Public Health Services

Strategic Plan

FY 2023-24 and FY 2024-25

COUNTY OF SAN DIEGO
HEALTH AND HUMAN SERVICES AGENCY

LIVE WELL SAN DIEGO

Accredited Health Department
PHAB
Advancing Public Health Performance
Public Health Accreditation Board

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Message from the Public Health Officer

Dear Reader,

On behalf of the Department of Public Health Services (PHS), County of San Diego Health and Human Services Agency (HHSA), I am proud to present the Public Health Services Strategic Plan FY 2023-24 and 2024-25. The goals, strategies, and objectives of this two-year plan 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.

In FY 2022-23, PHS has been engaged in the ongoing COVID-19 pandemic response, followed by Monkeypox (MPOX), and the Triple Pandemic (influenza, COVID-19, and respiratory syncytial virus). The County has applied innovative strategies developed during the COVID-19 pandemic to these other outbreaks and incidents to keep San Diegans safe and address inequities by focusing on communities at greatest risk. For the MPOX local health emergency declared in August 2022, special attention was made to enlist the LGBTQ+ community; the County team met regularly with sector partners; and multiple sites were established for vaccine distribution and establishing new contracts to provide hands-on safety net services. This local health emergency for MPOX was allowed to expire on November 10, 2022; and the end of the County's 3-year-long emergency declaration for COVID-19 was announced on February 28, 2023.

This plan captures not only a wide array of objectives for each of the seven Branches, it also reflects a focus on health equity and community engagement, long-standing priorities for PHS but a renewed emphasis across the nation based on the lessons from the pandemic. Each Branch plan sets forth a population health goal and a health equity goal. Each plan features a "story" of the work to advance the health equity goal by weaving together how Branch operations and objectives, partners and shared strategies are bringing about positive change in the community. This plan advances *Live Well San Diego*, a regional vision to build better health, live safely, and thrive. The plan also aligns with County, HHSA, and PHS initiatives and reflects the content of new County and Agency strategic plans with their emphasis on sustainability, equity, community, and justice, along with the empowerment of the workforce. This plan is also aligned with plans at the federal and state levels and captures PHS efforts to assist in the development of the Community Enrichment Plans (that together comprise the County-wide Community Health Improvement Plan), which are expected to be finalized by Winter of 2023.

This is an exciting time for public health as there is a national commitment to strengthen the workforce, expand capacity, and rebuild the infrastructure after an very challenging period of time. PHS, achieved public health accreditation in 2016, and was reaccredited on August 21, 2023. We will continue to build on lessons from the pandemic, including the vital importance of strong communication and collaboration with partners with a focus on equity. I welcome your ideas and feedback on this plan and so appreciate your interest and support for a healthier, safer and thriving county.

Wilma J. Wooten, M.D.

Wilma J. Wooten, M.D., M.P.H.
Public Health Officer, Public Health Services

San Diego County

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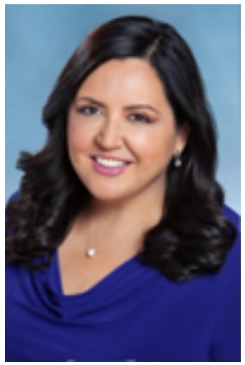

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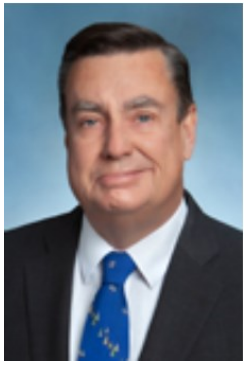

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Vision, Mission, and Values

County of San Diego

VISION: A just, sustainable future, and resilient future for all.

MISSION: Strengthen our communities with innovative, inclusive, and data-driven services through a skilled and supported workforce.

VALUES: Integrity, Equity, Access, Belonging, Excellence, and Sustainability.

Health and Human Services Agency

VISION: A region that is Building Better Health, Living Safely, and Thriving to advance a just, sustainable, and resilient future for all.

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

VALUES: Integrity, Equity, Access, Belonging, Excellence, and Sustainability

Public Health Services

VISION: Healthy People in Healthy and Equitable Communities.

MISSION: To promote health and improve quality of life by

- Preventing disease, injury, and disability
- And by protecting against, and responding to, health threats and disasters.

VALUES: Diversity, Respect, Collaboration, Responsiveness, Transparency

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

Introduction

Since 1850, San Diego County has a history of over 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 that is family-focused and community-based.

PHS as Part of an Integrated Structure of HHSA

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. The HHSA structure continues to evolve in order to responsive to changing trends and needs.

Currently, HHSA includes eight service departments: 1) Aging and Independence Services; 2) Behavioral Health Services; 3) Child and Family Well-Being, a new department as of February 2023, that integrates Child Welfare Services and First 5 San Diego; 4) Homeless Solutions and Equitable Communities (HSEqC), a new department as of July 2021; 5) Housing and Community Development Services; 6) Medical Care Services, created in 2017-18 to focus on many facets of clinical operations across HHSA; 7) Public Health Services; and 8) Self Sufficiency Services, which includes the Office of Military and Veterans Affairs. Some departments have different governance structures, such as the In-Home Supportive Services (IHSS) Public Authority. IHSS is a part of HHSA, however, as a public authority, IHSS is overseen by the Board of Supervisors. The First 5 San Diego Commission, now part of the new department Child and Family Well-Being, is governed by a Commission that includes a member of the Board of Supervisors, the Director of HHSA, and the Public Health Officer. HSEqC was formed as a result of key concerns about equity, which the COVID-19 pandemic elevated, and an emphasis on strategic and innovative approaches to address these persistent challenges. Currently, HSEqC coordinates service delivery and community engagement efforts in the Regions, whereas these duties were previously performed by Regional Directors and their regional staff.

The five administrative support departments (Agency Compliance Office; Agency Contract Support; Human Resources; and Information Technology Services) play an important role, providing essential support to HHSA's eight operational departments. The fifth department is the Agency Budget Office which is led by the Chief Financial Officer who reports directly to the Agency Director and Chief Operations Officer. These administrative support functions contribute to the operational excellence essential to advancing the *Live Well San Diego* vision.

Introduction

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 with an emphasis on supporting the community.

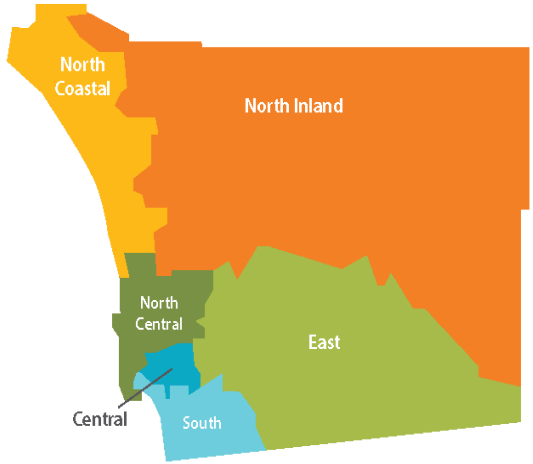
There are six (6) regions that cover the expanse of the county—Central, East, North Central, North Coastal, North Inland, and South Region. North Coastal and North Inland Regions are administratively combined, with one Community Leadership team (CLT) that captures community voice to inform planning and service delivery, making it five (CLTs) for six regions. Since July 2021, the new (HSEqC), specifically the Office of Equitable Communities within HSEqC, coordinates service delivery and community engagement efforts in the regions, whereas these duties were previously performed by Regional Directors and their regional staff *(Figure 1)*.

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 the annual planning process, and align with the County of San Diego Strategic Plan.

Recently, the GMS was "re-imagined" to help ensure that the County management system adapts to changing priorities and conditions. At the core of the GMS is Community Engagement, based on the principle that "all that we do should be for, and created in partnership with, the people we serve." The outer ring was added to reflect the core values of the County which are: integrity, equity, access, belonging, excellence, and sustainability (*Figure 2*).

Figure 1: Map of Six HHSA Service Delivery Regions.



Source: HHSA Regions at Live Well San Diego | Home (livewellsd.org)

Figure 2: County of San Diego General Management System Reimagined, 2021.

Source: CAO Recommended Operational Plan FY 2022-23 and 2023-24, Introduction.

Introduction

Live Well San Diego Vision

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 *(Figure 3)*.

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.

Figure 3: Live Well San Diego Vision Pyramid.

Source: Data & Indicators at Live Well San Diego | Home (livewellsd.org)

Live Well San Diego involves formally recognized partners in every sector through a shared vision for wellness across the region. There are currently more than 500 recognized partners, 5 Regional Community Leadership Teams (CLTs) across the HHSA regions, and over 350 HHSA contractors who are expected to advance the vision. This reflects the scope, evolution, and maturation of this collective effort.

New County and Agency Strategic Plans

While *Live Well San Diego* remains the regional vision for the County of San Diego, the Board of Supervisors has adopted a new County strategic plan in FY 2021-22 featuring initiatives that span the entire organization and break down silos, contributing to the overall success of the region. These five initiatives are Sustainability, Equity, Community, Justice and Empower.

In step with the BOS, HHSA revisited its strategic plan, adopting six initiatives that align with the County's. PHS is aligned to these plans, and goals that advance the Agency and County initiatives are called out in the PHS plan.

Introduction

Both plans appear in Appendix II.

There are six (6) Agency strategic Initiatives, and five (5) County initiatives as they align to the Agency initiatives *(Figure 4)*.

Figure 4: Strategic Initiative Alignment: Six Agency Initiatives (top) that directly support five County Strategic Initiatives (bottom).

Source: 2022-24 HHSA Strategic Plan, also referred to as the "Agency Promise."

Figure 5: Mobilizing for Action through Planning and Partnership.

Source: National Association for County and City Health Officials.

Evolving Regional Planning Process

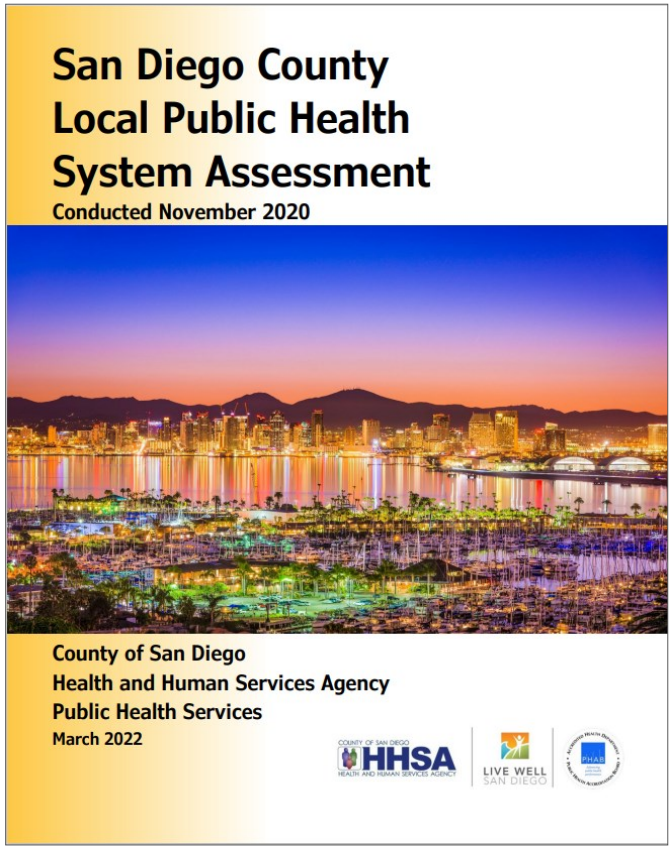
As an accredited public health department, PHS has adopted a structured planning process and framework, called Mobilizing for Planning and Partnership (MAPP), to identify community priorities (*Figure 5*).

Community engagement is at the heart of MAPP. Community Leadership Teams (CLTs) for each of the HHSA Regions identify priorities for change that are captured in their respective Community Enrichment Plans (CEPs). There are five CLTs and five CEPs for the six HHSA regions, since North Coastal and North Inland are combined for this purpose. PHS engages the community through CLTs, comprised of partners across all sectors in each region, who know first-hand what the needs are and have the influence to drive change. 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 Building Better Health, Living Safely, and Thriving. PHS works closely with the Office of Equitable Communities (OEqC), within the HSEqC department, in this regional planning process because OEqC leads activities to engage the community.

Introduction

A Community Health Status Assessment is conducted in a continuous fashion, with data (in visually-friendly formats and dashboards) developed principally by the PHS Office of Community Health Statistics. These data are presented annually to the Community Leadership Teams (CLTs) within each of the five regions. Consistent with the MAPP framework, feedback is also collected from members of the CLTs as to what are key strengths and weaknesses of the community, forces of changes, and what members consider to be the priorities for the CLT moving forward. At ongoing CLT meetings, Information and data are also provided by PHS staff and other local agencies and partners, who own unique data about issues on which they are focused. PHS maintains this community data by creating dashboards and posting to a website that residents or partners can easily access. PHS also coordinates 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 year.

Figure 6: MAPP Assessment–Local Public Health System Assessment, conducted virtually in November 2020.



To enhance alignment between PHS programs and resources, PHS collects and shares information about those programs that could advance community enrichment plans and/or benefit from active community engagement. This information is updated on an ongoing basis and made available to community engagement staff and the CLTs. For example, CalFresh Healthy Living programs information is provided to help the CLTs address food insecurity; Overdose prevention awareness information is shared with CLTs focused on substance abuse concerns.

The most recent Local Public Health System Assessment was convened in a virtual format. This provided an opportunity for almost 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 (EPHS). A new Essential Services framework, rolled out in September 2020, by the Centers for Disease Control and Prevention was used to design the questions, because this framework better integrated equity and current public health practice. The LPHSA produced scores by each of essential services that indicate how well the system is performing, as captured in the report on the Assessment *(Figure 6)*.

Source: https://www.sandiegocounty.gov/content/dam/sdc/hhsa/programs/phs/documents/Local_Public_Health_System_Assessment.pdf

Introduction

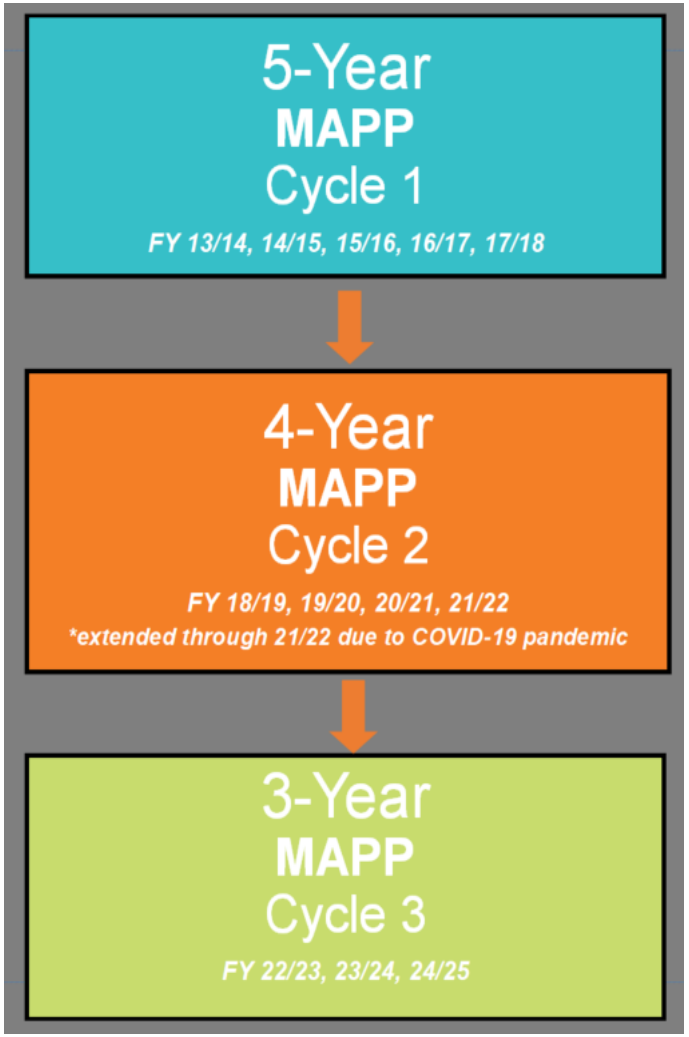
This PHS Strategic Plan is a product that draws from the results of the four Assessments described above, along with analysis and discussion conducted within the department, to identify strategic issues, formulate goals and strategies, and then implement the plan through objectives and action steps.

While San Diego County still adheres to MAPP, NACCHO is revisiting its own MAPP Framework with an emphasis on equity and engagement. MAPP 2.0, includes several alternative assessments (Community Partner and Community Context Assessments) and is expected to be launched in the Summer of 2023. MAPP 2.0 will influence future planning activities at PHS.

The Community Health Status Assessment, Community Health Improvement Plan, as well as key elements of the MAPP process, were on a five-year cycle in FY 2013-18 when the first formal cycle was undertaken. However, the County has adopted a three-year cycle with the intent to ensure the CHA and CHIP are kept current. Similarly, the PHS Strategic Plan is on a two-year cycle, so that it is in-synch with the two-year County budget or Operational Plan.

COVID-19 caused some disruption to the planning cycle as efforts were focused on the pandemic response. The previous planning cycle was extended by a year (FY 2021-22) to allow some time to refocus attention and re-start the CLTs in FY 2022-23 *(Figure 7)*.

Figure 7. MAPP Planning Cycles in San Diego County.



Source: Prepared by Office of Performance & Improvement Management, Public Health Services Administration Branch, HHSA.

Introduction

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 2023-2024 and 2024-2025. This plan sets forth what PHS seeks to achieve as an organization, the key objectives or steps PHS will take to achieve its goals, and indicators for PHS to determine if progress has been achieved. It also provides a guide for making decisions and allocating resources to pursue its strategies and priorities.

Immediately after this section appears the Methodology Section, which provides details on the overall approach and context of this PHS Strategic Plan. The "Structure" of the plan follows and details how this plan is put together and is different than previous plans. For each Branch Plan, there is a "Story" of a health equity goal, explained in greater detail in this section. In this way, we illustrate how what the Branch is doing programmatically impacts an important population health indicator. The idea is to bring to life the important work each Branch does in at least one area, where health disparities present special challenges.

After the health equity goal, the respective Branch plan follows—including goals, strategies, objectives, and measures. Strategic alignment is demonstrated in several ways. Alignment is shown through the use of icons to illustrate alignment to strategic initiatives represented on the PHS Strategic Initiatives Framework. Additionally, strategic alignment to national, State, and local plans, including the *Live Well San Diego* vision, is described after each individual Branch plan.

Several appendices follow all of the Branch strategic plans. The PHS Strategic Initiatives Framework, which displays all initiatives in which PHS plays a key role, appears as (**Appendix I**). New County and Agency Strategic Plans are included because these priorities reflect some new directions the enterprise is taking and are reflected in PHS priorities and efforts. (**Appendix II)** Due to the importance of leveraging resources to implement community plans, alignment of this PHS Strategic Plan with the priorities identified by regional CLTs is provided (**Appendix III)**. How this plan is consistent with requirements of the Public Health Accreditation Board is also detailed (**Appendix IV**). To show how the efforts of PHS and its partners contribute to the health and wellbeing of the community in the long-term, two dashboards of key population indicators are included (**Appendix V**). Finally, key organizational information is shared in the last section of this Plan where financial data and organizational charts are provided **(Appendix VI).**

Methodology

General Overview

Public Health Services has adopted a frequent, two-year planning cycle to keep its PHS Strategic Plan fresh. Every second year, the department conducts a thorough review process, most recently in FY 2020-21, after a pause over several years due to the COVID-19 response. The planning process beings with a "Strategic Review," which involves leadership, senior staff, and frontline staff through Branch activities. The PHS planning process places great emphasis on alignment. Alignment is so critical to a department that is part of a large County and health department, which explains efforts to ensure PHS objectives leverage new Board of Supervisor, County and Agency initiatives and visa versa.

In addition to the robust strategic planning process, this section describes the history of health equity considerations that contributed to the emergence of health equity objectives featured in each of the Branch plans. The focus on health equity, particularly after the COVID-19 response, is shared by the Board of Supervisors and at all levels of the County enterprise. In FY 2021-22, the County, at the urging of the Board of Supervisors, has modified its budget process to consider equity in all resource decisions, a major shift in practice.

Other features of the planning process are the alignment of the strategic plan to community planning; an important and challenging task give the structure of HHSA with six regions, five Community Leadership Teams, each with a community plan The existing community plans (referred to as Community Enrichment Plans or CEPs) are out of date and new plans are being developed. PHS is closely involved in supporting this effort and also sharing with community leaders how its programs can support their objectives on the ground, within their communities. Alignment to strategic priorities and national, state and local plans is also detailed.

Evidence-based research and practice is behind all formulation of goals, strategies and objectives. A new policy was adopted that identifies for all PHS staff resources of evidence-based programs and practice. It is this research that helps to bridge the gap between objectives and their ultimate impact in terms of community change, and help PHS to "tell stories" of how programs contribute to positive community change.

Without implementation and monitoring, a plan has limited if any value. In the interest of formalizing its performance management and quality improvement activity, PHS adopted a policy for a Performance Accountability System in 2022. This shows maturity in the monitoring, sharing, and actively discussing performance data to inform action.

PHAB accreditation requirements are also an important guidepost to these efforts and help PHS ensure that it is moving in the right direction and building a strong infrastructure for accountability.

Methodology

The Emergence of Health Equity Goals and Inclusion of Population Health Goals

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). These disparities persist despite targeted efforts through interventions and resources from federal, State, and local public health departments.

"Health Equity Goals are one of the latest ways PHS conveys the importance of health equity considerations."

This Strategic Plan features "**Health Equity Goals**" within each of the Branch Plans. These Goals are one of the latest ways PHS conveys the importance of health equity considerations in all PHS work. This imperative was further revealed by the COVID-19 pandemic given the disparities in impact that this pandemic engendered.

PHS has a long history of commitment to advance health equity across all of its programs. 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.

PHS has elevated considerations of health equity across the department. Its Office of Health Equity and Climate Change (OHECC), 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.

Back in 2016-17, Metrics Workshops were convened in which each Branch was asked 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. 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.

The results of these discussions laid the foundation for future planning from a health equity perspective, including the development of each Branch's strategic plan. Health equity priorities and strategies to address these disparities has been featured in previous strategic plans; in this plan, as stories about a health equity goal for each Branch.

"**Population Health Goals,**" and associated objective, appear with the Health Equity Goal at the top of each Branch Plan. This is the first PHS strategic plan in which Population Health Goals, like the Health Equity Goals, are placed up front. The intention is to be deliberate in communicating the aspiration for community change. To the extent feasible, the goals, objectives and measures adopted align with, or support improvement over the long term in the Population Health Goal. These Population Health Goals, and associated objectives, are based on Healthy People 2030—either the same as a the Healthy People 2030 goal or adapted for relevance to our operations and/or community served.

Methodology

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 at the beginning of each fiscal year, calls for every HHSA department to assess current programs and operations, conduct an environmental scan and SWOT (Strengths, Weaknesses, Opportunities, and Threats) analysis, and identify strategic advantages and disadvantages.

The Strategic Review, conducted within PHS, involves collecting data and discussing emerging trends and changing priorities through executive, leadership, and senior staff meetings. Exercises are also conducted within each Branch to ensure all staff are engaged in discussions about current challenges and future trends. The Strategic Review includes an examination of key performance measures to ensure that key measures, which are shared with the public as part of the County Operational Plan, best reflect the major programs of the department and that the targets are adequately aggressive.

A more in-depth Strategic Review is conducted every other year within the two-year planning cycle. In FY 2021-22, when the last in-depth planning cycle was undertaken, a new step was added to the process. A "Speed Review of Measures" was introduced to review all measures for impact, relevancy, and alignment. Meetings were convened with the Public Health Officer, Deputy Public Health Officer, and the Branch Chief and team to examine all Branch performance measures. The meetings were intentionally kept short and focused, and objectives and measures that were no longer relevant were dropped at the same time new objectives and measures for current priorities were adopted. This practice also provided opportunity to identify potential synergies and ways to leverage resources.

Alignment to Community Planning in the Regions

Community planning in PHS is led by five Community Leadership Teams for the six regions (North Coastal and Inland Regions have one CLT), guided by the HHSA Office of Equitable Communities (OEqC), with data and technical support provided by the PHS Administration team. The five Community Enrichment Plans (CEPs) are currently being updated by the CLTs that have been restarted after a pause during the COVID-19 pandemic.

As of Spring 2023, priorities have been identified by each CLT and work has begun to frame goals, objectives and measures. New CEPs are expected by fall of 2023. PHS is actively participating in the planning process and presenting information about PHS programs that align and support community efforts. Information is shared between PHS Branches and the CLTs routinely to ensure that community leaders are made aware of programs that provide direct support to communities and/or could benefit from expanded community participation.

The PHS Strategic Plan includes goals, objectives and measures that are directly related to programmatic efforts within the

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communities. For example, the work of the Chronic Disease & Health Equity Unit includes policy, systems, and environmental change efforts in which individual communities are engaged in the process. There are also new goals related to community engagement and health equity that appear throughout the PHS Strategic Plan which support community planning efforts.

Historically, 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 their CLT initiatives. CHSU is a valuable resource for data both as part of the formal community assessment process and also during monthly CLT and CLT workgroup meetings within each of the regions. PHS also provides technical assistance in the development, design and monitoring of CEPs, and this is reflected among PHS Strategic Plan objectives.

Alignment to National, State, and Local 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. A description of the alignment of Branch plans with national, state, and local plans and priorities appears after each individual Branch plan. Also, icons are used throughout the Plan to illustrate alignment to initiatives in the PHS Strategic Initiatives Framework, as well as health equity and community engagement priorities that have been elevated at the County and Agency levels.

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. PHS adopted a formal policy in 2022 which identifies the roles and responsibilities of all staff to utilize evidence-based practices when designing, developing, and implementing practices, processes, and programs. Also, key evidence-based resources such as "The Guide to Community Prevention Services," Community Preventive Services Task force, are identified.

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.

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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 is implementing this Strategic Plan over the next two fiscal years, FY 2023-24 and 2024-25. A Performance Accountability System policy, adopted in 2022, identifies the basic steps in performance management and quality improvement, with an emphasis on maintaining, sharing, and actively monitoring performance data (see Figure 7), as well as ensuring performance challenges are considered for quality improvement activities, referred to as integration.

All strategic plan objectives and associated measures are tracked through a performance management system. A report of results for high-priority objectives, that are part of the County's two-year Operational Plan, is distributed 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. The public receives results for these objectives annually when the operational plan is published.

Each Branch monitors all measures in their respective strategic plan using a scorecard also generated through the performance management system. Results are shared with their team and progress is discussed ongoing. Performance dialogues are encouraged within each Branch to get staff to routinely look at performance data and discuss strategies when performance falls short of expectations.

For each Branch, there is at least one "Population Health Goal," that appears at the top of the Branch plan, along with an associated objective that is regularly monitored. New population data is only available once a year or every several years, and any impacts of program activity are not likely to be revealed over the longer term. These objectives are based on the Healthy People 2030, and include infant mortality rate or new reports of HIV Disease diagnosis, for example.

In addition, several dashboards of population indicators are maintained. *Live Well San Diego* indicators have been identified to track long-term changes in support of the *Live Well San Diego* vision. Also, PHS tracks additional population indicators that are closely related to public health programs and services in the PHS Outcomes Dashboard, and some of these indicators are the same as the Population Health Goals in this strategic plan. Dashboards that capture these indicators appear in **Appendix V**. Population data are being combined with measures of programs and operations to help "tell the story" of the contributions of PHS, other County departments, and partners across every sector to bring about positive change in the community.

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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 achieved reaccreditation August 21, 2023. PHS is committed to maintaining its adherence to PHAB reaccreditation standards, following the new 2022 version, which is framed by the 10 Essential Public Health Services and Foundational Public Health Services, and reflecting input from experts on the future of public health.

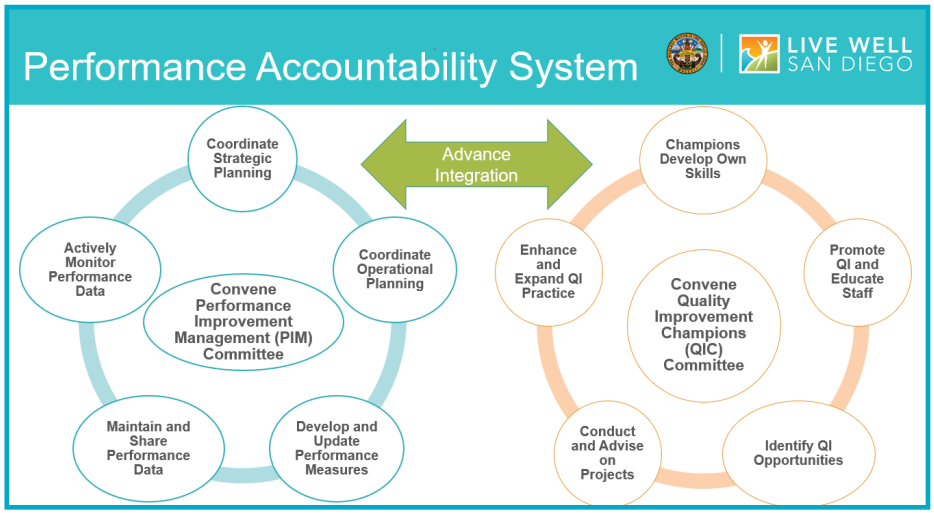
Accreditation requirements for strategic planning specify that the County must show that it has engaged staff at various levels and across the department in developing the plan. Also, the implementation of the plan needs to be tracked and revised as needed. The strategic plan must outline the department's contributions towards improving health outcomes, which this plan does through stories about the health equity goals featured in each Branch plan. **Appendix IV** shows how the PHS Strategic Plan aligns with the new PHAB reaccreditation standards.

Integrated Quality Improvement Project Program

PHS understands that the environment and needs of residents are dynamic. This requires that San Diego County continuously work to improve its 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 standardizing enforcement of tobacco retailer licensing. Both of these important objectives have benefited from a QI project conducted by a team that identified and tested solutions to improve performance.

Since 2010, PHS adopted a goal of conducting a certain number of QI projects each year; the target is currently 8 and increasing to 10 by FY 23-24, 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 were designated across all Branches to engage staff at all levels in QI.

Figure 8: Performance Accountability System for Public Health Services.



Source: HHSA-PHS-ADMIN-PMQI-001 PHS Performance Accountability System Policy, May 30, 2022.

Methodology

Beginning in 21-22 there was a concerted effort to expand QI culture and practice using resources provided through Federal and state grants.

In the Performance Accountability System, integration of performance management and quality improvement is an important expectation of accredited public health departments *(Figure 8)*. Performance challenges should be addressed with some type of mitigation, and QI projects may be warranted to identify and implement solutions. Conversely, a QI project may identify a key process that warrants monitoring to ensure performance is maintained or improves. A Performance Improvement Management Committee and a Quality Improvement Champions Committee work together to advance this integration.

Staff Support

The Public Health Officer, Deputy Public Health Officer, the Performance Improvement Manager, a Program Manager, a QI Specialist, and several other staff and interns coordinate this effort. Epidemiologists from the Community Health Statistics Unit provide key technical support.

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. A performance data team helps maintain the performance management system. The Quality Improvement Champions Committee also supports these efforts because performance data is key to any Quality Improvement project.

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

Guide to Branch Plans

Description

PHS has seven branches, six programmatic and one administrative. Each branch has its own plan that together comprise the PHS Strategic Plan.

Public Health Services Branches

Administration (PHS Admin)

California Children's Services (CCS)

Epidemiology and Immunization Services (EISB)

HIV, STD, and Hepatitis Branch (HSHB)

Maternal, Child, and Family Health Services (MCFHS)

Public Health Preparedness and Response (PHPR)

Tuberculosis Control and Refugee Health (TBC-RH)

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.
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.

Guide to Branch Plans

Structure

Health Equity and Population Health Goals

Each Branch section begins with a short description of each Branch, and a listing of its **units** and **programs**. A **Health Equity Goal** and a **Population Health Goal** appear in a gold box. Measurable Objectives associated with these Goals are also identified. The Health Equity Goal is the priority that each Branch adopted several years ago to address concerns about inequities. The Population Goal, is based on Healthy People 2030,* although in some cases the exact wording and target is adapted for San Diego County. The Population Health Goal may be broader than the Health Equity Goal; however, many if not all Branch programs and operations advance both goals. For some Branches, these two Goals are the same. Immediately after the cover page for each Branch Section, is the:

STORY which starts with a Health Equity Goal, followed by the **BRANCH STRATEGIC PLAN**, which starts with a Population Health Goal.

Telling Stories about Health Equity Goals

The intent of the **Story** is to help bring the work of each Branch to life by illustrating how operations and programs contribute to an important outcome related to health equity. This Story is included to demonstrate how PHS is using its measures to track progress of activities at the operations and program levels to "turn the curve" and improve equity in community health and well-being. On the first page of each Story, you will see measures organized as described in *Figure 9*.

Figure 9: Measures Used to "Tell a Story."

Type of Measures	Definition	Question that is Answered
Health Equity Goal and Objective(s) (Outcome)	Impact that we are seeking	What change or improvement is needed for community health and well-being?
Programs (Measures)	Program efforts to bring about	What actions are being taken within the program to bring about change?
Operations (Measures)	Operations that support program success	How are day-to-day operations monitored to ensure everything is running smoothly?

You will find the **Health Equity Goal** which captures the impact that we seek, and the associated objective with quantitative targets that can be monitored to assess change over the longer term. Some of these Health Equity Goals also appear in the PHS Outcomes Dashboard because it is an outcome prioritized by PHS (this Dashboard is required of all accredited public health departments). (**Appendix V**). Below the population health indicator, selected **program measures** appear that capture some, although not all, of the activities underway to address the problem and move the population health indicator in a positive direction. These program measures also appear in the Branch Strategic Plans that follow. Below the program measures, you will find **operations measures**. Operations measures are used to monitor whether everything is running smoothly in the implementation of programs. Unlike program measures, operations measures do not

**Healthy People 2030 are data-driven national objectives to improve health and well-being over the next decade. Released by the U.S. Department of Health and Human Services every decade since 1980, Health People objectives are developed in collaboration with a diverse group of stakeholders, partners and organizations.*

Guide to Branch Plans

Structure

necessarily appear in Branch Strategic Plans as these measures are internal-facing and used to monitor day-to-day activity.

The Story also includes **narrative** about the **priority concern**, **strategy for change**, and **partners in getting it done,** referring to organizations with whom the PHS and the larger County enterprise have partnered with to achieve a positive impact. Additional context of the health equity concern at hand, indicated with the magnifying glass, is also provided. **Five health equity lenses**–Age, Gender, Geography, Race/Ethnicity, and Socioeconomic Status–are applied. Data and analysis that expands on these disparities appears here.

Branch Strategic Plans and Components

These Stories of the Health Equity Goals describe only a piece of what each Branch does. The full Branch Strategic Plan follows. On the first page of each Strategic Plan appears the **Population Health Goal** and associated objective in a gold box. The alignment key is also on this first page *(Figure 11)*. The Population Health Goal, based on Healthy People 2030, reflects what many Branch programs and operations contribute to. The Population Health goal may be broader in scope than the Health Equity Goal. For some Branches, these goals are the same.

Each Branch plan is very comprehensive. These plans are organized in either of two ways: 1) Strategically, with different units and program supporting multiple strategies; or 2) Programmatically, in which the programs and units are listed, and all other components organized underneath. MCFHS is a combination in which the Chronic Disease and Health Equity section is organized strategically, and the Family Health and Preventive Services section is organized programmatically.

For all Plans, **goals** are then identified, followed by **strategies** and **objectives** to achieve the goals, and then **measures** by which progress is tracked *(Figure 10)*. Measures that are related because they support the same objective appear together underneath the objective. Most of the measures in the Branch Plans are program measures. The

Figure 10: Definitions of Components of Branch Strategic Plans.

- **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).
- **Measure:** How progress is to be measured (begins with numerical target provided if there is one).

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quantitative target appears first in the presentation of the measure. For the few qualitative measures that appear in these plans, the result or deliverable appears first.

Time Period for Objectives

Most objectives have a quantitative performance target that the Branch program must achieve and/or sustain over the course of two years. Objectives that do not explicitly state a date are intended to be accomplished by the end of every fiscal year (June 30) for the two years in which this plan is in effect (FY 2023 -24 and 2024-25). Some objectives are longer-range, particularly those related to policy, systems, and environmental (PSE) change efforts, and these objectives and respective timeframes are identified in the plan. Incremental timeframes for specific tasks are captured in work plans that each program maintains.

How Alignment is Demonstrated

PHS carefully aligns to County and Agency direction as this is the best way to leverage PHS work. Alignment of Branch Strategic Plans is captured in two ways.

Figure 11: Alignment Icons Explained

Strategic Initiative. Indicates the Goal/Objective is captured on the ***PHS Strategic Initiative Framework***, which identifies those initiatives (launched and led by the Board of Supervisors; by a combination of the CAO, HHSA, or PHS; or by PHS). For all initiatives in the Framework, PHS has a specific role. The Framework appears in **Appendix I.**

- A yellow star refers to a Board of Supervisors Initiative.
- A grey star refers to an initiative that is a combination of CAO, HHS or PHS Initiatives.
- A green star refers to a PHS initiative.

Health Equity Focus. Virtually all PHS work addresses a health equity concerns. This is why PHS chose to identify those Goals/Objectives where there is a specific reference to equity and/or the Goal/Objective is the same or related to the Health Equity Goal featured in the Story at the beginning of each Branch plan. The magnifying glass is used to indicate analysis by one or more of the five health equity lenses Age, Gender, Geography, Race/Ethnicity, and Socioeconomic Status.

Community Connection. At PHS, community engagement is at the core of delivering essential services in the region. A new emphasis on community engagement from the Board of Supervisors (and reflected in County and Agency Strategic Plans), and the imperative that PHS support the development and implementation of community health improvement plans (referred to as Community Enrichment Plans), are reasons why several Goals/Objectives are called out.

OP **Operational Plan.** These measures are in the Operational Plan and have been identified and prioritized by PHS leaders and the Agency Executive Office because these measures convey core activities within the department and are easy for the public to understand and see value. These measures also typically have multiple years of data and are benchmarked to either previous performance or Federal, State, or best practice standards.

AP **Agency Promise.** These measures appear in the HHSA Strategic Plan Scorecard. The same measures are monitored across all HHSA departments to track progress on six initiatives in the plan, also called the "Agency Promise."

ap **Agency Promise (PHS only).** These measures have been adopted by PHS to align with or support the six initiatives in the HHSA Strategic Plan Scorecard.

Guide to Branch Plans

Structure

Icons to Flag Strategic Initiatives and Priorities

Figure 11 defines the icons used to show alignment. You will find a star icon for goals or objectives that specifically support initiatives in the PHS Strategic Initiatives Framework (**Appendix I**). In addition, you will see icons for those goals and objectives that reflect a health equity focus or advance community planning and engagement. Finally, there is an icon that shows which measures are of high priority and, as such, appear in the County Operational Plan. These measures are also in orange font.

Tables with Narrative Explaining Alignment with National, State and Local Plans

The second way in which alignment is demonstrated is in a table that appears at the end of each Branch Strategic Plan. This table explains how each Branch plan is aligned to elements or components within these national, state, and local plans. This alignment discussion clarifies how PHS leverages any ongoing efforts and all available resources for greatest impact in San Diego County.

Additional Objectives that Support New County and Agency Initiatives

A few goals and associated strategies, objectives and measures were added to all or some of the Branch Plans because of new County and Agency strategic plans. While this work was already happening to varying degrees within each Branch, these additions further elevate these efforts. These additional objectives focus on community engagement and health equity, and appear at the end of each Branch plan, with the exception of the Administration Branch in which these objectives are integrated throughout. The objectives call for Branches to support the development and implementation of Community Enrichment Plans and to convene meetings with partners to further collective impact initiatives. The objectives also require that each Branch continue to apply an equity lens to maximize accessible service and resources, which includes utilizing tools, such as the Healthy Places Index Tool, in the design and implementation of its programs.

The objectives will also be marked with the icons for Health Equity and Community Connection.

Administration Branch of Public Health Services

Administration (PHS Admin) directs public health programs, safeguards the public's health, coordinates a unified response during emergencies, and spearheads efforts to strengthen the public health workforce and infrastructure.

Units and Programs

- Executive Office Team*
- Office of Border Health
- Community Health Statistics Unit
- Fiscal, Budget, and Contract Support
- Grants Administration
- Office of Health Equity and Climate Change
- Medi-Cal Administrative Activities/Targeted Case Management (MAA/TCM)
- Nursing Unit
- Office of Performance and Improvement Management
- Policy and Legislative Analysis
- Sustainability Coordination

Health Equity Goal: Strengthen the workforce and infrastructure

- **Objective:** Self-rating of 3 out of 4 indicating "knowledgeable" achieved across all domains on the Core Competencies for Public Health Professional Survey. This includes the Health Equity Skills Domain.

Population Health Goal: Make sure the local health department has the necessary infrastructure for key public health services.

- **Objective**: Increase the use of relevant, professional core competencies in workforce development.

The Health Equity Goal is the priority that each Branch adopted in 2016 to address concerns about inequities. The Population Health Goal is based on Healthy People 2030.

*The Executive Office Team refers to the Public Health Officer (PHO), Deputy PHOs, Director of Nursing, and Assistant and Deputy Directors, along with several staff administrative staff. Also included are a human resources officer from Agency Human Resources and information technology staff from Agency Information Management Services who are assigned to PHS.

**The PHS Administration Strategic Plan is organized by unit or office. The goals and strategies (followed by objectives and measures) are aligned by the criteria for performance excellence under the Baldrige Excellence Framework (*refer to Baldrige Excellence Framework)* to ensure fidelity to this framework.

Story of a Health Equity Goal—Strengthen the Workforce and Infrastructure

Administration Branch of Public Health Services (Admin)

Impact that we seek:

Health Equity Goal: Strengthen the workforce and infrastructure

- **Objective:** Self-rating of 3 out of 4 indicating "knowledgeable" achieved across all domains on the Core Competencies for Public Health Professional Survey. This includes the Health Equity Skills Domain.

The Health Equity Goal is the priority that each Branch adopted in 2016 to address concerns about inequities.

Program efforts to bring about change:

(Measures appear in Strategic Plan)

- Ensure 70% (of 866) **all PHS permanent** staff:
  - complete trainings in Outbreak Management Under ICS*, Health Literacy 101, Data Literacy, and Racial Equity in FY 2022-23.
  - complete trainings on the National Incident Management System (NIMS) and the Incident Command System (ICS)*, Public Health 101, Data Literacy, and advanced courses in Cultural Responsiveness, Customer Service in FY 2023-24.
- Ensure 90% of **all PHS permanent** staff complete review of the PHS Health Equity Policy and Procedure in FY 2023-24.

Operations that support program success:

- Hire 100% of staff in timely fashion, to build up the workforce and maximize new grant dollars.
- Tracking, analysis, and evaluation of all surveys and trainings to gather feedback and gather data as to effectiveness.
- Ensure 50% average completion rate for all workforce surveys and training evaluations.

Story of a Health Equity Goal—Strengthen the Workforce and Infrastructure

Administration Branch of Public Health Services (Admin)

Why is this a Priority?

After the COVID-19 pandemic, there is new focus on building the public health workforce. County results in 2021 to a national survey, called the Public Health Workforce Interests and Needs Survey (PH WINS), show that 77% of employees do not have a public health degree. Because relatively few employees have formal public health training, Public Health Services (PHS) is focused on building competencies. PHS has rolled out an expanded training program tailored to public health workforce interests and needs, and with new CDC infrastructure dollars, PHS will further expand workforce training and development strategies. Trainings specifically target areas of need identified through surveys (e.g., PHS WINS, Core Competencies for PH Professionals).

Strategy for Change

Multiple training modules, designed and developed internally, focus on strengthening core competencies and building understanding and commitment to public health sciences, health equity, and emergency response (i.e., NIMS/ICS* and PHS-designed "Outbreak Management Under ICS"). PHS is advancing health equity by training staff on various social and economic conditions that contribute to inequities and the impact on underserved and underrepresented groups across the County. Creating effective public health approaches to address these inequities requires public health professionals to possess specific knowledge, skills, and abilities (KSAs) related to cultural responsiveness, customer service, racial equity, health literacy, emergency response, leadership development, 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, and responses to key surveys, is measured.

The trainings include: 1) NIMS/ICS* Training 2) Outbreak Management Under ICS; 3) Public Health 101 including Public Health History, Essential Concepts in Public Health, Data, Health Equity, and Climate Change; 4) Cultural Competency/Responsiveness and Customer Service Training; 5) Health Literacy; 6) Racial Equity; and 7) Data Literacy. Also Diversity and Inclusion efforts are to ensure D&I is infused into Branch Operations (i.e., branch impact plans) and trauma-Informed care e-learning training is required of all staff per HHSA policy to advance trauma-informed approaches to service delivery and integration.

Partners in Getting this Done

The Knowledge Center (TKC) within HHSA; the Government Training Agency (GTA), de Beaumont Foundation, Association of State and Territorial Health Officials, the Council on Linkages between Academia and Public Health Practice, Bay Area Regional Health Inequities Initiative, Gallup Consulting, Public Health Advocates.

**NIMS/ICS refers to National Incident Management System/Incident Command System—referring to emergency preparedness training developed by the Federal Emergency Management Agency.*

Story of a Health Equity Goal–Strengthen the Workforce and Infrastructure

Administration Branch of Public Health Services (Admin)

Looking through the Health Equity Lens: PHS Staff Training Efforts in Health Equity

The COVID-19 pandemic made even clearer that the public health workforce needs to be prepared and able to serve the needs of a diverse population. PHS Admin is committed to developing the competencies and abilities of all PHS staff by developing and delivering tailored trainings in accordance with CDC standards, and, in future, building workforce capacity through strategies approved through a national CDC public health infrastructure grant.

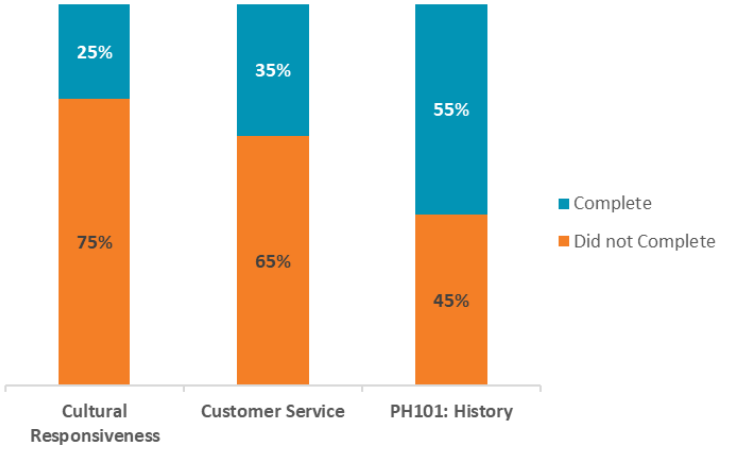
The figures to the right capture data as of March 2023 for key trainings offered to all PHS staff. New staff (266 who started in December 2019 or later) were required in FY 2022-23 to take training in Cultural Responsiveness, Customer Service, NIMS/ICS, Outbreak Management Under ICS, Racial Equity, Data Literacy, Health Literacy, all 5 modules of the Public Health 101 series, a priority because so few staff have a formal background in public health (23%). Also in 2022-23, all veteran PHS staff are expected to complete Outbreak Management Under ICS, Health Literacy, Data Literacy, and Racial Equity. Review of the Health Equity Policy and Procedure is also mandatory and being tracked in 2022-23. In 2023-24, the focus will be on veteran staff updating their NIMS/ICS training, taking the updated PH 101 series, Data Literacy, Health Literacy, Racial Equity, and taking advanced courses in Cultural Responsiveness and Customer Service.

Completion of trainings is closely tracked. The targets are 100% for training modules among new staff, and 90% for training modules for all staff. These are ambitious goals although progress has been made, particularly with the PH History 101 for new staff. Second offerings of Outbreak Management Under ICS, Racial Equity, Health Literacy, Cultural Responsiveness, and Customer Service are being offered again in the spring of 2023 to increase completion rates.

Evaluations, in accordance with CDC standards, are conducted after each training to collect feedback to inform improvements to the training modules. To encourage engagement and assess learning, staff do pre and post tests and are polled throughout the training with questions to check their understanding of the material.

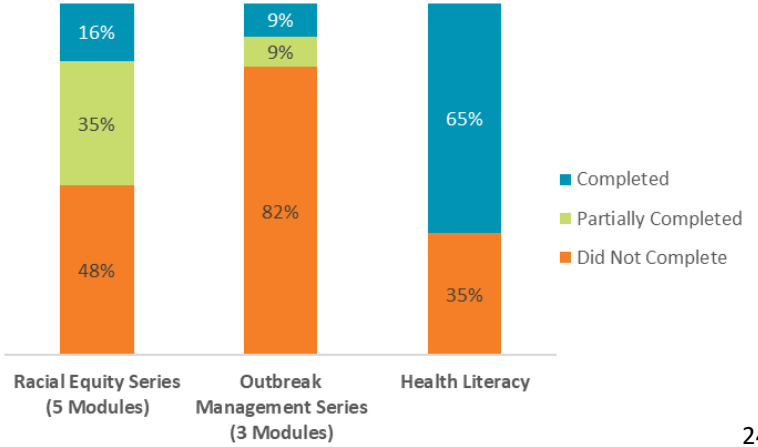
Training Completion by New PHS Staff

(New PHS employees–266)



Training Completion by All PHS Staff

(All PHS employees–866)



Branch Plans

Administration Branch of Public Health Services (Admin)

Population Health Goal: Make sure the local health department has the necessary infrastructure for key public health services.

- **Objective**: Increase the use of relevant, professional core competencies in workforce development.

The Population Health Goal is based on Healthy People 2030.

Alignment Key:

Strategic Initiative (from the Strategic Initiative Framework):

- Strategic Initiative: Board of Supervisors
- Strategic Initiative: Combination of CAO, HHSA, or PHS Initiatives
- Strategic Initiative: PHS Initiative

Health Equity Focus

Community Connection

OP **Operational Plan** (Priority)

AP **Agency Promise,** Measure in HHSA Strategic Plan Scorecard

ap Additional PHS Measure that supports the Agency Promise

Administration Branch of Public Health Services (Admin)

Executive Office Team

Public Health Infrastructure

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

Strategy 1.1: Adhere to the Baldridge Excellence Framework criteria for leadership that is proven to contribute to organizational success.

Objective 1.1.1: Maintain accreditation status of the public health department for the County of San Diego to ensure programs and services are effective, evidence-based, promote equity, and advance population health.

- Maintain or increase conformance to requirements compared to 2016 results when first accredited (fully demonstrated for 94 of 100 measures).

Objective 1.1.2: Recognize cultural diversity and health priorities through communication to internal and external communities.

- 75 percent of timely issuance of health, cultural social, and professional observance recognitions.

Customer Service

GOAL 2: Create a culture of CUSTOMER SERVICE within PHS that enables staff to always serve, engage, and be responsive to feedback from customers.

Strategy 2.1: Adhere to the Baldridge Excellence Framework criteria for Customer Focus that is proven to contribute to organizational success.

Objective 2.1.1: Provide leadership for PHS on the Customer Service H.E.A.R.T. Initiative.

AP
- **Achieve and maintain a customer service survey score (referring to the H.E.A.R.T. survey) across PHS of 4 or higher (out of 5).**

- Increase by 25 percent each year the number of H.E.A.R.T. responses submitted internally and externally.

Objective 2.1.2: Support the effectiveness of the Health Services Advisory Board (HSAB) and implementation of its strategic plan.

- Achieve and maintain a score of 4 or higher (out of 5) for self-survey of HSAB members regarding their satisfaction with the Board, the value of its work, and the support provided by the PHS staff.

Administration Branch of Public Health Services (Admin)

Executive Office Team

Community Connection

GOAL 3: Through community engagement, strengthen and invigorate communities with opportunities to grow, connect, and thrive.

Strategy 3.1: Seek opportunities to intentionally work together toward shared goals and actions that strengthen healthy, safe, and thriving communities.

Objective 3.1.1: Strengthen and expand partnerships and community engagement through outreach and education; providing transparency, and seeking opportunities to intentionally work together for collective impact.

ap

- **For a minimum of 4 times per year, engage in collaborative meetings with partners, to advance one major initiative (collective impact, health equity, or other) led by each Branch.**

Administration Branch of Public Health Services (Admin)

Border Health

Community Connection

Binational Issues

GOAL 4: Provide LEADERSHIP that guides the organization, advance health equity for all residents, and establishes an environment that promotes success through diversity and inclusion.

Strategy 4.1: Binational communication, coordination, and collaboration among public health agencies in the United States with counterpart agencies in Mexico is considered a best practice for facilitating the exchange of information, and promoting collaborative responses, on public issues of mutual interest.

Objective 4.1.1: Develop and implement a five-year PHS departmental Audacious Goal and strategic plan to support cross border collaboration to improve health outcomes in the California-Baja California region for the FY 2023-2028 time frame.

- At least six (6) meetings conducted of the San Diego & Imperial County Border Health Collaborative (the Collaborative) to enhance relationships among public, private, healthcare, and academic institutions to protect and improve the health of individuals, families, and communities along the California-Baja California border in San Diego and Imperial Counties.
- Twice (2) a year convene the Border Health Consortium of the Californias (BHCC) general members and facilitate information sharing and foster collaborations amongst leaders from California, United States, and Baja California, Mexico, to address shared border health concerns.
- At least three (3) times a year a meeting of the five (5) workgroups of the Collaborative (HIV, Mental Health, Tuberculosis, Cancer, and Obesity) to address prevention and education priorities, including hosting an annual training, conference, or symposium to increase collaboration amongst binational stakeholders and increase capacity and resource sharing of border health priorities.
- Six (6) Queso Fresco Task Force meetings facilitated, bringing together local, state, and federal partners in developing/ revamping educational materials to enhance efforts in reducing adverse public health impacts of consuming unpasteurized soft cheeses that are commonly imported from Mexico and locally.
- Annual education operations and bi-annual blitz operations held with key partners to share information, gather data and assess the quantities of unpasteurized cheeses that are confiscated at the border ports of entry.

Administration Branch of Public Health Services (Admin)

Border Health

- At least two (2) International visits conducted, including meetings with the Public Health Officer, internal and external HHSA colleagues, and Tijuana Health Jurisdiction (ISESALUD) counterparts, to discuss public health priorities and opportunities for continued collaboration.
- Annual meetings facilitated with the CDC, Customs Border Protection, and PHS to address border health concerns and key priorities.

Health Equity Focus

Objective 4.1.2: Facilitate collaborative activities among County and external partners while serving as a central point of contact for border health information.

- 50 activities in San Diego County for Binational Health Week efforts.
- 19,000 people reached in San Diego County for Binational Health Week Efforts.

Objective 4.1.3: Improve public health and emergency communication with non-English speaking communities in San Diego County.

- Three (3) training workshops in public health and emergency preparedness delivered to agencies and partners serving vulnerable and isolated communities.
- 20 partners that are actively participating in Partner Relay activities.
- One (1) drill implemented to support partner engagement and system efficacy.
- 500 participants in Partner Relay Communication Network.

Administration Branch of Public Health Services (Admin)

Community Health Statistics

Transparency and Open Government

Goal 5: Manage DATA, ANALYTICS, AND INFORMATION in a continuous fashion to ensure decisions are evidence-based and data driven.

Strategy 5.1: Adhere to the Baldridge Excellence Framework criteria for Measurement, Analysis, and Knowledge Management that is proven to contribute to organizational success.

Objective 5.1.1: Enhance the reliability and accuracy of population data provided by the Community Health Statistics Unit (CHSU) through quality assurance checks.

- Two (2) policies and procedures issued that capture internal approach to data validation.
- Two (2) *Live Well San Diego* health and well-being data systems produced, which includes the Community Profiles and Demographic Profiles, to provide data and visualizations through the lens of health equity and the social determinants of health.

Objective 5.1.2: Identify, collect, and maintain a wide array of data, reports, and information products.

- Degree to which the Community Health Assessment, capturing comprehensive population and health data across each of five (5) regions, completed, and updated quarterly once issued (shared with OPIM).
- Delivered regularly, community data and profiles presentations to Community Leadership Teams.
- 50 percent of key data and reports are prepared for approval for publication based on a project grid timeline.

Customer Service

Objective 5.1.4: Increase the accessibility of, and satisfaction with, data services.

- 105 percent increase in web traffic to Community Health Statistics Unit (CHSU) website annually.
- 95 percent of data requests sent to CHSU are responded to within 48 hours.
- **Four (4) data and visualizations developed and/or maintained in support of the County of San Diego Board of Supervisors, CAO, HHSA, and PHS goals and initiatives regarding emerging issues.**
- At least three (3) data products developed related to heat illness, climate change, and heat forecasting.

Administration Branch of Public Health Services (Admin)

Community Health Statistics

Health Equity

Live Well San Diego

Objective 5.1.5: Maintain and monitor population indicators to help assess collective impact of PHS and other partners in the *Live Well San Diego* collective impact efforts.

- 90 percent of *Live Well San Diego* Indicators are up-to-date and accessible to the community.
- One (1) community health and demographic map atlas series developed, and one (1) internal Medical Operations Center (MOC) GIS trainings provided.

Objective 5.1.6: Apply and equity lens in the use of data to maximize accessible services and resources while cultivating culturally responsive efforts to address inequities.

ap

- **Seven (7) Branches provided technical assistance by CHSU in the use of the Health Equity data to inform program or service delivery design and implementation for at least one (1) program.**

Administration Branch of Public Health Services (Admin)

Fiscal, Budget, and Contract Support

County Resources and Contracting Policies

GOAL 6: Design, manage, and innovate work processes to increase OPERATIONAL effectiveness.

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

Objective 6.1.1: Improve the monitoring of contracts to ensure that Branches are in compliance with contracting standards and guidelines.

- 65 percent of contracts selected for Quality Assurance audits have no findings and require no action to address these findings.

Objective 6.1.2: 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 (4) best practice trainings provided to PHS Contracts and Fiscal Group meetings over the course of each year.

Objective 6.1.3: Increase contracting competency of all PHS Contract 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 new Analysts that have taken COR I and COR II within six (6) months of date of hire.
- 100 percent of new Analysts that have taken ACS training series within six (6) months of date of hire.
- 100 percent of total Analysts that have taken two (2) Department of Procurement and Contracting trainings on the Learning Management System during the period.

Administration Branch of Public Health Services (Admin)

Grants Administration

Workforce and Public Health Infrastructure

GOAL 7: Design, manage, improve, and innovate work processes to increase OPERATIONAL effectiveness.

Strategy 7.1: Adhere to the Baldridge Excellence Framework criteria for Operations Focus that is proven to contribute to organizational success.

Objective 7.1.1: Appropriate staff hired to carry out and fulfill grant objectives related to each of the following: Expanding Laboratory Capacity Original and Expansion grants, CDC COVID-19 Health Disparities Grant, Public Health Workforce Grant, CDC Infrastructure Grant, and CDPH Future of Public Health Grant.

- 100 percent ***permanent*** staff hired through new grants.
- 100 percent ***temporary*** staff hired through new grants.

Objective 7.1.2: Contract and fiscal administration conducted that is related to each of the following grants: Expanding Laboratory Capacity Original and Expansion grants, CDC COVID-19 Health Disparities Grant, Public Health Workforce Grant, CDC Infrastructure Grant, and CDPH Future of Public Health Grant.

- 100 percent contracts procured/amended for each grant identified above.
- 100 percent of budget expended for each grant identified above.

Objective 7.1.3: Ensure adequate progress is being made toward implementing each of the following grants: Expanding Laboratory Capacity Original and Expansion grants, CDC COVID-19 Health Disparities Grant, Public Health Workforce Grant, CDC Infrastructure Grant, and CDPH Future of Public Health Grant.

- Less than 15 percentage points difference between completion of work plan milestones and time remaining before each grant identified above ends.

Administration Branch of Public Health Services (Admin)

Health Equity and Climate Change


Health Equity Focus


Community Connection


Racism: A Public Health Crisis

GOAL 8: Promote equitable access to better health, safety, and opportunities to thrive that enhance well-being.

Strategy 8.1: Apply an equity lens to maximize accessible services and resources, cultivate culturally responsive efforts to address inequities and elevate the equity implications of climate change.

Objective 8.1.1: Increase in BARHII Survey scores (an organizational self-reflection tool survey for health equity) that reflects progress in cultivating inclusion, diversity, equity, and antiracism throughout PHS through multiple initiatives, the success of which are measure through the BARHII Survey.

ap • **Achieve 70 percent of staff to provide positive responses to a key question within the BARHII Survey that reflects PHS organizational commitment to address conditions that impact health equity (2019 score was 66 percent).**

Objective 8.1.2: Conduct a health disparities summit to engage community partners on issues related to inequities.

- Completion of health disparities summit and plan of action to address prioritized inequities in San Diego County by April 30, 2024.

Objective 8.1.3: Coordinate health equity work across the department through the PHS Health Equity Working Group (HWEG) comprised of representatives from all seven PHS branches.

- Health Equity tool updated, and related products developed, as identified by the HEWG and Public Health Officer by June 30, 2024.

Objective 8.1.4: Maintain up to date PHS Health Equity Plan (July 2023-June 2025), PHS annual workplans, Branch impact plans (for diversity and inclusion), and Health Equity Workgroup Charter.

- Health Equity plans, with goals and objectives, advanced by 2025.

Objective 8.1.5: Develop, maintain, and promote the content of the PHS Health Equity website.

- Health equity webpage maintained and updated throughout FY 2023/25, providing a history of health equity in PHS, current health equity efforts, and additional health equity resources.
- Baseline and targets for growth in usage of the new PHS Health Equity website are established.

Administration Branch of Public Health Services (Admin)

Health Equity and Climate Change


Health Equity Focus


Community Connection


Sustainability and Climate Change

Objective 8.1.6: Provide population health data for the Board of Supervisors strategic initiative of Sustainability, including health impacts of climate change, environmental justice, climate action plan, Regional Decarbonization Framework, and climate adaptation.

- Data reports and updates regarding climate change are produced and posted to the Community Health Statistics Unit's website by November 30, 2024.

Objective 8.1.7: Support the County budget process with data that facilitate decisions that consider equity, including as criteria for resource distribution.

AP
- **Provide disaggregated data by race and ethnicity, and other equity factors or lenses and data on lived experience, as part of the new County budget process.**

Objective 8.1.7: Enhance public health competencies, knowledge, skills, and abilities by providing on-going trainings related to climate change and public health impacts.

- 75 percent of new staff (hired after December 31, 2019) complete "Climate Change 101" to improve their understanding of basic principles of climate change and its impact on public health. by the end of FY 2024-25.
- 90 percent of all staff complete "Climate Change 101" training.

Objective 8.1.8: Inform and engage the public about climate change and its impacts on public health, including equity implications.

- 5 presentations delivered to the community on the public health impacts of climate change.
- One summit on excessive heat to be hosted in coordination with partners before the end of FY 2024-25.

Objective 8.1.9: Contribute to the research on climate change to build the body of evidence-based data and information about the impact of climate change on public health and the equity implications of climate change.

- White paper and clinical guidance document for staff on excessive heat that is made available to the public and professional community.

Administration Branch of Public Health Services (Admin)

Medi-Cal Administration Activities–Targeted Case Management

County Resources and Contracting Policies

GOAL 9: Maximize Medi-Cal Administrative Activities and Targeted Case Management revenue in compliance with State and Federal regulations.

Strategy 9.1: Support cost-effective revenue generation activities that will bring the greatest benefit to County programs and provider participants while ensuring program integrity.

Objective 9.1.1: Develop plans to improve outreach and strengthen the MAA/TCM program.

- Two (2) outreach plan and marketing tools will be developed to help bring in new MAA/TCM providers by end of each fiscal year.

Objective 9.1.2: Improve quality and accuracy of MAA/TCM claims.

- 90 percent accuracy in time study submittals by monitoring and providing additional resources like data sharing with providers, with the goal od increasing claimable TCM encounters.
- 95 percent of MAA time surveys conducted by County personnel are subject to Quality Assurance Reviews.

Administration Branch of Public Health Services (Admin)

Nursing Unit

Health Equity Focus

GOAL 10: Ensure clinical nursing practice across core public health programs and initiatives through compliance of State and Federal regulations, policies, and quality improvement.

Strategy 10.1: Adhere to the Baldridge Excellence Framework criteria for Operations Focus that is proven to contribute to organizational success.

Objective 10.1.1: Ensure detention facilities across the County provide proper care as reflected in annual audits of medical, mental, nutrition, and environmental health at these facilities.

- At least 96 percent rating achieved with nutritional inspections of community correctional facilities annually with support for compliance provided by the Nursing Unit.
- 100 percent of variances resolved of medical/mental health post inspections with submission of corrective action plans within 10 days.
- 100 percent of variances resolved of environmental post inspections (i.e., for temperature, sanitation, or other) with submission of corrective action plans within 10 days.

Objective 10.1.2: Facilitate collaboration of clinical services and operations to help ensure quality of care of clients.

- Bi-monthly meetings are reconvened of the Clinical Quality Management (CQM) Steering and General Committees to monitor, revise, and review policies and procedures, clinic operations and outcomes, and to mitigate risk.

Administration Branch of Public Health Services (Admin)

Performance and Improvement Management

Performance Management and Quality Improvement

Goal 11: Manage DATA, ANALYTICS, AND INFORMATION in a continuous fashion to ensure decisions are evidence-based and data driven.

Strategy 11.1: Adhere to the Baldridge Excellence Framework criteria for Measurement, Analysis, and Knowledge Management that is proven to contribute to organizational success.

Objective 11.1.1: Increase the accessibility of performance data to managers and staff alike, while promoting its utilization for decision-making.

ap
- **At least four (4) Flash performance reports issued.**
- Quarterly updates of all seven (7) Branch strategic scorecards.
- At least seven (7) scorecards (one per Branch) that capture how PHS is turning the curve on major population change efforts are developed and maintained.

Objective 11.1.2: Continue to build Quality Improvement (QI) capacity throughout Public Health Services (PHS).

OP ap
- **A minimum of ten (10) formal QI projects conducted each year (at least one within each Branch) to address key performance gaps and engage staff in identifying and resolving barriers to success.**

ap
- **At least 50 percent of PHS staff receive training or some form of exposure to quality improvement to help embed continuous improvement into daily work**.
- Improve scores on the QI Self-Assessment Survey (2023 baseline of 4.0 out of 6.0) reflecting a maturation in QI culture across PHS.
- A score of 4 (on a scale of 1 to 5) across all elements of QI project storyboards (QI on QI Project).
- A score of 4 (on a scale of 1 to 5) across all elements of QI project charter (QI on QI project).

Objective 11.1.3: Identify, collect, and maintain a wide array of data, reports, and information products.
- All seven (7) branches provide updated information quarterly to be compiled into the Annual Accomplishments Report.

Administration Branch of Public Health Services (Admin)

Performance and Improvement Management

Customer Service

GOAL 12: Create a culture of CUSTOMER SERVICE within PHS that enables staff to always serve, engage, and be responsive to feedback from customers.

Strategy 12.1: Adhere to the Baldridge Excellence Framework criteria for Customer Focus that is proven to contribute to organizational success.

Objective 12.1.1: Enhance PHS Administration external and internal customer service.

- Satisfaction scores of 4 or higher (out of 5) on training in performance management and quality improvement.

Community Connection

GOAL 13: Through community engagement, strengthen and invigorate communities with opportunities to grow, connect, and thrive.

Strategy 13.1: Seek opportunities to intentionally work together towards shared goals and actions that strengthen healthy, safe, and thriving communities.

Objective 13.1.1: Support the development and implementation of Community Enrichment Plans, working with the Office of Equitable Communities.

- Up to five (5) Branches provide information about programs, resources, and tools to advance implementation of Community Enrichment Plans, when applicable.

ap

- **At least four (4) performance reports issued for each of the five (5) Community Enrichment Plans by the end of FY 2023-24.**

Administration Branch of Public Health Services (Admin)

Policy and Legislative Analysis

Public Health Infrastructure

GOAL 14: Design, manage, improve and innovate work processes to increase OPERATIONAL effectiveness.

Strategy 14.1: Adhere to the Baldridge Excellence Framework criteria for Operations Focus that is proven to contribute to organizational success.

Objective 14.1.1: Ensure policies and operations manuals are up-to-date and staff are aware of content, utilizing the Policy Tech system.

- 30 percent of all branch policies and procedures that were updated and approved by the review deadline.
- 30 percent of all branch operation manuals that were updated and approved by the review deadline.
- 75 percent of reading tasks that were completed by the assigned due date.

Objective 14.1.2: Develop and review legislative proposals so that PHS remains responsive to Federal, State, and Board of Supervisors direction by identifying implications and opportunities for public health programs and services.

- Within an average of 5 days, legislative proposals are reviewed and feedback provided to the County Office of Strategy and Innovation (OSI) which coordinates legislative activity for all County departments.
- Legislative Program input for public health developed and provided annually to OSI.

Administration Branch of Public Health Services (Admin)

Sustainability Coordination

Sustainability

GOAL 15: Support Countywide effort to advance sustainability by promoting economic sustainability for all, combatting climate change, cultivating a natural environment, and promoting resiliency for all San Diego residents.

Strategy 15.1: Ensure sustainability efforts for economy, climate, environment, and resiliency are implemented throughout PHS.

Objective 15.1.1: Communicate with employees about sustainability program updates, successes, and opportunities for improvement at a minimum of once a quarter, at senior staff meetings and the PHS newsletter, and in other internal communications.

OP • **Quarterly updates on the sustainability program delivered through the PHS newsletter, featuring a Sustainability Champion, or other communications such as senior staff meetings.**

- 90 percent of all staff complete the training on climate change (referred to as "Climate Change 101").

Objective 15.1.2: Continue to implement remote and hybrid work environments to reduce emissions and the office footprint as Public Health Services migrate to alternate and new facilities, while maximizing shared workspaces.

OP • **24 percent reduction in Vehicle Miles Traveled and associated emissions, maintained through teleworking and a smaller office footprint at PHS.**

- At least 50 percent of staff across PHS (will vary by Branch) telework at least one time per month, maintaining full business operations while reducing miles travelled to the office and associated emissions.

Objective 15.1.3: Reduction in HHSA Fleet Carbon Emission from gasoline fuel vehicles.

AP • **Reduction in PHS carbon emissions that add to overall HHSA Fleet total emissions *(target to be determined).***

Objective 15.1.4: Ensure facilities are maintained to increase staff productivity, lower operational costs, and increase the lifespan of assets for the public health department.

- No more than 50, 150, and 300 average days that facility maintenance work orders take to complete based on complexity, respectively (Complexity Rating 1–simple; Rating 2–more complex; Rating 3–major and capital projects).

Administration Branch of Public Health Services (Admin)

Workforce Development

 *Health Equity Focus*

 *Community Connection*

 *Talent and Team Development*

GOAL 16: Ensure that the County and its residents are served by an agile, adaptable, highly skilled public health WORKFORCE.

Strategy 16.1: Adhere to the Baldridge Excellence Framework criteria for Workforce Focus that is proven to contribute to organizational success.

Objective 16.1.1: Conduct surveys to assess workforce competencies for public health professionals, employee engagement, leadership, and health equity to strengthen the workforce and ensure operational success.

- 50 percent ***TOTAL*** average completion rate for ***ALL SURVEYS*** of workforce (Leadership, BARHII internal and external, Organizational Equity Assessment survey, Gallup/Employee Engagement, Core Competencies for Public Health Professionals, PH WINS).
- 50 percent completion rate of priority surveys rolled out (Core Competency for Public Health Professionals Assessment Survey).
- 50 percent completion rate of priority surveys rolled out (Public Health Services Strengths Based Management Employee Survey—Gallup).
- 50 percent completion rate of priority surveys rolled out (BARHII and organizational self-reflection tool survey for health equity).
- 50 percent completion rate of priority surveys rolled out (PH WINS).

Objective 16.1.2: Enhance public health staff competencies, knowledge, skills, and abilities by providing on-going trainings.

- Self-ratings of 3 out of 4 (indicating "knowledgeable") achieved on the Core Competencies for Public Health Professionals survey across all Domains. Focus is improving 2021 scores for Health Equity Skills Domain (2.73 out of 4) and Public Health Science Skills Domain (2.61 out of 4).
- 70 percent of all permanent staff complete training on Health Literacy, Data Literacy, and/or Outbreak Management under ICS training, coordinating with the Agency Human Resources Department.

ap
- **80 percent of all permanent staff receive Data 101 training by the end of FY 2023-24. Note: *When this training, designed by the Community Health Statistics Unit, began in March 2022-23, only new staff were required to attend.**

Administration Branch of Public Health Services (Admin)

Workforce Development

- 90 percent of all PHS permanent staff complete review of the PHS Health Equity Policy and Procedure by the end of FY 2023-24.

OP • **Ensure 100 percent of permanent staff (those hired before December 31, 2019) complete mandatory trainings on the National Incident Management System (NIMS) and the Incident Command System (ICS) to enhance responsiveness to public health emergencies (number of training sessions depends on individual's level and role).**

- 75 percent of new staff (hired after December 31, 2019) complete "Climate Change 101" to improve their understanding of basic principles of climate change and its impact on public health. by the end of FY 2024-25. *(also appears in OHEC section).*
- 90 percent of all staff complete "Climate Change 101" training *(also appears in OHEC section).*

Objective 16.1.3: Provide staff feedback and help staff feel supported so that they are more satisfied and remain to pursue and advance in their careers in public health.

AP • **90 percent retention rate or higher maintained of public health staff.**

- 90 percent of performance reviews completed timely across all Branches.
- Increase in number of PHS staff recognized through the County's award and recognition programs.

AP • **At least 38 percent of employees are fully engaged based on an enterprise-wide Employee Engagement Assessment conducted for all County employees every other year.**

ap • **An average of 4.25 (out of 5) employee engagement scores reached as reflected in the PHS Employee Engagement (Gallup) survey scores (compared to 4.21 from 2021-22) administered to all PHS employees.**

Administration Branch of Public Health Services (Admin)

Alignment to National, State, and Local Plans Public Health Services Administration Branch	
	The Public Health Services Administration Branch (PHS Admin) aligns to The Ten Essential Services (ES) of Public Health, specifically ***ES 1-Assessments***, ***ES 3-Communication***, ***ES 4-Partnership***, ***ES 5-Plans and Policies***, ***ES 6-Enforcement***, ***ES 8-Workforce***, ***ES 9-Improvement, Evaluation, and Research***, and ***ES 10-Infrastructure***. For example, PHS Admin assesses and monitors public health status and needs by preparing various reports, including the Community Health Assessment, which leads to the development of the Community Health Improvement Plan, known as Community Enrichment Plan, to ensure strategies are in place to mitigate the health issues. PHS Admin manages data, analytics, and information in a continuous fashion to ensure decisions are evidence-based and data-driven. Furthermore, PHS Admin continuously communicates with the public about public health prevention and response efforts, including using the California Health Alert Network San Diego, among other mechanisms, and provides resources in multiple languages to meet community demands. PHS Admin assures an effective system that enables equitable access to individual services and care needed to be healthy. In addition, PHS Admin leads workforce development opportunities for staff to ensure a skilled and competent public health workforce with a culture of exceptional customer service to provide to the community. PHS Admin also enforces policies, develops plans like the Department Strategic Plan, and assesses for effectiveness using a performance management system, Clear Impact, to monitor data quarterly, and implements quality improvement strategies to ensure there is a culture of excellence and continuous improvement. PHS Admin provides infrastructure and operational support to the six Branches within Public Health Services to ensure all staff are supported.
HEALTHY PEOPLE 2030	PHS Admin aligns to Healthy People 2030's ***Health Disparities***, ***Health Literacy***, and ***Social Determinants of Health*** priority areas. PHS Admin is committed to health equity and has an Office of Health Equity and Climate Change to provide infrastructure to support staff and the Department. PHS Admin also monitors data through a health equity lens. Furthermore, PHS Admin facilitates communication, collaboration, and coordination at the local, state, and federal level in the U.S. and Mexico to address public health concerns in the San Diego–Tijuana border region. Lastly, PHS Admin improves public health and emergency communication with non-English speaking communities in San Diego County.
Let's Get Healthy California	PHS Admin aligns to the State of California's Let's Get Healthy California ***Healthy Beginnings*** and ***Redesigning the Health System*** goals. For example, PHS admin promotes strategy development that stimulates innovation, guides operations, and leverages opportunities to have the greatest impact. Furthermore, PHS Admin designs, manages, improves, and innovates work processes to increase operational effectiveness. PHS Admin also works with health systems by maximizing the Medi-Cal Administration Activities and Targeted Case Management revenue in compliance with State and Federal regulations.
LIVE WELL SAN DIEGO	PHS Admin aligns to the County of San Diego *Live Well San Diego* vision of ***healthy***, ***safe***, and ***thriving*** San Diego County communities. A few examples include providing leadership that guides the organization, advances health equity for all residents, and establishes an environment for success. Furthermore, PHS Admin works to advance *Live Well San Diego* with initiatives and events that actively engage partners and strengthen community connections, while also monitoring and sharing information that "tells the story" of the Public Health Services contributions to the collective impact effort of *Live Well San Diego*.

Administration Branch of Public Health Services (Admin)

Alignment to National, State, and Local Plans
Public Health Services Administration Branch

PHS Admin aligns to the County and/or HHSA Strategic Initiatives of ***Sustainability***, ***Workforce***, ***Community Engagement***, ***Equity***, ***Service Delivery Coordination***, and ***Systems and Technology***. For example, PHS Admin provides leadership that guides organization, advances health equity for all residents, and establishes an environment for success. PHS Admin addresses local health challenges by strengthening leadership capacity of public health staff, municipal partners, and other stakeholders. Moreover, PHS Admin is leading sustainability efforts in the Department to ensure information and trainings, including National Incident Management System and Incident Command, are provided to staff and implement remote and hybrid work environments to reduce emissions and the office footprint. PHS enhances its workforce by providing professional and training opportunities on public health competencies to ensure a highly skilled and competent workforce. Lastly, PHS Admin collaborates with federal, state, local, and binational partners to protect the health of the community.

California Children's Services (CCS)

California Children's Services (CCS) is a statewide case management program for certain diseases or health problems that are chronic, disabling, or life threatening. CCS provides authorizations for diagnostic and treatment services, equipment, medical case management, and physical and occupational therapy services to children under age 21 with medical conditions such as Diabetes, Cystic Fibrosis, Spina Bifida, Hemophilia, Sickle Cell Disease or Cerebral Palsy.

Units and Programs

- Case Management Unit
- Medical Therapy Unit

Health Equity Goal: Transition successfully from care

- **Objective:** Ensure comprehensive transition plans are in place for 90% of CCS clients, almost half of whom are over the age of 18 (comprise 44% of all clients) and have disabling conditions that are expected to last beyond their 21st birthday. *Health Equity Lens: Disability.*

Population Health Goal: Improve health and well-being in people with disabilities.

- **Objective:** Reduce the proportion of children with complex medical conditions who delay care because of cost.

The Health Equity Goal is the priority that each Branch adopted in 2016 to address concerns about inequities. The Population Health Goal is based on Healthy People 2030.

Story of a Health Equity Goal–Transition Successfully From Care

California Children's Services (CCS)

Impact that we seek:

Health Equity Goal: Transition successfully from care

- **Objective:** Ensure comprehensive transition plans are in place for 90% of CCS clients, almost half of whom are over the age of 18 (44% or 1,333) and have disabling conditions that are expected to last beyond their 21st birthday. *Health Equity Lens: Disability.*

The Health Equity Goal is the priority that each Branch adopted in 2016 to address concerns about inequities.

Program efforts to bring about change:

(Measures appear in Strategic Plan)

- Ensure 75% or more of children demonstrate a positive change on the Functional Standardized Test Score or show documentation of progress toward therapy goals.
- Ensure 100% percent of all clients will have a medical home based on a quality review of a sample of cases

Operations that support program success:

- To support these young adults, CCS conducts transition planning assessments, conducts workshops, and performs quality improvement processes.

Story of a Health Equity Goal—Transition Successfully From Care

California Children's Services (CCS)

Why is this a Priority?

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. They are a vulnerable population with increased risk for chronic disease outcomes and development of other comorbidities. Almost half (43.75% or 1,333) of CCS clients over the age of 18 have disabling conditions that are expected to last beyond their 21st birthday. This is why it is so important that a comprehensive transition plan is in place prior to their 21st birthday.

Strategy for Change

CCS Social Workers conduct case reviews and make attempts to contact all clients turning 18 and 20 to offer individualized transitional planning resource assessments and ensure clients have signed release of information forms or legal conservatorship documents on file. In addition to individual TP assessments provided by a CCS nurse or social worker, the CCS program coordinates regular transition planning workshops for CCS youth who are 16 years of age or older and identified with a medical condition that will not be resolved prior to their 21st birthday. The workshops aim to link clients who will soon age out of the program with valuable community resources. To increase accessibility of information and resources related to transition planning, the CCS program transitioned from 1 annual in-person workshop at a centralized location (2016) to regional workshops (2019-2020), to virtual workshop in 2022, and will now be implementing a combination of virtual and regional workshops in 2023.

The CCS program also utilizes Quality Improvement (QI) methodologies to improve program performance in key areas including transition planning.

Partners in Getting this Done

Medi-Cal Managed Care Plans/Health Care Options, San Ysidro Health, Home & Community-Based Alternatives Waiver, Access to Independence, California State University San Marcos– Disability Support Services, CA Department of Rehabilitation, Exceptional Family Resource Center, Legal Aid Society of San Diego, Maxim Healthcare Services, North County Transit District, Palomar College Disability Resource Center, San Diego Regional Center, Southern Caregiver Center, Together We Grow.

Story of a Health Equity Goal—Transition Successfully From Care

California Children's Services (CCS)

Looking through the Health Equity Lens: Transition Age Clients

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' target is to ensure that 90% 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.

- In 2021, an estimated 23,827 (3.3 percent) of children under 18 in San Diego County experienced some form of disability.
- **Sex**: Among the population under age 18, 4.3 percent of males had a disability and 2.4 percent of females had a disability in 2021.
- **Geography**: Among the regions, East Region had the highest percentage of children under 18 with a disability in 2021, where 3.9 percent of the population under age 18 had a disability.
- **Race/Ethnicity**: in 2021, 3.1 percent of non-Hispanic White children under 18 years old had a disability and 3.4 percent of Hispanic or Latino children under 18 years old had a disability.
- **Socioeconomic Status**: In 2021, an estimated 17 percent of children under 18 years old with a disability came from households living below the poverty level. In contrast, 13.1 percent of children under 18 without a disability came from households living below the poverty level.
- Among the population under 18 with a disability, 73.1 percent had a cognitive difficulty in 2021.

U.S. Census Bureau, 2017-2021 American Community Survey 5-year Estimates.

Branch Plans

California Children's Services (CCS)

Population Health Goal: Improve health and well-being in people with disabilities.

- **Objective:** Reduce the proportion of children with complex medical conditions who delay care because of cost.

The Population Health Goal is based on Healthy People 2030.

Alignment Key:

Strategic Initiative (from the Strategic Initiative Framework):

- Strategic Initiative: Board of Supervisors
- Strategic Initiative: Combination of CAO, HHSA, or PHS Initiatives
- Strategic Initiative: PHS Initiative

Health Equity Focus

Community Connection

OP **Operational Plan** (Priority)

AP **Agency Promise,** Measure in HHSA Strategic Plan Scorecard

ap Additional PHS Measure that supports the Agency Promise

California Children's Services (CCS)

Health Equity Focus

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.

Customer 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 (5 on a scale of 7).

Health Equity Focus

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 550 appropriate uses of all interpretation services (phone, in-person, and written) to meet the needs of clients. (Target based on prior year averages).

Community Connection

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

- Every quarter, CCS will score 4 out of 4 (100 percent) 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. It has become a widely accepted model for how primary care should be organized and delivered through the health care system.

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

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

California Children's Services (CCS)

GOAL 3: Ensure optimal utilization of Special Care Center (SCC) 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 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 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.

- 75 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.

Health Equity Focus

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.

California Children's Services (CCS)

Performance Management and Quality Improvement

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.

OP
- **97 percent of medical eligibility determinations made within five (5) working days of receipt of all medical documentation based on a quality review of a sample of cases.**
- 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.

ADDITIONAL OBJECTIVES THAT SUPPORT NEW COUNTY AND AGENCY INITIATIVES

Community Connection

GOAL 7: Through community engagement, strengthen and invigorate communities with opportunities to grow, connect, and thrive.

Strategy 7.1: Seek opportunities to intentionally work together toward shared goals and actions that strengthen healthy, safe, and thriving communities.

Objective 7.1.1: Strengthen and expand partnerships and community engagement through outreach and education; providing transparency; and seeking opportunities to intentionally work together for collective impact.

- At least two (2) activities per quarter in which CCS participates that support increased collaboration with County or Community programs.

ap
- **For a minimum of 4 times per year, engage in collaborative meetings with partners, to advance one major initiative (collective impact, health equity, or other) led by each Branch.**

California Children's Services (CCS)

Health Equity Focus

GOAL 8: Equitable access to better health, safety, and opportunities to thrive that enhance well-being.

Strategy 8.1: Apply an equity lens to maximize accessible services and resources and cultivate culturally responsive efforts to address inequities.

Objective 8.1.1: Apply a health equity lens to the design and implementation of programs.

ap • **At least one (1) program will use Health Equity data to inform the design or delivery of services.**

California Children's Services (CCS)

Alignment to National, State, and Local Plans California Children's Services Branch	
	The California Children Services Branch (CCS) aligns to The Ten Essential Services (ES) of Public Health, specifically ***ES 4-Partnership, ES 5-Plans and Policies, ES 6-Enforcement, ES 7-Access, and ES 9-Improvement, Evaluation and Research***. For example, CCS collaborates with community and service providers to deliver whole person care coordination to people living with disabilities, which is a component of San Diego Advancing and Innovating Medi-Cal (SDAIM), the local approach to California Advancing and Innovating Medi-Cal (CalAIM). In addition, CCS ensures an optimal utilization of Special Care Center Services to improve health outcomes for their clients. Furthermore, CCS is committed to operational excellence and providing services that benefit their clients' needs.
HEALTHY PEOPLE 2030	CCS aligns to Healthy People 2030's ***Health Equity***, ***Health Literacy***, and ***Social Determinants of Health*** priority areas. For example, the Branch ensures timely transition planning services to promote optimal health and independence once these clients leave the CCS programs.
Let's Get Healthy California	CCS aligns to the State of California's Let's Get Healthy California ***Healthy Beginnings***, ***Living Well***, and ***End of Life*** goals. For example, CCS engages Medical Therapy Program patients in activities to improve their physical functional level. In addition, CCS ensures children have the specialized mobility requitement they need to enhance their function level as they engage in community activities.
LIVE WELL SAN DIEGO	CCS aligns to the County of San Diego *Live Well San Diego* vision of healthy, safe, and thriving San Diego County communities, specifically the ***Building Better Health*** and ***Thriving*** components. For example, CCS promotes the health and well-being of their clients to ensure they are thriving and reaching their full potential. In addition, CCS staff provide case management services for certain diseases or health conditions that are chronic, disabling, or life threatening.

CCS aligns to the County and/or HHSA Strategic Initiatives of ***Community Engagement, Equity***, ***Service Delivery Coordination, Sustainability***, and ***Systems & Technology***. For example, CCS coordinates efforts to improve health equity in services provided to clients, encourages family participation in their programs, and ensures clients have a medical home and receive appropriate care. Furthermore, CCS supports a sustainable future for youth to connect them to other services to transition successfully to adulthood and promote optimal health and independence once they leave the CCS program.

Epidemiology and Immunization Services Branch (EISB)

The Epidemiology and Immunization Services Branch (EISB) works to identify, prevent, and control communicable diseases.

Units and Programs

- **Epidemiology Unit**
  - Childhood Lead Poisoning Prevention Program (CLPPP)
  - Disease Reporting and Surveillance
  - Disease Investigations
  - Healthcare Associated Infections (HAI)
  - HIV/AIDS Surveillance
- **Immunization Unit**
  - Vaccine Warehouse, Management & Distribution
  - Vaccine Preventable Disease Investigations & Response
  - Vaccine Preventable Disease Prevention & Health Promotion Immunization Epidemiology & Surveillance
- **Public Health Laboratory Unit**
  - Disease Prevention, Control, and Surveillance
  - Environmental Health and Bio-Terrorism Protection
  - Reference and Specialized Testing
  - Waters Testing
  - Genomic Epidemiology and Sequencing
- **Vital Records and Statistics Unit**
  - Administration
  - Birth Registration
  - Death Registration
  - Medical Marijuana Identification Card (MMIC)

Health Equity Goal: Address childhood lead poisoning

- **Objective:** Ensure 95% of children under age 21 who have elevated blood levels (3.5 cg/dL or greater) receive case management services in timely fashion (depending upon lead levels). *Health Equity Lens: Geography, Refugee Status.*

Population Health Goal: Promote healthy and safe home environments.

- **Objective:** Reduce blood lead levels in children aged 1 to 5 years from 3.31 micrograms per deciliter (mcg/dL) to 1.18 mcg/dL.

The Health Equity Goal is the priority that each Branch adopted in 2016 to address concerns about inequities. The Population Health Goal is based on Healthy People 2030.

Story of a Health Equity Goal—Address Childhood Lead Poisoning

Epidemiology and Immunization Services Branch (EISB)

Impact that we seek:

(Indicator appears in PHS Outcomes Dashboard)

Health Equity Goal: Address childhood lead poisoning

- **Objective:** Ensure 95% of children under age 21 who have elevated blood levels (3.5 cg/dL or greater) receive case management services in timely fashion (depending upon lead levels). *Health Equity Lens: Geography, Refugee Status.*

The Health Equity Goal is the priority that each Branch adopted in 2016 to address concerns about inequities.

Program efforts to bring about change:

(Measures appear in Strategic Plan)

Offer education and outreach:

- To a minimum of 200 healthcare providers.
- To a minimum of 3,000 individuals and families with children.

Deliver case management services to 95% of children at each of these blood levels:

- 14.5 mcg/dL receive case management services within one week of referral.
- 9.4-14.4 mcg/dL who receive case management services within two weeks of referral.
- 3.5-9.4 mcg/dL who receive case management services within two months of referral.

Operations that support program success:

- Monitor and maintain manageable caseloads among Public Health Nurses.
- Review data to identify cases in which children are due for retesting of lead levels.
- Conduct bi-weekly quality assurance reviews to ensure through and complete case management.

Story of a Health Equity Goal—Address Childhood Lead Poisoning

Epidemiology and Immunization Services Branch (EISB)

Why is this a Priority?

Lead poisoning is considered the most preventable environmental disease of young children by the Centers for Disease Control & Prevention (CDC). 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. Exposure to lead can affect nearly every system in the body and cause negative health effects that result in lifelong learning and behavior problems. Of 111 cases from 2016-20 in San Diego County, 45% in Central and East Regions; more children of refugee or immigrant status have elevated lead levels

Strategy for Change

Childhood Lead Poisoning Prevention Program (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, qualify to receive nursing case management services which may include a home visit, health assessment, and an environmental investigation.

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.

Partners in Getting this Done

Environmental investigations are performed in collaboration with the County Department of Environmental Health. San Diego contracts with Family Health Centers of San Diego to focus on providing education and outreach to the community. 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.

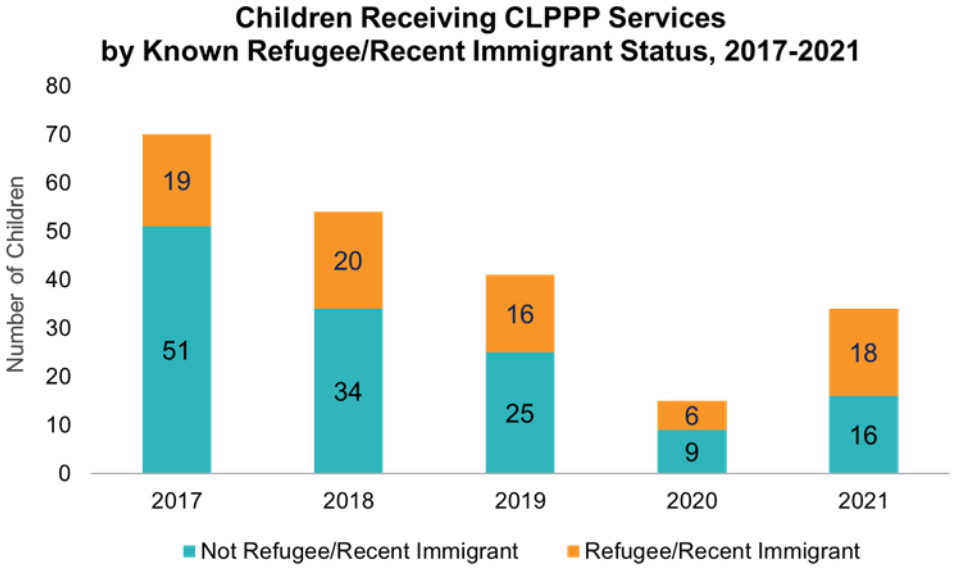
Story of a Health Equity Goal—Address Childhood Lead Poisoning

Epidemiology and Immunization Services Branch (EISB)

Looking through the Health Equity Lens: Children receiving services from the Childhood Lead Poisoning Prevention Program (CLPPP)

The figure to the right shows the number of children under 21 years of age receiving CLPPP services between 2017 and 2021 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.

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.



Source: *San Diego County Childhood Lead Poisoning Prevention Program (CLPPP) WebCMR Registry, 10/10/2022.*

Branch Plans

Epidemiology and Immunization Services Branch (EISB)

Population Health Goal: Promote healthy and safe home environments.

- **Objective:** Reduce blood lead levels in children aged 1 to 5 years from 3.31 micrograms per deciliter (mcg/dL) to 1.18 mcg/dL.

The Population Health Goal is based on Healthy People 2030.

Alignment Key:

Strategic Initiative (from the Strategic Initiative Framework):

- Strategic Initiative: Board of Supervisors
- Strategic Initiative: Combination of CAO, HHSA, or PHS Initiatives
- Strategic Initiative: PHS Initiative

Health Equity Focus

Community Connection

OP **Operational Plan** (Priority)

AP **Agency Promise,** Measure in HHSA Strategic Plan Scorecard

ap Additional PHS Measure that supports the Agency Promise

Epidemiology and Immunization Services Branch (EISB)

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.

OP
- **100 percent of reported cases of select communicable diseases (hepatitis A, meningococcal) are investigated within 24 hours of receipt of report.**

Objective 1.1.2: Initiate investigation of reported selected healthcare acquired infections (HAIs) in a timely fashion.

- 95 percent of Candida auris cases are investigated within one (1) business day.

Objective 1.1.3: Initiate investigation of reported selected enteric cases in a timely fashion.

- 90 percent of selected Enterics (Salmonellosis, Shigellosis) with investigation initiated withing one (1) business day.

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.

Health Equity Focus

GOAL 3: Reduce childhood lead poisoning through education/outreach, and early identification/treatment of children with elevated blood lead levels.

Strategy 3.1: Abide by Federal and State standards to identify and manage children with elevated blood lead levels.

Objective 3.1.1: Provide lead poisoning prevention, education, and outreach to healthcare providers through various methods, including grand rounds, presentations at local healthcare facilities, and distribution of provider newsletters.

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

Objective 3.1.2: 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 risk of lead exposure.

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

Objective 3.1.3: 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 or equal to 14.5 mcg/dL receive case management services within one (1) week of referral.

- 95 prevent of children with blood levels 9.5–14.4 mcg/dL who receive case management services within two (2) weeks of referral.
- 95 percent of children with blood levels 3.5 –9.4 mcg/ dL who receive case management services within two (2) months of referral.

IMMUNIZATIONS UNIT

GOAL 4: Provide a comprehensive Immunization Information System (IIS) to the community.

Strategy 4.1: Maintain a secure web-based system available to authorized users to access patient vaccine records.

Objective 4.1.1: Produce reports on data completeness from the State Immunization System (IIS).

- 100 percent of data completed for health insurance eligibility in the State Immunization Information Systems (IIS) among healthcare providers.

Objective 4.1.2: Document immunization volume entered into the State Immunization Information System (IIS).

- 100 percent of immunization volume entered into the State Immunization Information System (IIS) will be tracked and reported on a monthly basis.

GOAL 5: Promote high-quality immunization practices among public and private providers.

Strategy 5.1: Develop and implement policies, procedures, and training that supports quality immunization practices and accountability.

Objective 5.1.1: Provide annual vaccine storage, 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 percent of State-Purchased Influenza Vaccine Program providers attend annual program requirements training.
- Minimum of four (4) Immunization Skills Institute trainings provided per year.

GOAL 6: Promote the importance of immunizations throughout the County and monitor coverage across schools and childcare centers.

Strategy 6.1: Ensure vaccine accessibility to uninsured, low-income, and at-risk individuals in San Diego County.

Objective 6.1.1: Distribute State-Purchased influenza vaccines 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 vaccines are distributed to Public Health Center clinics and community providers with a 501(c)(3) non-profit status.

Objective 6.1.2: Support efforts of Regional Public Health Center clinics to immunize children, with no missed opportunities, through the following activities:

Epidemiology and Immunization Services Branch (EISB)

OP • **99 percent of children ages 0 through 18 served at Public Health Center (PHCs) clinics are provided age-appropriate vaccines.** This is equivalent to a one (1) 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.

Strategy 6.2: Promote and provide accurate information and resources about immunizations.

Objective 6.2.1: 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 7: Minimize the spread of vaccine-preventable diseases through timely investigation of suspect cases.

Strategy 7.1: Ensure prompt investigation of reported vaccine-preventable diseases to prevent further spread and maintain workforce readiness to respond to outbreaks.

Objective 7.1.1: Reduce the spread of vaccine-preventable diseases by collaborating with Regional Public Health Centers and the Public Health Preparedness and Response Branch to conduct mass vaccination events.

- A minimum of five (5) collaborative mass vaccination exercises conducted throughout San Diego County.

PUBLIC HEALTH LABORATORY UNIT

Public Health Infrastructure

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 (1) working day to ensure rapid diagnosis and treatment that's consistent with federal standards.

- 90 percent of TB samples tested and reported within one (1) working day.

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.

OP • **100 percent of audits (10 different lab licenses and permits) find the laboratory operation in compliance.**

Objective 8.1.4: Provide submitters with ongoing education on what is acceptable for samples sent to the Public Health Services Laboratory.

- 95 percent of samples found to be acceptable.

Epidemiology and Immunization Services Branch (EISB)

Objective 8.1.5: Notify the Department of Environmental Health and Quality (DEHQ) of exceedances for recreational beach water to help improve timeliness of public notification.

- An average of 10 hours to report to the DEHQ from time of sample receipt for recreational beach water exceedances.

VITAL RECORDS AND STATISTICS UNIT

GOAL 9: Provide timely and accurate death certificates for grieving families in San Diego County.

Strategy 9.1: Ensure superior service delivery to create the best possible customer experience, with performance that is superior to State mandated timeframes for registering deaths.

Objective 9.1.1: Register all death certificates and issue associated burial permits in a timely fashion.

- An average of two (2) hours to register death certificates after submission.

GOAL 10: Provide timely and accurate birth certificates to new parents 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 live births.

Objective 10.1.1: Register birth certificates in a timely fashion.

OP • **95 percent of birth certificates registered within 10 days of birth to maintain accurate census data, representing best practice as the State has adopted a new 21-day timeline standard.**

ADDITIONAL OBJECTIVES THAT SUPPORT NEW COUNTY AND AGENCY INITIATIVES

Community Connection

GOAL 11: Through community engagement, strengthen and invigorate communities with opportunities to grow, connect, and thrive.

Strategy 11.1: Seek opportunities to intentionally work together toward shared goals and actions that strengthen healthy, safe, and thriving communities.

Objective 11.1.1: Strengthen and expand partnerships and community engagement through outreach and education; providing transparency; and seeking opportunities to intentionally work together for collective impact.

ap • **At least once per year, provide information about programs, resources, and tools to advance implementation of Community Enrichment Plans annually.**

Epidemiology and Immunization Services Branch (EISB)

ap • **For a minimum of 4 times per year, engage in collaborative meetings with partners, to advance one major initiative (collective impact, health equity, or other) led by each Branch.**

Health Equity Focus

GOAL 12: Equitable access to better health, safety, and opportunities to thrive that enhance well-being.

Strategy 12.1: Apply an equity lens to maximize accessible services and resources, while cultivating culturally responsive efforts to address inequities.

Objective 12.1.1: Apply a health equity lens to the design and implementation of programs.

ap • **At least one (1) program will use Health Equity data to inform the design or delivery of services.**

Alignment to National, State, and Local Plans Epidemiology and Immunization Services Branch	
	The Epidemiology and Immunization Services Branch (EISB) aligns to The Ten Essential Services (ES) of Public Health, specifically ***ES 1-Assessments***, ***ES 2-Investigations***, ***ES 3-Communication***, ***ES 6-Enforcement***, ***ES 7-Access***, ***ES 9-Improvement, Evaluation, and Research***, and ***ES 10-Infrastructure***. For example, EISB assesses and monitors health status factors that influence health, community needs, and assets. EISB also investigates, diagnoses, and addresses health conditions and hazards affecting populations, all while ensuring timely and complete reporting of diseases. Furthermore, EISB provides a comprehensive immunization Information System (IIS) and collaborates with the community on outreach efforts for immunizations, disease, lead poisoning prevention. EISB is also involved in enforcement efforts with the Public Health Officer Orders when public health emergencies are declared in San Diego County. ESIB prepares epidemiology research papers to share information on infectious diseases and the best practices or lessons learned. EISB also coordinates efforts with the health system and shares data using electronic systems such as the California Immunization Registry, CAIR, and WebCMR.
HEALTHY PEOPLE 2030	EISB aligns to Healthy People 2030's ***Health Equity***, ***Health Literacy***, and ***Social Determinants of Health*** priority areas. EISB monitors data on diseases, vital records, immunizations, and lead poisoning through a health equity lens. Based on the data, EISB provides resources to communities that are most adversely affected, including materials in various languages. Furthermore, EISB monitors disease outbreaks, especially during the COVID-19 response, to identify health disparities through the Health Places Index (HPI) scores. For communities with lower HPI scores, more resources or services are provided to ensure all communities are healthy and thriving.

Epidemiology and Immunization Services Branch (EISB)

Alignment to National, State, and Local Plans Epidemiology and Immunization Services Branch	
Let's Get Healthy California	EISB aligns to the State of California's Let's Get Healthy California ***Healthy Beginnings*** goal. For example, EISB supports efforts of regional Public Health Center clinics to immunize children, with no missed opportunities, through providing children with age-appropriate vaccines. In addition, EISB works to reduce childhood lead poisoning through education and outreach, and early identification and treatment of children.
LIVE WELL SAN DIEGO	EISB aligns to the County of San Diego *Live Well San Diego* vision of ***healthy***, ***safe***, and ***thriving*** San Diego County communities. A few examples include promoting the importance of immunizations throughout the County and monitoring coverage across schools and childcare centers. Furthermore, the Branch provides effective surveillance, investigation, and response to protect the community of disease.
	
EISB aligns to the County and/or HHSA Strategic Initiatives of ***Workforce***, ***Community Engagement***, ***Equity***, and ***Service Delivery Coordination***. For example, EISB provides effective surveillance, investigation, and response to protect the community from disease through an equitable approach to help those most at risk. In addition, EISB minimizes the spread of vaccine-preventable disease through timely investigations of suspect cases and maintains a skilled workforce ready to respond to outbreaks. EISB uses a comprehensive IIS to utilize advanced technology, while working with the local community on the electronic health records to provide timely diagnosis of diseases and preventing further spread of outbreaks. Lastly, EISB reduces the number of childhood lead poisoning cases through education, outreach, early identification, and early treatment of children.	

HIV, STD, and Hepatitis Branch (HSHB)

The HIV, STD, and Hepatitis Branch (HSHB) ensures the development and delivery of quality HIV, STD, and viral hepatitis testing, care and treatment, and prevention services.

Units and Programs

- **STD Clinical Services**
- **STD Surveillance**
- **STD Prevention**
- **HIV Testing, Treatment, and Prevention Planning**
- **Fiscal and Contract Services**
- **Community Health Services**
- **HIV Planning Group**
- **Eliminate Hepatitis C Task Force**
- **Intensive Case Management**
- **Administration**

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

- **Objective:** Reduce by 90% the HIV disease diagnosis case counts in San Diego County (from 2017 baseline of 422 to 42 by 2030). *Health Equity Lense: Race/Ethnicity and other.*

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

- **Same Objective as above.**

The Health Equity Goal is the priority that each Branch adopted in 2016 to address concerns about inequities. The Population Health Goal is based on Healthy People 2030.

Story of a Health Equity Goal—Prevent HIV Infection and Address Rising STD Rates

HIV, STD, and Hepatitis Branch (HSHB)

Indicator that we seek to impact:

(Indicator appears in PHS Outcomes Dashboard)

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

- **Objective:** Reduce by 90% the HIV disease diagnosis case counts in San Diego County (from 2017 baseline of 422 to 42 by 2030). *Health Equity Lens: Race/Ethnicity and other.*

The Health Equity Goal is the priority that each Branch adopted in 2016 to address concerns about inequities.

Program efforts to bring about change:

(Measures appear in Strategic Plan)

- Test 100% of individuals seeking services at County STD clinics for HIV.
- Connect at least 95% of clients with newly confirmed HIV diagnoses to primary care within 30 days.
- At least 95% of persons with diagnosed HIV infection are virally suppressed by the end of 2025.

Operations that support program success:

- Ensure 100% monitoring and timely payment of contracted providers.
- Convene at least 24 meetings annually of the HIV Planning Group and subcommittees.
- Train 100% of staff in cultural competency that is specific to their job function.

HIV, STD, and Hepatitis Branch (HSHB)

Why is this a Priority?

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. 44% of those diagnosed with HIV are Hispanic/Latinos, almost all males; Black males have higher rates of other STDs; 1.6 times more cases of chlamydia among women than men.

Strategy for Change

HSHB's strategy to address this health equity priority integrates the same approach for all STDs including HIV and involves:

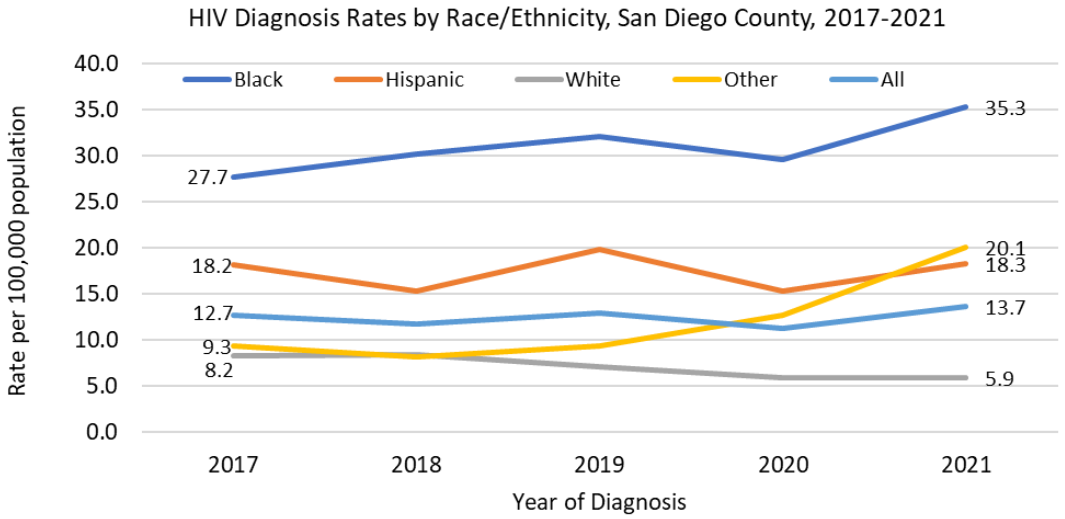
1. **Testing** in communities disproportionally impacted by these diseases.
2. Linking persons to **treatment** quickly and effectively.
3. Directing **prevention** efforts towards communities with disproportionate risk for infection
4. **Engaging** and mobilizing community efforts to achieve collective impact in reducing HIV and STD transmission
5. **Improving** outcomes through proactive performance and quality management and relentless focus on customer services

Partners in Getting this Done

Two collective impact efforts—**Getting to Zero and Hepatitis C Elimination**—reflect a community wide strategy and commitment to preventing HIV Infection and addressing rising STD rates., with the HIV, STD and Hepatitis Branch of PHS serving as the backbone. For these and all other activities, HSHB works closely with the HIV Planning Group and subcommittees and the Ryan White Clinical Quality Management Committee.

HIV, STD, and Hepatitis Branch (HSHB)

	HIV	Gonorrhea	Chlamydia	Syphilis
Gender	90% male	3 times higher in males than females, and increased by 57.6% from 2015 to 2017	1.6 times higher in women than men	79.5% of cases are men who have sex with men
Age	64% of incident cases were 20-39 years of age at diagnosis	Highest rates in men aged 20-29	2.6 times higher in women aged 20-24 than men	Highest in men aged 25-34
Geography	43% were diagnosed while residing in Central	Rates highest in most densely populated communities	Rates highest in most densely populated commu-	Rates highest in most densely populated com-
Race/Ethnicity	44% were Hispanic/ Latino	3.8 times higher in Black males than white males, and 2.8 times higher than Latino males Black women have a 5.1 times higher rate than white women and 3.1 times higher rate than Latino women		Black males have 1.8 times higher rate of infection than white males



Source: HIV/HCV Epidemiology and Surveillance Program, Epidemiology & Immunization Services Branch, HHSA, County of San Diego, 2023

Branch Plans

HIV, STD, and Hepatitis Branch (HSHB)

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

Objective: Reduce by 90% the HIV disease diagnosis case counts in San Diego County (from 2017 baseline of 422 to 42 by 2030). *Health Equity Lense: Race/Ethnicity and other.*

The Population Health Goal is based on Healthy People 2030.

Alignment Key:

Strategic Initiative (from the Strategic Initiative Framework):

- Strategic Initiative: Board of Supervisors
- Strategic Initiative: Combination of CAO, HHSA, or PHS Initiatives
- Strategic Initiative: PHS Initiative

Health Equity Focus

Community Connection

OP **Operational Plan** (Priority)

AP **Agency Promise,** Measure in HHSA Strategic Plan Scorecard

ap Additional PHS Measure that supports the Agency Promise

HIV, STD, and Hepatitis Branch (HSHB)

Getting to Zero

Eliminate Hepatitis C

Special Note regarding the HSHB Strategic Plan:

*This entire plan reflects the Board of Supervisors initiative referred to as **Getting to Zero**. Now in its seventh year, this initiative is to end the HIV epidemic over the next decade with comprehensive strategies, by engaging community partners, and setting goals based on national targets.*

***Eliminate Hepatitis C Initiative**, modelled after the Getting to Zero initiative, was launched in FY 2018-19. Hepatitis C is a serious liver disease that can go unnoticed until long-term complications develop that can lead to death. This plan also addresses Hepatitis C as part of overall efforts to test, treat, and prevent sexually transmitted disease.*

HIV = Human immunodeficiency virus; HCV = Hepatitis C Virus; STD: Sexually Transmitted Diseases.

Health Equity Focus

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

Strategy 1.1: Conduct HIV, HCV and STD testing in communities disproportionately impacted by HIV, HCV and STDs; link individuals who test positive to care and treatment resources; link individuals who test negative to prevention resources.

Objective 1.1.1: Increase availability and opportunity for screening and testing of individuals at risk of HIV, HCV or STDs.

- Online ordering platform maintained to provide women ages 25 and under with chlamydia and gonorrhea home testing kits.
- Online ordering availability maintained of self-testing for HIV, STDs, and monitoring related to PrEP usage.
- Funding provided to screen 100 percent of females for chlamydia and gonorrhea who are booked into County juvenile detention facilities.
- 100 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 to promote rapid availability of STD testing without appointments.
- 100 percent of individuals seeking services at County's STD clinics are screened for HIV and HCV using an opt-out protocol unless they are known to be HIV-positive or decline testing.
- At least 5,000 HIV tests conducted through focused testing in County facilities and contracted services.
- At least 95 percent of people living with HIV are aware of their serostatus by 2025 (baseline 2019 90 percent).
- HIV and HCV screening conducted with a minimum of 500 persons through County Harm Reduction Services.

HIV, STD, and Hepatitis Branch (HSHB)

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

- Surveillance-based HIV Partner Services conducted with 100 percent of individuals newly diagnosed with HIV outside of a program funded by HHSA.
- Partner Services conducted with 100 percent of individuals diagnosed with primary or secondary syphilis and all residents of child-bearing potential with any stage of syphilis.

Objective 1.1.3: Deploy through contracting both focused and routine HIV testing services.

- 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 San Diego County communities that are disproportionately impacted by HIV but where HIV-positivity rates for focused testing have not reached one (1) percent for two (2) years.

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

- Comprehensive STD services provided every weekday at various County STD clinics.

Health Equity Focus

GOAL 2 (TREAT): Link all persons living with HIV or STDs to treatment.

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

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

OP
- **At least 94 percent of newly diagnosed persons linked to HIV medical care within one (1) month (30 days) of informing them of their diagnosis.**
- At least 95 percent of persons with diagnosed with HIV infection retained in HIV medical care by the end of 2025.
- At least 95 percent of persons with diagnosed HIV infection are virally suppressed by the end of 2025.
- Reduce the proportion of new HIV diagnoses that progress to AIDS within one (1) year by 50 percent (from 2016 baseline).

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

- At least 65 percent of interviews of primary and secondary syphilis cases conducted within 30days of specimen collection.
- 100 percent of pregnant individuals with any stage of syphilis receive adequate treatments.
- 80 percent of patients identified as having possible anti-microbial resistance are followed up on and included among those patients treated for gonorrhea.
- 100 percent of patients diagnosed with STDs in County STD clinics are provided CDC-recommended or alternative treatments.

HIV, STD, and Hepatitis Branch (HSHB)

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

- On a quarterly basis develop priority list and investigate persons living with HIV who do not appear to be receiving HIV primary care.
- At least 25 percent of investigated persons living with HIV, not in care and still residing in San Diego, are re-linked to care.

Objective 2.1.4: Ensure availability of appropriate treatment in areas of San Diego County disproportionately impacted by syphilis, HCV, gonorrhea, and chlamydia.

- Every weekday, comprehensive STD services are provided at various County STD clinics.
- 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 have not received treatment.

Objective 2.1.5: Reduce new HIV diagnoses.

- 75 percent reduction in number of new cases of HIV diagnosed by the end of 2025.

Objective 2.1.6: Provide assistance to 100 percent of persons living with HIV who are currently or were formerly incarcerated in local detention facilities.

- Routine, opt-out HIV testing availability for 100 percent of 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 (1) in-person or virtual interview conducted by the Intensive Case Management Program with 100 percent of identified HIV-positive inmates 30 days prior to their scheduled release.
- 100 percent of HIV-positive inmates receive anti-retroviral medication and are linked to HIV primary care upon scheduled release.
- Five (5) months of inpatient substance abuse treatment, followed by six (6) months of sober living, provided for formerly incarcerated persons living with HIV who have substance use disorders.

Objective 2.1.7: Maintain STD surveillance system.

- 100 percent of new lab reports and Confidential Morbidity Reports (CMRs) entered into the California Reportable Disease Information Exchange (CalREDIE).
- Incoming syphilis reactors processed to determine priority for disease investigation activities.
- Syphilis summary reports provided to assist medical providers who are staging syphilis and determining need for treatment.
- Locally prioritized cases as well as cases referred from other jurisdictions assigned for case investigation.

- Annual slide deck developed that provides key information related to syphilis, HCV, gonorrhea, and chlamydia infections in San Diego County.
- QA activities conducted to support transition to receiving electronic lab reports.

Objective 2.1.8: Reduce new HCV diagnoses.

- HCV testing opportunities expanded with populations vulnerable to HCV acquisition.
- Funding opportunities identified to support linkage of 100 percent of HCV-positive individuals to treatment and follow-up.

Health Equity Focus

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

Strategy 3.1: Conduct HIV, HCV, 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 STD Clinic patients who are vulnerable to HIV infection are provided pre-exposure prophylaxis (PrEP) education.
- 100 percent of uninsured individuals who have had a recent high-risk exposure to HIV and meet PEP treatment guidelines are provided non-occupational post-exposure prophylaxis (nPEP).
- Contracted services with community providers to ensure PrEP navigation is available to individuals in areas of San Diego County where there is disproportionate HIV transmission.

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 communities of the County disproportionately impacted by HIV.
- 100 sites enrolled in the County of San Diego Condom Partner Distribution Program, where priority populations are known to congregate and/or do business.

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

- Every weekday, comprehensive STD services are provided.
- Schools and youth-service organizations assisted as requested to build their capacity to address sexual health and prevent STDs.
- Clean needles, naloxone, fentanyl test strips, health education and risk reduction, and linkage to other support services provided to participants in Harm Reduction Services.

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.

HIV, STD, and Hepatitis Branch (HSHB)

Objective 3.1.5: Prevent congenital syphilis.

OP
- **Confirm 100 percent of individuals of childbearing potential who are diagnosed with any stage of syphilis have been screened for pregnancy status.**
- At least 90 percent of pregnant individuals with any stage of syphilis are interviewed.
- At least one (1) sexual partner for at least 90 percent of pregnant individuals diagnosed with any stage of syphilis.
- 100 percent of pregnant individuals diagnosed with any stage of syphilis will receive penicillin-based treatment (based on CDC recommendations) at least 30 days prior to delivery.
- Appropriate diagnostic evaluation and/or treatment is confirmed for 100 percent of infants born to individuals with untreated or inadequately treated syphilis at the time of delivery.
- All pregnant individuals with syphilis will be offered public health nursing care management by coordinating with Maternal, Child and Family Health Services Branch and the Medical Care Services Division.


Health Equity Focus


Community Connection

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, STD, and HCV transmission.

Objective 4.1.1: Provide trainings to improve knowledge and understanding among 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 (1) full-day STD training for non-clinicians and educators convened each year.
- At least four (4) STD 101 trainings conducted for representatives of health care organizations, community-based organizations, schools and social service organizations each year.
- At least one (1) full-day STD training conducted for clinicians every other year.
- On a monthly basis, publish the STD Update, providing information regarding STD rates and an editorial note related to HIV and STDs in San Diego County.

Objective 4.1.2: Promote awareness of HIV and STDs in San Diego County.
- Activities coordinated for annual observance of National HIV Testing Day (observed on June 27).

- A. Brad Truax award ceremony coordinated annually on World AIDS Day (observed December 1 of each year) to recognize exceptional accomplishments of local individuals.
- HIV testing and education provided at the San Diego LGBT Pride festival annually.
- Activities coordinated to promote awareness of STDs during STD Awareness Month annually in April.
- Activities coordinated to promote awareness of HCV during HCV Awareness month annually in July.

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

- An ongoing assessment conducted of the needs of persons living with or vulnerable to HIV, including a needs assessment once every three (3) years, an assessment of system capacity and capability every three (3) years, and special studies of focus populations every three (3) years.

Objective 4.1.4: As funding becomes available, conduct media campaigns to promote awareness of HIV, HCV and STDs, prevention strategies, and available resources.

Objective 4.1.5: 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, allowing them to order condoms and other safer sex materials directly from the California AIDS Clearinghouse.
- Availability of condoms at all County STD Clinics.

Objective 4.1.6: Maintain an online and social media presence to promote awareness of HIV, HCV and STDS as public health concerns, and provide information, education and resources regarding testing, treatment, and prevention.

- Maintain three (3) regional websites related to HIV testing, treatment, and prevention resources in coordination with contracted providers: North County (North Coastal and North Inland regions); Central San Diego (Central and North Central regions); and South Bay (South region).
- Coordinate with HHSA Communications Office to develop messages regarding HIV, HCV, and STDs, and deploy them through Facebook, Twitter, TikTok, Grindr, and other social media spaces commonly used in focus communities.

Objective 4.1.7: Support the HIV Planning Group.

- At least 24 meetings of the HIV Planning Group and its subcommittees conducted annually.
- At least four (4) regional planning meetings conducted annually.
- HIV Planning Group and committees provided with logistical support and subject matter expertise.
- Steering Committee provided with support for its membership activities.
- Mileage reimbursement, childcare reimbursement, and refreshments offered to promote attendance by persons living with HIV.

HIV, STD, and Hepatitis Branch (HSHB)

- Monthly report on Getting to Zero delivered to the Steering Committee.
- Monthly expenditure reports provided for all HIV-related services.
- Trainings and presentations coordinate and/or provided for 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 and 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, noting disparities in regard to gender and race/ethnicity.
- Outcomes for populations showing disparities in health outcomes related to HIV treatment.
- 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.

Objective 4.1.10: Provide gender responsive healthcare.

- Appropriate gender responsive healthcare protocols are developed and deployed.
- All paper and electronic forms are reviewed and updated to reflect gender appropriately.
- Environment and procedures at all county STD clinics are reviewed and adjusted as necessary.

Objective 4.1.11: Develop knowledge base of LGBTQ communities in San Diego County.

- Needs assessment of LGBTQ communities in San Diego County conducted.
- Assessment of system capacity and capabilities regarding care for LGBTQ+ communities in San Diego County conducted.

Objective 4.1.12: Develop focus on anti-racism, anti-sexism and anti-ableism in healthcare.

- Training provided to HSHB staff quarterly regarding anti-racism, anti-sexism, and anti-ableism.

HIV, STD, and Hepatitis Branch (HSHB)

Performance Management and Quality Improvement

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, STD and viral hepatitis testing, treatment and prevention efforts.

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

- Monthly operational monitoring reports regarding timely receipt and processing of invoices, monthly progress reports, procurements, status of expenditures and achievement of contract deliverables, STD clinic operations, Intensive Case Management operations, Community Health Services operations, and contract operations.
- At least eight (8) meetings Conducted annually of the Ryan White Clinical Quality Management Committee.
- At least one (1) 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 HEART initiative.
- 100 percent of staff participate in cultural competency training specific to their job functions.

Use of Data

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; National STD Prevention Conference; U.S. Conference on HIV and AIDS; National Prevention Conference; National Biomedical Prevention Conference; and National Harm Reduction 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.

Talent and Team Development

Objective 5.1.3: Develop workforce capacity.

- Cultural competencies are identified for each staff member in HSHB that are necessary for success and provide trainings that help to develop those competencies.
- Assistance provided for each staff member in identifying career goals and 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.

HIV, STD, and Hepatitis Branch (HSHB)

Customer Service

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 address any areas that would benefit from improvement.
- Annually, client satisfaction surveys conducted of all clients receiving Ryan White services.
- Annually, Ryan White customer satisfaction survey results compiled and analyzed, and presented to the Non-Medical Standards and Evaluation Committee of the HIV Planning Group.

IT Gaps and Use of Data

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 (CalREDIE) maintained by staff support.
- Training and technical assistance regarding usage of ARIES and LEO offered, as needed to contracted providers.
- Electronic health record system deployed.

Contract Resources and Contracting Policies

GOAL 6: (CONTRACT): Implement and maintain a contracting process that supports and promotes strategic plan goals.

Strategy 6.1: Ensure consistent monitoring of all contracted services.

Objective 6.1.1: Success of contractors ensured through monitoring plans for 100 percent of contracted services.

- Monthly review of performance and expenditures conducted for 100 percent of contracts.
- Timely payment of contracted providers ensured.
- Exceptional customer service offered to providers of contracted services (as rated in an annual survey administered by HHSA Agency for Contracted Services).

Talent and Team Development

GOAL 7: Retain, develop and recruit staff to support the missions of the County, HHSA, PHS and HSHB.

Strategy 7.1: Ensure that HSHB has the ability to recruit and retain talent representing the diversity of the communities we serve.

HIV, STD, and Hepatitis Branch (HSHB)

Objective 7.1.1: A variety of trainings and strength-based engagement opportunities provided to ensure all staff can contribute to the success of HSHB.

- All staff provided with trainings regarding policies, procedures, and expectations relevant to their roles.
- Quarterly trainings provided to staff regarding HSHB programs and services.
- Quarterly trainings provided to staff regarding the different communities served by HSHB to improve cultural competency and humility in service planning, design, delivery and monitoring.
- Quarterly trainings provided regarding structural and institutional factors that lead to health disparities and inequalities, focusing on anti-racism, anti-sexism, anti-homophobia, anti-transphobia and anti-ableism.
- All staff provided with the Clifton Strengths Finder.
- All staff provided with the opportunity for one-on-one meetings with their supervisors at least every other week.
- All managers and supervisors provided with trainings regarding engaging their direct reports in achieving the mission of HSHB, PHS, HHSA and the County.
- Staff accomplishments celebrated at every all-staff meeting.
- All staff have development plans and at least one (1) tangible development goal is discussed at least twice per year with their supervisor.

Strategy 7.2: Create opportunities for staff to support engagement and belonging of their colleagues.

Objective 7.2.1: A variety of employee engagement and belonging opportunities provided to ensure all HSHB staff are valued and feel a sense of inclusion.

- Staff Committee convened at least four (4) times per year to plan and execute staff engagement, recognition, and development activities.
- Staff Committee convened at least four (4) times per year to support H.E.A.R.T.
- Staff Committee convened at least four (4) times per year to focus on anti-racism, anti-sexism, anti-homophobia, anti-transphobia, and anti-ableism.

HIV, STD, and Hepatitis Branch (HSHB)

ADDITIONAL OBJECTIVES THAT SUPPORT NEW COUNTY AND AGENCY INITIATIVES

Health Equity Focus

Community Connection

GOAL 8: Through community engagement, strengthen and invigorate communities with opportunities to grow, connect, and thrive.

Strategy 8.1: Seek opportunities to intentionally work together toward shared goals and actions that strengthen healthy, safe, and thriving communities.

Objective 8.1.1: Strengthen and expand partnerships and community engagement through outreach and education; providing transparency; and seeking opportunities to intentionally work together for collective impact.

ap • **At least once per year, provide information about programs, resources, and tools to advance implementation of Community Enrichment Plans annually.**

ap • **For a minimum of 4 times per year, engage in collaborative meetings with partners, to advance one major initiative (collective impact, health equity, or other) led by each Branch.**

Alignment to National, State, and Local Plans HIV, STD, and Hepatitis Branch	
	The HIV, STD, and Hepatitis Branch (HSHB) aligns to The Ten Essential Services (ES) of Public Health, specifically ***ES 1-Assessments***, ***ES 2-Investigations***, ***ES 3-Communication*** and ***ES 10-Infrastructure***. For example, HSHB mobilizes medical providers, community-based organizations, community groups, and individuals in efforts to eliminate HIV and STD transmission. Furthermore, HSHB assesses HIV and STD transmission and investigates cases to ensure proper case management and treatment is provided to the community.
HEALTHY PEOPLE 2030	HSHB aligns to Healthy People 2030's ***Health Equity*** and ***Social Determinants of Health*** priority areas. For example, HSHB links persons living with HIV or STDs to treatment services and ensures those that are most vulnerable receive appropriate care.
Let's Get Healthy California	HSHB aligns to the State of California's Let's Get Healthy California ***Healthy Beginnings*** goal. For example, HSHB links all persons at risk for HIV and STD to prevention resources. Furthermore, HSHB prevents congenital syphilis by ensuring all pregnant women with syphilis are offered public health nursing case management.

HIV, STD, and Hepatitis Branch (HSHB)

Alignment to National, State, and Local Plans HIV, STD, and Hepatitis Branch	
LIVE WELL SAN DIEGO	HSHB aligns to the County of San Diego *Live Well San Diego* vision of healthy, safe, and thriving San Diego County communities, specifically the ***Safety*** component. A few examples include identifying all persons infected with HIV and STDs so they are informed and linked to care, providing education and outreach about HIV and STDs, continually improving outcomes and services for clients, maintaining systems for building knowledge and identifying evidence-based practices, and monitoring performance and quality of services. HSHB also ensure at least 85 percent of clients with newly confirmed HIV diagnosis are connected to primary care within 30 days of being informed of their diagnosis.

HSHB aligns to the County and/or HHSA Strategic Initiatives of ***Sustainability***, ***Workforce***, ***Community Engagement***, ***Equity***, ***Service Delivery Coordination***, and ***Systems and Technology***. For example, HSHB conducts HIV and STD testing in communities most disproportionately impacted, linking individuals who test positive to care and treatment resources and those who test negative to prevention. Furthermore, HSHB continually seeks to improve outcomes for all services and activities, monitors performance of programs to ensure quality services are delivered to the community. HSHB also develops its workforce capacity and encourages staff to attend conferences and educational opportunities to build the knowledge base of best practices related to HIV and STD prevention, treatment, and control efforts across the United States.

Maternal, Child, and Family Health Services (MCFHS)

The Maternal, Child, and Family Health Services (MCFHS) works to promote health

Units and Programs

- **Chronic Disease and Health Equity Unit (CDHE)****
  - CalFresh Healthy Living Program
  - Childhood Obesity Initiative
  - Live Well @ Work
  - Racial and Ethnic Approaches to Community Health (REACH)
  - Tobacco Control Resource Program (TCRP)
  - Diabetes Prevention
- **Family Health and Preventive Services Unit (FHPS)**
  - Adolescent Health Initiative
  - Black Infant Health (BIH)
  - California Home Visiting Program (CVHP)
  - Child Health and Disability Prevention (CHDP)
  - Comprehensive Perinatal Services Program (CPSP)
  - Birth Equity
  - Health Care Program for Children in Foster Care
  - Local Oral Health Program (LOHP)
  - Office of Violence Prevention (OVP)
  - Perinatal Care Network (PCN)
  - Sudden Infant Death Syndrome (SIDS)
- **Surveillance Unit**

CDHE Health Equity Goal: Advance health in all policies. Objective: No more than 43% of deaths in San Diego County have chronic disease as a contributor. *Health Equity Lens: All.*

CDHE Population Health Goal: Use health policy to prevent disease and improve health, including tobacco use policies. Objective: Reduce use of electronic vapor products by high school youth by 25% (from 11% to 8.25%) by 2026 and by 35% (11% to 7.15%) by 2030.

FHPS Health Equity Goal: Reduce infant mortality. Objective: Reduce the three-year average infant mortality rate per 1,000 live births to no more than 5.0 deaths by 2030 with focus on reducing the infant mortality rate for Black infants, which currently in San Diego County is 7.3 deaths. *Health Equity Lens: Race/Ethnicity.*

FHPS Population Health Goal: Improve the health and safety of infants. Objective: Reduce the rate of infant mortality from 5.4 (in 2020) to 5.0 per 1,000 live births across all race and ethnicities.

The Health Equity Goal is the priority that each Branch adopted in 2016 to address concerns about inequities. The Population Health Goal is based on Healthy People 2030.

Story of a Health Equity Goal—Advance Health in All Policies

Maternal, Child, and Family Health Services (MCFHS)

Chronic Disease and Health Equity Unit (CDHE)

Health Equity Goal: Advance health in all policies.

- **Objective:** No more than 43% of deaths in San Diego County have chronic disease as a contributor. *Health Equity Lense: All.*

The Health Equity Goal is the priority that each Branch adopted in 2016 to address concerns about inequities.

Program efforts to bring about change:

(Measures appear in Strategic Plan)

Consistent with the HiAP approach:

- Increase by at least one additional jurisdiction that has adopted and implemented policies to eliminate smoking in all outdoor recreational and non-recreational public places and that adopt tobacco retail licensing policy.
- Ensure 85% of retailers are in compliance with youth access law and tobacco laws.
- 10 food pantries, annually, will adopt the Nutrition Pantry Program.
- Provide nutrition and physical activity education to 1,000 CalFresh Healthy Living eligible individuals to promote healthy eating, food resource management, and/or physical activity.

Operations that support program success:

- Utilize the Healthy Places Index or similar tool to advance equity in the design or implementation of at least one program; also support other Branches in the use of the tool.

Story of a Health Equity Goal—Advance Health in All Policies

Maternal, Child, and Family Health Services (MCFHS)

Chronic Disease and Health Equity Unit (CDHE)

Why is this a Priority?

Health in all Policies (HiAP) is a proven approach to addressing chronic disease. 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 healthcare 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. Tobacco control policy is an important part of Health in all Policy, as are all policies that contribute to environmental changes that encourage healthy eating, physical activity and reduced use of tobacco products and exposure to smoke.

Strategy for Change

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 CalFresh Healthy Living Program (SNAP-Ed), 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.

Through the Tobacco Control Resource Program, CDHE is working on comprehensive tobacco retail licensing (TRL) policies in five jurisdictions (Chula Vista, El Cajon, Lemon Gove, Poway, and Oceanside). If successful, local policies facilitate better enforcement and compliance with the new state law prohibiting the sale of flavored tobacco products. Also, under the new Tobacco Retail Licensing Program, CDHE can soon begin enforcement of illegal sales of tobacco products to underage people (<21) and to enforce the local and the State ban on the sale of flavored tobacco products.

Partners in Getting this Done

We have utilized the Healthy Places Index tool in our planning process for CalFresh Healthy Living FFY24-26 funding cycle. The HPI, among other health and qualifying data, were used to identify 9 communities to prioritize all of our planned Policy, Systems, and Environment (PSE) change activities. Activities involving partnerships such as those with schools, early care, youth partners, cities, active transportation experts, local agriculture, healthcare will be prioritized based on the HPI data.

Story of a Health Equity Goal—Advance Health in All Policies

Maternal, Child, and Family Health Services (MCFHS)

Chronic Disease and Health Equity Unit (CDHE)

Looking through the Health Equity Lens: Health in All Policies

Three behaviors (poor diet, physical inactivity, and tobacco use) contribute to four chronic disease (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 for the 3-4-50 concept.

According to the California Health Interview Survey, between 2019-2021, 8.4% of San Diegan adults had never been diagnosed with diabetes. Of those, 86.6%, or roughly seven of eight adults with diabetes, had type II diabetes. Overall, in 2021, the highest diabetes medical encounter rates belonged to:

- **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.

In 2021, 26.1% of San Diegan adults had ever been diagnosed with high blood pressure and 6.7% of San Diegan adults were diagnosed with borderline high blood pressure. Overall, in 2021, the highest hypertension medical encounter rates belonged to:

- **Gender**: Males;
- **Age**: Those over 65;
- **Race/Ethnicity**: Those who are African American/Black; and
- **Socioeconomic Status**: Those who lived in communities with low median household incomes.

A review of 3-4-50 data showed that in 2020, regardless of region, overall cancer accounted for the greatest percentage of chronic disease deaths, followed by overall heart disease. When examining the data by health equity lens across the County, noticeable difference exist:

- **Gender**: Death from overall cancer, overall heart disease, an diabetes was higher among males; death from chronic obstructive pulmonary disease (COPD) and stroke risk was higher among females;
- **Age**: Higher death rates found in those over the age of 65;
- **Geography**: 3-4-50 chronic disease 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 a higher risk of death for all 3-4–50 disease whereas African Americans/Blacks and Asian Pacific Islanders were at a higher risk for diabetes;
- **Socioeconomic Status**: Overall, those residing in communities with lower median household incomes had higher rates of the 3-4-50 chronic disease deaths.

Story of a Health Equity Goal—Reduce Infant Mortality

Maternal, Child, and Family Health Services (MCFHS)

Family Health and Preventive Services Unit (FHPS)

Impact that we seek:

(Indicator appears in PHS Outcomes Dashboard)

Health Equity Goal: Reduce infant mortality

- **Objective:** Reduce the three-year average infant mortality rate per 1,000 live births to no more than 5.0 deaths by 2030 with focus on reducing the infant mortality rate for Black infants, which currently in San Diego County is 7.3 deaths. *Health Equity Lens: Race/Ethnicity.*

The Health Equity Goal is the priority that each Branch adopted in 2016 to address concerns about inequities.

Program efforts to bring about change:

(Measures appear in Strategic Plan)

For infants served by the Black Infant Health Program, ensure:

- 88% of infants have a normal birth weight (at least 2,500 grams).
- 90% of infants born will have initiated breastfeeding.

For pregnant women who call the Perinatal Care Network (PCN) phone line, ensure:

- 75% of pregnant women who call the PCN phone line in their first or second trimester od pregnancy with no prenatal care are linked to a provider within 30 days.

Operations that support program success:

- 50% of active Comprehensive Perinatal Services Program providers receive a quality assurance visit.

Story of a Health Equity Goal—Reduce Infant Mortality

Maternal, Child, and Family Health Services (MCFHS)

Family Health and Preventive Services Unit (FHPS)

Why is this a Priority?

Over the past 2 decades, San Diego's African-American infants have been about 2 to 4 times as likely to die before reaching their first birthday, compared to other large race/ethnic groups in the County (White, Asian, and Hispanic). Factors responsible for this gap are not completely understood but include perpetual upstream issues like institutional racism, class oppression, and gender discrimination, which have trickle-down effects that influence many social determinants of health. Black infants have the highest infant mortality rate at 7.3 deaths per 1,000 live births in 2017-2019.

Strategy for Change

The County of San Diego's Family Heath and Preventive Services Unit has three programs that offer resources and services. The Black Infant Health (BIH) program, administered by Neighborhood House Association, follows a group-based and client-centered case management approach that works to specifically address access to quality healthcare and social connections. The Perinatal Equity Initiative (PEI) program aims to change systems that contribute to social injustices, economic disparities, and racial and health inequities. With guidance from a community advisory board, PEI implemented a public awareness campaign, implicit bias training program for healthcare professionals, and a fatherhood parenting program. In turn, these programs improve the health and well-being of mothers as well as reduce infant mortality among this population. The Birth Equity Program is tasked with identifying contributing factors of fetal and infant loss in San Diego County with a particular focus on the experiences of African-American mothers and babies. This information is, in turn, used to develop community-based interventions aimed at improving birth outcomes for families.

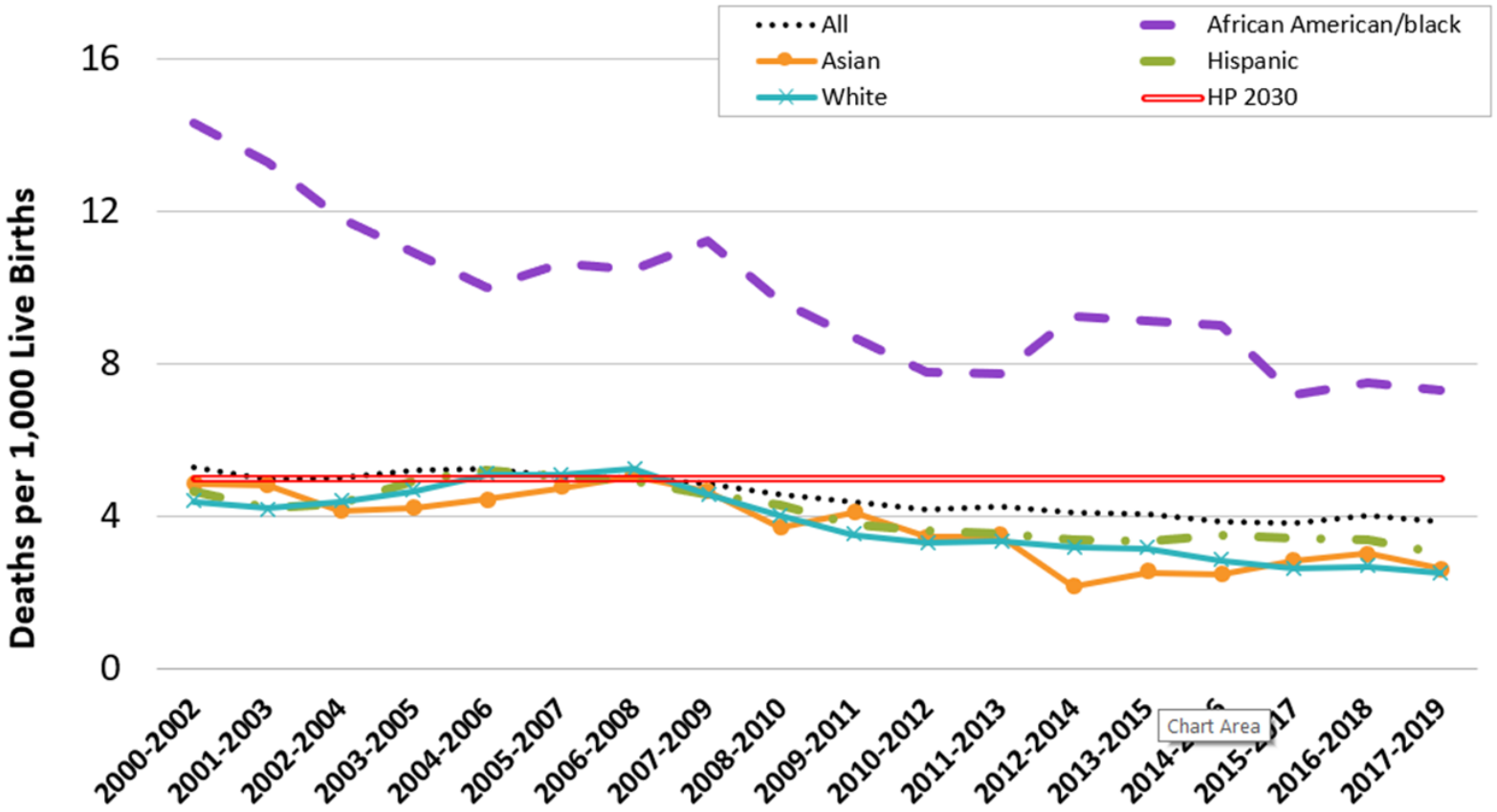
Partners in Getting this Done

- BIH and Perinatal Equity Initiative (PEI) Subcontractors, Advisory Boards, and Subcommittees
- California Department of Public Health, Maternal Child, and Adolescent Health (MCAH) Division
- Community-based organizations and key stakeholders
- MCAH Family Support Collaborative
- Perinatal providers
- Public Health Services and other County departments, including the Board of Supervisors

Maternal, Child, and Family Health Services (MCFHS)

Family Health and Preventive Services Unit (FHPS)

Looking through the Health Equity Lens: Infant Mortality



Notes about figure above: Rates not shown for Unknown race/ethnicity and groups with fewer than 20 events in any period (Native American/Alaskan, Pacific Islander, other, and two or more races). The large proportion of births with unknown race/ethnicity affects the accuracy of statistics by race/ethnicity. Interpret with caution rates calculated for fewer than 20 deaths since they are considered statistically unreliable. Rates based on small numbers may fluctuate dramatically year to year even when the changes are not meaningful or statistically significant.

- Source: California Department of Public Health, Center for Health Statistics and Informatics, Birth Cohort Statistical Master Files.
- Prepared by: County of San Diego, Health and Human Services Agency, Public Health Services, Maternal, Child and Family Health Services.

Maternal, Child, and Family Health Services (MCFHS)

Chronic Disease and Health Equity Unit:

Population Health Goal: Use health policy to prevent disease and improve health, including tobacco use policies.

- **Objective:** Reduce use of electronic vapor products by high school youth by 25% (from 11% to 8.25%) by 2026 and by 35% (11% to 7.15%) by 2030.

Family Prevention and Health Services:

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

- **Objective:** Reduce the rate of infant mortality from 5.4 (in 2020) to 5.0 per 1,000 live births across all race and ethnicities.

The Population Health Goal is based on Healthy People 2030.

Alignment Key:

Strategic Initiative (from the Strategic Initiative Framework):

- Strategic Initiative: Board of Supervisors
- Strategic Initiative: Combination of CAO, HHSA, or PHS Initiatives
- Strategic Initiative: PHS Initiative

Health Equity Focus

Community Connection

OP **Operational Plan** (Priority)

AP **Agency Promise,** Measure in HHSA Strategic Plan Scorecard

ap Additional PHS Measure that supports the Agency Promise

Maternal, Child, and Family Health Services (MCFHS)

**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 FPHS 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 and after the duration of this MCFHS Branch Strategic Plan (FY 2023-24 to 2024-25). 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 2023-2025 (10/1/23 through 9/30/25). The REACH objectives are based on a program continuation outcome of a five-year grant application that is currently under review by the Centers for Disease Control and Prevention, pending notice by August 30th.*

Health Equity Focus

CHRONIC DISEASE AND HEALTH EQUITY UNIT – SAN DIEGO COUNTY CHILDHOOD OBESITY INITATIVE

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

Strategy 1.1: Through the San Diego County Childhood Obesity Initiative (COI), reduce and prevent childhood obesity in San Diego County with a focus on policy, system, and environmental (PSE) changes through collective impact.

Objective 1.1.1: Increase access to healthy food and/or physical activity opportunities through PSE change.

- A minimum of one (1) jurisdiction or community entity (school board, municipality, etc.) adopts at least one (1) PSE annually.

Health Equity Focus

CHRONIC DISEASE AND HEALTH EQUITY UNIT – CALFRESH HEALTHY LIVING

Strategy 1.2: Through the CalFresh Healthy Living (CFHL) Program, improve the likelihood that individuals eligible for Supplemental Nutrition Assistance Program (SNAP) will make healthy food choices within a limited budget and choose physically active lifestyles in San Diego County with a focus on policy, system, and environmental changes.

Objective 1.2.1: Improve opportunity for TK-12 students to participate in daily quality physical activity (N=12 districts total).

- Seven (7) school districts will improve quality-standards-based Physical Education instruction (FY 23-24).
- Five (5) school districts will improve quality-standards-based Physical Education instruction (FY 24-25).

Objective 1.2.2: Advance active transportation municipal policies through the Healthy Cities, Healthy Residents (HCHR) project

- Two (2) active transportation municipal policies are drafted or updated (FY 23-24).
- Two (2) active transportation municipal policies are implemented (FY 24-25).

Objective 1.2.3: Provide Safe Routes to Schools technical assistance to cities and their respective school districts to develop and implement semi-permanent infrastructure improvements (quick-builds).

- Implement capacity-building curriculum with a minimum of 2 coalitions (inclusive of school districts and municipalities) (FY 23-24).
- Implement a minimum of two "quick-build" projects in a minimum of 2 cities (one per city) in collaboration with their respective school districts (FY 24-25).

Objective 1.2.4: Distribute fresh produce to neighborhood markets and/or convenience stores in underserved communities with limited access to healthy food.

- Recruit and engage five (5) neighborhood markets and/or convenience stores annually to participate in fresh produce distribution.

Objective 1.2.5: Assist farmers markets and other farmers' direct sales strategies to improve utilization of Electronic Benefits Transfer (EBT) and/or other food assistance programs.

- One (1) farmers market and/or other farmers' direct sales strategies annually will increase acceptance of payment through EBT and/or other food assistance programs (for a total of 2).

Objective 1.2.6: Assist small to medium, BIPOC, woman-led, and/or climate-smart farms in San Diego County become more economically viable while serving SNAP-eligible populations.

- Provide training and technical assistance to three (3) farmers annually (for a total of 6)

Objective 1.2.7: Provide nutrition and physical activity education to CalFresh Healthy Living eligible individuals to promote healthy eating, food resource management, and/or physical activity.

- 1,000 eligible individuals receive nutrition and physical activity education annually.

Birth Equity

Objective 1.2.8: Institutionalize lactation supportive trainings for County of San Diego home visitors (HV) staff.

- County home visitation programs will adopt protocol for lactation education training/professional development of County HV program staff (FY 23-24).
- 25 percent of staff will complete training (FY 24-25).

CHRONIC DISEASE AND HEALTH EQUITY UNIT – TOBACCO CONTROL

Health Equity Focus

Tobacco Retail

Strategy 1.3: Reduce promotions of tobacco products, exposure to secondhand smoke, and access to tobacco products through the Tobacco Control Resource Program to prevent smoking and encourage tobacco cessation.

Maternal, Child, and Family Health Services (MCFHS)

Objective 1.3.1: Increase the number of jurisdictions that adopt Policy, System, and Environmental (PSE) changes to limit or control tobacco use.

- One (1) additional jurisdiction in San Diego County adopts and implements a policy that eliminates smoking in all outdoor recreational and non-recreational public places (including parks/beaches, sidewalks, dining, entryways, worksites, event sites, bike lanes/paths, alleys, and parking structures).
- One (1) additional jurisdiction in San Diego County to adopt and implement a comprehensive tobacco retail licensing policy.

Strategy 1.3.2: Implement a licensing program for tobacco retailers that reduces access to tobacco products among youth and ultimately contributes to a reduction in smoking.

OP
- **85 percent (221 of 260) of licensed tobacco retailers in the unincorporated area of San Diego County comply with youth access laws prohibiting sales to anyone under 21.**

CHRONIC DISEASE AND HEALTH EQUITY UNIT – RACIAL AND ETHNIC APPROACHES TO COMMUNITY HEALTH

Racism: A Public Health Crisis

Strategy 1.4: Through the Racial and Ethnic Approaches to Community Health (REACH) grant ** support implementation, evaluation, and dissemination of culturally-tailored interventions that includes evidence-based strategies related to nutrition, physical activity, and clinical-community linkages strategy.

Objective 1.4.1: Improve nutrition in priority populations.

- Two (2) employers adopt lactation supportive policies for employees annually.
- A minimum of three (3) County Food Service Operations annually will adopt improved practices to source food that is sustainable, equitable, and local.

Objective 1.4.2: Increase opportunities for physical activity through improvements to the built environment.

- A minimum of three (3) pedestrian and/or bicycle facilities conceptual design plans completed (FY 23-24).
- A minimum of four (4) pedestrian and/or bicycle facilities conceptual design plans completed (FY 24-25).

Objective 1.4.3: Increase demand and access to COVID-19, influenza, and other routine adult vaccination opportunities.

- Implement a minimum of one (1) vaccination promotion public information campaign for priority populations annually.

Maternal, Child, and Family Health Services (MCFHS)

Talent and Team Development

CHRONIC DISEASE AND HEALTH EQUITY UNIT – LIVE WELL @ WORK

Strategy 1.5: Through the Live Well @ Work (LW@W) program, improve population health through new or enhanced employee wellness initiatives.

Objective 1.5.1: Increase employer-focused policy, system, and environmental (PSE) changes to improve employee health and safety in the workplace.

- A minimum of ten (10) employers annually will adopt at least one PSE change to improve employee health, safety, and/or organizational support for healthy eating, physical activity, and/or safe working environments.

CHRONIC DISEASE AND HEALTH EQUITY UNIT – DIABETES PREVENTION PROGRAM

Strategy 1.6: Through the Diabetes Prevention Program (DPP) initiative, create infrastructure to screen, refer, and enroll people into lifestyle change programs.

Objective 1.6.1: Establish or enhance clinical systems for patient screening and referral to clinical or community lifestyle change programs.

- A minimum of one (1) clinical setting or community-based organization adopts new or improved policies or protocols for patient screening and referral to lifestyle change programs annually.

Sustainability and Climate Change

GOAL 2: Actively combat climate change through innovative or proven policies, green jobs, sustainable facility construction or maintenance, and hazard mitigation.

Strategy 2.1: Protect the region, economy, climate, environment, and communities by developing policies that reduce disparities for current and future generations.

Objective 2.1.1: Work with County departments (including Department of Purchasing and Contracting) to develop a Board of Supervisors' policy that supports local, sustainable, and equitable County food purchasing.

OP • **Degree to which progress is achieved in developing a Board policy for sustainable County food purchasing.**

Objective 2.1.2: Provide technical support to 10 community-based organizations, local coalitions, and cities to increase their capacity for healthy and equitable planning, including increasing natural landscaping where possible to reduce contributors to climate change.

OP • **At least 10 community-based organizations, local coalitions, and cities are provided technical support.**

Maternal, Child, and Family Health Services (MCFHS)

FAMILY PREVENTIVE AND HEALTH SERVICES UNIT–BLACK INFANT HEALTH

Health Equity Focus

Racism: A Public Health Crisis

Birth Equity

GOAL 3: Reduce preventable fetal and infant morbidity and mortality with a focus on the disproportionate African-American infant mortality rate *(Same goal used for Strategy 3.1-3.3).*

Strategy 3.1: Assure pregnant women receive adequate care and services using a comprehensive approach that includes outreach, screening, health communication and education, and case management.

Objective 3.1.1: Ensure infants born who are served by the Black Infant Health (BIH) program will have positive health outcomes.

OP
- **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).

FAMILY PREVENTIVE AND HEALTH SERVICES UNIT – PERINATAL CARE NETWORK

Health Equity Focus

Birth Equity

Strategy 3.2: Take a comprehensive approach that includes outreach, screening, health communication and education, and care coordination to assure pregnant women receive proper care and services.

Objective 3.2.1: Ensure pregnant women who call the PCN toll-free phone line receive complete intake services and are quickly linked to providers.

- 75 percent of pregnant women who call the PCN phone line in their first or second trimester of pregnancy with no prenatal care are linked to a provider within 30 days.

FAMILY PREVENTIVE AND HEALTH SERVICES UNIT – SUDDEN INFANT DEATH SYNDROME PROGRAM

Health Equity Focus

Birth Equity

Strategy 3.3: 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 3.3.1: Review and respond to referrals to ensure provision of resources and assistance to families and others affected by SIDS.

- 90 Percent of SIDS referrals contacted within three (3) business days.

- 90 percent of participants attending a SIDS Safe Sleep presentation correctly identify a safe sleep environment for an infant.

FAMILY PREVENTIVE AND HEALTH SERVICES UNIT –CHILD HEALTH AND DISABILITY PREVENTION PROGRAM

GOAL 4: Promote early detection, prevention, and management of disease and disabilities, including oral health, for all children in San Diego County.

Strategy 4.1: Conduct periodic and comprehensive preventive health examinations through qualified Child Health and Disability Prevention (CHDP) providers and ensure care coordination and treatment of health conditions detected.

Objective 4.1.1: Ensure eligible children in out-of-home placement receive preventive health examinations to identify and correct medical issues.

OP
- **90 percent of children in out-of-home placement receive timely preventive health examinations.**

Objective 4.1.2: Ensure that children in out-of-home placement receive dental examinations to identify and correct dental issues.

OP
- **90 percent of children in out-of-home placement receive timely dental examinations.**

Objective 4.1.3: 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 facility site review.
- At least 80 percent of CHDP providers due for recertification will score 88 percent or higher on the medical record review.

Objective 4.1.4: 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 (7) days of receipt of referral.
- At least 40 percent of medical records reviewed will have documentation of a dental referral at one (1) year of age.

FAMILY PREVENTIVE AND HEALTH SERVICES UNIT – OFFICE OF VIOLENCE PREVENTION

GOAL 5: Strengthen families by improving the health of women and men and reducing family violence in San Diego County.

Strategy 5.1: Implement the countywide Family Violence Prevention and Response Initiative in partnership with other County Departments and community partners.

Objective 5.1.1: Increase awareness among community partners and organizations about the different types of violence and violence prevention strategies.

- 600 community partners and County staff trained on various forms of violence, which impact the community and provide resource materials to assist in awareness and prevention.

Objective 5.1.2: Build capacity for domestic violence identification and response among healthcare organizations (e.g., healthcare systems, hospitals, community clinics, private healthcare providers).

- Five (5) Health CARES (Conduct screening, Assess, Report, Evaluate, and Safety plan) trainings conducted for healthcare and community health providers.
- Three (3) healthcare systems and community health providers update their domestic violence protocols to align with state laws.

FAMILY PREVENTIVE AND HEALTH SERVICES UNIT – ORAL HEALTH PROGRAMS

Health Equity Focus

GOAL 6: Promote oral health education and prevention for all children in San Diego County.

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

Objective 6.1.1: Help ensure all children are assessed for oral health.

- 66 percent of eligible children entering school receive an oral health assessment and submit an Oral Health Assessment form.

Objective 6.1.2: Train pediatric healthcare providers to educate families on the importance of oral health, the first dental visit, and preventive services.

- 10 new pediatric provider offices trained and provided with technical assistance to implement fluoride varnish who serve Medi-Cal patients and are within vulnerable ZIP Codes of focus.

Objective 6.1.3: Increase the number of oral health providers who will see very young children by age one or when the first teeth erupt.

- 10 new dental provider offices trained and provided with technical assistance to see children by age one (1) or first tooth eruption who serve Medi-Cal patients and are within vulnerable ZIP Code of focus.

SURVEILLANCE, EPIDEMIOLOGY, AND EVALUATION UNIT

Performance Management

GOAL 7: Integrated performance excellence framework that delivers ever-improving value and contributes to the Agency's ongoing success.

Strategy 7.1: Ensure ethical and evidence-based decision-making through an integrated monitoring and evaluation plan that provides relevant information for better-informed decision-making.

Objective 7.1.1: Utilize dashboards and data to highlight progress for contractors and staff.

- Produce two (2) new dashboards per year for large programs to illustrate progress toward key program objectives.
- Provide consultation to three (3) PHS Branches per year to help ensure programs are designed and implemented with a health equity lens (such as the Health Equity Tool).

Objective 7.1.2: Share program innovations and successes.

Develop two (2) abstracts per year or one (1) brief, white paper, or manuscript to share program innovations and successes.

ADDITIONAL OBJECTIVES THAT SUPPORT NEW COUNTY AND AGENCY INITIATIVES

Health Equity Focus

Community Connection

GOAL 8: Increase equitable access to better health, safety, and opportunities to thrive that enhance well-being.

Strategy 8.1: Apply an equity lens to maximize accessible services and resources and cultivate culturally responsive efforts to address inequities.

Objective 8.1.1: Apply a health equity lens to the design and implementation of programs.

ap • **At least one (1) program will use Health Equity data to inform the design or delivery of services.**

GOAL 9: Through community engagement, strengthen and invigorate communities with opportunities to grow, connect, and thrive.

Strategy 9.1: Seek opportunities to intentionally work together toward shared goals and actions that strengthen healthy, safe, and thriving communities.

Objective 9.1.1: Strengthen and expand partnerships and community engagement through outreach and education; providing transparency; and seeking opportunities to intentionally work together for collective impact.

- At least once per year, provide information about programs, resources, and tools to advance implementation of Community Enrichment Plans annually.

ap • **For a minimum of 4 times per year, engage in collaborative meetings with partners, to advance one major initiative (collective impact, health equity, or other) led by each Branch.**

Maternal, Child, and Family Health Services (MCFHS)

Alignment to National, State, and Local Plans Maternal, Child, and Family Health Services Branch	
	The Maternal, Child, and Family Health Services Branch (MCFHS) aligns to The Ten Essential Services (ES) of Public Health, specifically ***ES 3-Communication***, ***ES 4-Partnership***, ***ES 5-Plans and Policies***, ***ES 7-Access***, ***ES 9-Improvement, Evaluation and Research***, and ***ES 10-Infrastructure***. For example, MCFHS has various programs that provide services to those most vulnerable and mobilizes partnerships to ensure these services (e.g., Oral Health, Black Infant Health, Chronic Disease and Health Equity, Perinatal Care Network) are delivered to the community. These programs have evidence-based plans that lead to policy, system, and environmental changes.
HEALTHY PEOPLE 2030	MCFHS aligns to Healthy People 2030's ***Health Equity***, ***Health Literacy***, and ***Social Determinants of Health*** priority areas. For example, MCFHS promotes early detection, prevention, and management of disease and disabilities for all children in San Diego County, including oral health. The Branch ensures children in out-of-home placement receive preventive health examinations to identify and correct medical conditions. Furthermore, MCFHS has a Chronic Disease and Health Equity Unit that implements policy, system, and environmental change in multiple areas.
Let's Get Healthy California	MCFHS aligns to the State of California's Let's Get Healthy California ***Healthy Beginnings*** and ***Living Well*** goals. For example, MCFHS reduces preventable fetal and infant deaths and takes a comprehensive approach with outreach, health communication and education, and care coordination to increase awareness of risk factors and improve systems of care. Furthermore, MCFHS strengthens families by improving the health of women and men while reducing family violence in San Diego County. MCFHS also collaborates with community partners to increase awareness of the role of fathers in the health and well-being of their families.
LIVE WELL SAN DIEGO	MCFHS aligns to the County of San Diego *Live Well San Diego* vision of healthy, safe, and thriving San Diego County communities, specifically the ***Building Better Health*** and ***Thriving*** components. MCFHS creates environments and policies that promote health equity and encourages healthy behaviors and healthy communities to reduce chronic disease and promote equity for all residents. Moreover, MCFHS reduces preventable fetal and infant morbidity and mortality with a focus on the disproportionate African-American infant mortality. MCFHS also works with food and tobacco retailers and ensures that children in out-of-home placements receive timely and preventive oral health examinations.

Maternal, Child, and Family Health Services (MCFHS)

Alignment to National, State, and Local Plans Maternal, Child, and Family Health Services Branch
MCFHS aligns to the County and/or HHSA Strategic Initiatives of ***Sustainability, Workforce, Community Engagement***, ***Equity***, ***Service Delivery Coordination, and Systems and Technology***. For example, MCFHS creates environments and policies that promote health equity and encourage healthy behaviors and communities to reduce chronic disease for all residents. Furthermore, MCFHS promotes early detection, prevention, and management of disease and disabilities for all children in San Diego County, including oral health. MCFHS also prevents, reduces, and responds to family violence in the region and collaborates with community partners and organizations. MCFHS is committed to sustainability and monitors goals on the development of a Board policy to support local, sustainable, and equitable food purchases and technical assistance provided to the community to increase healthy and equitable planning to address climate change.

Public Health Preparedness and Response (PHPR)

The Public Health Preparedness and Response (PHPR) Branch supports emergency preparedness for all types of disasters—natural and man-made. The Branch fosters preparedness within communities by supporting health and medical system response through readiness activities; supports county efforts to respond to public health threats and events through collaborative activities in monitoring and planning of responses; and promotes preparedness through drills, training, and exercises to ensure that county public health and medical staff can effectively respond to disasters and emergencies.

Units and Programs

- **Contract & Grant Administration Unit**
- **EPI–Bioterrorism Unit**
- **Programs and Planning Unit**
- **Exercise and Response Unit**

Health Equity Goal: Improve community preparedness.

- **Objective:** Ensure that healthcare facilities in San Diego communities where health outcomes are relatively poor are reporting critical preparedness information to the local emergency medical coordination program. *Health Equity Lens: Geography, Socioeconomic Status.*

Population Health Goal: Improve emergency preparedness and response by building community resilience.

- **Objective:** Increase the proportion of agencies identified in the Emergency Preparedness Act that are prepared for disease outbreak after getting preparedness information.

The Health Equity Goal is the priority that each Branch adopted in 2016 to address concerns about inequities. The Population Health Goal is based on Healthy People 2030.

Story of a Health Equity Goal—Improve Community Preparedness

Public Health Preparedness and Response (PHPR)

Impact that we seek:

Health Equity Goal: Improve community preparedness.

- **Objective:** Ensure that healthcare facilities in San Diego communities where health outcomes are relatively poor are reporting critical preparedness information to the local emergency medical coordination program. *Health Equity Lens: Geography, Socioeconomic Status.*

The Health Equity Goal is the priority that each Branch adopted in 2016 to address concerns about inequities.

Program efforts to bring about change:

(Measures appear in Strategic Plan)

Conduct a variety of coalition activities to help prepare those in the healthcare community who service individuals with access and functional needs, or others special needs, for emergencies:

- Conduct at least 4 exercises to prepare those in the healthcare community who serve individuals with special needs.
- Convene at least 10 meetings of the San Diego Healthcare Disaster Coalition (SDHDC) annually.
- Request and analyze Essential Elements of Information (EEI) for at least two drills or real-world activations.

Operations that support program success:

- Administer the San Diego Healthcare Disaster Coalition (SDHDC).
- Maintain and improve information sharing tools for the Medical Operations Center (MOC).

Public Health Preparedness and Response (PHPR)

Why is this a Priority?

Disasters and public health emergencies exacerbate existing healthcare inequities and increase negative health outcomes. One and a half times (1.5) as more people in Central Region do not have health insurance compared to SD County average; 13.5 percent of people in Central Region do not have a usual source of care. These populations will likely place a greater demand on nearby hospitals. PHPR is focused on assisting healthcare facilities across San Diego County, located in communities in which conditions do not support good health outcomes (per the Healthy Places Index), to improve their reporting of information as to how prepared they are for an emergency to the local emergency medical coordination program.

PHPR routinely offers training and exercises to help healthcare facilities meet the CMS Emergency Preparedness Rule while exposing them to a variety of hazards and planning scenarios. PHPR supports the ability of the healthcare service delivery system to meet the needs of the whole community in preparing for, responding to, and recovering from public health emergencies and threats. When facilities are not able to meet the needs of the populations they serve, impacts are felt throughout the local medical and healthcare delivery system.

The intent of focusing on improving the collection of Essential Elements of Information (EEI) is to assess the extent to which local facilities communicate requested information to the public health/medical lead in order to facilitate situational awareness and the effective management of resources in a timely manner. Examining response rates by low-scoring Healthy Places Index (HPI) areas allows PHPR to focus on ensuring that communication channels with providers serving those areas are in place.

Strategy for Change

PHPR administers a variety of hospital, skilled nursing facilities, clinic, and other healthcare provider emergency preparedness activities funded through the Hospital Preparedness Program. This includes outreach to an estimated 85 skilled nursing facilities (SNFs) and 1300 long-term care (LTC) 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, larger exercises and trainings and channels for communication.

At least two Homeland Security Exercise and Evaluation (HSEEP Tabletop (TTX) and a minimum of two Full-Scale Exercises (FSE) offered to help prepare those in the healthcare community who service individuals with access and functional needs, or others special needs, for emergencies. A minimum of ten CMS provider types engaged in SDHDC meetings, trainings, and exercises. A minimum of four quarterly redundant communication drills with health and medical system entities.

Partners in Getting this Done

- San Diego Healthcare Disaster Coalition (SDHDC) members
- Public Health Services Community Health Statistics Unit
- Emergency Medical Services

Story of a Health Equity Goal—Improve Community Preparedness

Public Health Preparedness and Response (PHPR)

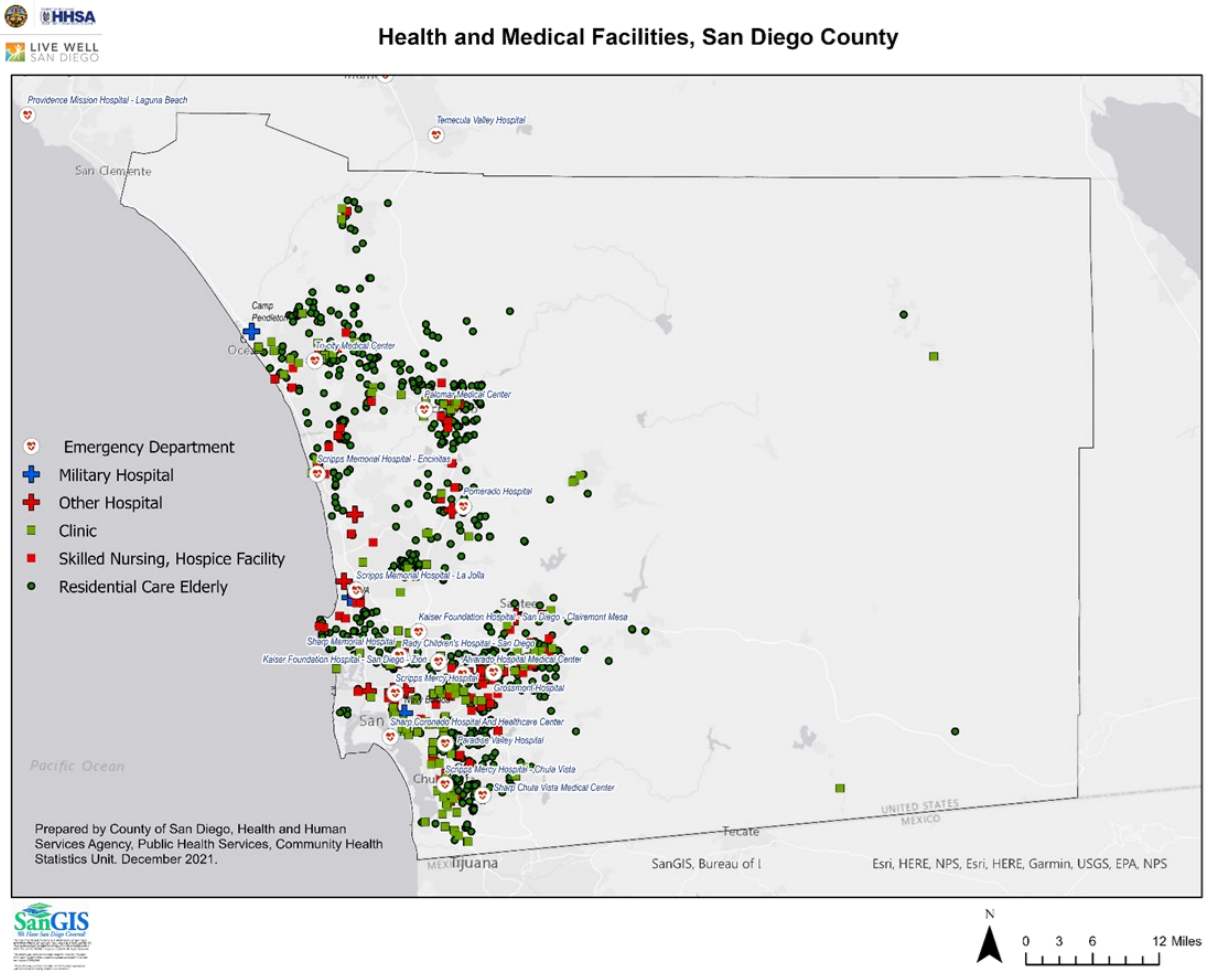
Looking through the Health Equity Lens:

Community Preparedness

There are hundreds of facilities that are subject to the CMS Emergency Preparedness requirements. There include hospitals, federally qualified health care clinics, skilled nursing facilities, residential care facilities for the elderly, and end-stage renal disease facilities, among others.

In August 2022, the United States Government Accountability Office (GAO) released "Public Health Preparedness, COVID-19 Medical Surge Experiences and Related HHS Efforts." The GAO reported the Administration for Strategic Preparedness and Response (ASPR) is currently revising the Hospital Preparedness Program (HPP) Capabilities Guidance and emphasizing, an "Increased focus on deliberate engagement of and planning for at-risk groups to ensure preparedness and response functions do not exacerbate health care inequities."

According to ASPR, disasters and emergencies such as the COVID-19 pandemic have affected communities of color and underserved populations especially hard. Therefore, understanding the complex relationships that affect fair access to health care during emergencies may be beneficial to healthcare professionals. As a recipient of HPP funding, PHPR anticipates the release of this new guidance in 2023.



Public Health Preparedness and Response (PHPR)

Population Health Goal: Improve emergency preparedness and response by building community resilience.

- **Objective:** Increase the proportion of agencies identified in the Emergency Preparedness Act that are prepared for disease outbreak after getting preparedness information.

The Population Health Goal is based on Healthy People 2030.

Alignment Key:

Strategic Initiative (from the Strategic Initiative Framework):

- Strategic Initiative: Board of Supervisors
- Strategic Initiative: Combination of CAO, HHSA, or PHS Initiatives
- Strategic Initiative: PHS Initiative

Health Equity Focus

Community Connection

OP **Operational Plan** (Priority)

AP **Agency Promise,** Measure in HHSA Strategic Plan Scorecard

ap Additional PHS Measure that supports the Agency Promise

Public Health Preparedness and Response (PHPR)

Health Equity Focus

Resilience, Safety and Security

GOAL 1: Ensure that the healthcare preparedness infrastructure is strong in order to meet the needs of communities in which conditions do not support good health outcomes.

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

Objective 1.1.1: Conduct a variety of coalition activities to help prepare those in the healthcare community who service individuals with access and functional needs, or others special needs, for emergencies.

- At least four exercises—two Homeland Security Exercise and Evaluation (HSEEP) Tabletop (TTX) and two Full-Scale Exercises (FSE)—offered to help prepare those in the healthcare community who service individuals with access and functional needs, or others special needs, for emergencies.
- Request and analyze Essential Elements of Information (EEI) for at least two drills or real-world activations.

Workforce

GOAL 2: Strengthen the public health preparedness and response workforce readiness to support the timely implementation of intervention and control measures through robust training and exercise programs for public health responders, other agency staff and County environmental health, emergency management, and emergency medical services partners.

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

Objective 2.1.1: Ensure Medical Operations Center (MOC) staff readiness to respond to disasters and/or public health threats by completing training sessions of key response functions each fiscal year.

OP
- **A minimum of one quarterly training for Medical Operations Center (MOC) Responders focused on ICS and hazard-specific responses to ensure MOC staff readiness to respond to disasters and/or public health threats.**
- 90 percent of staff assigned to the MOC must complete the MOC Responder Training and ICS 100, 200, 700, and/or 800 courses.
- A minimum of two-deep response personnel or critical positions. MOC Critical Positions are: MOC Director, Medical Director, Medical SME, Safety Officer, Operations Chief, Logistics Chief, Planing Chief, WebEOC Controller, Finance Chief, Healthcare Provider Status Team, and Support Unit.

IT Gaps

GOAL 3: Enhance technology and procedures to ensure disaster preparedness inventory is maintained, updated, and ready to deploy within four (4) hours.

Strategy 3:1: Adopt the latest technology and systems to enhance and support state-of-the-art readiness and response.

Public Health Preparedness and Response (PHPR)

Objective 3.1.1: Ensure PHPR readiness to fulfill logistics requests during disasters and/or public health threats.

- A minimum of one (1) PHPR staff trained to support EZTrack (administered by PHPR) to ensure adequate coverage during an emergency or public health event.

GOAL 4: Facilitate countermeasures to mitigate and 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 (6) Medical Point of Dispensing (MPOD) mass vaccination influenza exercises planned and/or conducted annually in each of the six (6) HHSA Operational Area Regions.
- One (1) MPOD mass vaccination/medication dispensing functional exercise planned and/or conducted annually.
- At least three (3) quarterly meetings attended of the State Regional Disaster Medical Health Coordination (RDMHC) and Region VI Medical Health Operational Area Coordination (MHOAC).

Community Connection

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

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

Objective 5.1.1: Conduct and coordinate ongoing surveillance, planning, and response.

- A minimum of ten (10) meetings annually of the San Diego Healthcare Disaster Coalition convened annually.
- 100 percent of events that meet the Heat Plan activation criteria to which the Excess Heat Task Force responds/activates.
- 80 percent of HHSA Public Health Nursing staff receive annual competency training in mass care and shelter.
- 80 percent of HHSA Public Health Nursing staff "fit-tested" annually to determine appropriate personal protective equipment.
- A minimum of four (4) Medical Reserve Corps communication drills conducted each year.

ADDITIONAL OBJECTIVES THAT SUPPORT NEW COUNTY AND AGENCY INITIATIVES

Community Connection

GOAL 6: Through community engagement, strengthen and invigorate communities with opportunities to grow, connect, and thrive.

Strategy 6.1: Seek opportunities to intentionally work together toward shared goals and actions that strengthen healthy, safe, and thriving communities.

Public Health Preparedness and Response (PHPR)

Objective 6.1.1: Strengthen and expand partnerships and community engagement through outreach and education; providing transparency; and seeking opportunities to intentionally work together for collective impact.

- Connect partners through an exchange each quarter using new sharing technology and a public-facing website developed for the San Diego Healthcare Disaster Coalition (SDHDC). This reflects the strength of information exchange and collaborative planning among local healthcare entities.

ap • **For a minimum of 4 times per year, engage in collaborative meetings with partners, to advance one major initiative (collective impact, health equity, or other) led by each Branch.**

Health Equity Focus

GOAL 7: Equitable access to better health, safety, and opportunities to thrive that enhance well-being.

Strategy 7.1: Apply an equity lens to maximize accessible services and resources and cultivate culturally responsive efforts to address inequities.

Objective 7.1.1: Apply a health equity lens to the design and implementation of programs.

ap • **At least one (1) program will use Health Equity data to inform the design or delivery of services.**

Public Health Preparedness and Response (PHPR)

Alignment to National, State, and Local Plans Public Health Preparedness and Response Branch	
	The Public Health Preparedness and Response Branch (PHPR) aligns to The Ten Essential Services (ES) of Public Health, specifically ***ES 4-Community Engagement***, ***ES 5-Plans and Policies***, and ***ES 10-Infrastructure*** with the public. For example, PHPR strengthens community resilience and health equity by engaging healthcare entities to ensure timely assessment and sharing of essential information to increase emergency preparedness and reduce harm due to disasters and public health emergencies. Furthermore, PHPR has plans in place to properly prepare for emergency and natural disasters.
HEALTHY PEOPLE 2030	PHPR aligns to Healthy People 2030's ***Health Equity*** and **Social Determinants of Health** priority areas. PHPR conducts a variety of coalition activities to help prepare those in the healthcare community who service individuals with access and functional needs, or other special needs, for emergencies.
Let's Get Healthy California	PHPR aligns to the State of California's Let's Get Healthy California ***Living Well*** and ***Redesigning the Health System*** goals. For example, PHPR facilitates countermeasures to mitigate and ensure continuity of emergency operations management during emergency response and recovery. Furthermore, PHPR ensure medications can be effectively distributed in the event of an emergency.
LIVE WELL SAN DIEGO	PHPR aligns to the County of San Diego *Live Well San Diego* vision of healthy, safe, and thriving San Diego County communities, specifically the ***Building Better Health*** and ***Safety*** components. PHPR supports the health systems infrastructure to respond to public health threats and disasters. In addition, PHPR strengthens the public health preparedness and response readiness to support the implementation of intervention and control measures through robust training. This includes quarterly training for Medical Operations Center (MOC) Responders focused on ICS and hazard-specific responses to ensure MOC staff readiness to respond to disasters and/or public health threats. PHPR increases and sustains the highest possible level of readiness by building internal staff capacity and preparedness planning.
	
PHPR aligns to the County and/or HHSA Strategic Initiatives of ***Sustainability***, ***Workforce***, ***Community Engagement***, ***Equity***, ***Service Delivery Coordination***, and ***Systems and Technology***. For example, PHPR facilitates counter measures to mitigate and ensure continuity of emergency operations management during emergency response and recovery with partners to ensure timely response. PHPR also enhances technology and procedures to ensure disaster preparedness inventory is maintained and ready to deploy within four hours. PHPR also builds capacity of staff, departments, volunteers, and mitigates threats and manages through surveillance, planning, training, and exercises.	

Tuberculosis Control and Refugee Health (TBCRH)

Tuberculosis Control and Refugee Health Branch (TBCRH) detects, controls, and prevents the spread of tuberculosis (TB) in our community through treatment, case management, contact investigation, and education. Through collaboration with community partners, the Branch supports the County TB Elimination Initiative, to improve effective TB prevention through risk assessment, testing and treatment of latent TB infection. The Branch also partners with various communities and organizations to address health concerns affecting newly arriving refugee groups and implements the Refugee Health Assessment Program (RHAP). This program provides newly arrived refugees, asylees, victims of trafficking, and other eligible entrants with culturally and linguistically appropriate comprehensive health assessments.

Units and Programs

- **Case Management**
- **Disease Investigation**
- **Cure TB and Binational TB**
- **Clinical Services Unit**
- **Education & Outreach Unit**
- **Surveillance Unit**
- **Contact Investigation Unit**
- **TB Elimination Initiative**
- **Refugee Health**
- **Clerical and Administrative Unit**

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

- **Objective:** Reduce the annual Tuberculosis incidence rate to 5 cases per 100,000 by 2030, compared to the 2015-2019 baseline of 7.4. This is a 30% reduction in cases (244 to 170). *Health Equity Lens: Geography and Birth Country*.

Population Health Goal: Reduce the rate of new active TB cases (TB incidence).

- **Objective**: Reduce the annual Tuberculosis incidence rate to 5 cases per 100,000 by 2030, compared to the 2015-2019 baseline of 7.4. This is a 30% reduction in cases (244 to 170).

The Population Health Goal is based on Healthy People 2030. The Health Equity Goal is the priority that each Branch adopted in 2016 to address concerns about inequities.

Story of a Health Equity Goal—Treat Latent Tuberculosis Infection (LTBI)

Tuberculosis Control and Refugee Health (TBCRH)

Impact that we seek:

Health Equity Goal: Expand risk assessment, testing and treatment for latent tuberculosis infection to decrease rate of new active cases.

- **Objective:** Reduce the annual Tuberculosis incidence rate to 5 cases per 100,000 by 2030, compared to the 2015-2019 baseline of 7.4. This is a 30% reduction in cases (244 to 170). *Health Equity Lens: Geography and Birth Country.*

The Health Equity Goal is the priority that each Branch adopted in 2016 to address concerns about inequities.

Program efforts to bring about change:

(Measures appear in Strategic Plan)

- Ensure 65% of contacts with new LTBI who initiate treatment complete it.
- At least two TB Elimination Initiative (TBEI) Community of Practice members initiate and track latent TB infection care cascade changes, annually.
- Incorporate TB prevention messaging into County provider outreach in at least one zip code with a high TB incidence, annually.
- Provide at least 20 trainings annually for community organizations that serve populations that are at risk for TB.

Operations that support program success:

- Conduct monthly latent TB infection treatment appointments for County regional public health centers, providing safety net services using telehealth and in-person options.
- Conduct quarterly TBEI Community of Practice meetings and an annual TBEI Advisory Committee meeting.
- Use a health equity lens in the design and delivery of LTBI testing and treatment services.

Story of a Health Equity Goal—Treat Tuberculosis Infection (LTBI)

Tuberculosis Control and Refugee Health (TBCRH)

Why is this a Priority?

Tuberculosis (TB) is a life-threatening disease that spreads through the air with profound medical and economic consequences. Every year, about 200 San Diegans are diagnosed with active TB disease. About 10% die during treatment. Isolation from family and friends and exclusion from the workplace while contagious results in stigma, lost wages and loss of employment, putting people with active TB at risk for poverty and homelessness.

Furthermore, the burden of TB is borne disproportionately (see Health Equity lens section). 70% of active TB cases occur among persons born outside of the US. TB rates are more than 8 times higher among non-US-born residents than US-born residents; more than 50% of TB cases are Hispanic and about one-third of TB cases are Asian/Pacific Islander.

Latent TB infection (LTBI) occurs when people who have been infected with the bacteria do not become sick with active TB right away, but instead harbor the germs in their body. People living with LTBI can become sick with active TB at any time in the future if they are not treated with short-term medications. About 175, 000 San Diegans are living with LTBI. Since only 25% are aware of their infection and 15% have been treated, a key TB prevention strategy is testing high-risk populations and treating people with LTBI.

Strategy for Change

The Tuberculosis Control and Refugee Health (TBCRH) branch is coordinating the **San Diego County Tuberculosis Elimination Initiative (TBEI)**, approved by the County Board of Supervisors. The TBEI is a public-private partnership that creates a coordinated tuberculosis (TB) elimination framework to serve the County's diverse population. The initiative focuses on effective TB prevention, including risk assessment, testing, and treatment of latent TB infection (LTBI) cases to prevent progression to active TB. This initiative expands TB prevention conducted by the Branch via the critical TB elimination strategies of interrupting transmission by prompt diagnosis and treatment of active TB, and TB prevention by prompt diagnosis and treatment of LTBI in persons exposed to active TB.

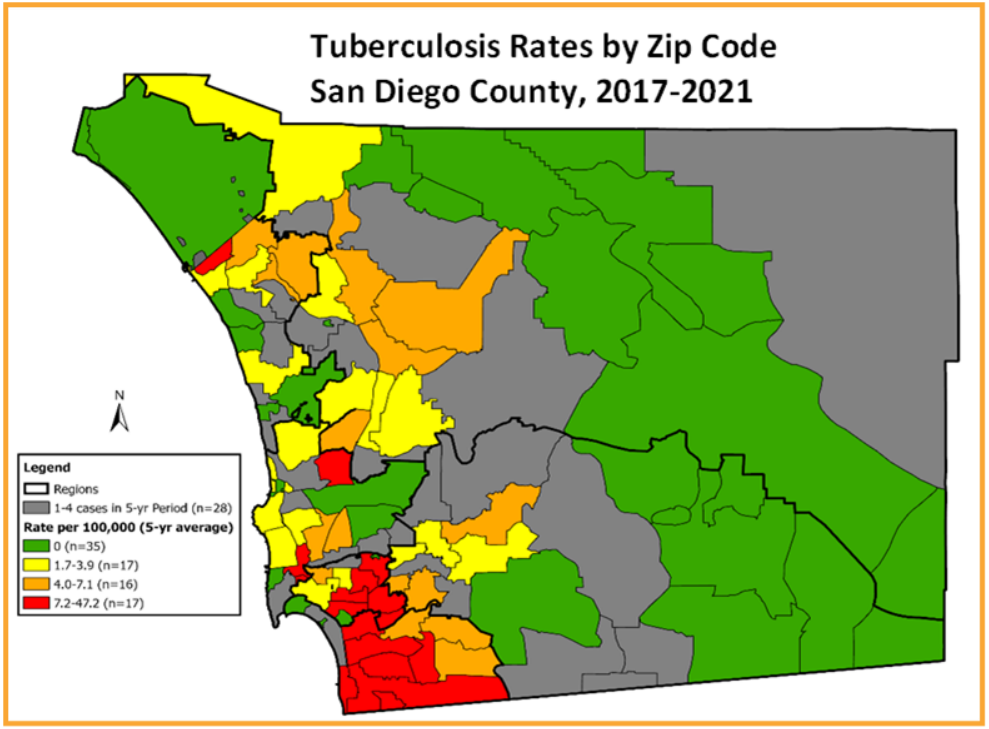
Partners in Getting this Done

The TB Elimination Initiative convenes stakeholders from over 25 public and private sector organizations throughout the County, including federally qualified health clinics and tribal organizations, other health care organizations, community-based organizations, TB survivors, and educational institutions that serve populations at high risk for TB.

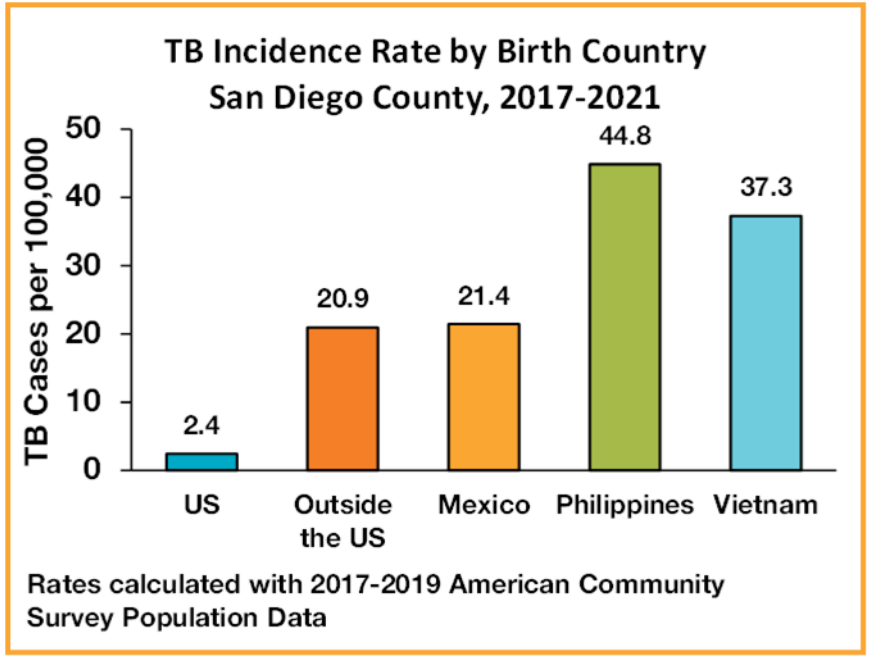
Story of a Health Equity Goal—Latent Tuberculosis Infection (LTBI)

Tuberculosis Control and Refugee Health (TBCRH)

Looking through the Health Equity Lens: Tuberculosis Rates for San Diego County



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



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

The rate of tuberculosis (TB) in San Diego County has been consistently higher than reported TB rates (cases per 100,000) in California and the nation over the past decade. During 2017 through 2021, people born outside the US compromised 72% of San Diego County's active TB cases. TB rates were higher among non-US-born (20.9) compared with US-born (2.4) and varied by birth country (see graph on right). Among all cases, 31% were born in Mexico, 20% were born in the Philippines, and 6% were born in Vietnam. Of the remaining persons born outside the US, more than 40 birth countries were represented, including nations in Asia, Africa, and South and Central America.

Between 2017 and 2021, rates of TB were highest in the South and Central Regions of the County. The overall TB case rate for the population living in the 39 San Diego County Health Equity zip codes was more than three times for the population living in other County zip codes.

Tuberculosis Control and Refugee Health (TBCRH)

Population Health Goal: Reduce rates of infectious diseases and improve health for people with chronic infections.

- **Objective**: Reduce the annual Tuberculosis incidence rate to 5 cases per 100,000 by 2030, compared to the 2015-2019 baseline of 7.4. This is a 30% reduction in cases (244 to 170).

The Population Health Goal is based on Healthy People 2030.

Alignment Key:

Strategic Initiative (from the Strategic Initiative Framework):

- Strategic Initiative: Board of Supervisors
- Strategic Initiative: Combination of CAO, HHSA, or PHS Initiatives
- Strategic Initiative: PHS Initiative

Health Equity Focus

Community Connection

OP **Operational Plan** (Priority)

AP **Agency Promise,** Measure in HHSA Strategic Plan Scorecard

ap Additional PHS Measure that supports the Agency Promise

Tuberculosis Control and Refugee Health (TBCRH)

Tuberculosis Elimination Initiative (TBEI)

Special Note regarding the TBCRH Strategic Plan:

The TB Elimination Initiative *is a collective impact effort modelled after the* ***Getting to Zero*** *initiative. TBEI is a public-private partnership launched in January 2020 to build a coordinated TB elimination framework for the County. The initiative focuses on effective TB prevention, including risk assessment, testing and treatment of latent TB infection cases to prevent progression to active TB. An estimated 85 percent of active TB cases are due to progression of long-standing latent TB infection to active TB. This initiative is reflected throughout the TBCRH strategic plan and therefore is only called out up front as an initiative within the PHS Strategic Framework.*

Tuberculosis = TB

GOAL 1: Eliminate TB in San Diego County through mitigating and measuring the impact of active TB cases.

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

Objective 1.1.1: Ensure active TB cases are reported in a timely fashion by the community to Public Health Services to prevent further transmission.

OP • **98 percent of active TB cases reported within one (1) working day from start of treatment.**

Objective 1.1.2: Test individuals diagnosed with TB for HIV, per the CDC standard of care for active TB.

OP • **95 percent of all persons with active TB, alive at diagnosis, are tested for HIV infection.**

Objective 1.1.3: Produce an epidemiology report of TB in San Diego.

- Annual TB epidemiology report issued.

Community Connection

Strategy 1.2: Employ a multidisciplinary, team-based approach to case and contact management to reduce opportunity for transmission and prevent future cases of infectious TB.

Objective 1.2.1: Ensure individuals diagnosed with active TB complete treatment 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.

Tuberculosis Control and Refugee Health (TBCRH)

Health Equity Focus

Strategy 1.3: Enhance prevention, diagnosis, and treatment of TB disease and latent TB infection.

Objective 1.3.1: 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.

- 90 percent of evaluations of elicited contacts to sputum smear-positive TB are completed.
  - 75 percent of contacts with new LTBI initiate treatment.
  - 65 percent of contacts with new LTBI who initiate treatment complete it.

Customer Satisfaction

Strategy 1.4: Provide patient-centered clinical services to ensure availability of TB screening and medical services for those who are uninsured.

Objective 1.4.1: Monitor clinical services and customer satisfaction on a regular basis.

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

Objective 1.4.2: Provide access to latent TB infection treatment countywide, as part of community safety net medical care, in collaboration with regional public health centers.

- Conduct monthly latent TB infection treatment appointments for County regional public health centers, using telehealth and in-person options.

Health Equity Focus

GOAL 2: Eliminate TB in San Diego County by promoting awareness of TB prevention, including risk assessment, diagnosis, and treatment of latent TB infection (LTBI).

Strategy 2.1: Improve the level of knowledge and awareness about TB in the medical community, especially medical providers and their staff.

Objective 2.1.1: Increase adoption of latent TB care cascade best practices by community medical providers.

- At least two (2) TB Elimination Initiative Community of Practice members initiated and tracked latent TB infection care cascade changes, annually.

Objective 2.1.2: Conduct outreach to medical providers in high TB incidence communities.

- TB prevention messaging incorporated into County provider outreach in at least one (1) zip code with a high TB incidence, annually.

Tuberculosis Control and Refugee Health (TBCRH)

Strategy 2.2: Improve the level of knowledge and awareness about TB risk, testing, and treatment for LTBI in the community.

Objective 2.2.1: Provide trainings for community organizations that serve populations that are at risk for TB, to promote knowledge and awareness of TB risk, testing, and treatment throughout the county.

- At least 20 trainings, reaching 500 individuals, provided annually.

Objective 2.2.2: Provide trainings and educational opportunities to staff and students at schools, to decrease TB transmission on school campuses.

- At least two (2) Peer Educator Project school classes provided annually.

GOAL 3: Improve the health of newly arrived refugees in San Diego County.

Strategy 3.1: Provide prompt, high-quality health screening and referral services for new refugee arrivals and other persons eligible for the Refugee Health Assessment Program (RHAP), including asylees and victims of trafficking.

Objective 3.1.1: Monitor the volume of health assessments conducted by the Refugee Health Assessment Program (RHAP).

- Volume or number of health assessment services reviewed quarterly.

Objective 3.1.2: Ensure incoming refugees start the health assessment process.

- 90 percent of incoming refugees start the health assessment process within 30 days.

Objective 3.1.3: Ensure timely completion of the health assessment for all individuals eligible for the Refugee Health Assessment Program (RHAP) who start the assessment.

OP • **90 percent of RHAP eligible individuals who start the health assessment process complete the health assessment process within 90 days.**

ADDITIONAL OBJECTIVES THAT SUPPORT NEW COUNTY AND AGENCY INITIATIVES

Community Connection

GOAL 4: Through community engagement, strengthen and invigorate communities with opportunities to grow, connect, and thrive.

Strategy 4.1: Seek opportunities to intentionally work together toward shared goals and actions that strengthen healthy, safe, and thriving communities.

Objective 4.1.1: Strengthen and expand partnerships and community engagement through outreach and education; providing transparency; and seeking opportunities to intentionally work together for collective impact.

ap • **At least once per year, provide information about programs, resources, and tools to advance implementation of Community Enrichment Plans annually.**

Tuberculosis Control and Refugee Health (TBCRH)

ap • **For a minimum of 4 times per year, engage in collaborative meetings with partners to advance one major initiative (collective impact, health equity, or other) led by each Branch.**

Health Equity Focus

GOAL 5: Equitable access to better health, safety, and opportunities to thrive that enhance well-being.

Strategy 5.1: Apply an equity lens to maximize accessible services and resources and cultivate culturally responsive efforts to address inequities.

Objective 5.1.1: Apply a health equity lens to the design and implementation of programs.

ap • **At least one (1) program will use Health Equity data to inform the design or delivery of services.**

Tuberculosis Control and Refugee Health (TBCRH)

Alignment to National, State, and Local Plans Tuberculosis Control and Refugee Health Branch	
	The Tuberculosis Control and Refugee Health Branch (TBCRH) aligns to The Ten Essential Services (ES) of Public Health, specifically ***ES 1-Assessments***, ***ES 2-Investigations***, ***ES 3-Communication***, ***ES 4-Partnership***, and ***ES 6-Enforcement***. TBCRH conducts public health surveillance for active TB to describe epidemiology in San Diego County (ES-1). The Branch investigates all reported active TB cases by collaborating with community healthcare providers, to ensure accurate diagnoses and timely completion of treatment, and conducting contact investigations to ensure prompt evaluation and treatment of persons exposed to TB (ES-2, ES-6). TBCRH educates communities and their medical providers about TB (ES-3). TBCRH also coordinates and participates in the San Diego County TB Elimination Initiative, a collective impact approach, bringing community partners together to focus on effective TB prevention (ES-4).
HEALTHY PEOPLE 2030	TBCRH's overarching goal aligns with Healthy People 2030's Infectious Disease Objective: Reduce TB cases (IID-17). The strategies to accomplish this goal align with the Healthy People 2030 ***Health Equity***, ***Health Literacy***, and ***Social Determinants of Health*** priority areas. Examples include providing TB diagnosis, treatment, and prevention clinical services for persons without access to health care ,while improving the level of knowledge and awareness about TB in the community, especially medical providers, their staff, and high-risk populations. The Refugee Health Assessment program also supports this priority area by providing high quality health screening and referral services to newly arrived refugees.
Let's Get Healthy California	TBCRH aligns to the State of California's Let's Get Healthy California ***Redesigning the Health System*** goal, which requires the health care system to be better aligned toward population health goals and outcomes. For example, TBCRH collaborates with community partners of the San Diego County TB Elimination Initiative to improve effective TB prevention in the health care system. The Branch's activities to improve the health of newly arrived refugees in San Diego County by providing high quality health screening and referral services also support this goal.
LIVE WELL SAN DIEGO	TBCRH aligns to the County of San Diego *Live Well San Diego* vision of healthy, safe, and thriving San Diego County communities, specifically the ***Building Better Health*** and ***Safety*** component. TBCRH enhances prevention, diagnosis, and treatment of TB disease and latent TB infection, to reduce opportunity for transmission and to achieve the best health outcomes. The Branch's activities to improve the health of newly arrived refugees in San Diego County by providing high quality health screening and referral services also support this component.

Tuberculosis Control and Refugee Health (TBCRH)

Alignment to National, State, and Local Plans
Tuberculosis Control and Refugee Health Branch

TBCRH aligns to the County and/or HHSA Strategic Initiatives of ***Sustainability***, ***Workforce***, ***Community Engagement***, ***Equity***, ***Service Delivery Coordination***, and ***Systems and Technology***. TBCRH conducts its operations, using a sustainability lens and by developing and maintaining a skilled and diverse workforce. Examples of community engagement include collaboration with health care providers to prevent, diagnosis, and treat TB, educating the community via outreach activities, and participating in the San Diego County TB Elimination Initiative. In support of Equity and Service Delivery Coordination initiatives, the Branch provides case management for all persons with active TB, while providing diagnostic and treatment services via the TB Clinic and LTBI clinics in regional public health centers for persons without access to health care. Additionally, the Branch implements the Refugee Health Assessment Program in collaboration with a community health care system to provide initial health assessments and referrals for newly arrived refugees.

Summary

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.
- **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 2022.

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.

Summary

Highlights of Each Branch Plan

Administration Branch, Public Health Services, is coordinating efforts within the department to support a competent public health workforce, use data to drive performance and decisions through the use of data visualization, and combat the opioid crisis through a comprehensive Opioid Initiative.

California Children's Services Branch is expanding efforts to ensure children 0-21 years of age receive optimal care to improve health outcomes, transition to adulthood, and have access to resources and services through San Diego Advancing and Innovating Medi-Cal (SDAIM), the local approach to California Advancing and Innovating Medi-Cal (CalAIM).

Epidemiology and Immunization Services Branch is improving immunizations coverage, minimizing the spread of disease by providing effective surveillance, investigation, and response to protect the community from disease, and streamlining processes for pandemic responses. The Branch is also enhancing its laboratory capacity through several grant funding opportunities to improve testing, processing, and data collection, in addition to building a new state-of-the-art PHS Laboratory.

HIV, STD, and Hepatitis Branch is making strides with the Getting to Zero initiative to ensure availability of testing, access to treatment, prevention of new infections, and engagement of community partners to implement strategies that improve health outcomes related to HIV. The Branch is also focusing efforts on prevention, screening, and treatment of syphilis, prioritizing childbearing individuals.

Maternal, Child, and Family Health Services Branch reaches diverse and vulnerable populations to improve health outcomes and decrease health disparities through new interventions by leveraging programs with new funding and implementing policy, system, and environmental changes. The Branch launched a new focus with the Perinatal Equity Initiative with a goal of improving birth and maternal health outcomes for African-American families in San Diego County.

Public Health Preparedness and Response Branch is continuously improving processes to be readily available and prepared for public health emergencies, strengthening its capacity with incident management and surge capacity, and collaborating with health systems in San Diego County.

Tuberculosis and Refugee Health Branch is actively engaging partners in the region to build a coordinated Tuberculosis Elimination Initiative framework that serves the County's diverse population through a surveillance, prevention, and treatment approach.

Summary

Frameworks

Guided by Framework of Best Practice and Standards of Excellence

PHS is grounded by national evidence-based frameworks and standards, and these are reflected in the PHS Strategic Plan. These include the 10 Essential Public Health Services, Public Health Reaccreditation, Foundational Public Health Services, Public Health 3.0, and. Baldrige's Performance Excellence Framework.

The **10 Essential Public Health Services** was originally released in 1994 and updated in 2020. The revised version is intended to bring the framework in line with current and future public health practice. Equity is intentionally placed at the center of all actions *(Figure 12)*.

Public Health Reaccreditation Standards are organized by the 10 Essential Public Health Services and aligned with the Foundational Public Health Services. These standards reflect the level of achievement expected of a health department *(Figure 13)*. The Public Health Accreditation Board is the governing authority that oversees Accreditation and Reaccreditation, which was launched in September 2011. The County of San Diego was officially accredited in May 2016 and, in August 2023, achieved reaccreditation.

The **Foundational Public Health Services Framework** was developed in 2013 to define at a minimum, the public health capabilities, and programs that no jurisdiction can be without. In 2022, the FPHS was revised to reflect the evolving nature and modernization of governmental public health. The FPHS framework outlines the unique responsibilities of governmental public health and can be used to explain the vital role of governmental public health in a thriving community; identify capacity and resource gaps; determine the cost for assuring foundational activities; and justify funding needs. *(Figure 14)*.

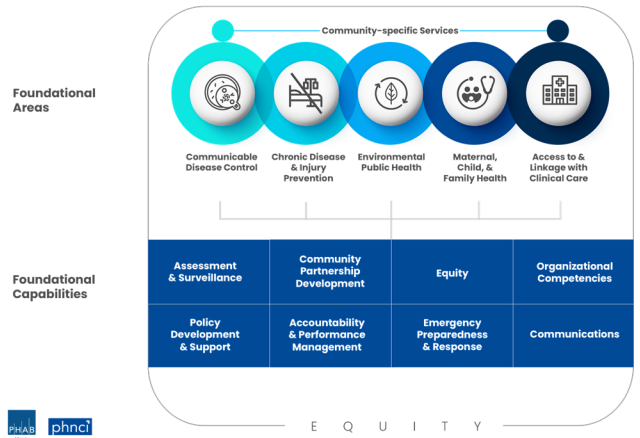
Figure 12: Ten Essential Public Health Services

Source: Centers for Disease Control and Prevention

Figure 13: Reaccreditation Standards

Source: Public Health Accreditation Board

Figure 14: Foundational Public Health Services



Source: The Public Health National Center for Innovations

Summary

Frameworks

Guided by Framework of Best Practice and Standards of Excellence

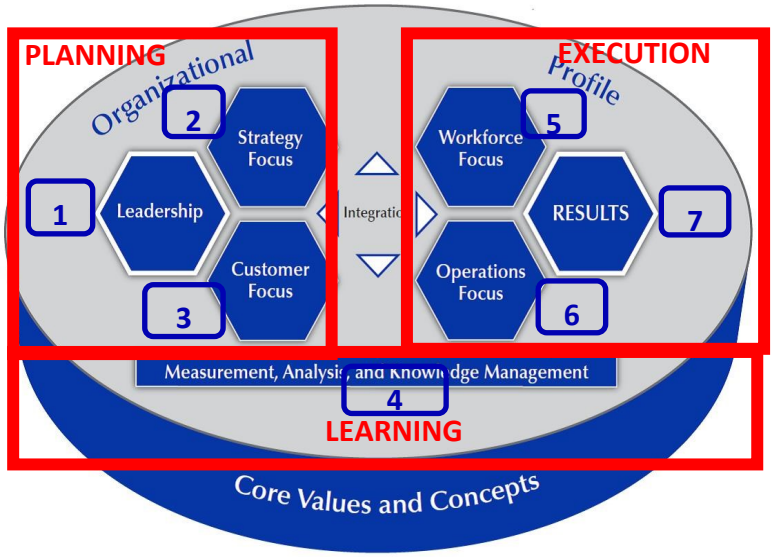
At the core of **Public Health 3.0** there is emphasis of collaborative engagement and actions that directly affect the social determinants of health inequity. This framework embraces the notion that local communities will lead the charge in taking public health to the next level and ensuring its continued success, which includes five key components of the framework, launched in 2016. These five components include the Chief Health Strategist, cross-sector partnership, public health accreditation, actionable data, and sustainable funding. Cross-sectoral collaboration is inherent to the Public Health 3.0 vision, and the Chief Health Strategist role requires high-achieving health organizations with the skills and capabilities to drive such collective action. Pioneering US communities are already testing this approach to public health, with support from several national efforts *(Figure 15)*.

Figure 15: Public Health 3.0.

Source: Office of the Assistant Secretary for Health, U.S. Department of Health and Human Services.

The **Baldrige Performance Excellence Framework** has also shaped the County's approach to planning. 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. Several regions apply a Baldrige community model along with MAPP in developing community enrichment plans *(Figure 16)*.

Figure 16: Baldridge Performance Excellence Framework.



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

Appendices

Overview of Appendices

- **APPENDIX I–PHS STRATEGIC INITIATIVES FRAMEWORK:**

  Major initiatives to address priorities and emerging needs of the County Board of Supervisors, the Chief Administrative Officer, the Health and Human Services Agency, and the Public Health Officer, or a combination. PHS plays a role in all of these initiatives.

- **APPENDIX II–NEW COUNTY AND AGENCY STRATEGIC PLANS:**

  These plans capture current priorities of the County and Agency; the County has five initiatives, and the Agency Strategic Plan has six initiatives that are intentionally aligned with the County 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 visa versa. The new FY 2023-2025 CEPs are currently under development.

- **APPENDIX IV–CONFORMITY TO PUBLIC HEALTH ACCREDITATION BOARD STANDARDS: VERSION 2022:**

  How this plan reflects adherence to the Public Health Accreditation Board (PHAB) 2022 Standards & Measures for Reaccreditation, reflecting best practices in public health.

- **APPENDIX V–DASHBOARDS: PUBLIC HEALTH SERVICES OUTCOMES DASHBOARD AND *LIVE WELL SAN DIEGO* INDICATORS DASHBOARD:**

  Key community or population indicators that PHS is tracking to assess long-term benefits to the community; including the Public Health Services Outcomes Dashboard and the *Live Well San Diego* Indicators Dashboard.

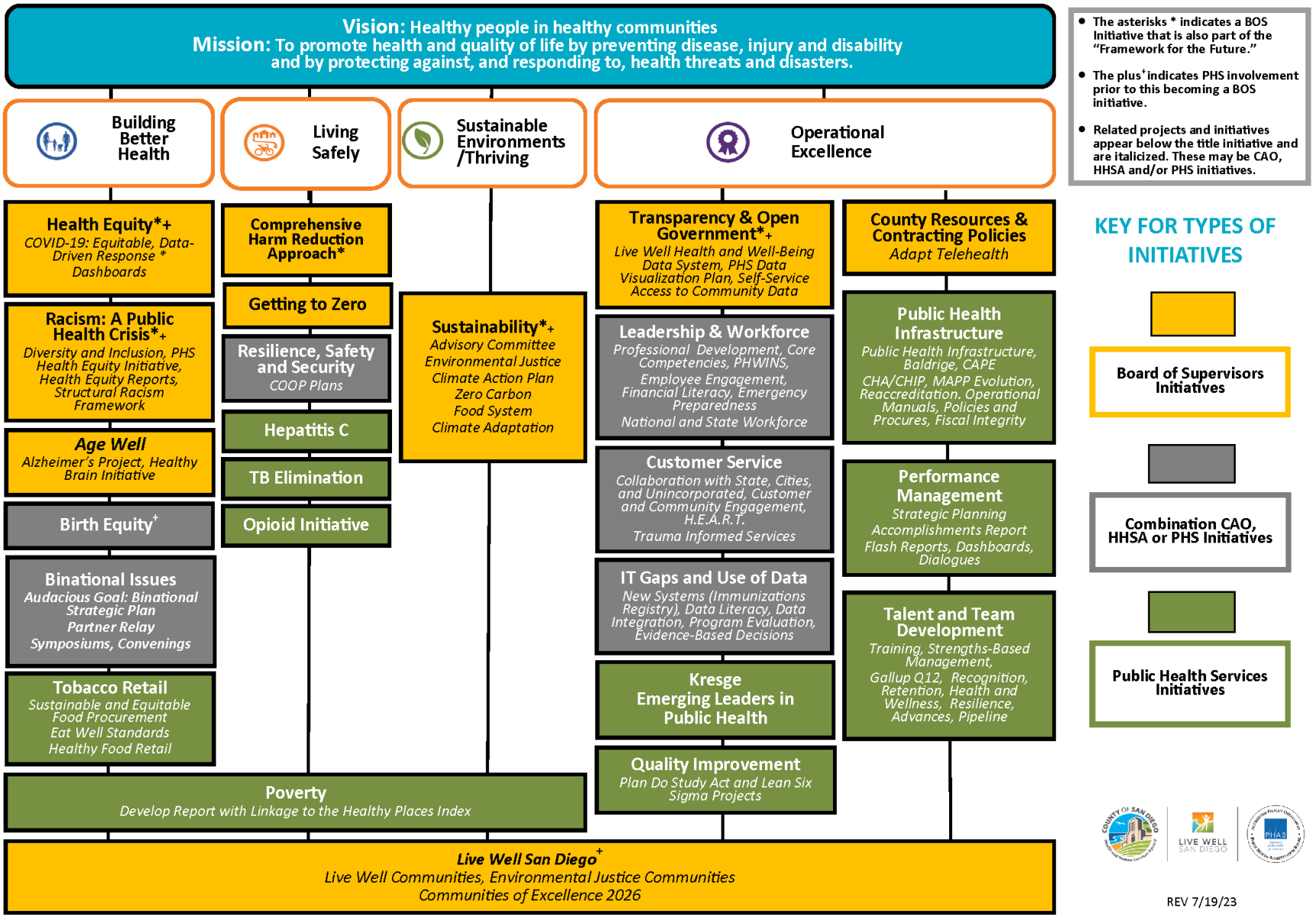
- **APPENDIX VI–FINANCIAL AND ORGANIZATIONAL INFORMATION:**

  Financial information, including staffing by full-time equivalents (FTEs), the approved budget for Fiscal Year 2022-23, and the organizational structure of Public Health Services.

Appendix I–Strategic Initiatives Framework

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

Strategic Initiatives Framework FY 2022-2024



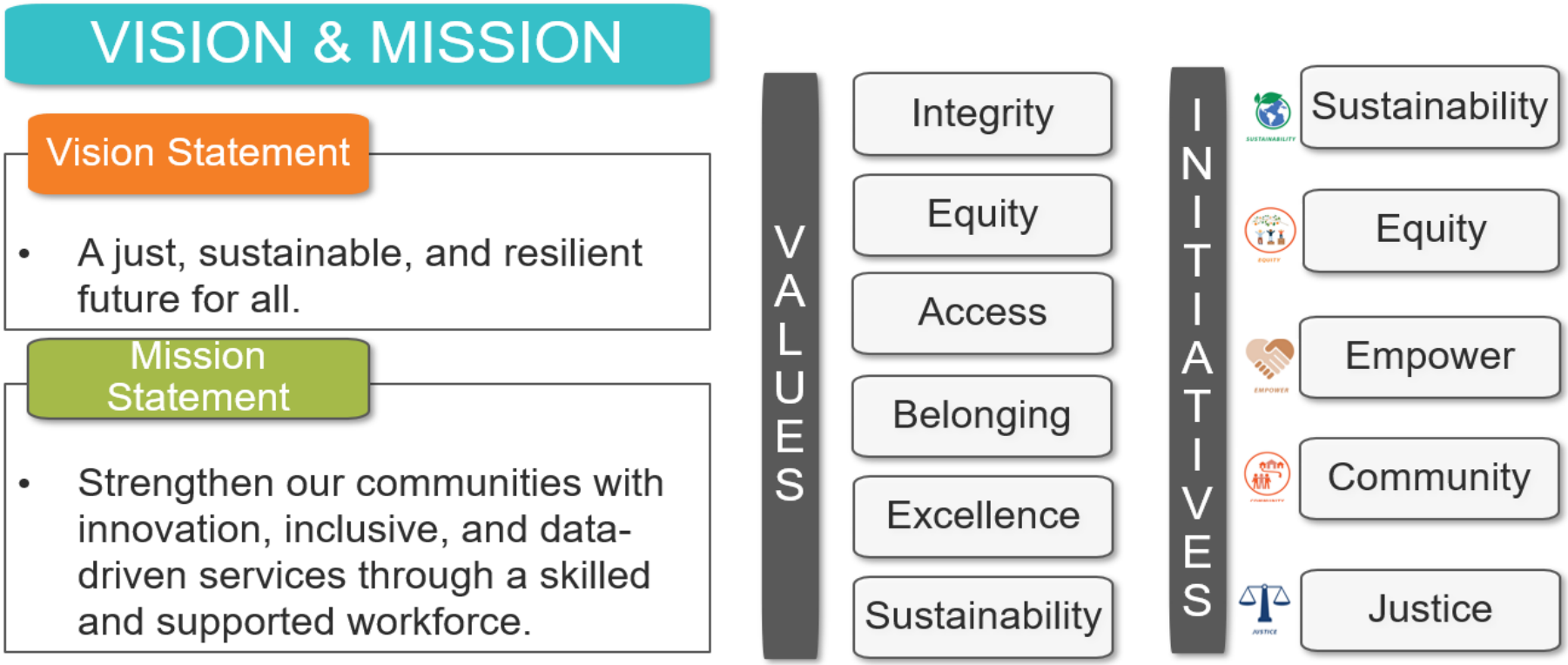
Source: [Public Health Services (sandiegocounty.gov)]

Appendix II– New County and Agency Strategic Plans

While *Live Well San Diego* remains the regional vision for the County of San Diego, the Board of Supervisors (BOS) has adopted a new County Strategic Plan in FY 2021-22 featuring initiatives that span the entire organization and break down silos, contributing to the overall success of the region. These five initiatives are Sustainability, Equity, Community, Justice, and Empower *(Figure 17)*.

In alignment with the BOS, the Health and Human Services Agency (HHSA) revisited its Strategic Plan, adopting six initiatives that align with the County's. In turn, Public Health Services (PHS) has plans and goals that advance the Agency and County initiatives and are called out in this PHS plan (Figure 16).

Figure 17: County of San Diego Strategic Plan.



Source: https://www.sandiegocounty.gov/content/dam/sdc/cao/docs/stratplan.pdf

Appendix II–New County and Agency Strategic Plans

Figure 17: Health and Human Services Agency Strategic Plan.

HHSA Vision, Mission, and Values

VISION
A region that is building better health, living safely, and thriving to advance a just, sustainable, and resilient future for all.

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

VALUES
In recognition that "The noblest motive is the public good", we are dedicated to: Integrity | Equity | Access | Belonging | Excellence | Sustainability.

CORE COMPETENCY
Advancing Opportunities for All San Diegans to Live Well.

Strategic Initiative Alignment

HHSA has identified six Agency Strategic Initiatives ***(Sustainability, Workforce, Community Engagement, Equity, Service Delivery Coordination, and Systems & Technology)*** that drive long-term Agency-wide performance excellence and focus our efforts on Agency goals to deliver increasing value to the people we serve. These Agency Strategic Initiatives directly support our County Strategic Initiatives ***(Sustainability, Empower, Community, Equity, and Justice).***

Source: 2022-24 HHSA Strategic Plan, also referred to as the "Agency Promise."

Appendix III–Alignment to Regional Community Enrichment Plans

Regional Community Enrichment Plans (CEPs) provide a strategic framework to address local priorities. Together, these CEPs make up the overall *Live Well San Diego* Community Health Improvement Plan (CHIP). These Plans are developed by Regional Community Leadership Teams (CLTs), five CLTs total for the six regions. North Coastal and North Inland regions are combined and have one Leadership Team and one community plan.

Map of Six HHSA Service Delivery Regions.

Source: HHSA Regions at Live Well San Diego | Home

Multiple perspectives are engaged in planning 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. The CEPs represent the goals of the CLTs, with a focus on what the leaders agree are of greatest need and that the members of the CLTs are best positioned to have an impact. Goals, and associated objectives, typically reflect how the CLT hopes to leverage assets and resources of its members and other partners to address priority needs as identified through community assessment activities.

There have been two cycles of CEPs issued. The first cycle was FY 2014-2018, and the second cycle was FY 2019-2021. The second cycle was extended by one year (FY 2021-22), due to delays in initiating the current cycle as a result of COVID pandemic, in which staff and community members alike were consumed with other activities related to the response. Also, there were some departmental organizational changes to strengthen community connection and engagement. The latter refers to the formation of the Homeless Solutions and Equitable Communities (HSEC) department within HHSA. Coordination of regional activity and community work is now provided through the Office of Equitable Communities (OEqC), with Public Health Services providing technical assistance for the assessment, planning, and development of CEPs. The current three-year planning cycle (FY 2023-25), is well underway, with the expectation that there will be new CEPs finalized by the Summer of 2023.

The relationship between community planning and PHS strategic planning is depicted in Figure 18. The alignment of activities illustrates how PHS provides technical assistance and resources (through grants and program activities) to support the design and implementation of the CEPs.

Source: HHSA Regions at Live Well San Diego | Home (livewellsd.org)

Appendix III–Alignment to Regional Community Enrichment Plans

Figure 18. Alignment of Planning Activities for PHS Strategic Plan and Community Enrichment Plans

CLT: Community Leadership Team

CEP: Community Enrichment Plan developed by each CLT

Source: Prepared by Office of Performance & Improvement Management, Public Health Services Administration Branch, HHSA, to capture Community Enrichment Planning process.

Appendix III–Alignment to Regional Community Enrichment Plans

A deliberate and interactive planning approach has been adopted, starting with Regional Data Presentations. This process starts with the collection and sharing in assessment data, per Step 1 in Figure 18. PHS and other agencies, prepare, post, and present community assessment data to the CLTS. This planning cycle began in the 2022 calendar year with presentations delivered to each CLT by the PHS Community Health Statistics Unit. CHSU delivers these presentations on an going basis at the start of, and during, the planning process.

The assessment data is part of what the CLTs use to develop strategic priorities for community plans, per Step 2 in Figure 18. Also, a survey of CLT member priorities, presentations from various community agencies, and ongoing discussion, contribute to the identification of several priorities for each region (as identified in Figure 19 "Priority Areas by Region as Identified by Community Leadership Teams"). Because of challenges in getting CLT members to decide on specific goals and objectives, a facilitator has been secured by PHS, using health disparities grant monies through the Centers for Disease and Prevention, to assist the respective CLTs in the development of their CEPs.

The priorities that each CLT has identified reflect a changed landscape after COVID-19. Behavioral health, homelessness, and housing are the top, shared interests of the CLTs, in addition to health and wellbeing and other topics that have been previously the focus of the CEP, see Figure 19 for list of regional priorities.

As of Spring 2023, each CLT is framing goals, objectives and measures, that best defines their commitments to address the Priorities identified, per Step 3 in Figure 18. The facilitator, who has considerable local community experience, is guiding the discussions, assisted by PHS staff and the HHSA community engagement team. At each of the CLT meetings beginning March 2023 up through August 2023, these discussions and ongoing data and partner presentations are conducted and represent a "deep dive" into these Priorities.

The final CEPs are not expected until the fall of 2023. By then five CEPs should be ready with objectives and actions. PHS staff will provide technical assistance to help identify appropriate measures based on evidence-based research.

In addition to supporting the development of the five CEPs, PHS also supports the implementation of the CEPs. To ensure that the CLTs and the HHSA community engagement staff, who coordinate CLTs activities, are aware of public health programs and grants, a regular process for information sharing between PHS Branches and the CLTs has been created, per Step 4 in Figure 18. A sample of key public health programs—such as CalFresh Healthy Living and Racial and Ethnic Approach to Community Health—which support implementation of Priorities identified by the CLTs appears in Figure 20. PHS also has a strong interest in sharing this information because these programs benefit from greater community involvement. PHS program staff are encouraged to come to CLT meetings to deliver presentations about their programs and participate in meetings.

The PHS Strategic Plan includes objectives that call out for support to both design and implementation of the CEPs. One objective that appears in each Branch Plan is to "provide information about programs, resources, and tools to inform and advance the implementation of community plans." The plan for the Administration Branch of PHS (Admin) specifically calls out for the provision of data and technical support to the Community Health Assessment and the Community Health Improvement Plan (referring to the five CEPs).

Other PHS Branches also have objectives that align and support implementation of the CEPs. The MCFHS Branch of PHS will be supporting some of the objectives that will ultimately emerge in the new CEPs related to policy, systems and environmental changes efforts within the communities, in addition to health and well-being program through CalFresh Healthy Living, farmers' markets, food pantries, and tobacco retail control efforts.

Finally, and as reflected in Step 5, Figure 18, PHS supports the monitoring of progress toward implementing the community plans. This includes working with the CLTs and HHSA community engagement staff to identify measures, setting up a system for tracking progress, and developing quarterly reports of progress for each of the CEPs. The performance management system utilized by PHS will be leveraged to support tracking of progress.

Appendix III–Alignment to Regional Community Enrichment Plans

Figure 19. Priority Areas by Region as Identified by Community Leadership Teams

Common Themes Across Regions:

Homelessness, Behavioral Health, and Economic Insecurity

Region	THREE PRIORTIES		
South	Homelessness	Behavioral Health	Food Insecurity
East	Thriving and Inclusive Communities	Behavioral Health Solutions: Prevention and Early Intervention	Resilient Youth and Families
Central	Housing for All	Health and Wellbeing	Education and Economic Development
North Central	Food and Housing Insecurity	Behavioral Health	Youth
North County (Coastal and Inland)	Homelessness	Mental Health	Substance Abuse

Source: Prepared by Office of Equitable Communities and Public Health Services, HHSA, on behalf of Community Leadership Teams.

Appendix III–Alignment to Regional Community Enrichment Plans

This Table captures only those CEP Priorities for which there are relevant public health programs to support implementation. This program-specific support provided by PHS Branches is in addition to the overall CEP data, design and implementation assistance that the department provides.

Figure 20. Sample of PHS Branch Programs Shares with Community Partners

Regional Priority Area	Branch	PHS Program, Initiative, Campaign, etc.	Description
Food Insecurity ***(South and North Central)***	Maternal, Child, and Family Health Services	CalFresh Healthy Living (CFHL)	**CFHL** provides funding to support local farmers and connect low income/SNAP recipients to locally grown produce. *Samantha Sonnich, Program Manager, Samantha.sonnich@sdcounty.ca.gov*
Food Insecurity ***(South and North Central)***	Maternal, Child, and Family Health Services	Racial and Ethnic Approaches to Community Health (REACH), Food Systems Strategy	REACH works to improve neighborhood food supply chain through urban agriculture, mobile farmer's markets, and serves as a key component of community revitalization in food-insecure neighborhoods. *Spencer Stein, Project Manager, Spencer.stein@sdcounty.ca.gov*
Substance Use ***(North County)***	Administration, PHS–Grant Support	Overdose Data to Action (OD2A)	**OD2A** focuses prevention efforts to reduce opioid use disorder, increase treatment resources, and reduce emergency department visits and deaths from opioid overdoses. *Chiara Leroy, Program Manager, Chiara.Leroy@sdcounty.ca.gov.*
Health & Other Topics ***(Central, East, and North Central)***	Public Health Preparedness and Response	Hospital Preparedness Program – San Diego Healthcare Disaster Coalition (SDHDC)	**SDHDC** workgroup focuses on minimizing the disparities of health across the County by minimizing inefficiencies within the public health preparedness and response system through shared resources and improved communication. *Jennifer Wheeler, Health Planning and Program Specialist. (Jennifer.Wheeler@sdcounty.ca.gov)*
Homelessness and Housing ***(South, Central, North Central and North County)***	Epidemiology and Immunization Services	Public Health Services Infectious Disease Temporary Lodging Program (TLP)	**TLP** prevents the further spread of a communicable/infectious disease through providing non-congregate shelter for individuals identified as not having an appropriate place to isolate (e.g., unsheltered, or displaced due to roommate). Individuals are provided daily meals, wellness calls, and referred to resources upon check-out from property. *Mary Grace Sadile, Health Planning and Program Specialist MaryGrace.Sadile@sdcounty.ca.gov*

Source: Prepared by Office of Performance & Improvement Management, Public Health Services Administration Branch, HHSA.

Appendix IV–Conformity to Public Health Accreditation Standards

The Public Health Accreditation Board (PHAB) is the accrediting organization for public health departments. Public Health Services was accredited on May 17, 2016, and applied for reaccreditation in May 2022, submitted documentation in October 2022, and was officially reaccredited on August 21, 2023. Maintaining accreditation is important to demonstrate that the health department is aligned to the 10 Essential Public Health Services and fulfills the foundational areas and capabilities for public health. The table below demonstrates how the PHS Strategic Plan aligns to the Standards and Measures for Reaccreditation: Version 2022 (Figure 21).

Figure 21. Consistent with Strategic Planning Requirements for Reaccredited Public Health Departments.

Reaccreditation Measure	Requirements	Guidance	Alignment to PHS Strategic Plan
10.1.1 A **ADOPT a department-wide strategic plan.**	**Requirement 1:** **The process to develop the strategic plan.**	**a. How the health department's staff at various levels and the governing entity or advisory board are engaged in developing the strategic plan.**	**Staff at all levels of the department are engaged** in the process of developing the strategic plan. Annually, PHS Administration coordinates a **Strategic Review** for the department. This involves meetings with PHS leadership and senior staff to participate in an environmental scan and to discuss key trends and challenges, including alignment with current priorities of the Board of Supervisors, County, HHSA, and Public Health Officer. Branch Chiefs convene their staff as part of the Strategic Review to gather input on issues impacting their programs and the implications. The Health Services Advisory Board (HSAB) is kept informed and input is solicited on the strategic plan to foster transparency and shared ownership of the health department's strategic plan and priorities. Board Office Aides are also briefed on the strategic plan at least annually by the Public Health Officer, at which time feedback is also requested to ensure is in alignment with Board priorities.
		b. Strategic planning process steps.	PHS has adopted a frequent, **two-year planning cycle to keep its strategic plan fresh**. Every second year, the department conducts a thorough review process, most recently in FY 2020-21, coordinated by PHS Administration Branch and involving all PHS staff. **The process starts with an environmental scan. Then a series of presentations and guided discussions are held or convened** at ongoing PHS leaders and senior staff meetings. A these meetings, environmental scan and other "futuring" and operational assessment information is presented. Most importantly, these presentations all involve guided or facilitated discussion of key trends, issues, and implications for the department, which includes a SWOT exercise. This results of these discussions are compiled by PHS Administration and shared back with the Branches through the Chiefs who then engage all of their own staff in discussions about the implications for their operations. A template with the results of each Branch's strategic review is submitted to PHS Administration , including any recommended changes to specific objectives and performance measures. **A new steps was added to the most recent planning cycle and this was a "Speed Review" of all performance measures**, involving the Public Health Officer, Deputy Public Health Officer, and appropriate program staff. The intent is to provide a more comprehensive review of all Branch performance measures.

Appendix IV–Conformity to Public Health Accreditation Standards

Figure 21 continued. Consistent with Strategic Planning Requirements for Reaccredited Public Health Departments.

Reaccreditation Measure	Requirements	Guidance	Alignment to PHS Strategic Plan
10.1.1 A **ADOPT a department-wide strategic plan.**	**Requirement 2:** **Department-wide strategic plan**	**a. Health department's mission, vision, and guiding principles or values.**	The Vision, Mission, and Values establish the overall future direction for the organization. **Because the County, HHSA, and PHS are part of an integrated enterprise, the Vision, Mission, and Values of all three entities is important**. *Live Well San Diego* remains the overarching vision for a collective impact effort that engages the County enterprise along with many partners across every sector. The Board of Supervisors recently adopted a new County Strategic Plan, and a new Agency Strategic Plan was also issued by the Agency Director, both of which are carefully aligned to each other, and include new Mission, Vision, and Values respectively. Both the County and Agency plans intend to break down silos across the County enterprise through shared initiatives and bring new emphasis to equity, sustainability, and justice, among other themes. See Appendix II.
		b. Strategic priorities.	**A PHS Strategic Initiatives Framework** was created at the request of the Public Health Officer because there is a wide array of strategic priorities to which the PHS Strategic Plan aligns–Initiatives that come from the Board of Supervisors, the Chief Administrative Officer (CAO), the Agency Director (HHSA), or the Public Health Officer, or a combination. This is a reflection of how important alignment is across the entire County enterprise in order to leverage limited resources. The PHS plan **identifies those goals that are specifically aligned to one or more of these initiatives in the PHS Strategic Initiatives Framework** with a "star" icon and the specific Initiative identified (see Appendix I). Icons are also used to identify objectives that support important initiatives such as health equity and community engagement, both a current emphasis within the new County and Agency plans. Alignment of each Branch plan by strategic priorities or goals to National, State, and local plans appears at the end of each plan. The Branch plans themselves are organized either by program or by strategic priority. For example, the HIV, STD, and Hepatitis Branch PHS organizes its plan around its strategy of Test, Prevent, Treat, Engage, and Improve, a strategy that has proven successful with the Getting to Zero initiative.

Appendix IV–Conformity to Public Health Accreditation Standards

Figure 21 continued. Consistent with Strategic Planning Requirements for Reaccredited Public Health Departments.

Reaccreditation Measure	Requirements	Guidance	Alignment to PHS Strategic Plan
10.1.1 A **ADOPT a department-wide strategic plan.**	**Requirement 2:** **Department-wide strategic plan**	**c. Objectives with measurable and time-framed targets.**	Goals, strategies, objectives, measures with targets appear in each of the seven Branch Plans. **Virtually every objective has a measurable and time-framed performance target. Many of the objectives have multiple, measurable time-framed targets.** There are a few objectives that are qualitative in nature and thereby results are captured in terms of degree of completion or some other qualitative scale. The objectives and measures are typically one year targets for each of the two-years that the plan covers. There are exceptions, particularly for objectives and measures that relate to Policy, Systems, and Environmental (PSE) changes, because the horizon for change is longer. These may be three or more years because the grants also have longer time frames.
		d. Strategies or actions to address objectives.	For each goal, a strategy is identified. These strategies represent the **"approach or how we will go about achieving the goal" and are based on, or informed by, the research, evidence, or best practices.** For example, PHS Administration has strategies that conform to the Malcolm Baldrige Excellence Framework. Similarly, the TBCRH Branch strategies are based on the collective impact approach, and is called the TB Elimination Initiative. And the HSHB Branch strategies are also based on collective impact, and referred to as Getting to Zero.

Appendix IV–Conformity to Public Health Accreditation Standards

Figure 21 continued. Consistent with Strategic Planning Requirements for Reaccredited Public Health Departments.

Reaccreditation Measure	Requirements	Guidance	Alignment to PHS Strategic Plan
10.1.1 A **ADOPT a department-wide strategic plan.**	**Requirement 2:** **Department-wide strategic plan**	**e. A description of how the strategic plan's implementation is monitored, including progress towards achieving objectives, and strategies or actions.**	The strategic plan is updated every quarter. **Staff are required to update all measures in their Branch Plans each quarter.** The results for these measures are entered into an individual scorecard for each Branch within a performance management system. Altogether, there are more than 100 measures across the seven Branches. While "**Branch Strategic Plan Scorecard Reports"** that are generated from this system are already distributed internally within each Branch, beginning in FY 2022 -23, these scorecards were shared quarterly with PHS leadership. A special scorecard tracks the priority measures from each Branch that also appear in the County Operational Plan. **Called the "Flash Report" (of about 15-20 measures total) this report is generated quarterly and distributed to all PHS staff**. Special focus is placed on those objectives in which targets are not being met; with staff providing commentary to explain the performance and mitigation. When performance is below target, this may elevated by the Chief to PHS leadership or referred up to the Monthly Operational Review meetings. A mitigation plan is then required.
		f. Linkage with the Community Health Improvement Plan (CHIP).	There are measures in the PHS strategic plan that **capture what the department is doing to support the development of the Community Improvement Plan (CHIP), referred to as Community Enrichment Plans** of which there are five, one for each Community Leadership Team in San Diego county. For example, there are measures regarding developing, presenting, and maintaining the Community Health Assessment. There are also measures of Branch efforts to provide resources and tools to advance the implementation of Community Enrichment Plans, and for PHS Administration to ensure that there is quarterly monitoring of these CEPs. Also, objectives reflect that PHS supports the implementation of the CEPs through a number of objectives related to policy, systems, and environmental change efforts that have historically been a priority for the CLTs.

Appendix IV–Conformity to Public Health Accreditation Standards

Figure 21 continued. Consistent with Strategic Planning Requirements for Reaccredited Public Health Departments.

Reaccreditation Measure	Requirements	Guidance	Alignment to PHS Strategic Plan
10.1.1 A **ADOPT a department-wide strategic plan.**	**Requirement 2:** **Department-wide strategic plan**	**g. Linkage with performance management.**	The PHS Strategic Plan is comprised of **seven individual Branch Strategic Plans, each including goals, objectives, and performance measures**. Each Branch Strategic Plan has at least 20 measures, and some larger Branches have up to 50 measures. Performance measures are also used to "tell the story" of the work within each Branch. Each Branch Plan has a **Health Equity Goal** and a **Population Health Goal. The Health Equity Goal within each of the Branch Plans includes a narratives about how the work of the department contributes to positive community change or outcomes.** All of the program measures identified for these stories come from the respective Branch plan. Also, objectives and measures appear that show that PHS is advancing in performance management and quality improvement–such as, objectives calling for 10 QI projects each year, expansion in the use of scorecards by individual branches, and increasing the number of PHS staff who are exposed in some way to quality improvement.

Appendix IV–Conformity to Public Health Accreditation Standards

Figure 21 continued. Consistent with Strategic Planning Requirements for Reaccredited Public Health Departments.

Reaccreditation Measure	Requirements	Alignment to PHS Strategic Plan
10.1.2 A **MONITOR Implementation of the department-wide strategic plan.**	**Requirement 1:** **Monitoring of progress towards all the strategic plan objectives.**	PHS Staff are required to **monitor progress towards all objectives and measures** in their Branch Plans **each quarter**. The results for all measures are entered into an individual scorecard by a designated performance improvement representative for each Branch within Clear Impact, a performance management system. Altogether, there are more than 100 measures across the seven Branches. While scorecard reports generated from this system are already distributed internally within each Branch, beginning in FY 2022-23, these scorecards are shared routinely with PHS leadership. A special scorecard ("Flash Report") tracks the priority measures from each Branch that also appear in the County Operational Plan, and Strategic Plan Scorecards track all measures for each Branch. **When performance is below target, staff provide commentary to explain the performance and mitigation.** The issue may be elevated by the Chief to PHS leadership or referred to at the Monthly Operational Review meetings. A mitigation plan is then discussed. **Monitoring of progress towards all PHS objectives and measures on a quarterly basis provides opportunities to assess what strategies or actions have been completed, whether timelines or targets require adjusting, or if additional resources are needed to support implementation.**
	Requirement 2: **Communication with governance and staff at various levels concerning implementation of the strategic plan.**	Staff at all levels of the department are engaged in the implementation of the strategic plan. **Implementation updates are regularly communicated to PHS staff (both leadership and front line staff) on progress towards the implementation of the strategic plan via reports, presentations, and meetings.** In addition to sharing implementation updates within PHS in a variety of ways, updates on progress are also communicated to the governing body, the County Board of Supervisors (BOS), and the Health Services Advisory Board (HSAB), a citizen advisory board to the BOS. HSAB is kept informed and input is solicited on the implementation of the strategic plan to foster transparency and shared ownership of the health department's strategic plan and priorities. **Board Office Aides are also briefed on the strategic plan at least annually by the Public Health Officer, at which time feedback is also requested to ensure is in alignment with Board priorities.** During the annual budget process, budget presentations delivered by each County business group include updates on performance objectives and measures, as appear in a performance table within the Operational Plan. For PHS, the update on performance measures is delivered by the Public Health Officer (PHO). As part of this annual budget presentation, the PHO describes whether the goals and objectives established were met and achievements for some of the measures. This type of regular communication fosters increased awareness of priorities and provides an opportunity for dialogue on the feasibility and effectiveness of priorities and objectives as the plan is implemented.

Appendix V–Dashboards

The San Diego County Public Health Services (PHS) 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 Indictors 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 PHS 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 uses 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 the collective efforts of many partners across the county are contributing to positive change in the region. There are also many measures that fall under the top 10 Indicators that are part of this shared measurement system.

Appendix V–Dashboards

COUNTY OF SAN DIEGO
HEALTH AND HUMAN SERVICES AGENCY

LIVE WELL SAN DIEGO

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

PHAB

	Indicator	Description	We want to increase this ↑ / We want to decrease this ↓	San Diego County	Central Region	East Region	North Central Region	North Coastal Region	North Inland Region	South Region	Target
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). 2021.	↓	43%	42%	44%	45%	41%	42%	42%	Prevent the percent of deaths due to the four chronic diseases (cancer, heart disease and stroke, type 2 diabetes, and pulmonary diseases such as asthma) to no more than **50%**.
	Infant Mortality Rate	Three-year average Infant Mortality Rate per 1,000 live births. 2018-2020.	↓	3.7	4.2	3.9	3.1	3.1	3.2	4.5	Reduce the 3-year average rate of infant deaths to **5.0 per 1,000** births by 2030.
	HIV Disease Diagnosis Estimates	Reported HIV Disease diagnosis case counts and percentages between 2017-2021 time period.	↓	100% (1,934)	40% (771)	10% (199)	14% (264)	9% (181)	6% (119)	21% (400)	Reduce the number of new HIV diagnoses by **90%** (from 2017 baseline level of 422 to 42) by 2030.
	Tuberculosis Incidence Rate	Annual Tuberculosis Incidence Rate per 100,000 population. 2021.	↓	6.1	8.5	3.8	5.3	2.0	3.5	12.3	Reduce Incidence of Tuberculosis in the county to **5 cases per 100,000** by 2030.
KNOWLEDGE - Learning throughout the lifespan											
KNOWLEDGE	High School Education	Overall Graduation Rate: the percentage of those age 25 years and older with a high school diploma or equivalent. 2021.	↑	88.3%	83.5%	89.8%	94.7%	89.8%	88.6%	81.1%	Increase the percentage of adults, age 25 years and older, with a high school diploma or equivalent to **90%**.
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). 2023.	↓	4.9%	5.4%	5.7%	3.9%	4.4%	4.0%	6.7%	No SMART Target. We want this to decrease over time.
	Income Inequality	Number of Total Earned Income Tax Credits. 2021 tax year.	↓	12,948	1,358	2,384	2,369	1,070	1,851	3,916	No SMART Target. We want this to decrease over time.
	Poverty	Percent of the population below poverty level. 2021.	↓	10.7%	16.2%	12.1%	9.1%	8.6%	8.7%	10.9%	Reduce the proportion of people living below the poverty threshold to **10%** by 2030.
COMMUNITY - Living in a clean and safe neighborhood											
COMMUNITY	Childhood Lead in Schools	The number of child cases with a blood lead level of 14.5mcg/dl or greater in the San Diego Childhood Lead Poisoning Prevention Program. 2018-2022.	↓	102	24	14	18	11	5	14	Ensure **95%** of children with blood levels <3.5 mcg/dL receive case management services within two months of referral.
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. 2023.	↑	62.8%	56.0%	63.4%	67.8%	64.7%	65.4%	57.0%	No SMART Target. We want this to increase over time.

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

Appendix V–Dashboards

Live Well San Diego Dashboard
Top 10 Population Outcome Indicators

LIVE WELL SAN DIEGO

	Indicator	Description	We want to increase this / We want to decrease this	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	Life Expectancy	Average number of years a person is expected to live at birth. 2021.	↑	80.6	80.3	78.0	86.6	81.5	78.9	77.9
	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. 2020.	↑	94.9%	94.9%	93.4%	96.2%	95.5%	94.9%	93.8%
KNOWLEDGE - Learning throughout the lifespan										
KNOWLEDGE	Education: High School Diploma or Equivalent	Percent of population aged 25 and over with at least a High School Diploma or Equivalent. 2020.	↑	88.0%	82.5%	89.4%	94.6%	89.6%	88.7%	81.0%
STANDARD OF LIVING - Having enough resources for a quality life										
STANDARD OF LIVING	Unemployment Rate	Percent of the total labor force that is unemployed. 2021.	↓	7.3%	8.5%	8.4%	6.0%	5.9%	5.9%	9.8%
	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. 2020.	↑	58.0%	54.1%	57.3%	61.6%	57.1%	60.3%	55.4%
COMMUNITY - Living in a clean and safe neighborhood										
COMMUNITY	Security: Overall Crime Rate	Overall Crime rate per 100,000 population. 2020.	↓	1830.5	N/A	N/A	N/A	N/A	N/A	N/A
	Physical Environment: Air Quality	Percent of days that air quality was rated as unhealthy for sensitive populations. 2020.	↓	13.4%	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. 2021.	↑	62.0%	78.7%	51.7%	71.5%	50.2%	42.6%	77.7%
SOCIAL - Helping each other to live well										
SOCIAL	Vulnerable Populations: Food Insecurity	Percent of adult population below 200% FPL not able to afford food. 2021.	↓	29.7%	25.7%	42.2%	36.7%	25.8%	29.3%	21.6%
	Community Involvement: Volunteerism	Percent of residents who volunteer. 2019.	↑	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 March 2023.

Appendix V–Dashboards

Live Well San Diego Dashboard
Top 10 Population Outcome Indicators

	Indicator	Description	We want to increase this / We want to decrease this	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	Life Expectancy	Average number of years a person is expected to live at birth. 2021.	↑	80.6	80.3	78.0	86.6	81.5	78.9	77.9
	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. 2020.	↑	94.9%	94.9%	93.4%	96.2%	95.5%	94.9%	93.8%
KNOWLEDGE - Learning throughout the lifespan										
KNOWLEDGE	Education: High School Diploma or Equivalent	Percent of population aged 25 and over with at least a High School Diploma or Equivalent. 2020.	↑	88.0%	82.5%	89.4%	94.6%	89.6%	88.7%	81.0%
STANDARD OF LIVING - Having enough resources for a quality life										
STANDARD OF LIVING	Unemployment Rate	Percent of the total labor force that is unemployed. 2021.	↓	7.3%	8.5%	8.4%	6.0%	5.9%	5.9%	9.8%
	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. 2020.	↑	58.0%	54.1%	57.3%	61.6%	57.1%	60.3%	55.4%
COMMUNITY - Living in a clean and safe neighborhood										
COMMUNITY	Security: Overall Crime Rate	Overall Crime rate per 100,000 population. 2020.	↓	1830.5	N/A	N/A	N/A	N/A	N/A	N/A
	Physical Environment: Air Quality	Percent of days that air quality was rated as unhealthy for sensitive populations. 2020.	↓	13.4%	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. 2021.	↑	62.0%	78.7%	51.7%	71.5%	50.2%	42.6%	77.7%
SOCIAL - Helping each other to live well										
SOCIAL	Vulnerable Populations: Food Insecurity	Percent of adult population below 200% FPL not able to afford food. 2021.	↓	29.7%	25.7%	42.2%	36.7%	25.8%	29.3%	21.6%
	Community Involvement: Volunteerism	Percent of residents who volunteer. 2019.	↑	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 March 2023.

Appendix VI–Financial and Organizational Information

The Public Health Services (PHS) two-year budget for Fiscal Years 2022-23 and 2023-24 was adopted by the County of San Diego Board of Supervisors (BOS) and provides 216.3 million in year one and $208.1 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 (HHSA) 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 2022-24.

Staffing levels have increased by about 9.8% percent from FY 2021-22 to FY 2022-23 with a total of 730 total staff positions. Epidemiology and Immunizations Services and California Children's Services have the most staff; Epidemiology and Immunizations Services and HIV, STD, and Hepatitis Branches 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 adjustments as authorized by the BOS.

Appendix VI–Financial and Organizational Information

Figure 22. Public Health Services Staffing by Branch.

	Fiscal Year 2021-22 Adopted Budget	Fiscal Year 2022-23 Adopted Budget	% Change
Administration	47.00	49.00	4.26%
California Children's Services	141.75	148.75	4.94%
Epidemiology and Immunization Services	236.00	270.00	14.41%
HIV, STD and Hepatitis	65.00	76.00	16.92%
Maternal, Child and Family Health Services	78.00	82.00	5.13%
Public Health Preparedness and Response	28.00	27.00	-3.57%
Tuberculosis Control and Refugee Health	69.25	77.25	11.55%
Total	**665.00 FTE's**	**730.00 FTE's**	**9.77%**

Figure 23. Public Health Services Budget by Branch.

	Fiscal Year 2021-22 Adopted Budget	Fiscal Year 2022-23 Adopted Budget	% Change
Administration	$ 15,963,754	$ 15,047,310	-5.74%
California Children's Services	$ 23,115,933	$ 24,707,137	6.88%
Epidemiology and Immunization Services	$ 236,684,988	$ 100,893,989	-57.37%
HIV, STD and Hepatitis	$ 26,584,885	$ 28,487,430	7.16%
Maternal, Child and Family Health Services	$ 27,521,880	$ 26,094,770	-5.19%
Public Health Preparedness and Response	$ 5,645,250	$ 7,044,534	24.79%
Tuberculosis Control and Refugee Health	$ 12,528,944	$ 14,107,742	12.60%
Total	**$ 348,045,634**	**$ 216,382,912**	**-37.83%**

Appendix VI–Financial and Organizational Information

Figure 24. Public Health Services Budget by Categories of Expenditures.

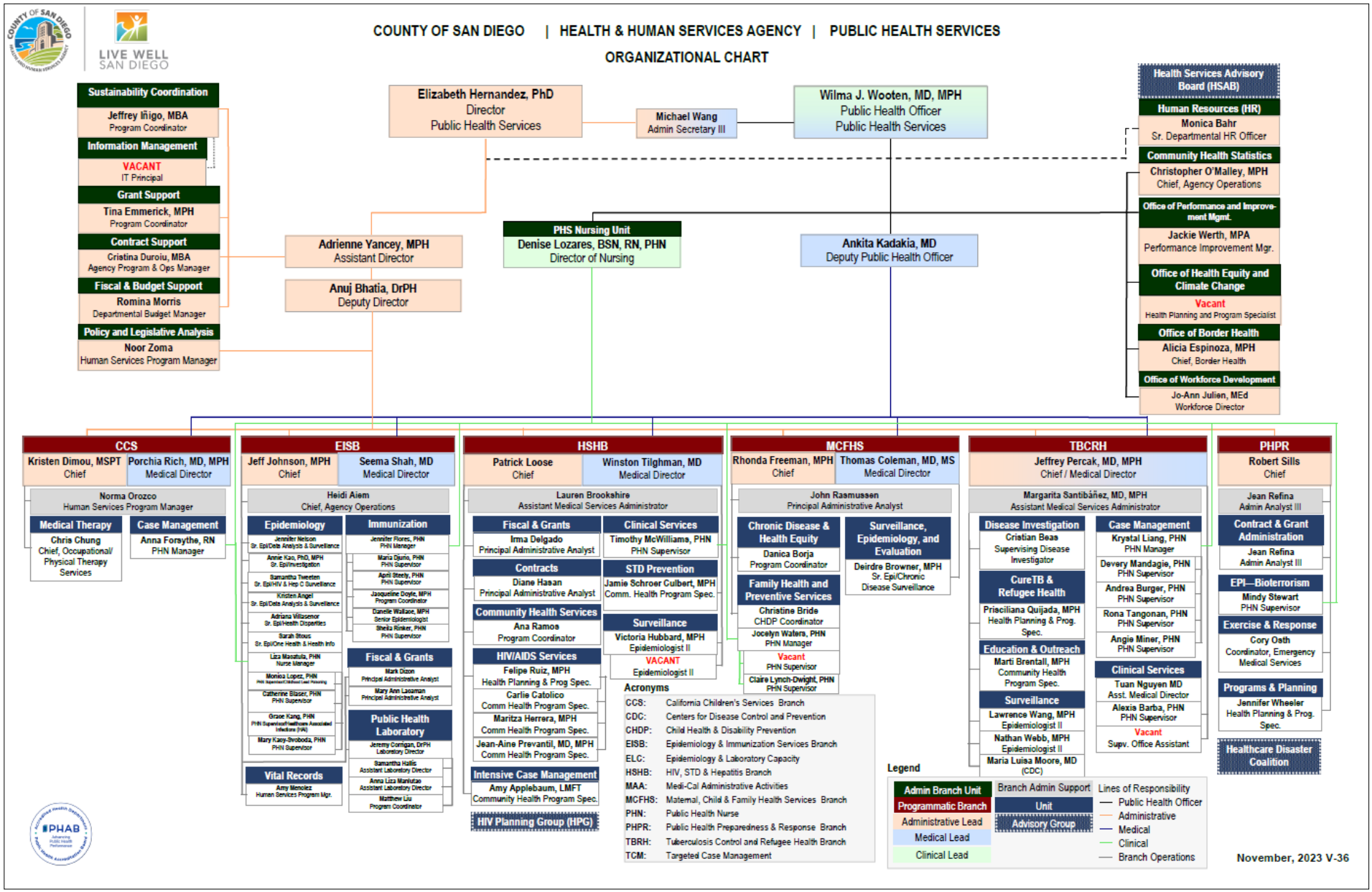
	Fiscal Year 2021-22 Adopted Budget	Fiscal Year 2022-23 Adopted Budget	% Change	Fiscal Year 2023-24 Recommended Budget
Salaries & Benefits	$ 93,776,024	$ 103,116,540	9.96%	$ 108,187,233
Services & Supplies	$ 231,840,647	$ 94,803,412	-59.11%	$ 83,500,381
Other Charges	$ 2,748,228	$ 2,748,228	0.00%	$ 2,748,228
Capital Assets Equipment	$ 20,673,646	$ 15,714,732	-23.99%	$ 13,689,732
Costs Applied in General Fund	$ -992,911	$ 0	-100.00%	$ 0
Total	**$ 348,045,634**	**$ 216,382,912**	**-37.83%**	**$ 208,125,574**

Figure 25. Public Health Services Budget by Categories of Revenues.

	Fiscal Year 2021-22 Adopted Budget	Fiscal Year 2022-23 Adopted Budget	% Change	Fiscal Year 2023-24 Recommended Budget
Licenses, Permits & Franchises	$ 80,000	$ 80,000	0.00%	$ 80,000
Intergovernmental Revenues	$ 325,117,950	$ 193,058,358	-40.62%	$ 185,032,268
Charges for Current Services	$ 9,196,915	$ 3,953,410	-57.01%	$ 3,722,162
Miscellaneous Revenues	$ 516,727	$ 516,727	0.00%	$ 516,727
Other Financing Sources	$ 5,262,638	$ 3,566,638	-32.23%	$ 3,566,638
Health & Human Services Fund Balance	$ 0	$ 0	0.00%	$ 0
Committed Realignment	$ 0	$ 0	0.00%	$ 0
Net County Cost	$ 7,871,404	$ 15,207,779	93.20%	$ 15,207,779
Total	**$ 348,045,634**	**$ 216,382,912**	**-37.83%**	**$ 208,125,574**

Appendix VI–Financial and Organizational Information

Figure 26. Public Health Services Organizational Chart.



County of San Diego

Health and Human Services Agency

Public Health Services Strategic Plan

FY 2023-24 and FY 2024-25

COUNTY OF SAN DIEGO
HEALTH AND HUMAN SERVICES AGENCY

LIVE WELL SAN DIEGO

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