| PHS Snapshot of Strategic Plan FY2025-27

ID: 93534

County of San Diego Health and Human Services Agency
Public Health Services Snapshot of Strategic Plan

The Public Health Services (PHS) Strategic Plan aligns with the County of San Diego and Health and Human Services Agency (HHSA) Strategic Plans. HHSA initiatives fall under six strategic initiatives: Sustainability, Workforce, Community Engagement, Equity, Service Delivery Coordination, and Systems & Technology. PHS supports these County and HHSA initiatives, as shown below, which are aligned to The Foundational Public Health Services (areas in red and capabilities in green).

Vision: Healthy people in healthy and equitable communities.

Mission: To promote health and improve quality of life by preventing disease, injury and disability, and by protecting against, and responding to, health threats and disasters.

Values: Collaboration, Diversity, Respect, Responsiveness, Transparency

Key (Quantitative Measure):

- **RED = 0 to 74%** *(Below Target)*
- **YELLOW = 75 to 94%** *(Approaching Target)*
- **LIGHT GREEN = 95 to 99%** *(Good Performance)*
- **DARK GREEN = 100 to 109%** *(Strong Performance)*
- **BLUE = Above 110%** *(Exceptional Performance)*

Key (Qualitative Measure):

- **RED = 0** *(Not Started)*
- **YELLOW = 1** *(In Progress, But Behind Schedule)*
- **LIGHT GREEN = 2** *(In Progress, on Schedule)*
- **DARK GREEN = 3** *(Completed)*
- **BLUE = 4** *(Completed Ahead of Schedule)*

Key for Goal Alignment to County of San Diego Strategic Initiatives

Icon Legend – Goals are aligned to the HHSA Strategic Framework and Icons demonstrate County Strategic Alignment. However, icons used very slightly due to icons available within Clear Impact system. This legend key identifies icons used within the PHS Strategic Plan that demonstrate County framework alignment.

County Framework	PHS Strategic Plan Icon
SUSTAINABILITY	
EMPOWER	
COMMUNITY	
EQUITY	
JUSTICE	

Administration Branch of Public Health Services

HE Health Equity Goal: Advance health equity across San Diego County by identifying and addressing the root causes of disparities highlighted in the Community Health Assessment (CHA), ensuring all communities have equitable opportunities for optimal health.

HE Health Equity Objective: Annually review CHA data through 5 lenses (age, gender, geography, race/ethnicity, and socioeconomic status) to identify equity gaps and reduce barriers for communities across the county (most recent equity gap indicators below).

Current Target Value

I SDC Three-year average Infant Mortality Rate per 1,000 live births - San Diego County	5.0 per 1,000
I SDC Annual Tuberculosis Incidence Rate per 100,000 population - San Diego County	5.0 per 100,000
I SDC Reported HIV Disease diagnosis case counts - San Diego County	42

PH **Population Health Goal: Improve population health outcomes for San Diego County residents by coordinating and supporting implementation of the Community Health Improvement Plans (CHIP).**

PH **Population Health Objective: Facilitate and monitor annual implementation of the CHIP and 5 regional Community Enrichment Plans (CEPs) to advance population health outcomes in priority areas (see below for priority indicators).**	Current Target Value
I SDC Overall Graduation Rate: the percentage of those age 25 years and older with a high school diploma or equivalent - San Diego County	90.0%
I SDC Percent of the population below poverty level - San Diego County	10.0%

California Children's Services

HE **Health Equity Goal: Transition successfully from pediatric to adult care.**

HE **Health Equity Objective: Ensure comprehensive transition plans are in place for 90% of California Children's Services clients, almost half of whom are over the age of 18 (comprised of 44% of all clients) and have disabling conditions that are expected to last beyond their 21st birthday.**	Current Target Value
PM CCS Children aged 14 and over, whose medical record indicates a condition that requires a transition plan, will have the appropriate documents (Transition Planning Checklist/Case Note of Transition Planning) among their records, based on a quality assurance review of a sample of cases - Cumulative YTD Average	90.0%

Epidemiology and Immunization Services Branch

HE **Health Equity Goal: Address childhood lead poisoning.**

PH **Population Health Goal: Promote healthy and safe home environments.**

R **Health Equity & Population Health Objective: Ensure 95% of children under age 21 who have elevated blood levels (3.5mcg/dL or greater) receive case management services.**	Current Target Value
PM CLPPP 1.1.3.1: 95% of children with blood levels ≥14.5 mcg/dL who receive case management services within one (1) week of referral. - Cumulative YTD Average	95.0%
PM CLPPP 1.1.3.2: 95% of children with blood levels 9.5-14.4 mcg/dL who receive case management services within two (2) weeks of referral. - Cumulative YTD Average	95.0%
PM CLPPP 1.1.3.3: 95% of children with blood levels 3.5-9.4 mcg/dL who receive case management services within two (2) months of referral. - Cumulative YTD Average	95.0%

HIV, STD, and Hepatitis Branch

HE **Health Equity Goal: Prevent HIV infection and address rising STD rates.**

PH **Population Health Goal: Reduce the number of new HIV infections.**

R **Health Equity & Population Health Objective: Reduce by 90% the HIV disease diagnosis case counts in San Diego County (from 2017 baseline of 422 to 42 by 2030).**

Current Target Value

I SDC Reported viral suppression among persons living with diagnosed HIV in the Ryan White program is 95% by 2030 - San Diego County

95%

Maternal, Child, and Family Health Services

HE **Health Equity Goal: Reduce infant mortality.**

PH **Population Health Goal: Improve the health and safety of infants.**

R **Health Equity & Population Health Objective: Maintain County-wide infant mortality rates at or below 5 deaths per 1,000 live births while achieving measurable reductions in the three-year average infant mortality rate among African-American/Black infants.**

Current Target Value

I SDC Three-year average Infant Mortality Rate per 1,000 live births - San Diego County

5.0 per 1,000

Public Health Preparedness and Response

HE **Health Equity Goal: Advance equitable preparedness.**

HE **Health Equity Objective: Advance equitable emergency response by addressing social determinants of health and expanding access to timely, appropriate public health and medical services across all communities.**

Current Target Value

I PHPR Percent of Flu POD (Point of Dispensing) sites addressing a social determinant of health through data-driven approaches, including, but not limited to, using an equity lens (i.e., access to and utilization of services).

90.0%

PH **Population Health Goal: Support community health readiness.**

PH **Population Health Objective: Enhance system readiness through data-driven planning, equity-informed emergency coordination, and disaster workforce development.**

Current Target Value

I PHPR Percentage of County Public Health Nurses reporting confidence in readiness to deploy to local disasters, measured through assessments provided during non-response periods.

90.0%

Tuberculosis Prevention and Care

HE **Health Equity Goal: Expand latent tuberculosis (TB) infection risk assessment, testing, and treatment to decrease rate of new active TB cases (incidence).**

PH **Population Health Goal: Reduce the rate of new active TB cases.**

	Current Target Value
R Health Equity & Population Health Objective: Reduce the annual TB incidence rate to 5 cases per 100,000 by 2030.	
I SDC Annual Tuberculosis Incidence Rate per 100,000 population - San Diego County	5.0 per 100,000

Sustainability 🌎

Operational Plan Measures	Current Target Value
OP Admin 1.1.1.1: 20% average reduction in vehicle miles traveled maintained by supporting remote and hybrid work environments to reduce emissions and the office footprint as Public Health Services and Medical Care Services migrate to alternate and new facilities and maximize shared workspaces. - FY YTD Monthly	20%
OP ONE Ensure nurses who attend the Public Health Nurse Residency and Nursing Essentials of Nursing Onboarding programs rate their overall satisfaction with the program as 4.65 or higher (on a scale of 0-5). Ensuring high-quality training is essential for maintaining a highly skilled nursing workforce that staffs the County's Public Health Centers, responds to public health emergencies, provides in-home visitation services, and many other essential programs serving clients.	4.65

Workforce 🤝

Operational Plan Measures	Current Target Value
OP PHPR 1.1.1.1: One (1) quarterly training for Medical Operations Center (MOC) Responders focused on ICS and hazard-specific responses to ensure MOC staff readiness to respond to disasters and/or public health threats. - Cumulative YTD	4
OP PHS/MCS 3.1.3.3: At least four (4) listening sessions for workgroups convened to engage employees in identifying opportunities to assess areas of overlap and implement efficiencies to streamline operations as Public Health Services and Medical Care Services integrate services into one department. - Cumulative YTD Average	4
OP Admin 2.1.1.2: Issue the Customer Experience survey to all PHS and MCS customers and achieve a minimum average satisfaction rating of four (on a 1- 5 scale). Develop and implement an improvement plan for areas with a rating lower than four. - Cumulative YTD Average	4.00
OP Admin 3.1.4.1: Four (4) articles in the PHS newsletter per year that raise awareness of and opportunities for employees to learn and participate in Employee Resource Groups (ERGs), events and/or activities to continue a workplace centered belonging. - Cumulative YTD Sum	4

Community Engagement 🏘️

Operational Plan Measures	Current Target Value
OP HSHB 1.2.1.1: 90% of individuals of childbearing potential who are diagnosed with any stage of syphilis have been screened for pregnancy status. - Cumulative YTD Average	90.0%
OP ONE Coordinate 5 community forums to provide education and gather feedback on the Medi-Cal Transformation initiative (previously CalAIM). These forums are an opportunity for community partners and residents to speak directly with County staff on the challenges and opportunities around accessing CalAIM and impact the planning and implementation, with the ultimate goal of ensuring all qualified Medi-Cal enrollees may benefit from Medi-Cal Transformation to achieve positive health outcomes and well-being.	5
OP ONE Implement three (3) strategies to increase revenue for core programs to ensure fiscal sustainability for essential health care and care coordination services.	3
OP ONE Implement three (3) strategies to strengthen collaboration between the Public Health Nurse Homeless Outreach Team and partners, including the City of San Diego, law enforcement agencies, and organizations working with unsheltered communities to improve trust in public health initiative.	3

OP ONE	Invite oral health experts to provide trainings during four San Diego County Oral Health Coalition meetings to support dental care in non-traditional settings with a focus on trauma-informed care.	4
OP ONE	Three (3) meetings coordinated at a minimum with Managed Care Plans, Street Medicine providers, and multi-sector stakeholders, as applicable, to support the growth and integration of street medicine services into the broader continuum of healthcare services, ultimately enhancing service delivery. Cumulative YTD Sum	3
OP ONE	Implement a pilot program for the Transitions Clinic Network (TCN) to provide culturally and linguistically responsive health and social care services to justice-involved clients exiting San Diego County jails. Community Health Workers (CHWs) with lived incarceration experience build rapport, offer mentorship, and guide clients before and after release, helping them connect to necessary health and social services upon reentry.	1

Equity 👥

Operational Plan Measures

		Current Target Value
OP ONE	Ensure 95% of patient encounters include pharmacy-based transition of care when admitted or discharged from the San Diego County Psychiatric Hospital or the Edgemoor Distinct Part Skilled Nursing Facility to improve patient outcomes. This will be carried out by integrating a clinical pharmacy program to ensure pharmacists evaluate current medications, new medications, and their compatibilities to ensure a smooth transition to and from hospital care.	95.0%
OP MCFHS	3.1.1.1: 88% of infants served by the Black Infant Health (BIH) program have a normal birth weight (at least 2,500 grams). - Cumulative YTD Average	88.0%
OP MCFHS	4.1.1.1: 90% of children in out-of-home placement receive timely preventive health examinations - FY YTD Monthly	90.0%
OP MCFHS	4.1.2.1: 90% of children in out-of-home placement receive timely dental examinations - FY YTD Monthly	90.0%
OP MCFHS	2.1.1.2: Five (5) or more neighborhood markets and/or convenience stores in CalFresh-eligible communities are supported to participate in fresh produce distribution to increase access to healthy produce. - Annual	5
OP TBPC	3.2.1.1: 95% of individuals diagnosed with TB complete treatment. - Annual	95.0%
OP EISB	3.1.2.1: 99% of children ages 0 through 18 years served at Public Health Center (PHCs) clinics are provided age-appropriate vaccines. - Cumulative YTD Average	99.0%

Service Delivery Coordination 🤝🏠👥⚖️

Operational Plan Measures

		Current Target Value
OP EISB	7.1.2.1: 100% of audits (7 different lab licenses and permits) find the laboratory operation in compliance. - Cumulative YTD Average	100.0%
OP EISB	4.1.1.1: 100% of reported cases of select communicable diseases (hepatitis A, meningococcal infection) are investigated within 24 hours of receipt of report. - Cumulative YTD Average	100.0%
OP TBPC	3.1.2.1: 95% of all persons with active TB, alive at diagnosis, are tested for HIV infection. - Cumulative YTD Average	95.0%
OP TBPC	3.1.1.1: 98% of persons diagnosed with active TB reported within one working day from start of treatment. - Cumulative YTD Average	98.0%
OP HSHB	1.1.3.1: At least 94% of newly diagnosed persons linked to HIV medical care within one month (30 days) of informing them of their diagnosis. - Cumulative YTD Average	94.0%
OP CCS	5.1.1.2: 97% of CCS beneficiaries have their medical eligibility determined within five (5) business days upon receipt of all necessary documentation, based on State CMS Net/MSBI report. - Cumulative YTD Average	97.0%
OP Admin	11.1.2.1: A minimum of seven (7) formal QI projects conducted each year (at least one within each Branch) to address key performance gaps and engage staff in identifying and resolving barriers to success. - Cumulative YTD Sum	7

Systems & Technology 🌎🤝🏠👥⚖️

Current

Operational Plan Measures

		Target Value
OP ONE	Ensure 90% of referrals to the Home Visiting Program are contacted within one business day so that they may receive timely access to primary prevention, reduce disparities and improve health outcomes. Linking families to the home visiting program empowers them to feel prepared and supported to make positive, healthy choices and establish a solid foundation for years to come. - Cumulative YTD Average	90.0%
OP VR	9.1.1.1: 95% of birth certificates registered within 10 days of birth to maintain accurate census data, representing best practice as the State has adopted a new 21-day timeline standard. - Cumulative YTD Average	95.0%