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COUNTY OF LOS ANGELES
Public Health

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February 17, 2023

TO: Each Supervisor

FROM: Barbara Ferrer, Ph.D., M.P.H., M.Ed.
Director

SUBJECT: **LOS ANGELES COUNTY'S EFFORTS TO ADDRESS SOCIAL DETERMINANTS OF HEALTH (ITEM 9, BOARD AGENDA OF MAY 17, 2022)**

This report is in response to the Board of Supervisors May 17, 2022, motion directing the Department of Public Health (Public Health) and the Anti-Racism Diversity & Inclusion Initiative (ARDI) to: 1) Conduct a landscape analysis and provide a summary of existing programs, policies, and initiatives led by County departments that address one or more of the key areas of the multiple social determinants of health; 2) Provide an analysis of existing funding streams or opportunities to leverage federal, state, and philanthropic funding to support future efforts; 3) In collaboration with community stakeholders, produce a gap analysis that identifies key opportunities to coordinate and integrate the delivery of services needed to optimize the health of County residents, including but not limited to policies, systems, practices, and programming changes; and 4) In collaboration with community stakeholders, develop a set of recommendations including, but not limited to, policy changes, funding strategies, and metrics to better coordinate efforts identified in the landscape analysis and to address the needs identified in the gap analysis to reduce health inequities and track progress. The motion directs the use of the Healthy People 2030 social determinants of health (SDoH) framework: Economic Stability, Education Access and Quality, Healthcare Access and Quality, Neighborhood and Build Environment, and Social and Community Context.

Public Health and ARDI led a multidepartment team that determined that the scope of the project required conducting the analysis in two phases: Phase 1, which presents the findings of the landscape analysis regarding programs of County departments addressing the Healthy People 2030 SDoH domains, and Phase 2, which will include the gap analysis, funding stream analysis, and reporting back on stakeholder recommendations.

The key findings of the attached Phase 1 report demonstrate that County departments conduct programs that address all the Healthy People 2030 SDoH domains and do so in a variety of ways. County departments conduct programs that are largely cross-sectoral, with 62 percent of reported programs addressing multiple SDoH domains, and collaborative, with 83 percent of reported

programs involving a collaborative partner. More than 30 percent of reported County programs involve an interdepartmental collaboration. Finally, the findings of this landscape analysis offer insight regarding County approaches to SDoH that will contribute to the Office of Prevention Services Task Force's efforts to develop a comprehensive prevention services framework.

We look forward to presenting the findings and recommendations of Phase 2, which will be submitted to your Board in April 2023. If you have any questions or would like additional information, please let me know.

Attachment

BF:da:sv

c: Chief Executive Officer
Acting County Counsel
Executive Officer, Board of Supervisors
Anti-Racism Diversity and Inclusion Initiative
Aging and Disabilities
Economic Opportunity
Health Services
Mental Health
Public Social Services
Los Angeles County Office of Education

Social Determinants of Health Landscape Analysis Los Angeles County

Introduction

This report is in response to the Board of Supervisors May 17, 2022, motion which directed the Department of Public Health (Public Health) and the Anti-Racism Diversity & Inclusion Initiative (ARDI) to: 1) Conduct a landscape analysis and provide a summary of existing programs, policies, and initiatives led by County departments that address one or more of the key areas of the multiple social determinants of health; 2) Provide an analysis of existing funding streams or opportunities to leverage federal, state, and philanthropic funding to support future efforts; 3) In collaboration with community stakeholders, produce a gap analysis that identifies key opportunities to coordinate and integrate the delivery of services needed to optimize the health of County residents, including but not limited to policies, systems, practices, and programming changes; and 4) In collaboration with community stakeholders, develop a set of recommendations including, but not limited to, policy changes, funding strategies, and metrics to better coordinate efforts identified in the landscape analysis and to address the needs identified in the gap analysis to reduce health inequities and track progress. To best respond to the motion, the study team has divided the project into two phases. This Phase 1 report addresses the motion's Directive 1: *Conduct a landscape analysis and provide a summary of existing programs, policies, and initiatives led by County departments that address one or more of the key areas of the multiple social determinants of health*. The Phase 2 report, to be submitted in April 2023, will include a gap analysis, a funding stream analysis, and reporting on stakeholder recommendations.

Background

The U.S. Department of Health and Human Services Healthy People 2030 framework is the fifth iteration of the Healthy People initiative, based on the 1979 report Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention. The Healthy People 2030 initiative builds on 40 years of learnings to inform and address the current public health priorities. Healthy People 2030 is a framework of principles that outlines the essential nature of health and holistic well-being to a thriving society; goals to build an inclusive, equitable, and healthy community for all; and an action plan that equips local jurisdictions with the information and tools to promote health and eliminate health disparities in alignment with Healthy People 2030. The Board's motion directed Public Health and ARDI to analyze how County programs address social determinants of health (SDoH) through the lens of Healthy People 2030. Healthy People 2030 defines five overarching domains of SDoH.

Abbv	Social Determinant of Health Domain	Goal
SDoH 1	Economic Stability	Help people earn steady incomes that allow them to meet their health needs
SDoH 2	Education Access and Quality	Increase educational opportunities and help children and adolescents do well in school
SDoH 3	Healthcare Access and Quality	Increase access to comprehensive, high-quality health care services
SDoH 4	Neighborhood and Built Environment	Create neighborhoods and environments that promote health and safety
SDoH 5	Social and Community Context	Increase social and community support

This analysis builds on the work of the Los Angeles County Office of Prevention Services Task Force, which has already conducted an assessment of County prevention programming. This body is tasked with developing a comprehensive community-based prevention services delivery system towards delivering upstream interventions to address social determinants of health. Although the prevention framework that guides the Task Force is not the same as the Healthy People 2030 SDoH framework and does not focus on the same aspects of County programs, it is aligned in its purpose of reducing disparities in SDoH. Furthermore, the examination of how County programs address these SDoH domains will inform and advance prevention services work.

Outline of Report

This report provides: 1) a summary of the analytic methods used in the landscape analysis, 2) descriptions and summaries of findings using a series of seven visualizations of the data collected, 3) implications of the findings and limitations of the data, and 4) next steps.

Methods

This Phase 1 report reflects the results of a landscape analysis examining existing programs, led by County departments that address one or more of the key areas of the multiple social determinants of health. There will be a Phase 2 report back to the Board on this motion, which will include a gap analysis, a funding stream analysis, and reporting on stakeholder recommendations.

Framework

To perform this landscape analysis, Public Health and ARDI surveyed a host of Los Angeles County departmental programs and examined how they each address the Healthy People 2030 SDoH domains. The analysis looked for general patterns of relationships between programs, departments, SDoH, and collaborative partners. The analytic framework for the landscape analysis was focused on two primary dimensions of these relationships – programs that address multiple SDoH domains and program collaborations both among departments and between departments and other partners.

Due to the large number of county departments studied, the analyses were stratified into two groups. Group A was comprised of departments and other county entities specifically identified in the board motion: Aging and Disabilities, Economic Opportunity, Health Services, County Office of Education, Mental Health, Public Health, and Public Social Services. Group B was comprised of additional county departments, as well as First 5 LA, the Los Angeles Homeless Services Authority (LAHSA), and the LA County Development Authority (LACDA). Please see Table 1 for a full breakdown.

This group stratification provided a useful analytic tool, since the departments/county entities in group A are those whose missions align most closely with the Healthy People 2030 framework.

Group	Department/County Entity	Abbv
A	Aging and Disabilities Department	ADD
A	CEO – Anti-Racism Diversity & Inclusion Initiative	ARDI
A	Department of Economic Opportunity	DEO
A	Health Services	DHS
A	Los Angeles County Office of Education	LACOE
A	Mental Health	DMH
A	Public Health	DPH
A	Public Social Services	DPSS
B	Alternate Public Defender	APD
B	Animal Care and Control	AN
B	Arts and Culture	Arts
B	Auditor – Controller	AU
B	Beaches and Harbors	BH
B	CEO - Alternatives to Incarceration	CEO - ATI/JCOD
B	CEO - Homeless Initiative	CEO-HI
B	CEO - Poverty Alleviation Initiative	CEO-PAI
B	Child and Family Services	DCFS
B	Child Support Services	CSSD
B	Consumer and Business Affairs	CA
B	District Attorney	DA
B	Fire	FD
B	Human Resources	HR
B	Internal Services	ISD
B	Los Angeles County Development Authority	LACDA
B	Los Angeles Homeless Services Authority	LAHSA
B	Medical Examiner	ME
B	Military and Veterans Affairs	MVA
B	Probation	Prob
B	Public Defender	PD
B	Public Library	Library
B	Public Works	DPW
B	Regional planning	DRP
B	Sheriff	LASD
B	Treasurer and Tax Collector	TTC

Table 1 - Department Roster with abbreviations

Data collection

There were two main sources of data for the landscape analysis: a departmental survey and individual departmental consultation meetings. Much of the survey data used for this analysis were originally collected by the Anti-Racism Diversity & Inclusion Initiative (ARDI) as part of the Prevention Services Taskforce (PST) assessment regarding departmental prevention programming. With ARDI's permission,

Public Health circulated the PST survey findings back to their original departments and requested that they add any additional programs-- including those deemed not to be prevention-focused-- that address SDoH. Thirty-three departments submitted surveys to ARDI, 15 departments provided updates to this study team. The study team also met with 18 departments and other entities one-on-one to explain the request and navigate challenges with program and data comparability.

Data Analysis

Once the departmental surveys were returned, the data was cleaned, duplicate entries were consolidated, and programs were coded according to the SDoH domains they addressed. Each program could be assigned one or more SDoH domains. The study team used an Inter-Rater Reliability process, which means having two individuals code the data separately and then subsequently meet to resolve any discrepancies and agree on a final set of codes. The coded table, with data on county departments and government entities, program descriptions, SDoH domains, collaborative partners, and restricted vs. unrestricted funding, was then uploaded to Power BI, where matrices, visualizations, and advanced filters were utilized for analysis.

Findings

Distribution of Programs by SDoH domain

Figure 1 displays the number and proportion of programs by SDoH domain, and Figure 2 shows the same data disaggregated by Group A and Group B.

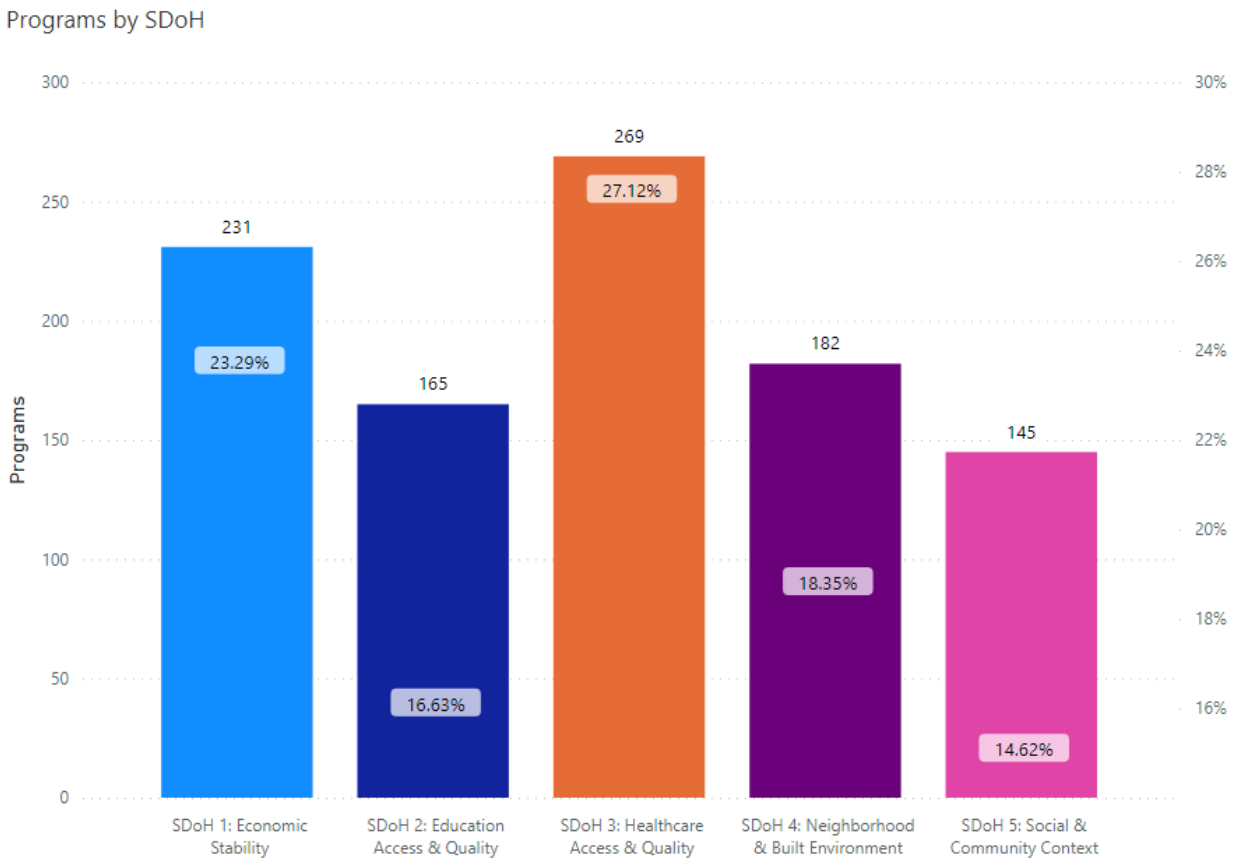

Figure 1 - Programs by SDoH domain (n, %)

Note: because many programs have been assigned to multiple domains, the sum of programs in this chart (992) exceeds to total number of programs (519).

Our program survey yielded a total of 519 programs, assigned to 992 SDoH domains, resulting in a SDoH assignment/program ratio of 1.91. In other words, each program addressed an average of just under 2 SDoH domains.

The SDoH category with the most assigned programs was SDoH 3: Healthcare Access & Quality (269), followed by SDoH 1: Economic Stability (231), SDoH 4: Neighborhood & Built Environment (182), SDoH 2: Education Access & Quality (165), and SDoH 5: Social & Community Context (145).

Given the focus of this analysis on SDoH, the relatively higher representation of health and health access related programs is not a surprise (27% compared to an average of 18% across the other 4 categories). This pattern is reinforced when these results are disaggregated by group (Figure 2), with Group A, which represents a higher proportion of health-oriented departments (see Table 1), having an SDoH 3 share of 38% compared to 16% across the other four domains. Group A also had a slightly lower SDoH assignment/program ratio of 1.87. Group B programs were more likely to address SDoH domain 1: Economic Stability (27%), and SDoH 4: Neighborhood and Built Environment (24%). Group B had a slightly higher SDoH assignment/program ratio of 1.95.

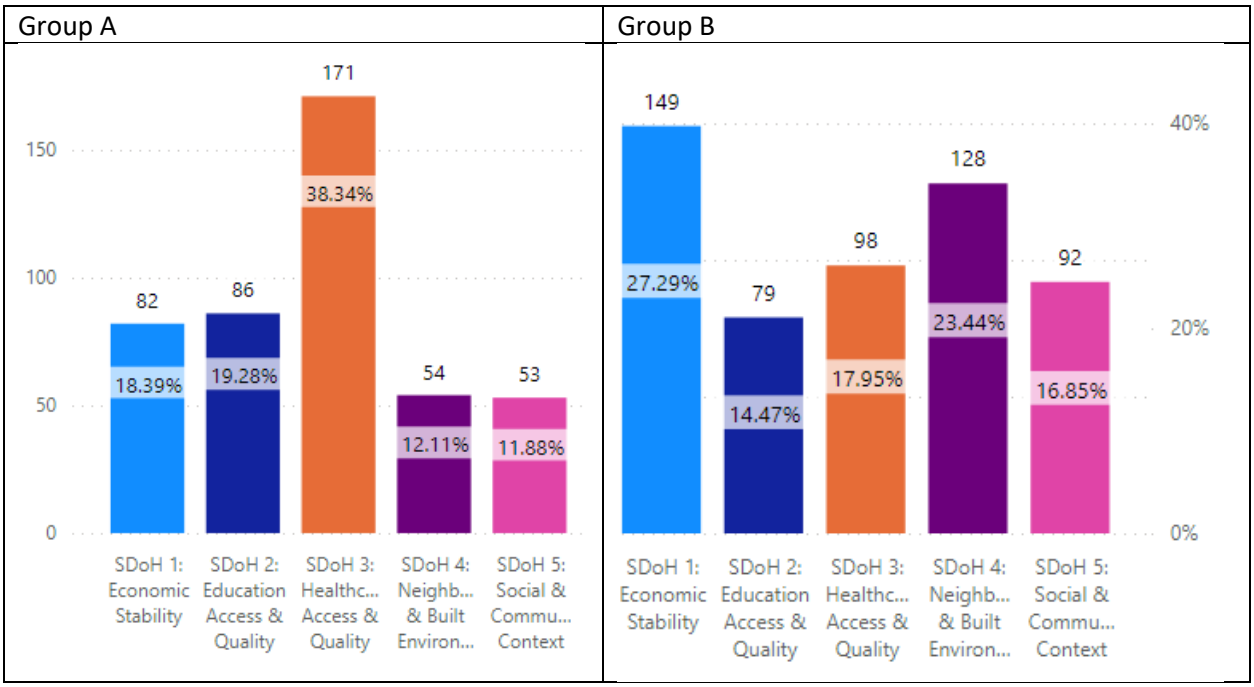

Figure 2 - Programs by SDoH domain (by Group)

Summary

- ***A total of 519 programs were assigned to 992 SDoH domains, with each program assigned to an average of just under two domains (1.91).***
- ***County departments deliver programs that address all five domains of SDoH, with a somewhat higher proportion addressing SDoH 1 and 3, which most closely align with health and economic security basic needs social safety net programs.***

- ***Programs most frequently address the domains with which their departmental mission is most closely aligned (E.g., Economic Opportunity - SDoH 1; Public Health - SDoH 3; Regional Planning - SDoH 4).***

Reflections

Overall, these findings demonstrate that the County is conducting substantial work in all the different SDoH domains. Additionally, the analysis by group shows that even the departments and other less health-focused entities not mentioned in the board motion also implement a large volume of programs addressing multiple SDoH domains. Even though County departments are not explicitly oriented around an SDoH approach, their programmatic portfolios largely align with the SDoH domains laid out in the Healthy People 2030 framework. This means that the Board could consider using Healthy People 2030 as an analytic or strategic framework in their planning and decision-making.

Proportion of SDoH Domains by Department

Figure 3 represents the proportion of programs assigned to each SDoH domain within each department. The purpose of this graph is to show which departments have programs addressing a broad range of domains and which departments have programs more concentrated on a smaller number of domains.

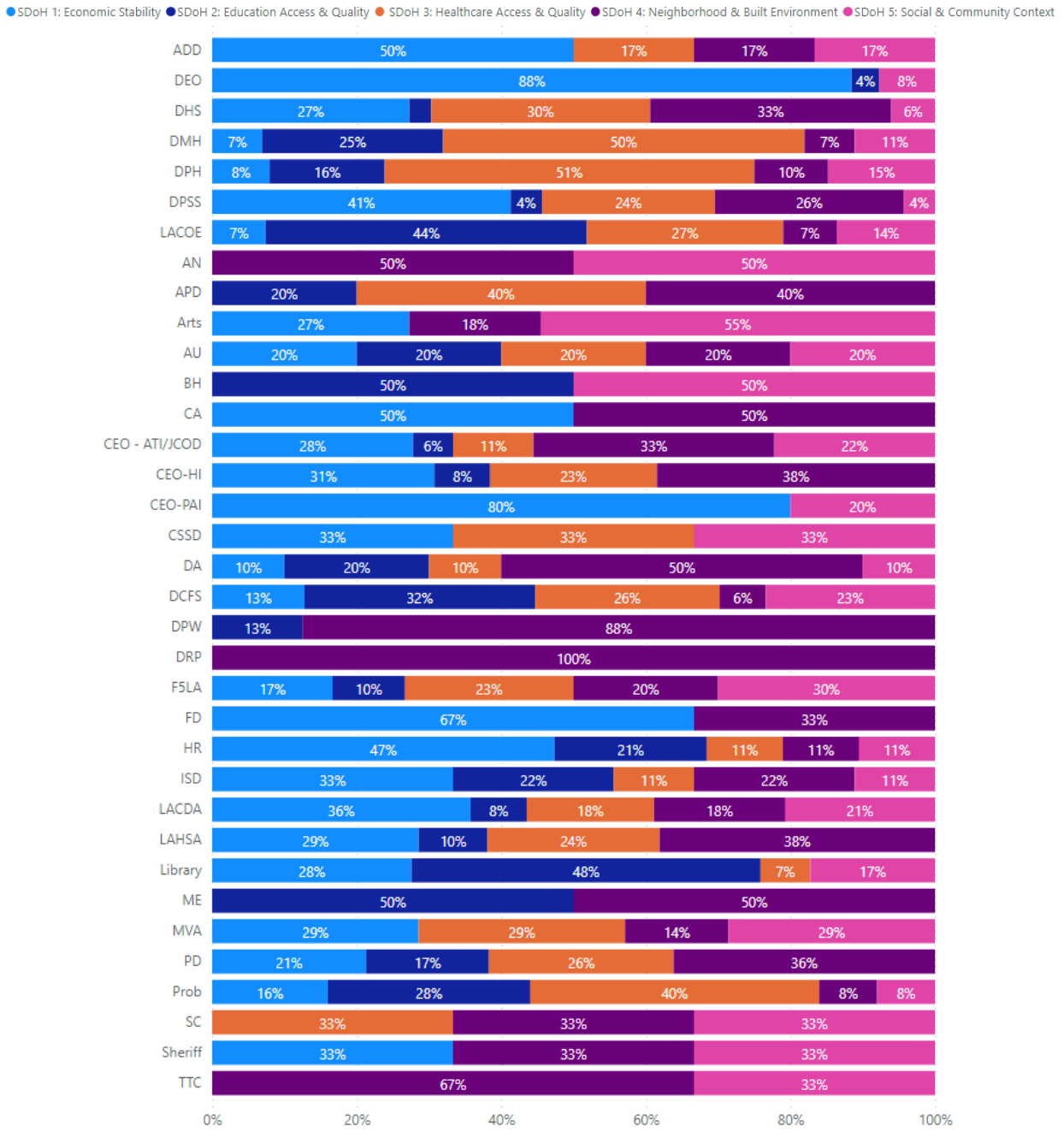

*Figure 3 - Proportion of programs assigned to SDoH by department - DHS excluded all health care programs and focused only on purse upstream SDOH programs that could be labeled as prevention that had fungible funding sources****

Overall, 26 of 35 County departments (74%) provide programs addressing three or more domains of SDoH and 20 (57%) provide program addressing at least four of the five domains.

These findings suggest that despite a few departments' focus on mission-aligned domains, almost all departments reach outside of their traditional priority domains to engage in cross-sector ***strategies*** that address the root causes of health inequities by tapping into multiple SDoH in their ***programming***. For instance, Public Defender conducts work in four SDoH domains and Public Health conducts work in five SDoH domains.

Several departments (e.g., Beaches & Harbors, Fire, Medical Examiner, Regional Planning, Public Works, Consumer and Business Affairs, Treasurer-Tax Collector) offer notable exceptions to this pattern. These exceptions make sense given the specific nature of these departments' external facing services, and the relationship between social determinants of health and the mission and priorities of these departments.

Summary

- ***97% of County departments address multiple SDoH domains in their reported programs.***
- ***57% of County departments address at least four SDoH domains in their reported programs.***

Reflections

Overall, these findings demonstrate that individual departments are working across SDoH domains. Although additional examination is warranted, qualitative data from consultative departmental interviews suggest that this represents an intentional pattern of work. For instance, when a department or other entity working with the education sector encounters economic stability factors affecting the educational outcomes of their programs, that department may use a mix of internal resources and interventions, as well as external collaborations to address those factors rather than simply referring clients out to "economic stability" focused departments for additional assistance. This results in an ever-adapting constellation of internal and collaborative cross-sectoral programming.

Proportion of Restricted/Unrestricted Funding by SDoH Domain

Figure 4 shows the proportions of restricted and unrestricted program funding by SDoH domain.

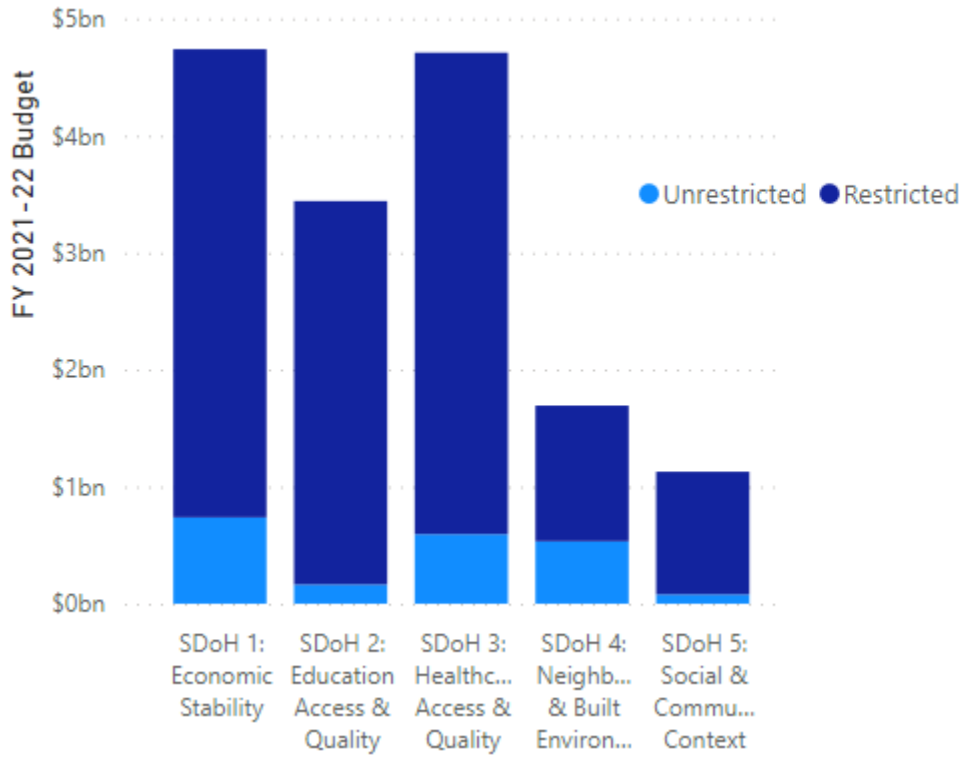

Figure 4 - Funding by SDoH domain (by restricted, unrestricted)

Overall, 13% of the funding reported for FY 2021-22 was unrestricted and 87% of funding was restricted. However, these proportions varied by domain, ranging from only 5% unrestricted funds for SDoH 2 to 36% unrestricted funds for SDoH 4. The relatively small proportion of unrestricted funds

notwithstanding, overall unrestricted funds were less collaborative, with SDoH 5 (99%) and SDoH 2 (96%) collaborative programs supported by restricted funds, compared to the average of 87%. On the other hand, SDoH 4 (52%) and SDoH 1 (80%) collaborative programs used restricted funds far below average.

Summary

- ***The reported programming indicates departmental funding is highly restricted, averaging 87% of funding across SDoH domains.***
- ***SDoH 2 reported programs with most highly restricted funding and SDoH 4 reported programs with the least restricted funding.***
- ***Funding restrictions for programs with at least one collaborative partner varies by SDoH.***

Reflections

Overall, the findings regarding restricted and unrestricted funding suggest new avenues for investigation. Although there do seem to be relationships between collaboration on SDoH domains and funding restrictions, this landscape analysis did not capture the precise nature of those relationships. For instance, does restricted funding *allow* or *require* or *preclude* more cross-sectoral or collaborative programming? More specifically, does the push towards collaboration and more multi-focus programming come from departments looking to expand or innovate or from requirements of the funding agency? Additionally, what are the comparative impacts of restricted vs. unrestricted funding? Is there an ideal balance between the two that best supports departmental objectives and countywide goals? Investigating these questions may clarify funding gaps and opportunities and shape interdepartmental collaboration strategy more broadly.

Proportion of Programs Addressing Single and Multiple SDoH Domains

Figure 5 shows the number and proportion of programs addressing single and multiple SDoH domains. The chart on the left includes all programs and the chart on the right divides the programs by domain. Each band on the bars represents the number of domains addressed by programs in that domain. The purpose of this figure is to show which SDoH domains are more often addressed by programs that cut across multiple domains, and which are more often addressed by programs more exclusively focused on that domain.

Figure 5 –Multiple SDoH programs by (Overall, SDoH)

Note: The numbers in the bar on the left sum to 519 (the total number of programs across departments), and the numbers in the bars on the right sum to 992 (the total number of SDoH domains addressed across all 519 programs). Summing the numbers across each color on the right results in 1, 2, 3, 4 and 5 times the number with the same color on the left.

Of the 519 programs, 196 programs address a single SDoH domain and 323 address multiple domains. 200 programs address two domains, 98 address three domains, 23 address four domains, and two address all five domains. SDoH domains 1 and 3 have the highest proportion of programs (30% and 24% respectively) that address those domains exclusively. This reflects the relatively high proportion of programs that are singularly focused on addressing basic needs and on providing specific health-related services. General Relief Cash Grant Assistance or Breathe: LA's Guaranteed Income Program. Conversely, SDoH domains 2 and 5 have the lowest proportion of programs that address only those domains. In the case of domain 2, this is largely due to the fact that many County health and mental health programs target school-aged children and thus affect educational success by improving children's health. For example, Student Well-being Centers address the health and wellness needs of students and their families fostering a greater ability to learn. In the case of SDoH 5 this is largely due to the fact that many County health, basic needs and neighborhood improvement programs include community engagement and social support components. For example, *promatoras*, community health workers, and community liaison teams are premised on the idea that community connections strengthen high quality and culturally competent health services.

Group analysis

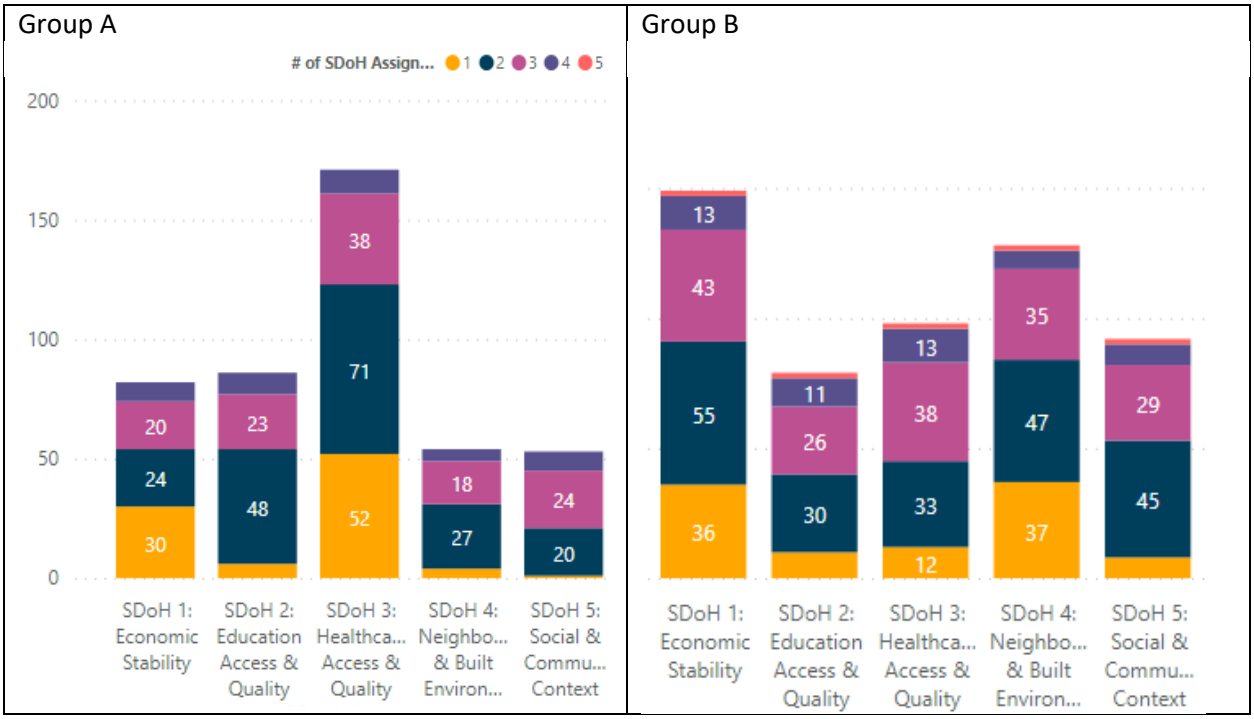

Figure 6 – Multiple SDoH programs by SDoH (by Group)

Group A – SDoH 3 dominates the work of Group A, accounting for 165 of the 239 programs (69%) reported for Group A. SDoH 1 and SDoH 3 remain overrepresented among single domain assignment. There are minimal single assignment programs outside of SDoH 1 and SDoH, possibly explained by explicit health and basic economic needs focus for Group A entities.

Group B – SDoH 1 and SDoH 4 are overrepresented among single domain assignment. Otherwise, there is a relatively even distribution of programs and multiple assigned bands.

Summary

- ***62% of programs address multiple SDoH domains.***
- ***All SDoH domains are addressed predominantly by programs that cut across multiple domains.***
- ***Programs addressing SDoH 1 and 3 are the most likely to focus solely on those domains.***
- ***Programs addressing SDoH 2 and 5 are the most likely to cut across multiple domains.***

Reflections

Overall, these findings reveal interesting dynamics about single and multiple domain programs. Of all programs, 38% address a single domain and 62% address multiple domains. Examining programmatic and even population outcomes across this divide might offer insight about whether programs addressing only one domain are more effective than those addressing multiple domains and suggest best approaches for program design and program portfolio composition to address social determinants of health.

Distribution of Specific SDoH Domain Combinations

The Figure 7 provides a visual representation of the numbers of different specific SDoH domain combinations addressed by County programs.

Figure 7a shows the number of programs addressing each domain exclusively. Figure 7b shows the specific two-domain combinations for all programs that address two domains. Figure 7c shows all specific three-domain combinations, and Figure 7d shows all four-domain combinations.

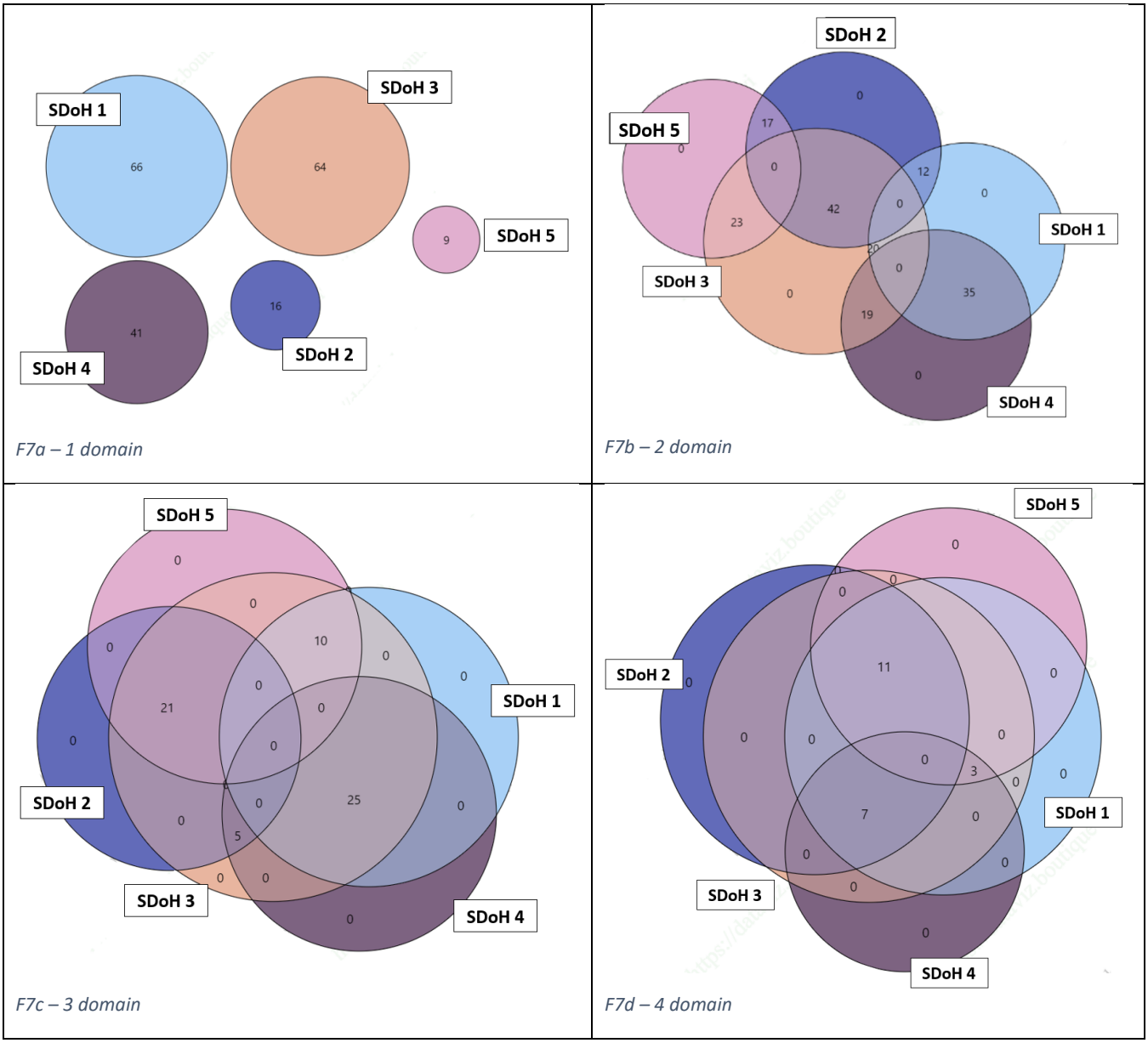

Figure 7- SDoH domain combinations

SDoH domains 1 and 3 had the most programs addressing them exclusively (65 and 64 respectively). Among programs addressing only two domains, the most common combinations were between domains 2 and 3 (42), followed by domains 3 and 5 (23). The most common three-domain combinations were 1, 3 and 4 (25), followed by 2,3, and 5 (21). The most common four-domain combination involved domains 1, 2,3, and 5 (11) followed by 1,2, 3, and 4 (7). There were two programs that were assigned to a combination of all five domains.

Summary

- ***SDoH 3 was represented in all the most frequent combinations as well as the most frequent single domain program categories.***
- ***The most common 2-SDoH combinations were between Education Quality and Access and Healthcare Quality and Access, and between Healthcare Quality and Access and Social and Community Context.***
- ***The most common 3 SDoH combinations were between Economic Stability, Healthcare Access and Quality, and Neighborhood and Built Environment, and between Education Quality and Access, Healthcare Quality and Access, and Social and Community Context.***
- ***The most common 4-SDoH combinations were between Economic Stability, Education Quality and Access, Healthcare Quality and Access, and Social and Community Context, and between Economic Stability, Education Quality and Access, Healthcare Quality and Access, and Neighborhood and Built Environment.***

Reflections

Overall, the Euler diagrams offer an SDoH domain by domain breakdown of the multi-domain bands in the bar graphs from Finding 4. Specifically, these diagrams illustrate which domains are involved in the most cross-sectoral programming. Ultimately, programmatic crossover appears concentrated among several key combinations. Do these concentrations of programs represent emergent or high priority areas of work? Is there something powerful about a program that addresses a specific combination of domains? The crossover between SDoH 2 (education), SDoH 3 (health), and SDoH 5 (social and community context) might reflect the wide adoption of community health workers as a community engagement best practice in health interventions. By extension, what can be learned from the combinations with no program examples? Further examination may reveal if this reflects limited opportunities to implement programs in these spaces, the demonstrated ineffectiveness of these combinations, or other considerations altogether.

Interdepartmental Collaboration

All Programs

Table 2 shows interdepartmental collaborations between county departments. The values are displayed in percentage of overall collaborations and the most prolific collaborations interdepartmental collaborations are easily identified by the dark blue highlight.

Of the 519 reported programs, there were 669 interdepartmental collaborations. The departments with the most collaborations are DPH (26%) and CEO – ATI (16%), accounting for 42% of all interdepartmental collaborations. The departments most frequently serving as collaborating partners were Probation (13%), DMH (11%), DCFS (8%), APD (8%), DA (7%), and DPH (7%), accounting for 54% of all collaborative partners.

DPH reports its most frequent interdepartmental collaborators are DHS (5%), DMH (4%), Probation (3%), and DCFS (3%). CEO - ATI reports its most frequent departmental collaborators are Probation (3%), Public Defender (2%), APD (2%), and DA (2%).

Summary – All Programs

- ***30% of all reported programs involve an interdepartmental collaboration.***
- ***DPH and CEO – ATI reported the most interdepartmental collaborations, accounting for 42% of the total reported.***

- ***DPH was the primary department for the top 4 interdepartmental collaborations, accounting for 15% of all interdepartmental collaborations***

By SDoH Domains

Tables 3 – 7 show collaborations among county departments by SDoH domain.

The analysis examined if interdepartmental collaborative programs were more represented in some SDoH domains than others. Additionally, the analysis examined which departments operate the largest number of interdepartmental collaborative programs in each domain and number of interdepartmental collaborative relationships.

Overall, of the 519 total programs, 155 (30% overall and 37% of collaborative programs) involve an interdepartmental collaboration. Except for SDoH 3 (48%), there was relatively even distribution of collaborative programs assigned across domains: SDoH 1 (42%), SDoH 4 (40%), SDoH 5 (36%), followed by SDoH 2 (34%).

In **SDoH 1**, CEO – ATI (24%), DPH (13%) and DEO (13%) were lead for 50% of all interdepartmental collaborations. Probation (16%), DCFS (9%), DPSS (9%) were the most frequent interdepartmental partners.

In **SDoH 2**, DPH (23%), CEO – ATI (15%), Library (11%), DCFS (9%) were lead for 58% of all interdepartmental collaborations. Probation (17%), DMH (17%), DCFS (13%) DPH (9%), and DHS (9%) were the most frequent interdepartmental partners.

In **SDoH 3**, DPH (34%), CEO – ATI (11%), DMH (9%), and Public Defender (8%) were lead for 62% of all interdepartmental collaborations. DMH (15%), Probation (12%), DHS (11%), District Attorney (10%), and DPH (9%), were the most frequent interdepartmental partners.

In **SDoH 4**, DPH (21%), CEO – ATI (19%), and DRP (11%) were lead for 51% of all interdepartmental collaborations. APD (13%), DA (11%), Probation (10%), and Public Defender (9%) were the most frequent interdepartmental partners.

In **SDoH 5**, DPH (35%), CEO – ATI – (11%) were lead for 46% of all interdepartmental collaborations. DMH (14%), Probation (13%), DCFS (9%) and DHS (8%) were the most frequent interdepartmental partners.

DPH reports its most frequent collaborating departments are DHS (5%), DMH (4%), DCFS (3%), Probation (3%), and District Attorney (2%). CEO – ATI reports its most frequent collaborating departments are APD (2%), PD (2%), Probation (2%), and DA (2%). It should be noted that CEO-ATI reported programs with a higher number of collaborative partners, which is reflected in its large share of collaborations. However, other departments reported more collaborative programs – programs with at least one collaborator.

Summary –By SDoH domains

- ***37% of collaborative programs and 30% of all programs involve an interdepartmental collaboration***
- ***Collaborations appear concentrated among natural partner departments such as allied health fields (DPH, DMH, DHS) or public safety and justice (PD, APD, Probation, DA) within the most relevant SDoH domains***

Primary Dept	ADD	APD	Arts	DA	DCBA	DCFS	DEO	DHR	DHS	DMH	DPH	DPR	DPSS	DPW	DRP	DYD	FD	ISD	JCOD	LASD	Library	MVA	ODR	Parks & Rec	PD	Prob	RR/CC	TTC	Various Depts	WDACS	Total
DPH		1.20%	0.90%	2.09%		2.99%		0.45%	4.93%	3.89%	0.30%	0.90%	1.20%							0.90%	0.45%			0.45%	1.20%	2.99%				0.90%	**25.71%**
CEO - ATI/JCOD		2.39%	0.60%	1.79%		0.60%	0.60%	0.60%		0.60%	0.60%		0.60%			0.60%	0.60%	0.60%	0.90%						2.39%	2.39%					**15.84%**
Library					0.15%	0.30%			0.15%	0.75%	0.90%							0.75%							0.90%				0.45%	**4.33%**
DHS		0.90%		0.90%														0.15%		0.45%					0.90%	0.90%					**4.19%**
Prob		0.30%		0.75%		0.45%				1.35%	0.60%													0.45%	0.30%						**4.19%**
DMH		0.60%		0.60%		0.90%			0.75%		0.45%														0.30%	0.15%				0.30%	**4.04%**
LACDA	0.45%								0.75%	0.30%												0.45%		1.49%						0.60%	**4.04%**
PD		1.49%		0.60%						0.60%										0.75%						0.60%					**4.04%**
DCFS										0.90%			0.60%							0.45%						1.49%					**3.44%**
DEO								0.45%	0.15%	0.30%			0.45%						0.15%	0.15%			0.30%	0.15%		0.90%					**2.99%**
DRP			0.15%								0.45%			1.35%			0.30%							0.30%				0.15%			**2.69%**
Superior Courts		0.45%		0.45%						0.45%	0.45%														0.45%	0.45%					**2.69%**
LACOE			0.45%							0.75%	1.35%																				**2.54%**
CSSD						0.45%							0.45%								0.45%			0.45%						0.45%	**2.24%**
ISD						0.45%							0.45%													0.45%				0.90%	**2.24%**
DPSS						0.15%	0.15%			0.45%	0.90%										0.15%										**1.79%**
ADD				0.30%					0.30%	0.30%			0.45%							0.30%											**1.64%**
DPW			0.15%		0.15%						0.45%	0.15%			0.15%			0.15%		0.15%	0.15%			0.15%							**1.64%**
AU						0.75%																				0.75%					**1.49%**
DA		0.30%																		0.15%					0.45%	0.45%					**1.35%**
CEO-PAI					0.15%	0.45%					0.15%		0.15%					0.15%									0.15%				**1.20%**
CEO - ARDI								0.75%																				0.15%			**0.90%**
LAHSA									0.30%	0.30%	0.30%																				**0.90%**
Arts																													0.75%		**0.75%**
CA						0.15%							0.30%													0.15%				0.15%	**0.75%**
BH						0.30%																				0.30%					**0.60%**
TTC					0.30%										0.30%																**0.60%**
FD								0.15%																		0.30%					**0.45%**
MVA										0.45%																					**0.45%**
HR											0.30%																				**0.30%**
Total	**0.45%**	**7.62%**	**2.24%**	**7.47%**	**0.75%**	**7.92%**	**0.75%**	**2.39%**	**7.32%**	**11.36%**	**7.17%**	**1.05%**	**4.63%**	**1.35%**	**0.45%**	**0.60%**	**0.90%**	**1.79%**	**1.05%**	**3.29%**	**1.20%**	**0.45%**	**0.30%**	**3.44%**	**5.98%**	**13.15%**	**0.15%**	**0.30%**	**0.75%**	**3.74%**	**100.00%**

Table 2- Collaborative programs: Primary department by department (% of total collaboration)

Primary Dept	ADD	APD	Arts	DA	DCBA	DCFS	DEO	DHR	DHS	DMH	DPH	DPSS	DYD	FD	ISD	JCOD	LASD	Library	MVA	ODR	Parks & Rec	PD	Prob	RR/CC	Various Depts	WDACS	Total
CEO - ATI/JCOD		3.97%	0.79%	3.17%		0.79%	0.79%	0.79%		0.79%	0.79%	0.79%	0.79%	0.79%	0.79%	0.79%						3.97%	3.97%				**23.81%**
DPH		0.79%		0.79%		1.59%			3.17%	2.38%		2.38%										0.79%	1.59%				**13.49%**
DEO								1.59%	0.79%	0.79%		1.59%				0.79%	0.79%			1.59%	0.79%		3.97%				**12.70%**
Library					0.79%	0.79%					1.59%				1.59%								1.59%			1.59%	**7.94%**
CEO-PAI					0.79%	1.59%					0.79%	0.79%			0.79%									0.79%			**5.56%**
CSSD						0.79%						0.79%						0.79%			0.79%					0.79%	**3.97%**
DHS		0.79%		0.79%													0.79%					0.79%	0.79%				**3.97%**
ISD						0.79%						0.79%											0.79%			1.59%	**3.97%**
LACDA	0.79%								0.79%										0.79%		0.79%					0.79%	**3.97%**
PD		2.38%															1.59%										**3.97%**
DCFS										0.79%		0.79%											0.79%				**2.38%**
DPSS						0.79%	0.79%											0.79%									**2.38%**
Arts																									1.59%		**1.59%**
AU						0.79%																	0.79%				**1.59%**
FD									0.79%														0.79%				**1.59%**
Prob						0.79%				0.79%																	**1.59%**
ADD																	0.79%										**0.79%**
CA												0.79%															**0.79%**
CEO - ARDI									0.79%																		**0.79%**
DA																							0.79%				**0.79%**
DMH										0.79%																	**0.79%**
HR											0.79%																**0.79%**
MVA										0.79%																	**0.79%**
Total	**0.79%**	**7.94%**	**0.79%**	**4.76%**	**1.59%**	**8.73%**	**1.59%**	**3.97%**	**5.56%**	**6.35%**	**3.97%**	**8.73%**	**0.79%**	**0.79%**	**3.17%**	**1.59%**	**3.97%**	**1.59%**	**0.79%**	**1.59%**	**2.38%**	**5.56%**	**15.87%**	**0.79%**	**1.59%**	**4.76%**	**100.00%**

Table 3 - Collaborative programs: Primary department by department (% of SDoH 1: Economic Stability)

Primary Dept	APD	Arts	DA	DCFS	DEO	DHR	DHS	DMH	DPH	DPSS	DYD	FD	ISD	JCOD	LASD	Library	Parks & Rec	PD	Prob	WDACS	Total
DPH				4.26%			7.45%	4.26%		2.13%						1.06%	1.06%		3.19%		**23.40%**
CEO - ATI/JCOD	1.06%	1.06%		1.06%	1.06%	1.06%		1.06%	1.06%	1.06%	1.06%	1.06%	1.06%	1.06%				1.06%	1.06%		**14.89%**
Library				1.06%				4.26%	1.06%				2.13%						2.13%		**10.64%**
DCFS								2.13%		1.06%					1.06%				4.26%		**8.51%**
Prob			1.06%	1.06%				3.19%	1.06%								1.06%				**7.45%**
LACOE		1.06%						2.13%	3.19%												**6.38%**
ISD				1.06%						1.06%									1.06%	2.13%	**5.32%**
DHS	1.06%		1.06%															1.06%	1.06%		**4.26%**
DMH				2.13%			1.06%		1.06%												**4.26%**
LACDA																	3.19%				**3.19%**
AU				1.06%															1.06%		**2.13%**
BH				1.06%															1.06%		**2.13%**
DEO										1.06%									1.06%		**2.13%**
DPW																1.06%	1.06%				**2.13%**
CEO - ARDI						1.06%															**1.06%**
DA																			1.06%		**1.06%**
DPSS									1.06%												**1.06%**
Total	**2.13%**	**2.13%**	**2.13%**	**12.77%**	**1.06%**	**2.13%**	**8.51%**	**17.02%**	**8.51%**	**6.38%**	**1.06%**	**1.06%**	**3.19%**	**1.06%**	**1.06%**	**2.13%**	**6.38%**	**2.13%**	**17.02%**	**2.13%**	**100.00%**

Table 4 - Collaborative programs: Primary department by department (% of SDoH 2: Education Access & Quality)

Primary Dept	APD	Arts	DA	DCFS	DEO	DHR	DHS	DMH	DPH	DPR	DPSS	DYD	FD	ISD	JCOD	LASD	Library	MVA	Parks & Rec	PD	Prob	WDACS	Total
DPH	1.76%	1.18%	2.94%	3.53%		0.59%	6.47%	5.29%	0.59%	1.18%	1.18%					1.18%	0.59%		0.59%	1.76%	4.12%	1.18%	**34.12%**
CEO - ATI/JCOD	1.18%	0.59%	0.59%	0.59%	0.59%	0.59%		0.59%	0.59%		0.59%	0.59%	0.59%	0.59%	0.59%					1.18%	1.18%		**10.59%**
DMH	1.18%		1.18%	1.76%			1.76%		1.18%											0.59%	0.59%	0.59%	**8.82%**
PD	0.59%		2.35%					2.35%								0.59%					2.35%		**8.24%**
Prob	0.59%		1.18%	0.59%				1.76%	1.18%										0.59%	0.59%			**6.47%**
DHS	1.18%		1.18%																	1.18%	1.18%		**4.71%**
DPSS								1.76%	2.35%														**4.12%**
LACDA							1.18%	0.59%										0.59%	0.59%			0.59%	**3.53%**
Superior Courts	0.59%		0.59%					0.59%	0.59%											0.59%	0.59%		**3.53%**
CSSD				0.59%							0.59%						0.59%		0.59%			0.59%	**2.94%**
DCFS								0.59%			0.59%					0.59%					1.18%		**2.94%**
LACOE		0.59%						0.59%	1.18%														**2.35%**
LAHSA							0.59%	0.59%	0.59%														**1.76%**
AU				0.59%																	0.59%		**1.18%**
DA	0.59%																			0.59%			**1.18%**
Library							0.59%		0.59%														**1.18%**
ADD																0.59%							**0.59%**
CEO - ARDI						0.59%																	**0.59%**
HR									0.59%														**0.59%**
MVA								0.59%															**0.59%**
Total	**7.65%**	**2.35%**	**10.00%**	**7.65%**	**0.59%**	**1.76%**	**10.59%**	**15.29%**	**9.41%**	**1.18%**	**2.94%**	**0.59%**	**0.59%**	**0.59%**	**0.59%**	**2.94%**	**1.18%**	**0.59%**	**2.35%**	**6.47%**	**11.76%**	**2.94%**	**100.00%**

Table 5 - Collaborative programs: Primary department by department (% of SDoH 3: Healthcare Access & Quality)

Primary Dept	ADD	APD	Arts	DA	DCBA	DCFS	DEO	DHR	DHS	DMH	DPH	DPR	DPSS	DPW	DRP	DYD	FD	ISD	JCOD	LASD	MVA	Parks & Rec	PD	Prob	TTC	Various Depts	WDACS	Total
DPH		1.88%	1.25%	3.13%		1.88%		0.63%	1.25%	1.88%		1.25%	0.63%							1.25%			1.88%	2.50%			1.25%	**20.63%**
CEO - ATI/JCOD		3.13%	0.63%	2.50%		0.63%	0.63%	0.63%		0.63%	0.63%		0.63%			0.63%	0.63%	0.63%	1.25%				3.13%	3.13%				**19.38%**
DRP			0.63%								1.88%			5.63%			1.25%					1.25%			0.63%			**11.25%**
DHS		1.25%		1.25%														0.63%		0.63%			1.25%	1.25%				**6.25%**
DPW			0.63%		0.63%						1.88%	0.63%			0.63%			0.63%		0.63%								**5.63%**
PD		3.75%																		1.25%								**5.00%**
Prob		0.63%		1.25%						0.63%	0.63%											0.63%	0.63%					**4.38%**
LACDA	0.63%								1.25%	0.63%											0.63%						0.63%	**3.75%**
Superior Courts		0.63%		0.63%						0.63%	0.63%												0.63%	0.63%				**3.75%**
ADD				0.63%					0.63%	0.63%			1.25%															**3.13%**
DA		0.63%																		0.63%			1.25%	0.63%				**3.13%**
DMH		1.25%		1.25%																			0.63%					**3.13%**
CA						0.63%							0.63%											0.63%			0.63%	**2.50%**
LAHSA									0.63%	0.63%	0.63%																	**1.88%**
AU						0.63%																		0.63%				**1.25%**
CEO - ARDI								0.63%																	0.63%			**1.25%**
TTC					0.63%										0.63%													**1.25%**
Arts																										0.63%		**0.63%**
FD																								0.63%				**0.63%**
ISD																											0.63%	**0.63%**
LACOE											0.63%																	**0.63%**
Total	**0.63%**	**13.13%**	**3.13%**	**10.63%**	**1.25%**	**3.75%**	**0.63%**	**1.88%**	**3.75%**	**5.63%**	**6.88%**	**1.88%**	**3.13%**	**5.63%**	**1.25%**	**0.63%**	**1.88%**	**1.88%**	**1.25%**	**4.38%**	**0.63%**	**1.88%**	**9.38%**	**10.00%**	**1.25%**	**0.63%**	**3.13%**	**100.00%**

Table 6 - Collaborative programs: Primary department by department (% of SDoH 4: Neighborhood & Built Environment)

Primary Dept	ADD	APD	Arts	DA	DCBA	DCFS	DHR	DHS	DMH	DPH	DPR	DPSS	DRP	ISD	JCOD	LASD	Library	Parks & Rec	PD	Prob	Various Depts	WDACS	Total
DPH		0.84%	1.68%	2.52%		4.20%	0.84%	7.56%	5.88%	0.84%	1.68%					1.68%	0.84%	0.84%	0.84%	3.36%		1.68%	**35.29%**
CEO - ATI/JCOD		2.52%		2.52%											0.84%				2.52%	2.52%			**10.92%**
DCFS									1.68%			0.84%				0.84%				2.52%			**5.88%**
LACDA	0.84%																	4.20%				0.84%	**5.88%**
Library									0.84%	1.68%				0.84%						1.68%		0.84%	**5.88%**
LACOE			0.84%						1.68%	2.52%													**5.04%**
Superior Courts		0.84%		0.84%					0.84%	0.84%									0.84%	0.84%			**5.04%**
CSSD						0.84%						0.84%					0.84%	0.84%				0.84%	**4.20%**
ADD				0.84%				0.84%	0.84%			0.84%											**3.36%**
ISD						0.84%						0.84%								0.84%		0.84%	**3.36%**
Arts																					1.68%		**1.68%**
AU						0.84%														0.84%			**1.68%**
BH						0.84%														0.84%			**1.68%**
DEO							0.84%		0.84%														**1.68%**
DMH						0.84%																0.84%	**1.68%**
TTC					0.84%								0.84%										**1.68%**
CEO - ARDI							0.84%																**0.84%**
CEO-PAI						0.84%																	**0.84%**
DHS																0.84%							**0.84%**
DPSS										0.84%													**0.84%**
MVA									0.84%														**0.84%**
Prob									0.84%														**0.84%**
Total	**0.84%**	**4.20%**	**2.52%**	**6.72%**	**0.84%**	**9.24%**	**2.52%**	**8.40%**	**14.29%**	**6.72%**	**1.68%**	**3.36%**	**0.84%**	**0.84%**	**0.84%**	**3.36%**	**1.68%**	**5.88%**	**4.20%**	**13.45%**	**1.68%**	**5.88%**	**100.00%**

Table 7 - Collaborative programs: Primary department by department (% of SDoH 5: Social & Community Context)

Reflections

Overall, these findings show interdepartmental collaboration across all SDoH domains. However, the nature of and reason for the collaboration remain unclear. Some of the reported programs seem to reflect authentic partnerships, where multiple departments actively coordinate on the implementation of a program that serves shared stakeholders. Other reported programs seem to reflect a large initiative with multiple areas of semi-autonomous work and, therefore, the collaboration more closely resembles a shared funding source than integrated services. Furthermore, interdepartmental collaborations are not always intentional by design, or even voluntary arrangements, as some are directed by departmental or County leadership. An examination of these dynamics may yield additional useful context for any strategy around interdepartmental collaboration to address SDoH domains.

Collaboration between Departments and other Entities

All programs

Table 8 shows the distribution of collaborations between County departments and other entities on all programs reported by each department. The total column on the far right indicates the percentage of all collaborations that were reported by each department. The total row at the bottom represents the percentage of all program collaborations that were with a particular type of entity. The blue shaded percentages in the body of the table represent the distribution of collaborations across departments and collaborating entities, with darker blue indicating a higher percentage of collaborations.

Of the 519 reported programs, there were 1,616 partner group collaborations. The vast majority of those partners are CBOs or other County departments (62%), followed by local municipal partners (12%), County (9%), External Partners (7%), Public Authority (6%), State (3%), and Federal (.06%). The departments with the most collaborations are DPH (28%), LACDA (12%), LACOE (9%), CEO – ATI (8%), and DMH (5%).

More than half of LACDA's partners are local municipalities. This is because LACDA has discreet programs with many of LA County's 88 incorporated cities. Most of DPH's program partners are County departments, followed by CBOs. Most of LACOE's partners are CBOs, followed by local municipalities.

Summary – All Programs

- ***83% of all reported programs involve a collaborative partner.***
- ***LACDA and DPH reported the most collaborative programs, accounting for 40% of the total reported.***
- ***11% of total collaborations were between DPH and CBOs.***
- ***54% of collaborations with local municipalities were with LACDA and another 22% were with LACOE.***
- ***LACDA, DPH, LACOE, CEO – Homeless Initiative, and DMH accounted for 78.4% of CBO collaborations and 30.22% of total collaborations.***
- ***Collaborations with CBOs and local municipalities are concentrated among a subset of county departments, while collaborations among county departments are more evenly distributed.***

Primary Dept	CBOs	County	County Depts.	External Partners	Federal	Local Municipal	Public Authority	State	**Total**
DPH	6.37%	1.73%	10.64%	3.77%	0.06%	1.30%	2.66%	1.42%	**27.97%**
LACDA	3.16%		1.67%	0.19%		6.44%	0.87%		**12.31%**
LACOE	3.40%	0.37%	1.05%	0.56%		2.60%	0.37%	0.62%	**8.97%**
CEO - ATI/JCOD		1.24%	6.56%	0.12%					**7.92%**
DMH	2.04%	0.50%	1.67%	0.06%		0.12%	0.37%	0.12%	**4.89%**
DHS	0.99%	0.37%	1.73%	0.12%					**3.22%**
PD		1.11%	1.67%	0.25%					**3.03%**
DPSS	0.56%	0.12%	0.74%	0.31%		0.50%	0.43%	0.25%	**2.91%**
Library	0.25%	0.06%	1.79%	0.19%			0.19%	0.25%	**2.72%**
Prob	0.43%	0.31%	1.73%			0.19%	0.06%		**2.72%**
DEO	0.37%	0.19%	1.24%	0.56%			0.25%		**2.60%**
DCFS	0.80%	0.25%	1.42%						**2.48%**
AU		0.93%	0.62%					0.31%	**1.86%**
LAHSA	1.30%		0.37%						**1.67%**
ADD	0.50%		0.68%			0.37%	0.06%		**1.61%**
DRP		0.12%	1.11%				0.25%	0.06%	**1.55%**
CSSD		0.37%	0.93%				0.19%		**1.49%**
ISD	0.19%		0.93%					0.19%	**1.30%**
DPW	0.06%	0.12%	0.68%	0.06%		0.06%	0.06%	0.06%	**1.11%**
Superior Courts			1.11%						**1.11%**
DA	0.19%	0.12%	0.56%						**0.87%**
CEO-HI				0.62%		0.19%			**0.80%**
FD	0.12%	0.37%	0.19%					0.12%	**0.80%**
Arts	0.25%		0.31%	0.12%		0.06%			**0.74%**
TTC		0.25%	0.25%				0.12%		**0.62%**
CEO - ARDI		0.12%	0.37%				0.06%		**0.56%**
CEO-PAI		0.06%	0.50%						**0.56%**
MVA	0.25%		0.19%						**0.43%**
CA			0.31%			0.06%			**0.37%**
AN				0.25%					**0.25%**
BH			0.25%						**0.25%**
HR			0.12%						**0.12%**
ME		0.12%							**0.12%**
WDACS	0.06%								**0.06%**
Total	**21.29%**	**8.85%**	**41.40%**	**7.18%**	**0.06%**	**11.88%**	**5.94%**	**3.40%**	**100.00%** [1]

Table 8 – Collaborative programs: Primary department by type of collaborative partner (% of total collaboration)

[1] Note: CBOs are community-based organizations; "County" refers to non-departmental county entities such as County Counsel, Superior Court, or various county commissions; external partners include vendors, universities, and other non-CBO extra-county partners; "public authority" includes semi-autonomous authorities such as LAHSA or LACDA.

By SDoH Domains

Tables 9 – 13 show collaborations between county departments and collaborative partners by SDoH domain.

Primary Dept	CBOs	County	County Depts.	External Partners	Local Municipal	Public Authority	State	**Total**
LACDA	5.20%		1.53%	0.31%	13.46%	2.45%		**22.94%**
DPH	4.59%	0.92%	5.20%	0.92%	0.61%	1.83%	0.92%	**14.98%**
CEO - ATI/JCOD		1.83%	9.17%					**11.01%**
DEO	1.53%	0.92%	4.89%	1.83%		0.92%		**10.09%**
DPSS	1.22%	0.31%	0.92%	0.31%	0.31%	1.22%		**4.28%**
Library	0.61%		3.06%				0.61%	**4.28%**
DHS	1.53%	0.31%	1.53%	0.31%				**3.67%**
LACOE	1.53%				1.53%			**3.06%**
PD		0.92%	1.53%	0.31%				**2.75%**
CEO-PAI		0.31%	2.14%					**2.45%**
CSSD		0.61%	1.53%			0.31%		**2.45%**
FD	0.31%	0.92%	0.61%				0.31%	**2.14%**
ISD	0.31%		1.53%				0.31%	**2.14%**
ADD	0.92%		0.31%		0.61%			**1.83%**
AU		0.92%	0.61%				0.31%	**1.83%**
LAHSA	1.83%							**1.83%**
DMH	0.92%		0.31%			0.31%		**1.53%**
CEO-HI				0.92%	0.31%			**1.22%**
DCFS		0.31%	0.92%					**1.22%**
Arts	0.31%		0.61%					**0.92%**
Prob	0.31%		0.61%					**0.92%**
CA			0.31%		0.31%			**0.61%**
MVA	0.31%		0.31%					**0.61%**
CEO - ARDI			0.31%					**0.31%**
DA			0.31%					**0.31%**
HR			0.31%					**0.31%**
WDACS	0.31%							**0.31%**
Total	**21.71%**	**8.26%**	**38.53%**	**4.89%**	**17.13%**	**7.03%**	**2.45%**	**100.00%**

Table 9 - Collaborative programs: Primary department by type of collaborative partner (% of SDoH 1: Economic Stability)

Primary Dept	CBOs	County	County Depts.	External Partners	Local Municipal	Public Authority	State	Total
DPH	8.42%	0.73%	8.06%	3.30%	1.83%	3.66%	1.47%	**27.47%**
LACOE	8.42%	0.73%	2.20%	1.10%	6.96%	0.73%	1.47%	**21.61%**
Library	0.73%	0.37%	3.66%	0.73%		1.10%	0.73%	**7.33%**
DMH	2.93%	0.37%	1.47%		0.37%	0.73%	0.37%	**6.23%**
CEO - ATI/JCOD		0.73%	5.13%					**5.86%**
DCFS	1.83%	0.37%	2.93%					**5.13%**
LACDA	1.47%		1.10%		2.56%			**5.13%**
DPSS			0.37%	0.73%	1.83%	0.73%	1.10%	**4.76%**
Prob	0.73%	0.37%	2.56%		0.37%	0.37%		**4.40%**
AU		1.10%	0.73%				0.37%	**2.20%**
ISD	0.37%		1.83%					**2.20%**
DHS		0.37%	1.47%					**1.83%**
PD		0.73%		0.37%				**1.10%**
BH			0.73%					**0.73%**
DA	0.37%		0.37%					**0.73%**
DEO			0.73%					**0.73%**
DPW			0.73%					**0.73%**
LAHSA	0.73%							**0.73%**
CEO - ARDI			0.37%					**0.37%**
CEO-HI				0.37%				**0.37%**
ME		0.37%						**0.37%**
Total	**26.01%**	**6.23%**	**34.43%**	**6.59%**	**13.92%**	**7.33%**	**5.49%**	**100.00%**

Table 10 - Collaborative programs: Primary department by type of collaborative partner (% of SDoH 2: Education Access & Quality)

Primary Dept	CBOs	County	County Depts.	External Partners	Federal	Local Municipal	Public Authority	State	Total
DPH	9.73%	2.49%	13.12%	7.47%	0.23%	2.26%	3.17%	2.26%	**40.72%**
LACOE	4.30%		0.90%	0.68%		3.62%	0.23%	0.23%	**9.95%**
DMH	3.85%	0.90%	3.39%	0.23%		0.23%	0.45%	0.23%	**9.28%**
LACDA	2.26%		1.36%	0.23%		4.30%	0.23%		**8.37%**
PD		1.58%	3.17%	0.23%					**4.98%**
CEO - ATI/JCOD		0.68%	4.07%						**4.75%**
Prob	0.45%	0.45%	2.49%			0.23%			**3.62%**
DHS	0.90%	0.45%	1.81%						**3.17%**
DPSS	0.45%		1.58%	0.23%		0.45%		0.23%	**2.94%**
DCFS	0.68%	0.23%	1.13%						**2.04%**
CSSD		0.45%	1.13%				0.23%		**1.81%**
LAHSA	1.13%		0.68%						**1.81%**
AU		0.68%	0.45%					0.23%	**1.36%**
Superior Courts			1.36%						**1.36%**
ADD	0.23%		0.23%			0.23%			**0.68%**
CEO-HI				0.45%		0.23%			**0.68%**
DA		0.23%	0.45%						**0.68%**
Library			0.45%	0.23%					**0.68%**
MVA	0.23%		0.23%						**0.45%**
CEO - ARDI			0.23%						**0.23%**
HR			0.23%						**0.23%**
ISD								0.23%	**0.23%**
Total	**24.21%**	**8.14%**	**38.46%**	**9.73%**	**0.23%**	**11.54%**	**4.30%**	**3.39%**	**100.00%**

Table 11 - Collaborative programs: Primary department by type of collaborative partner (% of SDoH 3: Healthcare Access & Quality)

Primary Dept	CBOs	County	County Depts.	External Partners	Local Municipal	Public Authority	State	**Total**
DPH	3.45%	2.19%	10.34%	1.25%		1.25%	0.94%	**19.44%**
CEO - ATI/JCOD		1.88%	9.72%	0.31%				**11.91%**
LACDA	3.76%		1.88%	0.31%	3.45%	1.57%		**10.97%**
DRP		0.63%	5.64%			1.25%	0.31%	**7.84%**
DHS	1.88%	0.63%	3.13%	0.31%				**5.96%**
DPW	0.31%	0.63%	2.82%	0.31%	0.31%	0.31%	0.31%	**5.02%**
PD		1.88%	2.51%	0.31%				**4.70%**
LAHSA	2.51%		0.94%					**3.45%**
Prob	0.31%	0.63%	2.19%		0.31%			**3.45%**
DMH	0.94%	0.63%	1.57%					**3.13%**
LACOE	0.63%	0.63%	0.31%	0.31%		0.31%	0.94%	**3.13%**
ADD	0.63%		1.57%		0.31%	0.31%		**2.82%**
DA	0.31%	0.31%	1.57%					**2.19%**
AU		0.94%	0.63%				0.31%	**1.88%**
FD	0.31%	0.94%	0.31%				0.31%	**1.88%**
Superior Courts			1.88%					**1.88%**
CEO - ARDI		0.63%	0.63%			0.31%		**1.57%**
CEO-HI				1.25%	0.31%			**1.57%**
DPSS	0.63%	0.31%		0.31%		0.31%		**1.57%**
TTC		0.63%	0.63%			0.31%		**1.57%**
CA			1.25%					**1.25%**
AN				0.63%				**0.63%**
Arts			0.31%	0.31%				**0.63%**
ISD			0.31%				0.31%	**0.63%**
DCFS	0.31%							**0.31%**
ME		0.31%						**0.31%**
MVA	0.31%							**0.31%**
Total	**16.30%**	**13.79%**	**50.16%**	**5.64%**	**4.70%**	**5.96%**	**3.45%**	**100.00%**

Table 12 - Collaborative programs: Primary department by type of collaborative partner (% of SDoH 4: Neighborhood & Built Environment)

Primary Dept	CBOs	County	County Depts.	External Partners	Local Municipal	Public Authority	State	**Total**
DPH	4.31%	1.96%	16.47%	4.71%	1.57%	3.53%	1.18%	**33.73%**
LACDA	3.14%		2.75%		9.02%			**14.90%**
LACOE	2.35%	0.78%	2.35%	0.78%	0.78%	0.78%	0.78%	**8.63%**
CEO - ATI/JCOD		1.18%	5.10%	0.39%				**6.67%**
DCFS	1.57%	0.39%	2.75%					**4.71%**
ADD	0.78%		1.57%		0.78%			**3.14%**
CSSD		0.78%	1.96%			0.39%		**3.14%**
Arts	1.18%		0.78%	0.39%	0.39%			**2.75%**
DEO	0.39%		0.78%	1.18%		0.39%		**2.75%**
Library			2.75%					**2.75%**
AU		1.18%	0.78%				0.39%	**2.35%**
DMH	0.78%	0.39%	0.78%			0.39%		**2.35%**
Superior Courts			2.35%					**2.35%**
ISD	0.39%		1.57%					**1.96%**
TTC		0.78%	0.78%			0.39%		**1.96%**
AN				0.78%				**0.78%**
BH			0.78%					**0.78%**
DHS	0.39%		0.39%					**0.78%**
DPSS	0.39%		0.39%					**0.78%**
MVA	0.39%		0.39%					**0.78%**
Prob	0.39%		0.39%					**0.78%**
CEO - ARDI			0.39%					**0.39%**
CEO-PAI			0.39%					**0.39%**
DA	0.39%							**0.39%**
Total	**16.86%**	**7.45%**	**46.67%**	**8.24%**	**12.55%**	**5.88%**	**2.35%**	**100.00%**

Table 13 - Collaborative programs: Primary department by type of collaborative partner (% of SDoH 5: Social & Community Context)

The purpose of examining the data on collaboration by domain is to see if collaborations are more frequent among certain domains, if some departments have more active collaborations in certain domains, and if the types of collaborative partners are distributed differently across domains.

Overall, of the 519 total programs, 419 (81%) involve a collaborative partner. There was relatively even distribution of collaborative programs across domains: SDoH 2 (85%), followed by SDoH 5 (83%), SDoH 3 (81%), SDoH 1 (79%) and SDoH 4 (76%).

In **SDoH 1**, LACDA (23%), DPH (15%), CEO-ATI (11%), and DEO (10%) account for 59% of all collaborations. 39% of all collaborations were interdepartmental (CEO-ATI: 9%), 22% were with CBOs, and 17% were with local municipal partners (LACDA: 13%).

In **SDoH 2**, Public Health (27%), and LACOE (22%) account for 49% of all collaborations. 34% of all collaborations were interdepartmental, 26% were with CBOs (DPH: 8%, LACOE: 8%), and 13% were with Local municipal partners.

In **SDoH 3**, Public Health (41%), LACOE (10%), DMH (9%), and LACDA (8%) account for 68% of all collaborations. 38% of all collaborations were interdepartmental (DPH:13%), 24% were with CBOs (DPH: 9%), and 12% were with Local municipal partners.

In **SDoH 4**, DPH (19%), CEO – ATI (12%), LACDA (11%), and Regional Planning (8%) account for 50% of all collaborations. 50% of all collaborations are interdepartmental (DPH: 10%, CEO-ATI: 10%), 16% were

with CBOs, and 14% are with other county entities. No other SDoH domain has more than 8% of collaborations with other county entities, which may reflect the public safety and justice orientation of SDOH, which involves courts, parole boards, and other commissions.

In **SDoH 5**, Public Health (34%), LACDA (15%), and LACOE (9%) combine to account for 58% of all collaborations. 47% of all collaborations were with interdepartmental (DPH: 16%), 17% were with CBOs, and 13% were with Local municipal partners (LACDA: 9%).

Summary –By SDoH Domains

- ***The most prolific collaborative relationships are between LACDA and Local municipal partners in SDoH 1, DPH and CBOs in SDoH 3, DPH and county depts/CEO – ATI and county depts. in SDoH 4, and DPH and county depts/LACDA and Local municipal partners in SDoH 5.***
- ***County departments are well represented overall, 41% across domains, and are dispersed among SDoH domains and departments.***

Reflections

Overall, these findings highlight types of extramural collaborations that make sense given the types of programming involved. LACDA collaborates with local municipal governments as a part of its community development work. Public Health, LACOE, and DMH all work with CBO contractors as a part of delivering culturally competent services. As much as these findings might highlight gaps where additional collaborations could be cultivated, they also show which departments engage in the same types of collaborations. This could suggest a potential opportunity for sharing best practices in implementing these partnerships. For instance, departments involved in collaborations with CBOs in the SDoH 2 domain, may benefit from sharing best practices around working with CBOs in the education space and strategizing around any specific strengths or challenges of doing that work. These insights could inform County protocols around working with certain types of partners in particular domains towards more positive outcomes.

Limitations

- ***Methodological constraints resulted in analysis of programs representing only 19% of the overall County budget.***
- ***Incongruent program implementation, service delivery practices, and financial management of programs across departments.***
- ***Challenges identifying and defining relevant programs.***

This analysis encountered multiple limitations that impacted the findings.

The most significant limitation for this landscape analysis is completeness of the data. The 519 programs had a total reported budget (FY2021-22) of $7.6B. This represents only 19.3% of the $39.3B FY 21-22 LA County budget. Although 100% of the County budget is not dedicated to programs and service delivery and delivering programs is not the sum total of what departments do, the data available for this analysis is likely an undercount of the full extent of relevant services. The ability to observe patterns in the data and generalize results is impacted by completeness of the data.

Departmental budgeting practices were frequently cited as a limitation by departments attempting to comply with data requests. Some of the more prominent challenges with data collection stemmed from the variation in the ways departments design and budget for programs. Some departments conduct

their work through discrete programs and were able to provide data easily; other departments provide routine services that may dedicate various funding sources to one large area of work; still other departments may provide community programming but are supported entirely by personnel time that is not easily broken out on a program level. This variation of budgeting and financial management practices results from different requirements imposed by funding agencies (federal, state, local, statutory funding parameters, etc.), and from differences in scale and scope of the program. For instance, the CalWORKS cash assistance program reported more than $1B in annual program spending, which requires different accounting management practices from a contracted afterschool program with a $70,000 budget. These incongruencies also presented some challenges in comparing these data across departments.

These challenges echo many of the barriers identified by the Prevention Services Task Force's funding streams analysis, which is concurrently being completed and submitted to the Board. In that analysis, the Task Force discovered that the County currently lacks several multi- and cross-departmental budgeting management capabilities, in part due to technological limitations that hinder the County's ability to track funding sources, patterns, and use across various grants, programs, departments, and regional entities. Until these challenges are resolved, it will be difficult for the County to holistically capture and understand the full breadth of program spending and funding available for dedicated prevention services, investments to address SDoH, or other emerging strategic priorities.

Finally, another limitation with this approach to conducting the landscape analysis did not capture some initiatives that were relevant to addressing SDoH, since some departments address SDoH or other racial justice issues outside of program work. For instance, Public Health's Center for Health Equity and Office of Violence Prevention, and Child Support Services' Office of Equity, are not programs and their impact cannot be documented in program budgets and or directly detected in program outcomes. Instead, their work is dispersed in many areas in the form of technical assistance and improvement to County services.

Conclusion

This analysis demonstrates a landscape in which County departments conduct programs that address social determinants of health in a variety of ways. County departments conduct programs across multiple domains, with 85% of County departments addressing multiple domains - and 60% of County departments addressing at least 4 domains - in their reported programs. Additionally, departmental programs are largely cross-sectoral and address an average of nearly two SDoH domains each, and 62% of reported programs address multiple domains. Finally, 83% of reported programs involve a collaborative partner. 37% of these collaborative programs involve an interdepartmental collaboration, which appear concentrated among natural partner departments such as the allied health fields or public safety and justice. There are of course areas of robust concentrated activity—within social determinant domains and within collaborative relationships—and areas of more scarce activity.

This landscape analysis invites new lines of inquiry regarding how and why programs are structured this way and how effective they are at addressing disparities in social determinants of health. The findings also warrant deeper examination to understand the nature of gaps and further consultation with stakeholders to identify the best opportunities to strengthen the county-wide safety net. Ultimately, this work helps to illuminate how County programs address these domains and will advance prevention services work to address the social determinants of health in a coordinated and impactful manner.

Next Steps

Given the broad scope of the Board Motion directives, the study team requested to divide the analysis and report into two phases. This Phase 1 report reflects the findings of the landscape analysis regarding programs of County departments addressing the Healthy People 2030 SDoH domains. Phase 2 will further examine these findings to identify opportunities to build out programming, SDoH domain coverage, collaborative partnerships, and funding streams to strengthen how the County addresses social determinants of health.

The gap analysis will be presented to multiple stakeholder groups organized in collaboration with the interdepartmental workgroup identified in the Board Motion: Aging and Disabilities, Economic Opportunity, Health Services, County Office of Education, Mental Health, Public Health, and Public Social Services, to and solicit feedback and recommendations from the groups that most closely advise these departments. The Phase 2 report will include findings from gap and funding stream analyses, as well as stakeholder feedback and recommendations and will be submitted to the Board of Supervisors in April 2023.

COUNTY OF LOS ANGELES
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CHIEF EXECUTIVE OFFICER
Fesia A. Davenport

June 24, 2024

To: Supervisor Lindsey P. Horvath, Chair
Supervisor Hilda L. Solis
Supervisor Holly J. Mitchell
Supervisor Janice Hahn
Supervisor Kathryn Barger

From: Fesia A. Davenport
Chief Executive Officer

REPORT BACK ON LOS ANGELES COUNTY'S EFFORTS TO ADDRESS SOCIAL DETERMINANTS OF HEALTH (ITEM NO. 9, AGENDA OF MAY 17, 2022)

On May 17, 2022, the County of Los Angeles (County) Board of Supervisors (Board) adopted the "Los Angeles County's Efforts to Address Social Determinants of Health" motion directing the Department of Public Health (DPH) and the Chief Executive Office's (CEO) Anti-Racism, Diversity, and Inclusion (ARDI) Initiative, in collaboration with other relevant departments, to assess existing efforts and opportunities to address the five key areas of social determinants of health.

In response to the Board motion, DPH submitted an initial Phase 1 report providing a landscape analysis of County programs addressing Social Determinants of Health (SDoH) as defined by the Healthy People 2030 framework. The landscape assessment examined data collected from a funding streams analysis conducted in November 2022 which identified 528 programs in 29 County departments and associated regional entities and presented findings on how these programs were distributed across SDoH domains, how programs cut across domains, and how departments collaborated with each other and external partners.

The Attachment provides CEO-ARDI's report back building upon the prior analysis. This Phase 2 report offers greater detail regarding prevention programs and existing spending across departments, as well as analyzing systemic and structural barriers to program analyses and decision making. The report is organized into the following sections:

- **Program Inventory Data and Analysis:** The study team conducted a review of department submitted budget and program data. The data was then organized into program spending categories across the five SDoH domains and the four prevention tier levels described in the County Model for Prevention and Promotion, which was adopted by the Board in 2023.

- **Process and Infrastructure Findings:** The process to gather feedback identified some barriers to conducting a Countywide landscape and program budget analysis. These findings build upon learnings from the County's Prevention Services Task Force, which included internal and external stakeholder interviews with departmental leadership and administrative staff.

- **Recommendations:** The report presents action steps the County can take to address gaps in SDoH and prevention and promotion programming, including establishing more structured data collection and multi-departmental protocols for program tracking.

The report is intended to inform the assessment of Countywide programs serving residents across the multiple social determinants of health.

Should you have any questions concerning this matter, please contact me or D'Artagnan Scorza, Ph.D., Executive Director of Racial Equity, at (213) 974-1761 or dscorza@ceo.lacounty.gov.

FAD:JMN:CDM
DS:HJN:MLC:es

Attachment

c: Executive Office, Board of Supervisors
County Counsel
Aging and Disabilities
Economic Opportunity
Health Services
Mental Health
Public Health
Public Social Services

Los Angeles County's Efforts to Address Social Determinants of Health

PHASE 2 REPORT

County of Los Angeles
Anti-Racism, Diversity, & Inclusion

CREATING AN LA COUNTY WHERE WE ALL THRIVE

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Executive Summary

On May 17, 2022, the County of Los Angeles ("County") Board of Supervisors ("Board") adopted the "Los Angeles County's Efforts to Address Social Determinants of Health" motion directing the Department of Public Health (DPH) and the Chief Executive Office's Anti-Racism, Diversity, and Inclusion (ARDI) Initiative, in collaboration with other relevant departments, to assess existing efforts and opportunities to address the five key areas of social determinants of health.

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This second report (Phase 2) builds upon the previous submission by offering a more detailed look into prevention programs and budgeting across departments, as well as analyzing systemic and structural barriers to program analyses and decision making.

The Phase 2 report has been organized into three main sections summarized below:

I. Program Inventory Data and Analysis

The study team conducted a deeper review of reported budget and program data across departments and entities, including coding each program by Level of Risk & Prioritized Support. The analytic lens combines the federal government's Healthy People 2030 SDoH framework and the Los Angeles County Model for Prevention and Promotion, which allowed programs within SDoH domains to be categorized further by the latter model's tier levels for prevention and promotion: primary, secondary, tertiary, and remedy.

As with the Phase 1 report, the Program Inventory Data and Analysis draws upon a dataset of self-reported programs originally compiled by the Prevention Services Task Force through a department-by-department basis. In this Phase 2 report, we include the reported budgeted spending and program count for each department across prevention levels and SDoH domain, in addition to patterns of investment across these categories.

It is important to note that while the funding and program count comparisons may help summarize the County's existing investment priorities, they do not, and cannot, assess whether such prioritization is intentional. If there is more programming or spending in one domain (and/or prevention tier) compared to another, the summary analysis in this report does not indicate whether this finding reflects a strategic priority or an inadvertent oversight. The analysis simply highlights the disparity as a gap for further consideration. For instance, several departments report program spending that is heavily shaped, limited, and/or informed by federal, state, and external grant requirements.

II. Process and Infrastructure Findings

The second section of the Phase 2 report describes the existing structural barriers to conducting a Countywide landscape and budgetary analysis, including data completeness, lack of coordination among assessment efforts, varied program development protocols, and disparate frameworks. These barriers have also hindered efforts by other entities (including the Prevention Services Task Force and County leadership writ large) to analyze and offer fully-informed recommendations relating to funding, programming, and spending across County departments. The study team identified the following learnings and areas of opportunity to improve County processes for investments in prevention, promotion, and the Social Determinants of Health:

- **Improving data completeness, accuracy, and consistency.**
  The County's existing data infrastructure relating to budget analyses, data collection, and evaluation is often insufficient and/or unreliable when it comes to demonstrating how the County is currently responding to community conditions across its many programs. There is also a historical lack of shared terminology to define and track functions, including varied definitions of "program" as a unit of analysis.

- **Establishing a unified approach to analyze program impact.**
  This report examines existing programs rather than a larger, hypothetical universe of "possible" programs. This approach, which inherently centers the status quo, has some limitations, most significantly an inability to know what types of programs might be missing in the County's portfolio. A unified approach to assessing needs and identifying gaps would enable County decision makers to review budget requests or program proposals based on whether they advance longer-term strategic goals, lead to equitable outcomes, and increase wellbeing across all populations.

- **Acknowledging and aligning variations in program development practices across departments.**
  There are many reasons why programs are developed and proposed, several of which are not always directly in response to comprehensive and coordinated Countywide planning (e.g., in response to needs identified from existing operations, new funding opportunities, policy changes, and/or invitations to collaborate with other entities). Such diverse practices illustrate the numerous motivations involved in program development and partially explain how the County's network of services might have developed gaps over time. Concurrently, identifying where such gaps might exist – and the solutions at hand to resolve them – will require a comprehensive analysis of programs and services, including identifying opportunities to create new programs, expand on existing programs, and/or utilize funding strategies to support such programming.

It will be critical to address these structural and technical limitations so the County can manage its investments more effectively, make strategic funding decisions, and coordinate across the full array of prevention and promotion services.

III. Recommendations and Next Steps

Finally, this report offers the following recommendations and next steps on how the County might address gaps in SDoH and prevention programming and establish more structured data collection and multi-departmental coordination protocols moving forward:

1. Develop a **Countywide program taxonomy** that enables departments to categorize and report their programs and spending based on the multiple Social Determinants of Health and the Countywide model for prevention and promotion.

2. Create a **Countywide programs database** using the common taxonomy and establish the mechanisms to keep the program data up to date on a fiscal year basis, along with their detailed budgets.

3. Develop a **common framework** that departments can use to assess their programs and determine how those programs are closing outcomes gaps and addressing needs at the population level.

4. In alignment with the July 2023 Board motion on "Building LA County's Prevention Infrastructure," **enhance the capabilities of the CEO Budget Office and new Prevention and Promotion Systems Governing Committee** to work with departments to play a more strategic role in tracking and coordinating across funding streams for the multiple Social Determinants of Health.

IV. Appendix

An Appendix follows these three main report sections, where the study team has also included **Additional Opportunities and Emergent Programs**, which were identified while reviewing program data and creating this report. However, these highlighted programs are not meant to be comprehensive or definitive program recommendations – especially because they were not developed using a systemic framework nor with the input of subject matter experts across the County's various departments. Instead, they are included as highlighted opportunities meriting further study and potential support.

I. Program Inventory Data and Analysis

Los Angeles County's Efforts to Address Social Determinants of Health

PROGRAM INVENTORY OVERVIEW, FY2021-22

In 2021, LA County's Prevention Services Task Force began compiling a Countywide **program inventory** of prevention and promotion services across all County departments and regional partners.

In 2023, the Department of Public Health and Anti-Racism, Diversity, & Inclusion Initiative further updated, categorized, and analyzed this inventory using the new Countywide model for Prevention & Promotion and the five overarching Social Determinants of Health domains as defined by the U.S. Department of Health and Human Services (HHS):

1. Economic Stability | **2. Education Access and Quality** | **3. Health Care Access and Quality** | **4. Neighborhood and Built Environment** | **5. Social and Community Context**

Social Determinants of Health Domains

Graphics source: U.S. Department of Health and Human Services

TOPLINES

County departments and regional partners reported

528

PROGRAMS

providing prevention and promotion across diverse services and populations

$5.59 BILLION+

Total County investment in prevention & promotion

FY2021-22

$12M

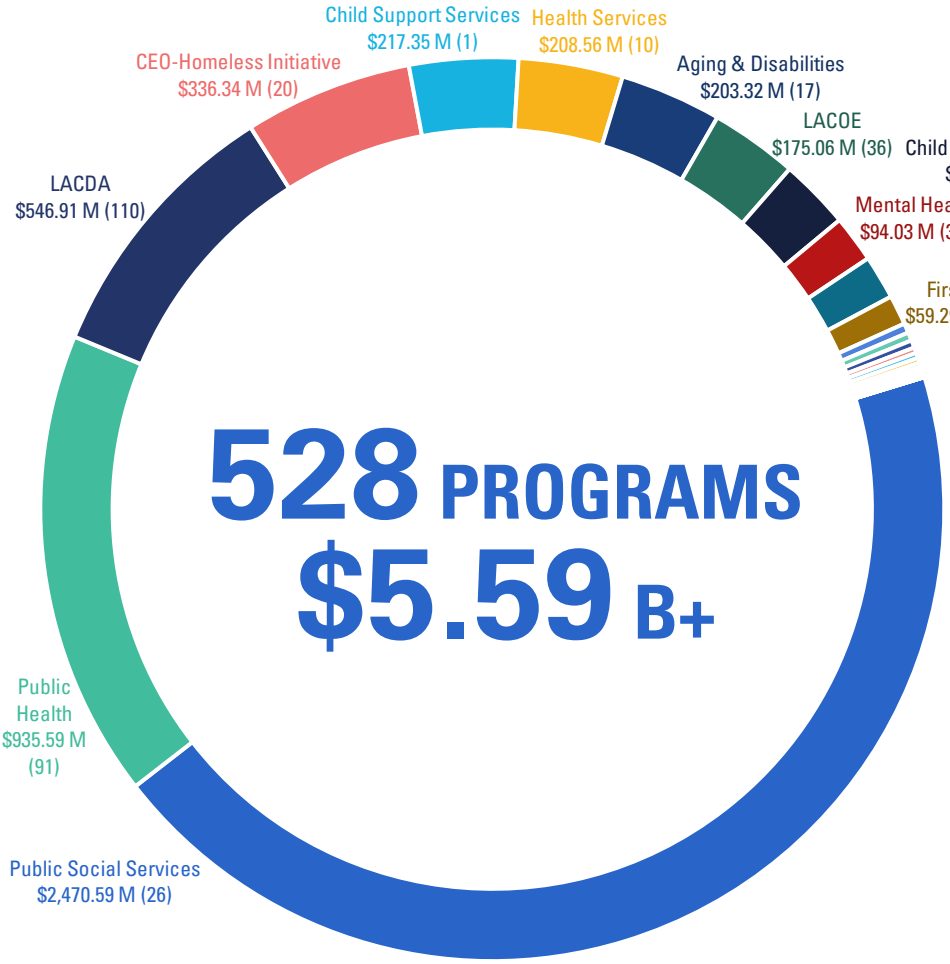
Average program size

$756K

Median program size

LA County's Prevention and Promotion Program Portfolio

County departments and regional partners reported the following prevention and promotion programs in FY2021-22, totaling at least $5,587,900,480 (as some departments did not submit a full list of programs and/or budget figures for certain programs). Departments are displayed in decreasing order of total reported budget (in millions), with their total number of reported programs shown in parentheses.



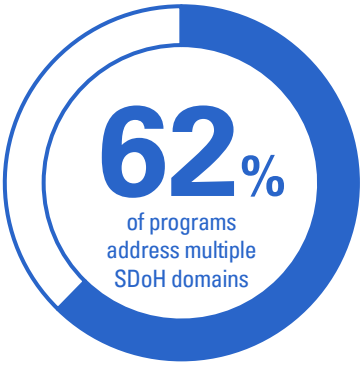
Additional Departments	$	(#)
Probation	$19.19 M	10
Public Works	$16.72 M	7
Consumer & Business Affairs	$15.04 M	6
LAHSA	$11.12 M	1
Public Defender	$10.57 M	15
Arts & Culture	$9.76 M	6
CEO-Poverty Alleviation Initiative	$8.17 M	4
District Attorney	$6.34 M	15
Internal Services	$4.20 M	4
Public Library	$2.37 M	19
Human Resources	$1.93 M	10
Beaches & Harbors	$1.75 M	1
Regional Planning	$1.71 M	11
Sheriff	$0.93 M	2
Auditor-Controller	$0.88 M	1
Alternate Public Defender	$0.63 M	8
Military & Veterans Affairs	$0.57 M	2
Medical Examiner	$0.25 M	1
Treasurer & Tax Collector	$0.21 M	2
Animal Care & Control	$0.04 M	2
JCOD (CEO-ATI)	N/A	6
Fire	N/A	1

County departments and entities vary widely in size and scope. The budget and count of programs displayed above (and in charts elsewhere in this report) provide a high-level summary of efforts to address SDoH, prevention, and promotion in Los Angeles County, **but these data alone should not be utilized as the sole or primary means to interpret the total impact of departmental prevention efforts**.

For example, it is possible for one department to run a lower-cost program that makes a large impact on a community's wellbeing on a preventative basis (e.g., a youth mentorship program), while another department may administer an essential but high-cost program that has a downstream impact limited to a smaller number of residents (e.g., hospital emergency room services). Similarly, the quantity of programs cannot tell the full story regarding the impact of such programs and their departments.

Additionally, it is important to contextualize the timing of the information request for this project. Since this effort started in summer 2021, several County departments and new programs have been established and/or expanded, including but not limited to departments such as Justice, Care, & Opportunities (JCOD, then reporting under CEO-Alternatives to Incarceration), Economic Opportunity, Aging & Disabilities, and Youth Development (which is not included in this dataset).

Visualizing the Social Determinants of Health Across LA County's Prevention and Promotion Program Portfolio



Nearly two-thirds of the County's prevention and promotion programs serve multiple domains across the social determinants of health.

329 programs (62%) address at least two of the five domains, and 124 programs (23%) address at least three domains.

COMMON MULTI-DOMAIN PROGRAMS:

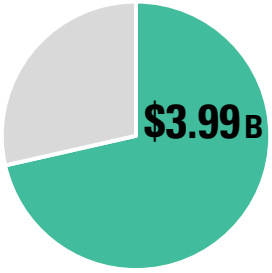
Programs providing "**whole person care**" to special populations (e.g., justice impacted individuals, transition aged youth, older adults, etc.) intentionally designed to support individuals' needs holistically

Initiatives between two or more departments created to facilitate connections, eliminate duplication, and increase access across services (e.g., linkages and benefits navigator programs)

A large portion of the County's programs that provide **supportive housing and rental assistance**, given their focus on both Economic Stability and Neighborhood and Built Environment

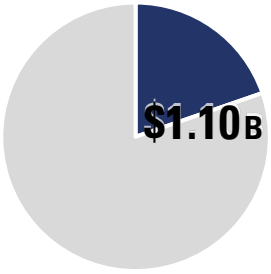
The County's 528 prevention and promotion programs sum up to $5.59B+ and can be categorized into the five overlapping SDoH domains:

240 programs address **Economic Stability**, totaling



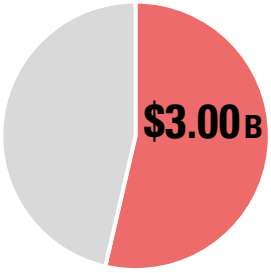
in reported program budget

171 programs address **Education Access & Quality**, totaling



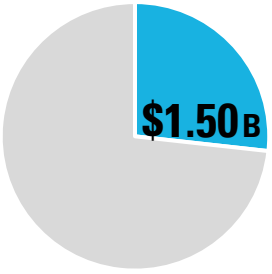
in reported program budget

269 programs address **Health Care Access & Quality**, totaling



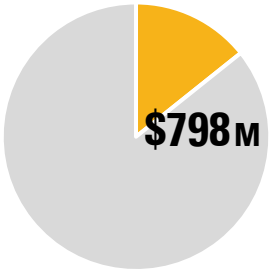
in reported program budget

182 programs address **Neighborhood & Built Environment**, totaling



in reported program budget

146 programs address **Social & Community Context**, totaling



in reported program budget

TAKEAWAYS & CAVEATS

Visualizing the Data

The charts in this report primarily utilize program spending as the unit of visualization and analysis, although program counts are listed, as well. It is important to acknowledge that this may visually bias departments with a smaller number of high budget programs, while inadvertently underrepresenting departments with lower cost programs, even if the latter may manage an extensive and varied portfolio.

In addition, departments often have differing definitions of what constitutes a "program." Some departments shared multiple programs offering identical services that had been divided geographically (e.g., across jurisdictions or SPAs), while others reported large Countywide programs that contain numerous subprograms submitted under a consolidated budget exceeding $100 million.

For instance, Child Support Services (CSSD) has the fifth highest prevention spending in this study and reported only one program, Child Protection ($217 million in FY21-22). Meanwhile, Mental Health (DMH) reported 33 programs totaling $94 million, with an average program size of $2.85 million. From this quantitative information alone, it is not possible to objectively conclude which department is making a 'larger impact' in prevention and promotion, although several charts in this report visually display CSSD much more prominently than DMH.

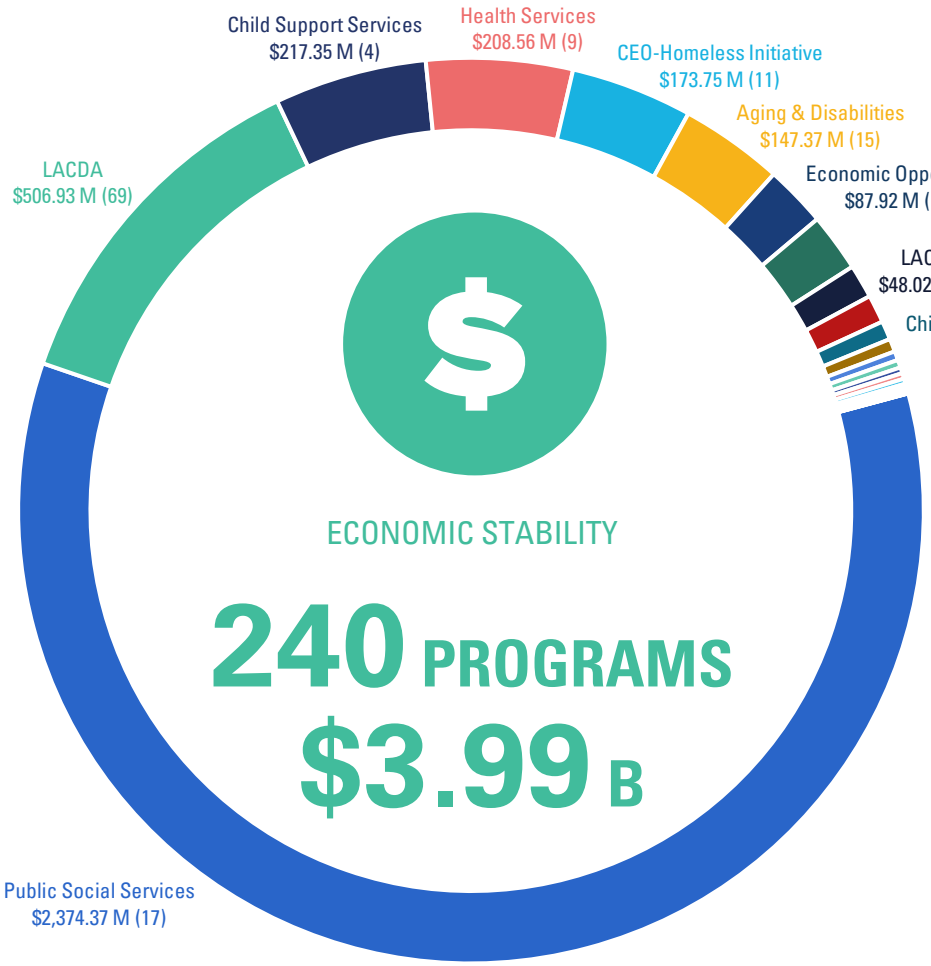
Limitations to Domain Classification

Although report staff categorized each program across SDoH domains, **it is not currently possible to provide an itemized breakdown of spending when programs cover multiple domains**. For example, if a $10 million program was determined to address both Economic Mobility and Education Access & Quality, it is typically unfeasible to divide the budget between domains. Departments were not asked to report detailed spending at the domain level, and even if they had been, such a task would usually not be as simple as allocating $6 million for one domain and $4 million for the other given the intersectional and overlapping nature of programs.

SDoH 1: Economic Stability

County departments (and regional entities) reported the following programs which were categorized by DPH & ARDI staff as addressing Economic Stability, defined by HHS to include programs that "**help people earn steady incomes that allow them to meet their health needs.**"

Departments are displayed in order of total reported budget within this SDoH domain (in millions), with the number of programs shown in parentheses. As noted previously, several of the programs displayed below also address other SDoH domains.



Additional Departments	$	(#)
Consumer & Business Affairs	$12.82 M	5
LAHSA	$11.12 M	1
Public Defender	$8.39 M	8
CEO-Poverty Alleviation Initiative	$8.17 M	4
Probation	$7.30 M	5
Internal Services	$4.20 M	3
Arts & Culture	$3.71 M	3
Human Resources	$1.93 M	10
Public Library	$1.13 M	8
District Attorney	$1.07 M	3
Auditor-Controller	$0.88 M	1
Military & Veterans Affairs	$0.57 M	2
Sheriff	$0.47 M	1
Alternate Public Defender	$0.24 M	2
JCOD (CEO-ATI)	N/A	5
Fire	N/A	1

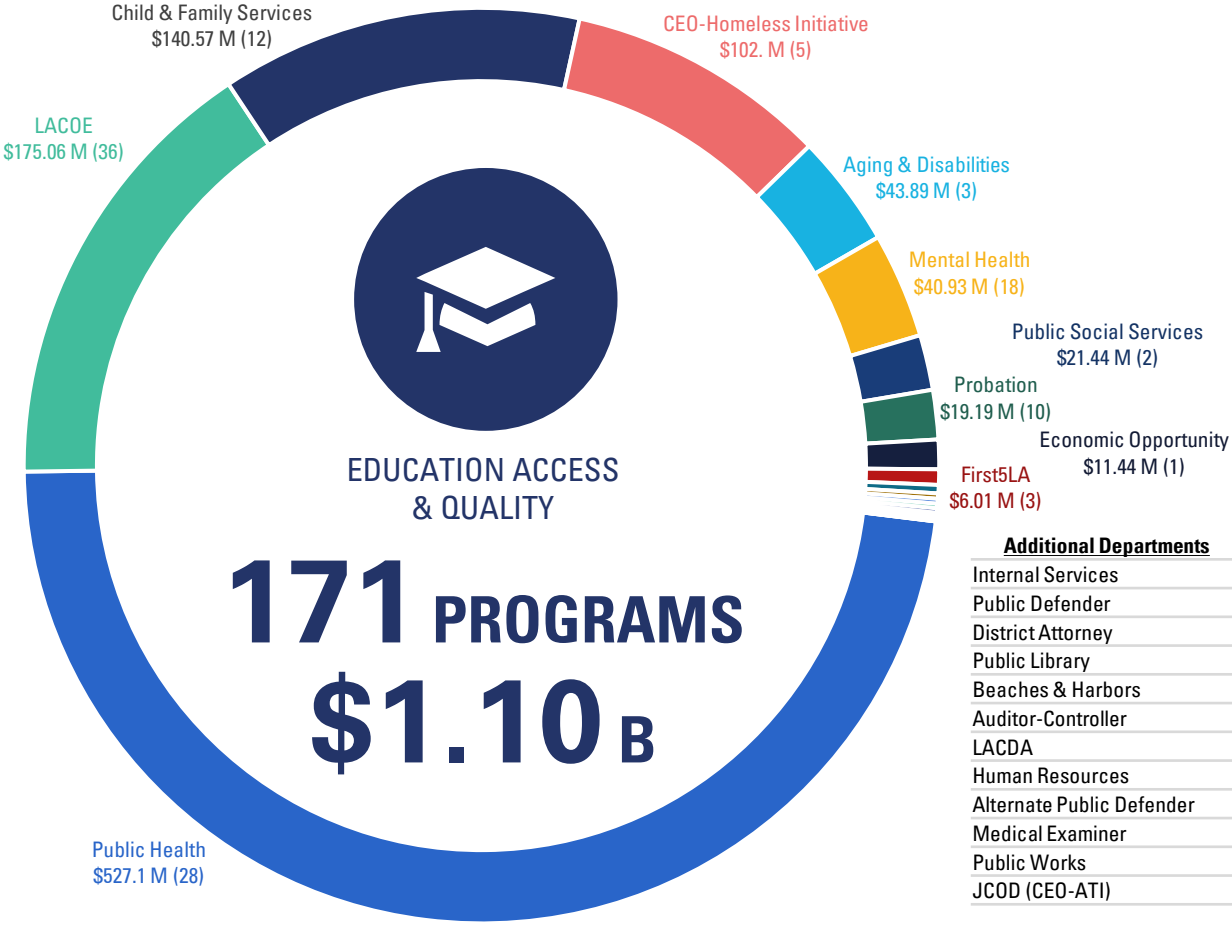
OBSERVATIONS

- Public Social Services (DPSS), which disburses large scale assistance programs including CalWORKs, General Relief, and In-Home Supportive Services, has by far the largest program budget dedicated to this domain.
- The Los Angeles County Development Authority (LACDA) administers rental assistance and public housing programs and has most of its programs dually listed under this domain and Neighborhood & Built Environment (SDoH 4). CEO-Homeless Initiative, which has seen an increase in budget allocation since this data was gathered (in part due to the County's Declaration of Local Emergency on Homelessness), is similarly classified under these two domains as well.

SDoH 2: Education Access & Quality

County departments (and regional entities) reported the following programs which were categorized by DPH & ARDI staff as addressing Education Access & Quality, defined by HHS to include programs that "**increase educational opportunities and help children and adolescents do well in school.**"

Departments are displayed in order of total reported budget within this SDoH domain (in millions), with the number of programs shown in parentheses. As noted previously, several of the programs displayed below also address other SDoH domains.



Additional Departments	$	(#)
Internal Services	$3.25 M	2
Public Defender	$2.07 M	5
District Attorney	$1.90 M	4
Public Library	$1.77 M	14
Beaches & Harbors	$1.75 M	1
Auditor-Controller	$0.88 M	1
LACDA	$0.87 M	15
Human Resources	$0.81 M	4
Alternate Public Defender	$0.29 M	4
Medical Examiner	$0.25 M	1
Public Works	$0.16 M	1
JCOD (CEO-ATI)	N/A	1

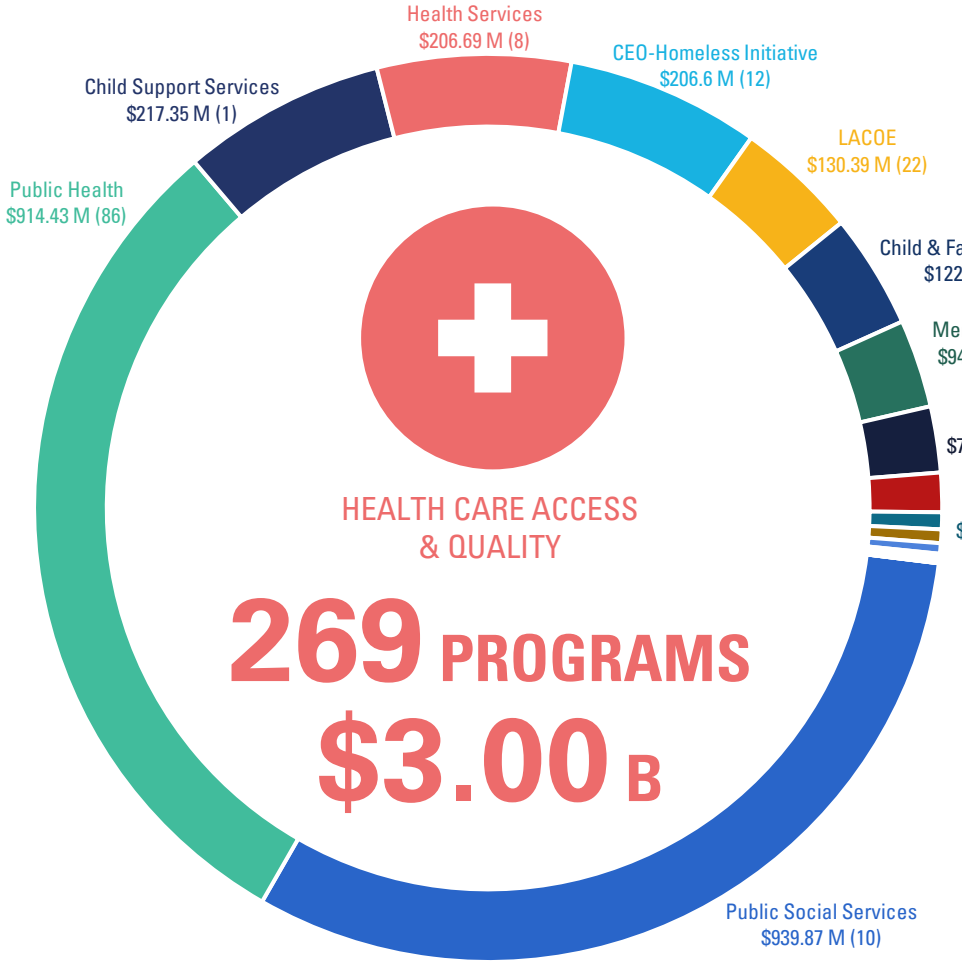
OBSERVATIONS

- Public Health (DPH) holds the largest share of prevention and promotion spending in this domain, with many of its programs centering public education to address issues such as child passenger safety, nutrition, student wellbeing, substance use, immunizations, pre- and perinatal care, sudden infant death syndrome (SIDS), and sexually-transmitted infections (STIs).
- Unsurprisingly the Los Angeles County Office of Education has the second largest budget here, with the bulk allocated toward eighteen Head Start and Early Learning programs totaling more than $151 million in FY21-22.

SDoH 3: Health Care Access & Quality

County departments (and regional entities) reported the following programs which were categorized by DPH & ARDI staff as addressing Health Care Access & Quality, defined by HHS to include programs that "**increase access to comprehensive, high-quality health care services**."

Departments are displayed in order of total reported budget within this SDoH domain (in millions), with the number of programs shown in parentheses. As noted previously, several of the programs displayed below also address other SDoH domains.



Additional Departments	$	(#)
LAHSA	$11.12 M	1
Public Defender	$4.20 M	10
District Attorney	$3.02 M	11
Internal Services	$0.95 M	1
Auditor-Controller	$0.88 M	1
Military & Veterans Affairs	$0.57 M	2
Alternate Public Defender	$0.38 M	4
Human Resources	N/A	2
JCOD (CEO-ATI)	N/A	2

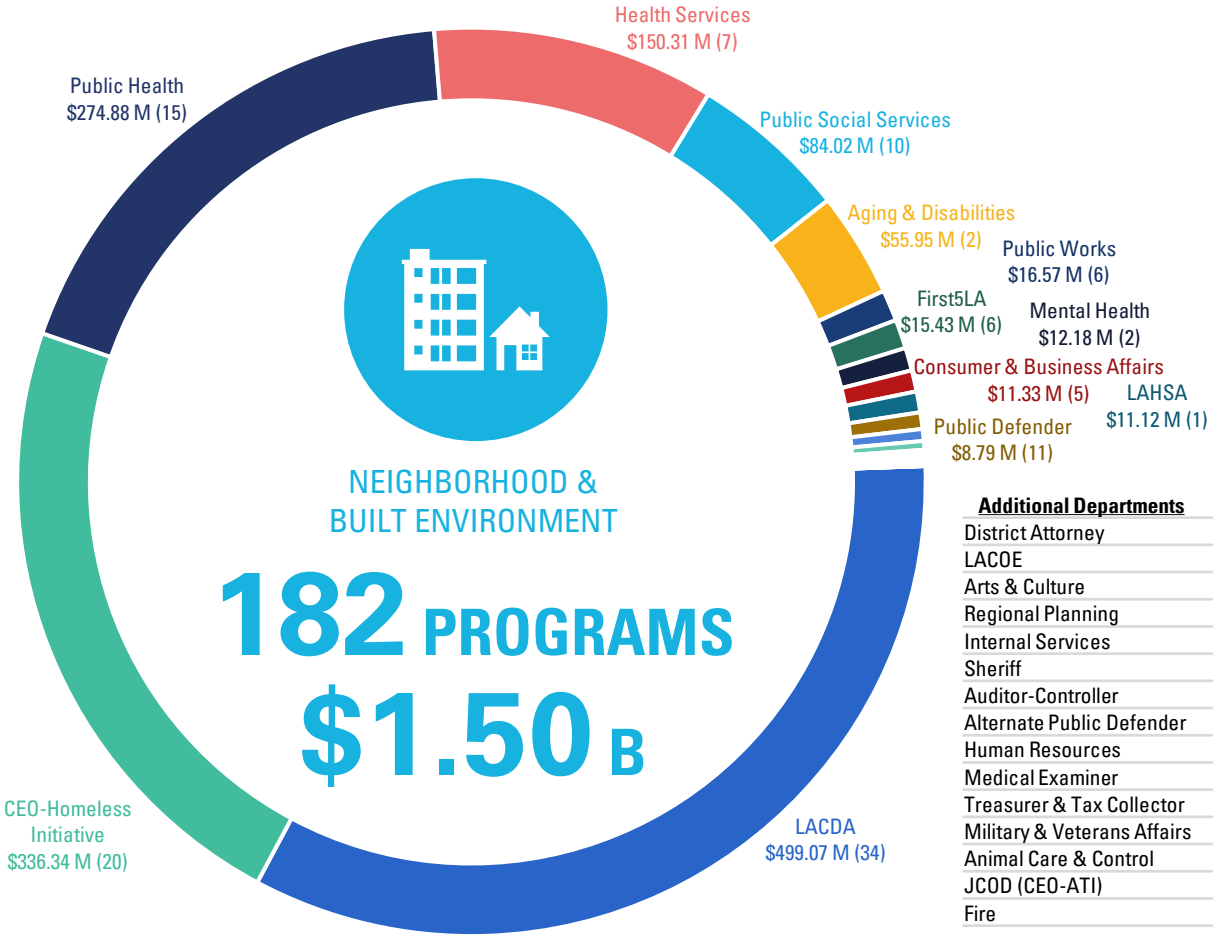
OBSERVATIONS

- Although the County's three main health departments (Public Health, Health Services, and Mental Health) are represented prominently, this chart also visually displays how other departments play large role in also providing and facilitating connections to Health Care Access & Quality for various residents.
- Public Social Services (DPSS)'s program budget in this domain is dominated by In-Home Supportive Services, an $844 million program dually listed under SDoH 1 that helps pay for assistance and care services for older adults and people with disabilities so they can remain safely in their own homes.

SDoH 4: Neighborhood & Built Environment

County departments (and regional entities) reported the following programs which were categorized by DPH & ARDI staff as addressing Neighborhood & Built Environment, defined by HHS to include programs that "**create neighborhoods and environments that promote health and safety**."

Departments are displayed in order of total reported budget within this SDoH domain (in millions), with the number of programs shown in parentheses. As noted previously, several of the programs displayed below also address other SDoH domains.



Additional Departments	$	(#)
District Attorney	$6.34 M	15
LACOE	$4.66 M	6
Arts & Culture	$2.00 M	2
Regional Planning	$1.71 M	11
Internal Services	$1.30 M	3
Sheriff	$0.93 M	2
Auditor-Controller	$0.88 M	1
Alternate Public Defender	$0.63 M	8
Human Resources	$0.38 M	2
Medical Examiner	$0.25 M	1
Treasurer & Tax Collector	$0.21 M	2
Military & Veterans Affairs	$0.20 M	1
Animal Care & Control	$0.04 M	2
JCOD (CEO-ATI)	N/A	6
Fire	N/A	1

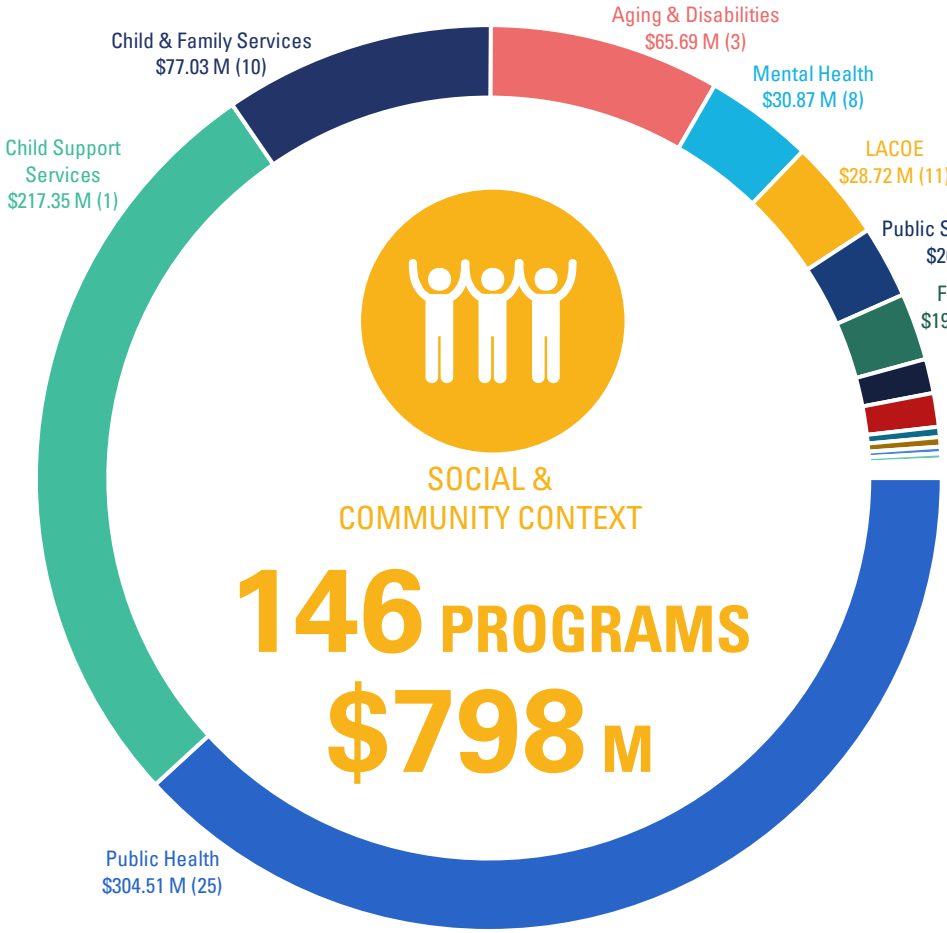
OBSERVATIONS

- The Los Angeles County Development Authority (LACDA) administers rental assistance and public housing programs and has most of its programs dually listed under this domain and Economic Stability (SDoH 1). CEO-Homeless Initiative is similarly classified under these two domains.
- Spending in this domain trails SDoH 1 and 3, perhaps reflecting the County's limited jurisdictional authority in this space, as many authorities and budgets relating to physical infrastructure, planning, and zoning are held by cities and other local entities, with the limited exception of unincorporated areas.

SDoH 5: Social & Community Context

County departments (and regional entities) reported the following programs which were categorized by DPH & ARDI staff as addressing Neighborhood & Built Environment, defined by HHS to include programs that "**increase social and community support**."

Departments are displayed in order of total reported budget within this SDoH domain (in millions), with the number of programs shown in parentheses. As noted previously, several of the programs displayed below also address other SDoH domains.



Additional Departments	$	(#)
Internal Services	$2.9 M	1
LACDA	$2.72 M	40
Health Services	$1.87 M	2
Beaches & Harbors	$1.75 M	1
Public Library	$1.10 M	5
District Attorney	$0.98 M	3
Auditor-Controller	$0.88 M	1
Probation	$0.78 M	2
Military & Veterans Affairs	$0.57 M	2
Sheriff	$0.47 M	1
Human Resources	$0.38 M	2
Animal Care & Control	$0.04 M	2
JCOD (CEO-ATI)	N/A	4
CEO-Homeless Initiative	N/A	1
Treasurer & Tax Collector	N/A	1

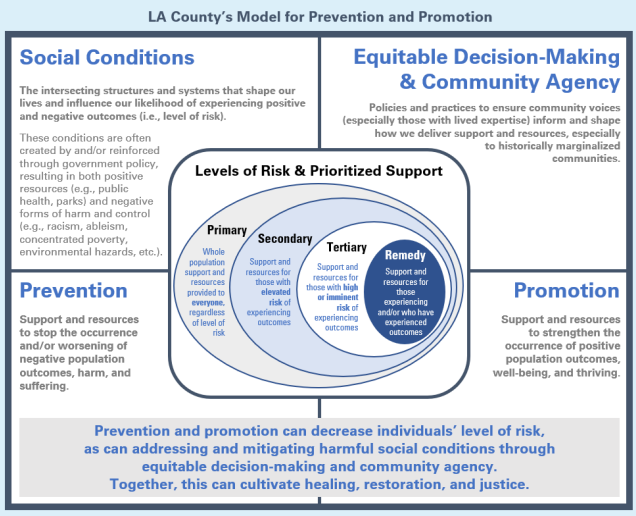
OBSERVATIONS

- Quantifying the monetary value of social connections and interpersonal relationships can often be more complicated than quantifying itemized costs relating to equipment, labor, cash assistance, or physical resources.
- Many of the largest programs in this domain are those that prioritize connecting residents with specific lived experiences (e.g., foster youth, people with disabilities, people living with chronic diseases, survivors of violence, individuals with substance use disorder) with community-centric supports along with physical and mental health care or economic supports. As a result, **137 of the 146 programs (94%) in this domain also address another domain**.

Prevention and Promotion Levels

To organize the County's programs across how and when they address community needs, the study team utilized definitions for **levels of risk and prioritized support** created by the Prevention Services Task Force through its Countywide Model for Prevention and Promotion, which was adopted by the Board of Supervisors on July 25, 2023:

- **Primary:** Whole population support and resources provided to **everyone**, regardless of level of risk;
- **Secondary:** Support and resources for those with **elevated risk** of experiencing outcomes;
- **Tertiary:** Support and resources for those with **high or imminent risk** of experiencing outcomes; and
- **Remedy:** Support and resources for those experiencing and/or who have experienced outcomes.

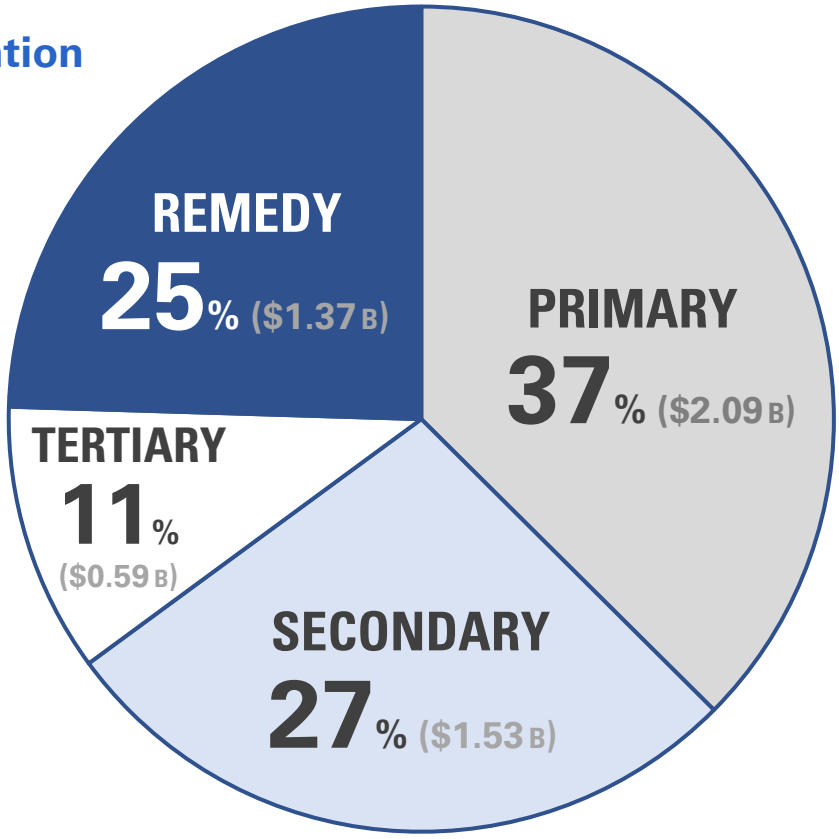


Pictured above: LA County's Model for Prevention and Promotion. To learn more and review in detail, please see **pages 35-43 of Attachment III** submitted to the Board by the Prevention Services Task Force.

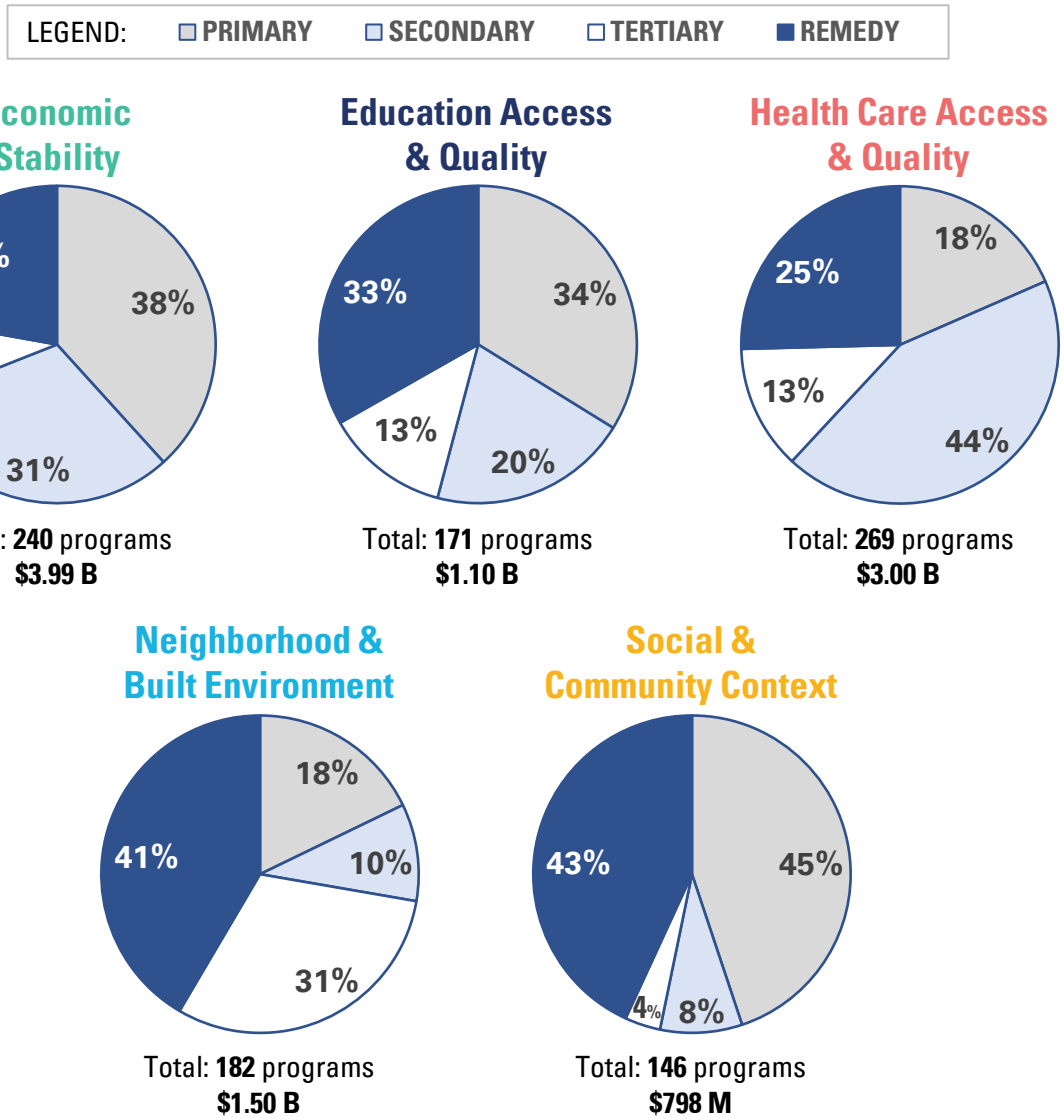
Distribution of County programs across prevention and promotion levels

Report staff analyzed the program summary information and descriptions provided by departments and assigned each of the 528 programs to one of the four levels.

It is common for programs (especially those with numerous subprograms and target populations) to offer multiple services, resources, and interventions across various levels. Staff assigned programs to a level based on their overall description, while acknowledging that there may be limitations to this approach due to the high-level summary information provided to reviewers.



The distribution of programs across prevention and promotion levels varies widely between each of the five overlapping SDoH domains:



Total: **240** programs
$3.99 B

Total: **171** programs
$1.10 B

Total: **269** programs
$3.00 B

Total: **182** programs
$1.50 B

Total: **146** programs
$798 M

OBSERVATIONS

- More than 88% of spending within **Social & Community Context** is dedicated to either primary prevention (45%) or remedy (43%). This may reflect how many programs in this domain have been constructed by departments and their funding sources – either to serve the general population or to target community resources toward specific populations who have already experienced negative outcomes (e.g., justice-impacted individuals, DCFS-involved families, transition-aged youth (TAY), or homeless individuals).

- Secondary prevention (44%) leads within **Healthcare Access & Quality**, followed by remedy (25%). Meanwhile, only 13% of program funds in this domain are dedicated toward tertiary prevention. This may reflect the difficulty (and/or inefficacy) of programs targeted toward individuals at imminent risk of experiencing a health outcome, when it may be 'too late' to prevent negative outcomes, versus remedy (e.g., treating individuals who already have a disease) or secondary prevention (e.g., providing support to individuals with elevated risk but when a health condition is still preventable).

OBSERVATIONS (continued)

- Over 72% of program spending within **Neighborhood & Built Environment** is dedicated to either tertiary prevention or remedy programs. This reflects how many housing resources and supports funded by the County are targeted toward those at imminent risk of homelessness, already unhoused, or currently experiencing housing instability. Moreover, many of these programs are dedicated or targeted toward specific communities at higher risk of becoming homeless, including DCFS-involved families, justice-impacted individuals, or those already qualifying for other public assistance programs. While the County may provide some upstream and universal programs relating to housing (e.g., tenant protections or resources), many of these are less expensive to administer or similarly dedicated to smaller target populations involved with other County systems.

- While we offer the summary statistics and analysis regarding prevention levels and SDoH, **it is important to note that we cannot provide a comprehensive evaluation regarding the efficacy or appropriateness of the County's spending across prevention and promotion programs**. Although the County currently spends more in upstream prevention for some SDoH than others, it's unclear whether an equal distribution or some alternative spending plan across prevention tiers would be more effective or impactful on the lives of residents.

    - For instance, the study team found that **Healthcare Access & Quality** was dominated by secondary prevention and remedy programs, but included fewer tertiary prevention programs (i.e., programs serving individuals at "imminent" risk of experiencing certain outcomes such as health conditions). While at first glance this could suggest a need to enhance tertiary programming, it could alternatively be true that it is far more effective to intervene and address health conditions early, before a disease or condition (e.g., a heart attack, stroke, or serious infection) is already imminent. This would then justify disproportionate spending in secondary prevention, which serves individuals at elevated risk further upstream. However, this type of decision calculus could vary greatly across outcomes (e.g., diseases, types of carceral involvement, educational populations, etc.) as well as overall SDoH domains.

- **Evaluating the efficacy and recommended approach across prevention tiers and SDoH domains requires a thorough understanding of the County's long-term strategic goals**, such as closing racial disproportionalities and disparities and the detailed strategies and tactics to achieve these goals across target populations and each SDoH. Moreover, as indicated previously in this report, budgeted spending is not necessarily a representative nor fair unit of evaluation for programs and departments and their impact on residents' lives. Finally, investment decisions are also heavily influenced by federal, state, and local policy priorities and funding constraints, which are beyond the scope of this Phase 2 report.

II. Process and Infrastructure Findings

While gathering the information summarized in this report, the study team identified several structural barriers that hinder the County's ability to accurately measure investments across SDoH domains, as well as prevention and promotion more broadly. These barriers are listed and organized into the following three findings described in this report section:

- **Improving data completeness, accuracy, and consistency.**
- **Establishing a unified approach to analyze program impact.**
- **Acknowledging and aligning variations in program development practices across departments.**

Several of these findings – including both challenges and opportunities – reiterate findings identified through the Prevention Services Task Force's Funding Streams Analysis previously submitted to the Board.

Improving Data Completeness, Accuracy, and Consistency

The County's existing data infrastructure relating to budget analyses, data collection, and evaluation is often insufficient and/or unreliable when it comes to demonstrating how the County is currently responding to conditions across its many programs. These include the following challenges previously identified by the Prevention Services Task Force, which originally collected the data set utilized in this report:

- The County lacks strong reporting mechanisms to increase visibility on programmatic use of funds, according to discussions with CEO-Budget, departmental staff, and initiative staff on braiding and blending funding; and

- Under the County's current technology and budget monitoring platforms, there is an inability to consistently track programs or funding streams to their specific functional uses (e.g., SDoH or prevention tiers).

Consequently, the study team shares the following observations:

- **There is also a historical lack of shared terminology to define and track functions.** While the Board of Supervisors recently adopted the Prevention Service Task Force's Countywide model for prevention and promotion, departments did not previously share common definitions for prevention, nor did many departments routinely categorize all programs by SDoH domain. The 528 programs in this data set represent programs identified by departmental staff in partnership with the CEO-Budget and operations team, specifically for departments that provided data. The study team for this report evaluated the departmental survey responses – including program descriptions – and categorized programs by SDoH and prevention level of risk.

- **Additionally, protocols regarding program development, budgeting, and strategy vary across departments.**
  This has led to inconsistency in the definition of "program" as a unit of analysis across different departments. As a result, some submitted programs are extremely targeted efforts with a narrow scope and budgets less than $100,000, whereas other programs comprise entire areas of work, such as wide-reaching benefits programs with annual budgets exceeding $10 or even $100 million. This variation in key attributes limits the utility of "program" as a unit of analysis, especially for large programs that include sub-programs with widely varying services. Moreover, County departments typically use traditional incremental-based budgeting, rather than other models such as zero-based budgeting. A comprehensive picture of budgeting by programs may require the use of a common program taxonomy for both departmental operating budgets and budget requests.

- **Given the inconsistency in program definitions, reporting, and completeness in the data submitted by some departments, there are likely multiple County programs that address the SDoH but are not included in the data set summarized in this report.**
  For instance, staff may not have fully considered how some of their programs may, in fact, be preventative or promotive across outcomes normally held by other departments or domains, resulting in an undercount of programs. The subsequent analysis was further complicated given that some programs do not neatly align with SDoH domains or the defined prevention risk categories. While the team who assembled this report attempted to mitigate this by utilizing multiple staff to evaluate and tag programs and by reconciling any discrepancies in categorization, the process of sorting these 500+ programs is subjective.

- **Beyond this report, we also identify inconsistency in data reporting standards. Departments conduct data collection and evaluation on their programs differently, which limits the County's ability to conduct further analyses relating to efficacy and impact.**
  These inconsistencies appear across issues, such as demographic option choices and data disaggregation, which affect the County's ability to identify community needs and serve certain marginalized and minority populations, as well as measurements, targets, and terminology for well-being. Often, the County is comparing apples to oranges in its data, especially across departments, which makes cross-domain comparisons difficult.

Because the County does not yet have adequate data completeness, accuracy, and consistency, stakeholders with budget management authority at the CEO, departmental, and coordinating initiative level all express the lack of visibility into County programs and funding streams across varying levels.

At the departmental level, staff may have visibility into their own programs but are limited in their ability to braid funding streams with funds that are restricted by the funder. Many departments relying primarily on multiple non-County dollars have neither the infrastructure nor the staff to manage the complexity of dozens of different funding streams and conduct multi-SDoH, multi-prevention tier, and/or disproportionality and community investment analyses across programs.

At the coordinating initiative level, staff may have some visibility into specific funding streams but otherwise face similar challenges in reviewing and obtaining the necessary information to conduct analyses. Some stakeholders express concern that the County's current budget technology and practices may not provide the same level of detail that other jurisdictions have in order to make coordinated, fully informed budget and strategic planning decisions.

A Note on Intersectional Analyses

County data sources rarely report data intersectionally with an overlay across multiple attributes or identities.

Dr. Kimberlé Crenshaw, who in 1989 coined the term **intersectionality** as it is used today in social justice spaces, describes it as "a lens, a prism, for seeing the way in which various forms of inequality often operate together and exacerbate each other. We tend to talk about race inequality as separate from inequality based on gender, class, sexuality, or immigrant status. What's often missing is how some people are subject to all of these, and the experience is not just the sum of its parts."

While the County may currently report and analyze outcomes by racial categories, age groups, or gender identities individually, it is rare for departments to regularly report program data using race, age, and gender overlayed on top of one another. One example of this could entail reporting on outcomes experienced specifically by older Black women as a singular group, as this group may have different outcomes than older adults, older Black adults, older women, Black adults, Black women, and/or women, respectively. The inconsistency and/or absence of such analyses lead to limitations in understanding disproportionalities and disparities and hinders the ability of County decision makers to advance equity across communities through County programs, resources, and services.

Establishing a Unified Approach to Analyze Program Impact

Countywide Needs Assessments and Analytic Frameworks

This report compares domain and prevention level spending among County programs to understand current spending prioritization. An analysis on existing programs rather than a larger, hypothetical universe of "possible" programs inherently centers the status quo and thus makes this report an internal-facing analysis. This approach has some limitations, most significantly an inability to know what types of programs might be missing in the County's portfolio. Moreover, further analysis in the form of needs assessments across SDoH, prevention tiers, and other service categories may be required to ascertain the most effective steps that County must take to impact outcomes across communities.

Ideally, needs assessments would examine SDoH and prevention levels of risk explicitly on a Countywide scale across a variety of demographic groups, especially studying populations already known to experience concentrated disadvantage and/or marginalization. The assessments should also reference specific socioenvironmental indicators (e.g., life course outcomes, prevention outcomes, population metrics). County programs could then address these indicators specifically and utilize them for program impact evaluation. Subsequent Countywide analyses could examine which domains receive sufficient investment and have the most measurable success. Moreover, County decision makers could review budget requests or program proposals based on whether they advance longer-term strategic goals, lead to equitable outcomes, and increase wellbeing across all populations.

There are currently numerous needs assessments being developed and implemented across the County, including, but not limited to, the Los Angeles County Health Survey and the State of Black Los Angeles County report. However, without direct connections to the SDoH domains and prevention categories, these assessments are not suitable to conduct a gap analysis for these frameworks. Any programmatic gap analysis should reference an explicit SDoH and prevention services strategy. **Without a strategy that establishes priorities, it is challenging to know whether the absence of a program represents a glaring omission, deficiency, or simply the deprioritization of that program amid competing and more pressing priorities and budgetary constraints.** While the current gap analysis can provide some insight regarding the relative priorities of County departments regarding SDoH, the takeaways of these findings are limited without an integrated assessment and strategy.

Aligning Variations in Program Development Practices

Existing Program Development Practices

A gap analysis is a strategic tool that allows decisionmakers to understand how resources are deployed and where additional coverage may be required. However, this is not the only approach to programmatic strategic decision making (or even the most common approach) that does not fully acknowledge the variety of reasons for how and why programs are developed.

There are many reasons why programs are developed and proposed, several of which are not always directly in response to comprehensive and coordinated Countywide planning. For instance, programs are developed:

- In response to needs identified during implementation of existing programs or based on learnings from conditions on the ground;
- Based on internal departmental strategy and planning regarding assessed needs;
- In response to funding opportunities;
- In response to invitations to collaborate with other entities, including those with additional sources funding; and/or
- In response to policy changes or new legislation that compels it.

These diverse practices illustrate the multiple perspectives and motivations involved in program development and partially explain how a network of services might develop gaps over time. Concurrently, identifying where such gaps might exist – and the solutions at hand to resolve them – will require a comprehensive analysis of programs and services, including identifying opportunities to create new programs, expand on existing programs, and/or utilize funding strategies to support such programming.

Ultimately, addressing gaps in a broad Countywide prevention and promotion continuum of care is one of many approaches, but it is important to consider how strategic programming decisions made from this position might impact other program development practices to ensure the multiple layers of strategy align.

III. Recommendations

Recommendations

Based on the findings of this gap analysis and in response to the limitations outlined above, the study team recommends the following:

1. **Integrate the SDoH and Board's adopted model for prevention and promotion categories into the Countywide taxonomy currently under development within CEO, which will enable the County to better categorize and analyze program activity, contracts, and spending to support decision making.**

   AND

2. **Explore the feasibility of integrating this taxonomy into the County's budget preparation system upgrade and establish mechanisms to maintain up to date program data across both efforts.**

   As the County implements a new governance structure for prevention and promotion, including but not necessarily limited to the Prevention and Promotion Systems Governing Committee and the Prevention and Promotion Coordination and Implementation Team (PPCIT), it is critical that these entities are able to delineate and oversee guidelines for coordination, collaboration, and decision-making authority.

   For instance, funding sources identified in the program inventory reviewed in this report are currently utilized across multiple departments and branches. Other sources have more narrow uses defined by the payer and often fall under a single department's purview. In both scenarios, the ability to coordinate between departments and agencies often rely on time consuming and ad hoc processes such as MOUs applied on a case-by-case scenario.

   As a result, there is an opportunity for County departments to adopt streamlined processes that enable the ability to identify, coordinate, and report effectively on funding sources at the County level, as opposed to on a programmatic or departmental level.

   ARDI and the Internal Services Department (ISD) are currently exploring the feasibility of developing a program taxonomy and corresponding data system to categorize program activities, spending, contracting, and funding sources, including tracking SDoH and prevention tiers. This effort will also enable the County to better conduct Performance Budgeting and multidepartmental spending analyses. CEO-Budget and Operations Management Branch (CEO-BOMB) is currently engaging in a budget preparation system upgrade that will include the development of priority-based budgeting capabilities.

ARDI and BOMB will incorporate learnings from this report and other ongoing efforts, including:

- Using the budgeting and program planning process to assign and document SDoH and prevention level category data, as well as program service data such as target geographies and demographics. This will strengthen data congruency and support a more comprehensive, accurate, and versatile dataset from which to conduct future landscape and gap analyses.

- Reviewing health outcome indicators from the Healthy People 2030 to adopt as key indicators for County strategy to address social determinants of health and across departments more broadly. Not all indicators will have local data available, but it is worth exploring proxies that otherwise connect programmatic outcome objectives and HP2030 SDoH outcome objectives to the extent possible.

- Within any new budget and program database or analysis, utilizing a framework that explicitly connects SDoH domains, prevention services, and program level indicators to be used across departments, building upon the Board-adopted Countywide Model for Prevention and Promotion, which was created by the County's Prevention Services Task Force.

3. Develop a common framework that departments can use to assess their programs and determine how those programs are closing gaps and addressing needs at the population level.

In addition to a focus on resourcing discrete efforts that align with SDoH priorities, applying a Countywide framework and integrating it into programming and planning can help ensure all residents are healthy, experience justice, and thrive.

Social determinants of health are systemic and impact people and communities in profound ways. Per Healthy People 2030, "SDoH are the conditions in the environments where people are born, live, work, play, worship, and age that affects a wide range of health, functioning, and quality of life outcomes and risks." Additionally, health and quality of life outcomes can manifest in different ways and to different degrees depending on the community disparity. Therefore, any efforts towards equity must consider SDoH; doing so will yield both normative and substantive benefits by holistically reducing disparities and improving health outcomes for the most historically marginalized communities through County legislation, programs, and service delivery.

A shift toward a Countywide framework that acknowledges the root causes of social conditions, systemic barriers, and disproportionalities and disparities is already currently underway, especially with the Board's recent adoption of the Vision, Guiding Principles, and Countywide Model for Prevention and Promotion developed by the Prevention Services Task Force. The adoption of these values was a crucial first step in creating a unifying ethos across all County departments, including enabling staff and community members to understand the role that various County programs and agencies play in ensuring wellbeing for all LA County residents.

Moving forward, systemic changes will likely require the incorporation of SDoH, as well as prevention and promotion language and metrics into Countywide and multi-departmental strategic planning, including efforts such as the LA County Strategic Plan and the Racial Equity Strategic Plan. As the Board signaled in its recent establishment of the Prevention and Promotion Services Governing Committee and its newly created responsibilities and authorities, a unified framework around which program development and analysis is oriented on a Countywide basis will facilitate comprehensive tracking of key indicators.

The inclusion of SDoH indicators into efforts such as Countywide strategic plans and initiatives will help build awareness and comprehension among departments regarding the drivers of disparities, which will result in improved program design and better outcomes tracking. This would be a paradigm shift that would place a greater emphasis on targeting gaps through collaboration, prevention, and promotion efforts.

Within SDoH and prevention integrated into decision making and planning, departments will be encouraged to conduct further analyses to determine whether additional upstream or downstream resources would be beneficial. Departments will thus be better equipped to identify and uplift opportunities to address funding, policy, and regulatory barriers to providing these resources and help inform the County's prevention and promotion policy agenda, which is currently being developed by the Prevention and Promotion Systems Governing Committee.

The efforts described above represent substantial changes not only to program planning and measurements, but also to planning processes and coordination across departments.

4. In alignment with the July 2023 Board motion on "Building LA County's Prevention Infrastructure," enhance the County's capabilities to track and coordinate across funding streams to strengthen programs aligned with the multiple SDoH.

The County needs to build capacity for and better incentivize the coordination of funding sources across departments and ensure the County is maximizing their use. For example, the CEO – Homeless Initiative has worked to develop strategic analytical capabilities to sustain funding and coordinate housing related funds across multiple departments, leading for more effective and expansive use of available resources, including federal, state, and external funding streams.

The effectiveness of the recommendations contained in the Task Force's Funding Streams Analysis can be achieved by incentivizing departments to work collectively through **transparency, collaboration, and accountability**. Key stakeholders will need to agree to share information, reports, and other details to promote the County's overall goal of maximizing the use of existing and potential grant funds. Additionally, as seen in the American Rescue Plan (ARP) Act and Inflation Investment and Jobs Act (IIJA), cohesive and coordinated applications have been increasingly encouraged at the State level for federally allocated funding. As a result, the County may benefit from further coordinated applications across multiple departmental agencies to source additional prevention funding as they become available.

Conducting Programmatic Gap Analyses

There is an opportunity for the County to establish frameworks, systems, and processes to assist departmental staff as they analyze cross-cutting problems and develop strategies to address them. Such efforts should draw on the SDoH and prevention frameworks described above. For instance, the County could establish a tool that would consist of a series of worksheets, questions, and criteria to help staff categorize programs (e.g., by SDoH and prevention level of risk) and develop solutions, by guiding staff through the following process:

1) Define the problem.
2) Identify SDoH outcome indicators.
3) Define target population by levels of risk.
4) Identify existing prevention, promotion, and intervention activities by SDoH domains and levels of risk.
5) Brainstorm new prevention, promotion, and intervention activities by SDoH domains and levels of risk.
6) Brainstorm collaborative partners by SDoH domain and jurisdiction.
7) Rank programmatic options by assessing the above criteria.
8) Develop the program.

IV. Appendix

While reviewing program data and compiling this report, the study team identified certain opportunities and emergent programs which may hold promise as strategies to address programmatic gaps across in the Social Determinants of Health. However, because our efforts were not comprehensive and did not actively involve subject matter experts across the County's various departments, we have included some of these findings here in the Appendix, rather than including them as definitive recommendations.

Additional Opportunities and Emergent Programs

Given the nature of the findings and limitations of the Comparative Budget and Programmatic Analysis, the next steps regarding SDoH involve further inquiry in two areas:

1) What are some specific areas in which the County can invest to close program gaps and advance community, family, and/or individual wellbeing; and
2) How should SDoH and prevention tiers inform the County's broader programmatic and service strategies to reduce racial disproportionality and disparities among County communities?

Building Upon Existing Efforts

There are many opportunities to move forward and address programmatic gaps in SDoH and prevention frameworks. In addition to efforts aligned with existing strategic plans and initiatives, including but not limited to the Center for Health Equity, ARDI, and the County's Racial Equity Strategic Plan, there are several examples where this work is already underway across multiple departments. This includes multiple cross-cutting collaborative initiatives that were designed specifically to address systemic challenges or fill previously "missing" services.

Additionally, many initiatives housed within the Chief Executive Office, such as the Poverty Alleviation Initiative, Homeless Initiative, and ARDI, have been created with this purpose in mind -- to lay the groundwork to address a specifically identified and complex problem until the work is complete or sufficiently established to transition into a standing department or entity. This also describes the crosscutting efforts of the Prevention Services Task Force, a convening of 20 County departments and entities that is currently transitioning its work to support the newly established Prevention and Promotion Systems Governing Committee and Prevention and Promotion Coordination and Implementation Team (PPCIT).

In recent years, the Board has also restructured, reimagined, and reconstructed departments to serve specific County populations and help individuals meet their whole person needs across all SDoH domains on a preventative basis, including the newly formed Justice, Care, and Opportunities Department, Aging and Disabilities Department, and Department of Youth Development, among other entities.

Emergent Programs

While conducting this gap analysis and mapping how programmatic development decisions are made, the team identified emergent programs not included in the data set that are currently under development to address gaps in existing programming. These programs are in large part a response to emergent needs or systemic gaps among multiple County departments and initiatives and could benefit from additional action and focused investment in the areas of economic stability, job opportunity, community safety, and healthcare access.

- Economic Stability: Abundant Birth Guaranteed Income (GI) Project

  Social Determinants of Health, such as Economic Stability (SDoH 1), Healthcare Access (SDoH 3) and Education Access and Quality (SDoH 2), have long impacted pregnancy and birthing outcomes leading to disparities for the most vulnerable and underserved individuals and communities, and fostering injustice in birthing. The LA County GI Abundant Birth Project was developed to address several of these social determinants by providing one year of guaranteed income support to individuals during their pregnancy and birthing journey. The goal of the GI program is to allow those at higher risk for maternal mortality and morbidity to have greater financial access to better housing, healthier food options, childcare for their babies and other children, and pursuit of educational advancement. The funds can also create a more financially stable environment overall for their household.

  Critically, this monthly income can also support post-birth, one of the most critical times for birthing people, especially if they are not working at the time, on maternity leave, in need of longer leave, and/or simply bonding with their child(ren). This monthly income will also address birth equity outcomes by supporting individuals who otherwise could not afford or obtain needed services like doulas, birthing center services, or mental health support. Such services and support are especially important given inequitable and discriminatory experiences, attitudes, and treatment that many individuals unfortunately face when accessing medical care, especially communities of color, as well as immigrant and LGBTQ+ populations.

  Participants will receive referrals to resources in their community that are focused on birthing equity and improvement of maternal/infant health outcomes, some of which will include financial planning and preparedness, educational resources to complete deferred schooling, skills training, and more. Ultimately, this basic guaranteed income helps to mitigate risk factors resulting from intersecting social determinants of health, and allows expectant families to learn, plan, and prepare for their birthing journey, thereby lowering stress, which is an identified contributor to negative birth outcomes. If proven successful, additional resources may be merited to extend and/or sustain the initiative.

- Employment Opportunity and Workforce Development: Community Health Workers

  Community Health Workers (CHWs) have emerged as a best practice in delivering services to historically marginalized communities. Given that many CHWs come from under-resourced communities and often have similar lived experience to the patients and community members the County serves, CHWs are critical to building trust with individuals and helping them access the care and resources they need. In doing so, CHWs play a critical role in closing racial and socio-economic gaps in access to care and health status and is a key equity strategy for the Departments of Health Services (DHS), Mental Health (DMH) and Public Health (DPH).

  These departments have long valued the expertise of CHWs. For several years, DHS, DMH, and DPH have supported the integration of community health workers, *promotores*, and peer specialists in clinics and community settings. Currently, up to 1,200 CHWs play a wide variety of roles across the departments, including but not limited to systems navigation, case management, and community outreach and education. All three departments also contract with community-based organizations (CBOs) that employ additional CHWs who provide services and are key members of the CHW workforce.

  During 2022, the departments conducted a planning process involving 12 listening sessions with 95 staff from 57 CBOs with current or past County contracts to provide CHW services, as well as focus groups with 60 staff from the three health-related departments. This process yielded two primary goals to enhance the CHW service model at the County including:

  1. Boosting recruitment of CHWs to work at the allied health departments by updating the salary structure and removing administrative barriers in the hiring process; and
  2. Strengthening partnerships with contracted CBOs from provide CHW services, including training opportunities and sharing key talking points for outreach and education.

  Beyond these goals, the planning process developed a framework to provide additional enhancements to the CHW workforce, including the following priorities:

  - Create a trauma-informed work environment to Support CHWs with Lived Experience and/or community leadership experience;
  - Expand training and peer learning for CHWs;
  - Strengthen partnerships with contracted CBOs to provide CHW services;
  - Strengthen community engagement practices & internal coordination; and
  - Advocate for stable funding and other policies to boost the CHW workforce.

  This framework outlines a series of recommendations to advance the CHW work for the next year in anticipation of expansion and enhanced integration across DHS, DMH and DPH and may be leveraged and/or expanded to include other CHW programs across the County beyond the health cluster with an infusion of coordinated resources and collaboration.

- Community Safety: Gun Violence Prevention

  The frequency of mass shootings in the United States is staggering. Nearly 500 mass shootings were recorded nationwide as of September 12, 2023. In 2022, there were 466 recorded firearm homicides in Los Angeles County. In response to the unexpectedly high rates of gun violence and following high profile shootings in Buffalo, New York and Uvalde, Texas in 2023, the LA County Office of Violence Prevention, housed in DPH, convened a cross-sector Gun Violence Prevention Task Force to develop a Gun Violence Prevention Platform (GVPP).

  Released in March of 2023, the GVPP uses a public health framework to develop a plan to act on gun violence that focuses on data-driven prevention, intervention, and healing strategies that address the nature, extent, and distribution of gun violence and what affected residents say are the impact of violence on their communities. The platform cites 40 strategies in total and includes a focus on root causes and the upstream conditions that give rise to violence. Strategies range from common sense gun legislation, public awareness campaigns, and training programs for relevant service providers to intervention services, healing spaces and services, and primary and prevention interventions for youth.

  The Gun Violence Prevention Task Force is currently focused on six key strategies that will drive immediate action. These include:

  - Supporting robust common sense gun safety legislation including the reinstatement of the federal ban on assault weapons and large capacity magazines and a federal law mandating universal background checks for all gun sales, including those conducted by private sellers.
  - Increasing access to comprehensive culturally relevant physical and mental health services for all students, K-12 and enhancing school safety.
  - Promoting social connection and healing through access to safe spaces and programs that address harm, trauma, and the impact of violence.
  - Increasing violence prevention, intervention, and healing programs to promote a culture of peace within neighborhoods.
  - Increasing awareness of Gun Violence Restraining Orders (GVROs) through a public awareness campaign that will inform and educate the public on California's landmark GVRO law including what GVROs are, how to apply for one, who can apply for one, the application process, and how to access resources that can provide assistance.
  - Developing a communications plan to elevate the issue of gun violence as a critical public health issue, and that creates clear statements on the root causes of gun violence, GVP activities, and gun violence as predictable and preventable.

  These GVPP strategies elevated by the Task Force are relevant to multiple SDoH domains, including (but not limited to) Health Care Access and Quality (SDoH 3), Neighborhoods and Built Environment (SDoH 4), and Social & Community Context (SDoH 5), and provide a menu of options for immediate and ongoing investment.

- Access to Health Services: Student Well-being Centers

  Adolescent independence is an important developmental process for school-aged youth and barriers to independence can lead to unhealthy behaviors and uninformed decision-making. Barriers to healthcare access impede the ability of school-aged youth to develop personal agency. These barriers are often environmental: with much of their day spent at school as well as logistical and financial barriers, many students, particularly those in lower-income neighborhoods, face difficulty accessing healthcare, leading to reduced access to sexual and reproductive health care, mental health services, and substance use programs.

  Student well-being centers are a network of 40+ school-based centers to provide students with direct access to confidential sexual health, mental health, and substance use counseling and support. Providing on-campus services allows students to access care without having to risk truancy or confide in third parties. Additionally, the program empowers participants' sense of personal agency in health care decision-making and provides the knowledge and skills for student participants to become peer advocates for a positive health climate on campus, at home, and in their own personal lives. The initiative is a collaboration between DPH, the Los Angeles County Office of Education (LACOE), the Los Angeles Unified School District (LAUSD), and Planned Parenthood.

  Student and adolescent healthcare independence is an issue that falls under all five SDoH domains, but particularly Education Access and Quality (SDoH 2) and Healthcare Access and Quality (SDoH 3).