FPL. The most glaring disparities in housing burden were seen by geography, with more than 3/4 (75%) of adults in the Southeast Health District[40], and nearly 2/3 (64%) of adults in the South Service Planning Area 6 households were housing burdened. See the data snapshot in Figure 25 below.

**Housing Instability – Unstable Housing/Homelessness in the past 5 Years:** In the 2023 LACHS, adults 18+ years old were asked if they were ever homeless or did not have their own place to live/sleep in the past 5 years. An estimated 7% (524,000) reported experiencing this outcome. Black/African American (16%), American Indian/Alaska Native (14%*[41]), and US-born Latinx (10%) adults faced the highest housing instability in the county compared to Asians (2%) and Whites (4%). Though disaggregated gender identity data were statistically unstable due to small numbers and should be interpreted with caution, Transgender females (36%*[36]) and Gender non-binary, non-conforming, or Queer (16%*) adults faced higher housing instability compared to cis-gender males (7%) and females (6%). Adults with lower education and income levels also experienced more housing instability. See the data snapshot in Figure 26 below.

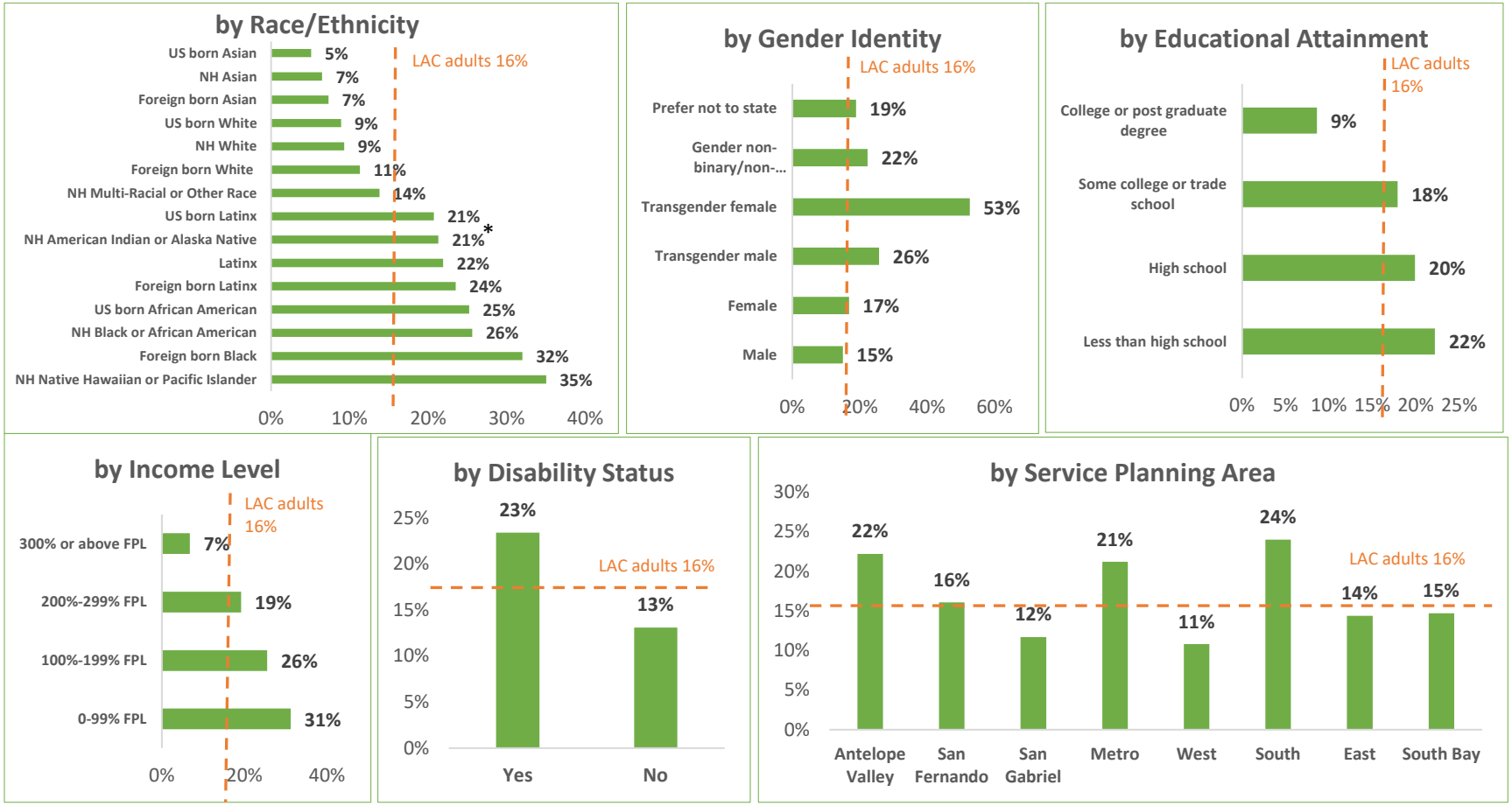
**Food Insecurity – Overall and Very Low Food Security (Households):** Food insecurity is a scaled variable based on a series of responses to six survey questions about hunger and food availability[42]. One in four (25%) of all LA County households overall and 30% of households with children experienced food insecurity in 2023, while 11% of all households and 13% of households with children experienced very low food security i.e., food insecurity with severe hunger. Consistent with other socio-economic outcomes, we see glaring disparities based on race/ethnicity, gender identity, education, and income levels of individuals who live in these households. See Figure 27 with the data snapshot below.

**Difficult Access to Childcare:** In 2023, parents/guardians/decision makers of children 0-12 years old were asked about their experience finding needed childcare on a regular basis in LA County. More than 1/3 (37%) or an estimated 320,000 children were reported having experienced difficulty accessing needed childcare. Disparities were seen based on parents/guardians/decision makers' race/ethnicity, income levels, and geography (66.4% among the Central Health District residents, and 45% among Metro Service Planning Area[43] 4 residents). See Figure 28 below for a data snapshot on difficulty accessing needed childcare.

## Figure 24: LACHS Socio-Economic Stability Data – Housing Unaffordability Snapshot.

**16% (544,000) of LA County households, and 16% (1,263,000) of adults experienced a delay/inability to pay their rent/mortgage int he past 2 years.**

**Note:** *The estimate is statistically unstable (relative standard error >30%) and therefore may not be appropriate to use for planning or policy purposes.

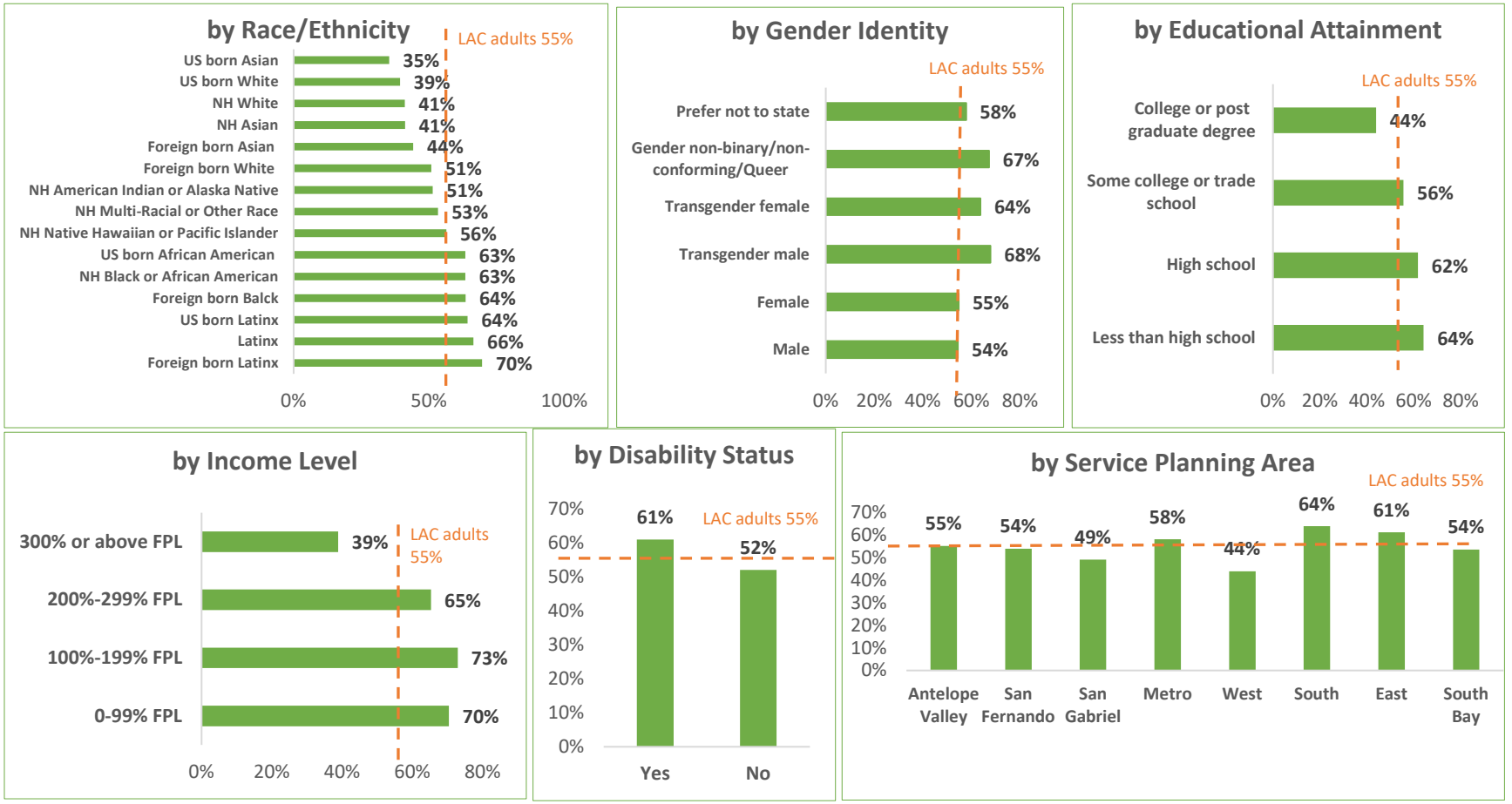



*For more detailed master data table click here:*

- *Housing Unaffordability - http://www.publichealth.lacounty.gov/ha/docs/2022LACHS/MDT/Adult/Module%205/Housing/LACHS2023_Adult_UnablePayRent.xlsx*

## Figure 25: LACHS Socio-Economic Stability Data – Housing Burden Snapshot

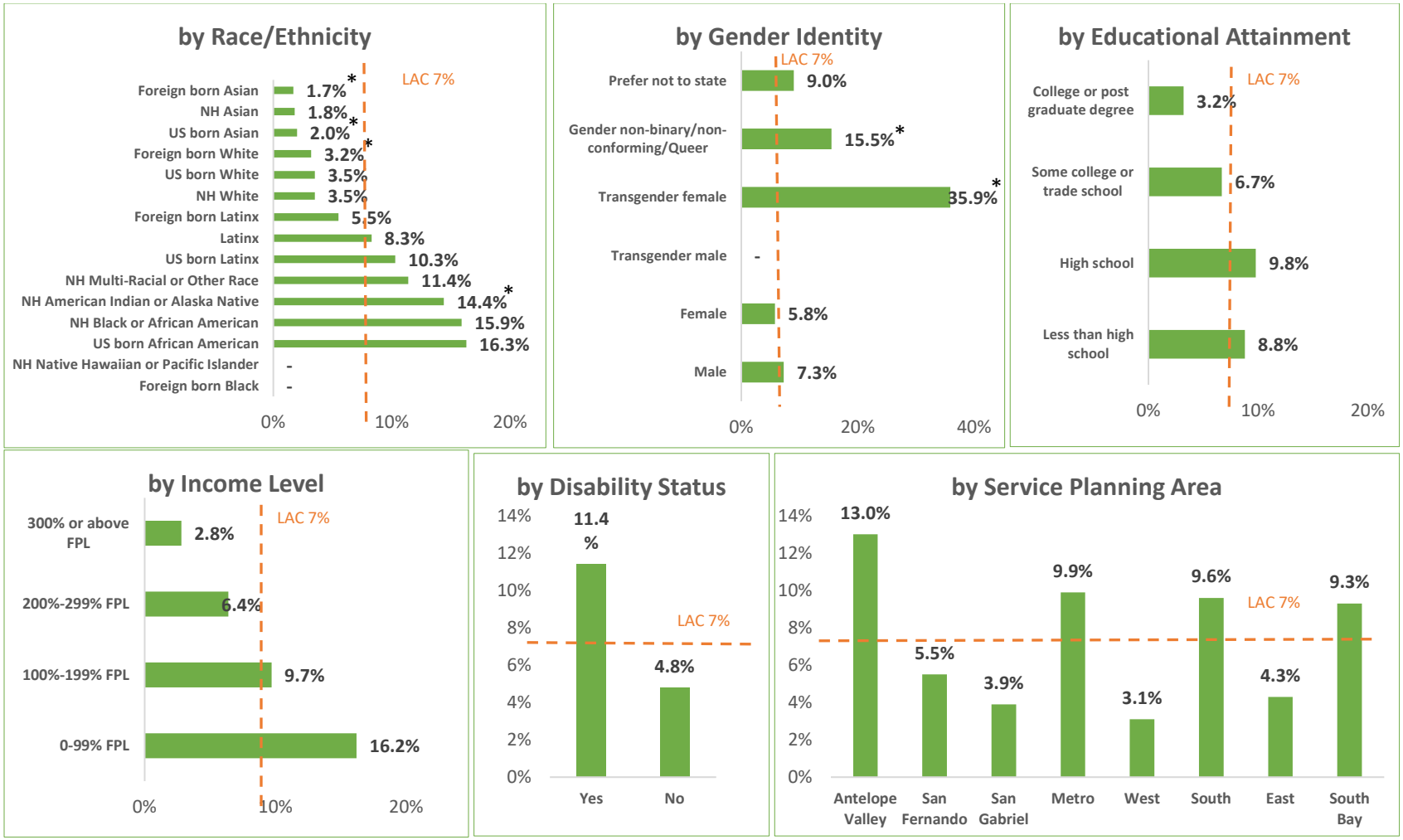
**54% (1,798,000) of LA County households and 55% (4,267,000) of adults spend more than 30% of total monthly income on their rent/mortgage.**




- *Housing Burdened - http://www.publichealth.lacounty.gov/ha/docs/2022LACHS/MDT/Adult/Module%205/Housing/LACHS2023_Adult_IncomeRent30Pct.xlsx*
- *Severely Housing Burdened - http://www.publichealth.lacounty.gov/ha/docs/2022LACHS/MDT/Adult/Module%205/Housing/LACHS2023_Adult_IncomeRent50Pct.xlsx*

## Figure 26: LACHS Socio-Economic Stability Data – Housing Instability/Homelessness in the Past 5 years Snapshot

**7% (524,000) of LA county Adults 18+ years old experienced housing instability/homelessness in the past 5 years.**



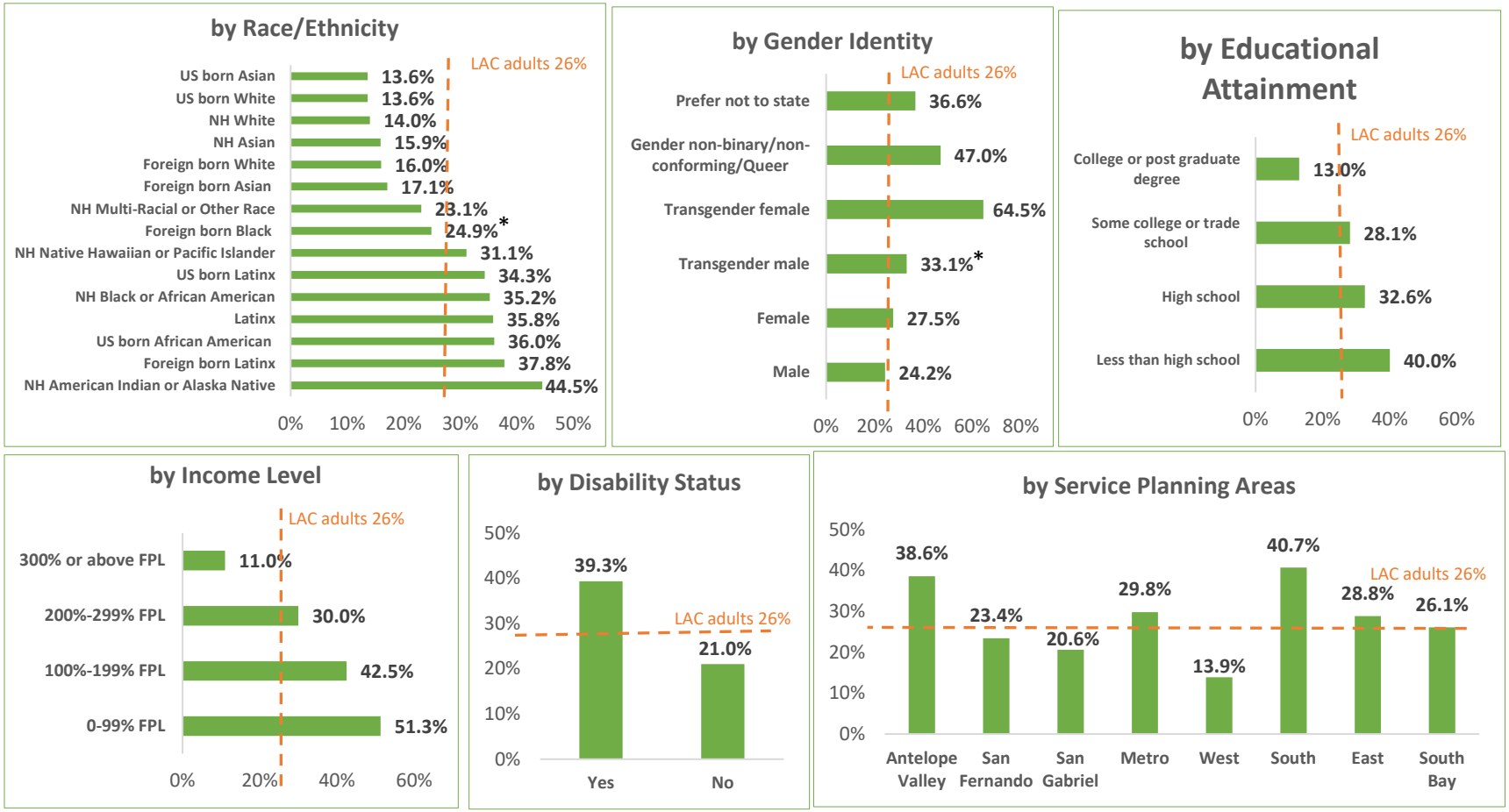

*For a detailed master data table on Housing Instability click here:*

- *Housing Instability - http://www.publichealth.lacounty.gov/ha/docs/2022LACHS/MDT/Adult/Module%205/Housing/LACHS2023_Adult_HousingInstability.xlsx*

## Figure 27: LACHS Socio-Economic Stability Data – Food Insecurity Snapshot

**25% (848,000)** of LA County Households and **26% (2,059,000)** of adults 18+ years old are food insecure.

**11% (363,000)** of LA County Households and **11% (853,000)** of adults had very low food security.

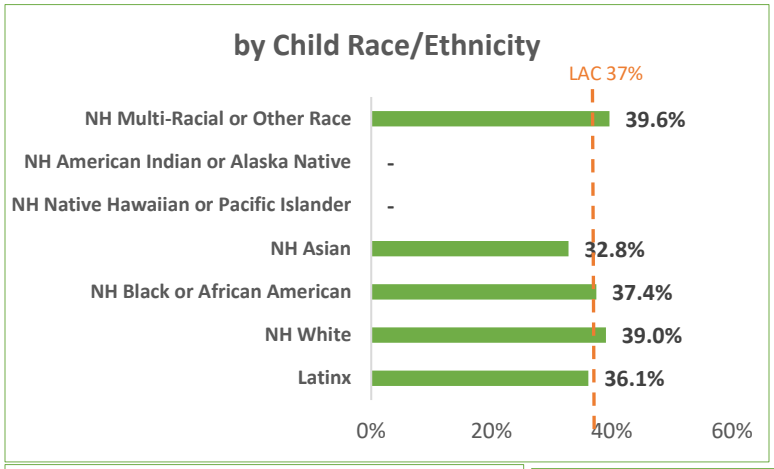


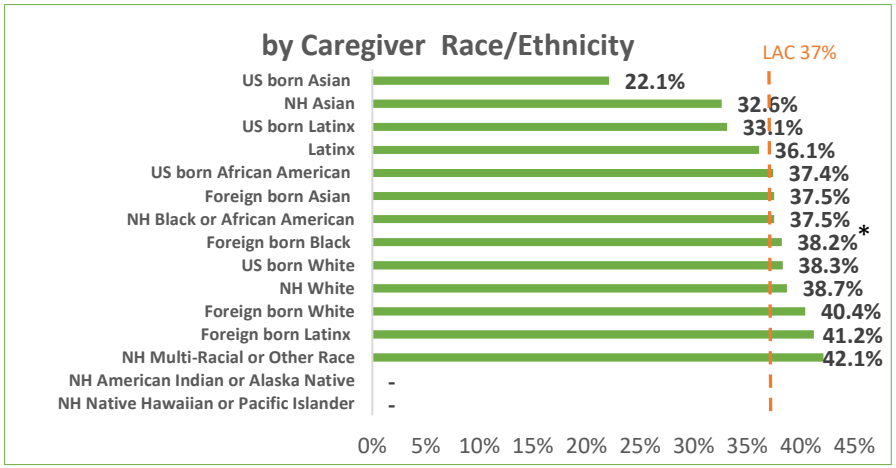

*For detailed master data tables on Food Insecurity for both the household level and on the population/individual level click on the links below:*

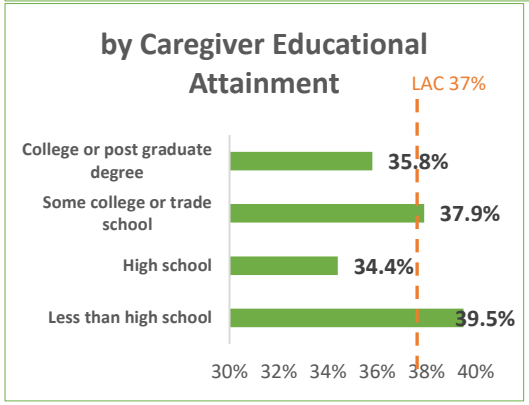
- *Food Insecurity (household level) - Overall - http://www.publichealth.lacounty.gov/ha/docs/2022LACHS/MDT/Adult/Module%205/Food%20Insecurity/LACHS2023_Adult_HHFoodInsecOverall.xlsx*
- *Food Insecurity - Very Low or Low Food Security (household level) - http://www.publichealth.lacounty.gov/ha/docs/2022LACHS/MDT/Adult/Module%205/Food%20Insecurity/LACHS2023_Adult_HHFoodInsecVeryLow.xlsx*
- *Food Insecurity (individual level) - Overall - http://www.publichealth.lacounty.gov/ha/docs/2022LACHS/MDT/Adult/Module%205/Food%20Insecurity/LACHS2023_Adult_FoodInsecOverall.xlsx*
- *Food insecurity (individual level) - Very Low or Low Food Security -http://www.publichealth.lacounty.gov/ha/docs/2022LACHS/MDT/Adult/Module%205/Food%20Insecurity/LACHS2023_Adult_FoodInsecVeryLow.xlsx*

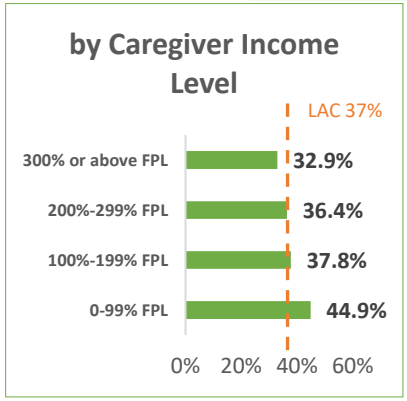
## Figure 28: LACHS Socio-Economic Stability Data – Difficulty Accessing Needed Childcare (12 years old or less) Snapshot

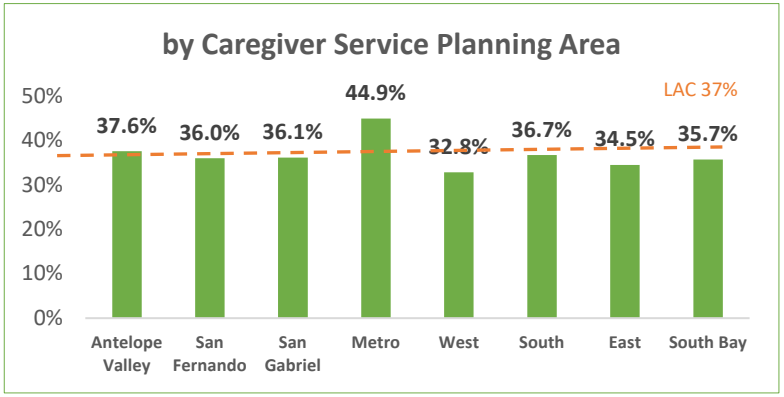
**37% (320,000)** of LA County parents/guardians/decision makers of children 0-12 years old reported difficulty finding needed childcare on a regular basis.



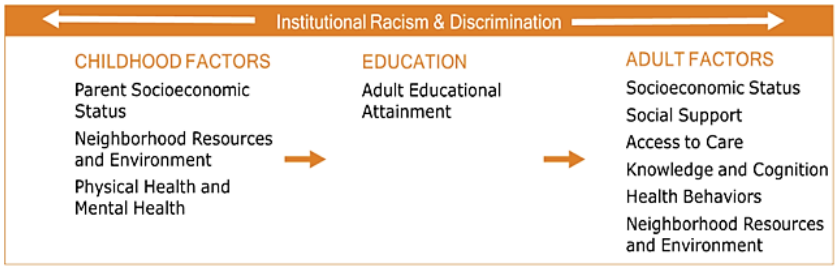

*For a detailed master data table on difficulty accessing needed childcare click here:*

- *Difficulty Accessing Childcare - http://www.publichealth.lacounty.gov/ha/docs/2022LACHS/MDT/Child/Module%207/Children%20Ages%200%20to%2012%20Years/LACHS2023_Child_DiffFindCare12Younger.xlsx*

## Education, Access, and Quality

Education and health are closely connected. Education significantly influences how long people live, their overall health, how healthy their behaviors are, and their level of education plays an important role in health by shaping their job opportunities, income, and access to the supports and resources needed for good health and well-being. Education is also negatively affected by discrimination, institutional biases, and systemic racism. These factors create unequal access to opportunities and essential resources that everyone needs to succeed and sustain their optimal health and well-being throughout life.

**Figure 29: Pathways Connecting Education and Health**




*Adapted from Hummer, R. A. & Hernandez, E. M. (June 2013). The Effect of Educational Attainment on Adult Mortality in the United States. Population Bulletin, 63 (1).*

For instance, starting from early childhood development influenced by parental education levels to future health behaviors, health, and access to healthcare as an adult, there are clear connections and pathways linked to a person's education level. Figure 29 shows pathways connecting education to factors that influence health as an adult that are all impacted by institutional/systemic racism and discrimination.[44]

### Educational Attainment in Los Angeles County

In LA County, roughly 1/5 (20%) of all adults 25+ years old did not graduate from high school in 2022. This is an estimated 1,369,000 adults[45]. There are persistent racial and ethnic disparities in educational attainment across the county (see Figure 31) with the largest gaps seen between white and Hispanic adults.

**Figure 30: American Community Survey 2022 1-Year Estimates on Educational Attainment Percentages, LA County by Race/Ethnicity.**

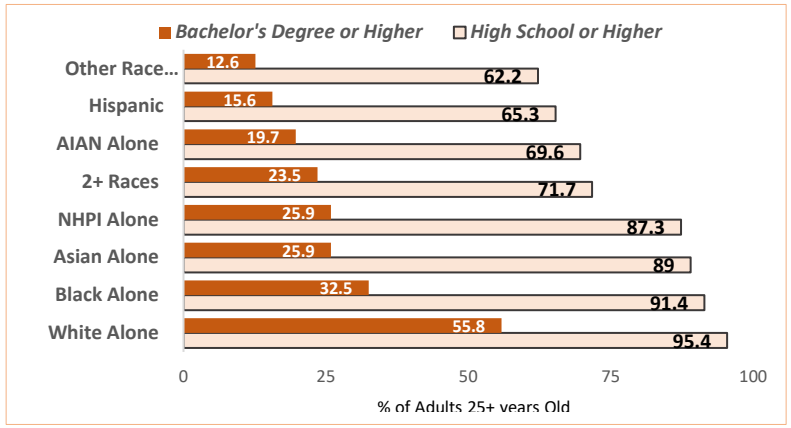
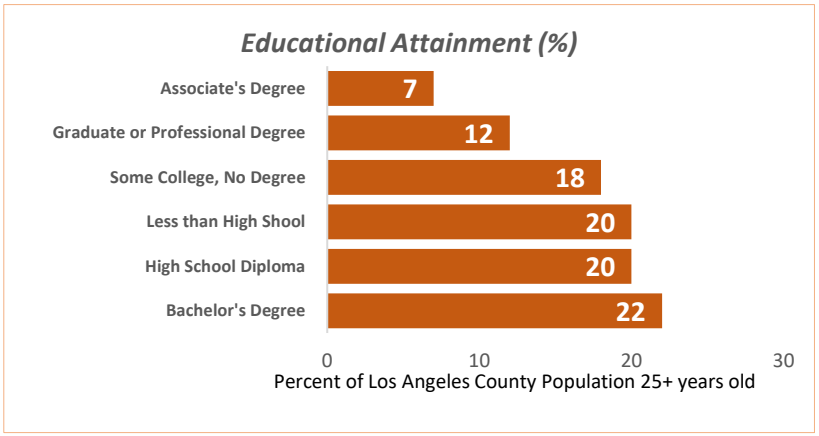
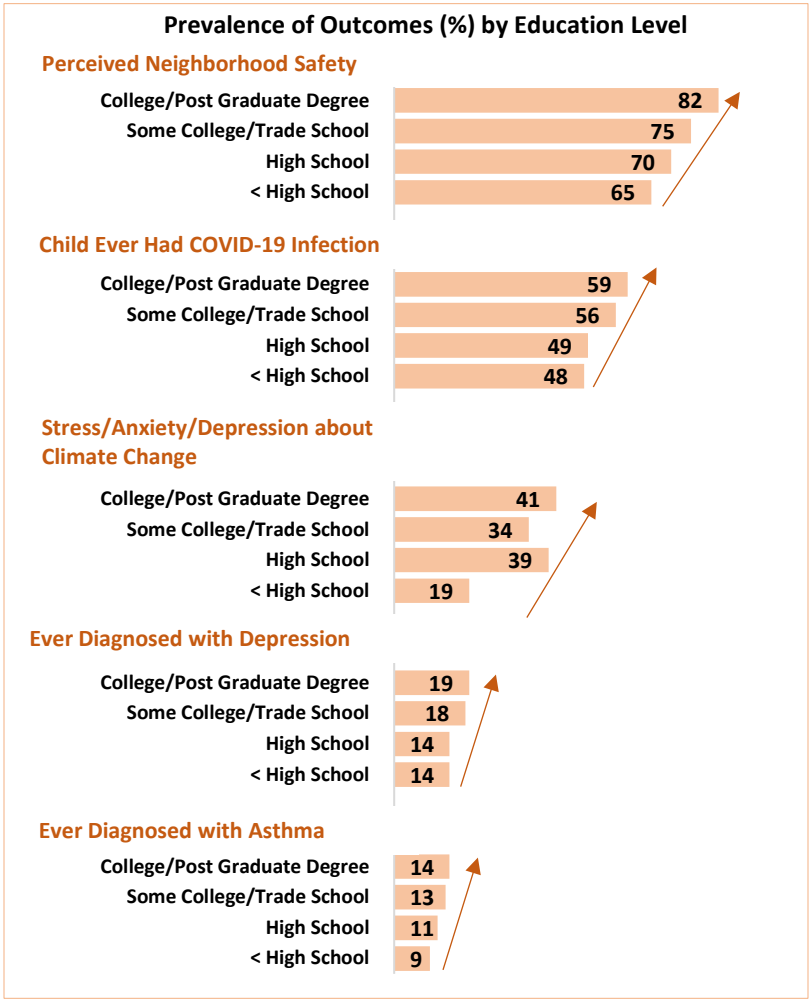



**Figure 31: American Community Survey 2022 1-Year Estimates on Educational Attainment Percentages, Los Angeles County.**

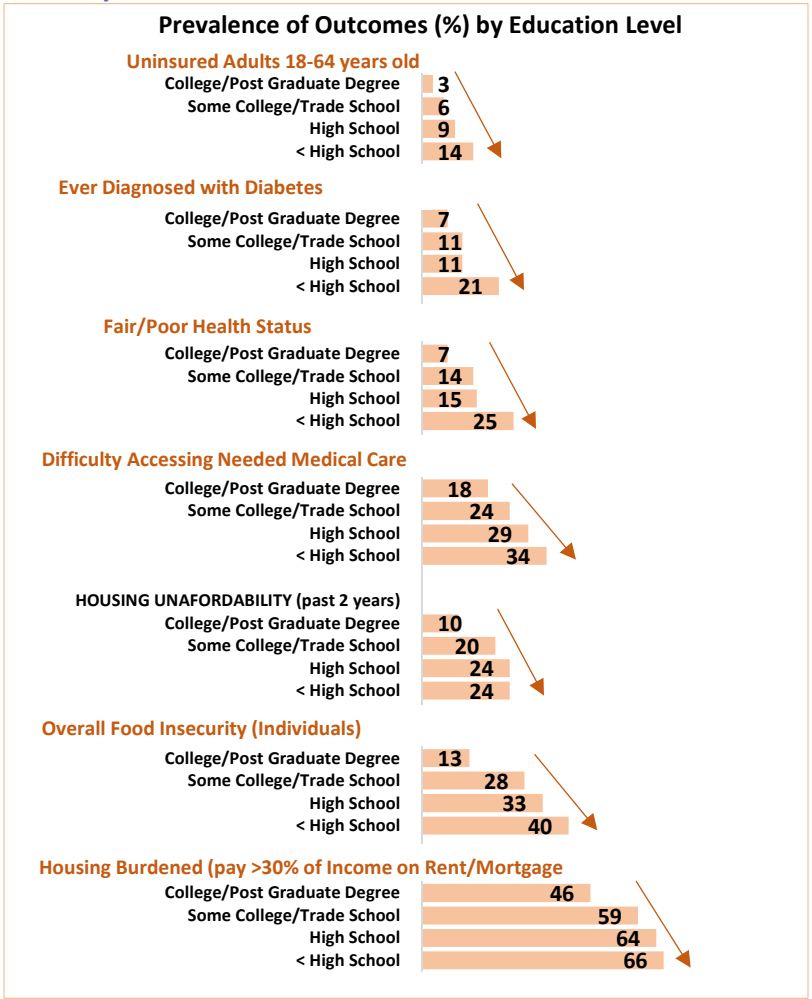


**Observed Relationships between Health Outcomes and Education level.**
Trends were seen between the self-reported educational attainment of LA County adults and various health outcomes based on the Los Angeles County Health Survey. Below is a summary of these linear relationships (Figures 32a & 32b).

### Figure 32a: LACHS SDOH Indicators and Health Outcomes Related to Educational Attainment




### Figure 32b: LACHS SDOH Indicators and Health Outcomes Inversely Related to Educational Attainment.



## Healthcare Access and Quality:

Access to quality healthcare is essential for maintaining good health, preventing illness, getting treatment for illnesses and injuries, managing chronic conditions, and improving overall quality of life by reducing pain, improving illness, and managing symptoms of chronic conditions. Many groups of people and communities in Los Angeles lack access to quality healthcare services, leading to disparities in health outcomes based on factors such as income, race/ethnicity, and geographic location across the county.

**Difficulty Accessing Needed Medical Care:** Cross-sectional health surveillance data from the 2023 Los Angeles County Health Survey (LACHS) show that around one in four (25.4%) adults (18+ years old) reported difficulty accessing needed medical care. Glaring disparities were seen when stratified by race/ethnicity, with almost 1/3 of Latinx (31.5%), 1/4 (24.6%) of Asian, 23.4%*[46] of American Indian or Alaska Natives (AIAN), 1/5(19.6%) of Black/African Americans, 17% of whites and 11.5%[47] of Native Hawaiian or Pacific Islanders (NHPI) reporting difficulty accessing needed medical care. Medical care access difficulties were found to be inversely related to adult education level, and income level with prevalence ranging from 18.4% among those with a college/post-graduate degree to more than 1/3 (34.4%) among those with less than a high school education, and from 16.2% among those living at three or more times the federal poverty level (300+%FPL) to 36.5% among those living below the poverty level (0-99%FPL). The prevalence of reported medical care access difficulty was nearly one in three (32.7%) among adults with a disability compared to only 22% among those without a disability. Most glaring of all was the finding that nearly 1/2 (48.7%) of gender non-binary/non-conforming/Queer adults reported difficulty accessing needed medical care in 2023, compared to 24.8% among cis-gender males. See figure 33 below for a data snapshot on residents experiencing difficulty accessing needed medical care.

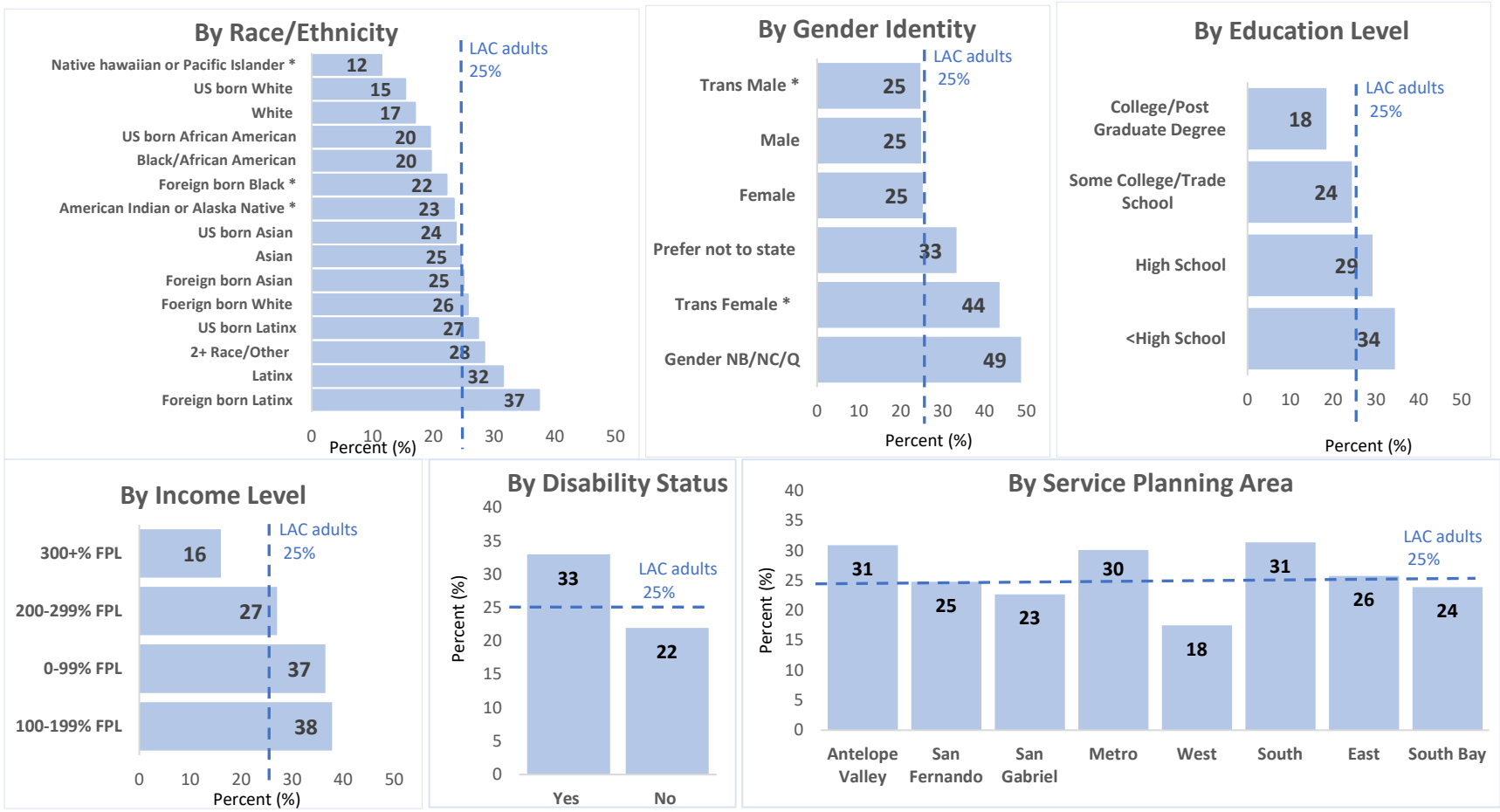
**No Regular Source of Health Care:** Several studies show that vulnerable and marginalized groups utilize less care compared to their counterparts. These groups, particularly in urban settings like Los Angeles County tend to utilize care only in emergency settings i.e., hospital outpatient or emergency room services, since they otherwise may have no regular source of care[48]. Overall, in LA County, more than 1 in 5 (21.4%, 1,682,000) adults reported not having a regular source of health care. Impacted groups include younger adults 18-39 years old, Gender non-binary/non-conforming/Queer, Latinx, and those with lower educational attainment and income levels. See Figure 34 for a data snapshot of residents with no regular source of care.

**No Health Insurance:** The Affordable Care Act (ACA) was signed into law in March 2020 and since then has created expanded healthcare coverage in California and across the nation. Despite the increase in health insurance coverage, in Los Angeles County, 7% (an estimated 448,000) of adults 18-64 years old remain uninsured, with the highest impacted groups being those aged 25-29 years old, those with Less than high school education level, those living below the poverty level (0-99% FPL) and Latinx individuals. See Figure 35 for a data snapshot on the uninsured 18–64-year-old residents in Los Angeles County.

## Figure 33: LACHS Healthcare Access and Quality Data – Difficulty Accessing Needed Health Care Snapshot

**25% (1,992,000)** of LA County adults 18+ years old had difficulty accessing needed medical care.

**13% (258,000)** of LA County Parents/Guardians/Caregivers of children <18 years old had difficulty accessing needed medical care for the child.

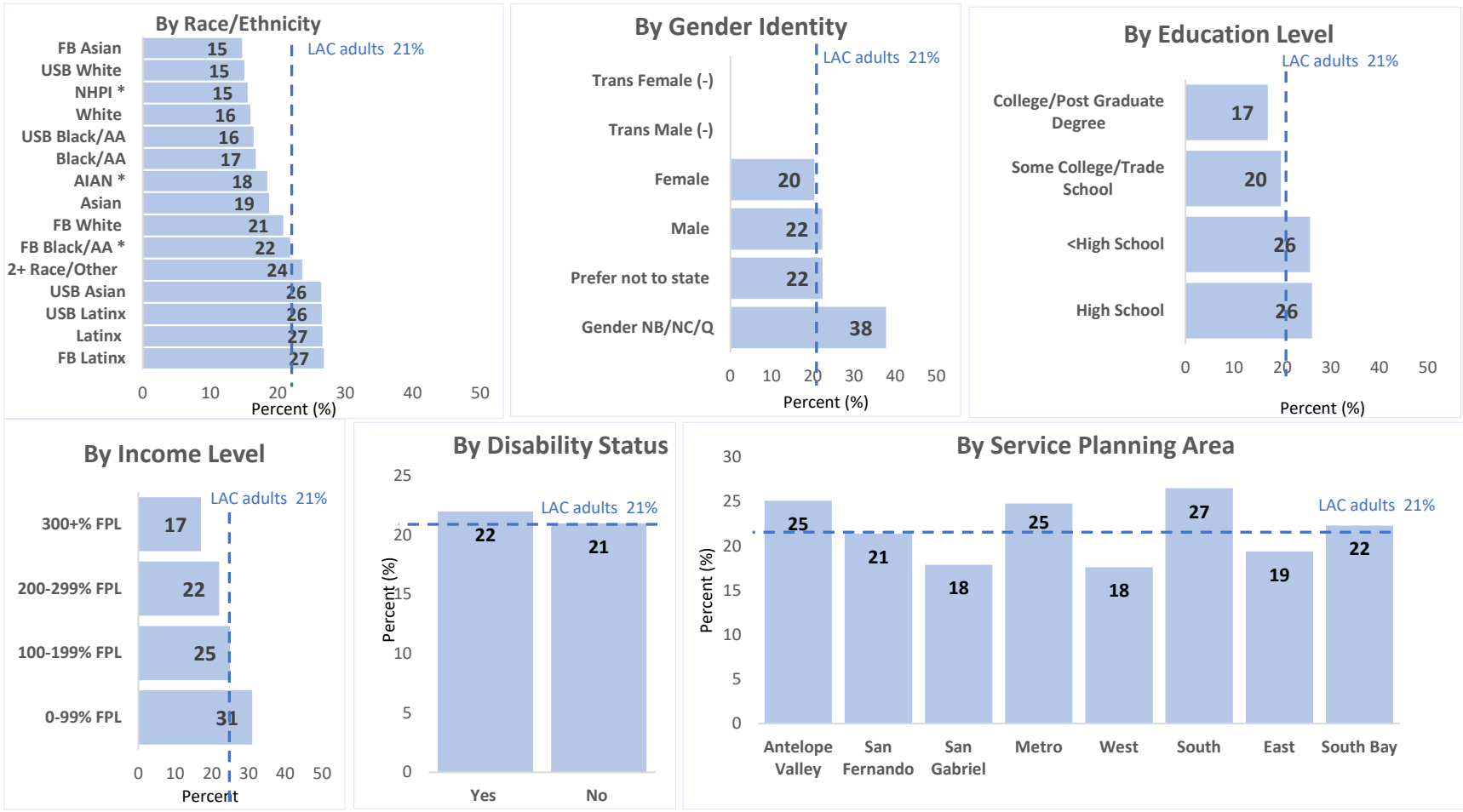



*For detailed master data tables on difficulty accessing medical care, click on the link below:*

- *Difficulty Accessing Medical Care - http://www.publichealth.lacounty.gov/ha/docs/2022LACHS/MDT/Adult/Module%206/Access%20to%20Care/LACHS2023_Adult_DiffAccCare.xlsx*
- *Difficulty Accessing Medical Care for Child - http://www.publichealth.lacounty.gov/ha/docs/2022LACHS/MDT/Child/Module%204/Difficulty%20Access%20Medical%20Care/LACHS2023_Child_DiffAccessCare.xlsx*

## Figure 34: LACHS Healthcare Access and Quality Data – No Regular Source of Health Care Snapshot.

**21% (1,682,000)** of LA County adults 18+ years old with no regular source of healthcare. **8% (145,000)** of LA County children <18 years old with no regular source of healthcare.



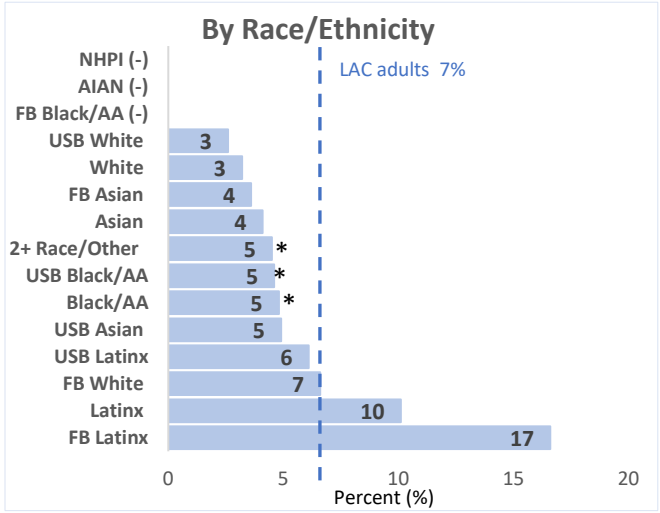

*For detailed master data tables on access to a regular source of medical care, click on the link below:*

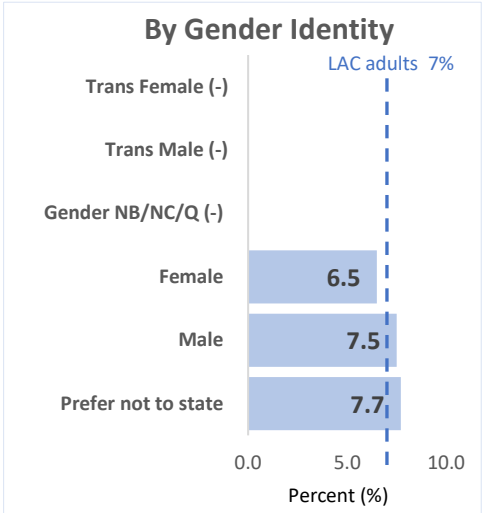
- *No Regular Source of Care - http://www.publichealth.lacounty.gov/ha/docs/2022LACHS/MDT/Adult/Module%206/Regular%20Source%20of%20Care/LACHS2023_Adult_NoRegSourceCare.xlsx*
- *No Regular Source of Care for Child - http://www.publichealth.lacounty.gov/ha/docs/2022LACHS/MDT/Child/Module%204/Regular%20Source%20Care/LACHS2023_Child_NoRegSourceCare.xlsx*

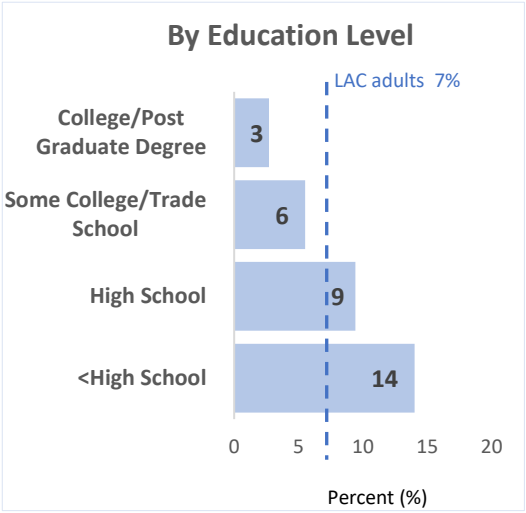
## Figure 35: LACHS Healthcare Access and Quality Data – No Health Insurance Coverage Snapshot.

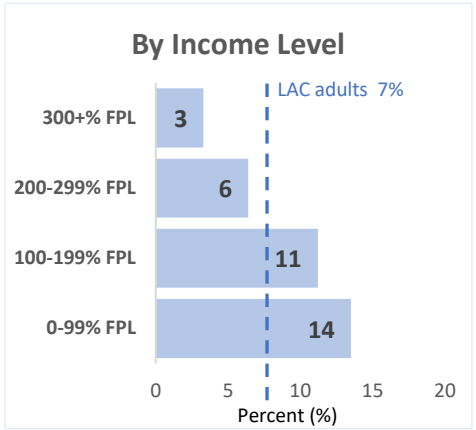
**7% (448,000)** of LA County adults (18-64 years old) had no health insurance.

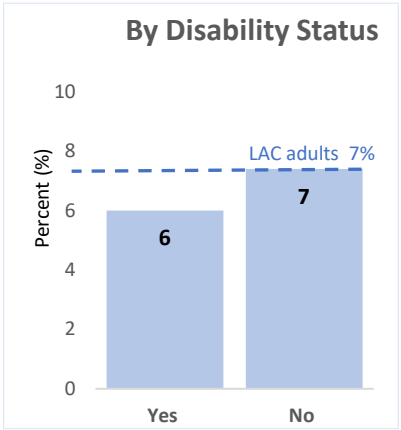
**2% (36,000)** of LA County children (<18 years old) had no health insurance.

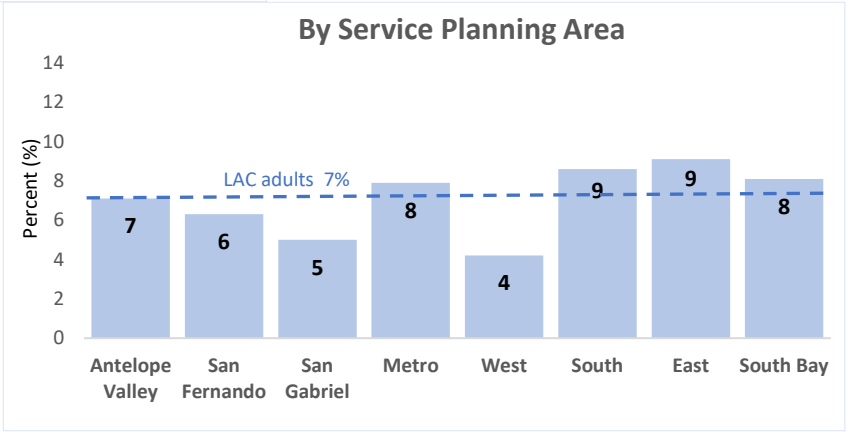



*For detailed master data tables on lack of health insurance coverage, click on the link below:*

- *Uninsured (18-64 years old) - http://www.publichealth.lacounty.gov/ha/docs/2022LACHS/MDT/Adult/Module%206/Insurance/LACHS2023_Adult_Uninsured18to64.xlsx*
- *Insurance Type (18-64 years old) - http://www.publichealth.lacounty.gov/ha/docs/2022LACHS/MDT/Adult/Module%206/Insurance/LACHS2023_Adult_INSType18to64.xlsx*
- *Insurance Type (65+ years old) - http://www.publichealth.lacounty.gov/ha/docs/2022LACHS/MDT/Adult/Module%206/Insurance/LACHS2023_Adult_INSType65Plus.xlsx*

## Climate Change, Neighborhoods and Built Environment

Our physical environment, climate, and neighborhood resources play crucial roles in promoting good health and well-being and shaping our exposures to risks and hazards. These roles are all interconnected, e.g., neighborhood resources like low-emission public transportation, safe parks, community gardens, and other green spaces, improve air quality, reduce heat islands, and facilitate social interaction, physical activity, and other forms of recreation for residents.

**Anxiety and Stress Around the Issue of Climate Change:** Climate change is real and touches upon the realm of public health and safety through various health effects such as respiratory and heart diseases, pest-related diseases like Lyme Disease and West Nile Virus, water quality, and food-borne diseases, as well as increased injuries, violent crimes, and deaths[49]. Based on data from the 2023 LACHS, issues related to climate change can trigger nervousness, depression, and emotional stress in more than 1/3 (35.6%) of adult residents in LA County, an estimated 2.7 million residents. The data show that impacted groups within the county include Gender non-binary/Non-conforming/Queer community, adults with higher educational attainment and higher income levels, adults with a disability, and adults who reside in San Fernando – SPA 2, and West – SPA5, compared to other County SPA's. See below for a snapshot of anxiety and stress related to climate change (figure 36).

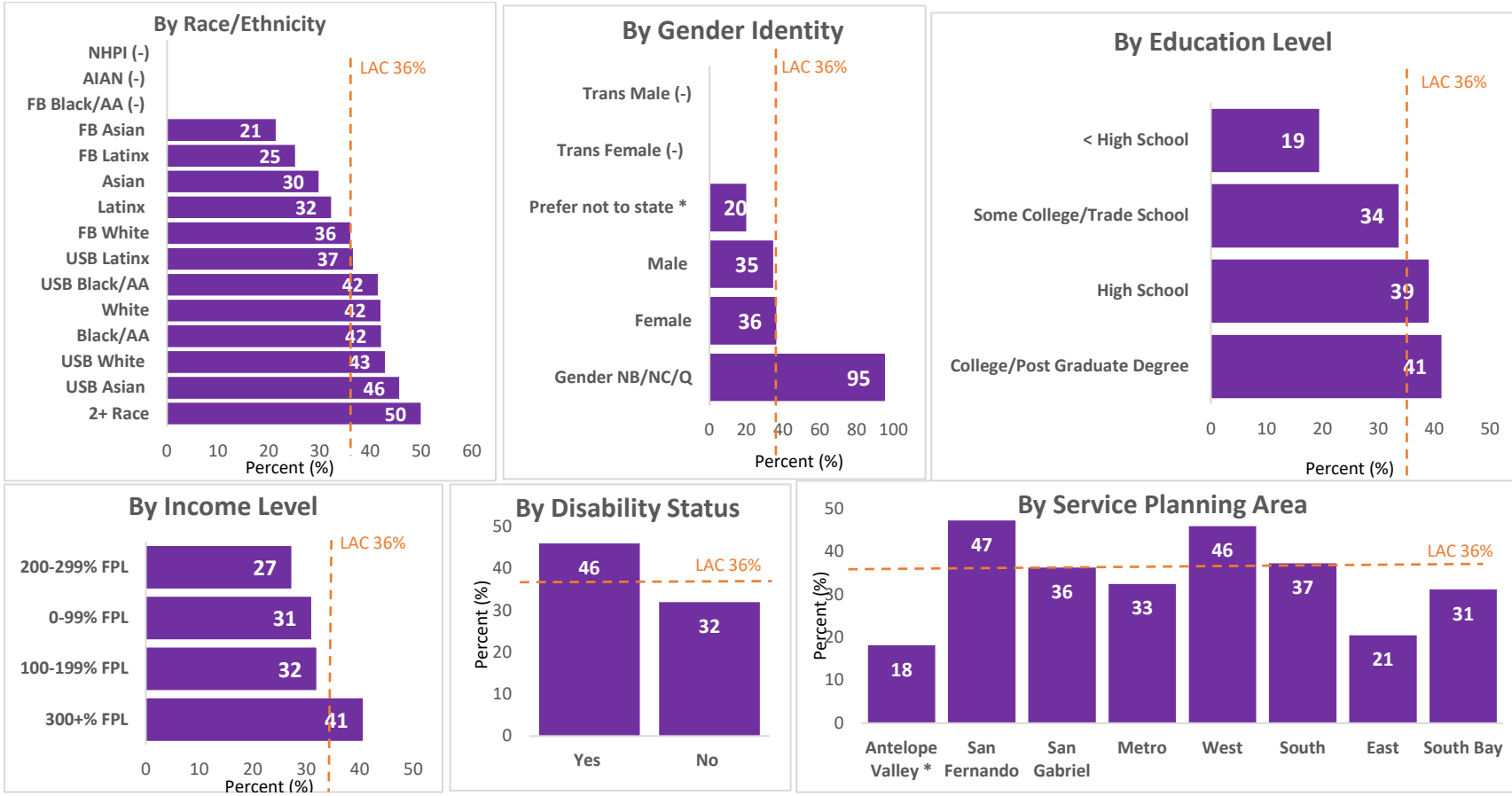
**Asthma:** One of the most ubiquitous health outcomes related to environmental hazards/climate change is asthma prevalence. In LA County there is a slow but consistent rise in asthma prevalence among adults from 6.1% in 2002 to 7.6% in 2023. This is now affecting an estimated 597,000 adults. For children 0-17 years of age, the prevalence is trending lower in recent survey cycles from a high of 9% in 2011 to 7.3% in 2023. However, this still impacts an estimated 143,000 children in the county. See Figure 37 below for a snapshot of Asthma prevalence.

**Neighborhood Safety:** We cannot ignore the importance and impact of "place" as it relates to health, safety, and well-being.[50] Neighborhood safety is an important factor in maintaining good physical and mental health and promoting healthy behaviors such as physical activity and social engagement. Where we live and how we experience/perceive our spaces influences our health behaviors, exposure to hazards, and health outcomes, such as life expectancy, based on factors such as environmental toxic exposures/harms, crime/violence, and availability of health supportive resources in our community. In LA County we are seeing a decline in perceived neighborhood safety from 84% of adults in 2011 to 74% in 2023. The data also shows large disparities in safety perception by race/ethnicity, gender identity, education, and income level. Figure 38 shows a snapshot of neighborhood safety perception.

**Safe Park Access for Children**: The availability of safe parks and recreational spaces is vital to any community as it provides many public health benefits including ease of access to a resource to combat obesity, diabetes and other chronic diseases via physical activity. Parks are also good for improving mental health outcomes for users. Unfortunately, Los Angeles County is relatively park-poor compared to other jurisdictions in the country[51]. Also, crime at park locations is an issue to be aware of for park users (particularly for women and children). LACHS data show that in 2023, 82% of Children ages 1-17 years of age, had easy access to a park, playground or other place that is safe from crime and this safe access decreases for older children, Latinx, Black and American Indian Alaska Native children, and based on caregiver socio-demographic characteristics. See Figure 39 for a snapshot of safe park/playground access for children in LA County.

## Figure 36: LACHS Climate Change, Neighborhood and Built Environment Data – Anxiety/Stress About Climate Change Snapshot.

**36% (2,790,000)** of LA County adults reported that the issue of climate change makes them feel nervous, depressed or emotionally stressed.

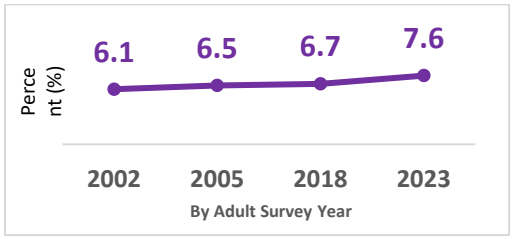


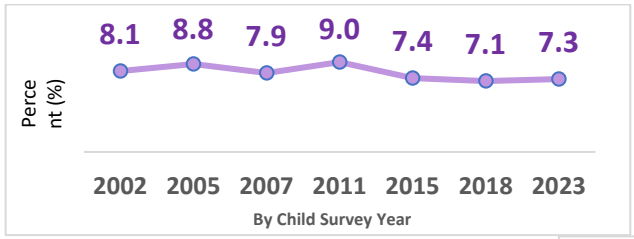

*For detailed master data tables on climate change outcomes, click on the link below:*

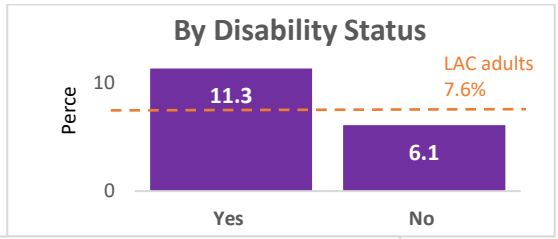
- *Nervous, Depressed, Stressed about climate change - http://www.publichealth.lacounty.gov/ha/docs/2022LACHS/MDT/Adult/Module%209/LACHS2023_Adult_ClimateChangNerv.xlsx*
- *Willing to have a tree planted at residence - http://www.publichealth.lacounty.gov/ha/docs/2022LACHS/MDT/Adult/Module%205/Climate%20Change/LACHS2023_Adult_FreeTreePlanted.xlsx*
- *Household experienced hazardous weather event - http://www.publichealth.lacounty.gov/ha/docs/2022LACHS/MDT/Adult/Module%205/Climate%20Change/LACHS2023_Adult_HazardWeatherEvent.xlsx*
- *Household Member- physical harm due to hazardous weather event - http://www.publichealth.lacounty.gov/ha/docs/2022LACHS/MDT/Adult/Module%205/Climate%20Change/LACHS2023_Adult_PhysHealth_HazardWeather.xlsx*
- *Household Member- mental health harmed due to hazardous weather event - http://www.publichealth.lacounty.gov/ha/docs/2022LACHS/MDT/Adult/Module%205/Climate%20Change/LACHS2023_Adult_MentalHealth_HazardWeather.xlsx*

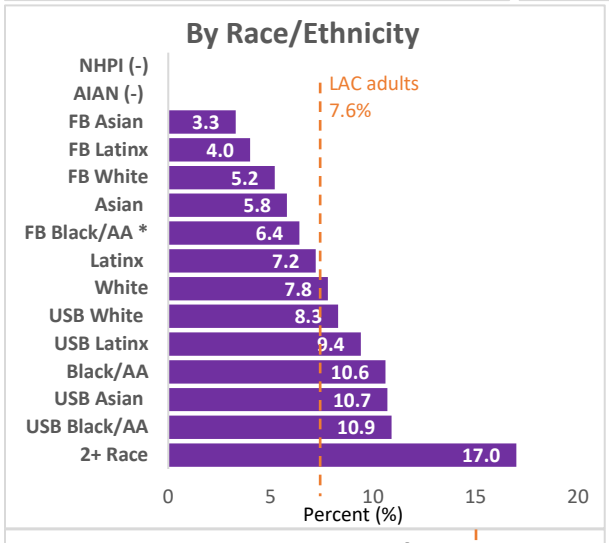
## Figure 37: LACHS Climate Change, Neighborhood and Built Environment Data – Asthma Prevalence Snapshot

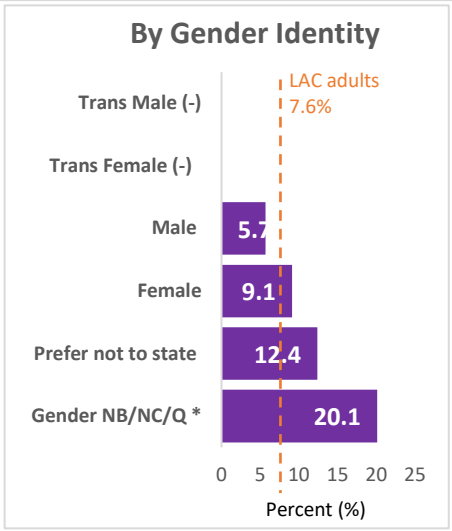
In 2023, the asthma prevalence in LA County adults 18+ years old was **8% (597,000)** and was **7% (143,000)** among children <18 years old.

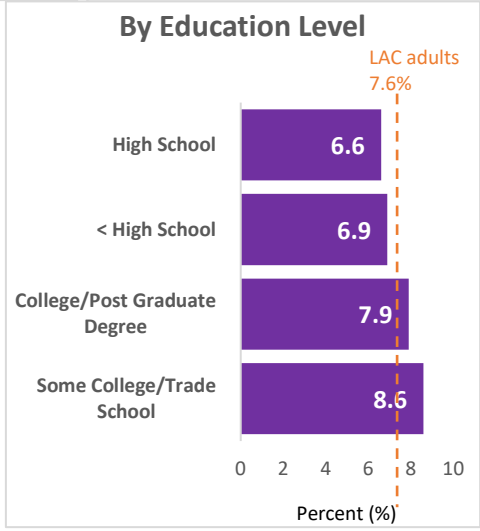


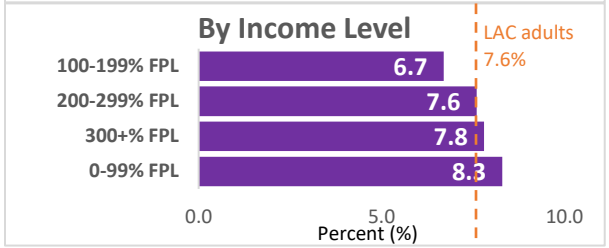



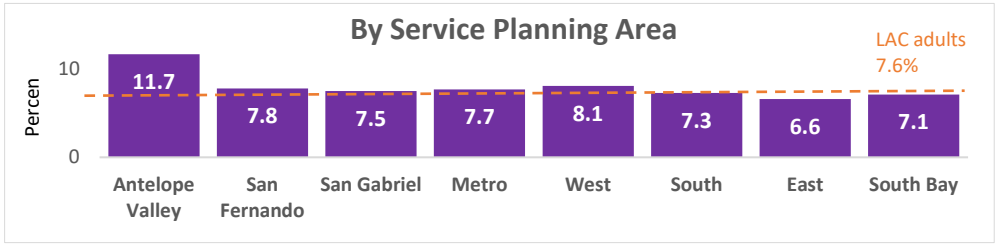



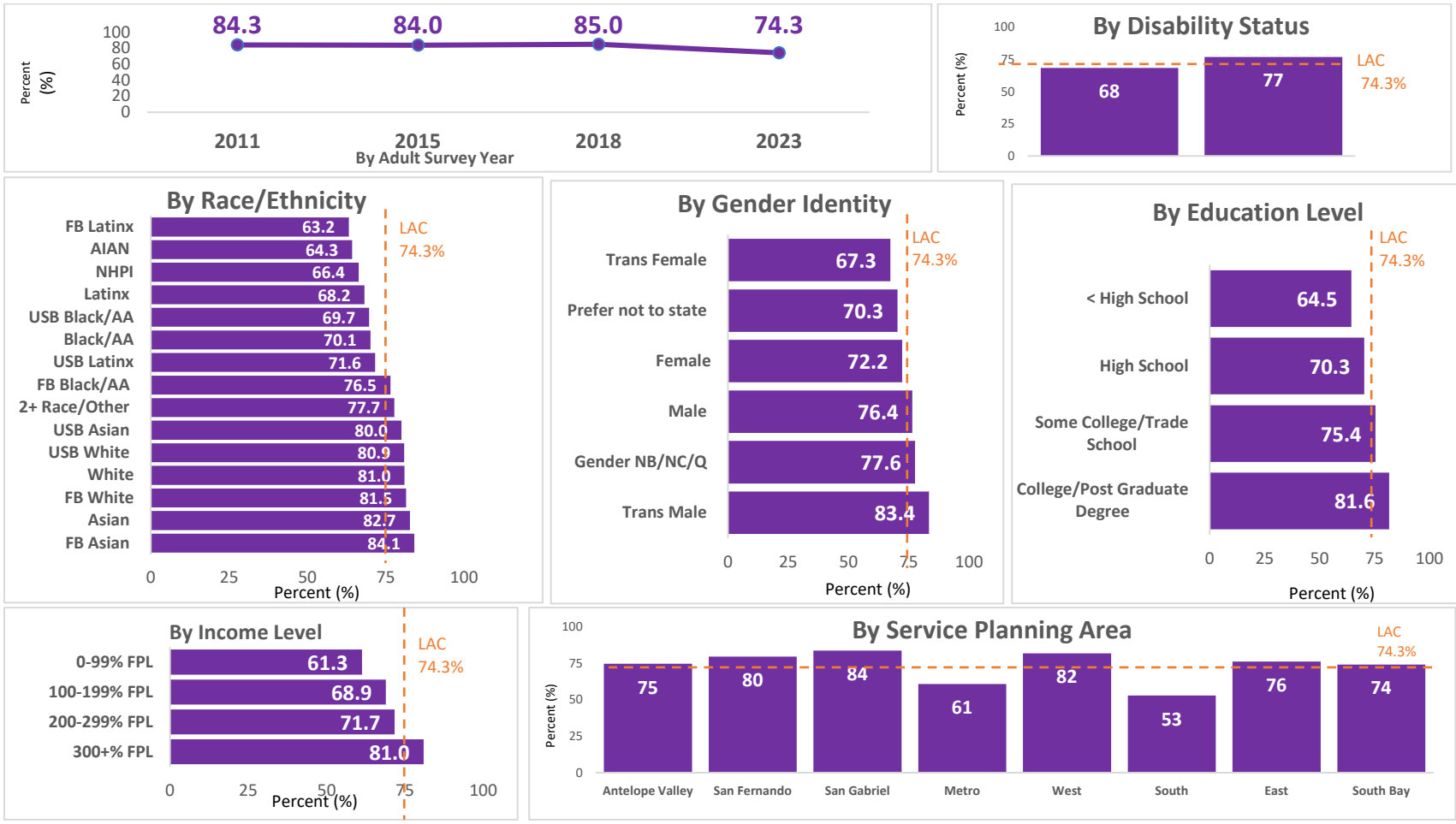




*For detailed master data tables on asthma prevalence in LA County, click on the link below:*

- *Adults Ever Diagnosed with Asthma - http://www.publichealth.lacounty.gov/ha/docs/2022LACHS/MDT/Adult/Module%207/Medical%20Conditions/LACHS2023_Adult_EverDiagAsthma.xlsx*
- *Adults with Current Asthma - http://www.publichealth.lacounty.gov/ha/docs/2022LACHS/MDT/Adult/Module%207/Medical%20Conditions/LACHS2023_Adult_CurrentAsthma.xlsx*
- *Children Ever Diagnosed with Asthma - http://www.publichealth.lacounty.gov/ha/docs/2022LACHS/MDT/Child/Module%202/Asthma/LACHS2023_Child_EverDiagAsthma.xlsx*
- *Children with Current Asthma - http://www.publichealth.lacounty.gov/ha/docs/2022LACHS/MDT/Child/Module%202/Asthma/LACHS2023_Child_CurrentAsthma.xlsx*

## Figure 38: LACHS Climate Change, Neighborhood and Built Environment Data – Perceived Neighborhood Safety Snapshot.

In 2023, only **74.3% (5,828,000)** of LA County adults 18+ years old perceived their neighborhood to be safe from crime.

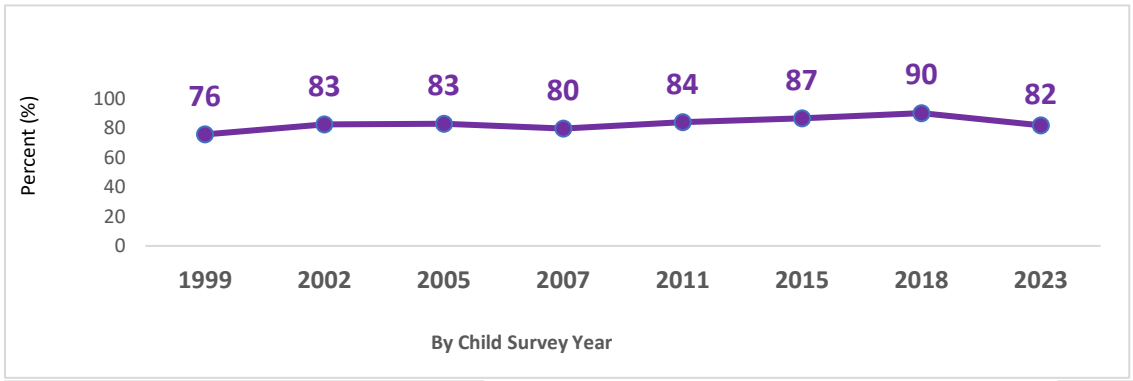


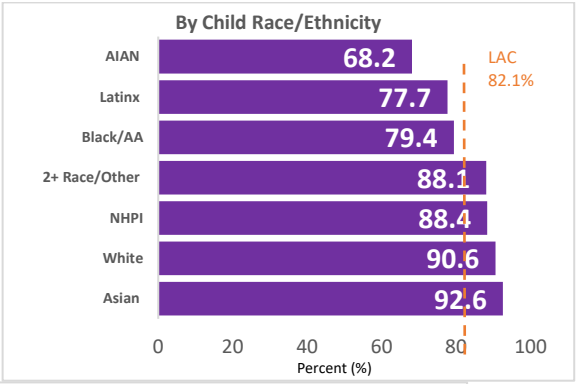

*For detailed master data tables on neighborhood safety, click on the link below:*

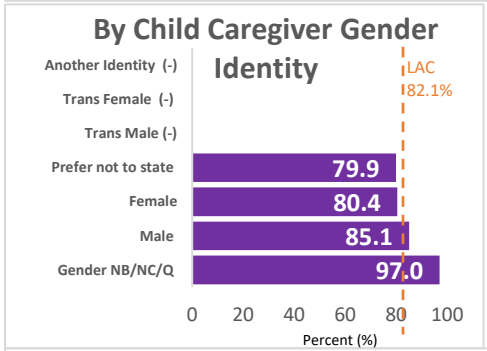
- *Perceived Neighborhood Safety - http://www.publichealth.lacounty.gov/ha/docs/2022LACHS/MDT/Adult/Module%204/Neighborhood%20Safety/LACHS2023_Adult_NeighSafety.xlsx*
- *Had Anything Stolen/Damaged inside or outside your home - http://www.publichealth.lacounty.gov/ha/docs/2022LACHS/MDT/Adult/Module%204/Neighborhood%20Safety/LACHS2023_Adult_AnythingStolenHome.xlsx*
- *Mugged, Punched or Hi, or shot in neighborhood - http://www.publichealth.lacounty.gov/ha/docs/2022LACHS/MDT/Adult/Module%204/Neighborhood%20Safety/LACHS2023_Adult_MuggedNeigh.xlsx*
- *Sexually Assaulted in your neighborhood - http://www.publichealth.lacounty.gov/ha/docs/2022LACHS/MDT/Adult/Module%204/Neighborhood%20Safety/LACHS2023_Adult_SexAssaultNeigh.xlsx*

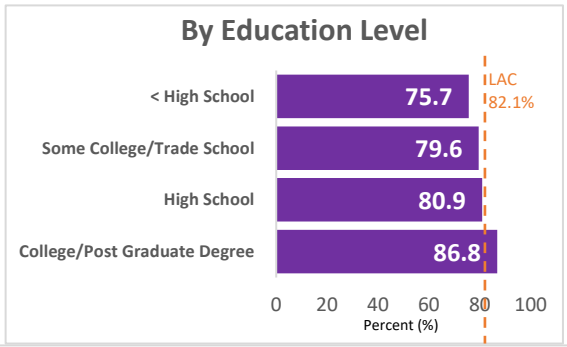
## Figure 39: LACHS Climate Change, Neighborhood and Built Environment Data – Safe Park/Playground Access for Children .

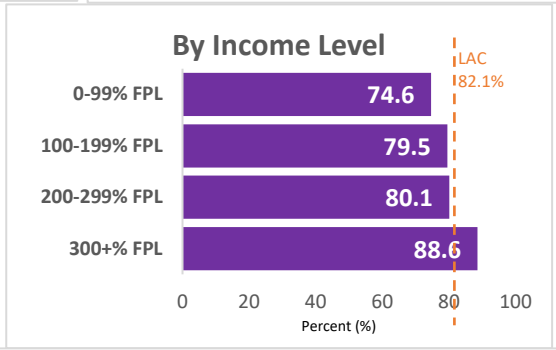
**82% (1,485,000)** of LA County children <18 years old had easy access to a park, playground or other safe place that is safe from crime.

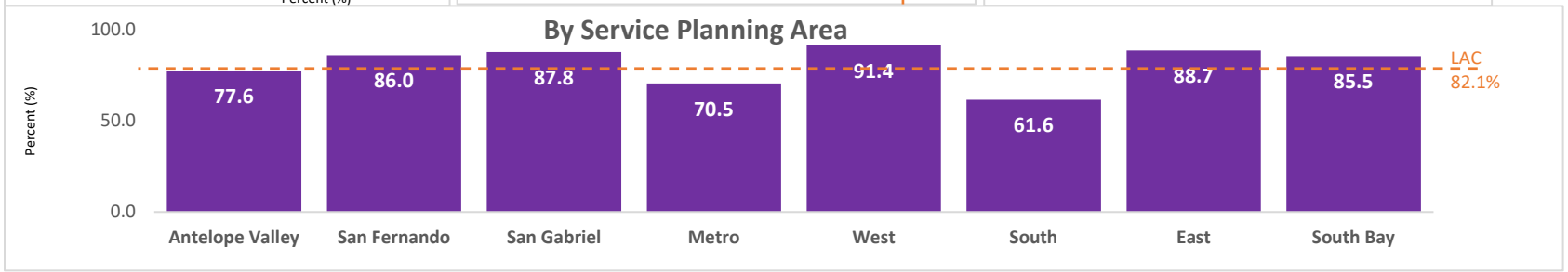



*For detailed master data tables on neighborhood safety for children in LA County, click on the link below:*

- *Perceived Safe Park/Playground - http://www.publichealth.lacounty.gov/ha/docs/2022LACHS/MDT/Child/Module%208/Community/LACHS2023_Child_SafeParkAccess.xlsx*

## Social and Community Context

How residents of Los Angeles County interact with each other greatly impacts overall health and well-being in our communities. Given the magnitude of social change, increased political polarization and partisanship, growing economic inequality, and experiences from major events, like the COVID-19 pandemic, the ensuing mandatory social isolation, the racial tensions, and protests/clashes from the reaction to public killings of African American men, and other forms of continued systemic and institutional racism and discrimination, have greatly impacted social and community fabric in Los Angeles County. These individually and collectively have often led to disagreements and challenges in finding common ground or compromise on solutions for addressing the social and community factors that influence health outcomes. Hate crimes are also rising in LA County, with some of the biggest increases in incidents in more than 20 years[52]. The psychosocial impacts are being felt among different minority communities including Black/African Americans, the Jewish and Muslim communities, members of the LGBTQIA2S communities and gender-based violence against women and Transgender individuals.

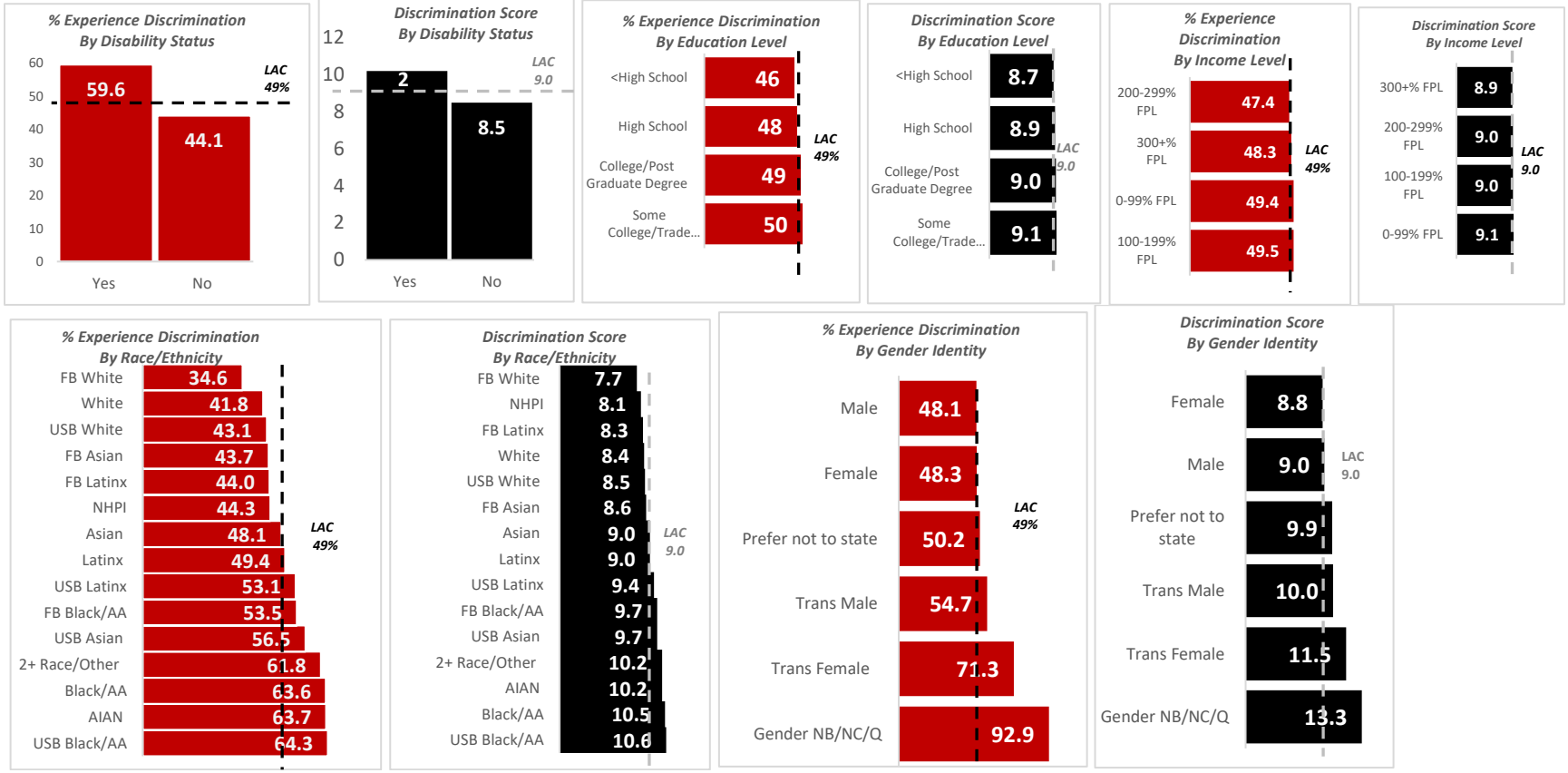
**Discrimination:** Discrimination has a profound and multifaceted impact on health, affecting both mental and physical well-being through stress, unhealthy behaviors, and limited access to health promoting resources and social determinants of health. Addressing discrimination and promoting fairness is essential for improving health outcomes and reducing disparities. Discrimination can be interpersonal or structural (i.e., policies, laws or rules) and takes on many forms. It involves unfair and inequitable treatment of individuals based on their characteristics such as race/ethnicity, immigrant status, gender identity, sexual orientation, disability status, and age. Discrimination hurts people and harms health as is evident in large numbers of empirical studies that link discrimination to adverse health outcomes[53]. Based on the 2023 LACHS, nearly 1/2 (49%) of LA County adults reported experiencing discrimination at least once a year, 21% experienced discrimination at least once a month, and 9% experienced discrimination at least once a week. An average score of discrimination metric was also calculated based on survey responses. Data are based on the 5-item Everyday Discrimination Scale (Short Version): 1) You are treated with less courtesy or respect than other people; 2) You receive poorer service than other people in restaurants or stores; 3) People act as though they think you are not smart; 4) People act as if they are afraid of you; and 5) You are threatened or harassed[54] The frequency of each experience was assessed by Likert scale responses: never, less than once a year, a few times a year, a few times a month, and at least once a week. The total score of discrimination experience was calculated by scoring the responses according to the Likert scale and then summing the responses across items. The total score ranges from 5 to 25. See Figure 40 for a snapshot of Discrimination in LA County.

**Depression & Suicide:** There is an upward trend in ever being diagnosed with depression (8.8% in 1999 to 16% in 2023) and experiencing current depression (8.3% in 2011 to 12.4% in 2023). Nearly 13% (an estimated 1,006,000 adults) of LA County adults reported they had ever seriously thought about committing suicide, and 4.1% (an estimated 320,000) of adults reported having attempted suicide. Appendix-C has a snapshot of psycho-social health indicators such as depression (Ever Diagnosed and Current Depression - Figure 41a; At Risk for Major Depression – Figure 41b) and suicide ideation and attempts (Figure 42).

## Figure 40: LACHS Social and Community Context Data – Discrimination (at least once per year/average score)Snapshot.

**49% (3,808,000) of LA County adults 18+ years old reported experiencing discrimination at least once a year.**

LA County adults 18+ years old had an **average discrimination experience score of 9.0**

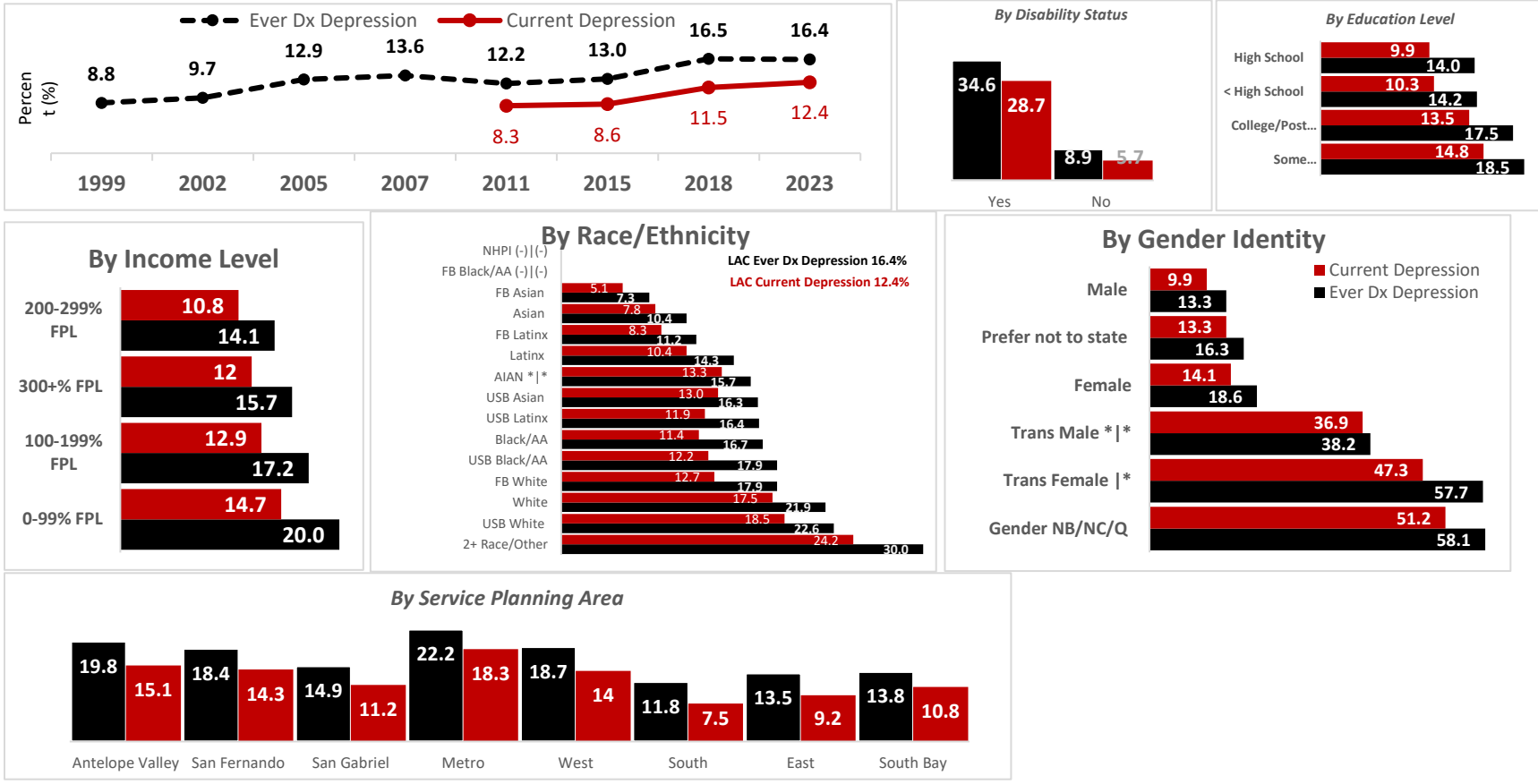



*For detailed master data tables on Discrimination Experience, click on the link below:*

- *Experience Discrimination at least Once a Year - http://www.publichealth.lacounty.gov/ha/docs/2022LACHS/MDT/Adult/Module%205/Discrimination/LACHS2023_Adult_DiscOnceYear.xlsx*
- *Experience Discrimination at least Once a Month - http://www.publichealth.lacounty.gov/ha/docs/2022LACHS/MDT/Adult/Module%205/Discrimination/LACHS2023_Adult_DiscOnceMonth.xlsx*
- *Experience Discrimination at least Once a Week - http://www.publichealth.lacounty.gov/ha/docs/2022LACHS/MDT/Adult/Module%205/Discrimination/LACHS2023_Adult_DiscOnceWeek.xlsx*
- *Average Score of Discrimination Experience - http://www.publichealth.lacounty.gov/ha/docs/2022LACHS/MDT/Adult/Module%205/Discrimination/LACHS2023_Adult_DiscExpScore.xlsx*

## Figure 41a: LACHS Social and Community Context Data – Ever Diagnosed and Current Depressions Snapshot.

There is an upward trend in the prevalence of adults ever diagnosed with depression. **The prevalence has increased from 8.8% in 1999 to 16.4% in 2023.**
Similarly, there is an upward trend in adults with current depression in LA County. **The prevalence increased from 8.3% in 2011 to 12.4% in 2023.**



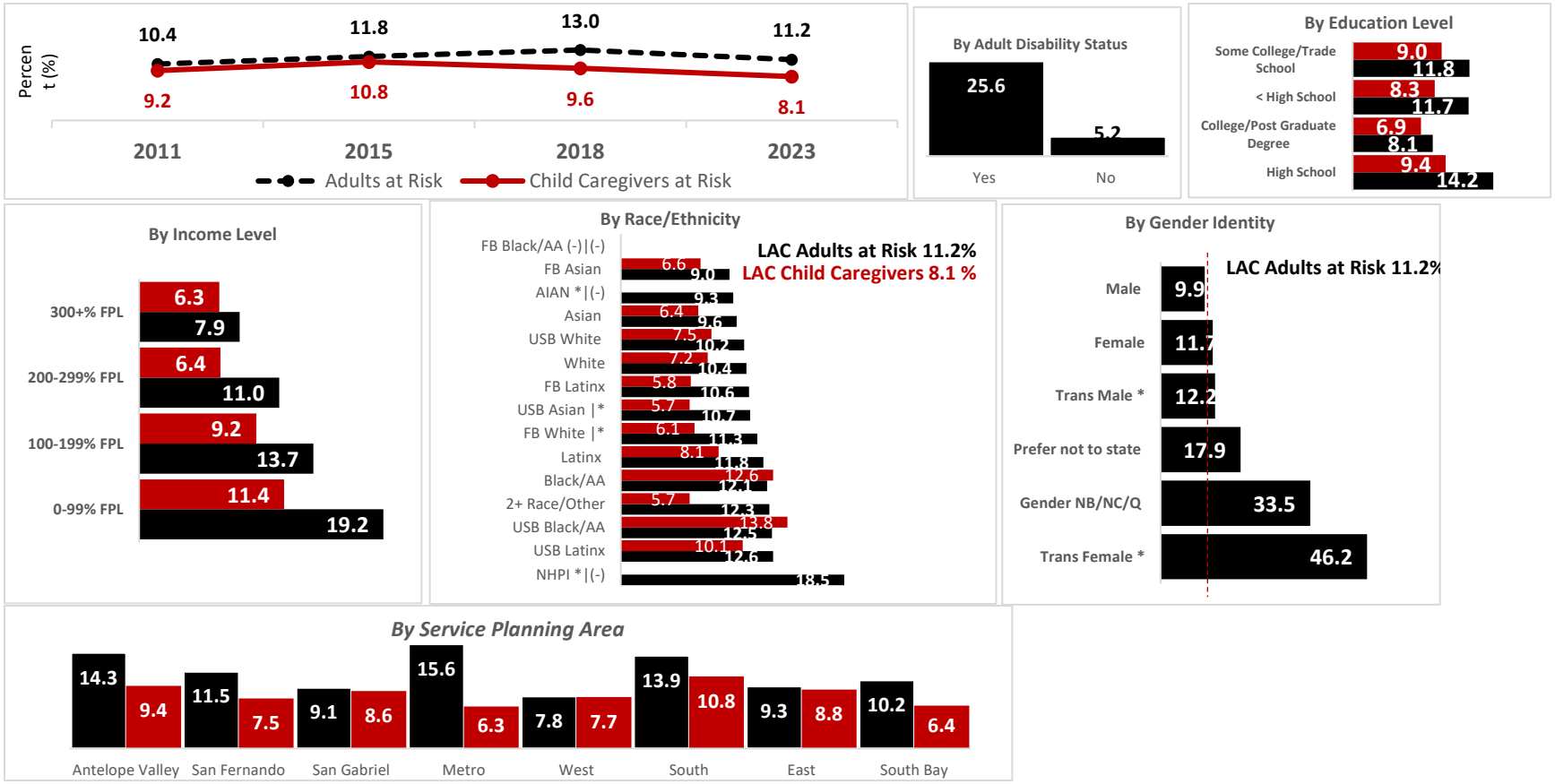

*For detailed master data tables on Depression Prevalence, click on the link below:*

- *Ever Diagnosed with Depression - http://www.publichealth.lacounty.gov/ha/docs/2022LACHS/MDT/Adult/Module%207/Mental%20Health/LACHS2023_Adult_EverDiagDep.xlsx*
- *Current Depression - http://www.publichealth.lacounty.gov/ha/docs/2022LACHS/MDT/Adult/Module%207/Mental%20Health/LACHS2023_Adult_CurrentDep.xlsx*
- *Received Counselling for Depression - http://www.publichealth.lacounty.gov/ha/docs/2022LACHS/MDT/Adult/Module%207/Mental%20Health/LACHS2023_Adult_DepCouns.xlsx*
- *Taking Medication for Depression - http://www.publichealth.lacounty.gov/ha/docs/2022LACHS/MDT/Adult/Module%207/Mental%20Health/LACHS2023_Adult_DepMed.xlsx*
- *Currently Taking Medications and/or Receiving Counseling for Depression –Overall - http://www.publichealth.lacounty.gov/ha/docs/2022LACHS/MDT/Adult/Module%207/Mental%20Health/LACHS2023_Adult_DepMed_CounsOverall.xlsx*

## Figure 41b: LACHS Social and Community Context Data – At Risk for Major Depression Snapshot.

**11.2% (875,000)** of LA County adults 18+ years old were found to be at risk for major depression.

There was a downward trend in parents/guardians/caregivers of children (aged 17 or younger) who were at risk for major depression from a high of **10.8% in 2015 to 8.1% in 2023.**

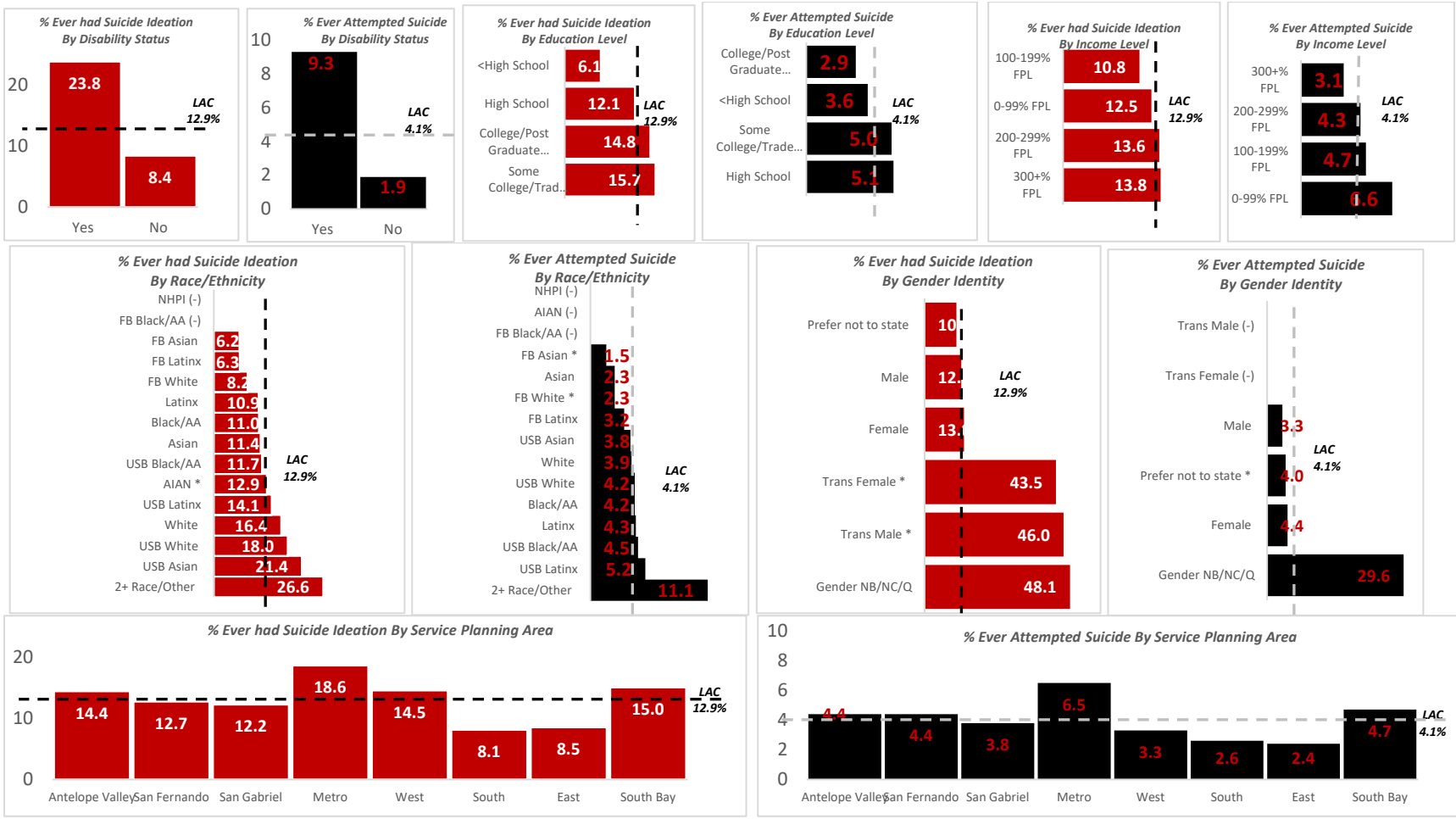



*For detailed master data tables on Depression Risk, click on the link below:*

- *Adults at Risk for Major Depression - http://www.publichealth.lacounty.gov/ha/docs/2022LACHS/MDT/Adult/Module%207/Mental%20Health/LACHS2023_Adult_RiskMajorDep.xlsx*
- *At Risk for Major Depression - Child Parents, Guardians, or Decision Makers - http://www.publichealth.lacounty.gov/ha/docs/2022LACHS/MDT/Child/Module%208/Respondent%20Mental%20Health/LACHS2023_Child_ParentRiskMajDep.xlsx*

## Figure 42: LACHS Social and Community Context Data – Suicide Ideation and Attempts Snapshot

**12.9% (1,006,000)** of adults 18+ years old in LA County reported that they had ever seriously thought about suicide.
**4.1% (320,000)** of LA County adults have ever attempted suicide.



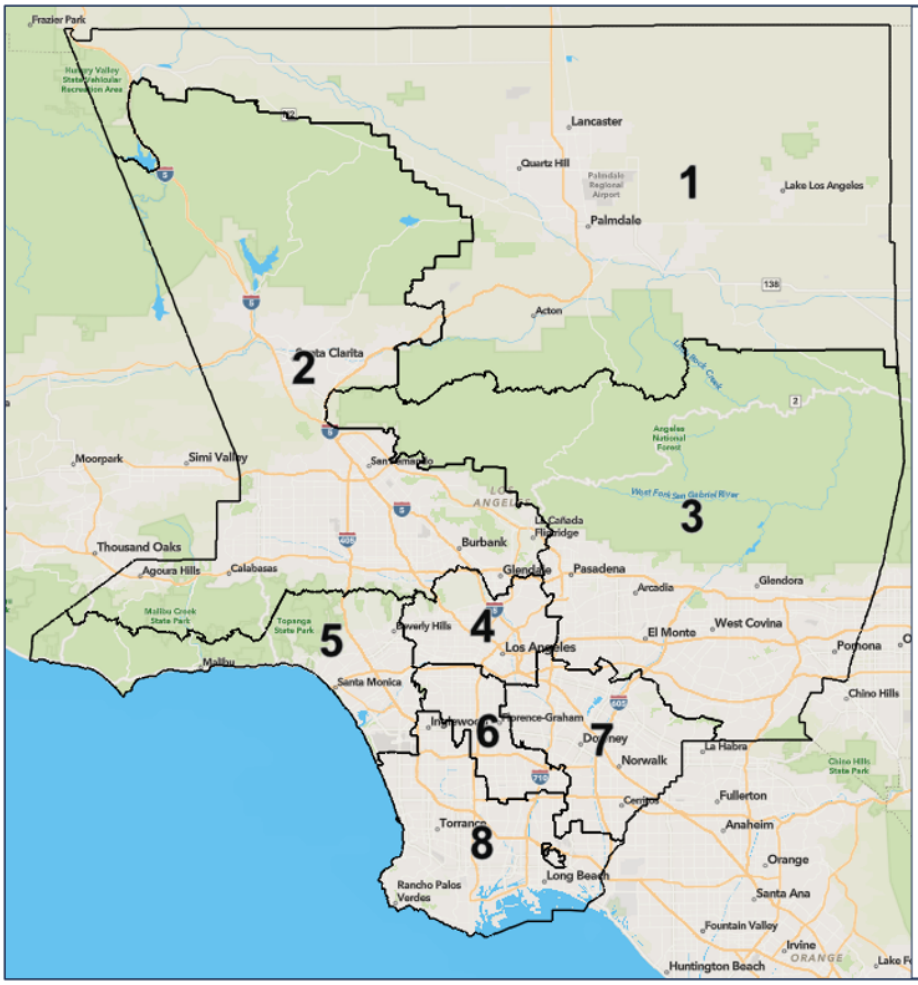

*For detailed master data tables on Suicide Ideation and Attempts, click on the link below:*

- *Ever Seriously Thought of Suicide - http://www.publichealth.lacounty.gov/ha/docs/2022LACHS/MDT/Adult/Module%204/Suicide/LACHS2023_Adult_EverThinkSuicide.xlsx*
- *Ever Attempted Suicide - http://www.publichealth.lacounty.gov/ha/docs/2022LACHS/MDT/Adult/Module%204/Suicide/LACHS2023_Adult_EverAttemptSuicide.xlsx*

**Data Notes:**

- Some estimates marked by an (*) are statistically unstable (relative standard error >30%) and may not be appropriate for planning/policy purposes. Other estimates are suppressed (-) for purposes of confidentiality where cell sizes less than 5 are not reported.
- Race/Ethnicity: Latinx includes respondents of any race. All other races presented are non-Hispanic (excludes any mention of Hispanic ethnicity). Race and ethnicity were re-coded based on the LA County Department of Public Health Standard of Practice for collecting and reporting race and ethnicity data.
    - FB – Foreign Born | USB – US Born | Gender NB/NC/Q – non-binary, non-conforming, Queer |
    - AA – African American | AIAN – American Indian/Alaska Native | NHPI – Native Hawaiian and Pacific Islander |
- Income Level: Based on the U.S. Census 2022 Federal Poverty Level (FPL) thresholds which for a family of four (2 adults, 2 dependents) correspond to annual incomes of $27,750 (100% FPL), $55,500 (200% FPL), and $83,250 (300% FPL). [These thresholds were the values at the time of survey interviewing.].

# Appendix IV – Service Planning Areas (SPA)




**What Is a Service Planning Area (SPA)?**

A Service Planning Area, or SPA, is simply a specific geographic region within Los Angeles County.

Due to the large size of LA County (4,300 square miles), it has been divided into 8 geographic areas. These distinct regions allow the Department of Public Health to develop and provide more relevant public health and clinical services targeted to the specific health needs of the residents in these different areas.

**SPA 1 – Antelope Valley**

**SPA 2 – San Fernando Valley**

**SPA 3 – San Gabriel Valley**

**SPA 4 – Metro**

**SPA 5 – West**

**SPA 6 – South**

**SPA 7 – East**

**SPA 8 – South**

http://publichealth.lacounty.gov/chs/SPAMain/ServicePlanningAreas.htm

# References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