Los Angeles County Community Health Equity Improvement Plan (CHEIP) (2024-2029) - REVISED

Introduction

The Community Health Equity Improvement Plan (CHEIP) 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. Communities use the CHEIP to set priorities, reduce duplication, strengthen partnerships, and coordinate actions to maximize collective impact.

This document is a mid-term revision of the CHEIP and primarily contains updates to the workplan. As we enter the third year of implementation, Public Health and partners reviewed the plan and identified opportunities to improve clarity and adjust timelines to better align with current efforts. This revision also introduces a fifth focus area on overdose prevention, reflecting an ongoing priority and work led by Public Health and partners.

Reflection on the past two years of implementation also highlights significant challenges that have affected this work – some longstanding and persistent, others more recent and unprecedented. Ongoing attacks on public health infrastructure, substantial reductions in public health funding, weakened environmental and occupational health protections, reduced access to healthcare and social services, and shifts in immigration policies have all adversely affected public health efforts. At the local level, this has contributed to devastating cuts to programs and declines in engagement, particularly among impacted communities that face additional barriers such as increased fear of deportation or detention, risks of family separation, loss of services, or individuals discouraged from seeking care and preventive services.

While the CHEIP remains grounded in collaboration and a shared commitment to advancing health, its initial strategies were developed under a different set of external conditions. Today's challenges are even broader, deeper, more complex, and further stress the systems that support the community. Yet, amid these evolving realities and the additional challenges they present, Public Health and partners remain committed to advancing the priorities outlined in the Plan.

Additionally, efforts beyond the CHEIP are underway to address these broader challenges. County agencies, including Public Health, and community partners are working to better support residents by equipping staff with the tools, knowledge, and resources needed to help communities navigate changes that may undermine progress and worsen existing inequities. A few such efforts and partnerships that the CHEIP partners actively engage with include:

- Office of Immigrant Rights – Know Your Rights.
- ARDI Equity Policy Initiatives – Los Angeles County
- The CCF Wildfire recovery fund - California Community Foundation
- The TransLatin@ Coalition
- LA vs. Hate

Revisions to the CHEIP

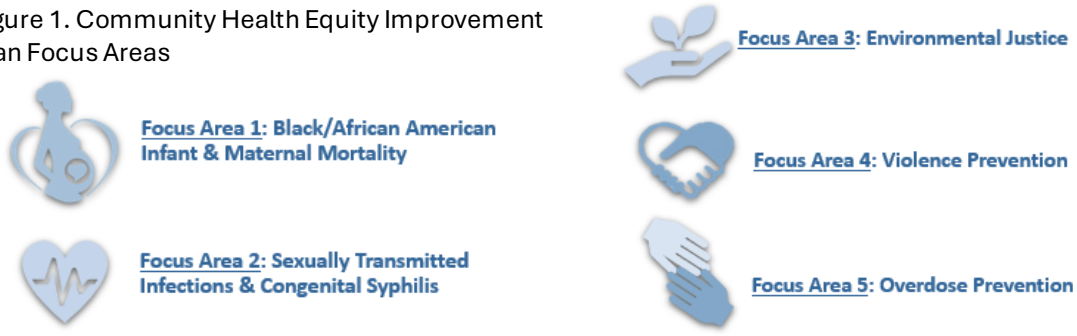
As CHEIP partners have implemented strategies in each Focus Area, adjustments were made to update timelines and to refine select goals, strategies, and activities in the Plan. Overall, highlighted revisions include:

- Addition of Overdose Prevention as a 5th Focus Area of the CHEIP (see section III)
- Addition of a measurable goal related to congenital syphilis (see section II focus area 2)
- Refined Goals, Strategies, and Activities, including revised target dates and activities
- Refined Performance Measures
- Updates of Partners

New Focus Area: Overdose Prevention

The CHEIP now includes Overdose Prevention as a Focus Area. Decades of evidence support the notion that when it comes to substance use, prevention comes first, treatment works, and recovery is possible. While the challenges from the overdose crisis are difficult, data shows we can make a difference by working together on a public health approach to close the gap of preventable deaths and to reach our shared goals of healthier people, safer streets, and stronger communities.

Figure 1. Community Health Equity Improvement Plan Focus Areas



For updates on the CHEIP, please visit the Community Health Equity Improvement Plan (CHEIP) website http://publichealth.lacounty.gov/pie/planning/chip.htm).

FOCUS AREA 1: BLACK INFANT AND MATERNAL HEALTH

Edits were made to this section to better align the timelines, clarify language, and add supporting population indicators and performance measures. Also note the additional context for the measurable goal and recent trends in data:

The 2023 data show an increase in the disparity in infant mortality rates between White and Black/African American babies. This increase reflects ongoing structural challenges, including hospital maternity ward closures, rising homelessness, and longstanding inequities in access to care and resources across our systems. It is also influenced by the lingering effects of the COVID-19 pandemic on earlier outcomes (2020–2022), reduced or insufficient investment in Public Health's critical family supports, and the delay between service implementation and service impact on countywide rates. Together, these factors help explain the 2023 increase and underscore the need for sustained, increased investment to reverse the trend.

A 50% reduction is ambitious considering the current societal context in which Public Health is trying to improve racial disparities in perinatal health outcomes. There is ongoing and sometimes overt racial discrimination in our systems. Meeting our goal would require (1) the ability to connect every Black pregnant person in LA County to culturally-affirming and -responsive supports, respectful and quality care, and real pathways to upward mobility, and (2) sustained, ongoing financial support for programs and services that Public Health knows make an impact: guaranteed income, housing support, midwifery care, doula support, intimate partner violence prevention, group prenatal, fatherhood engagement, preconception counseling and policy change.

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.

Population Indicators (PI)	Los Angeles County	PI updates
Infant mortality rate (IMR) (per 1,000 live births) *Data source: 2021 & 2023 California Department of Public Health, California Comprehensive Birth/Death File (Dynamic) for Los Angeles County, assembled by Office of Health Assessment & Epidemiology, Los Angeles County Department of Public Health. Data extracted and prepared by Los Angeles County Department of Public Health, Maternal, Child and Adolescent Health (MCAH) Program.*	3.9 (2021)	**4.0. (2023)**
Black/African American infant mortality rate (per 1,000 Black/African American live births) *Data source: Los Angeles County Department of Public Health, Maternal Child and Adolescent Health (MCAH) Program as of 2023*	6.9 (2021)	**8.9 (2023)**
Gap in IMR between Black/AA and White babies *Data source: 2007-2018 California Department of Public Health, Birth and Death Statistical Master Files. 2019-2024 Annual Birth & Death Data Files, assembled from California Department of Public Health Vital Records Data. Office of Health Assessment & Epidemiology, Los Angeles County Department of Public Health.* *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 American Indian/Alaskan Native, Native Hawaiian/Pacific Islander, Other, and Unknown races due to small cell sizes and unstable estimates. Three-year averages are used to account for random and annual rate fluctuations.*	Black/AA IMR was 3 times that of White infants (2019-2021 3-Year Avg.)	**Black/AA IMR was 3.4 times that of White infants (2022-2024 3-Year Avg.)**

USEFUL AND INCLUSIVE DATA

Strategy 1: By August 2027 ~~June 2025~~, launch and maintain a publicly accessible data dashboard of maternal and infant mortality and associated data disaggregated by race and ethnicity.	**Work Plan Activities:** **1.1** By October 2024, develop a protocol for dashboard data collection and management. **1.2** By December 2026 ~~May 2025~~, distribute survey to 10 AAIMM external community partners to assess dashboard utility, accessibility, and inclusiveness. **1.3** By August 2027 ~~May 2026~~, Public Health implements recommendations for dashboard improvement from AAIMM community partners. **1.4** By December 2027 ~~2026~~, present data dashboard at five (5) community events after implementation.
	Performance Measures: • Number of engagements with the data dashboard site ~~Visits to the data dashboard site increase by 5% each month for the first six months after implementation~~ • ~~Engage stakeholders to solicit input that informs the development of the dashboard~~
	Partners: • AAIMM Steering Committee and Data & Evaluation Workgroup – advisors • Public Health – data platform development lead • First 5 LA – collaborator • Academic partner – co-lead • Contractors – website development/design

POLICY AND SYSTEMS CHANGE	
Strategy 2: By January 2027 ~~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.	**Work Plan Activities:** **2.1** By June ~~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. **2.2** By June ~~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. **2.3** By October ~~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. *(Previously Activity 2.5)* **2.4** Through December 2026 ~~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. **2.5** By January 2027 ~~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. *(Previously Activity 2.4)*
	Performance Measures: • Number of Abundant Birth Coaching sessions • Number of persons served by the Guaranteed Income program • Percentage of participants that felt they had a positive experience from participating in the Abundant Birth Project so far.

	Partners: • AAIMM network - outreach collaborators ~~Community Action Teams – Program lead and members (Individuals/Organizations)~~ • AAIMM Village Fund CBOs – outreach collaborators • Abundant Birth Project participating counties (Alameda, Contra Costa, Los Angeles, Riverside) - participants • AAIMM Steering Committee Members – participant referrals and linkage • Black Infant Health Program – participant referrals and linkage • Internal/External LA County partners – participant referrals and linkage • Pregnant Women/Birthing Persons and Partners who are now parents, inclusive of those who have experienced perinatal loss – participant referrals and linkage for parenting support
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.	**Work Plan Activities:** **3.1** By March 2025, seek contracts between the AAIMM Doula Program and health plans to receive Medi-Cal reimbursement for doula services **3.2** By December 2025, promote program services with physicians, health plans, and community partners. **3.3** Through ~~By~~ December 2027 ~~2026~~, advocate for doulas as an evidence-informed home visiting model for funding.
	Performance Measures: • Number of Medi-Cal health plans where the DPH Doula program is billing for Medi-Cal reimbursement for services • Percentage of LAC health plans with AAIMM doula service contracts secured
	Partners: • Doula professionals – advisors and advocates • Public Health – ~~Co-~~lead contract collaborators • Managed Care Plans – contracted partners • LA County Medi-Cal Doula Hub – technical assistance provider • ~~AAIMM Community Action Teams – Lead advisors and advocates~~

BUILDING PARTNERSHIPS	
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.	**Work Plan Activities:** **4.1** By December 2024 and semi-annually thereafter, select AAIMM Village Fund grantees through a collaborative decision-making process. **4.2** By June 2025 and quarterly thereafter, provide capacity building trainings for grantees via the Village Fund learning collaborative. **4.3** By December 2025, promote the AAIMM Village Fund to expand pool of potential grantees and pool of funders. **4.4** By December ~~June~~ 2026, determine metrics for Village Fund grantee services to include on AAIMM data dashboard.
	Performance Measures: • Percent increase in the pool of grantees • Amount of funding invested in Village Fund • Grantees report that they are better off (or clients better off) because of participation in the Village Fund.
	Partners: • Public Health – founder, funder, promoter • AAIMM network- ~~Lead~~ promoters and grantee selectors • Private Philanthropy – funder • First 5 LA ~~Public Funders~~ – funder, promoter • Village Fund grantees – program/service leads, advisors

<table>
<tr><th colspan="2">ORGANIZATIONAL READINESS</th></tr>
<tr><td rowspan="3">Strategy 5:
By June 2027 and ongoing ~~December 2025~~, strengthen the ability of Community Action Teams to identify local needs and develop and implement at least one strategy in response to local needs assessment implemented to address disproportionality in Black/African American infant and maternal mortality.</td><td>Work Plan Activities:
5.1 By June 2027 ~~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.
5.2 By June 2027 ~~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.
5.3 By December ~~June~~ 2027, provide 20 capacity building trainings to the AAIMM CAT members, community partners and interested individuals.
5.4 By December 2028, conduct 100 community events/activations in response to landscape analysis findings and elevate community voices.</td></tr>
<tr><td>Performance Measures:
• Number of community events/activations implemented from landscape assessment
• Number of strategies implemented to address disparities in Black Infant Maternal Mortality</td></tr>
<tr><td>Partners:
• Organizations and community members in Service Planning Areas 1, 2, 3, 6 & 8 – collaborators and advisors
• AAIMM CATs – lead</td></tr>
<tr><td rowspan="3">Strategy 6:
By December 2027 ~~June 2026~~, finalize a three-to-five-year strategic plan through shared decision-making in the AAIMM Steering Committee.</td><td>Work Plan Activities:
6.1 By December 2026, provide programmatic updates to the AAIMM Steering Committee on the existing strategic plan to identify ongoing gaps in services.
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.
6.3 By December 2027, finalize the three-to-five-year AAIMM Strategic Plan.</td></tr>
<tr><td>Performance Measures:
• Number of partners that provide feedback to develop strategic plan. ~~Feedback collected from community and stakeholders regarding priorities selected for the AAIMM strategic plan~~
• % of strategic plan actions completed</td></tr>
<tr><td>Partners:
• AAIMM Steering Committee Members – lead
• AAIMM CAT – contributors
• Contracted consultants – strategists
• Public Health – co-lead
• First 5 LA – co-lead
• Coalition Strengthening Partners – community co-lead</td></tr>
</table>

FOCUS AREA 2: SEXUALLY TRANSMITTED INFECTIONS AND CONGENITAL SYPHILIS

Edits were made to this section to better align the timelines, clarify language, and add supporting activities.

As noted in the full report, higher infections among men, including men who have sex with men (MSM), can lead to increased syphilis rates among women and people with reproductive potential through sexual contact, increasing the risk of congenital syphilis. Congenital syphilis represents one of the most severe outcomes of the STI epidemic and indicates gaps in screening and treatment. In reviewing the plan and the existing strategies, it was decided that in addition to the measurable goal related to MSM, it was important to also include a goal related to congenital syphilis.

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

Measurable Goal:

1. 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.
2. The rate of congenital syphilis will decrease by 15% over five years.

Population Indicators (PI)	Los Angeles County	PI updates
Rate of Primary & Secondary syphilis in MSM (rate per 100,000 persons) *Data source: LA County Public Health, Division of HIV and STD Programs. These data do not include Long Beach and Pasadena.*	2022 Overall: 354 *Black/African American: 610* *Latinx: 353*	**2023 Overall: 342** *Black/African American: 635* *Latinx:* 335
Rate of congenital syphilis (per 100,000 live births) *Data Source: LA County Public Health, Division of HIV and STD Programs. These data do not include Long Beach and Pasadena.*	2022: 153	**2024: 121** *(using preliminary 2024 livebirth data)*

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.	**Work Plan Activities:** **1.1.** By December 2024, update user-friendly, accessible data reports to meet the diverse needs of stakeholders. **1.2.** By December 2025, engage community members and establish user feedback mechanisms for continuous data improvement. **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. **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.
	Performance Measures: • Percent of STI reports that include demographics • Percent of STI reports that include geographic information maps • Total page views of HIV/STI data dashboard pages
	Partners: • Community members – advisors • Community Clinics – collaborators and contributors • Health Plans – collaborators

	• Providers – contributors and 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.	**Work Plan Activities:** **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. **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: • Number of providers visited • Percent increase in provider self-reported knowledge of recent LAC syphilis trends and screening guidelines at a follow-up visit
	Partners: • California Department of Health Care Services – monitor, ensure compliance • California Department of Public Health – monitor, ensure compliance • Health Care Delivery Systems and Birthing Hospitals – collaborators, contributors • Community Clinics – collaborators and 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.	**Work Plan Activities:** **3.1** By March 2025, conduct focus groups, key informant interviews, and community feedback sessions to inform the development of targets STI prevention campaigns. **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. **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: • 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 • 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: • Media partners – content distribution lead • Community members – lead advisors • Public Health – campaign management lead

BUILDING PARTNERSHIPS	
Strategy 4: By June 2027 ~~January 2025~~, ~~establish~~ strengthen partnerships ~~council to~~ with community stakeholders through routine~~ly~~ engagement and collaborative planning ~~solicit community input and feedback to identify actions and activities that will improve~~ to inform STI prevention and control efforts.	**Work Plan Activities:** **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. **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. **4.3** By June 2027, convene at least 6 meetings of the HIV/STI Prevention Advisory Workgroup (a stakeholder group of public health partners, community-based organizations, and providers across Los Angeles County) to garner additional input on sustaining HIV/STI prevention goals and informing DHSP strategies, especially during periods of funding uncertainty and potential funding reductions.
	Performance Measures • 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 • Number of recommendations implemented
	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 June 2028 ~~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:** **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. **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. **5.3** By June 2028 ~~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: • PHI training framework developed • Updated tailored HIV and STI prevention and control curriculum for PHIs and CEDIS • Percent increase in PHI and CEDIS with self-reported knowledge gain and skills development
	Partners: • Subject Matter Experts – content contributors • HIV and STI workforce – collaborators and ambassadors • Public Health – collaborators, curriculum and training management

FOCUS AREA 3: ENVIRONMENTAL JUSTICE

Edits were made to this section to better align the timelines, clarify language, and add supporting activities. Additional revisions may be added at a future time to include other priority issues.

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:

1. 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 (PI)	Los Angeles County	PI updates
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. *Data Source: Los Angeles County Department of Public Health, Office of Environmental Justice, Lead Program 2024 RASSCLE Surveillance database archive as of 7/17/26*	503 (35%) of 1438 total in Los Angeles County (2022)	**469 (30.9%) of 1517 total in Los Angeles County (2024)**

USEFUL AND INCLUSIVE DATA	
Strategy 1: By December 2026 ~~2025~~, post data on a publicly accessible platform that shares environmental, climate, and related health conditions, informed by strategic planning stakeholder input.	**Work Plan Activities:** **1.1** By June 2026 and ongoing, map industrial sources of pollution across LA County, including oil and gas operations, industrial sites, solid waste operations, etc. ~~By June 2025, map environmental justice indicators, excessive heat indicators, pollution burden indicators, and health impacts indicators for internal use.~~ **1.2** By June 2026, publish a Heat Risk Dashboard for heat related illness, emergency department visits, and deaths to be updated monthly. ~~By December 2025, and annually thereafter, publish annual health impacts and trend data for selected health outcomes related to excessive heat.~~ **1.3** By December 2026, publish selected pollution burden indicators using CalEnviroScreen data for selected unincorporated communities across LA County. ~~By December 2025, and annually thereafter, publish selected pollution burden indicators and trend data in Environmental Justice communities and across LA County.~~
	Performance Measures: • Number of engagements with the site • ~~Percentage of selected Indicators that are mapped~~ • ~~Number of annual data reports published~~
	Partners: • Subject Matter Experts – advisors and contributors • Community Organizations – advisors • Public Health – data platform development
Strategy 2: By June 2026 ~~December 2025~~ and annually thereafter, ensure the Office of Environmental Justice	**Work Plan Activities:** **2.1** By June 2026 ~~2025~~, determine content to be updated on the publicly accessible OEJCH webpage based on stakeholder input. **2.2** By June 2026 ~~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.

USEFUL AND INCLUSIVE DATA	
and Climate Health (OEJCH) program webpage provides up-to-date, relevant information for the public, based on input gathered from strategic planning stakeholder engagement.	**Performance Measures:** • Number of engagements with the site ~~Number of visits to webpage~~ • ~~Annual review completed with stakeholder input~~
	Partners: • Community members – advisors • Community organizations – advisors • Data Reporting organizations – contributors • Public Health – data platform development and maintenance

POLICY AND SYSTEMS CHANGE	
Strategy 3: By June 2028, implement actions/efforts on at least three priority policy issues (e.g., oil/gas, heat, etc.). ~~December 2025, develop an initial policy agenda on priority environmental justice and climate health issues that identifies at least 3 priority policy policies actions to pursue.~~	**Work Plan Activities:** **3.1** By December 2025, identify environmental justice and climate health issues for inclusion in an initial policy landscape scan. **3.2** By March 2026 ~~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. *(Previously Activity 3.1)* **3.3** By June 2026 and ongoing, engage community for input to inform efforts on priority policy issues and actions. *(Previously Activity 3.2)* ~~December 2025, develop an initial policy agenda on priority environmental justice and climate health issues based on the landscape scan.~~
	Performance Measures: • Number of actions/efforts implemented on priority policy issues ~~Policy agenda developed~~
	Partners: • Public Health – policy analysis and policy agenda development • Community organizations – advisors • ~~Community members – advisors~~ • ~~Data Reporting organizations – contributors~~

BUILDING PARTNERSHIPS	
Strategy 4: By December 2028 ~~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:** **4.1** By December 2025 and ongoing, 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. **4.2** By December 2028 ~~2027~~, enroll 2000 ~~new~~ participants in the "Lead-Free Homes LA Program" to eliminate lead paint hazards in their homes throughout LA County.
	Performance Measures: • Number of homes per year in which lead paint hazards have been remediated
	Partners: • Community organizations, schools, school districts, child care providers, libraries – outreach, recruitment, enrollment, and collaboration • Housing authorities – program implementation and collaboration • Public Health – program oversight of the Lead-Free Homes LA program
Strategy 5: By December 2025 and annually	**Work Plan Activities:** **5.1** By June 2025, and annually thereafter, map environmental, climate, and health indicators across CPHT communities. *(Previously Activity 5.2)*

thereafter, provide training and develop maps for each of the Community Public Health Teams (CPHTs), to build knowledge and awareness of local environmental and climate justice issues in the initial pilot communities.	**5.2** By December 2026 ~~June 2025~~, provide training for Public Health and Community Health Worker staff engaged in CPHTs on Environmental Justice and Climate Health issues. *(Previously Activity 5.1)* **5.3** By December 2026 ~~2025~~, and annually thereafter, share map of industrial pollutio and sources ~~environmental, climate and health indicators~~ with CPHTs.
	Performance Measures: • Percent of initial pilot communities for which a map showing environmental justice and climate indicators is created • Percent increase in CPHT staff with self-reported knowledge gain and skills development ~~Percent of initial pilot communities for which a CPHT staff training is held.~~
	Partners: • Community Public Health Teams – lead contributors, collaborators • Public Health – environmental justice mapping development
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.	**Work Plan Activities:** **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. **6.2** By May 2026, convene one symposium on environmental justice and climate health.
	Performance Measures: • Number of EJ and climate health symposium participants ~~Number of interested partners identified to collaborate on an environmental justice and climate health symposium~~
	Partners: • Health focused stakeholders – advisors, collaborators • Regulators – advisors, collaborators • 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.	**Work Plan Activities:** **7.1** By January 2027, implement Strategic Plan actions. **7.2** By January 2028, evaluate Strategic Plan.
	Performance Measures: • Percent of strategic plan actions initiated
	Partners: • Partners (CBOs, government and non-government agencies, regulators, academic partners/researchers, community members, other jurisdictions) – collaborators, advisors • Public Health – implementation lead

FOCUS AREA 4: VIOLENCE PREVENTION

No major changes were made to this section; edits were made to better align the timelines, clarify language, or add supporting activities.

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.

Population Indicators (PI)	Los Angeles County	PI updates
Gap in homicide rates between African Americans and the LA County average homicide rate. *Data Source: Los Angeles County Department of Public Health Office of Violence Prevention. Linked Mortality Data File, OHAE*	In 2021, the Rate Gap: 25.3 per 100,000 *(LA County- 8.1 per 100,000; Black/African American- 33.4 per 100,000)*	**In 2023, the Rate Gap was 16.3 per 100,000** *(LA County- 6.6 per 100,000; Black/African American- 22.9 per 100,000)*
Number of assault-related trauma hospital visits *Data Source: Los Angeles County Department of Public Health Office of Violence Prevention*	5,379 (2021)	**4,757 (2024)**
Suicide Rate among Los Angeles County Residents *Data Source: Los Angeles County Department of Public Health Office of Violence Prevention. Linked Mortality Data File, OHAE*	7.8 per 100,000 (2021)	**8.3 per 100,000 (2023)**
Estimated number of females, transgender females, and gender non-binary/con-confirming/queer individuals who reported ever experiencing physical violence by an intimate partner. *Data Source: 2023 Los Angeles County Health Survey Data*	448,000 (2023)	*Next update 2027*

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

POLICY AND SYSTEMS CHANGE	
Strategy 2: By June 2027, ~~January 2026~~ establish a Los Angeles County Sexual Assault Council to improve coordination across county systems and service providers to improve services to survivors of sexual assault and inform investments ~~invest~~ in prevention programs.	**Work Plan Activities:** **2.1** By October 2024, assess capacity and willingness of potential partners to establish a council. **2.2** By June 2025, ~~establish~~ convene a Los Angeles County 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. **2.3** By June 2027, ~~By a date to be determined by the Council,~~ develop a strategic plan~~,~~ ~~through the Sexual Assault Council,~~ to advance policy, practice, and systems change to support survivors of sexual assault.
	Performance Measures: • Number of diverse stakeholders in Sexual Assault Council • Percentage of Sexual Assault Council members who were engaged in the development of the strategic plan ~~Strategic plan developed~~
	Partners: • Sexual Assault Council – lead strategic plan development • Community Based Organizations – council members, advisors • Health Care Providers ~~Organizations~~ – council members, advisors • Mental Health Providers – council members, advisors • Law Enforcement – council members, advisors • Survivors – advisors, members • Advocates – advisors, members • Public Health – lead convenor

BUILDING PARTNERSHIPS	
Strategy 3: By July 2027 ~~2026~~, expand initiatives and services to address gender-based violence (GBV) across the lifespan by strengthening inter-agency coordination and collaboration; providing training and technical assistance; and funding Community Based Organizations (CBOs) to implement GBV prevention models and programming.	**Work Plan Activities:** **3.1** By June 2025 ~~July 2026~~, fund community-based organizations to implement GBV prevention programming. *(Previously Activity 3.3)* **3.2** By June 2026 ~~July 2025~~, complete a GBV environmental scan to understand the current landscape of county and community efforts to address GBV. *(Previously Activity 3.1)* **3.3** By June 2026 ~~July 2025~~, identify and engage departments and organizations and partners that address and respond to GBV. *(Previously Activity 3.2)* **3.4** By June 2027, provide Teen Dating Violence Prevention educational presentations for at least two county departments and twenty community groups or organizations.
	Performance Measures: • Number of county/community programs/initiatives that are actively involved in inter-agency collaboration on GBV. ~~Percent of county programs/initiatives that integrated addressing/preventing gender-based violence as a component of their work~~ • Number of grants ~~partnerships~~ with CBOs focused on addressing/preventing GBV • Percent of GBV program participants who report that they know how to help someone experiencing gender-based violence.
	Partners: • Community organizations – lead prevention programming • County partners – coordination and policy development

	• Public Health – lead training development and coordination
Strategy 4: 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 (CAP) networks by: 1) increasing investment in nine communities disproportionately impacted by violence, and 2) building infrastructure for peer violence intervention training and county services alignment.	**Work Plan Activities:** **4.1** By December 2024, confirm additional county and grant 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. **4.2** By June 2025, complete first year of pilot Peer to Peer Academy with ARPA funding and draft recommendations for ongoing academy. **4.3** By December 2026 ~~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. **4.4** By December ~~June~~ 2026, develop plan for coordination with two additional initiatives in TPI communities. **4.5** By June 2027, develop a workplan ~~establish a strategic plan~~ for strengthening regional collaboration and strategic coordination among cities for implementing Community Violence Intervention (CVI).
	Performance Measures: • Number of formalized partnerships to align services in TPI communities • Amount invested in communities disproportionately impacted by violence • ~~Percent of stakeholders reporting improved connections~~ • ~~Number of referrals between county initiatives~~
	Partners: • Trauma Prevention Initiative network partners – TPI programming lead • LA County Parks and Recreation – park programming lead • County departments – collaborators, referral partners • Community leaders – advisors • Survivors of violence/Advocates - advisors • Public Health – convenors, fiscal lead
Strategy 5: By June 2025 and ongoing, implement a comprehensive plan to promote gun ~~firearm~~ safety through community education and awareness, policy change, and peer approaches.	**Work Plan Activities:** **5.1** By September 2024 and ongoing, Public Health collaborates with community and County department partners to distribute gun safety locks countywide through county hospitals, clinics, libraries, and OVP contracted agencies. **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. **5.3** By June 2025, coordinate with Regional Violence Prevention Coalitions established in each of the County's Supervisorial Districts (SDs) ~~Service Planning Areas (SPAs)~~ to implement priority strategies in the Gun Violence Prevention Plan.
	Performance Measures: • Number of gun safety locks and educational materials distributed • Number of community/county partners who are engaged in efforts to promote gun safety as part of comprehensive plan ~~Number of RVPC's implementing gun violence prevention projects~~ • ~~Number of community members connected to GVRO resources~~
	Partners: • Regional Violence Prevention Coalitions – lead convenors in each region • Trauma Prevention Initiative networks - advisors • County departments – advisors, strategy implementation • Community leaders – advisors, policy contributors

	• Survivors of violence/Advocates - advisors, trained peers, policy contributors • Public Health – data and webpage lead, gun safety locks coordination

ORGANIZATIONAL READINESS	
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.	**Work Plan Activities:** **6.1** By June 2025, conduct Gang and GBV training for TPI agencies and OVP staff. **6.2** By June 2026, provide trauma-informed systems change training and technical assistance to support two (2) new county departments.
	Performance Measures • Number of County staff trained • Number of community stakeholders trained • Percent training participants reported increased knowledge and skills regarding trauma-informed care and practice change
	Partners: • Trauma Prevention Initiative Community Action for Peace networks - collaborators • County departments – collaborators • Public Health – lead capacity development & coordination
Strategy 7: By June 2028 ~~2026~~, develop a coordinated communications strategy to promote a shared understanding of violence and violence as a public health issue.	**Work Plan Activities:** **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. **7.2** By June 2027 ~~2025~~, facilitate discussion with County Leadership Committee (CLC) and Community Partnership Council (CPC) regarding coordinated communications. **7.3** By June 2028 ~~2026~~, develop a communications workplan with CLC and CPC.
	Performance Measures: • Communications workplan finalized and approved • Development of a gun safety billboard campaign in partnership with LACMA and LA Care Health Plan
	Partners: • County Leadership Committee – advisors • Community Partnership Council – advisors • LA County Medical Association – collaborator, media campaign contributor • LA Care Health Plan – collaborator, media campaign contributor • Public Health – lead communications management
Strategy 8: By June 2026 and ongoing, ~~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.	**Work Plan Activities:** **8.1** By June 2024, conduct first review of a veteran suicide death as part of the Veteran Suicide Review Team. **8.2** By June 2025, implement California Department of Public Health funded Youth Suicide Prevention Pilot Program and report on activities and outcomes. **8.3** By June 2026 ~~2025~~, develop outreach materials and host ongoing trainings on gun safety tools - including gun violence restraining orders (GVROs) - and how they can be used in suicide prevention.
	Performance Measures: • Number trainings/events where OVP distributed suicide prevention resources and materials • Percent of training participants who report they will use the information they learned in the training in their work
	Partners: • California Department of Public Health – advisors and collaborators

	• Local suicide prevention organizations – advisors, contributors, collaborators • Veteran organizations – collaborators, coordinators, advisors • Youth-focused organizations – collaborators, advisors, and contributors • Public Health – lead convenor and program management • County Departments – advisors, collaborators • School Districts - advisors, collaborators

FOCUS AREA 5: OVERDOSE PREVENTION

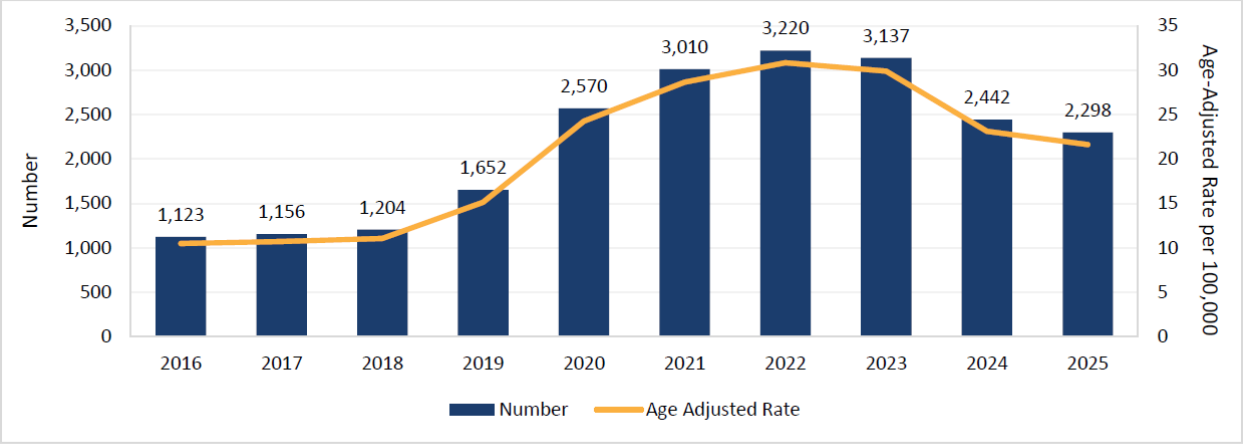
The revised CHEIP includes Overdose Prevention as a new Focus Area. As in outline of the initial CHEIP, this section includes an overview, a set of strategies, work plan activities, and performance measures, types of partners, and additional collaborative actions to support or complement the work of the CHEIP.

What the Data Says About the Issue

An overdose occurs when a toxic amount of a drug or a mix of substances, taken intentionally or accidentally, overwhelms the body's ability to maintain life. In Los Angeles County, the shift from heroin and prescription opioids to fentanyl and methamphetamine have fundamentally altered the lethality of the local drug supply. It is approximately 50 times more potent than heroin, meaning even microscopic amounts can be fatal. Overdose rates are highest among people experiencing homelessness, among Black Los Angeles County residents, and in lower-income areas.

Between 2022 and 2025, LA County experienced a nearly 30% decline in overall drug-related overdose and poisoning deaths compared to the prior year, including a 40% reduction in fentanyl-related deaths and a 25% reduction in methamphetamine-related deaths. (figure A & B).

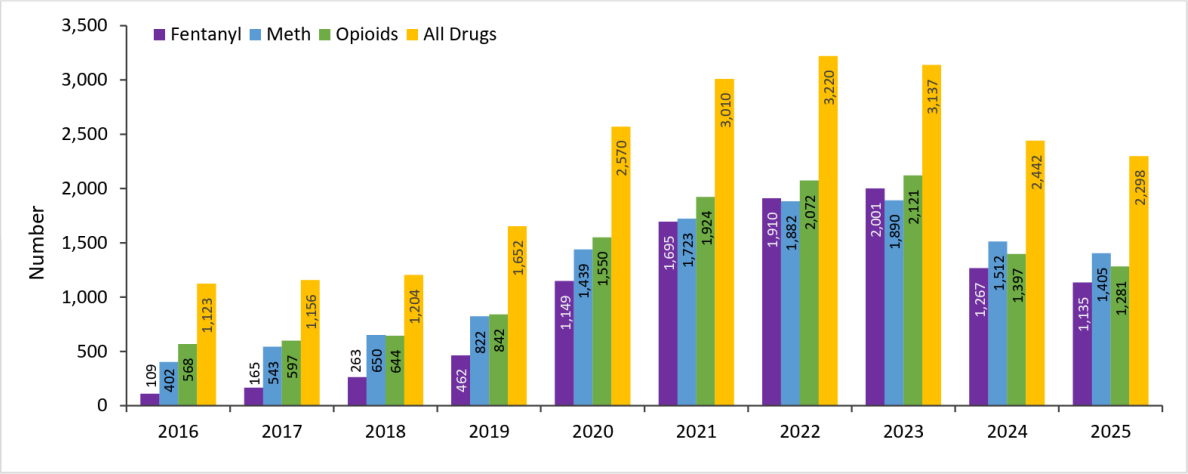
Figure A. Age-Adjusted Drug Overdose Death Rate in Los Angeles County 2016-2025.



*Note: Accidental drug overdose deaths refer to accidental deaths involving alcohol and/or other drugs.

Source: Substance Abuse Prevention and Control Bureau (SAPC), Los Angeles County Department of Public Health

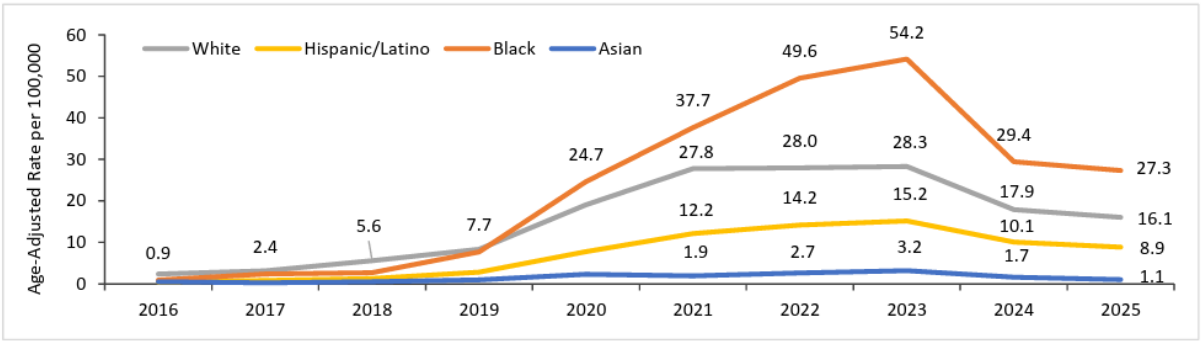
Figure B. Number of Drug Overdose Deaths by Drug Type, Los Angeles County 2016-2025

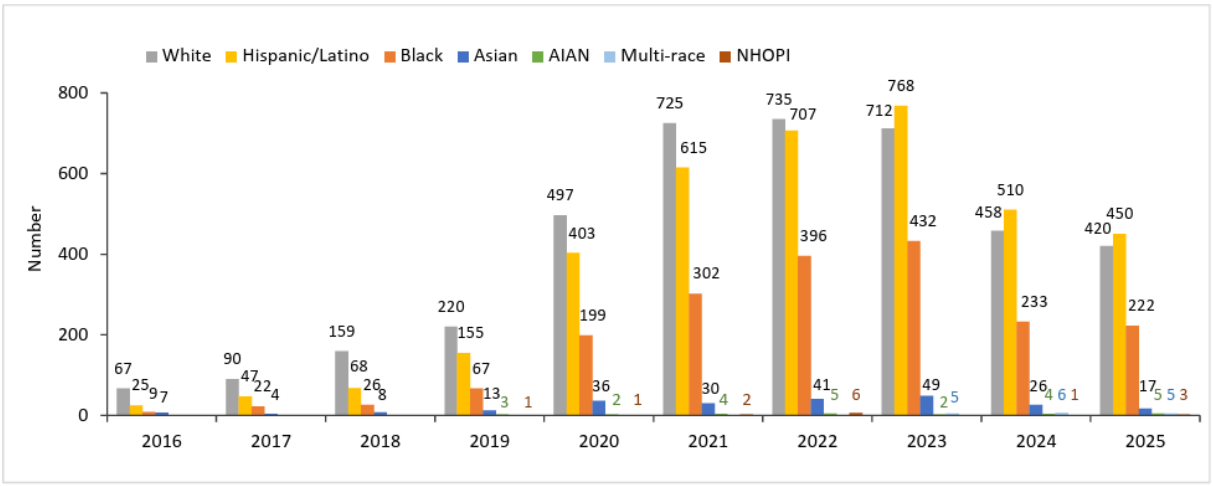


Source: Substance Abuse Prevention and Control Bureau (SAPC), Los Angeles County Department of Public Health

However, preventable disparities still exist by race/ethnicity. Black residents are disproportionately represented in overdose and poisoning death rates, whereas Latinx and White residents account for the highest numbers of fatalities (Figure C). Additionally, in 2025, fentanyl overdose deaths occurred most often among adults between ages 40 - 64, followed by adults between ages 26 - 39 (Figure D).

Figure C: Fentanyl-Related Overdose Deaths by Race/Ethnicity

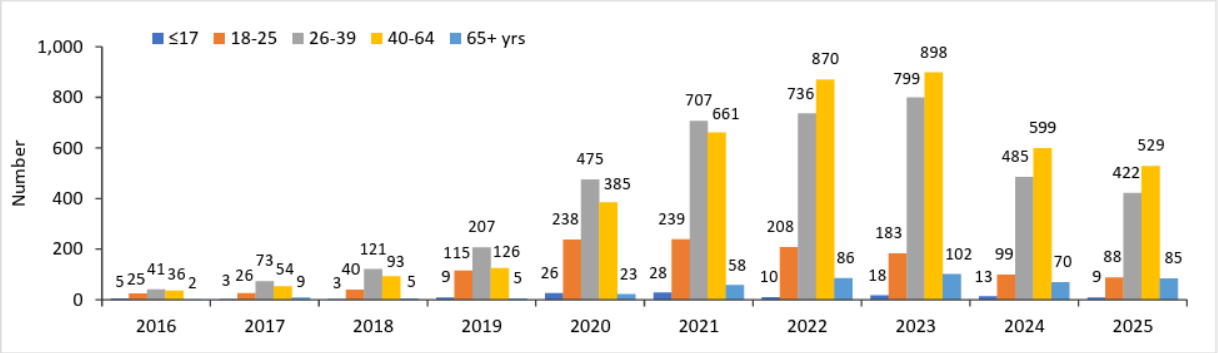




Notes: AIAN: American Indian/Alaskan Native. Multi: Multiple-race. NHOPI: Native Hawaii or Other Pacific Islander. Multiple-race available starting 2023.

Source: Substance Abuse Prevention and Control Bureau (SAPC), Los Angeles County Department of Public Health

Figure D: Fentanyl-Related Overdose Deaths by Age Group

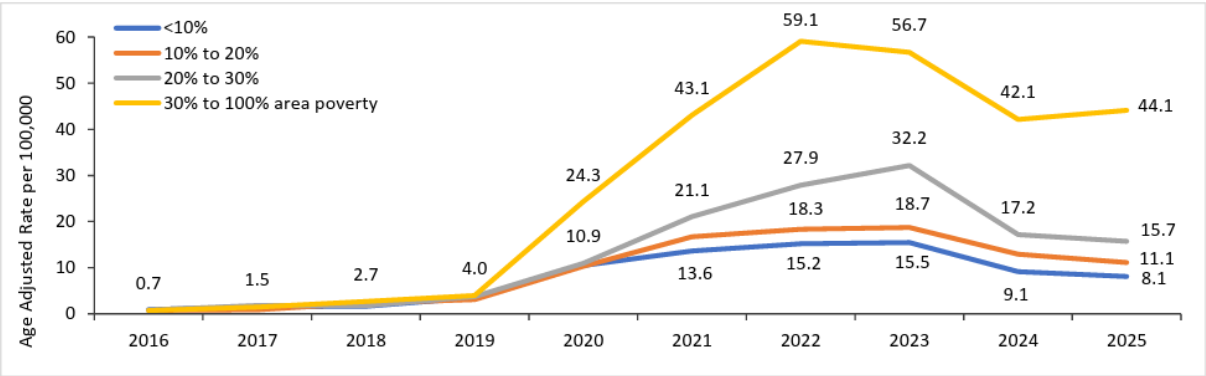


Source: Substance Abuse Prevention and Control Bureau (SAPC), Los Angeles County Department of Public Health

Overdose and Area Poverty

There is a general linear but complicated relationship between area-level poverty and drug overdose deaths. Demographic factors at play in areas with higher poverty include lower funded schools (due to tax-based funding structures), lower educational attainment opportunities, higher unemployment rates and lower median incomes. These factors play into other stressors like housing overcrowding, housing instability and homelessness associated with higher area-poverty. In Los Angeles County, residents that live in areas with higher poverty endure consistently higher rates of accidental overdose deaths compared to those with lower area-poverty. These geographic gaps widened and were more pronounced during the COVID-19 Pandemic years from 2020 to 2023 and these gaps narrowed in 2024 but widened in 2025 (Figure E).

Figure E: Age-Adjusted Rate of Accidental Overdose Deaths by Area Poverty, Los Angeles County, 2016-2025



Source: Substance Abuse Prevention and Control Bureau (SAPC), Los Angeles County Department of Public Health

Though drug-related overdose deaths and poisonings show a significant drop, it underscores the need for more investment in overdose prevention, harm reduction, treatment and recovery to continue this trajectory.

Public Health's Substance Abuse Prevention and Control Bureau (SAPC) and partners have been collaboratively expanding substance use prevention, harm reduction, treatment, and recovery services in Los Angeles County. The collaborative engages in the following:

- Making drug-related treatment more accessible through the Reaching the 95% (R95) Initiative working to close the gap between LA County residents who need drug-related treatment and those who actually receive it. While substance use disorder (SUD) Treatment has been proven to save lives, only approximately 5% of people with SUDs access treatment services.
- Providing services in more field-based community locations.
- Streamlining the admissions process for contracted provider agencies to reduce barriers to care.
- Expanding substance use prevention services.
- Increasing additional harm reduction syringe service programs and expanding existing harm reduction programs to increase reach and connect with people before they might have otherwise engaged in treatment.
- Expanding to additional treatment sites.
- Increasing additional contingency management programs for people with stimulant use disorder.
- Expanding the availability of addiction medications in all care settings.
- Enhancing access to peer support programs.
- Expanding partnerships with drop-in health hubs in communities with high service needs.

Public Health Action and Partners

The strategies identified in this section were informed by a continuous process of community engagement. Measures were developed in collaboration with the LA County Harm Reduction Steering Committee, the SAPC Provider Advisory Committee, and community engagement specialists who collaborate with Public Health on addiction medication access. The harm reduction steering committee includes LA County residents with lived experience with drug use, receiving harm reduction services, and with lived experience of homelessness. The provider advisory committee includes LA county treatment agency staff, most of whom have lived experience with substance use and treatment. Additionally, the measures were informed by community engagement specialists, hired and contracted by Public Health's SAPC Division, who conduct community events on overdose prevention and addiction medications in prioritized communities.

Focus Area Strategies, Work Plan Activities, Performance Measures & Partners

Results Statement: All people and communities in Los Angeles County have a chance to pursue their dreams and to fulfill their promise without dying of drug overdose.

Measurable Goal(s)

1. Reduce the gap in drug overdose rate between African Americans and the Los Angeles County average by 20% in three years.
2. Reduce the gap in drug overdose rate between high-poverty neighborhoods and the Los Angeles County average by 10% in three years.

Population Indicator(s) (PI)	Los Angeles County
Gap in drug overdose rate between African Americans and the Los Angeles County average *Source: Los Angeles County Department of Public Health Substance Abuse Prevention and Control. Data Report: Drug Overdoses in Los Angeles County. Data source is the Medical Examiner*	2025 AA rate: 60.5 per 100K, LAC avg rate: 21.6 per 100K
Gap in drug overdose rate between high-poverty neighborhoods and the Los Angeles County average *Source: Los Angeles County Department of Public Health Substance Abuse Prevention and Control. Data Report: Drug Overdoses in Los Angeles County. Data source is the Medical Examiner*	2025 high poverty neighborhood rate: 76.9 per 100K, LAC avg rate: 21.6 per 100K

USEFUL AND INCLUSIVE DATA	
Strategy 1: By December 2026, and annually thereafter, update SAPC's Alcohol and Other Drug Surveillance Dashboard and publish an updated Data Report	**1.1** By July 2026, publish the updated Data Report: Drug Overdoses in Los Angeles County **1.2** Annually thereafter, publish updated data
	Performance Measures • Number of dashboard views and report downloads
	Partners • Medical Examiner - data source • Community organizations – advisors, collaborators

POLICY AND SYSTEMS CHANGE	
Strategy 2: By June 2028, increase the number of agencies with one or more licensed clinicians and that are providing services directly to clients as evidenced by billing data to not fewer than 20 or more agencies that operate substance use treatment programs serving prioritized communities.	**2.1** By July 2026, develop and publish instructions to the network on how they should operationalize the DPH incentive program to grow their clinical workforce through developing an implementation plan. **2.2** By January of 2027, process capacity building payments to agencies who have submitted approved implementation plans. **2.3** By July 2027 and annually thereafter, review and expand the ASAM4 capacity building program based upon agency performance.
	Performance Measures • Number of agencies that hired one or more licensed clinicians and confirm, through billing data, that these clinicians provide services directly to clients • Number of treatment admissions
	Partners: • SAPC treatment agency network - collaborator • Department of Mental Health - collaborator • California Department of Health Care Services - collaborator

BUILDING PARTNERSHIPS	
Strategy 3: Beginning July 2026 and ongoing expand the number of harm reduction syringe services programs operating through contracts with DPH, and review contracts for expansion.	**3.1** By July 2026, collect and approve budgets reflective of priority activities **3.2** Between July 2026-June 2029, annually expand network invoicing on DPH-approved overdose prevention activities
	Performance Measures • Number of contracted network • Number of contract utilization
	Partners: • SAPC harm reduction agency network - collaborator • Health Services Harm Reduction Division - collaborator • Harm Reduction Steering Committee - advisor

ORGANIZATIONAL READINESS	
Strategy 4: Between July 2026-June 2029, conduct updated harm reduction, naloxone and addiction medicine trainings throughout the SAPC network of contracted prevention, harm reduction, treatment, and recovery services agencies.	**4.1** Between July 2026-June 2029, annually develop and deploy training plan and review program data to determine impact of trainings.
	Performance Measures • Number of trainings • Number participants in trainings • Number of naloxone and addiction medications distributed by SAPC network.
	• SAPC contracted agency network – collaborator • UCLA – collaborator • Azuza Pacific University - collaborator

Collaborative Actions

Reducing the gap in drug overdose 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 overdose rates.

1. **Expand Community-Driven Naloxone Access, Community-Based Drug Checking, and Overdose Prevention and Response Education**
   Implement naloxone distribution and overdose prevention programs in partnership with community-based organizations, faith-based institutions, outreach programs, and housing programs focused on areas of highest need. Community-based organizations should utilize the California naloxone distribution program to access naloxone for distribution. Test strips are also available, and community members can work with UCLA's drug checking program at http://www.drugcheckingla.com to support additional quantitative drug checking.

2. **Co-Design Culturally Responsive Prevention and Anti-Stigma Campaigns**
   Participate in Service Planning Area based prevention networks to operationalize substance use prevention programming. Review literature for stigmatizing terms that increase barriers for people impacted by substance use. Utilize and promote anti-stigma responses to substance use using the toolkit items posted on Rewriting LA County's Story campaign website: http://bylaforla.org

3. **Universal Screening for Substance Use in Community Settings**
   Utilize culturally responsive screening tools to help identify community members in need of addiction support. Learn more about Public Health substance use services via the **www.RecoverLA.org** (optimized for mobile devices). Help navigate people to substance use and recovery services through the Substance Abuse Service Helpline (SASH) or by visiting the Service and Bed Availability Tool at **http://sudhelpla.org**. Substance use services include outpatient and intensive outpatient treatment, residential treatment, withdrawal management, and Opioid Treatment Programs.

4. **Expand Treatment Navigation and Re-Engagement Services**
   Develop substance use service navigation as a core component of community healthcare, including offering on-site counseling, medications, and support within the scope of the workforce available in these settings. Participate in Public Health trainings on substance use service best practices and develop implementation plans adapted to local community needs. Take advantage of telehealth access to substance use treatment services through the substance use service access tools available in Los Angeles County.

5. **Participate in Community-Driven Overdose Data Sharing for Collaborative Action**
   Review the data reports posted on the Public Health Data Reports and Briefs page and participate in local overdose prevention coalitions that support collecting overdose reversal data for reporting. Participate in community needs assessment survey and other point in time survey assessments through which invaluable information informs the development of the overdose prevention and response.