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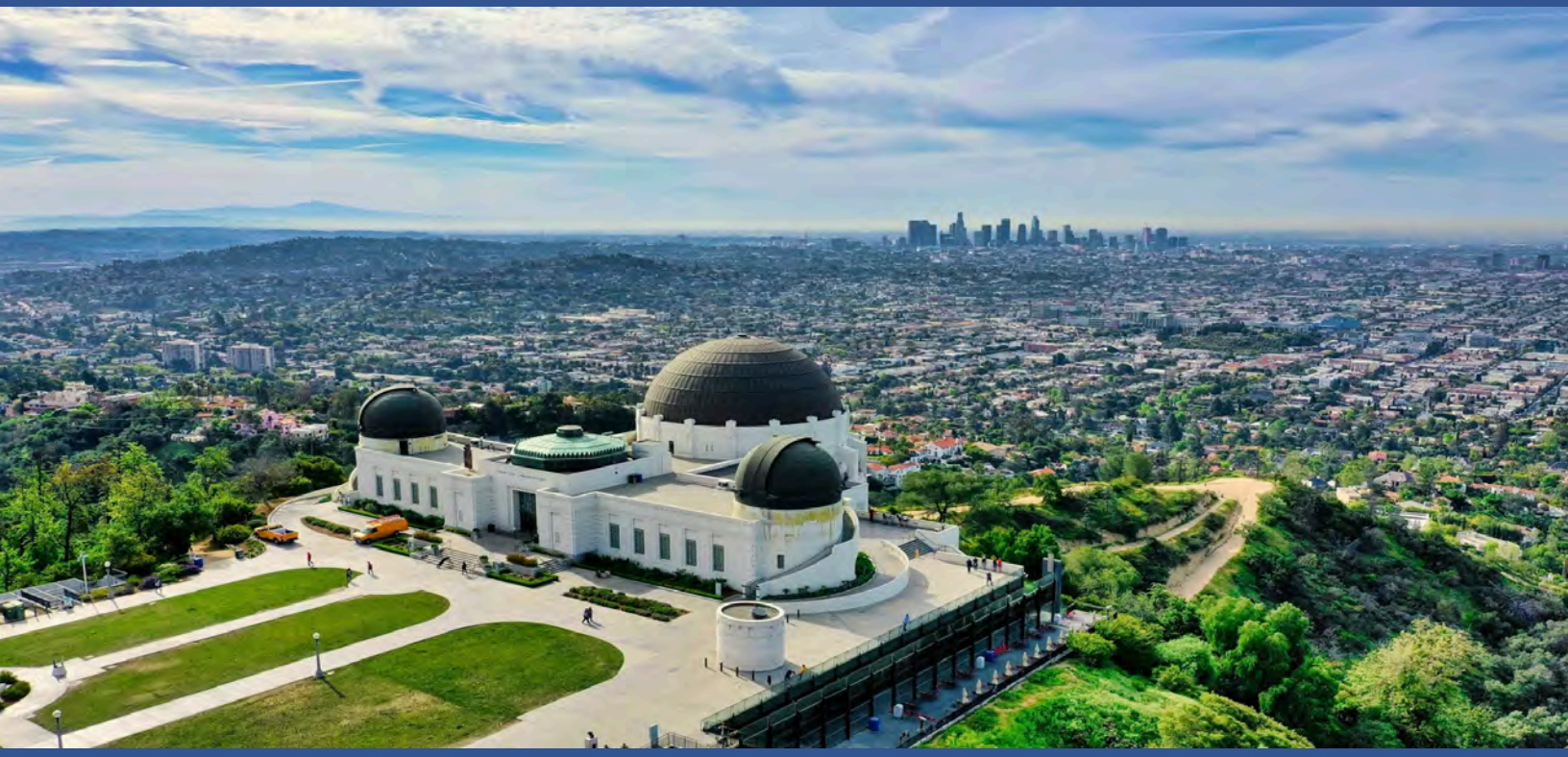

HEALTH COMMISSION

2025

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Gratitude is extended to the AIDS Healthcare Foundation for generously funding the printing of this year's annual report. Their support plays a crucial role in sharing the organization's progress, impact, and vision with the community. This partnership enables broader engagement with stakeholders and furthers efforts to promote health and equity. The contribution is deeply appreciated.

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Introduction to Annual Report 2025

The Los Angeles City Health Commission (Health Commission) is a government body established in 2014 by the Los Angeles City Council (Ordinance No. 183093), with the mission to improve the health and wellness of citizens residing in Los Angeles City. The Health Commission is composed of volunteer commissioners and staff that focuses on understanding the health needs of people in Los Angeles City, conducting public health research, and providing information and recommendations that help Angelenos lead healthy lives.

The Health Commission is requesting funding and resolution authority for three positions consisting of one Executive Director, one Legislative Analyst, and one Commission Executive Assistant to allow the Commission to fulfill its mission. The Executive Director position would require a Master's Degree in Public Health and some management experience. This position will be responsible for oversight of the Commission and serve as the liaison with the Los Angeles County Departments of Public Health, Mental Health, and Health Services, as well as with the various City Departments that provide health and safety services. This role is crucial to developing partnerships and assisting in the coordination of the provision of services to the City of Los Angeles, by identifying areas of need and recommended actions. This necessitates a high level of research, which would be the main role of the Legislative Analyst, a position that would require, at least, a Bachelor's degree in Public Health. This research is the basis for the development of this Annual Report, which articulates the areas of need and provides recommendations to address those needs.

The Office of the City Clerk has provided the needed assistance in the conduct of Health Commission meetings. However, a dedicated Commission Executive Assistant would also provide support to the Executive Director and the Legislative Analyst, as well as to the Commissioners. The Health Commission is also requesting funds to support research programs to benefit the City's communities. We are requesting funding to conduct research studies focusing on the following: 1) Hospital bed shortages and access issues especially for BIPOC communities; 2) Nursing shortages statewide; 3) Shortages of California licensed physicians due to technical maintenance of certifications and other logistical or economic reasons; 4) Pharmaceutical and drug shortages; 5) Expanding access to healthcare for unhoused populations; 6) Increases in infectious diseases, including respiratory illness and COVID-19, in Los Angeles schools; 7) Effectiveness of mobile healthcare units in meeting the needs of the homeless population and community outreach; 8) Public health prevention strategies for the upcoming Los Angeles 2028 Olympics; and 8) Effectiveness of advance practice nurses working with the Los Angeles Police Department and Paramedics to address mental health issues with the homeless population.

The table below provides the requested positions and salary costs, based on the level of knowledge, experience, and expertise needed and consistent with City position classifications, and estimated office expenses and equipment costs.

Salaries	
Executive Director (9225 Equivalent)	$159,815
Management Analyst (9184)	$125,238
Commission Executive Assistant I (9734-1)	$98,845
Total Salaries	$383,898
Expense	
Printing and Binding of Annual Report	$1,000
Office and Administrative	$3,000
IT Services and Support	$65,000
Total Expense	$69,000
Equipment	
Furniture, Office, and Technical Equipment	$60,000
Total Equipment	$60,000
Research	
4 Studies @ $300,000 each	$1,200,000
Total Research	$1,200,000
Total Los Angeles City Health Commission Budget	$1,712,898

Section I: Homelessness

Introduction:

In April 2025, homeless initiatives in Los Angeles County became funded by Measure A, which replaced the previous Measure H, (the quarter-cent sales tax which has funded homeless services since 2017). Measure H was initially set to end in 2027. Measure A imposes a half-cent sales tax to fund county homeless services in addition to the Los Angeles County Affordable Housing Solutions Agency (LACAHSA). This tax officially took effect on April 1, 2025 (Los Angeles County, 2024). Measure A is expected to generate roughly $1.1 billion annually, and this will help support both existing programs and new initiatives which aim to assist the homeless in LA County. Measure A has become the primary funding source for homeless initiatives in Los Angeles County (Los Angeles County, 2024).

Under Measure A, the Los Angeles County Chief Executive Office's Homeless Initiative (CEO-HI) established the following priorities (Los Angeles County, 2024):

1. Increase the number of people moving from encampments into permanent housing to reduce unsheltered homelessness.
2. Reduce the number of people with mental illness and/or substance use disorders who experience homelessness.
3. Increase the number of people permanently leaving homelessness.
4. Prevent people from falling into homelessness.

These goals are important to consider, given the general trend seen in LA County and LA City's unhoused population. According to the 2025 Greater Los Angeles Homeless Count, as of September 2025, Los Angeles County reported an estimated 72,308 individuals experiencing homelessness. For a second consecutive year, homelessness is down across Los Angeles County, falling 4% to 72,308. Within the city of Los Angeles, homelessness has declined 3.4% to 43,699. In terms of the distribution of unhoused individuals who experience sheltered versus unsheltered homelessness, the numbers vary significantly. Unsheltered homelessness in LA County has fallen 9.5% in 2025. In contrast, sheltered homelessness increased 8.5%. Within the City of LA, unsheltered homelessness has declined 7.9% and sheltered homelessness increased 4.7%. Since 2023, unsheltered homelessness has dropped 14% countywide and 17.5% within Los Angeles City (USC Today).

As of 2024, approximately 28,000 people were in permanent housing programs in LA County. This is the greatest number on record, reflecting a 2.5% increase from 2023 (USC Today).

Within LA County, the sheltered population has increased by 8.5%. In LA City, there was a 4.7% increase (USC Today). According to the RAND Corporation, researchers have learned

that “rough sleeping” is the most common form of unsheltered homelessness within Hollywood, Skid Row, and Venice as of 2025. This kind of homelessness means living without any form of shelter, (tent, makeshift shelter, or vehicle). The populations studied by RAND in these neighborhoods represent 40% of the total unsheltered population.

In the baseline year of 2024, unsheltered homelessness remained the most prominent form of homelessness, as nearly 70% of all homeless individuals (n=52,365) experienced unsheltered homelessness on a single night throughout Los Angeles County.

Interim Housing and Transitional Housing

Recommendations:

1) Strengthen real-time data systems and cross-agency coordination for improvements in placement efficiency and lower the duplication of services.
2) Continue to implement and evaluate the interim housing bed rate increases. As bed rate increases are released in phases, the data should be accompanied by clear evaluation metrics to assess the impact on provider sustainability, staffing levels, and service quality. Funding allocations should account for operational costs, such as fair wages, and should be frequently reviewed to ensure that small and large facilities are supported equitably.
3) Expand and institutionalize pathways to permanent housing. Programs such as the Inside Safe and Pathway Home should adopt shared standards for transition planning. This will include embedding housing navigation services early, streamlining subsidy access, and tracking long-term housing stability outcomes ultimately to help prevent the cycle back into homelessness.
4) Launch an inclusive feedback and accountability framework. A robust feedback network should be enforced in order to obtain data from interim housing residents, case managers, and service providers. Regular input on areas of improvement, challenges, and successes will help guarantee that programs are continually aligned with the greater goal of permanent housing placements.

Background:

In 2024, Los Angeles City and County made significant steps towards addressing homelessness through various interim housing initiatives. Ultimately, this development reflected a growing commitment to improving services in permanent housing, as well as helping transitioning individuals into permanent housing. This worked in tandem with Measure A's goal to increase the number of people moving into permanent housing from encampments. Measure A is a half-cent sales tax adopted in LA County which helps resolve homelessness by efforts such as making housing more affordable and accessible with services. Measure A formally replaced the previous Measure H, taking effect in April of 2025.

Among the most significant city-wide initiatives is the *Inside Safe Program*, launched by Mayor Karen Bass in December of 2022. This program helps move individuals from encampments into interim, in addition to permanent housing. The *Inside Safe Program* helps provide temporary housing to individuals in encampments, commonly through their placement in hotels or motels. This process helps rapidly connect these individuals to supportive services and longer-term housing options. According to the Mayer's Office, the city allocated $185 million for the 2024-25 budget for the program. $105.5M of this budget went into the Homelessness Emergency Account, and the remaining balance of $80M was appropriated to the Inside Safe Reserve account. In 2025, the *Inside Safe Program* has made great progress.

As of August 2025, Inside Safe has helped a total of 5,042 Angelenos move indoors, (Inside Safe, 2025). The program has permanently housed 1,198 individuals, and 109 encampments have been addressed by Inside Safe. There have been 15 council districts where Inside Safe operations have taken place (Mayor Karen Bass, City of Los Angeles).

For Los Angeles County, *Pathway Home Expansion* represents the county's commitment to addressing homelessness. The Pathway Home program centers on relocating individuals from encampments into permanent housing. The program provides housing navigation services to help assist individuals through the leasing process. Additionally, it helps provide time-limited subsidies for individuals whose income is inadequate to cover rent. Once participants are housed, they continue to receive supportive services which ensures stability. In 2024, the Pathways Home program accomplished 34 total encampment resolutions, eliminated 677 recreational vehicles, provided 1222 individuals access to interim housing, and permanently housed 233 individuals (Los Angeles County Homeless Initiative, 2025). As of September 2025, the Pathways Home program completed 64 total encampment resolutions, removed 1020 recreational vehicles, provided 1748 individuals access to interim housing, and permanently housed 395 individuals (County of Los Angeles Homeless Initiative).

Also launched in December 2024, the Pathway Home RV Interim Housing Pilot Program is a bold new project to provide safe parking, case management, and supportive services for RV dwellers. Based out of the Crenshaw area, the program's aim is to help individuals transition from RV living to stable housing while simultaneously addressing public space concerns.

Research shows a positive trend in reducing unsheltered homelessness in both the County and the City, alongside an increase in the utilization of shelter resources. According to a report prepared by California Policy Lab, 23,000 service participants who were unsheltered during FY 2023–24 also accessed interim housing during that year (Figure 7). This represents about a third of unsheltered service participants (California Policy Lab, 2025).

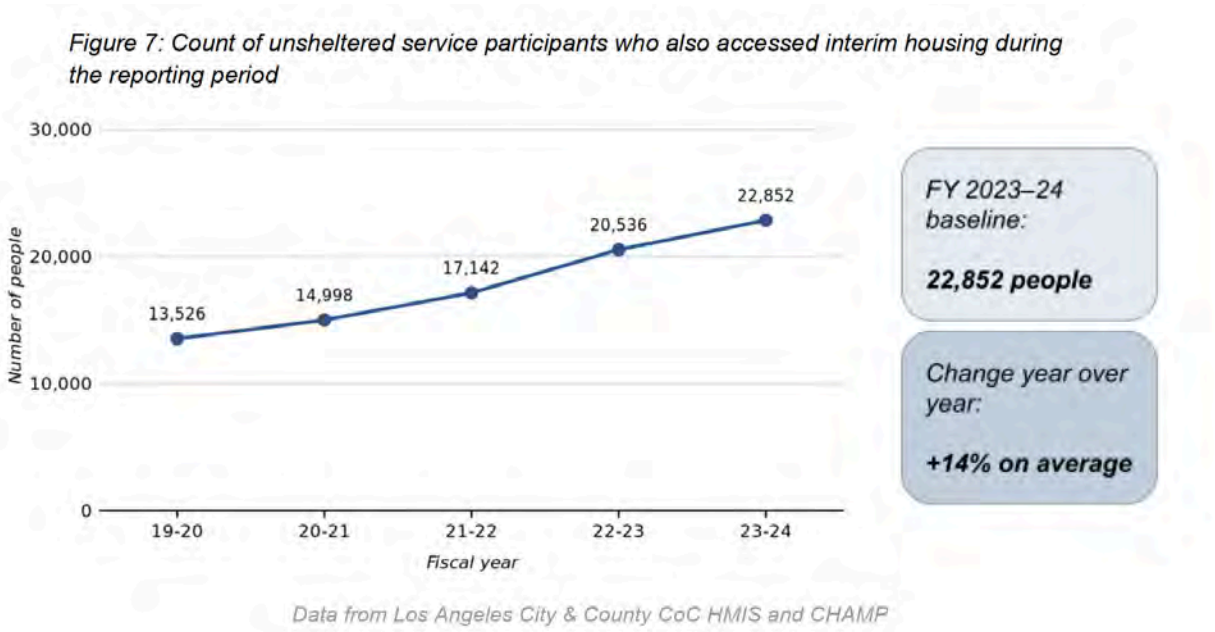

Figure 1. The last five years have seen a positive trend in the number of unsheltered people accessing shelter. The count of unsheltered service participants accessing shelter increased by 14% each year on average, with a total five-year change of 69%. Please note that there is no graph updated as of 2025.

Source: California Policy Lab (2025). *Data Subcommittee Measure A Baselines Report.*

Due to the expansion of interim settings accessible to individuals in LA, coordinated service delivery through numerous stakeholders, the Los Angeles Homeless Services Authority (LAHSA,) LA City, and LA County Department of Health Services, have become more essential to help prevent repetition of services and a redundant use of means. Through this effort, LAHSA has created a real-time bed tracker, an essential tool which helps monitor the availability of interim housing beds across both the city and county. The bed tracker allows LAHSA and its providers to observe occupied, available, and offline beds. Ultimately, this helps enable more rapid placement of individuals into suitable shelter spaces, reducing the time one would wait for a bed generally. This program underscores LAHSA's continued commitment to decision making driven by data, and ongoing improvements in addressing homelessness throughout Los Angeles County.

This system was piloted in January 2024 with positive results, originally launched with the Inside Safe and Pathway Home programs. Full implementation of this program was initiated as of January 2025, which allowed the system to oversee more shelter sites throughout the Continuum of Care (CoC). To ensure the system's success, LAHSA has helped train shelter providers, officially mandating the entry of data into the Homelessness Management Information System (HMIS) and bed inventory database. Continuous routine check-ins are directed in order

to monitor data accuracy and adhere to the platform's protocols. This helps ensure that the system's data is updated and reliable.

Despite the positive early outcomes of the bed tracking system, further research is critical in order to fully assess the system's effects on the greater CoC network. The system plans to initiate an inventory module and new matching process for the Family and Youth Coordinated Entry System (CES) at some point in 2025. Unfortunately, evaluations of adoption rates and the extent to which CoC partners have integrated this new system into their processes is not extensively documented in sources which are publicly accessible. In order to best understand the program's impact, it would be beneficial to collect feedback from different stakeholders. Additionally, research can also help identify any obstacles to system adoption such as resistance from certain provider groups. Research could also focus on identifying any barriers to system adoption, such as technical challenges or resistance from certain provider groups, and addressing these issues to ensure widespread uptake.

Alongside the expanded programming, a combined effort between the County and City, known as the *Interim Housing Bed Rate Adjustments* initiative, took effect in January of 2024. The initiative aims to address the financial sustainability of interim housing solutions. In 2024, the City Council approved an initial bed increase which aimed to help service providers reach operational costs more efficiently. During that time, the City budgeted $140.9 million to support 6,700 interim housing beds, not including the 1,502 rooms from the Inside Safe program, which was not impacted by the increase in bed rates (City of Los Angeles, Office of the Chief Administrative Officer, 2024).

Following the initial growth, a collaborative working group was established to create a more comprehensive interim housing bed rate formula. This group included representatives from the City Administrative Officer (CAO), the Chief Legislative Analyst (CLA), LAHSA, Abt Associates, and more County departments. This group has worked to guarantee transparency in funding allocations, and they considered instructions from the City Council to implement a living wage of $25 per hour for on-site IH workers (City of Los Angeles, Office of the Chief Administrative Officer, 2024). These developments in 2024 have led to the proposal of additional bed rate increases which ended up taking effect in 2025.

Since then, updated rates have taken effect as of July of 2025. The new rates are structured based on the number of beds per site. For family sites with 14 units or fewer, the rate will be set at $169 per unit. Those who have 15 units or more will have a rate of $135 per unit. This adjustment considers that family shelters have higher capacities, typically accommodating a greater number of individuals per room compared to single adult facilities (County of Los Angeles Homelessness Initiative).

An additional report released by the CAO addressed an interim increase for all single adult beds to be effective on January 1, 2025, in an effort to relieve complications shared by service providers with the original rates that were approved on January 1, 2024. As of December

19, 2024, Mayor Bass concurred with the Council's agreement of an $80 bed rate effective January 1, 2025. Per the direction of the City Council, the CAO was advised to report back regarding an interim bed rate increase for the single adult portfolio that went into effect prior to July 1, 2025. This has led to the approval of an $80 bed rate, effective from January 1, 2025, to June 30, 2025, for sites that are receiving lower rates (City Administrative Officer, 2025).

Action Plan:

The Health Commission urges the incorporation of the stated recommendations to improve interim and transitional housing.

Housing First and Permanent Supportive Housing

Recommendations:

1) Prioritize more funding of Permanent Secure Housing (PSH) and embed supportive property management in PSH models in the City of Los Angeles. Supportive property management should be the standard in permanent supportive housing. Property managers must receive training in trauma-informed care, de-escalation techniques, and cultural responsiveness. They should additionally collaborate with case managers to address tenant challenges with support rather than immediate enforcement. This partnership will help reduce evictions, build trust with residents, and contribute to a greater and more stable housing environment.
2) Launch flexible housing navigation teams in interim housing. In order to improve transitions for high-acuity individuals, specialized housing navigation teams must be incorporated into interim housing programs. These teams could begin working with clients 60–90 days before exit, ensuring that permanent housing placements are adaptable to individual needs, such as proximity to medical care services or community connections. Coordination early with landlords and supportive service providers helps to minimize delays as well as placement mismatches.
3) Extend post-housing stabilization support to two years. One year of support is frequently insufficient for individuals with complex needs. A 24-month stabilization period should be the standard for PSH participants. This should include regular check-ins, peer support programs, and access to crisis intervention services. This extensive type of engagement will help address the challenges that can emerge well after initial placement, such as isolation, relapse, or benefit interruptions.
4) Invest in community-building and social infrastructure projects. Housing stability is not just structural, but it holds great social components. PSH sites should be equipped with resources to foster community, reduce isolation, and promote engagement. This includes resident councils, peer-led programming, communal and cultural spaces, and regular activities that allow tenants to connect with each other. A strong social foundation within housing environments will increase residents' sense of belonging within PSH and reduce voluntary exits.
5) Take use of vacant units, adaptive reuse and prefabricated modular housing for utilization in permanent supportive housing, and housing first programs.

Background:

There is a greater trend of individuals exiting to permanent housing over the past few years. For the second consecutive year, homelessness has declined both within LA City and County, falling by 3.4% and 4.0% respectively. In 2024, the amount of permanent housing placements reached an all-time high of roughly 27,994, representing a 2.5% increase from the previous year. This achievement has been made possible primarily because of the 2,950 permanent supportive housing units which were created in 2024, which can be attributed to Prop HHH. Prop HHH was passed in 2016, and it authorized the City of Los Angeles to issue over 1 billion dollars to fund the development of permanent supportive housing and affordable housing for those experiencing homelessness. This result occurred in part due to the 2,960 permanent supportive housing units created in 2024. Ultimately, this has pushed the amount of housing

placements since 2017 to over 125,000. Innovations made by LAHSA such as Master Leasing, active system management, and additional key policy changes have enabled more people to acquire necessary documents to secure housing. These changes contributed to an increase of 23.4% in the number of individuals transitioning from interim to permanent housing, totalling 11,146 people (LAHSA, 2025).

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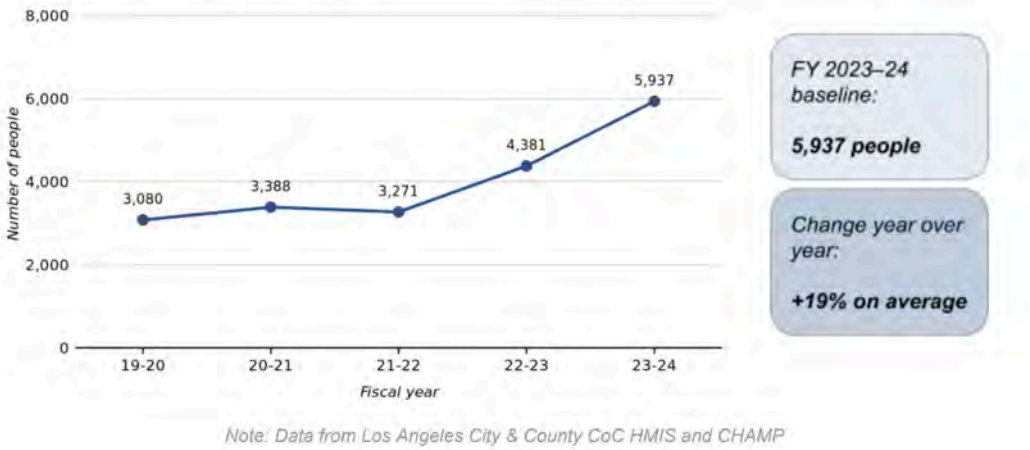
Figure 9: Count of unsheltered service participants who exited to permanent housing during the reporting period



Note: Data from Los Angeles City & County CoC HMIS and CHAMP

About 6,000 service participants who were unsheltered during FY 2023–24 exited to permanent housing during that year (Figure 9).

Although comprehensive data showing the precise percentage of interim housing residents who transitioned to permanent secure housing (PSH) in 2024/2025 is not readily available, a 2024 audit revealed that 73% of LA City's interim housing is occupied (Pathways to Permanent Housing Homeless Audit 2024). Therefore, 27% of the interim housing is not being fully utilized for those who require housing. The same agency also highlighted that LAHSA does not regularly check data to oversee their performance providers, causing delays in data.

Challenges have arisen during the process of transitioning individuals from interim to permanent support housing. A report conducted by the Chief Executive Office of Los Angeles County has helped detail these obstacles. Significant differences were examined when looking at the health status profiles and demographics of people surveyed who go from interim housing to permanent housing, and in exiting to homelessness.

In the data, individuals services were documented in two systems:

1. The Homeless Management Information System (HMIS).
2. The Coordinated Homeless Assistance Management Program (CHAMP).

In both systems, whites were shown to be the least likely demographic group to exit to permanent housing among the racial groups (23%). Females, which consisted of 29% of the HMIS sample and 26% of the CHAMP sample were more likely than males (26% of the HMIS sample and 23% of the CHAMP sample) to exit to permanent housing. From the HMIS sample, veterans were more likely to exit to PH than non-veterans (34% compared to 23%).

Additional subpopulation differences were depicted with those who have substance use problems, mental health problems, and high versus lower Coordinated Entry System (CES) acuity scores were found throughout all three outcomes. People with substance abuse problems flagged in HMIS were less likely to exit interim housing into homelessness compared to those with no substance use problems. For the 2024-2025 numbers, the following table illustrates the same common theme across Los Angeles; that many homeless individuals experience mental health challenges.

Table 1.

Homelessness and Mental Illness in LA (2025):

Statistic	2024–2025 Change / Value
Homeless Population	↓ 4%
Unsheltered Homeless	↓ 9.5%
Chronic Homelessness	↓ 22% (since 2023)
% with Severe Mental Illness	60%+

Sources: LA Homeless Count 2025 nytimes

Over 60% of the homeless population in Los Angeles experiences severe mental illnesses, as shown in the table above, despite the fact that the general rate of homelessness is in decline. Programs such as the Los Angeles County Department of Mental Health (LACDMH) Homeless Outreach and Mobile Engagement (HOME) Program have been established to help those who are homeless and have mental health issues. Launched in 2020, the HOME program provides outreach and engagement, in addition to street treatment to unhoused people ages 18 and older who have some form of a disability, including mental illnesses. The multidisciplinary group consists of local community health workers, registered nurses, psychiatrists, medical case workers, psychiatric technicians, and additional clinical and administrative professionals who do "relentless outreach" to help and engage clients. The people HOME targets are often unable to access food, shelter and/or clothing as a result of their conditions.

According to LACDPH, the HOME team is able to provide:

1. Street psychiatry
2. Connection to primary medical care
3. Immediate assistance for basic needs
4. Access to housing/shelter
5. Psychiatric inpatient and outpatient services
6. Benefits and conservatorship establishment
7. Intensive follow-up care
8. Initiation of court-ordered treatment on an outpatient

The HOME Program takes a more humanistic and compassionate approach compared to other similar programs, helping individuals by forming bonds with them according to Dr. Shayan Rab, a psychiatrist and member of Los Angeles County Department of Mental Health's Homeless Outreach and Mobile Engagement (HOME) program team. In addition to helping diagnose and treat the homeless population across Los Angeles, the team works tirelessly to find both permanent and interim housing for individuals, hoping to break the challenging cycle many experience. Despite the fact that HOME's diverse strategies are successful for many clients, people who are considered "gravely disabled" often refuse their services. To combat this occurrence, HOME staff occasionally pursue a short-term outpatient conservatorship, involving placing the client on short term psychiatric hold so that they can receive critical treatments. Working closely with the Public Guardian office, they help decide whether a more long-term convertership arrangement is necessary.

Social service agencies such as the People Concern have also helped in the effort to transition people into interim and later permanent housing. As of 2024, the agency has helped 1,571 clients into interim housing, a 34% increase from FY 22/23 (The People Concern, 2025). On average, individuals spent 270 days in interim housing before being housed in 2023-2024 (The People Concern, 2025).

It is crucial to evaluate the long-term success of both sheltered and unsheltered individuals who transition to permanent supportive housing. Retention rates at the one and two year marks function as key indicators of long-term housing success. Many individuals struggle to stay housed because of personal and systematic barriers working against their overall well beings. In FY 2023-2024, the Department of Mental Health (DMH) served 2,812 households which included 127 minor children - in MHSA and other dedicated PSH units. The retention rate across DMH PSH was 94% (Department of Mental Health, 2024).

Figure 3, by the California Policy Lab, shows the number of people who exited to permanent housing without returning within the time span of 24 months (bottom line). The number of people exiting without returning in 24 months reduced slightly over the three years between FY 2019–20 and FY 2021–22 (average annual change: –6%). This trend of decrease was slightly greater than the corresponding trend for the same period for those exiting who did

not return within 12 months (average annual change: –4%), in turn slightly greater than the corresponding trend for all exiters (average annual change: –2%). However, there is some evidence arising that shows that this trend may reverse as more data is collected. Both the measure of total exits to permanent housing and the measure of exits without returning in the period of 12 months increased between FY 2021–22 and FY 2022–24.

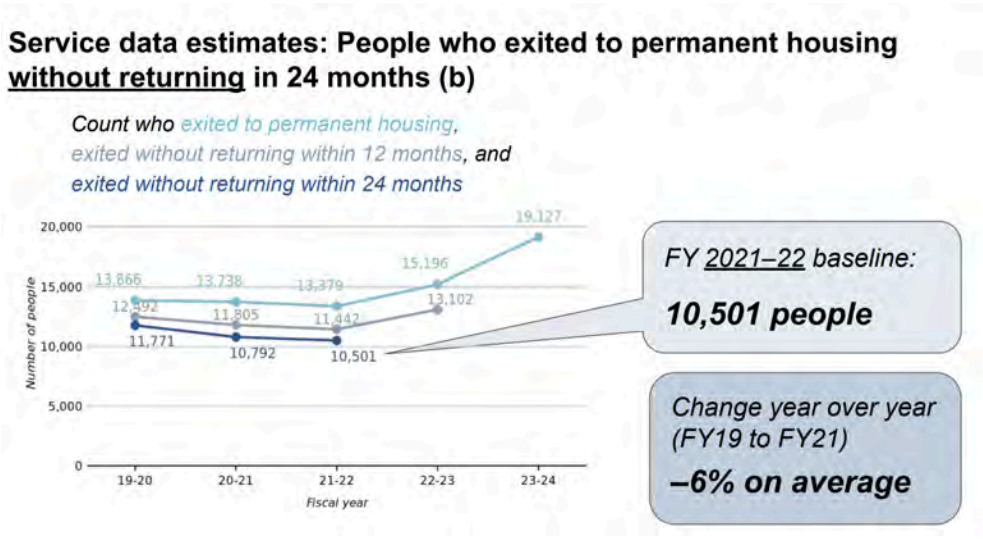


Figure 3. Among those who exited to permanent housing, the number who did not return to homelessness within 24 months declined between FY 2019–20 and FY 2021–22 (–6% average annual change), a steeper drop than the 12-month return metric (–4%) and all exiters (–2%). Recent increases in 12-month and overall exit rates between FY 2021–22 and FY 2023–24 suggest the 24-month trend may also begin to rise (California Policy Lab).

Many people choose to leave PSH because of both personal preferences and safety concerns. Some individuals leave PSH because they prefer living closer to family, or in neighborhoods they believe offer greater opportunities and connections, as well as a sense of cultural familiarity. Additionally, individuals often leave PSH because they feel unsafe in their housing environment, sometimes having conflict with neighbors. Financial instability also remains a significant barrier to continuously securing PSH. Evictions often occur when one cannot pay rent. In order to help those in these types of circumstances, the city must take a wide strategic approach and provide both financial support, case management, and community integration efforts to reach long-term housing retention rates.

To further enhance the effectiveness of long term housing, efforts must be made to reduce the wait-times to receive mental health services and also improve the sharing of data between agencies. LACDMH's data from 2019 showed that many individuals seeking services through Full-Service Partnerships (FSP) experienced delays when accessing support. As result, 20% of the participants were at risk of losing their housing after only the first year. To address this reality, strategies such as hiring more staff, or integrating telehealth services to provide more

immediate care should be considered. This will ensure that individuals are not left waiting for critical care during the time they need it most, which often puts their housing in jeopardy. In addition, effective and communicative data sharing across agencies must be achieved in order to achieve the best response and course of action. Miscommunications of data often result in delays in care and duplicated efforts. According to LACDMH's 2020 Annual Report, the lack of data integration between mental health service agencies and housing providers was a critical challenge which has led to inefficiencies that delay service output and increase the likelihood of one's homeless recurrence. Creating more centralized databases that incorporate CES housing placement data along with mental health service records will ensure that providers can access client information efficiently and therefore clients can be helped in a quicker manner.

By focusing on reducing wait times and improving data integration, LA City could significantly improve both the efficiency and effectiveness of its homelessness response for its most vulnerable clients. This approach would lead to faster interventions, more coordinated care, and ultimately, higher rates of housing retention and mental health stability for those in need.

Action Plan:

The Health Commission urges the adoption of the stated recommendations to improve and support permanent supportive housing.

Substance Abuse and Sobering Centers

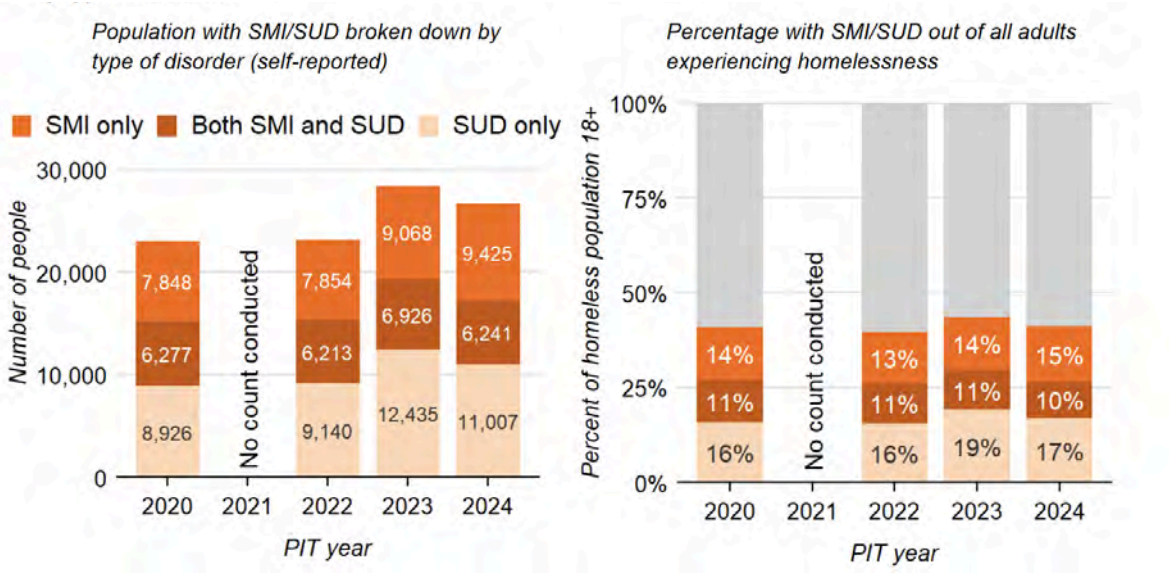
Recommendations:

1) Prioritize mental health and substance use disorder diagnosis in housing placement. Enhance the prioritization system for individuals with co-occurring mental health disorders and substance use disorders (SMI/SUD) in both interim housing and Permanent Supportive Housing (PSH). Through focusing on those with the highest acuity and providing tailored services, LA County and City can ensure that people with the greatest needs are housed more effectively, leading to improved outcomes in housing stability.
2) Expand access to timely and integrated mental health support. Reduce wait times for mental health services by increasing staffing levels, specifically in high-demand areas, and assimilate in telehealth solutions. Mobile mental health teams and inflated crisis stabilization services should be introduced to supply immediate support for individuals with SMI/SUD. These efforts can help stabilize housing placements and prevent individuals from losing housing because of delays in care.
3) Improve data integration across housing and mental health systems. Develop a centralized, shared database that incorporates Coordinated Entry System (CES) housing placement data with mental health service records. This data integration will create improved communication between housing and mental health providers, streamline referrals, reduce duplication, and prevent delays. This effort will lead to more rapid interventions and an increasingly coordinated approach to housing and support services.
4) Support legislative efforts for diverse housing models. Continue to advocate for legislative support. Although Housing First should remain the center approach, integrating diverse models like sober living environments will offer a broader range of housing options that help people during their various stages of recovery. These models can help ensure that individuals are placed in the most suitable environments based on their current needs.
5) Increase investment in Full-Service Partnerships (FSP) and intensive case management. Broaden the reach of Full-Service Partnerships (FSP) and additional intensive case management services for individuals who have SMI/SUD. These services should be scaled to serve a greater number of individuals, ensuring that those in PSH with mental health and substance use issues receive needed support.

Background:

In 2024, an estimated population of approximately 27,000 people self-reported a permanent or long-term severe mental illness, a permanent or long-term substance use disorder, or both (Point-in-Time Homeless Count, 2024).

Figure 4 shows the different types of disorders broken-down in the LA population.



Data from Los Angeles City & County CoC PIT Count. There was no count in 2021 due to COVID-19.

As seen in Figure 4, roughly 35,000 people receiving services in LA County had evidence of a serious mental illness (14,056 with serious mental illness alone and an additional 20,446 with both SMI and SUD), representing about 30% of all service participants experiencing homelessness. Roughly 29,000 were evidenced to have a substance use disorder, representing about 26% of service participants. Almost 50% of the people counted in the SMI/SUD metric had both a mental health disorder and a substance use disorder, representing 18% of the total service participants experiencing homelessness. The number of service participants with either disorder has unfortunately been increasing over the past couple of years.

Given that a key priority of Measure A funding is to reduce homelessness amongst individuals suffering from substance abuse and mental health disorders, Los Angeles City and County have undertaken significant initiatives to address substance abuse among individuals experiencing homelessness, focusing on the development of sobering centers and the implementation of supportive policies.

In 2024, California lawmakers introduced Assembly Bill 2893 (AB 2893), a proposal aimed at amending the state's existing Housing First policy. The Housing First policy mandates that housing programs allow all individuals into their programs regardless of their substance use status or criminal record. It ensures care based on a "hierarchy of need," as people need to receive help before working on personal matters and goals (Digital Democracy Calmatters, 2024).

The new Assembly Bill introduced seeks to allocate up to 10% of the state's program funds for supportive community residences which emphasize abstinence in recovery while simultaneously still permitting Medication-Assisted Therapy (MAT). This bill marks a

significant shift in California's legislative efforts in approach to homelessness, as AB 2893 calls for state-funded sober living environments as an alternative housing model. The proposed bill highlights the following measures for implementation:

1. Funding Allocation: Up to 10% of state funds for homelessness services will be directed toward supportive community residences requiring abstinence-based recovery.
2. Applicant Requirements: Programs which receive these funds must follow strict abstinence-based recovery policies, (an exception being the MAT for opioid treatment).
3. Monitoring and Compliance: The bill will mandate periodic evaluations to ensure that the funded residences observe the program's regulations. A focus will be on long-term housing stability and achieving high housing retention rates as opposed to returns to homelessness.
4. Certification Fees: The Department of Health Care Services (DHCS) will be authorized to charge certification fees, capped at $1,000. This will help cover the administrative costs associated with the residences.

AB 2893 has generated both support and criticism within the housing and recovery communities. Proponents of the bill argue that abstinence-based housing options are essential for individuals actively seeking sobriety, which will provide a structured and positive environment to support recovery long-term. Advocates argue that integrating sober housing into programs funded by the state will diversify housing solutions and better serve those who struggle with substance use disorders. On the flip side, critics claim that the bill has the potential to create housing policies that are exclusionary, having the effect of barring people who are not ready for abstinence who need access to shelter. The opponents of the bill argue that Housing First is the most effective form of approach for reducing homelessness, and shifting it to an abstinence based model will restrict housing access to some of the most susceptible populations. As of November 2025, the bill has yet to be introduced and is still held under submission in committee.

In 2025, Governor Newsom pioneered a State Action for Facilitation on Encampments (SAFE) Task Force, which has since partnered with the city in order to connect individuals with shelter and care. His statewide task force has begun with Los Angeles as the first Southern California operation. Partnering with Mayor Karen Bass through her Inside Safe Program and the County of Los Angeles, the SAFE Task Force has addressed a major encampment in a Los Angeles neighborhood on the side of a freeway. Before clearing the encampment, dozens of people were helped as they received supportive services and housing. This work reflects a larger part of California's strategies, which have led to reductions in unsheltered homelessness throughout the state. The SAFE Task force specifically targets emergency management, social services, health care, substance use support, resource and land management, and public safety as the key priorities for ensuring that the unhoused population receives solid support.

Working in tandem, the close coordination between the Mayor's Inside Safe Program and the Governor's SAFE Task Force helped all the people in the encampment accept shelter and

support. Mitigation measures will also go into place to help prevent repopulation of the area, as it is not safe for human habitation.

As of February 2025, the Housing Element Rezoning Program has taken effect. The program has adopted several implementing ordinances which intend to renew the City's zoning regulations to allow for additional housing units to be built. Important elements of the Housing Element Rezoning Program are described as follows:

The City is currently working to develop the Housing Element Rezoning Program's strategies to create new opportunities for deed restricted affordable housing. The City aims to meet its state housing obligations and provide greater housing access which is necessary for Los Angeles to adhere to its great housing needs. The Housing Element Rezoning Program consists of various implementation programs such as the Citywide Housing Incentive Program, Resident Protections Ordinance, Housing Element Sites Ordinance, Citywide Adaptive Reuse Ordinance, and Community Plan updates. These programs will work together to help create the necessary zoning capacity which is required for the City and its strong housing needs. A strong focus will be placed on incentivizing the development of lower-income housing.

The reason that this program is necessary for Los Angeles to implement is because the 2021-2029 Housing Element's zoning analysis found that the City does not have the zoning capacity necessary to accommodate its RHNA obligations. Therefore under state law, Los Angeles is legally obligated to develop and assume a rezoning program to create at least 255,432 new units of housing capacity by February of 2025 (Los Angeles City Planning, 2025). This effort aims to help mitigate the housing crisis that is currently underway in the City of Los Angeles and will provide more low-income housing to Angelenos.

Action Plan:

The Health Commission urges the adoption of the stated recommendations to improve responses to substance abuse and the long term support of sobering centers.

Early Intervention and Safety Nets

Recommendations:

1) Enhance data integration to improve early intervention. Data integration and predictive analytics have been shown to improve the effectiveness of homelessness prevention programs by identifying at-risk populations more accurately (Greer et al., 2021). Building on the work of the HPU, LA County should continue to enhance data sharing across agencies and integrate predictive models to identify those most at risk of homelessness. This approach allows for more proactive interventions, ensuring that those who are most vulnerable receive timely support before becoming homeless.
2) Provide eviction prevention and legal services. Eviction is one of the most common pathways into homelessness. Studies have shown that providing legal assistance and representation to tenants facing eviction can reduce the likelihood of homelessness (Pierce, 2020). Renters who receive legal aid are more likely to avoid eviction and stay in their homes. Additionally, rental assistance programs that help cover back rent or prevent eviction due to non-payment have proven to be highly effective in preventing homelessness.
3) Strengthen social safety nets. Social safety nets such as unemployment benefits, disability assistance, and public health programs play a crucial role in preventing homelessness. By expanding eligibility and improving access to these programs, individuals at risk of losing their housing due to financial strain can be supported. Research shows that providing a robust safety net reduces the risk of homelessness among vulnerable populations (Kemp, 2021).
4) Strengthen the community-based prevention network community-based programs, like FamilySource Centers and Solid Ground, have shown positive results in preventing homelessness by providing localized support. Strengthening these community hubs and expanding their reach can help identify individuals at risk early on, providing them with immediate, targeted interventions. Research indicates that community-based programs tailored to local needs are more successful in keeping people housed compared to broader, less focused interventions (National Alliance to End Homelessness, 2019).

Background:

Determining the precise number of individuals in Los Angeles County who experienced homelessness for the first time in 2025 is challenging due to the limitations of the annual Point-in-Time (PIT) Count, which have not yet been updated. The PIT Count provides a snapshot of homelessness on one single night; it does not capture comprehensive data on the duration or recurrence of homelessness among individuals.

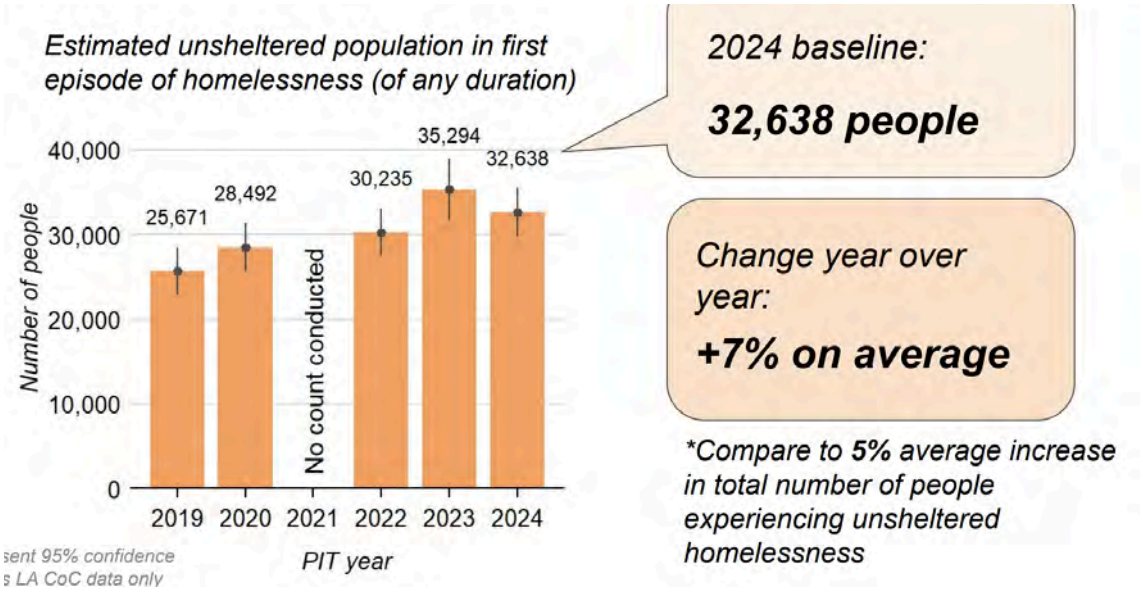
As of 2025, the PIT Count revealed that on a single night in Los Angeles, 43,695 individuals were experiencing homelessness. Out of this number, 16,723 people were experiencing sheltered homelessness and 26,972 individuals were enduring unsheltered homelessness. Additionally, a new precision scale was introduced this year in order to help the public determine the likelihood of the presented statistical estimate reflecting the state of homelessness on the night of the 2025 Homeless count. The scale consists of four levels:

1. Very Precise (VP)
2. Moderately Precise (MP)
3. Moderately Imprecise (MI)
4. Very Imprecise (VI).

LAHSA does not recommend for the public to use estimates labeled as “Very Imprecise," and advises readers to use caution when using “Moderately Impercise” estimates. Both of these categories are less likely to reflect the true state of homelessness for their population during the night of the Homeless Count.

The 2024 PIT data revealed that for 32,638 individuals, this was their first experience of homelessness:

Figure 5.



As shown in Figure 5, although 2024 depicts a decrease in the total number of people experiencing homelessness for the first time compared to 2023, it still shows a drastic increase from earlier years: First-time homelessness increased by nearly 7000 individuals compared to prior baselines. In 2024, over 60,000 people turned to homelessness services for the first time, and the region still faces a deficit of more than 485,000 affordable housing units, according to the Los Angeles Homeless Services Authority (LAHSA).

In 2025, the Los Angeles Homeless Services Authority (LAHSA) released the 2025 Greater Los Angeles Homeless Count results for the Los Angeles Continuum of Care (LA CoC) and the City of Los Angeles. The Sheltered Count in the LA CoC was revised from 23,503 individuals to 23,362 people, (a difference of 141 people). As a result, the exact number of total individuals experiencing homelessness in the LA CoC was also revised down by 141 to 67,777

people. Specifically for the City of Los Angeles, the sheltered count was revised from 16,727 to 16,723, (a difference of four people). The total estimate for the City was also revised downward by four people to 43, 695.

LAHSA operates a comprehensive Homelessness Prevention Program which aims to prevent homelessness for individuals and families at risk. Their program provides financial assistance for rent arrears, future rent payments, and legal services to help avoid evictions. The Homeless Prevention Program also connects clients with case management services to address underlying issues that have the potential to lead to housing instability (County of Los Angeles Homeless Initiative, 2024). LAHSA's program serves a crucial role in keeping individuals and families housed before they become homeless, focusing on people who do not yet meet the threshold for emergency homeless services.

In addition, the Homelessness Prevention Unit (HPU), a collaboration between the Los Angeles County Department of Health Services (Housing for Health, and CalPolicy Lab) employs predictive analytics to identify those at high risk of homelessness. Through analyzing data from different county services, the HPU proactively intervenes using support and resources to prevent individuals from losing their homes.

On a larger and more broadened scale, the Solid Ground Homelessness Prevention Program (HPP), initiated in 2018, targets families in Los Angeles who are at risk of homelessness but still do not qualify for other supportive services. The program provides financial counseling, case management, and additional resources to stabilize housing. Operating through FamilySource Centers, it has expanded over time, as additional programs have been launched throughout the city. In order to receive HPP services, one must:

1. Reside within the City of Los Angeles
2. Be at or below 50% of the Area Median Income (AMI)
3. Be at high risk of homelessness (delinquent on rent) or face the risk of homelessness (Community Investment for Families Department, 2025).

While specific data on the outcomes of both of these programs is still being collected, the initiatives by LAHSA, HPU, and Solid Ground demonstrate the strong and multi-leveled approach to preventing homelessness across Los Angeles.

Action Plan:

The Health Commission urges the adoption of the stated recommendations above to improve early interventions and community-based safety nets in order to prevent individuals from going into homelessness.

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Section II: Healthy Living

Introduction

The Los Angeles City Health Commission is dedicated to understanding, preventing, and addressing the public health challenges affecting all residents of Los Angeles City. Since the adoption of the *Plan for a Healthy Los Angeles* in 2015, the Commission has worked to prioritize addressing the root causes of health disparities and systemic inequities through policy development, cross-sector collaboration, and community-centered initiatives. The launch of the *Health Atlas* in 2013 provided a vital framework for identifying social and health vulnerabilities, insights that proved essential during the COVID-19 pandemic and continue to guide current public health strategies.

This section of the report examines several public health issues that have gained new urgency in recent years, including infectious disease preparedness, equitable access to care, and the evolving landscape of work and education. In 2025, the Commission evaluated long-term lifestyle and policy changes stemming from the pandemic, including the ride of remote and hybrid work, the push for a four-day workweek, and the expanded use of artificial intelligence in medicine. Additionally, the Commission reviewed the emerging efforts to reduce youth gun violence in schools and improve healthcare access for underserved populations.

Through engagement with experts, policymakers, and local organizations, the Commission continues to deliver timely and actionable recommendations that promote equity, overall well-being, and resilience for all communities across Los Angeles.

Plan for a Healthy Los Angeles

Recommendations:

1) Encourage the Los Angeles Mayor's Office to allocate funds to the Department of City Planning for staffing and resources to fully implement the Plan (Khoshniyati, 2022).
2) Encourage consistent collaboration between City Departments and Agencies responsible for the implementation of programs in the Plan and request regular updates (Khoshniyati, 2022).
3) Encourage periodic updates to the City's Health Atlas (Program 59) to track changes in key health and vulnerability metrics (Khoshniyati, 2022).
4) Urge the Los Angeles City Council to create a Healthy Communities Task Force (Program 58) as soon as possible (Khoshniyati, 2022).
5) Evaluate the effectiveness of place-based policing interventions in economically disadvantaged areas post-pandemic.
    a) Monitor crime rates in neighborhoods with high violence and promote community trust between law enforcement and local stakeholders to support public safety in all neighborhoods (Los Angeles City Planning, 2021).
    b) Provide access to educational safety resources, including the 2024 Community Health Improvement Plan (CHIP), to community members in high-crime neighborhoods to encourage violence prevention and improve local infrastructure, firearm safety measures, family support services, and crisis response.

Background:

Originally adopted in 2015, the Plan for a Healthy Los Angeles forms the Health, Wellness, Equity, and Environmental Justice component of the General Plan. In 2021, technical amendments were introduced to the Health Element to emphasize compliance with Senate Bill 1000, which mandates that local jurisdictions integrate Environmental Justice into their general plans. As part of this process, the Health Atlas, an accompanying document that spatially measures various indicators of community vulnerability, was updated to offer the most current data and insights. Under Senate Bill 1000, the Health Element addresses topics such as identifying disadvantaged communities and developing policies and programs related to air and water quality, public facilities, food access, safe and sanitary housing, physical activity, health risks, and civic engagement, with a special focus on prioritizing these vulnerable communities.

The plan continues to center on its original seven goals:

1. Los Angeles, a Leader in Health and Equity
2. A City Built for Health
3. Bountiful Parks and Open Spaces
4. Food that Nourishes the Body, Soul, and Environment

5. An Environment Where Life Thrives
6. Lifelong Opportunities for Learning and Prosperity
7. Safe and Just Neighborhoods

These objectives are built on a vision of a healthy Los Angeles featuring neighborhoods that meet residents' essential needs, provide access to healthy and sustainable environments, and offer opportunities for economic, educational, and social growth.

The first version of the Health Atlas, released in June 2013, delivered a "rigorous analysis of health outcomes and underlying inequities" to enhance public understanding of how disparities affect community health (Khoshniyati, 2022). By detailing geographic variations in socio-economic conditions, demographic characteristics, and health factors, the Atlas enabled a deeper analysis of inequality patterns, helped set priorities, and informed the creation of the Plan for a Healthy Los Angeles. As a result, the Plan outlines a high-level policy vision along with measurable objectives and implementation programs designed to tackle geographic inequities and elevate health and well-being as city priorities.

In July 2023, the Department of City Planning finalized an evaluation of the Health Element's implementation programs. The resulting Health Element Programs Progress Report summarizes the progress of 91 programs since the plan's inception in 2015, with further details available in the Environmental Justice Policy section of the document.

In March 2023, Dr. John MacDonald, a Professor of Criminology and Sociology at the University of Pennsylvania, expanded on the concept of safer neighborhoods during his evaluation of the Safer Cities Initiative. In 2009, his study with Dr. Richard Berk demonstrated the effectiveness of a "place-based policing intervention" implemented over eight years on Los Angeles's Skid Row. This intervention aimed to meaningfully reduce crime and disorder linked to homeless encampments in economically disadvantaged areas—primarily through fines and citations in densely populated zones (Berk & MacDonald, 2010; National Institute of Justice, 2011). Additionally, the Los Angeles Police Department targeted offenses such as drug use, public intoxication, and prostitution. The intervention led to significant reductions in nuisance crimes (nearly 70%), property crimes (65%), and violent crimes (61%), offering promising evidence for similar future strategies (Berk & MacDonald, 2010).

Action Plan:

The Health Commission urges the continued and complete implementation of the goals, objectives, policies, and programs detailed in the Plan for a Healthy Los Angeles to prioritize health and environmental justice for the future of City development and growth.

Policy Landscape and Recommendations for a Healthy LA

Recommendations:

1) Secure Medi-Cal reimbursement parity to ensure funding levels match private insurance.
2) Pass Proposition 35 to provide stable funding for community health centers and increase Medi-Cal provider rates.
3) Expand the Program of All-Inclusive Care for the Elderly (PACE) to serve as the preferred option for home-based senior care.
4) Advocate for continuous Medi-Cal coverage and flexible redetermination policies to prevent gaps in care.
5) Expand the AltaMed Nursing Collaborative to train 250 new LVNs, CNAs, and RNs in three years.
6) Increase funding for primary care residency programs, such as UC PRIME and Song-Brown.
7) Expand the "Doctors & Dentists from Mexico Pilot Program" (AB 1045, AB 2860) to increase Spanish-speaking healthcare providers and advocate for community health centers to serve as training sites for future healthcare professionals.
8) Pass Proposition 1 to invest $6.4 billion in mental health treatment, housing support and pass Measure A's allocation of $1 billion to combat homelessness.
9) Expand Value-Based Care (VBC) models to prioritize patient health outcomes.
10) Advocate for statewide incentives for preventive care services, such as immunizations and screenings.

Background:

Los Angeles faces significant healthcare disparities, particularly among Latinx, low-income, and other historically marginalized communities. AltaMed Health Services, a leader in providing comprehensive healthcare, emerged from the Chicano Civil Rights Movement and has since expanded into one of the largest community health networks in Southern California. Serving over 500,000 patients annually across more than 60 sites, AltaMed offers primary care, dental, behavioral health, pharmacy, and senior care services, emphasizing culturally competent and equitable healthcare (Constant, 2024). Despite these advances, workforce shortages and uneven resource distribution remain major barriers to achieving equitable outcomes.

The COVID-19 pandemic exacerbated long-standing disparities, disproportionately affecting low-income communities of color. Post-pandemic challenges include economic inequality, strained healthcare resources, and a workforce crisis. According to the California Health Care Foundation *California Physicians Almanac 2025* report, although the physician supply in California increased by 33% between 2006 and 2022, many regions still do not meet recommended primary-care physician levels (Coffman 2025). Many frontline healthcare workers have reported burnout, and the shortage of Latino physicians and nurses continues to limit access

for Spanish-speaking and culturally diverse patients. In Los Angeles County, while nearly half of the population is Latino, only 6% of physicians and 12% of registered nurses come from the Latino community (Constant, 2024). Amid these issues, organizations such as AltaMed are expanding bilingual services and multilingual AI documentation tools to mitigate the effects of representation gaps.

Seniors represent another growing vulnerable group. By 2030, Los Angeles County's senior population (60+) is expected to reach 2.5 million, rising to nearly 3 million by 2060 (Constant, 2024). This demographic shift increases the demand for senior healthcare services, housing support, and long-term care options. Programs such as the Program of All-Inclusive Care for the Elderly (PACE) help seniors remain in their homes while receiving necessary healthcare and social services, yet expanding such initiatives remains an ongoing challenge. Furthermore, homelessness among seniors is on the rise, with thousands of unhoused elderly individuals dying in recent years due to inadequate social services (Constant, 2024).

Healthcare access also depends on adequate funding and infrastructure. Proposition 1 aims to address the behavioral health crisis by investing $6.4 billion in mental health and housing support (Constant, 2024). Similarly, Proposition 35 seeks to provide stable funding for Medi-Cal providers, ensuring continued care for underserved populations (Constant, 2024). Additionally, Measure A proposes a $1 billion annual revenue stream to combat homelessness. These initiatives are essential to strengthening the healthcare system and improving access to care for marginalized communities (Constant, 2024). In 2025, AltaMed secured a major $1.8 million grant to expand mobile outreach programs (MOVE) targeting underserved and mobility-challenged seniors, launched the Viva Gold program to coordinate care for chronically ill Medicare patients, and partnered with an AI-platform supporting multilingual clinical documentation in 28 languages, reinforcing its commitment to culturally-responsive and linguistically-accessible care.

AltaMed's shift toward Value-Based Care (VBC) represents a transformative approach to healthcare delivery, emphasizing quality outcomes rather than service volume (Constant, 2024). This model prioritizes preventive care, coordinated treatment, and patient-centered services. However, successful implementation requires significant investment in data-sharing infrastructure, provider training, and policy advocacy to secure sustainable funding models.

Behavioral health and telehealth services have also become critical components of modern healthcare. Many underserved communities lack access to mental health support and struggle with untreated conditions due to stigma, cost barriers, or provider shortages (Constant, 2024). Additionally, telehealth services have expanded access to care, particularly in "language deserts" where non-English-speaking patients face communication barriers. Expanding telehealth infrastructure and ensuring linguistic accessibility are necessary to bridge this gap.

Action Plan:

The Los Angeles City Health Commission encourages the adoption of the stated recommendations to address healthcare disparities while focusing on funding stability, workforce expansion, preventative care, and integrated health services in Los Angeles.

Remote Working

Recommendations:

1) Strongly urge employers to maintain existing wages and benefits when implementing a reduced-hour or four-day workweek (Khoshniyati, 2022).
2) Urge employers to evaluate the individual needs of their workforce, including employees with disabilities, caregiving responsibilities, or lack of reliable internet access, to ensure hybrid and remote models are equitably implemented.
3) Consider exploring policy tools to incentivize companies that offer at least two remote workdays per week, aligning with shifting workforce expectations and environmental goals (Khoshniyati, 2022).
4) Highlight the proven increases in productivity and significant reductions in employee burnout that are consistently associated with the implementation of four-day workweeks.
5) Encourage businesses to adopt boundaries on after-hours communications to protect employees from digital burnout and maintain personal time in accordance with California's 2024 proposed "Right to Disconnect" bill (AB 2751).
6) Encourage employers to begin preparing for the integration of AI tools into remote work environments.

Background:

The COVID-19 pandemic transformed the American workplace, normalizing remote work and setting the stage for long-term changes in how, when, and where people work. What began as a temporary response to a public health crisis has, for many organizations, become a permanent structural shift.

In 2021 and 2022, the Los Angeles City Health Commission began closely tracking these shifts. A key reference point was a presentation by Andrew Barnes, founder of New Zealand's Perpetual Guardian, who pioneered a four-day workweek model even before the pandemic. His model aimed to reverse declining productivity and foster a healthier, more engaged workforce. Barnes reported significant increases in employee satisfaction, efficiency, and overall well-being (Barnes, 2020). These early findings inspired further consideration of flexible work schedules as a viable long-term strategy.

Remote work, broadly defined as completing job duties outside of a central office, typically through digital tools, expanded rapidly during the pandemic. A 2023 report by the International Labour Organization (ILO) highlighted that "innovative working time arrangements," including hybrid schedules and reduced hours, resulted in increased productivity, better work-life balance, and improved employee retention. Employers benefited from decreased turnover and lower operational costs, while workers gained flexibility and autonomy. The ILO

described pandemic-era flexibility as a "win-win for both employers and employees" (International Labour Organization, 2023).

Yet, by late 2023 and into 2025, as pandemic restrictions had lifted and COVID-19 cases had declined, a renewed emphasis on in-person collaboration emerged—particularly in the public sector. In March 2025, California Governor Gavin Newsom issued Executive Order N-22-25, requiring state agencies to implement hybrid work models with at least four in-person days per week beginning July 1, 2025. The mandate underscores a growing debate between the productivity gains of remote work and the social and collaborative benefits of physical office environments (Office of Governor Gavin Newsom, 2025). However, in July 2025, a pushback on Executive Order N-22-25 from a new union agreement issued that 100,000 California state workers would not have to be back in offices until 2026 (Fox-Sowell, 2025). Meanwhile, legislation continues to reflect evolving workforce values. In 2024, California Assembly Bill 2751, known as the "Right to Disconnect" bill, was introduced, proposing that employees should not be required to respond to work-related messages outside of scheduled hours unless in emergencies. This mirrors labor protections in countries like France and Italy and reflects growing concern about the erosion of personal boundaries in a hyper-connected digital world (California Legislative Information, AB-2751, 2024).

The benefits of flexible and reduced-hour work are supported by academic and organizational research. A study by Voglino et al. (2022) demonstrated significant reductions in physical and psychological symptoms among employees working fewer hours. Other research (Akerstedt et al., 2001; 2002) found that shorter workweeks were associated with improved sleep quality and reduced mental fatigue, highlighting the physiological toll of extended work hours. Remote work also expands employment access for individuals who previously faced barriers to traditional employment, such as parents of children with disabilities, people living in remote areas, and individuals with chronic health conditions (Wontorczyk and Rożnowski, 2022). Additionally, telework reduces commute times and lowers greenhouse gas emissions, offering environmental benefits relevant to LA's broader climate goals (Liu et al., 2019).

However, remote work is not without drawbacks. Studies have documented psychosocial risks such as isolation, difficulty disconnecting, blurred boundaries between work and personal life, and unequal access to home-based work environments (Chawla et al., 2020). These risks are compounded when organizations fail to provide adequate structure or resources for remote employees. Further complicating the picture is the rapid rise of artificial intelligence in professional settings, including medicine, marketing, law, and administration. AI tools can enhance productivity and automate routine tasks in remote environments, but they also introduce ethical questions around surveillance, privacy, job security, and bias. As these technologies become more embedded in remote workflows, thoughtful oversight and regulation will be essential. Remote and hybrid work have become mainstream expectations that demand public and private institutions respond accordingly. For Los Angeles, the challenge and opportunity lie in designing future-facing policies that balance innovation, equity, health, and productivity.

Action Plan:

The Los Angeles City Health Commission strongly encourages the implementation of these recommendations to enhance employee health, boost workplace productivity, and foster greater engagement across all levels of the workforce.

Artificial Intelligence in the Workplace

Recommendations:

1) Assess the benefits and potential drawbacks of regular AI use as an aid for physicians in Los Angeles County, ensuring that such technologies enhance patient care without compromising clinical judgment.
2) Implement stringent data protection measures to safeguard patient information when using AI for recording medical histories, in compliance with California's AB 3030, which mandates disclosure of AI-generated communications in healthcare settings.
3) Explore and develop AI applications aimed at identifying and addressing recurring health disparities within vulnerable communities, utilizing tools like Cedars-Sinai's Division of Artificial Intelligence in Medicine (AIM) to target conditions disproportionately affecting underserved populations.

Background:

Artificial intelligence (AI) refers to the capability of a digital computer or computer-controlled system to perform tasks commonly associated with human intelligence, such as learning, reasoning, problem-solving, and decision-making (Encyclopedia Britannica). In recent years, especially since the COVID-19 pandemic, AI's presence in the healthcare workplace has expanded dramatically, driven by advancements in data processing, computing power, and machine learning algorithms.

In June 2023, the Los Angeles City Health Commission was briefed by KFF Health News correspondent Darius Tahir, who outlined AI's growing role in medicine. Tahir referenced a U.S. Food and Drug Administration (FDA) study, which found that the majority of AI-enabled medical devices approved since 1997 were concentrated in radiology, followed by cardiovascular, hematology, neurology, and ophthalmic specialties (Tahir, "FDA's List"). For example, AI has helped improve the precision and affordability of prostate cancer screenings through enhanced MRI interpretation, illustrating how AI can aid both clinical accuracy and cost reduction (U.S. FDA). However, Tahir also raised caution about the introduction of generative AI tools into patient care settings. In a 2023 article, he described how companies like Nabla and Microsoft have begun piloting AI "copilots" that attend virtual patient visits, transcribe conversations, and summarize encounters into standardized notes (Tahir, "AI Medical Notes"). These tools could reduce administrative burden for physicians but also raise serious concerns about patient confidentiality, data security, and the potential for AI-generated "hallucinations," where the system provides inaccurate or misleading information.

To address these issues, the FDA and industry researchers have emphasized the need for higher-quality training data, human oversight, and transparent regulatory standards to ensure AI tools are safe and effective in clinical care (Wu et al., 2021). In support of transparency and

patient trust, California passed Assembly Bill 3030 (AB 3030) in 2024. The law requires healthcare providers to notify patients when AI is involved in documentation or communication, making California the first U.S. state to mandate AI disclosure in healthcare interactions (California Legislative Information). In 2025, the FDA published a major final rule requiring manufacturers of AI-enabled medical devices to disclose AI use, document model updates, and ensure transparency, marking the first federal regulation explicitly addressing adaptive AI in clinical tools (U.S. FDA, 2025). The California Privacy Protection Agency (CPPA) also expanded its AI protections in 2025, proposing new regulations requiring biometric consent, disclosure of training datasets, and independent audits for high-risk medical AI programs (CPPA, 2025).

Cedars-Sinai Medical Center has been a leader in AI innovation. Its Division of Artificial Intelligence in Medicine (AIM), directed by Dr. Sumeet Chugh, applies AI to urgent public health challenges, including sudden cardiac arrest, cardiac imaging, and genetic conditions. Dr. Chugh has emphasized that AI can improve healthcare equity by identifying risk in populations often underrepresented in traditional medical models—such as older Black men or cancer survivors (Cedars-Sinai, "Artificial Intelligence in Medicine"). AIM also supports broader public health efforts by applying AI in clinical genetics, COVID-19 modeling, and surgical decision-making. In 2024–2025, Cedars-Sinai and UCLA Health collaborated on new AI pilot programs aimed at improving triage in virtual urgent care. Preliminary results showed faster diagnostic turnaround and improved clinical accuracy in low-acuity cases, suggesting AI may play a key role in reducing patient wait times in underserved areas of Los Angeles County (Cedars-Sinai, "AI in Urgent Care").

At the national level, the FDA has streamlined its regulatory approval for AI-enabled devices, approving more than 950 AI/ML-based medical tools by late 2024, a major increase from fewer than 100 a decade ago (U.S. FDA, "AI/ML Database"). However, this rapid growth has raised concerns about transparency. Many AI systems function as "black boxes," providing little explanation for their decisions, which can erode trust and increase the risk of bias—especially when applied to historically underserved populations (Wu et al., 2021). Leading medical organizations like the American Medical Association and the National Academy of Medicine have called for "explainable AI," standardized auditing, and updated medical ethics frameworks to ensure AI tools advance health equity rather than perpetuate existing disparities (Wu et al., 2021).

In Los Angeles, where public and private health systems serve one of the nation's most diverse populations, these developments are shaping how clinics and hospitals adopt AI tools. The challenge remains to balance innovation with accountability, and to ensure that AI is used to advance, rather than undermine, equitable healthcare access.

Action Plan:

The Health Commission advocates for increased investment in research exploring the use of artificial intelligence in medicine to reduce barriers to quality healthcare access throughout Los Angeles County.

COVID-19 Updates

Recommendations:

1) Ensure COVID-19 data is inclusive and accessible for all racial and ethnic groups to address health disparities (LACHC, 2022).
2) Adhere to current prevention guidance for COVID-19 prevention and increase awareness of potential exposures amidst fluctuating case numbers.
3) Keep at-home COVID-19 tests readily available to facilitate prompt testing when symptoms arise.
4) Encourage leaders at national and local levels to take practical actions to maintain access to safe, high-quality, essential health services (LACHC, 2022).
5) If infected or exposed to COVID-19, self-isolate and consult healthcare providers about antiviral treatments like Paxlovid, if eligible, to reduce symptoms and transmissibility.

Background:

Beginning in late 2023, Los Angeles County experienced a gradual and steady rise in COVID-19 transmission, driven by increased travel, school reopenings, colder temperatures, and public fatigue towards preventive measures. Despite these increases, hospitalization rates remained near historic lows, and mortality reached its lowest point since the start of the pandemic. In a presentation to the Los Angeles City Health Commission, Dr. Paula Cannon of the Keck School of Medicine of USC emphasized that although seasonal fluctuations are expected, waning immunity (typically more than six months after vaccination or infection) continues to leave populations vulnerable to periodic waves (Cannon 2023).

A central concern highlighted in the 2022 LACHC report remains the emergence of new, more transmissible variants capable of bypassing existing immunity. To support early detection and targeted interventions, Los Angeles County continues to use a tiered variant classification system that distinguishes between variants under monitoring, variants of interest, and variants of concern. Dr. Cannon further explained that although SARS-CoV-2 is not especially mutagenic, the enormous number of global infections has enabled the virus to “optimize its design” through increased transmissibility and antibody evasion. Prolonged infections in immunocompromised individuals have occasionally produced recombinant forms, reinforcing the importance of robust surveillance. Wastewater monitoring, which is less biased than clinical testing, remains a leading indicator of regional transmission. Researchers such as Karthikeyan have shown that wastewater trends reliably predict future surges, including detection of the Pirola variant in mid-2023 (Karthikeyan 2022).

By mid-2024 and into 2025, newer subvariants such as NB.1.8.1, JN.1, JN.1.18, and later KP.2, KP.3, and LB.1 (part of the “FLiRT” mutation family) circulated widely in Los Angeles County. Although these subvariants demonstrated higher transmissibility, evidence showed no

increase in disease severity (Los Angeles Times 2025; California Department of Public Health 2025). Wastewater concentrations across California reached some of their highest levels in early 2025, with Los Angeles County among the regions showing the greatest viral activity, even while hospitalizations remained comparatively low (California Department of Public Health 2025).

In response to the evolving viral landscape, both the CDC and the California Department of Public Health updated their guidance. For 2025–2026, the CDC recommended that everyone aged six months and older receive the updated COVID-19 vaccine formulated for JN.1-lineage variants. Adults aged 65 and older, along with those who are moderately or severely immunocompromised, were advised to receive two doses, spaced six months apart (CDC 2025). Los Angeles County expanded mobile vaccination efforts and strengthened partnerships with public libraries and community organizations to provide free COVID-19 and influenza vaccinations regardless of insurance or immigration status (LA County Library 2025). This became especially important after federal COVID-19 funding cuts exceeded $11 billion, resulting in over $60 million in lost support for Los Angeles County, affecting essential services such as lab testing, contact tracing, and outbreak investigation (Melley, AP News 2025).

The Los Angeles Unified School District (LAUSD) also updated its protocols for the 2024–2025 and 2025–2026 school years. While routine large-scale testing programs have ended, LAUSD continues to implement “response testing” for symptomatic students or known exposures, consistent with state and federal recommendations. Ventilation improvements, including the replacement of HEPA filters funded through state grants, remain a priority (LAUSD 2025).

Vaccine technology has also continued to evolve. The FDA approved updated mRNA boosters effective against JN.1-related variants, while non-mRNA options such as Novavax provide alternatives for those unable or unwilling to receive mRNA vaccines (FDA 2023). In 2025, Pfizer and Moderna launched Phase 3 clinical trials for a combined influenza–COVID vaccine, with enrollment sites in California, including Los Angeles (U.S. FDA 2025).

In March 2025, Los Angeles County officially rescinded its final remaining local COVID-19 health officer order, signaling a transition from emergency response to long-term management (LACDPH 2025). The county continues to prioritize wastewater surveillance, equitable vaccine access, high-risk population protections, and public communication to prevent disproportionate impacts in its most vulnerable communities. Collectively, these developments reflect a shift toward sustained, adaptable disease management as SARS-CoV-2 continues to evolve.

Action Plan:

The Health Commission urges continued investment in vaccination outreach, variant surveillance, and equitable access to testing and treatment to ensure Los Angeles County remains prepared for future COVID-19 surges while protecting public health across all populations.

Gun Violence and Preventative Measures in Los Angeles Schools

Recommendations:

1) School safety policies should take a comprehensive approach, addressing all weapon types and related behaviors, including possession, threats, and bystander exposure.
2) These policies must apply to the entire school community, not just students, recognizing that violence impacts and involves individuals beyond traditional roles of victim and perpetrator.
3) A public health prevention model should be adopted, including annual statewide data collection on youth firearm possession and use, supported by infrastructure for policy development and outcome monitoring.
4) Policies should foster supportive, inclusive educational environments rather than punitive or exclusionary ones, ensuring consistent and fair responses to weapon-related incidents.
5) Student perspectives should be actively included in the policy-making process, incorporating their lived experiences, needs, and feedback to shape effective and relevant strategies.
6) Disciplinary responses should be paired with local oversight that accounts for students' backgrounds, such as poverty, disability, or racial identity, and the context of each incident, ensuring equity, social justice, and proportionality in enforcement.

Background:

Guns remain the leading cause of death for American children, with 2,281 deaths among individuals aged 0–17 recorded in 2020, the highest since 1997 (Urban Peace Institute 2023). Updated CDC data released in 2025 confirm that firearms remain the number one cause of death for children and adolescents for the third consecutive year, with more than 2,500 pediatric firearm deaths reported for 2023 (Centers for Disease Control and Prevention 2025). In Los Angeles, rising violent crime and ongoing community trauma continue to affect students' daily lives. An LAUSD survey found that nearly 90% of students in high-crime neighborhoods reported exposure to violence as either victims or witnesses. Among those exposed, 27% exhibited symptoms of PTSD and 16% screened as clinically depressed (Stein et al. 2003).

The urgency of school-based safety efforts escalated in Fall 2024, when four firearms were discovered on LAUSD campuses during the first month of the school year, including two in a single week (Los Angeles Times 2024). These incidents reignited debates over the removal of school police from campuses after 2020 protests and intensified calls for broader, preventative approaches to school safety. By early 2025, LAUSD reported a record number of weapons confiscated during the 2024–2025 school year, over 1,200 weapons total, including more than 20 firearms, with the majority being knives or improvised weapons often linked to social media–related conflicts (Los Angeles Unified School District 2025; Los Angeles Times 2025).

In response, LAUSD expanded its Every School Safe training modules for the 2024–2025 academic year. Mandatory for staff and strongly encouraged for parents and students, these modules now include trauma-informed de-escalation, fentanyl awareness, online grooming prevention, suicide prevention, and restorative practices, reflecting a shift toward a holistic school safety model (AALA 2024). California also advanced statewide reforms: the proposed 2024 bill to regulate active shooter drills was signed into law in 2025, banning hyper-realistic simulations such as simulated gunfire, requiring parental notification, and mandating trauma-informed procedures to mitigate unnecessary fear and psychological harm (California Legislative Information 2025).

Additional policy changes intersect with mental health and violence prevention. In June 2024, LAUSD adopted its Phone-Free School Day policy, with districtwide implementation beginning January 2025. As part of this rollout, the district hired more than 150 additional psychiatric social workers, expanded school-based mental health clinics, and established trauma-response teams for secondary schools (Los Angeles Unified School District 2025). These efforts follow a 2025 advisory from the U.S. Surgeon General, which found that conflicts originating on social media increasingly spill into offline violence, underscoring the need for phone-free environments and digital conflict de-escalation strategies (Office of the Surgeon General 2025).

Community-based violence prevention programs also continue to play a critical role. The Urban Peace Institute reported that its LA Peace Plan contributed to nearly a 41% reduction in retaliatory violence and helped achieve the lowest homicide rates since the 1960s (Urban Peace Institute 2022). Programs like REACH, founded by attorney Lara Drino, provide trauma-informed counseling and social support for children affected by violence, offering up to six free therapy sessions and additional case management for families needing long-term assistance (Drino 2023; Moe 2018).

Research consistently shows that early exposure to violence disrupts emotional regulation, cognitive development, and long-term well-being. Mueller and Tronick's (2019) work demonstrates that unaddressed trauma increases the risk of behavioral challenges, academic disengagement, and later involvement in the justice system. Yet as Dr. Ron Avi Astor argues, school policy often centers disproportionately on firearm-related mass shootings. His findings show that threats in many California high schools stem from everyday weapons—knives, clubs, and improvised objects. In nearly 90% of surveyed schools, over 15% of students had seen a weapon on campus, and in 40% of schools, 8–15% of students reported carrying one themselves (Astor and Benbenishty 2019). This highlights the need for policies addressing the full spectrum of weapons and safety risks, not solely guns.

Under updated California Education Code sections 32280–32289.5, all public schools, including LAUSD, must maintain annually updated Comprehensive School Safety Plans (CSSPs) that integrate physical safety, emotional wellness, student voice, behavioral intervention

supports, and evidence-based violence prevention strategies (California Department of Education 2025). In 2025, California further strengthened its commitment by launching the Violence Prevention and Recovery Grants Program, which provides $50 million annually to expand trauma-informed school practices, restorative justice efforts, and community violence intervention partnerships statewide (California Department of Education 2025). Together, these initiatives reflect a broader shift toward proactive, trauma-informed, and community-centered approaches to school safety.

Action Plan:

The Health Commission supports a comprehensive, trauma-informed approach to school safety that prioritizes mental health services, inclusive policies, and preventative strategies to reduce youth violence and promote equitable learning environments across Los Angeles County.

Racism and Health Equity

Recommendations

1) Implement and enforce anti-discrimination policies across healthcare, housing, and employment sectors.
2) Establish ongoing community forums and advisory committees to ensure that marginalized communities have their voices heard.
3) Enhance partnerships with community-based organizations to allow for more access to health information.
4) Use culturally tailored communication strategies to reach diverse populations effectively.
5) Expand and invest in research to:
    a) Track long-term health outcomes of individuals experiencing racial discrimination.
    b) Further understand the neurobiological and inflammatory mechanisms linking racism to chronic disease.
    c) Leverage advanced technologies (e.g., fMRI and microbiome analysis) to further understand the pathways by which racism impacts health.
6) Increase access to mental health services, particularly for communities experiencing high levels of discrimination.
7) Integrate trauma-informed care practices in healthcare settings to better address the psychological effects of racism.

Background:

In Los Angeles, the persistent impact of racism on health equity is increasingly coming into focus. Research presented by experts such as Professor Gilbert C. Gee of UCLA underscores that racism operates at multiple levels, from interpersonal discrimination to structural forces that shape health across the entire life course (Gee 2024). From prenatal development to adulthood, exposure to racial discrimination contributes to chronic stress that elevates the risk of chronic disease, mental health disorders, and ultimately reduces life expectancy. This life course perspective makes clear that the health effects of racism are not isolated events, but cumulative challenges that intensify over time.

Recent Los Angeles–based studies have combined neuroimaging, biological assays, and population surveys to examine these mechanisms in greater depth. Findings indicate that individuals who report higher levels of discrimination show altered activity in key brain networks involved in emotional regulation and stress response, such as the Default Mode Network and Central Executive Network (Gee 2024). Additional research emerging from the Keck School of Medicine in 2025 reveals that chronic racial stress is associated with reduced gut microbiome diversity and elevated inflammatory markers, including IL-6 and C-reactive protein, biological pathways linked to cardiovascular and metabolic disease (USC Keck School of Medicine 2025). A 2025 UCLA–LA County collaborative study further found that ongoing

exposure to discrimination is associated with shorter telomere length and accelerated biological aging among Black and Latino residents, highlighting the profound physiological toll of racism (UCLA Health 2025).

Survey data across Los Angeles show that the burdens of discrimination are not uniformly distributed. African American residents consistently report higher levels of discrimination related to race and skin color, with corresponding increases in anxiety, depression, and trauma (Gee 2024). These disparities emphasize the need for policies that both address immediate health consequences and dismantle structural conditions that produce unequal exposures to discrimination. Recognizing the scope of the challenge, the Centers for Disease Control and Prevention established the Center for Health Equity Innovation in 2025 to standardize measures of structural racism and strengthen surveillance of discrimination-related health outcomes (Centers for Disease Control and Prevention 2025).

In response to mounting evidence, California and Los Angeles County have advanced new policy frameworks to address racism as a public health crisis. In January 2025, the California Office of Racial Equity released the state's first Racial Equity Action Plan, formally designating racism as a public health crisis and requiring racial-equity impact assessments across state health agencies (California Office of Racial Equity 2025). That same year, the Los Angeles County Department of Public Health launched *Heal LA: The Anti-Racism and Health Equity Strategic Framework*, which expands anti-racism training for healthcare providers, invests in community-led resilience initiatives, and enhances countywide data infrastructure to track inequities (Los Angeles County Department of Public Health 2025).

Community-based responses have also strengthened. In 2025, Los Angeles County expanded its network of Community Healing Hubs in South Los Angeles, East Los Angeles, and the Antelope Valley. These hubs provide trauma-informed counseling, culturally grounded healing circles, legal advocacy support, and stress-reduction services for residents disproportionately affected by discrimination (Los Angeles County Department of Public Health 2025). Together with local academic partnerships, these programs aim to empower communities through culturally responsive care, resource navigation, and social support networks.

Collectively, the growing body of scientific research and the emergence of strong policy responses affirm that racism is not only a social or moral issue, but it is also a measurable public health threat. The evidence from Los Angeles demonstrates that dismantling the health impacts of racism will require coordinated strategies spanning policy reform, community engagement, clinical practice, and sustained investment in equity-driven research.

Action Plan:

The Health Commission supports adopting the recommendations outlined above to ensure that Los Angeles can take critical steps toward a more equitable and healthier future for all its residents while promoting further research to best understand the impact of racism and discrimination on the communities most impacted.

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Section III: Medical Services

Introduction

The Los Angeles City Health Commission monitors the delivery and outcomes of health services to residents of Los Angeles. The Commission meets with experts to identify and address emerging health issues in the City of Los Angeles, ensuring a proactive response to both ongoing and new challenges, such as disease outbreaks and public health emergencies. By collaborating with these experts, the Commission aims to improve its understanding of the health landscape and provide effective recommendations that benefit the community.

In 2016, the Los Angeles Fire Department (LAFD) established the Emergency Medical Services (EMS) Bureau as a response to the overwhelming number of medical emergencies. EMS makes up more than 85% of the LAFD's emergency calls (LAFD). Because the LAFD responds to over 1,500 medical calls and transports over 600 patients daily, former Medical Director, Dr. Stephen Sanko M.D., recognizes the LAFD as a medical organization (Sanko, 2022). As a result, the Los Angeles City Health Commission deems it necessary to provide adequate attention, funding, and support to the LAFD and EMS Bureau in order to deliver quality health services and improve health outcomes for Angelenos.

The Los Angeles County Emergency Medical Services Agency oversees the EMS system. The EMS Agency is responsible for the management of EMS data, EMS personnel training programs, designating hospitals and care centers. Its responsibilities also include overseeing finances, developing policies and procedures, and approving training programs. This section will explore the services provided by EMS and the challenges its providers face.

In order to address the growing healthcare demands of Angelenos, the expansion of hospital capacity and the continued implementation of the Affordable Care Act (ACA) are vital. Increasing the number of hospital beds will improve access to care, especially for underserved communities. The ACA has expanded health care coverage to many individuals, however outreach and education are needed to inform the public about their eligibility and assist the public in navigating both enrollment and services. The Los Angeles City Health Commission recognizes the importance of expanding hospital infrastructure and educating the public to ensure all Angelenos have access to necessary healthcare services.

This section will also discuss new developments regarding major communication diseases such as Typhus, Hepatitis, and sexually transmitted infections/diseases (STI/Ds). Current information can be accessed by the LA County Department of Public Health, however there is a need for city-specific data to understand and mitigate the spread of disease. The Los Angeles

City Health Commission calls on the LA County Department of Public Health for an established partnership and frequent exchange of data to evaluate and address health risks.

Emergency Medical Services (EMS) Calls

Recommendations:

1) Hire social workers to help navigate frequent EMS users through their local healthcare system.
2) Expand the number of field resources that can safely evaluate low acuity patients to avoid unnecessary ambulance transports to local emergency departments.
3) Expand the number of field resources that can safely clear patients with mental health emergencies and transport them to mental health urgent care centers.
4) Increase the number of Advanced Provider Response Units (APRU), Sobriety Emergency Response Units (SOBER), and Alternative Destination Response Units (ADRU).
5) Continue the LA City's Innovation Fund to financially support LAFD projects that can improve the efficiency and effectiveness of their services.
6) Increase compensation for clinicians working at the LAFD to increase retention.
7) Establish and invest in community-based mental health urgent care facilities, sobering centers, and Federally Qualified Health Centers (FQHCs) in communities that lack such resources.
8) Re-design behavioral health educational curricula for EMS providers.
9) Develop an opt-in location tracking system that enables EMS users to share the location of high impact public health incidents (e.g. bystander CPR, gun violence, etc.).
10) Improve pay and benefits for EMS medical directors and RN-educators (Sanko, 2025).
11) Request funding for one full time EMS physician level medical director and at least 3 associate MD medical directors.
12) Require current BLS for EMTs and current ALS for paramedics (Sanko, 2025).
13) Fund resuscitation academy for all EMS captains and education for all paramedics (Sanko, 2025).
14) Implement annual AED and CPR training for City employees, local schools, and at risk communities (Sanko, 2025).
15) Require hospitals in Los Angeles to meet with EMS Medical Director, evaluate in/out-of-hospital cardiac arrest (IHCA/OHCA) survivors for procedures and survivorship recommendations (Sanko, 2025).

Background:

The Los Angeles Fire Department-Emergency Medical Services (LAFD-EMS) is the second biggest EMS agency in the United States, responsible for over 4 million residents and 471 square miles of jurisdiction. The LAFD operates 106 stations and employs over 1,300 paramedics (Cohen, 2025). In 2024, the LAFD received 500,000 calls. This averaged to 1,500 incidents and the transportation of 600 patients to hospitals every day (LAFD Strategic Plan 2023-2026). With the increase in volume of calls, the LAFD-EMS continue to evaluate the efficacy of the new Los Angeles Tiered Dispatch System (LA-TDS) which replaced the Medical Priority Dispatch System in 2014 (Sanko et al., 2020).

The objective of the implementation of LA-TDS is to reduce call-processing times for time-sensitive emergencies via rapid, streamlined questions to identify the type of emergency for faster recognition, rapid dispatch of medical services, and aid callers to administer life-saving assistance prior to the arrival of first responders (Sanko et al., 2020). Despite the rise in EMS calls, there was an 18.8% decrease in call-processing time and a 4.1% decrease in total response time in almost every time-sensitive medical emergencies except for drownings requiring resuscitation. LA-TDS has shown to be effective in decreasing call-processing time, triaging time-critical medical emergencies, and the dissemination of resources.

Los Angeles continues to experience a rise in 911 calls due to low-acuity patients (e.g. non-urgent medical conditions such as a cold), mental health crises, and repeated calls from frequent 911 users. To combat the rise in calls and focus EMS resources on major and life-threatening incidents, the LAFD launched a mobile integrated healthcare system called the Advanced Provider Response Units (APRUs) (Sanko et al., 2020). APRUs consist of an advanced practice provider, such as a physician assistant, a paramedic, and a firefighter. These units provide on-scene care and referrals to low-acuity patients, connect frequent 911 users to social workers, and transport patients experiencing a mental health crisis to psychiatric care centers. The implementation of these units enabled long term care and solutions, and reduced time by half - from 46 minutes to less than 20 minutes.

The EMS Bureau Strategic Plan outlines 6 goals (Cohen, 2025):

- Goal 1: Provide for the delivery of exceptional EMS.
- Goal 2: Expand and improve Continuous Quality Improvement programs.
- Goal 3: Provide effective EMS Training.
- Goal 4: Support excellent Emergency Medical Dispatch services and maintain an effective Tiered Dispatch System.
- Goal 5: Improve EMS Bureau project management and collaboration.
- Goal 6: Provide effective field EMS oversight.

To meet these goals, the LAFD has expanded their use of telemedicine and video 911. In 2020, the LAFD launched the LAFD Telemedicine Program (LTP) at the emergency dispatch center which employs specially trained physicians, physician assistants, and nurse practitioners to screen potential COVID-19 patients as well as individuals with non-life-threatening issues (Prange, 2020). The LTP is aimed to enhance patient care and decrease dispatching ambulances to low-acuity patients who are capable of safely self-monitoring and treating themselves. To be connected to LTP, a dispatcher will screen 911 callers using the LA Tiered Dispatch System protocol. If the caller is a non-urgent case, is between 2 and 65 years old, and has a smartphone, the dispatcher will refer the caller to a telemedicine provider.

Future directions of the program include the use of prehospital blood and integrating physician oversight. In December 2024, the LAFD was awarded a $380,000 Productivity

Investment Fund grant for the Development and Rapid Operationalization of Prehospital Blood (LA-DROP) pilot program (County of Los Angeles Fire Department, 2024). Funding will go towards purchasing equipment and blood products to launch LA-DROP, which is a prehospital blood transfusion program to save patients who are hemorrhaging at emergency scenes. As of 2024, LAFD paramedics can only give hemorrhaging patients salt water (County of Los Angeles Fire Department, 2024). With LA-DROP, paramedics will have the resources to give patients blood transfusions, meeting the same standard of care for hemorrhaging patients in hospitals. Severe trauma and hemorrhaging disproportionately affect underserved, low-income, and minority populations who stand to benefit the most from prehospital blood transfusion programs.

Reorganizing the LAFD is critical to provide adequate structure to support life-saving work (Sanko, 2025). This is evidenced by the LAFD Telemedicine Program, LA-DROP program, and most notably, cardiac arrest survival rates. In 2016, the cardiac arrest survival rate was 10.6% which dropped to 5.1% in 2023 (Sanko, 2025). The countywide Cardiac Arrest Task Force is led by the EMS Commission members and works toward meeting the American Heart Association (AHA) 2030 goals. Goals include:

- Bystander CPR >50%.
- AED usage >20%.
- Neuro-intact survival from cardiac arrest:
    - >8% at home.
    - >19% in public.
- In-hospital cardiac arrest, neuro-intact survival >24%.

In order to achieve the AHA's 2030 goals, the LAFD needs adequate medical management and to modernize medical organizations.

Future EMS innovation requires physician leadership and the expansion of EMS Physician Corps including Assistant Medical Directors and EMS Psychiatrist. The New York Fire Department employs 1 physician for every 100 paramedics. Under the Chief Medical Director, there are 10 Deputy Medical Directors for each division including Training, Dispatch, Online Medical Control, Hazmat/USAR, and Regional and State Advocacy. The LAFD is working to implement a similar model to better equip EMS.

Action Plan:

The Health Commission urges the adoption of the stated recommendations to improve response to EMS emergencies.

Expansion of County Hospitals and Funding

Recommendations:

1) Urge the Los Angeles City Council to introduce a resolution calling on the State of California and California lawmakers to intervene and purchase Saint Vincent Medical Center.
    a) Advocate for state and federal funding to support the acquisition, renovation, and expansion of county hospitals.
    b) Urge Los Angeles County to purchase and integrate Saint Vincent Medical Center into the Los Angeles County health system to immediately increase bed capacity and provide needed healthcare services to underserved populations.
2) Develop and fund projects to expand the infrastructure of existing county hospitals, such as adding new wings.
    a) Addressing staffing shortages by mitigating provider burnout and implementing policy changes to expand pipelines of healthcare professionals (UCLA Health, 2025).
3) Integrate a centralized system to track bed availability and patient need across Los Angeles County hospitals in real-time to forecast healthcare demands and allocate resources.

Background:

In August of 2018, Verity Health filed for Chapter 11 bankruptcy (Fine, 2022). Over the next couple of years, all 6 hospitals under Verity Health were sold including Saint Vincent Medical Center. Saint Vincent Medical Center had 381 beds, about 500 physicians, and a staff of 1,300 prior to its foreclosure in January of 2020.

Shortly after, the Center was purchased and leased to the state allowing it to reopen in April of 2020 in order to handle the overflow of COVID-19 patients. However, it was reported to have low occupancy and closed once again by the end of May. Since then, there have been no reports or proposals regarding the Center's reopening since April of 2020. The Los Angeles City Health Commission believes the Center has the capacity to provide medical services and care to the people of Los Angeles, especially those who are unhoused and face mental health issues (Reyes, 2022).

In 2019, a similar acquisition was made by the County of Santa Clara who obtained 3 facilities under Verity Health: St. Louise Regional Hospital in Gilroy, O'Connor Hospital in San Jose, and De Paul Health Center in Morgan Hill (County of Santa Clara, 2019). This acquisition provided over 450 beds and enabled the operation of accessible high-quality care in underserved communities. The Commission urges a similar acquisition of the St. Vincent Medical Center by the Los Angeles County Department of Health or, alternatively, that the Center be transformed

into a mental health hospital as well as a health center in order to assure the provision of health services to Los Angeles residents.

UCLA Health was able to achieve such a transition in 2021 when Olympia Medical Center was bought to undergo renovations with the goal of repurposing the medical center into a mental and behavioral health care facility by 2026 (UCLA Health, 2022). In 2024, UCLA Health also acquired West Hills Hospital and Medical Center in the San Fernando Valley, adding 260 beds (Grigoryants, 2024). This addition will increase critical inpatient hospital capacity for patients who need specialized treatment and care.

In July of 2024, the Los Angeles County Board of Supervisors approved $143 million to complete the Restorative Care Village at the Los Angeles General Medical Center's Boyle Heights campus (Garrova, 2024). Expected to be completed in 2026, this project will add 96 beds towards a mental health treatment facility which will provide round-the-clock psychiatric care for vulnerable residents with severe mental illness. Additionally, a Residential Withdrawal Management Facility is under construction which will provide 32 beds for patients with substance abuse disorders (City News Service, 2024).

Despite the recent addition of beds to LA County, there is still a need for hundreds of more beds in order to meet the needs of Angelenos experiencing serious mental illness (Garrova, 2024). Furthermore, UCLA researchers predict the U.S. will face a hospital bed shortage in 2032 (UCLA Health, 2025). Prior to the COVID-19 pandemic, U.S. hospital bed occupancy averaged 64% (UCLA Health, 2025). The pandemic exacerbated occupancy levels, and researchers found average occupancy rose to 75% post-pandemic (UCLA Health, 2025). At 75% occupancy, hospitals are on the brink of a bed shortage, with no buffer against seasonal fluctuations or unexpected surges (UCLA Health, 2025). If hospitalization rates and hospital bed capacity remain unchanged, occupancy rates could reach 85%. This level signals a bed shortage, which contributes to thousands of deaths each year (UCLA Health, 2025).

With staff shortages and hospital closures reducing bed availability in Los Angeles, increasing Medi-Cal reimbursements will cover rising costs of labor and medical supply costs to prevent hospital bankruptcy (Reyes, 2023). Therefore, the Health Commission encourages the allocation of government state funds for MediCal reimbursements.

Action Plan:

The Health Commission urges the adoption of the stated recommendations to maximize the use of existing medical centers to increase bed availability and provide adequate funding toward critical health services to prevent bankruptcy and closure of hospitals. The Commission urges the acquisition of Saint Vincent Medical Center by Los Angeles County.

Affordable Care Act (ACA) Implementation

Recommendations:

1) Call for immediate action from Congress to extend enhanced premium tax credits and restore funding to Medicaid.
2) Lobby for an increase of Medi-Cal reimbursements to all providers in hospitals and medical centers.
3) Develop a comprehensive educational campaign and community-based programs that focuses on informing individuals about available resources, how to navigate insurance plans, the benefits of having consistent primary care, and dispelling misconceptions about cost/barriers and fears.
    a) Provide linguistic support through multilingual resources and interpretation services.
4) Encourage collaboration between Los Angeles County Department of Health Services and transportation services to provide easier access to healthcare facilities, especially in areas with poor public transportation. Other potential alternatives include the expansion of programs such as Call the Car and ModivCare or partnerships with Uber and Lyft to provide free non-emergent transportation.
5) Prioritize initiatives aimed at improving access to primary care services such as establishing more community health centers, investing in telehealth, or expanding mobile clinics in areas with transportation challenges.
6) Coordination of mental health, substance use, and primary care services where mental health and substance use disorder systems are treated with equal importance to physical health care systems (Department of Mental Health, 2018).
    a) Provide culturally and linguistically appropriate recovery and resiliency-driven services (Department of Mental Health, 2018).
7) Continuous quantitative and qualitative evaluation of the ACA implementation and its impact.

Background:

In 2010, former President Barack Obama signed the Patient Protections Affordable Care Act (ACA) into law with the intention of (1) improving patient care, (2) improving the health of populations, and (3) reducing health care costs (LA County Department of Mental Health). To achieve these goals, the ACA expanded health care coverages through:

(1) Greater access to public health care coverage for low-income individuals via state Medicaid Programs
(2) Insurance exchanges which enable individuals to purchase health insurance using income-based subsidies such as Covered California

In addition, California's state Medicaid program (Medi-Cal) expanded its criteria for eligibility and underwent expansion to include a broader range of adults such as parents as well as adults without children. Furthermore, the income threshold for qualification was raised to 138% of the

federal poverty level which made millions of people eligible for coverage. By 2016, Los Angeles County had the highest Medi-Cal enrollment, with over 1.1 million residents–11.3% of the county's population–enrolled due to the expansion of the ACA (California Department of Health Care Services, 2017).

Since the implementation of the ACA and expansion of Medi-Cal, there have been significant increases in health care coverage for low-income individuals, specifically Latinos and individuals who have limited English proficiency (Sommers et al., 2016). Public health care coverage increased by 1.8 percentage points and the uninsured rates declined by 2.1 percentage points in the state of California.

In 2020, full-scope Medi-Cal eligibility was expanded to include individuals aged 19 to 25, regardless of immigration status, through the Young Adult Expansion (Verno, 2024). In 2022, the Older Adult Expansion was signed into law which further expanded eligibility to individuals over the age of 50 (Verano, 2024). Later that year, California expanded coverage to individuals aged 26 to 49, regardless of immigration status starting January 1, 2024, which covered an additional 700,000 Californians.

However, these gains are now at risk. In 2025, federal Medicaid funding cuts were passed in the "Big Beautiful Bill," which will jeopardize coverage for millions of low-income Californians who benefited from ACA-related expansions (Governor Gavin Newsom, 2025). Since 2021, the ACA's enhanced premium tax credits, or enhanced subsidies, have lowered the monthly payment for health insurance, making the purchase of health insurance more affordable and accessible (L.A. Care Health Plan, 2025). These tax credits have been essential to a record low 6.5% uninsured rate in California (L.A. Care Health Plan, 2025).

Approximately 2 million Californians rely on coverage through Covered California and up to 400,000 are at risk of losing insurance if the enhanced tax credits expire at the end of 2025 (L.A. Care Health Plan, 2025). L.A. Care Health Plan, the nation's largest public health plan, serves more than 2.6 million Angelenos (L.A. Care Health Plan, 2025). Without congressional action to restore tax credits, working families and small business owners will face premium increases that may double or triple beginning in January of 2026 (Governor Gavin Newsom, 2025). Such cuts would reverse progress in expanding coverage and create widespread disruption and coverage losses across LA County, where 1 in 4 residents depends on L.A. Care for access to care (L.A. Care Health Plan, 2025).

A recent analysis has projected the devastating losses as a result of funding cuts. As of 2025, 92% of enrollees receive some amount of premium tax credit (L.A. Care Health Plan, 2025). Almost half of adults purchasing coverage through the ACA are small business owners, employees of small businesses, or self-employed (L.A. Care Health Plan, 2025). The groups that will be hit the hardest include (Governor Gavin Newsom, 2025):

- Low-income Californians earning less than $62,000 annually.
- Older adults between the ages of 55-64.
- Almost 500,000 self-employed Californians.

Furthermore, communities of color would also be disproportionately impacted (Governor Gavin Newsom, 2025). Premiums would rise by (Governor Gavin Newsom, 2025):

- 122% for Latino Californians.
- 112% for Asian and Pacific Islander Californians.
- 106% for Black Californians.

Without enhanced premium tax credits, California's record enrollment and historic progress expanding health insurance coverage is at risk. These cuts to Medicaid funding would drive uninsured rates back upward and worsen inequities many communities of color already face.

Even before the 2025 cuts, many Angelenos with Medi-Cal or employer-sponsored coverage faced significant barriers in accessing primary care services (Saluja et al., 2019). Low-income patients with Medi-Cal were twice as likely to be refused for new patient primary care appointments. A quarter of Los Angeles County residents who were surveyed reported difficulties obtaining health care when they needed it, with more than 40% of those difficulties reported from the poorest income group living below the federal poverty level. Contributing factors include the lowest rates of Medicaid acceptance (~50%) and the high percentage of minority groups (e.g. racial and ethnic minority, non-English speakers, undocumented individuals) who face greater barriers to health care.

These challenges were more prevalent for immigrants, who face application and enrollment barriers despite eligibility expansions (Verano, 2024). Applicants report not being able to reach the county over the phone, lacking assistance in their language, or being unable to complete applications that require a Social Security number they do not have (Verano, 2024). Furthermore, immigrants who are eligible remain uninsured because of language and literacy barriers, confusion regarding policies, difficulties navigating enrollment, and fear largely driven by concerns over deportation or rejection of an immigrant visa. In August 2019, former President Donald Trump announced a policy which would reject immigrants applying for an immigrant visa if they used public assistance programs such as Medi-Cal (Verano, 2024). This ultimately led to a rise in uninsured individuals. Although this policy is no longer in effect, many immigrants remain afraid to enroll or use programs such as Medi-Cal.

A qualitative evaluation revealed key barriers to accessing health care: understanding primary care, finding or switching primary care providers, the perceived cost or barriers, preference for emergency/urgent care instead of primary care, obtaining timely appointments, and overcoming geography and transportation barriers (Saluja et al., 2019). To mitigate some of these barriers, the Los Angeles General Medical partnered with Uber and Lyft to provide transportation services to patients who are commuting to and from appointments as well as picking up medications (Cisneros, 2021). These initiatives are critical to bridging gaps between

coverage and access, though they are limited in scale compared to the systemic barriers facing low-income and immigrant populations.

Action Plan:

The Health Commission urges the adoption of the stated recommendations to combat barriers affecting the implementation of the Affordable Care Act and improve the access to primary care for individuals who continue to face difficulties. The Commission also calls for immediate action from Congress to extend enhanced premium tax credits and restore funding to Medicaid.

Maintenance of Certification (MOC)

Recommendations:

1) That the Los Angeles City Council pass an ordinance ensuring that hospitals and medical groups licensed within the City of Los Angeles may not mandate ABMS Maintenance of Certification (MOC) as a condition of employment or credentialing, but instead make it voluntary.
2) That the ordinance further protects against monopolistic practices by recognizing alternative nonprofit certification boards (such as NBPAS) as valid pathways for recertification, provided the physician was previously certified by ABMS, AOA, or similar bodies.

Background:

On April 18, 2024, the Federal Trade Commission, Justice Department, and the U.S. Department of Human and Health Services (HHS) launched an easily accessible online portal for the public to report health care practices that may harm competition. The online portal, HealthyCompetition.gov, allowed the public to report potentially unfair and anti-competitive health care practices to the FTC and the Justice Department's Antitrust Division. The launch of the new portal was an attempt to create a more competitive health care market that was fairer to patients, providers, payers as well as workers. This action recognizes how monopolistic systems can restrict access, raise costs, and undermine care delivery.

The American Board of Medical Specialties (ABMS) Maintenance of Certification (MOC) system is a prime example of such a monopolistic structure. It has been shown to:

- Increase costs to the health system without improving outcomes (Gray et al., JAMA 2014).
- Exclude qualified physicians from employment and hospital privileges.
- Limit access to care in underserved areas, including Los Angeles' Health Professional Shortage Areas (HPSAs), where 3.7 million people reside and only 47.6% of care needs are met.
- Contribute to physician burnout and attrition.

As Karen Schatten recently wrote in Medical Economics (Jan 2024), "With each physician lost, patient wait times increase, critically needed care is delayed, and overall access to care worsens, even in federally designated shortage areas." In short: MOC is not just a professional issue - it's a public health issue.

Scientific studies further confirm that:

- There is no proven correlation between MOC and improved clinical outcomes (Gray et al., 2014).

- Emergency department usage may actually be lower under physicians not required to complete MOC (Gray et al., Table 2).
- Only 4% of physicians report finding MOC truly beneficial (Cook et al., Mayo Clin Proc 2016).

In a city with overburdened ERs, physician shortages, and underserved communities, forcing physicians to comply with a costly, time-consuming process that does not improve care but excludes doctors from practice is not only illogical - it's harmful.

In October 2024, the American Board of Internal Medicine (ABIM) took steps to streamline the MOC program (Shryock, 2024). The ABIM eliminated the requirement to earn MOC points every 2 years, which did not compromise the MOC program and made it more efficient. With this elimination, 12,000 physicians will have their certification status updated to "Certified, Participating in MOC" as long as other requirements have been fulfilled (Shryock, 2024). The ABIM recognized MOC points were not achieving its intended purpose to improve clinical outcomes and had almost no benefit (Bascom, 2024).

The Commission believes the proposed ordinance outlined in the recommendations and action plan is a meaningful step the City Council can take to:

- Increase physician access.
- Reduce unnecessary health care costs.
- Improve equity in hiring and credentialing.
- And create fair and open certification pathways.

Action Plan:

The Health Commission urges the City Council to pass an ordinance that hospitals and medical groups licensed within the City of Los Angeles not require ABMS Maintenance of Certification (MOC), but make it optional. Furthermore, this ordinance prevents the monopolization of MOC allowing alternative nonprofit Boards the ability to recertify physicians and surgeons that have previously been certified by the American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) or similar certifying bodies.

Communicable Disease Response

Recommendations:

1) Enhance outreach at airports on communicable diseases.
    a) Develop educational materials, such as videos or pamphlets, if travel destinations have prevalence of communicable disease(s).
2) Increase communication on travel restrictions pertaining to infectious diseases by:
    a) Alerting individuals of prevalence and CDC recommendations on itineraries or tickets and in baggage claim areas.
    b) Including text message alerts as part of the Emergency Alert System.
    c) Mandate testing of communicable disease found in the area of arrival/departure before and after travel.
3) Invest in an engaging social media presence (X - formerly Twitter, Facebook, TikTok, and Instagram) to raise awareness and educate travelers and Angelenos about relevant communicable diseases.
    a) Producing simpler and more digestible content in languages spoken by large demographic groups in Los Angeles (e.g. Spanish, Chinese, Tagalog, etc.).
4) Invest in information technology for high quality infectious disease surveillance (e.g. app development to provide accessible services to monitor and control the spread of communicable diseases).
5) Collaborate with other City and County agencies to conduct outreach to disconnected and underserved communities.
    a) Targeted outreach to youth via collaborations with youth concerned agencies such as the Youth Development Department, LAUSD, Youth Councils, etc.
    b) Recruitment of community leaders to promote awareness and education to their respective communities regarding communicable diseases that predominantly affect them.
6) Evaluate the 2016-2020 Strategic Plan to determine effective objectives, assess which goals were met, and produce a new strategic plan post-COVID.

Background:

The Health Commission supports the Los Angeles County Department of Public Health Communicable Disease Control and Prevention (CDCP) Division's mission to "reduce the risk factors and disease burdens of preventable communicable diseases for all persons and animals in Los Angeles County, in partnership with others, through providing the health promotion, surveillance, investigation, laboratory, and disease prevention and control that meet quality standards" (CDCP). Collaborative city-wide efforts are crucial to support infectious disease prevention, education, surveillance, containment, and treatment, especially as new diseases arise. Best practices from past outbreaks should be used to improve current communicable disease programs and reduce risks and disease burden in Los Angeles.

The CDCP Division is responsible for the prevention and control of communicable disease which include tuberculosis, blood-borne, foodborne, vector-borne, communicable animal diseases, and diseases that are vaccine preventable. The Division developed a Strategic Plan for 2016-2020 which outlines the work necessary to achieve their mission into 7 strategies. These strategies are (1) strengthen disease surveillance and detection, (2) enhance communication, education, and outreach, (3) promote and support effective policy, legislation, and regulation, (4) research and advance innovation solutions, (5) strengthen preparedness and response, (6) advance workforce development and training, and (7) promote long-term planning and quality improvement of CDCP Programs. Currently, reports of the efficiency and effectiveness of these strategies and an updated strategic plan are not available.

After the COVID-19 pandemic led to over a million deaths in the U.S., the Transportation Security Administration (TSA) published the Transportation Security Preparedness Plan to Address the Event of a Communicable Disease in February 2024 (Bielby, 2025). TSA's preparedness plan aims to protect its workforce and the traveling public, and it has coordinated with the Department of Transportation (DOT) to develop a national aviation plan to prevent the spread of infectious diseases into the U.S. from international sources (Bielby, 2025).

TSA's preparedness plan outlines communication, collaboration protocols, and engagement platforms with various entities in order to minimize disruptions with transportation prior to or following an outbreak (TSA, 2024). Key tasks and considerations include (TSA, 2024):

- Protecting the transportation sector's workforce and the traveling public.
- Conducting research and adapting to relevant resources.
- Maintaining a publicly accessible website with information on current travel advisories and precautionary measures.
- Ensuring internal and external public messaging is accurate, timely, and accessible while coordinating with stakeholders and partners.
- Defining risk acceptance and conducting risk assessments, analyses, and updates as required.
- Executing risk management to minimize impacts on the transportation sector.
- Fulfilling all reporting requirements and requests for information and assistance.
- Identifying and reporting gaps in funding, staffing, or resources to appropriate entities.
- Monitoring and reporting workforce absenteeism, infections, and deaths.
- Modifying operations to accommodate workforce protections while maintaining TSA's essential functions.

TSA strongly emphasizes communication and collaboration as the foundation of response efforts (TSA, 2024). TSA engages with a network of partners including federal agencies such as the Department of Health and Human Services (HHS), the Centers for Disease Control and Prevention (CDC), the Department of Transportation (DOT), and the Department of Homeland

Security (DHS), as well as industry stakeholders, international partners, and the traveling public. Communication protocols are designed to ensure timely, consistent, and culturally appropriate messaging during a communicable disease outbreak (TSA, 2024). TSA uses platforms like the Homeland Security Information Network (HSIN), public-facing websites, and social media to distribute guidance and updates (TSA, 2024). Coordination through the Joint Information Center (JIC) ensures that all messaging is aligned with national directives and reduces confusion, misinformation, and disinformation during crises (TSA, 2024).

Protecting the transportation workforce, especially Transportation Security Officers (TSOs) is central to the preparedness plan (TSA, 2024). TSA has adopted the National Institute for Occupational Safety and Health (NIOSH) hierarchy of controls, implementing engineering measures such as protective barriers at checkpoints, administrative controls like social distancing and flexible scheduling, and provision of personal protective equipment (PPE) (TSA, 2024). The plan also outlines the use of Infection Control Monitors (ICMs) at airports to ensure compliance with safety protocols, monitor PPE usage, and provide feedback (TSA, 2024). Furthermore, TSA will coordinate with DHS and CDC to provide medical countermeasures (MCMs), vaccines, and equitable access to health care resources for its workforce (TSA, 2024). These measures will safeguard employee health and sustain essential transportation security functions during outbreaks.

Despite comprehensive planning, TSA has identified significant obstacles in executing preparedness measures which include funding limitations, supply chain disruptions, and constraints in statutory authority (TSA, 2024). For example, global demand may cause resupply delays for PPE (TSA, 2024).Workforce absenteeism due to illness or quarantine can disrupt operations or strain security capacity. These obstacles highlight the need for sustained investment, interagency coordination, and flexible policies to prevent and respond to communicable disease outbreaks.

In April 2025, the Trump administration announced the termination of infectious disease grants, cutting $45 million intended for Los Angeles County to combat the spread of measles and bird flu (Ellis & Ordner, 2025). Later in June, the “Big Beautiful Bill” passed which will slash $750 million per year from the county’s Department of Health Services (Ellis & Ordner, 2025). Barbara Ferrer, head of the LA County Department of Public Health, stated that these cuts will detrimentally impact patients and lead to employee layoffs (Ellis & Ordner, 2025). Funding cuts and employee layoffs will result in slower investigations into disease outbreaks and laboratories will have a smaller testing capacity (Hwang, 2024). Furthermore, these cuts have left the county without sufficient resources to maintain the bioterrorism watch program, which tracks potential outbreaks that may signal a biological attack (Ellis & Ordner, 2025). This funding also supported services such as childhood vaccinations, respiratory virus testing and monitoring, and public health data systems (Hwang, 2025).

These cuts have devastated public health departments at the county and state level. California has used this funding to address persistent public health outbreaks, including record-high rates of sexually transmitted infections, deadly flu seasons, and bird flu (Hwang, 2025). The most recent flu season was the deadliest in California, with more than 1,400 deaths attributed to it (Hwang, 2025). Furthermore, hundreds of herds in the Central Valley were wiped out by the bird flu, marking the largest outbreak in the country (Hwang, 2025). 38 people have also been infected by bird flu (Hwang, 2025).

In September 2025, in addition to devastating funding cuts, the federal government's health agencies have provided inconsistent and confusing messaging surrounding vaccine guidelines and recommendations (Barrón, 2025). As a result, a partnership between state governments of California, Hawaii, Oregon, and Washington called the West Coast Health Alliance has emerged (Barrón, 2025). The West Coast Health Alliance will develop its own public health guidelines separate from the CDC, with an emphasis on scientific evidence when issuing vaccine recommendations (Barrón, 2025).

This isn't the first time Los Angeles has faced inconsistent public health messaging from the Trump administration. Because of the Trump administration's handling of the COVID-19 pandemic, LA County responded by expanding vaccination sites, deploying mobile units, and directly engaging with communities to build trust and guarantee safe access to care for all residents, regardless of immigration status (Barrón, 2025). On the state level, California signed Assembly Bill 144 into law in 2025, requiring most health insurance plans to cover vaccines recommended by the CA Department of Public Health free of charge and without requiring proof of income (Barrón, 2025).

Action Plan:

The Health Commission urges the adoption of the stated recommendations and agency collaboration to help promote the mission of the Los Angeles County Department of Public Health and reduce the transmission of communicable diseases. The Commission also urges the Los Angeles County Department of Public Health to investigate the efficacy of the CDCP programs, especially in light of recent pandemics and outbreaks such as COVID-19, the bird flu, and measles.

Typhus Outreach and Education

Recommendations:

1) Implement stricter stray animal controls and promote community rodent control programs to eliminate food sources, harborage conditions, and pest infestation.
2) Continue the collaboration of the DPH Veterinary Public Health Program with Downtown Dog Rescue and Inner-City Law Center to provide flea prevention education and services to individuals living with pets in Skid Row.
3) Increase outreach and health education regarding flea-borne typhus infection by promoting the following:
    a) Regular use of flea control products and heartworm regimens on pets.
    b) Outdoor precautions by tucking pants into socks/boots when outdoors and applying EPA-registered insect repellent containing DEET.
    c) Avoiding wild or stray animals.
    d) Proper trash disposal by using secure cans with lids.
    e) Steps to eliminate potential animal habitats (e.g., closing up crawl spaces and removing vegetation).
4) Coordinate with homeless shelter and outreach organizations as points of contact for risk identification and mitigation for flea infestations.
    a) Regular data collections are needed to establish standard practices for admission, screening, prevention, and veterinary care.
    b) Tailored training and education materials focused on the screening, prevention, and treatment of fleas on animals.
    c) Connect residents with free or low-cost veterinary resources and distribution of flea treatments.

Background:

Typhus is a group of diseases caused by a bacteria known as rickettsia. The dominant diseases are louse-borne (epidemic), flea-borne (endemic), and scrub typhus which are transmitted by fleas, mites, lice, and/or their feces (LACDPH). Flea-borne typhus naturally occurs in LA County and spreads via the *Rickettsia typhi* bacteria found in infected fleas. Infection occurs when the infected fleas' feces come into contact with cuts, scrapes, or rubbed into the eyes. Symptoms include fever, body aches, hills, headaches, rashes, and, in rare cases, swelling of the brain and heart valves. In less than 1% of cases, death can occur. There is no vaccine to prevent typhus infection, but antibiotics can treat infection.

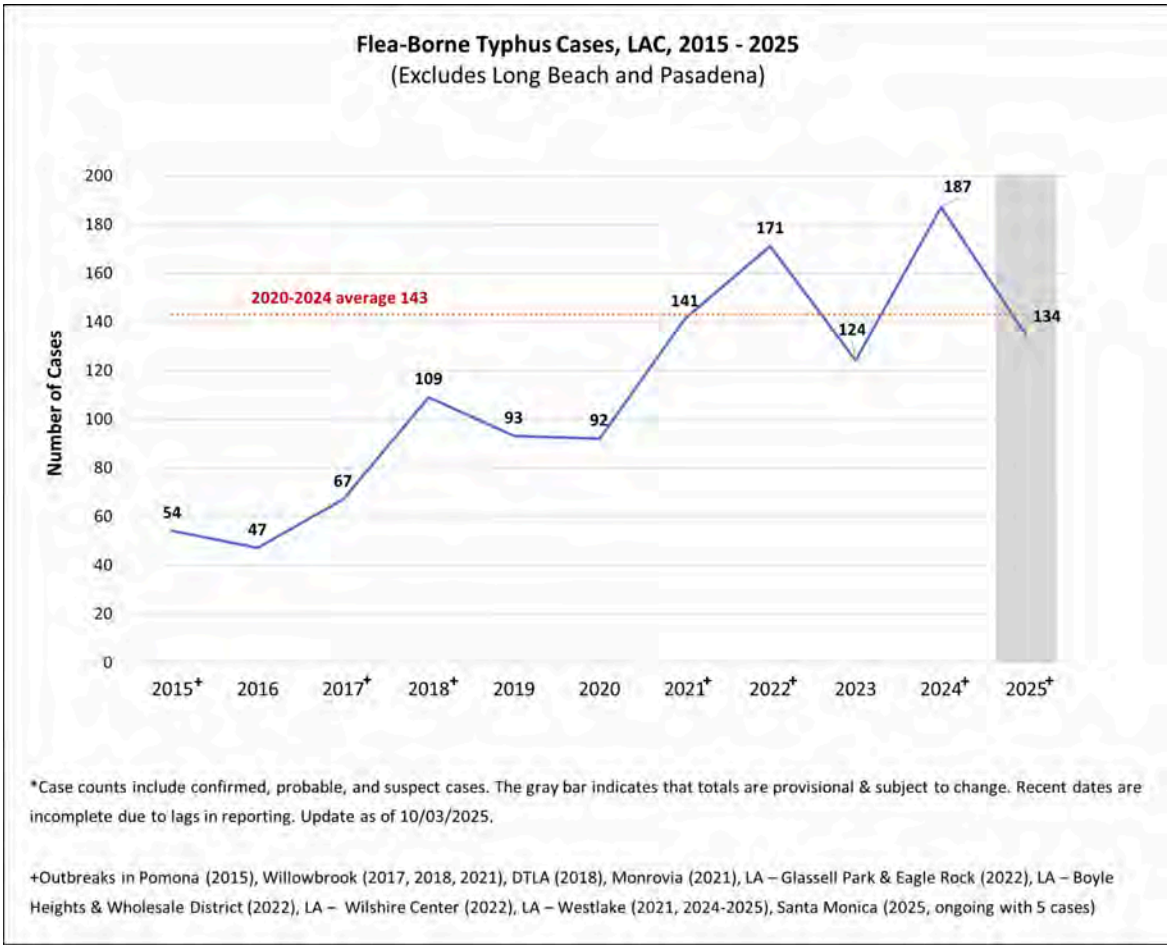

Figure 1. Number of Flea-Borne Typhus Cases Annually in Los Angeles Country, 2014-2025 (LACDPH)

Between 2013-2017, Los Angeles County (LAC) averaged 60 cases of typhus annually which was double the reported amount of the previous 5 years (LACDPH, 2019). LAC experienced its first significant outbreak of flea-borne typhus in 2018 when it saw an uptick of cases. In 2018, LAC surpassed 100 cases of typhus. The outbreak was identified in the downtown Los Angeles area with the majority of cases having a history of either living or working in the downtown area. 8 of the 19 cases occurred in individuals who are unhoused (LACDPH, 2018). Shortly after, another outbreak of 7 flea-borne typhus cases occurred in the Willowbrook area of Compton where 3 of the 4 cases required hospitalization (LACDPH, 2019). The annual average number of cases in LAC between 2018-2022 was 121 cases. In 2022, two outbreaks occurred in (1) Eagle Rock and Glassell Park communities and (2) Wholesale District and Boyle Heights communities (LACDPH, 2022). A total of 24 cases were reported with 19 being hospitalized, 4 experiencing homelessness, and 1 patient dying. Although LAC saw a drop in cases in 2023, there were 3 deaths from typhus in LAC (Office of the City Manager, 2024). In 2024, there was an uptick in cases reaching an all-time high of 187 cases (LACDPH, 2025). As a result, the average number of flea-borne typhus cases between 2020-2024 is 143 cases.

As of August of 2025, there have been 106 reported cases which is higher than the total cases this time last year (LACDPH, 2025). Earlier this year, LACDPH investigated an outbreak in Central Los Angeles (County of Los Angeles Public Health, 2025). LACDPH is currently investigating a second outbreak in Santa Monica, where all 5 cases required hospitalization but have since recovered (Hall, 2025). In response, LACDPH conducted an environmental assessment to identify transmission risk factors and carried out outreach to nearby schools, animal control agencies, veterinary practices, and residences (Hall, 2025). The Santa Monica Animal Shelter has implemented additional intake procedures to prevent the spread of typhus and will test fleas from cats brought in from areas near 25th and Kansas, Virginia, or Stewart streets (Hall, 2025). LACDPH continues to monitor Santa Monica for additional cases.

Individuals experiencing homelessness commonly own pets which puts them and homeless shelters at a higher risk of contracting zoonotic diseases including typhus (Carpenter et al., 2024). Due to limited data available, there is no characterization of standard practices for admission procedures, screening for flea infestation, prevention of flea infestation, and veterinary care. A recent study found that homeless shelters and outreach staff lacked the appropriate knowledge for screening, prevention, and treatment of fleas on pets (Carpenter et al., 2024). Furthermore, few homeless shelters and outreach staff provided any form of veterinary care or flea treatments. However, connecting individuals to free or lost-cost resources such as veterinary care or flea treatments would improve the health of owners and animals as well as mitigate the spread of zoonotic disease such as typhus.

The LACDPH identified trends in typhus cases which clustered in areas where environmental factors enabled the habitation of animal populations known to carry infected fleas. An increase in flea-borne typhus cases can be attributed to the increase in rodent reservoirs, homelessness, and free roaming animals, specifically cats (CDC, 2022). Although the number of cases have seen a decline, the LACDPH cautions adults with advanced age or a G6PD deficiency as they are at the greatest risk for severe health outcomes.

Action Plan:

The Health Commission urges the adoption of the stated recommendations to improve public health control over typhus transmission.

Hepatitis Outreach and Education

Recommendation:

1) Improve accessibility and quality of public restrooms (one toilet per 20 users as recommended by the WHO (Adams et al., 2008)) by increasing funding towards the Pit Stop Mobile Toilet Program.
2) Increase access to free [and anonymous] hepatitis A, hepatitis B, and hepatitis C testing and vaccinations in high-impact areas such as areas with a high density of homelessness or drug use and incarcerated settings.
    a) Coordinate a strategic plan for regular testing and immediate treatment in the Los Angeles County Jail System (Benor, 2024).
3) Implement practices to support patient navigation to ensure notification of positive test results and adherence of treatment (Hernandez-Tamayo et al., 2023).
    a) Case managers can provide counseling, spotlight barriers to treatment, and tailor treatment to the patient's needs.
4) Integrate a mobile, community-based treatment program to increase accessibility to screenings, vaccinations, and [on-site] treatment (Hernandez-Tamayo et al., 2023).
5) Identify communities at the greatest risk of contracting hepatitis and recruit stakeholders to improve hepatitis education, screening, and medical services (LACDPH).
6) Improve accessibility of resources and vaccination programs found on the LA County Department of Public Health site.
7) Fund paid staff and outreach teams to schedule patients for treatment, assist with transportation vouchers or other aid, etc. (Reyes, 2024).
    a) Hiring a small team would cost Los Angeles County's Public Health Department roughly $250,000 (Reyes, 2024).

Background:

Hepatitis is the inflammation of the liver which is caused by different strains of viral hepatitis: hepatitis A, B, C, D, and E. Hepatitis A, B, and C are the most common forms of viral hepatitis. Symptoms include abdominal tenderness or pain, fatigue, jaundice, dark colored urine, lightly colored stool, nausea, and vomiting (Johns Hopkins Medicine). Depending on the progression of hepatitis, cases can range from acute to chronic. Acute causes will present with sudden inflammation which goes away. However, chronic cases are long-term causing subtle symptoms and leading to liver damage. Some infections can lead to cirrhosis or liver cancer (LACDPH, 2020).

Hepatitis A virus (HAV) is spread through fecal consumption or sexual contact. Infection can occur when consuming food contaminated by hepatitis A, having sexual contact with an infected partner, or forgetting to wash after using the bathroom (LACDPH, 2017). Those infected with HAV can be contagious for 2 weeks before symptoms begin to present and 1 week after infection has taken place. Typically, patients fully recover, but people with weak immune

systems may take months to recover. There are currently no treatments for HAV other than maintaining proper nutrition, drinking sufficient fluids, and rest. However, there are methods of prevention. The LACDPH recommends vaccination for HAV which requires 2 doses of the vaccines 6 months apart.

From 2016-2018, the LACDPH warned of an outbreak occurring in the counties of Los Angeles, San Diego, and Santa Cruz. These outbreaks predominantly affected men who have sex with men (MSM), individuals who are unhoused, and individuals eliciting drugs. The LACDPH recommends that individuals who identify with these groups obtain the HAV or combined HAV/hepatitis B vaccine and post-exposure prophylaxis (PEP) to those exposed to HAV.

From November 2022 to May 2023, an outbreak occurred in multiple states including California with 100% of individuals infected reporting the consumption of organic strawberries imported from Baja California, Mexico between October and November 2022. As of September 2023, the CDC reported 10 cases, no deaths, and declared the outbreak to be over. In May 2023, a multistate outbreak and exposure at the Men's Central Jail occurred. In June 2023, a person was infected with HAV while detained at the Men's Central Jail. The LACDPH is recommending vaccinations to anyone detained in the Men's Central Jail in May of 2023.

In early 2024, the LACDPH reported a significant increase in hepatitis A infections in individuals experiencing homelessness and using illicit drugs (LACDPH, 2024). In response, the county offered free HAV vaccinations to unhoused populations and conducted outreach with community organizations (Feller, 2025). By October 2024, 41 cases were identified (Gounder & Balter, 2024). Of these cases, 24 involved individuals experiencing homelessness including 14 who reported using illicit drugs. 14 cases were genetically linked to the same strain indicating transmission from person-to-person through drug use equipment or consumption of food or water contaminated with hepatitis A. By November 2024, 17 cases had resulted in hospitalization, and 1 death had occurred (Gounder & Balter, 2024). Overall, LACDPH confirmed 165 cases in 2024, triple the number of cases from 2023 (LACDPH, 2025).

In May 2025, the LACDPH declared a hepatitis A outbreak, confirming 29 cases (LACDPH, 2025). Most infections occurred in individuals without typical risk factors, such as homelessness or travel (LACDPH). The increase in hepatitis A cases among individuals without risk factors corresponds to the increase in hepatitis A wastewater concentrations (LACDPH, 2025). Dr. Sharon Balter, health official at the LA County Department of Public Health, shared that these outbreaks tend to be geographically concentrated, typically in downtown LA (Stone, 2025). However, Dr. Balter shares recent cases have not been geographically concentrated and the LACDPH has not been able to trace chains of transmission (Stone, 2025). Dr. Timothy Brewer, infectious disease physician and epidemiologist at the University of California, Los Angeles, suggested outbreaks may be linked to food contamination and community circulation (Baumgaertner Nunn, 2025). Despite this, the LACDPH has stated the general public faces a low

risk of transmission (LACDPH, 2025). The LACDPH continues to offer free HAV vaccines for any unvaccinated residents and deploy mobile vaccine units to encampments and interim housing sites (Feller, 2025). The health department recommends the HAV vaccine and good hygiene practices, especially before eating and food preparation (Feller, 2025).

The data collected from wastewater has been invaluable to detecting and tracking the true magnitude of this outbreak, especially when individuals are asymptomatic or may not have access to healthcare (Lin, 2025). However, recent federal budget cuts could affect future detection services, as well as vaccination programs, epidemiology laboratory capacity, and hospital preparedness (Lin, 2025).

Hepatitis B (HBV) is spread through contact with an infected individual's bodily fluid. Although anyone can contract HBV, people at greater risk include infants born to mothers with HBV and people who have had sexual contact with an infected individual or shared needles (LACDPH, 2017). Most infections are mild with little to no symptoms while others can become chronic resulting in hospitalization, serious health issues, and even liver cancer (LACDPH, 2018). To prevent HBV, vaccinations are available at local pharmacies. Uninsured or underinsured individuals can access free or low cost vaccines at clinics enrolled in the Vaccines for Adults Program (LACDPH). Children who are 18 years or younger are eligible to receive the vaccine at no cost through the Vaccines for Children Program.

Hepatitis C (HCV) is the most common bloodborne infection, transmitted through blood or blood-contaminated objects. Individuals at the greatest risk of contracting HCV include anyone who has received a blood transfusion before 1989, hemodialysis patients, IV drug users, healthcare professionals who frequently work with needles, people engaging in IV drug use, and individuals with multiple sexual partners (LACDPH). Once infection occurs, symptoms include fatigue, nausea, vomiting, jaundice, and anorexia. The majority of infections have mild to no symptoms. Few (15-25%) infected individuals overcome acute infection without ongoing complications, such as HCV RNA in the bloodstream, and their alanine aminotransferase (ALT) levels return to normal (LACDPH). However, a chronic infection will develop in 75-85% of infected individuals. A majority of these chronic cases will continue to show fluctuating ALT elevations which can lead to the development of liver diseases such as cirrhosis, hepatic cancer, and liver failure. Currently, no vaccine is available for the prevention or treatment of HCV, however it can be treated with antiviral medications (Mayo Clinic, 2023).

In early 2019, the LACDPH notified Angelenos of 6 HCV cases tracing back to treatment at the Westside Multispecialty Medical Group. The LACDPH notified and recommended that any patients who received injections, infusions, or procedures from this clinic should be tested for HCV and HBV (LACDPH, 2019).

Most recently, HCV has disproportionately impacted marginalized populations such as individuals who engage in IV drug use, have been incarcerated in the Los Angeles County Jail System, or are unhoused (Reyes, 2023). Experts attribute its prevalence to (1) a disconnect from medical care, (2) lack of public investment, (3) misconceptions among physicians regarding treatment, and (4) the fact that many patients are unaware they even have HCV (Reyes, 2023). A 2012 UCLA study found that more than a quarter of individuals who reside on Los Angeles' Skid Row were infected with HCV and half of those infected were unaware they were infected with HCV (Reyes, 2023).

Within the Los Angeles County Jail System, over 1 in 3 inmates tested positive for HCV, meaning there are thousands of people living with the virus (Benor, 2024). Dr. Mark Bunin Benor, a family physician who worked in the LA County Jail from 2018-2023, reported that screening and treatment for HCV is not standard for intake routines (Benor, 2024). Additionally, Dr. Benor noted that physicians working at the county jail rarely screened for HCV because protocol only considered treatment for patients if they presented advanced liver fibrosis. The process for scheduling an appointment at the county hospital and delivering medications would take months which ultimately discouraged treatment (Benor, 2024). The county jail system has made changes such as qualifying for treatment without presenting liver fibrosis and making medications more accessible which has resulted in dozens being treated (Benor, 2024). However, thousands of cases remain untreated. Screening continues to be sparse and clinicians cannot initiate treatment. Dr. Benor reiterates that any initiatives to extinguish hepatitis C requires a focus in jails to coordinate testing and treatment. Currently, the LA County Jail has failed to undertake any efforts (Benor, 2024).

The Los Angeles County Department of Public Health allocates roughly $1 million towards programs aimed at combating all forms of hepatitis (Reyes, 2023). As a result of limited funding, the task of reaching out to infected individuals falls to unpaid volunteers through Project Connect (Reyes, 2024). Project Connect is a collaboration between the University of Southern California and the LACDPH which trains over 3,000 volunteers to contact individuals who tested positive for HCV and refer them to treatment plans (Reyes, 2024). Despite these efforts, issues arose due to financial difficulties affording medications, a lack of urgency, accessibility issues such as transportation, and over 70% of patient files containing incorrect information. Experts report that hiring a small team to continue outreach work would cost approximately $250,000 (Reyes, 2024). Outreach teams would be capable of bridging the gap between patients and obtaining healthcare by scheduling treatment, providing transportation vouchers, etc.

USC Street Medicine, a team that delivers care to patients outside the clinic, has demonstrated how street medicine models are contributing to the elimination of hepatitis C (Nolan, 2025). This model of medicine has been successful because of its long-term engagement over a one-off intervention and Electronic Medical Record (EMR) system which support

consistent follow-ups (Nolan, 2025). When patients transition into housing or are relocated, the street medicine team follows the patient to deliver care (Nolan, 2025). Additionally, hepatitis C treatment is integrated into general care, eliminating the need for separate teams or referrals (Nolan, 2025). Among patients tested, 24% were positive for hepatitis, and 82% of those completed treatment (Nolan, 2025). Furthermore, there was an 80% decrease in emergency visits, and a 75% decrease in hospitalizations and readmissions (Nolan, 2025).

Action Plan:

The Health Commission urges the adoption of the stated recommendations to improve public health control over hepatitis transmission.

Measles Outreach and Education

Recommendations:

1) Urge the California Department of Health to implement stricter adherence to required vaccinations and conduct more frequent audits of California schools. Potential community protections include:
    a) Tracking vaccination statuses and assigning case managers to ensure adherence.
    b) On-site vaccination programs to eliminate barriers such as transportation.
    c) Publication of schools audited for low vaccination rates (below 95%) or in violation of state law requiring children to be immunized against 10 communicable diseases including measles (Lambert et al., 2023).
2) Urge the Los Angeles Unified School District to increase outreach and health education regarding measles and vaccinations to dispel misconceptions or hesitancy.
3) Increase travel protections by:
    a) Increasing frequency of messages on kiosk screens.
    b) Alerting people of prevalence and CDC recommendations.
    c) Including health messages/alerts of disease(s) on itineraries or tickets (with incentives for airlines to implement this method) and in baggage claim areas.
    d) Mandate testing of measles especially in areas of arrival/departure with high prevalence before and after travel.

Background:

Measles is a contagious disease initially infecting the respiratory tract before spreading to the rest of the body. Although measles can affect any individual, it is commonly found in children under age 5 (WHO, 2023). Transmission occurs through contact with infected nasal or throat secrets which can occur when an infected individual breathes, coughs, or sneezes. Symptoms include high fevers, cough, runny nose, red watery eyes, small white spots inside the cheek, and a rash. The rash starts at the face or upper neck before spreading to the rest of the body, typically to the hands and feet. Measles can lead to severe complications such as blindness, brain swelling and damage (encephalitis), severe diarrhea and related dehydration, ear infections, and breathing problems, all of which can potentially lead to death (WHO, 2023). Infections during pregnancy can result in health issues for the mother, premature birth, and a low birth weight. At-risk groups involve malnourished children or children with a weak immune system due to diseases such as HIV. Other vulnerable groups include unvaccinated children and pregnant persons who have the highest rates of developing severe complications (WHO, 2023).

The most effective forms of prevention are routine childhood vaccinations and community-wide vaccination (WHO, 2023). There are no treatments for measles, but steps can be taken to alleviate symptoms and prevent complications such as drinking sufficient fluids, taking vitamin A supplements, and using antibiotics to treat infections or breathing problems.

Since 2014, there have been 3 notable outbreaks in Los Angeles. In 2014-2015, a large outbreak of measles traced back to Disneyland affected at least 131 California residents and residents from other states and neighboring countries (California Department of Public Health, 2020). Another outbreak occurred in 2019 resulting in 73 confirmed cases in California, of which 20 cases were Los Angeles County (LAC) residents and 14 cases were non-residents traveling through LAC (LACDPH, 2020). LAC Health Officer Dr. Muntu Davis confirmed that the outbreak began as a result of residents visiting countries such as Vietnam and Thailand and contracting measles (Karlamangla, 2019). The majority of residents who contracted the disease were unvaccinated. This prompted one of the largest quarantines in California which included more than 1,000 UCLA and Cal State L.A. students and staff members (Nelson, 2019). The most recent outbreak took place in 2020 due to international visitors who were unvaccinated or of unknown vaccination status (LACDPH, 2020). Dr. Davis recommended the MMR immunization as an effective preventative measure.

There were 0 cases of measles in 2023 and only 1 case of measles in a LA County resident in 2024 (Dador, 2024). Although there have been no local outbreaks in 2024, multiple travelers to Los Angeles were infected with measles, potentially exposing individuals.

As of September 9, 2025, there have been 1,454 confirmed cases of measles reported in 42 states and 3 confirmed deaths from measles (Centers for Disease Control and Prevention, 2025). This is the second highest total of measles cases in the United States since 1992 (Lin, 2025). LA County has recorded 4 cases of measles so far in 2025 (Lin, 2025). Most of this year's cases were linked to individuals who either traveled internationally or to parts of the United States with ongoing community transmission of measles (Lin, 2025).

On September 11, 2025, a school-aged LA County resident died from complications of a past measles infection (LACDPH, 2025). The child was infected with measles during infancy before they were eligible for the vaccine (LACDPH, 2025). They recovered from the infection, but developed and died from subacute sclerosing panencephalitis (SSPE), a rare complication from measles (LACDPH, 2025). SSPE is a progressive brain disorder that causes the loss of neurological function, and usually develops 7 to 10 years after initial infection despite recovery (LACDPH, 2025). There is no cure or treatment and death occurs 1 to 3 years after initial diagnosis (LACDPH, 2025). Developing SSPE is incredibly rare, affecting 1 in 10,000 individuals with measles (LACDPH, 2025). However, if measles is acquired during infancy, that risk rises to 1 in 600 (LACDPH, 2025).

With measles resurging in the United States, over 350 Southern California schools have been audited for failing to meet the measles vaccination threshold (Karan & Parsonnet, 2024). The California Department of Public Health requires schools to meet a 90% threshold of fully-vaccinated students (Palombo, 2024). According to data from 2024, 209 schools in Los Angeles County, 61 of which are in the Los Angeles Unified School District, are below the 95%

threshold in order to maintain herd immunity (Palombo, 2024). Schools who allow students to attend school without meeting immunization requirements risk losing funding during audits where students must be excluded from attendance reports, thus reducing average daily attendance funding (Lambert et al., 2023). School staff are required by California law to report vaccination rates every fall and report 30 day updates on students who are in the process of meeting vaccination requirements (Lambert et al., 2023). Due to the COVID-19 pandemic and the spread of misinformation, vaccination rates plummeted which made thousands of students ineligible to start school. To meet vaccination threshold requirements, school districts sent home information regarding vaccinations and held vaccination clinics (Lambert et al., 2023). Additionally, a health services team connected with the families to provide vaccination resources. These initiatives improved vaccination rates to meet threshold requirements.

Action Plan:

The Health Commission urges the adoption of the stated recommendations to improve public health control over the spread of measles and improve vaccination rates, especially in the Los Angeles Unified School District.

STD/HIV Testing and Resources

Recommendations:

1) Support the implementation of the Ending the HIV Epidemic Plan for Los Angeles County.
    a) Aim to not only increase awareness of HIV status, but to also increase early stage diagnoses.
    b) Tailor efforts with the input and implementation of community members of disproportionately affected populations to provide culturally appropriate services.
2) Improve working conditions and compensation for the waning workforces.
3) Increase STI screening at programs for people with SUD and at correctional facilities and at field outreach events for the individuals who are homeless.
4) Increase funding to HIV prevention programs like AIDS Project Los Angeles (APLA) in order to reduce the spread of STIs.
5) Educate individuals on the following (Huizenga, 2024):
    a) Increase public awareness of how STDs present to promote early detection and treatment.
    b) Educate individuals on condom effectiveness to encourage safer sex practices.
    c) Provide clear guidance on when and how often to get tested for STDs.
    d) Incorporate general health and hygiene education into STD prevention efforts.
    e) Destigmatize all STDs, with a particular focus on herpes and HIV.
6) Prevent the spread of STDS through school initiatives such as providing free condoms, implementing condom usage education, and strengthening education efforts promoting HPV vaccination for 7th-grade entry (Huizenga, 2024).
7) Implement awareness campaigns and interventions for detection such as declaring September as "National STD Check-Up Month" to identify asymptomatic carriers, ensuring same-day STD testing and treatment availability in all high schools, and encouraging annual STD testing for students each fall (Huizenga, 2024).
8) Support treatment efforts that ensure all infected individuals and their partners receive treatment to reduce reinfection and community spread (Huizenga, 2024).
9) Invest in research (Huizenga, 2024):
    a) Vaccine research for syphilis, gonorrhea, and chlamydia.
    b) Antibiotic research to combat resistant strains of gonorrhea.
    c) Accelerate herpes vaccine development.
10) Legalize sex work (Huizenga, 2024).

Background:

A sexually transmitted disease (STD), or sexually transmitted infection (STI), is an infection that is transmitted during sexual contact or through intimate physical contact (CDC, 2023). Infectious agents include viruses, bacteria, fungi, or parasites. In 2021, over 90,000 cases of STIs were reported in Los Angeles Country (LAC) and these numbers continue to rise

(LACDPH, 2021). The most commonly reported STIs in Los Angeles include chlamydia (58%), gonorrhea (31%), and syphilis (10%) (LACDPH, 2021). Another prominent STI is human immunodeficiency virus (HIV), which attacks the immune system and can develop into acquired immunodeficiency syndrome or AIDS if left untreated (CDC, 2023). In 2021, Los Angeles reported over 58,000 people living in HIV (PLWH), with males accounting for 90% of this population (LACDPH, 2021).

In response to the HIV epidemic in the United States, the CDC launched the Ending the HIV Epidemic (EHE) to reduce new HIV infections by 30% by 2030. The EHE initiative has 4 strategic pillars:

"1) **Diagnose** people living with HIV as early as possible;
2) **Treat** people living with HIV rapidly and effectively to achieve viral suppression;
3) **Prevent** new HIV transmissions using proven interventions;
4) **Respond** quickly to HIV outbreaks and deliver prevention and treatment services to people who need them" (LACDPH, 2021).

To tailor the national initiative, the Los Angeles County Department of Public Health - Division of HIV and STD Program developed the Ending the HIV Epidemic for Los Angeles County which was guided by the EHE pillars, but tailored with effective strategies and interventions that best fit the context of Los Angeles.

"Diagnose" aims to:

1. Increase the percentage of PLWH who are aware of their HIV status to 95%.
2. Reduce the number of undiagnosed persons living with HIV (LACDPH, 2021).

LACHPH plans to reach these numbers by implementing or expanding routine opt-out HIV screenings, especially in high prevalence communities, developing accessible HIV testing programs for at-home, self-testing, and improving annual re-screenings via technology and improved communication (LACDPH, 2021).

"Treat" aims to:

1. Increase the proportion of people diagnosed with HIV who are linked to HIV care within one month of diagnosis to 95%.
2. Increase the proportion of diagnosed PLWH who are virally suppressed to 95% (LACDPH, 2021).

Some strategies to reach these numbers include:

- Rapid linkage to HIV care and antiretroviral therapy for newly diagnosed individuals.
- Support for re-engagement/retention in HIV care and treatment adherence [especially for populations suffering from mental illness, substance abuse, etc.].
- Expand promotion of Ryan White Program services (medical care).
- Implement an emergency financial assistance program for PLWH to improve treatment adherence.
- Improve delivery of HIV services [to address workforce burnout].

- Develop a housing service to prevent homelessness in PLWH.
- Understand the impact of financial incentives to improve treatment adherence.

"Prevent" aims to:
1. Increase the proportion of persons prescribed PrEP with an indication for PrEP to at least 50% from a 2017 baseline of 21.5%.
2. Increase the number of syringe service programs by 50% (LACDPH, 2021).
The two main strategies to accomplish this include efforts to increase PrEP use by implementing strategies at LAC funded PrEP Centers of Excellence and improve integration of comprehensive syringe services programs (SSPs).

"Respond" aims to:
1. Develop and maintain capacity for cluster and outbreak detection and response.
2. Increase the proportion of people newly diagnosed with HIV that are interviewed for Partner Services within 7 days of diagnosis to at least 85%" (LACDPH, 2021).
Strategies to meet these goals include improving procedures used for cluster detection, time-space analysis, and response as well as increasing capacity of Partner Services.

Dr. Robert Huizenga outlines a 6 step initiative toward eliminating STDs: (1) education, (2) prevention, (3) detection, (4) treatment, (5) research, and (6) politics (Huizenga, 2024). **Education** involves informing individuals about the presentation of STDs, the effectiveness of condoms, regular testing, general health and hygiene, and the stigmatization of STDs with a focus on herpes and HIV. **Prevention** largely focuses on implementing interventions in schools: providing free condoms in schools, teaching kids how to use condoms properly, and pushing for HPV vaccination for entry to the 7th grade. Additionally, medical professionals should recommend doxycycline prophylaxis in men who have intercourse with multiple male partners per year. Valtrex taken prophylactically should be studied for Herpes Simple Virus prevention. **Detection** requires a coordinated awareness campaign. September should be declared as "National STD Check-Up Month" in order to identify symptomless "carriers." Within schools, implementing same day testing and treatment and encouraging students to test every fall will aid in detection. Furthermore, providing affordable online home-based STD testing and ensuring physician-initiated screenings can improve detection rates. **Treatment** is a crucial step that requires not only the treatment of all infected persons, but their partner(s) as well. Increased investment in (1) vaccine **research** for syphilis, gonorrhea, and chlamydia, (2) antibiotic **research** for resistant gonorrhea, and (3) efforts to accelerate herpes vaccine development. Lastly, **political reforms** are necessary to both destigmatize sex/sexually transmitted diseases and properly support the previously mentioned initiatives. This includes legalizing sex work and properly funding public health agencies.

In May 2025, the Trump administration signaled the elimination of $19.45 million in federal grants for HIV and STD prevention in Los Angeles County, causing the county to

prematurely terminate contracts with 39 community-based health providers (Buhl, 2025). These providers included the AIDS Healthcare Foundation, APLA Health, and the Los Angeles LGBT Center (Schrank, 2025). Other LAC providers who would face funding cuts included medical institutions and organizations ranging from major hospitals, nonprofits, and local clinics (Rector and Rust, 2025).

LAC has received $19.45 million annually through the CDC HIV Prevention and Surveillance Cooperative Agreement and the *Ending the HIV Epidemic* (EHE) initiative because it is one of 57 priority jurisdictions with a high prevalence of HIV (Buhl, 2025). Despite these efforts, public health leaders and healthcare providers warn that federal budget cuts have made the 2030 goal unlikely to be met and places decades of progress at risk of being reversed (Buhl, 2025).

Since 1993, the cooperative agreement has reduced new HIV infections in LAC from approximately 7,000 per year in the 1990s to 1,400 in 2024 (Buhl, 2025). In recent years, the CDC reported a 21% decrease in new HIV cases in jurisdictions receiving EHE funding, including Los Angeles (Buhl, 2025). LAC recorded a 13% decrease in reported HIV cases between July 2022 to June 2023 and July 2023 to June 2024 (St. John, 2025). However, certain areas, such as South Los Angeles, continue to be disproportionately impacted by HIV (St. John, 2025).

Without the federal funding, all domestic HIV prevention programs would be eliminated, including testing, pre-exposure prophylaxis (PrEP) programs, surveillance activities, and referrals to medical care (Buhl, 2025). Approximately tens of thousands of Angelenos rely on these programs and providers for HIV testing and/or PrEP medication to reduce the risk of infection (Schrank, 2025). Public health officials warn that this would reverse decades of work, leading to a dramatic rise in HIV infection rates (Buhl, 2025). The LAC Department of Public Health projects a 40% surge in new HIV cases and an increase in preventable deaths (Schrank, 2025). Department officials estimate that annual HIV infections could increase from the current 1,400 cases to between 1,900 and 2,050 cases (Buhl, 2025). Every new infection represents an estimated $500,000 in lifetime medical expenses (Buhl, 2025).

The impact of federal HIV funding cuts varies widely across LAC's network of service providers. Some organizations, such as APLA Health—a provider that services more than 20,000 patients, primarily from LGBTQ+ and medically underserved communities—have more diversified funding streams that offer a degree of protection (Buhl, 2025). However, many other community-based providers, such as Bienestar Human Services, rely almost entirely on federal dollars for HIV prevention and would face devastating consequences if those funds disappear (Buhl, 2025). Bienestar Human Services serves LGBTQ+ Latinos, undocumented immigrants, and people who inject drugs (Buhl, 2025). The agency anticipates losing approximately $3.7 million in funding and 19 full-time staff positions across its seven community centers (Buhl,

2025). While community providers are preparing to mitigate the damage, the magnitude of the funding cuts will exacerbate the vulnerability of communities that already experience structural barriers to care and disproportionately high rates of HIV infection. These communities include:

- Gay and bisexual men, specifically young Black and Latino gay and bisexual men (Buhl, 2025).
- Transgender women of color (Buhl, 2025).
- Cisgender women of color (Buhl, 2025).
- People who use injection drugs (Buhl, 2025).
- Low-income communities (Rector and Rust, 2025).
- Spanish speaking communities (Rector and Rust, 2025).

While physicians can provide HIV testing and prevention, many patients in these vulnerable communities lack a primary care provider or feel uncomfortable discussing sexual health due to stigmas (Buhl, 2025). Public health officials emphasize that without access to culturally competent and nonjudgmental clinicians or case managers, many patients will avoid seeking prevention services and/or health care (Buhl, 2025).

In June 2025, following widespread criticism from public health experts, HIV service providers, and congressional leaders, the Trump administration lifted its freeze on federal funding for HIV prevention and surveillance programs (Rust, 2025). Los Angeles County subsequently received confirmation from the CDC that it had been awarded nearly $20 million ($19,788,675) for the 12-month period beginning June 1—an increase of $338,019 from the prior year (Rust, 2025).

Although funding has been restored, concerns still remain. Public health officials have noted that the President's budget for the 2026 fiscal year proposes to completely eliminate this funding (Rust, 2025). Officials warn that these funding cuts would undermine lifesaving services and jeopardize decades of progress in reducing HIV transmission (Rust, 2025).

Action Plan:

The Health Commission urges the adoption of the stated recommendations to improve public health control over HIV transmission to work towards a 30% reduction of new HIV infections by 2030.

Meningitis Outreach and Education

Recommendations:

1) Perform antimicrobial susceptibility testing (AST) of all meningococcal isolates.
2) Urge health departments in LA County to submit all meningococcal isolates to the CDC for AST and whole-genome sequencing.
3) Encourage health departments in LA County to report any suspected meningococcal treatment or prophylaxis failures.
4) Increase outreach and health education regarding Meningitis Outbreaks and increase MenACWY vaccinations by:
    - Increasing awareness among vulnerable subpopulations (i.e. gay and bisexual men).
    - Utilizing LA Pride parades and similar festivals for LGBT+ communities.
    - Collaboration with MSM or LGBT+ organizations.
    - Increasing awareness about Meningococcal vaccination recommendations among men who have sex with men (MSM) regardless of risk and HIV status.
    - Raising awareness and improving access to education on safe sex practices.
    - Developing and implementing a community plan for providing immediate access to vaccines during a meningitis outbreak.
    - Utilizing electronic social networks such as Instagram, TikTok, Twitter, Tinder, Grindr, and other technology/social media platforms to provide outreach, education, and connect to sexual partners potentially exposed to the virus.
    - Initiating collaboration between the City and County to roll out health education plans earlier, especially with regards to outbreak alerts and emergency responses.
5) Implement practices to ensure adherence of the 2-dose vaccination schedule for all HIV-infected persons.
6) Implementation of reminder-recall or co-scheduling.
    a) Tracking completion rates
7) Ensure staff who work with MSM have completed recommended vaccinations.
8) Provide [referrals for] free MenACWY vaccines if vaccination is not feasible at primary care providers.

Background:

Meningococcal disease, also commonly known as meningitis, is caused by a bacteria known as *Neisseria meningitidis*. Because this bacteria can be found in the nose and throat, it can be transmitted through contact with saliva or air droplets via coughing or sneezing (LACDPH, 2022). Infection may present with flu-like symptoms such as high fever, headache, stiffness in the neck, vomiting, etc. As the infection becomes severe, meningitis can cause swelling in the brain or spinal cord, loss of a limb, brain damage, and potentially result in death.

Between 2006-2015, the United States has reported an average of 0.26 cases per 100,000 people annually with 14.9% of these cases being fatal (MacNeil et al., 2018). Of these cases, serogroups (variants) B, C, and Y made up the majority of the cases. Within Los Angeles County (LAC), meningitis incidences declined from 3.8 to 1.9 cases per 100,000 from 2015 to 2016 (LACDPH, 2016). The San Gabriel Valley reported the highest rates of meningitis within LAC at 3.4 cases per 100,000. Children under one year of age continued to be the age group experiencing the highest rate at 16.4 cases per 100,000.

Southern California has experienced two outbreaks of meningitis since 2013. The last outbreak occurred in 2016-17 resulting in 31 cases and 4 deaths. Of these cases, men who have sex with men were disproportionately affected with over 80% of cases representing this group (LACDPH, 2017). Since 2016, meningitis cases have significantly decreased to less than 10 cases annually (LACDPH, 2018).

Between 2019 to 2020, the Centers for Disease Control (CDC) reported a rise of penicillin- and ciprofloxacin-resistant meningococci in the United States. 11 cases, one of which was detected in California, contained blaROB-1 β-lactamase gene, linked to penicillin resistance, along with mutations linked to ciprofloxacin resistance. The CDC recommends antimicrobial susceptibility testing (AST) of such cases to better understand and monitor the resistance to penicillin and ciprofloxacin (Los Angeles County Health Alert Network, 2020).

As of 2016, Los Angeles has not experienced any local outbreaks. In May 2024, the CDC issued health advisory alerts of meningococcal disease linked to Umrah travel, an Islamic pilgrimage to Mecca, to the Kingdom of Saudi Arabia (CDC, 2024). Since April 2024, 12 global cases of meningococcal disease have been linked to Umrah travel, 5 of which were cases in the United States. Out of the 12 cases, 9 vaccinated status were known, all of which were unvaccinated. Of the 5 cases in the United States, 3 were caused by serogroup W (NmW), 1 was caused by serogroup C (NmC), and the last serogroup remains unknown (CDC, 2024). The isolate from the one U.S. NmC case was resistant to ciprofloxacin. The CDC recommends the quadrivalent meningococcal (MenACWY) conjugate vaccination and a booster dose of MenACWY if the last dose was administered more than 3 years ago for travelers to countries facing an epidemic of meningococcal disease. The CDC also recommends that health departments and healthcare providers use rifampin, ceftriaxone, or azithromycin instead of ciprofloxacin.

The California Department of Public Health (CDPH) noted that between May 2023-2024, there were 8 cases of ciprofloxacin-resistant invasive meningococcal disease (IMD) (LACDPH, 2024). Of the 8 cases, 6 were in southern California, including 2 in Los Angeles County. The CDPH determined that southern California has met the resistance threshold and as a result, ciprofloxacin should no longer be used for IMD post-exposure prophylaxis in Los Angeles County (LACDPH, 2024).

Action Plan:

The Health Commission urges the adoption of the stated recommendations to improve public health control over meningitis transmission.

Reproductive Health Education and Services

Recommendations:

1) Urge the state of California to increase accountability of school's implementation of the California Healthy Youth Act and *Health Education Framework for California Public Schools, Kindergarten Through Grade Twelve* by developing a grading system to measure school health policies and practices.
    a) Ensure schools are teaching a curriculum that includes the 20 sexual health education topics the Centers for Disease Control and Prevention (CDC) have identified as critical (Sexuality Information and Education Council of the United States, 2021).
    b) Ensure schools do not have exclusionary curriculum and lack inclusive curriculum that is trauma informed and culturally sensitive to the needs of young LGBTQ people and people of color (SIECUS, 2021).
2) Urge the state of California to develop a School Health Profile that is not self-reported and accurately reported by a sexual/reproductive health care professional.
3) Implement more onsite school-based health centers or Wellbeing Centers, spearheaded by Planned Parenthood, throughout the Los Angeles Unified School District.
4) Develop a referral system for connecting students to youth-friendly community providers for medical services not offered on school grounds.
    a) Host regular meetings throughout the year between school staff and healthcare providers from local/community organizations which offers an opportunity for staff to engage with providers, understand their services, and establish avenues for students to access their support (CDC, 2023).

Background:

Reproductive health is defined as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes" which enables individuals to "have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so" (World Health Organization). The Centers for Disease Control (CDC) and Prevention reproductive health services include [and are not limited to]:

- Sexual health education
- Family planning services
- Services to achieve, prevent, or assist pregnancy such as contraceptives or abortions
- Prevention tools such as testing and treatment for STDs, HIV, and pregnancy

These services are intended for both men and women to ensure they can make informed decisions, remain healthy, and safely engage in sexual activities. This section will focus on reproductive health education and services such as contraceptives or abortions. For more information about STDs or HIV testing and resources, please refer to the section above.

In Los Angeles, the LA County Department of Health Services (LAC DHS) provides reproductive health services which include preconception health, contraceptive care, abortions, and STI screenings. The LAC DHS's resource guide details reproductive rights as well as family planning services.

32 out of every 1,000 girls between the ages of 15 and 19 in California have infants every year (School-Based Health Alliance). However, when looking at certain races/ethnicities, these numbers become even more alarming. In African Americans, there are 37 births for every 1,000 girls and this number jumps to 51 in Latinas (SBHA). The SBHA reported only 41% of adolescents access reproductive services because of barriers such as:

- Lack of familiarity in navigating healthcare.
- Ability to pay for services.
- Fear of confidential information being disclosed to family members.
- Concerns about obtaining services without parental/guardian consent.

In response to this, the School-Based Health Alliance, a non-profit organization, has established school-based health and wellness centers (SBHCs) to provide critical reproductive and sexual health services which include education, contraception, counseling, and referral. In Los Angeles County alone, there are 78 SBHCs. Since the integration of SBHCs, studies indicate that adolescent girls with SBHCs on campus have higher rates of receiving reproductive preventive care and using hormonal contraception than girls without SBHCs (SBHA). Furthermore, SBHCs have reduced unplanned pregnancy rates.

The California Healthy Youth Act (AB 329), implemented in 2016, requires schools to provide students in 7th to 12th grade with comprehensive and medically accurate sexual health education which **must** include LGBTI inclusive curriculum (SBHA).

The most recent effort is a collaboration between the Los Angeles Unified School District, the LAC Health Department, and Planned Parenthood. This collaboration includes an initial investment of over $16 million to open 50 clinics at high schools that will offer a range of birth control options, testing and treatment for STIs, and counseling (Cha, 2019). Part of this initiative includes hundreds of "peer advocates" who are trained by a Parenthood staffer to provide information about safe sex. This program addresses many barriers adolescents face by allowing them to make/attend appointments during class and protecting information regarding the appointment and medical services from both school officials and parents. Wellbeing Centers will be staffed full time by 2 public health officials to provide both reproductive health education and counseling, and a medical provider will visit once a week to provide medical services.

Planned Parenthood Los Angeles (PPLA) also provides classroom education and teacher training to deliver "age-appropriate, medically accurate and culturally relevant sexual health education" to thousands of Angelenos every year (PPLA). PPLA's sex education curriculum is aligned with the California Healthy Youth Act's requirements and focuses on critical thinking,

gender equality, human rights, and access to health care. The high school curriculum also looks at the links between topics such as diverse orientations and identities, developing bodies, cultural norms, gender expectations, prevention, and rights in relationships. Presentations are given by PPLA educators with extensive training and expertise in teaching sex education. PPLA also facilitates a range of professional development trainings for teachers at public, charter, and private schools, with both topic and length customized to their needs. PPLA provides both technical assistance and capacity building.

PPLA not only delivers high-quality medical care, but also advances health equity across its 24 health centers in LA County, serving over 260,000 patients each year (Kamlager-Dove, 2025). These clinics provide "life-sustaining and life-saving services," including but not limited to abortions, STD testing and treatment, cancer screenings such as pap smears, and family planning (Dador, 2025). In July 2025, the "One Big Beautiful Bill" was passed with a provision that would defund Planned Parenthood, a move that many public health officials and lawmakers warned would create a public health crisis for hundreds of thousands of Angeleno patients (Dador, 2025). Despite funding cuts, PPLA announced they would continue to see and provide medical services to patients.

In California, more than 80% of Planned Parenthood's patients rely on Medi-Cal in order to receive cancer screenings, birth control, and other live-saving medical services (Kamlager-Dove, 2025). Defunding Planned Parenthood will cause (Kamlager-Dove, 2025):

- Cancers to go undetected.
- The STI crisis to worsen.
- A decline in wellness exams and preventative care.
- A reduction in accessibility to birth control.
- Patients to forgo routine appointments and rely on overcrowded emergency rooms.

In August 2025, the Trump Administration canceled a $12.3 million sexual education grant to California, claiming California was promoting "radical gender ideology" and state officials refused to alter materials (Blume, 2025). This grant supports sex education programs in homeless shelters, foster care group homes, juvenile justice facilities, and schools, educating ~13,000 youth every year (Blume, 2025). It also supports the California Personal Responsibility Education Program (CA PREP) which provides comprehensive sex education to adolescents using evidence-based models (Blume, 2025). CA PREP participants demonstrated a stronger understanding of sexual and reproductive health and experienced improved health outcomes (Blume, 2025).

In response, Governor Gavin Newsom signed a series of bills into law to protect patient privacy, reproductive freedoms, access to reproductive health care, and California physicians from out-of-state legal actions related to providing reproductive care (California Medical Association, 2025). AB 260 (Aguiar-Curry) allows providers to anonymously prescribe

medication abortion, requires California-regulated health plans to cover mifepristone despite changes in federal approval status, and protects providers from out-of-state legal actions (California Medical Association, 2025). AB 45 (Bauer-Kahan) strengthens privacy protections by prohibiting reproductive health information collected in research settings from being shared with out-of-state law enforcement (California Medical Association, 2025). AB 50 (Bonta) also strengthens privacy protections by restricting the release of patient information to out-of-state law enforcement (California Medical Association, 2025). AB 1525 (Assembly Judiciary Committee) protects attorneys who support patients and health care providers navigating abortion laws from State Bar disciplinary actions (California Medical Association, 2025).

Action Plan:

The Health Commission urges the adoption of the stated recommendations to improve public education and understanding of reproductive health, especially for Angeleno youth.

Maternal and Child Health Education and Services

Recommendations:

1) Addressing financial inequities by providing education and support (First5LA):
    a) Support Los Angeles County's partnership with The California Work & Family Coalition which has recruited 50 community members to provide education and Paid Family Leave (PFL) support (First5LA).
    b) Support African American Infant and Maternal Mortality (AAIMM) Initiative's public awareness campaign of Earned Income Tax Credit which increases employment and income for families and improves birth outcomes (First5LA).
2) Expand the AAIMM Doula Program to:
    a) Offer free training to increase the number of doulas in Los Angeles County, especially in the Antelope Valley, South LA, and the South Bay where Black infant mortality rates are highest (First5LA).
    b) Continue to provide free, culturally sensitive doula support through 2025.
    c) Collect quantitative and qualitative data.
3) Improve the cultural sensitivity of interventions in order to reduce disparities in vulnerable communities such as Black communities.
    a) Integrate the findings from the Resources, Inspiration, Support and Empowerment (R.I.S.E.) Study to improve usability and accessibility of Los Angeles County interventions, frameworks, and mobile health applications.
4) Urge federal and state governments to fund more OB/GYN residency spots, increase pay per delivery, and support the financing of 24/7 anesthesia and blood banking in hospitals that deliver infants.
5) Urge the Los Angeles County Department of Public Health to foster collaboration between their Environmental Health Division and Maternal, Child, and Adolescent Health Program.
    a) Collect comprehensive data on severe childbirth complications.
    b) Despite data showing the relationship between environmental health and maternal and infant health, little to no collaboration occurs between these two departments (Ross, 2023).

Background:

Although Los Angeles County (LAC) reports a lower infant mortality, low birth weight births, and preterm birth rate compared to the rest of the country, these rates are not consistent across racial and ethnic groups, most notably Black mothers (LACDPH). Black mothers are 4 times more likely to die from complications during pregnancy or childbirth and Black infants are 3 times more likely to die before completing 1 year of life compared to their White counterparts (First5LA, 2021). In response to such disparities, the LAC Department of Public Health (LACDPH) established the Maternal, Child, and Adolescent Health (MCAH) Programs. The MCAH Division's mission is "To maximize the health and quality of life for all women, infants,

children, adolescents, and their families in Los Angeles County" by planning, implementing, and evaluating services to address the health disparities and needs of these groups (LACDPH). The MCAH's work includes resources, programs, and information for before pregnancy, during pregnancy, after the baby is born, and child & adolescent health.

In 2017, the LACDPH's Office of Women's Health and Office of Health Assessment & Epidemiology published *Health Indicators for Women in Los Angeles County*. The statistics from the report are summarized in the chart below.

	Asian	Black	Latina	White
Percent of low weight (< 2,500 grams) births per 100 live births	6.7	12.1	6.5	6.5
Percent of preterm births (17 to 37 weeks gestation) per 100 live births	7.4	12.8	9.4	7.8
Birth rate for females 15 to 19 years (per 1,000 females 15 to 19 years)	2.7	28.7	31.7	4.3
Percent of all live births where mother received prenatal care in the first trimester of pregnancy	81.2	71.9	82.2	86.3
Percent of women with a recent live birth who received a postpartum checkup	94.2	88.1	91.1	94.8
Percent of women with a recent live birth who report exclusively breastfeeding at 3 months	46.1	31.5	29.6	58.6
Percent of women with a recent live birth who report experiencing depressive symptoms during or after a live birth	24.5	38.3	35.1	24.6

Although Black women and infants face a higher risk of dying in pregnancy and birth, understanding the data and underlying causes is quite complex. Multiple contributing factors

include socioeconomic status, pre-existing and pregnancy inducing chronic conditions, and health care inequities need to be properly analyzed.

	2021					2022					2023				
	LIVE BIRTHS	INFANT DEATHS	IMR	95 % CL		LIVE BIRTHS	INFANT DEATHS	IMR	95 % CL		LIVE BIRTHS	INFANT DEATHS	IMR	95 % CL	
White	21,065	71	3.4	2.6	4.2	20,124	53	2.6	1.9	3.3	19,385	50	2.6	1.9	3.3
Hispanic	52,502	210	4.0	3.5	4.5	53,070	212	4.0	3.5	4.5	50,272	215	4.3	3.7	4.8
African American	7,469	53	7.1	5.2	9.0	6,793	64	9.4	7.1	11.7	6,179	55	8.9	6.6	11.2
Asian	11,906	36	3.0	2.0	4.0	11,527	29	2.5	1.6	3.4	10,906	29	2.7	1.7	3.6
Los Angeles County	95,734	376	3.9	3.5	4.3	95,313	370	3.9	3.5	4.3	90,452	361	4.0	3.6	4.4

Figure 2. Infant Mortality Rate (infant deaths/1,000 live births) and counts by Mothers' Race/Ethnicity and Year, Los Angeles County 2021‑2023 (Franklin, Jones, O'Conner, 2025).

The figure above shows the number of live births and infant deaths from 2021 to 2023 among White, Hispanic, African American, and Asian mothers. The infant mortality rate (IMR) is calculated by the number of deaths to infants within the first year of life per 1,000 live births (Franklin, Jones, O'Conner, 2025). White infants have consistently experienced the lowest IMR across all groups, whereas Black infants have consistently experienced the highest IMR—rates that are 2 to 3.6 times higher than those of any other racial group (Franklin, Jones, O'Conner, 2025). Franklin and Jones stated that the leading cause of infant mortality is premature birth.

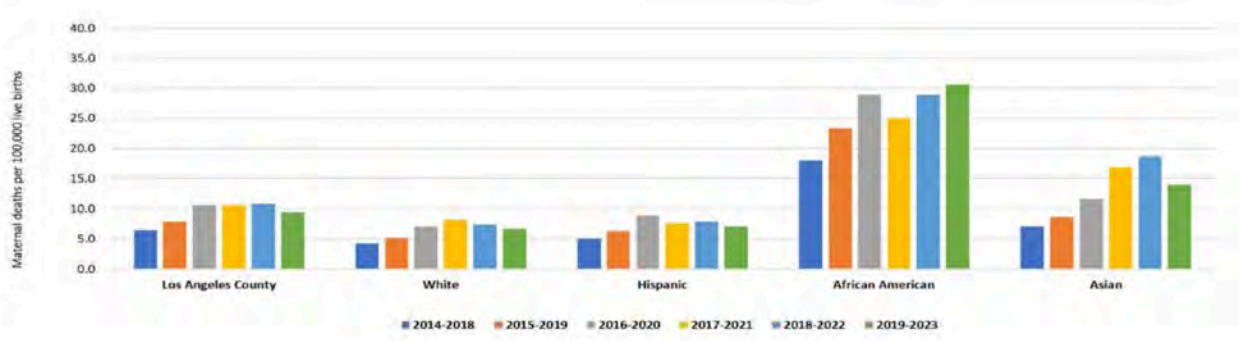

Figure 3. Maternal Mortality Ratio by Race/Ethnicity, Los Angeles County, 5-Year Moving Averages, 2014-2023 (Franklin, Jones, O'Conner, 2025).

Figure 3 shows the ratio of maternal deaths per 100,000 live births among White, Hispanic, African American, and Asian mothers. A maternal death is defined as the death of a woman while pregnant or within 42 days of termination of pregnancy from any cause related to or aggravated by pregnancy or its management (Franklin, Jones, O'Conner, 2025). Most notably, African American women experience a maternal mortality ratio 2 to 4 times higher than any race. Franklin and Jones also pointed out a few notable outcomes. Black women who have never smoked face worse outcomes than White women who did smoke. Black women with a college education also face worse outcomes than White women with a high school education.

Together, this data highlights a persistent pattern of racial inequities in maternal and infant health. Despite California having better averages and outcomes than the nation, Black mothers and infants still experience the poorest outcomes across all reported measures. The fact that Black women with higher education levels or no history of smoking still fare worse than White women with fewer socioeconomic advantages demonstrates that these disparities cannot be explained by individual lifestyle behaviors or factors alone. They reflect the broader structural determinants including unequal access to high-quality care and systemic biases within the health care system. The combined trends in infant and maternal mortality underscore the urgent need for targeted and culturally inclusive interventions as well as policy action to address the drivers of these inequities.

Because of the pervasive issues surrounding pregnancy and birth in Black communities, the LACDPH announced in 2018 it would reduce the gap between Black and White infant mortality rates by 30% (Ross, 2023). To achieve this goal, the LACDPH partnered with local and state departments and organizations, such as First 5 LA, which produced the African American Infant and Maternal (AAIMM) Initiative. This initiative improved upon the county's maternal and infant health programs by expanding access to doulas, breastfeeding education and support, etc. (Ross, 2023). Some evidence-based programs implemented by the AAIMM Initiative include Group Prenatal Care, Fatherhood Initiative, The Village Fund, and Cherished Futures for Black Moms & Babies (First5LA).

One of the key solutions aimed at reducing maternal and infant mortality rates are doulas. Doulas are "trained professionals who provide physical, emotional and informational support to a laboring person and/or family before, continuously during, and after childbirth to help them achieve the healthiest, most satisfying experience possible" (First5LA). They are known to:

- Provide unconditional and non-judgmental support.
- Reduce medical interventions (c-sections).
- Improve mental health because they are trained in full-spectrum and trauma care.
- Increase breastfeeding success.

AAIMM's Doula Program funds a team of Black doulas to serve 200 patients in LA County every year (Franklin, Jones, O'Conner, 2025). Doulas provide clients with (Franklin, Jones, O'Conner, 2025):

- 3 prenatal visits.
- Availability throughout pregnancy.
- Support for any pregnancy outcome.
- Labor and birth support.
- Mental health screening and referral.
- 3 postpartum visits, regardless of outcome.

Unlike many other states, California's maternal mortality rates have decreased because of efforts to reduce deaths caused by obstetric hemorrhage and preeclampsia. In 2022, Medicaid financed 41% of births nationwide which included 64% of Black mothers (Valenzuela & Osterman, 2023). Approximately 50% of counties in the U.S. do not have an OB/GYN. Women living below the poverty line have roughly 72 births per 1000. This creates a situation where both poor paying health maintenance organizations (HMOs) and the government compel doctors who accept these plans to spend less time with each pregnant woman. Government entities, insurance providers, and regulators have pressured obstetricians to adopt more aggressive approaches in inducing and augmenting labor. As a result, the prevalence of postpartum hemorrhage has increased from 2.7% to 4.3% between 2000 and 2019. This upward trend has predominantly affected women in rural and low-resource inner-city hospitals. Cedars-Sinai has emerged as a leader in the nationwide effort to reduce maternal mortality risks and increasing OB/GYN access to women of color due to their state of the art and high resource hospital. It is imperative for federal and state governments to fund more OB/GYN residency spots, increase pay for physicians and hospitals per delivery, and finance 24/7 anesthesia and blood banking in hospitals with high delivery volumes.

Additionally, like Philadelphia, an initiative to collect data on severe childbirth complications is essential, as these issues occur 70-80 times more than mortality. Lowering mortality rates hinges on addressing and mitigating these near misses.

In the United States, 20% of individuals who give birth experience Perinatal Mood Anxiety Disorders (PMADs) every year (Gregory & Accortt, 2024). Perinatal Mood Anxiety Disorders (PMADs) are defined as a mental health disorder experienced during pregnancy, after adopting a new baby, after giving birth to a new baby, or experiencing pregnancy/infant loss (Minnesota Department of Health, 2023). Diagnosis can include anxiety, psychosis, depression, obsessive-compulsive disorder (OCD), bipolar disorders, and post-traumatic stress disorder (PTSD) (Gregory & Accortt, 2024). Risk factors for PMADs include stress life events, pregnancy with twins or multiples, low or no social support, previous experiences with depression or anxiety, familial history of depression, difficulties getting pregnant, preterm (before 37 weeks) labor and delivery, pregnancy and birth complications, and racial discrimination (Gregory & Accortt, 2024).

PMADs are the most common complication of pregnancy. Prenatal depression and anxiety are linked with poorer maternal health behaviors and risk of developing postpartum depression (Gregory & Accortt, 2024). Less than 75% of individuals with PMADs receive treatment. When left untreated, PMADs can have traumatic short and long term consequences. In a 2022 CDC Report, mental health conditions made up 23% of perinatal deaths and more than 80% of pregnancy-related deaths were preventable (Gregory & Accortt, 2024).

Some notable social determinants of health include socioeconomic status, age, and race/ethnicity. Twice as many low-income respondents reported postpartum depression compared to their high-income counterparts (Gregory & Accortt, 2024). Younger respondents under the age of 20 were 2.7 times more likely to report experiencing postpartum depression compared to their counterparts over the age of 35. More American Natives (23%) and African American (18%) respondents reported experiencing postpartum depression compared to their White counterparts (9%) (Gregory & Accortt, 2024). In California, Black women experience PMADs two times the rate of White women. Despite the higher prevalence of PMADs in Black women, White women were twice as likely to initiate mental health treatment compared to Black women. In the instances where Black women initiated care, they were less likely to receive follow up treatment. Black women were also more likely to decline offers of medication and therapy. This has resulted in many Black women turning to family or faith leaders for care and support.

Although there are many PMAD interventions, individuals face barriers such as lack of awareness, stigma of discussing mental health concerns, fear of their baby being taken away, marital or family discord, apprehension due to history of medical racism, insurance or financial issues, exclusive reliance upon religion, and lack of access to Medicaid or free/low fee services (Gregory & Accortt, 2024). For Black patients, they report often experiencing worse communication with their physicians and advocate less for themselves compared to their White counterparts (Gregory & Accortt, 2024). Black patients felt discomfort when discussing mental health struggles with their White providers and offered culturally insensitive interventions. Additionally, mobile health apps further contribute to these disparities by catering to White women. To combat this, the Resources, Inspiration, Support and Empowerment (R.I.S.E.) Study for Black Maternal Mental Health works to test a mobile health (mHealth) web application informed by real world experiences. mHealth allows Black pregnant individuals to learn stress management techniques and help participants create a self-care plan in order to obtain emotional wellbeing.

Action Plan:

The Health Commission urges the adoption of the stated recommendations and agency collaboration to help promote the Los Angeles County Department of Public Health and African American Infant and Maternal Mortality Prevention Initiative's mission to improve maternal and infant mortality rates, especially among Black communities.

Medication Shortages

Recommendations:

1) Develop high-quality quantitative databases that include:
    a) Clinical and financial effects of the shortages to quantify impacts.
    b) Clinical and financial impact of shortages on patients and health care delivery to better inform purchasing decisions (FDA, 2019).
        i) Health outcomes for patients
        ii) Increased costs for health care providers
2) Better characterization of shortages using the following metrics: frequency, persistence, or intensity (FDA, 2019).
3) Develop a rating system to incentivize drug manufacturers for mature quality. management systems and adhere to Current Good Manufacturing Practices (FDA, 2019).
4) Allocate resources to enhance pharmacy automation and electronic health records to become more adaptable during shortages.
    a) Automated systems to track medication levels in real-time and flag low stock.
    b) Advanced electronic health records to incorporate alerts or alternatives for healthcare providers when medications are in shortage.
5) Lobby Congress to amend section 510(j) of the Federal Food, Drug, and Cosmetics Act to incorporate significant consequences for manufacturers that neglect to develop risk management plans or disclose manufacturing and supply chain data (ASHP, 2023).
6) Lobby the Federal Government and California legislature to outlaw Pharmacy Benefit Managers (PBMs) and Group Purchasing Organizations (PBOs) and empower pharmacy chains to compete in an open market for the lowest cost.
    a) Rescind the 1987 Medicare Anti-Kickback Safe Harbor.
7) Urge the federal government to diversify the manufacturing base by spreading purchase volume across federal agencies to more than 3 manufacturers.
8) Lobby Congress to direct investments and subsidies toward [new] domestic drug manufacturing (Kaiser, 2023).
    a) Incorporate a mandate of the production of older generic medication.
9) Require manufacturers to share:
    a) Data about their supply chain and production process to identify areas threatening shortages (Kaiser, 2023).
    b) Public resupply timelines when drug shortages occur.

Background:

As of November 2025, there are 76 drugs currently listed on the Food and Drug Administration's (FDA) drug shortage database which is a decrease from 141 drugs in January 2024. However, this number could be even higher than the FDA's report. The American Society of Health-System Pharmacists (ASHP) reported 214 active shortages in September 2025, down from the all-time high of 323 during the first quarter of 2024.

The FDA and ASHP both track drug shortages, but they do so in different ways and for different purposes (Pollock, 2025). The FDA focuses on national supply and demand, declaring a shortage only when the total available supply from all manufacturers cannot meet national demand (Pollock, 2025). In contrast, the ASHP reports shortages by company, dosage form, strength, and specific vial or syringe sizes, resulting in a significantly longer list than the FDA's (Pollock, 2025). This difference reflects each organization's purpose: ASHP tracks product-level and company-specific disruptions, while the FDA evaluates whether these disruptions can affect national drug availability. Despite this, Pollock (2025) notes neither system addresses the regional availability issues many patients encounter, even when the national supply is sufficient.

Drug shortages include medications to treat psychiatric conditions, respiratory illnesses, infections, heart failure, and cancer (Comer et al., 2023). Other drugs facing shortages are Adderall, cisplatin/carboplatin, amoxicillin, penicillin, albuterol, and children's acetaminophen and ibuprofen.

The FDA's Drug Shortages Task Force identified the following 3 root causes in 2019:

- Lack of incentive to produce drugs that are less profitable.
- Manufacturers are not rewarded for mature quality management systems nor incentivized to adhere to Current Good Manufacturing Practices which affect quality of drugs or cause disruptions.
    - Purchasers have limited information about facilities that produce drugs and don't have the ability to assess quality management standards.
- Logistical and regulatory challenges negatively impact a market's ability to recover after disruptions.

The shortage of crucial drugs began prior to the COVID-19 pandemic, but has been exacerbated by pandemic delays, closure of U.S. factories, and overreliance on foreign facilities (Comer et al., 2023). Almost 80% of manufacturers are foreign facilities and no U.S. agency monitors all manufacturers leaving a blind spot for incoming shortages (Christensen, 2023). Ultimately, the biggest constant is competition to offer the lowest price (Lopez, 2023). When manufacturers cut corners to reduce prices, the quality of drugs are compromised and manufacturers are unprepared when demand increases.

As a result of shortages, 8 in 10 hospitals and pharmacists reported that they had to ration drugs or even delay appointments, resulting in reduced quality of patient care (ASHP, 2023). 84% of the drugs in shortage are generics which make up 90% of prescriptions (Christensen, 2023). The most notable generic shortages are chemotherapy drugs due to poor manufacturing quality (ASHP, 2023). The severe chemotherapy drug shortages have caused the FDA to temporarily permit the import of medications manufactured by non-FDA approved Chinese manufacturers (Comer et al., 2023). According to the National Association of Boards of

Pharmacy (NABP, 2025), when drug shortages occur, there are disruptions in care, lower adherence, and an increase of burdens for both patients and providers.

Congress has introduced several bills in effort to address the factors contributing to drug shortages (NABP, 2025). The Drug Shortage Prevention Act expands existing reporting requirements by obligating manufacturers to notify the FDA of production disruptions, unexpected surges in demand, and other changes that could lead to a drug shortage (NABP, 2025). The End Drug Shortage Act strengthens early-warning systems by requiring clear definitions of demand surges and allowing the FDA to incorporate stakeholder reports into its official shortage designations (NABP, 2025). The Finance Committee's proposal would introduce Medicare incentives in order to encourage purchasers to enter multi-year contracts for generics that are prone to shortages (NABP, 2025). Longer-term purchasing agreements would promote a reliable supply of essential generic mediations through predictable pricing (NABP, 2025).

On the state level, many approaches have been taken to mitigate drug shortages such as strategic stockpiling, expanding pharmacists' authority for substitutions, improving transparency in supplies by tracking inventories and alerting the public of shortages, and reforming procurement policies (NABP, 2025). For example, California is among the states stockpiling medical abortion drugs to prepare for potential shortages due to future federal-level restrictions.

On the local level, the National Community Pharmacists Association (NCPA) and the University of Southern California (USC) have launched the first publicly available, interactive pharmacy shortage mapping tool (Nowosielski, 2025). These organizations partnered together to address availability issues due to pharmacy shortage areas (Nowosielski, 2025). This mapping tool allows users to track pharmacy closures or openings while separating data by state, country, and congressional district.

Action Plan:

The Health Commission urges the adoption of the stated recommendations to improve supply of medications and reduce the number of medications on the shortage list.

Community Health Workers/Promotoras de Salud

Recommendations:

1) Urge the Los Angeles County Department of Public Health to promote interagency and cross program collaboration with Community Health Workers and Promotoras in order to respond more effectively to community needs.
    a) Develop institutional mechanisms for Promotoras to continuously inform organizations about new developments from their interactions with community members (National Health Foundation).
2) Offer professional development opportunities for Community Health Workers and Promotoras.
    a) Allow Community Health Workers and Promotoras to attend trainings associated with professional networks, advocacy, and education (National Health Foundation).
    b) Partner with education/training providers and funders to advocate for lower-cost bilingual professional development (National Health Foundation).
    c) Provide cross trainings with agencies and promotoras.
3) Integrate Community Health Workers and Promotoras into community health programs and services by (National Health Foundation):
    a) Allowing for relationship building, community education, engagement, and mobilization in programmatic activities.
    b) Include Community Health Workers and Promotoras in the development and evaluation of program strategies, work plans, and evaluation tools.
    c) Provide ongoing guidance and supervision necessary to support and encourage Community Health Workers and Promotoras.
    d) Remove barriers that limit Community Health Workers and Promotoras' role including being limited to one issue and being confined to working in the office.
4) Develop training programs for Community Health Workers (CHWs) and Promotoras to successfully navigate new technologies for data tracking (National Health Foundation).
    a) Host group and individual training sessions to ensure CHWs and Promotoras are comfortable with forms and technology.
    b) Practice filling out forms, entering data, or using technologies with each CHW and Promotoras.
    c) Facilitate role-play activities that allow CHW and Promotor to identify mistakes in forms or digital processes such as incomplete forms.

Background:

Marginalized and minority communities face barriers such as language, customs and traditions, and socioeconomic status when accessing health services and information on healthcare (National Health Foundation). Community Health Workers (CHWs), also known as

Promotoras de Salud in Spanish, are community members who deliver culturally competent healthcare. Because Promotoras come from and are a part of the communities they serve, they share a language, culture, values, and understanding of community resources which allows them to build relationships, connect, and engage with patients (National Health Foundation). Promotoras not only share information with community members about local resources, but also act as advocates for both individual and community transformation by influencing the policies related to critical issues their communities face (Lemus, 2024). The seven core roles of Promotoras include the following (National Health Foundation):

1. Cultural mediation between communities and the social service system.
2. Culturally appropriate and accessible health education.
3. Ensure people get the services they need including enrollment.
4. Provide counseling and social support.
5. Advocate for individuals and communities within social services systems.
6. Provide direct services and administer health screening tests.
7. Build individual and community capacity.

The Promotor Model is able to create healthy communities in 3 stages: (1) relationship building, (2) sharing information and local resources, and (3) creating opportunities for community participation (Lemus, 2024). Building quality relationships has the potential to create community change and Promotoras develop social support networks as well as teach system navigation. Promotoras share information that reflect the circumstances that people live in such as the specific determinants of health present. They also employ individual and collective action to improve services such as teaching families how to advocate for access to healthy foods.

In 2020, the Los Angeles County Department of Public Health (LACDPH) established the Community Health Worker Outreach Initiative (CHWOI) to mobilize CHWs during the pandemic. CHWOI coordinated with 16 community-based contracts, such as East LA Women's Center and Clínica Msr Oscar A. Romero, to use existing CHW networks and peer providers (LACDPH). Since 2020, over 500 CHWs have been trained on COVID-19 mitigation strategies, deployed to communities most impacted by the pandemic, and conducted community outreach to provide accurate information regarding COVID-19 (LACDPH). Some notable accomplishments include over 820,000 outreaches and 29,000 vaccine appointments (LACDPH). In 2023, CHWs expanded their roles to assist Angelenos in navigating systems to obtain food, housing, and financial assistance (LACDPH).

Two significant impacts from CHWs and Promotoras include reducing cancer disparities in Los Angeles and advancing clean energy in disadvantaged communities. Los Angeles County has one of the largest immigrant, LGBTQ+, and ethnically-diverse populations (Surani, 2024). Mapping late-stage breast cancer cases revealed geographic disparities in Koreatown and Pico-Union Neighborhoods, prompting targeted CHW and Promotora training (Surani, 2024). Cancer education was adapted for Korean, Spanish, and Tagalog speakers, with 42 CHWs and

Promotoras deployed to provide cancer education, screening navigation, and clinical trial recruitment. In Korean communities, 32 CHWs engaged 16 churches, identifying 237 women noncompliant with screening, ultimately increasing compliance from 0% to 68%. In 2023, over 100 cancer education events were held, leading to over 1,200 cancer screenings and 11 cancer diagnoses. CHWs at federally qualified health centers (FQHCs) made notable contributions such as significantly increasing the return rate for test kits and a fourfold increase in mammography outreach (Surani, 2024). These efforts highlight the crucial role of CHWs and Promotoras in addressing healthcare disparities through community-based interventions.

CHWs and Promotoras naturally connect with their communities which allows them to provide cost-effective services and encourage community participation in improving health while reinforcing cultural values and norms (Lemus, 2024). They help individuals keep appointments and increase access to prevention as well as follow up care while decreasing the effect of cultural and linguistic barriers for organizations (Lemus, 2024). Because of their essential role across California, California looked to CHWs and Promotoras to reduce health disparities, but has rolled back many initiatives. In 2019, the California Future Health Workforce Commission recommended the integration of CHWs into the health care system to improve the health of immigrant populations (Sánchez, 2025). California set out to (1) professionalize thousands of CHWs by creating a standardized certification program, (2) integrate 25,000 CHWs into the health care workforce by 2025, and (3) provide fair wages via Medi-Cal reimbursements (Sánchez, 2025). In 2022, the state approved $281 million for the California Department of Health Care Access and Information to recruit, train, and certify CHWs (Sánchez, 2025). The department attempted to standardize the process; however, community organizations argued that this approach would create barriers because it failed to account for lived experiences and cultural competencies (Sánchez, 2025).

As the department began offering more flexibility and allowing community-based training, federal funding cuts in 2024 forced the state to slash $250 million from the program (Sánchez, 2025). The state later eliminated the certification program in 2025 leaving CHWs without opportunities for career advancement or fair compensation.

Andrew DiLuccia, a spokesperson for the department, stated that the agency is considering a model that would accredit community organizations instead of individual CHWs, and it plans to allocate its remaining $12 million toward technical assistance, workforce development, and salaries for CHWs serving immigrant communities (Sánchez, 2025). Despite these efforts, California is missing opportunities to establish sustainable paths and careers for CHWs. Training opportunities are unevenly distributed, with most in San Francisco or Los Angeles, creating “training deserts” in most of the state (Sánchez, 2025). Furthermore, many programs require fees, degrees, proficiency in English, or prior experience which disproportionately affect immigrant CHWs. These barriers have left CHWs with decades of experience in low-paying positions and unable to access training necessary to advance (Sánchez, 2025).

Despite the elimination of the statewide certification program, local institutions have developed their own training and certification programs. In July 2025, 21 CHWs completed the pilot of the Community Health Worker Certification Program, a six-week hybrid initiative led by the USC Office of Health Affairs and Children's Hospital Los Angeles (Diaz, 2025). Designed to strengthen the CHW workforce in Southern California, the program prepared participants with the skills and knowledge to address chronic disease, promote health, and connect residents to care (Diaz, 2025). The program was developed with input from current CHWs, local health organizations, public health leaders, and community based organizations (Diaz, 2025). It used the C3 National Consensus Project and California's Core Competencies to guide the development of the program, helping to standardize and professionalize the CHW workforce (Diaz, 2025). Program leaders emphasized that initiatives like this invest in CHWs and strengthen the public health system by empowering trusted community members to lead change within their communities (Diaz, 2025).

Yet even with emerging local training efforts, CHWs continue to face significant structural and financial barriers that limit their ability to advance and sustain their work. Structural barriers that limit the Promotor Model include limiting the amount of time Promotoras spend with people, limiting issues Promotoras can discuss with families as well as the type of trainings they attend, and feeling undervalued by organizations. Additionally, as computers and electronic systems become more prevalent in data collection, Promotoras may need to develop new skills to adapt. Therefore, Promotoras must be trained to navigate new technologies, especially when they play a critical role in data collection for evaluation.

On average, CHWs earn around $21 per hour without benefits, forcing them to work a second job to support themselves (Sánchez, 2025). Medi-Cal reimbursements are tied to specific tasks, ranging from $9.46 to $27.54 per 30 minutes of work, which advocates argue does not fully compensate CHWs for the extensive time spent building trust and following up with patients (Sánchez, 2025). Many advocates contend that CHWs should earn at least $30 per visit, with benefits, yet wages often remain at roughly $21 an hour and frequently without benefits (Sánchez, 2025). This has caused many CHWs to feel left behind and undervalued having to guide patients through food assistance enrollment, managing medications, and systems navigation without fair compensation (Sánchez, 2025).

Additionally, inconsistent billing requirements across health plans have made it difficult for organizations and CHWs to receive payment. Initially, Medi-Cal began reimbursing CHW services in July 2022 (Sánchez, 2025). After Proposition 35 passed, California suspended a planned raise for CHWs. California still has not established standardized contracting for health plans, leaving each plan to set its own requirements (Sánchez, 2025). As a result, organizations have reported delays in payments with one noting it took almost 6 months to receive payment from one health plan.

Ongoing federal funding cuts and heightened immigration enforcement have exacerbated the strain on this workforce, leading to reduced CHW positions in some counties, such as Fresno, where staffing dropped from 49 to 20 CHWs (Sánchez, 2025). Advocates warn that without stable investment and structural support, California risks undermining a crucial workforce responsible for advancing health equity among immigrant communities and communities of color (Sánchez, 2025).

Action Plan:

The Health Commission urges the adoption of the stated recommendations and agency collaboration to help deliver culturally tailored health care. The Commission also urges the Los Angeles County Department of Public Health to integrate community health workers in its programs and extend professional development opportunities to community health workers.

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Section IV: Environmental Health

Introduction

Environmental health is a priority of the Los Angeles City Health Commission, as the city continues to confront evolving environmental challenges that directly influence community health outcomes across Los Angeles. Building on the foundations established through the Plan for a Healthy Los Angeles and the launch of key planning tools such as the Health Atlas, the Commission has increasingly focused on how environmental exposures, climate hazards, and infrastructural vulnerabilities shape health inequities across communities. In partnership with city departments, community organizations, and academic experts, the Commission evaluates both longstanding environmental burdens and emerging threats—including extreme heat, wildfire smoke, poor air quality, flooding, drought, and unsafe working conditions—to inform data-driven policy recommendations.

In recent years, the city has undertaken significant efforts to integrate environmental justice into its planning practices, including the development of the Environmental Justice Policy Program and the Climate Vulnerability Assessment. These initiatives deepen the city's understanding of the intersecting physical, social, and infrastructural factors that heighten vulnerability in historically marginalized neighborhoods. They also highlight the importance of community engagement, cross-departmental coordination, and sustained investment in resilience-building strategies. Within this context, the Commission's review of environmental health issues in 2025 reflects a growing recognition that climate and environmental stressors are central drivers of health disparities across Los Angeles.

This section of the report examines three areas of environmental health that have gained urgency amidst accelerating climate change and emerging environmental hazards:

1) the environmental justice policy landscape guiding City planning efforts;
2) natural disasters and their impacts on the health of Angelenos; and
3) the cascading health effects of infrastructure vulnerabilities, including energy, water, transportation, occupational hazards, and healthcare systems.

These topics illustrate how environmental conditions and the physical and infrastructural landscape influence exposure, disease risk, and community resilience. Through this analysis, the Commission aims to support informed policymaking and advance strategies that protect public health, promote environmental justice, and strengthen the city's capacity to adapt to a rapidly changing climate.

Environmental Justice Policy Program

Recommendations:

1) Look to build on previous and current efforts of the Los Angeles City Planning and target highly impacted communities.
2) Recommend that the Los Angeles City Council and Mayor's Office allocate funds to the Department of City Planning for continued meaningful and inclusive community engagement.
3) Recommend that the Chief Legislative Analyst and the City Administrative Officer work to identify how to provide opportunities to compensate community-based and non-profit organizations that the Department of City Planning, and potentially other city departments, can contract with for community outreach and engagement.

Background:

In September of 2025, The Department of City Planning presented a multi-year initiative called the Environmental Justice Policy Program to the Commission, which had launched in August 2023. The program was designed to review and update the General Plan's existing goals, policies, and programs to better centralize and strengthen environmental justice priorities. This effort included a focused examination of the Health Element, the Air Quality Element, and targeted amendments to the Open Space Element. As part of the process, an inter-departmental working group—comprising over 25 City departments and additional agencies— developed an implementation plan that outlines future programs, priorities, timeframes, and potential funding sources.

The Plan for a Healthy Los Angeles (Health Element) outlines goals covering leadership in health and equity, parks and open space, safe and just neighborhoods, healthy environments, and lifelong learning. Each goal is supported by policies that include specific objectives and implementation programs. In July 2023, the Environmental Justice team completed an evaluation of the Health Element's 91 implementation programs (spanning 2015 through 2022) (Los Angeles City Planning, 2021). The Health Element Programs Progress Report found that approximately 75–78% of these programs are being implemented—either fully or partially—by the responsible departments. The report, detailed in Chapter 8 of the Plan for a Healthy Los Angeles, also highlighted both key accomplishments and challenges, emphasizing opportunities for continued funding and prioritization by the Council and Mayor.

A cornerstone of the Environmental Justice Policy Program is its community engagement. The Department's outreach strategy includes multiple channels—such as a dedicated Working Group, a Technical Advisory Committee, community events, office hours, surveys, and an online presence—to gather ongoing feedback from those most impacted by environmental injustices (Los Angeles City Planning, 2025). In addition, an Environmental Justice Working Group

comprising more than 20 community-based organizations has been convened to ensure that local voices and expertise are directly incorporated into shaping new policies and programs.

The Health Element also prioritizes enhancing the City's resilience to climate hazards in its most vulnerable communities. The Climate Vulnerability Assessment (CVA), led by the Department of City Planning, examines both physical and social vulnerabilities related to climate change impacts—including extreme heat, wildfires, extreme precipitation and flooding, sea level rise, coastal flooding, and drought (Los Angeles City Planning, 2025). The CVA integrates data from the Health Element, Equity Index, Local Hazard Mitigation Plan, CalEnviroScreen, and other sources to create a comprehensive baseline reference point for current climate conditions and vulnerabilities across the City of Los Angeles. Complementing this, the Community Partners Program (CPP) actively engages Community Based Organizations (CBOs) in vulnerable communities to capture lived experiences and insights that may not be fully reflected in the baseline data (Los Angeles City Planning, 2024). In collaboration with City partners like the Climate Emergency Mobilization Office (CEMO) and the Emergency Management Department (EMD), this process will culminate in a detailed Climate Vulnerability Assessment report after one year.

Together, these initiatives underscore Los Angeles City Planning's commitment to embedding environmental justice into its General Plan—ensuring that future policy updates are both data-driven and deeply informed by community engagement.

Action Plan:

The Health Commission urges the continued adoption of recommendations to build upon the environmental justice work and Climate Vulnerability Assessment (CVA) of Los Angeles City Planning to further prioritize the most vulnerable and climate hazard-impacted communities.

Natural Disasters and Their Impacts on the Health of Angelenos

Recommendations:

1) Expand Los Angeles's extreme heat response system by increasing cooling centers, accessible hours, and targeted outreach to vulnerable populations.
2) Strengthen citywide air-quality monitoring and deploy low-cost sensors in pollution-burdened neighborhoods to improve real-time wildfire smoke and ozone surveillance (Yu et al., 2023; Meng et al., 2023).
3) Increase investment in home weatherization and green infrastructure– including tree canopy expansion– in historically redlined and heat-vulnerable areas (Kim et al., 2021; Los Angeles County Chief Sustainability Office, 2021).
4) Develop citywide resilience plans addressing wildfire smoke events, including N95 distribution, clean-air shelters, and employer protections for outdoor workers (Yu et al., 2023; Meng et al., 2023; ArcGIS StoryMap, 2025).
5) Enhance stormwater management capacity in flood-prone neighborhoods and provide emergency mold remediation assistance for low-income renters (Los Angeles County Chief Sustainability Office, 2021).
6) Implement drought-resilient water infrastructure upgrades and expand household access to safe, affordable drinking water during drought emergencies.
7) Integrate climate hazard projections into health planning, prioritizing communities with documented cumulative environmental burdens.

Background:

Los Angeles faces a rapidly evolving landscape of natural disasters driven by climate change, with significant implications for public health. Extreme heat, wildfires and smoke, flooding and extreme precipitation, and prolonged drought have intensified across the region, with scientific assessments projecting continued worsening in frequency, duration, and severity. High-resolution climate modeling shows that inland and suburban areas of Los Angeles County are expected to experience the greatest increases in extreme heat days due to built-environment characteristics, low vegetation, and existing temperature disparities (Kim, Sun, & Irazábal, 2021). These projections align with regional climate vulnerability assessments identifying extreme heat as one of the city's most pervasive and inequitable health threats (Los Angeles County Chief Sustainability Office, 2021).

Extreme heat contributes to a wide range of health risks, including heat exhaustion, dehydration, cardiovascular strain, and respiratory distress. Older adults, young children, people with chronic illnesses, and outdoor workers face disproportionate risk during extreme temperature events. Compounding these challenges, elevated temperatures also accelerate the formation of ground-level ozone, a pollutant widely associated with respiratory illness. A study by Robles, Bai, and Meng using data from the California Health Interview Survey showed that demonstrates that adolescents living in high-ozone regions experience heightened asthma

symptom severity, especially when facing lower levels of support at home, reflecting the compounding effects of environmental and social stressors (Robles, Bai, & Meng, 2023). These findings highlight how climatic and environmental conditions intersect with community-level vulnerabilities to shape unequal health burdens during extreme heat events.

Wildfires and smoke have also emerged as critical public health threats in Los Angeles, a trend made clear by the devastating January 2025 wildfires. Occurring during what is typically the region's highest anticipated rainfall month, these unseasonably early fires burned tens of thousands of acres and produced sustained smoke exposure across the county. The compromised air-quality led to the closure of schools and an increase in respiratory complaints among healthcare facilities. Beyond direct smoke inhalation, the fires caused widespread smoke infiltration into homes that were not burned, leaving behind hazardous soot, ash, and indoor air contamination. Environmental assessments documented that even intact homes accumulated toxic residues, including heavy metals such as lead, while soils near affected neighborhoods showed elevated levels of contaminants following ash deposition (ArcGIS StoryMap, 2025). These on-the-ground effects are consistent with scientific evidence showing that wildfire-related $PM_{2.5}$ produces more severe acute respiratory and cardiovascular impacts than $PM_{2.5}$ from non-wildfire sources (Yu et al., 2023). Short-term wildfire smoke exposure is also associated with measurable economic and social consequences, including increased work-loss days among adults (Meng et al., 2023). As fire seasons extend into winter, events like those in January 2025 highlight the urgent need for smoke-resilient infrastructure and public health interventions.

Flooding and extreme precipitation—worsened by stronger atmospheric river events and aging stormwater systems—pose additional risks to community health. Heavy rainfall can trigger flash flooding, disrupt transportation, overwhelm stormwater and sewage infrastructure, all of which can endanger indoor environments. Residents living in older or poorly maintained housing face elevated risks of prolonged moisture intrusion and mold growth following flood events, conditions that can persist for months and exacerbate respiratory illness. These impacts disproportionately affect vulnerable populations, particularly in under-resourced communities where delayed repairs, limited remediation resources, and renter displacement can extend exposure and hinder recovery (Los Angeles County Chief Sustainability Office, 2021; Los Angeles City Planning Department, 2025). Additionally, extreme precipitation events disrupt access to healthcare and emergency services, with medically fragile individuals facing heightened danger when mobility or transportation is compromised (Los Angeles County Chief Sustainability Office, 2021).

Prolonged drought intensifies multiple environmental stressors across the region. Drought contributes to reduced water supply reliability, increased dust levels, elevated wildfire ignition risk, and loss of urban vegetation—all of which exacerbate respiratory conditions and heat exposure. These impacts align with environmental justice analyses indicating that low-income communities and communities of color disproportionately bear the cumulative burdens of drought, heat, and poor air quality (Los Angeles City Planning Department, 2025). As drought

events become more frequent and severe, addressing inequities in water access, air quality, and urban cooling will be crucial to protecting public health.

Across all hazards, the distribution of environmental exposures in Los Angeles reflects systematic differences in the built environment and underlying population health characteristics, some of which can be traced in part to historical patterns of land use and investment, including the legacy of redlining. Variability in factors such as surface materials, tree canopy coverage, housing age, and proximity to emission sources such as freeways influences both baseline exposure levels and the physiological stress experienced during climate-related events. Epidemiologically vulnerable groups—including adolescents with asthma, older adults living alone, unhoused individuals, essential workers with high outdoor exposure, and individuals with chronic diseases—exhibit heightened sensitivity to heat, particulate matter, ozone, and other hazard-related stressors. Chronic disease vulnerability is further shaped by long-term air pollution exposure, with studies showing that sustained exposure to ozone, $PM_{2.5}$, and nitrogen oxides is associated with higher prevalence of type 2 diabetes among adults in California, thereby increasing physiological susceptibility to heat, smoke, and other climate related environmental stressors (Meng et al. 2023). The interaction of these environmental and health determinants increases susceptibility to adverse health consequences as climate-driven hazards intensify. Strengthening environmental monitoring capacity, emergency preparedness systems, and public health infrastructure will therefore be essential for reducing exposure differentials and mitigating the health impacts of future climate-driven hazards.

Action Plan:

The Los Angeles City Health Commission urges the adoption of the recommendations listed above to strengthen the city's climate and public health resilience. Integrating climate science, public health data, and community-centered planning will be crucial to reducing health inequities and ensuring that all Angelenos are protected in a rapidly warming and increasingly unstable climate.

Infrastructure and Cascading Health Impacts

Recommendations:

1) Prioritize grid resilience upgrades in heat-vulnerable neighborhoods, including improvements to substations, distribution lines, and cooling-demand management where impervious surfaces and limited shade increase system stress.
2) Retrofit older residential buildings with improved cooling, ventilation, and filtration, including enhanced insulation, upgraded HVAC systems, and air filters to reduce indoor heat exposure and wildfire-smoke infiltration.
3) Strengthen water-system reliability and seismic resilience, including modernization of aging LADWP pipes and contingency planning for potential aqueduct disruption along the San Andreas Fault (Los Angeles County Chief Sustainability Office, 2021; National Academy of Engineering, 2020).
4) Require healthcare facilities to increase emergency water preparedness, with expanded on-site storage, diversified vendor contracts, and routine testing of emergency water-delivery connections (Seiple, 2018).
5) Upgrade hospital ventilation and filtration systems, especially in older facilities, to maintain safe indoor air quality and clinical operations during extended wildfire-smoke episodes.
6) Accelerate emission-reduction strategies in goods-movement and port-adjacent corridors, including electrification of heavy-duty vehicles and targeted nitrous oxide reduction efforts (Meng et al. 2022).
7) Expand stormwater, drainage, and wastewater resilience, reducing overflow, contamination, and service interruptions during extreme precipitation events.
8) Strengthen protections for outdoor and essential workers through heat-illness prevention measures, clean-air access during smoke events, and work-modification standards on high-pollution or high-heat days.

Background:

Los Angeles's infrastructure systems– including the electrical grid, transportation network, water systems, and healthcare facilities– play an essential role in determining how effectively the region can withstand and recover from climate-related hazards. As extreme heat, wildfire smoke, flooding, and drought intensify, these systems face increasing pressures that produce cascading public health impacts. Infrastructure vulnerabilities are not evenly distributed across the region; instead, they reflect differences in built-environment characteristics, historical investment patterns, and long-term system maintenance.

The urban heat island (UHI) effect illustrates how built-environment characteristics amplify climatic stress. Neighborhoods with high concentrations of asphalt, limited tree canopy, and older housing stock experience elevated surface temperatures thus increasing electricity demand during peak hours, and reducing the efficiency of aging HVAC systems and distribution

infrastructure. Rising temperatures substantially increase demand on the electrical grid as cooling systems run longer and at higher intensity, particularly in neighborhoods with extensive impervious surfaces and limited shade cover (Kim, Sun, & Irazábal, 2021). These localized temperature differentials increase reliance on air conditioning during peak demand periods, straining an electrical grid that is already vulnerable to failures during heatwaves. Electrical disruptions, in turn, compromise access to cooling, refrigeration for medications, and the operation of powered medical devices, creating acute health risks for older adults and individuals with chronic conditions (Los Angeles County Chief Sustainability Office, 2021).

Transportation and goods-movement infrastructure further shape exposure patterns. Communities located near major freeways and port-adjacent corridors experience elevated concentrations of nitrogen dioxide and particulate matter, driving respiratory morbidity. Policy evaluations of California's goods movement emission reductions demonstrate that improvements in nitrogen dioxide levels are associated with clinically meaningful declines in asthma and COPD-related emergency visits, highlighting how infrastructural emissions directly influence population health (Meng et al., 2022).

Healthcare facilities themselves represent a critical component of infrastructure vulnerability, and recent assessments indicate substantial fragility in the systems they depend on. Hospitals rely on large volumes of water to support essential operations—including sanitation, HVAC cooling, sterilization of medical equipment, and thermal regulation for IT server function—resulting in average daily water consumption exceeding 48,000 gallons per facility (Seiple, 2018). Despite this reliance, only 6.9% of surveyed hospitals stored the minimum emergency water required by state guidance, and most maintained less than 12% of their needed volume (Seiple, 2018). Many hospitals rely on external vendors to supply emergency water during disasters; however, over half contract with a single vendor, and only 36% have tested the hose connections required for tanker delivery (Seiple, 2018). Modeling of outage scenarios suggests that 40-62 hospitals in Los Angeles County would lose full operational capacity within 12 hours of a major water disruption, indicating that water system fragility, not only electrical outages, is a major determinant of hospital resilience during climate-driven events (Seiple, 2018).

Housing infrastructure also plays a central role in determining exposure and recovery capacity. Older homes with inadequate insulation, poor ventilation, or aging cooling systems are less able to maintain safe indoor temperatures during heatwaves or keep wildfire smoke from infiltrating indoor spaces. Residents living in older rental housing may experience slower post-event recovery due to delayed repairs, mold accumulation after flooding, or inadequate air filtration following smoke events.

Wildfire smoke presents an additional challenge for healthcare infrastructure. Smoke infiltration during major wildfire events, such as the January 2025 fires, can degrade indoor air quality even in facilities located far from burn areas, particularly those with aging ventilation or insufficient filtration systems (ArcGIS StoryMap, 2025). Hospitals with older HVAC systems or

limited capacity to upgrade filtration face heightened operational and clinical burdens during prolonged smoke episodes, which often coincide with surges in respiratory illness.

Water and wastewater systems also demonstrate vulnerability to climate impacts. Flooding can overwhelm stormwater drainage, resulting in runoff contamination, infrastructure damage, and service interruptions. Conversely, drought conditions stress groundwater basins, elevate concentrations of contaminants in aging pipes, and reduce the reliability of imported water sources (Los Angeles County Chief Sustainability Office, 2021). Additionally, because Los Angeles's two major aqueducts cross the San Andreas Fault at a single point, physical disruption in the event of a large earthquake could sharply limit imported water availability for both residential and healthcare infrastructures (National Academy of Engineering, 2020).

Outdoor and essential workers– including port workers, delivery drivers, construction workers, and agricultural laborers– face disproportionately high exposure to extreme heat, particulate matter, and ozone. Short-term exposure to elevated $PM_{2.5}$ concentrations has been associated with increased work-loss days due to illness (Meng et al., 2023) , reflecting both direct physiological impacts and reduced workplace functioning during infrastructure disruptions.

These infrastructural conditions shape the distribution and severity of climate-driven health risks in Los Angeles. As hazard exposures intensify, strengthening the resilience of lifeline systems– including water supply, energy transmission, healthcare facility operations, and transportation networks– will be critical to protecting public health.

Action Plan:

The Los Angeles City Health Commission recommends prioritizing investments that enhance the resilience of energy, water, transportation, and healthcare infrastructure to withstand climate-driven stressors. Expanding air-quality monitoring, deploying adaptive cooling and ventilation strategies, modernizing electrical and water infrastructure, and reducing transportation-related emissions—while integrating climate hazard projections into capital planning and prioritizing high-risk areas—will be critical to mitigating cascading health impacts and sustaining essential services as climate conditions continue to evolve.

Crystalline Silica Exposure in the Workplace (Silicosis)

Recommendations

1) Prohibit the manufacture, supply, and processing of artificial stone containing more than 1% crystalline silica (Barnes et al., 2019; Glass & Hoy, 2024).
2) Designate silicosis as both a compensable and reportable work-related disease.
    a) Expand access to workers' compensation and streamline claims processes, addressing the current gap where only 7% of affected workers receive compensation (Rodriguez & Parmar, 2024; Reyes & Carcamo, 2023).
3) Improve public health surveillance systems to enable timely identification, case investigations, and response to silicosis cases.
4) Establish a multi-sector task force to coordinate initiatives across workers, employers, healthcare systems, and local government.
    a) Develop a proactive medical screening program to monitor workers' health status before the onset of silicosis.
    b) Characterize the at-risk workforce to guide culturally and linguistically tailored outreach, education, and training on silica exposure risks and health consequences (Fazio et al., 2023; Rodriguez & Parmar, 2024).

Background:

Silicosis is a progressive, incurable lung disease caused by inhaling free crystalline silica particles, a byproduct of cutting, grinding, or polishing materials such as engineered stone, concrete, and brick (Barnes et al., 2019). It is the most common occupational lung disease globally, associated with mining and stone cutting, but now re-emerging in the artificial stone countertop fabrication industry. Traditionally, chronic silicosis developed slowly over 10 to 30 years of low-level exposure which was most common (Barnes et al., 2019). However, accelerated and acute forms of silicosis have become more prevalent due to extreme and prolonged exposure in the artificial stone countertop fabrication industry (Barnes et al., 2019). Accelerated silicosis can develop in as little as 1 to 10 years, while acute silicosis may appear within weeks or months of exposure (Barnes et al., 2019). Accelerated and acute forms are now increasingly diagnosed in Los Angeles.

California has seen a dramatic and alarming resurgence of silicosis, classifying it as an epidemic. In 2019, only six cases were reported. Between 2019 and 2022, 52 patients were diagnosed with silicosis where all but one were Spanish-speaking Latino immigrants (Fazio et al., 2023). Notably, 71% of these cases occurred in Los Angeles County, and more than 60% of known cases originated in the San Fernando Valley (Fazio et al., 2023). In 2023 alone, 91 countertop workers in California were diagnosed with silicosis, with 50 treated at Olive View-UCLA Medical Center (Health Services Los Angeles County, 2024). Cal/OSHA estimates that of the 4,040 workers employed in California fabrication shops, between 500 and 850 may develop silicosis, with 90 to 160 expected to die (Rojas & Morris, 2023). The median age of

affected workers is 45 years of age, and nearly one in five have already died (Reyes and Carcamo, 2023). In most cases, diagnosis was delayed or workers were misdiagnosed with tuberculosis or bacterial pneumonia (Reyes and Carcamo, 2023). By the time they received a proper diagnosis, more than one-third already had severe lung scarring (Reyes and Carcamo, 2023).

The health consequences of silica exposure go beyond silicosis. In addition to silicosis, excessive silica exposure is linked to lung cancer, autoimmune diseases, chronic kidney disease, bronchitis, and heightened susceptibility to lung infections (Barnes et al., 2019). Silicosis remains irreversible and incurable. Treatment is limited to managing symptoms, slowing disease progression, and preventing infections. Management strategies include bronchodilators, pulmonary rehabilitation, supplemental oxygen, and preventive vaccines which only alleviate, not prevent, symptoms. For patients with end-stage respiratory failure, lung transplantation may be considered, but most patients are ineligible due to age or comorbidities, and donor lungs are scarce (Barnes et al., 2019).

Silicosis exposure can be reduced through proper protection. Preventative measures include minimizing exposure using water-based cutting systems and vacuum filtration tools, providing full-body personal protective equipment (PPE), and implementing respiratory protection (Rodriguez and Parmar, 2024). However, PPE such as respirator systems can cost $1,000–$2,000, making them unaffordable for many small shops. Moreover, even with water-spraying systems, the resulting dust is finer and may travel deeper into the lungs, accelerating disease onset (Rodriguez and Parmar, 2024). While PPE can offer temporary relief, long-term dust control and exposure reduction are the only reliable prevention methods. Unfortunately, many fabrication shops either fail to follow or cannot afford to implement OSHA standards (Reyes and Carcamo, 2023).

The underlying workplace hazards contributing to the current epidemic include insufficient PPE, failure to enforce or comply with OSHA safety standards, inadequate dust suppression systems, and lack of regular medical screenings (Barnes et al., 2019). Respirators are often replaced with flimsy face masks, and comprehensive PPE is rarely available for these professions. Even when employers attempt water-based dust suppression, the resulting mist can exacerbate inhalation risks. Educational gaps further worsen the issue. Many workers are monolingual Spanish speakers, often with less than a high school education, and are uninsured or covered only by restricted-scope Medi-Cal. As undocumented immigrants, they may also avoid medical institutions or government agencies out of fear of deportation or retaliation. This leads to underreporting, lack of diagnosis, and a lack of advocacy for safer workplace conditions.

Cal/OSHA has implemented an Emergency Temporary Standard to mitigate silica exposure (Department of Industrial Relations, 2023). Employers must now use wet-cutting techniques, vacuum systems with HEPA filters, and provide respiratory protection (Department

of Industrial Relations, 2023). They are also mandated to report confirmed cases of silica-related diseases to Cal/OSHA and the California Department of Public Health within 24 hours (Department of Industrial Relations, 2023). Employers must use language-appropriate and accessible communication to educate workers, many of whom speak Spanish or indigenous languages (Department of Industrial Relations, 2023). Cal/OSHA is conducting enforcement inspections, and non-compliant employers may face significant fines (Department of Industrial Relations, 2023). While compliance may cost California businesses an estimated $66 million over the next decade, projected direct benefits are estimated at $603 million, not including gains in worker health, productivity, and reduced suffering.

Internationally, Australia has emerged as a leader in protecting workers. Ranked among the top countries in healthcare equity and outcomes, Australia became the first nation to ban the manufacture, supply, processing, and installation of engineered stone containing more than 1% crystalline silica (Glass and Hoy, 2024). Their success offers a promising model for California and the greater U.S.

Action Plan:

The Health Commission supports adopting the recommendations outlined above to protect workers from harmful silica exposure and its long-term health consequences .

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Section V: Los Angeles 2028 Olympics

Introduction

The Los Angeles City Health Commission works to understand, prevent, and respond to potential threats to health in Los Angeles County, including both persistent concerns to the county and those relating to its role in a global context. In July of 2017, the International Olympic Committee historically declared Los Angeles the host city for the 2028 Olympic and Paralympic Games (IOC, n.d.). This will mark the city's third time hosting the Olympic Games, previously hosted in 1932 and 1984, and the first time to host the Paralympic Games. With prior planning experiences from the LA84 games, public officials see these games as an opportunity to reshape the city's physical infrastructure (Rodriguez, 2024). Notably, this will be the first "no build" games in the history of the event, "maintaining a focus on people first to create a lasting human legacy" (LA28, n.d.). Prior to the start of the games, this commitment has been seen in the investment in youth sports, aid to local businesses, creation of local jobs, and plans for environmental and transportation improvements across the county.

The LA28 Games Agreement required the establishment of three working groups, designed to bring a diverse group of stakeholders from across the region together to advise on and support the games planning. These groups include 1) Community Business and Procurement (CBP), 2) Local Hire (LH), and 3) Sustainability (City of Los Angeles, 2023). The selected participants on the committees come from organizations across Los Angeles County and are committed to priorities including cross collaboration with education institutions, representation among multiple sector interests in the field, and community-rooted alliances.

This section of the report concentrates on countywide developments and plans for the upcoming LA28 Games and how they will impact the future wellbeing of Angelenos. In evaluating a wide array of issues alongside notable researchers, faculty members, and field leaders, the Commission hopes to be able to effectively advise stakeholders to allocate the necessary resources toward improving the health outcomes and living conditions of vulnerable groups prior to the start of the games.

Communicable Disease Control and Emergency Preparedness

Recommendations:

1) Strengthen disease surveillance by expanding real-time monitoring, including after hours primary care and emergency department visits, to identify and respond to infectious outbreaks swiftly.
2) Conduct pre-Games risk assessments in collaboration with local, national, and international agencies to anticipate and mitigate potential disease transmission threats.
3) Implement rigorous hygiene and food safety protocols for caterers and vendors to minimize gastrointestinal illnesses, following the successful model of the Beijing 2008 Games (Moy et al., 2010).
4) Ensure sufficient medical personnel, facilities, and rapid response teams at all venues, in collaboration with Cedars-Sinai, to provide timely care and reduce strain on local health systems.
5) Engage the private sector to incentivize technological innovations that could aid in public health surveillance during and after the Olympic and Paralympic Games (Rimoin, 2025).

Background:

Mass gatherings, including that of the Olympic and Paralympics Games, present a risk for widespread transmission of infectious diseases (McCloskey et al., 2014). The prevention of infectious disease through surveillance and response strategies has therefore been a priority of Olympic planning committees for many years.

In their 2019 study, Ziad Memish and his colleagues updated planning and surveillance systems recommended for monitoring public health risks and threats from mass gatherings. They identified the following existing and potential threats:

- "Transmission of communicable diseases, including antibiotic-resistant bacteria infections
- Water and sanitation-related disorders
- Non-communicable diseases and exacerbation of conditions (i.e. diabetes, hypertension, COPD, cardiovascular events)
- Mental health and psychosocial disorders
- Thermal disorders including heat hyperpyrexia, heat stroke, heat exhaustion, and dehydration
- Stampedes
- Accidents, trauma, and crush injuries
- Alcohol and substance abuse" (Memish et al., 2019).

Given aforementioned risks and additional unlisted risks, planners must address a range of critical considerations when preparing for mass gatherings, including the 2028 Olympics and Paralympic Games. These include:

- Improving risk assessment and management, surveillance and alert systems, and outbreak alert and response prior to the start of the Games (Memish et al., 2019)
- Ensuring a robust system for rapid identification of attendees with communicable diseases and their contacts (Memish et al., 2019)
- Establishing clear guidelines for water and waste management and identification of other potential physical hazards (Memish et al., 2019)
- Emergency planning and response including on-site care for minor injuries or illnesses (Memish et al., 2019)
- Appropriate protocol for effective and timely stabilization and transport of patients (Memish et al., 2019)requiring evacuation in case of trauma (Memish et al., 2019)
- Updating travel guidelines, including vaccinations, in the months before visitors arrive at the Games (Memish et al., 2019)

Additionally, through analysis of public health planning from the London 2012 Olympic and Paralympic Games, the Los Angeles 2028 games can reduce the number of cases of communicable diseases to alleviate strains on public healthcare systems.

During the 1996 Atlanta and 2000 Sydney Olympic Games, infectious disease made up less than 1% of health-care visits (Jorm et al., 2003). Of these 1% of cases, the most common reasons for healthcare visits included respiratory infections (6.7%) and gastroenteritis (3.7%) with a few cases of salmonellosis, tuberculosis, bacterial meningitis, and hepatitis B reported (WHO, 2007). The morbidity resulting from these infections was quite low (2-3%). The number of cases of communicable disease dramatically reduced by 40% in the 2008 Beijing Olympic Games, which was attributed to improved health-protection measures relating to food safety and hygiene (Moy et al., 2010). This minimized the incidence of gastrointestinal diseases caused by contaminated food and water associated with compromised hygiene practices by caterers at mass gatherings.

Further preventive measures have been taken in more recent Olympic Games to improve the system in which public health issues are addressed. Specifically, the 2012 London Games ensured that health systems had the capacity and personnel in place to improve surveillance, reporting, and intelligence systems that would allow them to recognize and mitigate these issues in a timely manner (Enock, 2008). Collaboration between local, national, and international agencies and governments also worked to develop a public health risk assessment for the Olympic Games. From these initial assessments, a gap in surveillance was found for visitors who saw a primary care provider out of typical hours as well as visitors who visited the emergency department, leading to the establishment of two new surveillance systems that continue to operate in England. This set a standard for Olympic committees to thoroughly report cases of communicable disease and investigate probable causes for infectious outbreaks.

The Los Angeles 2028 Olympics and Paralympic Committees have already begun making similar efforts to ensure accessible and quality medical services will be provided to visitors and athletes at the upcoming games. In September of 2024, Cedars-Sinai, a nonprofit academic healthcare organization serving the Los Angeles community, was announced as the official medical provider for the LA28 games. Their services will cover medical care for athletes, coaches, team personnel, and visitors who travel to Los Angeles for the games, making them a critical resource and medical advisor in establishing medical services in the Olympic village and at the sporting venues (USOPC, 2024). Cedars-Sinai also emphasized that their role in the LA28 games goes beyond a commitment to the health and wellbeing of athletes and visitors, as they seek to make long-term improvements to the health and wellbeing of Angelenos before the games begin.

In July 2025, the Commission hosted Dr. Anne Rimoin, Professor of Epidemiology at the UCLA Fielding School of Public Health and Gordon-Levin Endowed Chair in Infectious Diseases and Public Health, to discuss public health preparedness for large-scale events. In preparation for the LA28 games, Dr. Rimoin emphasizes a preventive health approach in which proactive communication and preparation is key. This includes anticipating vector-borne threats, common disease outbreaks, airborne respiratory infections, and heat-related illness. She identifies five goals to strengthen public health responsiveness:

1) Leveraging academic, scientific, and local expertise through co-collaboration with institutions on policymaking.
2) Implementing comprehensive risk assessments to identify baseline health indicators and potential disease hotspots.
3) Improving surveillance systems and encouraging use of real-time data for waste water and air monitoring.
4) Unifying public health messaging and expanding multilingual signage.
5) Adding onsite diagnostic and prevention infrastructure.
    a) Mobile hubs for rapid testing (i.e. COVID, influenza, RSV).
    b) Pre-arrival vaccination opportunities.
    c) Distribution of free PPE and sanitation kits.

Action Plan:

The Health Commission advises the adoption of infectious disease surveillance and response strategies for the 2028 Olympic and Paralympic Games in order to enhance public health infrastructure and establish long-term health initiatives to protect both visitors and Angelinos.

Environmental Impact and Sustainability Goals

Recommendations:

1) Prioritize the transition to 100% electric buses, 60% electric medium-duty delivery vehicles, and 40% zero-emissions drayage trucks by expanding charging infrastructure and supporting fleet electrification.
    a) Ensure that 40% of funding is directed towards zero emissions buses while reducing funding to combustion technology in order to support a timely transition to zero emissions and reduce pollution from existing internal combustion engine buses (LACI, 2024).
2) Accelerate Metro's expansion of transit lines and multimodal transportation options to ensure seamless connectivity between Olympic venues while reducing traffic congestion and emissions.
3) Establish high-volume transit "mobility hubs" near event venues, equipped with bike and scooter storage, rideshare drop-off zones, and integrated transit access to encourage alternatives to personal vehicle use (LACI, 2024).
4) Develop permanent charging infrastructure at municipal airports to enable battery-electric buses and hybrid-electric aircraft while improving regional goods movement and emergency preparedness.
5) Ensure that sustainability initiatives support, not displace, existing communities by aligning green space and transportation investments with affordable housing and economic development efforts.

Background:

Since 2008, Los Angeles has consistently ranked below the top 100 U.S. cities in air quality. Longitudinal analysis from the Environmental Protection Agency's Air Quality Index (AQI) shows that Los Angeles experiences only 11% of "good air quality days," compared to a national average of 63.9% (Sherlock, 2024). This poses significant health risks for both athletes and spectators of the 2028 Summer Los Angeles Olympic and Paralympics Games, which will primarily take place outdoors. According to Dr. Liz Joy, former president of the American College of Sports Medicine, poor air quality can exacerbate preexisting conditions such as stroke, asthma, heart disease, and COPD. Although it is unlikely that air quality will markedly improve in the years leading up to the Games, LA28 and its partner institutions have a responsibility to safeguard attendee health and prevent further decline in Los Angeles's air quality.

In response to these air quality concerns, LA28 has developed an ambitious framework that integrates zero emissions solutions for the 2028 Games and accelerates the implementation of charging infrastructure across the city.

The Los Angeles Cleantech Incubator (LACI), a nonprofit organization that helps early-stage clean technology startups grow in Los Angeles, has been crucial as a partner in planning environmental goals for the 2028 Games. In the early stages of planning, LACI has supported transportation planning by "identifying how best to incorporate zero emission transportation solutions, building upon the momentum created by LACI's public-private Transportation Electrification" (LACI, 2024). In their report, *Going for Gold*, LACI outlines measures necessary to catalyze medium and heavy-duty charging infrastructure investments in the Los Angeles Region prior to the 2028 games. As a result of collaboration between Southern California Edison, Los Angeles Department of Water and Power, Los Angeles Metropolitan Transportation Authority, and the City and County of Los Angeles, transportation electrification partnerships have been established with the goal of "reducing greenhouse gas emissions and air pollution by 25% beyond existing commitments" (LACI, 2024). This is defined by four regional targets to reduce energy expenditures from vehicles:

- 100% of buses to become electric.
- 60% of medium-duty delivery vehicles to be electric.
- 40% of drayage trucks (for Port of Los Angeles and Long Beach) to become zero emissions.
- 95,000 chargers installed to support transit and goods movement across LA county.

Recommendations included in LACI's blueprint for transportation electrification are divided into five categories:

1) School bus depot electrification.
2) Transit bus depot electrification.
3) Energy and transportation hubs at municipal airports.
4) Mobile energy and charging assets for last mile transportation.
5) Electric-vehicle-integrated fleet management service.

LACI's first goal, school bus depot electrification, has enormous benefits for reducing emissions and air pollution reductions, but also is essential for priming students on sustainability goals for the next decade. The establishment of these buses in underrepresented communities in Los Angeles County can help "spur familiarity with and support for clean energy technologies, driving momentum for further accelerated electrification." Outside of school-based transportation initiatives, transit agencies have set out to advance the implementation of zero emission buses before the enactment of the Innovative Clean Transit rule in 2029, which will limit the state of California to only purchasing electric buses. The electrification of transit buses preceding the 2028 Olympics will also diminish the environmental impact of the games by encouraging visitors and spectators living in, commuting from, or traveling to events to utilize these services rather than driving their own vehicle. This also eliminates many concerns of security and traffic congestion around venues. LA28 anticipates that these high-volume transit buses will operate from "mobility hubs," which are proximate transit stops to the venues. These

hubs will be located in areas with existing access to transit infrastructure, car parking lots, rideshare drop-off/pick-up, and spaces for bikes or scooters.

In order to achieve widespread electrification, LACI emphasizes that depots for staging vehicles, mobile battery energy storage systems (BESS), and associated charging will be critical to the project's success. Their blueprint also suggests that municipal airports are "an ideal footprint for this operation," as it presents an opportunity to catalyze permanent charging infrastructure installations at municipal airports. During the 2028 games, charging infrastructure located at municipal airports could be helpful for storing and charging battery-electric buses, as 1 acre of space can support twenty buses. Given Los Angeles' anticipated transition to electric energy, these charging and energy assets will eventually be needed to charge electric ground support equipment and hybrid-electric aircraft. Investment in energy storage and charging infrastructure can, therefore, become part of the transformative legacy that LA28 seeks to be for Los Angeles by "expanding the economic potential that hybrid aviation can provide to regional goods and people movement." In a zero-emissions future, this can also largely benefit emergency preparedness for the City of Los Angeles where large amounts of battery energy storage systems and chargers can be used to support first responders and disaster relief efforts, making this initiative a valuable long-term investment for policymakers.

Using a $139 million U.S. Department of Transportation Grant, Metro also plans to play an active role in "restoring community connectivity by investing in high-quality multimodal transportation options to enable affordable, reliable mobility and access to opportunity ahead of the 2028 games" (Metro, n.d.). Transit officials hope that these games will leave a lasting impact on the metro system in Los Angeles, which has struggled since the pandemic in 2020 (Uranga, 2024). During Los Angeles's last Olympic Games in 1984, there were no transit lines, commuter rail lines, or designated bus lanes. Since then, more than 100 miles of rail have been built, Metrolink was established, the bus network has grown, and the number of bicyclists and pedestrians has significantly increased (Uranga, 2024).

Metro's planned expansion will enable transit to reach most of the major Game venues, providing incentive for more spectators to choose public transit, walking, or biking to save time on their commute. They have also provided little incentive for attendees to drive to the games as limited parking will be available and there will be tight security around the Game's borders (Uranga, 2024). Additionally, to ensure the full event capacity can be supported, a supplemental, temporary bus system of zero emissions and compressed natural gas buses from Metro and partner agencies will be used for travel to and from venues.

In conjunction with policies prioritizing green energy, organizers of the LA28 Games should focus on shaping these changes to accommodate the lifestyle and culture of low-income neighborhoods in Los Angeles County. Although there are many anticipated positive effects of improving local infrastructure, University of Utah researchers Alessandro Rigolon and Tom

Collins warn of the “green gentrification cycle,” in which such changes result in an influx of wealthier residents who price out and displace the very people meant to benefit (Potter, 2024). They suggest that, in order to improve the quality of life for people in low-income neighborhoods, parks and housing policies must be designed with the goal of building wealth and capacity for the people who live around them.

Action Plan:

The Health Commission urges the adoption of stated recommendations to advance the implementation of zero-emission transportation and sustainable infrastructure in preparation for the 2028 Olympic and Paralympic Games.

Public Health Care System Strain

Recommendations:

1) Establish early relationships with community partners to facilitate public health planning.
2) Develop a reliable system of transportation for athletes and visitors with medical needs that cannot be addressed at the venue.
3) Enforce safety standards for catering companies providing food at the venue to minimize risk of gastrointestinal and food-borne diseases.

Background:

Due to their scale, the Olympic and Paralympic Games have the potential to place significant strain on local health services. In a report with experiences from Sydney 2000, Athens 2004, Beijing 2008, Vancouver 2010, and London 2012 host cities, six themes were identified among each of their respective health care arrangements:

1) Importance of early planning and relationship buildings: clarifying roles early to establish responsibilities and expectations, and communicating with external and internal groups in the planning process from the start (Kononovas, 2014).
2) Development of medical services: anticipating that most healthcare concerns can be addressed inside the Olympic venue while also making arrangements for regional hospitals in case of emergency (Kononovas, 2014).
3) Preparing for health risks: providing and supporting medical personnel who can treat gastrointestinal and food-borne diseases, which are generally the most common communicable disease seen at the Olympic Games (Kononovas, 2014).
4) Understanding and addressing risks: arranging full-staffed security is likely one of the most resource-demanding tasks (Kononovas, 2014).
5) Managing administration and logistical issues: arranging staff permission to work at games venues can be complex and frequently faces delays or errors (Kononovas, 2014).
6) Planning and assessing health legacy programs: creating and executing health initiatives that have lasting benefits for the host city has not yet been effective (Kononovas, 2014).

Action Plan:

The Health Commission urges the adoption of the stated recommendations to improve the efficiency of responses to public health emergencies and minimize the spread of disease at the 2028 Olympic and Paralympic Games venues.

Neighborhood Development

Recommendations:

1) Continue reducing financial barriers for youth participation in the PlayLA sports programs, ensuring that children from low-income communities can engage in accessible, high-quality recreation.
2) Ensure that city policies for the LA28 games avoid criminalizing or forcibly displacing unhoused individuals.
3) Provide incentives for property owners to make low-income rental units available and integrate informal housing stock into official housing solutions.
4) Collaborate with community colleges and workforce development initiatives to provide vocational training for unhoused individuals actively seeking work, particularly in sectors relevant to Olympic job opportunities.

Background:

In addition to efforts to improve physical infrastructure, former Mayor of Los Angeles, Eric Garcetti, launched PlayLA in 2021. This program seeks to provide affordable and accessible sports programming to young Angelenos of all abilities in light of the upcoming Olympic and Paralympic Games (Rodriguez, 2024). Collectively, the LA28 and International Olympic Committee have invested $160 million into this initiative, making it the "single largest commitment to youth sport development in California" (City of Los Angeles, 2024). In its first year of operation, PlayLA has offered a variety of sports to children ages 5-17 including setting volleyball, adaptive swimming, goalball, para equestrian, para surfing, wheelchair basketball, adaptive athletics, and wheelchair tennis and paracanoe. Given its core mission to offer youth recreational sports programs at a low cost, Los Angeles Department of Recreation and Parks has used the majority of this funding to subsidize participation fees for leagues, classes, and clinics with the goal of reducing cost to $10 per child. The grant is also dedicated to support quality sport programming in well-maintained, secure environments with trained coaches at recreation centers and sports facilities across the city, emphasizing support in areas that serve low-income neighborhoods as the community moves forward from the COVID-19 pandemic (LA28, n.d.). By 2028, the City of Los Angeles anticipates that 100% of its eligible recreation and aquatic centers will offer low to no-cost youth sports programming (LA28, 2025).

Increasing accessibility and affordability of these programs is critical not only for the children's physical health, but also mental health in allowing for friendly competition and friendship building. In a study conducted by Isabelle Doré, Associate Professor in the School of Kinesiology and Physical Activity Sciences at the University of Montreal, and her colleagues on the correlation between athletic participation and adolescent mental health, recreational sports in childhood and early adolescence was positively associated with mental health in late adolescence (Doré et al., 2019). Hence, to promote mental health, strategies such as PlayLA which encourage youth to engage and remain involved in sport are an effective promotive factor.

Outside of youth communities, LA28 has also introduced several initiatives to engage local and small businesses in preparation for the Games. Through its Community Business Supplier Program, the committee has pledged to allocate 75% of its spending to local businesses and 25% to small businesses (LA28, 2025). This increased financial support has been made possible by LA28's "no-build" approach, which emphasizes sustainability through temporary infrastructure and venue overlays - at least 90% of which are designed to be reused or made from recyclable materials (IOC, 2025). Another recently developed, business-oriented initiative is the Resilient by Nature project, created in response to the Los Angeles wildfires of early 2025. While not launching until early 2026, the Community Resilience Fund aims to provide grants to local nonprofits supporting three focus areas: wildfire resilience and nature restoration, ocean protection, and cooling systems. LA28 is also investing in longer-term solutions to help communities prepare for future environmental shocks and to pilot systems that could be applied globally (Hoover, 2025).

In conjunction with youth community development, LA28 seeks to leave a legacy on the city by restoring infrastructure used to house LA's unsheltered residents rather than forcing them into displacement. The upcoming Games present an opportunity to place funds towards socially productive endeavors including education, housing, and healthcare that can truly better Los Angeles populations rather than attempting to revitalize working class neighborhoods (Boykoff, 2025).

In a report written in collaboration between Economic Roundtable, UCLA School of Law, California State Polytechnic University, and Pathways to Housing, ten specific recommendations were detailed to help the city of Los Angeles excel as a host for the 2028 Olympic Games. The leading priority is ensuring that Angelenos have an income through employment or a basic income grant while also securing stable housing. Other priorities include identifying high-risk individuals to avert preventable homelessness, protection of renters through revision of eviction policies, and record expungement and jail diversion programs (Flaming et al., 2024). With the nation's largest population of unsheltered homeless individuals living on its streets, the report asks Los Angeles policymakers to avoid legislation that would criminalize and displace street residents. Instead, the authors urge these policymakers to "develop harmony and preserve human dignity [... by] upholding human rights in organizing and delivering the Olympic Games, including the safety and well-being of residents" (Flaming et al., 2024). This also provides an opportunity to demonstrate societal improvement from the 1984 Olympics in which the Los Angeles Police Department (LAPD) forced unhoused individuals from the streets using threats of arrest and harassment without any transportation or alternative housing plans. This is also increasingly important given a recent Supreme Court ruling on Grants Pass v. Johnson, authorizing nationwide laws that restrict sleeping on public property.

Despite short-term successes like Inside Safe, an initiative by Mayor Karen Bass to move encampments of unhoused people into interim motel housing, there is yet to be a cost-effective

and sustainable solution to the homeless challenge facing Los Angeles (City of Los Angeles, n.d.). In order to improve upon previous efforts, future plans for restorative interventions must focus on prevention of homelessness through "jail and shelter diversion, emergency rent assistance, landlord conflict mitigation, landlord damage mitigation, and income support" (Murphy, 2024). Additionally, early exits to homelessness through "ready access to housing choice vouchers" appear to be viable early interventions to provide stable housing and avoid long-term harm.

However, if ordinances displacing unhoused residents continue prior and into the Olympic Games, the presence of law enforcement should at least be "complemented by short-term and permanent housing [as well as] engagement of health, mental health and substance abuse services, and case managers who can provide whole person support" (Flaming et al., 2024). Researchers also suggest that community colleges can provide valuable training to individuals that can aid them in becoming more employable. Given the reality that the city cannot fund this program for all homeless adults, training should be targeted at the estimated 40% of unsheltered adults that are actively seeking work, making them motivated and good candidates for employment interventions. This population includes adults ages 25-34 (47%) and 35-44 (42%), individuals not classified as "chronically homeless" (46%), adults with children (46%), and individuals who have been homeless for up to 3 months (47%).

For unhoused individuals who are successful in retaining employment, labor laws are also needed to protect their rights and guarantee fair wages and treatment. This is particularly important to protect homeless adults who are recently employed, but whose earnings have been insufficient to pay for housing.

The 10 actions are:

1) Address homelessness as a problem of inadequate income by providing help in getting a job or providing a basic income.
2) Increase early exits from homelessness through interventions that result in stable housing. This includes using predictive screening tools that accurately identify individuals who are likely to be persistently homeless so they can be helped before, or soon after, they become homeless rather than after long-term harm has accumulated in their lives.
3) Provide incentives to make affordable space in the low-income rental market and the existing informal housing stock available for unsheltered individuals.
4) Extend restorative interventions to couch-homeless individuals who need employment or basic income interventions that will enable them to pay rent and have a claim to housing.
5) Increase the supply of affordable housing.
6) Protect renters from unjust evictions by requiring landlords to have just cause to terminate a tenant's lease and by ensuring the right to legal counsel.
7) Prevent homelessness through jail and shelter diversion, emergency rent assistance, landlord conflict mitigation, and income support.

8) Expand record expungement programs, especially for crimes related to homelessness and poverty. Complement law enforcement interventions with the engagement of housing providers, health, mental health and substance abuse services, community colleges, and case managers who provide whole-person support.
9) Enact and enforce labor laws that protect employed workers, ensure payment of living wages, and require fair scheduling.
10) Help newly housed individuals to overcome their isolation through service components that build social support networks and community ties.

Action Plan:

The Health Commission encourages the adoption of the stated recommendations to prioritize equitable community development initiatives, such as PlayLA, in preparation for the 2028 Olympic and Paralympic Games.

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Conclusion

The Los Angeles City Health Commission aims to provide policy recommendations in this report to address homelessness, healthy lifestyles, medical services, and COVID-19 surveillance and control in Los Angeles City. The recommendations are based on research, interviews, and presentations recently collected from experts and stakeholders in the Los Angeles community. The Health Commission encourages the City Council and public health community to adopt the recommendations contained within this report to improve the health of Los Angeles residents. The Health Commission also recommends that the City Council and Mayor implement the programs that are stipulated in the Plan for a Healthy Los Angeles. The Commission's work lies almost entirely on the dedicated work of volunteers. In order to produce high-quality research and effective recommendations for major public health concerns, the Health Commission requires financial support. A 2025-26 budget allocation of $1,712,898 would provide adequate funding for full-time staff and directed research, which the Health Commission believes is necessary to accomplish its goals and objectives. With the World Cup as well as the Olympics coming with the potential for an epidemic impact of infectious disease, our commission should have the resources available to properly collect data and educate the City Council, Mayor, City Attorney, Comptroller and their senior staffs about the risks of these international events and what preparedness is required.

2025 Los Angeles City Health Commissioners



HOWARD C. MANDEL, MD, FACOG
President (Council District Five)

Howard C. Mandel MD, FACOG is a practicing Obstetrician Gynecologist who has dedicated his life to the practice of high-quality health care and assuring access to such care. To this end, Dr. Mandel's extensive leadership in political advocacy and his education of the public has spanned over 40 years. He has held positions and chaired the Board of Directors of several not-for-profit and educational institutions, served on advisory panels and councils, and has received recognition for his leadership locally, statewide and nationally.

Born in Brooklyn, New York, Dr. Mandel received his degrees from The Johns Hopkins University and New York University School of Medicine. His exposure early on to the medical care of the indigent at both Johns Hopkins Hospital and Bellevue Hospital bonded him to the defense of those who could not help themselves. As a volunteer at the Saban (Los Angeles) Free Clinic for over four decades, Dr. Mandel has advocated for equal access to health care for women, children, the homeless and the working poor.

Dr. Mandel currently advises Senators Michael Bennet and Mark Warner on health care policy. He also serves as the President of the City of Los Angeles Health Commission. He has advised the House of Representatives serving on the National Physician's Council for Health Care Policy and has previously served on "Obama for America Health Policy Advisory Committee." He was a National Co-Chair of Run Biden 2016 and was an advisor to then Senator Biden on health care issues during his 2007/2008 presidential campaign.

Likewise, he has served on several local and statewide governmental advisory panels, assisting Assembly members Burt Margolin, Barbara Friedman, Susan Davis, Wally Knox and Paul Koretz. He was an early supporter of Governor Howard Dean's 2004 presidential campaign, a member of the "Dean's List" and a founder of "Doctors for Dean". He later was one of three founders of "Doctors for Kerry" and served on the then California Attorney General, Kamala D. Harris' "Smart on Crime" Health Committee.

In addition to teaching and lecturing on topics such as Ob/Gyn Emergencies, Umbilical Cord Blood Banking, Menopause, Women's Health and Health Care Economics, he has appeared as an expert on numerous television news and informational programs on NBC, ABC, CNN, KTLA,

KCOP, E! Entertainment and UPN, and has made appearances on The Dennis Miller Show, The Mo Show, Strange Universe, Borderline and Medically Incorrect.

Dr. Mandel has been recognized for his leadership and public service by the State of California, County and City of Los Angeles, The Johns Hopkins University (Distinguished Alumnus Award 2015), Jhpiego (The Elyse Bila Ouedraogo Award 2015), The Oakwood School (Charles Haas Award 2011), Temple Israel of Hollywood (2007), the Saban (Los Angeles Free) Community Clinic (Lenny Somberg Award-1996 and Leo D. Fields Volunteer Award-1996), Los Angeles Committee on Philanthropy (1995), and the American College of Obstetrics and Gynecology (President's Community Service Award 1994), American Association of Gynecologic Laparoscopists (1985), Cedars-Sinai Medical Center (Leo G. Rigler Award 1985), New York University School of Medicine (Frederick C. Holden Prize 1981 and the James Constantine Award 1981). Most recently he was selected as one of the "Leaders of Influence: Top Los Angeles Doctors" by the Los Angeles Business Journal and previously one of the Top Three Gynecologists in Los Angeles by *Threebest related.com*.

Currently Dr. Mandel is a member on the Board of Directors of the National Board of Physicians & Surgeons, Friends of the Saban (Los Angeles Free) Community Clinic, WomenStrong International, Big Sunday, the UCLA School of Nursing Dean's Advisory Board and he Chairs the International Advisory Board of Jhpiego. He also serves as a Chair Emeritus on the Johns Hopkins University Krieger School of Arts and Sciences Dean's Advisory Board and on her School of Education's National Advisory Council. He has previously served on the Boards of Trustees of the Johns Hopkins University, of Temple Israel of Hollywood, Oakwood School and the Boards of Directors of Century City Hospital and the Los Angeles Free Clinic and its Hollywood Endowment Corporation as well as the Los Angeles Advisory Board of Children Now. He has served on the Performance Improvement Committees of Cedars-Sinai Medical Center, Century City Hospital and Century City Doctor's Hospital. He was the Chairman of Surgery as well as Chief of Gynecology at Century City Doctor's Hospital and served twice in that role at Century City Hospital. He represented Century City Doctor's Hospital to the American Medical Association, California Medical Association and the Los Angeles County Medical Association and previously did the same for Century City Hospital.

Dr. Mandel lives in Los Angeles with his wife Dr. Susan Mandel and has two children, Spencer, age 38 and Mallory 36.

2025 Los Angeles City Health Commissioners



NOMSA KHALFANI Ph.D., Co-CEO
1st Vice President (Council District Eight)

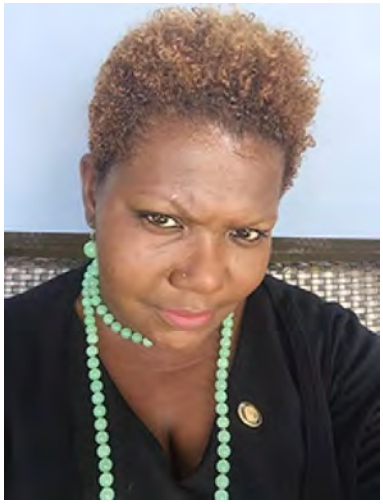
As Co-CEO, Nomsa leads and directs Essential Access Health, driving the organization's mission and strategic goals forward. She oversees key areas including federal and state programmatic initiatives, capacity-building efforts, finance and audits, organizational culture, and the development of new strategic business initiatives.

Before joining Essential Access, Nomsa held several leadership positions at St. John's Community Health, a network of federally qualified health centers in Los Angeles County. She is an alum of several prestigious leadership programs, including the Southern California Coro Women in Leadership Program, the Blue Shield of California Foundation Clinic Leadership Institute Emerging Leaders Program, the Women's Foundation California Dr. Beatriz Maria Solis Policy Institute, and the Executive Women's Leadership Cohort.

Nomsa currently serves as the 1st Vice-President of the Los Angeles City Health Commission, Board Chair at Community Asset Development Re-defining Education (CADRE), and Treasurer of the National Family Planning & Reproductive Health Association. Her past volunteer experience includes significant roles on the LA County Community Prevention and Population Health Taskforce, the Los Angeles County Anti-Racism, Diversity, and Inclusion Initiative Community Input Advisory Board, and the California Pan-Ethnic Health Network. Additionally, she contributed to the African American Infant and Maternal Mortality (AAIMM) Steering Committee, the Reproductive Health National Training Center Grantee Training Advisory Council, and the Reproductive Health National Training Center. In 2020, Nomsa was one of Southern CA's 50 Diverse Leaders.

Nomsa earned a Bachelor of Arts from the University of California, Santa Cruz, a Master of Arts from Phillips Graduate Institute, and a Doctor of Philosophy in Public Service Leadership from Capella University.

2025 Los Angeles City Health Commissioners



SHAMIKA OSSEY-HARRIS R.N., B.S.N.
2nd Vice President (Council District 15)

Shamika Ossey-Harris graduated with a Bachelor of Science Degree in Nursing from Mount Saint Mary's University in 2005, and began her Public Health Nursing career in 2007 with the County of Los Angeles. She has been an emerging leader in the community earning several awards, and recognition from local elected officials, the Federal Emergency Management Agency (FEMA) and the White House. Mrs. Ossey-Harris enjoys community engagement, promoting emergency preparedness, and has been a volunteer with the American Red Cross Los Angeles Region since 2014 as a Community Ambassador. As a Co-Founder and Co-Program Manager of the Watts Community Emergency Response Team (CERT) Training Program Mrs. Ossey-Harris volunteers her time engaging the community in emergency and disaster preparedness education and training. Mrs. Ossey-Harris currently serves as a SEIU 721 Union Steward, LA County Contract Bargaining Committee Member (LA County Registered Nurses), Co-Chair of LA County Department of Public Health's RN Joint Labor Management Committee, and Commissioner on the City of Los Angeles Health Commission (2nd Vice-President). Mrs. Ossey-Harris takes pride in committing over 17 years of community and nursing service in Los Angeles and surrounding communities.

2025 Los Angeles City Health Commissioners



JOHN HISSERICH M.P.H., DrPH.
Commissioner (Council District Two)

John Hisserich began his career at the Charles Drew Postgraduate School after serving three years of active duty in the U.S. Army, obtaining his BA in political science from Cal State LA and completing his Master's and Doctoral degrees in Public Health at UCLA. At the Drew School he was administrator of the first MEDEX Physician Assistant training program in California. He went from Drew to USC to serve as Director of the Cancer Surveillance Program, Deputy Director of the Norris Cancer Center and, after 34 years, retired as Associate Vice President for Health Affairs and Clinical Associate Professor of Community Medicine. Pursuing his interest in the interface between public policy and health care, Dr. Hisserich joined the staff of Assembly member Paul Krekorian who subsequently became a Los Angeles City Council member. Hisserich's role on the staff in both offices was focused on public safety and emergency medical services. Over the years he has had the opportunity to serve on several boards and commissions including, among others, the California Coastal Commission. The Committee of Bar Examiners of the California State Bar, the State Board of Food and Agriculture, the Court Reporters Board, the National Cancer Institute Cancer Control Peer Review Committee, the Los Angeles County Emergency Medical Services Commission, and the Board of Directors of the San Fernando Valley Community Mental Health Center. In addition, Hisserich served 43 years as a Reserve Deputy with the Los Angeles County Sheriff's Department assisting with the investigation of child abuse cases and also serving as an instructor for inmates participating in the Education Based Incarceration Program.

2025 Los Angeles City Health Commissioners



AMANDA COWAN
Commissioner (Council District One)

Amanda studied in the UK, obtaining her undergraduate degree in sociology & social work. While working for the National Health Service on harm reduction pilot programs she went back for her Masters degree in addiction and mental health.

Amanda has worked in a multitude of substance use settings including working within community based mutual aid programs, jails, hospitals, inpatient and outpatient treatment, to capacity building and technical assistance for agencies, working on policy, and conducting ethnography for research projects related to substance use, which has produced over fifteen published papers.

Amanda is executive director for Community Health Project LA, formerly Clean Needles Now, Los Angeles first needle exchange, an organization rooted in social justice and advocacy for people who use drugs.

Amanda currently sits on the community advisory board for both the National Institute of Drug Abuse & USC's Institute for Addiction Science as well as commissioner representing Supervisor Lindsey Horvath on LA County's Alcohol and other drugs commission.

2025 Los Angeles City Health Commissioners



CORINNE HO
Commissioner (Council District Three)

Ms. Ho is a native of Madagascar and arrived in Los Angeles from Canada in 1998. She began being involved with many social organizations, registering voters with the League of Women Voters, working with different law enforcement agencies including the National Council of Jewish Women to raise awareness about Human Trafficking and Labor Trafficking by organizing informative forums and implementing the requirements of Senate Bill 1193 throughout the City of Los Angeles.

Ms. Ho also worked directly with People Experiencing Homelessness and assisting them to be connected through services and housing. Ms. Ho was also a community organizer for the United Way of Greater Los Angeles, advocating for the building of Permanent Supportive Housings for those who experience chronic Homelessness.

Ms. Ho's self-care activities include hiking, doing puzzles, roller blading, singing, playing piano, cooking and speaking with her families that are spread around the globe.

Her expectation for participating in the Health Commission is to collaborate with her fellow Commissioners on advocacy matters, programs, and services needed to serve the people of Los Angeles.

2025 Los Angeles City Health Commissioners



IRMA AVILA C.N.A.
Commissioner (Council District Nine)

Irma Avila serves as the Los Angeles City Health Commissioner for City District 9. She has lived in Los Angeles for 25 years and become a highly experienced leader in public health. Throughout her career, Irma has shown great passion and dedication to protecting the health of the people of Los Angeles as she served as a Certified Nurse Assistant (CNA) for 12 years from 1994-2004 at Wilshire Retirement Center in Los Angeles, California. In 2010, Irma set a bold course of action as a community health educator for the Coalition for Occupational Safety and Health (SoCalCOSH) planning and disseminating health and safety curricula. In 2011, she expanded her efforts in public health with Best Start Metro Los Ángeles (BSMLA) by conducting outreach, leading health education initiatives, and serving as a liaison between parents and community stakeholders. Using her skills as a bilingual Spanish and English speaker, Irma played a key role with Choose Health LA Kids (CHLA Kids) and Champions for Change to spearhead community nutrition workshops, food demonstrations, and advocacy in healthy nutrition campaigns for children and families. Irma continues to aid community outreach events and health education projects by working in collaboration with First 5 LA to hold consulates, health fairs, and conferences in Los Angeles.

Irma Avila proudly serves various roles as member of the UCLA-LOSH Promotoras Committee (UCLA-Labor Occupational Safety & Health), a member of the Community Health Institute (CHI), member of the National Association of Community Health Centers (NACHC), secretary of EISNER Health Center, President of CD Tech – S.O.D.L.A. Group (Sociedad Organizada de Latinas Activas), President of All Peoples Community Center-Grupo M.E.J.O.R. (Mujeres En Justa Organización Reciproca), and commissioner of the Los Angeles City Health Commission.

Irma now lives with her husband Enrique Avila Martinez and her three children: Henry, Vincent, and Erick, and her granddaughters: Melanie and Melissa.

2025 Los Angeles City Health Commissioners



RON KATO M.B.A.
Commissioner (Council District 11)

Ron C. Kato before retiring in 2022 was the Executive Director of the MOA Wellness Center, a non-profit integrative medical clinic in Del Rey Los Angeles promoting lifestyle changes introducing people to alternative methods other than just taking medications to deal with their health issues. Headquartered in Japan, MOA has clinics worldwide and Ron has worked for them in Japan, Brazil and England. Other than his native language English, he speaks Japanese, Portuguese and Spanish fluently.

Ron worked actively with the late Councilmember Bill Rosendahl of Council District 11 and his staff since 2013 as the Los Angeles City Planning Department was preparing the draft for 'Plan for a Healthy Los Angeles' promoting wellness fairs at the local farmers market. As a native Angeleno it continues to be Ron's passion to see the 'Plan for a Healthy LA' implemented promoting health and wellness in body, mind and spirit for all Angelenos. He is looking forward to Los Angeles hosting the 2028 Olympics and hopes to collaborate with the committee in promoting one of its themes of sustainability to all aspects of improving the living conditions within the city and beyond.

Ron has been serving on the Health Commission since July 2016 and was reappointed by Councilwoman Traci Park. He is active in the Westside community serving on LAPD's Pacific Division's Community Police Advisory Board and Boosters and more recently returning to his roots in Sawtelle where he will be serving on the inaugural board of directors for the newly formed Sawtelle Japantown Association.

2025 Los Angeles City Health Commissioners



STEPHANIE LEMUS
Commissioner (Council District 13)

Stephanie Lemus grew up in the Pico-Union/Westlake area of Los Angeles with her Salvadoran immigrant mother and her two siblings. She attended California State University, Northridge (CSUN) where she double-majored in Anthropology and Central American Studies, with a minor in Pan-African Studies.

After graduating from CSUN, she earned a Master's Degree in Latin American Studies from California State University, Los Angeles (CSULA) where her primary research focused on the community of the Salvadoran diaspora in Los Angeles. In 2021, Stephanie earned her Doctorate in Education from the University of Southern California (USC) Rossier School of Education. She has worked with various non-profit organizations and groups for the past 15 years in community outreach, education, advocacy, healthcare, and public health.

Currently, Stephanie is an adjunct professor at CSUN's Central American Studies Department, Chicana/o Studies in the Los Angeles Community College District, and Ethnic Studies at Orange Coast Community College. She serves as a Community Advisory Board Member of the Cedars-Sinai Cancer Diversity & Inclusion (D&I) Steering Committee, also as President of the Southern California Association of Latin American Studies (SCALAS), and Vice-President of Paving the Road to Success a 501c3 organization that provides intervention/prevention and re-entry services to youth/young adults, families, and communities.

2025 Los Angeles City Health Commissioners



SUSIE SHANNON
Commissioner (Council District 14)

Susie Shannon has represented the 14th Council District on the Los Angeles City Health Commission since 2014, where she also served as president for two years.

Shannon has worked with homeless and low-income communities since 2005 and currently works with unhoused and low-income communities working for systems change and public policy to support solutions to homelessness and poverty. In 2015, Shannon spearheaded legislation to place California on a Housing First model, helping our chronic homeless community with underlying medical conditions achieve better health outcomes through housing. The legislation passed the California legislature and was signed by the Governor in September 2016. Shannon has also served as an expert witness to Congress on matters of homelessness and housing. Shannon serves on the boards of the Democratic National Committee and chairs the Poverty Council, the California Democratic Party and the Los Angeles County Democratic Party.

2025 Los Angeles City Research Associates



CLARE WILLIAMS
Research Associate

Clare Williams is a current undergraduate student at Duke University, where she is pursuing a B.S. in Biology with minors in Chemistry and Global Health. She has served on the Los Angeles Health Commission since 2021 and was a co-author of the 2021, 2022, and 2023 Annual Health Commission Reports, primarily focused on reporting for COVID-19 and the Healthy Living section.

At Duke University, Clare conducts research in the Coyne Laboratory where she examines the US28 and UL138 genes connected to latency in Human cytomegalovirus through infection of trophoblast organoids derived from the human placenta. She is also a lead writer for Duke's Medical Ethics Journal, which advocates for ethical education in pre-medical coursework and the promotion of a humanistic model of medical care, and a clinical volunteer at Healthcare in Action San Fernando Valley.

2025 Los Angeles City Research Associates



MONICA RODRIGUEZ
Research Associate

Monica Rodriguez is an alum from the University of Southern California (USC), where she graduated with a B.S. in Quantitative Biology with a minor in Cultural Competence in Medicine. She has served on the Los Angeles Health Commission since 2023. Prior to joining the Commission, she worked with the Youth Development Task Force to establish Los Angeles' first Youth Development Department where she later served on the inaugural Olivia Mitchell Youth Council.

At USC, Monica conducted research in the Kuhn/Hicks Laboratory where she correlates copy number status with gene expression on the single cell level, focusing on prostate cancer. Aside from research, she is on the Executive Board for USC's Southern California Research Journal to provide a platform for students to publicize their research and foster opportunities for scientific discourse.

2025 Los Angeles City Research Associates



NEYHA PARMAR
Research Associate

Neyha Parmar is a current undergraduate at the University of Southern California (USC), where she is pursuing a B.S. in Global Health. She has served on the Los Angeles Health Commission since 2024.

At USC, Neyha conducts research at the Department of Neurology in the Keck School of Medicine, where she studies mimickers of Multiple Sclerosis, specifically Neuromyelitis Optica (NMO) and Myelin Oligodendrocyte Glycoprotein Antibody Disease (MOGAD). She also works at the USC Zilkha Neurogenetic Institute, researching the genomics and epigenetics of pituitary and brain tumors.

Outside the lab, Neyha is a writer for USC's CURAM Magazine, which promotes health literacy and makes medical literature accessible to diverse communities. She also serves as the secretary of USC's chapter of the American Medical Women's Association (AMWA), supporting initiatives focused on advocacy, mentorship, and professional development for women in medicine.

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2025 Los Angeles City Research Associates



ILARI MACHERA
Research Associate

Ilari C. Machera is an undergraduate student at Rhodes College. He is projected to earn a B.A. in Health Equity and Africana Studies and is simultaneously on the pre-medical track. He is a rising senior in the graduating class of 2025.

Ilari is part of the Multicultural Vision Program (MVP) and Men Of Distinction (MOD) organizations, using his voice to advocate for the marginalized communities at Rhodes College. He uses his education in Health Equity to bring new knowledge to these organizations on how they can move forward in the fight for equality in policies at Rhodes.

While attending Rhodes College, Ilari works with numerous non-profit programs in Memphis, Tennessee. In one of his most recent contributions to the city, Ilari works with Bloom 901, a parks advocacy organization created to help people in park groups come together and organize. He also works with Memphis Union Mission, an emergency service that provides meals and shelter, as well as recovery programs to help address the underlying causes of homelessness.



EDEN WALDMAN
Research Associate

Eden Waldman is an 11th grade student in Los Angeles, CA. Her areas of interest include International Relations and local community work. Eden is passionate about seeking ways in which to help people both globally and locally. She is a Global Futures Institute (GFI) Scholar at her high school where she is undergoing a comprehensive course of study that seeks to explore ways to optimally help humankind through the exploration of three major themes; Environmental Futures, Global Identities, and the Future of Democracy. In addition, she is able to personally make a difference through GFI's study abroad/service program, pursuing independent research and working with a local population to tell their story.

Eden has completed a prestigious International Relations Summer program at Georgetown University. Furthermore, Eden works both in and out of school to stop the spread of hate and antisemitism. She is a Leventhal Intern, and a member of the Nazarian Fellowship; A four year program which encompasses community service projects, interfaith building, and promoting education and understanding on various conflicts in the Middle East. Eden has served as a student affinity group leader for two academic years. Eden has also established a global health club at school, where she works to educate her peers on health disparities across the world, and how to change them for the greater good. Additionally, Eden shares a passion for playing volleyball, and she plays varsity beach volleyball for her high school. In her free time she enjoys movies, travel, and photography. Eden lives with her parents and two younger siblings in Los Angeles. Eden joined the Los Angeles City Health Commission as a Research Associate in 2025.

2025 Los Angeles City Research Associates



SASCHA WEISS
Research Associate

Sascha Weiss is a senior at Pomona College, where she is pursuing a B.A. in Science, Technology and Society and a B.A. in Environmental Analysis.

Sascha joined the Commission in the summer of 2025 as a research associate and her primary interests are on the intersection of climate and community health, particularly the role of environmental exposures in disease prevention.

At Pomona, she recently served on the College's delegation to COP29 in Baku, Azerbaijan, where she engaged with global and subnational leaders on climate resilience and equitable clean energy transitions. She participated in discussions on environmental determinants of health, focusing on air quality, extreme heat, and disparities in toxic exposures. She previously interned at Essential Access Health, where she contributed to community-based health education initiatives focused on preventative care and STI awareness-building with L.A. teens.



RITA MORENO
Legislative Assistant, Office of the City Clerk

The Los Angeles City Health Commission greatly appreciates Rita Moreno, her diligent efforts in assisting the Commission's work, and her invaluable contributions to creating the Annual Report.

Appendix A

The following approved meeting agendas and presentations for the Los Angeles City Health Commission were discussed between January 2025 to November 2025. The Health Commission expresses our deepest gratitude to the presenters - government officials, healthcare providers, professors, researchers, advocates, and leaders in the community - who contributed their time and expertise to the LACHC Meetings. We believe the City Council should collaborate with community stakeholders and work together to confront challenges in the City of Los Angeles.