Community Health Equity Improvement Plan
for Los Angeles County

2024-2029

Last Revised: **July 2026**

July 2026 Revisions

This document is a mid-term revision of the 2024-2029 CHEIP. 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.

Full document and original version can be found at

http://publichealth.lacounty.gov/pie/planning/chip.htm

Overall, revisions include:

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

***see revisions in blue font**

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

This 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.

During its development, Public Health worked closely with community partners and stakeholders to review the most current data available and identify strategies that would collectively impact some of the most pressing public health issues in Los Angeles 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.

FOCUS AREAS

1: Black/African American Infant & Maternal Mortality

2: Sexually Transmitted Infections & Congenital Syphilis

3: Environmental Justice

4: Violence Prevention

5: Overdose Prevention

Equity As a Foundation

Health equity is achieved when everyone has a fair and just opportunity to attain their optimal health and well-being.

CHEIP builds on an Equity Framework established to guide the design or enhancement of programs and processes. Strategies are organized according to the following Equity 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.

Strengthen organizational readiness and capacity to adopt a just culture and advance health equity.

Get Involved

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.

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 plan to expand and update the plan with additional opportunities to further advance the collective impact on the targeted health priorities.

For Updates go to: http://publichealth.lacounty.gov/pie/planning/chip.htm

Focus Area 1: Black/African American Infant & Maternal Mortality

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.

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.

Strategies

Useful and Inclusive Data

Strategy 1: By **August 2027**, launch and maintain a publicly accessible data dashboard of maternal and infant mortality and associated data disaggregated by race/ethnicity.

Policy & Systems Change

Strategy 2: By **January 2027,** 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 African American Infant and Maternal Mortality (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 **June 2027 and ongoing**, 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 **December 2027**, finalize a three-to-five-year strategic plan through shared decision-making in the AAIMM Steering Committee.

Collaborative Actions

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.

2. Contribute to Inclusive Research and Data

Add to the body of data on 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.

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.

Focus Area 2: Sexually Transmitted Infections and Congenital Syphilis

Result Statement:

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

Measurable Goals:

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.**

Strategies

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 & 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.

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 **June 2027**, **strengthen** partnership**s with community stakeholders through** routine **engagement and collaborative planning to inform** STI prevention and control efforts.

Organizational Readiness and Capacity

Strategy 5: By **June 2028** , 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.

Collaborative Actions

1. Increase Syphilis Screening

Implement robust screening and treatment for syphilis for at-risk populations, including women of reproductive age and pregnant women.

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.

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.

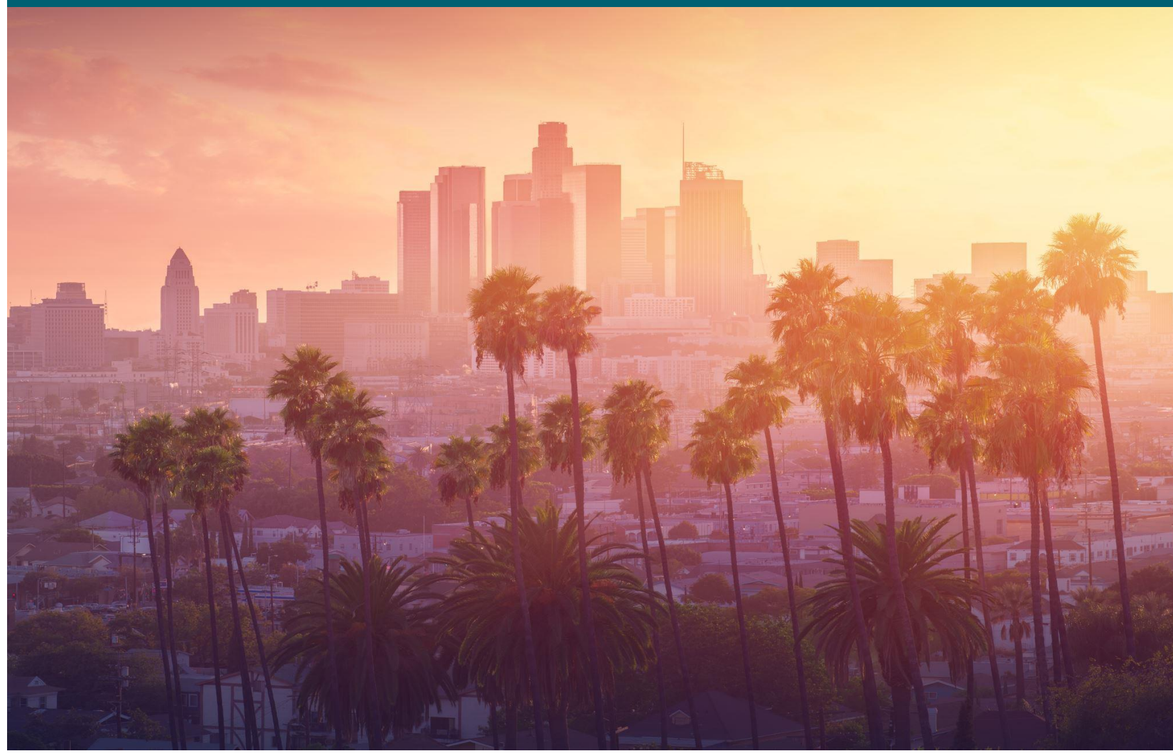
Focus Area 3: Environmental Justice

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.

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.



Strategies

Useful and Inclusive Data

Strategy 1: By December 2026**,** post data on a publicly accessible platform that shares environmental, climate, and related health conditions, informed by strategic planning stakeholder input.

Strategy 2: By June 2026 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 & Systems Change

Strategy 3: By June 2028, implement actions/efforts on at least three priority policy issues (e.g., oil/gas, heat, etc.).

Building Partnerships

Strategy 4: By December 2028, 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 (CPHTs), 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.

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.

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.

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.

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.

Focus Area 4: Violence Prevention

Result 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.

Strategies

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.

Policy & Systems Change

Strategy 2: By **June 2027**, 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** in prevention programs.

Building Partnerships

Strategy 3: By July 2027, expand initiatives and services to address gender-based violence 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**.

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 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.

Strategy 5: By June 2025 **and ongoing**, implement a comprehensive plan to promote **gun** safety through community education and awareness, policy change, and peer approaches.

Organizational Readiness and Capacity

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

Strategy 7: By June **2028,** develop a coordinated communications strategy to promote a shared understanding of violence and violence as a public health issue.

Strategy 8: By June **2026 and ongoing**, 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.

Collaborative Actions

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.

Collaborative Actions

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.
- 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 campaigns 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.

Focus Area 5: Overdose Prevention

Result 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:

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.

Strategies

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.

Policy & 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.

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.

Organizational Readiness and Capacity

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.

Collaborative Actions

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.

Collaborative Actions

3. 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.

4. 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.

Change requires the collective will and commitment of Public Health and partners.

The results in this plan cannot be achieved working in silos.

We hope this plan offers a roadmap that can be collectively used for reducing health inequities by addressing root causes of disproportionality in health outcomes.

See how to partner with us at:

http://publichealth.lacounty.gov/pie/planning/chip.htm