

Public Health Services

Strategic Plan

2019-2021



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Dear Reader,

On behalf of the Department of Public Health Services (PHS), County of San Diego Health and Human Services Agency (HHSA), I am very proud to present the *Public Health Services Strategic Plan 2019-2021*.

This document compiles the goals, strategies, and objectives of PHS. Activities detailed reflect the commitment of PHS staff and their community partners to make a difference in the lives of the more than 3.3 million residents of San Diego County and its 35 million annual visitors.

It is important that all strategic plans are living documents. This is particularly true today. As this *Plan* was being finalized, we are experiencing a global pandemic (i.e., COVID-19), a public health threat unlike any we have seen in our lifetime. Implementation of this *Plan* began in FY 2018-19 and was well underway at the time of publishing in 2020. PHS remains responsive and adaptive as it implements, monitors, and adjusts this *Plan* to ever changing conditions and new demands.

This *Plan* advances *Live Well San Diego*, a regional vision to build better health, live safely, and thrive. It aligns with the health priorities at the federal and state levels—including the federal *Healthy People 2020* document and the *Let's Get Healthy California Plan*. Additionally, the *Plan* aligns with local priorities. This includes the new *Community Health Improvement Plan*, which guides community health activities across HHSA Regions and engages partners from every sector. By aligning plans at every level of government, limited resources are leveraged and the potential impact of each plan is greatest.

Over the past five years, PHS has had many successes. In May 2016, PHS became a nationally recognized public health department—an honor held by 255 out of 2,800 local health departments nationwide as of July 2020. From March 2017 to October 2018, the County managed the response to a hepatitis A outbreak. This effort garnered the need for communication, coordination, and collaboration with homeless services and behavioral health providers, healthcare partners, and many levels of city municipalities. In December 2017, PHS also contributed to HHSA's receipt of the California Award for Performance Excellence, a recognition modeled after the Malcolm Baldrige National Quality Award. In June 2018, PHS was a recipient of the Kresge Foundation Emerging Leaders in Public Health (ELPH) award. This Kresge initiative includes a leadership development initiative to equip local public health officials with the knowledge and skills to lead in today's changing public health environment. These successes reflect a robust infrastructure and strong local partnerships, which are also characteristics that have been essential to the success of the San Diego County COVID-19 pandemic response.

This *Plan* reflects the importance of the work of PHS, and the scope and reach of its efforts. It captures areas of mutual interest shared with local community partners and stakeholders. These partnerships continue to deepen as new and ever more complex challenges arise. The *Plan* identifies ways that we will work together to help all residents across our diverse local communities to live well. Please take the time to review this *Plan* and feel free to provide comments to my office.

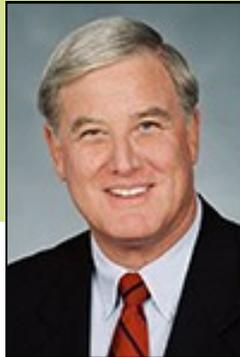
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Message

from the Director
and Public Health
Officer, Public
Health Services

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Vision, Mission, and Values

County of San Diego

VISION: A region that is Building Better Health, Living Safely and Thriving

MISSION: To efficiently provide public services that build strong and sustainable communities

VALUES: Integrity, Stewardship, and Commitment

Health and Human Services Agency

VISION: A region that is Building Better Health, Living Safely and Thriving

MISSION: To make peoples' lives healthier, safer and self-sufficient by delivering essential services in San Diego County

VALUES: Integrity, Stewardship, and Commitment

Public Health Services

VISION: Healthy people in Healthy 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: Diversity, Respect, Collaboration, Responsiveness, Transparency

The Vision, Mission, and Values establish the overall future direction for the organization. Because the County, HHS, and PHS are part of an integrated enterprise, the Vision, Mission, and Values of all three entities is important. *Live Well San Diego* is the overarching vision for this collective impact effort that engages the County enterprise along with many partners across every sector.

STRATEGIES

A decorative border consisting of a grid of colored rectangles in shades of blue, orange, yellow, and green, surrounding the central text.

Introduction

OBJECTIVES

Introduction



Since 1850, San Diego County has a history of almost 170 years of public health services. During this time, there has been significant organizational transformation to accommodate the region's growing and changing needs.

HHSA Organizational Transformation

Today, Public Health Services (PHS) is a department within the Health and Human Services Agency (HHSA). HHSA is one of four business groups in the County of San Diego government. HHSA provides a broad range of health and social services, promoting wellness, self-sufficiency, and a better quality of life for all individuals and families in San Diego County. It integrates health and social services through a unified service-delivery system.

PHS as Part of an Integrated Structure

The merger of individual County departments into a single Health and Human Services Agency was approved by the Board of Supervisors in 1996. In 1998, due to the size and diversity of the county, a new, regional delivery system was created, enabling

regional directors to better acquaint themselves with individual communities and develop partnerships to meet their unique needs.

Today, HHSA includes ten operational departments and offices: Aging and Independence Services; Behavioral Health Services (including Adult Services and Children, Youth and Family Services); Child Welfare Services; Eligibility Operations; Housing and Community Development Services; Integrative Services; Medical Care Services; Military and Veterans Affairs; Public Administrator/Guardian/Conservator; and Public Health Services. Medical Care Services was created in 2017-18 to focus on the many facets of clinical operations across HHSA. Integrative Services and Housing and Community Development Services are two departments that are focused on helping to address the social determinants of health—by working to ensure seamless service delivery across HHSA services and other County departments and expanding the availability of safe and affordable housing for low-income and special needs populations.

At the same time, the support departments (Agency Contract Support, Financial Support Services, Group Human Resources, Information Technology Services, and the Office of Strategy & Innovation) play an important role, providing essential financial, administrative, planning, program, and policy support to HHSA's ten operational departments and offices, and contribute to the operational excellence essential to advancing the *Live Well San Diego* vision (Figure 1).

A Regional, Community-Based Model

The County of San Diego, HHSA, and PHS have evolved over time. First there was the organizational redesign that began in 1996 that led to the creation of HHSA and a more integrated approach. And marked a transition from a programmatic organizational structure to an integrated, regional

model. This system is family-focused and community-based, reflective of business principles in which services are delivered in a cost-effective and outcome-driven fashion.

Strong Accountability and Outcome-Driven

This redesign also called for a shift toward strengthening accountability to taxpayers and an increased focus on outcomes through community-based prevention and early intervention strategies. With this focus in mind, the County adopted the General Management System (GMS). The first element of the GMS is strategic planning. All Groups within the County, including HHSA, adhere closely to the GMS, participate in annual planning process, and align with the County of San Diego Strategic Plan.



Live Well San Diego Vision Adopted

In 2010, a regional vision was adopted by the San Diego County Board of Supervisors, called *Live Well San Diego*. *Live Well San Diego* encompasses community engagement on all levels. It is based on the collective impact model, bringing all County departments and every sector together—from government, to business, to schools, to faith-based and community organizations—through a shared vision for wellness across the region.

There are three components of the *Live Well San Diego* vision that were developed over time. On July 13, 2010, the first component, Building Better Health, was adopted as a result of a two-year collaborative process that was spurred on by a surge in chronic disease and its impact on residents and the health care system. The focus of this component is improving the health of residents and supporting healthy choices.

The second component, Living Safely, was adopted on

October 9, 2012. It focuses on protecting residents from crime and abuse, making neighborhoods safe, and supporting resilient communities. The third component, Thriving, adopted on October 21, 2014, focuses on cultivating opportunities for all people to grow, connect and enjoy the highest quality of life. This third component involved extensive discussions with community partners to develop and design.

Live Well San Diego involves formally recognized partners in every sector—from government, to business, to schools, to faith-based and community organizations—through a shared vision for wellness across the region. There are currently more than 400 recognized partners, 5 Regional Community Leadership Teams (Leadership Teams) across the HHSA regions, and about 350 HHSA contractors who are expected to advance the vision. This reflects the scope, evolution, and maturation of this collective effort.

Figure 1. Live Well San Diego Vision Pyramid.



Source: County of San Diego, LiveWellSD.org.

Structured Regional Planning Process

As an accredited public health department, PHS has adopted a structured planning process and framework, called Mobilizing for Planning and Partnership (MAPP), to identify community priorities (Figure 2).

A Community Health Status Assessment is conducted regularly to gather data about community well-being, and updates are presented annually to Leadership Teams in each HHS service delivery region. For the Community Themes and Strength and Forces of Change Assessments, Leadership Teams were surveyed. The questions included were chosen to gather feedback on community health, economic opportunity, and offerings of culture and arts—in other words, to capture input about broader community well-being.

On September 23, 2016, a Local Public Health System Assessment provided an opportunity for more than 200 participants across all sectors to offer feedback and score the entire system (not limited to the County’s public health department) in terms of each of the 10 Essential Public Health Services.

Community engagement is at the heart of MAPP. Leadership Teams for each of the HHS Regions identify priorities for change that are captured in their respective Community Enrichment Plans (CEPs). This enables PHS to engage the

community through regional leaders who know first-hand what the needs are and who can effectively engage partners in advancing these priorities. These CEPs roll up into the County-wide Community Health Improvement Plan (CHIP). “Enrichment” is in the name of the CEPs to reflect that these plans recognize the importance of the social determinants of health that affect outcomes across all three components of *Live Well San Diego*, including *Living Safely* and *Thriving*.

The Community Health Status Assessment, Community Health Improvement Plan, and the PHS Strategic Plan, as well as key elements of the MAPP process, are now on a three-year planning cycle, instead of a five-year cycle as was previous practice. A shortened planning cycle was adopted to address the County’s rapidly changing needs and ensure that community improvement efforts are responsive.

This three-year cycle was also adopted to strengthen coordination with the Hospital Association of San Diego and Imperial Counties (HASDIC). Under the Community Benefits Program section of the Affordable Care Act, hospitals are required to perform their own community health status assessments every three years. The results of the assessments are meant to guide the hospitals in providing for communities of need.

Figure 2. MAPP Framework.



Source: National Association of County and City Health Officials.



Planning Efforts by PHS Branches

In addition to community input gathered as a result of the MAPP process, PHS Branches also collect information from community partners and stakeholders in a number of different ways. Input is gathered from various advisory committees, community and customer surveys, and ongoing program planning activity. This information helps to inform the priorities, goals, and objectives of this new strategic plan.

Structure of PHS

PHS has 465 full-time equivalent staff in FY 18-19. These staff are assigned across PHS's seven Branches:

1. **PHS Administration (PHS Admin)** directs public health programs, safeguards the public's health, and coordinates a unified response during emergencies.
2. **California Children's Services (CCS)** provides diagnostic treatment services, medical case management, and physical and occupational therapy services to children under age 21 with eligible medical conditions.
3. **Epidemiology and Immunization Services Branch (EISB)** works to identify,

prevent, and control communicable diseases.

4. **HIV, STD, and Hepatitis Branch (HSHB)** helps to assure the development and delivery of quality HIV, STD, and Hepatitis prevention and treatment services.
5. **Maternal, Child, and Family Health Services (MCFHS)** works to promote health and to protect and support pregnant women, children, families and communities.
6. **Public Health Preparedness and Response (PHPR)** supports emergency preparedness for all types of disasters—natural and man-made. This Branch, created in FY 16-17, was formerly called Emergency Management Services before some staff were transferred to HHSA's Medical Care Services Division.
7. **Tuberculosis Control and Refugee Health Branch (TBC-RH)** detects, controls, and prevents the spread of tuberculosis through treatment, case management and contact investigation. It also concentrates efforts on refugee health issues.



Structure of this Strategic Plan

In order to define and determine roles, priorities, and direction over the next three to five years, PHS has prepared this strategic plan for Fiscal Years 2019-2021. This plan sets forth what PHS plans to achieve as an organization, the key objectives or steps PHS will take to achieve its goals, and indicators for PHS and the community it serves to identify if progress is being achieved. It also provides a guide for making decisions and allocating resources to pursue its strategies and priorities.

The document is organized into several sections after this Introduction. The Methodology explains the steps that went into the making of the plan, including special Health Equity workshops convened in FY 2017-18 and the annual Strategic Review process. Following is an overview of how the plan is structured. Next is the heart of the plan—each individual plan of the seven PHS Branches are presented, including goals, strategies, objectives, and measures.

Implementation of this plan began in FY 2018-19 and was well underway at the time of publishing in 2020. Each Branch continues to adapt its goals, strategies, and objectives based on changing needs,

requirements, and conditions in order to remain responsive and relevant to the times.

Several appendices follow all of the Branch strategic plans. A health equity focus for each Branch is detailed, including data that illustrates the significance of the concern and how the respective Branch will be working to address the disparity (**Appendix I**). A list of key initiatives led by PHS, the Board of Supervisors, or some combination follows (**Appendix II**). Because of the importance of leveraging resources, alignment of this PHS Strategic Plan with the five regional Community Enrichment Plans (**Appendix III**) as well as other national, State, and local plans, including the *Live Well San Diego* vision (**Appendix IV**) is illustrated. To show how this plan will be tracked in terms of the long-term benefits to the community, two dashboards of key population indicators are included (**Appendix V**).

How this plan is consistent with requirements of the Public Health Accreditation Board (**Appendix VI**) is also detailed. Finally, key organizational data are shared in the last section of this Plan (**Appendix VII**) where financial information and organizational charts are provided.



PROCESS

Methodology

TECHNIQUE

Methodology

The Making of the Plan

Strategic Planning Process

General Overview

The County of San Diego Health and Human Services Agency (HHS) Department of Public Health Services (PHS) conducted a 24-month strategic planning process beginning in July 2016 to revise the PHS Fiscal Years 2013-18 Strategic Plan. Throughout Fiscal Years 2016-17 and 2017-18, “Metrics Workshops” were convened by each Branch to revisit strategic priorities and associated performance measures or metrics. The Public Health Services Fiscal Years 2019-21 Strategic Plan (Plan) reflects the work accomplished during these workshops and ongoing annual strategic review exercises conducted by all HHS departments.

Health Equity Metrics Workshops

The *Live Well San Diego* vision, adopted in 2010, is continuing to expand its reach (with more than 400 recognized partners) and point more attention and resources toward underserved communities through its Live Well Communities initiative. The Public Health Officer also wanted to reinforce the imperative of addressing health disparities in the refresh of this Plan. The Metrics Workshops were an opportunity for each Branch to take a holistic look at their objectives and measures. Each Branch examined their metrics through a health equity lens, referring to whether or not PHS programs were reaching all population groups and supporting an opportunity for equally successful outcomes. In examining the data, different equity lenses were

considered—race, ethnicity, gender, sexual orientation, and socio-economic status, as well as any other relevant dimension.

Structured exercises were conducted in which Branch staff identified actions that could be taken to address these disparities and then metrics that could be tracked to measure progress. These metrics were organized across three categories: population outcomes, program, and operational changes. Preliminary internal dashboards were subsequently developed to facilitate ongoing monitoring of

“Special workshops were convened by each Branch to examine metrics via a health equity lens.”

performance. The results of these discussions informed the development of each Branch’s Plan.

As part of this development process, each Branch identified a health equity priority (see **Appendix I**). Background on the importance of the priority, as well as data illustrating the nature of the disparity, are captured in this Appendix, as well as references to goals within this strategic plan aimed at addressing the problem.

Ongoing Strategic Review

HHSA had adopted an annual Strategic Review process as part of its journey to become recognized through the California Association for Performance Excellence (CAPE) Award, which is modeled after the Malcolm Baldrige National Quality Award. This annual review, conducted during the beginning of each fiscal year, calls for every HHSA department to assess current programs and operations, conduct an environmental

“An annual Strategic Review brings ongoing rigor to the strategic planning process.”

scan and SWOT (Strengths, Weaknesses, Opportunities, and Threats) analysis, and identify strategic advantages and disadvantages. Department priorities are then identified. The Strategic Review also includes an examination of key performance measures to ensure that these measures, which are shared with the public as part of the County Operational Plan, best reflect the priorities of the department and that the targets are adequately aggressive.

Strategic Review exercises are conducted within each Branch to ensure all staff are engaged in discussions about current challenges and future trends. Together, the Branches also conduct Strategic Review activities through executive, leadership, and senior staff meetings. The benefit of the Strategic Review process is that there is deliberate review of priorities and measures every year, and it culminates in a final review by all agency executives, including the Public Health Officer. Key initiatives that cut across PHS and other County of San Diego departments are also

considered in this review (see **Appendix II**), with consideration as to how PHS is either leading or supporting these initiatives. This practice also provides opportunity to identify potential synergies and ways to leverage resources.

Alignment to Community Planning in the Regions

Meetings were convened between community engagement staff for each HHSA Region and PHS Branch staff. Shared goals and opportunities to leverage resources and expertise were explored. This informed the development of the Community Enrichment Plans (CEPs) in each Region, as well as informed the PHS Strategic Plan. While Regions and their respective Leadership Teams guide planning at the local level, PHS and other HHSA and County departments provide the expertise and, where possible, resources through local, State, and Federal funding to help support and advance these shared goals. Furthermore, staff from Aging and Independence Services, Behavioral Health Services and other County departments also participated in these discussions to identify shared goals. See **Appendix III** for more on alignment to community planning.

Alignment to Local, State, and National Plans

Because PHS is part of a collective impact effort, *Live Well San Diego*, it is very important that there is alignment to any available plans and resources at all levels of government. Changes in community health can only be achieved if everyone is working together and leveraging limited resources by doing those things that are shown by the research to have the greatest impact. **Appendix IV** shows the alignment of the objectives by Branch with *Live Well San Diego*, the County of San Diego Strategic Plan, and other State and national health plans and efforts.





Evidence-Based Practice

The goals and objectives captured in this plan are based on the latest evidence-based practice. When developing goals, each program within PHS considers federal and State requirements, national research, and best practice. Public agencies that are leaders in terms of best practices are identified for benchmarking or comparative performance targets.

Increasingly, the importance of creating social and physical environments that promote good health for all is recognized, which is referred to as the social determinants of health. Positive community-wide change requires the contributions of many organizations, including PHS, other County departments, and partner organizations across every sector. Residents that are active and engaged are also key to community change. This is why it is so important that the strategies adopted are mutually reinforcing or coordinated, and based on or informed by research or evidence. The *Live Well San Diego* vision offers a framework for taking a broader perspective and bringing community partners together for action. This framework's components (Building Better Health, Living Safely, and Thriving), and associated strategies draw from the latest research and best practice.

Implementation and Monitoring

Public Health Services will be implementing this Strategic Plan over the next three fiscal years. The objectives are tracked through a performance management system, and reported quarterly to the entire PHS team through a simple, colorful Performance Flash Report. This encourages transparency on performance and a focus on improving results rather than laying blame.

Selected high-priority objectives are included in the County's two-year Operational Plan, and reported quarterly to HHSA management and annually to the public.

“The Live Well San Diego vision offers a framework that bridges the gap between objectives and their ultimate impact in terms of positive community change.”

Population indicators are also tracked—referring to measures such as infant mortality rate or unemployment rates—in which the status of an entire population are estimated. *Live Well San Diego* indicators have been identified to track long-term changes in support of the *Live Well San Diego* vision. PHS also tracks additional population indicators that are more directly related to public health programs and services. Dashboards that capture these indicators appear in **Appendix V**.

Conformance to Accreditation Requirements

A comprehensive planning process was followed in developing the PHS strategic plan. This process is in conformance with accreditation requirements of the Public Health Accreditation Board (PHAB), the accrediting organization for public health departments. Public Health Services was accredited on May 17, 2016, and will apply for reaccreditation in 2021 to demonstrate that it continuously meets nationally recognized standards in providing the 10 Essential Public Health Services to the community.

Accreditation requirements for strategic planning specify that the County must show that it has engaged staff at various levels and across the department in developing the plan. Also, the implementation of the plan needs to be tracked and revised as needed. **Appendix VI** shows how the PHS Strategic Plan aligns with the PHAB reaccreditation standards.

Quality Improvement Project Identification

PHS understands that the environment and needs of residents are dynamic. This requires that San Diego County continuously work to improve its

“Integration of performance management and quality improvement is an important expectation of accredited public health departments.”

programs and services. Performance for key objectives that fall below target goals may be identified for a quality improvement (QI) project. There are several instances of this—including a project to improve the timely linking of foster children to preventive health exams and the timely linkage of those newly diagnosed with HIV to primary care. Both of these important objectives have benefited from a QI project involving a team that identified and tested solutions to successfully improve performance.

PHS has adopted the goal of conducting eight QI projects each year, with at least one project carried out by each Branch. To build QI capacity and strengthen the continuous improvement culture within PHS, 25 QI Champions have been designated across all Branches to engage staff at all levels in QI.

Integration of performance management and quality improvement is an important expectation of accredited public health departments. Performance challenges should be addressed with some type of mitigation, and QI projects are often warranted to identify solutions. Conversely, a QI project may identify an important process that warrants monitoring to ensure performance improves.

Staff Support

The Public Health Officer, Performance Improvement Manager, a Community Health Program Specialist, a Health Equity Coordinator, and several other staff and interns coordinated this effort. Epidemiologists from the Community Health Statistics Unit provided key technical support to the Health Equity Metrics Workshops and developed and maintain the Dashboards used to track indicators.

The Performance Improvement Management Committee, comprised of representatives from each Branch, plays an invaluable role in assisting their respective Branch Chief and staff with strategic planning and performance management activities.

Appendix VII provides financial and organizational charts that reflect the staffing and resource commitments to implementing this strategic plan.



AGENDA

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The Plan

STRATEGY

Overview of Branch Plans

Public Health Services Branches

Administration (PHS Admin)

California Children's Services (CCS)

Epidemiology and Immunization Services (EISB)

HIV, STD, and Hepatitis (HSHB)

Maternal, Child, and Family Health Services (MCFHS)

Public Health Preparedness and Response (PHPR)

Tuberculosis Control and Refugee Health (TBC-RH)

This section contains individual Branch plans for each of the seven Branches—six programmatic and one administrative.

Structure of the Plans

Each Branch plan begins by identifying the units and programs within the Branch. Goals are identified, followed by strategies and objectives to achieve the goals, and then metrics by which progress is tracked.

Definitions

- **Branch:** Name of the branch within PHS.
- **Unit:** Refers to an organizational unit within the Branch that includes one or several programs.
- **Program:** Set of related activities, created, sponsored and/or funded by federal, State and local resources.
- **Goal:** Aspiration or broad statement of what we want to achieve in the longer term (three to five years).
- **Strategy:** Approach or how we will go about achieving the goal which should be based on, or informed by, the research, evidence or best practice.
- **Objective:** The change or improvement we seek or hope to accomplish in the shorter term (one to three years).
- **Metric:** How progress is to be measured (begins with numerical target provided if there is one).

Goals Used to Organize Branch Plans

For some Branch plans, the goals are organized by program; for other plans, the goals span across every program.

- For CCS, HSHB, PPHR, and TB, their respective plans use cross-cutting goals that reflect major areas of effort. For example, HSHB has organized its goals by Test, Treat, Prevent, Engage, and Improve, consistent with the County's Getting to Zero Initiative to eliminate HIV transmission and related deaths in the region.
- EISB, on the other hand, has organized its goals by individual programs. MCFHS using a combination of goals by program with the exception of its Chronic Disease and Health Equity Unit, in which one goal captures all programs related to creating environment and policy changes to advance health and health equity.
- PHS Admin, in addition to conforming to national public health accreditation standards, has organized its goals by the Baldrige Performance Excellence Framework (see *Figures 3 and 4* on the next page). As HHSA has embarked on the Baldrige journey, PHS Admin is working to promote and support the integration of this framework within this Branch and across the entire department. The Baldrige efforts are consistent with being a nationally accredited public health department in that the Baldrige criteria for excellence are comparable to the standards of the Public Health Accreditation Board.



Goals Aligned to Local, State, and National Initiatives

Alignment of goals is important because it shows that everyone is working together and leveraging limited resources. This is especially important given that PHS is part of a collective impact effort, *Live Well San Diego*. Goals for each Branch are aligned to various national and State initiatives (The 10 Essential Public Health Services, Let's Get Healthy California, the National Prevention Strategy and Healthy People 2020). The goals are also aligned to the County's *Live Well San Diego* vision. This alignment is displayed in **Appendix IV**.

Time Period for Objectives

Objectives that do not explicitly state a date are intended to be accomplished by the end of every fiscal year (June 30) for the three years in which this plan is in effect (FY 2019–2021). Some objectives are longer-range, particularly those related to policy, systems, and environmental changes. As noted previously, implementation of this plan began in FY 2018-19, before its publication in 2020.

Reference to Operational Plan Measures

Operational Plan measures are priority measures that are aligned with the Strategic Initiatives of HHSA and that communicate core services and organizational priorities. These measures demonstrate performance to San Diego County citizens and are approved by the Board of Supervisors every two years. Each Branch's Operational Plan measures are woven into their strategic plan and are emphasized by *orange italicized text*.



Reference to Health Equity Goals

As previously mentioned, each Branch has selected a specific health equity priority, explored in more detail in **Appendix I**. These health equity priorities are linked to specific goals and are referenced in each Branch's strategic plan, indicated by a magnifying glass icon. Most Branches have one or two goals that directly relate to their health equity priority. For HSHB, all goals are linked to its health equity priority.

Guided by National Accreditation Standards and Baldrige Criteria for Performance Excellence

This PHS Strategic Plan was developed in adherence to national public health accreditation standards based on the Ten Essential Public Health Services, developed under the auspices of the Centers for Disease Control and Prevention. Standards require that a health department be guided by a strategic plan (Essential Service 5) and that the plan be continuously monitored by the health department (Essential Service 9) (Figure 3).

Also, consistent with the County’s strategic goal of operational excellence, HHSA is pursuing the Baldrige Award, which recognizes organizations based on performance excellence (Figure 4).

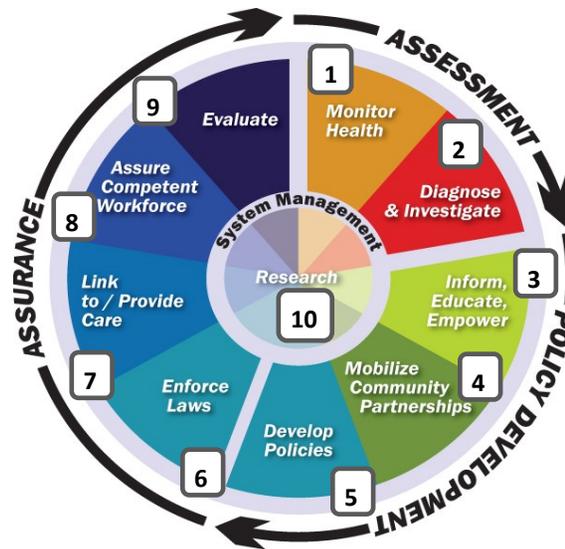
In December 2017, the County’s Health and Human



Services Agency received the California Award for Performance Excellence (CAPE) – Eureka Silver Level. The honor shows that HHSA used effective strategies and practices throughout the organization in order to improve services to its customers. This is a noteworthy achievement since very few local governments have achieved this level of recognition.

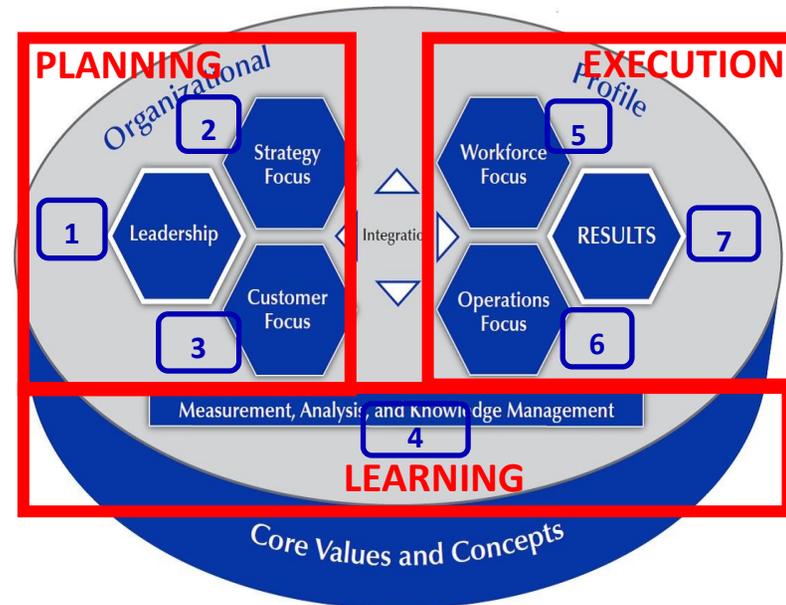
PHS, having already achieved national public health accreditation in 2016, had many of the practices consistent with the Baldrige criteria already in place. This contributed significantly to the efforts that were recognized by CAPE.

Figure 3. Ten Essential Public Health Services, on which Public Health Accreditation standards are based.



Source: Centers for Disease Control and Prevention.

Figure 4. Baldrige Performance Excellence Framework.



Source: National Institute of Science and Technology, Baldrige Performance Excellence Program.

Administration



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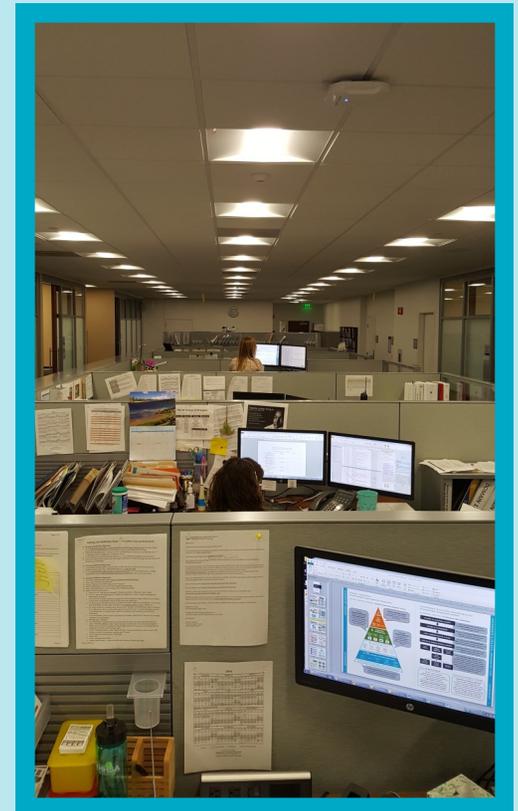
Goals

9

Strategies

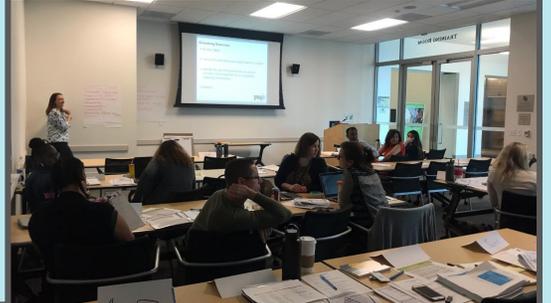
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Objectives





Services **SWOT** **San Diego** **LiveWell** **Thriving** **Community** **Safe** **HHSA** **Performance** **3-4-50**



ADMINISTRATION, PUBLIC HEALTH SERVICES (PHS ADMIN)

UNITS AND PROGRAMS

- **Administrative Support Unit**
 - Contract Support
 - Human Resources
 - Medi-Cal Administrative Activities/
Targeted Case Management (MAA/TCM)
- **Community Health Statistics Unit**
- **Management Information Systems Unit**
- **Border Health Unit**
- **Health Equity Unit**
- **Performance Management and Quality Improvement Unit**

Goals and objectives for all programs in PHS Admin are organized by the criteria for performance excellence under the Baldrige Excellence Framework (see Figure 4 on page 16) but for two exceptions. The exceptions are MAA/TCM and Office of Border Health. For these units, goals and objectives appear outside of the Baldrige Framework and are included at the end of this PHS Admin Plan.

GOAL 1 (LEADERSHIP): Provide leadership that guides the organization, advances health equity for all residents, and establishes an environment for success.

Strategy 1.1: Adhere to the Baldrige Excellence Framework criteria for **Leadership** that is proven to contribute to organizational success.

Objective 1.1.1: Maintain the department's adherence to statutory responsibilities and advance conformance to the highest standards.

- Compliance with PHAB accreditation standards, alignment with Baldrige criteria for performance excellence.

Objective 1.1.2: Address local health challenges by strengthening leadership capacity of public health staff, municipal partners, and other stakeholders.

- Number of trainings engaging staff, partners, and stakeholders.
- Framework for improved communication among partners.
- Leadership roles at federal, State, and local levels.

Objective 1.1.3: Proactively identify and mitigate risk through planning, data-informed decision-making, and effective risk mitigation.

- Performance Dashboards and Scorecards implemented, updated, and utilized at monthly meetings to review risks.
- Timely completion of the Monthly Operations Report (MOR).

- Objective 1.1.4:** Advance *Live Well San Diego* with initiatives/events that actively engage partners and strengthen community connections.
- Coordination, support, and participation in major events such as Public Health Champions (to recognize community partners for their achievements in public health), the Blood Drive, and Love Your Heart (to provide free blood pressure screenings and educate residents about heart health)
 - PHS partners who become recognized as *Live Well San Diego* partners.

- Objective 1.1.5:** Support the effectiveness of the Health Services Advisory Board (HSAB) and implementation of its strategic plan.
- Results of self-evaluation and H.E.A.R.T. scores of HSAB members, referring to a customer service survey used across the County to gather feedback as to whether staff demonstrate these qualities—Helpful, Expertise, Attentive, Respect, Timeliness—in the delivery of services.

- Objective 1.1.6:** Enhance responsiveness to public health emergencies through continuity of operations planning (COOP).
- 100 percent of staff completing training on National Incident Management System (NIMS) and Incident Command Systems (ICS) online and in classroom training.
 - Two COOP drills conducted annually.

- Objective 1.1.7:** Provide coordination, communication, and implementation of federal and State emerging practices in health equity to be infused across all PHS Branches.
- Participation on Health Equity Advisory Committee, State Office of Health Equity.
 - Annual work plan targets met toward implementing the Health Equity Plan.
 - Actions taken to address the Health Equity Priority that each Branch has identified (and that is highlighted in **Appendix I**).

- Objective 1.1.8:** Receive recognition for outstanding or innovative work and share this work with the professional and peer community.
- Number of scientific papers, abstracts, and presentations accepted or delivered.
 - Number of presentations delivered at National, State, and other conferences.
 - Number of national and State awards received (including Centers for Disease Control and Prevention, National Association of Counties, California State Association of Counties, and National Association of County and City Health Officers).

GOAL 2 (STRATEGY): Promote strategy development that stimulates innovation, guides operations, and leverages opportunities in order to have the greatest impact.

Strategy 2.1: Adhere to the Baldrige Excellence Framework criteria for **Strategy Planning** that is proven to contribute to organizational success.

Objective 2.1.1: Support comprehensive strategic and operational planning across all Branches.

- One strategic review process conducted annually as part of the HSA process of refreshing the County Operational Plan, including priority performance measures.
- Timely plans and reports based on a publication timeline.
- Number of planning workshops facilitated and satisfaction scores on events.

Objective 2.1.2: Support development of new three-year Community Health Assessment and Community Health Improvement Plans, the latter reflecting the priorities of Regional Community Leadership Teams.

- Up-to-date Community Health Assessment published.
- Up-to-date Community Health Improvement Plans.
- Ongoing monitoring of progress on key priorities, at least quarterly.

Objective 2.1.3: Partner with stakeholders to strengthen climate and health outreach and planning efforts, consistent with the County's Climate Action Plan and CDC's Building Resilience Against Climate Effects (BRACE) Framework.

- Outreach and planning efforts.
- Communication efforts (e.g., climate and health presentations and development of climate and health website with PHS and the community).
- Climate Change conference with key stakeholders convened.
- PHS Climate Change Adaptation Plan developed.

Objective 2.1.4: Work with partners to develop three strategic plans in the area of health equity (State, Regional* and Local)

- State and Regional Strategic Plans for health equity developed with input from PHS.
- New PHS Strategic Plan (three years) for Health Equity developed.
- Health Equity listening sessions (forums) with input from the key stakeholders.
- Bay Area Regional Health Inequities Initiative (BARHII) Assessment with the general public.

** The use of "Regional" in Objective 2.1.4 refers to the Public Health Alliance of Southern California, which is a coalition of the executive leadership in local health departments in Southern California.*

GOAL 3 (CUSTOMER): Create a culture of Customer Service within PHS that enables staff to serve, engage, innovate, and always be responsive to feedback from customers.



Strategy 3.1: Adhere to the Baldrige Excellence Framework criteria for **Customer Focus** that is proven to contribute to organizational success.

Objective 3.1.1: Provide leadership for PHS on the Customer Service H.E.A.R.T. Initiative.

- Participation by each Branch in meetings discussing good customer service approaches.
- Degree to which Impact Plans to improve H.E.A.R.T. scores completed by each Branch.
- Overall improvement in H.E.A.R.T. scores across PHS.

Objective 3.1.2: Enhance PHS Administration external and internal customer service.

- Improvement in H.E.A.R.T. scores for PHS Administration
- Satisfaction scores on events that PHS Administration coordinates.

Objective 3.1.3: Expand the availability of health promotion resources in multiple languages to meet the demands of the community.

- Percentage of health promotion materials available in threshold languages and refreshed every 5 years.

GOAL 4 (MEASUREMENT): Manage data, analytics and information in a continuous fashion to ensure decisions are evidence-based and data driven.

Strategy 4.1: Adhere to the Baldrige Excellence Framework criteria for **Measurement, Analysis, and Knowledge Management** that is proven to contribute to organizational success.

Objective 4.1.1: Increase the accessibility of performance data to managers and staff alike and promote its utilization for decision-making.

- New performance management system implemented that meets needs of management and staff alike.
- Performance Dashboards and Scorecards implemented, updated, and utilized at Branch and management meetings.
- At least four quarterly performance reports issued.
- At least twelve monthly meetings of the Performance Improvement Management Committee to continue to build engagement in performance management and quality improvement activities.

Objective 4.1.2: Continue to build Quality Improvement (QI) capacity throughout Public Health Services (PHS).

- At least two QI Champions designated, trained, and actively supporting each of the individual Branches.
- A minimum of eight formal QI projects conducted each year (at least one within each Branch) that address key gaps. *This is a priority measure that appears in the County Operational Plan.*
- A score of 5 out of 6 achieved in terms of QI culture as measured by a Self Assessment Tool designed by the National Association of County and City Health Officials (NACCHO), which indicates a “formal agency-wide QI” program.
- At least one QI Resource Fair or QI Workshop each year to build awareness of, and skills in, QI at all levels of the organization.

Objective 4.1.3: Enhance the reliability and accuracy of population data provided by the Community Health Statistics Unit (CHSU) through quality assurance checks.

- Policies and procedures issued that capture internal approach to data validation.
- *Live Well San Diego* health and well-being data system designed in order to efficiently and accurately generate annual data (200 disease groups, six levels of medical encounters, local geographies, and five lenses of health equity) for a variety of data products made readily available to the public.
- Population health reports produced.

Objective 4.1.4: Promote data literacy and expertise across PHS.

- At least 10 Data Threading meetings convened annually that draw staff inside and outside HHSA, including community partners, to learn about general interest topics, technical topics, and hands-on technical training to support data and analysis.
- Percentage of PHS staff who take a special training module on Data Literacy that was created to improve understanding of how to use data among all PHS staff.
- Develop and maintain subject matter expertise within the unit by participating in trainings, conferences, and seminars annually.

Objective 4.1.5: Identify, collect, and maintain a wide array of data, reports, and information products.

- 90 percent of *Live Well San Diego* Indicators are up-to-date and accessible to the community.
- New data resources developed at the request of County departments and partners.
- Seven Community Profiles maintained.
- Presentations of community data and profiles delivered regularly to Regional Community Leadership Teams.
- 50 percent of key data and reports are published timely, based on a pre-determined timeline.

Objective 4.1.6: Increase accessibility of, and satisfaction with, data services.

- A minimum of five percent increase in web traffic to Community Health Statistics Unit (CHSU) website annually.
- 95 percent of data requests (number and volume) to CHSU are met in a timely fashion.

GOAL 5 (WORKFORCE): Ensure that the County and its residents are served by an agile, adaptable and highly-skilled, public health workforce.



Strategy 5.1: Adhere to the Baldrige Excellence Framework criteria for **Workforce Focus** that is proven to contribute to organizational success.

Objective 5.1.1: Implement the six goals of the Workforce Development Plan 2017-19, and develop the 2020-2022 Workforce Development Plan.

- 80 percent of performance measures identified in Workforce Development Plan are implemented.
- Average score of three “Knowledgeable” out of top score of four “Proficient” for all PHS staff based on completion of self-assessment survey of competencies for public health professionals.

- Improvement in scores on other workforce-related surveys, including the Gallup Employee Engagement survey.
- Number of workshops convened on future skills needed by the PHS workforce within next five years, and completion of a report.
- Score of 75 percent or higher on an evaluation by staff of trainings offered and other workforce development efforts (indicating satisfied or very satisfied).

Objective 5.1.2: Coordinate with local universities to bring on volunteers/interns in order to build the public health workforce of the future.

- Number of student workers, interns, and graduate students who successfully complete internships within PHS.
- Number of presentations delivered to students either on-site or at universities.
- Number of participants in the preventive medicine residency program which serves to educate future doctors about the value of, and potential careers, in public health.

Objective 5.1.3: Promote staff engagement through Diversity and Inclusion (D&I) efforts across PHS, and help to build an understanding among staff of the principles of Health Equity.

- 80 percent of staff report in a survey that they understand what Healthy Equity is and how it relates to their work.
- 80 percent of staff report in a survey that they use a Health Equity lens to inform their work, as applicable.
- 80 percent of performance measures identified in the Health Equity Plan are implemented.
- 90 percent of PHS staff complete key training in health equity, public health and climate change.
- 90 percent of staff completing key training on trauma, Mental Health First Aid, cultural competency, and customer service.
- Degree to which staff engages in D&I activities.

Objective 5.1.4: Recognize staff in ways that are consistent with HHS's recognition program by encouraging Branch recognition efforts, and enhancing PHS-wide recognitions.

- Timely performance reviews.
- Creation of a new recognition policy for work groups or committees within PHS.
- Number of employee recognition awards delivered, and number of work groups or committees recognizing members.
- Annual All-Staff Recognition event convened.

GOAL 6 (OPERATIONS): Design, manage, improve, and innovate work processes to increase operational effectiveness.

Strategy 6.1: Adhere to the Baldrige Excellence Framework criteria for **Operations Focus** that is proven to contribute to organizational success.

Objective 6.1.1: Strengthen the administrative infrastructure through standardized processes and procedures.

- Manager's Manual created to provide ready guidance to managers, and to help orient new managers.
- Program Index maintained so that key statutory and other vital information for PHS programs is easily accessible.

- Number of PHS program operation manuals, policies, and procedures created or updated for all key administrative and program functions across the Branches.
- PHS Comprehensive Plan maintained to help monitor progress on key priorities of the Board of Supervisors, County, Agency and Public Health Officer.

Objective 6.1.2: Develop PHS procedures to ensure efficient and consistent implementation of key Agency contracting and fiscal policies across Branches.

- 50 percent of Agency contracting policies and budget, fund balance, and year-end fiscal procedures reviewed.
- 25 percent of new PHS procedures implemented by end of FY 2019-20; 25 percent implemented by end of FY 2020-21.

Objective 6.1.3: Improve timeliness of submission of Board Letters to the Board of Supervisors.

- 100 percent of Board Letters submitted timely by Branches to PHS Administration.

Objective 6.1.4: Improve the monitoring of contracts to ensure that Branches are in compliance with contracting standards and guidelines.

- 75 percent of contracts selected for Quality Assurance audits have no findings and require no actions to address findings.

Objective 6.1.5: Improve the financial literacy of all PHS analysts to ensure a solid foundational knowledge base, expand the knowledge pool and provide career development opportunities to staff.

- Four trainings provided at PHS Contracts Group meetings over the course of each year.
- Satisfaction scores of financial literacy trainings.

Objective 6.1.6: Increase contracting competency of all PHS Contracting Officer Representatives (CORs) and their support staff to ensure a solid foundational knowledge base, expand the knowledge pool, and provide career development opportunities to staff.

- 100 percent of CORs complete COR I training in addition to training mandated by HHS policy.
- 100 percent of CORs complete COR II training in addition to training mandated by HHS policy.

Objective 6.1.7: Facilitate the identification of gaps in information technology (IT) and implement IT projects to help achieve organizational excellence.

- IT Gaps Report completed.

Objective 6.1.8: Support the development of the Electronic Health Record (EHR) across appropriate PHS Branches and programs.

- Two clinics (Sexually Transmitted Disease and Tuberculosis) successfully implement EHR by end of FY 2020-21.

Objective 6.1.9: Administer the Public Health Information System (PHIS) by supporting users across the Branches and clinics.

- Policies and procedures for frequently-used PHIS functions are up-to-date by end of FY 2020-21.

GOAL 7 (RESULTS): Monitor and share information that “tells the story” of the contributions of Public Health Services to the collective impact effort of *Live Well San Diego*.

Strategy 7.1: Advance the organization’s performance and improvement across all key dimensions—leadership, strategy, customer, workforce, operations—so that they are consistent with the Baldrige Excellence Framework criteria for **Results**.

Objective 7.1.1: Performance across all key Branch programs is tracked and informs quality improvement efforts.

- At least four (quarterly) times per year, performance results for PHS priority measures (that appear in the County of San Diego Operational Plan) are monitored and reported.
- At least four (quarterly) times per year, performance results across each Branch in the PHS Strategic Plan are monitored and reported.
- At least four (quarterly) times per year, all PHS performance measures are reviewed altogether through the Performance Improvement Management Committee to identify improvement opportunities including quality improvement projects.

Objective 7.1.2: Population indicators maintained and monitored to help assess collective impact of PHS and other partners in the *Live Well San Diego* collective impact effort.

- 90 percent of *Live Well San Diego* Indicators are up-to-date and accessible to the community; 80 percent of the supporting *Live Well San Diego* Indicators are up-to-date and accessible to the community.
- 90 percent of the Public Health Services dashboard, which captures indicators that are more closely connected to the programs of PHS, are up-to-date, consistent with requirements of a nationally accredited public health department.

MEDI-CAL ADMINISTRATIVE ACTIVITIES/TARGETED CASE MANAGEMENT UNIT (MAA/TCM)

GOAL 8 (MAA/TCM): Maximize Medi-Cal Administrative Activities and Targeted Case Management revenue in compliance with State and federal regulations.

Strategy 8.1: Support cost-effective revenue generation activities that will bring the greatest benefit to County program and provider participants while ensuring program integrity.

Objective 8.1.1: Develop plans to improve outreach and strengthen the MAA/TCM program.

- Multi-faceted work plan for MAA/TCM developed by end of FY 2019-20.
- Outreach plan and marketing tools developed to help bring in new MAA/TCM providers by end of FY 2019-21.

Objective 8.1.2: Improve quality and accuracy of MAA/TCM claims.

- 100 percent of individuals who claim time to the Skilled Professional Medical Personnel (SPMP) activity over the County's benchmark of 5.33 percent, as established by the California Department of Health Care Services, are subject to targeted review and training.
- 100 percent of MAA and TCM time surveys conducted by County personnel are subject to Quality Assurance Reviews.

OFFICE OF BORDER HEALTH UNIT

GOAL 9 (BORDER HEALTH): Facilitate communication, collaboration, and coordination at the local, State and federal levels in the US and Mexico to address public health issues of mutual concern in the San Diego-Tijuana border region.

Strategy 9.1: Facilitate binational communication and coordination among public health agencies in the United States in order to promote exchange of information and collaborative responses on public health concerns of mutual interest.

Objective 9.1.1: Implement the PHS departmental Audacious Goal to develop a 5-year binational strategic plan to support cross-border collaboration to improve health outcomes in the California-Baja California border region.

- Activities conducted to improve cross-border emergency preparedness collaboration in the California-Baja California border region.
- Collaborative efforts to address obesity and other chronic diseases in the California-Baja California border region.
- Participation in Leaders Across Borders to improve leadership development in the California-Baja California border region.

Objective 9.1.2: Facilitate collaborative activities among County and external partners and serve as a central point of contact for border health information.

- Regular convening of Border Health Consortium of the Californias, the San Diego Border Health Collaborative, and Quarterly Border Health Update meetings.
- Bi-annual convening of San Diego college and university health centers to disseminate key public health updates for students.
- Annual convening of the CDC, Customs Border Protection, and PHS to address border health concerns.
- Bi-annual convening of the Queso Fresco Task Force to coordinate efforts to reduce the adverse public health impact of consuming unpasteurized soft cheese commonly imported from Mexico.
- International visits to PHS including meetings between Public Health Officers in San Diego and Tijuana.
- Activities and number of people reached in San Diego County for Binational Health Week efforts.

Objective 9.1.3: Improve public health and emergency communication with non-English speaking communities in San Diego County.

- Training workshops on public health and emergency preparedness delivered to agencies and partners serving vulnerable and isolated communities.
- Partners participating in the Partner Relay, an approach for communicating information in multiple languages during an emergency.
- Drills implemented to support partner engagement and system efficacy.



California Children's Services

6

Goals

6

Strategies

10

Objectives





Services **SWOT** **San Diego** **LiveWell** **Thriving** **Healthy** **Safe** **HHS**A

3-4-50

Performance

Community



CALIFORNIA CHILDREN'S SERVICES (CCS) BRANCH

UNITS

- Case Management Unit
- Medical Therapy Unit

GOAL 1: Coordinate efforts to improve health equity in services provided while also encouraging family participation in CCS programs.



Strategy 1.1: Infuse a family-centered care approach to rehabilitation services, in which families are recognized as the experts and work with service providers to make informed decisions about their child's care. This approach also recognizes the diversity of families and thereby the importance of integrating principles of health equity into all services.

Objective 1.1.1: Maintain high customer satisfaction scores for CCS customers.

- Scores on H.E.A.R.T and other customer surveys (4 on a scale of 5).
- Scores on the Measurement of Processes of Care, which is a tool to assess parents' perceptions of the care they and their children receive from children's rehabilitation treatment centers (4.5 on a scale of 7).

Objective 1.1.2: Ensure that CCS clients have access to all CCS services in their preferred language.

- To promote provision of services in the preferred language of clients, CCS staff will demonstrate a minimum of 350 appropriate uses of all interpretation services (phone, in-person, and written) to meet the needs of clients. (Target based on prior year averages)

Objective 1.1.3: Ensure that family members are offered opportunities to participate and offer feedback through advisory committees, team meetings, transition planning, and other activities.

- Every quarter, CCS will score 4/4 (100%) on the State checklist that defines criteria for implementation of Family Participation.

GOAL 2: Ensure that all CCS clients have a medical home and that their care is coordinated.

Strategy 2.1: Follow the medical home model or philosophy of primary care, which is patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety.

Objective 2.1.1: Ensure all CCS clients have a documented medical home/primary care providers.

- 90 percent of all clients will have a medical home based on a quality review of a sample of cases.

GOAL 3: Ensure optimal utilization of Special Care Center Services to improve health outcomes for CCS clients.

Strategy 3.1: Maximize use of Special Care Centers which are equipped to provide optimal care for those clients with serious, chronic illnesses that require professional attention so that clients achieve the best health outcomes and are as independent as possible.

Objective 3.1.1: Ensure all CCS clients utilize the Special Care Centers as recommended for their condition.

95 percent of CCS clients will appropriately utilize the Special Care Centers based on a quality assurance review of a sample of cases.

GOAL 4: Engage Medical Therapy Program (MTP) patients in activities to improve their functional level.

Strategy 4.1: Adhere to the Episodic Treatment Model (ETM), an evidence-based model for therapy service provision. By providing the optimal frequency and intensity of therapy at the optimal time, CCS therapists will be better able to improve the level of function of the children served.

Objective 4.1.1: Increase number of occupational and physical therapy plans of care with recommendations for ETM services.

- For at least 25 percent of those in the MTP caseload who are receiving physical or occupational therapy, the ETM model will be followed.

Objective 4.1.2: Improve the physical function of the children we serve.

- 65 percent or more of children will demonstrate a positive change on the Functional Standardized Test Score (FISC) or alternate standardized test, or show documentation of progress toward goals that are stated objectively and relate to therapy goals, based on Quality Assurance and/or Utilization Review audits of a sample of cases.

Objective 4.1.3: Ensure children have the specialized mobility equipment they need to enhance their functional level as they engage in community activities.

- 90 percent of cases will receive authorization for a specialized wheelchair in less than 10 days after therapist receives the quote from the vendor, based on quality audit.

GOAL 5: Ensure timely transition planning services for CCS clients to promote optimal health and independence once these clients leave the CCS program.



Strategy 5.1: Implement transition planning, or the process of preparing youth and families to move from pediatric to an adult model of health care, which has been found to optimize the long-term health of youth so that they can reach their full potential.

Objective 5.1.1: Ensure all children, 14 years and older, who are expected to have chronic health conditions past their twenty-first birthday, have documentation of a biannual review for long-term transition planning.

- 90 percent of 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.

GOAL 6: Promote operational excellence throughout for the benefit of customers and staff alike.

Strategy 6.1: Put Operational Excellence, a County initiative, into practice through continuous improvement and problem-solving, teamwork and leadership with a focus on customers' needs and keeping employees positive and empowered.

Objective 6.1.1: Provide CCS applicants timely access to services for children by determining program eligibility of applicants (financial, medical, and residential) in a timely fashion.

- 95 percent of financial eligibility determinations made within 30 days of receipt of documentation based on a quality review of a sample of cases.
- 95 percent of medical eligibility determinations made within five working days of receipt of all medical documentation based on a quality review of a sample of cases. *This is a priority measure that appears in the County Operational Plan.*
- 95 percent of residential eligibility determinations of applicants to the CCS program within 30 days of receipt of documentation based on a quality review of a sample of cases.



Epidemiology and Immunization Services

11

Goals

13

Strategies

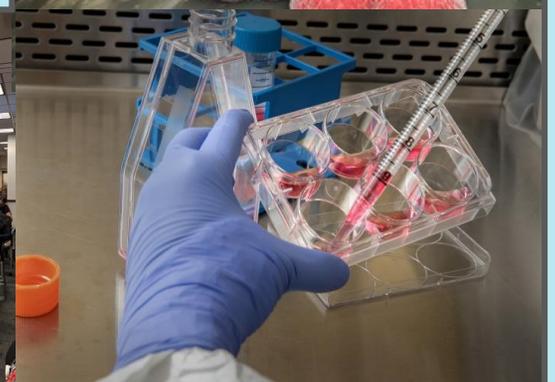
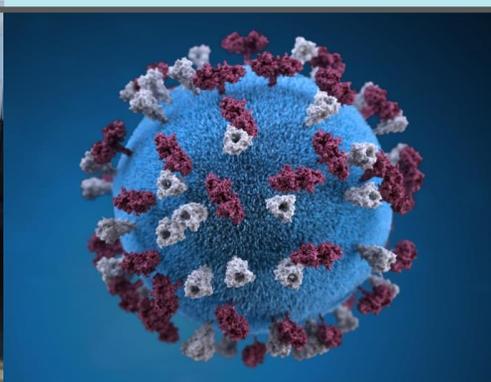
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Objectives





Services **SWOT** **San Diego** **LiveWell** **Thriving** **Community** **Safe** **HHSA** **Performance**
 3-4-50



UNITS AND PROGRAMS

- **Epidemiology Unit**
 - Childhood Lead Poisoning Prevention Program (CLPPP)
 - Disease Reporting and Surveillance
 - Disease Investigations
 - HIV/AIDS Surveillance
- **Immunization Unit**
 - Vaccine Management
 - Vaccine Preventable Disease Investigations
 - Community Education/Outreach
 - San Diego Immunization Registry
- **Public Health Laboratory Unit**
 - Disease Prevention, Control, and Surveillance
 - Environmental Health and Bio-Terrorism Protection
 - Reference and Specialized Testing
- **Vital Records and Statistics Unit**
 - Administration
 - Birth Registration
 - Death Registration
 - Medical Marijuana Identification Card (MMIC)

EPIDEMIOLOGY UNIT

Goal 1: Provide effective surveillance, investigation and response to protect the community from disease.

Strategy 1.1: Ensure prompt investigation of reported communicable diseases.

Objective 1.1.1: Initiate investigation of reported selected communicable disease cases in a timely fashion.

- 100 percent of reported cases of select communicable diseases (hepatitis A, meningococcal) are investigated within 24 hours of receipt of report. *This is a priority measure that appears in the County Operational Plan.*

GOAL 2: Ensure timely and complete reporting of HIV cases and AIDS cases.

Strategy 2.1: Investigate suspect HIV and AIDS cases identified through laboratories and providers to decrease underreporting, and collect risk history information to determine routes of transmission.

Objective 2.1.1: Report unduplicated newly identified HIV and AIDS cases in a timely fashion from the time of diagnosis or identification to the State Office of AIDS.

- 85 percent of unduplicated new HIV cases reported within 45 days.

Objective 2.1.2: Identify risk in unduplicated newly identified HIV disease cases in a timely fashion.

- Risk is identified within 45 days of report for 85 percent of unduplicated new HIV cases.

IMMUNIZATION UNIT

GOAL 3: Provide a comprehensive Immunization Information System (IIS) to the community.

Strategy 3.1: Maintain a secure web-based system available to authorized users to access patient vaccine records.

Objective 3.1.1: Produce reports for requests for Healthcare Effectiveness Data and Information Set (HEDIS) immunization data in the San Diego Immunization Registry.

- 100 percent of requests for Healthcare Effectiveness Data and Information Set (HEDIS) reports are completed within two weeks.

Objective 3.1.2: Document immunization volume entered into SDIR.

- 100 percent of immunization volume entered into SDIR will be tracked and reported on a monthly basis.

Objective 3.1.3: Monitor vaccine types entered into SDIR for tracking and planning purposes.

- 100 percent of immunization types entered into SDIR will be tracked and reported on a monthly basis.

GOAL 4: Promote high-quality immunization practices among public and private providers.

Strategy 4.1: Develop and implement policies, procedures, and training that support quality immunization practices and accountability.

Objective 4.1.1: Provide annual vaccine storage and handling, administration, and usage reporting trainings to State-Purchased Influenza Vaccine Program providers (includes Public Health Center clinic nurses and community providers).

- Minimum of 90% of State-Purchased Influenza Vaccine Program providers attend annual program requirements training.

Objective 4.1.2: Provide technical trainings to Public Health Nurses and community providers, including best practices for vaccine storage and handling, administration, and documentation.

- Minimum of four Immunization Skills Institute trainings provided per year.

GOAL 5: Promote the importance of immunizations throughout the County and monitor coverage across schools and childcare centers.

Strategy 5.1: Ensure vaccine accessibility to uninsured, low-income, and at-risk individuals in San Diego County.

Objective 5.1.1: Distribute State-Purchased influenza vaccine to public and non-profit community providers that serve low-income and at-risk populations.

- 100 percent of California Department of Public Health (CDPH) annually allocated State-Purchased influenza vaccine distributed to Public Health Center clinics and community providers with 501(c)(3) non-profit status.

Objective 5.1.2: Support efforts of Regional Public Health Center clinics to immunize children, with no missed opportunities, through the following activities:

- 99 percent of children ages 0 through 18 years served at Public Health Center (PHCs) clinics are provided age-appropriate vaccines. This is equivalent to a one-percent missed opportunity rate for children served at PHC's, which are typically children who are unable to get an appointment with their medical provider in time to get school-required vaccines and/or children who may lack a medical home. *This is a priority measure that appears in the County Operational Plan.*
- Quarterly missed opportunity report produced from the San Diego Immunizations Registry.

Strategy 5.2: Promote and provide accurate information and resources about immunizations.

Objective 5.2.1: Respond to a wide variety and volume of requests for immunization information or referrals.

- 100 percent of requests/referrals responded to or fulfilled within one business day.

Objective 5.2.2: Promote and monitor compliance with the California School Immunizations Law and report Immunization Assessments to the California State Immunizations Branch.

- 100 percent of Immunization Assessments for schools and childcare centers reported to the State each year.

GOAL 6: Minimize the spread of vaccine-preventable disease through timely investigation of suspect cases.

Strategy 6.1: Ensure prompt investigation of reported vaccine-preventable diseases to prevent further spread and maintain workforce readiness to respond to outbreaks.

Objective 6.1.1: Initiate investigations of vaccine-preventable diseases within CDPH-recommended response times to help control further spread of vaccine-preventable diseases.

- 100 percent of reported cases of select communicable diseases (hepatitis A, meningococcal) are investigated within 24 hours of receipt of report. *This is a priority measure that appears in the County Operational Plan.*

Objective 6.1.2: Reduce the spread of influenza by collaborating with Regional Public Health Centers and the Public Health Preparedness and Response Branch to conduct mass influenza vaccination events.

- A minimum of five collaborative influenza mass vaccination exercises conducted throughout San Diego County.

GOAL 7: Reduce childhood lead poisoning through education, outreach, and early identification and treatment of children with elevated blood lead levels.

Strategy 7.1: Abide by Federal and State standards to identify and manage children with elevated blood lead levels.

Objective 7.1.1: Initiate timely case management services by Public Health Nurses for children with high blood lead levels.

- 95 percent of children with blood levels greater than 14.5 mcg/dL receive case management services within one week of referral.

Objective 7.1.2: Provide lead poisoning prevention, education, and outreach to healthcare providers through various methods, including grand rounds, presentations at local healthcare facilities, and the distribution of a provider newsletter.

- A minimum of 200 healthcare providers receive lead poisoning prevention education and outreach annually.

Strategy 7.2: Focus on primary prevention to identify potential sources of lead exposure before children are exposed.

Objective 7.2.1: Conduct education and outreach in the community to individuals and families with children to increase awareness of lead poisoning and promote prevention and ways to reduce the risk of lead exposure.

- A minimum of 3,000 individuals and families with children will receive education and outreach annually.



PUBLIC HEALTH LABORATORY UNIT

GOAL 8: Maintain a state-of-the-art reference laboratory that incorporates the latest tools to support outbreak investigations and operates with the greatest efficiency to protect community health.

Strategy 8.1: Integrate advanced tools such as whole genome sequence techniques in the areas of microbiology and virology that are appropriate for public health and that target disease agents that are highly communicable or can become endemic.

Objective 8.1.1: Ensure tuberculosis (TB) samples received during operating hours are tested and reported by the laboratory within one working day to ensure rapid diagnosis and treatment, consistent with federal standards.

- 90 percent of TB samples tested and reported within one working day. *This is a priority measure that also appears in the County Operational Plan.*

Objective 8.1.2: Maintain compliance with federal and State accrediting requirements at the Public Health Services laboratory to ensure protection of community health and prevention of disease.

- 100 percent of audits (9 different lab licenses and permits) find the laboratory operation in compliance. *This is a priority measure that also appears in the County Operational Plan.*

Objective 8.1.3: Use molecular sequencing to support outbreak investigations.

- 95 percent of files with molecular information are successfully uploaded for data interpretation by CDC, with phylogenetic trees generated within three weeks of specimen receipt.

VITAL RECORDS AND STATISTICS UNIT

GOAL 9: Provide quality training for community death registration stakeholders in the use of Electronic Death Registration System (EDRS).

Strategy 9.1: Ensure all stakeholders throughout the County take training by specific user group (local registration districts, funeral homes, hospitals, coroner) in order to ensure these stakeholders have the ability to enter death data accurately prior to participating on the system, as required by the State.

Objective 9.1.1: Conduct trainings for new providers and mortuary staff in the use of the EDRS.

- A minimum of six (6) training sessions provided per year.

GOAL 10: Provide timely and accurate death certificates for grieving families in San Diego County.

Strategy 10.1: Ensure superior service delivery to create the best possible customer experience, with performance that is superior to State mandated timeframes for registering deaths.

Objective 10.1.1: Register all death certificates and issue associated burial permits in a timely fashion.

- An average of two hours to register death certificates after submission.

GOAL 11: Provide timely and accurate birth certificates to new parents in San Diego County.

Strategy 11.1: Ensure superior service delivery to create the best possible customer experience, with performance that is superior to State-mandated timeframes for registering live births.

Objective 11.1.1: Register birth certificates in a timely fashion.

- 95% of birth certificates registered within 10 days of birth to maintain accurate census data, exceeding the State goal of 90%. *This is a priority measure that appears in the County Operational Plan.*



HIV, STD, and Hepatitis

5

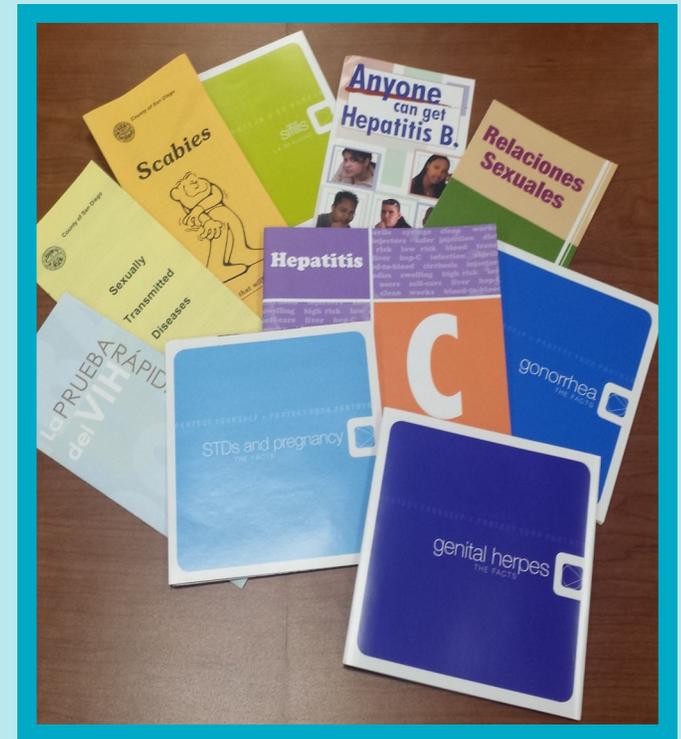
Goals

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Strategies

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Objectives



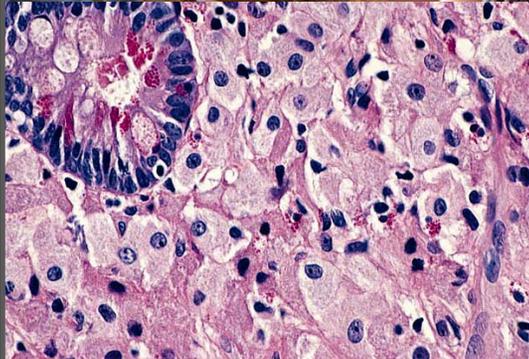


HIV TREATMENT
EMPOWERS YOU

IT'S YOUR LIFE. OWN THE JOURNEY.



GET TESTED
KNOW YOUR
OPTIONS



Services **SWOT** **San Diego** **LiveWell** **Thriving** **Community** **Safe** **HHSA** **Performance**
3-4-50



TEST
TREAT
PREVENT



UNITS AND PROGRAMS

- Clinical Services Unit
- Grants & Contracts Unit
- HIV/AIDS Services Unit
 - Care and Treatment Services
 - Data to Care
 - Intensive Case Management
- HIV & STD Field Services Unit
- Intensive Case Management Unit
- STD Prevention Unit
 - Clinical Services
 - Control
 - Prevention
- Surveillance Unit

GOAL 1 (TEST): Identify all persons infected with HIV and STDs so that they can be informed and linked to care.



Strategy 1.1: Conduct HIV and STD testing in communities disproportionately impacted, linking individuals who test positive to care and treatment resources and those who test negative to prevention resources.

Objective 1.1.1: Increase availability and opportunity for screening and testing of individuals at risk of HIV or STDs to increase awareness of their risk or disease status.

- Availability of chlamydia and gonorrhea home testing kits to women ages 25 and under.
- 80 percent of females booked into County juvenile detention facilities screened for chlamydia and gonorrhea.
- 90 percent of gay, bisexual, and other men who have sex with men are screened for gonorrhea and chlamydia in County STD clinics at all potential sites of exposure.
- An “express visit” system is developed and deployed at the Rosecrans STD Clinic to promote rapid availability of STD testing without appointments.
- 100 percent of individuals seeking services at County’s STD clinics are screened for HIV using an opt-out protocol unless they are known to be HIV-positive or decline testing.
- 10,000 HIV tests conducted through focused HIV testing in County facilities as well as through contracted services.
- Adoption of routine, opt-out HIV testing in health care settings by working with health care systems through the Getting to Zero Medical Advisory Committee.
- At least 90 percent of people living with HIV are aware of their serostatus.

Objective 1.1.2: Conduct Partner Services with persons newly diagnosed with HIV or syphilis.

- Surveillance-based HIV Partner Services conducted with all individuals newly diagnosed with HIV outside of a program funded by HHSA.
- Partner Services conducted with all individuals diagnosed with primary or secondary syphilis and all women of child-bearing age with any stage of syphilis.

Objective 1.1.3: Through contracting, deploy HIV testing services, both focused and routine, in areas of San Diego County where individuals living with undiagnosed HIV infection can be tested and informed of their status.

- Focused HIV testing maintained in communities in San Diego County that are disproportionately impacted by HIV and where HIV-positivity rates exceed one percent.
- Routine HIV testing deployed in communities in San Diego County that are disproportionately impacted by HIV but where HIV-positivity rates for focused testing have not reached one percent for two years.
- At least 90 percent of individuals newly diagnosed with HIV offered HIV Partner Services.
- Contracted services monitored to ensure alignment with local, State and federal requirements.
- Timely payment of contracted providers ensured.
- Exceptional customer service given to providers of contracted services as rated in an annual survey administered by HHSA Agency for Contract Services
- Monthly review of performance and expenditures for all contracts and adjustments made as necessary to ensure full expenditure of all awarded funding and achievement of objectives as set forth in statements of work.

Objective 1.1.4: Ensure availability of STD testing in areas of San Diego County disproportionately impacted by syphilis, gonorrhea, and chlamydia.

- Every week day, comprehensive STD services provided at the Rosecrans STD Clinic.
- At least one day per week, comprehensive STD services provided at the South, Central and North Coastal Regional Public Health Centers.

GOAL 2 (TREAT): Link all persons living with HIV or STDs to treatment services that follow national guidelines.



Strategy 2.1: Reduce transmission and improve health outcomes among individuals infected with HIV and STDs by ensuring the availability of treatment.

Objective 2.1.1: Ensure timely and continuous linkage to effective treatment for individuals diagnosed with HIV.

- At least 85 percent of clients with newly confirmed HIV diagnosis connected to primary care within 30 days of being informed of their diagnosis. *This is a priority measure that appears in the County Operational Plan.*
- 90 percent of persons with diagnosed HIV infection retained in HIV medical care by 2021.
- 80 percent of persons with diagnosed HIV infection are virally suppressed by 2021.
- Reduce the proportion of new HIV diagnoses that progress to AIDS within one year by 50 percent (from 28 percent in 2011 to 14 percent, by 2021).

Objective 2.1.2: Ensure timely linkages and effective treatment for STDs.

- 65 percent of interviews of primary and secondary syphilis cases conducted within 30 days of specimen collection.
- 100 percent of pregnant women with any stage of syphilis are confirmed to have received adequate treatments.
- 80 percent of patients identified as having possible medical resistance are followed up on and included among those patients treated for gonorrhea at the Rosecrans STD Clinic.
- 100 percent of patients diagnosed with STDs in County STD clinics are provided CDC-recommended treatments.

Objective 2.1.3: Identify persons living with HIV in San Diego County who are not virally suppressed and/or who are not receiving HIV primary care and re-link these individuals to appropriate care.

- Investigative priorities developed in coordination with the California Department of Public Health, Office of AIDS, and the HIV/AIDS Epidemiology Unit of the Epidemiology and Immunization Services Branch.
- 25 percent of persons living with HIV and still residing in San Diego County are re-linked to care.

Objective 2.1.4: Through contracting, ensure a continuum of HIV care and support services are available so that all persons living with HIV can experience the benefits of treatment.

- HIV care and treatment services in San Diego County are maintained in alignment with the priorities of the HIV Planning Group, to include primary care, medical specialty care, mental health and psychiatric care, oral health care, case management, early intervention services, outpatient and residential substance abuse treatment, emergency housing services, emergency financial assistance, food assistance, legal services, and outreach.
- 90 percent of individuals receiving any Ryan White-funded core medical service will achieve or maintain viral suppression within six months of program enrollment.
- Annual assessment of client satisfaction with services.
- Contracted services monitored for alignment with local, State, and federal requirements.
- Timely payment of contracted providers ensured.
- Exceptional customer service to providers of contracted services ensured.
- On a monthly basis, performance and expenditures for all contracts reviewed and adjustments made as necessary to ensure full expenditure of all awarded funding.

Objective 2.1.5: Ensure availability of STD treatment in areas of San Diego County disproportionately impacted by syphilis, gonorrhea, and chlamydia.

- Every weekday, comprehensive STD services provided at the Rosecrans STD Clinic.
- At least one day per week, comprehensive STD services provided to South, Central, and North Coastal Regional Public Health Centers.
- Field investigations conducted to provide treatment for individuals with gonorrhea and/or chlamydia who are diagnosed in County STD Clinics or juvenile detention facilities but who have not received treatment.

Objective 2.1.6: Reduce new HIV diagnoses.

- 25 percent reduction in number of new cases of HIV diagnosed annually (from 493 in 2016 to 370 in 2021).

Objective 2.1.7: Ensure continued funding for safety-net HIV services in San Diego County.

- Annually, submit a successful application for Ryan White HIV/AIDS Treatment Extension Act funding.
- On an ongoing basis, compete for all funding sources that support the County's Getting to Zero initiative; HIV testing, treatment, and prevention services; and STD testing, treatment, and prevention services.

Objective 2.1.8: Provide assistance to persons living with HIV who are incarcerated in local detention facilities or who were formerly incarcerated.

- Routine, opt-out HIV testing availability for all inmates ensured by coordinating with the Sheriff's Medical Detention Unit.
- Lists of new inmates who are HIV-positive are obtained by coordinating with the Sheriff's Medical Detention Unit.
- At least one in-person interview conducted with all identified HIV-positive inmates.
- 100 percent of HIV-positive inmates receive anti-retroviral medication and are linked to HIV primary care upon release.
- Five months of inpatient substance abuse treatment, followed by six months of sober living, provided for formerly incarcerated persons living with HIV who have substance abuse disorders.

Objective 2.1.9: Maintain STD surveillance system.

- 100 percent of new lab reports and Confidential Morbidity Reports (CMRs) entered into the California Reportable Disease Information Exchange, California's surveillance system for most reportable diseases.
- Incoming syphilis reactors processed to determine priority for disease investigation activities.
- Syphilis summary reports provided to assist medical providers who are determining the stage of a syphilis infection and need for treatment.
- Locally prioritized cases as well as cases referred from other jurisdictions assigned for case investigation.
- Data evaluated to assist with program planning and evaluation.
- Priority custom data requests fulfilled from internal and external sources.
- Annual slide deck developed for community members that provides key information related to syphilis, gonorrhea, and chlamydia infections in San Diego County.

GOAL 3 (PREVENT): Link all persons at risk for HIV and STD infection to prevention resources.



Strategy 3.1: Conduct HIV and STD prevention activities in communities with disproportionate risk for infection.

Objective 3.1.1: Link individuals at risk for HIV infection to biomedical interventions.

- 100 percent of individuals, who disclose activities placing them at high risk for HIV infection, are provided pre-exposure prophylaxis (PrEP) education.
- 100 percent of uninsured individuals who have had a recent high-risk exposure to HIV, are seeking services at the Rosecrans STD Clinic, and who meet post-exposure prophylaxis (PEP) treatment guidelines, are provided non-occupational post-exposure prophylaxis (nPEP).
- At least 50 percent of males, who are diagnosed with rectal gonorrhea and are not known to be HIV-positive, are provided PrEP education.
- PrEP navigation is available to individuals in areas of San Diego County where there is disproportionate HIV transmission by partnering with community providers.

Objective 3.1.2: Through contracting, ensure a continuum of HIV prevention services is available to reduce HIV transmission and infection.

- HIV prevention services in San Diego County are maintained in alignment with the priorities of the HIV Planning Group, to include:
 - Focused HIV testing, routine HIV testing, PrEP and PEP navigation for HIV-negative individuals, linkage to care for HIV-positive individuals, condom distribution, community-level interventions, and services for persons who inject drugs.
- Contracted services monitored in alignment with local, State and federal requirements.
- Timely payment of contracted providers ensured.
- On a monthly basis, performance and expenditures for all contracts reviewed and adjustments made as necessary to ensure full expenditure of all awarded funding.
- Exceptional customer service offered to providers of contracted services.
- On a monthly basis, review performance and expenditures for all contracts and make adjustments as necessary to ensure full expenditure of all awarded funding.

Objective 3.1.3: Ensure availability of STD education and prevention in areas of San Diego County disproportionately impacted by syphilis, gonorrhea, and chlamydia.

- Every weekday, comprehensive STD services provided at the Rosecrans STD Clinic.
- At least one day per week, comprehensive STD services provided at the South, Central, and North Coastal Regional Public Health Centers
- Schools and youth-service organizations assisted as requested to build their capacity to address sexual health and prevent STDs.

Objective 3.1.4: Provide timely treatment to sexual partners of individuals diagnosed with STDs.

- Preventive treatment offered to eligible sexual partners of individuals diagnosed with infectious syphilis.
- Patient-Delivered Partner Therapy offered to patients diagnosed with gonorrhea and/or chlamydia whose partners refuse to seek clinical evaluation.

Objective 3.1.5: Prevent congenital syphilis.

- Pregnancy status is determined for 100 percent of women of childbearing age diagnosed with any stage of syphilis.
- At least 90 percent of pregnant women with any stage of syphilis are interviewed.
- For at least 90 percent of pregnant women diagnosed with any stage of syphilis, at least one sexual partner is identified.
- 100 percent of pregnant women, diagnosed with any stage of syphilis, will receive penicillin-based treatment based on CDC recommendations at least 30 days prior to delivery.
- Confirm appropriate diagnostic evaluation and/or treatment for 100 percent infants born to mothers with untreated or inadequately treated syphilis at the time of delivery.
- All pregnant women with syphilis will be offered public health nursing case management by coordinating with Maternal, Child and Family Health Services Branch and Medical Care Services Division.

GOAL 4 (ENGAGE): Mobilize community efforts to achieve collective impact in reducing HIV and STD transmission.



Strategy 4.1: Engage medical providers, community-based organizations, community groups and individuals in efforts to eliminate HIV and STD transmission.

Objective 4.1.1: Provide trainings, convene meetings, and conduct ongoing monitoring to improve knowledge and understanding of health providers and improve treatment of all STDs.

- Quarterly monitoring of treatment of gonorrhea conducted to assess the extent to which providers are following CDC recommendations regarding treatment.
- Technical assistance provided to moderate-to-high-volume providers who are not following CDC guidelines for treatment of gonorrhea.
- At least one full-day STD training conducted for clinicians every other year.
- At least one full-day training on STD treatment for non-clinicians and educators convened each year.
- At least four STD basic overview trainings conducted for representatives of health care organizations, community-based organizations, schools and social service organizations each year.
- At least four meetings of the Getting to Zero Medical Advisory Committee conducted annually.
- On a monthly basis, publish the STD Update, providing information to providers regarding STD rates and an editorial note related to HIV and STDs in San Diego County.
- Plans for providers, detailing PrEP and the testing and treatment of STDs and congenital syphilis, developed and implemented.

Objective 4.1.2: Coordinate with business, community-based organizations, health care providers and contracted providers to promote awareness of HIV and STDs in San Diego County.

- Coordinate National HIV Testing Day, which is observed on June 27 of each year, to promote awareness.
- Coordinate the A. Brad Truax award ceremony on World AIDS Day, December 1 of each year, to recognize exceptional accomplishments of local individuals.
- Provide HIV testing and education annually at the San Diego Lesbian, Gay, Bisexual, and Transgender Pride festival.
- Promote awareness of STDs during STD Awareness Month, which is April of each year.

Objective 4.1.3: Engage persons living with HIV or at-risk for HIV in identifying system gaps and opportunities for systems improvement.

- Conduct biennially the Getting to Zero Summits, bringing together persons living with HIV, persons at risk for HIV infection, service providers and other stakeholders to inform the County's Getting to Zero initiative.
- Facilitate a community engagement process regarding STDs, among gay, bisexual, and other men who have sex with men, to inform STD prevention and control efforts.

Objective 4.1.4: Conduct media campaigns to promote awareness of HIV and STDs, prevention strategies, and available resources.

- HIV campaigns developed which focus on increasing awareness of HIV as a continuing public health threat, reducing HIV-related stigma, and improving knowledge about HIV testing, treatment, and prevention resources in San Diego County.
- Media campaigns conducted to promote the availability of Don't Think, Know, a chlamydia and gonorrhea home-testing program for women who are 25 years of age or younger.

Objective 4.1.5: Maintain an online and social media presence that promotes awareness of HIV and STDs as public health concerns and provides information, education, and resources regarding testing, treatment, and prevention.

- Three regional websites maintained that are related to HIV testing, treatment, and prevention resources, serving North County (North Coastal and North Inland regions), Central San Diego (Central and North Central regions), and South Bay (South region), in coordination with contracted providers.
- Facebook and Twitter messages regarding HIV and STDs communications are developed and deployed in coordination with HHS Communications Office.

Objective 4.1.6: Support availability of condoms for individuals at high risk for HIV and STD infection.

- Identification of businesses and other venues that have access to populations at high risk for HIV and/or STD infection by working with contracted providers.
- Enrollment of businesses and other venues into the Condom Distribution Partner Program, which allows business and other venues to order condoms and other safer sex materials directly from the California AIDS Clearinghouse.
- Availability of condoms at all County STD Clinics.

Objective 4.1.7: Support the HIV Planning Group in compliance with federal law.

- HIV Planning Group and committees provided logistical support and subject matter expertise.
- Steering Committee provided support with its membership activities.
- Mileage reimbursement, childcare reimbursement, and refreshments offered to promote attendance by persons living with HIV.
- Monthly report on the Getting to Zero jurisdictional plan delivered to the Steering Committee.
- Monthly expenditure reports provided for all HIV-related services.
- Trainings and presentations coordinated and/or provided to the HIV Planning Group.
- Monthly service utilization report prepared, identifying the number of persons receiving services, the types of services received, and key demographic information of the populations served.

Objective 4.1.8: Provide subject matter expertise to public and private health care systems, as well as medical providers.

- Paging system maintained so that medical providers with questions about treating STDs can receive immediate assistance from the STD Control Officer or designee.
- Health care systems educated about the availability of HSHB staff to:
 - 1) provide assistance in linkage to care for individuals newly diagnosed with HIV or
 - 2) conduct HIV-positive test disclosures for patients who do not return for test results.

Objective 4.1.9: Reduce disparities in outcomes.

- Annual review conducted of key outcomes related to new diagnosis, linkage to care, retention in care, and viral suppression for all persons living with HIV with regard to gender and race/ethnicity.
- Strategies developed for improving outcomes, with respect to the Getting to Zero Implementation Plan, for populations disproportionately impacted by HIV.
- Annual review of key outcomes related to new diagnosis and treatment for persons diagnosed with STDs with regard to transmission risk, gender, and race/ethnicity.
- Programming focus continues to be supported on youth, transgender individuals, women, Native Americans, and gay, bisexual, and other men who have sex with men and who are ages 50 and older.
- Referral and linkage services refined to address co-factors that lead to disparate outcomes, such as mental illness, substance abuse, unemployment/underemployment, poverty, lack of insurance, unstable housing, and food scarcity.
- Programs that provide assistance in navigating the health care system, including benefits access, are refined.

GOAL 5 (IMPROVE): Continually seek to improve outcomes for all services and activities.



Strategy 5.1: Maintain systems for building knowledge and managing performance to identify innovative, evidence-based practices that build on current strengths and create opportunities for improvement related to HIV and STD prevention, treatment, and control efforts.

Objective 5.1.1: Monitor performance of programs and quality of services routinely.

- Monthly dashboards developed and maintained that focus on HSHB programs, outcomes, and operations.
- Monthly internal meetings conducted to review dashboards and financial and contract performance among HSHB managers and supervisors.
- At least four meetings conducted annually of the Ryan White Clinical Quality Management Committee.
- At least one quality improvement project conducted annually.
- Annual quality assurance audit conducted of all Ryan White—funded outpatient ambulatory health services.
- Annual training and activities conducted for HSHB staff that advance the H.E.A.R.T. initiative.
- 100 percent of staff participate in cultural competency training specific to their job functions.

Objective 5.1.2: Attend key conferences to build knowledge base of best practices related to HIV and STD prevention, treatment, and control efforts across the United States.

- Attendance of staff at the following annual conferences: California STD and HIV Controllers Association; Ryan White HIV Treatment Conference; National Coalition of STD Directors; and the National STD Prevention Conference.
- Annual attendance of staff at local, state, and national meetings related to HIV and/or STD testing, treatment and/or prevention, or meetings that further the Getting to Zero initiative, HSHB mission, or core functions related to Public Health Services.

Objective 5.1.3: Develop workforce capacity.

- Cultural competencies are identified for each staff member in HSHB that are necessary for success and plans are created for providing trainings that help to develop those competencies.
- Assistance provided in identifying career goals for each staff member and the steps necessary for achieving those goals.
- Strengths-Based Management continues as a focus by providing trainings at all-staff meetings and other HSHB unit meetings.

Objective 5.1.4: Maintain a relentless focus on exceptional customer service.

- Annually, H.E.A.R.T. surveys conducted.
- H.E.A.R.T. survey results shared during all-staff meetings, celebrating areas of strength and working with staff to develop plans for addressing any areas that would benefit from improvement.
- Annually, client satisfaction surveys conducted of all clients receiving Ryan White services and compiled, analyzed, and presented to the Non-Medical Standards and Evaluation Committee of the HIV Planning Group.

Objective 5.1.5 Maintain data systems capable of measuring performance in HSHB operations, programs, and outcomes.

- AIDS Regional Information and Evaluation System (ARIES) maintained by staff support.
- Local Evaluations Online (LEO) maintained by staff support.
- California Reportable Disease Information Exchange (Calderite) maintained by staff support.
- Training and technical assistance regarding usage of ARIES and LEO offered to contracted providers, as needed.
- Incoming syphilis laboratory reports and Confidential Morbidity Reports processed by staff support.
- 100 percent of syphilis and gonorrhea case investigations are concluded and entered into Calderite semi-annually.
- Pilot developments for Calderite to assist California Department of Public Health, Office of AIDS.
- Electronic health record system for Rosecrans STD Clinic deployed.



Maternal, Child, and Family Health Services

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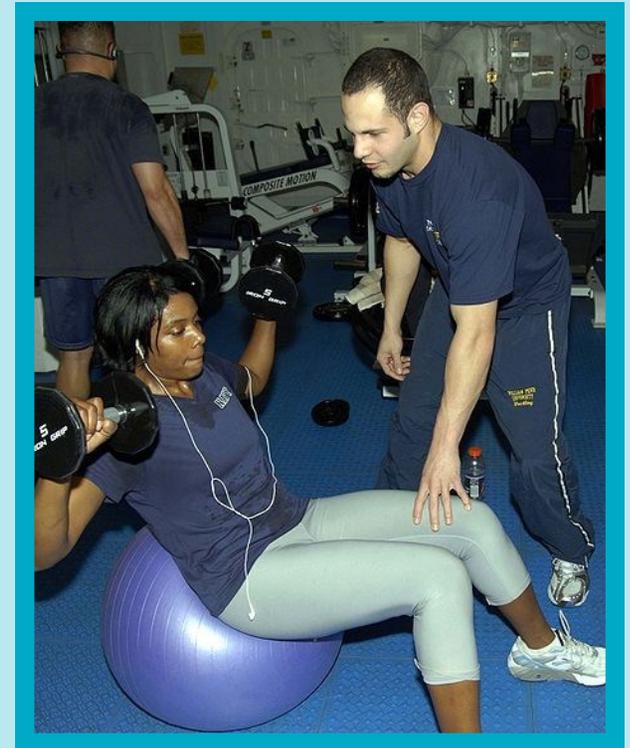
Goals

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Strategies

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Objectives





Services **SWOT** **San Diego** **LiveWell** **Thriving** **Community** **Safe** **HHSA** **Performance**
 3-4-50



UNITS AND PROGRAMS*

- **Chronic Disease and Health Equity Unit (CDHE)****
 - CalFresh Healthy Living Program
 - Childhood Obesity Initiative
 - Healthy Works Prevention Initiative
 - Heart Disease and Stroke Prevention
 - Lactation Supportive Environments (LSE)
 - Racial and Ethnic Approaches to Community Health (REACH)
 - Sodium Reduction Initiative (SRI)
 - Supplemental Nutrition Assistance Program—Education (SNAP-Ed)
 - Tobacco Control Resource Program (TCRP)
- **Family Health and Preventive Services Unit (FHPS)**
 - Adolescent Health Initiative
 - Black Infant Health
 - California Home Visiting Program
 - Child Health and Disability Prevention (CHDP)
 - Comprehensive Perinatal Services Program
 - Fetal and Infant Mortality Program Review
 - Men's Health Initiative
 - Nurse-Family Partnership Program
 - Office of Violence Prevention
 - Perinatal Care Network
 - Sudden Infant Death Syndrome (SIDS)
 - Dental Health Initiative – Share the Care
 - Health Care Program for Children in Foster Care
 - Local Oral Health Programs (LOHP)
- **Surveillance Unit**

**Not all programs listed above appear in the MCFHS plan that follows. This is because the CDHE portion of the plan is organized under one shared goal to which all programs contribute. The FHPS portion of the plan is organized by program but without listing every program that contributes to the goals and objectives identified.*

***Many objectives for the Chronic Disease and Health Equity Unit are to make Policy, System, and Environmental (PSE) change. These objectives will be achieved over several years or the duration of this MCFHS Branch Strategic Plan (i.e., 2019-2021). In some cases, these objectives are funded in whole or in part with federal grants that are to be achieved within two federal fiscal years FFY 2020-21 (10/1/19 through 6/30/21). A diamond appears next to these objectives.*



CHRONIC DISEASE AND HEALTH EQUITY UNIT

GOAL 1: Create environments and policies that promote health equity and encourage healthy behaviors and healthy communities in order to reduce chronic disease and promote health equity for all residents.



Strategy 1.1: Create infrastructure and capacity within the CDHE Unit to advance Policy, Systems, and Environmental (PSE) change that improves health equity, prevents chronic disease, and reduces the negative effects of climate change.

Objective 1.1.1: Participate in the update of the PHS Health Equity Plan and implement objectives from the new plan.

- At least three PHS Health Equity Plan objectives implemented by the CDHE Unit.

Objective 1.1.2: Develop and implement a communications plan for the CDHE Unit.

- One CDHE communication plan developed and implemented.

Objective 1.1.3: Assist in implementing objectives in the County's Climate Action Plan related to building healthy food systems as part of the Sustainability Task Force, in coordination with the lead County department, the Land Use and Environment Group.

- Support ongoing efforts to align with the County's Climate Action Plan to promote adaptability and resiliency, particularly for the most vulnerable populations.

Strategy 1.2: Through the Childhood Obesity Initiative (COI), reduce and prevent childhood obesity in the County of San Diego with a focus on policy and environmental changes.

Objective 1.2.1: Implement the COI policy agenda priority related to healthy food access or active transportation.

- A minimum of two governing bodies will adopt at least one COI policy agenda priority.

Objective 1.2.2: Expand COI partnership base that participate in COI Domains, Domain Council, or Leadership Council.

- A minimum of 10 new organizations participate.



Strategy 1.3: Improve the likelihood that Supplemental Nutrition Assistance Program—Education (SNAP-Ed)-eligible persons will make healthy food and physical activity choices within a limited budget consistent with the current Dietary Guidelines for Americans and Physical Activity Guidelines for Americans.

Objective 1.3.1: Improve opportunities for K-12 students to participate in daily, quality physical activity.

- 100% of 24,000 students at a total of 30 K-12 schools have access to daily, quality physical activity.



Objective 1.3.2: Designate childcare providers as Health and Wellness Champions to improve access to physical activity and healthy nutrition.

- A minimum of 15 childcare providers are designated as Health and Wellness Champions.

Objective 1.3.3: Assist public school districts in the implementation of universal school meals, Breakfast After the Bell, and/or after-school supper programs.

- At least two additional public school districts implement universal school meals, breakfast after the bell, and/or after-school supper programs.

Objective 1.3.4: Advance active transportation municipal policies through the Healthy Cities, Healthy Residents (HCHR) project.

- Three active transportation municipal policies are drafted or updated.

Objective 1.3.5: Enroll food retailers in the *Live Well Community Market Program* as an innovative way to improve access to healthy food in underserved communities.

- Assist five additional small- to medium-sized food retailers each year to be assessed and recognized. **This is a priority measure that appears in the County Operational Plan.*

Objective 1.3.6: Assist farmers' markets to improve utilization of Electronic Benefits Transfer (EBT) and/or other food assistance programs.

- Two farmers' markets will increase acceptance of payment through EBT and/or other food assistance programs.

Objective 1.3.7: Work with food pantries to adopt the evidence-based Nutrition Pantry Program.

- 15 food pantries adopt the Nutrition Pantry Program.

Objective 1.3.8: Provide nutrition and physical activity education to CalFresh Healthy Living eligible individuals to promote healthy eating, food resource management, and/or physical activity.

- A minimum of 10,000 eligible individuals receive nutrition and physical activity education.

Strategy 1.4: Reduce promotions of tobacco products, exposure to secondhand smoke, and access to tobacco products through the Tobacco Control Resource Program in order to prevent smoking and encourage tobacco cessation.

Objective 1.4.1: Increase the number of jurisdictions that adopt Policy, System, and Environmental (PSE) changes to limit or control tobacco use.

- Four additional jurisdictions adopt a policy that prohibits smoking, including cigarettes, cigars, hookahs, and electronic smoking devices in outdoor dining areas.
- One additional jurisdiction (Unincorporated) with a tobacco retail licensing (TRL) ordinance policy that includes electronic smoking devices (ESDs) and sufficient fees to conduct annual compliance checks of retailers.

Objective 1.4.1: Increase the number of jurisdictions that adopt Policy, System, and Environmental (PSE) changes to limit or control tobacco use.

- Four additional jurisdictions adopt a policy that prohibits smoking, including cigarettes, cigars, hookahs, and electronic smoking devices in outdoor dining areas.
- One additional jurisdiction (Unincorporated) with a tobacco retail licensing (TRL) ordinance policy that includes electronic smoking devices (ESDs) and sufficient fees to conduct annual compliance checks of retailers.
- Six additional jurisdictions with existing tobacco control policies that update the definition of "smoking," "tobacco product," "electronic smoking device," and "tobacco paraphernalia" to align local definitions with the State law standard.
- Four additional jurisdictions include tobacco-control-related considerations in zoning regulations, building codes, housing or other general plan elements, Housing and Urban Development consolidated plans, permitting processes, etc.

Objective 1.4.2: Integrate and expand tobacco control into healthy retail standards as part of the *Live Well Community Market Program*. 

- 12 markets recruited in cities with tobacco retail licenses in jurisdictions that have adopted a tobacco retail license ordinance to implement healthy retail standards as part of the *Live Well Community Market Program*.

Objective 1.4.3: Encourage smoke-free policies across County behavioral health treatment programs to improve health outcomes for clients and encourage prospects for recovery. 

- An additional 10% each year (from FY 18-19 to FY 20-21) of a total of 190 behavioral health treatment programs will achieve smoke-free policies that include tobacco cessation support for clients. *This is a priority measure that appears in the County Operational Plan.*

Objective 1.4.4: Advance cultural competency of programs by partnering with diverse members and organizations to advise and participate in the design and implementation of programs whenever feasible.

- Maintain a minimum of 25 non-California Tobacco Control Program-funded culturally diverse members or organizations represented in a community coalition as substantiated by acceptance of member agreement form and participation in four non-Tobacco Control Coalition activities.

Strategy 1.5: Promote lactation supportive environments to encourage breastfeeding because, according to the Centers for Disease Control and Prevention (CDC), breastfeeding is considered the “gold standard” for infant feeding and nutrition and reduces longer-term health risks for both the infant and the mother.

Objective 1.5.1: Engage organizations to support implementation of strategies that support families to meet their breastfeeding goals. 

- Lactation and/or breastfeeding policies implemented in six family daycare homes or childcare centers.

Strategy 1.6: Promote sodium reduction to within the *Current Dietary Guidelines for Americans* recommendations.

Objective 1.6.1: Engage the food sector to reduce sodium levels in packaged foods and meals provided by large institutions. 

- A minimum of four new institutions (e.g., universities, hospitals, and senior meal programs) procuring lower sodium food products.
- A minimum of 20 new ingredients and products lower in sodium procured by institutional partners.

Strategy 1.7: Support implementation, evaluation, and dissemination of culturally tailored interventions that include evidence-based strategies related to nutrition, physical activity, and clinical-community linkages.

Objective 1.7.1: Improve nutrition in priority populations. 

- A minimum of eight after-school programs that implement healthy nutrition standards.
- A minimum of five community markets that increase healthy food offerings.
- A minimum of two farmers' markets that implement Electronic Benefits Transfer (EBT) or the Women, Infants, and Children nutrition program (WIC) to improve access to healthy food.
- A minimum of three Federally Qualified Health Centers (FQHCs) and a minimum of five home visitation programs that

Objective 1.7.2: Increase opportunities for physical activity through improvements to the built environment.

- A minimum of one design plan developed to improve the built environment through traffic intersection modifications.

Objective 1.7.3: Increase referral and access to community-based health programs for the priority populations.

- A minimum of three FQHCs that implement bi-directional referrals to community-based lifestyle change programs for prediabetes, diabetes, and tobacco cessation.

Strategy 1.8: Implement approaches to reduce risks, complications, and barriers to cardiovascular disease prevention and control.

Objective 1.8.1: Increase approaches to reduce risks, complications, and barriers to prevention and control of high blood pressure and high blood cholesterol.

- A minimum of one FQHC that has a protocol to identify patients with undiagnosed hypertension.
- A minimum of five FQHCs that adopt evidence-based quality measurement for control of high blood pressure and high blood cholesterol at the provider level.
- A minimum of one FQHC that engages non-physician team members in high blood pressure and high cholesterol management.
- A minimum of one pharmacy that offers medication therapy management services to manage high blood pressure and high blood cholesterol.
- A minimum of three FQHCs that implement bi-directional referrals to community lifestyle change programs for high blood pressure and high blood cholesterol.

FAMILY HEALTH AND PREVENTIVE SERVICES (FHPS) UNIT—BLACK INFANT HEALTH

GOAL 2: Reduce the disproportionate African-American infant mortality rate.



Strategy 2.1: Assure pregnant women receive adequate care and services using a comprehensive approach that includes outreach, screening, health communication and education, and case management.

Objective 2.1.1: Ensure infants born who are served by the Black Infant Health program will have positive health outcomes.

- 88 percent of infants will have a normal birth weight (at least 2,500 grams).
- 90 percent of infants born will have initiated breastfeeding (excluding those with medical contraindications).

FHPS UNIT—CHILD HEALTH AND DISABILITY PREVENTION (CHDP)

GOAL 3: Promote early detection and prevention of disease and disabilities of CHDP-eligible children, all children entering first grade, and high-risk infants in San Diego County.

Strategy 3.1: Conduct periodic and comprehensive preventive health examinations through qualified CHDP providers and ensure care coordination and treatment of health conditions are detected.

Objective 3.1.1: Ensure eligible children in out-of-home placement receive preventive health examinations to identify and correct medical issues.

- 95 percent of foster children receive timely health exams per timeframes established by the State, higher than the recommended target of 90 percent. *This is a priority measure and appears in the County Operational Plan.*

Objective 3.1.2: Ensure that foster children in out-of-home placement receive dental examinations to identify and correct dental issues.

- 95 percent of foster children receive timely dental exams per timeframes established by the State, higher than the recommended target of 90 percent. *This is a priority measure and appears in the County Operational Plan.*

Objective 3.1.3: Ensure that CHDP providers due for recertification meet or exceed standards.

- At least 80 percent of CHDP providers due for recertification score 88 percent or higher on their facilities.
- At least 80 percent of CHDP providers due for recertification will score 88 percent or higher on the medical record review.

Objective 3.1.4: Conduct follow up on referrals in a timely fashion.

- 100 percent of initial follow up on referrals received from the State of California Newborn Hearing Screening Program are conducted within seven days of receipt of referral.
- At least 40 percent of medical records reviewed will have documentation of a dental referral at one year of age.

FHPS UNIT—CALIFORNIA HOME VISITING

GOAL 4: Enhance parent life-course development and improve pregnancy, child health, development, and safety.

Strategy 4.1: Implement an early childhood home-visiting service delivery model.

Objective 4.1.1: Ensure infants continue to breastfeed when their mothers receive home visitation from Public Health Nurses.

- 61 percent of infants continue to breastfeed up to 6 months of age.

FHPS UNIT—COMPREHENSIVE PERINATAL SERVICES AND PERINATAL CARE NETWORK

GOAL 5: Reduce morbidity and mortality among low-income women and their infants through enhanced prenatal care.

Strategy 5.1: Take a comprehensive approach that includes outreach, screening, health communication and education, and care coordination to assure pregnant women receive care and services.

Objective 5.1.1: Conduct quality assurance site visits for Comprehensive Perinatal Services Program (CPSP) providers.

- 85 percent of active CPSP providers receive quality assurance site visit.

Objective 5.1.2: Ensure pregnant women who call the Perinatal Care Network (PCN) toll-free phone line receive complete intake services and are quickly linked to providers.

- Number of pregnant women who call the PCN phone line and complete an initial intake.
- 75 percent of pregnant women who call the PCN phone line with no prenatal care are linked to a provider within 30 days.

FHPS UNIT—DENTAL HEALTH INITIATIVE (SHARE THE CARE) AND THE LOCAL ORAL HEALTH PROGRAM

GOAL 6: Ensure that children entering kindergarten receive an oral health screening.

Strategy 6.1: Take a comprehensive approach that includes education, preventive services, and referrals to establish dental homes.

Objective 6.1.1: Train pediatric health care providers to educate families on the importance of oral health, the first dental visit, and preventive services.

- A minimum of 40 providers will implement enhanced oral health activities to include oral health messages, referrals to the dentist by age 1 or when first teeth erupt, and/or apply fluoride varnish at well child exams for a minimum of six months.

Objective 6.1.2: Increase the number of oral health providers who will see very young children by age one or when the first teeth erupt.

- At least 25 oral health providers will implement enhanced oral health activities for a minimum of six months.

Strategy 6.2: Ensure children are linked to an oral health provider, establish a dental home, and receive early oral health prevention and treatment if needed.

Objective 6.2.1: Help ensure all children in San Diego County are assessed for oral health.

- 66 percent of children entering kindergarten submit an Oral Health Assessment Form.

FHPS UNIT—MEN'S HEALTH INITIATIVE

GOAL 7: Strengthen families and improve men's health.

Strategy 7.1: Take a comprehensive approach that includes organizational change, health communication, and education to promote men's health and fatherhood resources in FPHS programs and efforts among community partners.

Objective 7.1.1: Collaborate with community partners to increase awareness of the role of fathers in the health and well-being of their families.

- Identify at least three best methods to engage men in San Diego County in fatherhood activities that contribute to the health and well-being of their families.

GOAL 8: Reduce preventable fetal and infant deaths.

Strategy 8.1: Take a comprehensive approach that includes outreach, health communication and education, and care coordination to increase awareness of risk factors, improve systems of care, and support families who have suffered a loss.

Objective 8.1.1: Review and respond to referrals to ensure provision of resources and assistance to families and others affected by sudden infant death syndrome (SIDS).

- 90 percent of SIDS referrals contacted within three business days.
- 90 percent of SIDS participants correctly answer what a safe sleep environment is.

FHPS UNIT—OFFICE OF VIOLENCE PREVENTION

Goal 9: Prevent, reduce, and respond to family violence in San Diego County through trauma-informed practices.

Strategy 9.1: Implement the countywide Family Violence Prevention and Response Initiative in partnership with other County departments and community partners.

Objective 9.1.1: Increase knowledge and understanding of trauma-informed practices.

- At least 117 professionals receive training on trauma-informed practices through in-person or online training, annually (350 professionals trained over three years).
- Three health care partners provided technical assistance to support improved screening practices for family violence within health systems.

Public Health Preparedness and Response



5

Goals

5

Strategies

7

Objectives





Services **SWOT** **San Diego** **LiveWell** **Thriving** **Community** **Safe** **HHSA** **Performance** 3-4-50



PUBLIC HEALTH PREPAREDNESS AND RESPONSE (PHPR) BRANCH

UNITS

- Contract and Grant Administration Unit
- Exercise and Response Unit
- Epidemiology Bioterrorism Unit
- Programs and Planning Unit

GOAL 1: Strengthen community resilience to ensure timely assessment and sharing of essential information to reduce exposure to disasters and public health risks.



Strategy 1.1: Build capacity within the community to respond to emergencies by providing tools and training opportunities to residents, partners, providers, and other stakeholders.

Objective 1.1.1: Conduct a variety of outreach and training efforts in order to help ensure that all residents, including special needs and vulnerable populations, are prepared for emergencies.

- An annual risk assessment conducted annually to identify medical and health hazards across the county.
- At least three initiatives implemented to help prepare those with access and functional needs, or other special needs, for emergencies in coordination with the County Office of Emergency Services.
- Tools and information provided to assist health care facilities with their disaster response preparedness efforts.
- At least ten response partners and stakeholders engaged in meetings to identify critical assets, facilities, and other services within the jurisdiction to prioritize recovery operations, with the goal of restoration of community services to at least a day-to-day level comparable to pre-incident function.

GOAL 2: Strengthen the incident management framework to ensure earliest possible identification and investigation of an incident as well as timely implementation of intervention and control measures.

Strategy 2.1: Increase and sustain the highest possible level of readiness by building internal staff capacity and through planning.

Objective 2.1.1: Activate the public health emergency preparedness system regularly (either drills or real events) to ensure preparedness for disaster and/or public health threats.

- A minimum of seven activations annually. *This is a priority measure that appears in the County Operational Plan.*

Objective 2.1.2: Ensure staff are trained to assume incident management positions and other critical roles during emergencies.

- A minimum of two-deep response personnel per position are achieved and maintained.
- Four trainings offered annually to all Public Health Nurses (PHS, Regions, and Aging and Independence Services) on their role during a surge situation in which there is a need to meet increased demand due to a public health threat.

Objective 2.1.3: Ensure all emergency operational plans and annexes are completed within federally required timeframes.

- A minimum of five plans to be updated; can include but is not limited to: emergency operational plans, San Diego Disaster Healthcare

GOAL 3: Enhance technology, information management, and sharing systems to ensure timely communication of situational awareness and risk information.

Strategy 3.1: Adopt the latest technology and systems to enhance and support state-of-the-art, bi-directional communications.

Objective 3.1.1: Share situational awareness across health care and public health systems.

- A needs assessment developed for a timely bi-directional communication solution with real-time situational awareness data from non-hospital healthcare entities during a response.
- Participate in California Health Alert Network (CAHAN) annual drills, exercises, and real-life notifications, including statewide exercises and local drills to test the system.
- At least three staff within PHS are trained in the use and maintenance of CAHAN to ensure adequate coverage during an emergency or public health event.

GOAL 4: Facilitate countermeasures and mitigation to ensure continuity of emergency operations management during emergency response and recovery.

Strategy 4.1: Deploy the latest approaches for continuity of emergency operations through planning and exercises.

Objective 4.1.1: Ensure medications can be effectively distributed in the event of an emergency.

- Six Medical Point of Dispensing (MPOD) exercises conducted annually, one in each Regional Public Health Center.
- A minimum of four MPOD site trainings completed.
- At least three Region VI Medical Health Operational Area Coordination (MHOAC) meetings attended.

GOAL 5: Strengthen surge management through timely coordination and support of response activities with partners to ensure timely care.

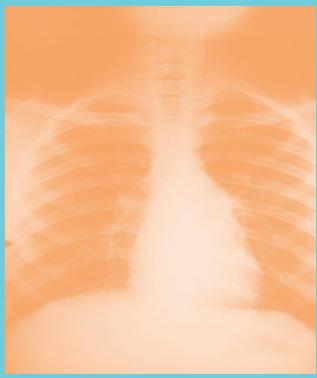
Strategy 5.1: Build capacity of staff, volunteers and providers to manage surge through planning, training, and exercises.

Objective 5.1.1: Conduct health care facility evacuations planning and execute evacuations.

- At least ten meetings annually of the San Diego Disaster Healthcare Coalition convened.
- At least ten ambulance-receiving hospitals trained on a patient tracking system to assist with the identification of patients in each hospital during an emergency.
- A minimum of one test of the patient tracking system conducted and trainings based on After Action Reports (AARs) updated.
- One no-notice Coalition Surge Test (CST) facilitated, involving the evacuation of twenty percent of the total patients in the operational area within a 90-minute restricted timeframe.

Objective 5.1.2: Train staff and identify volunteers to support medical surge needs.

- At least two outreach or recruitment activities held each year to ensure a robust Medical Reserve Corps of trained medical and public health professionals and community members who can be called on to serve as volunteers during an emergency.
- Four trainings offered annually to all Public Health Nurses (PHS, Regions, and Aging and Independence Services) on their role during a surge situation in which there is a need to meet increased demand due to a public health threat.
- 80 percent of public health nursing staff have received annual competency training in mass care and shelter and emergency response nursing skills.
- 80 percent of public health nursing staff have been “fit tested” annually to determine appropriate personal protective equipment.



Tuberculosis Control and Refugee Health

4

Goals

5

Strategies

7

Objectives





Services **SWOT** **San Diego** **LiveWell** **Thriving** **Community** **Safe** **HHSA** **Healthy** **3-4-50** **Performance**



TUBERCULOSIS CONTROL AND REFUGEE HEALTH (TBC-RH) BRANCH

UNITS

- Contact Evaluation Unit
- CureTB and Refugee Health Unit
- Tuberculosis Case Management Unit
- Tuberculosis Clinical Services Unit
- Tuberculosis Education and Outreach Unit
- Tuberculosis Surveillance Unit

GOAL 1: Eliminate TB in San Diego County by continuing to make progress in reducing the incidence of the disease.

Strategy 1.1: Provide comprehensive, timely tuberculosis (TB) case and surveillance services.

Objective 1.1.1: Test individuals diagnosed with TB for HIV, per the CDC standard of care for active TB.

- 95 percent of all cases with TB, alive at diagnosis, are tested for HIV infection. *This is a priority measure that appears in the County Operational Plan.*

Objective 1.1.2: Produce an epidemiology report of TB in San Diego.

- Annual TB epidemiology report issued.

GOAL 2: Increase awareness of TB risk.

Strategy 2.1: Improve the level of knowledge and awareness about TB in the community, especially medical providers, their staff, and high-risk populations, through targeted teaching, an awareness campaign and engagement campaign for community members and key stakeholders.

Objective 2.1.1: Provide trainings to promote knowledge and awareness of TB throughout the county.

- At least 50 trainings, reaching 1,500 individuals, provided annually.

GOAL 3: Enhance prevention, diagnosis, and treatment of TB disease and latent TB infection.



Strategy 3.1: Employ a multidisciplinary, team-based approach to case and contact management to reduce opportunity for transmission and prevent future cases of infectious TB.

Objective 3.1.1: Ensure individuals diagnosed with active TB complete treatment in order to reduce opportunity for transmission and to achieve the best health outcomes, based on the Centers for Disease Control and Prevention’s (CDC) National TB Indicators Program (NTIP).

- 95 percent of individuals diagnosed with TB complete treatment.

Objective 3.1.2: Ensure that contacts to persons with infectious TB are evaluated and those with new latent TB infection (LTBI) initiate and complete treatment to prevent future cases of infectious TB, meeting or exceeding goals that appear in CDC’s NTIP.

- 93 percent of evaluations of elicited contacts to sputum smear-positive TB are completed.
- 75 percent of contacts with new LTBI initiate treatment (exceeds NTIP goal of 70 percent).
- 65 percent of contacts with new LTBI who initiate treatment complete it.

Strategy 3.2: Provide patient-centered clinical services to ensure availability of TB screening and medical services for care.

Objective 3.2.1: Monitor clinical services and customer satisfaction on a regular basis.

- Customer satisfaction survey scores; also reviewed quarterly.
- Volume or number of key clinical services, including chest x-rays, TB tests (TB skin tests, QuantiFERON blood tests), sputum collection, provider visits, and nurse visits reviewed quarterly.

GOAL 4: Improve the health of newly arrived refugees in San Diego County.

Strategy 4.1: Provide prompt, high-quality health screening and referral services for new refugee arrivals.

Objective 4.1.1: Ensure incoming refugees start and complete the health assessment process.

- 90 percent of incoming refugees start the health assessment process.
- 90 percent of incoming refugees who start the health assessment process complete the health assessment process within 90 days. *This is a priority measure that appears in the County Operational Plan.*

ALIGNMENT

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Summary

FRAMEWORK

Why is the PHS Strategic Plan important? This Strategic Plan:

- **Promotes transparency** by helping the public see the activities and role of the local public health department.
- **Inspires collective action** between PHS and community partners to achieve positive outcomes for San Diego communities, consistent with the vision of *Live Well San Diego*.
- **Is essential to a well-managed organization**, consistent with the County's General Management System and Strategic Framework.
- **Reflects that PHS is conforming with requirements of a nationally accredited public health department** by creating, implementing, and monitoring a strategic plan. San Diego County was accredited in May 2016 and is seeking reaccreditation in 2021.



What is in the PHS Strategic Plan?

The **Introduction** and **Methodology** sections set up the framework by which this PHS Strategic Plan is organized. **The Plan** itself features the detail—goals, strategies, objectives, and associated performance metrics—by individual Branch. The plan reflects the span of responsibility and activity that each Branch has committed to:

- **For PHS Administration**, the Branch is guided by public health accreditation standards and the Baldrige criteria for Performance Excellence. PHS Administration ensures that there is an attention across the Department to operational excellence, data-driven decision-making, and continuous learning.
- **For California Children's Services**, the Branch is focused on improving care coordination and transition planning services for children aging out of CCS services, while improving health equity in services and encouraging family participation.
- **For Epidemiology and Immunizations Services**, the emphasis is improving immunizations coverage, promoting quality immunizations practices, and minimizing the spread of disease while also providing effective surveillance, investigation, and response to protect the community from disease. Maintaining a state-of-the-art laboratory and providing timely and quality birth certificates is among the many other goals of this Branch.
- **For the HIV, STD, and Hepatitis Branch**, a unifying priority is achieving the audacious goal of "Getting to Zero" and eliminating all new HIV cases, while also increasing a focus on STDs, given the continuing rise in numbers of STDs and the impact on certain populations.



- **For Maternal Child & Family Health Services**, the emphasis is to reach diverse and vulnerable populations to improve health outcomes and decrease health disparities through new interventions and by leveraging programs with new funding. This Branch also seeks to apply innovative and evidence-based approaches to creating environments and policies that promote health equity and encourage healthy behaviors and communities.
- **For Public Health Preparedness and Response**, the Branch is seeking to strengthen community resilience, incident management, and surge management in a variety of ways, including creative ways to engage volunteers, partners, and providers and build their capacity.
- **For Tuberculosis Control and Refugee Health**, the Branch seeks to eliminate TB in San Diego County through a variety of approaches that include comprehensive surveillance, increasing awareness, and enhancing the prevention, diagnosis, and treatment of the disease.



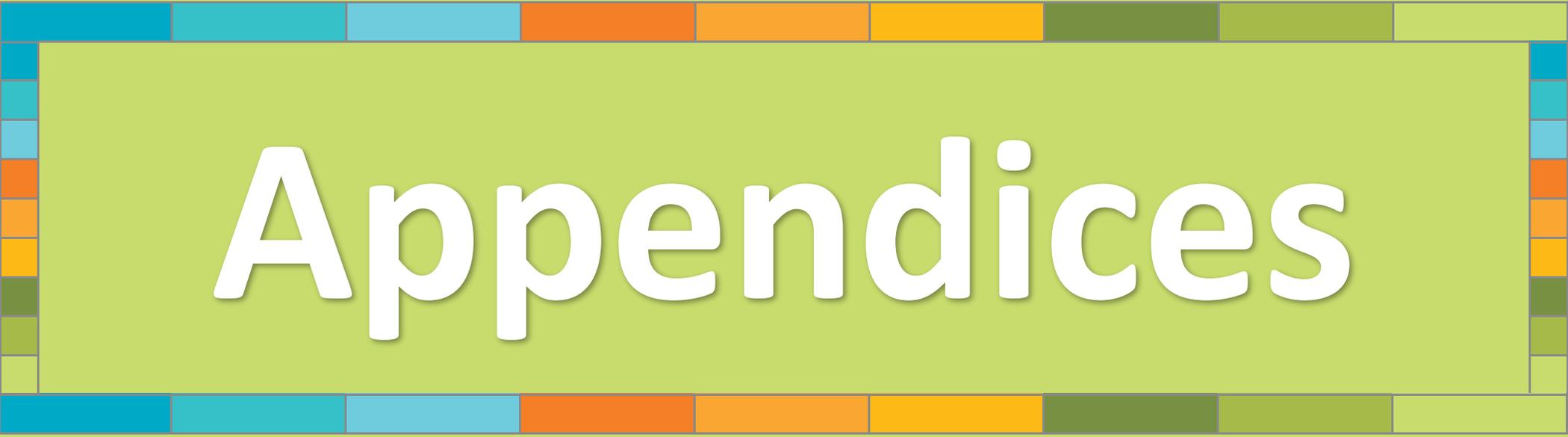
The **Appendices** that follow provide important ancillary information to understanding this Strategic Plan—including how this PHS Strategic Plan aligns with other plans and reflects a focus on health equity. All eight Appendices are listed in the “Overview of Appendices” (Page 77).

How Will the PHS Strategic Plan Be Used? This PHS Strategic Plan will:

- **Provide overall direction** within and across each of the PHS Branches in terms of agreed-upon goals and evidence-based strategies.
- **Guide action “on the ground”** with implementation objectives and associated metrics for every PHS program and unit, helping ensure that this plan is put to use.
- **Put a focus on health equity considerations** based on data illustrating the need.
- **Support monitoring of progress** by tracking objectives and metrics through a performance management system.
- **Convey how PHS program activity contributes to community health and well-being** in the long term through the use of dashboards and “logic models” that connect shorter-term activity to longer-term community change.



ALIGNMENT

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Appendices

FRAMEWORK

Overview of Appendices

- **APPENDIX I—HEALTH EQUITY:**
The health equity focus of each Branch, including why this equity concern is a priority and how each Branch plans to address it.
- **APPENDIX II—INITIATIVES:**
Major initiatives to address priorities and emerging needs of the County Board of Supervisors, the Chief Administrative Officer, County Directors, and the community and the role that PHS plays in implementing these initiatives.
- **APPENDIX III—ALIGNMENT TO COMMUNITY HEALTH IMPROVEMENT PLAN AND REGIONAL COMMUNITY ENRICHMENT PLANS:**
How Public Health Services (PHS) goals support Regional Community Enrichment Plans, which reflect local priorities for community health improvement, and vice versa.
- **APPENDIX IV—ALIGNMENT TO NATIONAL, STATE, AND LOCAL PLANS:**
How Branch goals align with the *Live Well San Diego* vision as well as other key State and national health plans and efforts.
- **APPENDIX V—DASHBOARDS:**
Key community or population indicators that PHS is tracking to assess long-term benefits to the community.
- **APPENDIX VI—CONFORMITY TO PUBLIC HEALTH ACCREDITATION REQUIREMENTS:**
How this plan reflects adherence to Public Health Accreditation Board requirements, reflecting best practices in public health.
- **APPENDIX VII—FINANCIAL AND ORGANIZATIONAL INFORMATION:**
Financial information, including staffing by full-time equivalents (FTEs), the approved budget for Fiscal Year 2018-19, and the organizational structure of Public Health Services.

PHS
STRATEGIC
PLAN

APPENDICES
I-VIII

Appendix I-Health Equity

Public Health Services (PHS) is committed to advancing health equity across all of its programs.

What is Health Equity?

The focus on reducing health disparities and the gaps in quality of life it produces is often referred to as health equity. Health equity is also integral to the vision of *Live Well San Diego* since this vision is that every resident, no matter the zip code in which that resident lives, works, or plays, has the opportunity to be healthy, safe, and thrive.

Achieving a high level of health at the individual or population level is reliant on a complex mixture of societal influences that all play different but important roles. Often referred to as the social determinants of health, factors such as access to healthy food, quality health care, housing, economic opportunities, education, and transportation (among others) greatly influence the ability to be healthy.

Why is Health Equity Important?

Race/ethnicity, gender, geography, age, and socioeconomic status are intertwined with the social determinants of health and often one or many of these factors produce health disparities (diseases or conditions that affect one population more than another), despite targeted efforts through interventions and resources from federal, State, and local public health departments.

Health equity is a public health tenet that entitles all persons the right to attain the highest level of their health potential without regard to their status in society and separate from their race/ethnicity, gender, age, or geography. Unless attention is paid to health equity, progress in addressing or resolving most major health conditions is improbable. If you are advancing health equity goals, you are advancing public health goals and vice versa.





PHS Office of Health Equity

PHS has elevated considerations of health equity across the department. Its Office of Health Equity (OHE), staffed by a Coordinator and supported by a Health Equity Committee with representation across all the Branches, has successfully developed plans, tools, trainings, and, most importantly, promoted conversations about health equity across the department.

Beginning in the 2016-17 planning cycle, workshops were convened by the PHS Administration Branch to examine data, frame goals, and develop objectives and associated metrics that reflect a heightened attention to these inequities. This health equity effort is now embedded in ongoing planning cycles. In addition, OHE is the lead office for other initiatives that are related to, and advance, health equity. These include the County's Diversity & Inclusion program; trauma-informed systems and services; the County's customer service initiative (referred to as H.E.A.R.T. for Helpfulness, Expertise, Attentiveness, Respect, Timeliness); and workforce development.

To help Branches embed health equity in their public health practice, a Health Equity Tool for programs

was developed. This tool is designed to provide some ideas and suggestions for advancing health equity, whether one is implementing a program, working in an administrative role, a contracting role, or in the laboratory. This tool provides guidance in looking at the work of public health through 12 functions—including referrals and collaboration, partnerships, customer service, data, research, contracts, etc. Various questions are posed for each function to encourage staff to explore whether or not the Branch, program, or unit has integrated health equity considerations. The tool is aligned to the ten Public Health Essential Services and Malcolm Baldrige Excellence Criteria. Examples of best practice in integrating health equity within each function are also provided.

This tool is intended to spur conversation, reveal challenges, and inspire action. There is also a Health Equity Tool for the individual which is part of a "Health Equity 101" training module developed by OHE and required for all PHS staff to take. OHE also developed a series of mandatory training modules that, in addition to Health Equity 101, incorporate health equity principles—including Public Health 101 and Climate Change.

Health Equity Priority by Branch

To reinforce the importance of health equity, each Branch has identified a Health Equity Priority for this three-year PHS Strategic Plan. This means

that, while advancing health equity is integral to all public health efforts, each Branch has selected a particular focus for its health equity efforts.

The tables on the following pages capture the health equity priority by Branch.

Information as to why health equity considerations are vitally important for the Branch to address is provided. For each Branch other than PHS Administration, available population data was examined to capture any disproportionality that informs why the particular health equity priority was chosen.

“Success requires collective efforts across all sectors to address the social determinants of health that influence health.”

The County of San Diego analyzes population health data by five lenses of health equity including: age, gender, geography, race/ethnicity, and socioeconomic status. In this way, differences in

rates of disease, death, and lifestyle behaviors are identified.

Goals or objectives within the Strategic Plan that reflect efforts to address these health inequity concerns are highlighted. Figures that illustrate these disparities and their significance are also included.

While these tables reflect some of the actions each

Branch is taking to address health inequities, success requires collective efforts across all sectors in order to improve the social determinants that influence health.



Health Equity Lenses



1. Age
2. Gender
3. Geography
4. Race/Ethnicity
5. Socioeconomic Status

Public Health Services Administration

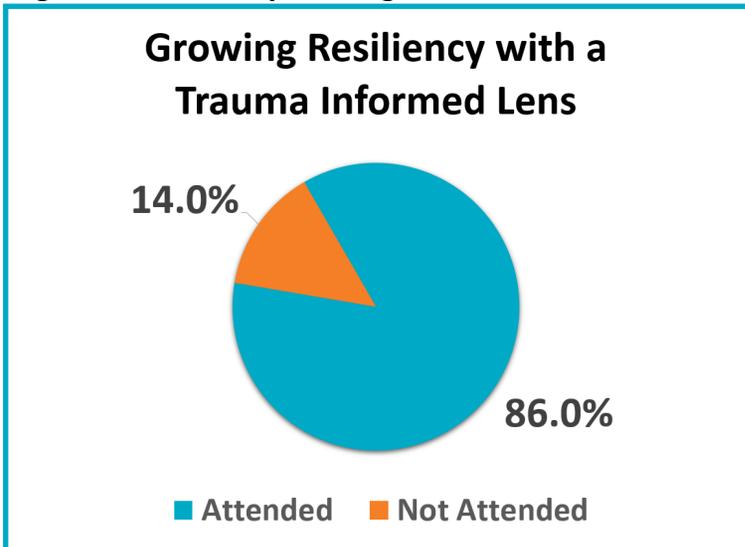
Table 1. Strengthening our Workforce.

<p>Health equity priority.</p>	<p>Strengthening Public Health Services’ workforce by providing training that emphasizes key components of health equity, cultural competence, diversity and inclusion, trauma-informed care, and customer service to ensure all staff understand the value of health equity and the need to be sensitive to health inequities.</p>
<p>Reference in the strategic plan.</p>	<p>Goal 3 for Admin is “Create a culture of Customer Service within PHS that enables staff to serve, engage, innovate, and always be responsive to feedback from customers.”</p> <p>Goal 5 for Admin is “Ensure that the County and its residents are served by an agile, adaptable, highly-skilled, public health workforce.”</p>
<p>Why a priority?</p>	<p>Health equity can be defined as a state in which all groups in a population have fair treatment and access to opportunities to achieve the greatest levels of health, well-being, and quality of life. Services and programs should meet the specific needs of individuals and groups rather than provide equal treatment to all residents. It is critical that Public Health Services employees receive sufficient training to enhance core competencies and build understanding and commitment to health equity. PHS is advancing health equity by raising awareness among staff of various social and economic conditions that contribute to inequities and the impact on underserved and underrepresented groups across the County. Creating effective approaches to address these inequities requires public health professionals to possess specific knowledge, skills, and abilities (KSAs) related to cultural competence, diversity and inclusion, customer service, and trauma-informed care. The workforce development plan aims to provide all employees with these KSAs, and the strategic plan establishes performance criteria through which employee training participation is measured.</p>
<p>How is the Branch addressing this health equity priority? <i>(continued on the following page)</i></p>	<p>PHS Admin is addressing this health equity priority by providing staff with training in health equity, cultural competency, customer service, trauma-informed care, and diversity and inclusion.</p> <p>Health Equity: A key component of workforce development on health equity for PHS staff includes mandatory training on health equity, public health basics, climate change, and public health. Currently, five modules are available to staff: three modules for Public Health 101 (History of Public Health, Concepts and Context of Public Health, and Data), one module for Health Equity 101, and one module for Climate Change 101. These modules will be assigned as mandatory training in the Learning Management System (LMS) in Fiscal Year 2019-2020. Additionally, in Fiscal Year 2018-2019 the Office of Health Equity issued a survey to PHS staff on health equity and cultural competency, based on the Bay Area Regional Health Inequities Initiative (BARHII) Toolkit survey for staff. The results are currently being analyzed and will inform workforce development efforts over the next few years.</p> <p>Cultural Competency: PHS serves a diverse set of customers and so cultural competency is essential. As the department sees staff retirements, experiences turnover, and welcomes new staff to the department, all PHS staff will be required to complete this training within the first six months. Beginning in 2019-2020, PHS will work with The Knowledge Center (TKC), HHSA’s training unit, to ensure that all staff have either taken or been assigned Cultural Competency training.</p> <p>Customer Service: The department has been prioritizing customer service for more than five years, since the launch of the Countywide H.E.A.R.T. effort. All PHS staff will be required to complete customer service training within the first 6 months of onboarding. Beginning in 2019-2020, PHS will work with TKC to ensure that all staff have either taken or been assigned customer service training.</p>

Table 1 Continued. Strengthening our Workforce.

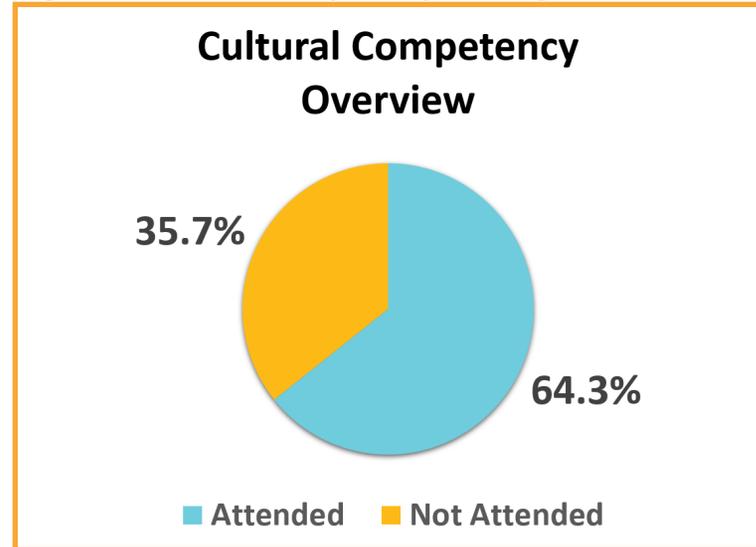
<p>How is the Branch addressing this health equity priority? <i>(continued from previous page)</i></p>	<p>Trauma-informed Care: In 2015, the Health and Human Services Agency (HHSA) issued a policy that all of its departments would take a trauma-informed approach to service delivery and integration. In 2018-2019, all staff were assigned an e-learning module as mandatory training and encouraged to complete it by December 15, 2018. Currently, PHS is serving on a working group to develop a follow-up module, Trauma-Informed 201, with practice scenarios and scripts for staff to use in various staff- and client-based situations. This will also be a mandatory e-learning module assigned to all PHS staff with targets set for completion within six to 12 months.</p> <p>Diversity and Inclusion: Training on Diversity and Inclusion (D&I) is mandatory only for departmental D&I Ambassadors who must complete five trainings. PHS Branches are required to maintain Diversity and Inclusion Action Plans and ensure D&I is infused into Branch operations through a variety of means.</p>
<p>What does the data show? <i>(see figures on the following page)</i></p>	<p>In order to demonstrate PHS’s commitment to strengthening the workforce, an analysis was performed to determine the number of employees who have participated in three core health equity trainings: <i>Growing Resiliency with a Trauma Informed Lens</i>, <i>Cultural Competency Overview</i>, and <i>Customer Service Excellence for PHS</i>. Additionally, PHS Administration requested that all staff read the <i>Diversity and Inclusion (D&I) Strategic Plan</i>. As of July 2019, there are 459* permanent employees of PHS, 33 Temporary Expert Professionals (TEPs), and 15 Student Workers (for a total of 507). The graphs below show the participation percentages of PHS employees in these trainings from the past three fiscal years (FY 16-17, 17-18, and 18-19).</p> <p>Figure 1a: This figure shows the rates of attendance for the <i>Growing Resiliency with a Trauma Informed Lens</i> training. This training is required of all permanent staff, TEPs, and Student Workers. Of the 507 total employees, 436 (86%) have attended the training.</p> <p>Figure 1b: The <i>Cultural Competency Overview</i> training has been provided to nearly two-thirds of all permanent PHS employees—295 of the 459 employees (64.3%). The graph below does not show attendance rates for TEPs, Student Workers, and Independent Contractors. This is an instructor-led, in-person course.</p> <p>Figure 1c: The <i>Customer Service Excellence for PHS</i> training module has had an attendance rate of 60.3% of all permanent PHS employees (277 of 459). The graph below does not show attendance rates for TEPs, Student Workers, and Independent Contractors. This training is also an in-person, instructor-led module.</p> <p>Figure 1d: The <i>Diversity and Inclusion (D&I) Strategic Plan</i> was read by 390 of the 459 (85%) permanent employees of PHS. This was a document that was mandated of all senior and frontline staff. Student workers, TEPs, and Independent Contractors are not included in this calculation.</p> <p><i>*Total budgeted staff for 2018-19 is 464.50, slightly more than the 459 staff on board count as of 7/30/19 that was used to calculate these participation results.</i></p>

Figure 1a. Resiliency Training.



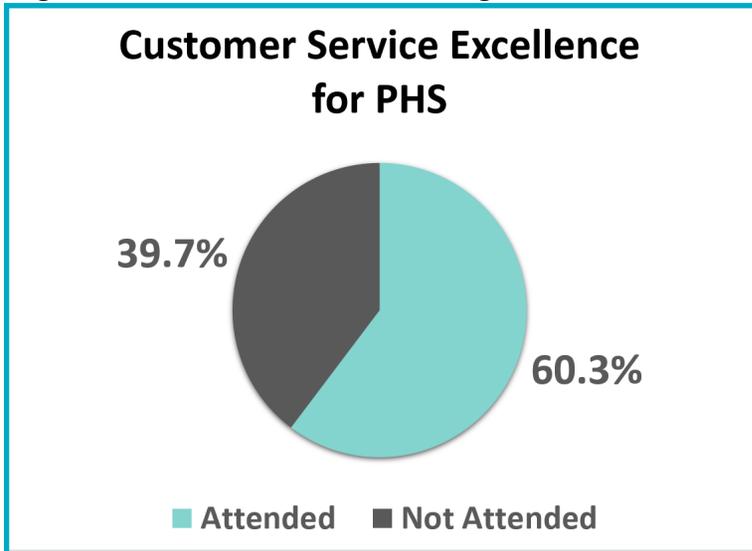
Source: County of San Diego, Department of Human Resources, The Knowledge Center. 2019.

Figure 1b. Cultural Competency Training.



Source: County of San Diego, Department of Human Resources, The Knowledge Center. 2019.

Figure 1c. Customer Service Training.



Source: County of San Diego, Department of Human Resources, The Knowledge Center. 2019.

Figure 1d. Diversity and Inclusion Training.



Source: County of San Diego, Department of Human Resources, The Knowledge Center. 2019.

California Children’s Services

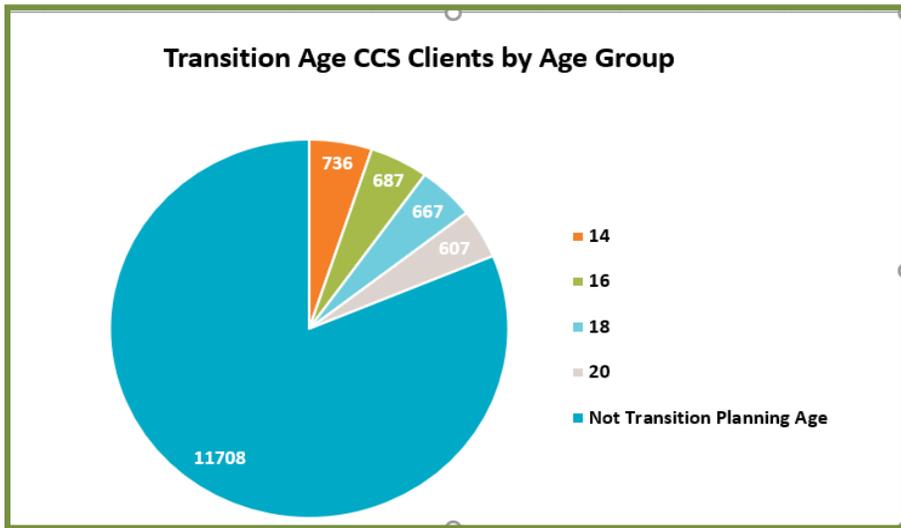
Table 2. Transition from Care.

Health equity priority	Transition from Care, referring to helping clients and their families prepare to successfully transition at age 21 from a pediatric to an adult model of health care.
Reference in the strategic plan.	Goal 5 for CCS is “Ensure timely transition planning services for CCS clients to promote optimal health and independence once these clients leave the CCS program.”
Why a priority?	<p>CCS clients have serious, complex, and/or chronic medical conditions and disabilities. While they receive various services through the CCS program, including medical case management and occupational and physical therapy, at the age of 21 they are no longer eligible for these same services. It became evident that under this current arrangement, clients were leaving the CCS program without effective care coordination knowledge, skills, and abilities. These clients and their families lacked the understanding of how best to prepare for transition to adulthood and adult medical care prior to exiting the CCS program and were not taking the steps necessary to optimize the long-term health of these youth so that they can reach their full potential.</p>
Looking across the health equity lenses.	<p>Across San Diego County, disability rates among children fluctuate for a variety of reasons. Overall, roughly three (3) percent of all children under 18 experienced some form of disability in 2017. When examining the available health equity data, higher rates were evident for certain geographies, by race/ethnicity, by gender, and by socioeconomic status (SES). When examining the available health equity lens data, of all children under 18 years of age with a disability:</p> <ul style="list-style-type: none"> • Gender: Males had a slightly higher proportion of those experiencing disability than females (3.7% vs 2.3%, respectively); • Geography: East Region and several of its smaller communities, most notably Alpine, Harbison Crest, La Mesa, and Lemon Grove, had a higher proportion of children under the age of 18 with some kind of disability. • Race/Ethnicity: Children identifying as American Indian/Alaskan Native or two or more races experienced higher estimates of disability than the County overall. • Socioeconomic Status: In San Diego County, one in five, or 20% of all children experiencing some type of disability also live in households with income below the federal poverty level.
How is the Branch addressing this health equity priority?	<p>CCS has undertaken a Quality Improvement project over the last few years in which it has tested ways to improve transition planning. Face-to-face interviews before the client turns 21, and using a Transition Planning Checklist, have been shown to contribute to gains in knowledge and changes in behaviors to prepare for the transition, as well as effective care coordination. Scores for transition readiness have improved for the subset of clients tested—those served in the medical therapy units with cerebral palsy. As a result, CCS is working to improve transition planning for all clients through face-to-face biannual review process and the use of the checklist to document improvements in readiness. The CCS program has also begun quarterly regional transition planning workshops to bring local resources to families and once again provide assistance through face-to-face discussion with experts including other parents who have completed the transition and can offer guidance.</p>

Table 2 Continued. Transition from Care.

<p>What does the data show?</p>	<p>Transition planning is a key component for clients who are aging out of CCS. There are many facets in the transition that include finding adult providers, addressing legal guardianship issues, and establishing new resources. The CCS’s target is to ensure that 80% of audited cases that have a chronic medical condition anticipated to last beyond the client’s 21st birthday have documentation of Transition Planning intervention per CCS policy. Figure 2a shows the segments of the CCS population that is of transition planning age. Figure 2b shows the targeted subset population for the past CCS Quality Improvement Project, children with Cerebral Palsy, and the ones in each age group where CCS transition planning efforts are focused: age 14, 16, 18, and 20. CCS staff are also striving to make an impact for other subset diagnostic populations.</p>
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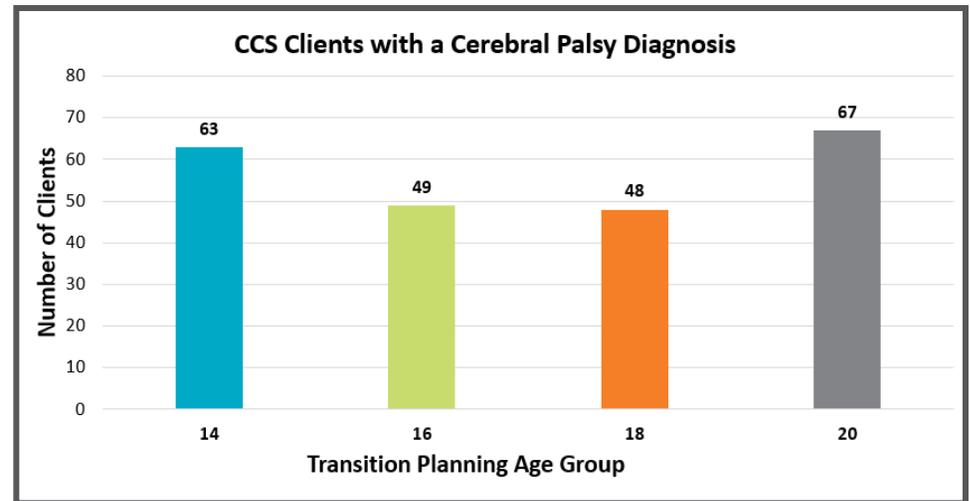
Figure 2a. Transition Age CCS Clients by Age Group.



Note: The transition planning age groups 14, 16, 18, and 20 have been identified by the State for transition planning assessments and assistance.

Source: Children’s Medical Services (CMS) Net—CMSNet. Data for San Diego County.

Figure 2b. CCS Clients with a Cerebral Palsy Diagnosis as Focus of Quality Improvement Project on Transition Planning.



Note: This is a subset population based on cerebral palsy diagnosis for the CCS Quality Improvement Project to develop best approach to transition planning.

Source: Children’s Medical Services (CMS) Net—CMSNet. Data for San Diego County.

Epidemiology and Immunization Services

Table 3. Childhood Lead Poisoning.

Health equity priority.	Childhood Lead Poisoning which disproportionately impacts low-income children and has serious, negative health effects.
Reference in the strategic plan.	Goal 5 in the EISB Strategic Plan is to “Reduce childhood lead poisoning through education, outreach, and early identification and through the treatment of children with elevated blood lead levels.”
Why a priority?	<p>Lead poisoning is considered the most preventable environmental disease of young children by the Centers for Disease Control & Prevention (CDC). Lead is invisible to the naked eye, has no smell, and most children exposed to it do not show any obvious symptoms. Exposure to lead can affect nearly every system in the body and cause negative health effects that result in lifelong learning and behavior problems. Children under the age of six are at the greatest risk of harmful health effects from lead poisoning, as their brains and nervous systems are still developing. Young children are also more likely to be exposed to lead and absorb lead more easily when they are exposed to it.</p> <p>Children at an increased risk of getting lead poisoning include those who spend time in older homes/buildings built before 1978 that have peeling or chipped paint, those who eat non-food items, and those who live in a home with an adult who works with lead in their job or hobby and may bring lead dust home on their clothes or equipment. Other risk factors for lead poisoning include the use of certain cosmetics, spices, home remedies, and dishware, as well as exposure to contaminated soil, candies, toys, jewelry or other products. Lead can accumulate in the body and no safe level has been identified. The only way to know if a child has lead poisoning is through a blood lead test.</p>
Looking across the health equity lenses.	<p>When looking at the available health equity data for children receiving lead poisoning prevention services, differences exist across the various lenses. In San Diego County from 2013-2017, the majority of children were:</p> <ul style="list-style-type: none"> • Age: Zero to two years of age (64% of 273 cases)¹; • Geography: Residing in the Central and East HHS Service Regions (79 and 75 of 273 cases, respectively)²; and • Race/Ethnicity: Hispanic/Latino (38% of 214 cases) followed by white children (35% of 214 cases)³. <p>The refugee status lens, while not a typical health equity lens, is important to the County of San Diego’s Childhood Lead Poisoning Prevention Program (CLPPP) efforts as lead poisoning rates are higher among refugee/immigrant clients compared to other CLPPP clients. CLPPP provides education and encourages refugee families to change or modify practices that may increase exposure to lead while providing home visits to ensure no new exposures pose a threat to their health. Refugee children are required to be screened for lead upon arrival, as well as to have follow up lead testing in accordance with CDC’s Lead Screening Guidelines for Newly Arrived Refugees.</p>

¹ Based on California mandates, children in government programs (WIC, Medi-Cal) are required to be lead tested at ages 1 and 2. For those not in government-funded programs, their health care providers are required to screen children at 1 and 2 to see if there are risk factors for lead and then test them accordingly. This is why the largest percentage of children in CLPPP are ages 0-2 years (64%).

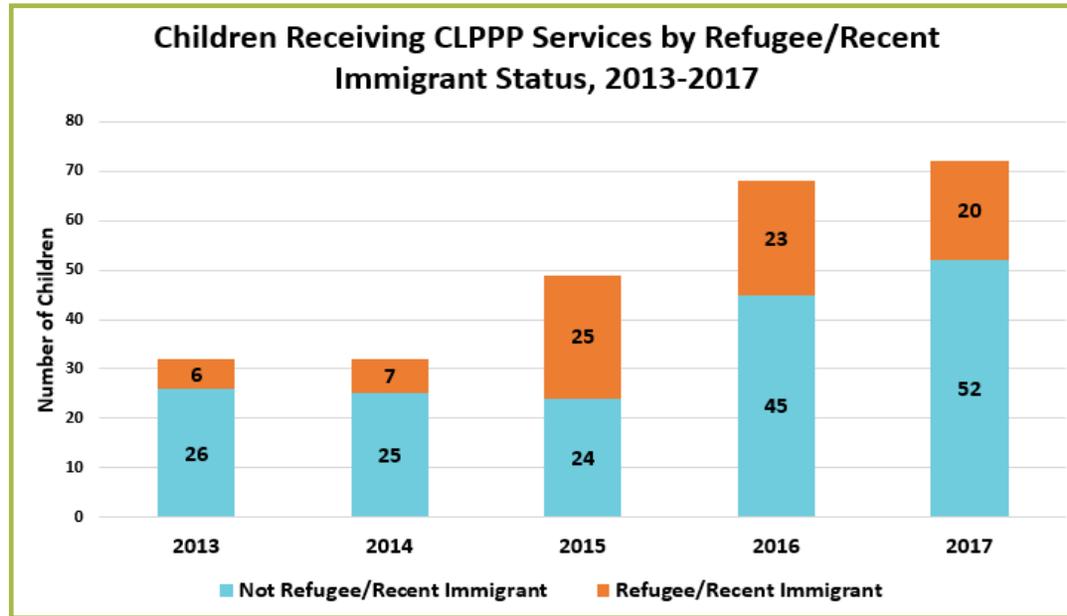
² These parts of the County are where the majority of the refugees are placed by the resettlement agencies when they arrive.

³ Those that are from Afghanistan, the country of origin for many San Diego County refugees, identify as white.

Table 3 Continued. Childhood Lead Poisoning Prevention.

<p>How is the Branch addressing this health equity priority?</p>	<p>CLPPP seeks to eliminate childhood lead poisoning by caring for lead-poisoned children and identifying and eliminating sources of lead exposure. Lead poisoned children, with venous blood lead levels (VBLL) of ≥ 9.5 mcg/dL, receive nursing case management services which includes a home visit, health assessment, and an environmental investigation (EI) when indicated (EIs are performed in collaboration with the County Department of Environmental Health). In 2018, CLPPP contracted with Family Health Centers of San Diego to enhance services and provide home visits to children with a VBLL of 4.5-9.4 mcg/dL. CLPPP also provides trainings and organizes Grand Rounds for health care providers to inform them of California State Mandates regarding lead screening, testing, and follow-up care. CLPPP works proactively to prevent lead poisoning by providing education and outreach services to families and community members and encouraging those at risk to get tested. CLPPP currently aims to reach over 200 healthcare providers and at least 3,000 individuals and families with young children each year.</p>
<p>What does the data show?</p>	<p><i>Figure 3a</i> below shows the number of children under 21 years of age receiving CLPPP services between 2013 and 2017 who had venous blood lead levels ≥ 9.5 mcg/dL in terms of refugee/recent immigrant status. Refugee/recent immigrant children include any children who moved to the U.S. from another country in the year prior to case identification.</p>

Figure 3a. Children Receiving CLPPP Services.



Source: San Diego County Childhood Lead Poisoning Prevention Program (CLPPP) WebCMR Registry, 2/5/2019.

HIV, STD, & Hepatitis Branch

Table 4. Preventing HIV Infection and Addressing Rising Rates of STDs.

Health equity priority.	Preventing all new Human Immunodeficiency Virus (HIV) infections and addressing the rising rates of sexually transmitted diseases (STDs).
Reference in the	All HSHB Strategic Plan goals address this health equity because of the integrated approach to combatting all STDs.
Why a priority?	<p>Rates for most sexually transmitted diseases (STDs) have increased dramatically in the County of San Diego, just as they have in California and the United States. These STDs include syphilis, gonorrhea, and chlamydia. The one important exception to this trend is HIV, which had been stable at approximately 500 infections per year until 2017, when there was a 21% decline in new diagnoses. The increase in STDs is attributable to many factors including a decrease in condom use, insufficient sexual health education, lack of access to medical care, and, for chlamydia and gonorrhea, an increase in extragenital testing.</p> <p>A sharp rise in congenital syphilis in California reinforces the County of San Diego’s commitment to treat cases of syphilis among women of childbearing age as the highest priority for STD disease investigation. Although San Diego County has not yet seen the precipitous 700% increase in cases seen in California as a whole, the County is nonetheless vulnerable to an increase in congenital syphilis. Most cases of congenital syphilis seen over the past five years in California and in San Diego County involve women who face multiple health equity barriers, including any combination of the following: poverty, distrust of medical and governmental systems, fear of intimate partner violence, substance use disorders, untreated mental illness, untreated trauma, lack of stable housing, lack of legal immigration status, and a lack of engagement in ongoing pre-natal care. It is too often the case that pregnant women infected with syphilis show up to emergency rooms for delivery without having received any prenatal care.</p> <p>For gonorrhea, the largest concern is the emergence of extremely drug resistant gonorrhea (XDR GC). Gonorrhea has developed resistance to all prior medication classes used to treat it, and if gonorrhea develops resistance to the current classes of medication used to treat it, there are not many viable fallback options. XDR GC has emerged in Great Britain, and although currently rare, it is very likely that cases will emerge in San Diego County.</p> <p>Substantial progress has been made in addressing the HIV epidemic in San Diego County. New diagnoses have declined and deaths among persons with HIV have also declined significantly. Nonetheless, HIV continues to be a major public health challenge in San Diego County, with one diagnosis occurring, on average, every day. Furthermore, the rates of new diagnoses among African-Americans and Latinos are much higher than among Whites.</p>
Looking across the health equity lenses. (continued on the following page)	<p>Though HIV infection rates were stable up until 2017 and then declined rather significantly, there are still disparities in HIV rates across San Diego County. From, 2013-2017, 2,392 people were diagnosed with HIV disease while residing in San Diego County, of which:</p> <ul style="list-style-type: none"> • Gender: 2,146 (90%) were male; • Age: 1,525 (64%) were 20-39 years of age at diagnosis; • Geography: 1,021 (43%) were diagnosed while residing in the Central Region; • Race/Ethnicity: 1,062 (44%) were Hispanic/Latino.

Table 4 Continued. Preventing HIV Infection and Addressing Rise of STDs.

<p>Looking across the health equity lenses. (continued from previous page)</p>	<p>While Latinos had a higher proportion of HIV cases from 2013-2017, African-Americans have the greatest risk by race/ethnicity because their population is smaller by comparison, representing only four percent of the overall population of San Diego County. Therefore, when standardizing the data, the rates of HIV cases among African-American residents are actually much higher than other race/ethnicities when divided by the total population of African-American individuals in the county.</p> <p>When examining the available data for STD rates within San Diego County across the health equity lenses, disparities continue to exist. Among individuals diagnosed with one of the three common STDs in San Diego County (e.g., chlamydia, gonorrhea, and syphilis), higher rates are found among males, those who are African-American, those living in more densely populated communities (particularly in the Central Region), and those roughly 20-34 years of age. The exception to this is chlamydia, where there are higher rates in females.</p> <p>Chlamydia is the most commonly reported disease in San Diego County. Cases of chlamydia increased by 10% from 18,904 cases in 2016, to 20,801 cases in 2017. By health equity lens:</p> <ul style="list-style-type: none"> • Gender: The rate of chlamydia in women is 1.6 times the rate in men; • Age: In 2017, 4,455.9 cases per 100,000 population were women aged 20-24 compared to 1,739.1 cases per 100,000 population for men in the same age group; and • Geography: Rates are higher in the more densely populated communities (e.g., Central Region). <p>The overall rate of gonorrhea increased by 18.4% from 151.8 cases per 100,000 in 2016, to 179.7 cases per 100,000 in 2017. By health equity lens:</p> <ul style="list-style-type: none"> • Gender: The rate of gonorrhea in males is almost three times the rate in females and increased by 57.6% from 2015 to 2017; • Age: Men aged 20 to 29 years have the highest rates of infection; • Geography: Rates are higher in the more densely populated communities (e.g., Central Region); and • Race/Ethnicity: The rate of gonorrhea in African-American males is 3.8 times that of white males and 2.8 times that of Latino males; the rate of infection in African-American females is 5.1 times that of white females and 3.1 times that of Latino females. <p>Lastly, the overall rate of primary and secondary syphilis increased by 10.7% from 15.9 cases per 100,000 in 2016 to 17.6 cases per 100,000 in 2017. Differences across the health equity lenses also exists:</p> <ul style="list-style-type: none"> • Gender: the majority of cases are male; 79.5% of cases are men who have sex with men (MSM); • Age: Rates are highest among males aged 25 to 34 years; • Geography: Rates are higher in the more densely populated communities (e.g., Central Region); and • Race/Ethnicity: African-American males have the highest rate of infection; the rate of infection in African-American males is 1.8 times that of white males.
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Table 4 Continued. Preventing HIV Infection and Addressing Rise of STDs.

<p>How is the Branch addressing this health equity priority?</p>	<p>HSHB has a multi-faceted strategy to Test, Treat, Link, Prevent, Engage, and Improve. This strategy, which integrates the same approach for all STDs including HIV, focuses on testing in communities disproportionately impacted by these diseases. Furthermore, the strategy calls for linking persons to treatment quickly and effectively. Prevention efforts are directed towards communities with disproportionate risk for infection. Mobilizing community efforts to achieve collective impact in reducing HIV and STD transmission includes maintaining an online and social media presence that promotes awareness and provides information, education and resources. Finally, the strategy calls for continually seeking to improve outcomes through proactive performance and quality management and relentless focus on customer services.</p> <p>Most visible is the County’s “Getting to Zero” initiative, adopted by the Board of Supervisors in 2016, which has the goal of eliminating all new diagnoses of HIV through the same strategy identified above. Progress is being made as indicated by a number of interim measures, including linking newly diagnosed persons to HIV medical care within 30 days of their HIV diagnosis. This year, the County has reached the national target of linking 85% of persons newly diagnosed with HIV to care.</p>
<p>What does the data show?</p>	<p>HIV diagnosis rates have declined to 11.9 per 100,000 among all residents (Figure 4a). However, there are significant disparities by rate and ethnicity with rates for African American residents more than three times the rate of White residents. Hispanics have HIV diagnosis rates about twice that of White residents (Table 4b). *2016 data used for calculating rates.</p>

Figure 4a. HIV Diagnosis Rates by Race/Ethnicity per 100,000.

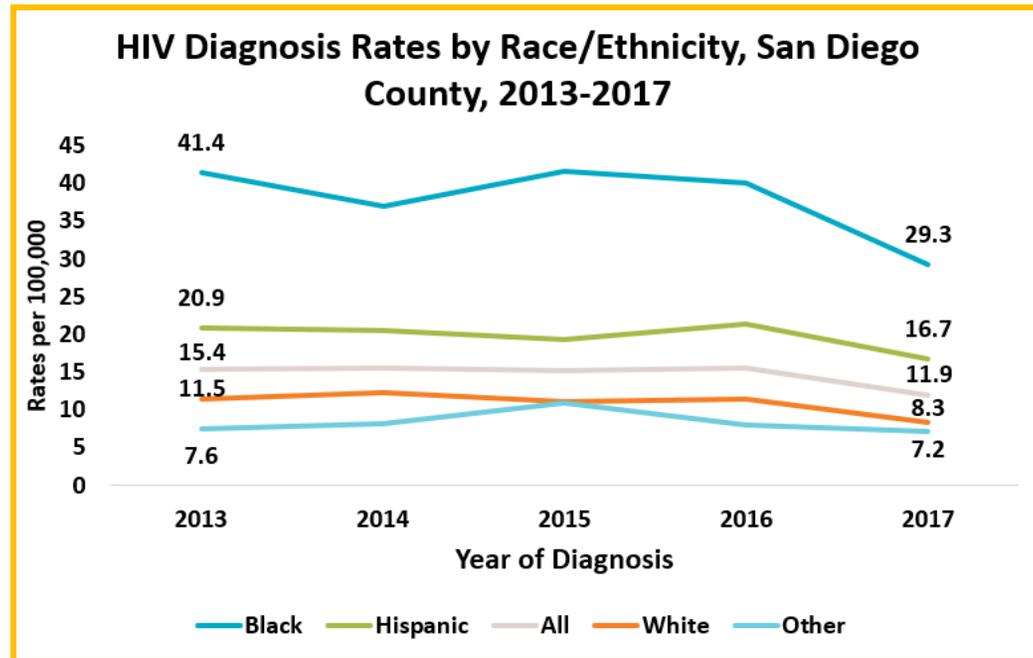


Table 4b. HIV Diagnosis Rates by Race/Ethnicity per 100,000.

RACE/ETHNICITY RATES PER 100,000					
	Black	Hispanic	All	White	Other
2013	41.4	20.9	15.4	11.5	7.6
2014	37	20.5	15.6	12.4	8.2
2015	41.7	19.4	15.3	11.1	11
2016	40.1	21.4	15.6	11.4	8
2017	29.3	16.7	11.9	8.3	7.2

Sources: County of San Diego, HHS, Epidemiology Program, 8/10/2018. California Department of Public Health, Office of AIDS, eHARS – enhanced HIV/AIDS Reporting System – data set for San Diego County, provided 4/4/2018.

Maternal, Child, and Family Health Services

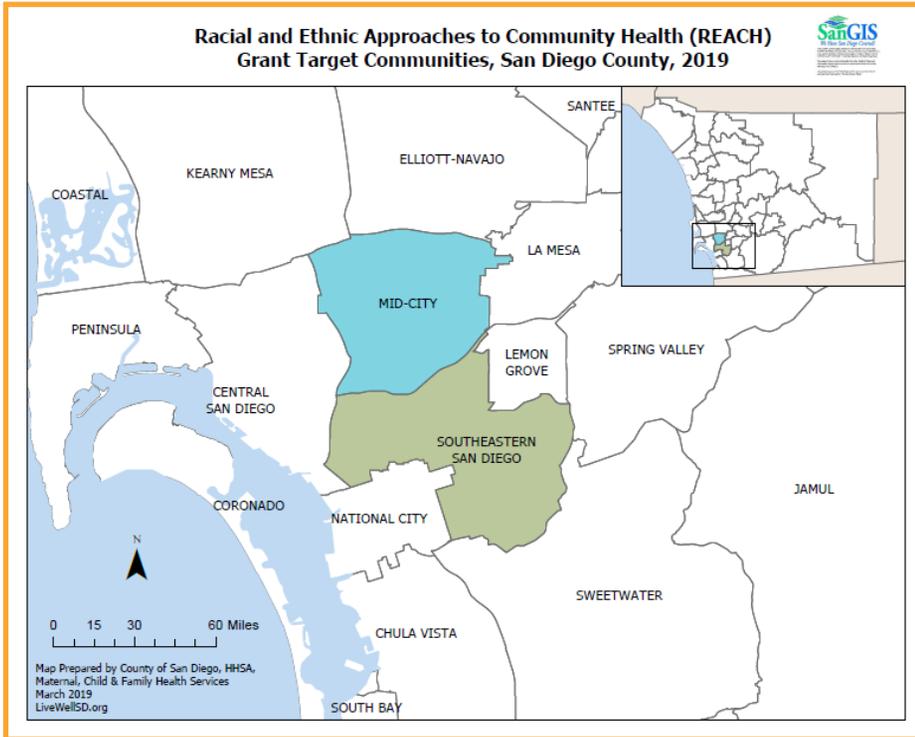
Table 5. Health Equity Health in All Policies (HiAP).

<p>Health equity priority.</p>	<p>Health in All Policies (HiAP), referring to a collaborative approach that integrates and articulates health considerations into policymaking across sectors to improve the health of all communities and people.</p>
<p>Reference in the strategic plan.</p>	<p>Goal 1 for CDHE of MCFHS is “Create environments and policies that promote health equity and encourage healthy behaviors and healthy communities in order to reduce chronic disease and promote health equity for all residents.” Objectives under this goal include a number of actions to make policy, systems, and environmental changes in coordination with Cities, Schools, Childcare Providers, Faith-Based Organizations, Retailers, Worksites, and others with a focus on creating more healthy environments for disadvantaged communities.</p>
<p>Why a priority?</p>	<p>HiAP recognizes that health is created by a multitude of factors beyond healthcare and, in many cases, beyond the scope of traditional public health activities. HiAP is built on the rationale that these factors, also referred to as the social determinants of health, are outside the direct control of the health care sector, and include: education, income, and the conditions in which people live, work, and play. Decisions across many policy arenas can positively or negatively affect the determinants of health. HiAP is an approach to policy-making in which decision-makers beyond the traditional health sector routinely consider health outcomes, including benefits, harms, and health-related costs.</p> <p>HiAP is integral to an array of initiatives and programs that seek to create environments that encourage healthy living, with a focus on communities that are disadvantaged and thereby at greater risk of poor health outcomes.</p>
<p>Looking across the health equity lenses. (continued on the following page)</p>	<p>Three behaviors (poor diet, physical inactivity, and tobacco use) contribute to four chronic diseases (cancer, heart disease and stroke, type 2 diabetes, and pulmonary diseases such as asthma) that cause over 50 percent of all deaths worldwide. This is the foundation of the 3-4-50 concept.</p> <p>According to the California Health Interview Survey, between 2015-2017, 9.1% of San Diegan adults had ever been diagnosed with diabetes. Of those, 85.8%, or roughly five in six of adults with diabetes, had type II diabetes. Overall, in 2017, the highest diabetes medical encounter rates belonged to:</p> <ul style="list-style-type: none"> • Gender: Males; • Age: Those over the age of 65; • Race/Ethnicity: Those who are African American/Black; and • Socioeconomic Status: Those who lived in communities with low median household incomes. <p>During the same timeframe, 26.5% of San Diegan adults had ever been diagnosed with high blood pressure. Of those, 33.8%, or roughly one-third of adults with high blood pressure, were not taking medicine for their high blood pressure. Overall, in 2017, the highest hypertension medical encounter rates belonged to:</p> <ul style="list-style-type: none"> • Gender: Females; • Age: Those over the age of 65; • Race/Ethnicity: Those who are African American/Black; and • Socioeconomic Status: Those who lived in communities with low median household incomes.

Table 5 Continued. Health in All Policies (HiAP).

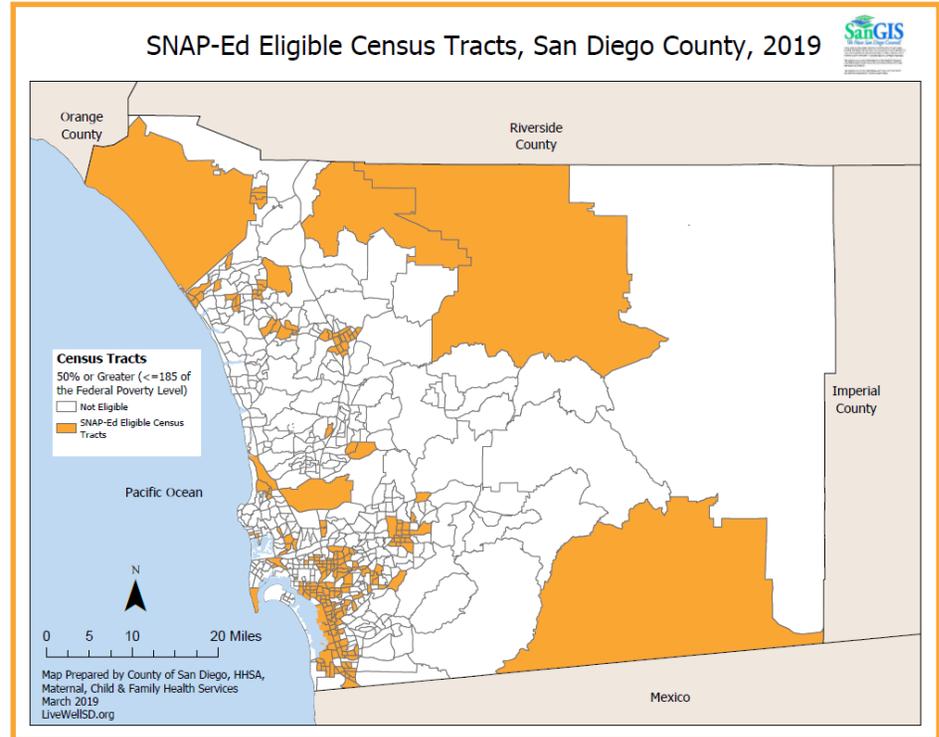
<p>Looking across the health equity lenses. <i>(continued from previous page)</i></p>	<p>A review of 3-4-50 data showed that, regardless of region, cancer accounted for the greatest percentage of chronic disease deaths, followed by coronary heart disease (CHD). When examining the data by health equity lens across the county, noticeable differences exist:</p> <ul style="list-style-type: none"> • Gender: Diabetes risk and death from CHD and cancer was higher among males; death from asthma, COPD, and stroke risk was higher among females; • Age: Higher death rates are found in those over the age of 65; • Geography: 3-4-50 chronic diseases have higher death rates of nearly all outcomes in the East and North Inland regions; • Race/Ethnicity: Compared to the county overall, whites were at higher risk of death for all 3-4-50 diseases whereas African Americans/Blacks were at a higher risk for diabetes and CHD; • Socioeconomic Status: Overall, those residing in communities with lower median household incomes had higher rates of the 3-4-50 chronic disease deaths.
<p>How is the Branch addressing this health equity priority?</p>	<p>CDHE has a number of programs that aim to improve health equity through HiAP approaches. One example is the San Diego Racial and Ethnic Approaches to Community Health (REACH) program that targets communities where there are racial, ethnic and socioeconomic disparities and high numbers of residents with uncontrolled high blood pressure or who are at risk for type II diabetes. Another example is the SNAP-Ed CalFresh Healthy Living Program, which includes interventions that improve access to healthy food and active living opportunities where SNAP-Ed eligible people live, play, shop, eat, worship, and work. Other programs include the Lactation Supportive Environments, Sodium Reduction Initiative, Childhood Obesity Initiative, and Tobacco Control Resource Program; all of which incorporate policy approaches affecting the conditions or environment in which people live.</p>
<p>What does the data show? <i>(see figures on the following page)</i></p>	<p>The figures on the next page depict communities that are the focus of the HiAP approach. Figure 5a shows the communities where the REACH program takes place Figure 5b shows the communities where SNAP-Ed program activities occur. The REACH program is focused on African Americans and Latinos who live in the Mid-City and Southeastern San Diego neighborhoods. The SNAP-Ed program focuses on low-income populations (up to 185 percent of the Federal Poverty Level).</p>

Figure 5a. Racial and Ethnic Approaches to Community Health.



Sources: 1.) SanGIS Subregional Areas (SRAs) Layer, 2019. 2.) Racial and Ethnic Approaches to Community Health (REACH) Grant Target Communities, San Diego County, 2019.

Figure 5b. SNAP-Ed Eligible Census Tracts.



Source: US Census Bureau; 2013-2017 American Community Survey 5-Year Estimates; Table C17002.

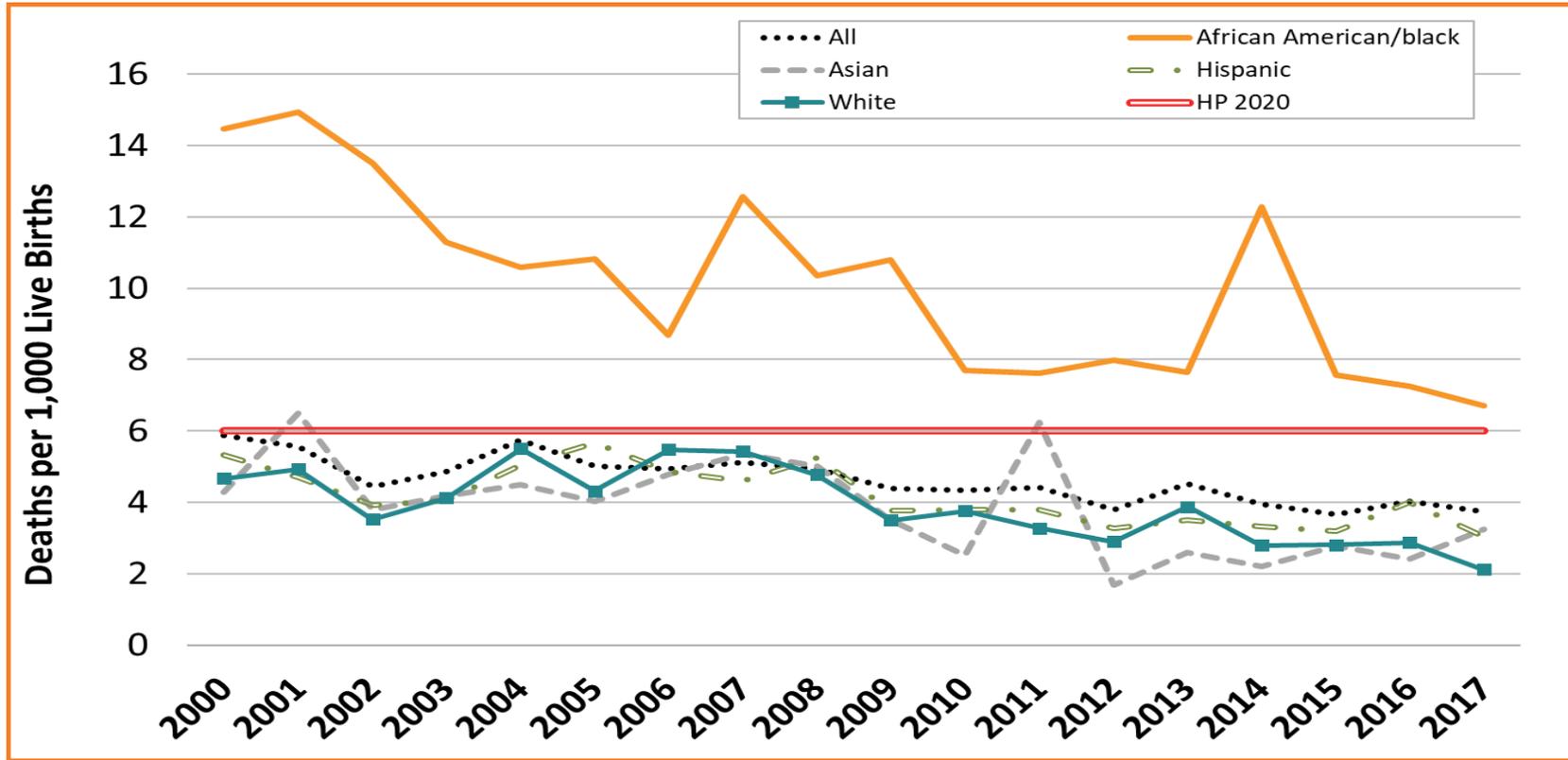
Maternal, Child, and Family Health Services

Table 6. Infant Mortality Rates.

Health equity priority.	Infant Mortality rates provide key information about maternal and infant health, and are also an important marker of the overall health of a society. These rates capture the death of a child less than one year of age per 1,000 live births.
Reference in the strategic plan.	Goal 2 for FHPS of MCFHS is “Reduce the disproportionate African American infant mortality rate.”
Why a priority?	In San Diego County, African-American infant mortality rates have been drastically higher than other race/ethnicity groups, although recent progress has been made. For the better part of two decades, African-American newborns were consistently at least two times as likely to die before their first birthday as compared to Whites. Many factors are responsible for this gap. Perpetual upstream issues like institutional racism, class oppression and gender discrimination have trickle-down affects which influence many of the social determinants of health.
Looking across the health equity lenses.	<p>In 2017, the infant mortality rate (IMR) in San Diego County was lower than the nation (3.7 deaths per 1,000 live births versus 5.7 deaths per 1,000 live births, respectively). Despite the lower infant mortality rates, higher rates were evident when considering age of mother, race/ethnicity, and education as a proxy for socioeconomic status (SES). The highest rates of infant mortality existed in:</p> <ul style="list-style-type: none"> • Age: Women aged 15-19 years (7 deaths per 1,000 live births); • Race/Ethnicity: Non-Hispanic blacks (6.7 deaths per 1,000 live births); and • Education: Women with less than a high school education (4.2 deaths per 1,000 live births).
How is the Branch addressing this health equity priority?	In an effort to reduce the risk to African-American infants, the County of San Diego’s Black Infant Health program, administered by Neighborhood House Association offer resources and services to address this health inequity. They follow a group-based and client-centered case management approach that works to specifically address access to quality health care and social connection. In turn, this method aims to improve the health and well-being of the mother as well as reduce the rate of infant mortality among this population.
What does the data show? (see figure on the following page)	The average infant mortality rate in the United States is higher than California and San Diego County, although all meet the Healthy People 2020 goal of no more than 6.0 deaths per 1,000 live births. However, the African American infant mortality rate in San Diego County was more than three times that of Whites—6.7 compared to 2.1—as shown in Figure 6a on the next page. On a positive note, the African American infant mortality infant rate has dropped from the 14.5 in 2000 to 6.7 in 2017. This disparity persists when averaging the data over a three year time period—from 2015-17, the African-American infant mortality rate is 7.2, compared to 2.6 for Whites.

Figure 6a. Infant Mortality Rate.

Infant Mortality Rate* by Race of Mother, San Diego County, 2000-2017



*Rate of infant deaths per 1,000 live births.

Note: Races/ethnicities with fewer than 5 cases/events in any period are not shown (Native American Indian/Alaska Native, Pacific Islander, Other, and Two or more races). While an increase in cases was observed in 2007 and 2014, these rates are subject to acute spikes due to the small number of live births for this category (<2,000).

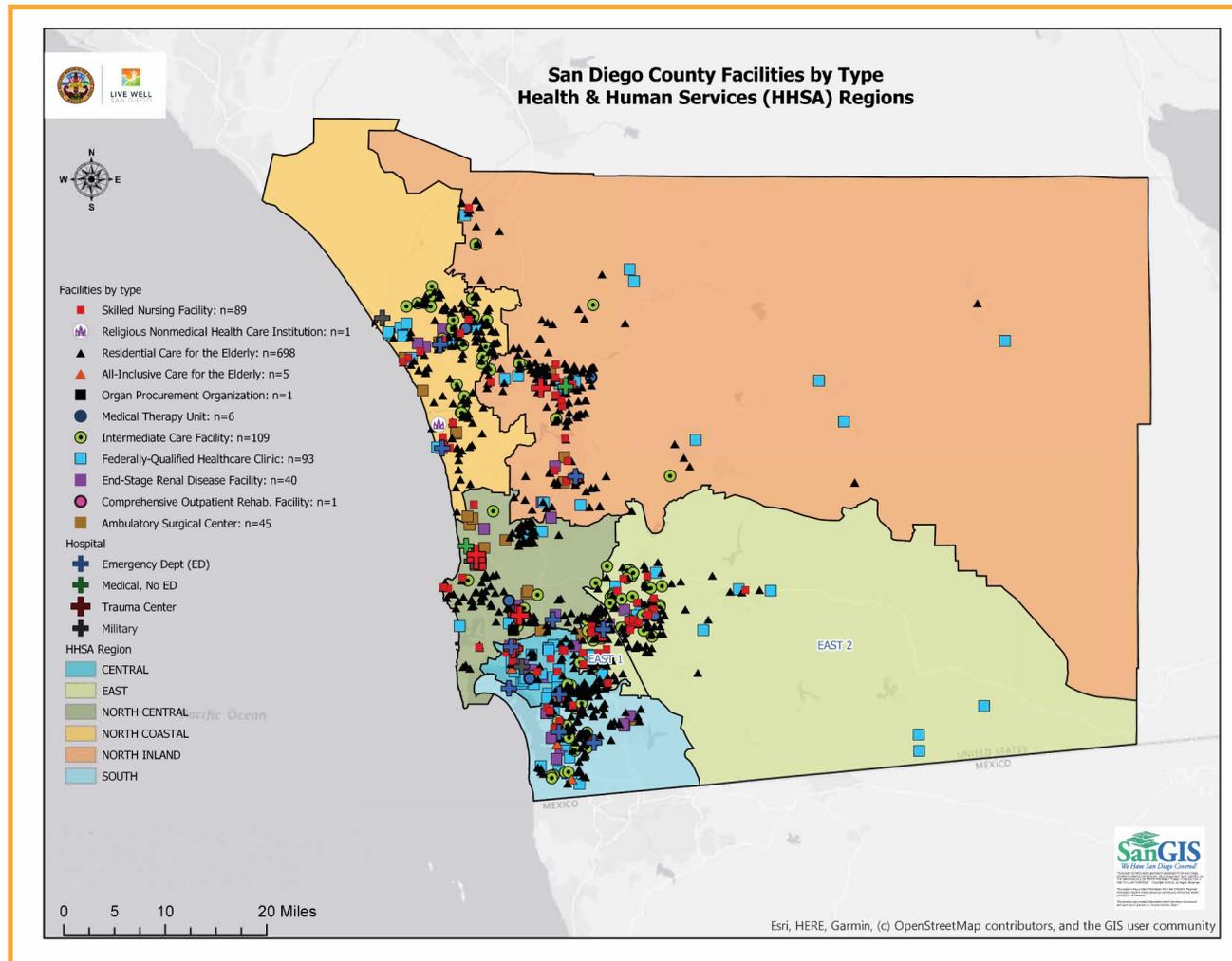
Source: State of California, Department of Public Health, Health Information and Research Section, Birth Cohort Statistical Files.
 Prepared by: County of San Diego, Health and Human Services Agency, Public Health Services, Maternal, Child, and Family Health Services (www.sdmcfhs.org), 2019.

Public Health Preparedness and Response

Table 7. Emergency Preparedness.

Health equity priority.	Emergency Preparedness for Healthcare Providers, which refers to a final rule published on September 16, 2016, by the Centers for Medicaid and Medicare (CMS). The rule serves to establish national, consistent emergency preparedness requirements for 17 different types of providers participating in Medicare and Medicaid.
Reference in the strategic plan.	Goal 1 in the PHPR Strategic Plan calls for PHPR to “Strengthen community resilience to ensure timely assessment and sharing of essential information to reduce exposure to disaster/public health risk” by pursuing the strategy to “build capacity within the community to respond to emergencies by providing tools and training opportunities to residents, partners, providers, and other stakeholders.” Assisting the 17 different types of providers to prepare for emergencies clearly falls under this goal.
Why a priority?	The imperative that hospitals, nursing homes, clinics, and other facilities are prepared for emergencies became clear in recent disasters such as Katrina, Sandy, Ebola, and Zika. Both inpatient and outpatient facilities, where vulnerable residents can be found, need to take actions to ensure the safety of their patients. In order to be in compliance with the final rule, these facilities are required to develop an emergency plan, emergency response policies and procedures, a communications plan, and a training and exercise program.
Looking across the health equity lenses.	According to the California Health Interview Survey, between 2014-2017, 25.5% of the uninsured population below age 65 were estimated to be eligible for Medi-Cal. The populations with only Medicare or Medicaid are higher proportionately in Central Region overall and in the communities of Anza-Borrego Springs, National City, and El Cajon. Whether or not patients are uninsured or underinsured is a “proxy” for greater vulnerability or need, an important consideration for disaster planning by health providers.
How is the Branch addressing this health equity priority?	PHPR administers a variety of hospital, skilled nursing facility, clinic, and other healthcare provider emergency preparedness activities funded through the Hospital Preparedness Program. This includes outreach to an estimated 1,500 facilities to help them develop emergency plans and conduct exercises to test those plans. This is an enormous undertaking that has required the development of toolkits and convening of training events where representatives from various facilities come to learn how to reach compliance under tight timeframes.
What does the data show? (see figure on the following page)	There are hundreds of facilities (<i>Figure 7a</i>) that are subject to these new requirements. These include hospitals, federally qualified health care clinics, skilled nursing facilities, residential care facilities for the elderly, and end-stage renal disease facilities, among others.

Figure 7a. San Diego County Facilities by Type.



Sources: 1.) County of San Diego, Health & Human Services Agency Public Health Services, Public Health Preparedness & Response, 2.) Office of Statewide Health Planning and Development, and 3.) State of California Department of Social Services, Community Care Licensing Division.

Tuberculosis and Refugee Health

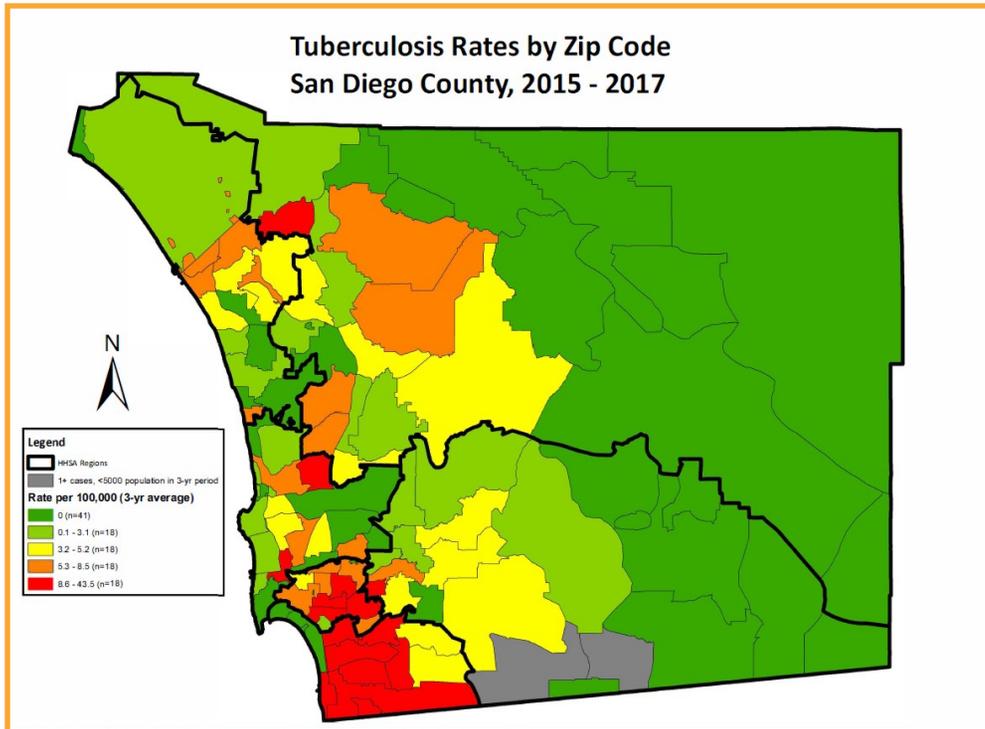
Table 8. Latent Tuberculosis Infection (LTBI).

<p>Health equity priority.</p>	<p>Latent Tuberculosis Infection (LTBI) refers to individuals who are infected with tuberculosis but do not have active disease. However, individuals with LTBI can develop active disease and spread that disease to others. Addressing LTBI is critical to San Diego County’s Tuberculosis Elimination initiative.</p>
<p>Reference in the strategic plan.</p>	<p>Goal 3 in the TBC-RH Strategic Plan is to “Enhance prevention, diagnosis, and treatment of TB disease and latent TB infection.”</p>
<p>Why a priority?</p>	<p>Substantial progress has been made in tuberculosis control (TB) in San Diego County. To build on improving trends, an initiative for TB Elimination has been adopted at both the national, state level, and by the County of San Diego. With gains in TB control, local transmission now accounts for only about 14 percent of cases in California; 6 percent of cases are imported from people who developed TB disease outside the United States; and 80 percent are due to reactivation of latent TB infection (LTBI). This is why a focus on LTBI is a crucial step in achieving the goal of TB elimination. Without treatment, these individuals harbor a 5-10 percent risk of reactivation and progression to active TB disease. Only 25 percent are aware of their infection and only 15 percent have been treated.</p> <p>The human and economic consequences of TB are even more compelling. A TB patient’s inability to work and loss of income affect their family, along with an overall depreciation in quality of life. Eliminating TB also benefits the public and reduces significant costs associated with protecting the public’s health. Direct per-patient costs for all TB cases in California is estimated to be \$31,000 for drug susceptible TB and \$115,000 for multidrug-resistant TB. Every \$1 of investment in TB prevention is estimated to result in \$12 in savings, according to the Centers for Disease Control and Prevention.</p>
<p>Looking across the health equity lenses.</p>	<p>The rate of tuberculosis (TB) in San Diego County has been consistently higher than reported TB rates in California and the nation between the years of 2011 and 2018. (Rates reported here are per 100,000.) TB rates were higher among non-U.S. born (22.7) compared with U.S. born (2.5) and varied by birth country (see Figure 8b). Below are the rates in terms of:</p> <ul style="list-style-type: none"> • Gender: Males had a higher rate of reported TB than females (7.8 versus 5.7, respectively); • Age: The rates of reported TB increase with age, with the highest TB rates in those over the age of 65 (13.5), followed by those aged 45-64 (7.2); • Geography: Between 2015 and 2017, rates of TB were highest in the South and Central Regions of the County. TB cases born outside of the United States comprised 72 percent of San Diego County’s cases. Of the 162 cases born outside the United States, 92 (57%) were from Asia (including 52 from the Philippines, and 19 from Vietnam), 54 (33%) were from Mexico, and four (2%) were from Africa; • Race/Ethnicity: Asian/Pacific Islanders had the highest rates of reported TB followed by Hispanics (24 and 9.3 respectively).
<p>How is the Branch addressing this health equity priority? (continued on the following page)</p>	<p>The Tuberculosis Control and Refugee Health (TBCRH) program has several ways in which it plans to address LTBI. These include finding and engaging individuals and populations at risk for LTBI using epidemiologic profiles, focusing testing resources on high-risk populations while reducing testing of low risk populations, and maximizing initiation and completion of LTBI treatment through the use of short-course medication regimens.</p>

Table 8 Continued. Latent Tuberculosis Infection (LTBI).

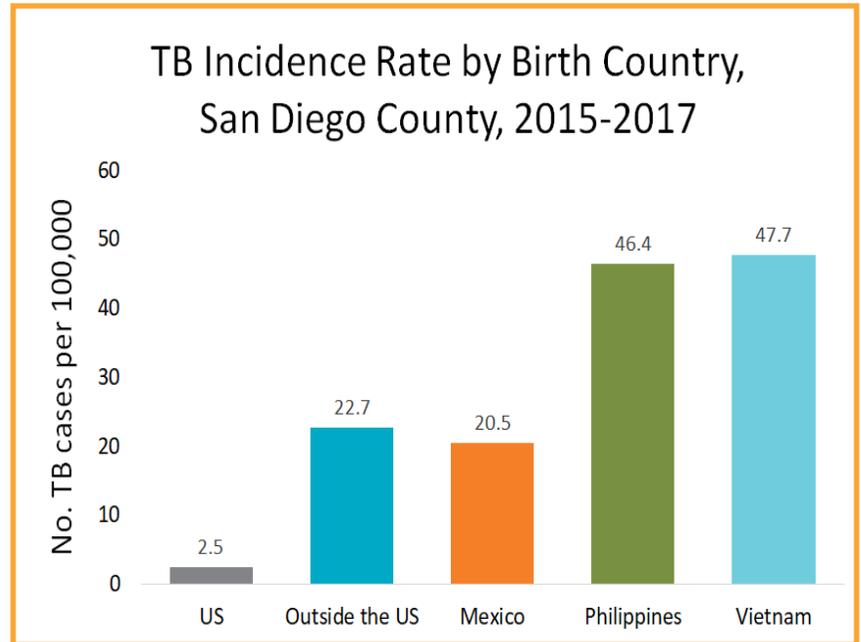
<p>How is the Branch addressing this health equity priority? <i>(continued from previous page)</i></p>	<p>The Branch currently employs a multi-disciplinary, team-based approach to case and contact management. It ensures that contacts to persons with infectious TB are evaluated, and that those with LTBI initiate and complete treatment. Several Quality Improvement projects have been conducted that seek to improve treatment initiation among persons with LTBI, including streamlining contact investigation reviews so that staff resources are more effectively spent on follow-up activities.</p>
<p>What does the data show?</p>	<p>TB incidence rates are highest in the South and Central Regions of the County (Figure 8a). TB incidence rates are higher among persons born outside the U.S. compared with U.S.-born persons (Figure 8b).</p>

Figure 8a. Tuberculosis Rates by Zip Code.



Source: Report of Verified Case of Tuberculosis, Tuberculosis Control and Refugee Health Branch, Public Health Services, Health and Human Services Agency, County of San Diego.

Figure 8b. Tuberculosis Incidence Rate by Birth Country.



Source: TB Registry, Tuberculosis Control and Refugee Health Branch, Public Health Services, Health and Human Services Agency, County of San Diego.

Public Health Services Strategic Plan 2019-2021

Appendix II-Initiatives

Public Health Services has designed a visual framework of the key initiatives that address emerging trends and challenging issues that often cut across other County of San Diego departments (*Figure 1*). In some cases, these initiatives engage the entire County of San Diego and several community partners. Just as with *Live Well San Diego*, these initiatives reflect a collective impact approach that bring stakeholders together to accomplish what one organization alone could not do. In fact, Public Health Services finds that the collective impact approach makes sense for the department's many high-level priorities, including its recent work to eliminate infectious diseases (e.g., Getting to Zero, Hepatitis C Elimination, and Tuberculosis Elimination).

The visual framework on the next page shows how each of these initiatives aligns with the County of San Diego Strategic Plan's Strategic Initiatives and the *Live Well San Diego* vision of a region that is *Building Better Health*, *Living Safely*, and *Thriving*. Public Health Services uses this framework as a roadmap to advance the County of San Diego's priorities to achieve key goals and outcomes. The framework categorizes initiatives into three different types: 1) Board of Supervisors; 2) Combination of Chief Administrative Officer, Countywide, Health and Human Services Agency, or Public Health Services; and 3) Public Health Services. Some of the initiatives are in italics to identify sub-projects related to the respective Initiative. Using a Comprehensive Plan, PHS monitors progress and outcomes on these initiatives.

County of San Diego Strategic Initiatives



Building Better Health



Living Safely



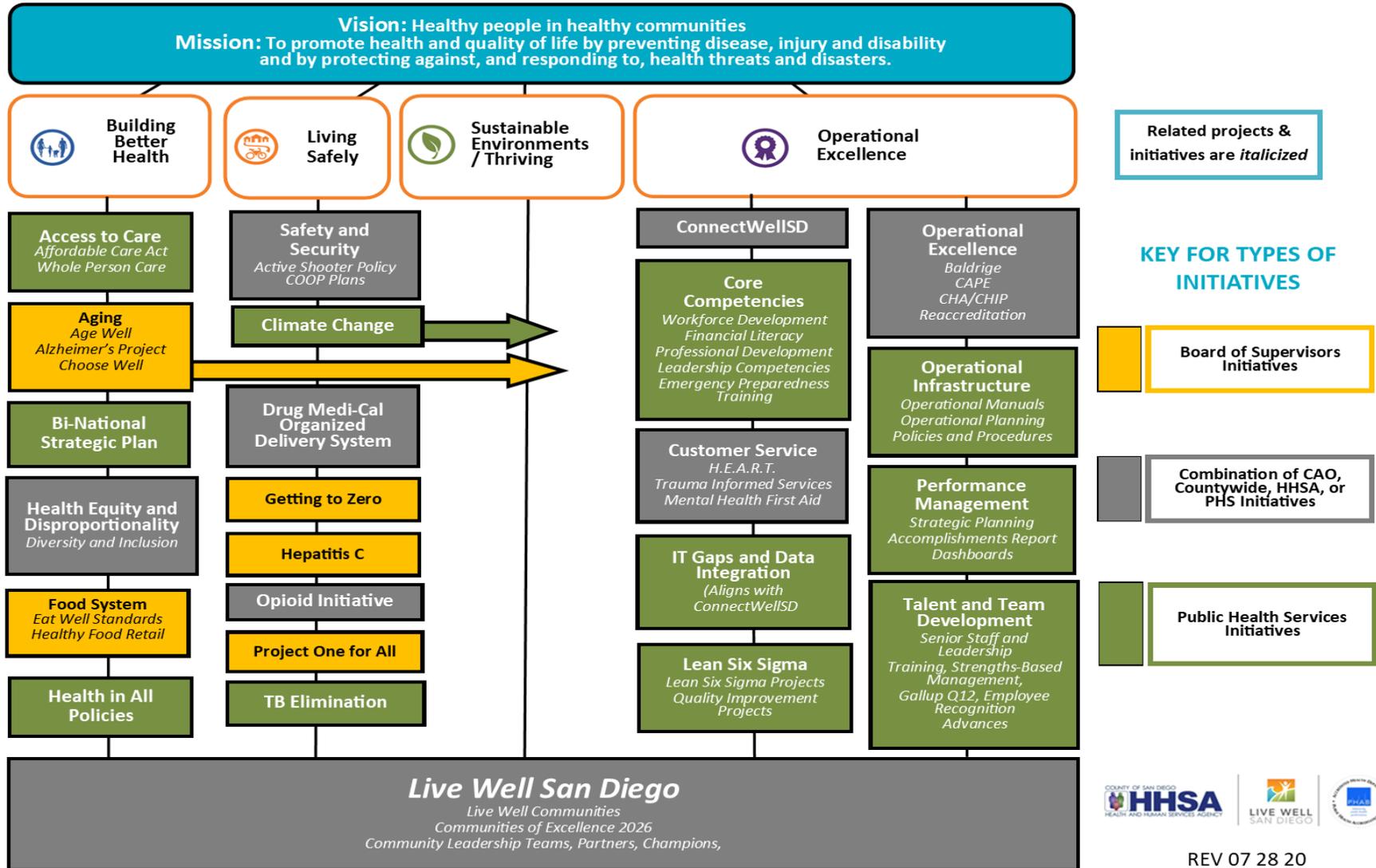
**Sustainable Environments/
Thriving**



Operational Excellence

Figure 1. Public Health Services Strategic Framework Map FY 2019-2021.

County of San Diego Health and Human Services Agency, Public Health Services Strategic Plan Framework Map FY 2019-2021



Public Health Services Strategic Plan 2019-2021

Appendix III-Alignment to Community Health Improvement Plan (CHIP) and Regional Community Enrichment Plans (CEPs)

Regional Community Enrichment Plans (CEPs) are intended to provide a strategic framework to address local priorities. CEPs make up the overall *Live Well San Diego* Community Health Improvement Plan and emphasize health in the broadest sense through the social determinants of health. These Plans are developed by Regional Community Leadership Teams (Leadership Teams) within each of the six HHS Regions who engage multiple perspectives so that all community stakeholders – individual citizens, private and nonprofit organizations, government agencies, academic institutions, and community- and faith-based organizations – can unite to ensure San Diegans are healthy, safe and thriving. Because these plans represent goals of the community teams, they are modified and adjusted as conditions, resources, and external environmental factors change. The tables in this appendix below show the linkages between the PHS Strategic Plan and the Regional CEPs. To learn more about the Leadership Teams in the Regions, please go [here](#) (LiveWellSD.org / Community / Community Leadership Teams). To learn more about NACCHO’s Mobilizing for Action MAPP process which was followed in order to develop the Regional CEPs, please see the Introduction of this Plan or go [here](#) (NACCHO.org / Education / Mobilizing for Action).

How Regions and PHS Collaborate

Staff across HHS Departments and the Regions meets regularly to promote stronger communication, collaboration and coordination. Meetings are held bi-monthly at which community engagement staff in the HHS Regions, program staff in Public Health Services, and subject matter expert staff from other departments across the HHS and County enterprise attend—including Aging & Independence Services; Behavioral Health Services; and Housing & Community Development Services. These meetings are called “Program Threading” meetings as they represent “threading” of program ideas to advance the *Live Well San Diego* vision of healthy, safe and thriving communities. These meetings facilitated the “threading” or coordination of the development of the CEPs for each of the six HHS Regions, as well as informed the development of this new Public Health Services Strategic Plan. Examples of topics discussed at recent Program Threading meetings are Partner Relay and Climate Change. Partner Relay is a project that involves a network of members to disseminate vital information during emergencies to Limited English Proficient populations. Climate change discussions were held in order to educate staff about the implications to public health and to gather input on strategies for conveying this information to San Diego County communities. In addition to “threading” discussions, PHS is an important source of technical assistance to Regions, and provide contracted staff with grant funding to support community change efforts.



How the PHS Strategic Plan and the Regional CEPs are Linked

The tables on the following pages show that there are several Branch goals in the PHS Strategic Plan that are linked to priorities, goals and objectives in the Regional CEPs. This shows how the work that PHS does is very much tied to what is happening in the Regions.

- For example, Maternal Child and Family Health Services (MCFHS) has goals to promote early detection and prevention of disease and disabilities for at-risk populations. Epidemiology and Immunizations Branch (EISB) has goals related to promoting immunizations and reducing childhood lead poisoning. These preventive health activities are also being advanced at the regional level in the East and North Central Regions and this is called out in their CEPs.
- MCFHS also has a goal to prevent chronic disease—primarily through policy, systems and environmental change efforts—to create healthy environments for residents in all San Diego communities. Every Regional CEP has adopted objectives to advance the same goal. The Regional CEP objectives reflect a wide range of innovative approaches, including increasing access to healthy foods through *Live Well Community Markets*; conducting outreach and enrollment in federal nutrition programs; and increasing opportunities for physical activity by promoting active transportation options, including walking and biking.
- The Public Health Preparedness and Response (PHPR) Branch has a goal to foster collaboration with health systems to respond, monitor, and plan for public health threats. In addition, the PHS Admin has a goal to develop a pipeline for the future public health workforce that supports the North County Regions and South Region Leadership Team goals.



CEPs Link to Other HHS and County Programs, Which Also Advance the Public's Health

These Regional CEPs capture many objectives that advance public health even if not called out specifically in the PHS Strategic Plan. For example, all of the Regions are undertaking activities to promote awareness and access to behavioral health resources and/or reducing illegal access to substance, particularly among youth. Regional CEPs reflect recognition of the impact of trauma and are increasing the knowledge of residents and community partners of the importance of trauma-informed approaches and services.

Crime prevention objectives are incorporated in several Regional CEPs, particularly for the Central Region and North County Regions, the latter with a focus on addressing gang activity. Most of the Regions have adopted objectives that are in line with the Age Well San Diego initiative to improve the quality of life for seniors, including their access to health care, housing, and



other resources. Regions are also coordinating intergenerational recreation activities that align with this initiative. These CEPs also reflect objectives related to civic life or engagement, such as promoting volunteerism and the development of local leaders through Resident Leadership Academies (RLAs). These RLAs are designed to help these leaders implement innovative approaches to reduce chronic disease within communities. Newer avenues of efforts are reflected in CEP objectives calling for education and advocacy on housing and transportation options, and promoting workforce development and economic vitality.



Linkages to Epidemiology and Immunization Services Branch

The East and North Central Regional Leadership Teams have selected goals relevant to the Epidemiology and Immunization Services Branch’s (EISB) Immunization unit and Childhood Lead Poisoning Prevention Program (*Table 1*). EISB supports the Regional Leadership Teams with these goals by ensuring children are immunized in San Diego County by delivering educational presentations to the community, developing health promotion material, and providing vaccination services. In addition, EISB promotes the prevention of lead exposure through outreach and education efforts.

Table 1. Alignment to Regional CEPs and EISB Goals.

PHS Strategic Plan	Alignment to Regional CEPs				
	Central	East	North Central	North County Regions	South
EISB Goal 2: Promote high-quality immunization practices among public and private providers.	---	Goal 6: Increase education and awareness of preventive healthcare services.	Goal 4: Improve access to quality care.	---	---
EISB Goal 5: Reduce childhood lead poisoning through education, outreach, and early identification and treatment of children with elevated blood lead levels.	---	Goal 6: Increase education and awareness of preventive healthcare services.	---	---	---

Linkages to Maternal Child and Family Health Services Branch

All Regional Leadership Teams have selected goals relevant to the Maternal Child and Family Health Services (MCFHS) Branch units and programs, which include the Chronic Disease and Health Equity Unit, Child Health and Disability Prevention Program, Perinatal Care Network Program, and Office of Violence Prevention. (Table 2). MCFHS supports the Regional Leadership Teams with these goals by providing technical assistance on policy, systems, and environmental change efforts relevant to chronic disease, disability, perinatal care, and trauma informed care.

Table 2. Alignment to Regional CEPs and MCFHS Goals.

PHS Strategic Plan	Alignment to Regional CEPs				
	Central	East	North Central	North County Regions	South
MCFHS Goal 1: Create environments and policies that promote health equity and encourage healthy behaviors and healthy communities in order to reduce chronic disease and promote health equity for all residents.	<p>Goal 2: Build resident capacity and leadership through the creation of healthy food choices and accessible food systems.</p> <p>Goal 3: Champion practices and policies that promote a healthy food system.</p>	<p>Goal 3: Support school attendance.</p> <p>Goal 7: Engage communities in civic life opportunities.</p> <p>Goal 9: Advance active living among older adults.</p>	<p>Goal 5: Encourage healthy eating.</p> <p>Goal 7: Create opportunities to be physically active.</p>	<p>Goal 2: Reduce the prevalence of poor nutrition, food insecurity, and hunger among North San Diego County residents.</p> <p>Goal 3: Increase physical activity among North San Diego County residents.</p>	<p>Goal 1: Create smoke/vape-free environments.</p> <p>Goal 3: Increase prosperity, education, and the economy.</p>

Table 2 Continued. Alignment to Regional CEPs and MCFHS Goals.

PHS Strategic Plan	Alignment to Regional CEPs				
	Central	East	North Central	North County Regions	South
<p>MCFHS Goal 1 Continued: Create environments and policies that promote health equity and encourage healthy behaviors and healthy communities in order to reduce chronic disease and promote health equity for all residents.</p>	<p>Goal 6: Enhance civic life by growing local leaders.</p>	<p>Goal 9: Advance active living among older adults.</p> <p>Goal 3: Support school attendance.</p> <p>Goal 12: Increase civic life through participation.</p>	---	<p>Goal 6: Reduce Unintentional Injuries within all Age Groups</p> <p>Goal 8: Identify opportunities for community partners and residents to provide input towards North County transportation efforts.</p>	---
<p>MCFHS Goal 3: Promote early detection and prevention of disease and disabilities of CHDP-eligible children, all children entering first-grade, and high-risk infants in San Diego County.</p>	---	<p>Goal 6: Increase education and awareness of preventive healthcare services.</p>	<p>Goal 4: Improve access to quality care.</p>	---	---

Table 2 Continued. Alignment to Regional CEPs and MCFHS Goals.

PHS Strategic Plan	Alignment to Regional CEPs				
	Central	East	North Central	North County Regions	South
MCFHS Goal 6: Ensure that pregnant women receive appropriate perinatal support and services and infants are born healthy.	---	Goal 6: Increase education and awareness of preventive healthcare services.	Goal 4: Improve access to quality care.	---	---
MCFHS Goal 10: Prevent, reduce, and respond to family violence in San Diego County through trauma-informed practices.	Goal 5: Expand understanding of the impact of trauma to make communities safer.	Goal 2: Increase awareness of the impact of trauma. Goal 4: Decrease stigma around behavioral health.	Goal 1: Increase awareness about the impact of trauma.	Goal 1: Increase awareness and access of mental health resources to North San Diego County residents at earliest point possible.	---

Linkages to Public Health Preparedness and Response Branch

The North County Regions Leadership Team has a goal relevant to the Public Health Preparedness and Response (PHPR) Branch (*Table 3*). PHPR supports the North County Regional Leadership Team with this goal by fostering collaborative efforts with the health system to respond, monitor, and plan for public health threats.

Table 3. Alignment to Regional CEPs and PHPR Goal.

PHS Strategic Plan	Alignment to Regional CEPs				
	Central	East	North Central	North County Regions	South
PHPR Goal 1: Strengthen community resilience to ensure timely assessment and sharing of essential information to reduce exposure to disaster/ public health risk.	---	---	---	Goal 7: Increase disaster preparedness and community recovery efforts.	---

Linkages to Public Health Services Administration Branch

The North County Regions and South Region Leadership Teams have selected goals relevant to the Public Health Services Administration (PHSA) Office (*Table 4*). PHSA supports these Leadership Teams with their goals by collaborating with local universities to onboard students for volunteer or internship experiences and develop a pipeline for the future public health workforce.

Table 4. Alignment to Regional CEPs and PHSA Goal.

PHS Strategic Plan	Alignment to Regional CEPs				
	Central	East	North Central	North County Regions	South
PHSA Goal 5: Ensure that the County and its residents are served by an agile, adaptable, highly skilled, public health workforce.	---	---	---	Goal 10: Leverage partnerships with businesses and local schools in North County to support education and workforce efforts.	Goal 3: Increase prosperity, education, and the economy.

Public Health Services Strategic Plan 2019-2021

Appendix IV-Alignment to National, State, and Local Plans

Live Well San Diego reflects a collective impact approach. This approach embodies the principle that everyone does what they do best to achieve common and mutual goals together. Changes in community health can only be achieved if everyone is working together and leveraging limited resources by doing those things that are shown by the research to have the greatest impact. This is why alignment is so critically important.

This Appendix shows how each Branch Strategic Plan goal aligns with *Live Well San Diego* as well as other State and national health plans and efforts. The Appendix is organized as follows:

Description of Plans

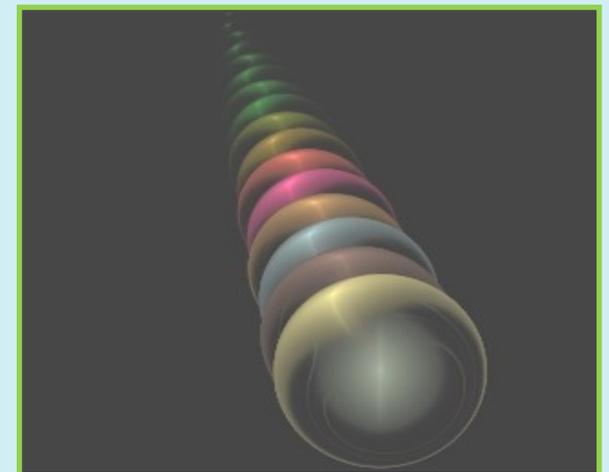
A summary of the content of each of the local, State, and national plans that are part of this analysis for alignment.

Key to Alignment Tables

This key displays all the goals or components for each of the local, State, and national plans to which the Branch Strategic Plans are compared for alignment.

Tables by Branch

The Tables appear by individual Branch. The individual Branch goals are listed in the left hand column, and those components of the local, State and national plans that align to each Branch goal appear in the appropriate right-hand column.



Description of Plans to Which the PHS Strategic Plan is Aligned



Live Well San Diego is the County’s vision for a region that is Building Better Health, Living Safely, and Thriving. This vision harnesses the efforts of individuals, organizations and governments to help all 3.3 million San Diego County residents live well. The *Live Well San Diego* vision is aligned to the County of San Diego Strategic Plan, which has four strategic initiatives: Building Better Health, Living Safely, Sustainable Environments/Thriving, and Operational Excellence. Public Health Services is an important part of the “backbone” of this collective impact effort and thereby it is essential that its Strategic Plan is aligned with *Live Well San Diego* and the County of San Diego Strategic Plan.



The **10 Essential Public Health Services** describe the public health activities that all communities should undertake. The Essential Services were developed under the auspices of the Centers for Disease Control and Prevention in 1994 to explain what public health is, clarify the role of public health, and provide accountability. The Public Health System is comprised of all public, private and voluntary entities that deliver these Essential Services. Public health accreditation requirements issued by the Public Health Accreditation Board are based on these 10 Essential Services with the addition of two additional domains for administration and governance.



Let’s Get Healthy California is a shared vision for the future health of Californians, reflecting a commitment to become a healthier state through joint efforts in six project goals and key indicators by which to measure progress. The Let’s Get Healthy California Task Force was started in 2012 with the purpose of developing a 10-year plan. Three of the goals capture health across the lifespan; three additional goals capture pathways to health. This is the State’s collective impact effort in which all residents, communities, and organizations are encouraged to participate and to share their innovation.



The National Prevention Strategy, launched by the Surgeon General in 2011, is a guide for the nation to provide the most useful and attainable means for leading a healthy lifestyle. Four Strategic Directions provide a strong foundation for all of our nation’s prevention efforts and include core recommendations necessary to build a prevention-oriented society.



Healthy People 2020 was first unveiled in November 2000 by the U.S. Department of Health and Human Services. The framework provides science-based, 10-year national objectives for improving the health of all Americans. For three decades, Healthy People has established benchmarks and monitored progress over time. Healthy People 2020 was launched in December 2010 and the development of Healthy People 2030 is underway. Healthy People 2020 contains 42 topic areas with more than 1,200 objectives. A smaller set of objectives are referred to as the Leading Health Indicators to which this PHS Strategic Plan is aligned.

Table 1. Key to Alignment Tables

<p>Branch Name</p> <p>GOALS</p>	<p><i>Live Well San Diego</i></p>  <p>LIVE WELL SAN DIEGO</p>	<p>10 Essential Public Health Services</p> 	<p>Let's Get Healthy California</p> 	<p>National Prevention Strategy</p> 	<p>Healthy People 2020</p>  <p>Only topics for Healthy People 2020 Leading Health Indicators are listed in this legend.</p>
<p>Goals of Branch are listed here</p>  <p>Building Better Health</p>  <p>Living Safely</p>  <p>Sustainable Environments/Thriving</p>  <p>Operational Excellence</p>	<p>Monitor Health</p> <p>Diagnose and Investigate</p> <p>Inform, Educate, Empower</p> <p>Mobilize Community Partnerships</p> <p>Develop Policies</p> <p>Enforce Laws</p> <p>Link to/Provide Care</p> <p>Assure Competent Workforce</p> <p>Evaluate</p> <p>Research</p>	<p>Healthy Beginnings</p> <p>Living Well</p> <p>End of Life</p> <p>Redesigning the Health System</p> <p>Creating Healthy Communities</p> <p>Lower the Cost of Care</p>	<p>Healthy and Safe Community Environments</p> <p>Clinical and Community Preventive Services</p> <p>Empowered People</p> <p>Elimination of Health Disparities</p>	<p>Access to Health Services</p> <p>Clinical Preventive Services</p> <p>Environmental Quality</p> <p>Injury and Violence</p> <p>Maternal, Infant, and Child Health</p> <p>Mental Health</p> <p>Nutrition, Physical Activity, and Obesity</p> <p>Oral Health</p> <p>Preparedness</p> <p>Reproductive and Sexual Health</p> <p>Social Determinants</p> <p>Substance Abuse</p> <p>Tobacco</p>	



**Administration
Public Health
Services
(PHS Admin)**



GOALS

<p>1. Provide leadership that guides the organization, advances health equity for all residents, and establishes an environment for success;</p>		<p>Assure Competent Workforce; Inform, Educate, Empower</p>	<p>Redesigning the Health System</p>	<p>Healthy & Safe Community Environments; Empowered People</p>	<p>Social Determinants</p>
<p>2. Promote strategy development that stimulates innovation, guides operations, and leverages opportunities in order to have the greatest impact;</p>		<p>Inform, Educate, Empower</p>	<p>Redesigning the Health System; Creating Healthy Communities</p>	<p>Healthy & Safe Community Environments</p>	
<p>3. Create a culture of customer service within PHS that enables staff to serve, engage, innovate, and always be responsive to feedback from customers;</p>		<p>Assure Competent Workforce</p>	<p>Redesigning the Health System</p>	<p>Empowered People</p>	
<p>4. Manage data, analytics, and information in a continuous fashion to ensure decisions are evidence-based and data driven;</p>		<p>Evaluate; Research</p>	<p>Redesigning the Health System</p>		
<p>5. Ensure that the County and its residents are served by an agile, adaptable, highly-skilled, public health workforce;</p>		<p>Assure Competent Workforce</p>	<p>Redesigning the Health System</p>	<p>Empowered People</p>	
<p>6. Design, manage, improve, and innovate work processes to increase operational effectiveness;</p>		<p>Develop Policies; Evaluate</p>	<p>Redesigning the Health System</p>		
<p>7. Monitor and share information that “tells the story” of the contributions of Public Health Services to the collective impact effort of <i>Live Well San Diego</i>;</p>		<p>Evaluate; Research; Monitor Health</p>	<p>Creating Healthy Communities</p>		
<p>8. Maximize Medi-Cal Administrative Activities and Targeted Case Management revenue in compliance with State and Federal regulations; and</p>		<p>Link to/Provide Care</p>	<p>Living Well; Redesigning the Health System; Lower the Cost of Care</p>	<p>Empowered People; Clinical & Community Preventive Services</p>	<p>Access to Health Services</p>
<p>9. Facilitate communication, collaboration, and coordination at the Local, State, and Federal levels in the US and Mexico to address public health issues of mutual concern in the San Diego -Tijuana border region.</p>		<p>Mobilize Community Partnerships; Link to/Provide Care</p>	<p>Creating Healthy Communities</p>	<p>Elimination of Health Disparities</p>	<p>Access to Health Services</p>



CALIFORNIA CHILDREN'S SERVICES (CCS)



GOALS

<p>1. Coordinate efforts to improve health equity in services provided while also encouraging family participation in CCS programs;</p>		<p>Inform, Educate, Empower</p>		<p>Empowered People; Elimination of Health Disparities</p>	
<p>2. Ensure all CCS clients have a medical home and that their care is coordinated;</p>		<p>Inform, Educate, Empower; Link to/Provide Services</p>	<p>Redesigning the Health System</p>	<p>Empowered People</p>	<p>Access to Health Services</p>
<p>3. Ensure optimal utilization of Special Care Center (SCC) Services to improve health outcomes for CCS clients;</p>			<p>Redesigning the Health System</p>		
<p>4. Engage Medical Therapy Program patients in activities to improve their functional level;</p>		<p>Evaluate</p>			
<p>5. Ensure timely transition planning services for CCS clients to promote optimal health and independence once these clients leave the CCS programs; and</p>		<p>Inform, Educate, Empower</p>	<p>Redesigning the Health System</p>	<p>Empowered People</p>	<p>Access to Health Services</p>
<p>6. Promote operational excellence throughout for the benefit of customers and staff alike.</p>					<p>Access to Health Services</p>



EPIDEMIOLOGY AND IMMUNIZATION SERVICES (EISB)



GOALS

1. Promote a comprehensive Immunization Information System (IIS) to the community;		Monitor Health		Clinical & Community Preventive Services	Immunization and Infectious Diseases
2. Promote high-quality immunizations practices among public and private providers;		Diagnose and Investigate		Clinical & Community Preventive Services; Elimination of Health Disparities	Immunization and Infectious Diseases
3. Promote the importance of immunizations throughout the County and monitor coverage across schools and childcare centers;		Monitor Health; Inform, Educate, Empower		Clinical & Community Preventive Services; Elimination of Health Disparities	Immunization and Infectious Diseases
4. Minimize the spread of vaccine-preventable disease through timely investigation of suspect cases;		Monitor Health; Diagnose and Investigate	Healthy Beginnings	Clinical & Community Preventive Services; Empowered People; Elimination of Health Disparities	Immunization and Infectious Diseases
5. Reduce childhood lead poisoning through education, outreach, and early identification and treatment of children with elevated blood lead levels;		Monitor Health; Diagnose and Investigate; Inform, Educate, Empower		Clinical & Community Preventive Services; Elimination of Health Disparities	
6. Provide effective surveillance, investigation and response to protect the community from disease;		Assure Competent Workforce	Healthy Beginnings	Clinical & Community Preventive Services; Empowered People; Elimination of Health Disparities	Clinical Preventive Services
7. Ensure timely and complete reporting of HIV and AIDS cases;		Monitor Health; Diagnose and Investigate; Enforce Laws	Healthy Beginnings	Clinical & Community Preventive Services; Empowered People; Elimination of Health Disparities	Clinical Preventive Services



EPIDEMIOLOGY AND IMMUNIZATION SERVICES (EISB)



GOALS

<p>8. Maintain a state-of-the art laboratory that incorporates the latest tools to support outbreak investigations and operates with the greatest efficiency to protect community health;</p>		<p>Monitor Health; Diagnose and Investigate; Evaluate</p>	<p>Healthy Beginnings</p>	<p>Clinical & Community Preventive Services; Empowered People; Elimination of Health Disparities</p>	<p>Clinical Preventive Services</p>
<p>9. Provide quality training for community death registration stakeholders in the use of Electronic Death Registration System</p>		<p>Monitor Health; Enforce Laws</p>			<p>Maternal, Infant, and Child Health</p>
<p>10. Provide timely and accurate death certificates for grieving families in San Diego County so that they may conduct necessary business after the loss of their loved one;</p>		<p>Monitor Health</p>	<p>End of Life</p>		
<p>11. Provide timely and accurate birth certificates to new parents in San Diego County.</p>		<p>Diagnose and Investigate</p>	<p>Healthy Beginnings</p>		<p>Maternal, Infant, and Child Health</p>



HIV, STD, AND HEPATITIS (HSHB)



GOALS

1. Test- Identify all persons infected with HIV and STDs so that they can be informed and linked to care;		Monitor Health		Empowered People	
2. Treat- Link all persons living with HIV or STDs to treatment services that follow national guidelines;		Link to/Provide Care			Access to Health Services
3. Prevent- Link all persons at risk for HIV and STD infection to prevention resources;		Link to/Provide Care		Clinical & Community Preventive Services	Clinical Preventive Services
4. Engage- Mobilize community efforts to achieve collective impact in reducing HIV and STD transmission; and		Mobilize Community Partnerships			
5. Improve- Continually seek to improve outcomes for all services and activities.		Evaluate	Creating Healthy Communities	Healthy & Safe Community Environments	



Maternal, Child, and Family Health Services (MCFHS)



GOALS

<p>1. Create environments and policies that promote health equity and encourage healthy behaviors and healthy communities in order to reduce chronic disease and promote health equity for all residents;</p>		<p>Inform, Educate, Empower; Develop Policies; Mobilize Community Partnerships</p>	<p>Living Well; Creating Healthy Communities</p>	<p>Healthy & Safe Communities; Clinical & Community Preventive Services; Elimination of Health Disparities; Empowered People</p>	<p>Access to Health Services; Maternal, Infant, and Child Health; Injury and Violence; Environmental Quality</p>
<p>2. Reduce the disproportionate African American infant mortality rate;</p>			<p>Healthy Beginnings</p>	<p>Clinical & Community Preventive Services; Elimination of Health Disparities</p>	<p>Maternal, Infant, and Child Health</p>
<p>3. Promote early detection and prevention of disease and disabilities of CHDP-eligible children, all children entering first grade, and high-risk infants in San Diego County;</p>		<p>Inform, Educate, Empower; Develop Policies; Link to/ Provide Care</p>	<p>Healthy Beginnings</p>		<p>Clinical Preventive Services; Mental Health</p>
<p>4. Enhance parent life-course development and improve pregnancy, child health, development, and safety;</p>		<p>Inform, Educate, Empower; Link to/ Provide Care</p>	<p>Healthy Beginnings</p>	<p>Clinical & Community Preventive Services; Empowered People</p>	<p>Access to Health Services; Oral Health</p>
<p>5. Reduce morbidity and mortality among low-income women and their infants through enhanced prenatal care;</p>		<p>Inform, Educate, Empower; Link to/ Provide Care; Evaluate</p>	<p>Healthy Beginnings; Redesigning the Health System</p>	<p>Clinical & Community Preventive Services; Empowered People</p>	<p>Access to Health Services; Clinical Preventive Services</p>
<p>6. Ensure that children entering kindergarten receive an oral health screening;</p>		<p>Inform, Educate, Empower; Develop Policies; Link to/ Provide Care</p>	<p>Healthy Beginnings</p>	<p>Clinical & Community Preventive Services</p>	<p>Oral Health</p>



**Maternal, Child,
and
Family Health
Services (MCFHS)**



GOALS

7. Strengthen families and improve men's health;		Monitor Health; Diagnose and Investigate	Living Well	Clinical & Community Preventive Services; Empowered People	Clinical Preventive Services
8. Reduce fetal and infant deaths; and		Monitor Health; Diagnose and Investigate	Healthy Beginnings	Clinical & Community Preventive Services; Empowered People	Maternal, Infant, and Child Health
9. Prevent, reduce, and respond to family violence in San Diego County through trauma-informed practices.			Living Well	Healthy & Safe Community Environments	



Public Health Preparedness and Response (PHPR)

GOALS



1. Strengthen community resilience to ensure timely assessment and sharing of essential information to reduce exposure to disaster/		Inform, Educate, Empower; Mobilize Community Partnerships		Healthy & Safe Community Environments	Preparedness
2. Strengthen the incident management framework to ensure earliest possible identification and investigation of an incident as well as timely implementation of intervention and control measures;		Monitor health; Diagnose and Investigate		Healthy & Safe Community Environments	Preparedness
3. Enhance technology, information management, and sharing systems to ensure timely communication of situational awareness and risk information;		Inform, Educate, Empower; Mobilize Community Partnerships		Healthy & Safe Community Environments	Preparedness
4. Facilitate countermeasures and mitigation to ensure continuity of emergency operations management during emergency response and recovery; and		Develop Policies		Healthy & Safe Community Environments	Preparedness
5. Strengthen surge management through timely coordination and support of response activities with partners to ensure timely care.		Mobilize Community Partnerships		Healthy & Safe Community Environments	Preparedness



Tuberculosis Control and Refugee Health (TBC-RH)

GOALS



<p>1. Eliminate TB in San Diego County by continuing to make progress in reducing the incidence of the disease;</p>		<p>Monitor Health; Diagnose and Investigate; Enforce Laws; Link to Services; Evaluate</p>	<p>Redesigning the Health System; Creating Healthy Communities</p>	<p>Clinical & Community Preventive Services; Elimination of Health Disparities</p>	<p>Immunizations and Infectious Diseases</p>
<p>2. Increase awareness of TB risk;</p>		<p>Inform, Educate, Empower</p>	<p>Living Well</p>	<p>Clinical & Community Preventive Services; Elimination of Health Disparities; Empowered People</p>	
<p>3. Enhance prevention, diagnosis, and treatment of TB disease and latent TB infection; and</p>		<p>Link to/Provide Care; Diagnose and Investigate; Mobilize Community Partnerships; Enforce Laws; Evaluate; Assure Competent Workforce</p>	<p>Redesigning the Health System; Creating Healthy Communities</p>	<p>Clinical & Community Preventive Services; Elimination of Health Disparities</p>	<p>Immunizations and Infectious Diseases</p>
<p>4. Improve the health of newly arrived refugees in San Diego County.</p>		<p>Link to/Provide Care; Mobilize Community Partnerships</p>	<p>Living Well</p>	<p>Clinical & Community Preventive Services; Elimination of Health Disparities</p>	<p>Health Related Quality of Life and Well Being</p>

Appendix V-Dashboards

Population Health Indicators Dashboard

The San Diego County Public Health Services utilizes two Dashboards to track key community or population measures. These Dashboards serve slightly different purposes. This explains why, although there is some overlap, the indicators selected for each are different. These include:

- **The Public Health Services Top 10 Population Indicators Dashboard.** This Dashboard was created to meet requirements of the Public Health Accreditation Board (PHAB). PHAB is seeking to collect these data from every health department when submitting for reaccreditation and annually thereafter. The purpose is for PHAB to begin to establish a national database of selected health outcomes and their associated objectives.
- **The *Live Well San Diego* Top 10 Indicators Dashboard.** This Dashboard has been in place for several years and is the primary tool for tracking the long-term progress achieved through the *Live Well San Diego* Initiative.

The Public Health Services Dashboard has outcomes measures that are more directly related to the programs and services of Public Health. For example, this Dashboard includes “HIV Disease Diagnosis Rates” and “Infant Mortality Rates.” The new PHS Dashboard, however, is intentionally aligned to the *Live Well San Diego* vision and is organized by the Areas of Influence.

PHAB will be using the outcome data shared by all the local health departments to validate and/or modify “logic models” which show how activities of accredited public health departments contribute to community health and well-being in the long term. Similarly, the County of San Diego uses the *Live Well San Diego* Indicators to monitor how collectively the many partners across the county are contributing to positive change. There are also many measures that fall under the top 10 Indicators that are part of this shared measurement system.



COMMUNITY



SOCIAL



KNOWLEDGE



STANDARD
OF LIVING



HEALTH





San Diego County Public Health Services Dashboard Top 10 Population Outcome Indicators



	Indicator	Description	<i>We want to increase this</i> <i>We want to decrease this</i>	San Diego County	Central Region	East Region	North Central Region	North Coastal Region	North Inland Region	South Region
HEALTH - Enjoying good health and expecting to live a full life										
 HEALTH	"3-4-50" Percent	Percent of deaths due to the four chronic diseases (cancer, heart disease and stroke, type 2 diabetes, and pulmonary diseases such as asthma). 2016.	↓	53%	53%	54%	51%	52%	52%	55%
	ADRD Death Rate	Alzheimer's Disease and Related Dementias (ADRD) death rate per 100,000 population. 2016.	↓	121.1	82.0	154.2	114.2	126.6	141.6	106.6
	Infant Mortality Rate	Annual Infant Mortality Rate per 1,000 live births. 2016.	↓	3.7	3.8	3.7	3.9	3.4	3.2	4.3
	Infant Mortality Rate	Three-year average Infant Mortality Rate per 1,000 live births. 2013-2015.	↓	4	4.8	5.2	3.3	3.5	3.8	3.8
	HIV Disease Diagnosis Estimates	HIV Disease diagnosis case counts and percentages between 2012-2016 time period.	↓	100% (2,462)	44% (1,081)	10% (237)	13% (326)	8% (198)	6% (136)	19% (480)
KNOWLEDGE - Learning throughout the lifespan										
 KNOWLEDGE	High School Education	Overall Graduation Rate: the percentage of those over the age of 25 with a high school diploma or equivalent. 2017.	↑	86.1%	79.4%	87.8%	95.2%	88.3%	86.0%	77.3%
STANDARD OF LIVING - Having enough resources for a quality life										
 STANDARD OF LIVING	Unemployment Rate	Percent of the total labor force that is unemployed (actively seeking employment and willing to work). 2018.	↓	3.9%	4.6%	4.8%	3.0%	3.5%	3.2%	5.1%
	Income Inequality	Number of Total Earned Income Tax Credits. 2017 tax year.	↓	7,059	1,811	1,104	1,300	738	857	1,249
	Poverty	Percent of the population below poverty level. 2017.	↓	13.4%	20.6%	13.2%	10.4%	10.7%	10.6%	15.4%
COMMUNITY - Living in a clean and safe neighborhood										
 COMMUNITY	Childhood Lead in Schools	The number of cases San Diego Childhood Lead Poisoning Prevention Program. 2009-2013.	↓	105	33	11	9	20	16	15
SOCIAL - Helping each other to live well										
 SOCIAL	Voting	Percent of the population who voted in a Federal/State/Local election in the last 12 months. 2018.	↑	43.8%	35.7%	45.1%	49.5%	46.1%	46.9%	37.0%

■ On the right track
 ■ Not on track
 ■ No change

To view more information about the *Live Well San Diego* Indicators and how we will measure progress, go to: http://www.sdcounty.ca.gov/hhsa/programs/sd/live_well_san_diego/indicators.html





Live Well San Diego Dashboard Top 10 Population Outcome Indicators



Indicator	Description	<i>We want to increase this</i> ↑ <i>We want to decrease this</i> ↓	San Diego	Central	East	North	North	North	South
			County	Region	Region	Central	Coastal	Inland	Region
HEALTH - Enjoying good health and expecting to live a full life									
	Life Expectancy	Average number of years a person is expected to live at birth. 2016.	↑ 82.1	80.9	79.5	84.1	83.3	82.7	81.7
	Quality of Life	Percent of the population 18 and older, not residing in nursing homes or other institutions, that is sufficiently healthy to be able to live independently. 2017.	↑ 94.9%	95.0%	93.2%	96.2%	95.5%	95.1%	93.9%
KNOWLEDGE - Learning throughout the lifespan									
	Education: High School Diploma or Equivalent	Overall Graduation Rate: the percentage of those over the age of 25 with a high school diploma or equivalent. 2017.	↑ 86.1%	79.4%	87.8%	95.2%	88.3%	86.0%	77.3%
STANDARD OF LIVING - Having enough resources for a quality life									
	Unemployment Rate	Percent of the population that is unemployed. 2018.	↓ 3.9%	4.6%	4.8%	3.0%	3.5%	3.2%	5.1%
	Income: Percent of population spending less than 1/3 of income on housing	Percent of the population spending less than 1/3 of their income on housing. 2016.	↑ 52.9%	48.0%	53.7%	56.3%	53.2%	54.2%	50.8%
COMMUNITY - Living in a clean and safe neighborhood									
	Security: Overall crime rate	Overall Crime rate per 100,000 population. 2017.	↓ 2032.6	N/A	N/A	N/A	N/A	N/A	N/A
	Physical Environment: Air Quality	Percent of days rated unhealthy for vulnerable populations. 2018.	↓ 6.1%	N/A	N/A	N/A	N/A	N/A	N/A
	Built Environment: Percent of population living within 1/4th a mile of a park or community space	Percentage of population that resides within a quarter mile of a park or community space. 2018.	↑ 61.3%	78.1%	51.5%	70.2%	50.8%	41.5%	77.4%
SOCIAL - Helping each other to live well									
	Vulnerable Populations: Food Insecurity	Percent of adult population 200% below FPL not able to afford food. 2017. <i>*indicates statistically unstable estimates. Proceed with caution.</i>	↓ 37.6%	39.8%	37.5%*	31.6%	35.5%	38.3%	40.1%*
	Community Involvement: Volunteerism	Percent of residents who volunteer. 2017.	↑ 25.5%	N/A	N/A	N/A	N/A	N/A	N/A

■ On the right track
 ■ Not on track
 ■ No change

To view more information about the *Live Well San Diego* Indicators and how we will measure progress, go to: http://www.sdcounty.ca.gov/hhsa/programs/sd/live_well_san_diego/indicators.html



Last Updated: June 2018.

Public Health Services Strategic Plan 2019-2021

Appendix VI-Conformity to Public Health Accreditation Requirements

The Public Health Accreditation Board (PHAB) is the accrediting organization for public health departments. Public Health Services was accredited on May 17, 2016, and will apply for reaccreditation in 2021, to demonstrate the health department continuously meets nationally recognized standards in providing the 10 Essential Public Health Services to the community. The table below demonstrates how the PHS Strategic Plan aligns to the PHAB reaccreditation standards (*Table 1*).

Table 1. Consistent with Strategic Planning Requirements for Reaccredited Public Health Departments.

Reaccreditation Measure	Requirements	Guidance	Alignment to PHS Strategic Plan
Measure 5.3: The health department is guided by a department strategic plan that is revised as the department priorities are achieved or adjusted.	Requirement 1: Implementation of the strategic plan is tracked and the plan is revised, as needed.	a. A description of how the health department's staff at various levels and across the department are engaged with a shared responsibility to implement and update the strategic plan.	Executives work with their staff to implement goals, strategies, and objectives for their individual Branch Plans. All PHS staff are held accountable for implementing relevant strategic plan goals, strategies, and objectives. Annually, PHS Administration coordinates a Strategic Review for the department. Branch Chiefs convene their staff to participate in the Strategic Review, gathering their input on key trends and challenges and ideas for updating objectives and Operational Plan performance measures. Every third year, a more in-depth strategic planning process is conducted, in accordance with the MAPP cycle, as described in the Introduction. Staff at all levels are engaged through a comprehensive strategic planning effort that builds on the Strategic Review, and includes workshops that focus on specific priorities—such as health equity, climate change, or operational excellence.
		b. A description of how the implementation of the plan is tracked.	The plan is tracked every quarter as staff provides updates on metrics for their Branch Plans. The results for these metrics are entered into scorecards for each Branch Plan. Key measures are tracked in a special dashboard created for the County's two-year Operational Plan and made available to the public. A quarterly flash report is assembled to monitor performance, with special focus on those goals in which targets are not being achieved. The flash report is disseminated to all staff at PHS.
		c. A description of the process for reassessing and revising department priorities	PHS department priorities are reassessed and revised at the end of the fiscal year during the annual Strategic Review process. PHS Administration conducts an environmental scan to assess trends and a SWOT analysis, and identifies strategic advantages and challenges with input from the Branches during meetings with staff that each Branch convenes. New priorities are selected for the department as a product of the Strategic Review. Every three years, following the MAPP cycle, PHS conducts a more in-depth strategic planning process to identify new priorities and aligns these priorities to the CHIP and CEPs.

Table 1 Continued. Consistent with Strategic Planning Requirements for Reaccredited Public Health Departments.

Reaccreditation Measure	Requirements	Guidance	Alignment to PHS Strategic Plan
<p>Measure 5.3 Continued</p>	<p>Requirement 1 Continued</p>	<p>d. A description of how unanticipated changes in priorities, level of resources, and/or opportunities are factored into strategic plan implementation/revision.</p>	<p>The County conducts an annual Budget Build process in the Spring to plan for anticipated and unanticipated funding and staffing resources for the upcoming fiscal year that starts in July, which is incorporated into the County’s two-year Operational Plan. When significant changes are made to funding, staffing, and services, PHS staff reflect these changes in their Branch plans when assessing updates at the end of the fiscal year. A description of the PHS financial resources is included in Appendix VII.</p>
		<p>e. A description of the process for reviewing and updating the plan.</p>	<p>Every year the two-year County Operational Plan is refreshed for the forthcoming fiscal year. About 15 PHS measures are captured in the County Operational Plan because these reflect core functions. These key measures are reviewed annually and the review engages all PHS staff and executives, and even Agency executives who review measures across all departments. The PHS Strategic Plan, by contrast, includes more than one hundred metrics which are reviewed altogether every third year to align with the MAPP process. As part of the workshops, the Branch Chiefs are asked to work with their staff to assess if a goal, strategy, or objective should be added, removed, or changed.</p>
<p>Measure 5.3: The health department is guided by a department strategic plan that is revised as the department priorities are achieved or adjusted.</p>	<p>Requirement 2: Department strategic plan</p>	<p>a. Strategic priorities.</p>	<p>PHS follows a set of aligned priorities that capture <i>Live Well San Diego</i> vision, the County strategic priorities, strategic priorities reflected in each PHS Branch plan as well as Initiatives that cut across all of the Branches (see Appendix II). Some Branches strategic plans use cross-cutting goals that reflect major areas of effort; where as some Branches organize their goals by individual program or a combination. Alignment of the PHS Strategic Plan to National, State, and local plans appears in Appendix IV.</p>
		<p>b. Goals and objectives with measurable time-framed targets.</p>	<p>Virtually every objectives has a measurable target. There are a few objectives that are qualitative in nature and thereby results are captured in terms of degree of completion or in some other qualitative fashion. Individual goals with objectives and metrics for each of the Branches typically have one year targets. There are exceptions, particularly for goals and objectives that related to Policy, Systems, and Environmental (PSE) changes because the horizon for change is longer.</p>
		<p>c. Consideration of agency infrastructure and capacity required for efficiency and effectiveness. Examples include: information management, communication (branding), workforce development, financial stability, etc.</p>	<p>The Public Health Services Administration provides support to all Branches and staff in the department. The strategic plan for the Administration Branch organizes the goals according to Baldrige Performance Excellence Criteria. The intent is to help guide PHS staff to aspire toward the highest level of excellence. It also reflects the success of HHSA in obtaining Baldrige recognition in 2018. These criteria cover all areas reflecting infrastructure and capacity to achieve operational excellence. More on this can be found in the PHS Administration Strategic Plan.</p>
		<p>d. The identification of changing or emerging trends that affect the effectiveness and/or strategies of the health department.</p>	<p>As part of the annual Strategic Review, changing and emerging trends are identified and discussed among all staff at various Branch levels and other meetings. In addition, PHS holds annual “Advances” (terminology used at HHSA for “retreats”) each Fall with Branch Chiefs, Public Health Leaders, and Senior Managers. These Advances are intended to get senior staff thinking about the future and include exercises such as environmental scans, SWOT analysis, analysis of emerging trends, and dialogue about forces of change.</p>
		<p>e. A description of how the strategic plan links to the Community Health Improvement Plan.</p>	<p>Through regular meetings between PHS program staff and regional teams, opportunities to collaborate are identified and this contribute to linkages of the respective plans. In this MAPP cycle, there were several areas of alignment including—preventive health care; policy, systems, and environmental change efforts to address chronic disease; emergency preparedness; and public health workforce development. See Appendix III.</p>

Public Health Services Strategic Plan 2019-2021

Appendix VII-Financial and Organizational Information

The Public Health Services (PHS) two-year budget for Fiscal Years 2018-2020 was adopted by the County of San Diego Board of Supervisors (BOS) and provides \$106.3 million in year one and \$109.5 million in year two, to support programs and services. The PHS budget is comprised of various funding sources, including Federal, State, County general funds, and reimbursements. The funding is allocated among the six PHS programmatic Branches and the PHS administrative Branch.

The budget is reviewed on an annual basis by the BOS, Chief Administrative Officer (CAO), Health and Human Services Agency (HHS) executive and budget offices, and the PHS administrative Branch. Financial monitoring is performed by the Branches during the fiscal year, and expenditure and revenue projections are prepared quarterly. Projections are made to compare current fiscal year to date spending with their budgets. PHS also prepares a budget annually to determine the funding allocations for each Branch. This section includes staffing and budget information by PHS Branch for Fiscal Years 2018-20.

Staffing levels have increased by about 5 percent from FY 2018-19 to FY 2019-20 when there will be 490 total staff positions. California Children's Services and Epidemiology and Immunizations Services have the most staff; HIV, STD and Hepatitis and Maternal, Child and Family Health Services received the largest percentage increase in staff compared to the other Branches.

All budget information provided does not include the Medical Care Services Division, Regional Public Health Centers or the County Services Areas. This explains differences between these numbers and those that appear in the County Operational Plan.

Note: The expense and revenue appropriations contained in this budget were valid at the time it was produced. The current approved budget will vary based upon mid-year adjustments as authorized by the BOS.



Table 1. Public Health Services Staffing by Branch.

	Fiscal Year 2018-19 Adopted Budget	Fiscal Year 2019-20 Adopted Budget	% Change
Administration	30.00	29.00	-3.33%
California Children's Services	138.25	141.75	2.53%
Epidemiology and Immunization Services	109.00	111.00	1.83%
HIV, STD and Hepatitis	48.00	55.00	14.58%
Maternal, Child and Family Health Services	58.00	66.00	13.79%
Public Health Preparedness and Response	19.00	20.00	5.26%
Tuberculosis Control and Refugee Health	62.25	67.25	8.03%
Total	464.50 FTE's	490.00 FTE's	5.49%

Table 2. Public Health Services Budget by Branch.*

	Fiscal Year 2018-19 Adopted Budget	Fiscal Year 2019-20 Adopted Budget	% Change
Administration	\$ 7,245,129	\$ 9,876,332	36.32%
California Children's Services	\$ 21,803,184	\$ 21,922,883	0.55%
Epidemiology and Immunization Services	\$ 23,392,286	\$ 24,458,725	4.56%
HIV, STD and Hepatitis	\$ 22,149,114	\$ 21,765,332	-1.73%
Maternal, Child and Family Health Services	\$ 16,009,101	\$ 15,853,666	-0.97%
Public Health Preparedness and Response	\$ 5,315,206	\$ 4,521,954	-14.92%
Tuberculosis Control and Refugee Health	\$ 10,392,979	\$ 11,194,357	7.71%
Total	\$ 106,306,999	\$ 109,593,249	3.09%

**The budget information does not include the Medical Care Services Division, Regional Public Health Centers, or the County Service Areas.*

Table 18. Public Health Services Budget by Categories of Expenditures.

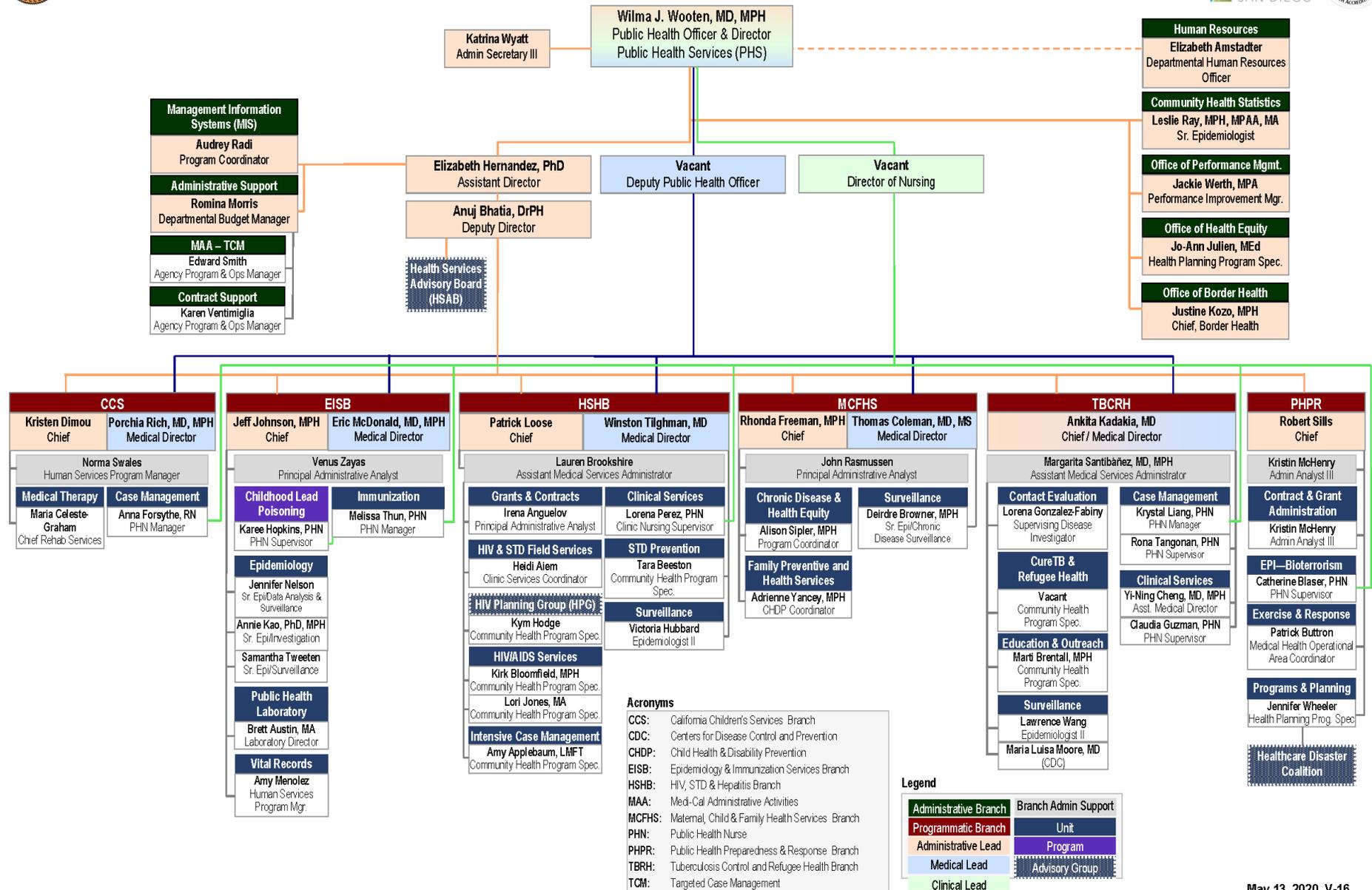
	Fiscal Year 2018-19 Adopted Budget	Fiscal Year 2019-20 Adopted Budget	% Change	Fiscal Year 2020-21 Recommended Budget
Salaries & Benefits	\$ 59,725,545	\$ 62,659,475	4.91%	\$ 65,404,845
Services & Supplies	\$ 42,835,226	\$ 44,397,546	3.65%	\$ 39,686,384
Other Charges	\$ 3,448,228	\$ 2,448,228	-29.00%	\$ 2,448,228
Capital Assets Equipment	\$ 298,000	\$ 88,000	-70.47%	\$ 88,000
Total	\$ 106,306,999	\$ 109,593,249	3.09%	\$ 107,627,457

Table 19. Public Health Services Budget by Categories of Revenues.

	Fiscal Year 2018-19 Adopted Budget	Fiscal Year 2019-20 Adopted Budget	% Change	Fiscal Year 2020-21 Recommended Budget
Licenses, Permits & Franchises	\$ 80,000	\$ 80,000	0.00%	\$ 80,000
Intergovernmental Revenues	\$ 92,926,303	\$ 96,067,535	3.38%	\$ 94,201,743
Charges for Current Services	\$ 3,124,785	\$ 3,427,793	9.70%	\$ 3,327,793
Miscellaneous Revenues	\$ 1,103,490	\$ 447,100	-59.48%	\$ 447,100
Other Financing Sources	\$ 150,000	\$ 150,000	0.00%	\$ 150,000
General Purpose Revenue Allocation	\$ 8,922,421	\$ 9,420,821	5.59%	\$ 9,420,821
Total	\$ 106,306,999	\$ 109,593,249	3.09%	\$ 107,627,457



ORGANIZATIONAL CHART



County of San Diego
Health and Human Services Agency
Public Health Services

Public Health Services Strategic Plan

2019-2021



Health Services Complex
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