OCTOBER 2023



2023 COMMUNITY HEALTH ASSESSMENT

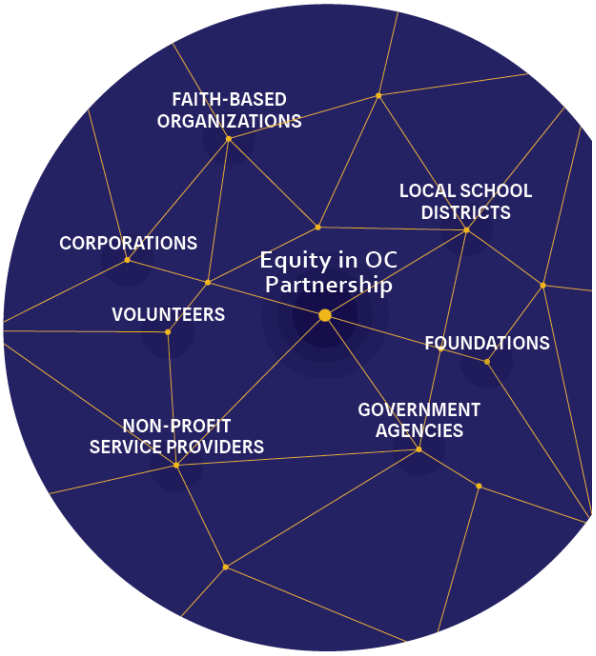
COMPILATION OF COUNTY HEALTH DATA AND COMMUNITY INSIGHTS GATHERED FROM COMMUNITY ENGAGEMENT SESSIONS

AN INITIATIVE OF OC HEALTH CARE AGENCY
PUBLIC HEALTH SERVICES
OFFICE OF POPULATION HEALTH AND EQUITY
OFFICE OF STRATEGY AND SPECIAL PROJECTS

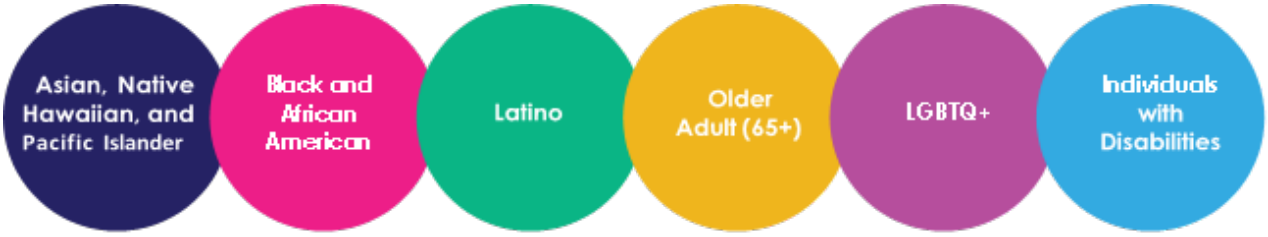
OC Community Health Needs Assessment | Background

Orange County Health Care Agency (HCA) began the Orange County Health Improvement partnership (HIP) in 2019 to complete the 12-month long assessment and planning for the 2020-2022 Orange County Health Improvement Plan. As part of the assessment, the HIP considered findings from existing needs assessment conducted by community partners including CalOptima's Member Health Needs Assessment, various health system's Community Health Needs Assessment, and OC Community Indicators report. A HIP Steering Committee established community-led HIP work groups to implement the health priorities identified including Social Determinants of Health, Access and System Navigation, Mental Health and Substance Abuse, Sexual Health, Older Adults, and Chronic Disease Prevention.

While HIP workgroups continued their work in the early months and throughout the COVID-19 Pandemic State of Emergency (2020-2023), attention was focused on addressing health disparities magnified by the pandemic, leading HCA to focus more efforts on addressing populations disproportionately impacted. HCA created the Office of Population Health and Equity (OPHE) in 2021 to address health disparities among populations at high-risk and underserved. The role of OPHE is to continue to champion the work of the former OC Health Improvement Partnership (2020-2022) through the newly-formed Equity in OC Partnership (EiOC). EiOC priorities included engaging and mobilizing 143 diverse partner organizations service 20 priority populations across all areas of Orange County, CA.



Among the 20 priority populations, six population collectives were created.



Population Collective members met frequently, at minimum weekly, with a total of 231 partners, 186 partner organizations, and 45 community members participating in a variety of activities:

Population Collective Activities

- Share assets (data, resources, information) with one another readily and easily
- Understand the EiOC's health equity goals and objectives
- Understand the value of policy and systems change to advance health equity
- Share policy proposals with one another
- Serve as a vehicle for sharing health equity information with the community
- Regularly advocate for investment and policies that help achieve health equity
- Inform one another of meetings they have with elected officials and staff
- Share power effectively with other Collective members
- Communicate openly with one another
- Communicate effectively with the broader public
- Engage community members with lived experiences of health inequity
- Influence key decision-makers in government
- Learn from community residents to ensure the work meets their needs

To support the work of the EiOC Population Collectives and to bring together the community on priorities that address health disparities, an updated website, www.equityinoc.com, houses the Population Health and Equity Collective data, the OC Equity Map, Population Overviews, a description of EiOC Partner Engagement, and events (past and current), along with materials from those events, and resources. The data dashboard contains information on populations served, such as American Indian/Alaskan Native, LGBTQ, and Older Adults. A geographic distribution of partners on a GIS map, the city where the partner is located, the ZIP Code, number of partners within each city, and information on OPHE grant recipients along with the type of grant each partner received was also made available on the website.

In 2023, HCA embarked on the renewal of a Community Health Needs Assessment utilizing the existing Mobilizing for Action through Planning and Partnership (MAPP) framework of the 2020-2022 OC Health Improvement Plan including four primary assessments:



This document is a compilation of the outcomes the MAPP and contains a summary of findings regarding health conditions and health determinants identified as priorities by the community:

- The primary data collected in Spring 2023 via the two qualitative assessments, Forces of Change Assessment and Community Themes and Strengths Assessment (CTSA) are integrated into all the areas in this document.
- Two in-person community sessions were held in July and August of 2023 and virtual sessions in October 2023 to introduce the survey utilizing the Delphi method created in both PDF and digital formats to capture community insights for further refinement of priority areas that will be utilized as workgroups are created to develop the 2024-2026 Orange County Community Health Improvement Plan (CHIP).

Finally, this document contains a list of local, state, and federal resources and assets available to the community. These resources are located at the end of the document along with references to key data reports relating to the local, state, and Federal indicators listed in the summary document.

A larger, complementary document includes an extensive list of data indicators including longitudinal data charts going back to 2010 (when possible) and equity maps. This data collection is intended to provide a single document for quick reference to help community members identify and revise priority areas.

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Orange County 2023 Community Health Assessment

Summary of Findings

August 2023

An initiative of

Orange County
2023 Community Health Assessment
Summary of Findings

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OVERVIEW

August 2023

This reference is designed to support individuals participating in the development of Orange County's 2024-2026 Community Health Improvement Plan (CHIP). The document provides, for each health condition or health determinant, summary of findings from the recent Community Health Assessment. This summary includes high-level data for related indicators, a brief discussion of known disparities, qualitative findings from the assessment, as well as mission statements for known current collaborative activities (not comprehensive).

This document is intended to assist in consideration of identified health conditions and determinants and then the scoring of each per the following categories:

- **Meaningfulness**
    - **Disparity / Inequity:** There is great disparity and/or inequity for this health condition/determinant within the county.
    - **Important:** This is a health condition/determinant which is important to my community and/or stakeholders.
    - **Outcome:** Improvement in this health condition/determinant would improve overall health in Orange County.
- **Feasibility**
    - **Current Effort:** This need is currently under-addressed in Orange County.
    - **Collaboration:** More collaboration or multi-sector approaches are needed to improve this health condition/determinant.
    - **Opportunity:** This is a health priority with which my organization / community would align.
- **Overall:**
    - This is a health condition/determinant that should be a high priority for our shared Community Health Improvement Plan.

Aggregation of individual scoring will allow determination of the highest priority health needs in Orange County to be addressed in the CHIP.

INDICATORS: High level view of county-wide indicators related to each condition or determinant to be considered is provided in the summary. These demonstrate over-all Orange County status compared to California and the United States, as well as compared to Healthy People 2030 goals.

EQUITY AND DISPARITIES: Also in each summary are brief descriptions of disparities revealed in the indicators to inform the scoring. Insights gained from census tract-level maps of related indicators from the Orange County Equity Map (based on the Social Progress Index[1]) are also provided.

QUALITATIVE FINDINGS: Summaries of qualitative findings from the following assessments are provided:

- **Community Themes and Strengths Assessment (CTSA):** Qualitative assessment of assets in the community and issues that are important to community members. Conducting the CTSA answers the following questions:
  - What is important to the community?
  - How is quality of life perceived in the community?
  - What assets does the community have that can be used to improve community health?

- **Forces of Change (FoC) Assessment:** A survey that identifies forces that may affect a community and opportunities, and threats associated with those forces. Conducting the FoC answers the following questions:
  - What is occurring or might occur that affects the health of the community or the local public health system?
  - What specific threats or opportunities are generated by these occurrences?

- **Local Public Health Services Assessment (LPHSA):** A survey developed by the National Public Health Standards that measures how well the local public health system delivers the 10 Essential Public Health Services, which encompass the activities, competencies, and capacities of the local public health system

These summaries are provided to highlight specific needs, barriers or opportunities that were identified through those assessments. Detailed findings from each assessment are available at: https://www.equityinoc.com/event/2023-community-health-assessment.

CURRENT COLLABORATIVE ACTIVITIES: Through the years, many collaborative activities have been initiated to address the conditions and determinants contained in this reference document. Critical to selection of priorities for the 2024-2026 CHIP is understanding the existing efforts and where there is an opportunity to fill a gap and/or support/strengthen existing efforts. The efforts included in these summaries are not yet comprehensive.

[1] The foundation of the Orange County Equity Map is a set of social and environmental metrics called the Social Progress Index. This index incorporates over 50 indicators that measure the health and wellness of a community. **Source:** Social Progress Index - Advance OC

HEALTH CONDITIONS

Topic	MENTAL HEALTH				
	Indicator Name	**Actual Value** (most recent year)	**CA Value**	**US Value**	**HP 2030 Goal**
Data	Percent of Adults Needing Help with Mental, Emotional, or Substance Abuse Problems (CHIS)	22.0% (2021)	25.0%	N/A	N/A
	Percent of Teens Needing Help with Emotional/Mental Health Problems (CHIS)	47.1% (2021)	36.7%	N/A	N/A
	Percent of Adults Needing and Receiving Behavioral Health Care Services (CHIS)	47.9% (2021)	53.8%	N/A	N/A
	Percent of Adults with Likely Serious Psychological Distress During Past Year (CHIS)	14.6% (2021)	17.0%	N/A	N/A
	Age-Adjusted Death Rate Due to Suicide per 100,000 (CDPH)	9.9 (2018-2020)	10.5	14.1 (2021)	12.8
	Percent of Adults Who Ever Thought Seriously About Committing Suicide (CHIS)	17.0% (2021)	19.1%	N/A	N/A
	Percent of 11th Graders Who Considered Suicide (CDE)	14.0% (2019-2021)	16.0% (2017-2019)	N/A	N/A
	Percent of Transgender 11th Graders Who Considered Suicide (CDE)	49.0% (2019-2021)	51.0% (2017-2019)	N/A	N/A
	Ratio of Population to Mental Health Providers (UWPHI)	283:1 (2022)	236:1	340:1	N/A
– Equity & Disparities	– Percent of Teens Needing Help with Emotional/Mental Health Problems: Hispanic (52.5%) reported needing help with behavioral health issues at higher rates than White (46.0%) and Asian (41.9%) – Percent of Adults Needing and Receiving Behavioral Health Care Services: Hispanic (34.5%) and Asian (39.3%) receive BHCS at lower rates than White (58.7%) – Percent of Adults with Likely Serious Psychological Distress During Past Year: In 2021, Hispanics experienced psychologic distress at the highest rate (18.2%), followed by Asians (15.7%); Whites experienced it the lowest rate (12.1%) – Percent of Transgender 11th Graders Who Considered Suicide: Almost half (49.0%) of transgender 11th graders reported considering suicide compared to only 14.0% of non-transgender 11th graders – North and Central County regions tends to have higher than median percentage of adults who had 14 or more poor mental health days.				
Qualitative Findings	**Need for increased awareness of mental health and support for mental health issues** – Communities are vulnerable to mental health, associated stigma prevents seeking help – Need for mental health education and community resources for both youth and adults – Recognition of community trauma, integration of health, mental health, and social services				

	– Increased awareness for mental health issues, increased resources for support – Education about mental health and stigma to address mental health resources **Difficulty accessing mental health care due to limited capacity, stigma, insurance, and cultural/language barriers of the complicated system** – Need more (and more culturally diverse) mental health providers, not enough mental health professionals work with Medi-Cal/Medicare, including peer-based providers – Stigma around seeking help results in difficulty navigating mental healthcare system – Insurance companies act as a barrier for mental health and substance use treatment – Sliding scale payment options are often not affordable – During COVID years, the need has increased while access/use decreased
Current Collaborative Activities	– BeWell: The mission is to make compassionate mental health care more accessible for our community – Community Suicide Prevention Initiative: The mission of the Orange County Community Suicide Prevention Initiative (CSPI) is to promote hope and help community members live more purposeful lives, with a particular focus on survivors, those at risk and their loved ones. – HCA's Behavioral Health Advisory Board

Topic	MATERNAL / FETAL HEALTH				
Data	**Indicator Name**	**Actual Value** (most recent year)	**CA Value**	**US Value**	**HP 2030 Goal**
	Percent of Mothers Who Received Early Prenatal Care (CPDH)	88.2% (2020)	85.8%	77.7%	80.5%
	Infant Mortality Rate per 1,000 Live Births (OCHCA)	2.8 (2020)	3.7	5.4	5.0
	Percent of Infants with Low Birth Weight (OCHCA)	6.2% (2020)	6.9%	8.2%	N/A
	Percent of Infants Exclusively Breastfed at Hospital Discharge (CDPH)	67.6% (2020)	69.7%	N/A	N/A
	Teen Birth Rate per 1,000 Females Ages 15-19 Years (CDPH)	6.9 (2020)	11.0	15.4	31.4
	Pregnancy-Related Mortality Rate per 100,000 Live Births (CDPH)	11.6 (2018-2020)	15.7	17.3 (2018)	N/A
	Percent of Births That Were Cesarian (CDC)	31.3% (2021)	30.8%	26.3%	23.6%
	Percent of Births Where Mother Had Diabetes (CDC)	11.0% (2021)	9.5%	N/A	N/A
	Fertility Rates per 1,000 Women Ages 15-44 (CDC)	49.5 (2020)	52.4	N/A	N/A

Equity & Disparities

- Infant Mortality Rate per 1,000 Live Births: Hispanic (3.7) had higher rate than White (2.3) and Asian (1.0)
- Percent of Infants Exclusively Breastfed at Hospital Discharge: Black (65.0%), Hispanic (61.4%), Asian (57.7%) and Pacific Islander (61.4%) infants were breastfed at lower rates than White (82.4%) and American Indian (82.4%)
- Teen Birth Rate per 1,000 Females Ages 15-19 Years: Hispanic (13.0) gave birth at a higher rate than White (2.2), Black (8.0) and Asian (0.5)
- Percent of Births That Were Cesarian: Almost three-quarters (72.3%) of cesarian births were to White mothers, with 21.5% of cesarian births to Asian mothers. Less than 3% of Black or Multiracial mothers had a cesarian birth
- Areas of South County have higher percentage of people who received early prenatal care compared to other regions of the County (Source: The 28th Annual Report on the Conditions of Children in Orange County).

Qualitative Findings	**Need for tangible resources and increased services for maternal and fetal care** – Lack of pediatric sub-specialists in the county – Lack of high-risk Obstetrics and Gynecologists in the county – Pediatric and Obstetric services feel provider-centered rather than family-centered – Pregnancy and birthing services – Increasing dissemination of resources, especially access to basic needs like food and clothing, transportation, childcare, and other for special needs families and homeless families – Lack of physically accessible health care offices for people on Medicare/Medi-Cal – Medi-Cal reimbursement rates are insufficient – Professionals leaving healthcare – Healthcare providers are overworked and understaffed **Opportunities**: – CalAIM initiatives offering expanded coverage and benefits to eligible individuals – CalOptima covering more services and focusing on Social Determinants of Health – Wider use of Promotoras and community health worker models
Current Collaborative Activities	– Orange County Breastfeeding Coalition – Orange County Perinatal Council: The mission is to support optimal perinatal health and wellness for Orange County's women and babies- before, during and after birth. – Orange County Home Visiting Collaborative: The vision is to create an integrated prenatal to three system of care, prioritizing families that will benefit most from early interventions.

Topic	DIABETES AND OBESITY				
Data	**Indicator Name**	**Actual Value** (most recent year)	**CA Value**	**US Value**	**HP 2030 Goal**
	Percent of Adults with Diabetes (CHIS)	8.4% (2021)	10.8%	N/A	N/A
	Age-Adjusted Hospitalization Due to Uncontrolled Diabetes per 10,000 (HCAI)	24.6 (2021)	25.0	N/A	N/A
	Age-Adjusted Hospitalization Due to Long-Term Diabetes Complications per 10,000 (HCAI)	88.9 (2021)	93.0	N/A	N/A
	Age-Adjusted Death Rate Due to Diabetes per 100,000 (CDPH)	14.9 (2018-2020)	22.3	15.2 (2010-2015)	13.7
	Percent of Adults Who Are Obese (CHIS)	24.2% (2021)	28.2%	41.8%	36.0%
	Adults Who Are Overweight or Obese (CHIS)	58.1% (2021)	62.0%	N/A	N/A
	Percent of 5th Graders Who Are Overweight or Obese (CHIS)	36.6% (2019)	41.3%	N/A	N/A
Equity & Disparities	– Percent of Adults with Diabetes: The percent of adults suffering from diabetes is higher among Hispanics (10.4%) than among Asian (8.3%) and White (7.2%) – Percent of Adults Who Are Obese: A greater percent of Hispanic (33.6%) adults are obese compared to White (25.4%) and Asian (6.2%) adults – Adults Who Are Overweight or Obese: A greater percent of Hispanic (70.2%) adults are overweight or obese compared to White (59.3%) and Asian (34.9%) adults – Diabetes was more prevalent in North County than in the rest of the county. – Obesity was more prevalent in parts of North County than in the rest of the county.				
Qualitative Findings	– Address accessibility for healthy eating for children, which addresses diabetes. – Address the lack of information, particularly in the schools on educating parents on healthy eating habits.				
Current Collaborative Activities	– Orange County Diabetes Collaborative				

Topic	SUBSTANCE USE				
Data	**Indicator Name**	**Actual Value** (most recent year)	**CA Value**	**US Value**	**HP 2030 Goal**
	Percent of Adults Who Smoke (CHIS)	7.1% (2021)	6.2%	11.7% (2021)	6.1%
	Age-Adjusted Drug Induced Death Rate per 100,000 (CDPH)	15.6 (2021)	17.8	32.4 (2021)	20.7
	Percent of Adults Who Binge Drink (UWPHI)	17.0% (2020)	18.0%	19.0%	N/A
	Percent of 7th Graders Who Use Alcohol or Drugs (CDE)	4.0% (2019-2021)	15.0% (2017-2019)	N/A	N/A
	Percent of 9th Graders Who Use Alcohol or Drugs (CDE)	8.0% (2019-2021)	15.0% (2017-2019)	N/A	N/A
	Percent of 11th Graders Who Use Alcohol or Drugs (CDE)	15.0% (2019-2021)	23.0% (2017-2019)	N/A	N/A
	Percent of 7th Graders Who Use E-Cigarettes (Vaping) (CDE)	2.0% (2019-2021)	4.0% (2017-2019)	N/A	N/A
	Percent of 9th Graders Who Use E-Cigarettes (Vaping) (CDE)	4.0% (2019-2021)	9.0% (2017-2019)	13.1% (2020)	10.5%
	Percent of 11th Graders Who Use E-Cigarettes (Vaping) (CDE)	7.0% (2019-2021)	11.0% (2017-2019)	13.1% (2020)	10.5%
	Age-Adjusted Opioid Prescription Rates per 1,000 (CDPH COSD)	287.4 (2021)	321.71	N/A	N/A
	Age-Adjusted Emergency Department Visit Rates Due to All Drug Overdoses per 100,000 (CDPH)	119.14 (2021)	148.19	N/A	N/A
Equity & Disparities	– Percent of Adults Who Smoke: Hispanics (9.0%) smoke at a higher rate than White (6.8%) and Asian (4.4%) – Percent of 11th Graders Who Use Alcohol or Drugs: White 11th Graders (21.0%) use alcohol or drugs at a higher rate than Black (17.0%), Hispanic (14.0%) or Asian (6.0%) 11th Graders – Age-Adjusted Emergency Department Visit Rates Due to All Drug Overdoses per 100,00: Black populations (239.68) visited ER at a higher rate than White (185.1), Native Hawaiian/Alaska Native (130.39), Hispanic (98.09) or Pacific Islander (42.87) populations – Areas of north and south county experienced drug and alcohol mortality rates from 2010-2012 to 2019-2021.				
Qualitative Findings	– Insurance companies act as a barrier for mental health and substance use treatment for the youth. – Hispanic/Latino: Substance use and food access support; lack of outreach to destitute people and children – Greater supports needed for students/youth who use alcohol, drugs, or who vape				

Current Collaborative Activities	– YOR Project (BeWell) – Connect OC

Topic	SEXUALLY TRANSMITTED DISEASES				
Data	**Indicator Name**	**Actual Value** (most recent year)	**CA Value**	**US Value**	**HP 2030 Goal**
	Chlamydia Incidence Rate per 100,000 (CDPH)	341.9 (2020)	448.2	481.3	N/A
	Gonorrhea Incidence Rate per 100,000 (CDPH)	142.8 (2020)	196.8	206.5	N/A
	Syphilis Incidence Rate per 100,000 (CDPH)	27.9 (2020)	38.3	12.7	N/A
	HIV Incidence Rate per 100,000 (CDPH)	8.2 (2020)	9.9	10.9	N/A

Equity & Disparities	– HIV Incidence Rate per 100,000: Parts of North and Central Orange County had the highest (12.3 – 18.4) rate in the county.
Qualitative Findings	
Current Collaborative Activities	– HIV Planning Council: In partnership with affected communities, service providers, philanthropists, and public health professionals, will support an accessible, culturally competent continuum of HIV prevention and care services that promotes optimal health, fosters self-sufficiency, reduces stigma and discrimination, and results in a community where new HIV infections are rare.”

Topic	VACCINE PREVENTABLE DISEASES				
Data	**Indicator Name**	**Actual Value** (most recent year)	**CA Value**	**US Value**	**HP 2030 Goal**
	Percent of Kindergartners with Required Immunizations (CDHS)	96.3% (2021)	N/A	93.0% (2021-2022)	95.0%
	Age-Adjusted Death Rate Due to Influenza/Pneumonia per 100,000 (CDPH)	13.7 (2018-2020)	13.5	N/A	N/A
	Tuberculosis Incidence Rate per 100,000 (CDPH)	5.2 (2018-2020)	5.0	2.2 (2020)	1.4
	COVID-19 Deaths in Orange County (OCHCA)	1,759 (2022)	N/A	N/A	N/A
	COVID-19 Boosters in Orange County (OCHCA)	595,090 (2022)	N/A	N/A	N/A

Equity & Disparities

- Percent of Kindergartners with Required Immunizations: Western County had the highest (98.1% - 99.4%) immunization rate in the county

Qualitative Findings

Need for increased culturally appropriate health education

- Culturally appropriate health education
- Lack of access to vaccine informative sessions and education on accessible health resources
- Better public health education on prevention options and self-care to reduce long-term health costs

Current Collaborative Activities

- HCA's Immunization Coalition: The mission is to positively impact the health status of the Orange County community by achieving and maintaining full immunization protection.

Topic	INJURIES AND ACCIDENTS				
Data	**Indicator Name**	**Actual Value** (most recent year)	**CA Value**	**US Value**	**HP 2030 Goal**
	Substantiated Child Abuse Rate per 1,000 (CA Department of Finance; Orange County Social Services Agency)	6.5 (2021)	6.3	8.1	8.7
	Age-Adjusted Death Rate Due to Unintentional Motor Vehicle Crashes per 100,000 (CDPH)	6.5 (2018-2020)	10.0	13.3 (2021)	10.1
	Age-Adjusted Unintentional Firearm Death Rates per 100,000 (CDPH)	4.7 (2018-2020)	10.0	13.3 (2021)	10.1
	Age-Adjusted Unintentional Injury Death Rates per 100,000 (CDPH)	29.8 (2018-2020)	37.9	64.7 (2021)	43.2
	Age-Adjusted Death Rate Due to Homicide per 100,000 (CDPH)	2.1 (2018-2020)	5.2	8.2 (2021)	5.5
	Age-Adjusted Death Rate Due to Falls per 100,000 (CDC Wonder)	5.3 (2020)	6.4 (2020)	N/A	N/A
	Age-Adjusted Death Rate Due to Firearms Among Children per 100,000 (KidsData)	2.3 (2020)	5.6	9.9	N/A
Equity & Disparities	– Age-Adjusted Death Rate Due to Falls per 100,000 was higher for males (6.3) than for females (2.4) – Equity Map: Regions of north and west County have a higher rate of violent crime than in the rest of the County.				
Qualitative Findings					
Current Collaborative Activities	– Orange County Trauma Center Coalition – Orange County Window Falls Coalition				

Topic	CANCER				
Data	**Indicator Name**	**Actual Value** (most recent year)	**CA Value**	**US Value**	**HP 2030 Goal**
	Age-Adjusted Death Rate Due to All Cancers per 100,000 (CDPH)	122.4 (2018-2020)	128.3	146.6 (2021)	122.7
	Age-Adjusted Death Rate Due to Breast Cancer per 100,000 (CDPH)	18.5 (2018-2020)	18.2	19.4 (2021)	15.3
	Age-Adjusted Death Rate Due to Colorectal Cancer per 100,000 (CDPH)	10.5 (2018-2020)	11.9	13.4 (2021)	8.9
	Age-Adjusted Death Rate Due to Lung Cancer per 100,000 (CDPH)	21.5 (2018-2020)	22.9	31.7 (2021)	25.1
	Age-Adjusted Death Rate Due to Prostate Cancer per 100,000 (CDPH)	17.6 (2018-2020)	19.1	19.0 (2021)	16.9
	Age-Adjusted Death Rate Due to Cervical Cancer per 100,000 (CDPH)	0.9 (2018-2020)	1.1	1.2 (2021)	N/A
Equity & Disparities	– Data do not point to clear disparities – Parts of the north County and pockets of south County have a lower percentage of adult population with cancer compared to the rest of the county. – Parts of the north County and pockets of south County have a lower percentage of adult population with cancer compared to the rest of the county.				
Qualitative Findings	– Hispanic and Latino Individuals are getting more involved in programs to improve health outcomes; with cancer survivorship increasing – Culturally sensitive mental health support for Hispanic/Latino cancer warriors is needed – Asian/Pacific Islanders, on the other hand, need access to early screening for breast and colon cancer screenings.				
Current Collaborative Activities	– UCI Orange County Cancer Coalition: The Mission is to facilitate collaboration of Orange County community resources for comprehensive cancer prevention and patient care.				

Topic	HEART DISEASE / STROKE				
Data	**Indicator Name**	**Actual Value** (most recent year)	**CA Value**	**US Value**	**HP 2030 Goal**
	Preventable Hospital Stays per 100,000 (UWPHI)	1,722 (2021)	2,256	2,809	N/A
	Age-Adjusted Death Rate Due to Coronary Heart Disease per 100,000 (CDPH)	72.6 (2018-2020)	80.7	92.8	71.1
	Percent of Adults Who Experienced Coronary Heart Disease (CHIS)	6.7% (2021)	7.1%	N/A	N/A
	Age-Adjusted Death Rate Due to Cerebrovascular Disease (Stroke) per 100,000 (CDPH)	36.3 (2018-2020)	37.0	41.1	33..4
	High Blood Pressure Prevalence (CHIS)	22.6% (2021)	26.8%	45.7%	42.6%
Equity & Disparities	– Preventable Hospital Stays: More American Indian/Alaskan Natives (5,391) had preventable hospital stays than Blacks (3,570), Hispanics (2,395), Asians (1,572) and Whites (1,558) – High Blood Pressure Prevalence: More Whites (28.1) suffer from high blood pressure than Asians (18.6%) and Hispanics (18.7%) – Wide areas of North County and parts of South County had a higher coronary heart disease among adults aged >=18 years than rest of the County. – High cholesterol among adults aged >= 18 years is more prevalent in north and parts of south County than in other regions of the County – High blood pressure among adults aged >= 18 years was more prevalent in north and parts of south County than in other regions of the County				
Qualitative Findings	– Lack of sub-specialists in the county – Lack of physically accessible health care offices for people on Medicare/Medi-Cal – Medical care costs wiping out seniors – Affordability of any insurance – Lack of preventative care – Rising need for comprehensive care; aging/dementia; increasing chronic illnesses – Medi-Cal reimbursement rates are insufficient – Professionals leaving healthcare – Create training programs to increase community well-being (i.e., financial literacy, health literacy programs)				
Current Collaborative Activities					

Topic	ASTHMA / CHRONIC OBSTRUCTIVE PULMONARY DISEASE				
Data	**Indicator Name**	**Actual Value** (most recent year)	**CA Value**	**US Value**	**HP 2030 Goal**
	Percent of Adults Ever Diagnosed with Asthma (CHIS)	11.8% (2021)	16.1%	N/A	N/A
	Age-Adjusted Hospitalization Rate Due to Adult Asthma per 10,000 (CDPH)	2.4 (2019)	3.1 (2019)	N/A	N/A
	Age-Adjusted Emergency Department Visit Rate Due to Adult Asthma per 10,000 (CDPH)	21.2 (2019)	35.4 (2019)	N/A	N/A
	Age-Adjusted Hospitalization Rate Due to Pediatric Asthma per 10,000 (CDPH)	6.4 (2019)	8.3 (2019)	N/A	N/A
	Age-Adjusted Emergency Department Visit Rate Due to Pediatric Asthma per 10,000 (CDPH)	43.4 (2019)	63.4 (2019)	N/A	N/A
	Age-Adjusted Death Rate Due to COPD per 100,000 (CDPH)	18.2 (2022)	22.0 (2022)	95.7 (2021)	107.2
Equity & Disparities	– Percent of Adults Ever Diagnosed with Asthma: White (14.4%) adults are diagnosed at a higher rate than Asian (10.6%) and Hispanic (9.7%) adults – Age-Adjusted Hospitalization Rate Due to Adult Asthma per 10,000: Blacks (9.6) are hospitalized at a higher rate than Asian (2.6), Hispanic (3.2) or White (3.3) – Age-Adjusted Emergency Department Visit Rate Due to Adult Asthma per 10,000: Blacks (104.3) are admitted to the ER at a higher rate than Asian (13.2), Hispanic (29.6), Native Hawaiian/Pacific Islander (76.8) or White (24.9). – Age-Adjusted Death Rate Due to COPD per 100,000: White (23.3) die at a higher rate than Asian (11.1), Hispanic (10.4) or Black (15.6) – Wide areas of north county and parts of south County had a higher coronary heart disease among adults aged >=18 years than rest of the County.				
Qualitative Findings					
Current Collaborative Activities					

Topic	ORAL HEALTH				
Data	**Indicator Name**	**Actual Value** (most recent year)	**CA Value**	**US Value**	**HP 2030 Goal**
	Percent of Children Who Visited a Dentist in Past 6 Months (CHIS)	64.3% (2021)	65.2%	N/A	N/A
	Ratio of Population to Dental Providers (UWPHI)	827:1 (2021)	1102:1	1380:1	N/A
Equity & Disparities	– Central census tracts had more dental visits due to cavities than South Orange County.				
Qualitative Findings					
Current Collaborative Activities	– HCA's Oral Health Collaborative: Vision is for all Orange County residents to have opportunities and resources for optimal oral health.				

Topic	**ALZHEIMER'S DISEASE / DEMENTIA**				
Data	**Indicator Name**	**Actual Value** (most recent year)	**CA Value**	**US Value**	**HP 2030 Goal**
	Age-Adjusted Death Rate due to Alzheimer's Disease	39.2 (2018-2020)	37.7	N/A	N/A
Equity & Disparities					
Qualitative Findings					
Current Collaborative Activities					

HEALTH DETERMINANTS

Topic	HOUSING / HOMELESS				
	Indicator Name	**Actual Value** (most recent year)	**CA Value**	**US Value**	**HP 2030 Goal**
Data	2022 Point in Time Count of persons experiencing homelessness https://www.ocgov.com/news/county-orange-releases-2022-point-time-count-results) and https://www.ochealthinfo.com/sites/hca/files/2022-05/2022%20PIT%20Data%20Infographic%20-%205.10.2022%20Final.pdf	5,718	171,500		
Equity & Disparities	– North (2,419) and Central (2,714) have a higher number of homeless persons than South (858) county – More homeless persons are recorded in North (2,419) and Central (2,714) Service Planning Areas compared to the South (585) Service Planning Area – North County had a higher percentage of population in housing where there is more than one resident per room.				
Qualitative Findings	**Affordable Housing** – Increased evictions and lack of post-eviction support – Lack of financial capacity increases homelessness and forces choices between essential needs – Unaffordability of Rent Prices – Need for more shelters – High cost of land and scarcity in places to build more housing – Increased wealth gap leading to more homelessness – Increase in nimbyism (Not in My Backyard) – Optimistic for Government and Organizational Support to provide additional resources (i.e. advocacy for rent control, Implementing Regional Housing Needs Assessment, Growth of housing trust) – Collaboration between government and Community-Based Organization's (CBO's) Fund ADA home modifications to allow people to remain in the community				
Current Collaborative Activities	– Orange County Continuum of Care: The mission is to advocate for more home building in Orange County, California to end the shortage, reduce housing costs, and make room for current and future Orange County residents. – Equity in OC Partnership – Improvement Projects – Family Solutions Collaborative Orange County				

Topic	WORKFORCE				
Data	**Indicator Name**	**Actual Value** (most recent year)	**CA Value**	**US Value**	**HP 2030 Goal**
	Rate of Unemployed Persons in Civilian Workforce (U.S. Bureau of Labor Statistics)	2.7% (2022)	11.1%	10.3%	N/A
Equity & Disparities	– A higher percentage of households in north and west County received food stamp benefits in the past 12 months compared to the rest of the County (Advance OC's Social Progress Index). – Regions of south County has over 75% of people earning more than 200% of federal poverty line compared to the rest of the County (Source: California Health Places Index.) – Areas of south and west County has over 60% of people aged 20-64 with a job compared to the rest of the County (Source: California Health Places Index.) – A higher percentage of households Central County received food stamp benefits in the past 12 months compared to the rest of the County. – Areas of South County have over 75% of people earning more than 200% of federal poverty line compared to the rest of the County (Source: California Health Places Index.) – Areas of South and West County have over 60% of people aged 20-64 with a job compared to the rest of the County (Source: California Health Places Index.)				
Qualitative Findings	**Increasing a diverse health care workforce** – More service providers added to the system – Increasing the number of providers in OC, especially providers that reflect the diversity of the community **Desired Healthcare System Reform** – Health care workers structured outside of the traditional provider-patient relationship – Increasing a diverse health care workforce – More connected services with price transparency				
Current Collaborative Activities					

Topic	CARE NAVIGATION				
Data	Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal
	Percent of People with a Usual Source of Care (CHIS)	87.2% (2021)	86.0%	76.0%	84.0%
	Percent of People Who Delayed or Had Difficulty Obtaining Care (CHIS)	16.6% (2021)	19.9%	17.6%	5.9%
	Difficulty Finding Specialty Care (CHIS)	12.3% (2021)	16.8%	4.7%	6.3%
Equity & Disparities	– Percent of People with a Usual Source of Care: A higher percentage of White (88.1%) receive usual source of care than Asian (84.7%) and Hispanic/Latino (74.1%) – Percent of People Who Delayed or Had Difficulty Obtaining Care: More Whites (21.6%) delayed or had difficulty obtaining care than Asian (10.7%) or Hispanic/Latino (14.2%) – Difficulty Finding Specialty Care: More Whites (12.7%) had difficulty finding specialty care than Asians (9.5%) – North and Central County have a higher percentage of adults who are up to date on a core set of clinical prevention services.				
Qualitative Findings	New patient systems are difficult to navigate – New systems are difficult to navigate for some communities – Difficulty navigating mental healthcare – Lack of access to affordable and quality care, preventing people from seeking help – Providers lack time to help patients navigate new tech and health information – Opportunity to offer digital literacy programs to help vulnerable people navigate telehealth Need for education surrounding how to navigate existing systems – Increasing access: simplifying ways to access care, education on healthcare navigation – Education on where and how to access services, and how to navigate the healthcare system and insurance – Lack of understanding of referral systems, difficulties using OCLINK, missed referral opportunities – Connect or link people to organizations that can provide the personal health services they may need Long wait times act as a barrier to care – Long wait times to access care, difficulty obtaining services as a CalOptima member – Lack of specialty care access due to low reimbursement and long wait times				
Current Collaborative Activities					

Topic	HEALTH INSURANCE ACCESS / ENROLLMENT				
Data	**Indicator Name**	**Actual Value** (most recent year)	**CA Value**	**US Value**	**HP 2030 Goal**
	Percent of Adults with Health Insurance: 18-64 Years (ACS)	90.4% (2021)	90.1%	87.8%	92.4%
	Percent of Children with Health Insurance (ACS)	96.4% (2021)	96.5%	94.6%	N/A
	Percent of Adults Ages 65+ with Health Insurance (ACS)	99.0% (2021)	98.9%	99.2%	N/A
	Percent of Adults Who Had Routine Check-Up in Past 12 Months (CHIS)	64.3% (2021)	60.2%	N/A	N/A
	Avoided Government Benefits Due to Concern Over Disqualification from Green Card/Citizenship (CHIS)	21.9% (2021)	18.8%	N/A	N/A
	Percent of Children Receiving a Development Assessment/Test (CHIS)	75.1% (2021)	72.2%	34.8% (2020-2021)	35.8%
	Ratio of Population to Health Care Providers (UWPHI)	955:1 (2020)	1234:1	1310:1	N/A
Equity & Disparities	– Percent of Adults with Health Insurance: 18-64 Years (ACS): 93.9% of White adults and 94.1% of Asian adults have health insurance compared to 90.4% of Black, 82.3% of Hispanic and 80.4% of AIAN adults – Geographic disparity exists with the highest rate of uninsured children at 8.3% compared to Orange County rate of 3.3% (The 28th annual report on the Conditions of Children in Orange County. – Percent of People with a Usual Source of Care (CHIS): 88.1% of Whites and 84.7% of Asians receive care compared only to 74.1% of Hispanics – Percent of People Who Delayed or Had Difficulty Obtaining Care (CHIS): More Whites (21.6%) delayed or had difficulty obtaining care compared to Hispanic (14.2%) or Asian (10.7%) – Percent of Adults Who Had Routine Check-Up in Past 12 Months (CHIS): More Whites (67.7%) have routine check-up compared to Asian (66.4%) and Hispanic (59.1%) – Regions in South County had a lower percent of children 18 years and younger who were uninsured.				
Qualitative Findings	**Insurance is a barrier to accessing care, whether due to inability to access insurance or price of co-pays** – High insurance costs, but people are not being paid livable wages – People feel it is too complicated to access insurance and care providers, leading to a lack of medical coverage for hearing aids and specific medical devices				

	– Insurance does not cover some necessary procedures (dental, weight loss) that may lead to poorer mental health and potential job loss – Insurance companies act as a barrier for mental health and substance use treatment – Insurance companies and reimbursement services could pay for care coordination, transportation, etc. – People choose high deductibles/copays and don't access care – Increase in part-time hires, decreasing healthcare access through employers – Lack of affordability for any insurance – Inadequate number of providers accepting insurance – New technology may not be covered by insurance, difficult to afford otherwise
Current Collaborative Activities	

Topic: FOOD ACCESS / NUTRITION

Data

Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal
Food Environment Index (UWPHI)	8.8 (2020)	8.8	7.0	N/A
Percent of Adults Who Are Food Insecure (CHIS)	39.7% (2021)	39.0%	10.2%	6.0%
Percent of HIV+ Adults Who Received Food Bank/Home Delivered Meals (HRSA)	14.7% (2021)	15.6%	14.7%	N/A

Equity & Disparities

- Parts of north and south county have a less percentage of population within ½- mile of a supermarket (AdvanceOC's Orange County Equity Map)
- Percent of Adults Who Are Food Insecure: Almost half of those food insecure were Hispanics (49.0%) compared to Whites (26.0%) and Asians (22.9%)

Qualitative Findings

End of Programming that Supported Food Security

- Lack of food programs that target core populations in need
- Reduction in school programming that assists low-income students
- COVID government assistance programs for food being phased out
- Need for food distribution similar to that during COVID

Need for education around food security and food access support

- Creative programming to distribute leftover food, eliminate food waste, or create community gardens
- Need for universal free meals for children
- Need for food access support
- Education on how to navigate food security
- Raise awareness of programs that accept donations from local stores and distribute at food pantries
- New models in Riverside: food boxes at doctors' offices
- Food banks providing healthier food

Issues affecting food availability

- Cost of healthy food continues to increase
- Climate change may impact crops and food access

Lack of youth nutrition prioritization

- School nutrition, structure of menus
- Marketing and brainwashing of youth regarding food
- Reduction in school programming that assists low-income students

Current Collaborative Activities

- HCA's County Nutrition Action Plan
- EiOC's Food Access Collaborative / OC Hunger Alliance

Topic	ECONOMIC DISPARITIES				
Data	**Indicator Name**	**Actual Value** (most recent year)	**CA Value**	**US Value**	**HP 2030 Goal**
	Per Capita Income in Orange County (ACS)	$ 47,334.00 (2021)	$ 42,396.00	$ 38,332.00	N/A
	Percent of People Living Below Poverty Level (ACS)	9.9% (2021)	12.3%	12.8%	8.0%
	Percent of Children Living Below Poverty Level (ACS)	10.8% (2021)	15.8%	16.9%	N/A
	Percent of Adults 65+ Living Below Poverty Level (ACS)	10.0% (2021)	11.1%	10.3%	N/A
	High School Graduate or Higher by Age 25 (ACS)	87.3% (2021)	84.4%	89.4%	N/A
Equity & Disparities	– Per Capita Income in Orange County: White ($62,278) enjoy a higher per capita income than Black ($40,976), AIAN ($27,611) and Asian ($46,136 – Percent of People Living Below Poverty Level: White (7.8%) has the least percent of people living below poverty level in comparison to Black (13.1%), AIAN (12.8%) and Asian (11.5%).				
Qualitative Findings	– Affordability of Health Care – Need for Financial Literacy and Increased Funding Opportunities – Lack of safety nets for workers like unions – Lack of cash assistance opportunities for the working poor and unhoused – Workforce development programs siloed – Increase in housing costs and inflation – Pandemic EBT ended, decrease in food assistance for vulnerable families – Decrease in pandemic relief funding, impacting communities with the lowest SPI first – Opportunities: – Neighborhood groups are forming access to CalFresh – Evaluation redesign of WIC to increase enrollment – Guaranteed income pilots to address economic disparities – Increase in minimum wage proposals to reduce economic disparities				
Current Collaborative Activities					

Topic	LANGUAGE ACCESS				
Data	**Indicator Name**	**Actual Value** (most recent year)	**CA Value**	**US Value**	**HP 2030 Goal**
	11th Grade Students Proficient in English/Language Arts (CA Dept of Education, KidsData)	66.8% (2021)	59.2%	N/A	N/A
Equity & Disparities	– Third grade language arts proficiency is notably lower in parts of north County compared to the rest of the County (Advance OC's Social Progress index) – More areas of north and central County had no household members who spoke English compared to rest of the County				
Qualitative Findings	**Linguistically competent services and resources increase access to resources and care** – Need for culturally competent language services and resources – Making healthy choices would be easier if there were clear, culturally competent and easily understood choices in multiple languages – Linguistic and cultural needs increases workforce – Bilingual and culturally competent partners **Language Barriers** – Language barriers and lack of language appropriate care prevent people from accessing care – Lack of translations for written material prevent equitable dissemination of information				
Current Collaborative Activities					

Topic	EXERCISE				
Data	Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal
	Percent of Adults Reporting Fair or Poor Health (UWPHI)	13.0% (2020)	14.0%	12.0%	N/A
	Adults 18+ Who Are Physically Inactive (Sedentary) (UWPHI)	21% (2020)	21%	22%	N/A
	Percent of 5th Graders Meeting All Fitness Standards (CDE)	28.5% (2019)	23.1% (2019)	23.2% (2019)	30.6%
	Percent of 7th Graders Meeting All Fitness Standards (CDE)	34.8% (2019)	28.2% (2019)	23.6% (2019)	30.4%
	Percent of 9th Graders Meeting All Fitness Standards (CDE)	42.2% (2019)	33.0% (2019)	23.2% (2019)	30.6%
Equity & Disparities	– North county has a higher percentage of children under five who are vulnerable on physical health and wellbeing (AdvanceOC's Orange County Equity Map)				
Qualitative Findings					
Current Collaborative Activities	– Orange County Nutrition and Physical Activity Collaborative: The mission is to lead coordinated efforts and maximize resources to decrease obesity and improve healthy eating and physical activity among Orange County families and communities.				

Topic	IMMIGRATION AND REFUGEES				
Data	Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal
Equity & Disparities					
Qualitative Findings	– Hispanic/Latino immigration support is needed – Immigration status constrains lower-income immigrants from receiving government support – Lack of federal policy on immigration – Immigrants fearful of accessing needed services resulting in exacerbation of health issues and potential spread of disease – Threats to access to resources and information o Immigration growth in OC impacting access o County programming designed for immigrants only – Opportunities to collaborate between organizations and the community o More local advocacy supporting immigrants and refugees o Refugee organizations left out of the current scheme – Need for more education and resources o More legal resources available and education on immigrant issues and needs o Education for COBs working with immigrant population on different immigration statuses, how people apply, barriers, etc. o Dashboard to visually see immigration-sphere in OC to increase comprehension – Policy changes and increased fear have resulted in separation of families and increased vulnerability of immigrants to exploitation and violence – Update K-12 education to be more current, immigration should be taught				
Current Collaborative Activities					

Topic	SOCIAL MEDIA / INFORMATION ACCESS				
Data	Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal
Equity & Disparities					
Qualitative Findings	**Automation's influence on information dissemination** – Media fragmentation to message targets – Creates "echo chambers" in places like social media where differing views can be muted – Social media impact on youth mental health – Social media to increase community engagement and awareness of issues among younger generations – Social media increases health communication – More social media engagement makes it easier for political organizers to seek rights for undocumented people – Social media and increased commercial use of the internet result in decreased privacy, parental involvement, and family cohesion				
Current Collaborative Activities					

Topic	DATA ACCESS AND SUPPORTS				
	Indicator Name	**Actual Value** (most recent year)	**CA Value**	**US Value**	**HP 2030 Goal**
Data					
Equity & Disparities	– Most of north and central county have a higher percentage of households without any internet access (Advance OC's Orange County Equity Map 2021) – Most of north and west County has a lower percentage of households that have broadband internet access compared to the rest of the County (Advance OC's Orange County Equity Map 2021) – Most of north and west County has a lower percentage of households that have cellular data compared to the rest of the County (Advance OC's Orange County Equity Map 2021)				
Qualitative Findings	– Optimistic about government leaders taking initiative to include more communities in data collection – Use relationships with different media providers (e.g., print, radio, television, the Internet) – Social media to increase health communication – Use relationships with different media providers (e.g., print, radio, television, the Internet) to share health information, matching the message with the target audience? – Develop health communication plans for media and public relations and for sharing information among LPHS organizations – Social media to increase community engagement – Increased sense of community, particularly for those who are physically isolated				
Current Collaborative Activities					

Orange County 2023 Community Health Assessment

Findings & Data Graphics

August 2023

An initiative of

Orange County
2023 Community Health Assessment
Summary of Findings

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OVERVIEW

August 2023

This reference is designed to support individuals participating in the development of Orange County's 2024-2026 Community Health Improvement Plan (CHIP). The document provides, for each health condition or health determinant, summary of findings from the recent Community Health Assessment. This summary includes high-level data for related indicators, a brief discussion of known disparities, qualitative findings from the assessment, as well as mission statements for known current collaborative activities (not comprehensive).

This document is intended to assist in consideration of identified health conditions and determinants, and then scoring each per the following categories:

- **Meaningfulness**
  - **Disparity / Inequity: There is great disparity and/or inequity for this health condition/determinant within the county.**
  - **Important: This is a health condition/determinant which is important to my community and/or stakeholders.**
  - **Outcome: Improvement in this health condition/determinant would improve overall health in Orange County.**
- **Feasibility**
  - **Current Effort: This need is currently under-addressed in Orange County.**
  - **Collaboration: More collaboration or multi-sector approaches are needed to improve this health condition/determinant.**
  - **Opportunity: This is a health priority with which my organization / community would align.**
- **Overall:**
  - **This is a health condition/determinant that should be a high priority for our shared Community Health Improvement Plan.**

Aggregation of individual scoring will allow determination of the highest priority health needs in Orange County to be addressed in the CHIP.

INDICATORS: Existing county data related for each condition or determinant to be considered is provided in the summary. These demonstrate over-all Orange County status compared to California and the United States, as well as compared to Healthy People 2030 goals. Following each summary are detailed charts that reveal trends and/or disparities, to be referenced as needed.

EQUITY AND DISPARITIES: **Also in each summary are brief descriptions of disparities revealed in the indicators to inform the scoring. Census tract-level maps of related indicators from the Orange County Equity Map, based on the Social Progress Index[1], are provided to show geographic disparities.**

QUALITATIVE FINDINGS: **SUMMARIES OF QUALITATIVE FINDINGS FROM THE FOLLOWING ASSESSMENTS ARE PROVIDED:**

- **Community Themes and Strengths Assessment (CTSA): Qualitative assessment of assets in the community and issues that are important to community members. Conducting the CTSA answers the following questions:**
  - **What is important to the community?**
  - **How is quality of life perceived in the community?**
  - **What assets does the community have that can be used to improve community health?**

- **Forces of Change (FoC) Assessment: A survey that identifies forces that may affect a community and opportunities, and threats associated with those forces. Conducting the FoC answers the following questions:**
  - **What is occurring or might occur that affects the health of the community or the local public health system?**
  - **What specific threats or opportunities are generated by these occurrences?**

- **Local Public Health Services Assessment (LPHSA): A survey developed by the National Public Health Standards that measures how well the local public health system delivers the 10 Essential Public Health Services, which encompass the activities, competencies, and capacities of the local public health system**

These summaries are provided to highlight specific needs, barriers or opportunities that were identified through those assessments. Detailed findings from each assessment are available at: https://www.equityinoc.com/event/2023-community-health-assessment.

CURRENT COLLABORATIVE ACTIVITIES: **Through the years, many collaborative activities have been initiated to address the conditions and determinants contained in this reference document. Critical to selection of priorities for the 2024-2026 CHIP is understanding the existing efforts and where there is an opportunity to fill a gap and/or support/strengthen existing efforts. The efforts included in these summaries are not yet comprehensive.**

[1] The foundation of the Orange County Equity Map is a set of social and environmental metrics called the Social Progress Index. This index incorporates over 50 indicators that measure the health and wellness of a community. **Source:** Social Progress Index - Advance OC

HEALTH CONDITIONS

Summary of Findings

Equity Map – Social Progress Index Indicators

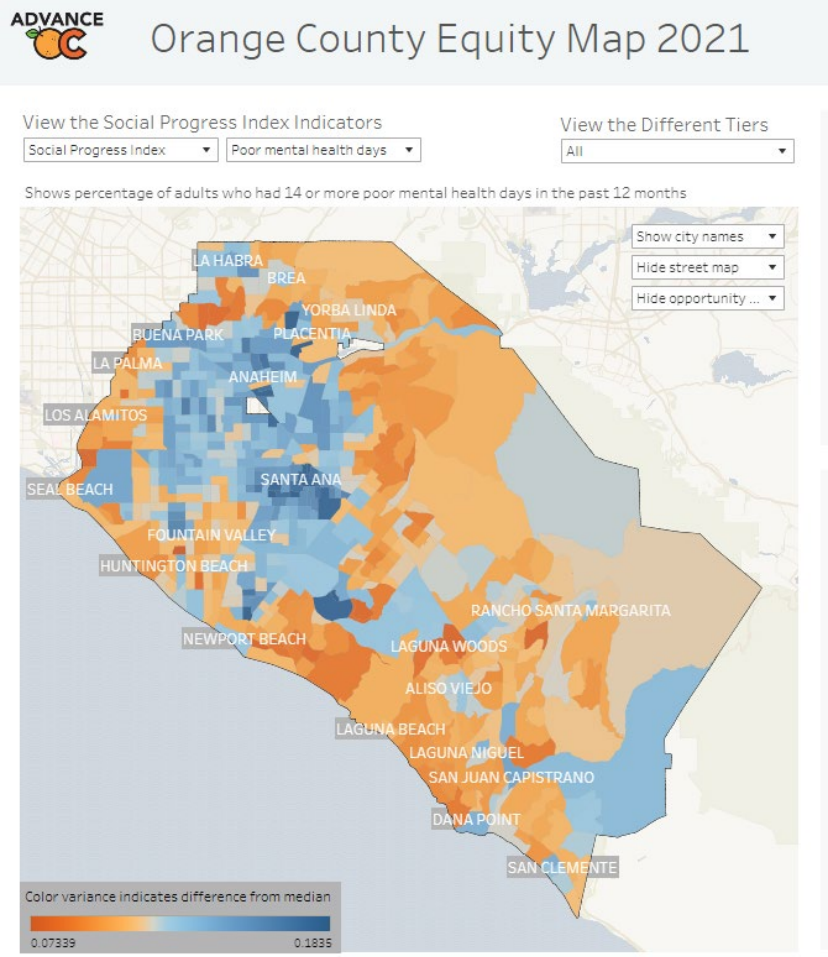
Health Indicators

Topic	MENTAL HEALTH				
Data	Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal
	Percent of Adults Needing Help with Mental, Emotional, or Substance Abuse Problems (CHIS)	22.0% (2021)	25.0%	N/A	N/A
	Percent of Teens Needing Help with Emotional/Mental Health Problems (CHIS)	47.1% (2021)	36.7%	N/A	N/A
	Percent of Adults Needing and Receiving Behavioral Health Care Services (CHIS)	47.9% (2021)	53.8%	N/A	N/A
	Percent of Adults with Likely Serious Psychological Distress During Past Year (CHIS)	14.6% (2021)	17.0%	N/A	N/A
	Age-Adjusted Death Rate Due to Suicide per 100,000 (CDPH)	9.9 (2018-2020)	10.5	14.1 (2021)	12.8
	Percent of Adults Who Ever Thought Seriously About Committing Suicide (CHIS)	17.0% (2021)	19.1%	N/A	N/A
	Percent of 11th Graders Who Considered Suicide (CDE)	14.0% (2019-2021)	16.0% (2017-2019)	N/A	N/A
	Percent of Transgender 11th Graders Who Considered Suicide (CDE)	49.0% (2019-2021)	51.0% (2017-2019)	N/A	N/A
	Ratio of Population to Mental Health Providers (UWPHI)	283:1 (2022)	236:1	340:1	N/A

- Equity & Disparities
  - Percent of Teens Needing Help with Emotional/Mental Health Problems: Hispanic (52.5%) reported needing help with behavioral health issues at higher rates than White (46.0%) and Asian (41.9%)
  - Percent of Adults Needing and Receiving Behavioral Health Care Services: Hispanic (34.5%) and Asian (39.3%) receive BHCS at lower rates than White (58.7%)
  - Percent of Adults with Likely Serious Psychological Distress During Past Year: In 2021, Hispanics experienced psychologic distress at the highest rate (18.2%), followed by Asians (15.7%); Whites experienced it the lowest rate (12.1%)
  - Percent of Transgender 11th Graders Who Considered Suicide: Almost half (49.0%) of transgender 11th graders reported considering suicide compared to only 14.0% of non-transgender 11th graders
  - North and Central County regions tends to have higher than median percentage of adults who had 14 or more poor mental health days.

Qualitative Findings	**Need for increased awareness of mental health and support for mental health issues** – **Communities are vulnerable to mental health, associated stigma prevents seeking help** – **Need for mental health education and community resources for both youth and adults** – **Recognition of community trauma, integration of health, mental health, and social services** – **Increased awareness for mental health issues, increased resources for support** – **Education about mental health and stigma to address mental health resources** **Difficulty accessing mental health care due to limited capacity, stigma, insurance, and cultural/language barriers of the complicated system** – **Need more (and more culturally diverse) mental health providers, not enough mental health professionals work with Medi-Cal/Medicare, including peer-based providers** – **Stigma around seeking help results in difficulty navigating mental healthcare system** – **Insurance companies act as a barrier for mental health and substance use treatment** – **Sliding scale payment options are often not affordable** – **During COVID years, the need has increased while access/use decreased**
Current Collaborative Activities	– **BeWell: The mission is to make compassionate mental health care more accessible for our community** – **Community Suicide Prevention Initiative: The mission of the Orange County Community Suicide Prevention Initiative (CSPI) is to promote hope and help community members live more purposeful lives, with a particular focus on survivors, those at risk and their loved ones.** – **HCA's Behavioral Health Advisory Board**

MENTAL HEALTH



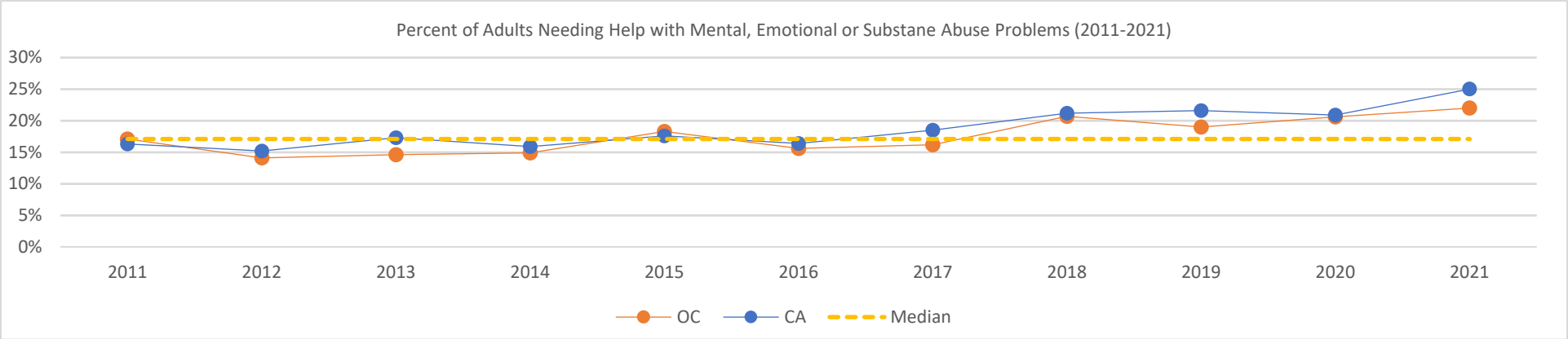
Sources: SPI, CDC PLACES Local Data, American Community Survey, First 5 OC, OC Health Care Agency and CA Opportuni

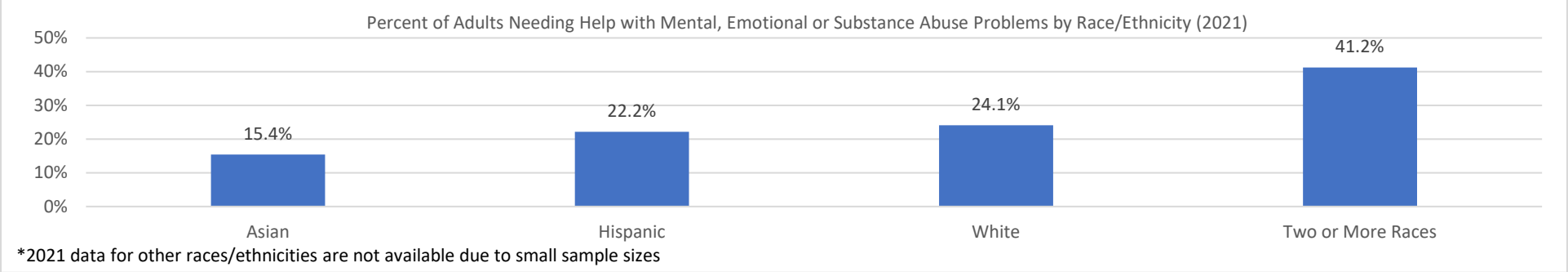
Poor Mental Health Days:

- **Blue census tracts experienced more poor mental health days than orange.**
- **North and Central County (bluer regions) tends to have higher than median percentage of adults who had 14 or more poor mental health days.**

Mental Health

Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Percent of Adults Needing Help with Mental, Emotional, or Substance Abuse Problems[2] (CHIS)	22.0% (2021)	25.0%	N/A	N/A	R/E

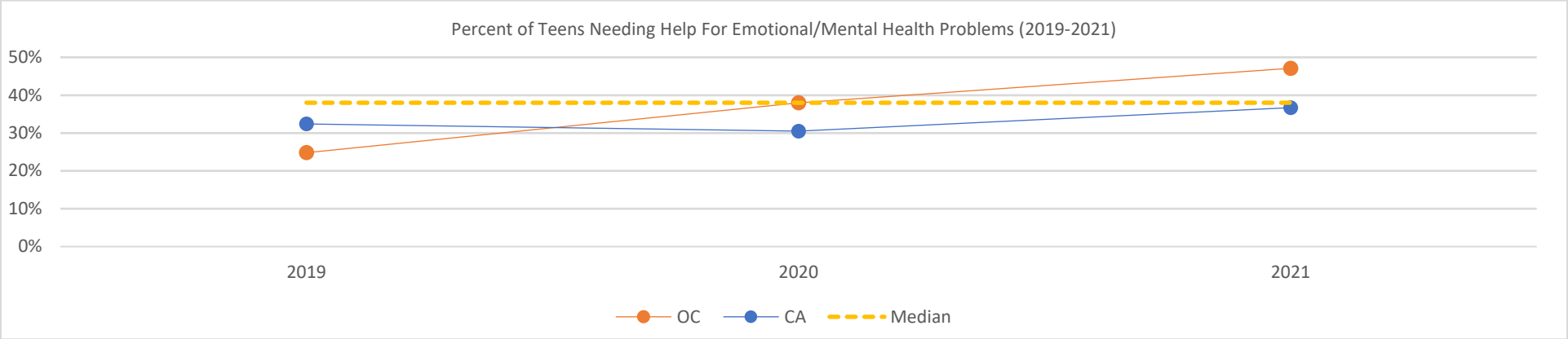


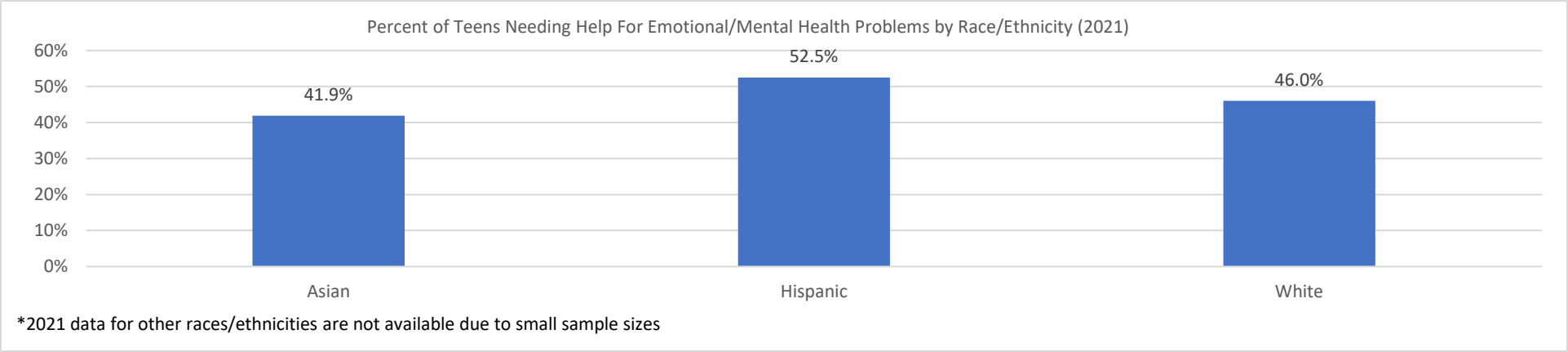


*2021 data for other races/ethnicities are not available due to small sample sizes

[2] **Definition:** Percent of adults who reported that there was a time in the past 12 months when they felt they might need to see a professional because of problems with their mental health emotions or nerves or their use of alcohol or drugs. **Source:** UCLA Center for Health Policy Research, Los Angeles, CA. AskCHIS 2011-2021. *Needed Help for Emotional/Mental Health Problems or Use of Alcohol/Drug* (California, Orange). Retrieved from: http://ask.chis.ucla.edu.

Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Percent of Teens Needing Help with Emotional/Mental Health Problems[3] (CHIS)	47.1% (2021)	36.7%	N/A	N/A	R/E

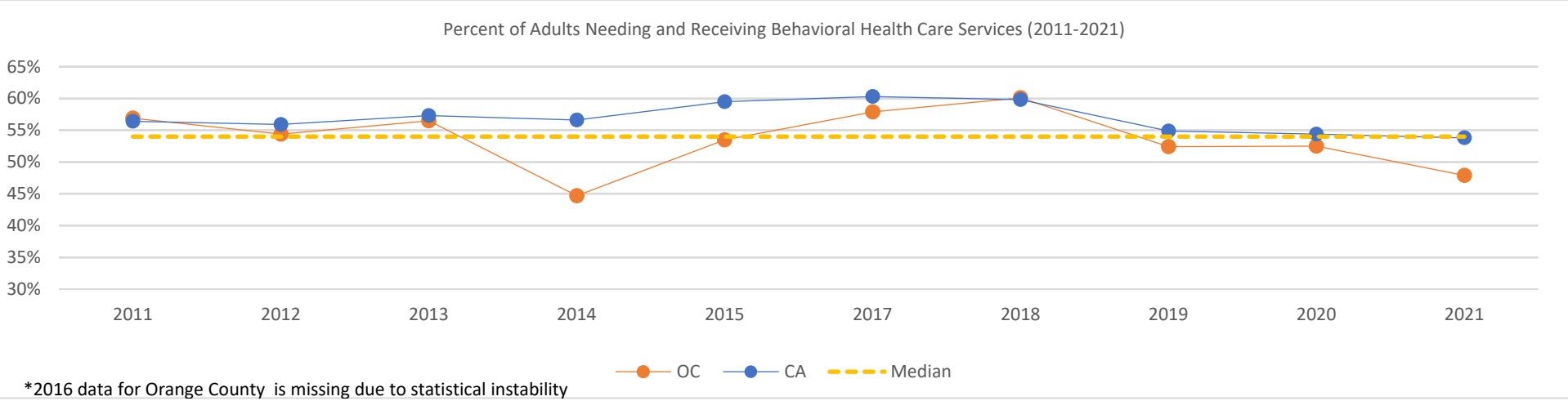




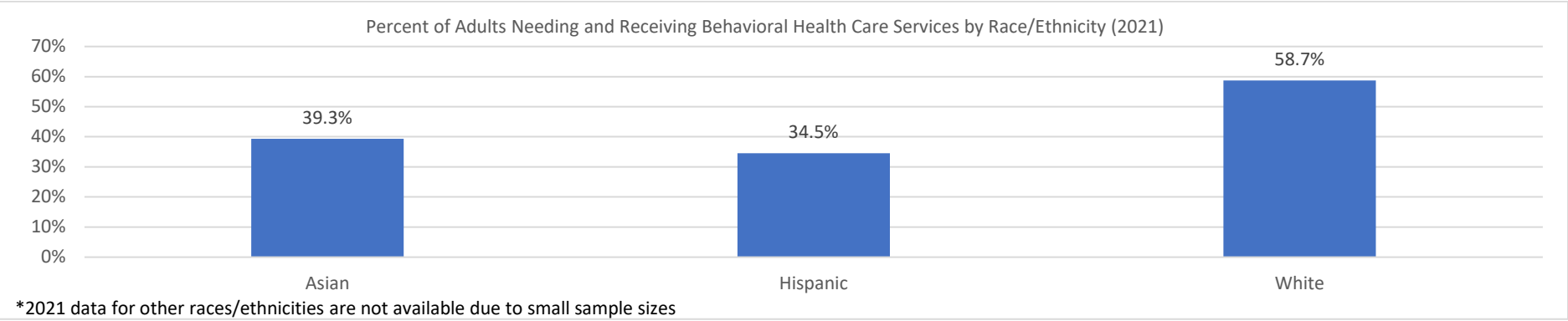
*2021 data for other races/ethnicities are not available due to small sample sizes

[3] **Definition:** Percent of teens who reported that during the past 12 months, they though they needed help for emotional or mental health problems, such as feeling sad, anxious or nervous. **Source:** UCLA Center for Health Policy Research, Los Angeles, CA. AskCHIS 2011-2021. Teen *Needed Help for Emotional/Mental Health Problems* (California, Orange). Retrieved from: http://ask.chis.ucla.edu.

Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Percent of Adults Needing and Receiving Behavioral Health Care Services[4] (CHIS)	47.9% (2021)	53.8%	N/A	N/A	R/E



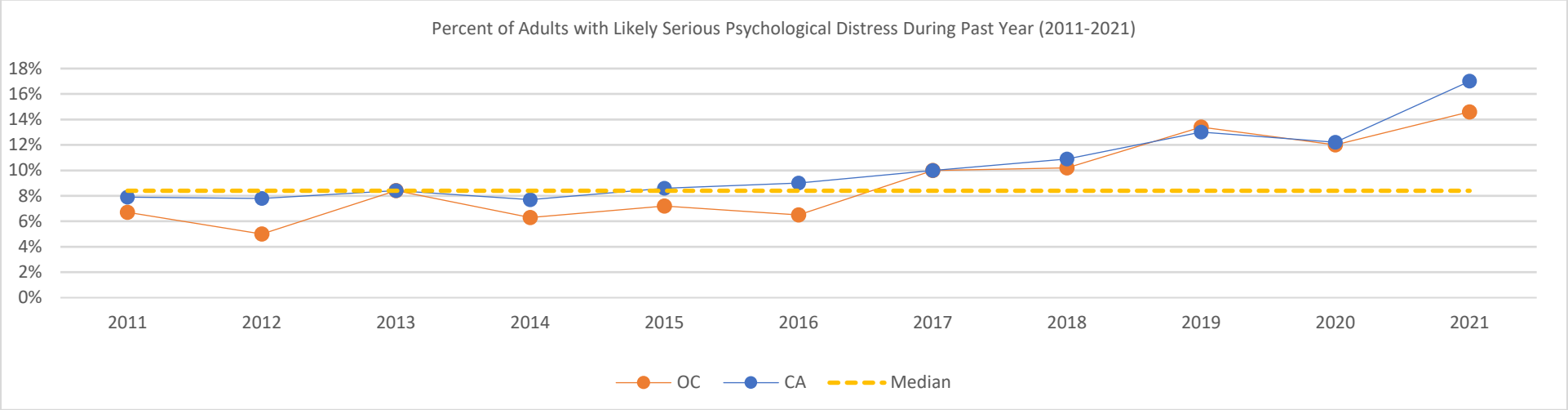
*2016 data for Orange County is missing due to statistical instability

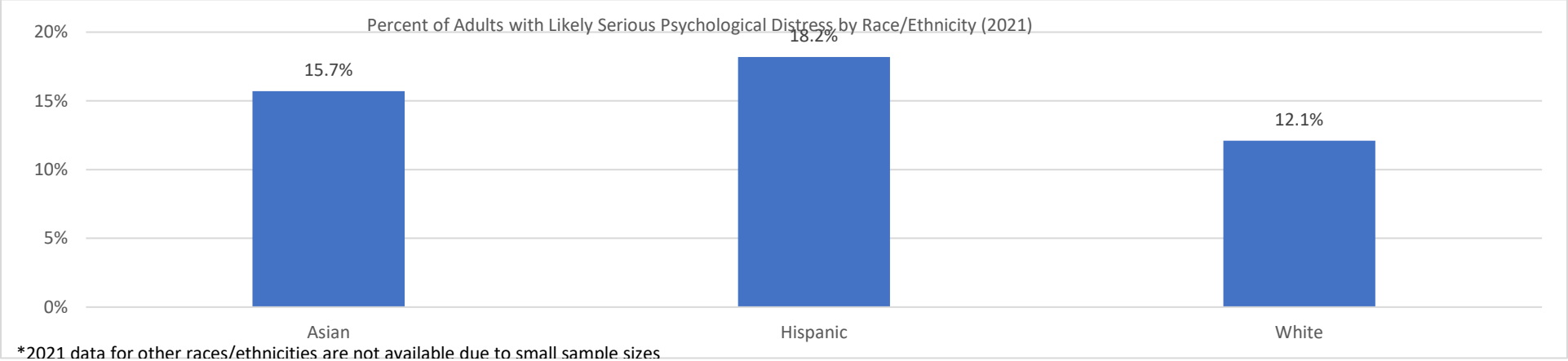


*2021 data for other races/ethnicities are not available due to small sample sizes

[4] **Definition:** Percent of adults who reported that there was a time in the past 12 months when they felt they might need to see a professional because of problems with their mental health emotions or nerves or their use of alcohol or drugs and whether they had seen their primary care provider or other professional. **Source:** UCLA Center for Health Policy Research, Los Angeles, CA. AskCHIS 2011-2021. *Sought Help for Self-Reported Mental/Emotional and/or Alcohol-Drug Issue(s)* (California, Orange). Retrieved from: http://ask.chis.ucla.edu.

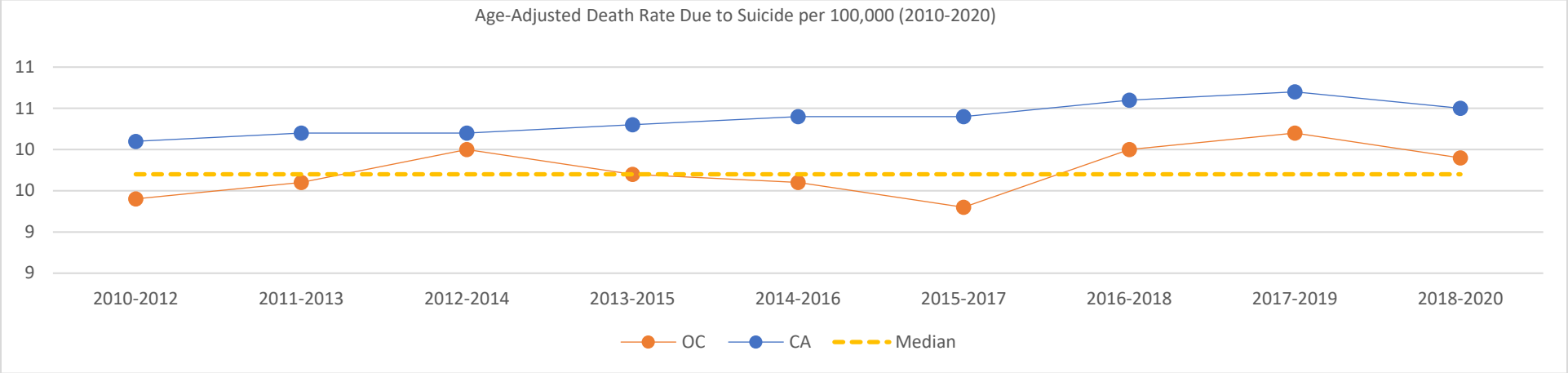
Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Percent of Adults with Likely Serious Psychological Distress[5] During Past Year (CHIS)	14.6% (2021)	17.0%	N/A	N/A	R/E





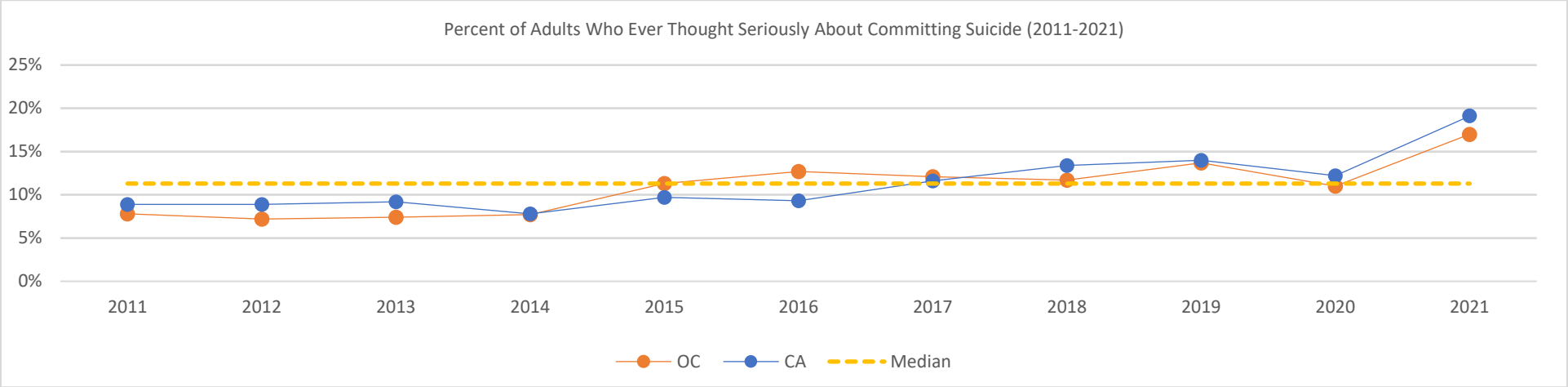
[5] **Definition:** Measured through the Kessler 6, a screen for psychological distress. **Source:** UCLA Center for Health Policy Research, Los Angeles, CA. AskCHIS 2011-2021. *Likely Has Had Serious Psychological Distress During Past Year* (California, Orange). Retrieved from: http://ask.chis.ucla.edu.

Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Age-Adjusted Death Rate Due to Suicide per 100,000[6] (CDPH)	9.9 (2018-2020)	10.5	14.1 (2021)	12.8	N/A

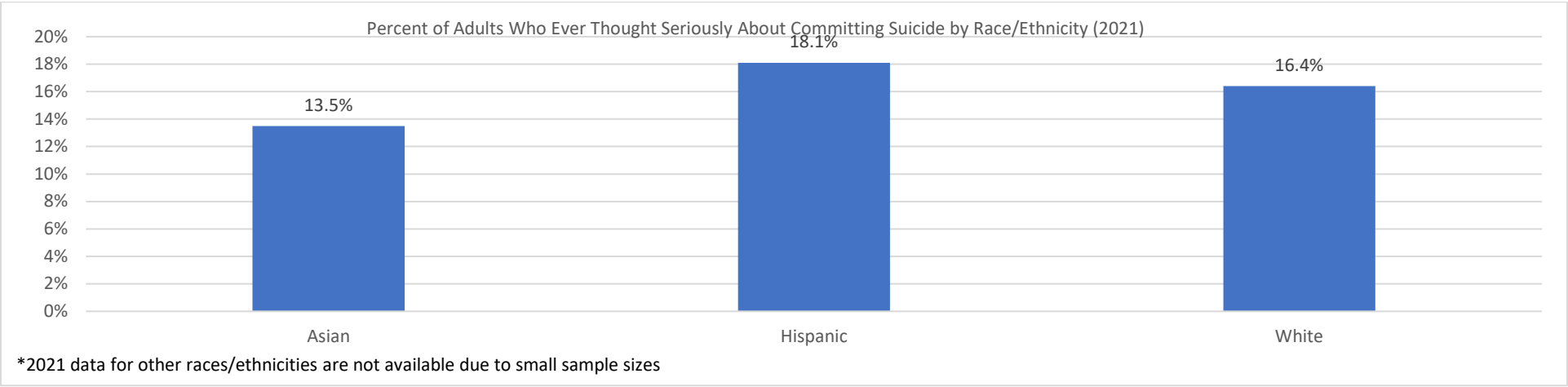


[6] **Definition:** Three-year averages of deaths from suicide divided by the total population and then multiplying by 100,000. **Source:** California Department of Public Health, Center for Health Statistics and Informatics (n.d.). *County Health Status Profiles 2010-2021.* Retrieved from: VSB County Health Status Profiles (ca.gov)

Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Percent of Adults Who Ever Thought Seriously About Committing Suicide[7] (CHIS)	17.0% (2021)	19.1%	N/A	N/A	R/E

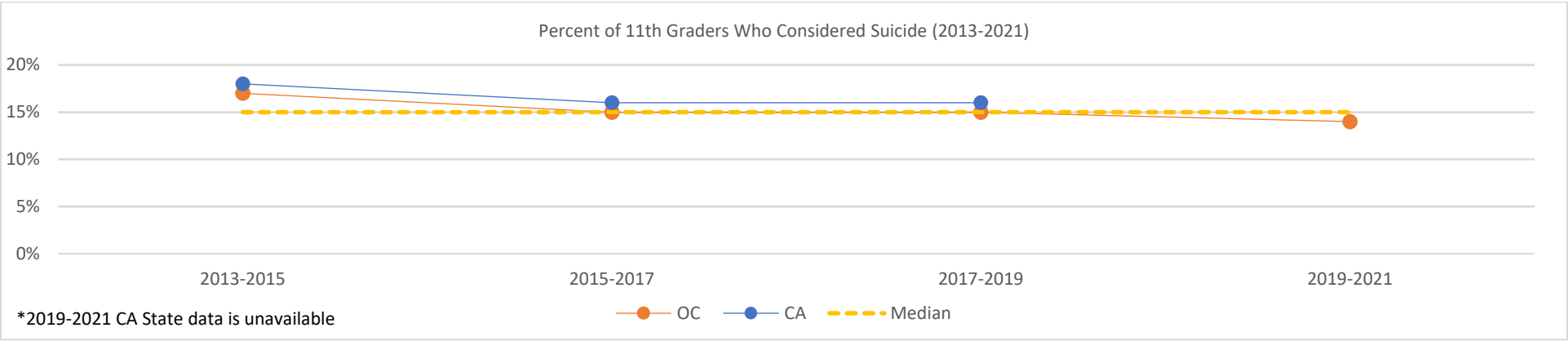


[7] **Definition:** Percent of adults who ever seriously thought about committing suicide. **Source:** UCLA Center for Health Policy Research, Los Angeles, CA. AskCHIS 2011-2021. *Ever Seriously Thought About Committing Suicide* (California, Orange). Retrieved from: http://ask.chis.ucla.edu.



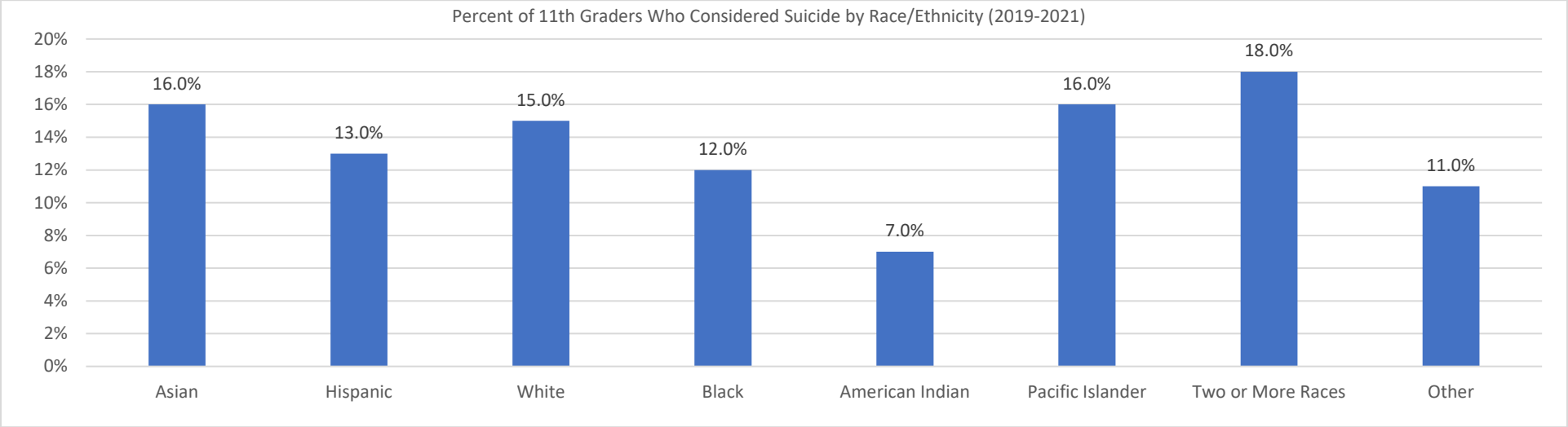
*2021 data for other races/ethnicities are not available due to small sample sizes

Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Percent of 11th[th] Graders Who Considered Suicide[8] (CDE)	14.0% (2019-2021)	16.0% (2017-2019)	N/A	N/A	R/E

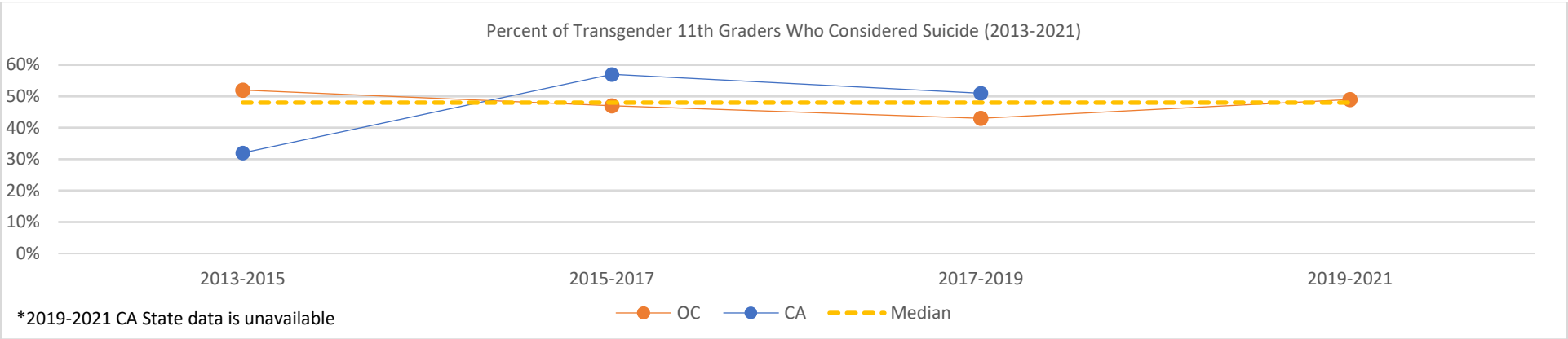


*2019-2021 CA State data is unavailable

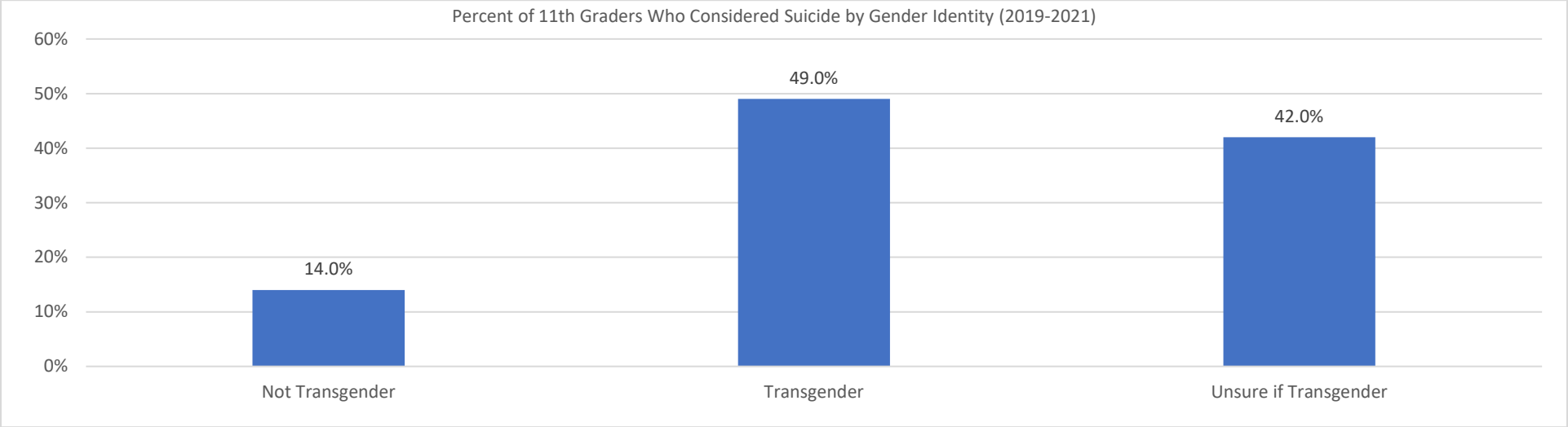
[8] **Definition:** During the past 12 months, percent of 11[th]th graders who ever seriously considered suicide. **Source:** California Department of Education, (n.d.). *California Healthy Kids Survey.* Retrieved from: The California School Climate, Health, and Learning Survey (CalSCHLS) System - Public Dashboards



Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Percent of Transgender 11th[th] Graders Who Considered Suicide[9] (CDE)	49.0% (2019-2021)	51.0% (2017-2019)	N/A	N/A	N/A

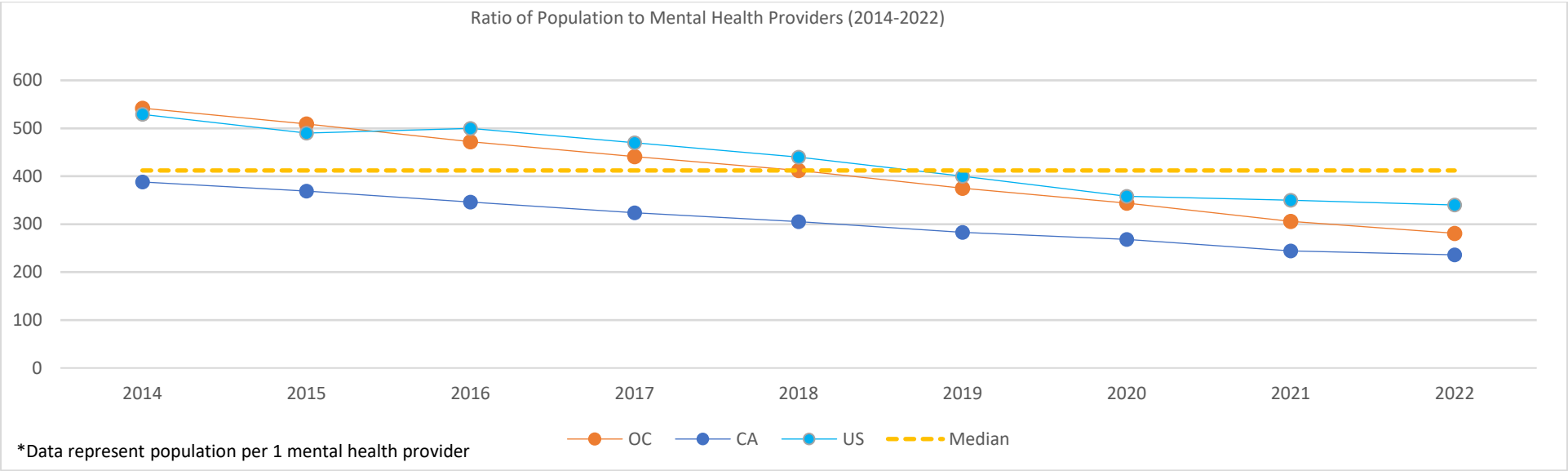


[9] **Definition:** During the past 12 months, percent of 11[th]th graders who ever seriously considered suicide. **Source:** California Department of Education, (n.d.). *California Healthy Kids Survey.* Retrieved from: [The California School Climate, Health, and Learning Survey (CalSCHLS) System - Public Dashboards]



Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Ratio of Population to Mental Health Providers[10] (UWPHI)	283:1 (2022)	236:1	340:1	N/A	N/A

[10] **Definition:** Average population served by one mental health provider in Orange County. **Source:** University of Wisconsin, Population Health Institute (n.d.). *County Health Rankings and Roadmaps, 2010-2021.* Retrieved from: Rankings data & documentation | County Health Rankings & Roadmaps.


Ratio of Population to Mental Health Providers (2014-2022)
600
500
400
300
200
100
0
2014
2015
2016
2017
2018
2019
2020
2021
2022
OC
CA
US
Median
*Data represent population per 1 mental health provider

Topic	MATERNAL / FETAL HEALTH				
Data	Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal
	Percent of Mothers Who Received Early Prenatal Care (CPDH)	88.2% (2020)	85.8%	77.7%	80.5%
	Infant Mortality Rate per 1,000 Live Births (OCHCA)	2.8 (2020)	3.7	5.4	5.0
	Percent of Infants with Low Birth Weight (OCHCA)	6.2% (2020)	6.9%	8.2%	N/A
	Percent of Infants Exclusively Breastfed at Hospital Discharge (CDPH)	67.6% (2020)	69.7%	N/A	N/A
	Teen Birth Rate per 1,000 Females Ages 15-19 Years (CDPH)	6.9 (2020)	11.0	15.4	31.4
	Pregnancy-Related Mortality Rate per 100,000 Live Births (CDPH)	11.6 (2018-2020)	15.7	17.3 (2018)	N/A
	Percent of Births That Were Cesarian (CDC)	31.3% (2021)	30.8%	26.3%	23.6%
	Percent of Births Where Mother Had Diabetes (CDC)	11.0% (2021)	9.5%	N/A	N/A
	Fertility Rates per 1,000 Women Ages 15-44 (CDC)	49.5 (2020)	52.4	N/A	N/A

Equity & Disparities

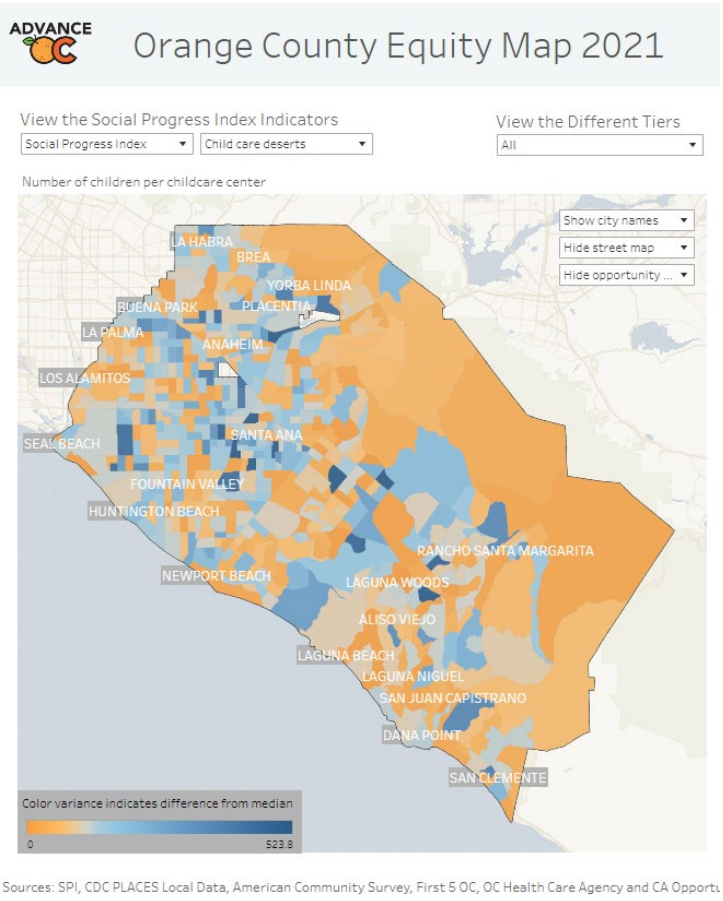
- Infant Mortality Rate per 1,000 Live Births: Hispanic (3.7) had higher rate than White (2.3) and Asian (1.0)
- Percent of Infants Exclusively Breastfed at Hospital Discharge: Black (65.0%), Hispanic (61.4%), Asian (57.7%) and Pacific Islander (61.4%) infants were breastfed at lower rates than White (82.4%) and American Indian (82.4%)
- Teen Birth Rate per 1,000 Females Ages 15-19 Years: Hispanic (13.0) gave birth at a higher rate than White (2.2), Black (8.0) and Asian (0.5)
- Percent of Births That Were Cesarian: Almost three-quarters (72.3%) of cesarian births were to White mothers, with 21.5% of cesarian births to Asian mothers. Less than 3% of Black or Multiracial mothers had a cesarian birth
- Areas of South County have higher percentage of people who received early prenatal care compared to other regions of the County (Source: The 28th Annual Report on the Conditions of Children in Orange County).

Qualitative Findings	**Need for tangible resources and increased services for maternal and fetal care** – **Lack of pediatric sub-specialists in the county** – **Lack of high-risk Obstetrics and Gynecologists in the county** – **Pediatric and Obstetric services feel provider-centered rather than family-centered** – **Pregnancy and birthing services** – **Increasing dissemination of resources, especially access to basic needs like food and clothing, transportation, childcare, and other for special needs families and homeless families** – **Lack of physically accessible health care offices for people on Medicare/Medi-Cal** – **Medi-Cal reimbursement rates are insufficient** – **Professionals leaving healthcare** – **Healthcare providers are overworked and understaffed** **Opportunities:** – **CalAIM initiatives offering expanded coverage and benefits to eligible individuals** – **CalOptima covering more services and focusing on Social Determinants of Health** – **Wider use of Promotoras and community health worker models**
Current Collaborative Activities	– **Orange County Breastfeeding Coalition** – **Orange County Perinatal Council: The mission is to support optimal perinatal health and wellness for Orange County's women and babies- before, during and after birth.** – **Orange County Home Visiting Collaborative: The vision is to create an integrated prenatal to three system of care, prioritizing families that will benefit most from early interventions.**

MATERNAL, FETAL, AND INFANT HEALTH AND FAMILY PLANNING

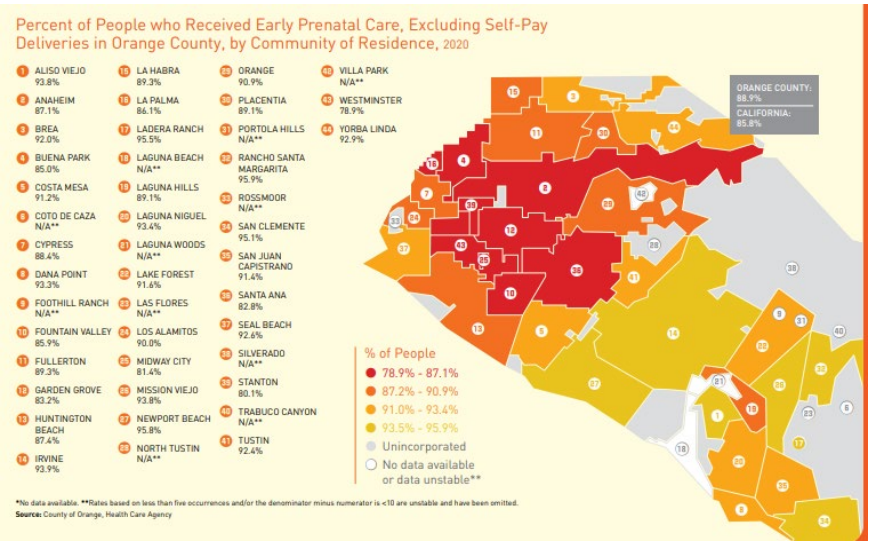
Child Care Deserts:

Blue census tracts had more child care deserts than orange.



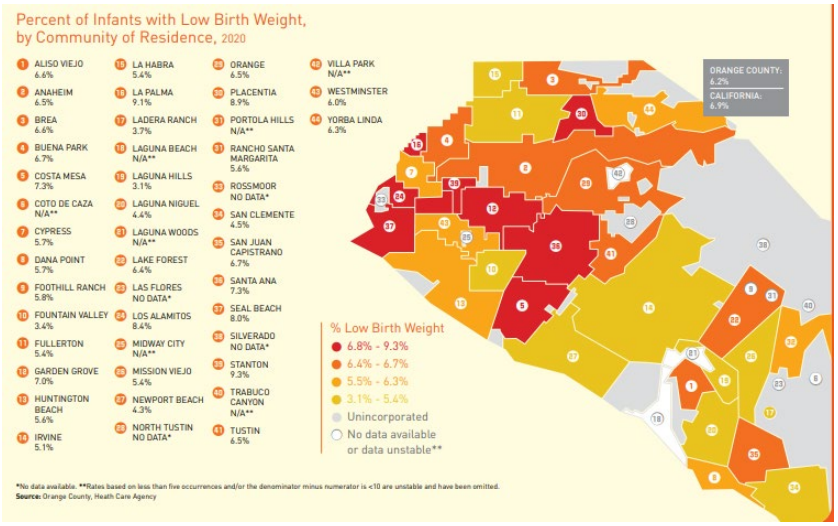
Early Prenatal Care:

Areas of South County have higher percentage of people who received early prenatal care compared to other regions of the County (Source: The 28th Annual Report on the Conditions of Children in Orange County).



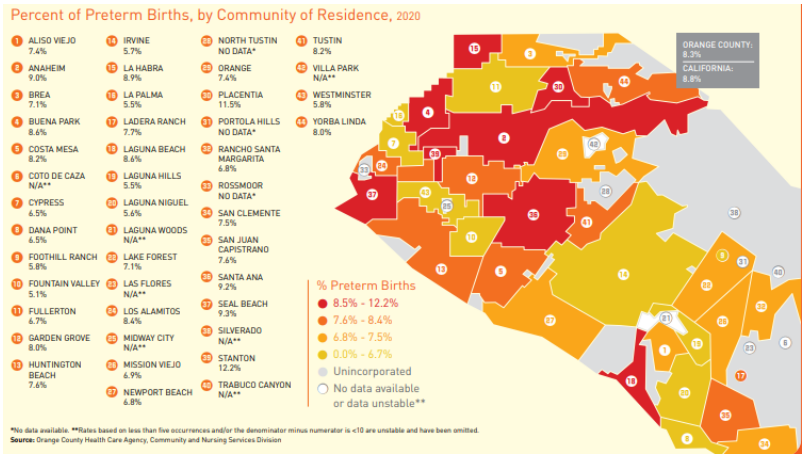
Low-Birth Weight:

Regions of south County have a lower percent of infants with low birth weights compared to rest of the county (Source: The 28th Annual Report on the Conditions of Children in Orange County).



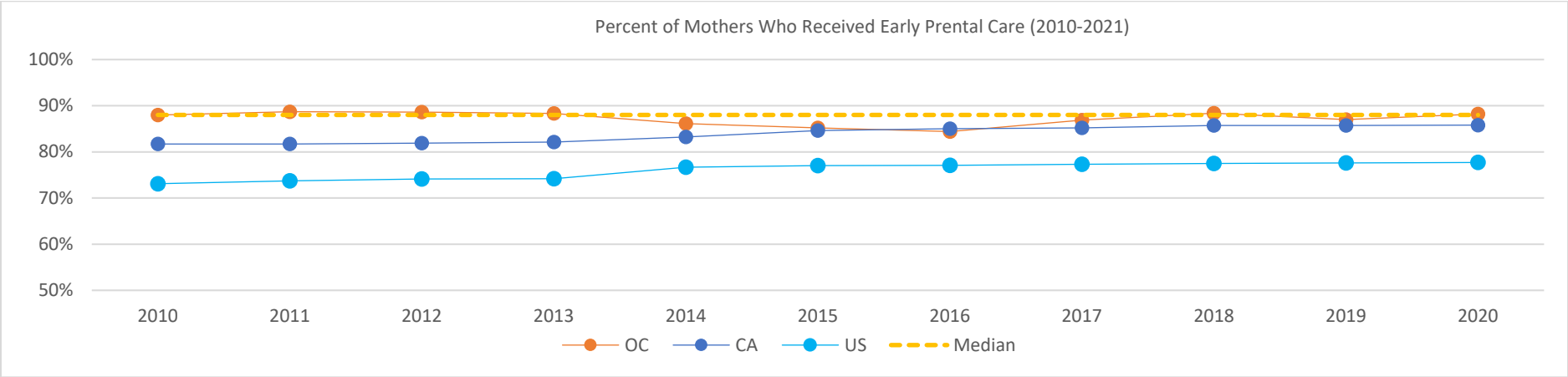
Pre-Term Births:

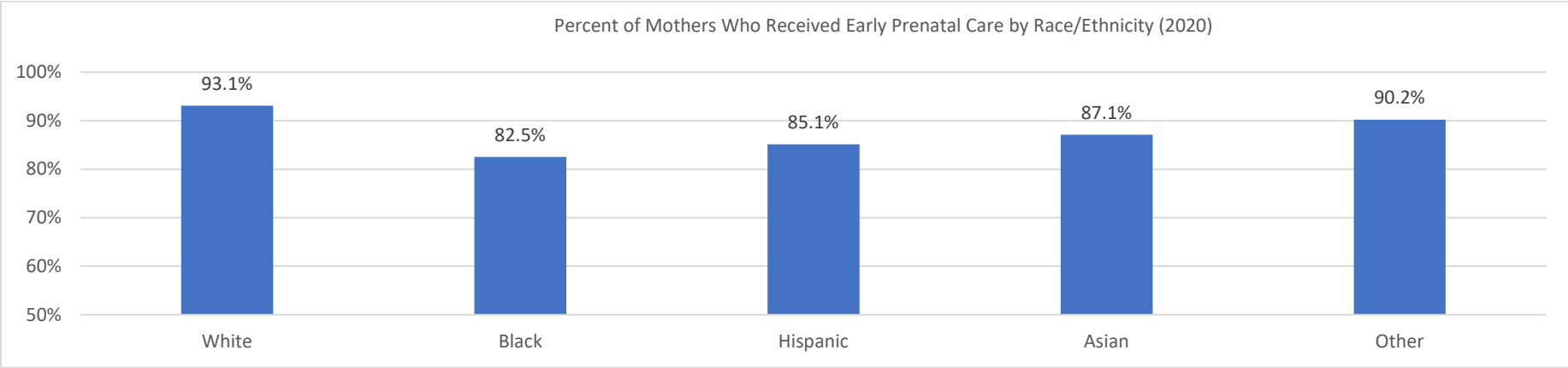
South County has a lower percent of preterm births compared to the rest of the County.



Maternal / Fetal Health

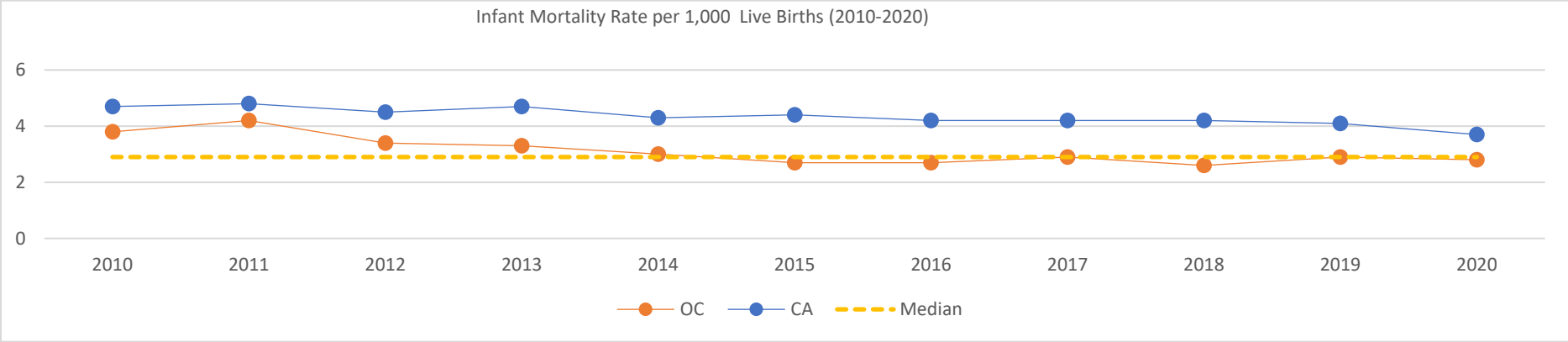
Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Percent of Mothers Who Received Early Prenatal Care[11] (CPDH)	88.2% (2020)	85.8%	77.7%	80.5%	R/E

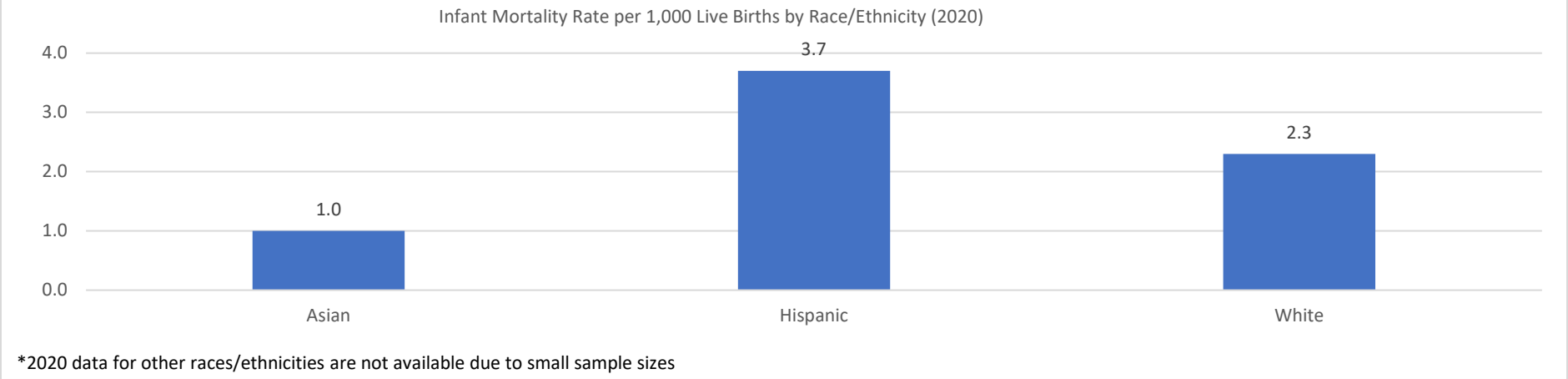




[11] **Definition:** Percent of women who received prenatal care during their first trimester of pregnancy. **Source:** California Department of Public Health, Center for Health Statistics and Informatics (n.d.). *County Health Status Profiles 2010-2021.* Retrieved from: VSB County Health Status Profiles (ca.gov)

Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Infant Mortality Rate per 1,000 Live Births[12] (OCHCA)	2.8 (2020)	3.7	5.4	5.0	R/E

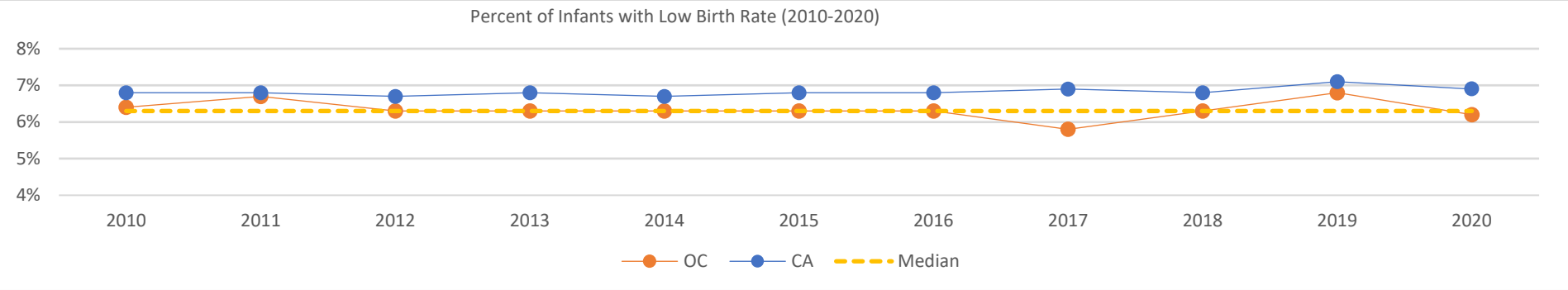


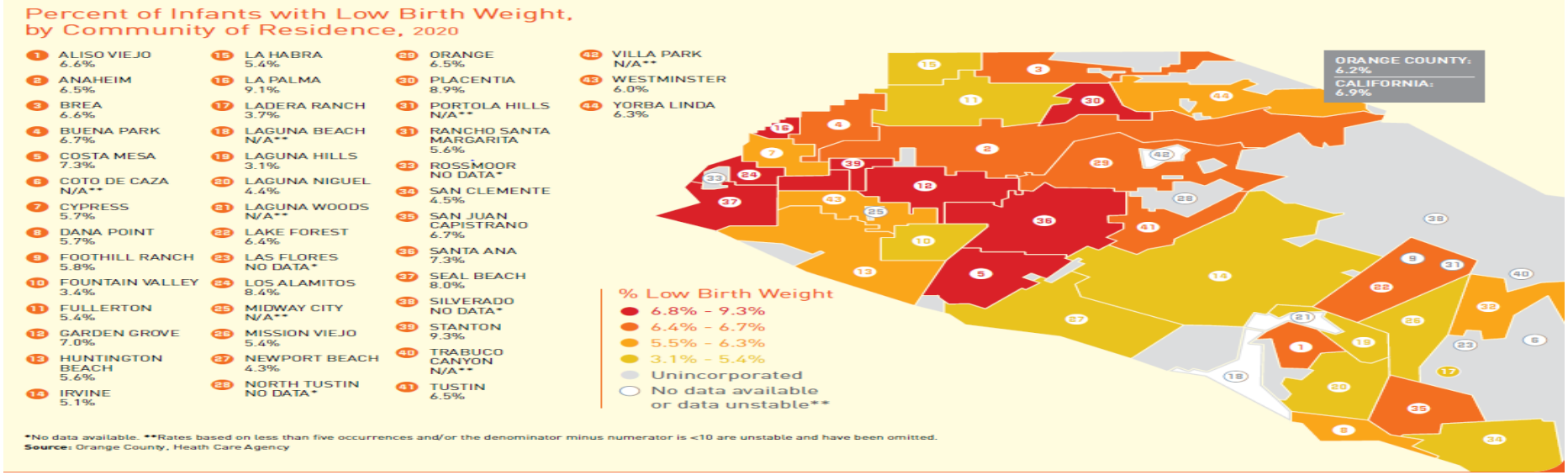


*2020 data for other races/ethnicities are not available due to small sample sizes

[12] **Definition:** Deaths of infants under one year of age per 1,000 live births. **Source:** Orange County Health Care Agency (OCHCA), Orange County Coroner Division (2022). *Infant Mortality Rate per 1,000 Live Births.*

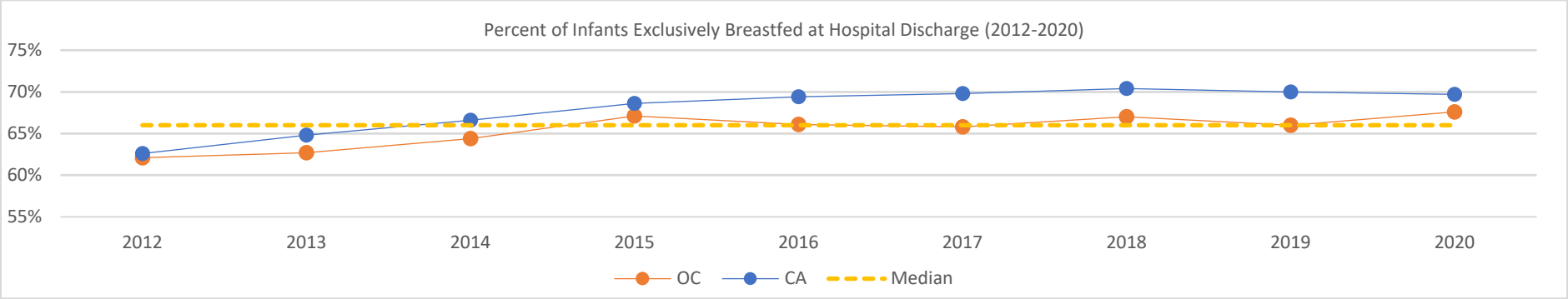
Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Percent of Infants with Low Birth Weight[13] (OCHCA)	6.2% (2020)	6.9%	8.2%	N/A	Geographic

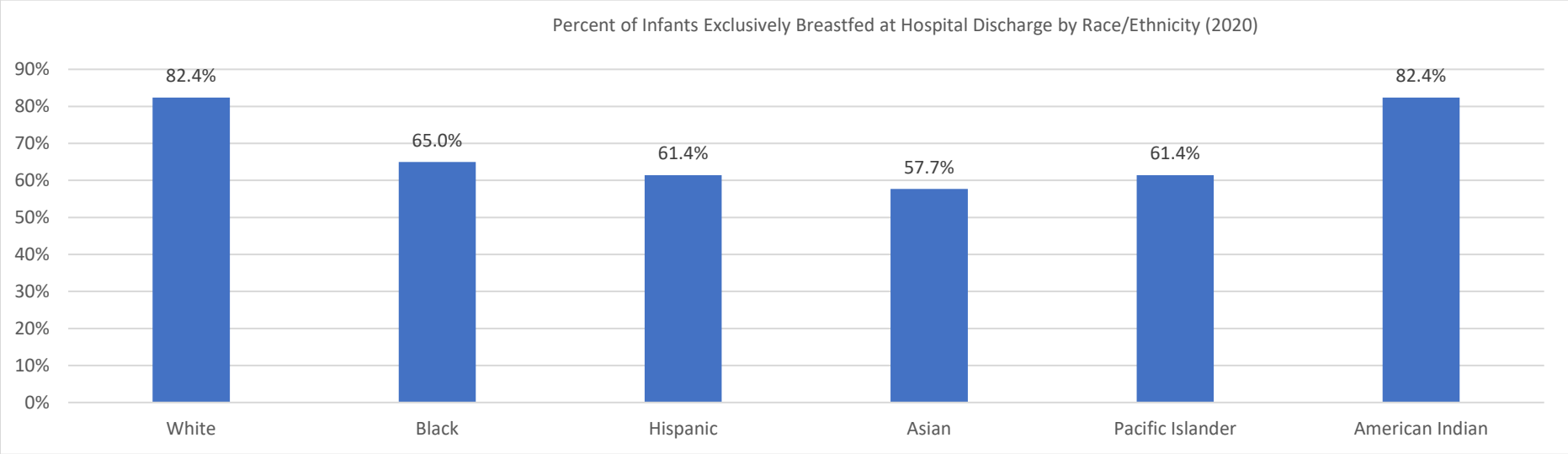




[13] **Definition:** Percent of infants that were born weighing less than 5 pounds, 8 ounces. **Source:** Orange County Health Care Agency, Community and Nursing Services Division (2022). *Low Birth Rate.*

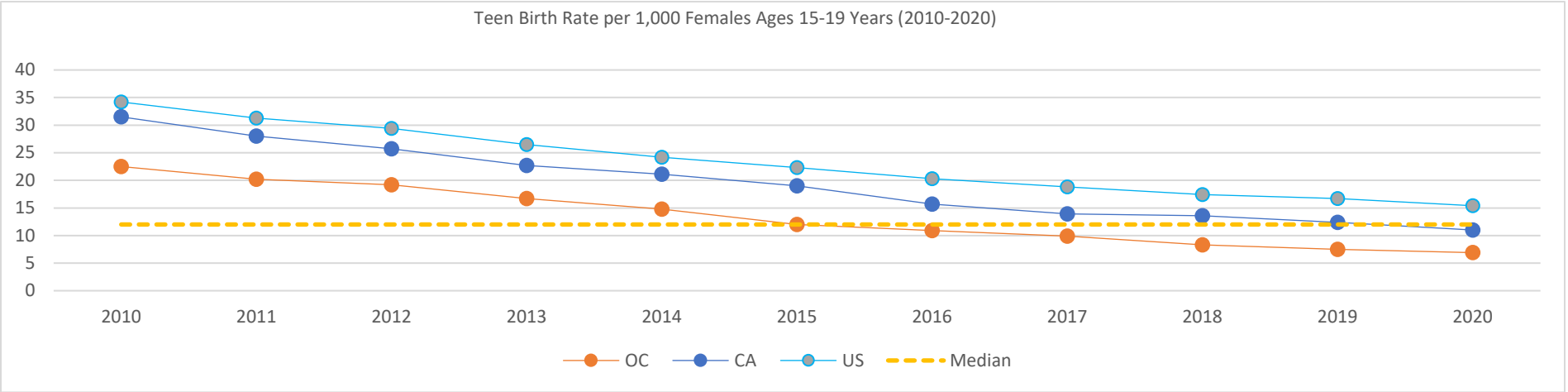
Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Percent of Infants Exclusively Breastfed at Hospital Discharge[14] (CDPH)	67.6% (2020)	69.7%	N/A	N/A	R/E

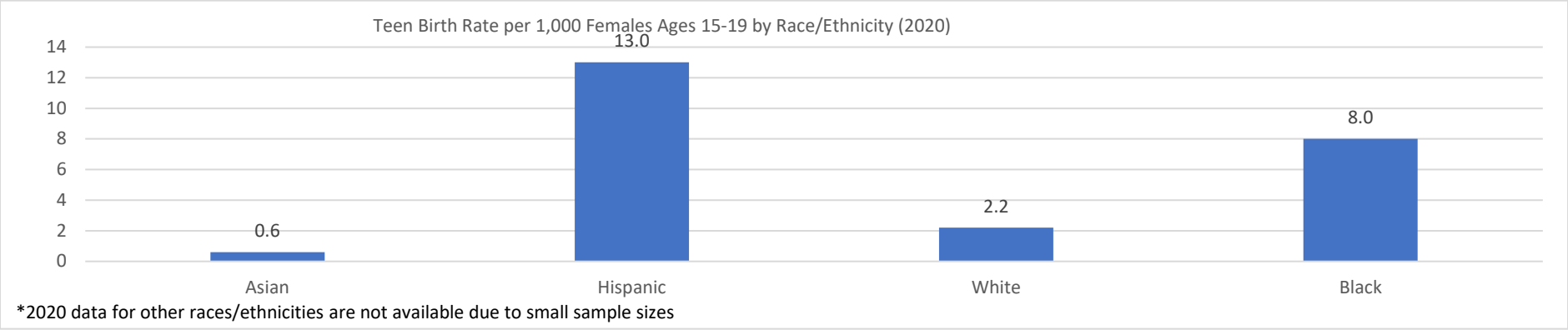




[14] **Definition:** Percent of infants that were fed only with human milk and no other supplements such as water, formula, food, or juice when discharged from the hospital. **Source:** California Department of Public Health, Center for Family Health, Genetic Disease Screening Program, *Newborn Screening Data, 2020*. NBS Form Version (D) Revised 12/2008. Maternal, Child, and Adolescent Health Program.

Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Teen Birth Rate per 1,000 Females Ages 15-19 Years[15] (CDPH)	6.9 (2020)	11.0	15.4	31.4	R./E

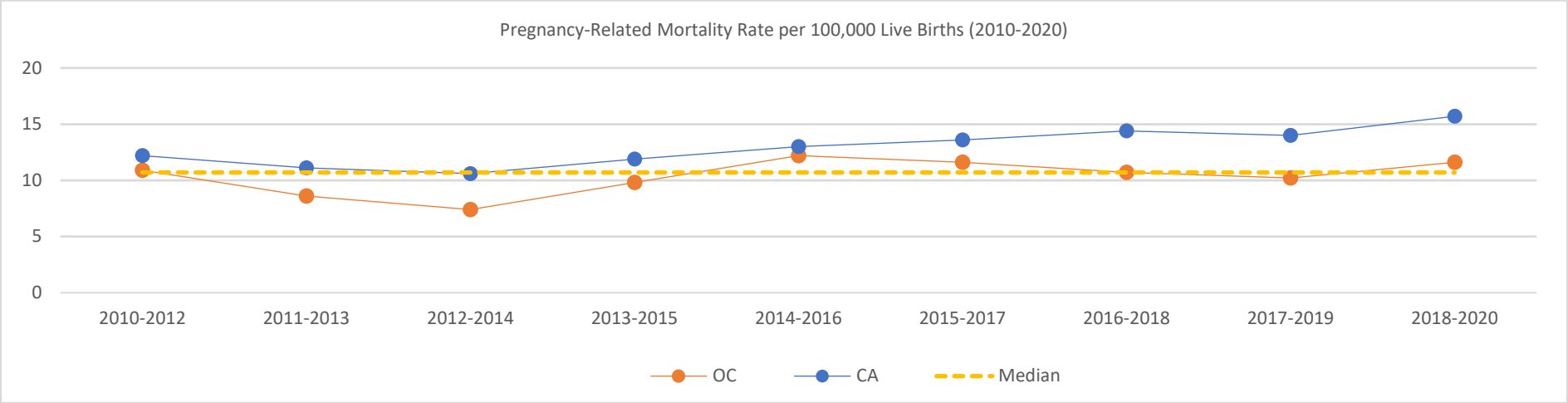




*2020 data for other races/ethnicities are not available due to small sample sizes

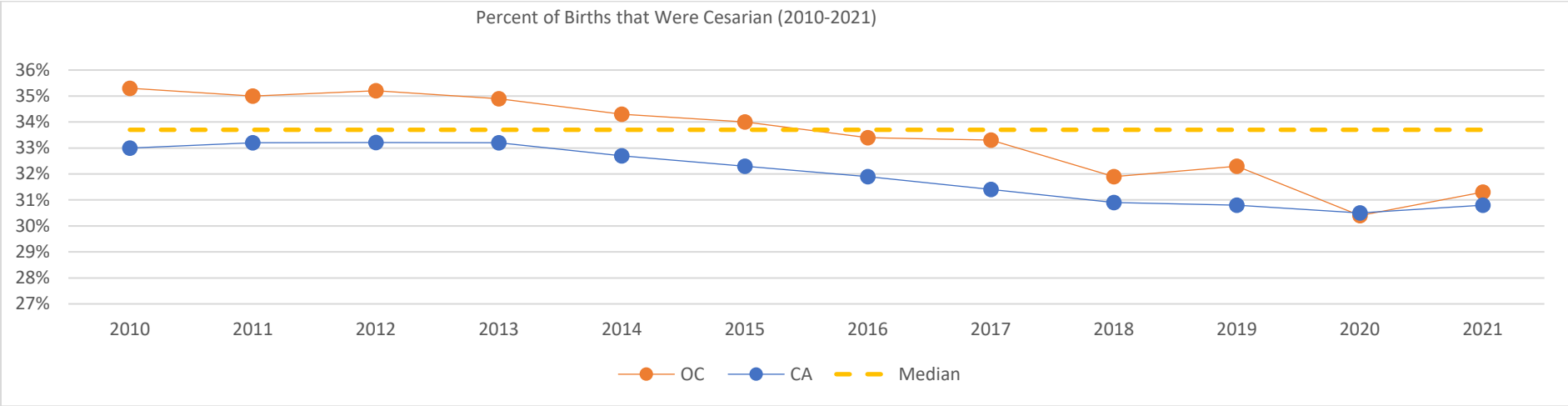
[15] **Definition:** Annual births to females ages 15-19 per 1,000 females. **Source:** California Department of Public Health, Center for Health Statistics and Informatics (n.d.). *County Health Status Profiles 2010-2021.* Retrieved from: VSB County Health Status Profiles (ca.gov).

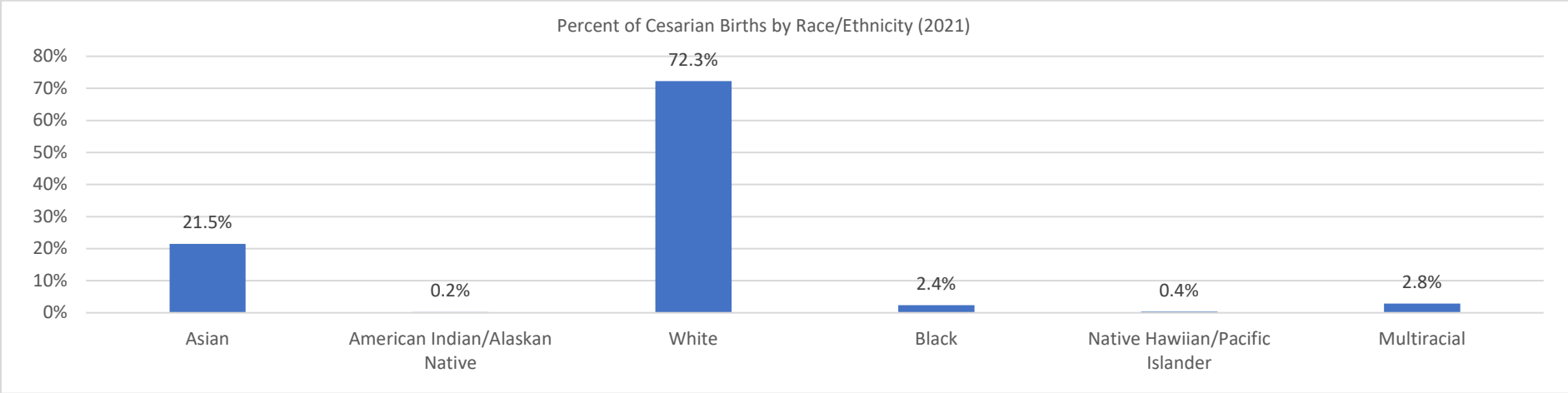
Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Pregnancy-Related Mortality Rate per 100,000 Live Births[16] (CDPH)	11.6 (2018-2020)	15.7	17.3 (2018)	N/A	N/A



[16] **Definition:** Deaths while pregnant or within one year of the end of pregnancy from causes related to or aggravated by the pregnancy or its management (per 100,000 live births). **Source:** California Department of Public Health; Maternal, Child and Adolescent Health Division (2022). *CA-PMSS: California Pregnancy-Related Deaths, 2008-2016* and *CA-PMSS: Pregnancy-Related Mortality in California, 2011-2019.* California Department of Public Health; Maternal, Child and Adolescent Health Division. 2022. Retrieved from: www.cdph.ca.gov/ca-pmss.

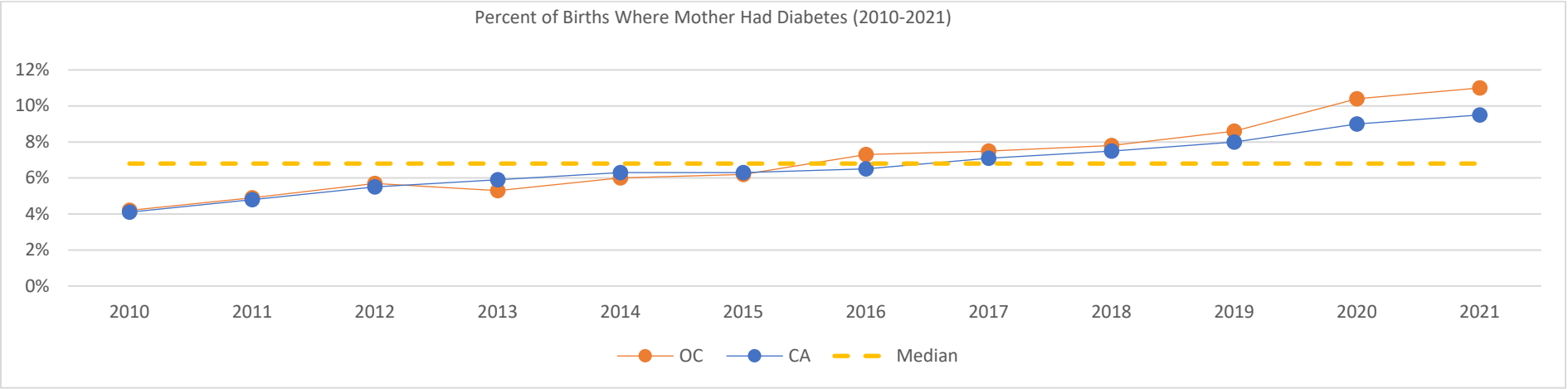
Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Percent of Births That Were Cesarian[17] (CDC)	31.3% (2021)	30.8%	26.3% (2021)	23.6%	R-E

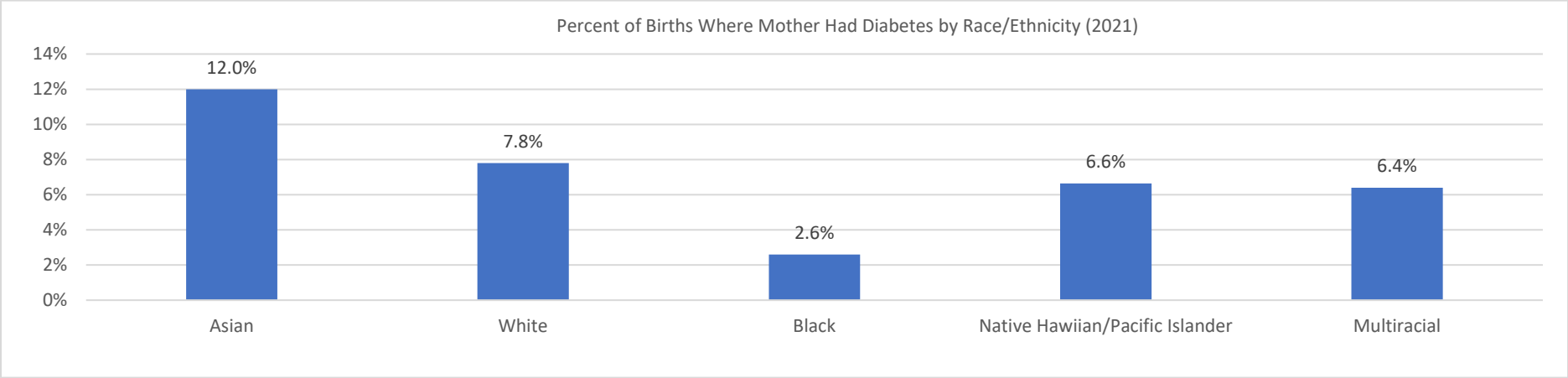




[17] **Definition:** Percent of births which were cesarean delivery. **Source:** Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, *Natality 2007-2021 on CDC WONDER Online Database*, released in 2021. Retrieved from: Natality, 2007-2021 Request Form (cdc.gov)

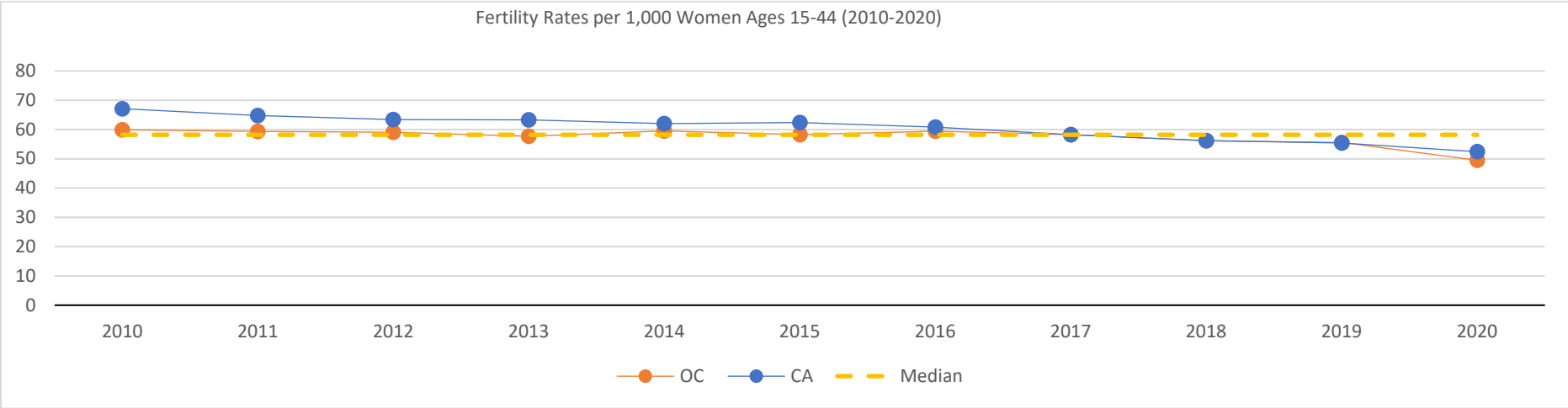
Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Percent of Births Where Mother Had Diabetes[18] (CDC)	11.0% (2021)	9.5%	N/A	N/A	R-E

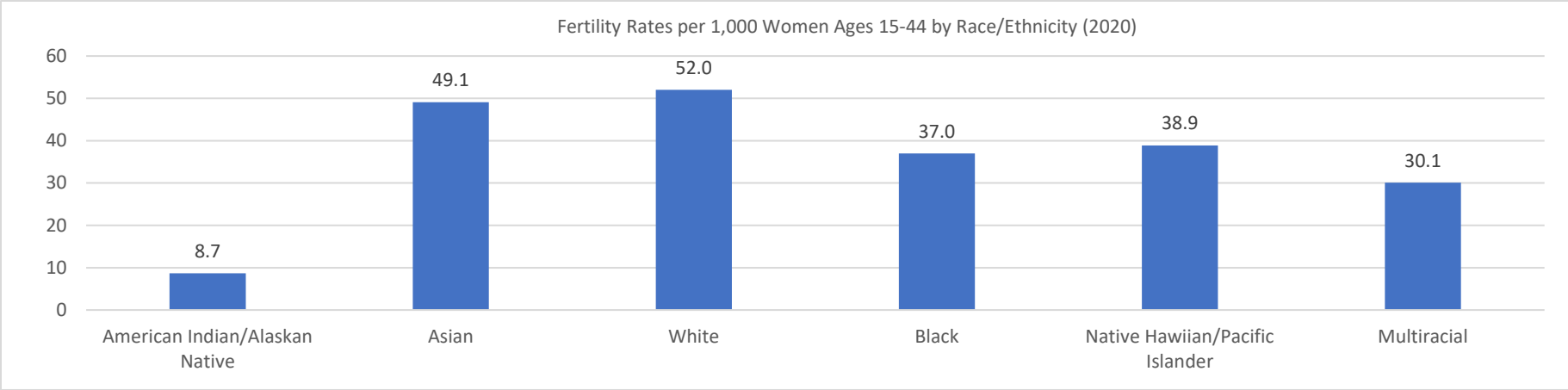




[18] **Definition:** Percent of births where the mother had diabetes. **Source:** Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, *Natality 2007-2021 on CDC WONDER Online Database*, released in 2021. Retrieved from: Natality, 2007-2021 Request Form (cdc.gov)

Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Fertility Rates per 1,000 Women Ages 15-44[19] (CDC)	49.5 (2020)	52.4	N/A	N/A	R-E





[19] **Definition:** Number of births divided by the number of females age 15-44 year old in the given year. **Source:** Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, *Natality 2007-2021 on CDC WONDER Online Database*, released in 2021. Retrieved from: Natality, 2007-2021 Request Form (cdc.gov)

Topic	DIABETES AND OBESITY				
Data	Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal
	Percent of Adults with Diabetes (CHIS)	8.4% (2021)	10.8%	N/A	N/A
	Age-Adjusted Hospitalization Due to Uncontrolled Diabetes per 10,000 (HCAI)	24.6 (2021)	25.0	N/A	N/A
	Age-Adjusted Hospitalization Due to Long-Term Diabetes Complications per 10,000 (HCAI)	88.9 (2021)	93.0	N/A	N/A
	Age-Adjusted Death Rate Due to Diabetes per 100,000 (CDPH)	14.9 (2018-2020)	22.3	15.2 (2010-2015)	13.7
	Percent of Adults Who Are Obese (CHIS)	24.2% (2021)	28.2%	41.8%	36.0%
	Adults Who Are Overweight or Obese (CHIS)	58.1% (2021)	62.0%	N/A	N/A
	Percent of 5th Graders Who Are Overweight or Obese (CHIS)	36.6% (2019)	41.3%	N/A	N/A

Equity & Disparities

- Percent of Adults with Diabetes: The percent of adults suffering from diabetes is higher among Hispanics (10.4%) than among Asian (8.3%) and White (7.2%)
- Percent of Adults Who Are Obese: A greater percent of Hispanic (33.6%) adults are obese compared to White (25.4%) and Asian (6.2%) adults
- Adults Who Are Overweight or Obese: A greater percent of Hispanic (70.2%) adults are overweight or obese compared to White (59.3%) and Asian (34.9%) adults
- Diabetes was more prevalent in North County than in the rest of the county.
- Obesity was more prevalent in parts of North County than in the rest of the county.

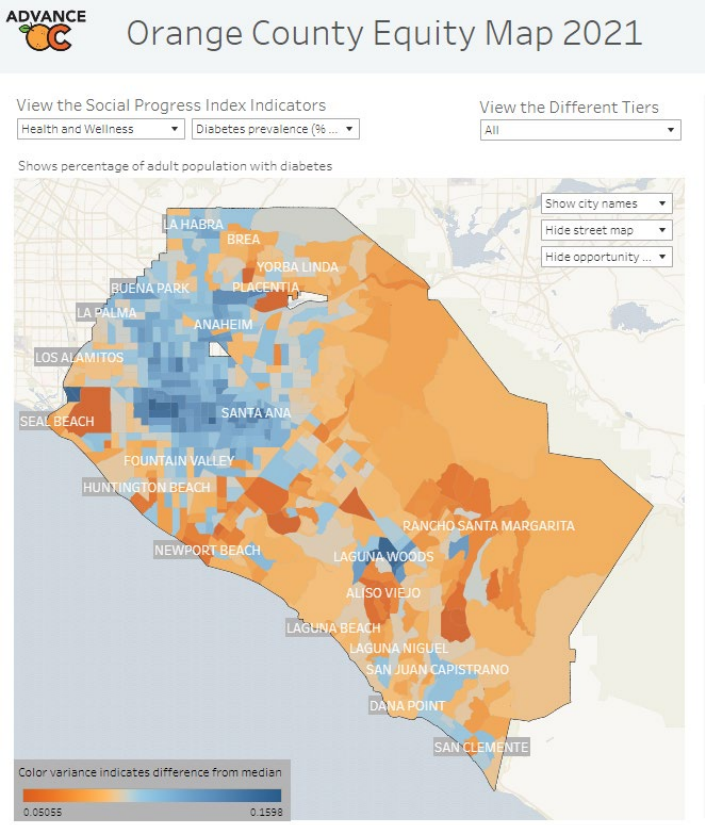
Qualitative Findings

- Address accessibility for healthy eating for children, which addresses diabetes.
- Address the lack of information, particularly in the schools on educating parents on healthy eating habits.

Current Collaborative Activities

- OC Diabetes Collaborative

DIABETES



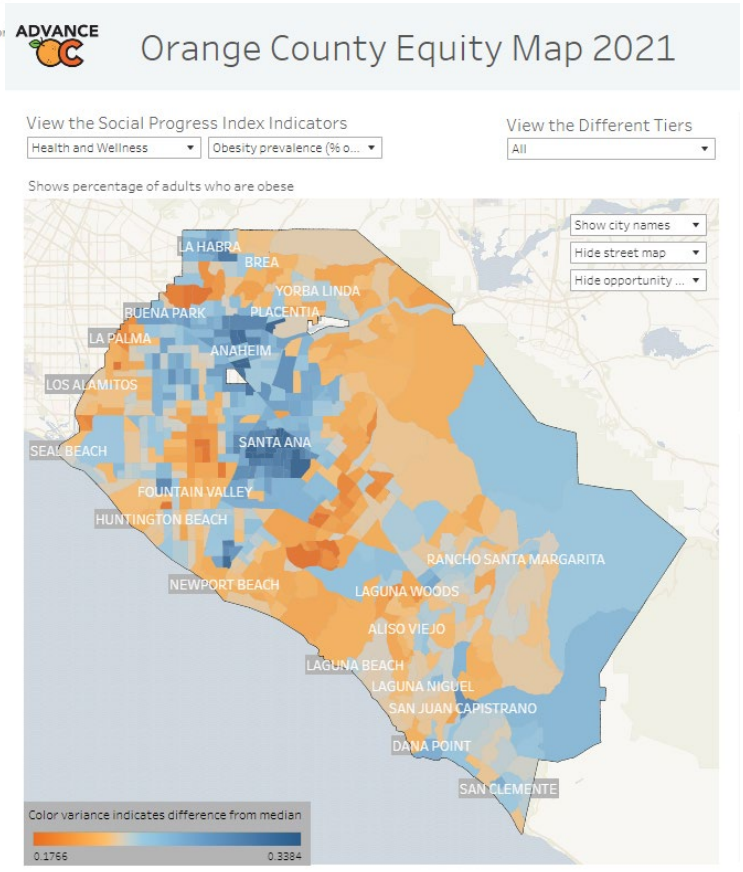
Sources: SPI, CDC PLACES Local Data, American Community Survey, First 5 OC, OC Health Care Agency and CA Oppor

Diabetes Prevalence:

- **Blue census tracts had higher prevalence of diabetes than orange census tracts.**
- **Diabetes was more prevalent in North County than in the rest of the county.**

Obesity Prevalence:

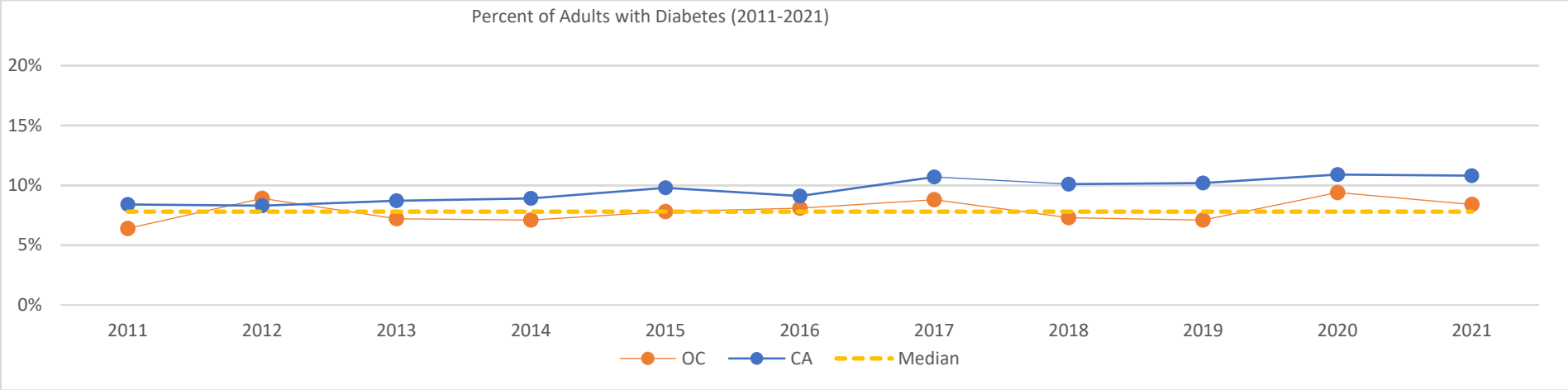
- **Blue census tracts had higher obesity prevalence than orange.**
- **Obesity was more prevalent in parts of North County than in the rest of the county.**

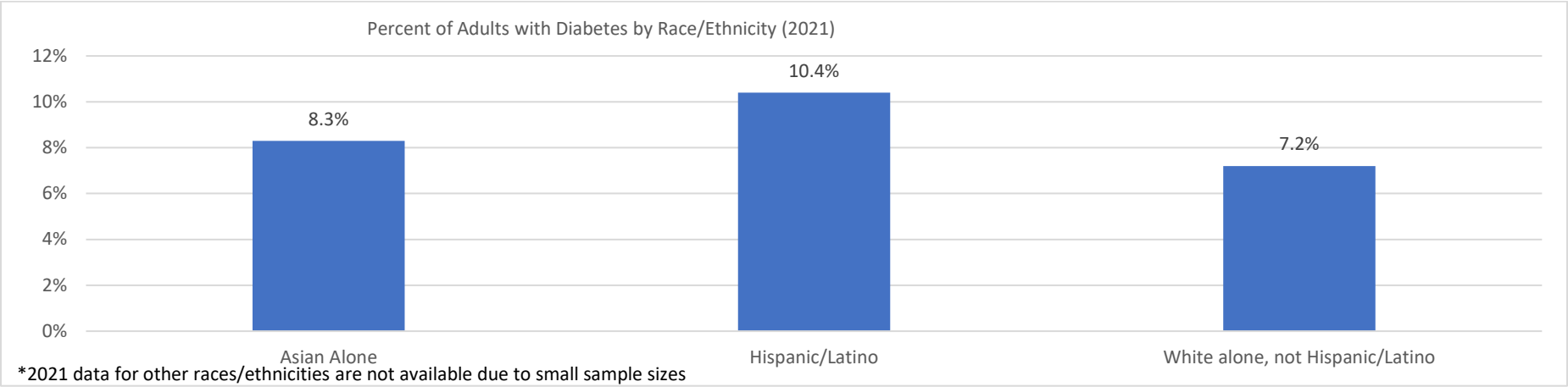


Sources: SPI, CDC PLACES Local Data, American Community Survey, First 5 OC, OC Health Care Agency and CA Opportur

Diabetes and Obesity

Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Percent of Adults with Diabetes[20] (CHIS)	8.4% (2021)	10.8%	N/A	N/A	R/E

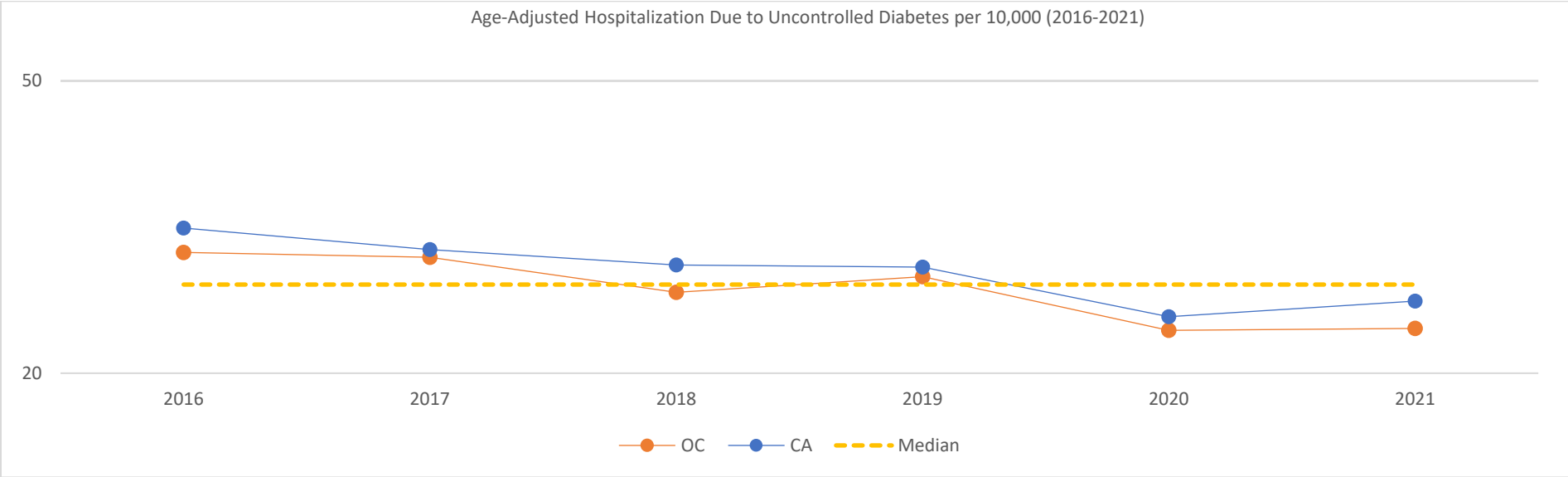




*2021 data for other races/ethnicities are not available due to small sample sizes

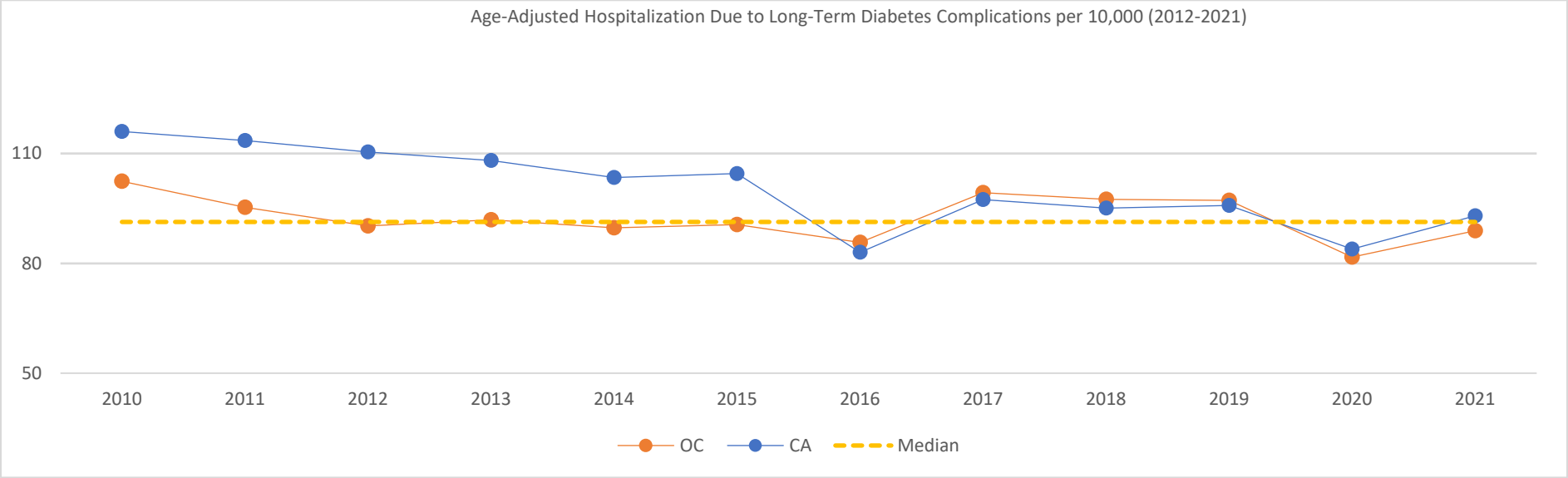
[20] **Definition:** Percent of adults who were told by a doctor that they had diabetes or sugar diabetes (other than during pregnancy). **Source:** UCLA Center for Health Policy Research, Los Angeles, CA. AskCHIS 2011-2021. *Ever Diagnosed with Diabetes* (California, Orange). Retrieved from: http://ask.chis.ucla.edu.

Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Age-Adjusted Hospitalization Due to Uncontrolled Diabetes per 10,000[21] (HCAI)	24.6 (2021)	25.0	N/A	N/A	N/A



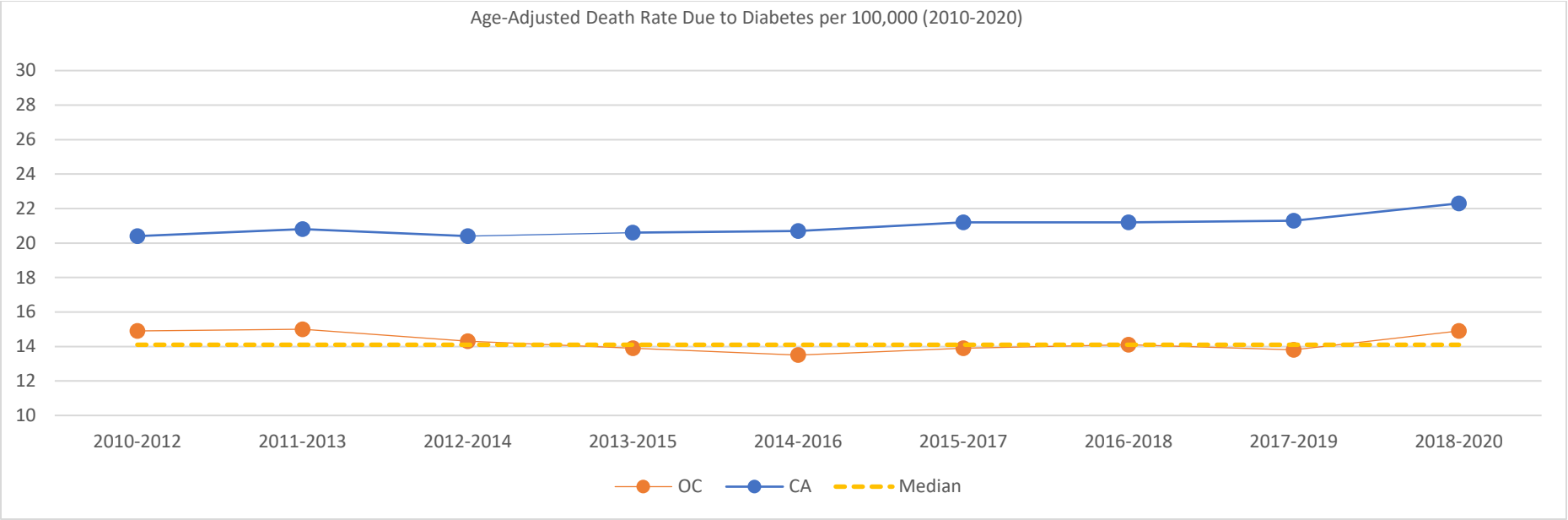
[21] **Definition:** Rate of hospitalization due to diabetes without mention of short-term or long-term complications per 10,000 population. **Source:** California Department of Health Care Access and Information Patient Discharge Data; Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators (n.d.) *Preventable Hospitalizations for Diabetes* (2016-2020). Retrieved from: Preventable Hospitalizations for Diabetes - HCAI

Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Age-Adjusted Hospitalization Due to Long-Term Diabetes Complications per 10,000[22] (HCAI)	88.9 (2021)	93.0	N/A	N/A	N/A



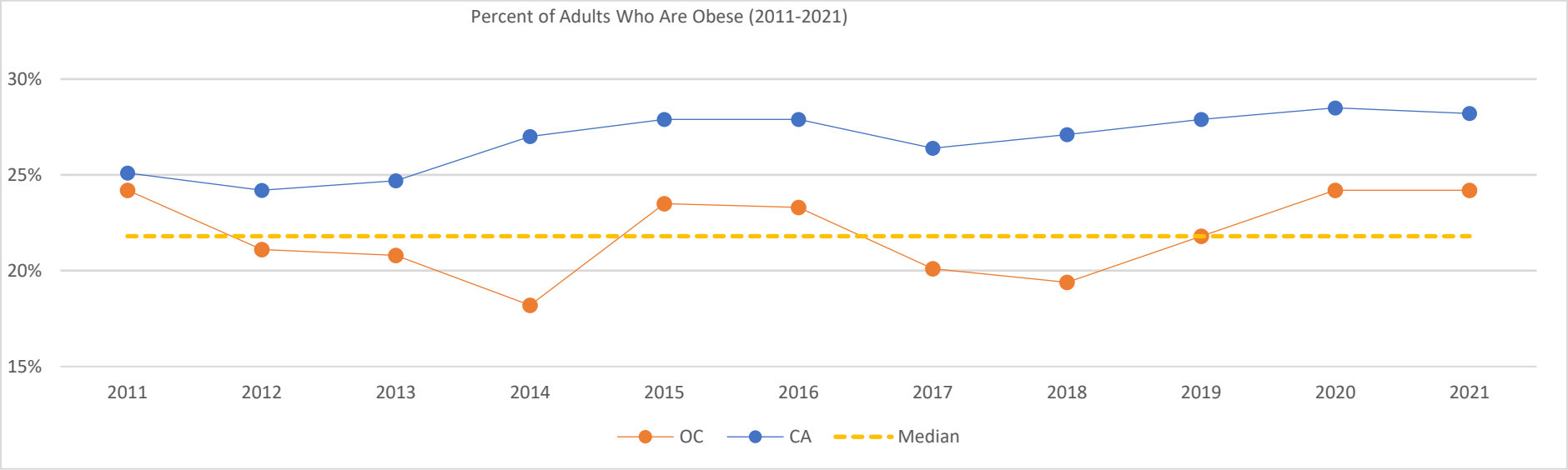
[22] **Definition:** Rate of hospitalization due to long-term complications from diabetes per 10,000 population. **Source:** California Department of Health Care Access and Information Patient Discharge Data; Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators (n.d.) *Patient Discharge Data*. Retrieved from: Preventable Hospitalizations for Diabetes - HCAI

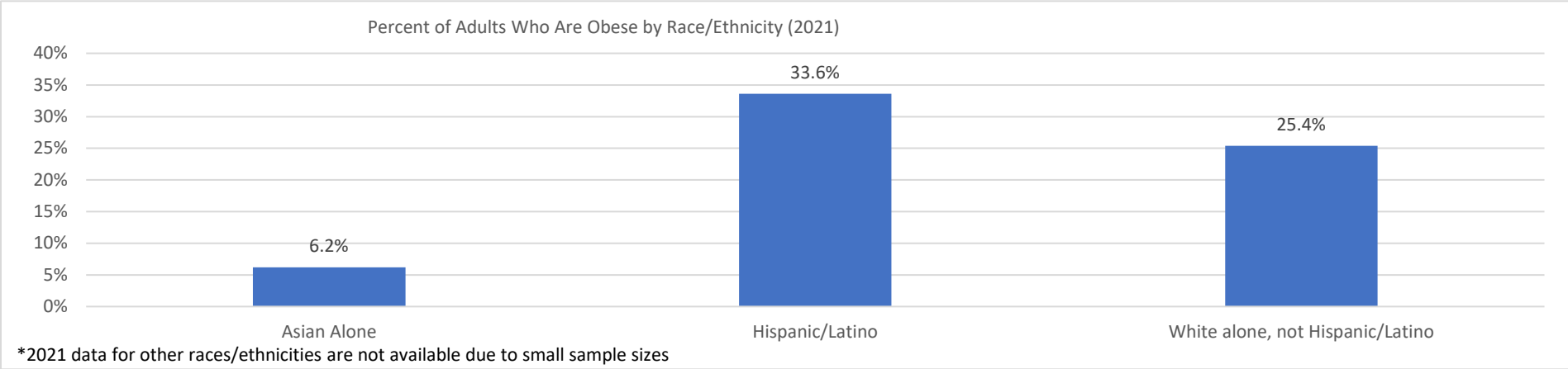
Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Age-Adjusted Death Rate Due to Diabetes per 100,000[23] (CDPH)	14.9 (2018-2020)	22.3	15.2 (2010-2015)	13.7	N/A



[23] **Definition:** Three-year averages of deaths from diabetes divided by the total population and then multiplying by 100,000. **Source:** California Department of Public Health, Center for Health Statistics and Informatics (n.d.). *County Health Status Profiles 2010-2021.* Retrieved from: VSB County Health Status Profiles (ca.gov)

Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Percent of Adults Who Are Obese[24] (CHIS)	24.2% (2021)	28.2%	41.8%	36.0%	R/E

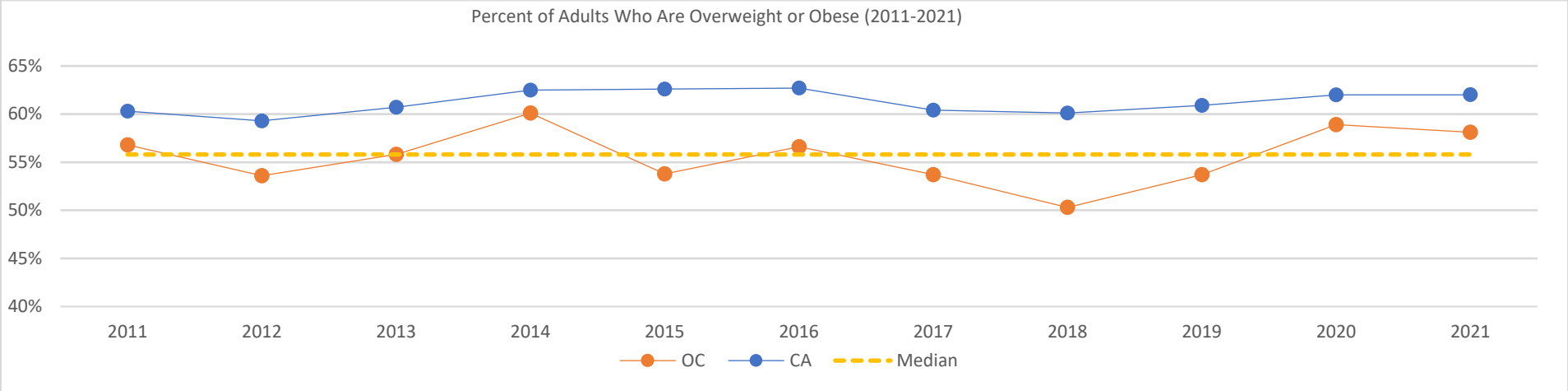


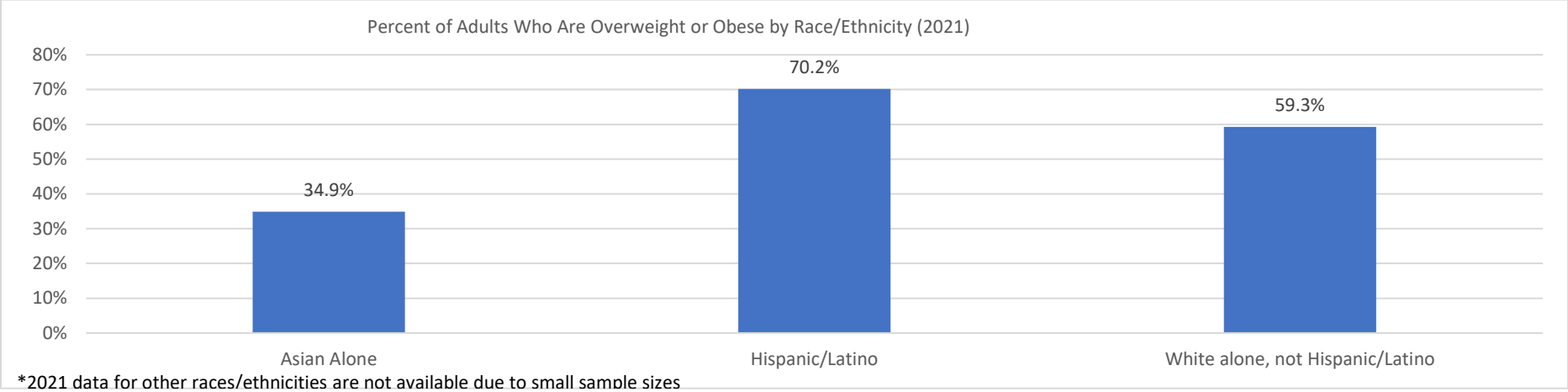


*2021 data for other races/ethnicities are not available due to small sample sizes

[24] **Definition:** Percent of adults had a body mass index of 30 or higher. **Source:** UCLA Center for Health Policy Research, Los Angeles, CA. AskCHIS 2011-2021. *Body Mass Index – 4* (California, Orange). Retrieved from: http://ask.chis.ucla.edu.

Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Adults Who Are Overweight or Obese[25] (CHIS)	58.1% (2021)	62.0%	N/A	N/A	R/E

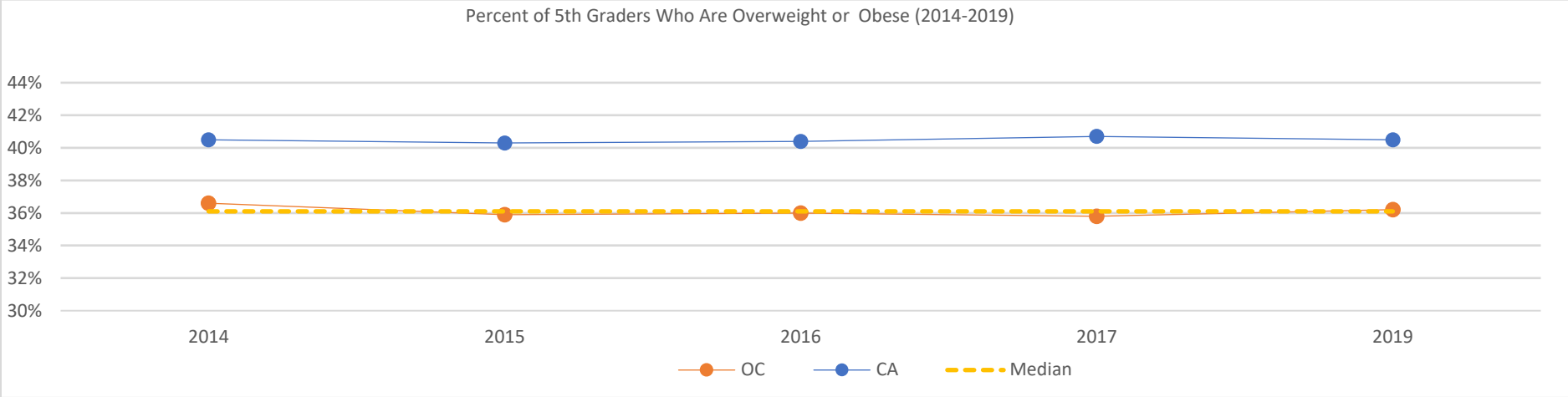




*2021 data for other races/ethnicities are not available due to small sample sizes

[25] **Definition:** Percent of adults had a body mass index of 25 or higher. **Source:** UCLA Center for Health Policy Research, Los Angeles, CA. AskCHIS 2011-2021. *Body Mass Index – 4* (California, Orange). Retrieved from: http://ask.chis.ucla.edu

Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Percent of 5th Graders Who Are Overweight or Obese (CHIS)[26]	36.6% (2019)	41.3%	N/A	N/A	N/A



[26] **Definition:** Percentage of public school students in grades 5, 7, and 9 with body composition above the "Healthy Fitness Zone" of the FitnessGram assessment, by grade level. **Source:** California Department of Education (2020, January). *Physical Fitness Testing Research Files*. Retrieved from: Students Who Are Overweight or Obese, by Grade Level - Kidsdata.org

Topic	SUBSTANCE USE				
Data	Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal
	Percent of Adults Who Smoke (CHIS)	7.1% (2021)	6.2%	11.7% (2021)	6.1%
	Age-Adjusted Drug Induced Death Rate per 100,000 (CDPH)	15.6 (2021)	17.8	32.4 (2021)	20.7
	Percent of Adults Who Binge Drink (UWPHI)	17.0% (2020)	18.0%	19.0%	N/A
	Percent of 7th Graders Who Use Alcohol or Drugs (CDE)	4.0% (2019-2021)	15.0% (2017-2019)	N/A	N/A
	Percent of 9th Graders Who Use Alcohol or Drugs (CDE)	8.0% (2019-2021)	15.0% (2017-2019)	N/A	N/A
	Percent of 11th Graders Who Use Alcohol or Drugs (CDE)	15.0% (2019-2021)	23.0% (2017-2019)	N/A	N/A
	Percent of 7th Graders Who Use E-Cigarettes (Vaping) (CDE)	2.0% (2019-2021)	4.0% (2017-2019)	N/A	N/A
	Percent of 9th Graders Who Use E-Cigarettes (Vaping) (CDE)	4.0% (2019-2021)	9.0% (2017-2019)	13.1% (2020)	10.5%
	Percent of 11th Graders Who Use E-Cigarettes (Vaping) (CDE)	7.0% (2019-2021)	11.0% (2017-2019)	13.1% (2020)	10.5%
	Age-Adjusted Opioid Prescription Rates per 1,000 (CDPH COSD)	287.4 (2021)	321.71	N/A	N/A
	Age-Adjusted Emergency Department Visit Rates Due to All Drug Overdoses per 100,000 (CDPH)	119.14 (2021)	148.19	N/A	N/A

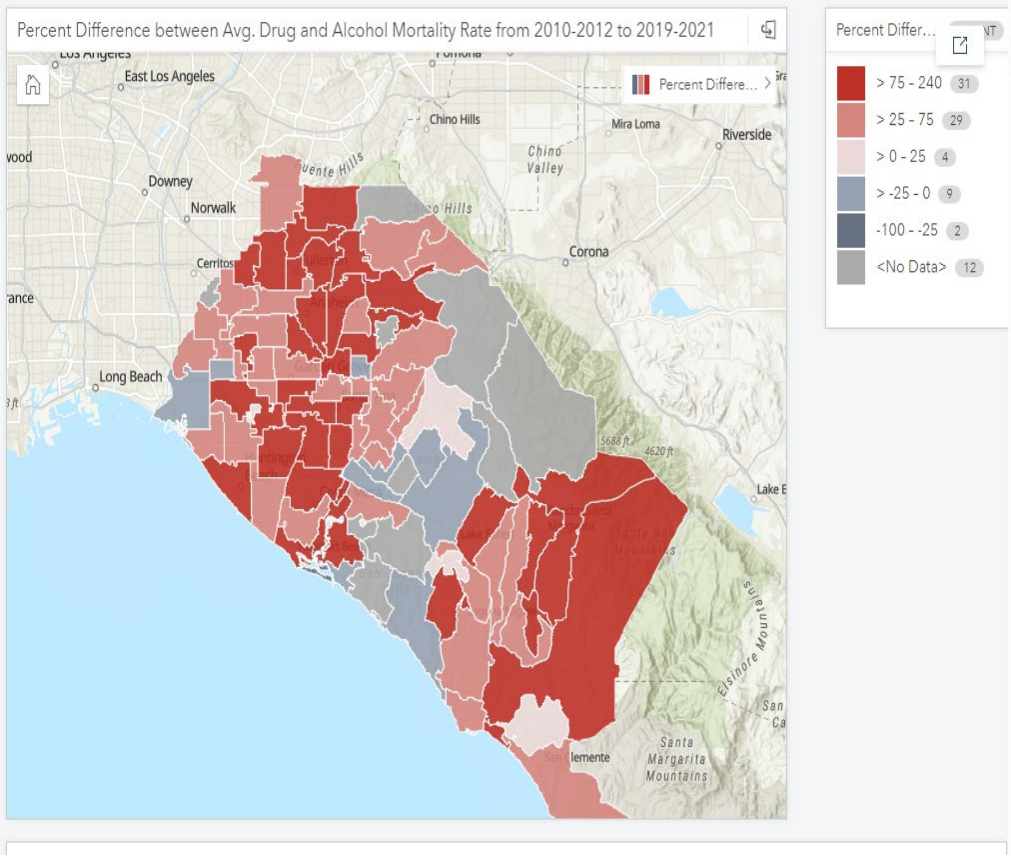
Equity & Disparities

- Percent of Adults Who Smoke: Hispanics (9.0%) smoke at a higher rate than White (6.8%) and Asian (4.4%)
- Percent of 11th Graders Who Use Alcohol or Drugs: White 11th Graders (21.0%) use alcohol or drugs at a higher rate than Black (17.0%), Hispanic (14.0%) or Asian (6.0%) 11th Graders
- Age-Adjusted Emergency Department Visit Rates Due to All Drug Overdoses per 100,00: Black populations (239.68) visited ER at a higher rate than White (185.1), Native Hawaiian/Alaska Native (130.39), Hispanic (98.09) or Pacific Islander (42.87) populations
- Areas of north and south county experienced drug and alcohol mortality rates from 2010-2012 to 2019-2021.

Qualitative Findings	– **Insurance companies act as a barrier for mental health and substance use treatment for the youth.** – **Hispanic/Latino: Substance use and food access support; lack of outreach to destitute people and children** – **Greater supports needed for students/youth who use alcohol, drugs, or who vape**
Current Collaborative Activities	– **YOR Project (BeWell)** – **ConnectOC**

SUBSTANCE USE

Drug and Alcohol Mortality:

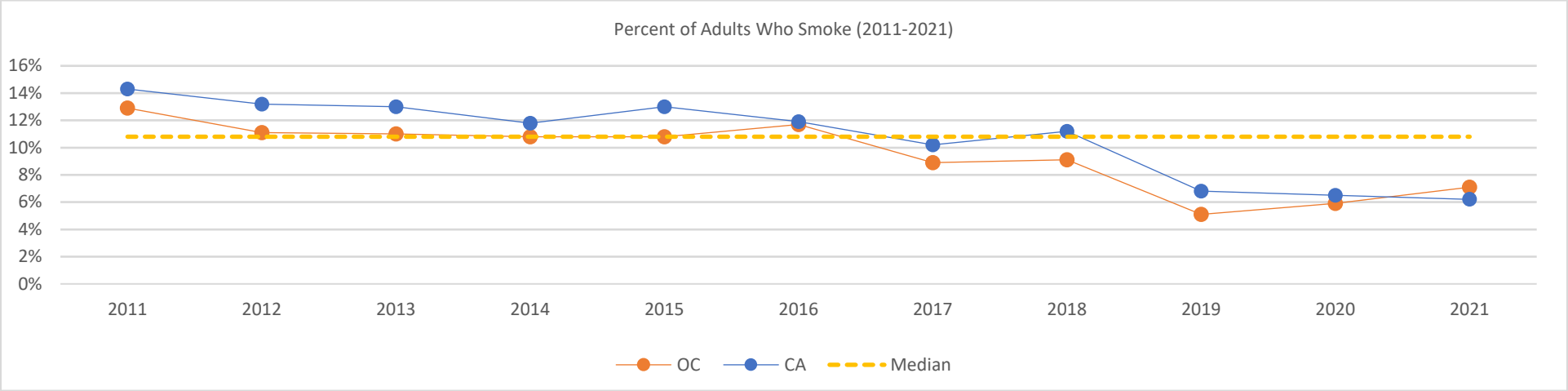


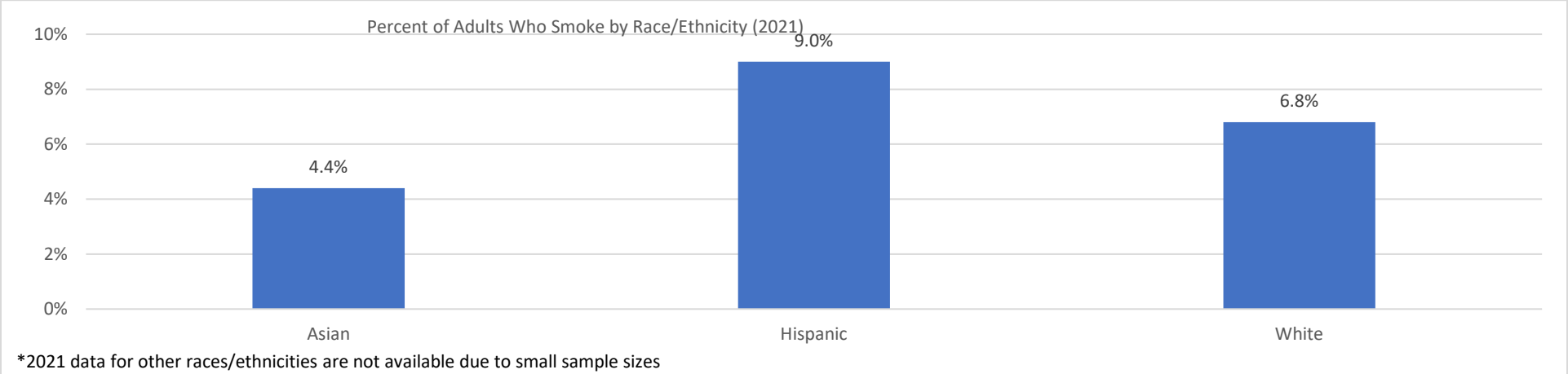
Areas with the darkest shades of red increased their drug and alcohol mortality rates from 2010-2012 to 2019-2021

Source: HCA Drug and Alcohol Misuse and Mortality dashboard

Substance Use

Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Percent of Adults Who Smoke[27] (CHIS)	7.1% (2021)	6.2%	11.7% (2021)	6.1%	R/E

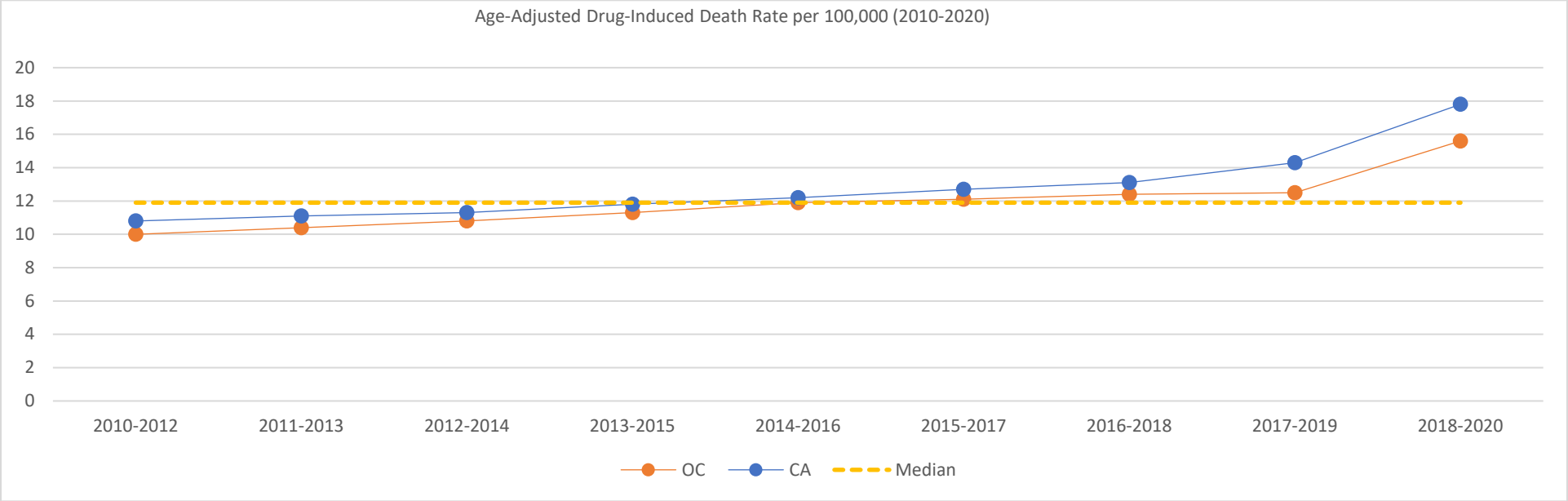




*2021 data for other races/ethnicities are not available due to small sample sizes

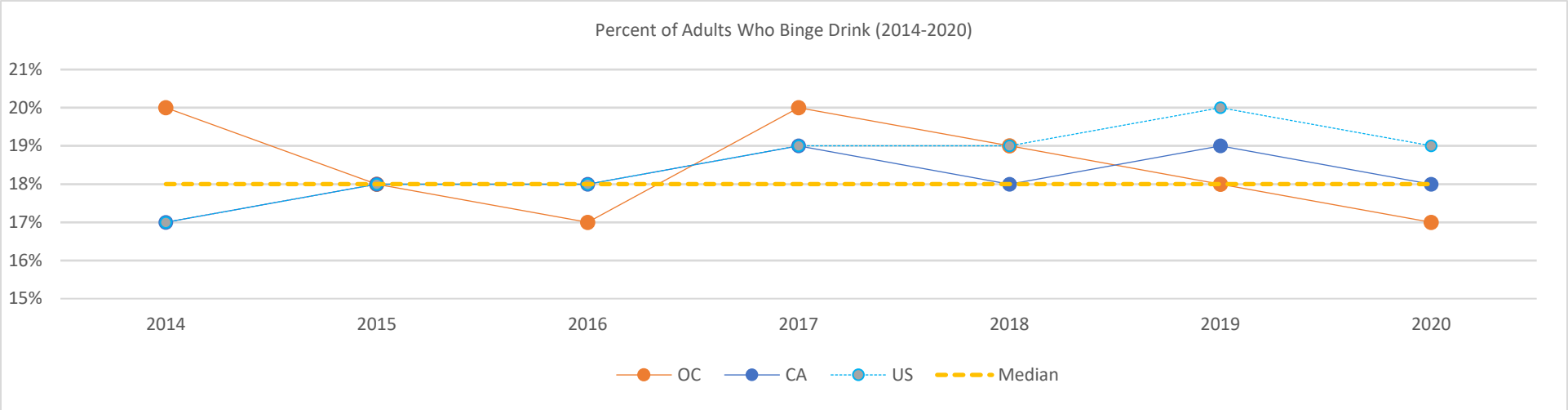
[27] **Definition:** Adults who smoked 100 or more cigarettes in their life were asked about current smoking habits. Adults who smoked fewer than 100 cigarettes or don't currently smoke are considered nonsmokers. **Source**: UCLA Center for Health Policy Research, Los Angeles, CA. AskCHIS 2011-2021. Current Smoking Status – Adults (California, Orange). Retrieved from: http://ask.chis.ucla.edu.

Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Age-Adjusted Drug Induced Death Rate per 100,000[28] (CDPH)	15.6 (2021)	17.8	32.4 (2021)	20.7	N/A



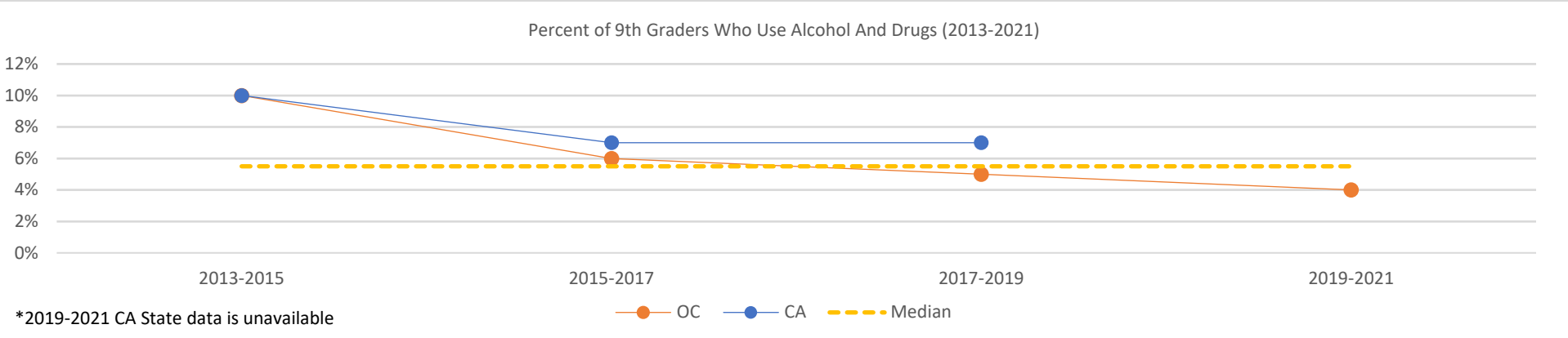
[28] **Definition:** Three-year averages number of drug induced deaths divided by the total population and then multiplying by 100,000. **Source:** California Department of Public Health, Center for Health Statistics and Informatics (n.d.). *County Health Status Profiles 2010-2021.* Retrieved from: VSB County Health Status Profiles (ca.gov)

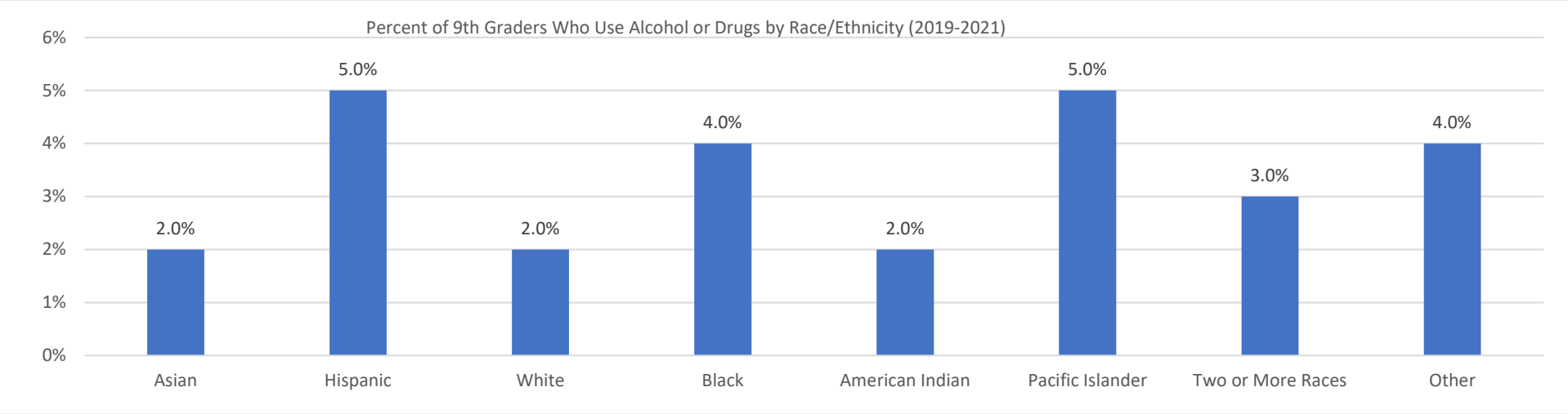
Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Percent of Adults Who Binge Drink[29] (UWPHI)	17.0% (2020)	18.0%	19.0%	N/A	N/A



[29] **Definition:** Percentage of adults reporting binge or heavy drinking. **Source:** Excessive Drinking | County Health Rankings & Roadmaps

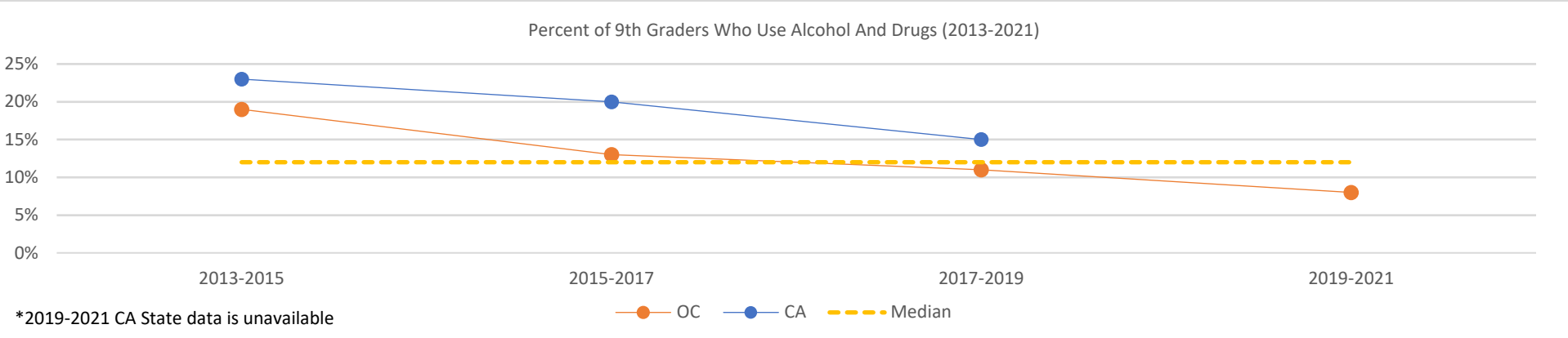
Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Percent of 7th Graders Who Use Alcohol or Drugs[30] (CDE)	4.0% (2019-2021)	15.0% (2017-2019)	N/A	N/A	R/E

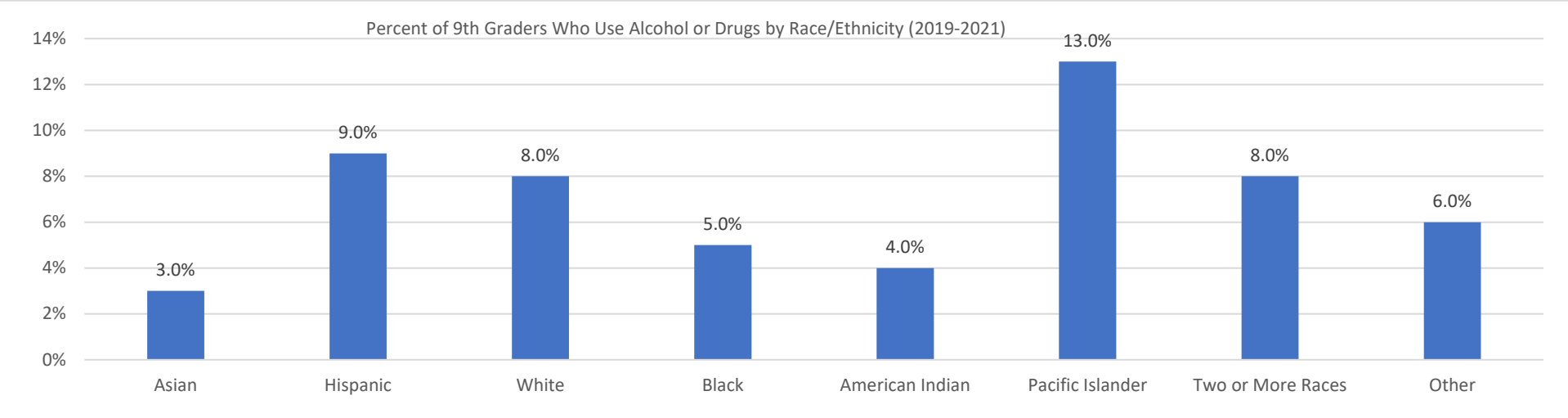




[30] **Definition:** One or more days in the past 30 days that the 7th Graders drank one more drinks of alcohol, five or more drinks in a row, use of marijuana, inhalants, prescription drug use, any other drug pill or medicine to get high, or use of two or more substances at the same time. **Source:** California Department of Education, (n.d.). *California Healthy Kids Survey.* Retrieved from: The California School Climate, Health, and Learning Survey (CalSCHLS) System - Public Dashboards.

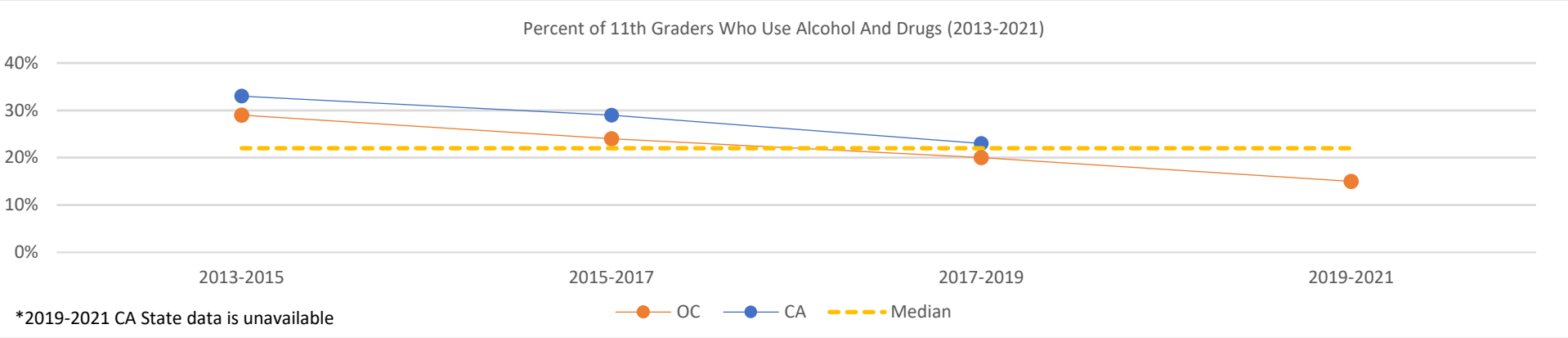
Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Percent of 9th Graders Who Use Alcohol or Drugs[31] (CDE)	8.0% (2019-2021)	15.0% (2017-2019)	N/A	N/A	R/E

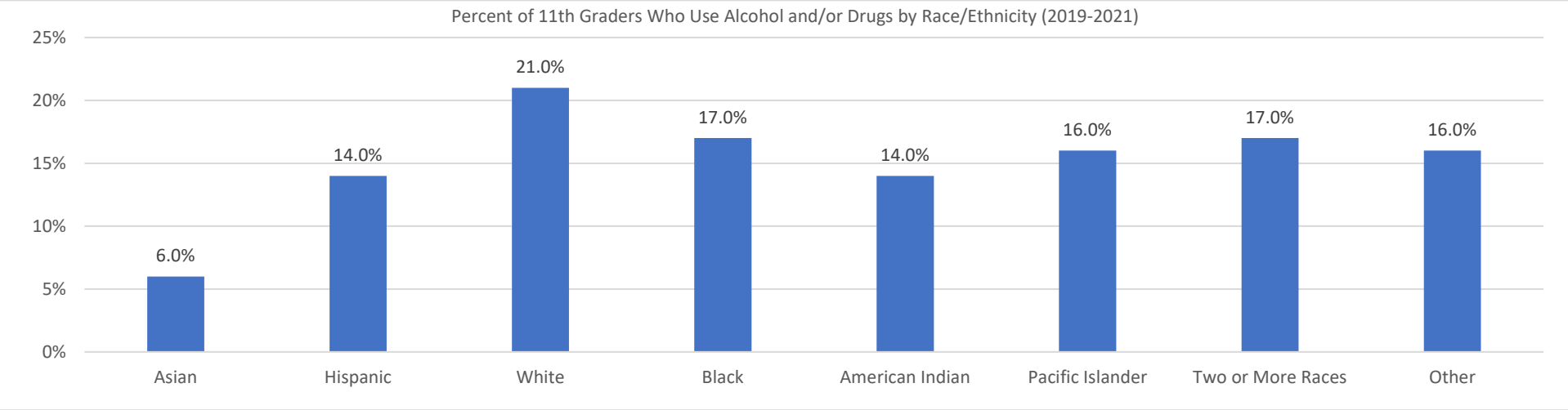




[31] **Definition:** One or more days in the past 30 days that the 9th Graders drank one more drinks of alcohol, five or more drinks in a row, use of marijuana, inhalants, prescription drug use, any other drug pill or medicine to get high, or use of two or more substances at the same time. **Source:** California Department of Education, (n.d.). *California Healthy Kids Survey.* Retrieved from: The Californial School Climate, Health, and Learning Survey (CalSCHLS) System - Public Dashboards.

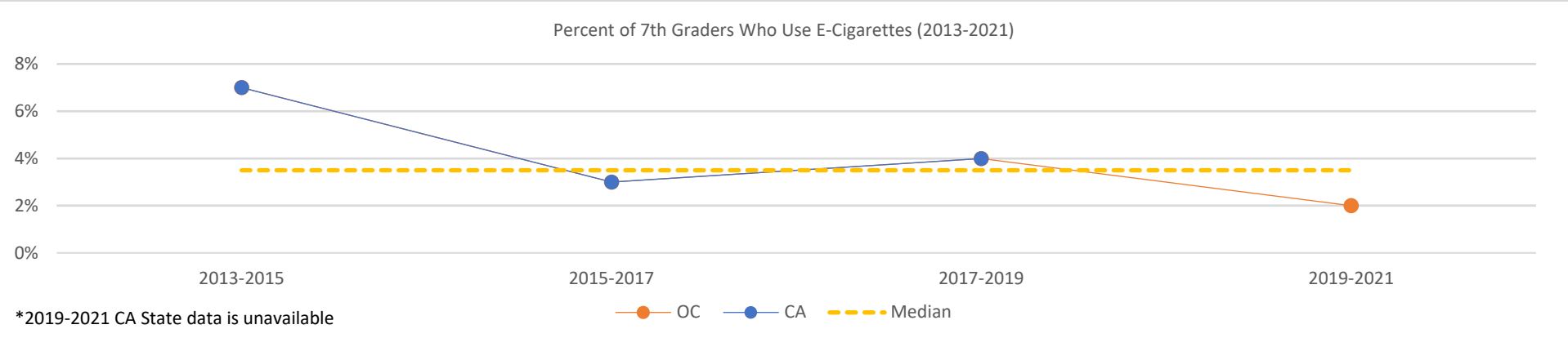
Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Percent of 11th[th] Graders Who Use Alcohol or Drugs[32] (CDE)	15.0% (2019-2021)	23.0% (2017-2019)	N/A	N/A	R/E

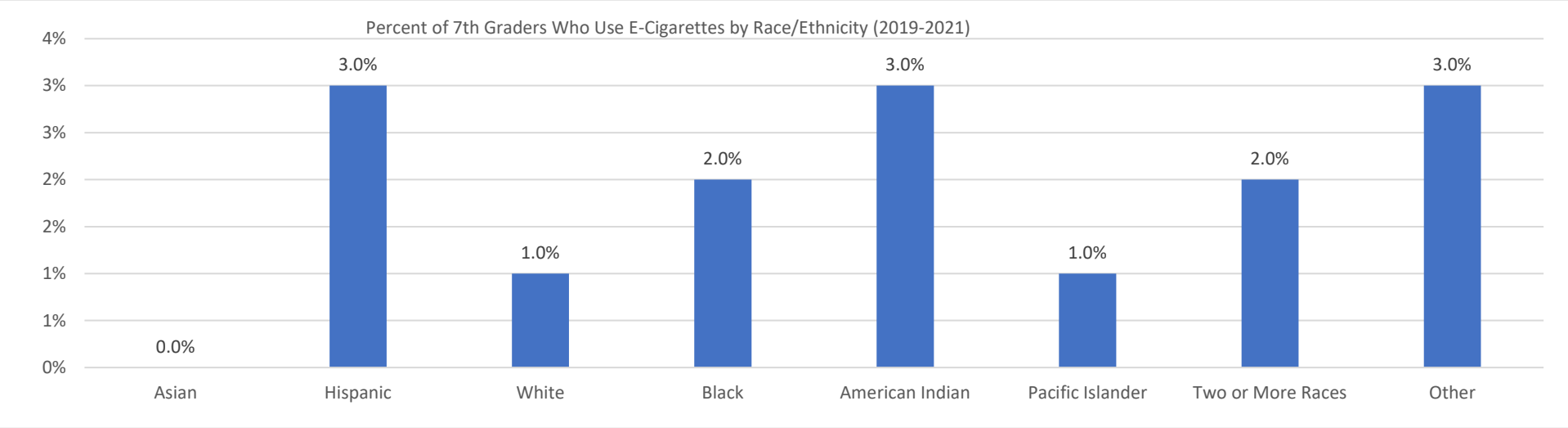




[32] **Definition:** One or more days in the past 30 days that the 11th[th] Graders drank one more drinks of alcohol, five or more drinks in a row, use of marijuana, inhalants, prescription drug use, any other drug pill or medicine to get high, or use of two or more substances at the same time. **Source:** California Department of Education, (n.d.). *California Healthy Kids Survey.* Retrieved from: The Californial School Climate, Health, and Learning Survey (CalSCHLS) System - Public Dashboards

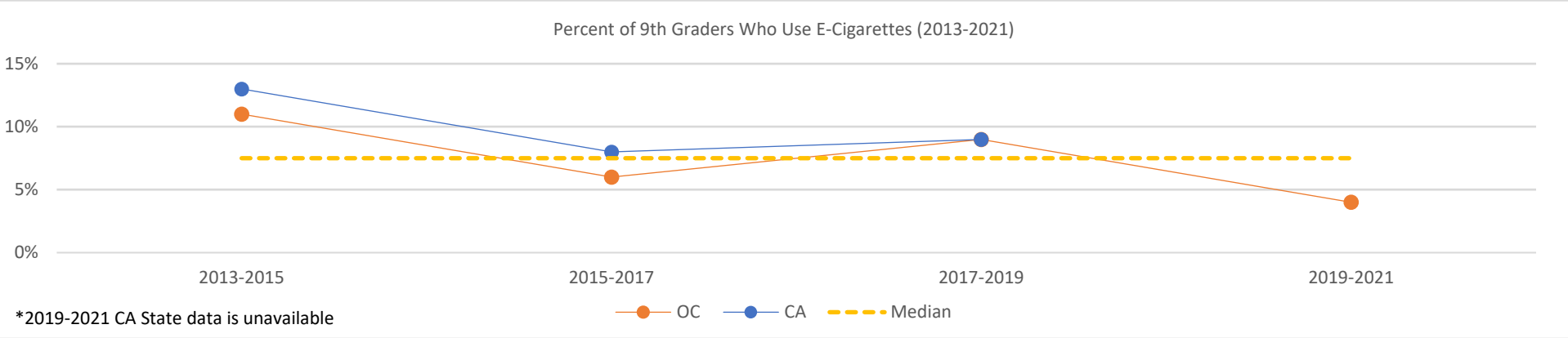
Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Percent of 7th Graders Who Use E-Cigarettes[33] (CDE)	2.0% (2019-2021)	4.0% (2017-2019)	13.1% (2020)	10.5%	R/E

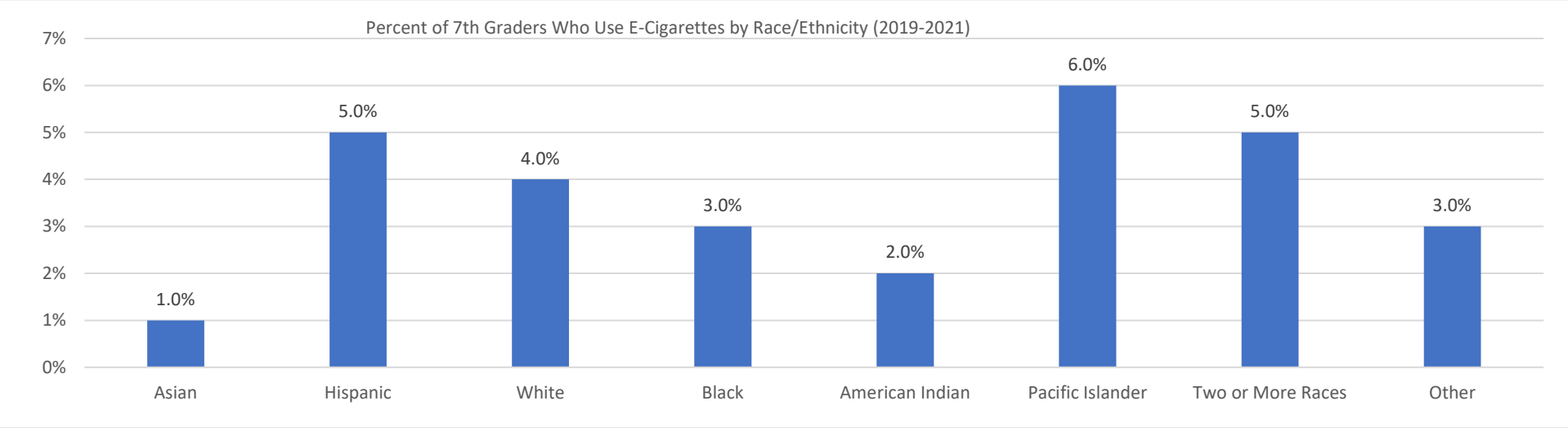




[33] **Definition:** One or more days in the past 30 days that the 7th Graders used electronic cigarettes/vape products. **Source:** California Department of Education, (n.d.). *California Healthy Kids Survey.* Retrieved from: The California School Climate, Health, and Learning Survey (CalSCHLS) System - Public Dashboards

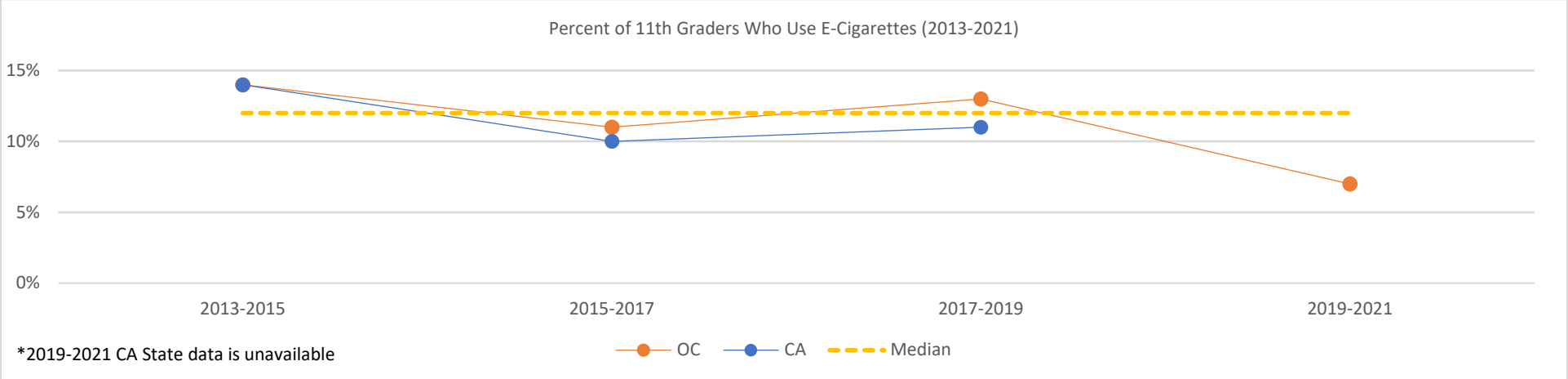
Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Percent of 9th Graders Who Use E-Cigarettes[34] (CDE)	4.0% (2019-2021)	9.0% (2017-2019)	13.1% (2020)	10.5%	R/E

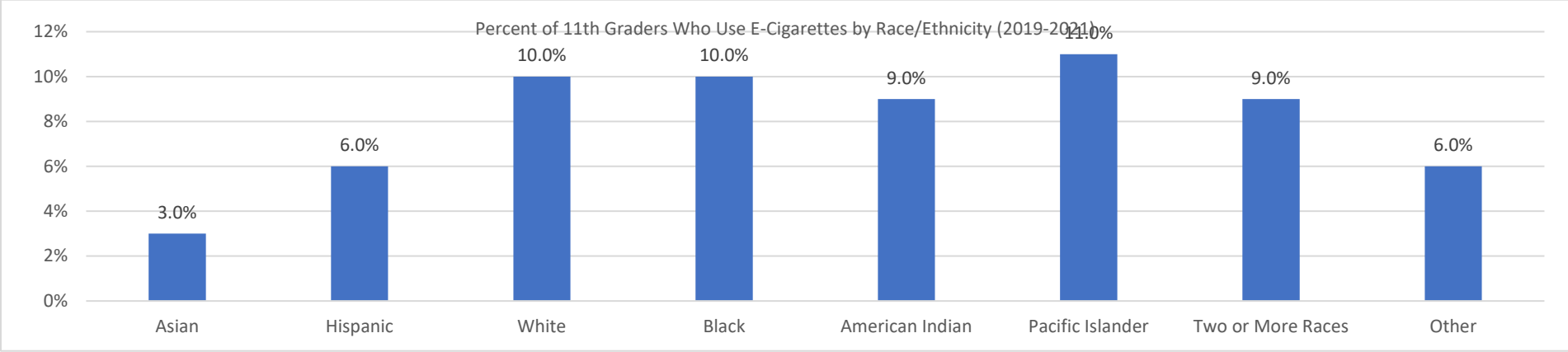




[34] **Definition:** One or more days in the past 30 days that the 7th Graders used electronic cigarettes/vape products. **Source:** California Department of Education, (n.d.). *California Healthy Kids Survey.* Retrieved from: The California School Climate, Health, and Learning Survey (CalSCHLS) System - Public Dashboards

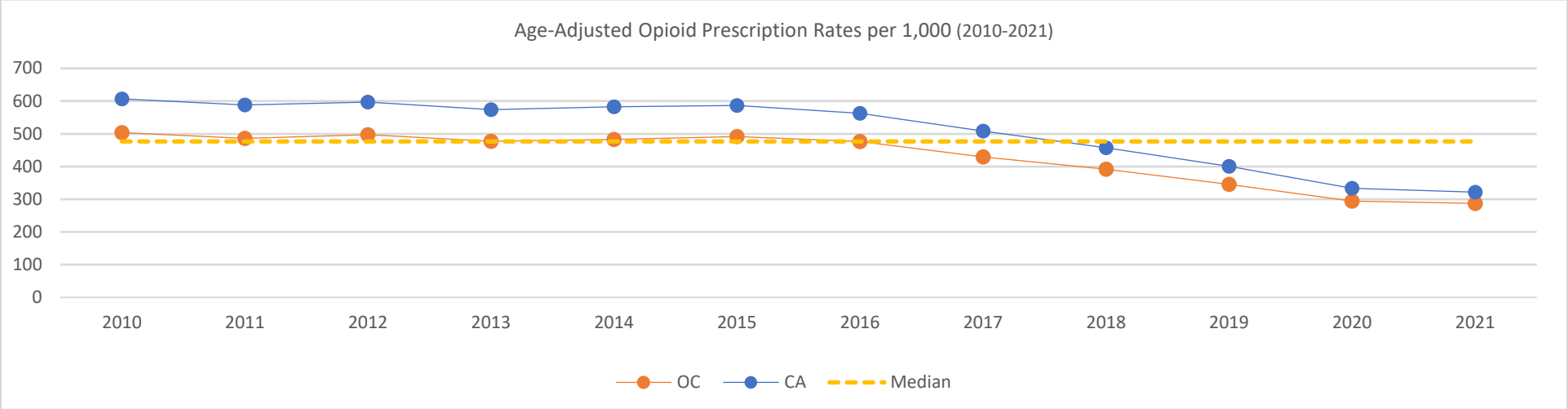
Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Percent of 11th[th] Graders Who Use E-Cigarettes[35] (Vaping) (CDE)	7.0% (2019-2021)	11.0% (2017-2019)	13.1% (2020)	10.5%	R/E





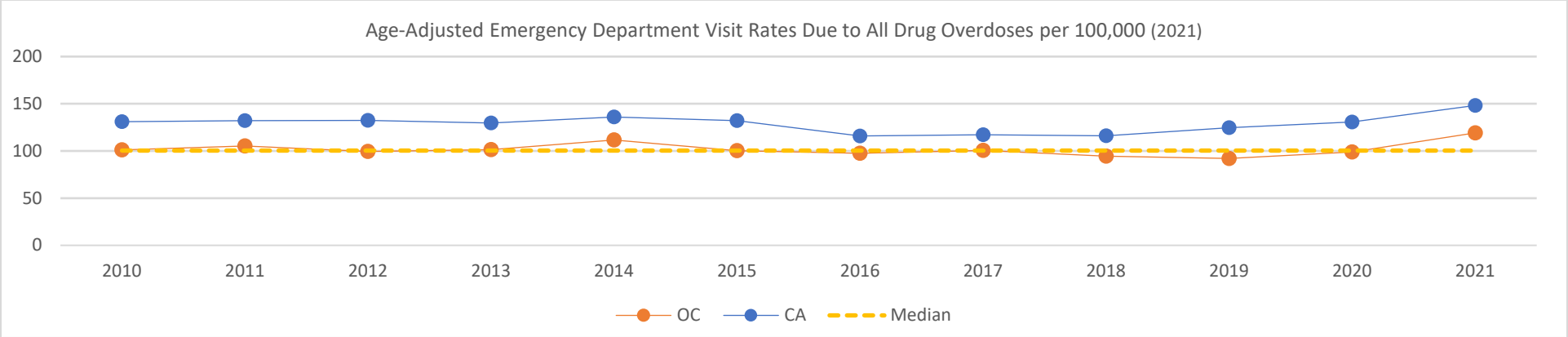
[35] **Definition:** One or more days in the past 30 days that the 11th[th] Graders used electronic cigarettes/vape products. **Source:** California Department of Education, (n.d.). *California Healthy Kids Survey.* Retrieved from: The Californial School Climate, Health, and Learning Survey (CalSCHLS) System - Public Dashboards

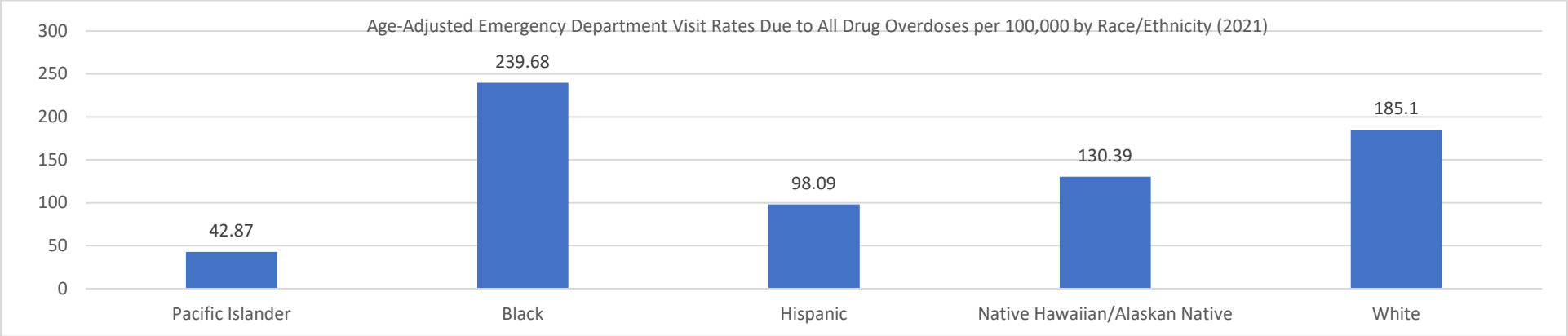
Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Age-Adjusted Opioid Prescription Rates per 1,000[36] (CDPH COSD)	287.4 (2021)	321.71	N/A	N/A	N/A



[36] **Definition:** Age-adjusted rate of the population with opioid prescription per 1,000 residents. **Source:** California Department of Public Health (n.d.). *California Overdose Surveillance Dashboard*. Retrieved from: https://skylab.cdph.ca.gov/ODdash/?tab=CTY.

Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Age-Adjusted Emergency Department Visit Rates Due to All Drug Overdoses[37] (CDPH)	119.14 (2021)	148.19	N/A	N/A	R/E





[37] **Definition:** All drug overdose emergency department visits caused by non-fatal acute poisonings due to the effects of drugs, regardless of intent (e.g., suicide, unintentional, or undetermined). Emergency department visits related to late effects, adverse effects, and chronic poisonings due to the effects of drugs (e.g., damage to organs from long-term drug use) are excluded from this indicator. Source: California Department of Public Health (n.d.). California Overdose Surveillance Dashboard. Retrieved from: https://skylab.cdph.ca.gov/ODdash/?tab=CTY.

Topic	SEXUALLY TRANSMITTED DISEASES				
Data	Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal
	Chlamydia Incidence Rate per 100,000 (CDPH)	341.9 (2020)	448.2	481.3	N/A
	Gonorrhea Incidence Rate per 100,000 (CDPH)	142.8 (2020)	196.8	206.5	N/A
	Syphilis Incidence Rate per 100,000 (CDPH)	27.9 (2020)	38.3	12.7	N/A
	HIV Incidence Rate per 100,000 (CDPH)	8.2 (2020)	9.9	10.9	N/A

Equity & Disparities

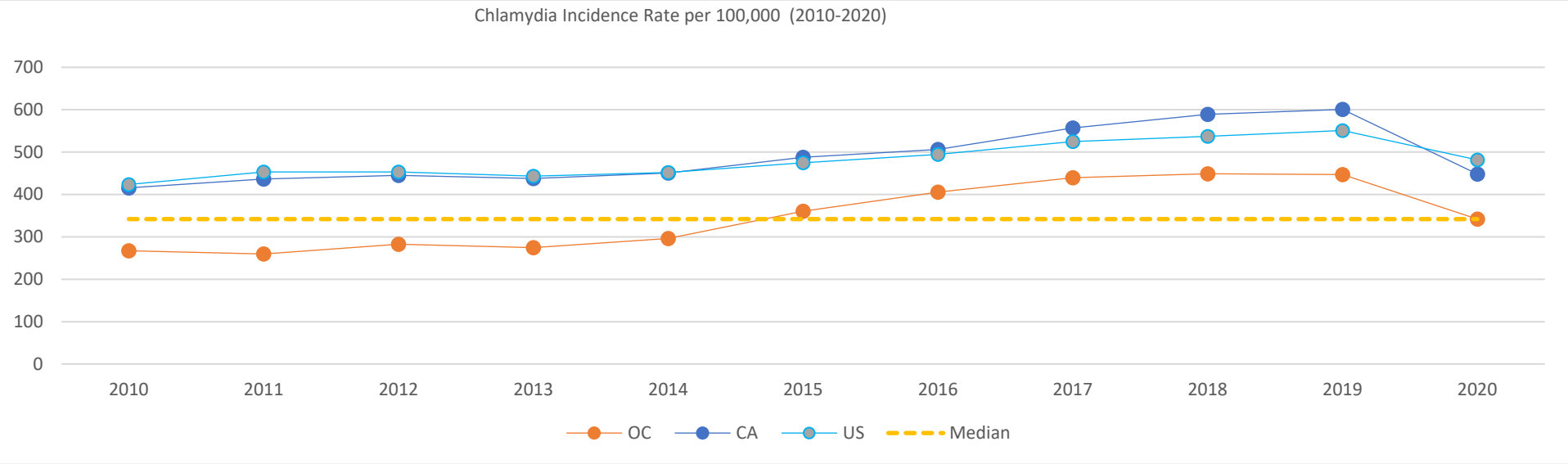
- **HIV Incidence Rate per 100,000: Parts of North and Central Orange County had the highest (12.3 – 18.4) rate in the county.**

Qualitative Findings

Current Collaborative Activities

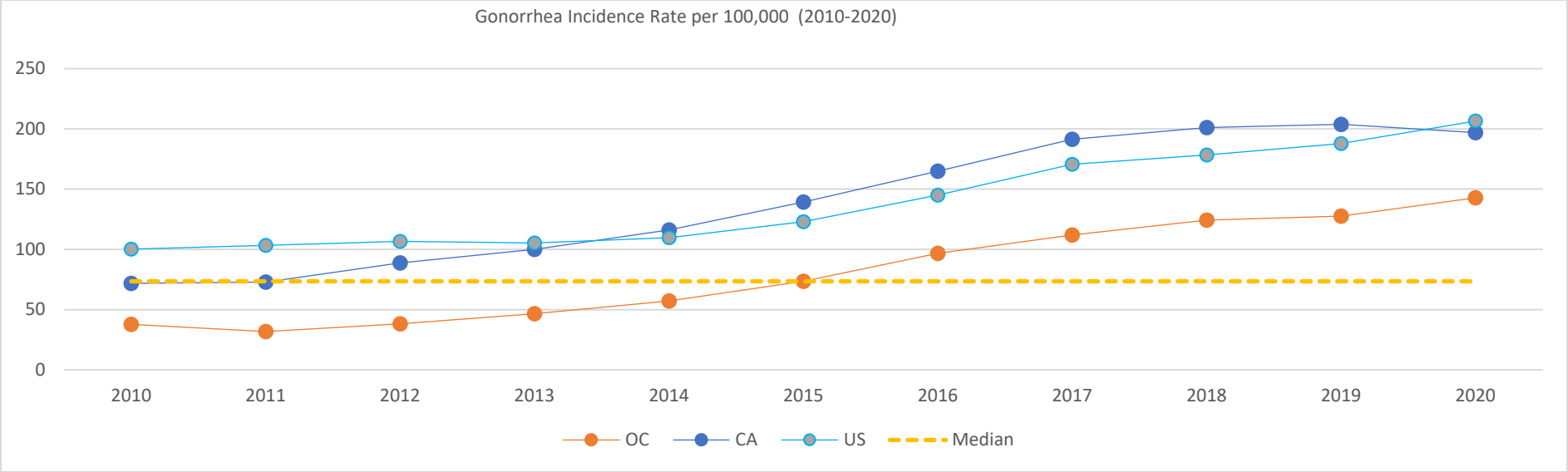
- **HCA"s HIV Planning Council: In partnership with affected communities, service providers, philanthropists, and public health professionals, will support an accessible, culturally competent continuum of HIV prevention and care services that promotes optimal health, fosters self-sufficiency, reduces stigma and discrimination, and results in a community where new HIV infections are rare."**

Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Chlamydia Incidence Rate per 100,000[38] (CDPH)	341.9 (2020)	448.2	481.3	N/A	N/A



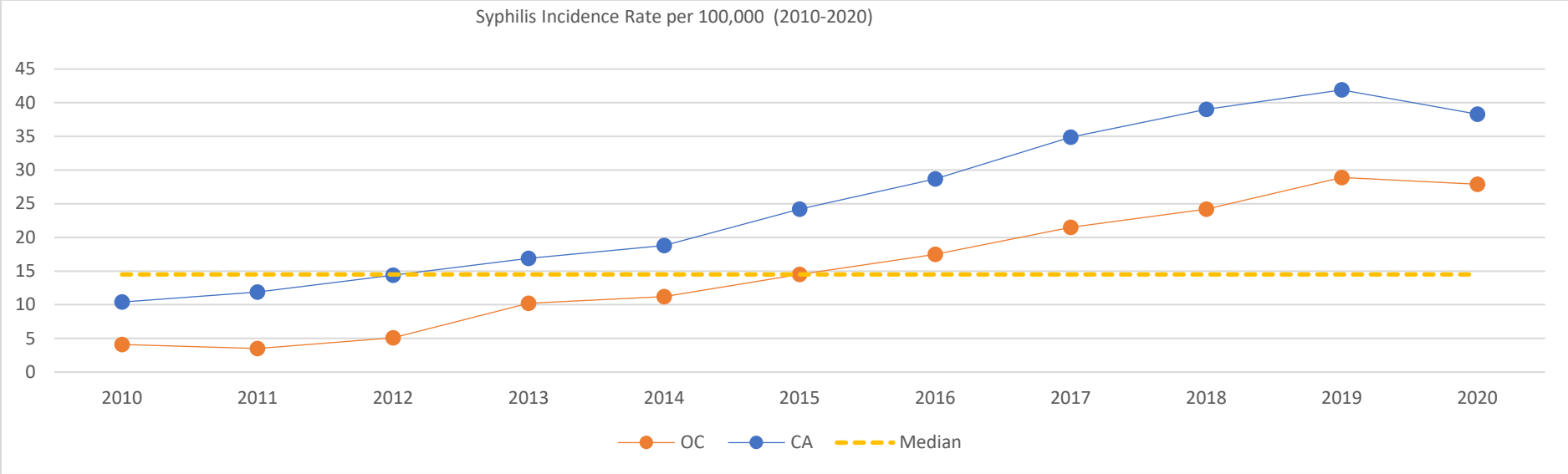
[38] **Definition:** Rates of Chlamydia per 100,000 population. **Source:** California Department of Public Health (n.d). *Sexually Transmitted Infection Data.* Retrieved from: Sexually Transmitted Diseases Data (ca.gov)

Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Gonorrhea Incidence Rate per 100,000[39] (CDPH)	142.8 (2020)	196.8	206.5	N/A	N/A



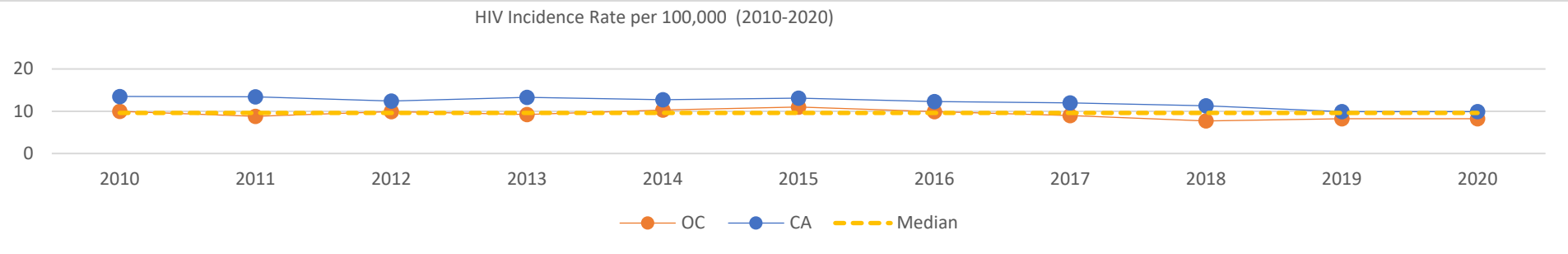
[39] **Definition:** Rates of Gonorrhea per 100,000 population. **Source:** California Department of Public Health (n.d). *Sexually Transmitted Infection Data.* Retrieved from: Sexually Transmitted Diseases Data (ca.gov)

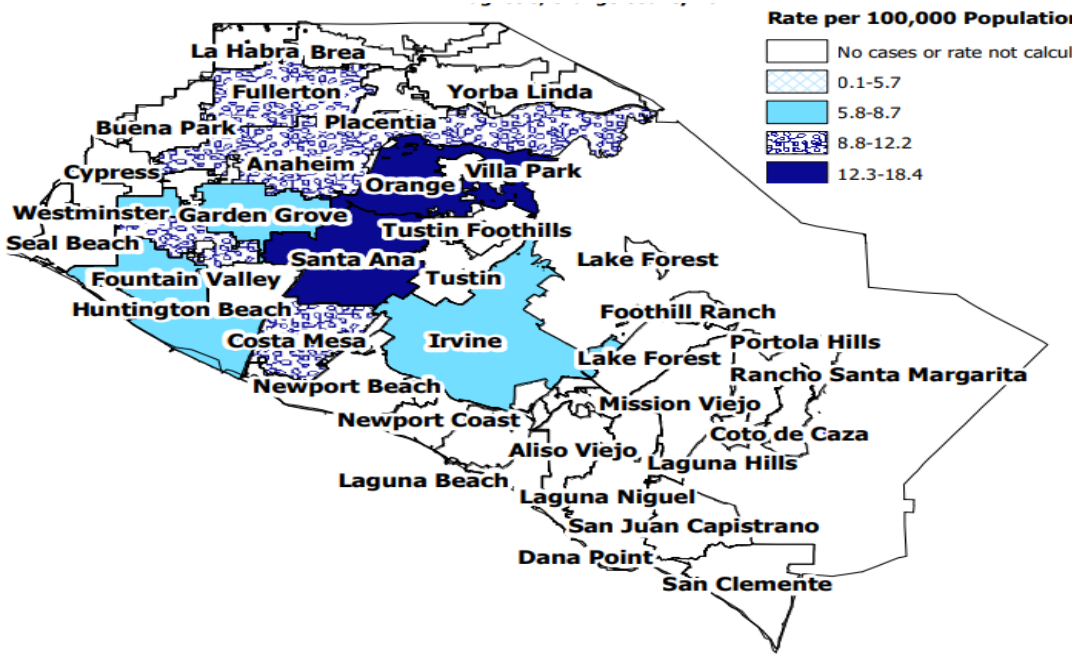
Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Syphilis Incidence Rate per 100,000[40] (CDPH)	27.9 (2020)	38.3	12.7	N/A	N/A



[40] **Definition:** Rates of Syphilis per 100,000 population. **Source:** California Department of Public Health (n.d). *Sexually Transmitted Infection Data.* Retrieved from: Sexually Transmitted Diseases Data (ca.gov)

Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
HIV Incidence Rate per 100,000[41] (CDPH)	8.2 (2020)	9.9	10.9	N/A	Geographic



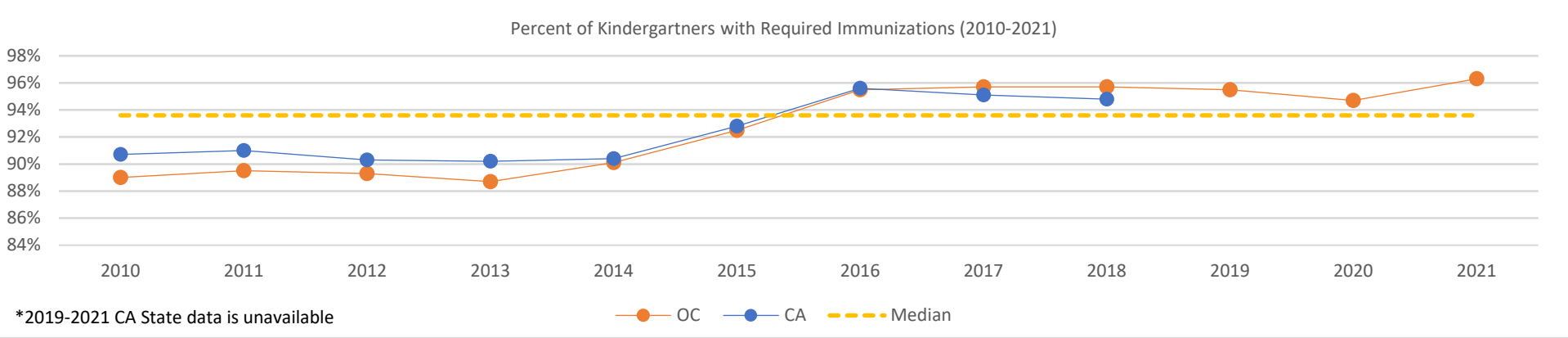


[41] **Definition:** Rates of HIV per 100,000 population. **Source:** California Department of Public Health (n.d). *Sexually Transmitted Infection Data.* Retrieved from: Sexually Transmitted Diseases Data (ca.gov)

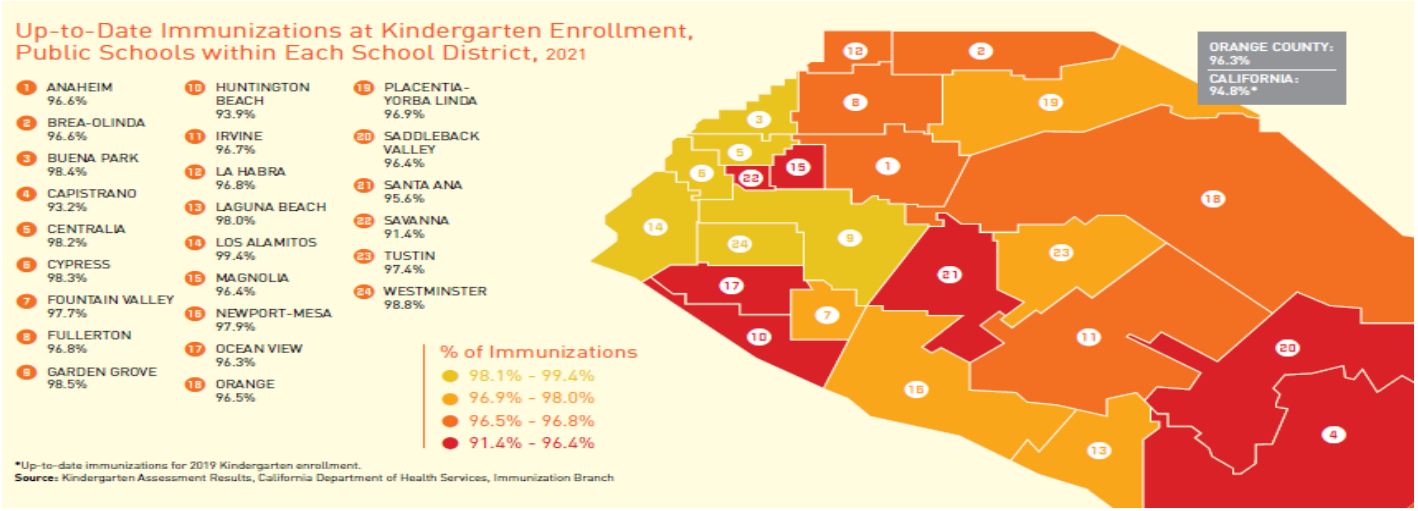
Topic	VACCINE PREVENTABLE DISEASES				
Data	Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal
	Percent of Kindergartners with Required Immunizations (CDHS)	96.3% (2021)	N/A	93.0% (2021-2022)	95.0%
	Age-Adjusted Death Rate Due to Influenza/Pneumonia per 100,000 (CDPH)	13.7 (2018-2020)	13.5	N/A	N/A
	Tuberculosis Incidence Rate per 100,000 (CDPH)	5.2 (2018-2020)	5.0	2.2 (2020)	1.4
	COVID-19 Deaths in Orange County (OCHCA)	1,759 (2022)	N/A	N/A	N/A
	COVID-19 Boosters in Orange County (OCHCA)	595,090 (2022)	N/A	N/A	N/A
Equity & Disparities	– Percent of Kindergartners with Required Immunizations: Western County had the highest (98.1% - 99.4%) immunization rate in the county				
Qualitative Findings	Need for increased culturally appropriate health education – Culturally appropriate health education – Lack of access to vaccine informative sessions and education on accessible health resources – Better public health education on prevention options and self-care to reduce long-term health costs				
Current Collaborative Activities	– HCA's Immunization Coalition: The mission is to positively impact the health status of the Orange County community by achieving and maintaining full immunization protection.				

Vaccine Preventable Diseases

Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Percent of Kindergartners with Required Immunizations[42] (CDHS)	96.3% (2021)	N/A	93.0% (2021-2022)	95.0%	Geographic

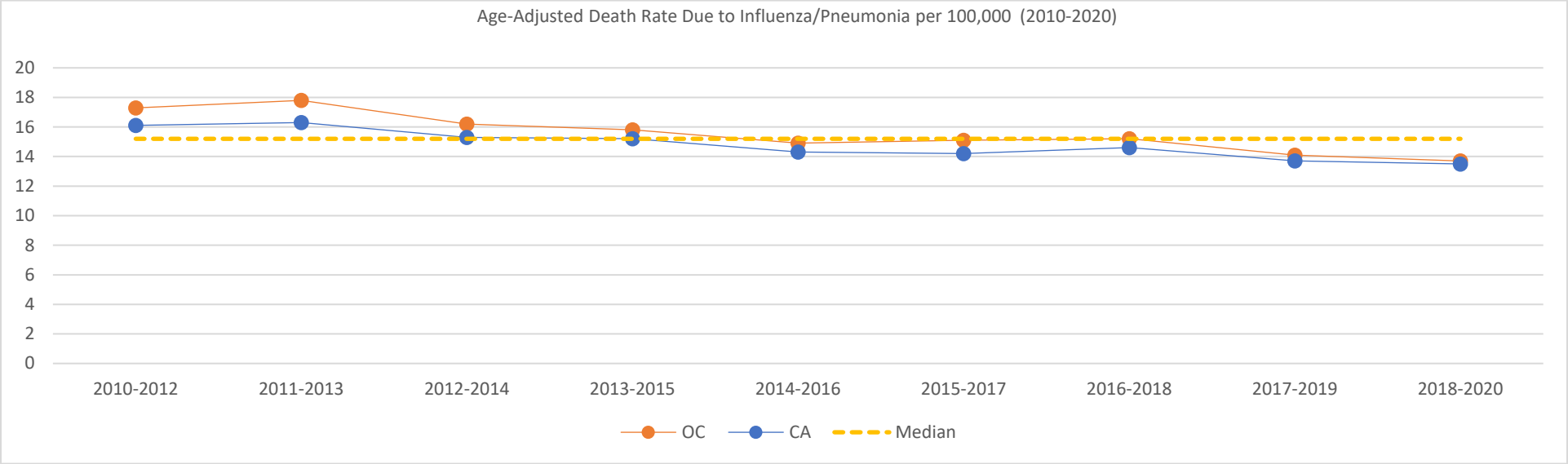


*2019-2021 CA State data is unavailable



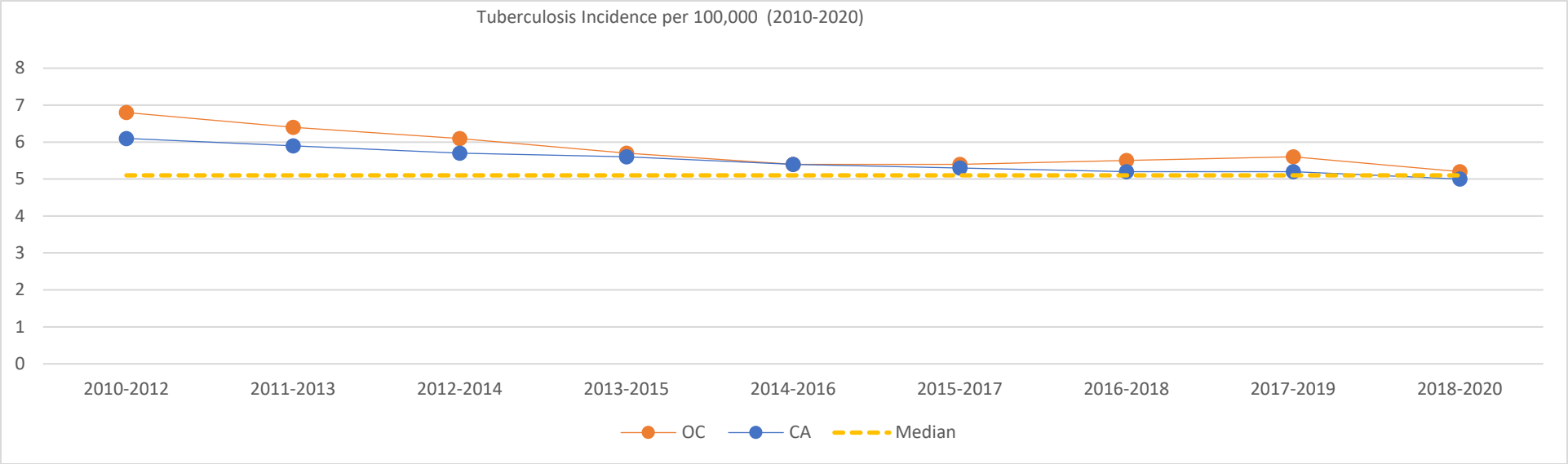
[42] **Definition:** Percent of children who received all of the doses of specific vaccines required at kindergarten entry. **Source**: California Department of Public Health, California Department of Health Services, Immunization Branch (n.d.). *Kindergarten Assessment Results*.

Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Age-Adjusted Death Rate Due to Influenza/Pneumonia per 100,000[43] (CDPH)	13.7 (2018-2020)	13.5	N/A	N/A	N/A



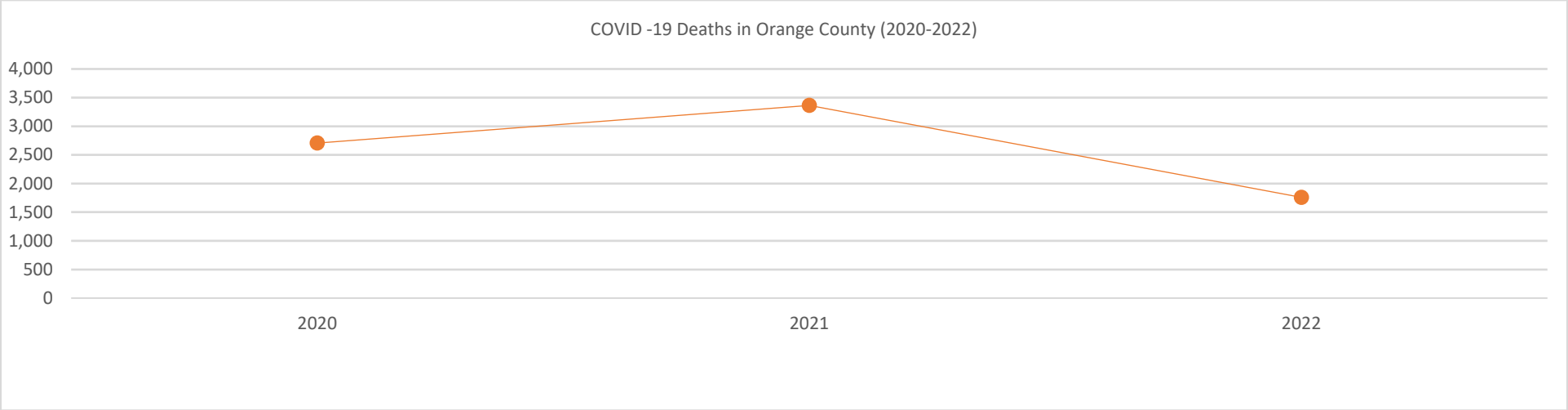
[43] **Definition:** Three-year averages number of deaths from the flu and/or pneumonia divided by the total population and then multiplying by 100,000. **Source:** California Department of Public Health, Center for Health Statistics and Informatics (n.d.). *County Health Status Profiles 2010-2021.* Retrieved from: VSB County Health Status Profiles (ca.gov)

Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Tuberculosis Incidence Rate per 100,000[44] (CDPH)	5.2 (2018-2020)	5.0	2.2 (2020)	1.4	N/A



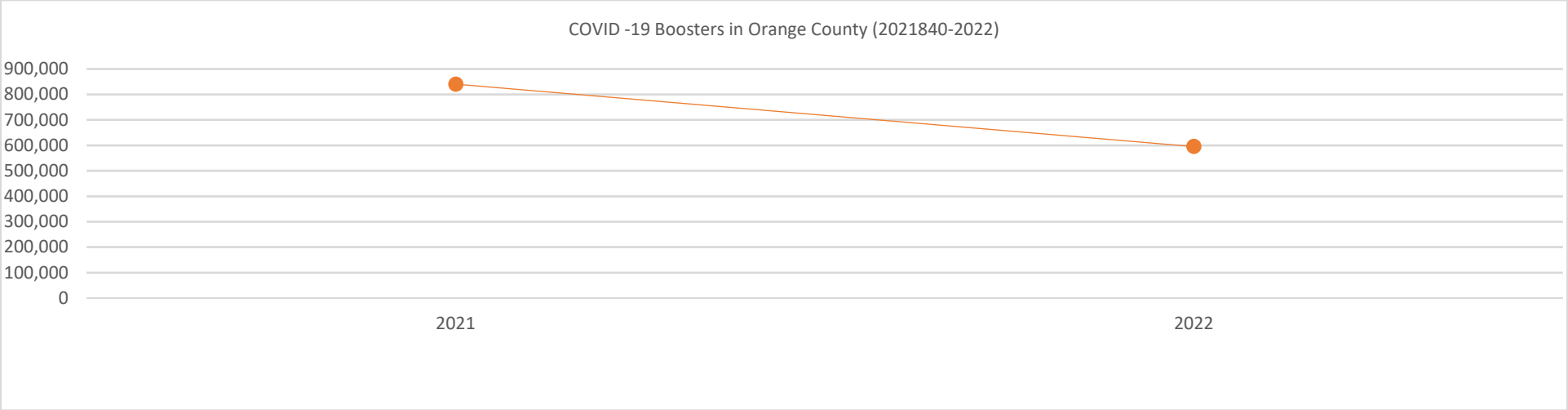
[44] **Definition:** Three-year averages of Tuberculosis rates per 100,000 population. **Source:** California Department of Public Health (n.d). *Sexually Transmitted Infection Data.* Retrieved from: Sexually Transmitted Diseases Data (ca.gov)

Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
COVID-19 Deaths in Orange County[45] (OCHCA)	1,759 (2022)		xx	N/A	N/A



[45] **Definition:** Number of deaths due to COVID-19 in Orange County. **Source:** Orange County Health Care Agency (n.d.). *Orange County COVID-19 Dashboard.* Retrieved from: http://data-ocpw.opendata.arcgis.com/

Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
COVID-19 Boosters in Orange County[46] (OCHCA)	595,090 (2022)	**N/A**	N/A	N/A	N/A



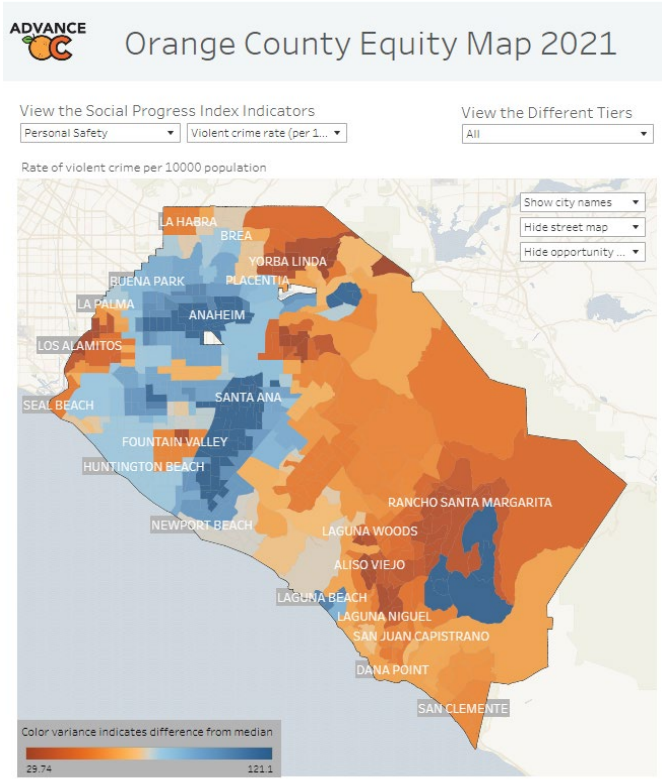
[46] **Definition:** Number of COVID-19 boosters administered in Orange County. **Source:** Orange County Health Care Agency (n.d.). *Orange County COVID-19 Dashboard.* Retrieved from: http://data-ocpw.opendata.arcgis.com/

Topic	INJURIES AND ACCIDENTS				
Data	Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal
	Substantiated Child Abuse Rate per 1,000 (CA Department of Finance; Orange County Social Services Agency)	6.5 (2021)	6.3	8.1	8.7
	Age-Adjusted Death Rate Due to Unintentional Motor Vehicle Crashes per 100,000 (CDPH)	6.5 (2018-2020)	10.0	13.3 (2021)	10.1
	Age-Adjusted Unintentional Firearm Death Rates per 100,000 (CDPH)	4.7 (2018-2020)	10.0	13.3 (2021)	10.1
	Age-Adjusted Unintentional Injury Death Rates per 100,000 (CDPH)	29.8 (2018-2020)	37.9	64.7 (2021)	43.2
	Age-Adjusted Death Rate Due to Homicide per 100,000 (CDPH)	2.1 (2018-2020)	5.2	8.2 (2021)	5.5
	Age-Adjusted Death Rate Due to Falls per 100,000 (CDC Wonder)	5.3 (2020)	6.4 (2020)	N/A	N/A
	Age-Adjusted Death Rate Due to Firearms Among Children per 100,000 (KidsData)	2.3 (2020)	5.6	9.9	N/A
Equity & Disparities	– Age-Adjusted Death Rate Due to Falls per 100,000 was higher for males (6.3) than for females (2.4) – Equity Map: Regions of north and west County have a higher rate of violent crime than in the rest of the County.				
Qualitative Findings					
Current Collaborative Activities	– Orange County Trauma Center Coalition – Orange County Window Falls Coalition				

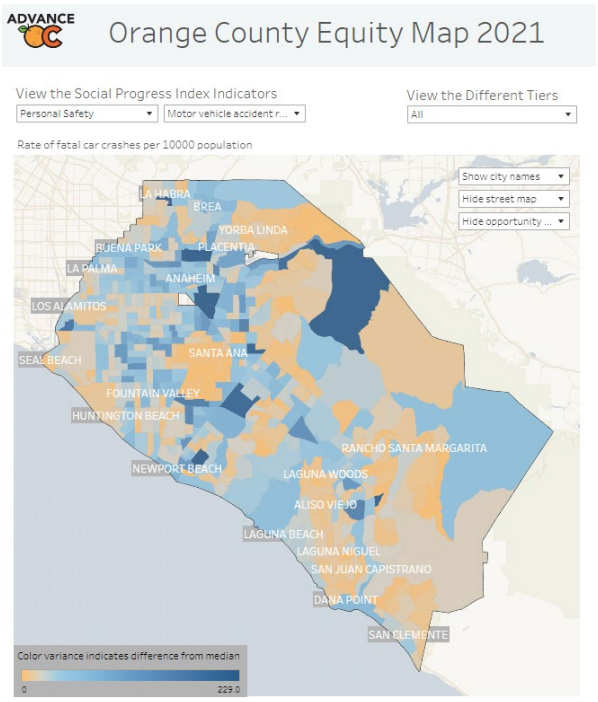
INJURIES AND ACCIDENTS

Violent Crime Rate:

- **Blue census tracts had higher violent crime rates than orange census tracts .**
- **Regions of north and west County have a higher rate of violent crime than in the rest of the County.**



Sources: SPI, CDC PLACES Local Data, American Community Survey, First 5 OC, OC Health Care Agency and CA Opport



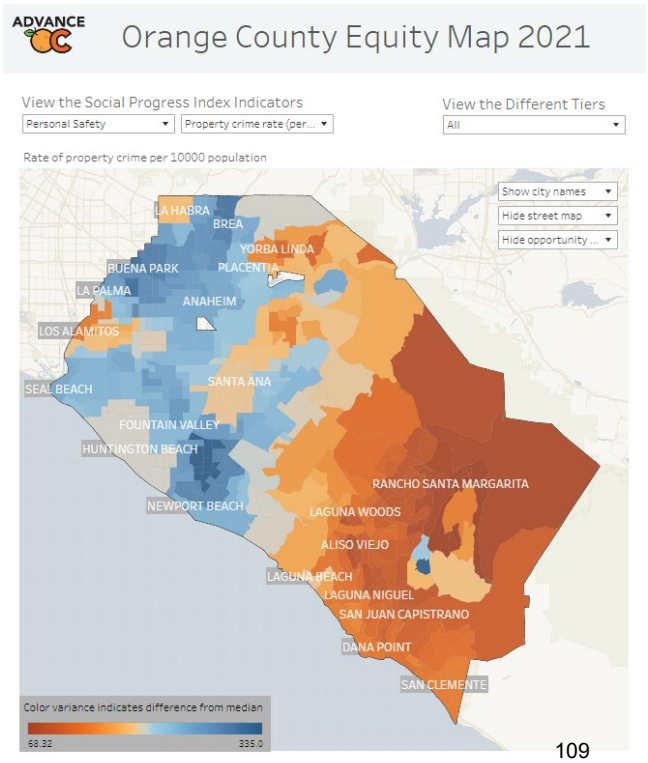
Motor Vehicle Accidents:

- **Blue census tracts had more motor vehicle accidents than orange census tracts.**

Property Crime Rates:

- **South County has a lower rate of property crime compared to the rest of the County.**

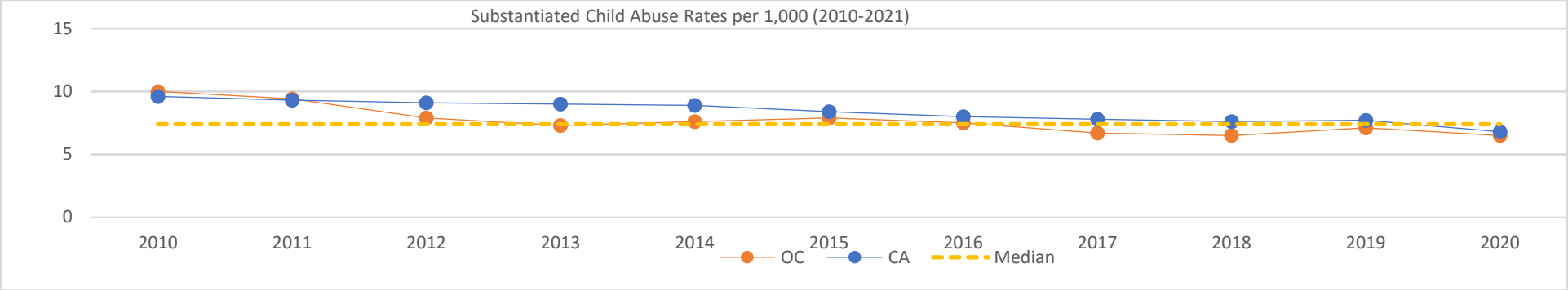
- **Blue census areas had higher property crime rates than red census tracts.**

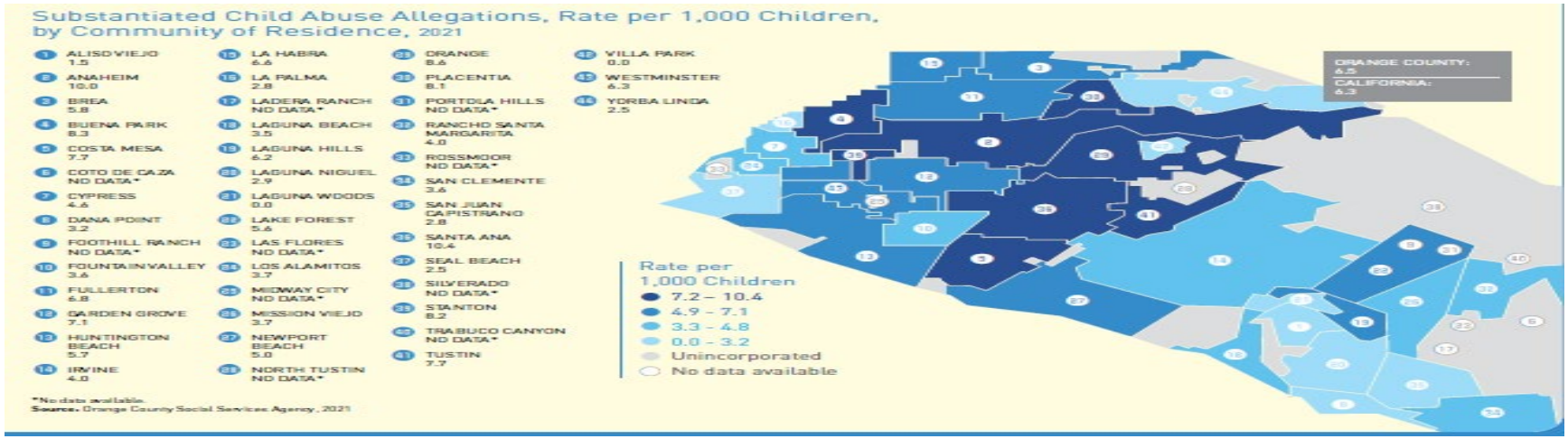


Sources: SPI, CDC PLACES Local Data, American Community Survey, First 5 OC, OC Health Care Agency and CA Opportur

Injuries and Accidents

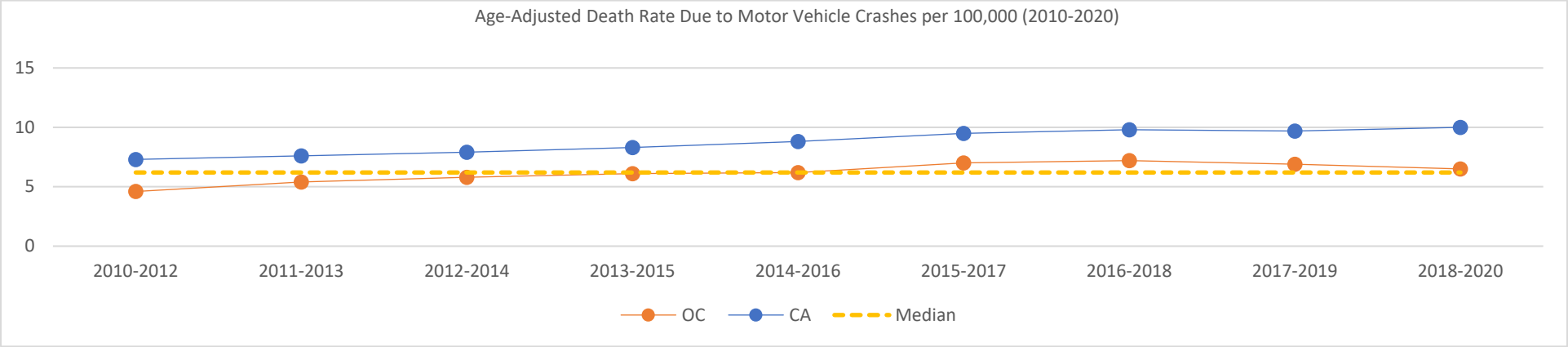
Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Substantiated Child Abuse Rated per 1,000[47] (CA Department of Finance; Orange County Social Services Agency)	6.5 (2021)	6.3	8.1	8.7	Geographic





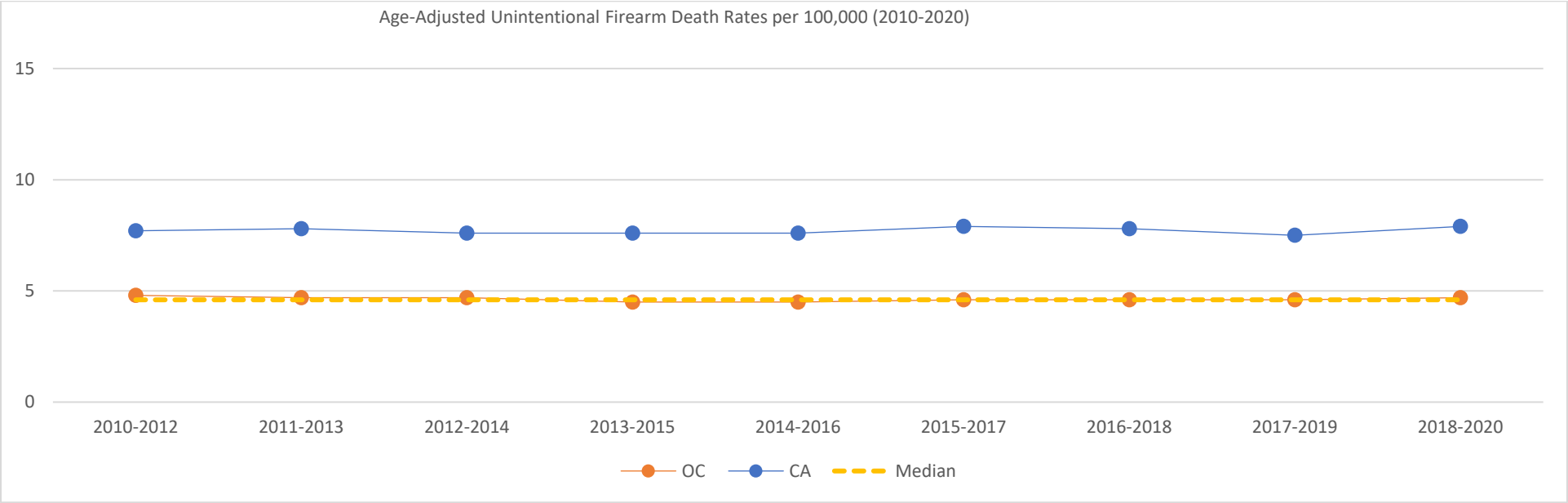
[47] **Definition:** Unduplicated count of child abuse allegations that are determined to have occurred per 1,000 children under the age of 18. **Source:** California Department of Finance; CWS/CMS 2021 Quarter 4 Extract, Orange County Social Services Agency.

Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Age-Adjusted Death Rate Due to Unintentional Motor Vehicle Crashes per 100,000[48] (CDPH)	6.5 (2018-2020)	10.0	13.3 (2021)	10.1	N/A



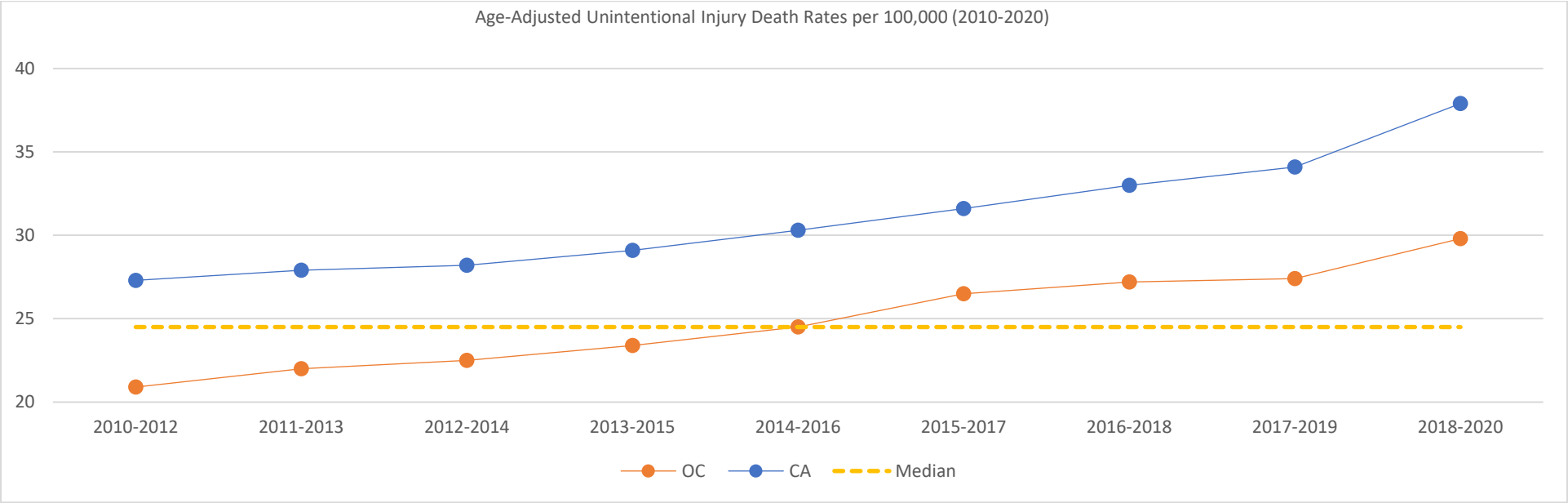
[48] **Definition:** Three-year averages of deaths from car crashes or accidents divided by the total population and then multiplying by 100,000. **Source:** California Department of Public Health, Center for Health Statistics and Informatics (n.d.). *County Health Status Profiles 2010-2021.* Retrieved from: VSB County Health Status Profiles (ca.gov)

Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Age-Adjusted Unintentional Firearm Death Rates per 100,000[49] (CDPH)	4.7 (2018-2020)	10.0	13.3 (2021)	10.1	N/A



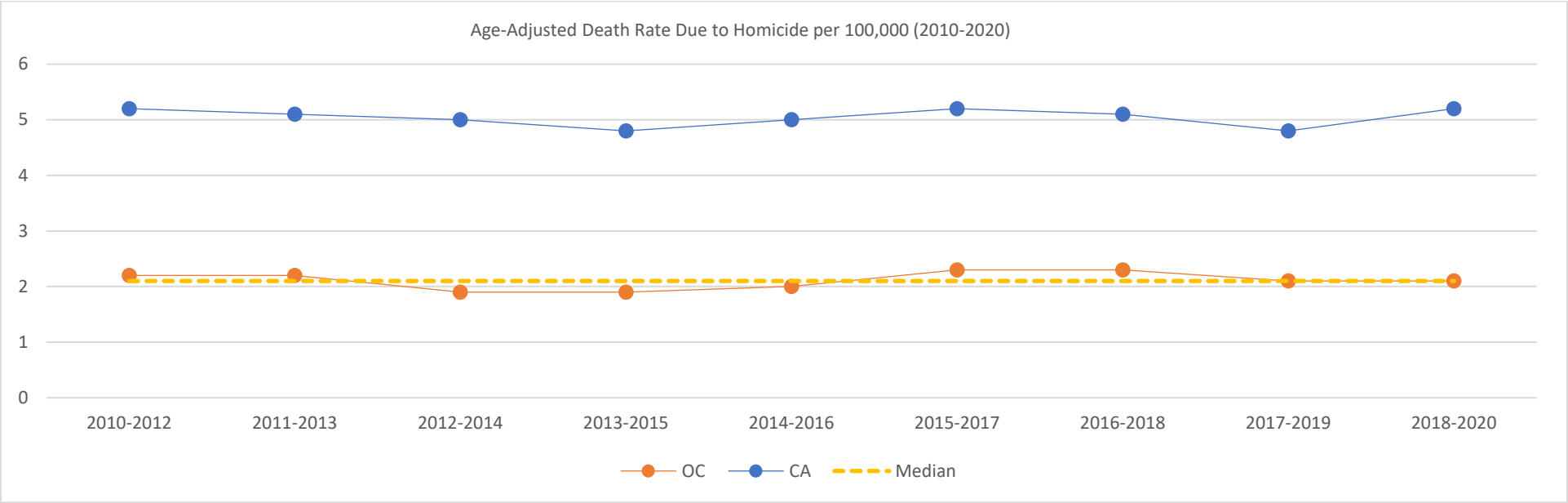
[49] **Definition:** Three-year averages of deaths from guns/firearms divided by the total population and then multiplying by 100,000. **Source:** California Department of Public Health, Center for Health Statistics and Informatics (n.d.). *County Health Status Profiles 2010-2021.* Retrieved from: VSB County Health Status Profiles (ca.gov)

Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Age-Adjusted Unintentional Injury Death Rates per 100,000[50] (CDPH)	29.8 (2018-2020)	37.9	64.7 (2021)	43.2	N/A



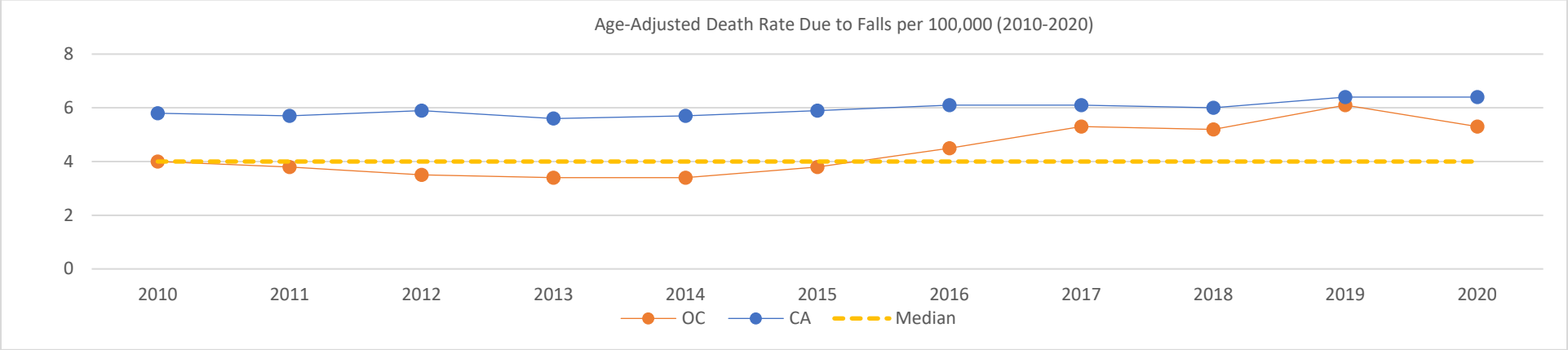
[50] **Definition**: Three-year averages of deaths from accidents divided by the total population and then multiplying by 100,000. **Source:** California Department of Public Health, Center for Health Statistics and Informatics (n.d.). *County Health Status Profiles 2010-2021.* Retrieved from: VSB County Health Status Profiles (ca.gov)

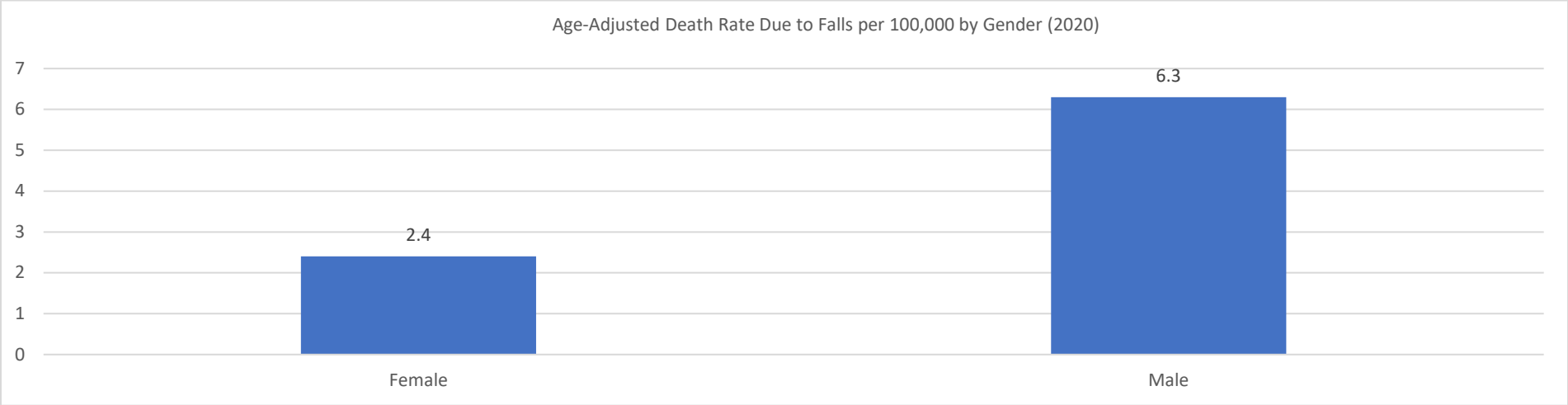
Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Age-Adjusted Death Rate Due to Homicide per 100,000[51] (CDPH)	2.1 (2018-2020)	5.2	8.2 (2021)	5.5	N/A



[51] **Definition:** Three-year averages of deaths from homicide/murder divided by the total population and then multiplying by 100,000. **Source:** California Department of Public Health, Center for Health Statistics and Informatics (n.d.). *County Health Status Profiles 2010-2021.* Retrieved from: VSB County Health Status Profiles (ca.gov)

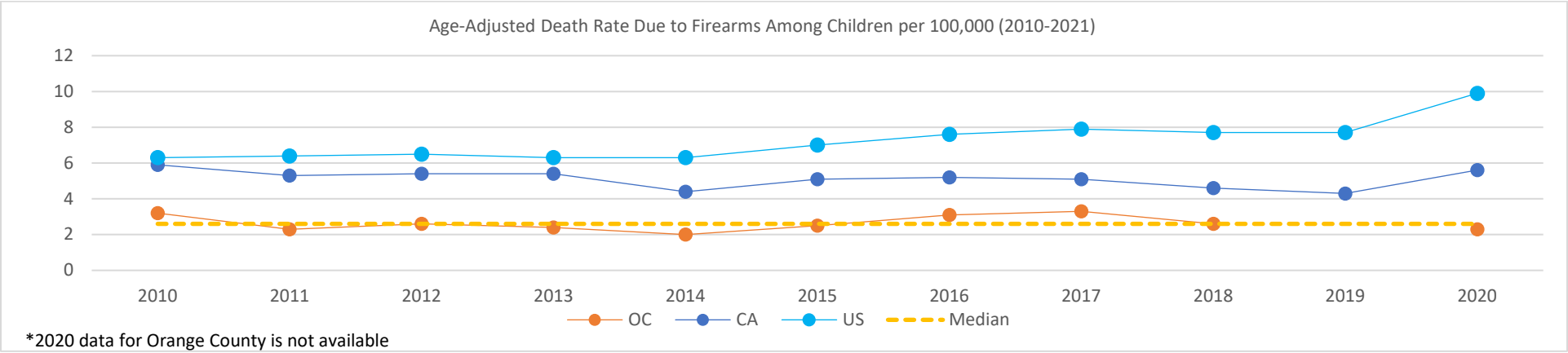
Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Age-Adjusted Death Rate Due to Falls per 100,000[52] (CDC Wonder)	5.3 (2020)	6.4 (2020)	N/A	N/A	Gender





[52] **Definition:** Three-year averages of deaths from falls divided by the total population and then multiplying by 100,000. **Source:** California Department of Public Health, Center for Health Statistics and Informatics (n.d.). *County Health Status Profiles 2010-2021.* Retrieved from: VSB County Health Status Profiles (ca.gov)

Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Age-Adjusted Death Rate Due to Firearms Among Children per 100,000[53] (KidsData)	2.3 (2020)	5.6	9.9	N/A	N/A

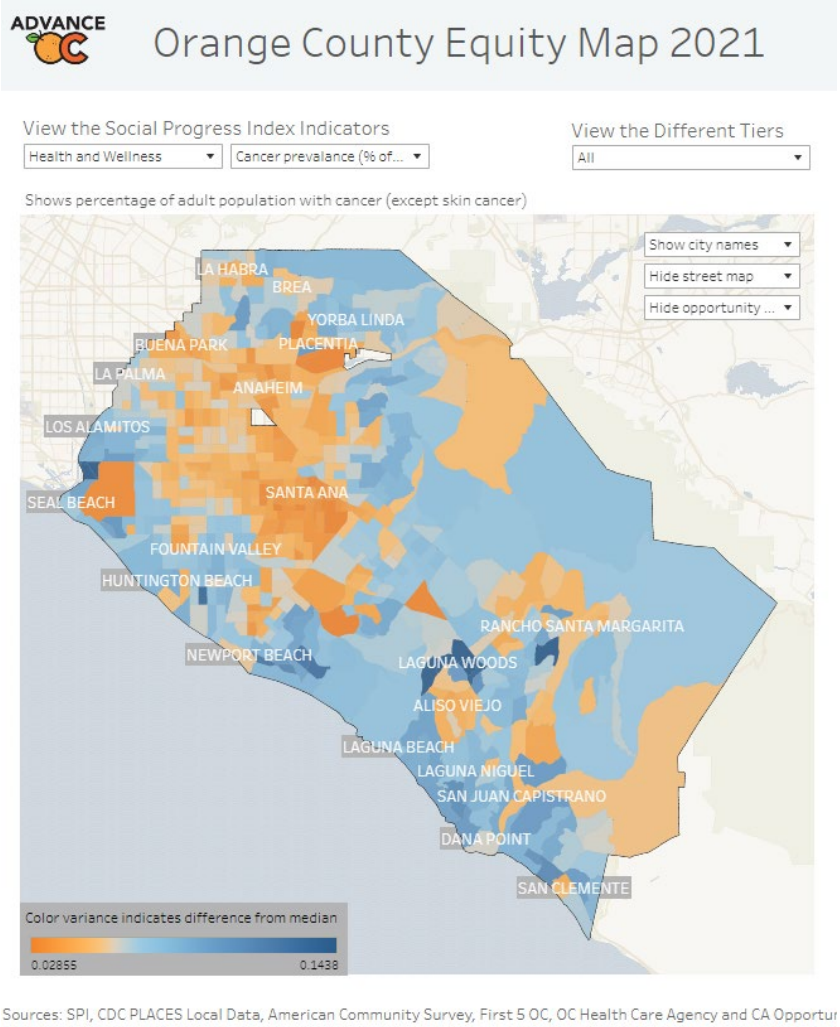


*2020 data for Orange County is not available

[53] **Definition:** Number of firearm-related deaths per 100,000 children and young adults ages 0-24. **Source:** California Department of Public Health, California Department of Finance, Death Statistical Files. *Population Estimates and Projections*. Retrieved from: Firearm Deaths - Kidsdata.org

Topic	CANCER				
Data	Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal
	Age-Adjusted Death Rate Due to All Cancers per 100,000 (CDPH)	122.4 (2018-2020)	128.3	146.6 (2021)	122.7
	Age-Adjusted Death Rate Due to Breast Cancer per 100,000 (CDPH)	18.5 (2018-2020)	18.2	19.4 (2021)	15.3
	Age-Adjusted Death Rate Due to Colorectal Cancer per 100,000 (CDPH)	10.5 (2018-2020)	11.9	13.4 (2021)	8.9
	Age-Adjusted Death Rate Due to Lung Cancer per 100,000 (CDPH)	21.5 (2018-2020)	22.9	31.7 (2021)	25.1
	Age-Adjusted Death Rate Due to Prostate Cancer per 100,000 (CDPH)	17.6 (2018-2020)	19.1	19.0 (2021)	16.9
	Age-Adjusted Death Rate Due to Cervical Cancer per 100,000 (CDPH)	0.9 (2018-2020)	1.1	1.2 (2021)	N/A
Equity & Disparities	– Data do not point to clear disparities – Parts of the north County and pockets of south County have a lower percentage of adult population with cancer compared to the rest of the county. – Parts of the north County and pockets of south County have a lower percentage of adult population with cancer compared to the rest of the county.				
Qualitative Findings	– Hispanic and Latino Individuals are getting more involved in programs to improve health outcomes; with cancer survivorship increasing – Culturally sensitive mental health support for Hispanic/Latino cancer warriors is needed – Asian/Pacific Islanders, on the other hand, need access to early screening for breast and colon cancer screenings.				
Current Collaborative Activities	– UCI Orange County Cancer Coalition: The Mission is to facilitate collaboration of Orange County community resources for comprehensive cancer prevention and patient care.				

CANCER



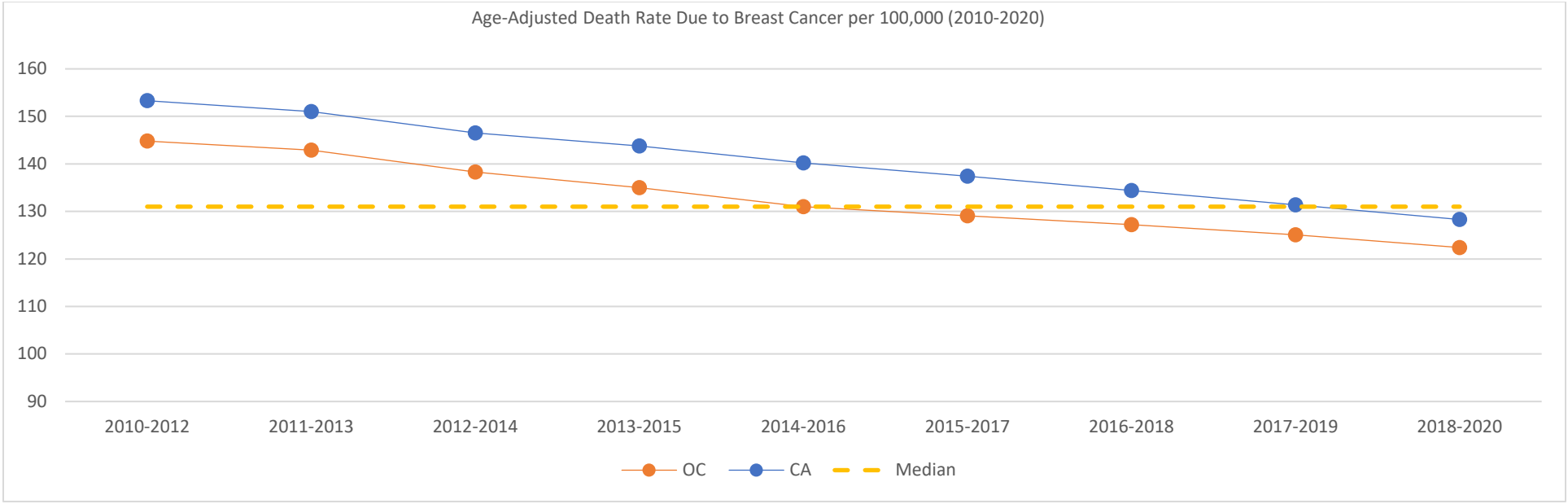
Sources: SPI, CDC PLACES Local Data, American Community Survey, First 5 OC, OC Health Care Agency and CA Opportur

Cancer Prevalence:

- **Blue census tracts had higher cancer prevalence than the orange census tracts.**
- **Parts of the north County and pockets of south County have a lower percentage of adult population with cancer compared to the rest of the county.**

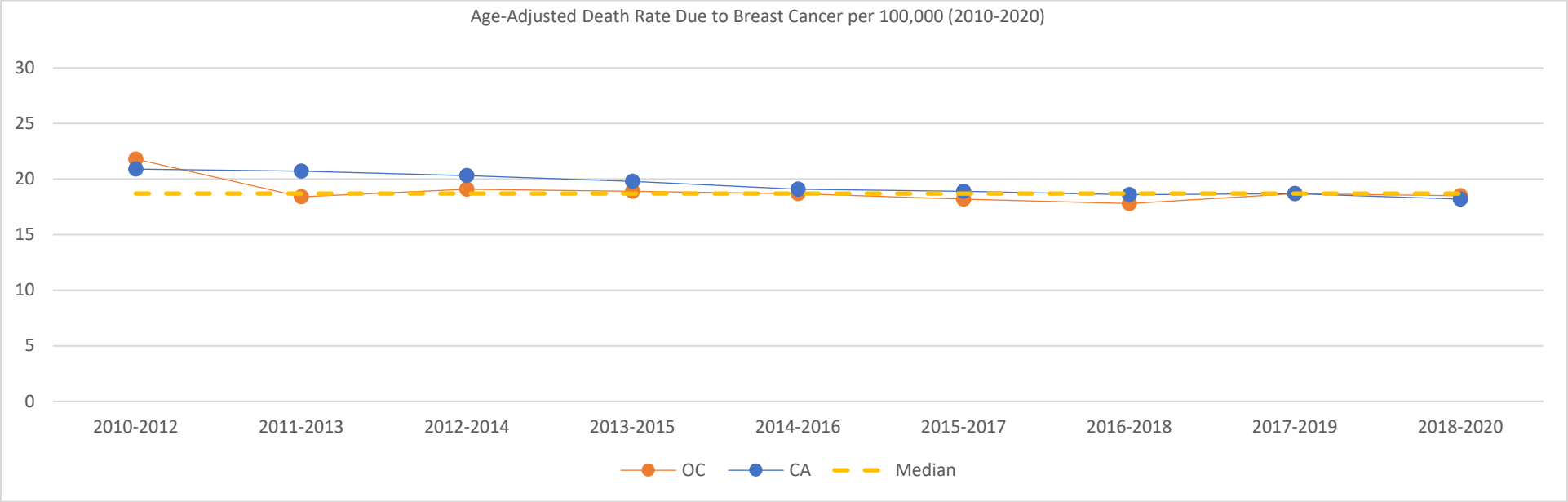
Cancer

Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Age-Adjusted Death Rate Due to All Cancers per 100,000[54] (CDPH)	122.4 (2018-2020)	128.3	146.6 (2021)	122.7	N/A



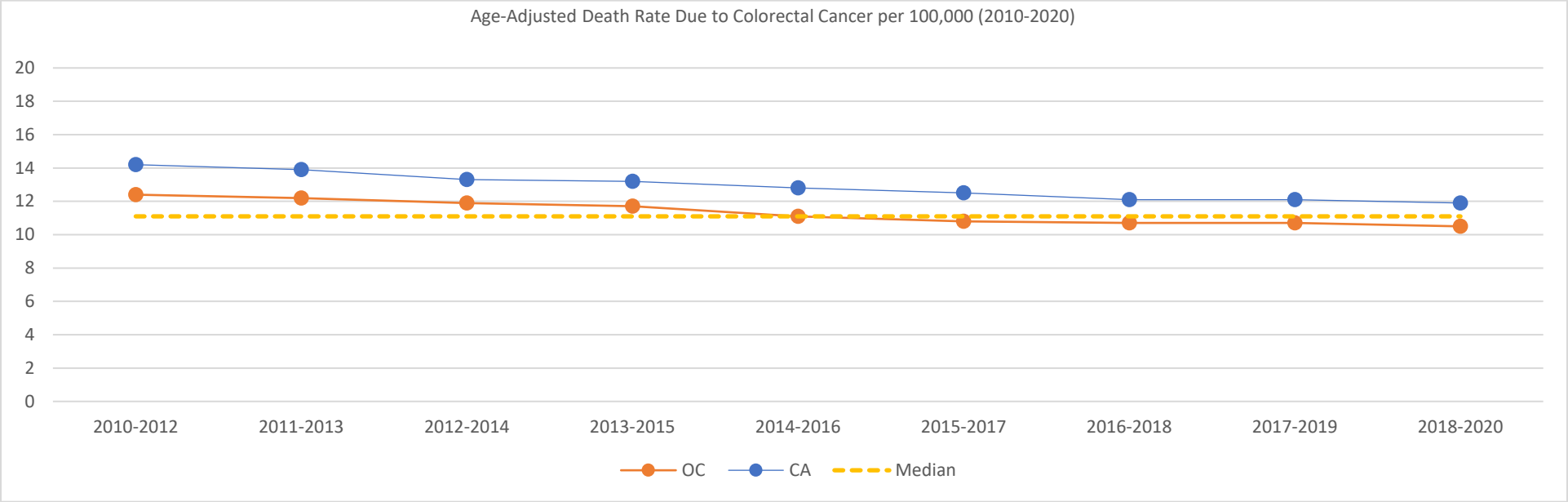
[54] **Definition:** Three-year averages number of deaths from all cancers divided by the total population and then multiplying by 100,000. **Source:** California Department of Public Health, Center for Health Statistics and Informatics (n.d.). *County Health Status Profiles 2010-2021.* Retrieved from: VSB County Health Status Profiles (ca.gov)

Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Age-Adjusted Death Rate Due to Breast Cancer per 100,000[55] (CDPH)	18.5 (2018-2020)	18.2	19.4 (2021)	15.3	N/A



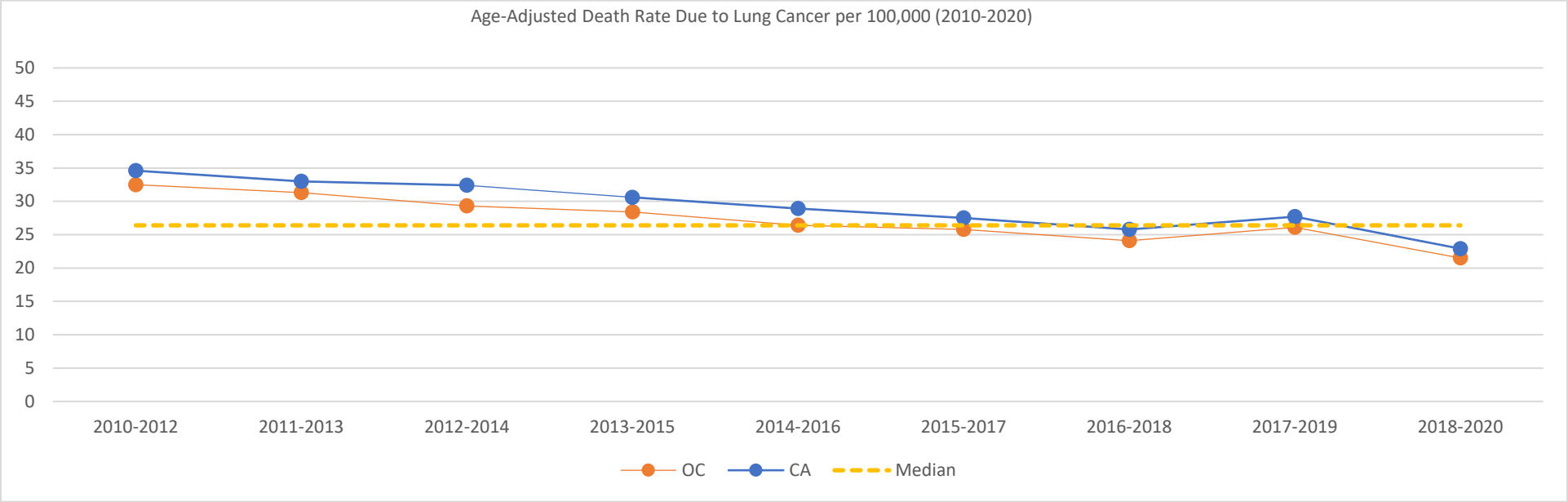
[55] **Definition:** Three-year averages number of deaths from breast cancer divided by the total population and then multiplying by 100,000. **Source:** California Department of Public Health, Center for Health Statistics and Informatics (n.d.). *County Health Status Profiles 2010-2021.* Retrieved from: VSB County Health Status Profiles (ca.gov)

Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Age-Adjusted Death Rate Due to Colorectal Cancer per 100,000[56] (CDPH)	10.5 (2018-2020)	11.9	13.4 (2021)	8.9	N/A



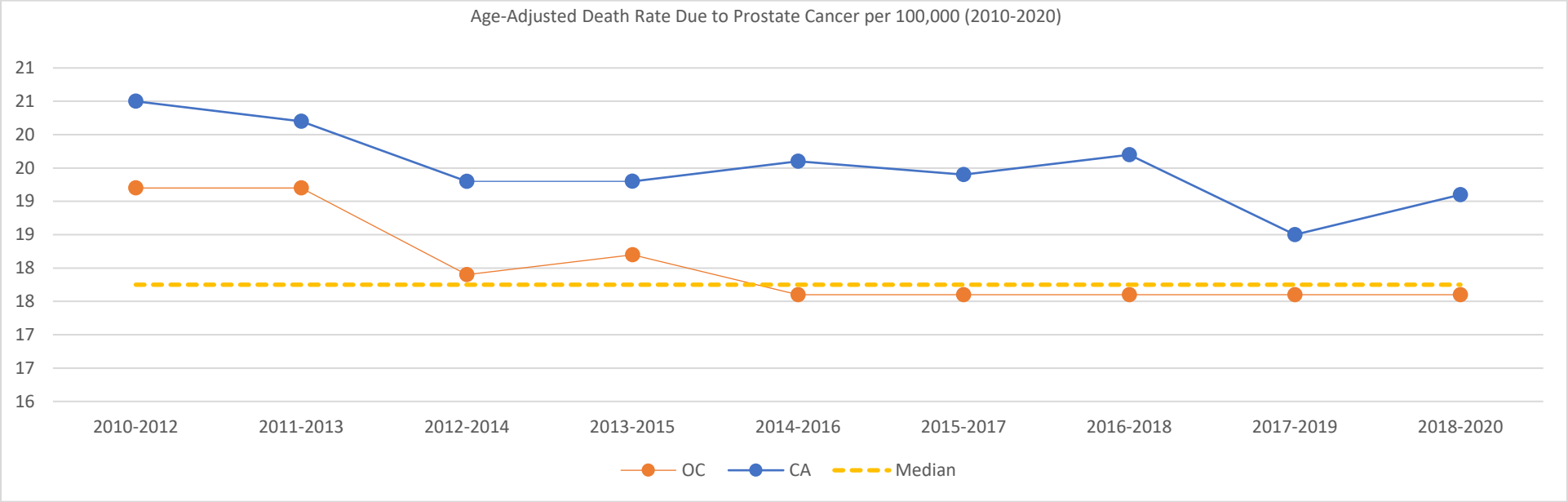
[56] **Definition:** Three-year averages number of deaths from colorectal cancer divided by the total population and then multiplying by 100,000. **Source:** California Department of Public Health, Center for Health Statistics and Informatics (n.d.). *County Health Status Profiles 2010-2021.* Retrieved from: VSB County Health Status Profiles (ca.gov)

Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Age-Adjusted Death Rate Due to Lung Cancer per 100,000[57] (CDPH)	21.5 (2018-2020)	22.9	31.7 (2021)	25.1	N/A



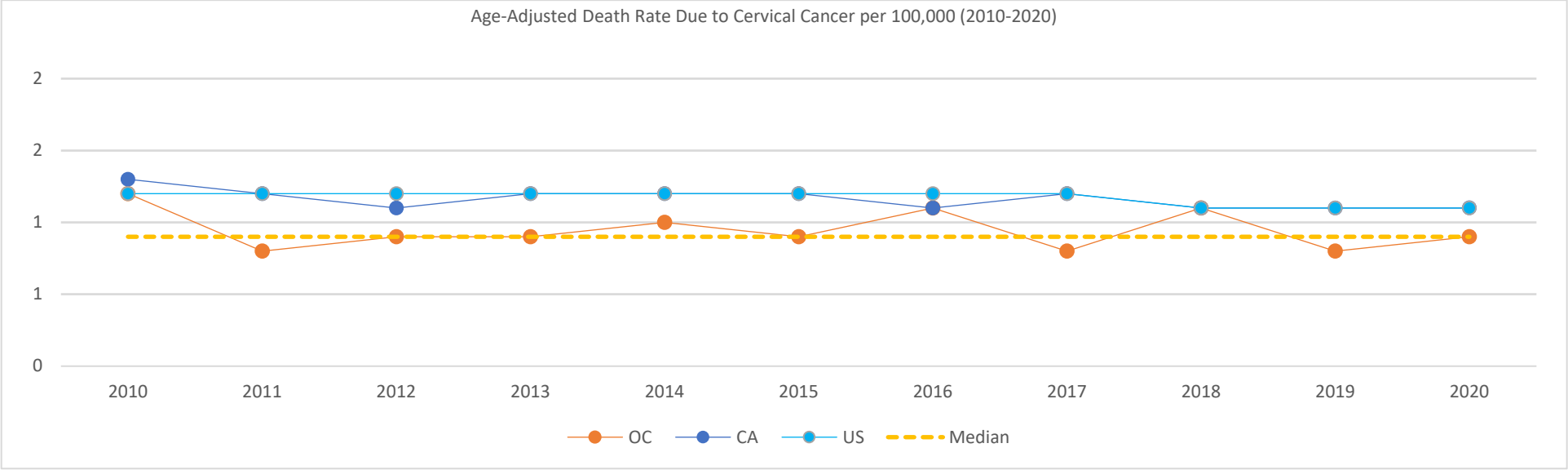
[57] **Definition:** Three-year averages number of deaths from lung cancer divided by the total population and then multiplying by 100,000. **Source:** California Department of Public Health, Center for Health Statistics and Informatics (n.d.). *County Health Status Profiles 2010-2021.* Retrieved from: VSB County Health Status Profiles (ca.gov)

Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Age-Adjusted Death Rate Due to Prostate Cancer per 100,000[58] (CDPH)	17.6 (2018-2020)	19.1	19.0	16.9	N/A



[58] **Definition:** Three-year averages number of deaths from prostate cancer divided by the total population and then multiplying by 100,000. **Source:** California Department of Public Health, Center for Health Statistics and Informatics (n.d.). *County Health Status Profiles 2010-2021.* Retrieved from: VSB County Health Status Profiles (ca.gov)

Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Age-Adjusted Death Rate Due to Cervical Cancer per 100,000[59] (CDC)	0.9 (2020)	1.1	1.2	N/A	N/A



[59] **Definition:** Three-year averages number of deaths from cervical cancer divided by the total population and then multiplying by 100,000. **Source:** Centers For Disease Control and Prevention, National Center for Health Statistics, CDC Wonder (n.d.). *Multiple Cause* of Death*, 1999-2020*. Retrieved from: Multiple Cause of Death, 1999-2020 Request (cdc.gov)

Topic	HEART DISEASE / STROKE				
Data	Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal
	Preventable Hospital Stays per 100,000 (UWPHI)	1,722 (2021)	2,256	2,809	N/A
	Age-Adjusted Death Rate Due to Coronary Heart Disease per 100,000 (CDPH)	72.6 (2018-2020)	80.7	92.8	71.1
	Percent of Adults Who Experienced Coronary Heart Disease (CHIS)	6.7% (2021)	7.1%	N/A	N/A
	Age-Adjusted Death Rate Due to Cerebrovascular Disease (Stroke) per 100,000 (CDPH)	36.3 (2018-2020)	37.0	41.1	33..4
	High Blood Pressure Prevalence (CHIS)	22.6% (2021)	26.8%	45.7%	42.6%

Equity & Disparities

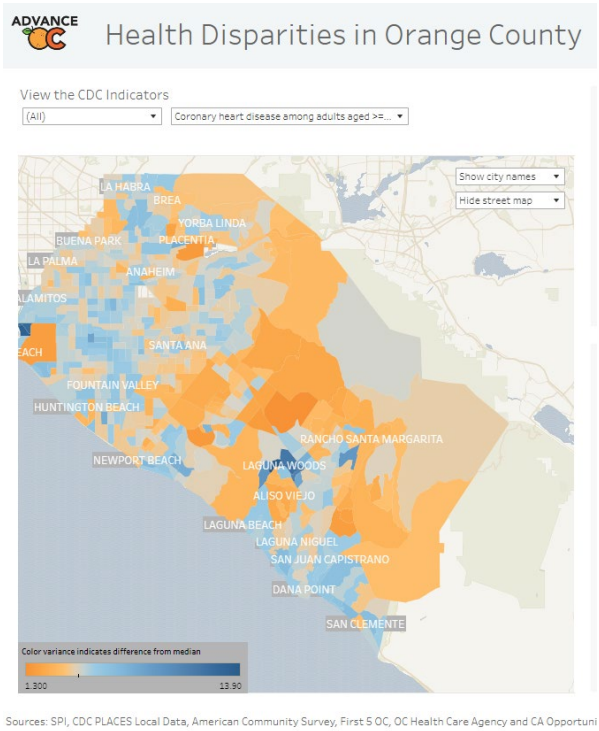
- Preventable Hospital Stays: More American Indian/Alaskan Natives (5,391) had preventable hospital stays than Blacks (3,570), Hispanics (2,395), Asians (1,572) and Whites (1,558)
- High Blood Pressure Prevalence: More Whites (28.1) suffer from high blood pressure than Asians (18.6%) and Hispanics (18.7%)
- Wide areas of North County and parts of South County had a higher coronary heart disease among adults aged >=18 years than rest of the County.
- High cholesterol among adults aged >= 18 years is more prevalent in north and parts of south County than in other regions of the County
- High blood pressure among adults aged >= 18 years was more prevalent in north and parts of south County than in other regions of the County

Qualitative Findings

- Lack of sub-specialists in the county
- Lack of physically accessible health care offices for people on Medicare/Medi-Cal
- Medical care costs wiping out seniors
- Affordability of any insurance
- Lack of preventative care
- Rising need for comprehensive care; aging/dementia; increasing chronic illnesses
- Medi-Cal reimbursement rates are insufficient
- Professionals leaving healthcare
- Create training programs to increase community well-being (i.e., financial literacy, health literacy programs)

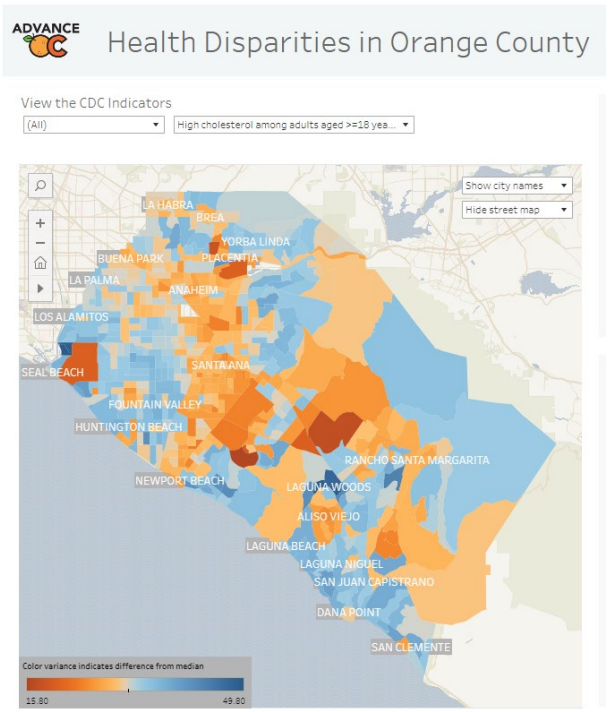
Current Collaborative Activities

HEART DISEASE/STROKE



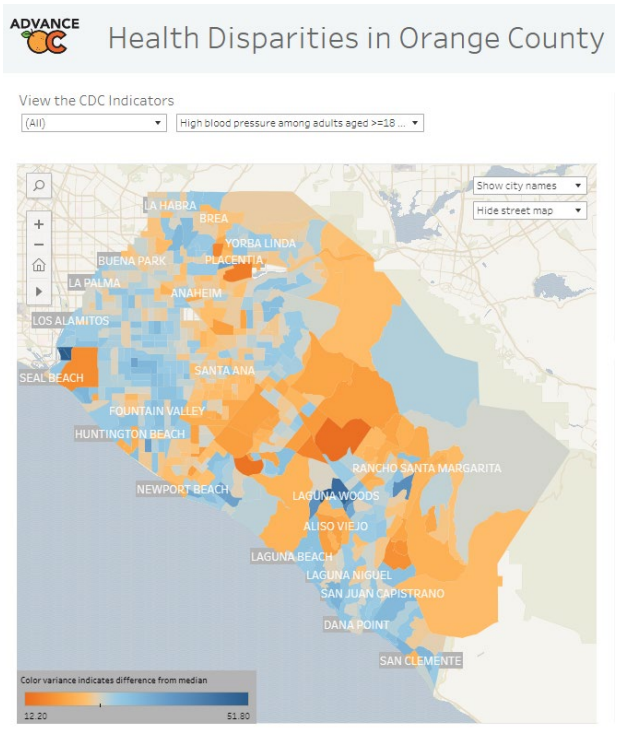
Coronary Heart Disease:

- **Blue census tracts had higher rates of coronary heart disease than orange census tracts.**
- **Wide areas of North County and parts of South County had a higher coronary heart disease among adults aged >=18 years than rest of the County.**



High Cholesterol:

- **Blue census tracts had higher rates of high cholesterol than orange census tracts.**
- **High cholesterol among adults aged >= 18 years is more prevalent in north and parts of south County than in other regions of the County**

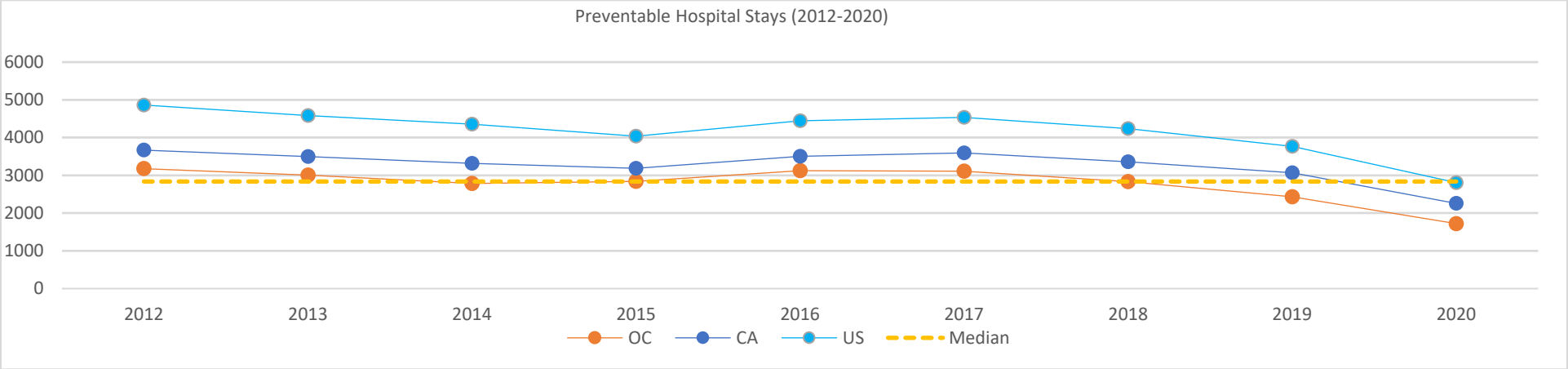


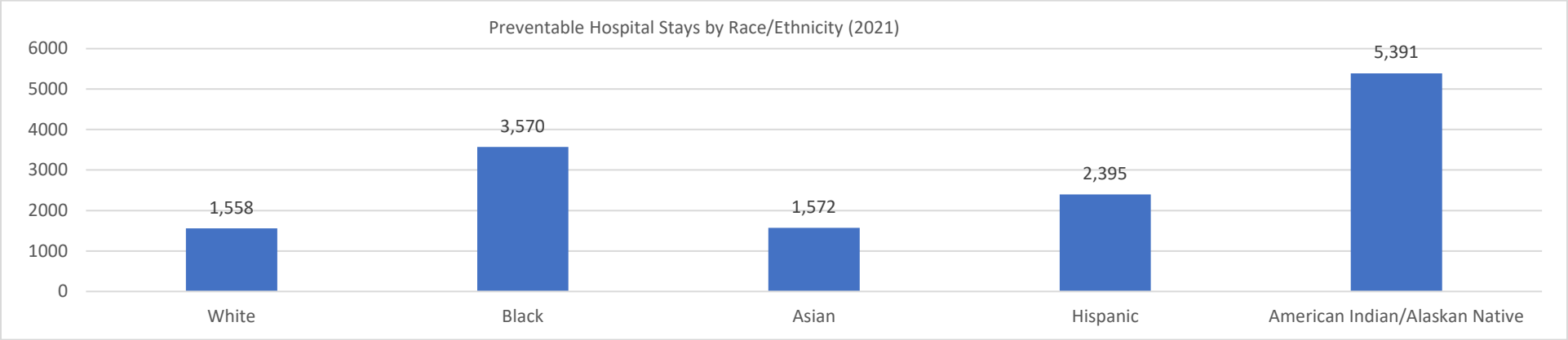
High Blood Pressure:

- **Blue census tracts had higher rates of high blood pressure than orange census tracts .**
- **High blood pressure among adults aged >= 18 years was more prevalent in north and parts of south County than in other regions of the County.**

Heart Disease / Stroke

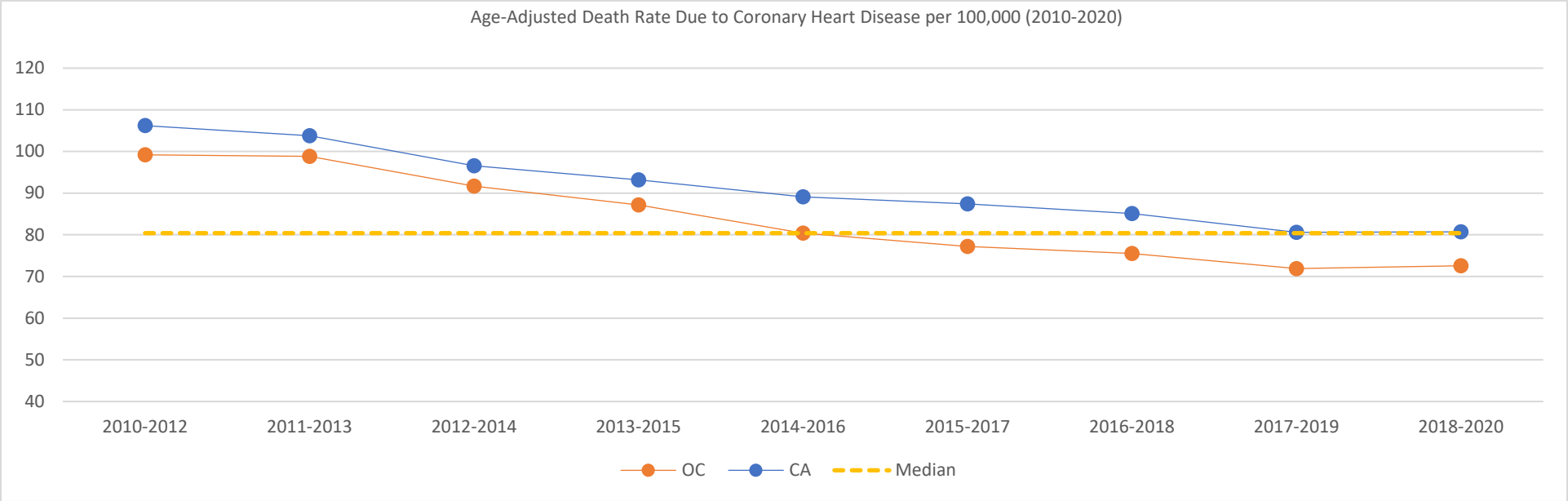
Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Preventable Hospital Stays per 100,000[60] (UWPHI)	1,722 (2021)	2,256	2,809	N/A	N/A





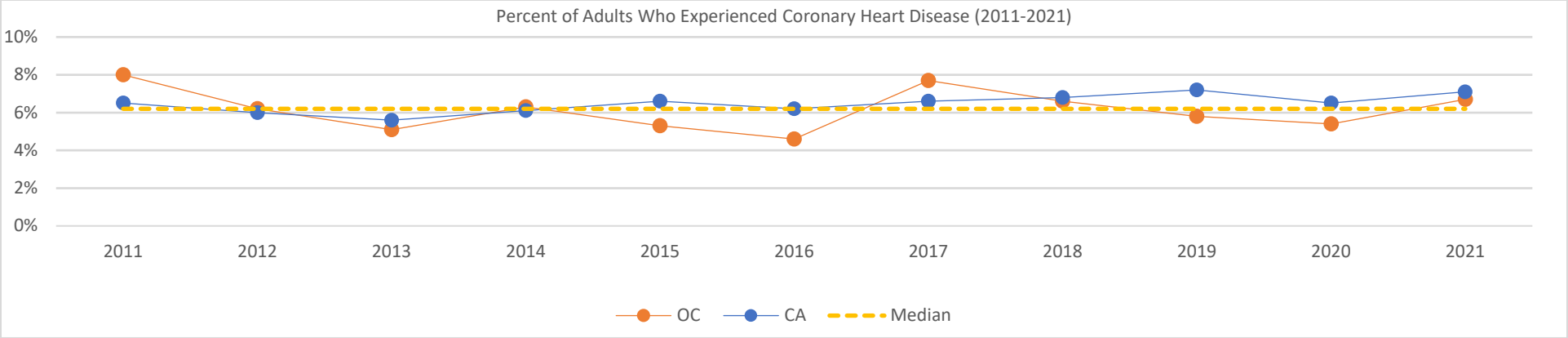
[60] **Definition:** Rate of hospital stays for ambulatory-care sensitive conditions per 100,000 Medicare enrollees. **Source:** University of Wisconsin, Population Health Institute (n.d.). *County Health Rankings and Roadmaps, 2010-2021.* Retrieved from: Rankings data & documentation | County Health Rankings & Roadmaps

Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity	
Age-Adjusted Death Rate Due to Coronary Heart Disease per 100,000[61] (CDPH)	72.6 (2018-2020)	80.7	92.8	71.1	N/A	



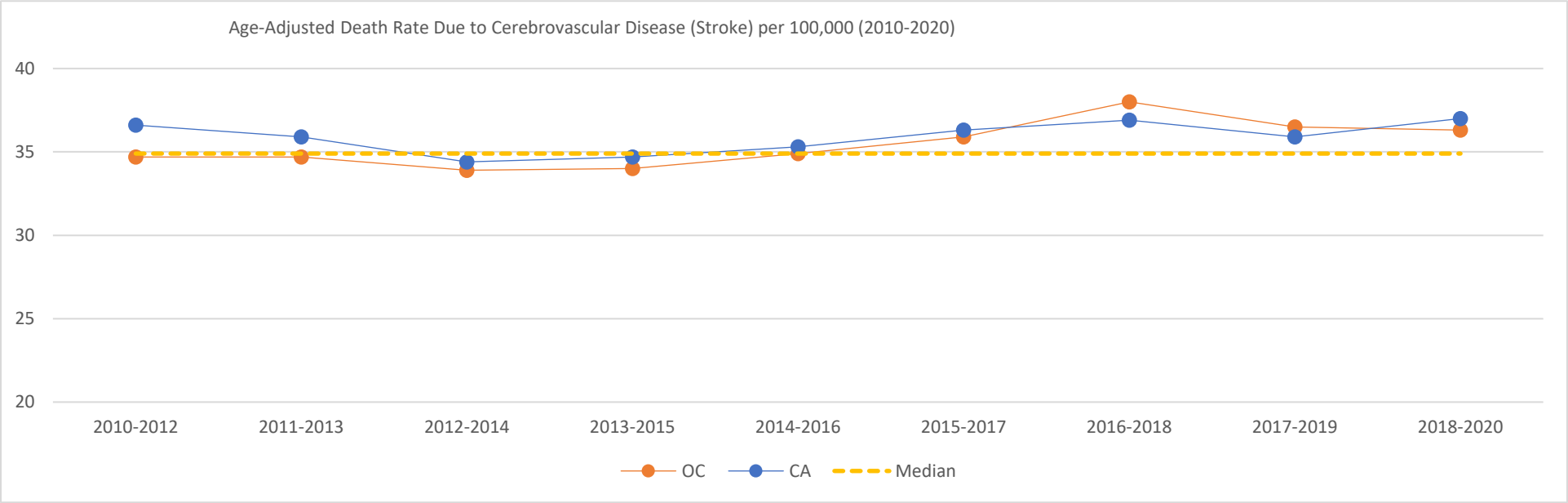
[61] **Definition**: Three-year averages of deaths from coronary heart disease divided by the total population and then multiplying by 100,000. **Source**: California Department of Public Health, Center for Health Statistics and Informatics (n.d.). County Health Status Profiles 2010-2021. Retrieved from: VSB County Health Status Profiles (ca.gov).

Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Percent of Adults Who Experienced Coronary Heart Disease[62] (CHIS)	6.7% (2021)	7.1%	N/A	N/A	N/A



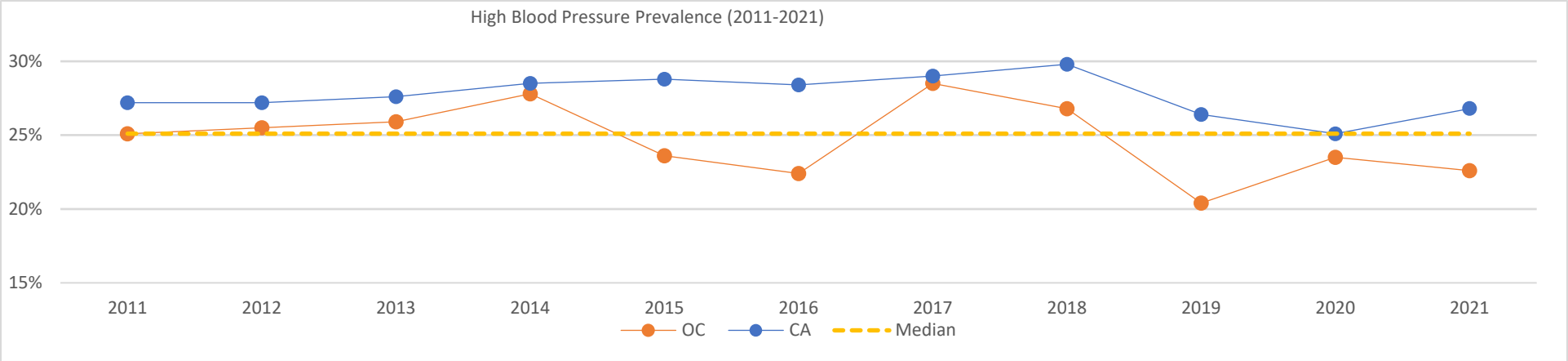
[62] **Definition:** Percent of adults who have been told by a doctor that they had heart disease. **Source:** UCLA Center for Health Policy Research, Los Angeles, CA. AskCHIS 2011-2021. *Ever Diagnosed with Heart Disease* (California, Orange). Retrieved from: http://ask.chis.ucla.edu.

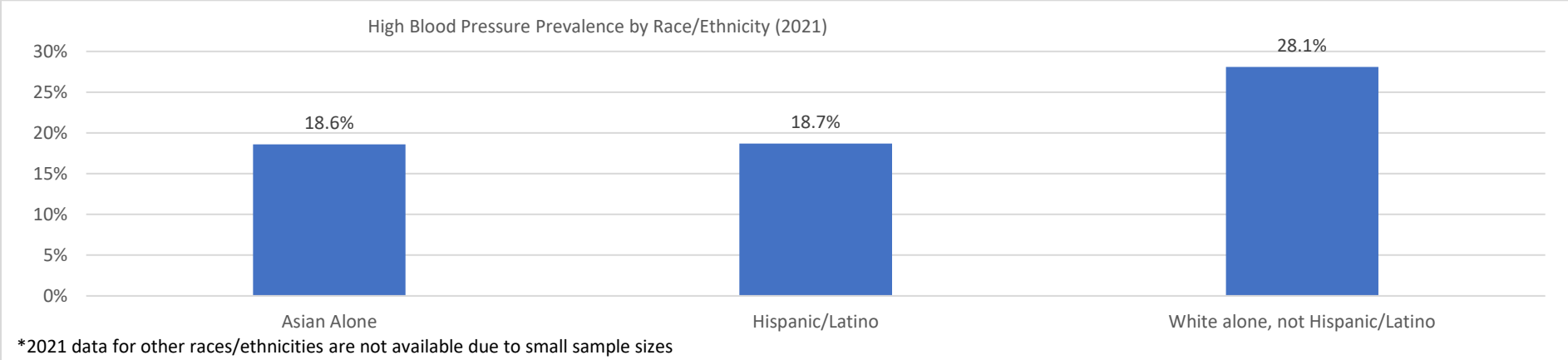
Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Age-Adjusted Death Rate Due to Cerebrovascular Disease (Stroke) per 100,000[63] (CDPH)	36.3 (2018-2020)	37.0	41.1	33..4	N/A



[63] **Definition**: Three-year averages of deaths from strokes divided by the total population and then multiplying by 100,000. **Source**: California Department of Public Health, Center for Health Statistics and Informatics (n.d.). County Health Status Profiles 2010-2021. Retrieved from: VSB County Health Status Profiles (ca.gov).

Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
High Blood Pressure Prevalence[64] (CHIS)	22.6% (2021)	26.8%	45.7%	42.6%	R/E



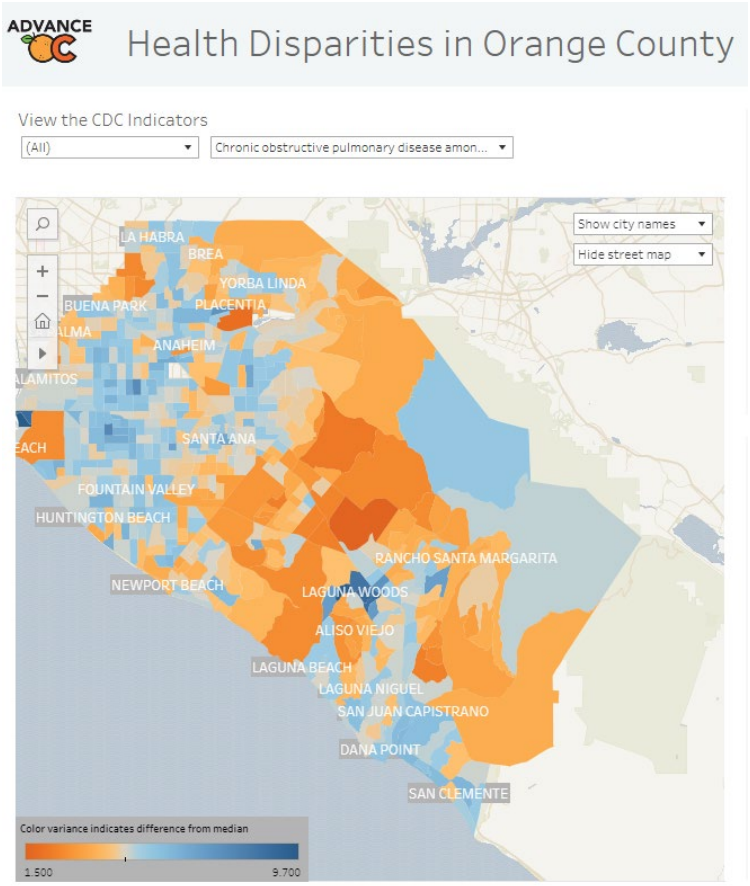


*2021 data for other races/ethnicities are not available due to small sample sizes

[64] **Definition:** Percent of adults told by a doctor that they had high blood pressure. **Source:** UCLA Center for Health Policy Research, Los Angeles, CA. AskCHIS 2011-2021. *Ever Diagnosed with Diabetes* (California, Orange). Retrieved from: http://ask.chis.ucla.edu.

Topic	ASTHMA / CHRONIC OBSTRUCTIVE PULMONARY DISEASE				
Data	Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal
	Percent of Adults Ever Diagnosed with Asthma (CHIS)	11.8% (2021)	16.1%	N/A	N/A
	Age-Adjusted Hospitalization Rate Due to Adult Asthma per 10,000 (CDPH)	2.4 (2019)	3.1 (2019)	N/A	N/A
	Age-Adjusted Emergency Department Visit Rate Due to Adult Asthma per 10,000 (CDPH)	21.2 (2019)	35.4 (2019)	N/A	N/A
	Age-Adjusted Hospitalization Rate Due to Pediatric Asthma per 10,000 (CDPH)	6.4 (2019)	8.3 (2019)	N/A	N/A
	Age-Adjusted Emergency Department Visit Rate Due to Pediatric Asthma per 10,000 (CDPH)	43.4 (2019)	63.4 (2019)	N/A	N/A
	Age-Adjusted Death Rate Due to COPD per 100,000 (CDPH)	18.2 (2022)	22.0 (2022)	95.7 (2021)	107.2
Equity & Disparities	– Percent of Adults Ever Diagnosed with Asthma: White (14.4%) adults are diagnosed at a higher rate than Asian (10.6%) and Hispanic (9.7%) adults – Age-Adjusted Hospitalization Rate Due to Adult Asthma per 10,000: Blacks (9.6) are hospitalized at a higher rate than Asian (2.6), Hispanic (3.2) or White (3.3) – Age-Adjusted Emergency Department Visit Rate Due to Adult Asthma per 10,000: Blacks (104.3) are admitted to the ER at a higher rate than Asian (13.2), Hispanic (29.6), Native Hawaiian/Pacific Islander (76.8) or White (24.9). – Age-Adjusted Death Rate Due to COPD per 100,000: White (23.3) die at a higher rate than Asian (11.1), Hispanic (10.4) or Black (15.6) – Wide areas of north county and parts of south County had a higher coronary heart disease among adults aged >=18 years than rest of the County.				
Qualitative Findings					
Current Collaborative Activities					

ASTHMA/CHRONIC OBSTRUCTIVE PULMONARY DISEASE

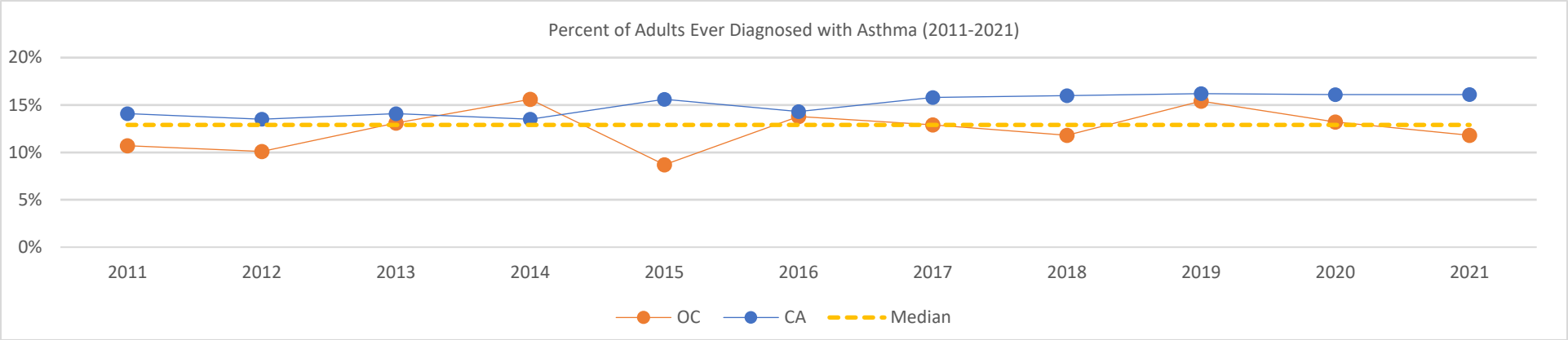


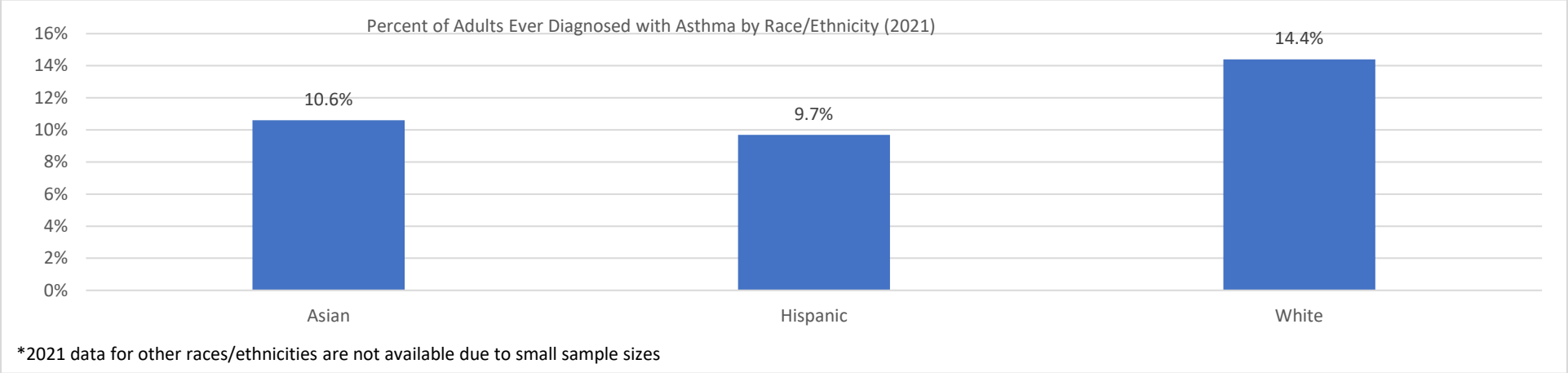
Chronic Obstructive Pulmonary Disease:

- **Blue census tracts had higher rates of COPD than orange census tracts.**
- **Wide areas of north county and parts of south County had a higher coronary heart disease among adults aged >=18 years than rest of the County.**

Asthma / Chronic Obstructive Pulmonary Disease

Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Percent of Adults Ever Diagnosed with Asthma[65] (CHIS)	11.8% (2021)	16.1%	N/A	N/A	R/E

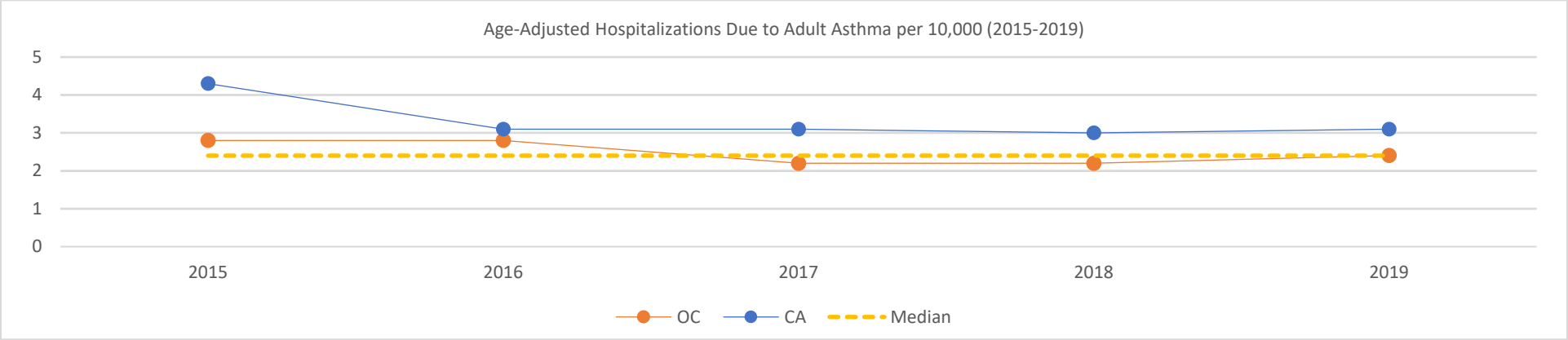


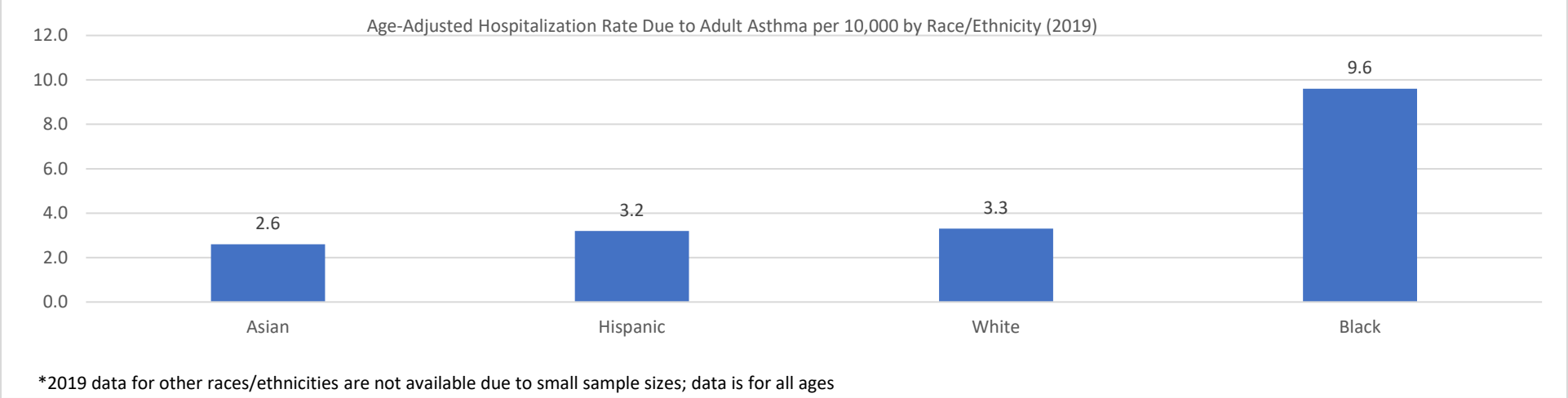


*2021 data for other races/ethnicities are not available due to small sample sizes

[65] **Definition:** Told by doctor that have asthma. **Source:** UCLA Center for Health Policy Research, Los Angeles, CA. AskCHIS 2011-2021. *Ever Diagnosed with Asthma* (California, Orange). Retrieved from: http://ask.chis.ucla.edu.

Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Age-Adjusted Hospitalization Rate Due to Adult Asthma per 10,000[66] (CDPH)	2.4 (2019)	3.1 (2019)	N/A	N/A	R/E

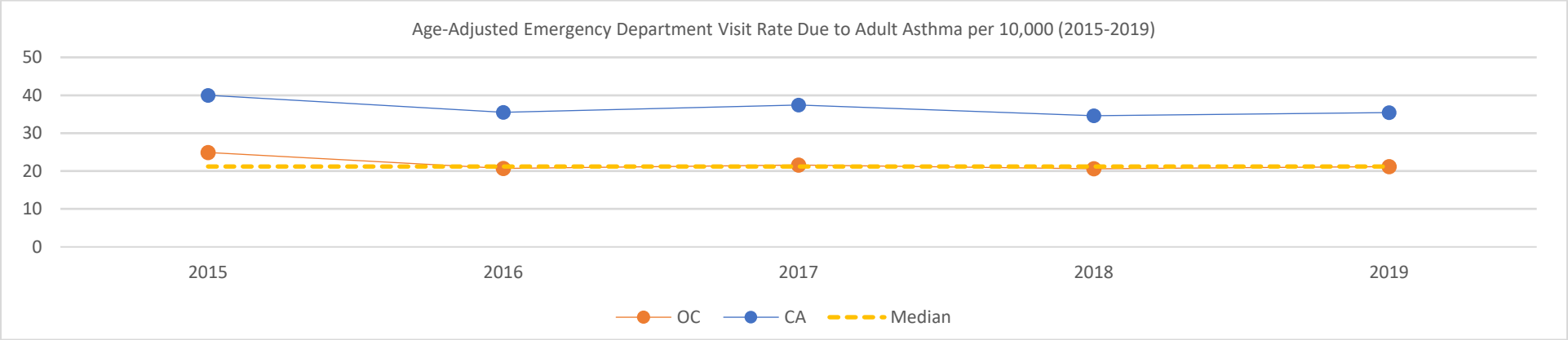


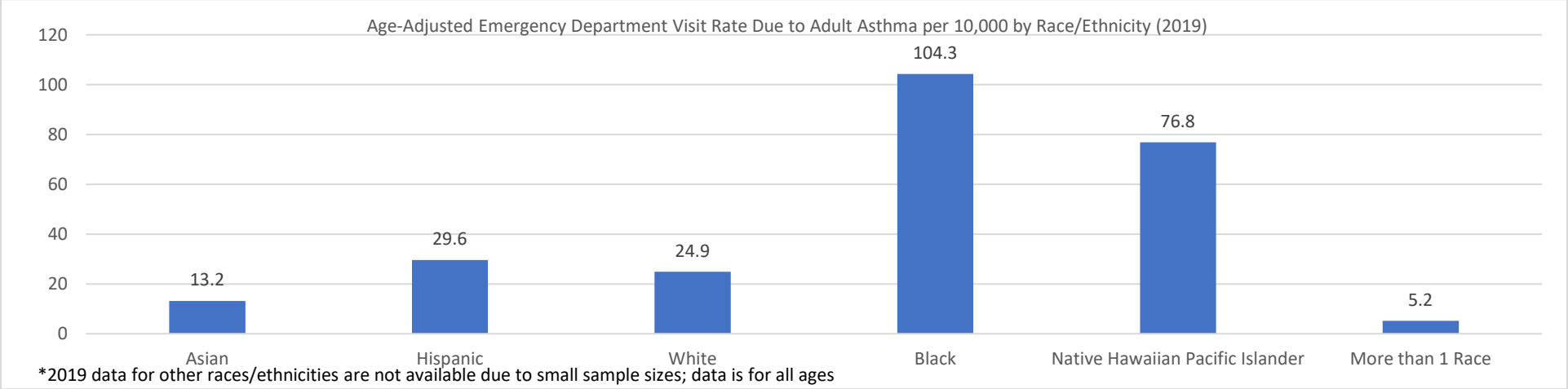


*2019 data for other races/ethnicities are not available due to small sample sizes; data is for all ages

[66] **Definition:** Number of asthma hospitalizations by the estimated population in that county and age group, age-adjusting to the 2000 U.S. Census, and multiplying by 10,000. **Source**: California Department of Public Health. (n.d). Asthma Hospitalization Rates by County. Retrieved from: Asthma Hospitalization Rates by County - Datasets - California Health and Human Services Open Data Portal

Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Age-Adjusted Emergency Department Visit Rate Due to Adult Asthma per 10,000[67] (CDPH)	21.2 (2019)	35.4 (2019)	N/A	N/A	R/E

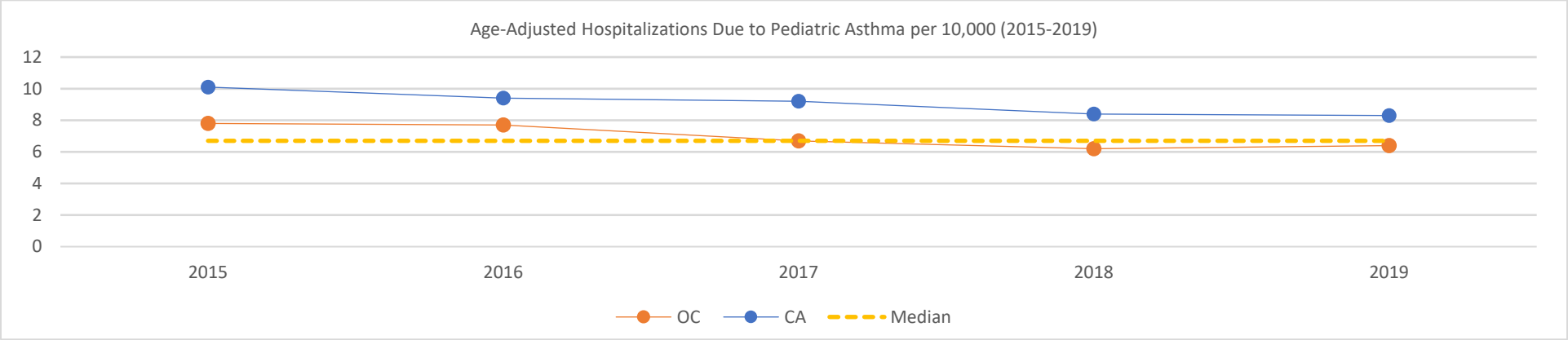




*2019 data for other races/ethnicities are not available due to small sample sizes; data is for all ages

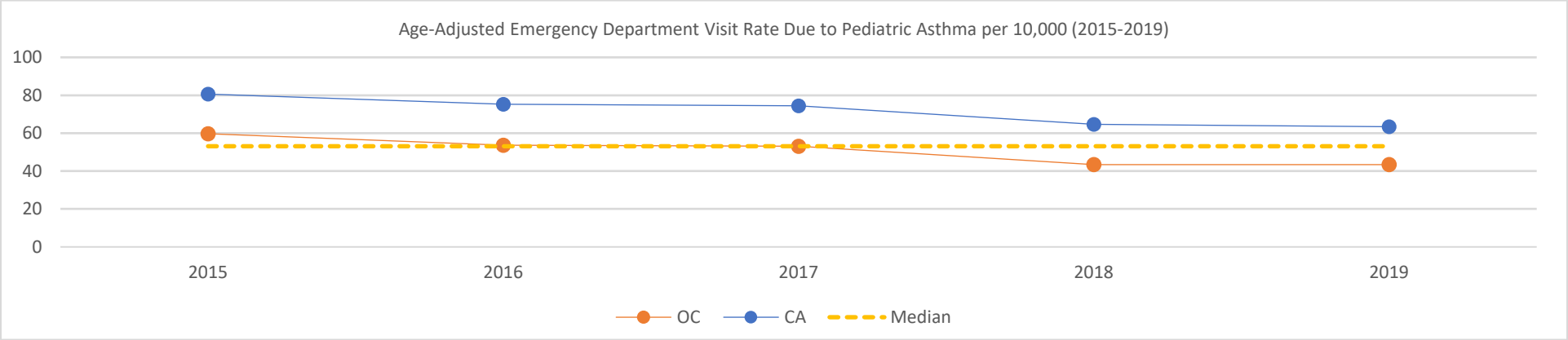
[67] **Definition:** Calculated by dividing the number of asthma emergency department visits by the estimated population in that county and age group, age-adjusting to the 2000 U.S. Census, and multiplying by 10,000. Source: California Department of Public Health. (n.d). Asthma Emergency Department Visit Rates. Retrieved from: Asthma Emergency Department Visit Rates - Datasets - California Health and Human Services Open Data Portal.

Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Age-Adjusted Hospitalization Rate Due to Pediatric Asthma per 10,000[68] (CDPH)	6.4 (2019)	8.3 (2019)	N/A	N/A	N/A



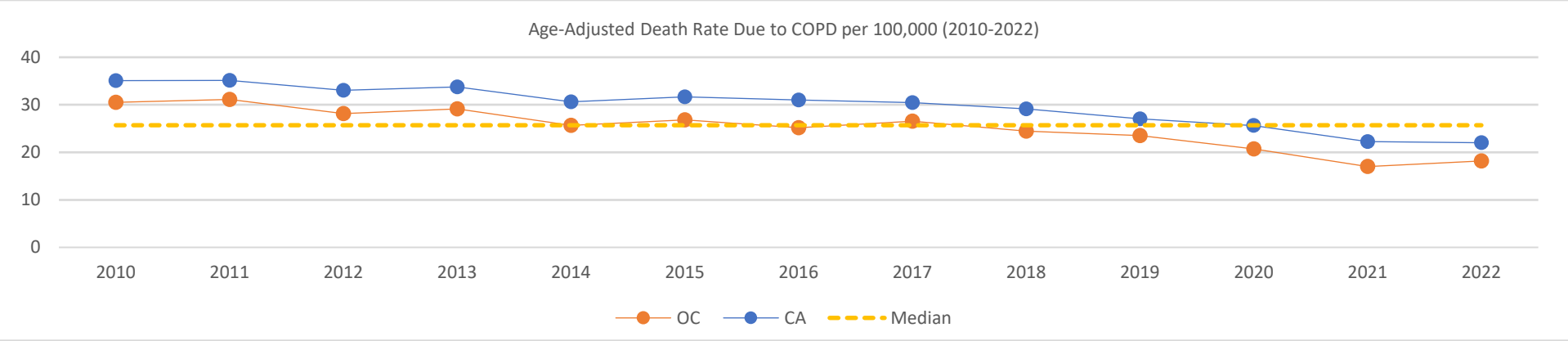
[68] **Definition:** Number of asthma hospitalizations by the estimated population in that county and age group (under the age of 5), age-adjusting to the 2000 U.S. Census, and multiplying by 10,000. **Source**: California Department of Public Health. (n.d). Asthma Hospitalization Rates by County. Retrieved from: Asthma Hospitalization Rates by County - Datasets - California Health and Human Services Open Data Portal

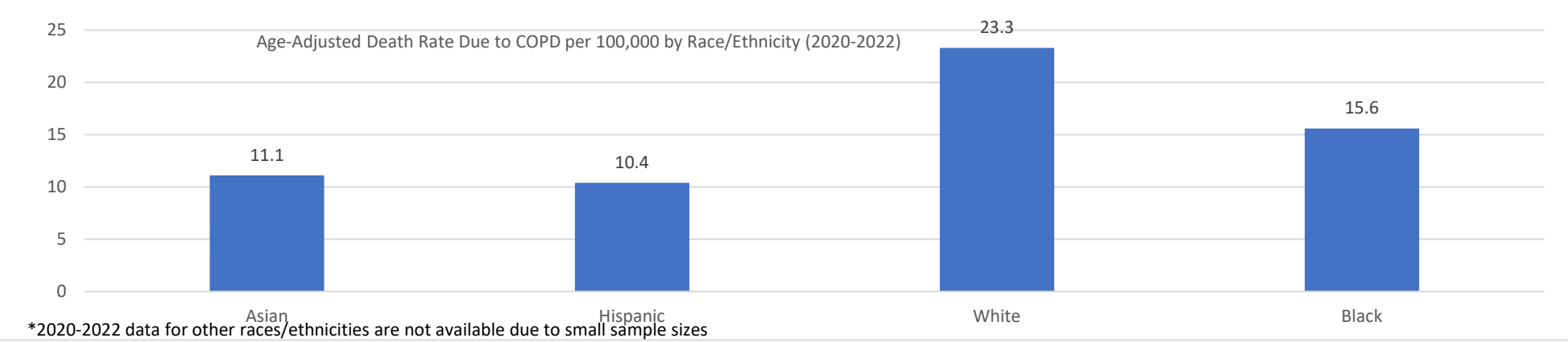
Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Age-Adjusted Emergency Department Visit Rate Due to Pediatric Asthma per 10,000[69] (CDPH)	43.4 (2019)	63.4 (2019)	N/A	N/A	N/A



[69] **Definition:** Calculated by dividing the number of asthma emergency department visits by the estimated population in that county and age group (under the age of 5), age-adjusting to the 2000 U.S. Census, and multiplying by 10,000. **Source**: California Department of Public Health. (n.d). Asthma Emergency Department Visit Rates. Retrieved from: Asthma Emergency Department Visit Rates - Datasets - California Health and Human Services Open Data Portal

Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Age-Adjusted Death Rate Due to COPD per 100,000[70] (CDPH)	18.2 (2022)	22.0 (2022)	95.7 (2021)	107.2	R/E



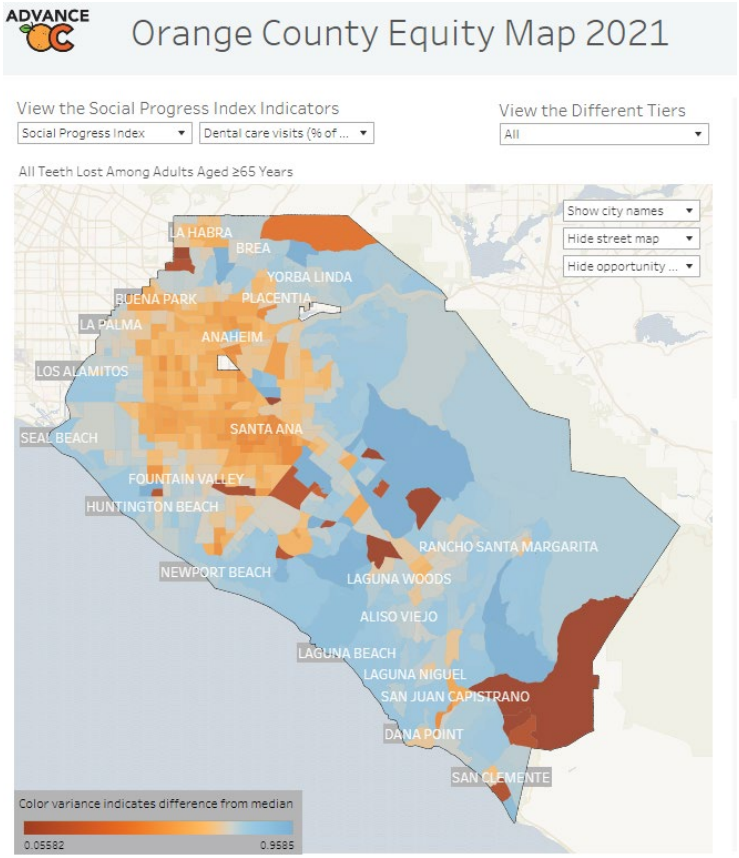


*2020-2022 data for other races/ethnicities are not available due to small sample sizes

[70] **Definition:** Rate of deaths due to chronic obstructive pulmonary disease per 100,000 population. **Source:** California Department of Public Health. (n.d). *California Community Burden Engine*. Retrieved from: California Community Burden of Disease Engine.

Topic	ORAL HEALTH				
Data	Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal
	Percent of Children Who Visited a Dentist in Past 6 Months (CHIS)	64.3% (2021)	65.2%	N/A	N/A
	Ratio of Population to Dental Providers (UWPHI)	827:1 (2021)	1102:1	1380:1	N/A
Equity & Disparities	– Central census tracts had more dental visits due to cavities than South Orange County.				
Qualitative Findings					
Current Collaborative Activities	– HCA's Oral Health Collaborative: Vision is for all Orange County residents to have opportunities and resources for optimal oral health.				

ORAL HEALTH

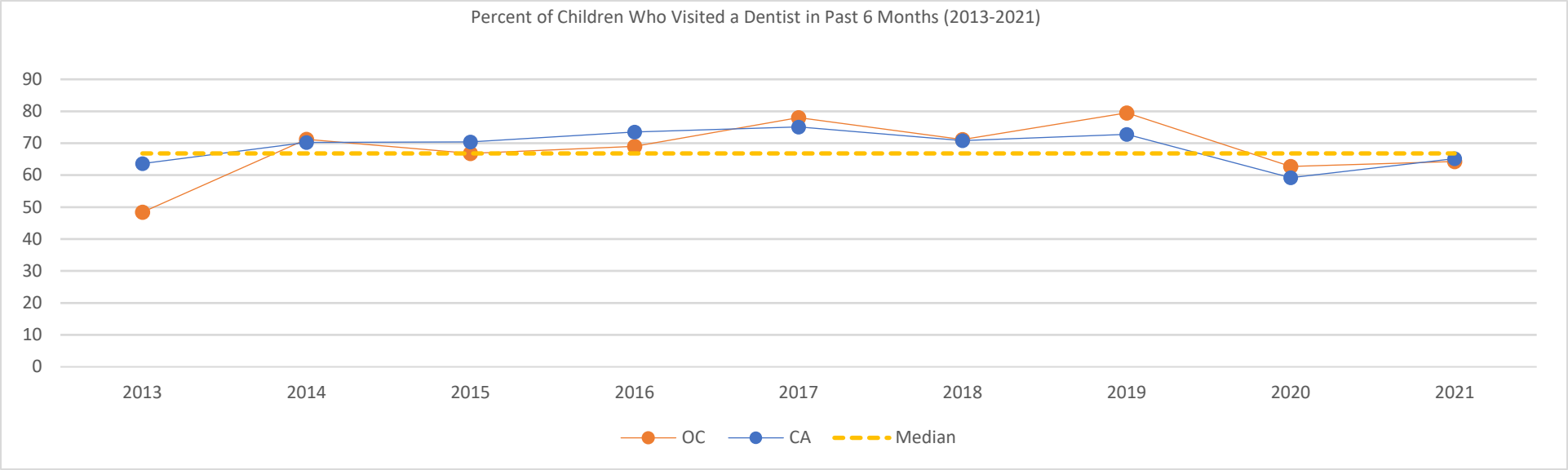


Dental Care Visits:

- **Blue census tracts had higher rates of dental care visits than orange census tracts**
- **Central census tracts had more dental visits due to cavities than South Orange County.**

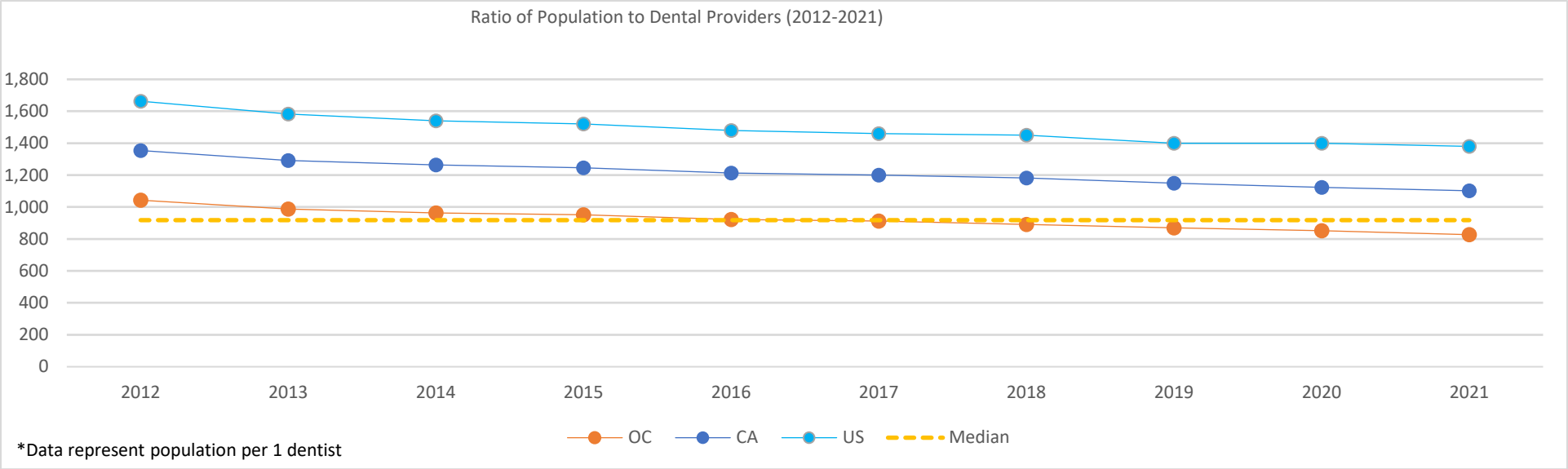
Oral Health

Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Percent of Children Who Visited a Dentist in Past 6 Months[71] (CHIS)	64.3% (2021)	65.2%	N/A	N/A	N/A



[71] **Definition:** Children ages 3-11 who had visited the dentist in past six months. **Source:** UCLA Center for Health Policy Research, Los Angeles, CA. AskCHIS 2011-2021. *Time Since Last Dental Visit* (California, Orange). Retrieved from: http://ask.chis.ucla.edu

Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Ratio of Population to Dental Providers[72] (UWPHI)	827:1 (2021)	1102:1	1380:1	N/A	N/A

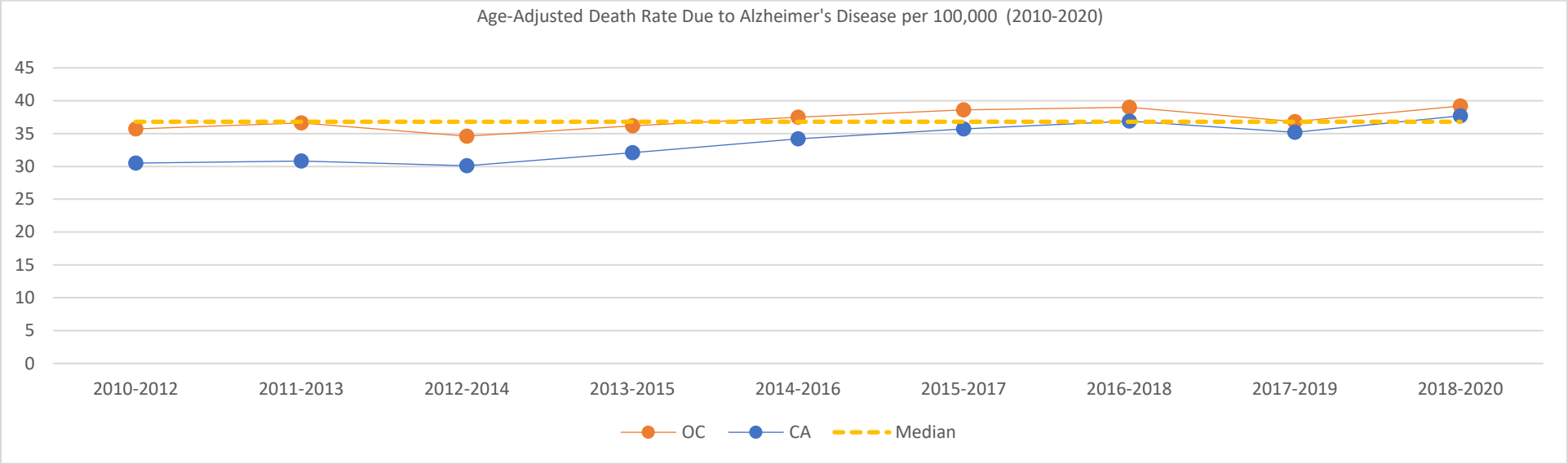


[72] **Definition:** Average number of people served by one dentist in Orange County. **Source:** University of Wisconsin, Population Health Institute (n.d.). *County Health Rankings and Roadmaps, 2010-2021.* Retrieved from: Rankings data & documentation | County Health Rankings & Roadmaps

Topic	**ALZHEIMER'S DISEASE / DEMENTIA**				
Data	**Indicator Name**	**Actual Value** (most recent year)	**CA Value**	**US Value**	**HP 2030 Goal**
	Age-Adjusted Death Rate due to Alzheimer's Disease	**39.2 (2018-2020)**	**37.7**	**N/A**	**N/A**
Equity & Disparities					
Qualitative Findings					
Current Collaborative Activities					

Alzheimer's Disease / Dementia

Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Age-Adjusted Death Rate due to Alzheimer's Disease[73]	39.2 (2018-2020)	37.7	N/A	N/A	N/A



[73] **Definition:** Three-year averages number of deaths from Alzheimer's Disease divided by the total population and then multiplying by 100,000**. Source:** California Department of Public Health, Center for Health Statistics and Informatics (n.d.). *County Health Status Profiles 2010-2021.* Retrieved from: VSB County Health Status Profiles (ca.gov)

HEALTH DETERMINANTS

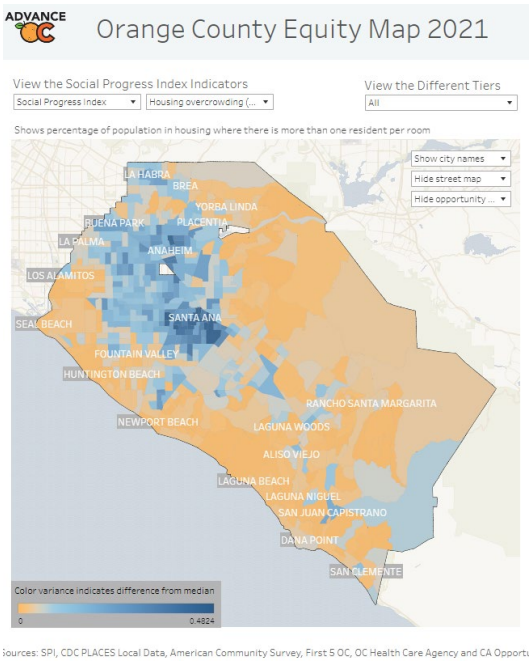
Summary of Findings

Equity Map – Social Progress Index Indicators

Health Indicators

Topic	HOUSING / HOMELESS				
	Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal
Data	2022 Point in Time Count of persons experiencing homelessness https://www.ocgov.com/news/county-orange-releases-2022-point-time-count-results) and https://www.ochealthinfo.com/sites/hca/files/2022-05/2022%20PIT%20Data%20Infographic%20-%205.10.2022%20Final.pdf	5,718	171,500		
Equity & Disparities	– North (2,419) and Central (2,714) have a higher number of homeless persons than South (858) county – More homeless persons are recorded in North (2,419) and Central (2,714) Service Planning Areas compared to the South (585) Service Planning Area – North County had a higher percentage of population in housing where there is more than one resident per room.				
Qualitative Findings	Affordable Housing – Increased evictions and lack of post-eviction support – Lack of financial capacity increases homelessness and forces choices between essential needs – Unaffordability of Rent Prices – Need for more shelters – High cost of land and scarcity in places to build more housing – Increased wealth gap leading to more homelessness – Increase in nimbyism (Not in My Backyard) – Optimistic for Government and Organizational Support to provide additional resources (i.e. advocacy for rent control, Implementing Regional Housing Needs Assessment, Growth of housing trust) – Collaboration between government and Community-Based Organization's (CBO's) Fund ADA home modifications to allow people to remain in the community				
Current Collaborative Activities	– Orange County Continuum of Care: The mission is to advocate for more home building in Orange County, California to end the shortage, reduce housing costs, and make room for current and future Orange County residents. – Equity in OC Partnership – Improvement Projects – Family Solutions Collaborative Orange County				

HOUSING/HOMELESS



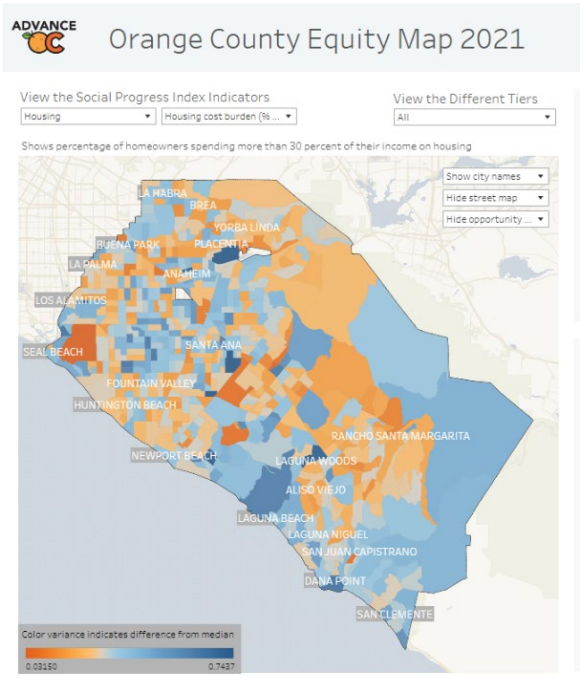
Sources: SPI, CDC PLACES Local Data, American Community Survey, First 5 OC, OC Health Care Agency and CA Opportu

Housing Overcrowding:

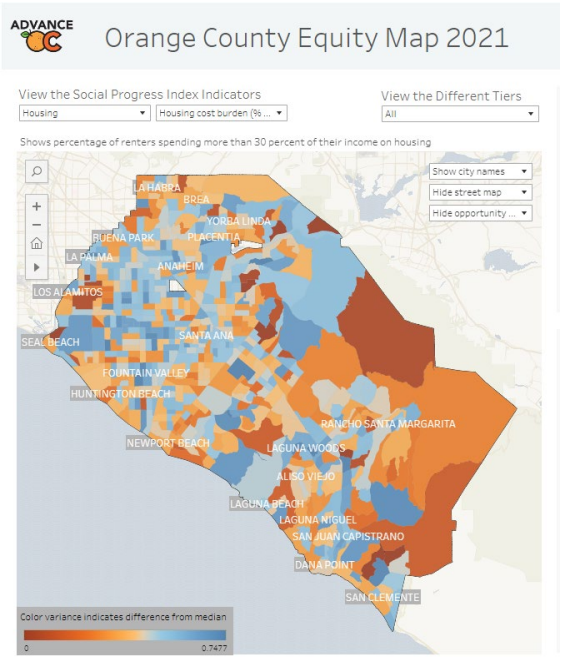
- **Blue census tracts had higher rates of housing over-crowding than in orange census tracts.**
- **North County had a higher percentage of population in housing where there is more than one resident per room.**

Housing Cost Burden for Ownership:

- **Blue census tracts experienced a lower housing cost burden (home ownership) than orange census tracts.**



Sources: SPI, CDC PLACES Local Data, American Community Survey, First 5 OC, OC Health Care Agency and CA Opportuni



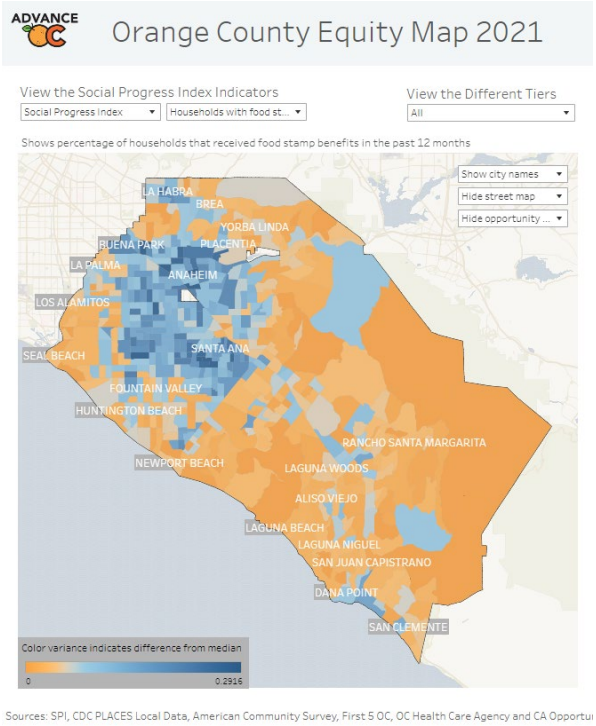
Sources: SPI, CDC PLACES Local Data, American Community Survey, First 5 OC, OC Health Care Agency and CA Opportun

Housing Cost Burden for Rent:

- **Blue census tracts experienced a lower housing cost burden (rent) than orange census tracts.**

Topic	WORKFORCE				
Data	Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal
	Rate of Unemployed Persons in Civilian Workforce (U.S. Bureau of Labor Statistics)	2.7% (2022)	11.1%	10.3%	N/A
Equity & Disparities	– A higher percentage of households in north and west County received food stamp benefits in the past 12 months compared to the rest of the County (Advance OC's Social Progress Index). – Regions of south County has over 75% of people earning more than 200% of federal poverty line compared to the rest of the County (Source: California Health Places Index.) – Areas of south and west County has over 60% of people aged 20-64 with a job compared to the rest of the County (Source: California Health Places Index.) – A higher percentage of households Central County received food stamp benefits in the past 12 months compared to the rest of the County. – Areas of South County have over 75% of people earning more than 200% of federal poverty line compared to the rest of the County (Source: California Health Places Index.) – Areas of South and West County have over 60% of people aged 20-64 with a job compared to the rest of the County (Source: California Health Places Index.)				
Qualitative Findings	Increasing a diverse health care workforce – More service providers added to the system – Increasing the number of providers in OC, especially providers that reflect the diversity of the community Desired Healthcare System Reform – Health care workers structured outside of the traditional provider-patient relationship – Increasing a diverse health care workforce – More connected services with price transparency				
Current Collaborative Activities					

WORKFORCE



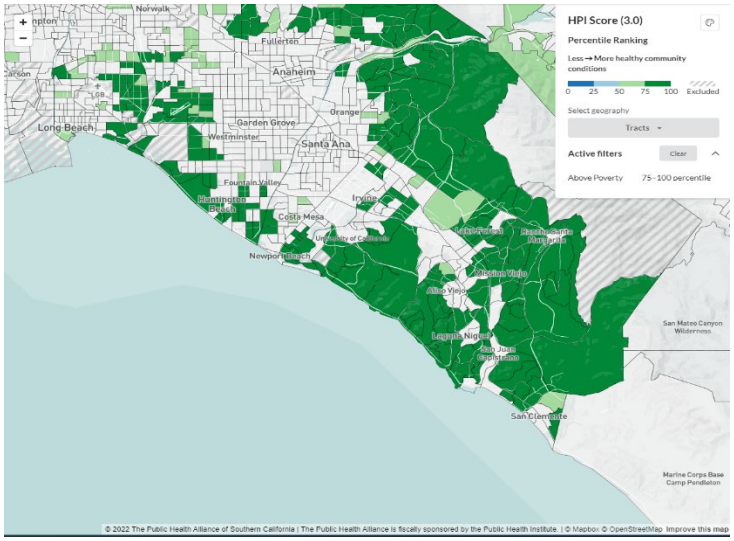
Sources: SPI, CDC PLACES Local Data, American Community Survey, First 5 OC, OC Health Care Agency and CA Opportui

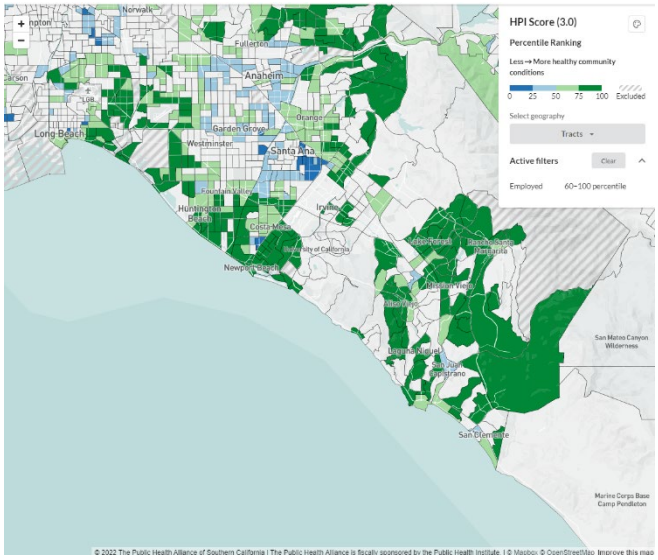
Household Receiving Food Stamps:

- **Blue census tracts receive food stamps at a higher rate than orange.**
- **A higher percentage of households Central County received food stamp benefits in the past 12 months compared to the rest of the County.**

Earning More than 200% Above Poverty:

- **Green census tracts have greater population with earnings above 200% of the Federal poverty line.**
- **Areas of South County have over 75% of people earning more than 200% of federal poverty line compared to the rest of the County (Source: California Health Places Index.)**

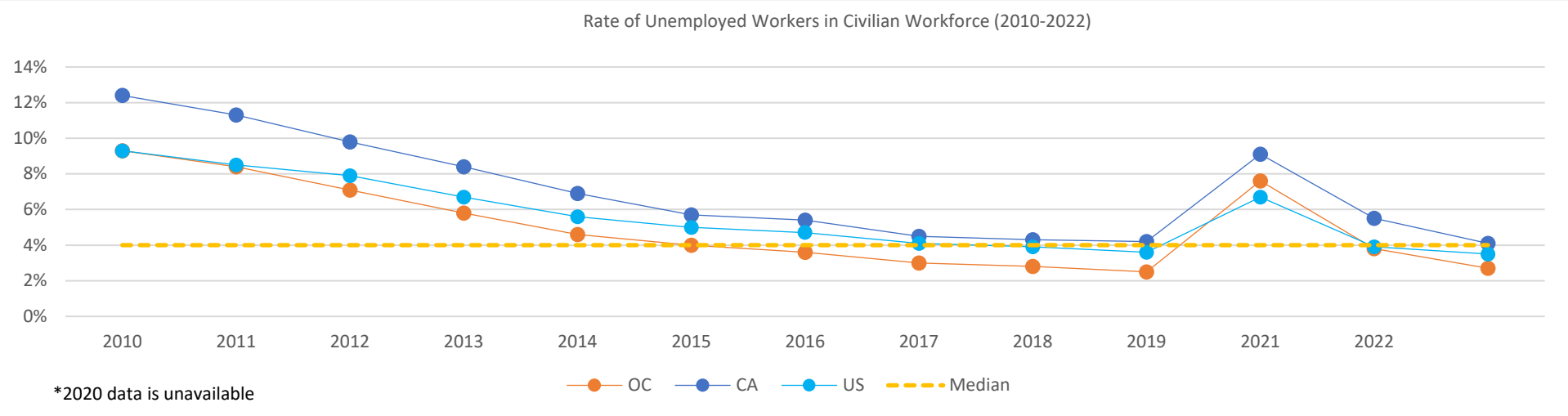




Adults with Job:

- **Green census tracts have more adults aged 20-64 with a job.**
- **Areas of South and West County have over 60% of people aged 20-64 with a job compared to the rest of the County (Source: California Health Places Index.)**

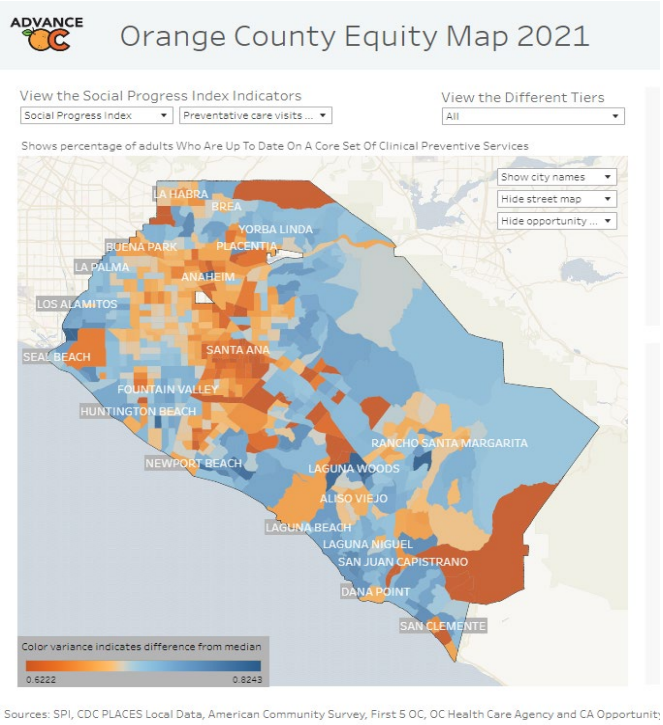
Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Rate of Unemployed Persons in Civilian Workforce[74] (U.S. Bureau of Labor Statistics)	2.7% (2022)	4.1%%	3.5%	N/A	N/A



[74] **Definition:** All persons who had no employment during the reference week, were available for work, except for temporary illness, and had made specific efforts to find employment at some time during the 4 week-period ending with the reference week. **Source:** US. Bureau of Labor Statistics. *Unemployment Rate in Orange County, CA*. Retrieved from: https:// Unemployment Rate in Orange County, CA (CAORAN7URN) | FRED | St. Louis Fed (stlouisfed.org)

Topic	CARE NAVIGATION				
Data	Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal
	Percent of People with a Usual Source of Care (CHIS)	87.2% (2021)	86.0%	76.0%	84.0%
	Percent of People Who Delayed or Had Difficulty Obtaining Care (CHIS)	16.6% (2021)	19.9%	17.6%	5.9%
	Difficulty Finding Specialty Care (CHIS)	12.3% (2021)	16.8%	4.7%	6.3%
Equity & Disparities	– Percent of People with a Usual Source of Care: A higher percentage of White (88.1%) receive usual source of care than Asian (84.7%) and Hispanic/Latino (74.1%) – Percent of People Who Delayed or Had Difficulty Obtaining Care: More Whites (21.6%) delayed or had difficulty obtaining care than Asian (10.7%) or Hispanic/Latino (14.2%) – Difficulty Finding Specialty Care: More Whites (12.7%) had difficulty finding specialty care than Asians (9.5%) – North and Central County have a higher percentage of adults who are up to date on a core set of clinical prevention services.				
Qualitative Findings	New patient systems are difficult to navigate – New systems are difficult to navigate for some communities – Difficulty navigating mental healthcare – Lack of access to affordable and quality care, preventing people from seeking help – Providers lack time to help patients navigate new tech and health information – Opportunity to offer digital literacy programs to help vulnerable people navigate telehealth Need for education surrounding how to navigate existing systems – Increasing access: simplifying ways to access care, education on healthcare navigation – Education on where and how to access services, and how to navigate the healthcare system and insurance – Lack of understanding of referral systems, difficulties using OCLINK, missed referral opportunities – Connect or link people to organizations that can provide the personal health services they may need Long wait times act as a barrier to care – Long wait times to access care, difficulty obtaining services as a CalOptima member – Lack of specialty care access due to low reimbursement and long wait times				
Current Collaborative Activities					

CARE NAVIGATION

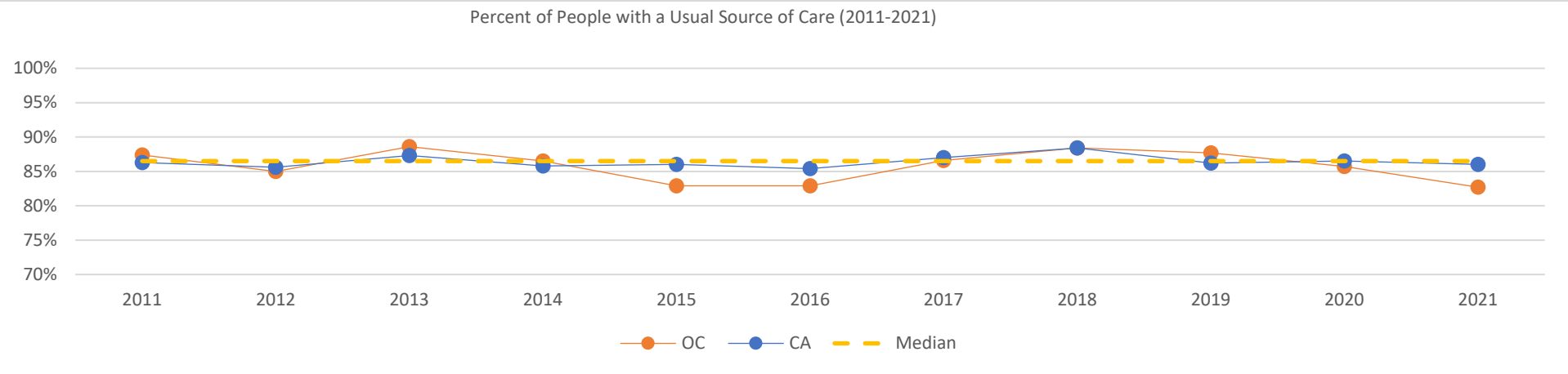


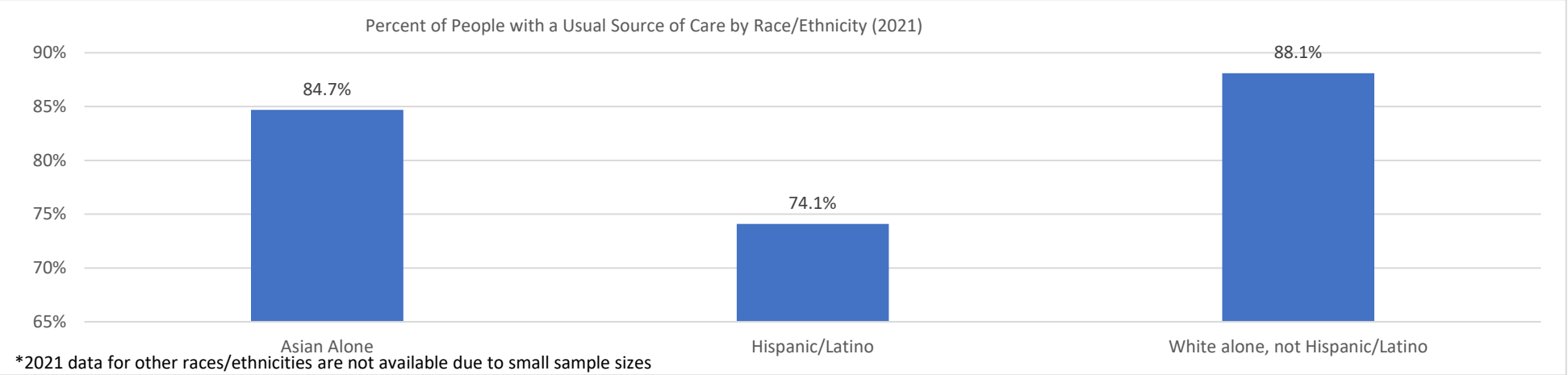
Sources: SPI, CDC PLACES Local Data, American Community Survey, First 5 OC, OC Health Care Agency and CA Opportunity

Preventive Care Visits

- **Blue areas are performing better on this indicator.**
- **North and Central County have a higher percentage of adults who are up to date on a core set of clinical prevention services.**

Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Percent of People with a Usual Source of Care[75] (CHIS)	87.2% (2021)	86.0%	76.0%	84.0%	R/E

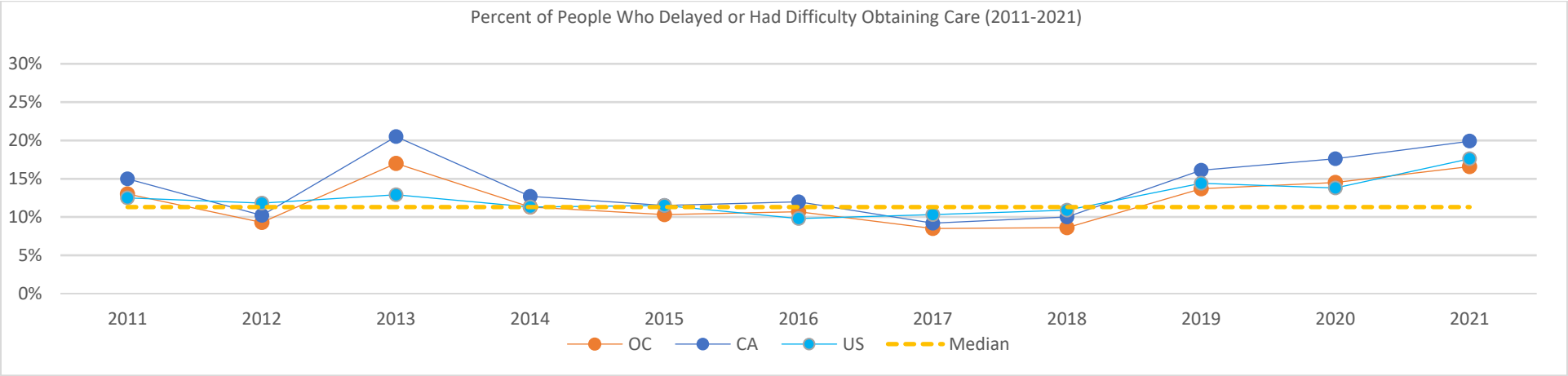


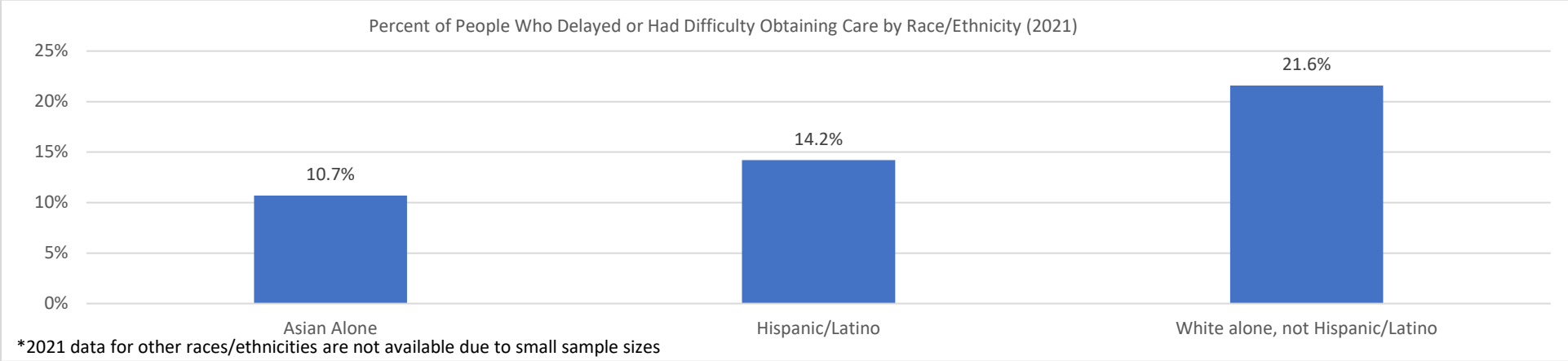


*2021 data for other races/ethnicities are not available due to small sample sizes

[75] **Definition:** Combines questions about last doctor's visit and type of location where doctor was seen, including doctor's office/HMO/Kaiser, community clinic/government clinic/community hospital, emergency room/urgent. **Source:** UCLA Center for Health Policy Research, Los Angeles, CA. AskCHIS 2011-2021. *People with a Usual Source of Health Care (California, Orange).* Retrieved from: http://ask.chis.ucla.edu.

Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Percent of People Who Delayed or Had Difficulty Obtaining Care[76] (CHIS)	16.6% (2021)	19.9%	17.6%	5.9%	R/E

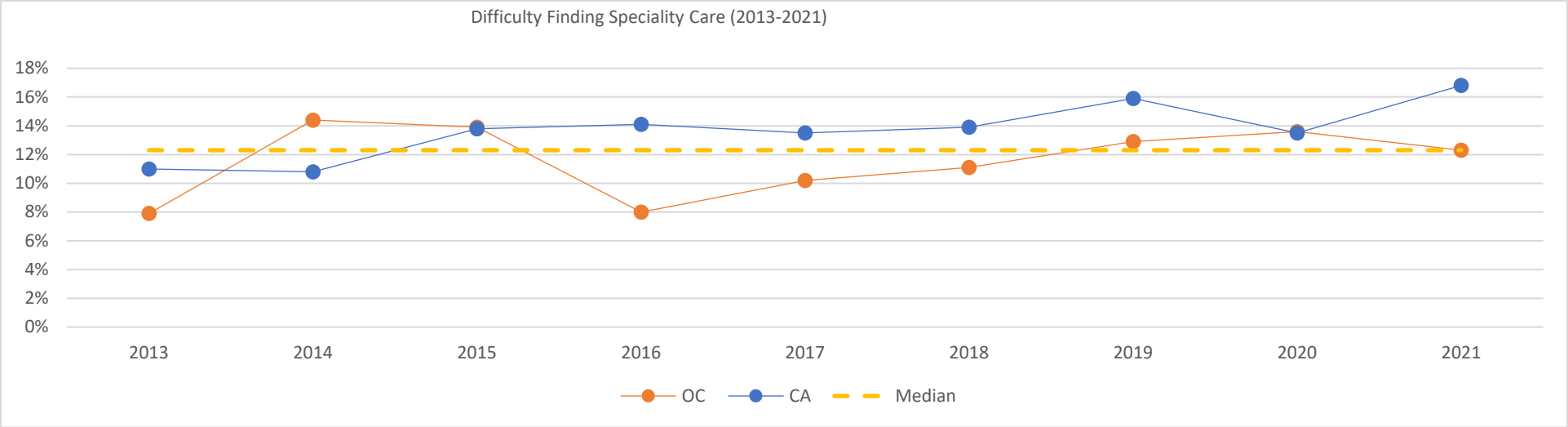


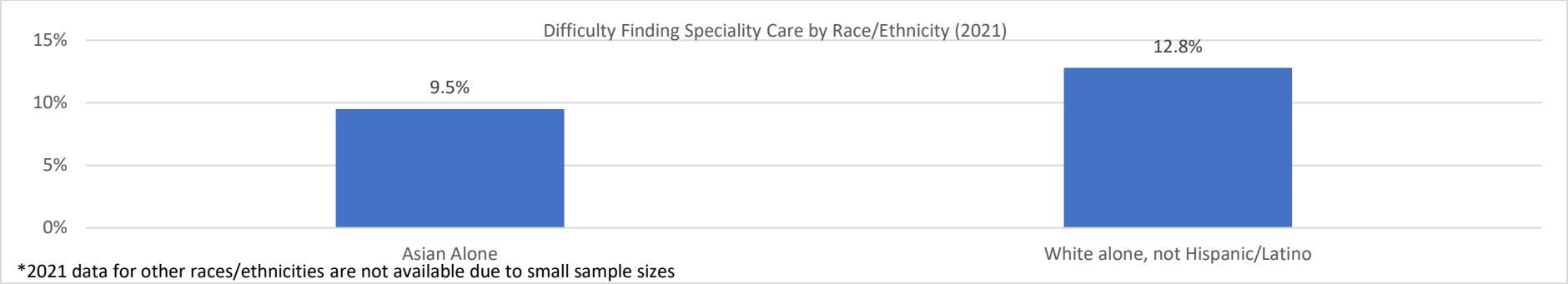


*2021 data for other races/ethnicities are not available due to small sample sizes

[76] **Definition:** During the past 12 months, did the person delay or not get other medical care they felt they needed-- such as seeing a doctor, a specialist, or other health professional. **Source:** UCLA Center for Health Policy Research, Los Angeles, CA. AskCHIS 2011-2021. *People Delayed or Had Difficulty Obtaining Care (California, Orange).* Retrieved from: http://ask.chis.ucla.edu

Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Difficulty Finding Specialty Care[77] (CHIS)	12.3% (2021)	16.8%	4.7%	6.3%	R/E





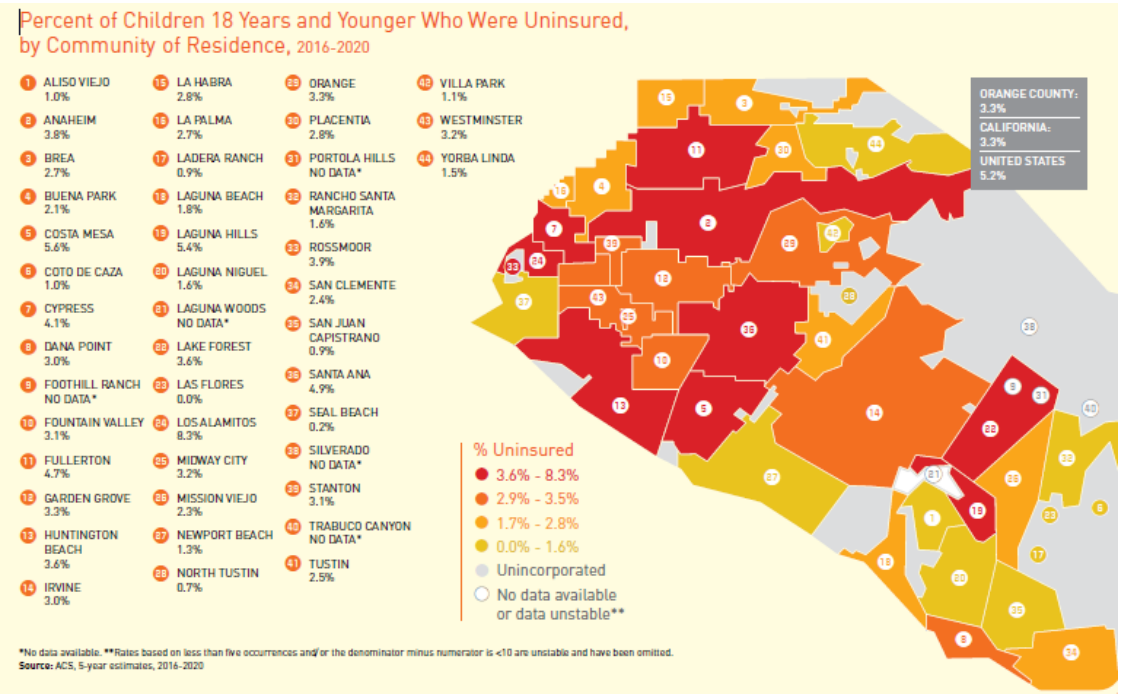
*2021 data for other races/ethnicities are not available due to small sample sizes

[77] **Definition:** Among those needing specialty care, whether they had any trouble finding a medical specialist who would see them and whether a medical specialist's office told them that they would not take them as a new patient." Those answering yes to either had difficulty obtaining specialty care. **Source:** UCLA Center for Health Policy Research, Los Angeles, CA. AskCHIS 2011-2021. *Difficulty Finding Specialty Care (California, Orange).* Retrieved from: http://ask.chis.ucla.edu.

Topic	HEALTH INSURANCE ACCESS / ENROLLMENT				
Data	Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal
	Percent of Adults with Health Insurance: 18-64 Years (ACS)	90.4% (2021)	90.1%	87.8%	92.4%
	Percent of Children with Health Insurance (ACS)	96.4% (2021)	96.5%	94.6%	N/A
	Percent of Adults Ages 65+ with Health Insurance (ACS)	99.0% (2021)	98.9%	99.2%	N/A
	Percent of Adults Who Had Routine Check-Up in Past 12 Months (CHIS)	64.3% (2021)	60.2%	N/A	N/A
	Avoided Government Benefits Due to Concern Over Disqualification from Green Card/Citizenship (CHIS)	21.9% (2021)	18.8%	N/A	N/A
	Percent of Children Receiving a Development Assessment/Test (CHIS)	75.1% (2021)	72.2%	34.8% (2020-2021)	35.8%
	Ratio of Population to Health Care Providers (UWPHI)	955:1 (2020)	1234:1	1310:1	N/A
Equity & Disparities	– Percent of Adults with Health Insurance: 18-64 Years (ACS): 93.9% of White adults and 94.1% of Asian adults have health insurance compared to 90.4% of Black, 82.3% of Hispanic and 80.4% of AIAN adults – Geographic disparity exists with the highest rate of uninsured children at 8.3% compared to Orange County rate of 3.3% (The 28th annual report on the Conditions of Children in Orange County. – Percent of People with a Usual Source of Care (CHIS): 88.1% of Whites and 84.7% of Asians receive care compared only to 74.1% of Hispanics – Percent of People Who Delayed or Had Difficulty Obtaining Care (CHIS): More Whites (21.6%) delayed or had difficulty obtaining care compared to Hispanic (14.2%) or Asian (10.7%) – Percent of Adults Who Had Routine Check-Up in Past 12 Months (CHIS): More Whites (67.7%) have routine check-up compared to Asian (66.4%) and Hispanic (59.1%) – Regions in South County had a lower percent of children 18 years and younger who were uninsured.				
Qualitative Findings	Insurance is a barrier to accessing care, whether due to inability to access insurance or price of co-pays – High insurance costs, but people are not being paid livable wages – People feel it is too complicated to access insurance and care providers, leading to a lack of medical coverage for hearing aids and specific medical devices – Insurance does not cover some necessary procedures (dental, weight loss) that may lead to poorer mental health and potential job loss				

	– **Insurance companies act as a barrier for mental health and substance use treatment** – **Insurance companies and reimbursement services could pay for care coordination, transportation, etc.** – **People choose high deductibles/copays and don't access care** – **Increase in part-time hires, decreasing healthcare access through employers** – **Lack of affordability for any insurance** – **Inadequate number of providers accepting insurance** – **New technology may not be covered by insurance, difficult to afford otherwise**
Current Collaborative Activities	

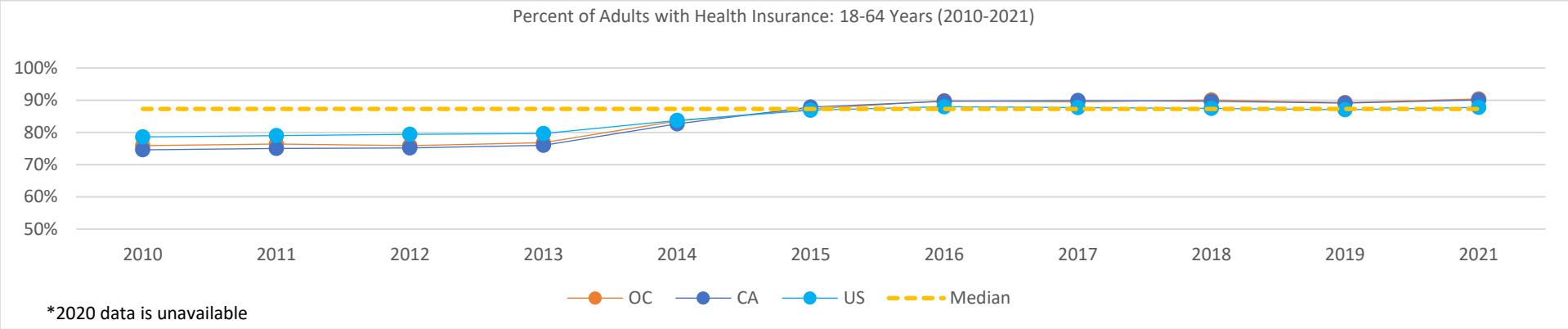
HEALTH INSURANCE ACCESS / ENROLLMENT

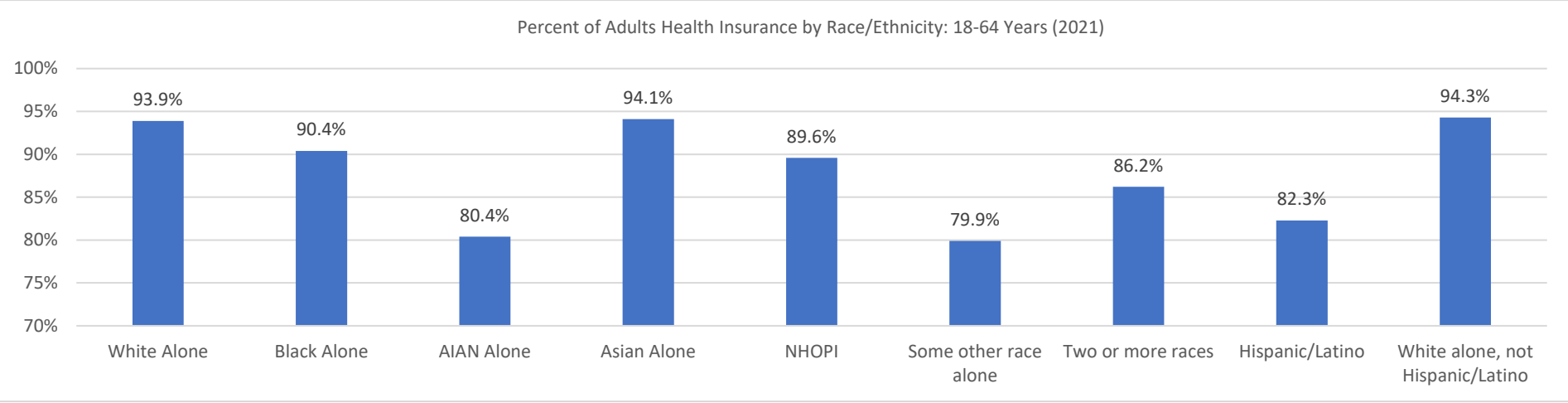


Percent of Children 18 Years and Younger Who Were Uninsured:

- **Orange and red areas are performing worse on this indicator.**
- **Regions in South County had a lower percent of children 18 years and younger who were uninsured.**

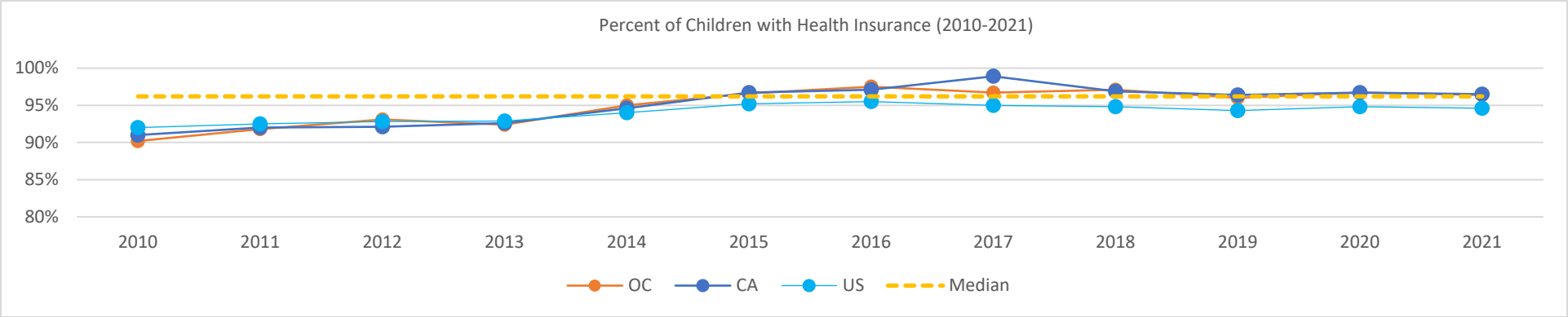
Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Percent of Adults with Health Insurance[78]: 18-64 Years (ACS)	90.4% (2021)	90.1%	87.8%	92.4%	R/E

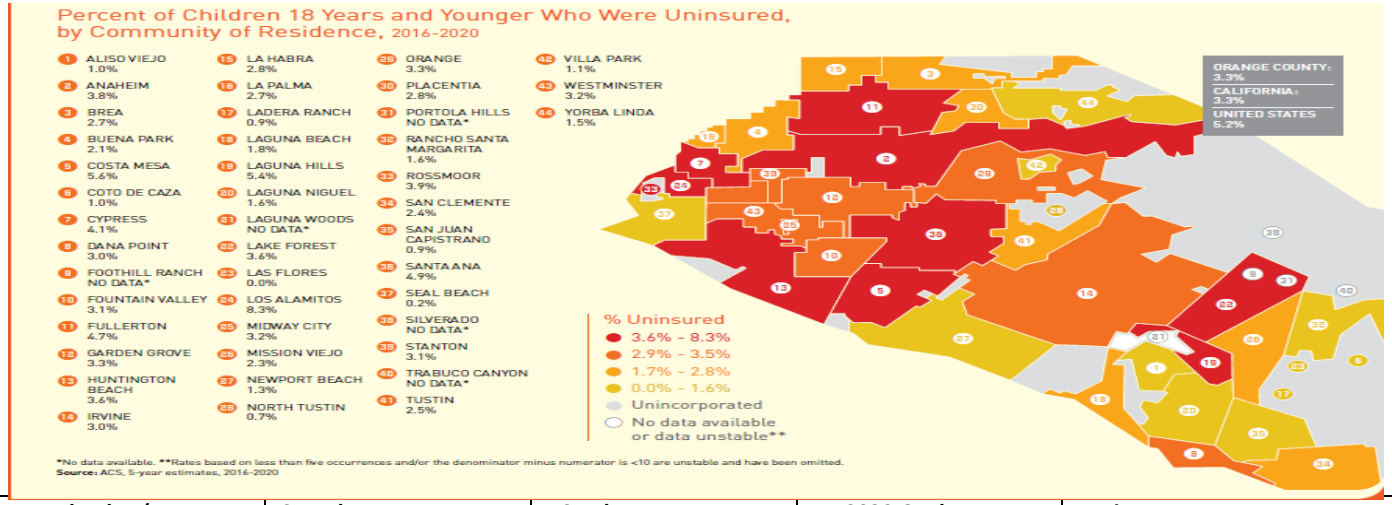




78 **Definition:** Adults ages 18 to 64 years old who have private health insurance through an employer or union, a plan purchased by an individual from a private company or public coverage through Medi-Call or VA Health Care. **Source:** U.S. Census Bureau (2021). Selected Characteristics of Health Insurance Coverage in the United States, 2010-2021, *American Community Survey 1-Year Estimates.* Retrieved from: adults with health insurance - Census Bureau Tables

Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Percent of Children with Health Insurance[79] (ACS)	96.4% (2021)	96.5%	94.6%	N/A	Geographic

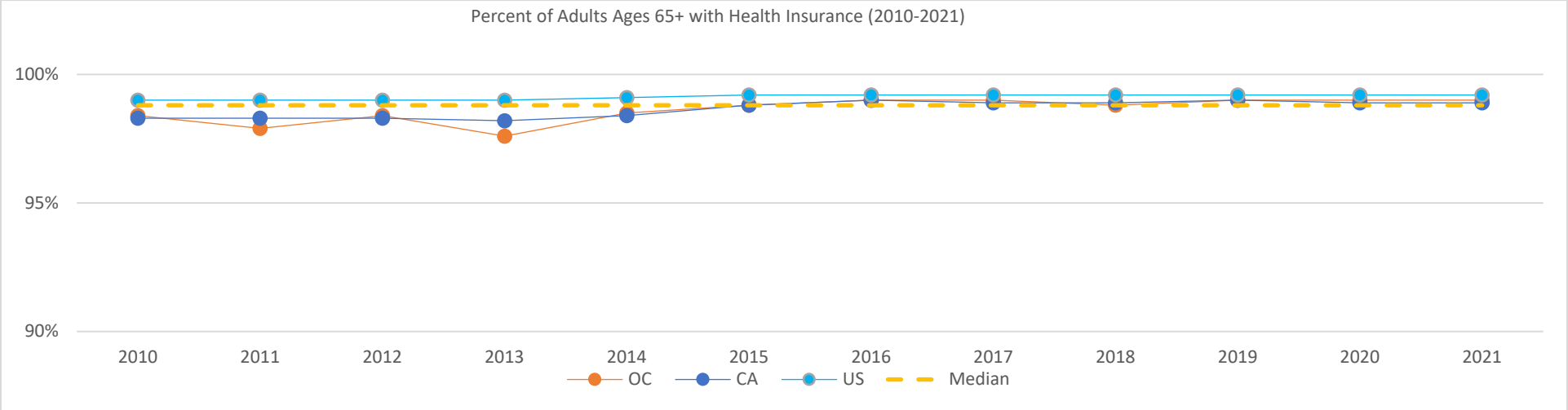




Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity

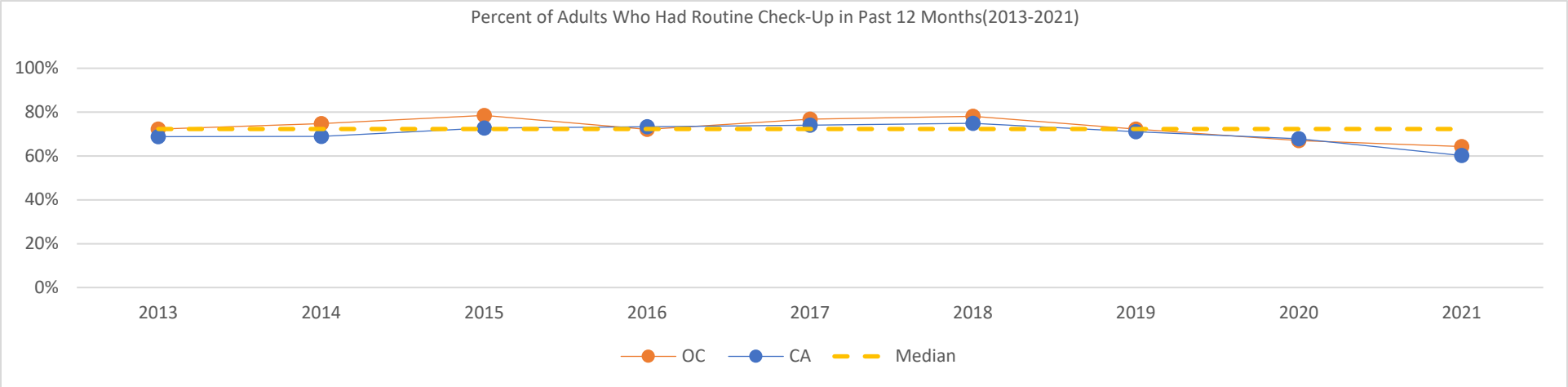
[79] **Definition:** Children under the age of 18 who have private health insurance through a parent's employer or union, a plan purchased by an individual from a private company or public coverage through Medi-Cal or Children's Health Insurance Program (CHIP). **Source:** U.S. Census Bureau (2021). Selected Characteristics of Health Insurance Coverage in the United States, 2010-2021, *American Community Survey 1-Year Estimates.* Retrieved from: adults with health insurance - Census Bureau Tables

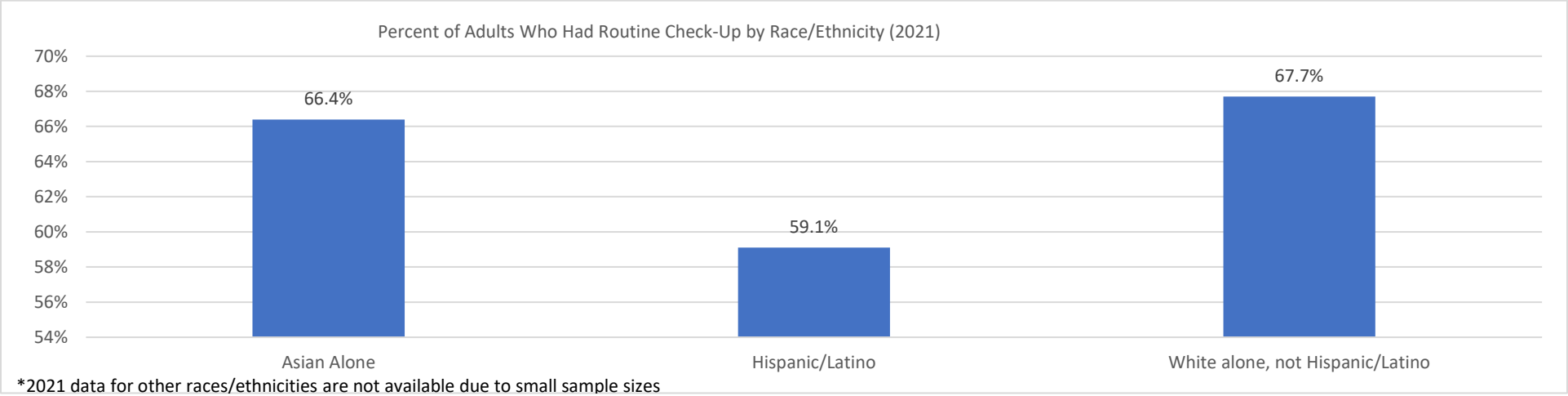
Percent of Adults Ages 65+ with Health Insurance[80] (ACS)	99.0% (2021)	98.9%	99.2%	N/A	N/A



[80] **Definition:** Adults ages 65 and older who Have private health insurance through an employer or union, a plan purchased by an individual from a private company or public coverage through Medicare or Medicaid. **Source:** U.S. Census Bureau (2021). Selected Characteristics of Health Insurance Coverage in the United States, 2010-2021, *American Community Survey 1-Year Estimates.* Retrieved from: adults with health insurance - Census Bureau Tables

Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Percent of Adults Who Had Routine Check-Up in Past 12 Months[81] (CHIS)	64.3% (2021)	60.2%	N/A	N/A	R/E

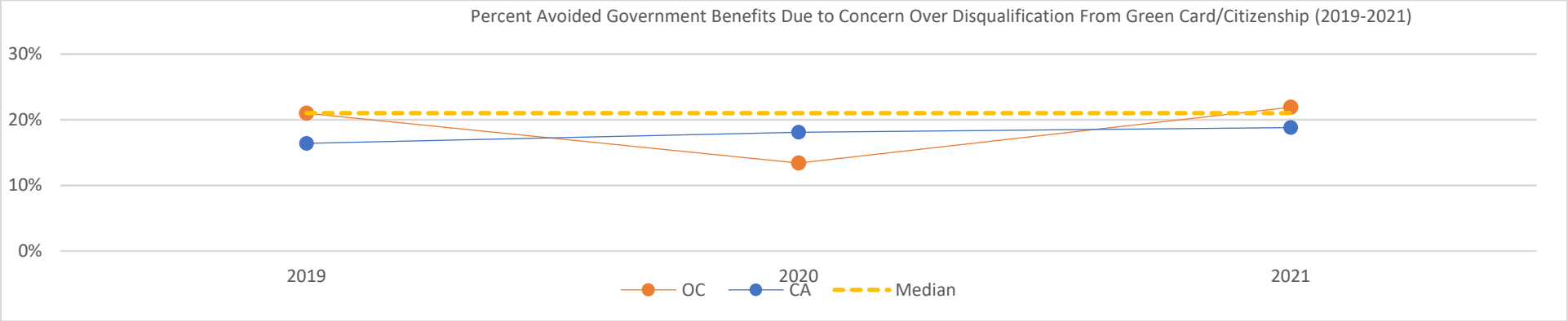


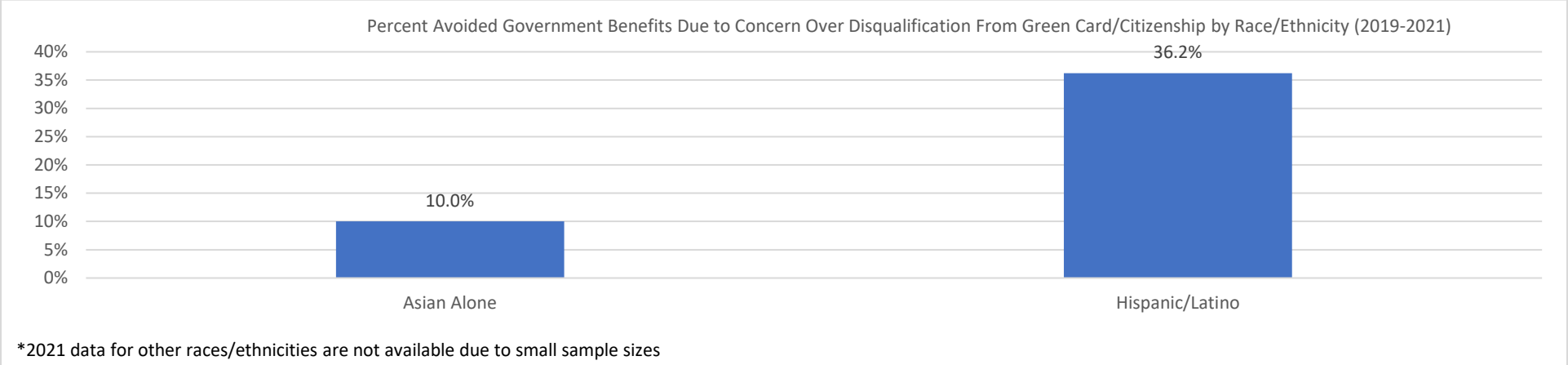


*2021 data for other races/ethnicities are not available due to small sample sizes

[81] **Definition: H**ow long has it been since the adult last saw a doctor or medical provider for a routine check-up. Source: UCLA Center for Health Policy Research, Los Angeles, CA. AskCHIS 2011-2021. *Routine Check-Up with Doctor in Past 12 Months (California, Orange).* Retrieved from: http://ask.chis.ucla.edu.

Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Avoided Government Benefits Due to Concern Over Disqualification from Green Card/Citizenship[82] (CHIS)	21.9% (2021)	18.8%	N/A	N/A	R/E

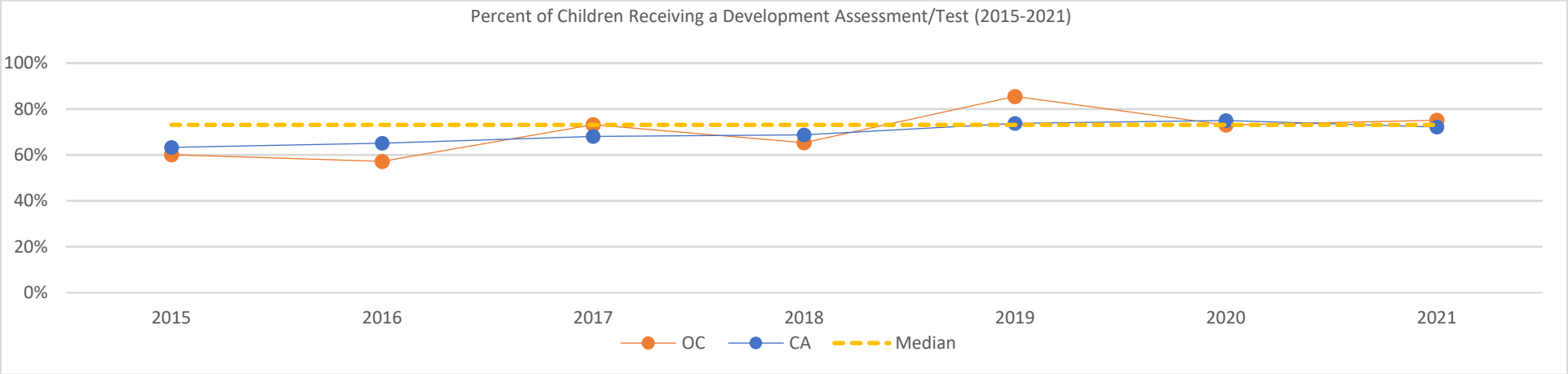


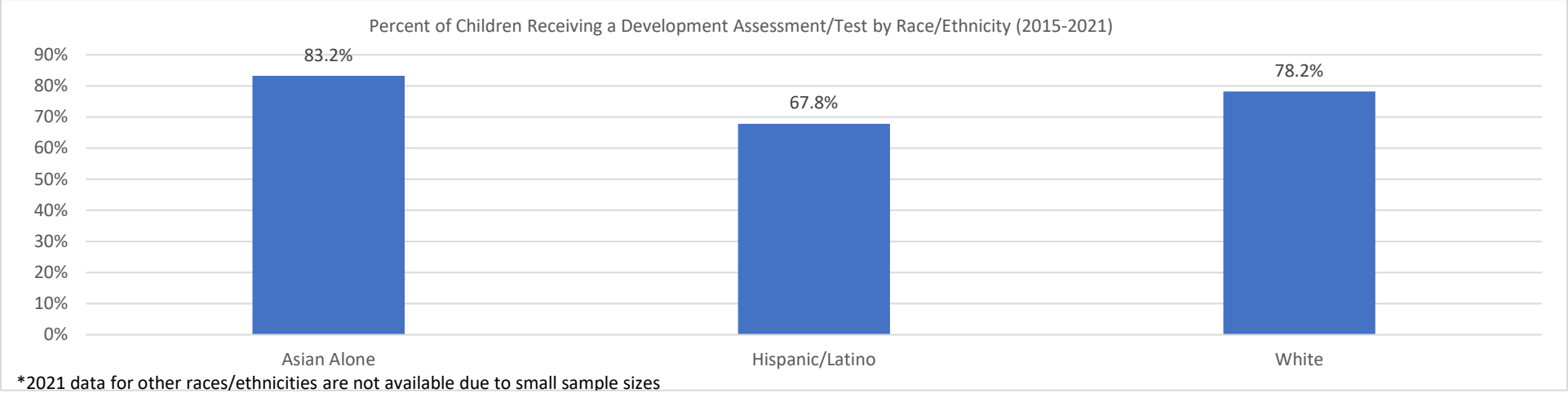


*2021 data for other races/ethnicities are not available due to small sample sizes

[82] **Definition:** "Was there ever a time when you decided not to apply for one or more non-cash government benefits, such as Medi-Cal, food stamps, or housing subsidies, because you were worried it would disqualify you or a family member, from obtaining a green card or becoming a U.S. citizen?" Source**:** UCLA Center for Health Policy Research, Los Angeles, CA. AskCHIS 2011-2021. *Ever Avoided Government Benefits Due to Concern Over Self or Family Members Disqualification from Green Card/Citizenship (California, Orange).* Retrieved from: http://ask.chis.ucla.edu.

Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Percent of Children Receiving a Development Assessment/Test[83] (CHIS)	75.1% (2021)	72.2%	34.8% (2020-2021)	35.8%	R/E

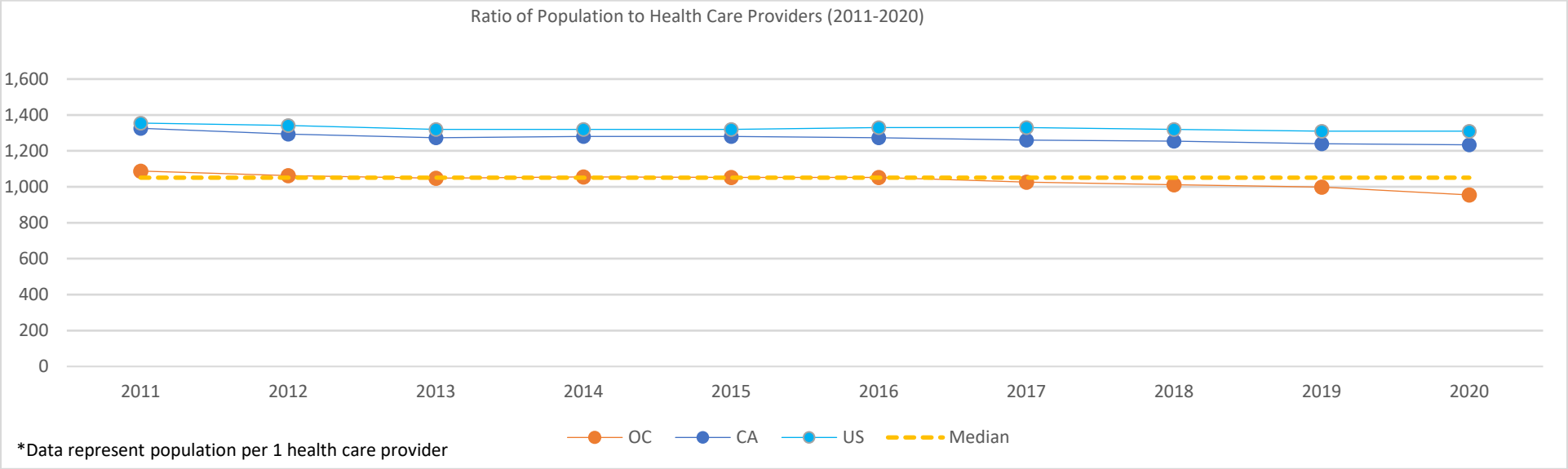




*2021 data for other races/ethnicities are not available due to small sample sizes

[83] **Definition:** "Did child's doctor, other health providers, teachers or school counselors ever do an assessment or tests of child's development?" Source**:** UCLA Center for Health Policy Research, Los Angeles, CA. AskCHIS 2011-2021. *Child's Doctor/Health Provider or School Officials Ever Did Development Assessment/Test (California, Orange).* Retrieved from: http://ask.chis.ucla.edu.

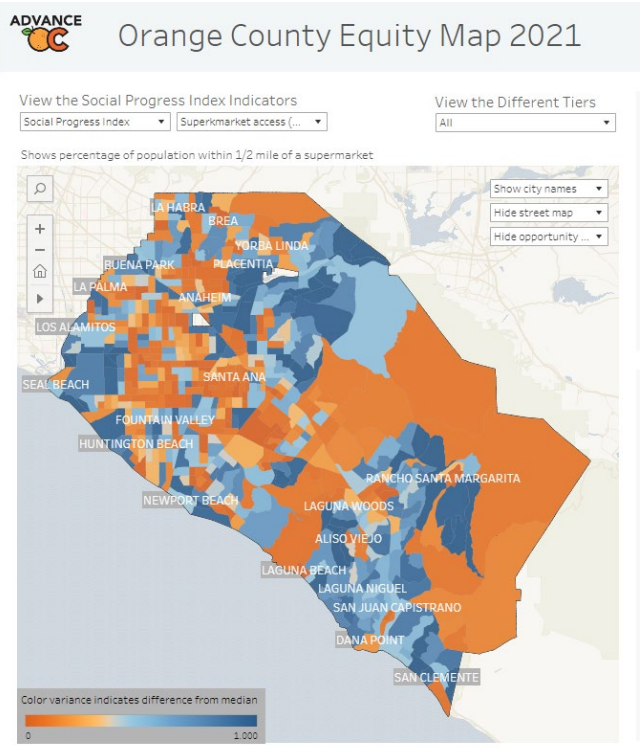
Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Ratio of Population to Health Care Providers[84] (UWPHI)	955:1 (2020)	1234:1	1310:1	N/A	N/A



[84] **Definition:** Average number of people served by one health care provider in Orange County. **Source:** University of Wisconsin, Population Health Institute (n.d.). *County Health Rankings and Roadmaps, 2010-2021.* Retrieved from: Rankings data & documentation | County Health Rankings & Roadmaps

Topic	FOOD ACCESS / NUTRITION				
Data	Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal
	Food Environment Index (UWPHI)	8.8 (2020)	8.8	7.0	N/A
	Percent of Adults Who Are Food Insecure (CHIS)	39.7% (2021)	39.0%	10.2%	6.0%
	Percent of HIV+ Adults Who Received Food Bank/Home Delivered Meals (HRSA)	14.7% (2021)	15.6%	14.7%	N/A
Equity & Disparities	– Parts of north and south county have a less percentage of population within ½- mile of a supermarket (AdvanceOC's Orange County Equity Map) – Percent of Adults Who Are Food Insecure: Almost half of those food insecure were Hispanics (49.0%) compared to Whites (26.0%) and Asians (22.9%)				
Qualitative Findings	End of Programming that Supported Food Security – Lack of food programs that target core populations in need – Reduction in school programming that assists low-income students – COVID government assistance programs for food being phased out – Need for food distribution similar to that during COVID Need for education around food security and food access support – Creative programming to distribute leftover food, eliminate food waste, or create community gardens – Need for universal free meals for children – Need for food access support – Education on how to navigate food security – Raise awareness of programs that accept donations from local stores and distribute at food pantries – New models in Riverside: food boxes at doctors' offices – Food banks providing healthier food Issues affecting food availability – Cost of healthy food continues to increase – Climate change may impact crops and food access Lack of youth nutrition prioritization – School nutrition, structure of menus – Marketing and brainwashing of youth regarding food – Reduction in school programming that assists low-income students				
Current Collaborative Activities	– HCA's County Nutrition Action Plan – EiOC's (new) Food Access Collaborative / *OC Hunger Alliance*				

FOOD ACCESS/NUTRITION



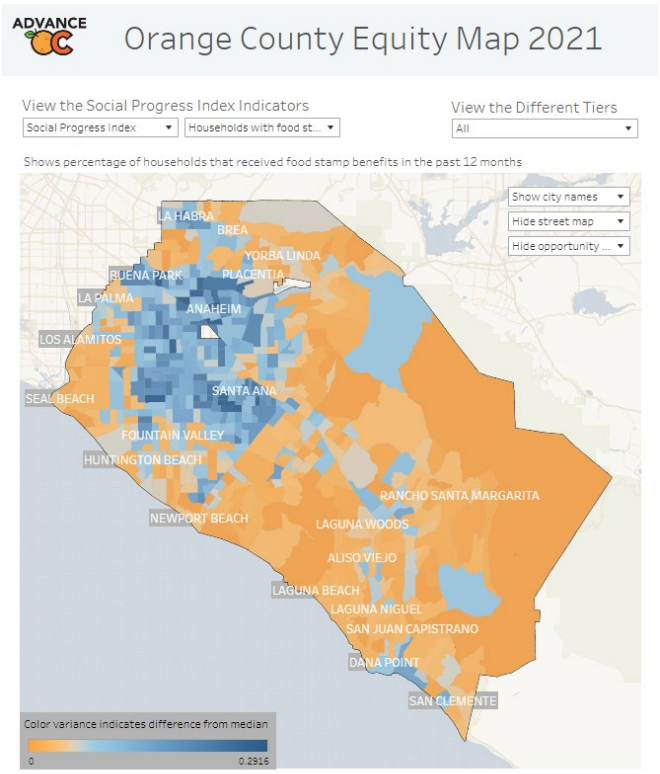
Sources: SPI, CDC PLACES Local Data, American Community Survey, First 5 OC, OC Health Care Agency and CA Opportun

Supermarket Access:

- Blue census tracts had greater access to **supermarkets than orange census tracts.**
- **Parts of North and South County (colored in shades of orange) had a less percentage of population within ½– mile of a supermarket.**

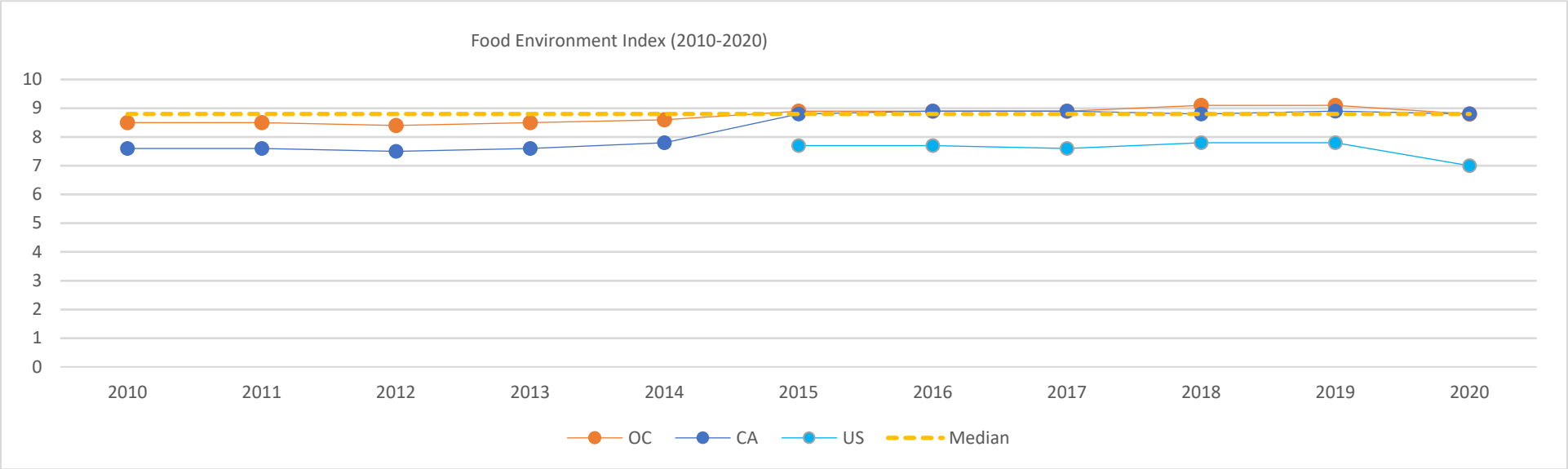
Household with Food Stamps:

- **Blue census tracts received food stamps at a higher rate than orange census tracts.**
- **A higher percentage of households in North and West County received food stamp benefits in the past 12 months compared to the rest of the County.**



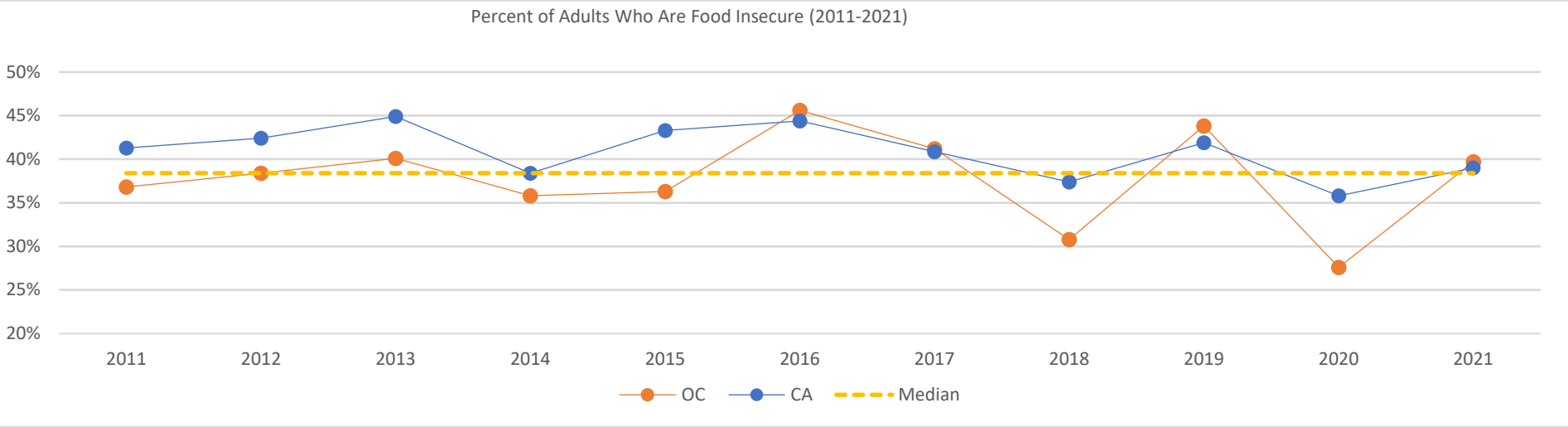
Sources: SPI, CDC PLACES Local Data, American Community Survey, First 5 OC, OC Health Care Agency and CA Opportui

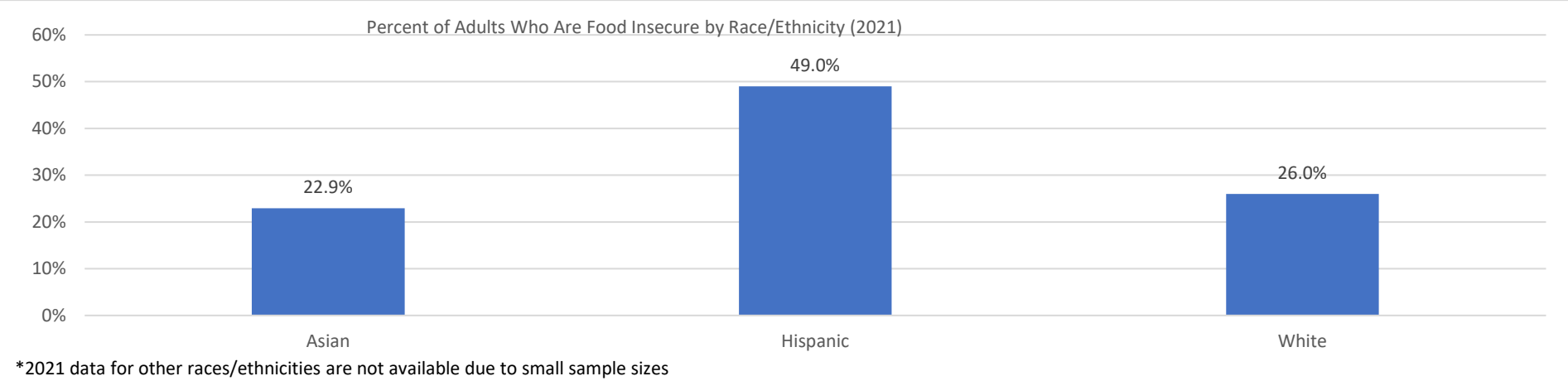
Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Food Environment Index[85] (UWPHI)	8.8 (2020)	8.8	7.0	N/A	N/A



[85] **Definition:** Combines access to food within a reasonable distance and general access to healthy food options. **Source:** University of Wisconsin, Population Health Institute (n.d.). *County Health Rankings and Roadmaps, 2010-2021.* Retrieved from: Rankings data & documentation | County Health Rankings & Roadmaps

Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Percent of Adults Who Are Food Insecure[86] (CHIS)	39.7% (2021)	39.0%	10.2%	6.0%	R-E

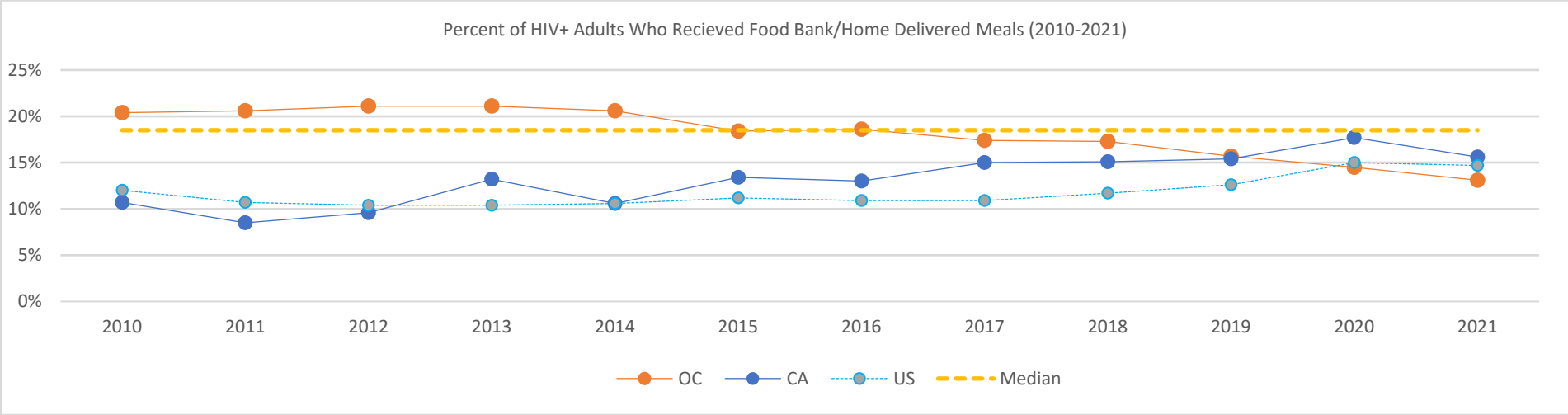




*2021 data for other races/ethnicities are not available due to small sample sizes

[86] **Definition:** Asked of adults whose income is less than 200% of the Federal Poverty Level, whether they were able to afford enough food. **Source:** UCLA Center for Health Policy Research, Los Angeles, CA. AskCHIS 2011-2021. *Food Security* (California, Orange). Retrieved from: http://ask.chis.ucla.edu

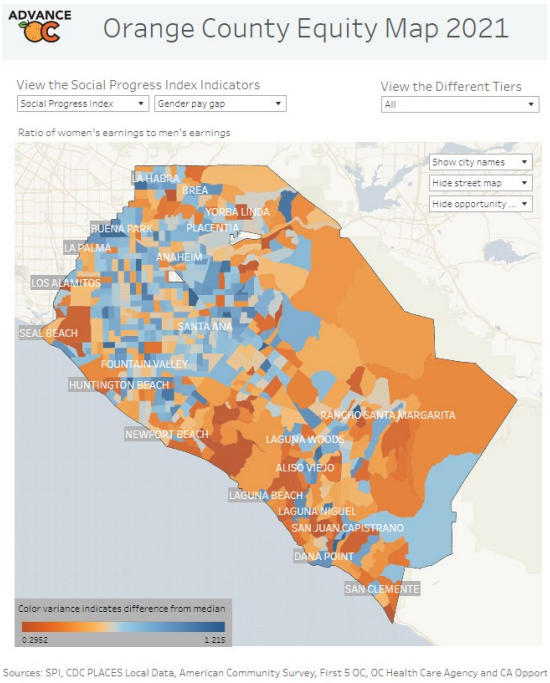
Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Percent of HIV+ Adults Who Received Food Bank/Home Delivered Meals[87] (HRSA)	14.7% (2021)	15.6%	14.7%	N/A	N/A



[87] **Definition:** Food Bank/Home Delivered Meals refers to the provision of actual food items, hot meals, or a voucher program to purchase food. **Source:** U.S. Department of Health Resources and Services Administration (HRSA) (n.d.). *Ryan White HIV/AIDs Program Compass Dashboard.* Retrieved from: Ryan White HIV/AIDS Program Compass Dashboard (hrsa.gov)

Topic	ECONOMIC DISPARITIES				
Data	Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal
	Per Capita Income in Orange County (ACS)	$ 47,334.00 (2021)	$ 42,396 .00	$ 38,332 .00	N/A
	Percent of People Living Below Poverty Level (ACS)	9.9% (2021)	12.3%	12.8%	8.0%
	Percent of Children Living Below Poverty Level (ACS)	10.8% (2021)	15.8%	16.9%	N/A
	Percent of Adults 65+ Living Below Poverty Level (ACS)	10.0% (2021)	11.1%	10.3%	N/A
	High School Graduate or Higher by Age 25 (ACS)	87.3% (2021)	84.4%	89.4%	N/A
Equity & Disparities	– Per Capita Income in Orange County: White ($62,278) enjoy a higher per capita income than Black ($40,976), AIAN ($27,611) and Asian ($46,136 – Percent of People Living Below Poverty Level: White (7.8%) has the least percent of people living below poverty level in comparison to Black (13.1%), AIAN (12.8%) and Asian (11.5%).				
Qualitative Findings	Economic Disparity – Affordability of Health Care – Need for Financial Literacy and Increased Funding Opportunities – Lack of safety nets for workers like unions – Lack of cash assistance opportunities for the working poor and unhoused – Workforce development programs siloed – Increase in housing costs and inflation – Pandemic EBT ended, decrease in food assistance for vulnerable families – Decrease in pandemic relief funding, impacting communities with the lowest SPI first – Opportunities: – Neighborhood groups are forming access to CalFresh – Evaluation redesign of WIC to increase enrollment – Guaranteed income pilots to address economic disparities – Increase in minimum wage proposals to reduce economic disparities				
Current Collaborative Activities					

ECONOMIC DISPARITIES



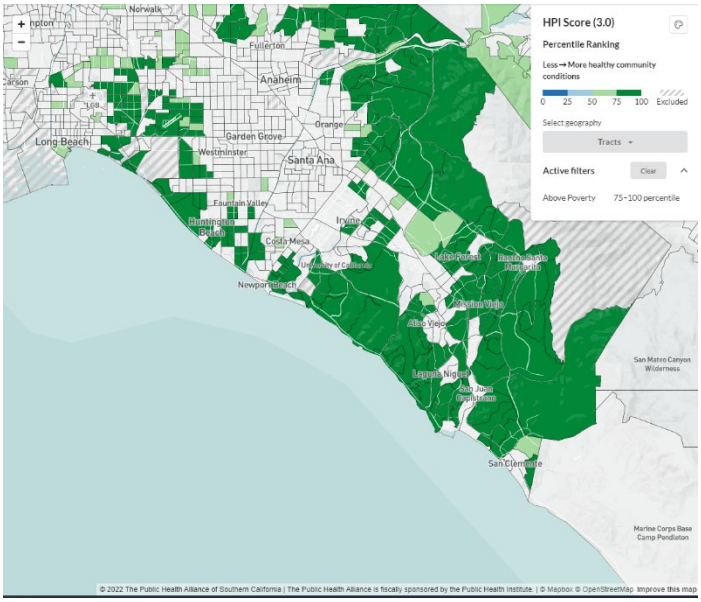
Sources: SPI, CDC PLACES Local Data, American Community Survey, First 5 OC, OC Health Care Agency and CA Opport

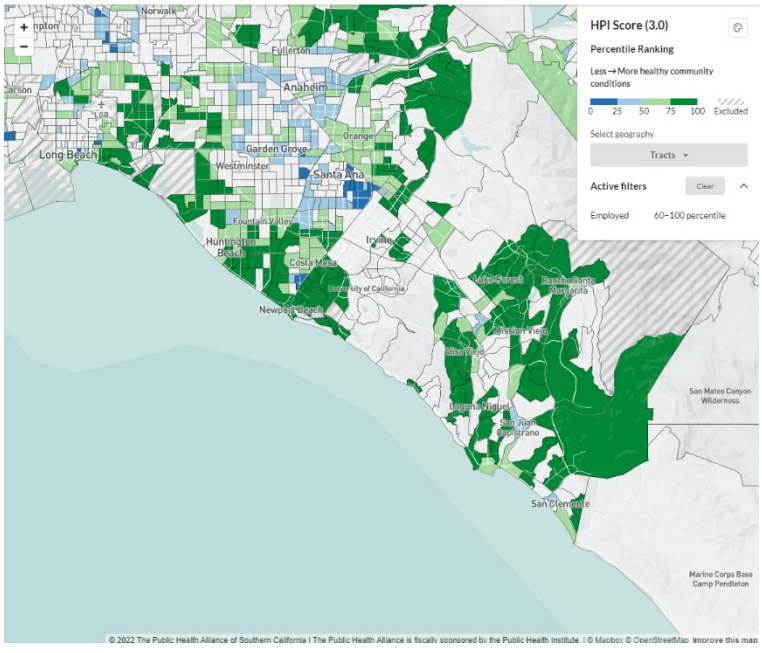
Gender Pay Gap:

- **Blue census tracts experienced a greater pay gap than orange census tracts.**
- **Parts of central and south county had a higher (shades of orange) gender pay gap (lower ratio) compared to other parts of the county.**

Earning Above Poverty Line:

- **Green census tracts had greater rates of people earning more than 200% of federal poverty line than orange census tracts.**
- **Areas of south County had over 75% of people earning more than 200% of federal poverty line compared to the rest of the County (Source: California Health Places Index.)**



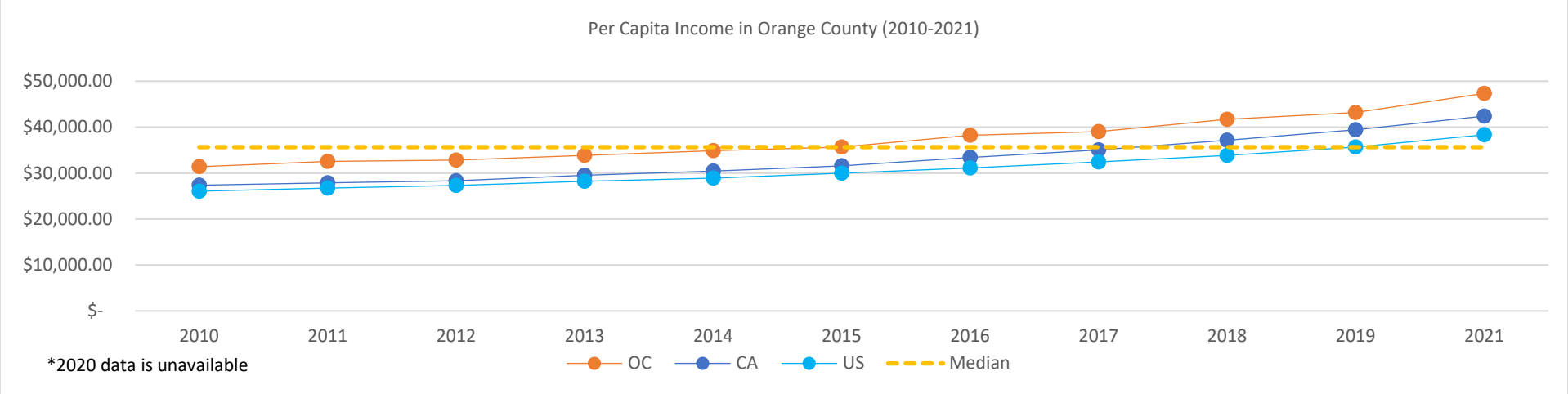


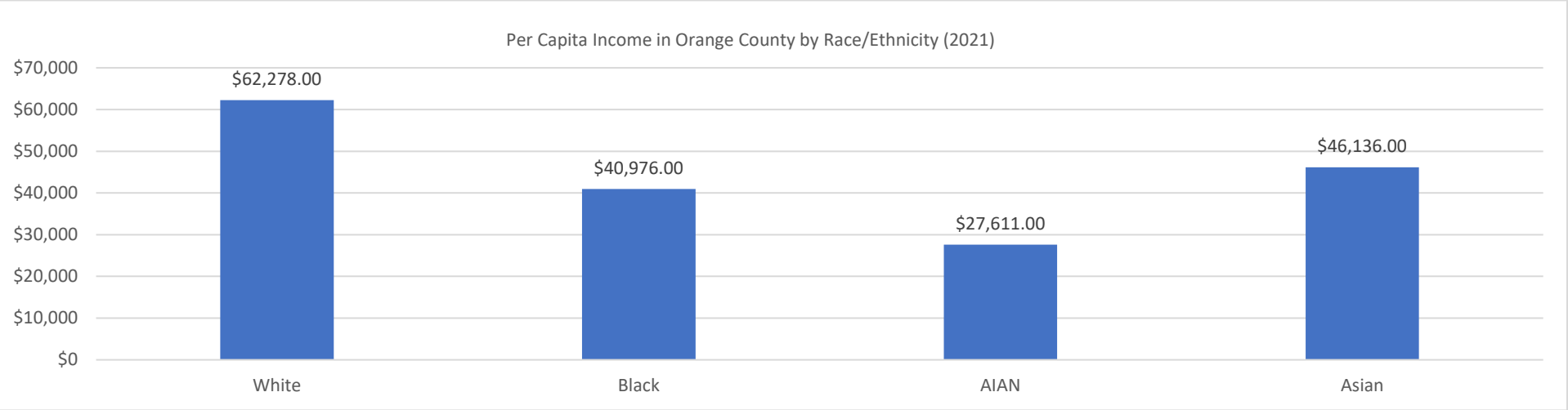
Percent with a Job:

- Green regions have higher rates of people aged 20-64 with a job than orange regions.
- Areas of south and west County has over 60% of people aged 20-64 with a job compared to the rest of the County (Source: California Health Places Index.)

Social and Economic Indicators

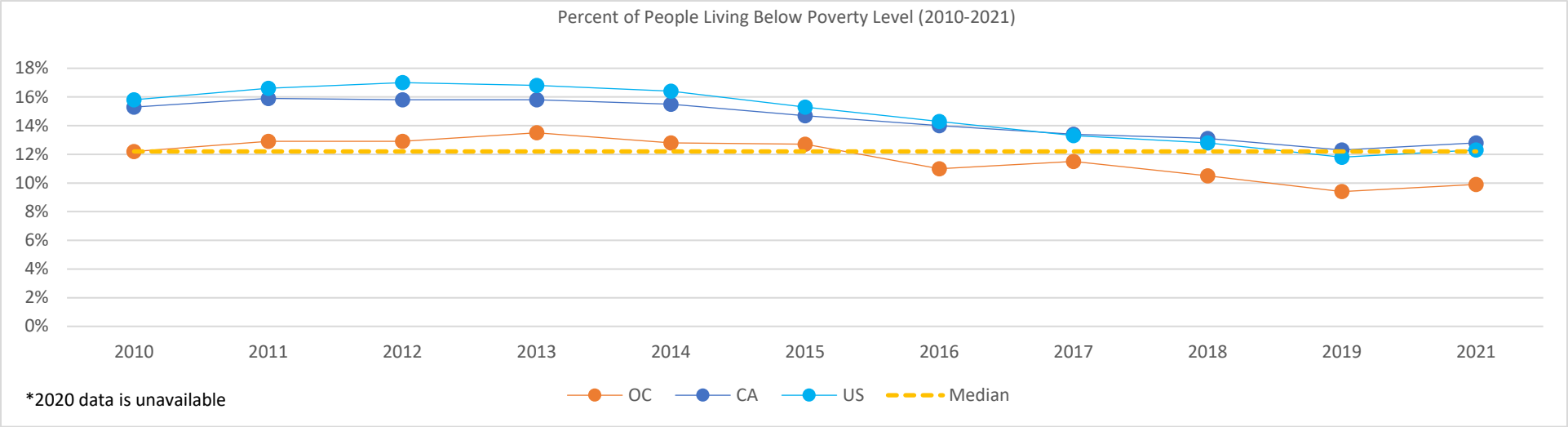
Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Per Capita Income[88] in Orange County (ACS)	$ 47,334.00 (2021)	$ 42,396.00	$ 38,332.00	N/A	R/E

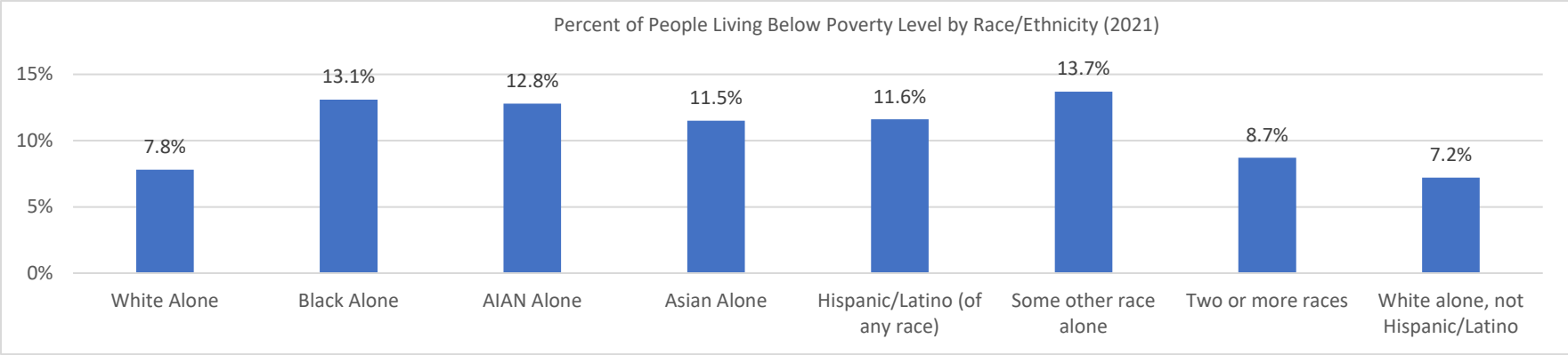




[88] **Definition**: Amount of money earned per person in a given year. **Source**: U.S. Census Bureau (2021). Per Capita Income in the Past 12 months, 2010-2021, *American Community Survey 1-Year Estimates.* Retrieved from: B19301: PER CAPITA INCOME IN THE ... - Census Bureau Table

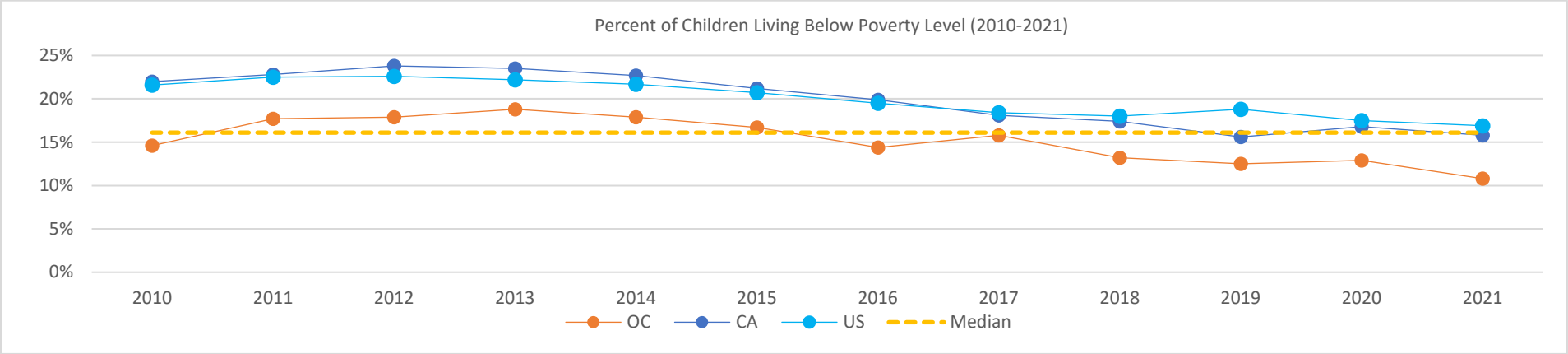
Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Percent of People Living Below Poverty Level[89] (ACS)	9.9% (2021)	12.3%	12.8%	8.0%	R/E

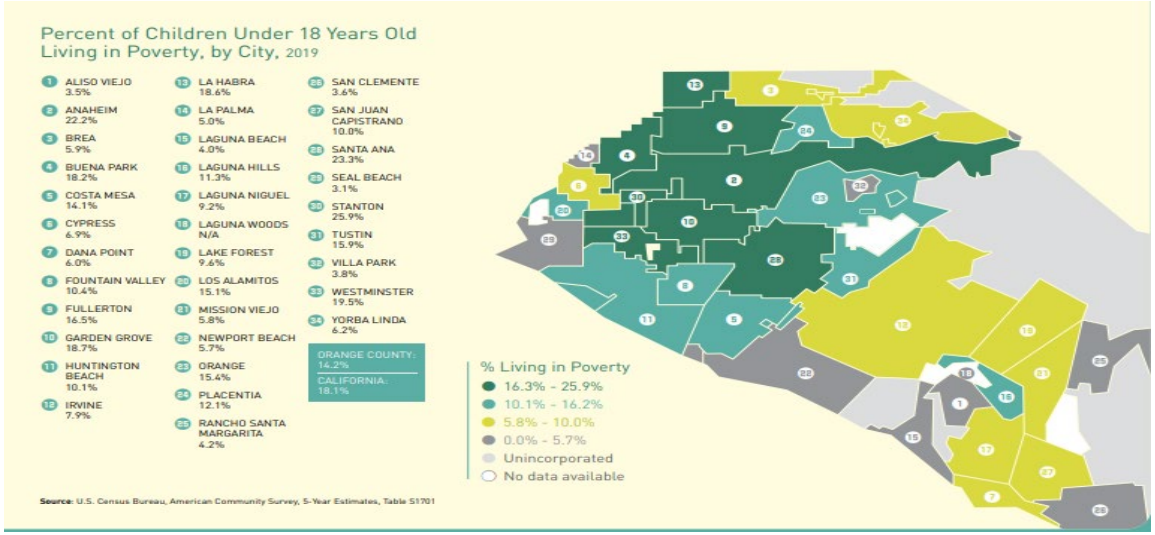




[89] **Definition:** When total income of that person's family is less than the threshold appropriate for that family. **Source:** U.S. Census Bureau (2021). Poverty Status in the Past 12 Months, 2010-2021, *American Community Survey 1-Year Estimates.* Retrieved from: S1701: POVERTY STATUS IN THE PAST ... - Census Bureau Table

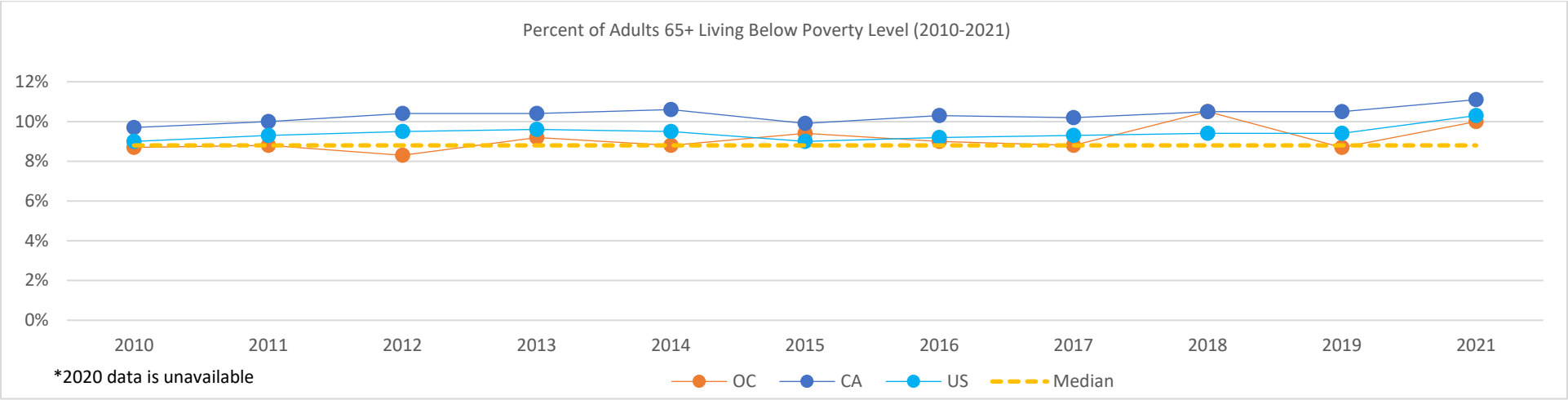
Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Percent of Children Living Below Poverty Level[90] (ACS)	10.8% (2021)	15.8%	16.9%	N/A	Geographic





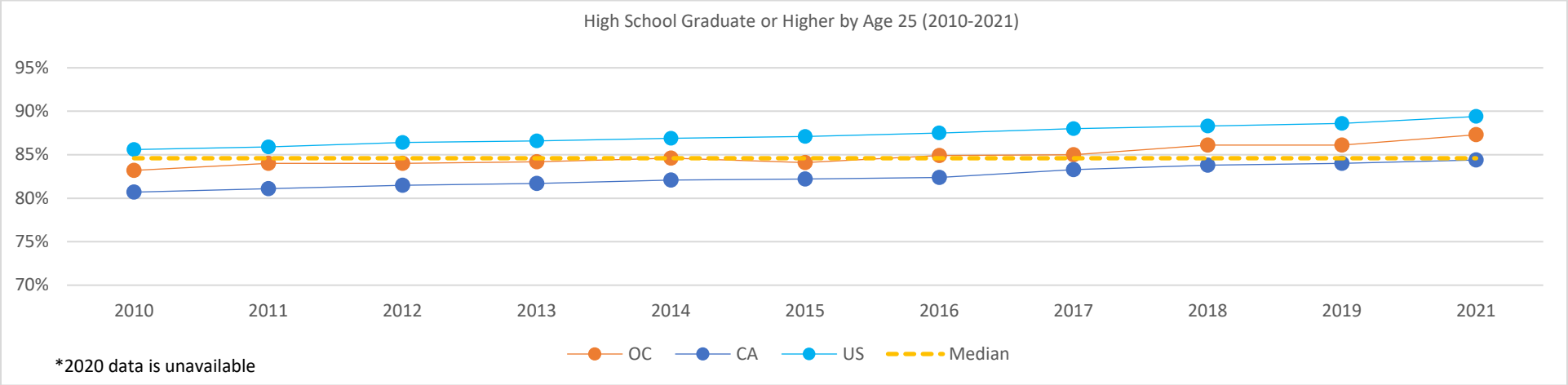
[90] **Definition:** When total income of that person's family is less than the threshold appropriate for that family. **Source:** U.S. Census Bureau (2021). Poverty Status in the Past 12 Months, 2010-2021, *American Community Survey 1-Year Estimates.* Retrieved from: S1701: POVERTY STATUS IN THE PAST ... - Census Bureau Table

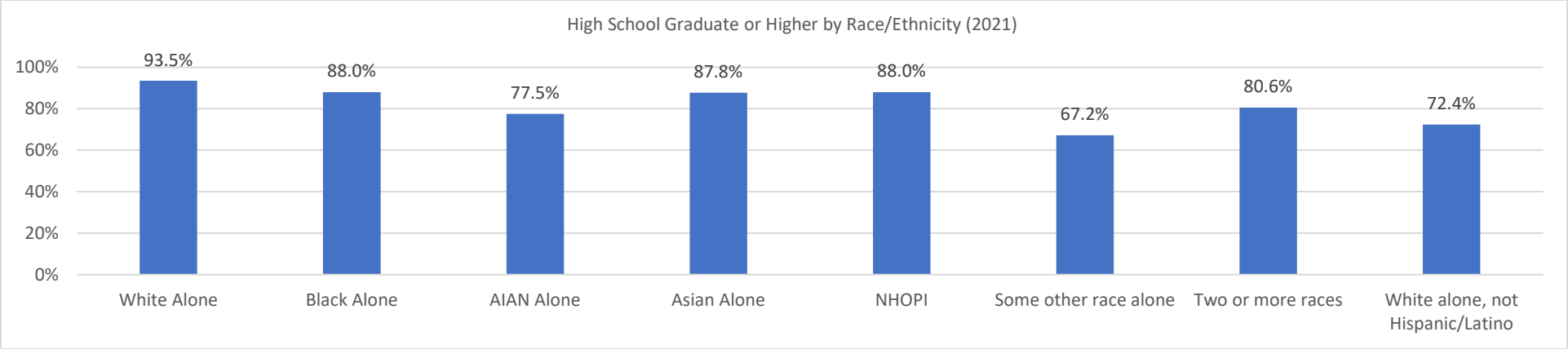
Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Percent of Adults 65+ Living Below Poverty Level[91] (ACS)	10.0% (2021)	11.1%	10.3%	N/A	N/A



[91] **Definition:** When total income of that person's family is less than the threshold appropriate for that family. **Source:** U.S. Census Bureau (2021). Poverty Status in the Past 12 Months, 2010-2021, *American Community Survey 1-Year Estimates.* Retrieved from: S1701: POVERTY STATUS IN THE PAST ... - Census Bureau Table

Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
High School Graduate or Higher by Age 25[92] (ACS)	87.3% (2021)	84.4%	89.4%	N/A	R/E

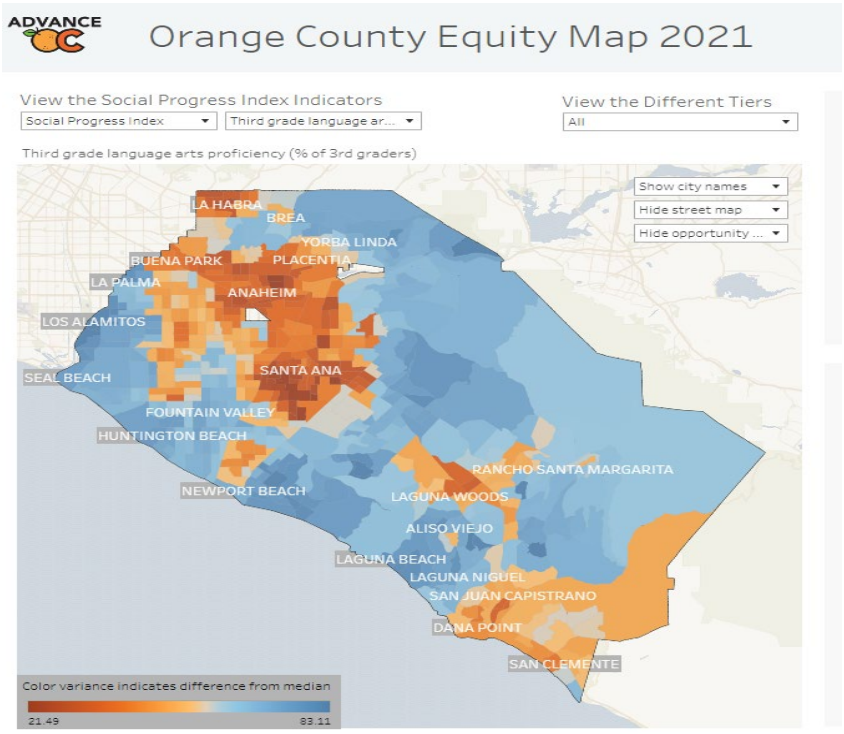




[92] **Definition:** People whose highest degree was a high school diploma or its equivalent, people who attended college but did not receive a degree, and people who received an associate's, bachelor's, master's, or professional or doctorate degree. **Source:** U.S. Census Bureau (2021) Education Attainment, 2010-2021, *American Community Survey 1-Year Estimates.* Retrieved from: S1501: EDUCATIONAL ATTAINMENT - Census Bureau Table.

Topic	LANGUAGE ACCESS				
Data	Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal
	11th Grade Students Proficient in English/Language Arts (CA Dept of Education, KidsData)	66.8% (2021)	59.2%	N/A	N/A
Equity & Disparities	– Third grade language arts proficiency is notably lower in parts of north County compared to the rest of the County (Advance OC's Social Progress index) – More areas of north and central County had no household members who spoke English compared to rest of the County				
Qualitative Findings	Linguistically competent services and resources increase access to resources and care – Need for culturally competent language services and resources – Making healthy choices would be easier if there were clear, culturally competent and easily understood choices in multiple languages – Linguistic and cultural needs increases workforce – Bilingual and culturally competent partners Language Barriers – Language barriers and lack of language appropriate care prevent people from accessing care – Lack of translations for written material prevent equitable dissemination of information				
Current Collaborative Activities					

LANGUAGE ACCESS



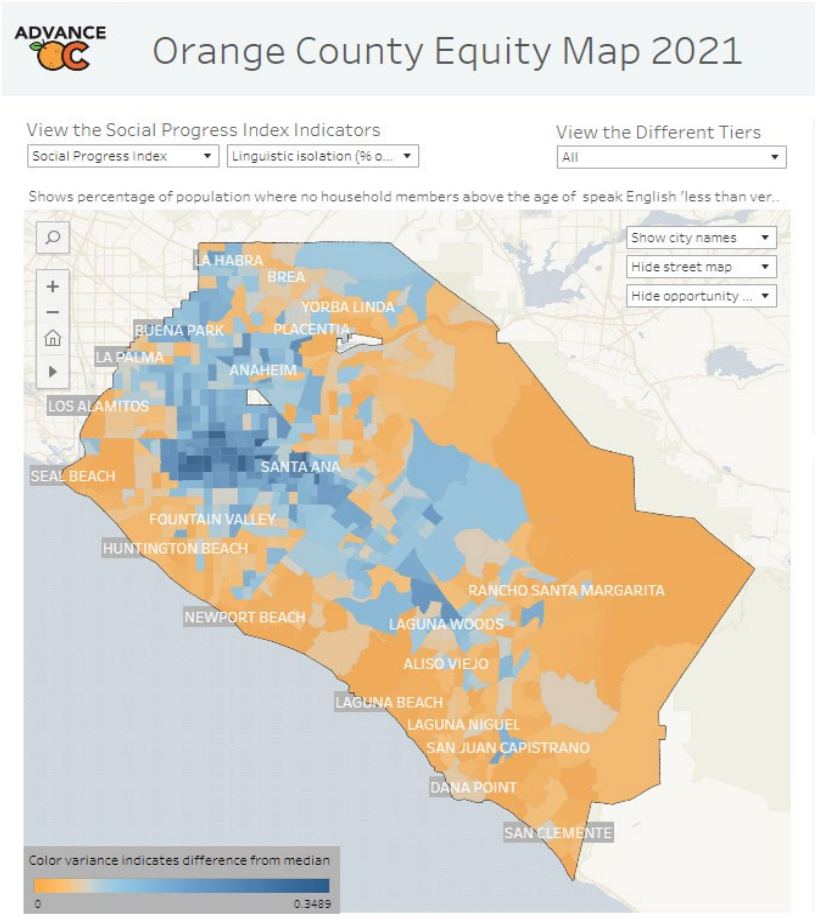
Sources: SPI, CDC PLACES Local Data, American Community Survey, First 5 OC, OC Health Care Agency and CA Opportunit

Third Grade Language Arts:

- **Orange areas are performing worse on this indicator.**
- **Third grade language arts proficiency is notably lower in parts of North County compared to the rest of the County.**

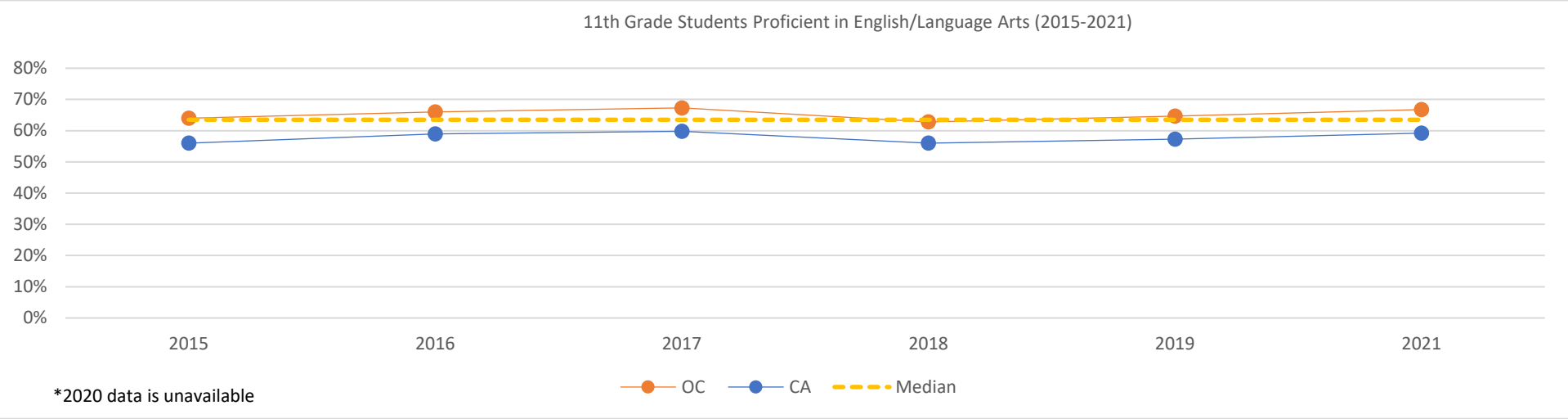
Linguistic Isolation

- **Blue areas are performing worse on this indicator.**
- **More areas of North and Central County had no household members who spoke English compared to rest of the County**



Sources: SPI, CDC PLACES Local Data, American Community Survey, First 5 OC, OC Health Care Agency and CA Opportur

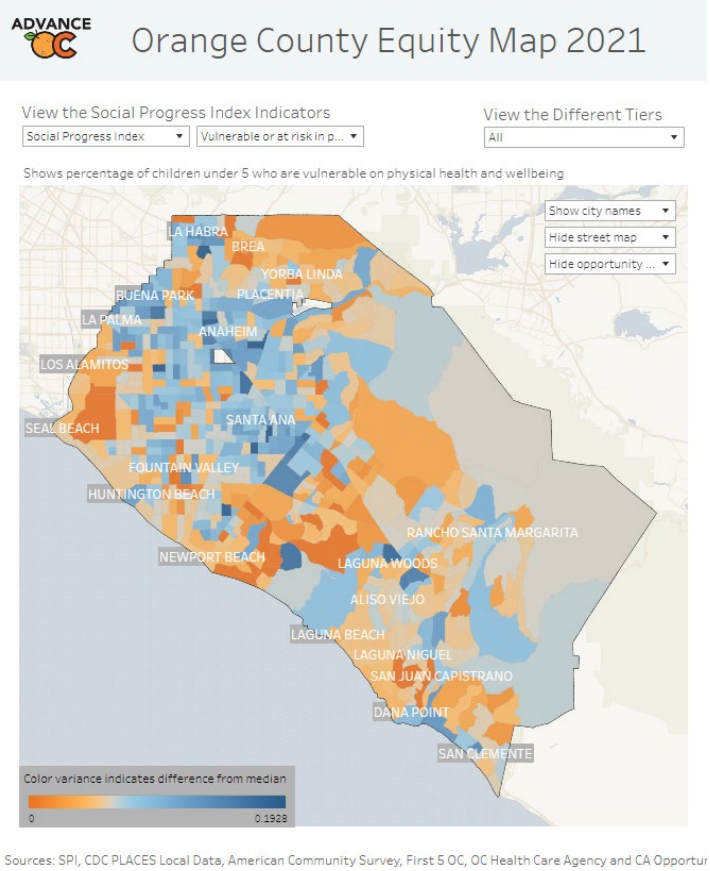
Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
11th Grade Students Proficient in English/Language Arts93 (CA Dept of Education, KidsData)	66.8% (2021)	59.2%	N/A	N/A	R/E



93 **Definition:** Percentage of public school students in Grade 11 who meet or exceed their grade-level standard on the California Assessment of Student Performance and Progress (CAASPP) Smarter Balanced Summative Assessment for English language arts/literacy (ELA). **Source:** Students Meeting or Exceeding Grade-Level Standard in English Language Arts (CAASPP), by Grade Level - Kidsdata.org

Topic	EXERCISE				
Data	Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal
	Percent of Adults Reporting Fair or Poor Health (UWPHI)	13.0% (2020)	14.0%	12.0%	N/A
	Adults 18+ Who Are Physically Inactive (Sedentary) (UWPHI)	21% (2020)	21%	22%	N/A
	Percent of 5th Graders Meeting All Fitness Standards (CDE)	28.5% (2019)	23.1% (2019)	23.2% (2019)	30.6%
	Percent of 7th Graders Meeting All Fitness Standards (CDE)	34.8% (2019)	28.2% (2019)	23.6% (2019)	30.4%
	Percent of 9th Graders Meeting All Fitness Standards (CDE)	42.2% (2019)	33.0% (2019)	23.2% (2019)	30.6%
Equity & Disparities	– North county has a higher percentage of children under five who are vulnerable on physical health and wellbeing (AdvanceOC's Orange County Equity Map) –				
Qualitative Findings	–				
Current Collaborative Activities	– Orange County Nutrition and Physical Activity Collaborative: The mission is to lead coordinated efforts and maximize resources to decrease obesity and improve healthy eating and physical activity among Orange County families and communities.				

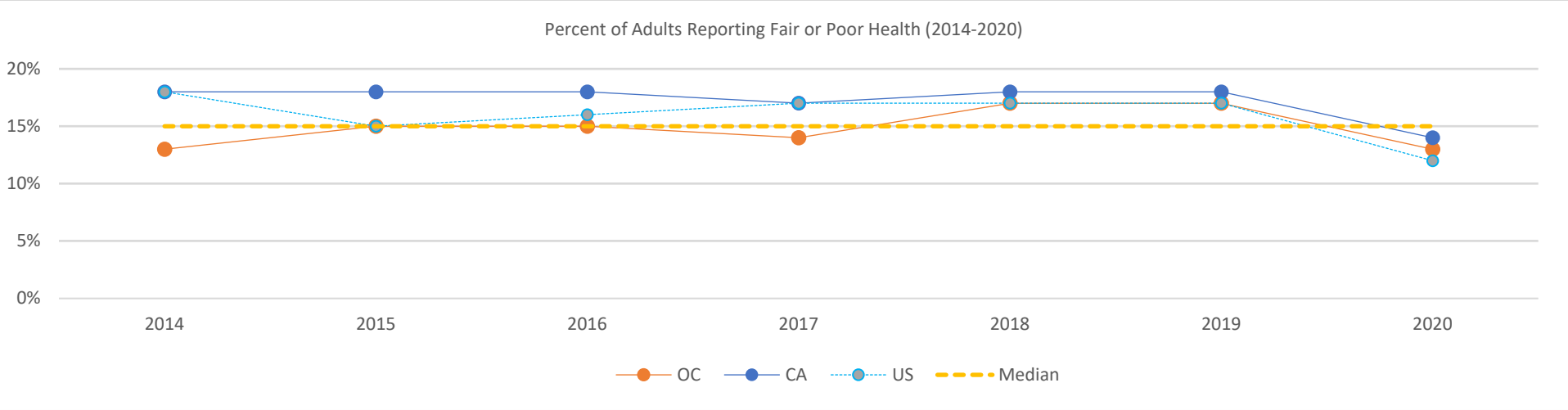
EXERCISE



Vulnerable or at Risk on Physical Health and Well-Being:

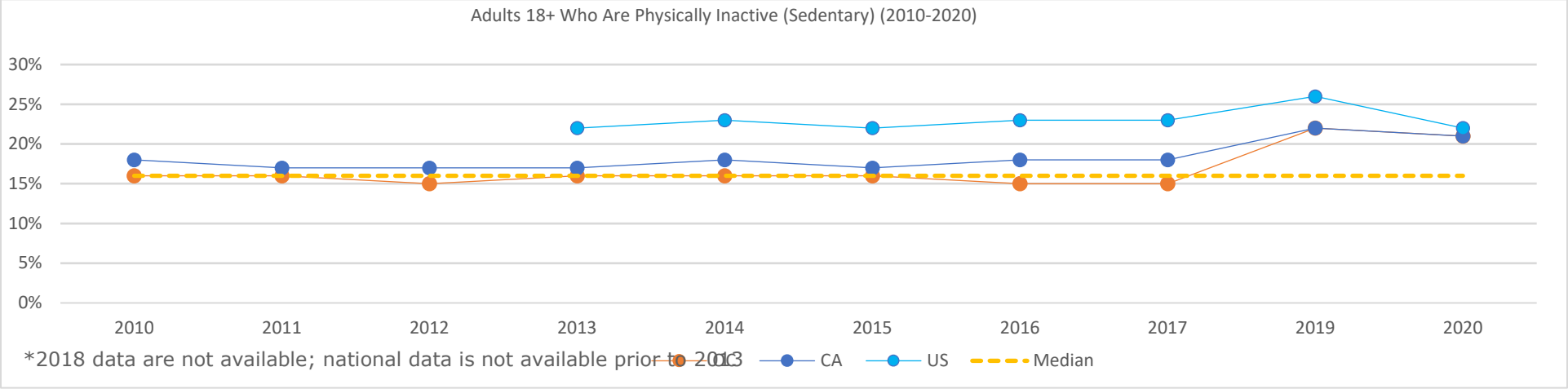
- **Blue regions are performing worse than the orange regions on this indicator.**
- **North county has a higher percentage of children under five who are vulnerable on physical health and wellbeing**

Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Percent of Adults Reporting Fair or Poor Health[94] (UWPHI)	13.0% (2020)	14.0%	12.0%	N/A	N/A



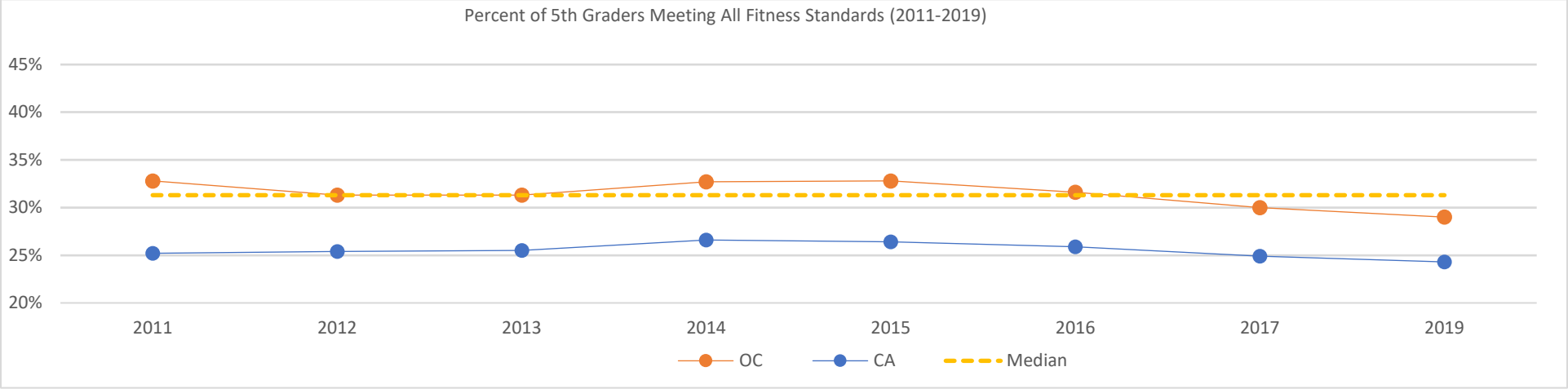
[94] **Definition:** Percent of adults self-reporting fair or poor health. **Source:** University of Wisconsin, Population Health Institute (n.d.). *County Health Rankings and Roadmaps, 2010-2021.* Retrieved from: Rankings data & documentation | County Health Rankings & Roadmaps.

Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Adults 18+ Who Are Physically Inactive (Sedentary) (UWPHI)[95]	21% (2020)	21%	22%	N/A	N/A



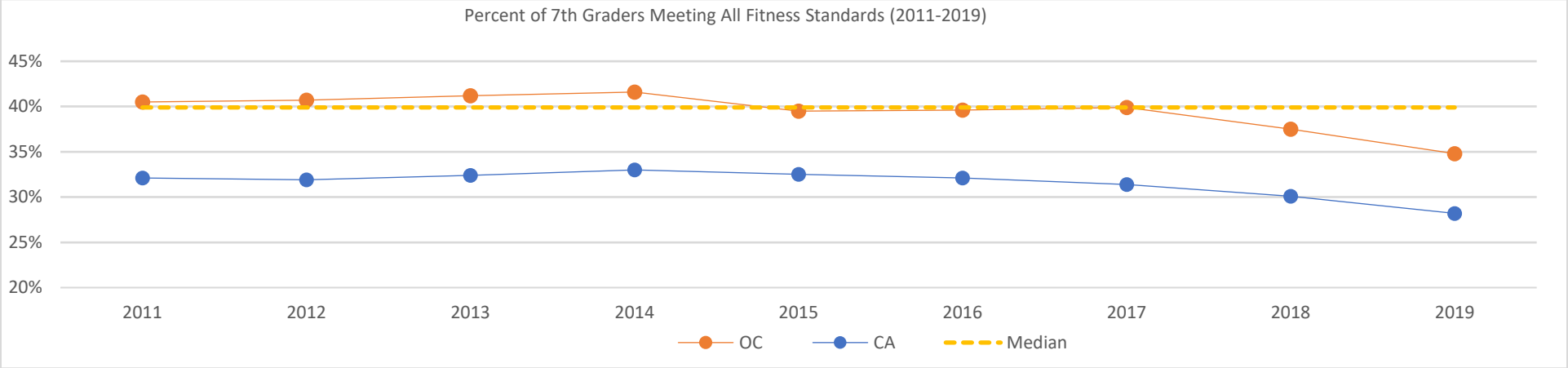
[95] **Definition:** Percentage of adults aged 18 and over reporting no leisure-time physical activity (age-adjusted). **Source:** University of Wisconsin, Population Health Institute (n.d.). *County Health Rankings and Roadmaps, 2010-2021.* Retrieved from: Rankings data & documentation | County Health Rankings & Roadmaps.

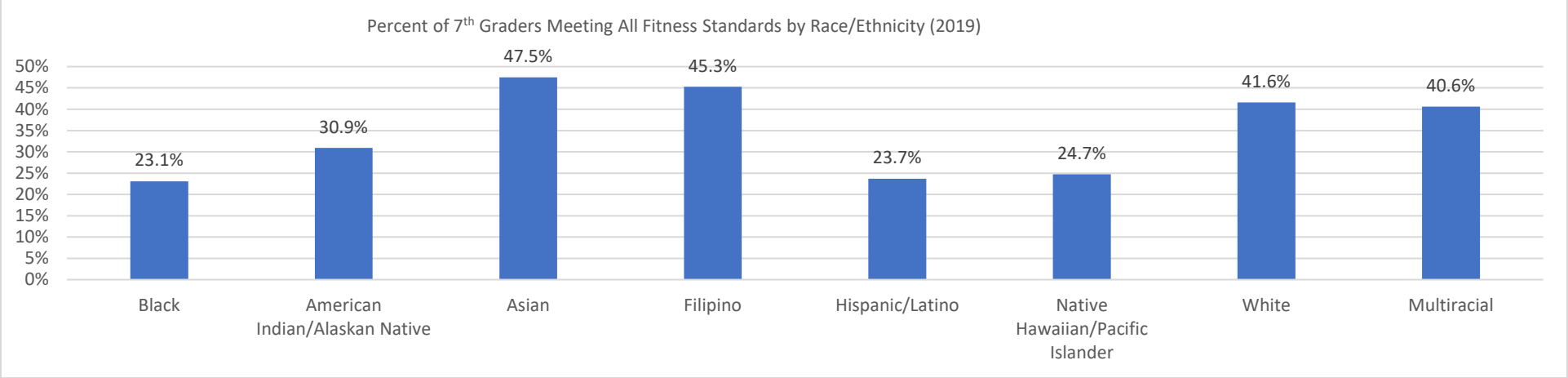
Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Percent of 5th Graders Meeting All Fitness Standards (CDE)[96]	28.5% (2019)	23.1% (2019)	23.2% (2019)	30.6%	N/A



[96] **Definition:** Percentage of public school students in grades 5, 7, and 9 scoring in the "Healthy Fitness Zone" on all six areas of the FitnessGram assessment, by grade level. **Source:** California Department of Education (2020, January). *Physical Fitness Testing Research Files*. Retrieved from: Students Meeting All Fitness Standards, by Grade Level - Kidsdata.org

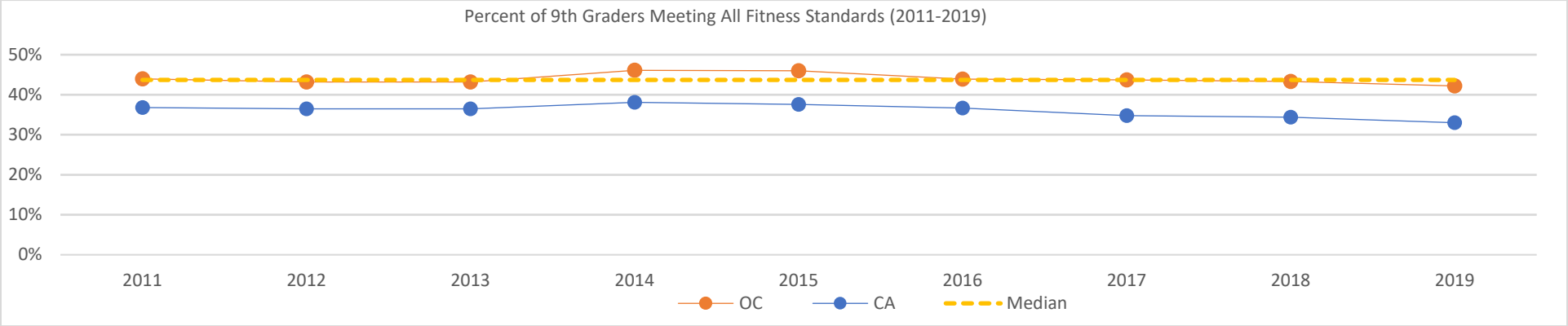
Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Percent of 7th Graders Meeting All Fitness Standards (CDE)[97]	34.8% (2019)	28.2% (2019)	23.6% (2020-2021)	30.4%	R-E

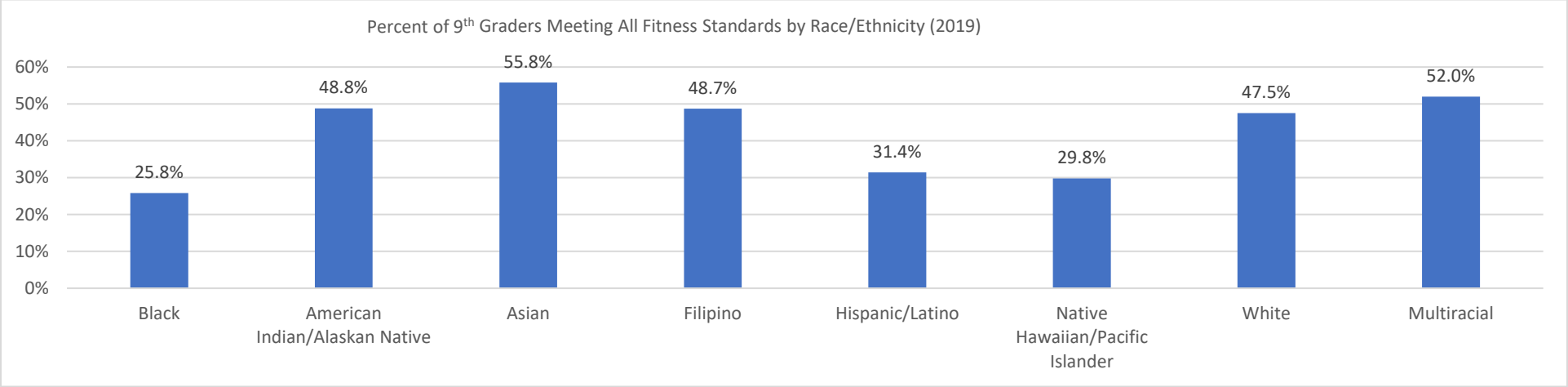




[97] **Definition:** Percentage of public school students in grades 5, 7, and 9 scoring in the "Healthy Fitness Zone" on all six areas of the FitnessGram assessment, by grade level. **Source:** California Department of Education (2020, January). *Physical Fitness Testing Research Files*. Retrieved from: Students Meeting All Fitness Standards, by Grade Level - Kidsdata.org

Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal	Equity
Percent of 9th Graders Meeting All Fitness Standards (CDE)[98]	42.2% (2019)	33.0% (2019)	23.2% (2019)	30.6%	R-E





[98] **Definition:** Percentage of public school students in grades 5, 7, and 9 scoring in the "Healthy Fitness Zone" on all six areas of the FitnessGram assessment, by grade level. **Source:** California Department of Education (2020, January). *Physical Fitness Testing Research Files*. Retrieved from: Students Meeting All Fitness Standards, by Grade Level - Kidsdata.org

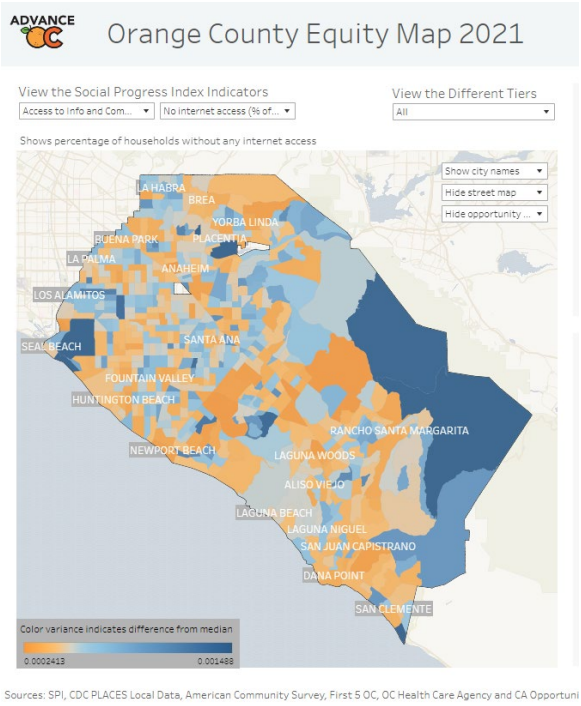
Topic	IMMIGRATION AND REFUGEES				
Data	Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal
	–				
Equity & Disparities					

Qualitative Findings	– Hispanic/Latino immigration support is needed
	– Immigration status constrains lower-income immigrants from receiving government support
	– Lack of federal policy on immigration
	– Immigrants fearful of accessing needed services resulting in exacerbation of health issues and potential spread of disease
	– Threats to access to resources and information
	  ○ Immigration growth in OC impacting access
	  ○ County programming designed for immigrants only
	– Opportunities to collaborate between organizations and the community
	  ○ More local advocacy supporting immigrants and refugees
	  ○ Refugee organizations left out of the current scheme
	– Need for more education and resources
	  ○ More legal resources available and education on immigrant issues and needs
	  ○ Education for COBs working with immigrant population on different immigration statuses, how people apply, barriers, etc.
	  ○ Dashboard to visually see immigration-sphere in OC to increase comprehension
	– Policy changes and increased fear have resulted in separation of families and increased vulnerability of immigrants to exploitation and violence
	– Update K-12 education to be more current, immigration should be taught				

Current Collaborative Activities					

Topic	SOCIAL MEDIA / INFORMATION ACCESS				
Data	Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal
	–				
Equity & Disparities					
Qualitative Findings	Automation's influence on information dissemination – Media fragmentation to message targets – Creates "echo chambers" in places like social media where differing views can be muted – Social media impact on youth mental health – Social media to increase community engagement and awareness of issues among younger generations – Social media increases health communication – More social media engagement makes it easier for political organizers to seek rights for undocumented people – Social media and increased commercial use of the internet result in decreased privacy, parental involvement, and family cohesion				
Current Collaborative Activities					

SOCIAL MEDIA/INFORMATION ACCESS

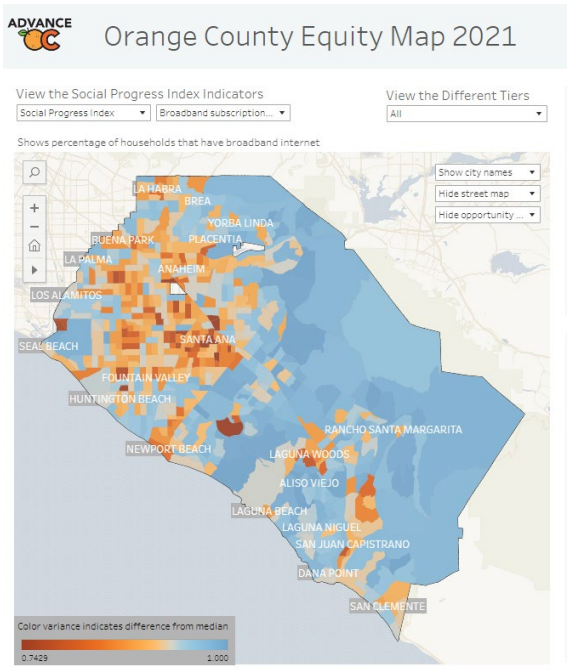


Sources: SPI, CDC PLACES Local Data, American Community Survey, First 5 OC, OC Health Care Agency and CA Opportuni

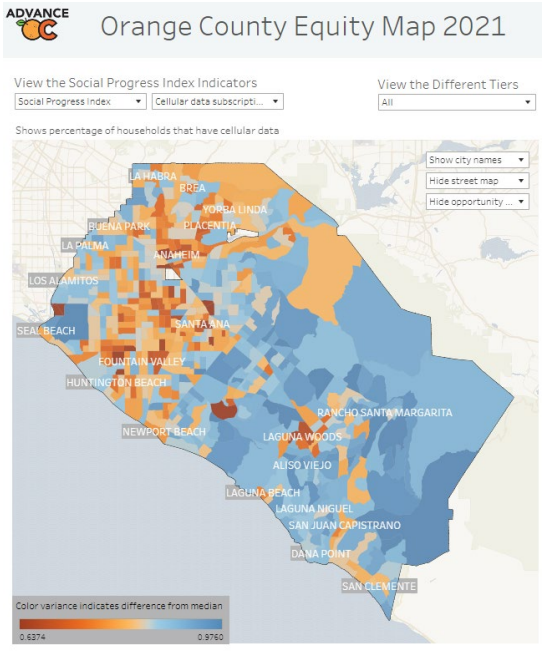
- **Blue regions have lower rates of internet access than orange regions.**
- **Most of North and Central county have a higher percentage of households without any internet access.**

Broadband Internet Access:

- **Blue regions have greater rates of broadband subscription than orange regions.**
- **Most of North and West County has a lower percentage of households that have broadband internet access compared to the rest of the County.**



Sources: SPI, CDC PLACES Local Data, American Community Survey, First 5 OC, OC Health Care Agency and CA Opportur



Sources: SPI, CDC PLACES Local Data, American Community Survey, First 5 OC, OC Health Care Agency and CA Oppor

Households with Cellular Data:

- **Blue regions have greater rates of cellular data subscription than orange regions**

- **Most of North and West County has a lower percentage of households that have cellular data compared to the rest of the County.**

Topic	DATA ACCESS AND SUPPORTS				
Data	Indicator Name	Actual Value (most recent year)	CA Value	US Value	HP 2030 Goal
Equity & Disparities	– Most of north and central county have a higher percentage of households without any internet access (Advance OC's Orange County Equity Map 2021) – Most of north and west County has a lower percentage of households that have broadband internet access compared to the rest of the County (Advance OC's Orange County Equity Map 2021) – Most of north and west County has a lower percentage of households that have cellular data compared to the rest of the County (Advance OC's Orange County Equity Map 2021)				
Qualitative Findings	– Optimistic about government leaders taking initiative to include more communities in data collection – Use relationships with different media providers (e.g., print, radio, television, the Internet) – Social media to increase health communication – Use relationships with different media providers (e.g., print, radio, television, the Internet) to share health information, matching the message with the target audience? – Develop health communication plans for media and public relations and for sharing information among LPHS organizations – Social media to increase community engagement – Increased sense of community, particularly for those who are physically isolated				
Current Collaborative Activities					

Orange County 2023 Community Health Assessment

Forces of Change

Findings
August 2023

An initiative of

Orange County
2023 Community Health Assessment
Forces of Change

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Overview of the Forces of Change

August 2023

About the Forces of Change: The Forces of Change (FoC) Assessment is a survey that identifies forces that may affect a community and opportunities, and threats associated with those forces. Conducting the FoC answers the following questions:

- What is occurring or might occur that affects the health of the community or the local public health system?
- What specific threats or opportunities are generated by these occurrences?

Process to Engage the Community: In April 2023, the FoC was administered to HCA leaders representing the Director's Office, Public Health Services, Strategy and Special Projects, Emergency Management Services, Communications, Environmental Health Services, and Information Technology. In May 2023, the FoC was administered to the Equity in OC participants.

Respondents were provided with findings from the 2019 FoC Assessment and asked to identify threats and opportunities that no longer exist, still exist, or are new to the county. Findings were integrated to prepare the overall results presented in this document.

On July 26, 2023, preliminary findings were shared with over 50 community representatives in order to validate the initial findings as well as update them with additional feedback from the participants. Finalized findings will inform the selection of priority health conditions and determinants for the 2024-2026 Orange County Health Improvement Plan.

Assessment Structure: The FoC questions and responses are divided into four areas:

- Economic Threats and Opportunities
- Technological Threats and Opportunities
- Political Threats and Opportunities
- Social Threats and Opportunities

Structure of Findings: Findings are provided in the following order:

- Forces of Change Assessment - Summary of Feedback
- Attachment A: Forces of Change Assessment Detailed Feedback

ECONOMIC FORCES

1. Affordable Housing

THREATS		OPPORTUNITIES	
• Land use availability • Housing affordability • Lack of housing support		• Organizational housing support • Income adjustments • Community retention	

2. Economic Disparities

THREATS		OPPORTUNITIES	
• Loss of pandemic support • Lack of support for working poor • Inflation • Ineffective Models of Funding		• Increased access to food • Education & workforce development • Health care reform • Income adjustments	

3. Health Care Costs

THREATS		OPPORTUNITIES	
• Provider availability • Government assistance program reform • Decreased access to care • Workforce reform		• Healthcare reform • Non-traditional health care systems	

4. Healthcare Financing Structures

THREATS		OPPORTUNITIES	
• Health care accessibility • Cost of health care • Provider burden • Need for holistic care		• Increased government support • Community education • Non-traditional health care providers	

5. Food Industry

THREATS		OPPORTUNITIES	
• Lack of youth nutrition prioritization • Decreased access to healthy food • Loss of food assistance programs		• Support for locally grown produce • Community programming • Health education • Government assistance	

Additional Topics and Comments

TECHNOLOGICAL FORCES

1. New Provider Technologies

THREATS		OPPORTUNITIES	
• Changes to care • Logistical difficulties in implementation • Lack of access to new technology • Data sharing		• Data sharing improves coordinated care • Improved health care • Community education	

2. New Patient Technologies

THREATS		OPPORTUNITIES	
• Lack of access to new technology • Technology is overwhelming • Decreased quality of care		• Positive change in health care • Planning for new technology implementation	

3. Automation

THREATS		OPPORTUNITIES	
• Information dissemination • Increase in economic disparity • Dangerous work environments		• Workforce development • Clarification on the impact of automation • New automation uses	

4. Personal Devices and Applications

THREATS		OPPORTUNITIES	
• Impact on health • Accessibility of new technology • Safety		• Increased outreach to diverse communities • Increased health communication • Increased positive health outcomes	

Additional Topics and Comments

POLITICAL FORCES

1. Immigration

THREATS		OPPORTUNITIES	
• Lack of community engagement • Policy changes creating uncertainty for immigrants • Access to resources and information • Increase in stigma and racism		• Collaboration between organizations and the community • More education and resources • Increased diversity in workforce and community	

2. Health For All

THREATS		OPPORTUNITIES	
• Structural changes limit access to care • Political uncertainty • Poorer public health outcomes		• Increased collaboration between organizations • Health care system reform	

3. Federal Administration

THREATS		OPPORTUNITIES	
• Reproductive health concerns • Policy changes impact quality of care • Need for connected services		• Increased community education and engagement • Increased awareness of public health issues	

4. State Administration

THREATS		OPPORTUNITIES	
• Changes in funding • Changes in political landscape		• Government support • Changes in health care settings • Increased community involvement	

Additional Topics and Comments

SOCIAL FORCES

1. Social Media and Globalization of Information

THREATS		OPPORTUNITIES	
• Dissemination of information • Disparities in media access • Impact of media on health		• Increased community connection • Education and information sharing • Organizational data usage	

2. Immigration

THREATS		OPPORTUNITIES	
• Political changes impacting immigrants • Immigrant impact on community health		• Educate families about rights and resources • Collaborations between counties	

3. Sense of Community and Cultural Assimilation

THREATS		OPPORTUNITIES	
• Loss of community connection		• Community engagement • Cultural competency in the community • Inter-organization collaboration	

Additional Topics and Comments

Attachment A

Forces of Change Assessment

Detailed Feedback

Forces of Change: Economic Forces

	Affordable Housing
Threats	**Land Use Availability** • Cost of land • Not enough homes for the population, no place to build more housing • Cities/communities not fully using land space **Housing Affordability** • Expensive rent and high interest rates • Increased evictions with no post-eviction support • Increased wealth gap leading to more homelessness • Some cities do not make an effort to create affordable housing **Lack of Housing Support** • Loss of pandemic housing support • Reduction in places that accept housing vouchers • Difficulty qualifying for shelter & housing support, "not struggling enough" • Lack of permanent supportive housing **Other** • Climate change migration • Not in my backyard (nimbyism) • House flippers are affecting homebuying process
Opportunities	**Organizational Housing Support** • New models of housing being developed • Advocacy for rent control • Advocacy at city level • Implementing Regional Housing Needs Assessment • Growth of housing trust • Collaboration between government and CBOs to support enrollment in housing support and expand programs to support community housing needs • More housing opportunities for older adults • Affordable housing with support on site (financial, mental health, etc.) (1x) • Central housing location where people can go to get back on their feet & feel safe (safety net) **Income Adjustments** • Cost of living adjustment • Improve minimum wage • Prevention of homelessness through financial support **Community Retention** • Fund ADA home modifications to allow people to remain in the community • Decrease housing costs to retain community members

Economic Forces

Economic Disparities

Threats

Loss of Pandemic Support

- Pandemic EBT ended, decrease in food assistance for vulnerable families
- Decrease in pandemic relief funding, impacting communities with the lowest SPI first
- But also recovery from loss of jobs

Lack of Support for Working Poor

- Lack of safety nets for workers like unions
- Lack of cash assistance opportunities for the working poor and unhoused
- Workforce development programs siloed
- Lack of living wages
- Inadequate pay/support for health-care workers

Older Adult Financial Security

- Fixed retirement rates for seniors/veterans
- Middle income older adults need assistance. Not "poor" enough for assistance/resources, not "rich" enough to maintain homes, afford healthcare, etc.

Inflation & Population Decline

- Slight increases in income are offset by increase in housing costs and inflation
- Increased cost of basic food and goods
- Impact of inflation is higher for low income communities
- Population decline in OC: affects funding of critical services

Ineffective Models of Funding

- Immigration status constrains lower-income immigrants from receiving government support
- Models of funding support those who can afford grant writers and consultants, but may eliminate grassroots organizations that serve the community

Opportunities

Increased Access to Food

- Neighborhood groups are forming access to CalFresh
- Evaluation redesign of WIC to increase enrollment

Education & Workforce Development

- New models of funding for education & workforce development
- Training programs for educators to bring awareness of local disparities, equity, and access
- Financial literacy
- Large employer job partnerships

Health Care Reform

- Community health equity navigators funding is needed
- Telehealth Opportunities

Income Adjustments

- Guaranteed income pilots to address economic disparities
- Minimum wage proposals to reduce economic disparities

Economic Forces

Health Care Costs

Threats

Provider Availability

- Provider burnout
- Insufficient healthcare professionals and clinics
- Desert of therapists/providers that resemble the community

Government Assistance Program Reform

- Medicaid rollback
- Loss of emergency Medi-Cal post-pandemic
- High reimbursement costs lead to providers rejecting patients on Medicaid/Medi-Cal
- Lack of enrollment assistance for government support programs

Decreased Access to Care

- People choose high deductibles/copays and don't access care
- Increase in part-time hires, decreasing healthcare access through employers
- Health communication is often written at a high literacy level
- Low-income families choose not to pay for healthcare as other needs take priority
- Decrease in preventative care, over-utilization of emergency services

Workforce Reform

- Businesses leaving
- Business model is changing
- Living wage policies are increasing costs

Opportunities

Non-Traditional Health Care Systems

- Opportunities to explore/build on non-traditional health care providers (i.e., community workers)
- Community Health Worker model
- More Medi-Cal benefits to leverage community health workers, doulas, housing support, etc.

Healthcare Reform

- Increased focus on prevention
- Healthcare reform: CalAIM, Community Supports, ECM, CalOptima
- Bundled services
- Guaranteed payment for quality
- Price transparency
- Community awareness of the ineffectiveness of the corporate model of healthcare
- Shift to telemedicine, reducing costs
- More service providers added to the system
- Expansion of Medi-Cal to undocumented people of all ages
- Increase opportunities for student involvement so they can support their community
- Provide support to healthcare providers (streamline mundane tasks)

Economic Forces

Health Care Financing Structures	
Threats	**Health Care Accessibility** • Language appropriate care • Preferential treatment based on personal resources • Lack of physically accessible health care offices for people on Medicare/Medi-Cal • Racial disparities in who can access care • Insufficient coordination between provider offices and managed care **Cost of Health Care** • Affordability of any insurance • Medical care costs wiping out seniors • Sliding scale payment options are often not affordable, but not enough mental health professionals work with Medi-Cal/Medicare • Doctors are seeking patients with higher reimbursement • Inadequate number of providers accepting insurance • Medi-Cal reimbursement rates are insufficient, and Medi-Cal financing may be impacted by state and federal budgets • Inconsistent charges for the same services **Provider Burden** • Professionals leaving healthcare • Healthcare providers are overworked and understaffed • Trying to meet numbers and sacrificing personalized care **Need for Holistic Care** • Lack of preventative care • Rising need for comprehensive care; aging/dementia; increasing chronic illnesses
Opportunities	**Increased Government Support** • Streamlined public program funding • CalAIM initiatives offering expanded coverage and benefits to eligible individuals • CalOptima covering more services and focusing on Social Determinants of Health • State legislation on universal healthcare **Community Education** • Better public health education on prevention options and self-care • Create training programs to increase community well-being (i.e., financial/health literacy) • Community Resource Fairs • Vaccination campaign and encouragement (community pharmacies) • More free health fairs to educate and screen community about hypertension, diabetes, etc. **Non-Traditional Health Care Providers** • Street healthcare workers treat common concerns among unhoused people • More promotoras/community health workers (CHWs) to navigate health care system, services and information on resources – across systems of care • Sustainable, dignified financial structure for CHWs and doulas managed care fee structures • Street healthcare workers to treat common concerns among unhoused people • Holistic care – don't fund for body parts

Economic Forces

Food Industry

Threats

Lack of Youth Nutrition Prioritization

- School nutrition, structure of menus; change in quality of school lunches
- Marketing and brainwashing of youth regarding food
- Reduction in school programming that assists low-income students

Decreased Access to Healthy Food

- Inflation – cost of healthy food continues to increase
- Fewer donations coming into food pantries
- Sacrificing quality and health for shelf life
- Higher demand for food resources since COVID threatening supply chains
- External forces like weather could impede farmers and mass distributors
- Climate change may impact crops and food access
- Cost of a nutritional meal vs fast food

Loss of Food Assistance Programs

- Lack of food programs that target core populations in need
- COVID government assistance programs for food being phased out

Opportunities

Support for Locally Grown Produce

- Initiatives on locally grown foods
- More certified Farmer's Markets for easy access to affordable produce
- Creative programming for community gardens
- Eliminate food waste with education, creative programming, or distribution of leftover food

Community Programming to Increase Food Access

- OC Hunger Alliance is a new collaborative system to improve the food system
- Raise awareness of programs that accept donations from local stores and distribute at food pantries
- New models in Riverside: food boxes at doctors' offices
- Food banks providing healthier food
- Make healthy food options affordable and accessible
- NPO funding to divert excess edible food (reducing food waste while feeding community)

Health Education

- Increasing awareness regarding chronic diseases centered around healthy food options
- Culturally appropriate nutrition education
- New education models to be developed to provide education, resources, and opportunities for health promotion in homes and schools

Government Support

- Increasing awareness of CalFresh and CalAIM food assistance program
- Expansion of CalFresh to include ethnic supermarkets and healthy food
- Raising the scale for seniors or low-income families to qualify for food resources

Technological Forces

New Provider Technologies

Threats

Changes to Care
- Less personal care
- More provider time may be spent on documentation
- Decreasing healthcare workforce

Logistical Difficulties in Implementation
- Difficult to bill for
- Inability for rapid implementation of new tech within county rules/structure
- Difficult to keep up with Standard technology opportunities
- Broadband support for low SPI areas insufficient to support using new tech
- Lack of funding for infrastructure to support new tech

Lack of Access to New Technology
- Organizational health literacy
- Telehealth services require internet access, video cameras
- Tech is a barrier for older adults
- Providers lack time to help patients navigate new tech and health information
- Low-income people who could benefit from telemedicine the most have the least access

Data Sharing
- More information sharing decreases individual privacy and may decrease trust
- Data breaches are becoming more common

Opportunities

Data Sharing Improves Coordinated Care
- Data exchange in the healthcare system
- Increased analytics cumulative, meaningful information to take action
- Increased collaboration among healthcare providers
- Data driven decision making and advanced analytics
- Integration of data of medical and social systems
- Easier identification of disease trends
- Integrated care coordination and easier transition across health systems
- One referral system for OC (currently 4)
- Interpreting data is function of data sharing

Improved Health Care
- Enhancements to virtual personal care
- More access needed in low-income areas
- Able to follow clients on the continuum of care
- Standardization will provide better care
- Ability to see new patients, expanding access
- Greater utilization of harm reduction practices

Need for Community Education
- Offer digital literacy programs to help vulnerable people navigate telehealth
- Learning curve to support a multi-generation workforce

Technological Forces

New Patient Technologies	
Threats	**Lack of Access to New Technology** • Dependent upon patient health literacy and ability to use systems and information • Providers not providing training on understanding new technology • New technology might not be covered by insurance • Inequitable access to technology; digital divide (1x) • Language barriers • Further increases in inequity • Individuals with limited access to technology may face challenges using new technologies • Lack of technology knowledge for older adults (2x) **Technology is Overwhelming** • Loss of privacy • Too many apps, no interoperability • Uncertainty or unreliability of web-based information; information overload • Unknown dangers of Artificial Intelligence • Constant changing of platforms (1x) **Decreased Quality of Care** • Feeling of less personal care • Decreased trust in the healthcare system and providers (1x) • Less time to share issues • Decreased quality especially for adults over 65 and non-primary English speakers who have trouble engaging in tele-health services • Bad user experience **Other** • Technical: Install video camera to seniors living alone (to detect falls)

Opportunities	**Positive Change in Health Care**
	• More reliable information
	• Quicker feedback loop on health status
	• Patient empowerment
	• Patient education
	• Digital literacy education
	• Less strain on healthcare system for tech savvy individuals
	• Increase telehealth use
	• Increased biometric identification to access anything
	• Apps make it easy to access services
	• Reinforces prevention
	• Convenience
	• Mail order pharmacies make prescription refills easier
	• Ability to use sensors to monitor patients
	• Greater emphasis on self-observed symptoms rather than a diagnosis
	• Technology for referral tools across systems of care (1x)
	• Language/translation
	
	Planning for New Technology Implementation
	• Succession planning for the next wave of technology
	• Corporations can donate devices or funding to implement training in the community
	• Offer digital literacy programs to help vulnerable people navigate telehealth
	  • Digital literacy education
	  • Assistance for seniors
	• More access to helping those who do not have access to technology
	• Create interdisciplinary partnerships between education and technology

Technological Forces

Automation

Threats

Information Dissemination

- Media fragmentation to message targets
- Creates "echo chambers" in places like social media where differing views can be muted
- Too much info disseminated that are not concise
- Increase difficulties for senior to work technology
- Automation may have room for marginal error, who will be deemed responsible?

Increase in Economic Disparity

- Jobs are being displaced by automation
- New AI/robot automation
- Increased financial stressors if fewer jobs available, leading to poorer social determinants of health
- Increase economic and social inequity secondary to loss of jobs or low paid jobs
- May require trade-workforce development, needs planning in the education sector

Dangerous Work Environments

- Dangerous work environments due to lack of personal interaction; increase in client stress
- Decreases in physical activity leading to weight gain, disease, pain and injury
- Potentially less direct social interaction

Other

- Zoom meetings discontinued after COVID, leading to lack of access to meetings, information

Opportunities

Workforce Development

- Safer work environments
- Increased tech jobs
- Risk stratification
- Predictability stratification
- More training for workers to focus on advanced skills (1x)

Clarification of the Impact of Automation

- Defining automation to the public
- Create common language and definitions for the public to understand
- Stratify data by race

New Automation Uses

- Safer driverless cars
- Increased self-sufficiency for people with disabilities
- Lower cost of products
- New AI/robot automation
- Automate the common tasks
- Efficiency in documentation
- Robot use in healthcare settings and home settings

Technological Forces

Personal Devices and Applications	
Threats	**Impact on Health** • Addiction to tech • Bullying • Decreased socialization and activity • Social media impact on youth mental health • Loss of value of close personal relationships • People become "armchair physicians" • Can influence literacy negatively using at a young age—not in APA guidelines • Negative impact on mental health at the individual and community level **Accessibility of New Technology** • Most marginalized may not be able to utilize • Lack of tech education for older adults • Unfamiliarity of some groups with technology • Cost of equipment can cause disparities **Safety** • New applications being developed • Media fragmentation to reach targets • Advertising sticks more and is more individualized • Technology (AI) moves too fast; rules, regulations, and safeguards cannot catch up • Staff need training

Personal Devices and Applications	
Opportunities	**Increased Outreach to Diverse Communities** • Improved outreach opportunities • Educational outreach; ability to deliver informed messaging • Social media to increase community engagement and awareness of issues among younger generations • When used appropriately, can increase social engagement for homebound older adults • Could be used to do outreach better and faster • New applications being developed • Workforce development **Increased Health Communication** • Social media increases health communication • With large volume of people who have access to personal devices/applicants, develop strategies to increase health communication e.g., warning signs, reminders. • Access to information including health promotion/education • Improve health communication through health literacy • Language access translations • Create communication standards using health literacy principles • The development of technology has increased interoperability; communication plan to educate the public to establish trust • Increased training to regulate the use of social media **Increased Positive Health Outcomes** • Decreased isolation • Emergency notifications • Phones for all to manage health appointments • Personal self-monitor/access medical needs, EKG, telehealth • Empowering patients self-care to actively participate in own healthcare through apps • Personal self-monitor/access medical needs, EKG, telehealth **Digital Literacy & Accessibility** • Consider hearing/seeing impaired needs with technology – older adults • Increase our safety with confidentiality. Others hacking into system • Intergenerational programs – pair older adults with youth • Need more portals for technologically savvy residents to public benefits or community resources/supports

Political Forces

Immigration

Threats

Lack of Community Engagement

- Lack of event attendance
- People do not vote or know what they're voting for
- Lack of connection between community and elected official

Policy Changes Creating Uncertainty for Immigrants

- Stress about the future of DACA and renewals
- Lack of Affordable Care Act coverage for low-income and undocumented
- Lack of federal policy on immigration
- Always an uncertainty with laws

Impact on Health

- Immigrants fearful of accessing needed services resulting in exacerbation of health issues and potential spread of disease
- Stressors have increased, potential for violence against immigrants has increased, separation of families has impacted mental health and economic stability
- Mental health needs and access
- Chronic health needs
- Cultural practices impact health decisions
- Increased volume, less access to social determinants of health
- Monitorization of health indicators tracked

Access to Resources and Information

- Immigration growth in OC impacting access
- County programming designed for immigrants only
- Enough certified enrollers to assist with the addition of newly eligible recipients, funding to support these efforts
- Economic disparities and wealth concentration and disinformation lead to fear of immigrants
- Systems have not kept up with translating for communities, language accessibility
- Long processing time for asylum applications, so they can't have healthcare and other basic needs met

Increase in Stigma and Racism

- Stigma continues and even has increased
- Increases separation of cultures rather than enriching each other
- Increase in AAPI racism due to COVID misinformation

Immigration	
Opportunities	**Collaboration Between Organizations and the Community** • Grassroots efforts and advocacy may strengthen communities • Mobilize the community • Better coordination among social determinants of health, work, education, housing, etc. • More social media engagement makes it easier for political organizers to seek rights for undocumented people • More local advocacy supporting immigrants and refugees • UC system educating doctors in low-income communities, PRIME – LC • Greater cohesion between organizations and people working to improve this area • Greater participation and engagement of inter-faith organizations who have access to different demographics • Providing housing, prevention of homelessness **Need for More Education and Resources** • Better training for teachers and daycare home providers • More legal resources available and education on immigrant issues and needs • Education for COBs working with immigrant population on different immigration statuses, how people apply, barriers, etc. • Dashboard to visually see immigration-sphere in OC to increase comprehension **Increased Diversity in Workforce and Community** • Linguistic and cultural needs increases workforce • Potential to reduce stigma, increase access to care, and community connectedness

Political Forces

Universal Health Insurance	
Threats	**Structural Changes Limiting Access to Care** • Reduction of capacity with increased Medi-Cal eligibility expansion • Medi-Cal rollback decreasing access for lower income Californians • Medi-Cal re-determination after end of pandemic • Share of cost to individual • Structural changes could decrease access (if costs shift to individuals), decrease quality (by limiting services), and lead to provider services **Political Uncertainty** • CalAIM creates uncertainty • HCA leadership change • Political forces treat Health For All as unnecessary • Duplication of politically driven funding creating duplication of providers; increasing capacity vs competing for clients • Politicization of health care/shifts in political values **Poorer Public Health Outcomes** • Immigrants may not feel welcomed in OC and don't seek needed healthcare early on. They then present to the healthcare system at later stages of disease • Less care and poor health outcomes • COVID response affecting perception of other public health issues
Opportunities	**Increased Collaboration Between Organizations** • CBOs to work with faith-based organizations to provide resources • Large organizations to work with grassroots organizations to reach community with effective partnership • Research from AdvanceOC showing which communities have special needs • Greater opportunities for community members to provide feedback • Collaboration with educational sector on health programs **Health Care System Reform** • Discussions may lead to new models that increase access and/or control costs • CalAIM creates opportunities to address • Increased Telehealth Opportunities • System for better coordinated care for the individual • Better training on health disparities and available resources for doctors • Expand definition of "first responder" • Expansion of funding opportunities through CalAim • Shift to funding based on keeping people healthy • Limiting the business side of healthcare (i.e., health insurance increasing rates every year) • Medi-Cal coverage for low-income persons who are undocumented • Lower healthcare costs to improve health outcomes

Political Forces

Federal Administration

Threats

Reproductive Health Concerns

- Decrease in reproductive health services due to political nature
- Reduced access to service, particularly prevention services, may result in poor health outcomes, increases in unplanned pregnancies (particularly teen), etc.
- Momentum of Roe v Wade may conjecture some concerns
- Changes in abortion resulting in wider healthcare problems
- Birthing rights
- Lack of federal protections for most vulnerable populations: transgender people, pregnant people, people who need abortions
- Federal leaders targeting certain issues/populations: LGBTQIA+ and birthing people

Policy Changes Impact Quality of Care

- Medicare trust fund shortages may change reimbursement to providers or other changes
- Threat of Medi-Cal block grants
- Inconsistencies in state and local regulations (misinforming program delivery)
- Federal protections can take years to roll out while states can pass bills marginalizing folks in hours
- Federal regulations not connected to real life; Federal government not understanding the needs of the community to implement change
-
-

Need for Connected Services

- Post COVID, scaling down of funding impact on services
- Lack of obtaining good services, veterans get released with very little mental health support, need community support to address PTSD, trauma.
- Need continuum of care

Other

- Advocacy training for OC non-profits (see nonprofit VOTE/independent sector report "The retreat of influence")

Opportunities

Increased Community Education and Engagement

- Increased community engagement and advocacy
- Increased education and awareness of importance of preventative services
- Need to move from community engagement to community action by way of clear, strong initiatives that are responsive to community needs
- Encourage youth to advocate for their health and future

Increased Awareness of Public Health Issues

- Opportunity to draw attention to issues
- Increased funding for public health initiatives
- Model for service delivery

Political Forces

State & Local Administration

Threats

Changes in Funding

- There likely will be diversion of funds from existing programs, new taxes and/or diversion of county funds to fund state initiatives
- Many counties receive American Rescue Plan Act funds but misusing dollars, need equity lens for future funding
- Funding decrease in government collections will lead to a reduction of services
- CalAIM and similar initiatives
- State budget deficit

Changes in Political Landscape

- CA senator Dianne Feinstein will retire from Congress in 2024
- Politicians mainly financed by PACs and corporations like Disney

Local Politics and Governance

- Nimbyism
- County politics and favoritism and ease with current contractors rather than buying into new providers
- Reduced advocacy/engagement from non-profit orgs and leadership means community leader advocacy is stunted

Other

- Crime rates due to decriminalization of crimes/punishments
- Decreasing public health workforce due to COVID
- New people coming from out of state to access services
- California has immigration problems but do not have support for immigrants when they enter the state

Opportunities	**State Government Support** • New policies should increase support for early childhood education, universal healthcare, affordable housing, family leave, etc. • Strong state budget to expand services • Raise or eliminate policies to reflect today's needs and environment • CalAIM benefit expansion • Government is enforcing state fair housing and low-income housing laws when challenged by municipalities • CA senator Dianne Feinstein will retire from Congress in 2024 **Local Government Support** • Having County entities educate local communities in plain language on State and Federal level issues that impact the public • OC Board of Supervisors: connection to this process! Funding priorities • Increase of funding for health equity, more transparency to the public of how the funds will be used **Changes in Health Care Settings** • HIPAA, fax vs mail, telemedicine • Will be stockpiling medicines re: abortion • Modernization of the behavioral health system • Improved education using health literacy principles for all opportunities **Opportunities for Community Involvement** • Need for strong, committed, supported community voices in collaboration with appointed leaders and county staff to lobby for local needs • Increase of funding for health equity, more transparency to the public of how the funds will be used • Opportunities for unique programming for health & mental health

Social Forces

Social Media and Globalization of Information

Threats

Dissemination of Information

- Information overload
- Polarization division
- New opportunities for exploitation and the propagation of misinformation including public health information
- Inaccurate health information on social media; dissemination of false and intentionally false information targeting certain populations
- Deep fakes, data breaches, unverified info
- Elon Musk and Twitter changes; Tik Tok Challenges

Disparities in Media Access

- Media fragmentation reduces access
- Digital divide and digital literacy
- Increasingly expensive to have streaming, cable
- Traditional communications for older adults and underrepresented populations

Impact of Media on Health

- Social media and increased commercial use of the internet result in decreased privacy, parental involvement, and family cohesion
- Impact on mental health and social connection
- Awareness on how too much screen time can be detrimental to health
- Cyberbullying
- Child and teen use of social media
- Diminished trust in reputable institutions

Other

- Addressing concerns with advancing technology like chat GPT
- Credit card debt due to overconsumption related to social media advertisement targeting

Opportunities	**Increased Community Connection** • Increased access to information and connectivity and sense of community, particularly for those who are physically isolated • Easier for marginalized populations (e.g., 2-SLGBTQIA+) to make connections • Increase community engagement • Overcomes large barrier of physical isolation for people with disabilities or older adults • Build on the opportunity to bring the community together to create positive change and collaboration **Education and Information Sharing** • Individual and organizational health literacy and digital literacy • Promotion of services, events, and health information through social media • Webinars – sharing of information, different use of platforms, etc. • Increased training for educators and parents about the harms about being plugged in constantly • Start integrating technology education in k-12. We live in a technology age, but the education on it is optional. **Organizational Data Usage** • Developing CBOs particularly to expand messaging and information appropriately • Social media platforms can gain tracking for new generations e.g. Gen Z and millennials

Social Forces

Immigration

Threats

Political Changes Impacting Immigrants

- Policy changes and increased fear have resulted in separation of families, immigrants not accessing critical services and healthcare, and increased vulnerability of immigrants to exploitation and violence
- Lack of policy to address DACA has resulted in feelings of hopelessness and despair
- Socially liberal leaders professing freedom for people who are undocumented then enforcing the backwards laws of the last administration
- Many people don't know immigration law and policy so they fear

Immigrant Impact on Community Health

- Community introduction to disease
- Chronic toxic stress, discrimination, racism, housing, being outed
- Immigration status/socioeconomic disparity contributing to inaccurate perceptions of who's part of "community"

Other

- Distrust of government
- Culturally informed methods of communicating new information on disease to immigrant communities

Opportunities

Collaboration Between Organizations and Local Government

- Need to identify and connect with partners
- Refugee organizations left out of the current scheme
- Neighborhood groups can intervene to provide education and resources
- Promotors de Salud de OC has been doing online webinars
- Collaboration between different counties to leverage resources and opportunities

Positive Changes Due to Immigration

- Population boost in aging or decaying areas
- Increase of GDP due to new taxpayers, consumers, workers
- Community revitalization

Opportunities to Update Education

- Need for updated community demographic data
- Update K-12 education to be more current, immigration should be taught
- Educate families about their rights and resources for immigrants
- Increasing awareness on reasons people immigrate

Government Assistance Program Reform

- CalOptima budget could be used to fund healthcare for all
- Medi-Cal new access for 50+ undocumented people
- Safe haven communities

Social Forces

Community and Cultural Assimilation

Threats

Loss of Community Connection

- Increased assimilation may result in a decrease of parental involvement and cohesion (particularly considering language barriers)
- Koss of cultural identity, and decrease in cultural competency in the larger community
- Hispanic community is a high-risk community
- Various ethnic groups living in silos
- Lack of funding to established language thresholds of OC
- Unrecognized or unaddressed groups
- American individualistic culture can lead to more isolated people, less sense of community
- Dominance of elite-narrative could pulsate negative outcomes (Asian hate, school shootings)

Other

- Aging population
- Disagreement regarding: what "community engagement" looks like
- Lack of dignified and respectful access to programs; limit/remove barriers.
- Actual connection

Opportunities

Community Engagement

- Opportunity to integrate individual communities to strengthen overall community
- Create public community building event
- Identify and promote strength
- Greater community engagement needed for positive change
- Place-based (geo-data) initiatives designed for specific populations of focus

Cultural Competency in the Community

- Acculturation
- Encourage appreciation of other cultures
- Celebrating different cultures uplifts our communities (i.e., Tet Festival)
- Increased understanding that all CBOs need to be reaching out to diverse communities
- More cultural competency
- Programs embracing culture and identity, especially school-based and city-based initiatives
- Increase support of ethnic studies in high school
- Better training for teachers on how to model respect for cultures
- Intergenerational programs for seniors and youth – digital literacy, etc.

Inter-Organization Collaboration

- Link ACES with police, fire, community – beyond health checkups
- Identify and create a specific program for building community cohesion, across the county, through cross-sector collaborations
- Create change through shared agendas
- Orange County cities leverage community centers to elevate the communities in more engaging efforts and having the County hold them accountable
- OC landscape is diverse; cultivate opportunities/strategies to foster inter-organizational collaboration

Orange County 2023 Community Health Assessment

Community Themes and Strengths

Findings
August 2023

An initiative of

Orange County
2023 Community Health Assessment
Community Themes & Strengths

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Overview of the CTSA
August 2023

About the CTSA: The Community Themes and Strengths Assessment (CTSA) is a qualitative assessment of assets in the community and issues that are important to community members. Conducting the CTSA answers the following questions:

- What is important to the community?
- How is quality of life perceived in the community?
- What assets does the community have that can be used to improve community health?

Process to Engage the Community: The CTSA was administered to over 100 Equity in OC community members during an Equity in OC Partnership virtual meeting. Community members selected one of 12 population breakout groups to join. The 12 population groups included:

- Asian American/Pacific Islander
- Black Community
- Children and Families
- Hispanic/Latinos
- Khmer
- Individuals with Disabilities
- LGBTQ+
- Spanish Speaking
- Older Adults
- South Asian, Middle Eastern, North African (also known as SWANA)
- Welcome All Comers (General)
- Youth

On July 26, 2023, preliminary findings were shared with over 50 community representatives in order to validate the initial findings as well as update them with additional feedback from the participants. Finalized findings will inform the selection of priority health conditions and determinants for the 2024-2026 Orange County Health Improvement Plan.

Assessment Structure: The CTSA is comprised of six questions that address the participant's perception of their community's health and how community members experience the effects of health inequities. The six questions are below:

- When you think about your community's health, what is one thing that comes to mind?
- What makes you optimistic or hopeful about your community's health? What is working well?
- What are the most important priorities for your community's health?
- What are the barriers in your community to better health?
- Who has the power over these barriers?
- What are some reasons why it is easier for some to make healthy choices than others

Structure of Findings: The feedback was synthesized to identify themes among the 12 population groups. Findings are provided in the following order:

- Overarching Themes & Findings
- Findings by Type: detailed insights about each theme (Attachment A)
- Findings by Population Group: detailed insights from each population segment (Attachment B)

COMMUNITY THEMES & STRENGTHS

EQUITY IN OC | OC health CARE AGENCY

LANGUAGE BARRIERS

NEEDS	BARRIERS	OPPORTUNITIES	STRENGTHS
• Culturally competent language services, staff and resources	• Lack of adequate translation services, especially for written materials	• Culturally competent and easily accessible resources provided in more languages	• Increase in language services and supports

EASIER ACCESS TO CARE/NAVIGATING THE SYSTEM

NEEDS	BARRIERS	OPPORTUNITIES	STRENGTHS
• Increasing access to timely and quality care and resources	• Lack of access to or understanding of resources and services	• Expanding awareness of resources • Improving transportation services	• Increased awareness and utilization of resources

MORE ACCESS TO FINANCIAL RESOURCES/AFFORDABLE CARE

NEEDS	BARRIERS	OPPORTUNITIES	STRENGTHS
• Increased support in accessing Medi-Cal coverage	• Lack of financial capacity to afford healthcare and basic needs	• Increasing financial literacy • Increasing funding opportunities for the community	• New government programs and initiatives supporting the community

WORKFORCE

NEEDS	BARRIERS	OPPORTUNITIES	STRENGTHS
• Providers that reflect community diversity • Availability of specialty providers • Support staff with competetive wages	• Distrust in the healthcare system • Lack of specialty providers and pediatric sub-specialists	• Investments in and capacity building for grassroots organizations • Inter-organization collaboration to expand service outreach • Increase trust in the healthcare system	• Bilingual and culturally competent partners

Additional Topics and Comments

COMMUNITY THEMES & STRENGTHS

EQUITY IN OC | OC health CARE AGENCY

SOCIAL DETERMINANTS OF HEALTH

NEEDS	BARRIERS	OPPORTUNITIES	STRENGTHS
• Reduce the risk of chronic and preventable diseases by addressing social determinants of health	• Lack of prioritization for preventative services	• Connecting social determiants of health to health services • Educating communities on culturally specific "healthy choices"	• Individuals are getting more involved in programs to improve health outcomes

SAFE AFFORDABLE HOUSING/SPACES

NEEDS	BARRIERS	OPPORTUNITIES	STRENGTHS
• Safe, open spaces • Affordable, stable housing	• Difficulty accessing housing support and resources • Difficulty accessing financial resources	• Safe, affordable housing for all communities	• Increase in green spaces

MENTAL HEALTH

NEEDS	BARRIERS	OPPORTUNITIES	STRENGTHS
• Mental health education • Culturally competent, trauma-informed care	• Stigma around seeking help	• Reducing stigma through education and awareness	• Increased resources for support

Additional Topics and Comments

COMMUNITY THEMES & STRENGTHS

EQUITY IN OC | OCHEALTH CARE AGENCY

COMMUNITY COLLABORATION

NEEDS	BARRIERS	OPPORTUNITIES	STRENGTHS
• More engagement between communities and the county/state	• Engaging the broader community • Cross-organization collaboration	• Having tangible health resources at events • Promoting community engagement	• Collaboration between EiOC and other collectives

CULTURE

NEEDS	BARRIERS	OPPORTUNITIES	STRENGTHS
• Increased culturally competent resources and services	• Lack of culturally competent resources	• Cultural competency in care facilities	• Increase in cultural awareness in local agencies and community partners

SENIORS / INTERGENERATIONAL

NEEDS	BARRIERS	OPPORTUNITIES	STRENGTHS
• Advocacy from those with lived experience • Safety and caregiving for the aging community	• Lack of transportation assistance for older adults	• Early intervention and prevention services • Access through mobile clinics • Intergenerational connections	• Young adults and those with lived experience providing insight and advocacy

Additional Topics and Comments

Attachment A

Findings by Type

LANGUAGE BARRIERS

Key Findings

- **Need(s): Culturally competent language services, staff, and resources**
- **Barriers: Lack of adequate translation services, especially for written materials**
- **Opportunities: Culturally competent and easily accessible resources provided in more languages; expansion of multi-lingual individuals seeking careers in health care**
- **Strengths: Increase in language services and resources**

Findings by Focus Group Question – Informing Action Planning

One Thing about Community Health

- Language barriers prevent communities from accessing healthcare – looking for additional translations, healthcare workers that can provide resources in multiple languages
- Funding for high school or college students to learn a language who enter the health field
- Foster interest and introduce more careers that need linguistically and culturally capable people in high school
- **SWANA:** Local government documents are not translated in SWANA languages/linguistically specific

Optimistic or Hopeful

- Increased language supports
- **AAPI:** Collaboration between AAPI organizations allow more in-language services + language justice

Important Priorities

- Resources in more languages to reduce language barriers
- **AAPI:** Elder care should expand language services
- **Older Adults:** Making resources accessible and easily understood

Barriers

- Language barriers, especially for written materials
- **AAPI:** Occur when words to describe mental health do not exist in their language
- **Khmer:** Needs more bilingual staff

Power to Change Barriers

- Needs linguistically competent services

Ease in Making Healthy Choices

- Having clear, culturally competent, and accessible (easy to understand) choices in their language

EASIER ACCESS TO CARE/ NAVIGATING THE SYSTEMS

Key Findings

- **Need(s): Increase and simplify access to timely, quality care and resources**
- **Barriers: Lack of access to or understanding of resources and services**
- **Opportunities: Expand awareness of resources and healthy choices; improving transportation services**
- **Strengths: Increased awareness and utilization of resources**

Findings by Focus Group Question – Informing Action Planning

One Thing about Community Health

- Education on health, health literacy, where and how to access services, how to navigate the healthcare system, insurance, and food security
- Culturally competent health education especially for communities that have diseases they are at higher risk for
- Holistic, personalized care that understands intersectionality
- **AAPI:** Transportation to medical facilities, especially for seniors; access to preventative care and early screenings
- **LGBTQ+:** Not enough community services for non-monosexuals
- **Black:** Further resources for cardiovascular health and doula care
- **Hispanic/Latino:** Hesitancy to utilize free/low-cost services in fear of usage affecting citizenship (being a public charge)
- **Spanish:** Lack of access to trades for those who want to start businesses
- **Older Adults:** Lack of connected services and available services

Optimistic or Hopeful

- Hopeful for transportation assistance; increased awareness and utilization of resources
- **Khmer:** Clinic for community members to access resources
- **LGBTQ+:** Recognition that the current health system does not work
- **Black:** Optimistic to close the health disparity gap
- **Hispanic/Latino:** Increased access to free healthcare for low-income people; local efforts to enroll eligible community members; food distribution similar to that during COVID
- **Children & Families:** More community partners; seeing schools as hubs for services and education for parents and families

Attachment A – Findings by Type

Important Priorities

- Increasing access to timely and quality care: simplifying ways to access care, education on healthcare navigation, language and culture appropriate care
- Increasing dissemination of resources, especially access to basic needs like food and clothing, transportation, childcare, and resources for special needs families & homeless families
- Services specific to isolated residents in SOC
- Dignified and respectful access to services no run arounds
- **LGBTQ+:** Resources more than just sexual health
- **Hispanic/Latino:** Representation in decision-making
- **Older Adults:** Educating families of older adults who need help; outreach to adult children to create awareness of services for their parents
- **Children & Families:** Concrete resources and easy access for families and children 0-5; keeping children on track with preventative care
- **Welcome All Comers:** Health advocates who connect residents with resources

Barriers

- Lack of transportation services; expectation for vehicle-reliant transportation
- Lack of access to affordable and quality care, preventing people from seeking help
- Lack of understanding of referral systems, difficulties using OCLINK, missed referral opportunities
- Long wait times to access care, difficulty obtaining services as a CalOptima member
- New systems are difficult to navigate for some communities (i.e., telehealth)
- Lack of access to info re: domestic violence, emergency shelters, food insecurity
- Inaccurate/unclear translations of County documents
- Challenges with communication with primary care physicians, especially for populations that don't know how to access valuable resources and services
- **AAPI:** Difficulty navigating mental healthcare
- **Individuals with Disabilities:** Language and culture barriers
- **SWANA:** Lack of access to vaccine informative sessions & education on accessible health resources
- **LGBTQ+:** North County is a resource desert. Lack of education on personal health needs for queer people; no intersectionality
- **Hispanic/Latino:** Stigma around using public resources adds to existing issues in the community; lack of knowledge regarding how the city works
- **Older Adults:** Lack of coordinated care
- **Youth:** Lack of knowledge about community resources
- **Welcome All Comers:** New systems are difficult to navigate for some communities (i.e., telehealth)

Power to Change Barriers

- None identified

Ease in Making Healthy Choices

- Easier access to resources, services, and networks
- Expanding knowledge and awareness of resources
- Better public transportation or other transportation services
- Improving communication about these healthy choices
- Access to primary care reflective of the patients' needs and preference
- Increase locations to access basic health care for working/blue collar communities
- Need one coordinated system that all agencies feed into that provide any service re: housing, food, education, legal, etc.
- **Individuals with Disabilities:** Addressing climate change to make healthy choices
- **Children & Families:** Easily accessible healthy choices
- **Youth:** Reinforcing or rewarding healthy choices

MORE ACCESS TO FINANCIAL RESOURCES / AFFORDABLE CARE

Key Findings

- **Need(s): Increased support in accessing Medi-Cal coverage and cost-sharing**
- **Barriers: Lack of financial capacity to afford healthcare in addition to basic needs; complicated administrative processes to enroll in MediCal**
- **Opportunities: Increasing financial literacy and funding opportunities for the community; simplify eligibility/enrollment processes**
- **Strengths: New government programs and initiatives supporting the community**

Findings by Focus Group Question – Informing Action Planning

One Thing about Community Health

- Issues accessing Medi-Cal: difficulty navigating, families not qualifying for Medi-Cal but unable to afford services without it
- Assistance with cost sharing, co-insurance, deductibles for Covered CA/Commercial coverage
- **Hispanic/Latino:** Disconnect between minority groups
- **Older Adults:** Excellent coverage through CalOptima
- **Children & Families:** Efforts to coordinate care and ensure equity through Med-iCal expansion and First Five investments in early childhood prevention services
- **Youth:** Issues in affording needs
- **Welcome All Comers:** Increase in gym memberships & utilization of innovative services

Optimistic or Hopeful

- New government programs funding social determinants of health and creating partnerships
- New government initiatives like expanding Medi-Cal for older adults, new CalAIM initiatives, Food4All and Health4All initiatives
- Simplify eligibility
- Should be open for everyone, undocumented immigrant simple requirement
- **Hispanic/Latino:** More support to enroll eligible folks in Medi-Cal
- **Children & Families:** Top officials are recognizing community needs; universal free meals for children
- **Welcome All Comers:** The county/community is not pouring money into existing programs that do not work

Attachment A – Findings by Type

Important Priorities

- Increasing financial literacy in communities
- Affordable care: care for symptomatic individuals, affordable prescriptions and healthcare services
- Increased accessible funding for economic empowerment and disseminating information
- **Hispanic/Latino:** Retaining healthcare coverage based on Med-iCal redetermination
- **Older Adults:** Affordable caregiving support and support for caregivers
- **Welcome All Comers:** Emphasis on social determinants of health: home ownership, education, employment, affordable healthcare, well-paying jobs

Barriers

- People are forced to choose between paying for essential needs (rent, food) and paying for healthcare
- Financial restrictions prevent access to resources and care
- High costs of insurance, but people are not being paid livable wages
- Admin burdens to MC
- Financial resources: cost of living & inflation
- Individuals with covered CA who cannot afford to see doctor or receive meds
- **AAPI:** People feel it is too complicated to access insurance and care providers, leading to a lack of medical coverage for hearing aids and specific medical devices
- **SWANA:** Insurance does not cover some necessary procedures (dental, weight loss) that may lead to poorer mental health and potential job loss
- **LGBTQ+:** Lawmakers do not want to adequately fund opportunities for this population
- **Children & Families:** Funding sources limit services to meet grant program goals, leading to less personalized care

Power to Change Barriers

- Those with funding have influence in decision-making, and could provide outreach and workshops.
- **Older Adults:** Insurance companies and reimbursement services could pay for care coordination, transportation, etc.
- **Youth:** Insurance providers, education sector, community centers and leaders, and mayors

Ease in Making Healthy Choices

- Access to financial stability, resources, and affordable care to receive care without financial burden
- **Youth:** Incentive programs
- **Welcome All Comers:** Education

WORKFORCE

Key Findings

- **Need(s): Providers that reflect community diversity; availability of specialty providers; competitive wages; educational opportunities for new workforce**
- **Barriers: Distrust in the healthcare system; lack of specialty providers and pediatric sub-specialists**
- **Opportunities: Investments in and capacity building for grassroots organizations; inter-organization collaboration to expand service outreach; increase trust in the healthcare system**
- **Strengths: Bilingual and culturally competent partners**

Findings by Focus Group Question – Informing Action Planning

One Thing about Community Health

- More behavioral health access
- **LGBTQ+:** Providers are not as "friendly" or "affirming" as they claim to be
- **Hispanic/Latino:** Cross-organization collaboration is encouraged to better refer clients; capacity- building investments into grassroots organizations

Optimistic or Hopeful

- **LGBTQ+:** Providers seem more open about identifying as LGBTQ+ themselves
- **Hispanic/Latino:** Partners have bilingual and culturally competent employees that enable trust in the community
- **Children & Families:** Caring pediatricians who focus on providing quality care for children both in the office and throughout the community; not enough pediatric sub-specialists in the county; high risk OB/GYNs in the county; pediatric psych inpatient program in the County

Important Priorities

- Increasing the number of providers in OC, especially providers that reflect the community
- Increase workforce development in health/public health (grants, stipends, continual education opportunities)
- Communication to demonstrate the system cares
- **Individuals with Disabilities:** Competitive living wages for support staff – staff are moving to LA County for better wages
- **Children & Families:** Work towards increasing in-person care

Attachment A – Findings by Type

Barriers

- Distrust in providers and the healthcare system
- Experiences with dismissive and uncaring providers
- Not just distrust of the system, it's the system's consistent prejudice
- **Individuals with Disabilities:** Not enough providers that go out to people in need
- **LGBTQ+:** Distrust in affirming providers
- **Hispanic/Latino:** Lack of trust in free/low-cost services
- **Children & Families:** Lack of specialty providers; lack of peer providers, mentors, navigators, and supporters; lack of infrastructure to support CBO's to provide community health workers and CalAIM services with office & service hours past 5pm
- **Welcome All Comers:** Providers create barriers with ineffective or complicated health communication; lack of communication between patient and provider

Power to Change Barriers

- Many grass roots organizations and CBOs have cultivated trust with community members which are gateways to discovering solutions-workforce
- **SWANA**: Culturally competent/linguistically competent services

Ease in Making Healthy Choices

- Increasing trust in the healthcare system and providers

SOCIAL DETERMINANTS OF HEALTH

Key Findings

- **Need(s): Reduce the risk of chronic and preventable diseases by addressing social determinants of health**
- **Barriers: Lack of prioritization for preventative services**
- **Opportunities: Connecting social determinants of health to health services; educating communities on culturally specific "healthy choices"**
- **Strengths: Individuals are getting more involved in programs to improve health outcomes**

Findings by Focus Group Question – Informing Action Planning

One Thing about Community Health

- **Hispanic/Latino:** Issues with the environment and housing

Optimistic or Hopeful

- **Older Adults:** Connecting social determinants of health to health services for holistic care
- **Hispanic/Latino:** Individuals are getting more involved in programs to improve health outcomes; Cancer survivorship has increased

Important Priorities

- Address social determinants of health to reduce the risk for chronic and preventable diseases
- **Hispanic/Latino:** Lack of information educating parents on healthy eating habits
- **Children & Families:** Reducing disparities in health outcomes

Barriers

- **Children & Families:** Lack of prioritization for preventative services; climate change

Power to Change Barriers

- None identified

Ease in Making Healthy Choices

- **Children & Families:** Defining "healthy choices" to be community-specific, acknowledging that communities often have limited choices
- **Hispanic/Latino:** Higher socioeconomic status, education, strong support system

SAFE, AFFORDABLE HOUSING/SPACES

Key Findings

- **Need(s): Safe, open spaces, and affordable, stable housing, including permanent supportive housing**
- **Barriers: Difficulty accessing shelter/housing support and resources, especially financial**
- **Opportunities: Safe, affordable housing for all communities**
- **Strengths: Increase in green spaces**

Findings by Focus Group Question – Informing Action Planning

One Thing about Community Health

- Communities are looking for safe, stable housing, particularly for people as they age.
- **Hispanic/Latino:** Housing crisis in low-income communities
- **Youth:** Safe housing and fitness

Optimistic or Hopeful

- Increase in green spaces
- **Older Adults:** Seniors are aging in place as desired
- **Welcome All Comers:** Project Homekey is providing permanent supportive housing

Important Priorities

- Safe, affordable housing for all communities
- Increased support for the homeless population
- Aligned system with all housing organizations
- More permanent supportive housing
- Reduce Admin burden to access affordable housing
- **Older Adults:** Exercise spaces for older adults
- **Children & Families:** Need for more shelters

Barriers

- Lack of safe, open spaces; difficulty accessing resources to gain affordable housing, especially financial
- Difficulty accessing/navigating shelters & getting help out of homelessness due to rules/restrictions at shelter
- Policing & criminalizing homeless population
- Years on a list for a voucher
- No available housing
- Housing not ADA
- **Children & Families:** No effective eviction diversion program

Power to Change Barriers

- Align tools and systems for agencies and organizations to provide prevention, assessment and resources/services

Ease in Making Healthy Choices

- Need safer open areas and stable, affordable housing
- **Children & Families:** Addressing climate change to make healthy choices

MENTAL HEALTH

Key Findings

- **Need(s): Mental health education and culturally competent, trauma-informed care; greater access, especially for youth and families**
- **Barriers: Stigma around seeking help; lack of peer-based, culturally competent services; limited availability and flexibility of services for youth**
- **Opportunities: Reducing stigma through education and increased awareness; promote health literacy**
- **Strengths: Increased resources for support**

Findings by Focus Group Question – Informing Action Planning

One Thing about Community Health

- Communities are vulnerable to mental health issues, but associated stigma prevents seeking help
- Domestic violence in communities lead to intergenerational trauma
- **Individuals with Disabilities:** Lack of culturally competent resources
- **LGBTQ+:** Assumptions about what the community has/does not have, and what the community looks like
- **Hispanic/Latino:** Embarrassment surrounding utilization of public services
- **Children & Families:** Mental health resources for both youth and adults
- **Youth:** Substance misuse

Optimistic or Hopeful

- Increased awareness for mental health issues, ending the stigma, and increased resources for support
- **AAPI:** Recognition of community trauma; integration of health, mental health, and social services
- **LGBTQ+:** Energy behind continuing to improve the quality of care
- **Children & Families:** ACES Aware Trauma Informed Network of Care; partnerships with institutions like police, churches, to raise awareness for domestic violence

Important Priorities

- Ending stigma so people can access care freely
- Education about mental health & stigma for families
- Linguistically & culturally appropriate, trauma-informed care
- OC is very diverse and the workforce needs to have awareness and know-how to achieve buy in
- **Black:** Need more mental health providers
- **Hispanic/Latino:** Substance use and food access support; lack of outreach to destitute people & children

Attachment A – Findings by Type

Barriers

- Stigma around seeking help results in difficulty navigating mental health care system
- Lack of workforce/peers
- Lack of providers who can relate to older adults or immigrants
- Peer based culturally competent services
- Children & teen Mental health need to be a priority
- Working parents unable to visit/attend health education during working hours
- Moderation of MHSA
- Not enough resources
- Long wait times more providers
- Normalize seeking services/aid
- Improving easy to understand health communications- health literacy
- Behavioral health workforce initiatives to increase access
- **Black:** Organization leaders are afraid of affirming the LGBTQ+ community in fear of controversy
- **Hispanic/Latino:** Lack of connection between the home and healthcare resources; awareness of the importance of parental involvement throughout childhood
- **Spanish:** Need focus on spiritual, psychological, emotional health
- **Children & Families:** Reducing homelessness
- **Youth:** Insurance companies act as a barrier for mental health and substance use treatment
- **Welcome All Comers:** Lack of social connectedness results in poorer mental health

Power to Change Barriers

- **SWANA:** State and federal efforts to force insurance providers to expand mental health coverage and address issues that lead to poor mental health

Ease in Making Healthy Choices

- **LGBTQ+:** Increased self-worth
- **Children & Families:** Awareness of red & green flags in relationships to prevent domestic violence

COMMUNITY COLLABORATION

Key Findings

- **Need(s): More engagement and transparency between communities and the county/state; support for issue-based, non-partisan advocacy**
- **Barriers: Engaging the broader community and cross-organization collaboration; investing in integration between CBOs and health care system**
- **Opportunities: Having tangible health resources at events; promoting community engagement**

Findings by Focus Group Question – Informing Action Planning

One Thing about Community Health

- Communities would like to see more engagement and involvement between them and the county/state in health policies/listening & action
- **LGBTQ:** Disconnect between minority groups
- **Children & Families:** Excellent pediatric & OB services, but the system feels provider-centered rather than family-centered

Optimistic or Hopeful

- Collaboration between EiOC and CBO's and other collectives have increased awareness of community issues, promoted community engagement, and communities have felt the effects.
- Financial investments in integration of CBOs & health care system
- Eventing has shown to spark conversations, finding solutions, promotion

Important Priorities

- Extended connection with funding/resource advocacy in South County
- Empowering the community and uplifting community voices, as well as having tangible health resources available at events.
- **SWANA:** Having places where women can learn to start a business
- **Children & Families:** Pregnancy and birthing services, and support for families until the child is a few years old
- **Older Adults:** Social connections for older adults

Barriers

- Difficulty engaging the broader community and collaborating between organizations
- Respectability politics keeping people outside of the system
- Transparency- trust is an issue
- Resources for non-profits and agencies to engage in issues based, nonpartisan advocacy
- **LGBTQ+:** Organizational leaders afraid of affirming LGBTQ+ community in fear of controversy
- **Children & Families:** Lack of connection between the home and healthcare resources; awareness of the importance of parental involvement throughout childhood

Power to Change Barriers

- Community groups collaborating with each other and the government, as well as education in schools and in the community, have the power to create change
- **Welcome All Comers:** Community members volunteering or contributing to neighborhood support

Ease in Making Healthy Choices

- Community engagement in healthy choices and having a healthcare network would create ease.
- **SWANA:** Creating more trust between the government and the community.
- **Welcome All Comers:** Programs that meet people where they are

CULTURE

Key Findings

- **Need(s): Increased culturally competent resources and services**
- **Barriers: Lack of culturally competent resources; systemic racism**
- **Opportunities: Cultural competency in care facilities**
- **Strengths: Increase in cultural awareness in local agencies and community partners**

Findings by Focus Group Question – Informing Action Planning

One Thing about Community Health

- There is a lack of culturally competent care and resources like homeless services, food distribution, and nutrition
- Communities are looking for health equity
- **AAPI:** There is a resistance towards western medicine
- **SWANA:** Diversity within SWANA community includes many cultures and international issues, leading to harmful cultural norms
- **Hispanic/Latino:** Immigration support is needed

Optimistic or Hopeful

- Increase in culturally competent care and cultural awareness in local agencies and community partners
- **Individuals with Disabilities:** Cultural change in CalOptima
- **SWANA:** Cross-community engagements, like cultural/ethnic markets
- **Hispanic/Latino:** Culturally appropriate health education; partners are bilingual and culturally competent
- **Youth:** More conversations around equity and the implementation of diversity, equity, and inclusion

Important Priorities

- Cultural competency in care facilities and culturally specific services
- OC is very diverse and the workforce needs to have awareness and know-how to achieve buy in
- **AAPI:** Cultural understanding, cultural foods in care facilities; bilingual and bi-cultural caregivers
- **SWANA:** Ensure healthcare providers who are ethnically and culturally aware of the community's needs are not overloaded
- **LGBTQ+:** Helping leadership lose fear to make change
- **Hispanic/Latino:** Culturally sensitive mental health support for cancer warriors
- **Welcome All Comers:** Health literacy

Attachment A – Findings by Type

Barriers

- Lack of culturally competent services, especially in-language mental health professionals
- **Khmer:** Lack of culturally aware staff in healthcare settings
- **Black:** Lack of treatment due to racism
- **Welcome All Comers:** Threats of deportation

Power to Change Barriers

- Acknowledge structural and systemic racism to begin healing & building trust
- **AAPI:** Community leaders of different generations & backgrounds
- **SWANA:** Culturally competent services

Ease in Making Healthy Choices

- **Individuals with Disabilities:** Reducing racism & having cultural acknowledgements
- **Hispanic/Latino:** Citizenship
- **Youth:** Promotoras, culturally based models, and peer leaders
- **Welcome All Comers:** Health communication in plain language, both written and verbal, and confirming understanding of the material

SENIORS/INTERGENERATIONAL

Key Findings

- **Needs: Advocacy from those with lived experience and care for the aging community**
- **Barriers: Lack of transportation and coordination assistance for older adults; technological requirements; language needs**
- **Opportunities: Early intervention and prevention services accessed through mobile clinics and intergenerational connection; more programs and services for health living; promote digital literacy**
- **Strengths: Young adults and those with lived experience providing insight and advocacy**

Findings by Focus Group Question – Informing Action Planning

One Thing about Community Health

- More activities for healthy socialization and health
- Daytime programs (cultural and linguistic needs)
- **AAPI:** concerned about senior health and safety, caregiving
- **Youth:** Youth health is doing well

Optimistic or Hopeful

- **AAPI:** Seniors connecting with youth about mental health
- **Spanish:** Senior centers connecting with mobile clinics to provide medical/dental care

Important Priorities

- Care coordination and transitions needed
- **AAPI:** Advocacy and care for aging community will allow them to age in their own homes
- **Individuals with Disabilities:** Having people with lived experience making decisions
- **Older Adults:** food insecurity, nutritious meals and nutrition education; addressing loneliness; education on navigating the system

Barriers

- Lack of accessibility/services
- Lack of cultural competent services/preferred language
- Lack of coordinators who can help setup transportation or appointments; call centers are a barrier

- Technological requirements to access care
- Health system is confusing to navigate
- **AAPI:** Transportation for older adults to doctor's appointments, events, etc.
  Older Adults: Lack of providers that older adults feel understand their generational experiences and needs

Power to Change Barriers

- Improved digital literacy
- Telehealth
- Young adults and those with lived experience can improve healthcare access and reduce barriers
- **AAPI:** Early intervention and prevention services, as well as intergenerational connections
- **Older Adults:** engage seniors in workforce; they can contribute to feel more socially engaged and continue being a part of community
- **Individuals with Disabilities:** Include services- work activity for blind, hard of hearing/deaf, immobile

Ease in Making Healthy Choices

- None identified

DATA COLLECTION

Findings by Focus Group Question – Informing Action Planning

One Thing about Community Health

- **SWANA:** Lack of accurate data
- **LGBTQ+:** Researchers collect data with little to no input from the community, and then implement services with no sustainability plans
- **Youth:** Report card of health indicators
- **Welcome All Comers:** Communities feel left behind by new technology; Issues with well-being (financial, mental, physical)

Optimistic or Hopeful

- **SWANA:** Government and leaders are taking the initiative to include the community in their data collection forms; the younger generation is taking initiative to conduct research and collect good information

Important Priorities

- **LGBTQ+:** Inclusive and representative data, and using data to drive action
- **Youth:** Battling health misinformation and disseminating accurate information; seeking education on mortality and morbidity rates

Barriers

- **Youth:** Acknowledging the statistics around behavioral and mental health

Power to Change Barriers

- None identified

Ease in Making Healthy Choices

- **Welcome All Comers:** Increased health literacy

HEALTHY CHOICES

Findings by Focus Group Question – Informing Action Planning

Ease in Making Healthy Choices

- **Children & Families:** Important to understand the implications of making choices and to understand the definition of "healthy" and "healthier choices"

NEEDS ASSESSMENT/INITIATIVE

Findings by Focus Group Question – Informing Action Planning

Optimistic or Hopeful

- **Older Adults:** Dementia Care Aware Initiative will connect at-risk individuals with services; Older Adults Needs Assessment

COMMUNITY INTEGRATION

Findings by Focus Group Question – Informing Action Planning

One Thing about Community Health

- **Individuals with Disabilities:** Importance of community integration that includes strong community resources

Optimistic or Hopeful

- **Individuals with Disabilities:** Importance of community integration that includes strong community resources

LACK OF TRUST IN PROVIDERS

Findings by Focus Group Question – Informing Action Planning

Barriers

- **Khmer:** Lack of trust in healthcare providers

Attachment B

Findings by Population Segment

Attachment B – Findings by Population Segment

Asian/Pacific Islanders

Theme	One Thing About Community Health	Optimistic or Hopeful	Important Priorities	Barriers	Power to Change Barriers	Ease in Making Healthy Choices
Language Barriers	Resources available in various languages as a way to reduce language barriers and increase capacity	Currently there is more in-language services and resources due to community-based organizations connecting with each other. This has resulted in more efforts for language justice.	Care for elders should include language services	Language barriers occur when words are not available in person's language to describe or talk about mental health.		It would be easier to make healthy choices if the clients were able to understand paperwork
Easier Access to Care/ Navigating the Systems	Difficulty with transportation, particularly to medical facility for seniors. Difficulty accessing the complicated health systems. Need access to early screening for breast and colon cancer screenings.		Timely and quality access to care (all care). Simplified ways to access to care, which would empower community members to access care, resources, and wellness.	Navigating the complex mental health system (mild to moderate, severe, which insurance/provider, etc.), long wait lists, and difficulty in getting resources discourages people from seeking help.		
More Access to Financial Resources/ Affordable Care	Navigating Medi-Cal insurance is difficult for the API collective.		Affordable care for symptomatic individuals (outside of routine care).	Lack of medical coverage for hearing aids and other specific medical device. It is complicated to access insurance and care. High cost of care and insurance.		More access to financial resources and affordable care.

Attachment B – Findings by Population Segment

Theme	One Thing About Community Health	Optimistic or Hopeful	Important Priorities	Barriers	Power to Change Barriers	Ease in Making Healthy Choices
Safe, Affordable Housing/ Spaces	Lack of affordable and safe housing, including accommodations as people age.		Safe and affordable housing, and community safety are priorities for the API collective	Another barrier is the lack of safe and open space (not too many parks) for residents to be physically active		It would be easier to make healthy choices if there was more access to safe and open spaces
Mental Health	Mental health issues and associated stigma.	More conversations surrounding mental health are occurring, which has allowed for recognition and acknowledgement of community trauma and led to more integration of health, mental health and social services.	Breakdown stigma and stereotypes by having engaging conversations about mental health and intergenerational trauma.	Stigmas about diseases and seeking help are barriers which result in difficulty navigating mental health care system.		
Community Collab-oration	Lack of resident engagement in local health policies and budget (i.e., city, county) affect community's health.	Organizations and agencies (such as EiOC, FQHC's/CBOs partnerships) are working collaboratively to serve the community. Community is being valued more, which has improved the community's	Community members and CBO's were listed as a priority, but the process of elevating and empowering the voice and engaging is complicated.		Grass root community service agencies and community members have the power to remove the barriers.	

Attachment B – Findings by Population Segment

Theme	One Thing About Community Health	Optimistic or Hopeful	Important Priorities	Barriers	Power to Change Barriers	Ease in Making Healthy Choices
		assets and resilience.				
Culture	Culturally congruent homelessness services, food distributions, nutrition as there is a resistance towards western medicine.	Increased efforts for culture appropriateness.	Cultural competency (language, cultural understanding, cultural foods in care facilities) and to have bilingual and bi-cultural caregivers.	Lack of culturally competent and sensitive mental health therapist to specific languages.	Community leaders from different generations and backgrounds have the power to change the barriers.	
Seniors / Inter-generational	Senior health and safety, caregiving, and intergenerational giving	Seniors are willing to open up and reach out for help, which bridges inter-generational gaps between youth and older adults through mental health conversations	Leadership, advocacy training, intergenerational understanding. Opportunities for residents to help older adults and youth age in their homes. In particular, how to care (with dignity and respect) for our aging community	Engagement is barrier for older adults 60+, particularly transportation to doctor appointments, events, etc.	Lack of investment in prevention and early intervention services for older adults is seen as a barrier; thus, it is important to engage younger family members to assist older adults	

Attachment B – Findings by Population Segment

Khmer

Theme	One Thing About Community Health	Optimistic or Hopeful	Important Priorities	Barriers	Power to Change Barriers	Ease in Making Healthy Choices
Language Barriers	Doctors/nursing who be able to provide language access and transportation services.	There has been more help in language access.	Accessing information in Khmer language leads to proper health education, and cultural competent care.	Staff who are bilingual		
Easier Access to Care/ Navigating the Systems	Provide education on health and food security.	A clinic in which community members are able to access help, with transportation assistance	Understanding fundamentals of health care (accessing / navigation), especially through language appropriate care and information	Being able to access all levels (clinic/hospital) of care. Lack of access to affordable and quality healthcare		
Community Collab-oration						Build networking within Orange County
Culture				Not having staff who understand culture in the clinic/hospital		
Seniors / Inter-generational					Those with lived experience and younger adults key to improving healthcare access for older generation	
Lack of Trust in Providers				Lack of trust in healthcare providers		

Attachment B – Findings by Population Segment

Individuals with Disabilities

Theme	One Thing About Community Health	Optimistic or Hopeful	Important Priorities	Barriers	Power to Change Barriers	Ease in Making Healthy Choices
Language Barriers						Education and materials that are appropriate (language, comprehension skills) would make easier to access healthy options
Easier Access to Care/ Navigating the Systems	Provide an education on health, food security. Better referral system than OCLINKS to make it easier to get appts and services, particularly if a CalOptima member.		Accessibility to services.	Language and cultural. Transportation services.		It would be easier to make healthy choices if individuals with disabilities had easier access to services, and transportation and interpretation services.
More Access to Financial Resources/ Affordable Care		More funding opportunities through EiOC, State, and Federal programs such as using CalAIM. Medicaid dollars to fund social determinants of health.		Money.		Having money and resources would make it easier to make healthy choices.
Workforce			Competitive/ living wages for supportive staff (we are losing people to LA County because	There are not enough providers due to the comfort levels of providers to go		

Theme	One Thing About Community Health	Optimistic or Hopeful	Important Priorities	Barriers	Power to Change Barriers	Ease in Making Healthy Choices
			they are paying more).	out to people in need.		
Mental Health	This population is experiencing mental health vulnerabilities and a lack of culturally competent resources					
Seniors / Inter-generational			People with lived experience at the table and able to make decisions regarding changes.		People with lived experience have the power to bring change and reduce the barriers faced by individuals with disabilities.	
Community Integration	Community integration that includes strong community resources	CHILAs and equity work resulting in increased collaboration between orgs. Also more inclusion of individuals and their communities in decision making - resulting in many policy changes occurring in the community.				

South Asian, Middle Eastern, North African (also known as South West Asian/North African)

Attachment B – Findings by Population Segment

Theme	One Thing About Community Health	Optimistic or Hopeful	Important Priorities	Barriers	Power to Change Barriers	Ease in Making Healthy Choices
Language Barriers	Local government information is not linguistically specific, resulting in language barriers.		Linguistically specific services; information should be translated (not google translate.	Language barriers	Include linguistically competent services to the SAMENA population and in native languages.	
Easier Access to Care/ Navigating the Systems	Population may not understand where to go to get the services they need.			Logistics for efforts such for vaccines were noted as a barrier. For example, vaccine informative sessions and education on accessible health resources.		
More Access to Financial Resources/ Affordable Care		Several initiatives such as Food4all; health4all bills have helped make the SAMENA population optimistic.	Availability of funding, which will lead to economic empowerment (access to capital).	Financial restrictions, as insurance does not cover some health needs (e.g. dental care, weight mgmt..) that may deteriorate over time and lead to isolation, depression, job loss.	County could give more funding to groups as equals in power. Organizations that have the funding could provide the outreach and workshops.	Population more financially secure.
Workforce				Health providers not taking patients seriously, being dismissive to SAMENA clients.	Existing service providers for other demographics can include culturally competent/	

Attachment B – Findings by Population Segment

Theme	One Thing About Community Health	Optimistic or Hopeful	Important Priorities	Barriers	Power to Change Barriers	Ease in Making Healthy Choices
					linguistically competent services to SAMENA.	
Safe, and Affordable Housing/ Spaces		Increased access to green spaces has population feeling optimistic as the community loves to walk, garden, etc.	Housing	Re housing, communities from the Middle East tend to not have access to capital or financial assistance.		
Mental Health	Mental health taboos/domestic violence issues faced by the SAMENA population, resulting in stigma.		Mental health is highly needed but there is resistance and stigma that hinders progress.		State and Federal efforts need to take action and force insurance providers to start looking at ignored health aspects leading to mental health illnesses.	
Community Collab-oration	Low engagement from county and state (always told to try to do the work ourselves), resulting in problems in organizing by community orgs and leaders. Community noted that they are willing to learn the system and processes as long as the	More collectives, more spaces for community members to gather and share their thoughts to help increase involvement.	Empowering the population through education and working alongside their community. The desire for more casual get-togethers would make people feel more relaxed and willing to participate. More places where women can learn to start a business.	Problems in organizing and engaging the broader community.	Community and religious leaders must provide more education so that the SAMENA pop can move forward in a similar trajectory to other racial/ ethnic groups. This could be accomplished by CBO's organizing community members, giving	Trust of government was a big reason for disparity in making healthy choices.

Theme	One Thing About Community Health	Optimistic or Hopeful	Important Priorities	Barriers	Power to Change Barriers	Ease in Making Healthy Choices
	SAMENA population are included.				Gov, Advocacy 101 trainings.	
Culture	Cultural barriers- SAMENA community is large and covers various cultures - many national and international issues, which can lead to harmful cultural norms.	Cross-community engagements that are occurring. Cultural and ethnic markets that are occurring.	Culturally specific services. Ensure that healthcare providers who are ethnically/ culturally aware of community's re not overloaded.	Cultural barriers.	Include culturally competent services to SAMENA.	
Data Collection	Lack of accurate data collection for the SAMENA population.	Government and leaders are taking initiative to include the community in data collection. Younger generation is taking initiative to conduct research, collect good information.				

LGBTQ+

Theme	One Thing About Community Health	Optimistic or Hopeful	Important Priorities	Barriers	Power to Change Barriers	Ease in Making Healthy Choices
Language Barriers			Resources in different languages, which would reduce language barriers.			Having high quality providers who have taken the time to truly learn about the communities' needs make it

Attachment B – Findings by Population Segment

Theme	One Thing About Community Health	Optimistic or Hopeful	Important Priorities	Barriers	Power to Change Barriers	Ease in Making Healthy Choices
						easier to make healthy choices, particularly if resources are in language of choice
Easier Access to Care/ Navigating the Systems	Community services are for mostly monosexuals. There is a disregard for inter-sectionality. There is a need for wrap around and holistic care.	Recognizing that the health system is not working is a big step.	Resources that are more than just sexual health.	Location of resources (north county is a desert). There is a lack of education on personal health needs, as a queer person not having a system that tells them what their needs might be. The LGBTQ+ have to choose either racial or faith resources over queer resources.		
More Access to Financial Resources/ Affordable Care			Financial literacy	Financial capacity and/or having to prioritize other factors/ situations over their health. Politicians and/or lawmakers did not want to adequately fund opportunities to serve this pop better.		Access to care without financial burdens.
Workforce	Providers who are not as "friendly" or	More providers seem to be open to identifying as	Not enough providers in OC that can provide	Not trusting affirming providers.		

Attachment B – Findings by Population Segment

Theme	One Thing About Community Health	Optimistic or Hopeful	Important Priorities	Barriers	Power to Change Barriers	Ease in Making Healthy Choices
	"affirming" as they claim to be.	LGBTQ+ themselves.	the right care. By building capacity, there can be increased advocacy for this population.			
Safe, Affordable Housing/ Spaces			Having safe spaces where can experience joy.			
Mental Health	There are a lot of assumptions made about what the community does/not have and what the community looks like.	Continuing to improve quality of care for the community.	Mental health			Self-worth
Community Collab-oration	Communities should be inclusive and share development processes, but it is not always the case. There is a disconnect with other minority groups.	There are a lot of folks from the community who are working within the system to advocate for improvement.		Leaders of organizations are afraid of creating "controversy" by affirming LGBTQ+ people.	The Healthcare systems, health plan and provider leaders were identified as having the power to change the barriers. The LGBTQ+ community have the power to change barriers but some noted that they were tired of hitting ceilings.	

Attachment B – Findings by Population Segment

Theme	One Thing About Community Health	Optimistic or Hopeful	Important Priorities	Barriers	Power to Change Barriers	Ease in Making Healthy Choices
Culture	A desert of competent care.		Helping leadership lose fear to make change (e.g., inclusive language, ask questions about identity, etc.).	Competent care.		
Data Collection	"Helicopter research" or researchers dropping in gather or implementing services with no sustainability plans.		Inclusive and representative data, and translating that data into action.			

Attachment B – Findings by Population Segment

Black

Theme	One Thing About Community Health	Optimistic or Hopeful	Important Priorities	Barriers	Power to Change Barriers	Ease in Making Healthy Choices
Easier Access to Care/ Navigating the Systems	Cardiovascular health, doula care and access, education, obesity, and diabetes.	Closing the health disparity gap.	Access to services and resources (how to get it out to the community).			
Workforce			Recruit more Black doctors to stay in Orange County.			Trust would make it easier to make healthy choices.
Mental Health	Mental health is still a huge barrier for the Black population.		Need for trauma informed care due to mental health concerns. Need more mental health providers. Educate families around mental health stigmas.	Inequitable care for black patients due to stereotypes and biases (mis-information)		
Community Collab-oration	The fact that we are able to survey the Black community was noted as a positive about its community's health.	Increased collaboration amongst organizations, an example being health fairs.			Government, nonprofit organizations, Medical societies (ACOG) and Black community members have power to change barriers.	Partnerships are a way to promote healthier choices.
Culture				Lack of treatment due to racism		

Attachment B – Findings by Population Segment

Hispanic/Latinos

Theme	One Thing About Community Health	Optimistic or Hopeful	Important Priorities	Barriers	Power to Change Barriers	Ease in Making Healthy Choices
Language Barriers	Language barriers discourage folks form accessing the health care they need in the community.			Language and literacy barriers related need for interpretation and translation, especially for written materials and information, leading to implicit biases		Healthier choices would be easier if language barriers were removed and cultural competency of providers improved.
Easier Access to Care/ Navigating the Systems	Issues with navigating the complicated health Insurance system. Many in the community do not know what services exist. There is need for health literacy. There is hesitancy about participating in free or low-cost resources in fear of them being a Public Charge (preventing them from getting citizenship status in the future). Some There is the lack of access to trades for those who want to start their own business (obtaining	Once folks find out about certain resources, they share the information with their community. This has increased access to free healthcare for low-income people (state expansion) and the local efforts to enroll everyone that is eligible. Community is hopeful about food distribution during the pandemic to the people who need it most.	Health care access for all, access to basic need such as food and housing, access to reliable transportation and childcare to attend scheduled appointments Increasing access to resource and having representation in the decision making.	Many in this population feel embarrassed for utilizing public assistance. This adds to existing issues in navigating insurance, transportation, childcare, access to preventive care, housing, healthy food, nutrition, and affordable care. There is a lack of knowledge of how our community/city works (when and where city hall boards are).		Access to resources, services, and networks.

Attachment B – Findings by Population Segment

Theme	One Thing About Community Health	Optimistic or Hopeful	Important Priorities	Barriers	Power to Change Barriers	Ease in Making Healthy Choices
	permits for trade, education, etc.).					
More Access to Financial Resources/ Affordable Care	More access to mental health services, specifically low cost for individuals that may not be able to have insurance.	Medi-Cal expansion for 50+, though there still needs to be help to enroll eligible folks because insurance paperwork is not easy. Additional funding and resources that are becoming available to help communities find health care opportunities.	Losing health care coverage based on the Medi-Cal re-determinations. Financial literacy is important as good paying jobs will result.	Lack of health insurance and lack of livable wages, resulting in many being on survival mode, which prevents them from focusing on health and future. For example, financial decisions such as deciding whether to pay for their rent or bills versus making healthier choices such as purchasing medications that they need.	Those who have money are the ones who influence the decisions	Eating healthy is expensive. Thus, finances and economic stability make it easier to make healthy choices.
Workforce	Grassroots orgs are highly trusted in the Hispanic community, therefore more capacity-building investments should be made to support their growth. One way to accomplish this would be to understand each other's service	Partners have bilingual and culturally competent employees that can provide quality services that enable trust in the community. Representation in this field allows us to connect with community and	The provider-patient ratio is not balanced. Need more providers that represent us.	Lack of trust for free/low-cost resources.		Tust would make it easier to make healthy choices.

Attachment B – Findings by Population Segment

Theme	One Thing About Community Health	Optimistic or Hopeful	Important Priorities	Barriers	Power to Change Barriers	Ease in Making Healthy Choices
	provisions and get to know each other's orgs so they can better refer clients.	gradually build trust.				
Social Determinants of Health (SDOH)	Social determinants of health related to environment and housing were noted as issues for the Hispanic/ Latino collective.	The community's health and well-being resulting from more individuals getting involved in programs to improve their health outcomes. For example, cancer survivorship is on the rise among this population.	Address accessibility issues and social determinants of health, which will reduce the risk for chronic and preventable diseases such as childhood obesity. Healthy eating for children, which addresses diabetes. Lack of information, particularly in the schools on educating parents on healthy eating habits.			Higher education, socioeconomic status, and a strong support system make it easier to make healthy choices.
Safe, Affordable Housing/ Spaces	The health and social implications of the housing crisis in low-income communities. Need affordable, safe housing, dignified and safe places, including increasing cameras to prevent crime and graffiti			A lack of a safe environments such as parks. Lack of affordable housing; many families in the community share housing and may have 2-3 families living together just		Having stable housing and environment would make it easier to make healthy choices.

Attachment B – Findings by Population Segment

Theme	One Thing About Community Health	Optimistic or Hopeful	Important Priorities	Barriers	Power to Change Barriers	Ease in Making Healthy Choices
	and having a space for youth to participate and learn new skills.			to be able to afford it.		
Mental Health	Feeling embarrassed by utilizing public assistance.	More resources for mental health are becoming available, which has a direct correlation to improved long-term health outcomes. Stigma about receiving certain health care services is slowly ending as conversations about getting help increase.	Mental health for monolingual Spanish and older adults, including the correlates to mental health such as substance use, education, food access, and health outcomes. Barriers to mental health access/ education especially in terms of outreach to destitute people and children.	Mental health challenges such as depression, anxiety are paralyzing. Shame associated with asking for help prevents people from seeking and securing support. There is focus on physical health, but attention to spiritual, psychological and emotional health is also needed.		
Community Collab-oration	"No one knows the community like the community itself", therefore the Hispanic/ Latino community should be involved in all steps of change when it comes to their community's health.	The partnerships that have grown throughout the past three years. Equity efforts have worked to bring together organizations to achieve a common goal in serving the community to improve health outcome. People	Having direct and tangible health resources at community events should be a priority.	Organizations are not working together to provide a better service to the community.	It is the community itself that can remove the barriers and increase the capacity of groups by bringing together a diverse group of stakeholders to make improvements. Local, state, and federal	

Attachment B – Findings by Population Segment

Theme	One Thing About Community Health	Optimistic or Hopeful	Important Priorities	Barriers	Power to Change Barriers	Ease in Making Healthy Choices
		are becoming more open to having conversations.			government guided by community vote has the power to remove the barriers. Systems exist that oppress and continue to marginalize communities of color or low-income communities. To change systems will need to increase community member participation.	
Culture	Health equity, culturally competent care and resources and immigration.	Increased cultural humility and empathy in local agencies and community partners. Culturally appropriate health education and partners who are bilingual and culturally competent.	More culturally sensitive mental health support is needed for the cancer warriors.	Lack of cultural sensitivity and culturally responsiveness to families.		Citizenship would make it easier to make healthy choices.
Seniors / Inter-generational	Youth health is perceived as doing well.	Senior centers that provide mobile medical/ dental care.				

Attachment B – Findings by Population Segment

Attachment B – Findings by Population Segment

Older Adults

Theme	One Thing About Community Health	Optimistic or Hopeful	Important Priorities	Barriers	Power to Change Barriers	Ease in Making Healthy Choices
Language Barriers		Increased language supports.	Older adults being seen and heard, especially for our older adults that identify with certain subgroups / populations (i.e., LGBTQ, veterans, etc.). This includes having services in their priority languages which are accessible and easy to understand.			Service announcements aimed at older adults were accessible, clear and understandable by this group.
Easier Access to Care/ Navigating the Systems	Confusing, disconnected services led by a lack of knowledge and availability of services.	Transportation assistance.	Educating families of older adults who need help. Outreach to adult children to create awareness of services for their parents. Address hearing, vision, and dental needs to older adults that impact their quality of life, mental health and overall health.	Accessing services. Delays in appointments. Transportation to services. Lack of understanding referral systems. Lack of coordinated care.	Family and friends with the right resources and access have the power to change barriers for older adults. Create a one stop shop to increase access and reduce barriers.	Better public transportation.
More Access to Financial Resources/	There is excellent coverage through CalOptima for older		Affordable care related to prescriptions and other services,		Insurance companies and other reimbursement	

Attachment B – Findings by Population Segment

Theme	One Thing About Community Health	Optimistic or Hopeful	Important Priorities	Barriers	Power to Change Barriers	Ease in Making Healthy Choices
Affordable Care	adults of limited financial means.		and affordable caregiving support for those older adults who need it and support for those giving care.		sources (Government)- could pay for care coordination, transportation, etc.	
Social Determinants of Health (SDOH)		Connecting social determinants of health to health services, with more conversations occurring from a holistic perspective.				
Safe, Affordable Housing/ Spaces	How seniors can continue to live in community, where they choose, independently and healthy. Losing housing due to loss of parent and cannot afford rent any longer.	More seniors are aging in place as desired.	Access to affordable housing and exercise venues. To allow more engagement and connections for seniors living in isolation.	Seniors living alone; their problems are often hidden especially if older adult children are out of the area. Older adults felt like a burden when seeking help, unsure of the help they need.		The environment- neighborhood, safe areas to walk, access to affordable, safe affordable housing.
Community Collab-oration		More organizations serving older adults are coming forward, especially in EiOC. Collab-oration with other CBOs better serves seniors. There is a growing awareness of senior problems and	Social connections for the older adult populations.		Long-term systemic change must come from education of community and through schools. The older adult individuals and community providers need to	

Attachment B – Findings by Population Segment

Theme	One Thing About Community Health	Optimistic or Hopeful	Important Priorities	Barriers	Power to Change Barriers	Ease in Making Healthy Choices
		needs with a growing community of organizations addressing the problems.			help older adults. Barriers can be overcome if every resident checks in on an older neighbor and provides support and information.	
Needs Assessment/ Initiatives		Dementia Care Aware Initiative has provided hope for the older adult collective. This Initiative will identify a greater number of people who experience cognitive disease, diagnose them earlier, and get them connected to services. The upcoming older adults needs assessment will spotlight this growing age group.				

Attachment B – Findings by Population Segment

Children and Families

Theme	One Thing About Community Health	Optimistic or Hopeful	Important Priorities	Barriers	Power to Change Barriers	Ease in Making Healthy Choices
Easier Access to Care/ Navigating the Systems	The fragmented, disparate needs of families, with some parents lack skills and do not always understand the process to seek help for mental health services, childcare, housing, and affordable medical care.	Having access to community partners and being able to obtain information that can be shared with families. There is more awareness of services and less fear to attain them. Schools are also seen as a hub for services and education for parents and families.	Addressing needs of homeless families before they enter homelessness so that no child is ever homeless. Need for families and children 0-5 to have concrete resources (developmental screens, OT/PT/SL services, mental health resources for parents) and access to those resources. Access to medical home; family planning and support for special needs including care for SUD and low-income families, screening, referral, resources; access to specialty care; keeping children on track with preventive care; assessing development.	Lack of access to resources and to care.		An environment that makes the healthy choice the easy choice and is accessible to all people.
More Access to Financial	The Medi-Cal expansion program	Many opportunities at	Dedicate more financial resources	Funding sources limiting services		Adequate income.

Attachment B – Findings by Population Segment

Theme	One Thing About Community Health	Optimistic or Hopeful	Important Priorities	Barriers	Power to Change Barriers	Ease in Making Healthy Choices
Resources/ Affordable Care	and First Five investments in early childhood prevention service. Efforts are taking place to coordinate care and ensure equity. There are families who are unable to afford services nor qualify for Medi-Cal.	the State level for funding and partnerships - i.e. CYBHI, ACES Aware, CalAIM, Community Schools, etc. Recognition by top officials about needs of the community's opening up funding sources for programs to serve families. Universal free meals, children now receive a healthy breakfast and lunch every school day and in summer.	to spread the message.	to meet their grant program goals, taking away autonomy of the programs to meet the individual needs of families in "chaotic" situations was noted as a barrier for this collective.		
Workforce		Strong, caring pediatricians who are focused on helping all children with quality care both in the doctor's office and throughout the community. There are pediatric sub-specialists available in the County - just not	Continue with virtual care if it meets clients' needs but work towards in person care as it is better to assess the needs of families in medical setting and in home. Workforce development	The lack of providers (specialty, mental health) to meet needs of community in a timely manner. Need for more peer providers, mentors, navigators, and supporters. Lack of trust in the system and		Trust in the service provider was noted as a way to make healthy choices.

Theme	One Thing About Community Health	Optimistic or Hopeful	Important Priorities	Barriers	Power to Change Barriers	Ease in Making Healthy Choices
		enough. There are high risk OB/GYN's available in the County. There is one pediatric psych inpatient program in the County		people providing services. Politics and taboos help erect those barriers, but are also capable of breaking them up. Build an infrastructure that will support CBO;s to provide community health workers and CalAIM services with office and service hours available after 5:00 p.m..		
Social Determinants of Health (SDOH)			Reducing disparities in health outcomes for children and families was noted to be a priority for this collective.	There needs to be a re-prioritization of prevention services and social determinants Climate change is going to be an increasing barrier to good health.		They cannot answer this question without defining what is meant by "healthy", and acknowledging that communities often have limited "choice". Awareness of the choices provided, understanding what the definition of "healthy" is as it will be different for many. The lack

Attachment B – Findings by Population Segment

Theme	One Thing About Community Health	Optimistic or Hopeful	Important Priorities	Barriers	Power to Change Barriers	Ease in Making Healthy Choices
						of understanding why making healthy choices is important, and how that will affect their health. Understanding of how choices can change one's health.
Safe, Affordable Housing/ Spaces			Affordable housing across all areas of the county, including the need for more shelters.	The lack of affordable housing is a barrier for families to The lack of an effective eviction diversion program and more affordable housing is a barrier to prevent homelessness.		A safe, affordable, and healthy environment, including one that is addressing climate change was noted as a way to make it easier to make healthy choices.
Mental Health	Domestic violence resulting in intergenerational trauma. T need for mental health resources for both youth and adults to help them cope with past trauma.	ACES Aware Trauma Informed Network of Care. Awareness about domestic violence in the family; more people speaking up bringing attention to the issue. Partnerships with gatekeepers like police (take back the night), church		Mental health issues and homelessness.		For domestic violence, being aware of red flags versus green flags in relationships.

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Theme	One Thing About Community Health	Optimistic or Hopeful	Important Priorities	Barriers	Power to Change Barriers	Ease in Making Healthy Choices
		etc., to bring awareness of domestic violence.				
Community Collaboration	There is excellent pediatric and OB medical services in county. OC has some of the pediatric and OB medical training programs in the county. The services are provider centered not family centered.	Home Visiting Collaborative is trying to help agencies work together on referral streams. The Autism assessment and treatment programs. Community Health Partners' engagement with the Early Development Index (EDI) data. Family Services Collaborative is a great partnership to assist homeless families. Collaboration between referring agencies has improved resulting in strong partnerships, collaboration, and funding opportunities.	Pregnant and birthing services with Public Health Nurses playing a great role in promoting healthy planning and support services once the baby is born through the first years of life.	Parental involvement as the more parents are tuned in to their children's lives, the healthier they grow up. Communities should dedicate ample time to ensure people are aware. Lack of systems connections and connections between health/ resource organizations. There needs to be the ability to connect medical care/home with other providers in a way that is not difficult for family.	Providers and the voice community members need to speak loudly to the decision makers. All people serving our community can help improve these barriers through awareness and education.	

Attachment B – Findings by Population Segment

Youth

Theme	One Thing About Community Health	Optimistic or Hopeful	Important Priorities	Barriers	Power to Change Barriers	Ease in Making Healthy Choices
Easier Access to Care/ Navigating the Systems	Education about resources in their community and access to resources for all	The fact that most young people have access to basic medical care was listed.		Lack of knowledge of community resources such as food pantries. Lack of seamless navigation, and vehicle-reliant transportation.		Reinforcing and rewarding healthy choices, providing knowledge and awareness of resources.
More Access to Financial Resources/ Affordable Care	Some in the youth collective reported issues in affording needs.	The new CalAIM initiatives.		Affordability, particularly private health care insurance and poor coverage for dental care across the board which effects overall health.	Insurance providers, the education sector, community centers/leaders, mayors were listed as have the power to change the barriers.	Incentive programs.
Safe, Affordable Housing/Spaces	Safe housing and fitness.		Safety.			
Mental Health	Mental Health challenges, including the diseases of substance misuse.			Stigma from getting. Insurance companies put up barriers, especially to mental health and substance misuse treatment.		
Community Collab-oration	Collaboration when asked about their community's health.	There are numerous community-	Community support, collaboration, and		Community groups and members. Youth	Community advocates.

Attachment B – Findings by Population Segment

Theme	One Thing About Community Health	Optimistic or Hopeful	Important Priorities	Barriers	Power to Change Barriers	Ease in Making Healthy Choices
		based organizations, and community engagement among neighbors. The Board of Supervisors were reportedly more aware of the issues of the youth.	more community representation.		have several advocacy groups that are doing great work in south county.	
Culture	Cultural diversity.	More conversations diversity, equity, inclusion				Promotoras and other culturally based models and peer leaders.
Data Collection	Status or report card of health care indicators.		Accurate health information and battling misinformation. Education on mortality and morbidity rates, with any improvements reflected in the data.	Acknowledging the statistics around behavioral and mental health.		

Attachment B – Findings by Population Segment

General

Theme	One Thing About Community Health	Optimistic or Hopeful	Important Priorities	Barriers	Power to Change Barriers	Ease in Making Healthy Choices
Easier Access to Care/ Navigating the Systems	Access and justice, and a lack of understanding of assets.		Access and having health advocates who connected residents with resources.	Poor outreach, new systems that are difficult for some communities (i.e., patient portal, telehealth visits, etc), transportation and a lack of follow-up or missed referral opportunities.		Knowledge that foods are healthy.
More Access to Financial Resources/ Affordable Care	Innovative services- gym membership, financial, and health are terms to describe this community's health.	It appears that the community/ county is not pouring money into existing programs that do not work.	Social determinants of health such as home ownership, education, employment, affordable health care and good paying jobs.			Education and having money to afford healthy choices.
Workforce				Providers create barriers with ineffective or complicated health communication. Providers do not respond because they do not care or there is no one to call back. This may partly be		

Attachment B – Findings by Population Segment

Theme	One Thing About Community Health	Optimistic or Hopeful	Important Priorities	Barriers	Power to Change Barriers	Ease in Making Healthy Choices
				due to staffing shortages.		
Safe, Affordable Housing/ Spaces	Stable housing.	Stanton is investing in park revitalization for better open space. Project Homekey is providing permanent supportive housing.	Stable housing so people can have the bandwidth to address issues like chronic health care needs.			Stable households.
Mental health				Being someone important enough to matter or it will result in growing mental health issues and stigma.		
Community Collab-oration	Connectiveness (community support system).	COVID brought together new partnerships that did not exist before (e.g. the EiOC Task Force). More people are making their voices heard and leaders are responding.			Community members (volunteering, neighborhood support, etc.) and all levels of government and advocates.	Programs that meet people where they are.
Culture	Inequities.	Culturally competent care.	Improving organizational and personal health literacy.	Threats of deportation.		Having plain language health communication, both verbal and written, and confirming

Attachment B – Findings by Population Segment

Theme	One Thing About Community Health	Optimistic or Hopeful	Important Priorities	Barriers	Power to Change Barriers	Ease in Making Healthy Choices
						understanding would make it easier to make healthy choices. Make health part of a community's culture.
Data Collection	Communities are feeling left behind- new technology. Well-being (financial, mental, physical, etc.).					Health literacy.
Healthy Choices						Understand the implications of making choices and the definition of "healthy" and "healthier choices"

EQUITY IN OC

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OC health CARE AGENCY

An initiative of OC health CARE AGENCY

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Addressing health inequities across Orange County by enabling system change.



Achieving Equity in Orange County

Health inequities are differences in health status or in the distribution of health resources among various populations. This is due to the social conditions in which people are born, grow, live, work, and age. Across Orange County (OC) we see differences in the length and quality of life; rates of disease, disability, and early death; severity of disease; and access to treatment because of these inequities.

Equity in OC is an OC Health Care Agency (HCA) initiative in collaboration and partnership with local Orange County community partners. Funded by a grant from the Centers for Disease Control and Prevention (CDC), the Equity in OC Initiative is a community-informed and data-driven initiative to address health inequities and disparities in Orange County by laying the foundation for creating a healthier, more resilient, and equitable Orange County.

Why Create Population Profiles?

These population profiles are snapshots of available data for various populations in Orange County. By laying out population-specific data in these profiles, we can identify systemic changes that can improve the quality of life within these communities. Since these population profiles are only the start of democratizing community-level data, we welcome feedback and input to further refine and improve this living document.

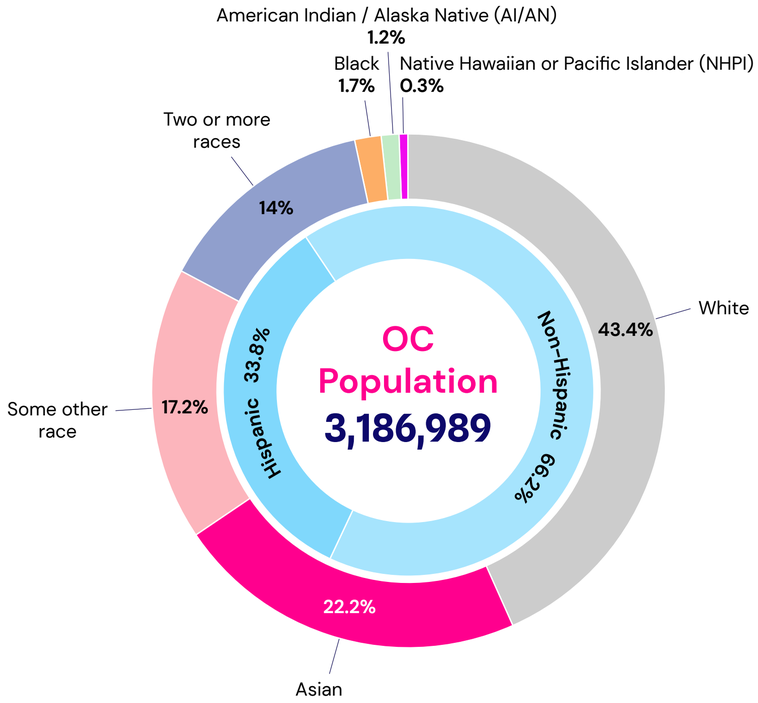
For more information go to www.equityinoc.com.

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Orange County at a Glance



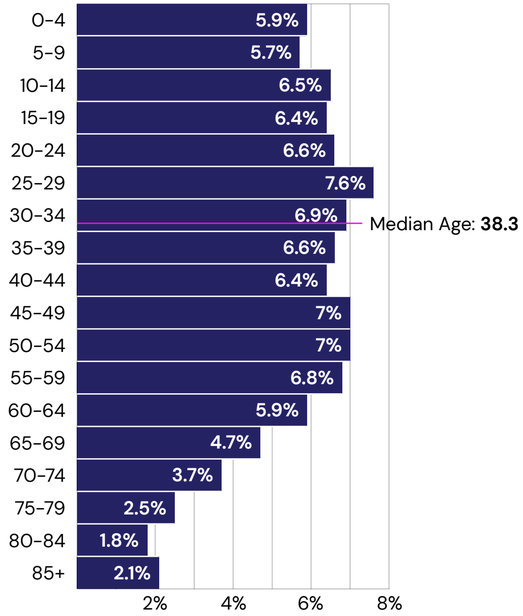
The United States (US) Census Bureau collects racial data according to guidelines by the US Office of Management and Budget (OMB), and these data are based on self-identification.

Racial categories in the census survey reflect a social definition of race in the US. It is not an attempt to define race biologically, anthropologically, or genetically. Also, categories of race include national origin or sociocultural groups. People who identify their origin as Hispanic, Latino, or Spanish may be of any race.

About the Topic of Race (census.gov)

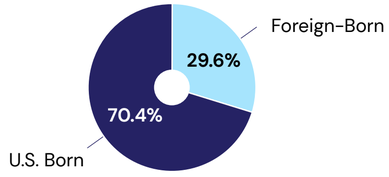
Source: 2020 Decennial Census

Population by Age Group



Source: 2020 ACS 5-Year Data, U.S. Census Bureau

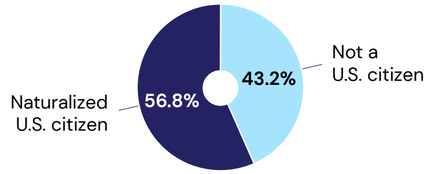
Population by Birth Origin



Source: 2020 ACS 5-Year Data, U.S. Census Bureau

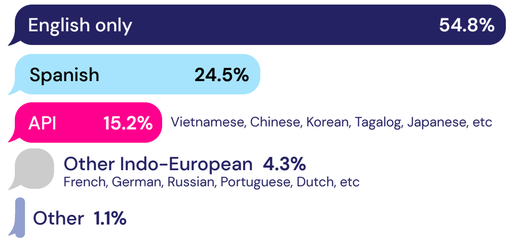
Population by Citizenship

of foreign-born residents



Source: 2020 ACS 5-Year Data, U.S. Census Bureau

Languages Spoken at Home



Source: 2020 ACS 5-Year Data, U.S. Census Bureau

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$94,441

Median Household Income

2020

Source: 2020 ACS 5-Year Data, U.S. Census Bureau



56.9%

Home Ownership Rate

as of March 2022

Source: U.S. Bureau of Labor Statistics



1,129,785

Total Housing Units

2020

Source: 2020 ACS 5-Year Data, U.S. Census Bureau



41.2%

Bachelor's Degree or Higher

2020

Source: 2020 ACS 5-Year Data, U.S. Census Bureau



10.1%

Persons in Poverty

2020

Source: 2020 ACS 5-Year Data, U.S. Census Bureau



3.1%

Unemployment Rate

as of March 2022

Source: U.S. Bureau of Labor Statistics

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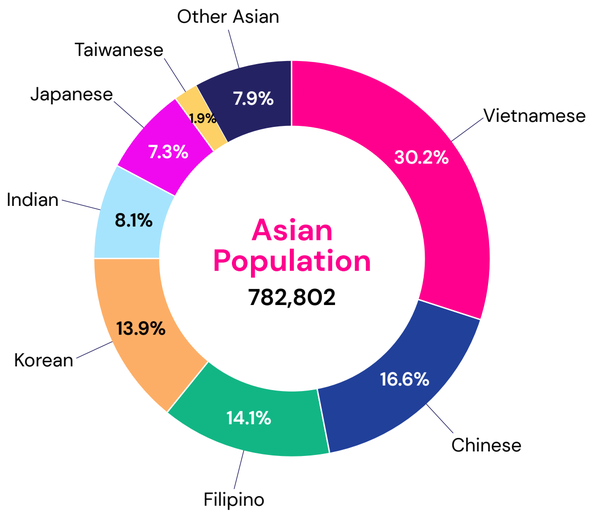
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Asian Population Overview in Orange County



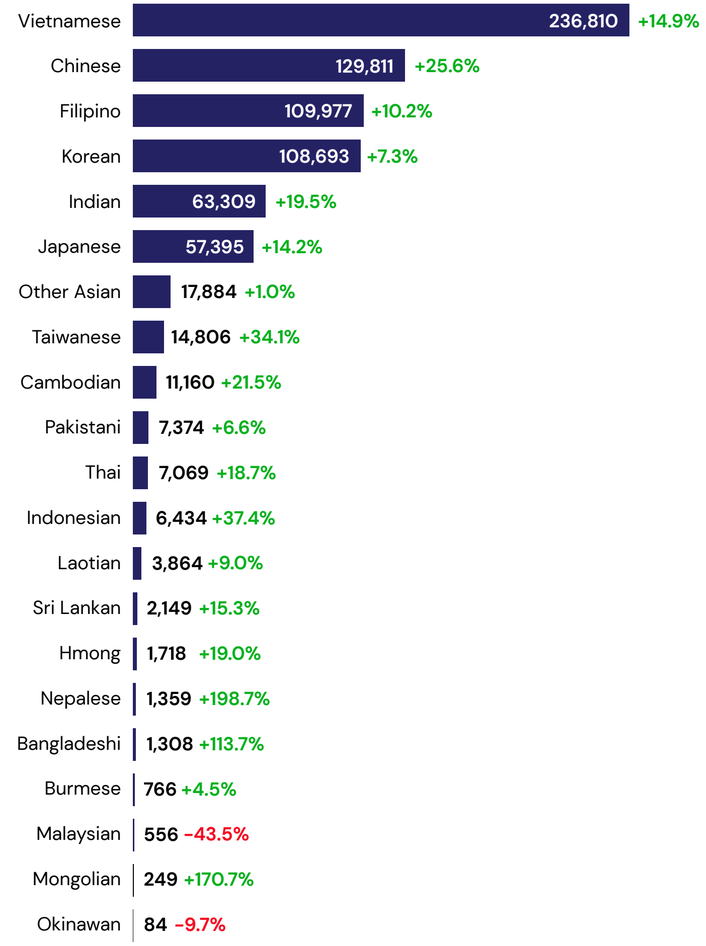
Source: 2019 ACS 5-Year Data, U.S. Census Bureau

Understanding the term API, NHPI, and ANHPI

Asian and Pacific Islander (API) is a term used to describe people of Asian or Pacific Islander descent in the US. The pairing of these two populations started in the 1980 US Census. In more recent surveys, **Native Hawaiian and Pacific Islander (NHPI)** became more common and distinct since Pacific Islander communities face more significant health and socioeconomic disparities compared to Asians and other groups. In this document, we will refer to these two communities, when possible, as **Asian, Native Hawaiian, and Pacific Islander (ANHPI).**

Asian Population by Ethnicity

Alone and in other combinations for Orange County, 2020, and percentage change since 2015



Source: 2020 ACS 5-Year Data, U.S. Census Bureau, AdvanceOC

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Asian Population: A Historical Context

According to the Orange County Historical Society, the first people who arrived in Orange County came thousands of years ago. They lived by hunting, fishing, and gathering plants and seeds. Afterwards, Shoshonean-speaking people arrived who were the ancestors of the tribes we know today as the Juaneño and the Gabrielino.

Orange County was officially formed on August 1, 1889, and agriculture and oil played a key role in its development. As a result for the need of cheap labor, the earliest Asian immigrants to California were predominantly Chinese, Japanese, and Filipino.

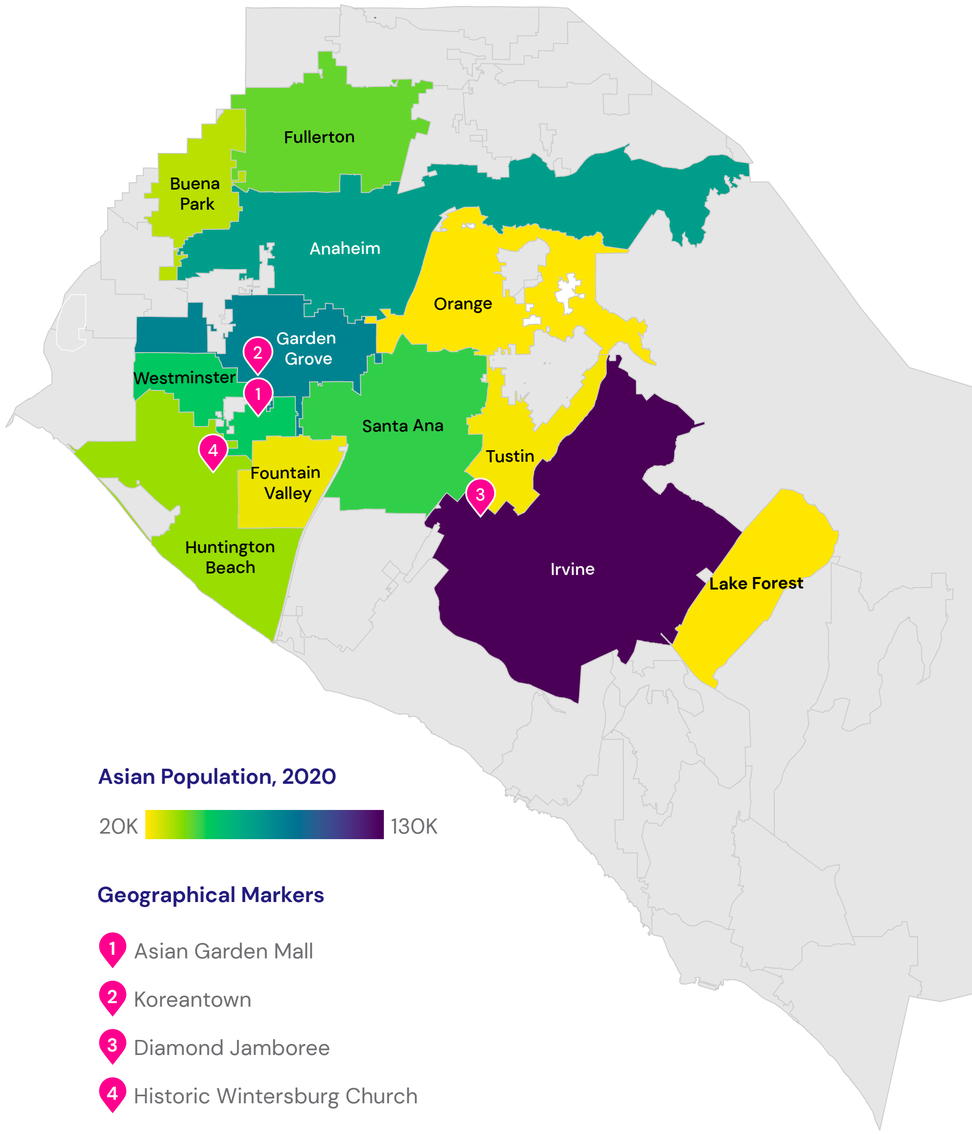
A Chinatown developed on 3rd St of Santa Ana in the 1880s and thrived for more than 20 years. The men who lived there had arrived to Orange County to build railroads, work in the local grape and celery fields, and start small businesses. On May 25, 1906, Chinatown suddenly vanished in flames. According to the OC historian Jim Sleeper, the fire had been ordered by the City Council. They justified this action since a man was found to have leprosy in Chinatown, and they deemed it a public health threat. During this period, the Chinese community were subjected to racially motivated hostilities including the Chinese Exclusion Act of 1882.

Top Cities of Asian Residents

2020, with percentage changes since 2015

City	2020		City	2020	
Irvine	136,809	+27%	Huntington Beach	34,001	+23%
Garden Grove	76,367	+7%	Buena Park	29,699	+17%
Anaheim	69,832	+12%	Fountain Valley	22,549	+6%
Westminster	49,985	+8%	Tustin	23,994	+26%
Santa Ana	44,402	+15%	Orange	22,099	+13%
Fullerton	38,699	+1%	Lake Forest	19,697	+36%

Source: 2020 ACS 5-Year Data, U.S. Census Bureau, AdvanceOC



Source: AdvanceOC

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According to OC History Land, the first Japanese immigrants settled in Orange County in the 1890s. Issei farm workers moved into the area and leased land to cultivate new crops such as tomatoes, beans, strawberries, and chili peppers. By 1942, Japanese immigrants and their children helped in making Orange County's 795 square miles one of the nation's richest agricultural areas. Unfortunately, Japanese Americans lost everything when they were forced into internment camps in 1942, following Executive Order 9066 issued by President Roosevelt.

According to the FilAm Tribune, the Filipino American population boom started after the Philippines became a US territory in 1898. They arrived as laborers, mostly working in the farms of Hawaii and California. In 1935, Congress passed the Tydings-McDuffy Act, which granted the Philippines independence and reclassified Filipinos as aliens. The act also limited their immigration to 50 individuals per year. This quota was avoided at the start of World War II when the US recruited Philippine-born Filipinos to serve in the military. This led to another significant wave of Filipino immigration.

According to the Center for Korean American Studies at UC Riverside, the first Korean settlement in the US was established in Riverside, CA in the early 1900s. American intervention in the Korean War between 1950 and 1953 triggered a second wave of Korean immigration. Around this time, sponsored Korean students arrived in the US. After 1965, students-turned professionals were able to apply for permanent residence under the Hart-Cellar Act. This also allowed for close relatives to immigrate. According to the book "Strangers from a Different Shore," Korean immigrants were mostly self-employed because of discrimination in the mainstream labor market. Also, the South Korean government offered capital to start businesses. In 1978, 80% of Koreans worked in the Korean ethnic economy.

According to the book, "Vietnamese in Orange County," the Vietnamese American population has been generalized as "refugees" despite coming from diverse backgrounds. Their migration paths varied, and they struggled with resettling into new homelands and rebuilding their lives. They are dispersed throughout the US, and many have settled into central Orange County cities of Westminster, Garden Grove, and Santa Ana. In 1975, the first wave of refugees arrived, and many were first taken to Camp Pendleton, a Marine Corps base north of San Diego. Vietnamese refugees were required to have sponsors to resettle. Residents and churches in Orange County served this role, and many Vietnamese refugees made a permanent home in the area. Little Saigon in Orange County grew into a commercial and residential hub. It is now home to the largest Vietnamese population outside of Vietnam.

After the Immigration and Nationality Act of 1965, which put an end to a quota system limiting immigration from non-western European countries, the Asian American population grew and diversified.

*These historical summaries of the five largest Asian subgroups in Orange County are from reliable public sources. The Asian American diaspora is diverse, and these summaries only begin to describe the vibrant communities living in Orange County. For more information, please look at the sources provided and the resources available through cultural and educational institutions in Orange County.

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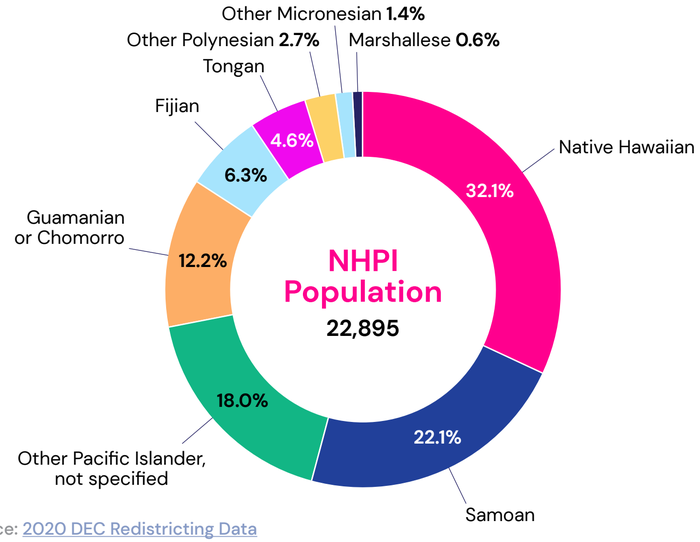
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NHPI Population Overview in Orange County

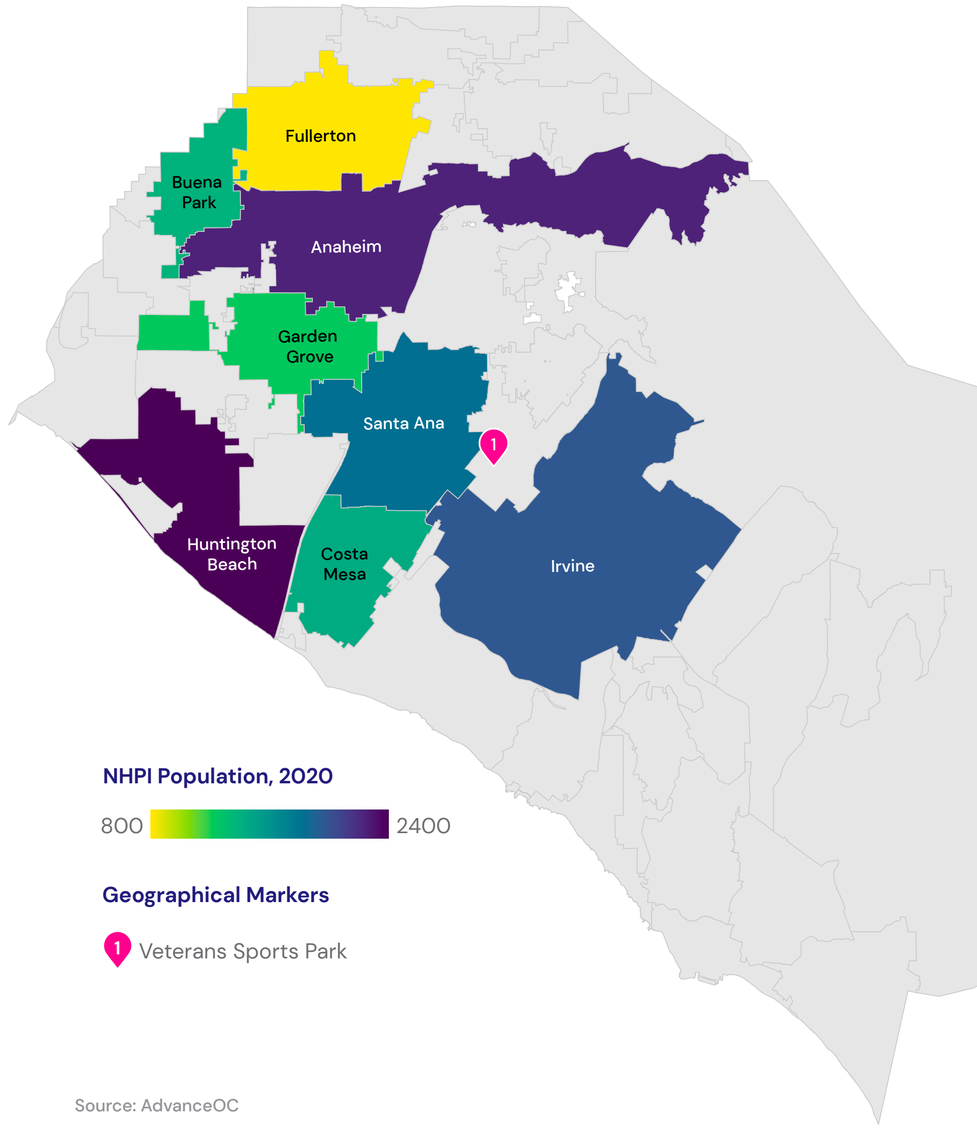


Source: 2020 DEC Redistricting Data

NHPI Population: A Historical Context

This population profile describes and groups Native Hawaiians and Pacific Islanders (NHPI) as distinct and separate when data are available.

The fusion of Pacific Islanders into a combined "Asian Pacific" term is historically charged. Pacific Islanders have long protested the marginalization and invisibility of their community. In 2009, they successfully advocated for their inclusion in the Native American and Indigenous Studies Association (NAISA). While Native Hawaiians and Pacific Islanders (NHPI) have been disaggregated from the "Asian American" racial category in the US Census, the White House Initiative on Asian Americans, Native Hawaiians, and Pacific Islanders (WHIAANHPI) has maintained a coalition approach. NHPI heritage month celebrations are observed in May with Asian Americans rather than in November with Native Americans.



Source: AdvanceOC

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In the 18th century, Hawaii and Pacific islands were exploited for resources and labor by US and European (Britain, France, Germany, Spain, Portugal, and the Netherlands) colonial interests.

Spain ceded control of Guam to the US at the end of the Spanish-American War in 1898. In 1899, Britain, Germany, and the US settled their power struggle over Samoa with the Tripartite Convention. This divided the islands into Western Samoa (controlled by Germany) and American Samoa. In 1914, New Zealand seized Western Samoa and ruled it as a colony for several decades. Hawaiians suffered a similar takeover due to foreign sugar growers.

President William McKinley was eager to gain a strategic advantage for the US Navy and fulfilled his promise to annex the islands. He called for a joint resolution in Congress, and, in August 1898, Hawaii became a US territory. It would remain a territory for another 61 years until 1959 when Hawaii became the 50th US state.

Legislation in 1950 granted citizenship to Guamanians/Chamorros, and similar legislation in 1951 made Samoa an unincorporated US territory. Guamanians/Chamorros and Samoans were free to move anywhere in the US. Tongans, Fijians, and other Pacific Islanders also chose to relocate to the US mainland since they had limited opportunities back home.

Today, the US mainland is home to a large and diverse NHPI community. NHPI populations are concentrated in areas close to military bases, which allows for off-island migration. Pursuing higher education is another factor why many NHPIs come to the mainland. Lack of opportunities for advanced degrees back home and a general belief that education is better on the mainland attracts NHPI young adults and families.

Top Cities of NHPI Residents

Alone and in other combinations for Orange County, 2020, with percentage changes since 2015

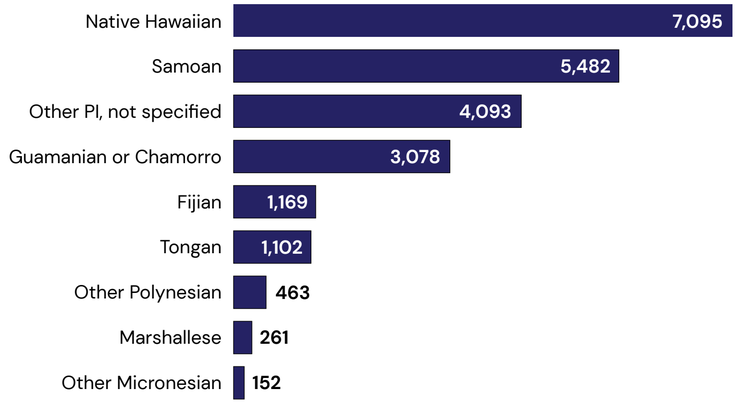
City	2020	
Huntington Beach	2237	+25%
Anaheim	2654	+12%
Irvine	2101	+138%
Santa Ana	1425	+2%

City	2020	
Costa Mesa	1229	+13%
Buena Park	746	-26%
Garden Grove	1159	-11%
Fullerton	868	-12%

Source: 2020 ACS 5-Year Data, U.S. Census Bureau, AdvanceOC

NHPI Population by Ethnicity

Alone and in other combinations for Orange County, 2020



Source: 2020 ACS 5-Year Data, U.S. Census Bureau

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ANHPI and COVID-19 in Orange County

According to the OC Health Care Agency as of May 10, 2022, over 500,000 cases and over 7,000 deaths have occurred in Orange County due to COVID-19 (SARS-CoV-2).

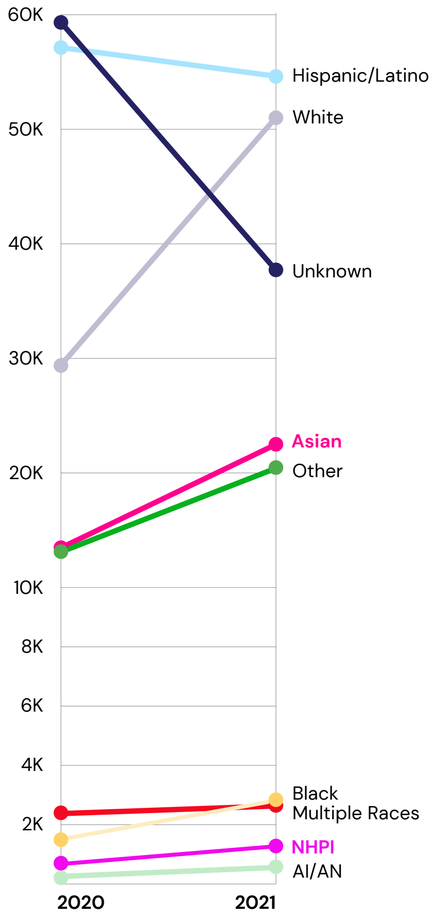
Among the 500,000 cases reported in Orange County, most of the COVID-19 cases are "unknown" since they did not have racial or ethnic classification. Unknown cases include those who did not identify with a particular racial or ethnic classification or may not have been asked for this information. With many unknown COVID-19 cases, generalizations about the impact of COVID-19 among various racial and ethnic groups should be avoided.

According to the California Immunization Registry, 76.3% of Orange County residents older than 5 years are fully vaccinated. The vaccination rate of California is 75.1%. Asians and Native Hawaiians and Pacific Islanders (NHPI) have the highest vaccination rates in Orange County.

To understand the impact of COVID-19 on the various populations of Orange County, a specific public health measurement is used: case or death rates per 100,000 people, which are the total

Total Cases

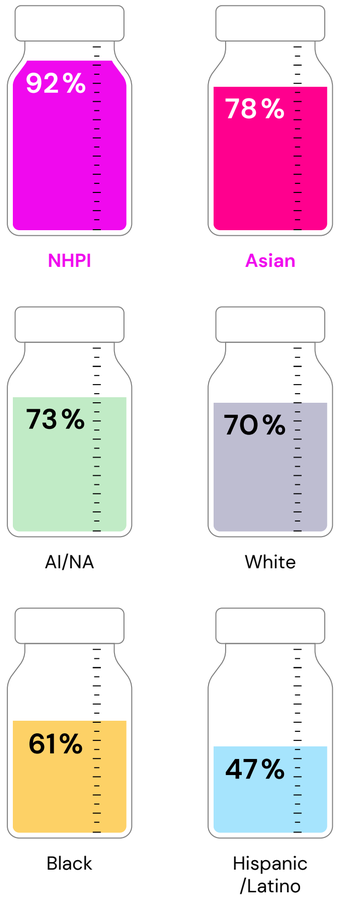
by race/ethnicity, 2020-2021



Source: OC Health Care Agency

Vaccination Rate

per 100K population, 2021



Source: OC Health Care Agency

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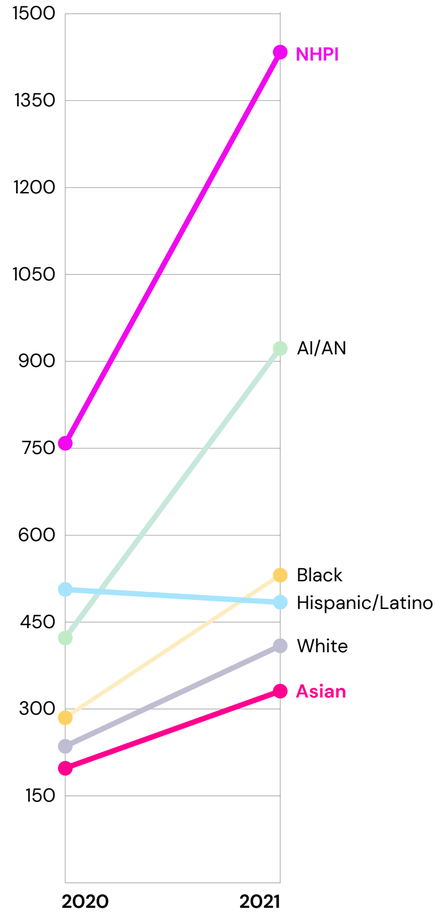
ANHPI and COVID-19 in Orange County (continued)

number of cases or deaths divided by the total population of a specific group and multiplied by 100,000. Using this standardized rate, Native Hawaiians and Pacific Islanders (NHPI) and American Indians and Alaska Natives (AI/AN) had the highest case and death rates in Orange County. However, the results of these calculations should be used with caution. Since the total population of these communities are small in Orange County, case and death rates can fluctuate depending on the reported number of cases and deaths.

The impact of COVID-19 on the Asian and Pacific Islander community was uneven, with some communities being more impacted such as low income and monolingual residents and ANHPI seniors. Isolated and vulnerable community members were left out of initial food distribution efforts and suffered from the lack of health information translated in different languages of the diaspora. As one of the highest groups to be vaccinated, the Asian and Pacific Islander community benefits from concerted outreach by a broad-based coalition of community-based organizations, faith-based groups, and healthcare providers.

Case Rate

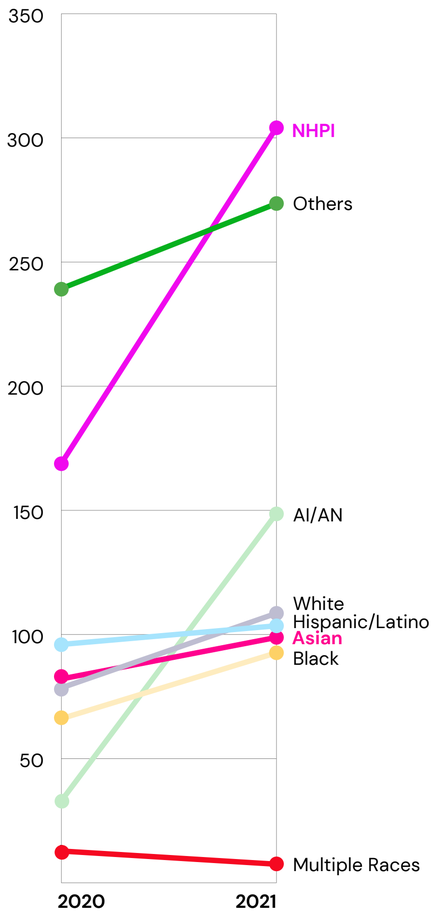
per 100K population by race/ethnicity, 2020-2021



Source: OC Health Care Agency

Death Rate

per 100K population, 2020-2021



Source: OC Health Care Agency

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Health and Mortality

According to the 2022 County Health Rankings, Asians in Orange County have a life expectancy of 87.2 years, which is the highest among racial and ethnic groups in the county.

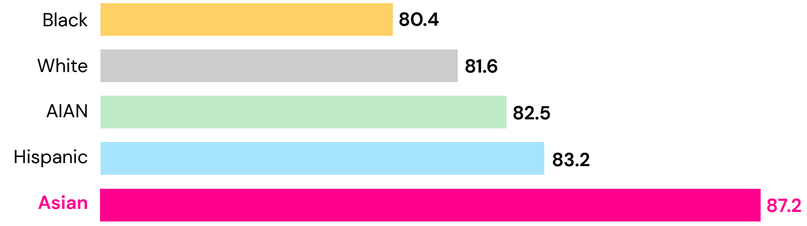
The "model minority" stereotype of the Asian community has left Asians out of public health and health policy conversations. Recently, CHIS data of Filipino, Vietnamese, Chinese, Japanese, and Korean individuals were analyzed, and the results were published in the American Journal of Public Health on February 20, 2020. Research showed that Asian American subgroups have more health problems and less access to health care when compared to non-Hispanic white adults.

Specifically, Filipino adults appear to have worse health outcomes compared to the other Asian subgroups. Vietnamese adults also had reduced health outcomes, and many Koreans had delayed access to health care services. Chinese adults ranked highly in reduced visits to a doctor in the past year, and Japanese individuals tended to have high blood pressure.

Recent childhood obesity data in Orange County show that Asian students in grades 5, 7, and 9 have the lowest childhood obesity rates. Meanwhile, Native Hawaiian and Pacific Islander (NHPI) students in the same grades show high rates of childhood obesity. Most NHPI students in grade 7 (53%) and grade 9 (54%) are classified as obese. Among Asian subgroups, Filipino students have higher rates of childhood obesity.

Life Expectancy at Birth in Orange County

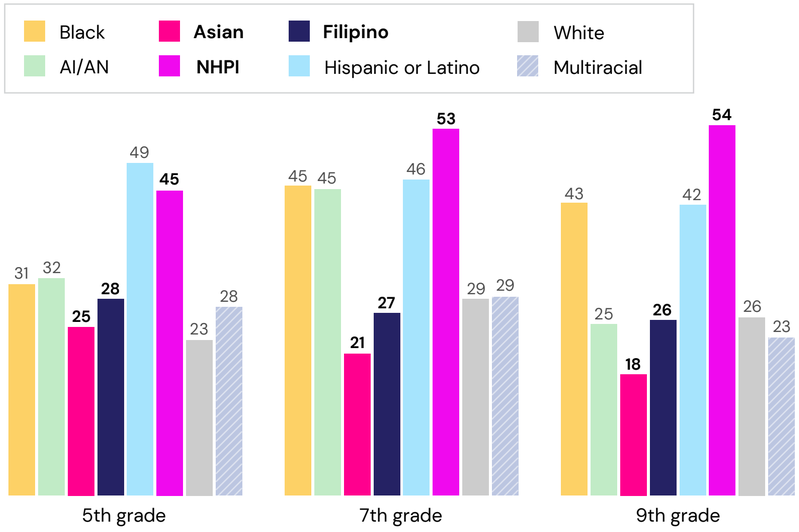
2020



Source: County Health Rankings

Childhood Obesity in Orange County

Percentage by Race/Ethnicity and Grade Level, 2019



Source: Kidsdata.org

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Health and Mortality (continued)

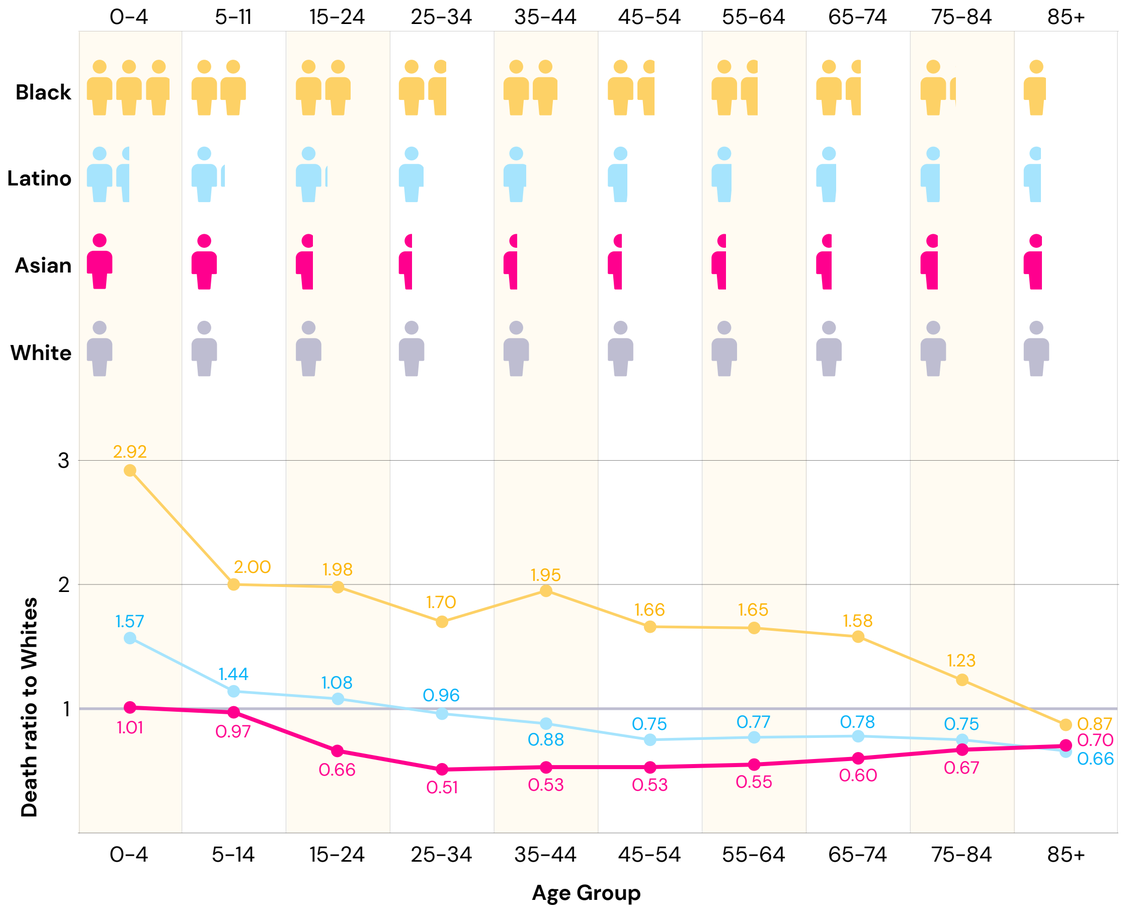
The California State of Public Health Report 2021 reports all-cause death rates and rate ratios of Asian, Black, Latino, and White residents. Whites are the reference group since they have been historically the largest group in the state. A rate ratio of 1.0 means that the rates are the same for both groups.

Asians have relatively similar or better outcomes than Whites. However, patterns and trends in Asian American mortality is unclear when all Asian subgroups are grouped together. Another factor to consider is whether the Asian population being assessed is born in the US or foreign born.

Although the US Census started disaggregating Asian subgroups in 1980, disaggregating death records occurred in 2003. In California, AB 1726 requires the California Department of Public Health to break down data by ethnicity and ancestry for Asians, Native Hawaiians, and Pacific Islanders. This mirrors the information collected by the US Census Bureau. AB 1726 takes effect in 2022.

California Deaths by Age Group

Ratio of the age-specific Asian, Black and Latino rates to White rates. A ratio of 1.0 means the rates are the same.



Source: California State of Public Health Report 2021

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Health and Mortality (continued)

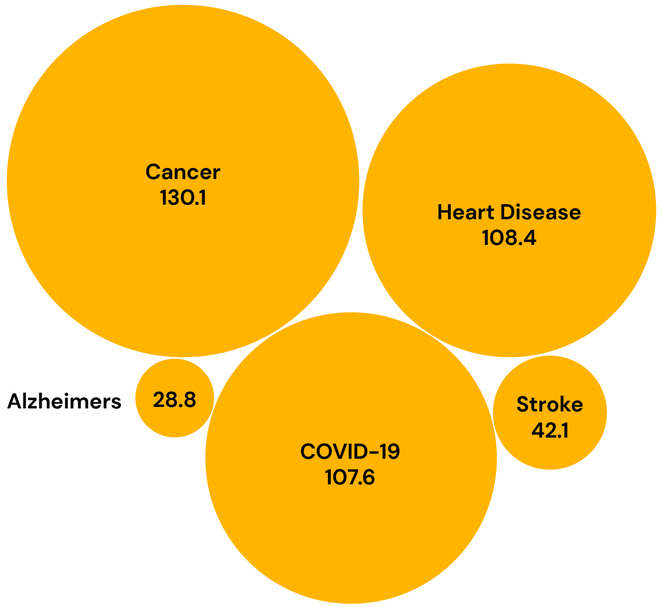
In Orange County, the five leading causes of death in 2021 among Asians are cancer, heart disease, COVID-19, stroke, and Alzheimer's disease.

According to the May 2021 Medical Policy Brief by the US Department of Health and Human Services (HHS), Asians, Native Hawaiians, and Pacific Islanders (ANHPI) the lowest cancer incidence rates and the lowest or second lowest rate of risk factors for heart disease among racial groups in the US. Even though ANHPIs have the lowest cancer incidence rates, research shows that they have high rates of liver cancer and stomach cancer. Cervical cancer incidence rates were 7 to 10 times higher for Vietnamese, Samoans, and Laotians when compared to non-Hispanic Whites in 1998-2002.

Asians across the US are at high risk for cardiometabolic diseases (CMDs), which includes type 2 diabetes, hypertension, coronary artery disease, and stroke. In the same Medical Policy Brief, ANHPIs have the highest hepatitis B-related mortality rate and incidence of tuberculosis. The rate of diagnosed diabetes was 9.2% for Asians when compared to 7.6% for non-Hispanic Whites in 2017-18. In specific Asian subgroups, diabetes rate is the highest among Indians (12.2%) and Filipinos (10.4%). The rate of undiagnosed diabetes was 4.6% for Asian Americans when compared to 2.5% for non-Hispanic Whites in 2013-2016.

Top 5 Leading Causes of Death Among Asians in Orange County

2021, and crude rate per 100,000 Asian population



Risk Factors for Cause of Death

- **Cancer**
  age alcohol use, tobacco use, poor diet, hormones, sun exposure
- **COVID-19**
  Immuno-compromised, unvaccinated, preexisiting conditions
- **Stroke**
  high blood pressure, high cholesterol, smoking, lack of exercise, older age, genetics
- **Heart Disease**
  high blood pressure, high cholesterol, smoking, age, family history
- **Alzheimers**
  increasing age, Family history, head injuries/ trauma, cognitive impairment

Source: OC Health Care Agency

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Health & Mortality (continued)

In Orange County, the five leading causes of death in 2021 among Native Hawaiians and Pacific Islanders (NHPI) are COVID-19, heart disease, cancer, accidents, and stroke.

NHPIs have 10% greater risk for heart disease than non-Hispanic Whites. Death from heart disease among NHPIs is 10% lower for men and is no different for women when compared to non-Hispanic Whites. The risk for high blood pressure is similar between NHPIs and non-Hispanic Whites. However, NHPIs are four times more likely to have a stroke and are 30% more likely to die from a stroke than non-Hispanic Whites.

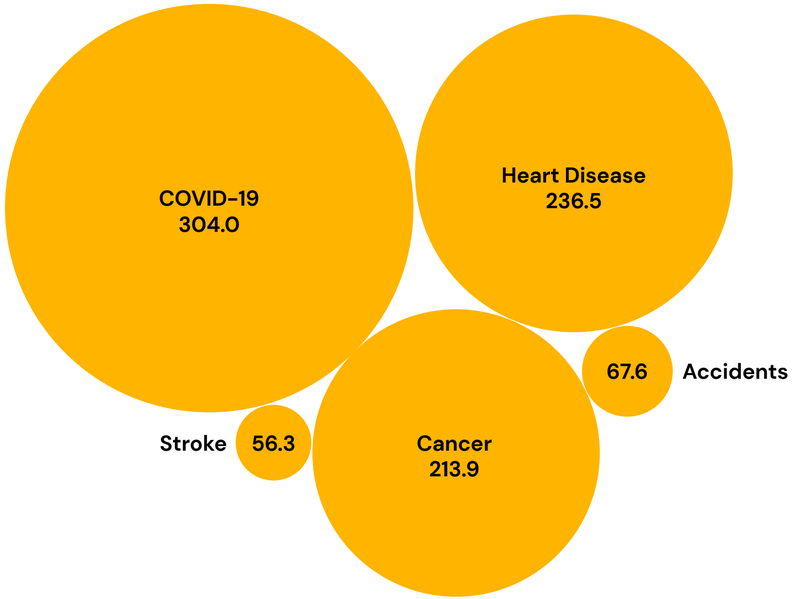
In terms of cancer, NHPIs are less likely to be diagnosed with cancer than non-Hispanic Whites. However, NHPIs have higher rates of lung and stomach cancer. NHPI men are more likely to develop liver cancer, while NHPI women are more likely to develop breast and cervical cancer. Cancer death rates are higher among NHPIs than for non-Hispanic Whites, especially death rates for lung, liver, stomach, breast, and cervical cancer.

Diabetes incidence and death rates among NHPIs are more than twice those of non-Hispanic Whites.

Source: U.S. Dept of Health and Human Services, Office of Minority Health.

Top 5 Leading Causes of Death Among Pacific Islanders in Orange County

2021, and crude rate per 100,000 Pacific Islander population



Risk Factors for Cause of Death

- **COVID-19**
  Immuno-compromised, unvaccinated, preexisiting conditions
- **Cancer**
  age alcohol use, tobacco use, poor diet, hormones, sun exposure
- **Stroke**
  high blood pressure, high cholesterol, smoking, lack of exercise, older age, genetics
- **Heart Disease**
  high blood pressure, high cholesterol, smoking, age, family history
- **Accidents**
  Unintentional injuries, falls, excessive drinking, substance abuse, unintentional poisonings

Source: OC Health Care Agency

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Health & Mortality (continued)

Access to Mental Health Services

During COVID-19 pandemic, survey data show that Orange County's Asian community (namely Cambodian, Chinese, Filipino, and Vietnamese) were most likely to see mental health advertisements on the internet, social media, or television. Billboards, buses, and bus shelters were the least likely places for them to see mental health advertisements.

Asian respondents were most likely to see advertisements with information to raise mental health awareness, available mental health services or resources, and suicide prevention.

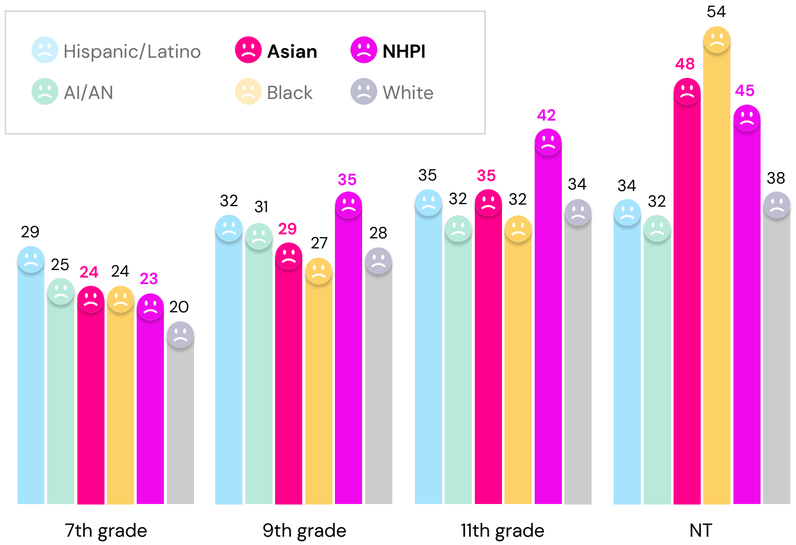
After viewing the advertisements, Asian respondents became aware of available resources and were more likely to share the information. When asked about challenges faced if offered a telehealth appointment for mental health or substance use services, Asian respondents were more comfortable sharing information and connecting with their doctor in person. Other challenges included feeling comfortable in their ability to use telehealth and technology, as well as privacy issues.

When asked about visit preference with their doctor, Asian respondents preferred a combination of telehealth and in-person visits. This trend is similar to the visit preference among Asian ethnic groups.

These findings suggest that a hybrid model for mental health services might be more popular and effective for Asian community.

Chronic Sadness or Hopelessness in Orange County Schools

percentage in the past 12 months by grade level, 2017-2019



Percentage of students that felt so sad or hopeless almost every day for two weeks or more that they've stopped doing some usual activities during the past 12 months.

7th grade	9th grade	11th grade	NT
25%	30%	35%	36%

Percentage of students that seriously considered attempting suicide during the past 12 months.

7th grade	9th grade	11th grade	NT
13%	15%	15%	19%

* NT includes continuation, community day, and other alternative school types
Source: California Healthy Kids Survey

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What are Social Determinants of Health?

The World Health Organization (WHO) defines social determinants of health (SDoH) as the conditions in which people are born, live, learn, work, play, worship, and age that impact health outcomes of a person or community. These circumstances are shaped by the distribution of money, power, and resources at the global, national, and local levels. These forces are outside the control of an individual or community and can greatly affect their overall health and well-being. Addressing these SDoH requires collective community action on a systemic level. The following pages highlight the status of the Asian, Native Hawaiian, and Pacific Islander population in Orange County across three social factors:

Health and Mortality

Comparing how long a group lives and determining their quality of life to the population at large can be a baseline for whether systemic disparities exist and how these disparities impact the community.

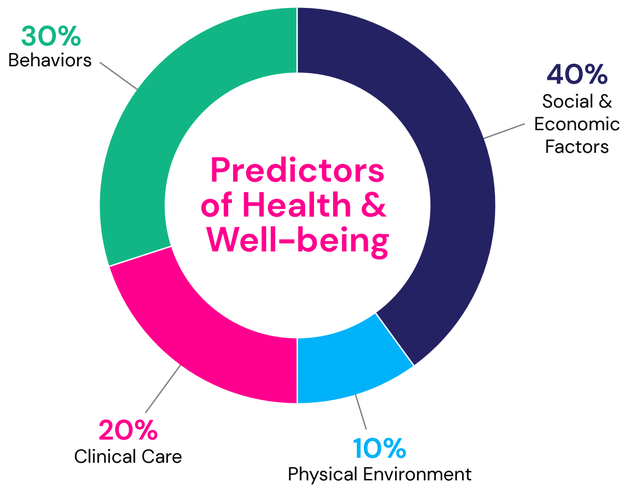
Economics and Education

Education does more than determine one's income. Individuals with higher education are more likely to be healthier and live longer. Improving education in various communities can bring significant health benefits to everyone.

Built Environment and Social Context

Where someone lives, how an individual gets around, and what is going on a person's community can greatly impact both individual and community health and well-being. Things like neighborhood walkability, cleanliness of air and water, and even the age of buildings in the community can affect quality of life.

> *It is unreasonable to expect that people will change their behavior easily when so many forces in the social, cultural, and political environment conspire against such change.*
>
> **National Academy of Medicine**



Source: County Health Rankings

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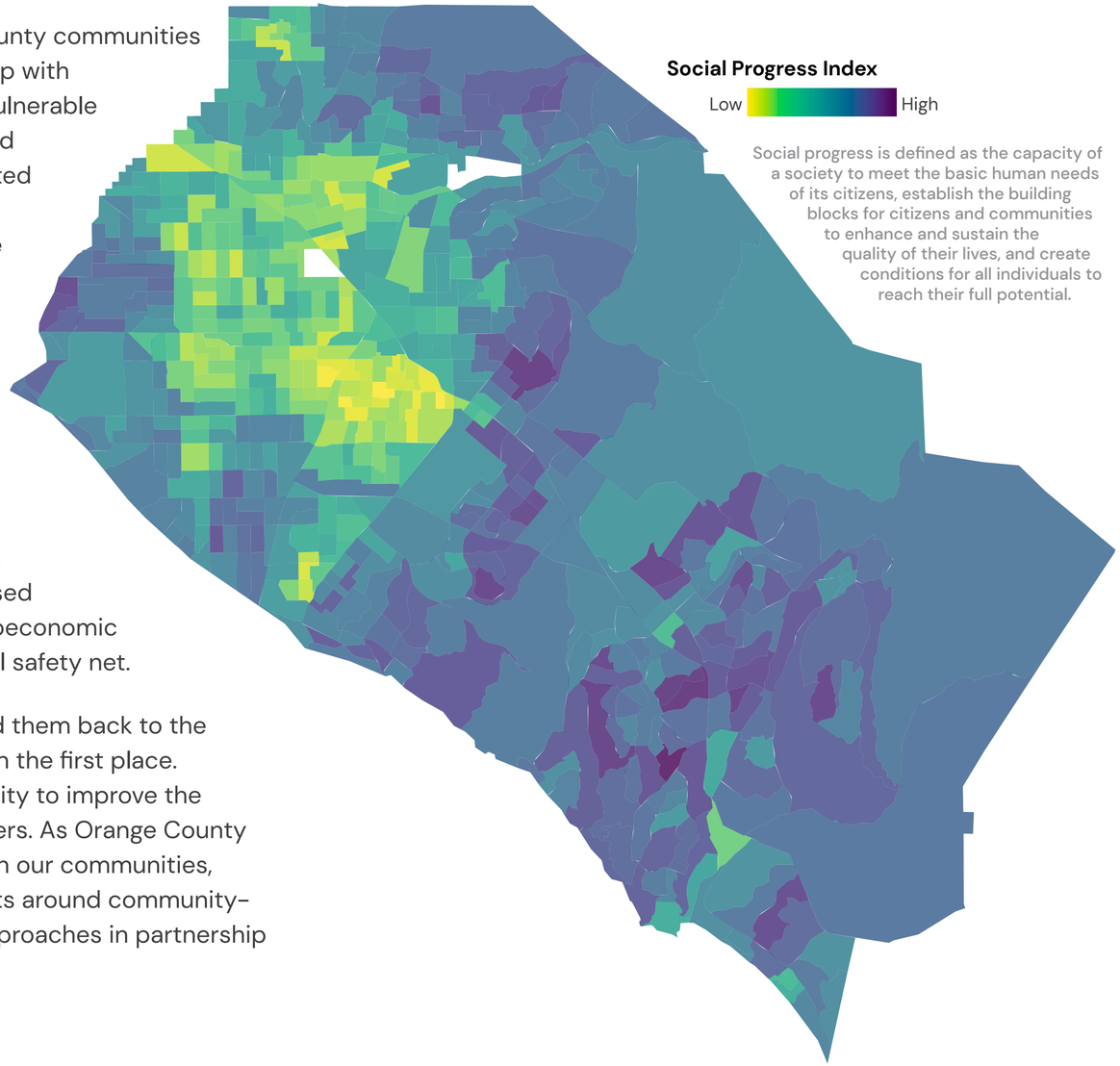
Mapping the Disparity

The COVID-19 pandemic impacted Orange County communities unequally and disproportionately. In partnership with AdvanceOC, a local non-profit, we identified vulnerable communities using comorbidity risk factors and social vulnerability. This rigorous analysis resulted in the Orange County Equity Map and guided the county's response and management of the pandemic.

What We Learned

The OC Equity Map measures social progress in various census tracts of the county. Analyzing and layering COVID-19 cases in Orange County showed that higher concentrations of COVID-19 cases occurred in low social progress areas. The pandemic exposed and magnified existing racial, gender, and socioeconomic inequities, including flaws in the county's social safety net.

We cannot treat and heal individuals then send them back to the systems and conditions that made them sick in the first place. Orange County sees COVID-19 as an opportunity to improve the health and well-being of all community members. As Orange County charts a path forward to rebuild and strengthen our communities, the Health Care Agency will center these efforts around community-informed, data-driven, and equity-oriented approaches in partnership and collaboration with community members.



Source: OC Equity Map, AdvanceOC

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SDoH Impacting Asian and NHPI Communities

Asians, Native Hawaiians, and Pacific Islanders (ANHPI) are the fastest growing racial and ethnic groups in the US. They represent 24 million people, nearly 100 different ethnic groups, and over 250 languages and dialects. ANHPIs vary in their demographic and socioeconomic characteristics.

Public insurance programs allow many low- and middle-income ANHPI children and families to have health insurance access and coverage. Nearly 17% of Asians and 28% of NHPIs rely on Medicaid. These programs are important for the Burmese, Bhutanese, and Marshallese communities since they have higher rates of poverty compared to other Asian and NHPI populations.

Since the ANHPI community is a largely immigrant community, restrictions on accessing health care services and programs due to immigration status has long-lasting impacts. Due to these restrictions, immigration and residency status is a major determinant of health status and health insurance coverage for the ANHPI population.

Asians are at high risk for cardiometabolic diseases (CMD), which include type 2 diabetes, hypertension, coronary artery disease, and stroke. Large observational studies suggest Asians may be disproportionately affected by CMDs. Even with the growth of Asians in the US, gaps still exist in understanding CMDs across Asian subgroups, and little is known about CMDs in disaggregated Asian subgroups.



2022 Tet Celebration at the Asian Garden Mall in Westminster, California. Photo courtesy of Gaston Castellanos.

Acculturation is a highly examined social factor for its influence on CMDs, and years lived in the US is associated with a higher risk of CMDs. Even though data are limited, South Asians and Filipinos have increased CMD risk.

The effect of English proficiency on CMD risk deserves further attention. Groups with limited English proficiency (LEP) may be at higher risk of poor health outcomes. However, a study highlights a gap in understanding how LEP affects CMD health among Asian

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subgroups. This is likely tied to health literacy, and one study found that Japanese individuals with low health literacy had an increased risk of hypertension. Addressing LEP and health literacy in the Asian community can further uncover health-related needs and gaps.

Educational attainment was associated with a higher risk of hypertension among Koreans, Filipinos, and Chinese and a higher risk of diabetes among Chinese, South Asians, and Japanese. This may reflect the varying immigration patterns of these Asian communities. For example, South Asians were more likely to immigrate to the US after the 1965 Immigrant Act, which favored immigrants with professional degrees. In 2015, 40% of Indians had a master's degree or higher. There is also a phenomenon known as the "healthy immigrant effect," and recent immigrants tend to be healthier even if they have lower socioeconomic status.

Social support influences CMD outcomes among various immigrant groups and other US-born populations. Several interventions with Filipinos and Koreans show that social support can assist in diabetes prevention, self-management, and physical activity.

Health insurance coverage rate for Native Hawaiians and Pacific Islanders (NHPI) is lower than most racial groups in the US. In 2008, one in four NHPIs (24.3%) under 65 years of age lacked health insurance coverage. This percentage is higher than most racial groups except for American Indians/Alaska Natives (30.7%) and Latinos (34.1%).

Two in three NHPIs (63.3%) aged 65 or older only had Medicare and lacked supplemental insurance. This percentage is higher than other racial groups, especially Whites (28.9%). While Medicare provides some basic coverage, it does not cover all health and medical expenses. Medicare beneficiaries may have significant out-of-pocket costs of uncovered services, which includes most routine preventive care, immunization, dental care, hearing aids, eyeglasses, outpatient prescription drugs, and long-term care. For a large proportion of NHPI seniors, this lack of supplemental insurance may be a barrier to accessing needed medications and health care.

LEP patients are vulnerable to disparities in health care access and quality. Effective communication between the patient and medical provider is important for the delivery of effective, high-quality care. Language barriers can affect patient-provider communications and can lead to inappropriate treatment or errors in diagnosing symptoms. Limited English proficiency can be a barrier to accessing quality care for linguistically diverse NHPIs.

Language access services ensure effective communication between LEP individuals and English speakers and are critical components of culturally and linguistically competent care. Language access services can include medical or health interpretation (oral) and translation (written) services. One in five NHPI adults (19.9%) in California reported that they found it "somewhat difficult" or "very difficult" to understand written information from their doctor.

> *The health insurance coverage rate for NHPIs is lower than most for other racial groups...*

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Anti-Asian Hate

While racism towards Asian Americans is not new in US history, ANHPIs in Orange County have been vulnerable to increased hate crimes and incidents due to tense US-China relations and the politicization of COVD-19.

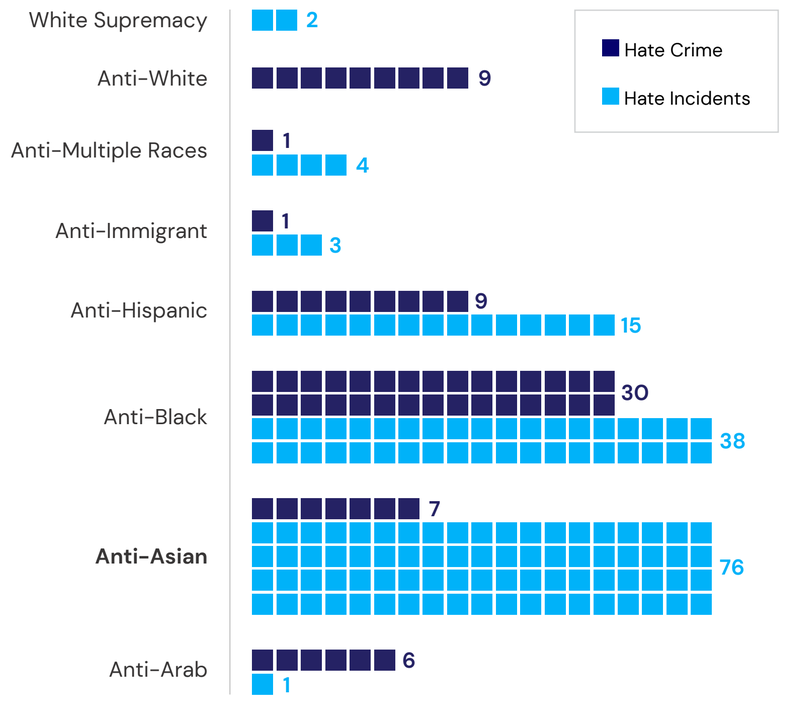
According to a 2021 Orange County Human Relations Commission report, 112 hate crimes were reported in Orange County, a 35% increase from 2019. A hate crime is defined as a crime motivated by bias against another person's race, color, disability, religion, national origin, sexual orientation, or gender identity. Hate crimes can include assaulting, injuring, or even touching someone in an offensive way because of their perceived protected class.

263 hate incidents were reported in Orange County, a 69% increase from 2019. A hate incident is defined as any hostile expression that may be motivated by another person's race, color, disability, religion, national origin, sexual orientation, or gender identity. Hate incidents can be verbal, physical, or visual behavior that contributes to or creates an unsafe or unwelcoming environment. Hate incidents can include name calling, using a racial or ethnic slur to identify someone, or using degrading language.

According to the May 2021 Stop Anti-AAPI Hate Mental Health Report, Asian who have experienced racism are more stressed by anti-Asian hate than the COVID-19 pandemic itself. One in five Asians who have experienced racism show racial trauma, which is the psychological and emotional harm caused by racism. They also have heightened symptoms of depression, anxiety, stress, and physical distress. Experiences of racism during the COVID-19 pandemic is more strongly associated with symptoms of post-traumatic stress disorder (PTSD).

Hate Crimes & Hate Incidents in Orange County

2020



69%

increase of hate incidents

in Orange County since 2019

1800%

increase of anti-Asian hate incidents

in Orange County since 2019

Source: OC Human Relation Report

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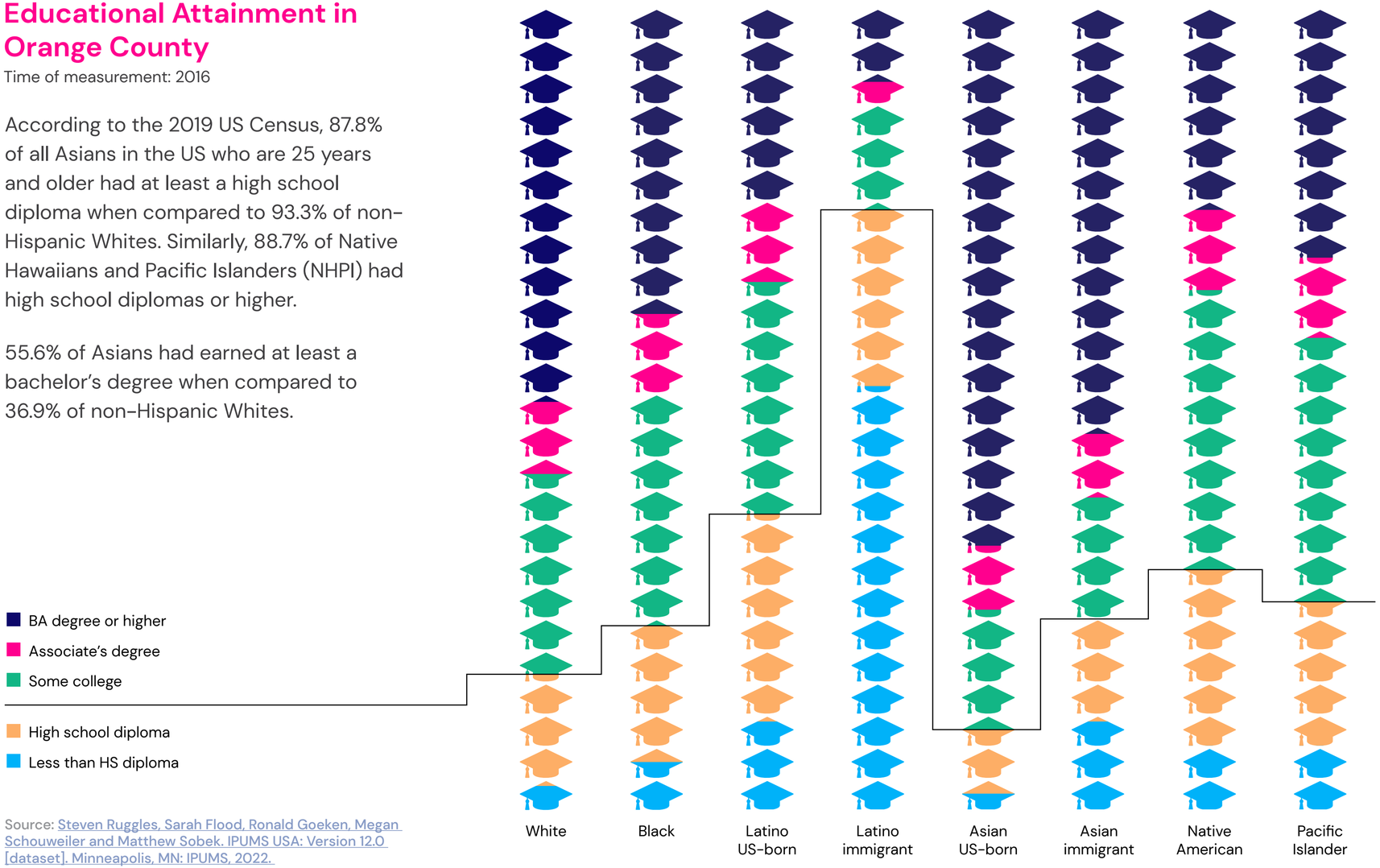
Economics and Education

Educational Attainment in Orange County

Time of measurement: 2016

According to the 2019 US Census, 87.8% of all Asians in the US who are 25 years and older had at least a high school diploma when compared to 93.3% of non-Hispanic Whites. Similarly, 88.7% of Native Hawaiians and Pacific Islanders (NHPI) had high school diplomas or higher.

55.6% of Asians had earned at least a bachelor's degree when compared to 36.9% of non-Hispanic Whites.



Source: Steven Ruggles, Sarah Flood, Ronald Goeken, Megan Schouweiler and Matthew Sobek. IPUMS USA: Version 12.0 [dataset]. Minneapolis, MN: IPUMS, 2022. https://doi.org/10.18128/D010.V12.0

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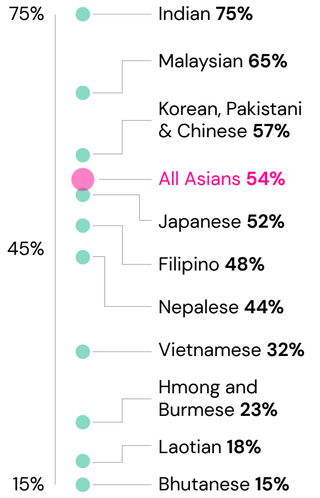
The share of Asians aged 25 years and older with at least a bachelor's degree varies greatly within the community. Indians (75%), Malaysians (65%), Mongolians (60%), and Sri Lankans (60%) are more likely to have at least a bachelor's degree. By comparison, fewer than one in five Laotians (18%) and Bhutanese (15%) had at least a bachelor's degree. Roughly a third of all Americans aged 25 years and older had a bachelor's degree or more in 2019.

Differences in educational attainment among Asian subgroups partly reflect the education levels those immigrants bring to the US. For example, three-quarters of Indians had a bachelor's degree or more education in 2019. Through visas for high-skilled workers, many of them already had a bachelor's degree when they arrived in the US. Since 2001, half of H-1B visas, which require a bachelor's degree or equivalent, were given to Indians.

According to the Pew Research Center, Asians are the most likely racial or ethnic group to move up from a lower income tier. Conversely, Asians are least likely to move down from an upper income tier. However, the reality of the socioeconomic status of Asians is one of disparities in education, income, wealth, and employment. Addressing assumptions of Asians' economic status is key to understanding the disparities within the group.

Educational Attainment by Asian Subgroups Nationally

Percentage of those ages 25 and older with a bachelor's degree or more

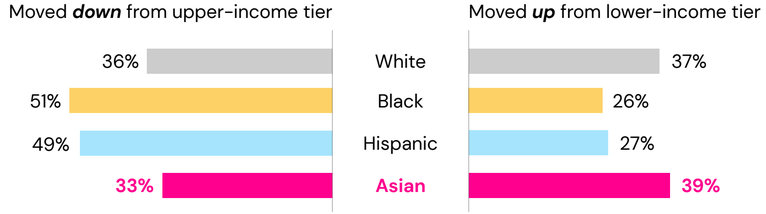


Note: Data not available for all Asian origin groups. "Chinese" includes those identifying as Taiwanese. See methodology for more.

Source: Pew Research Center analysis of 2017-2019 American Community Survey (IPUMS)

Income Tier Movement Nationally

Percentage of adults who moved up from the low-income tier or down from the upper-income tier, average of annual turnovers from 2000-2001 to 2020-2021



Source: Pew Research Center

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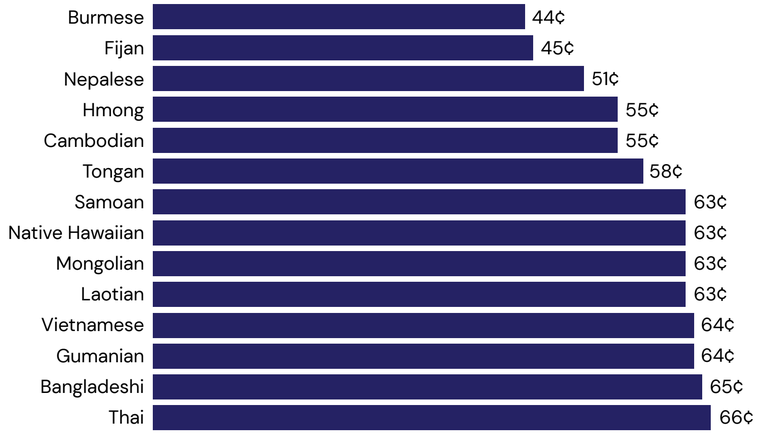
In the US, women earn $0.82 for every $1.00 earned by men of all races. Compared to non-Hispanic White men, non-Hispanic White women earn $0.79 for every $1.00. Asian women earn $0.90 for every $1.00 earned by non-Hispanic White men. However, within the Asian, Native Hawaiian, and Pacific Islander (AHNPI) community, this gap is widely different. Thai women earn $0.66 compared to non-Hispanic White men and Burmese women earn $0.44. In between, Vietnamese women earn $0.65, Native Hawaiian and Samoan women earn $0.63, Hmong women earn $0.55, and Fijian women earn $0.45.

In addition to the pay gap experienced by all women, Asians are more likely to work at gig jobs than non-Hispanic Whites or most American adults. In terms of any kind of gig work, 19% of Asians work in the gig economy when compared to 16% of all adults.

Source: American Progress

Gender Pay Gap Nationally

On average, Asian American women earn 85 cents for every $1.00 a white man earns. The following represents what women in different Asian subgroup populations earn relatively.



Source: National Asian Pacific American Women's Forum

Gig Workers by Race/Ethnicity Nationally

Percentage of adults who say they have ever earned money by...

	Doing any gig platform work	Making deliveries from a restaurant or store for a delivery app	Performing household tasks or running errands	Driving for a ride-hailing app	Shopping or deliverying groceries or household items	Using a personal vehicle to deliver packages via an app or website	Doing something else
U.S. adults	16%	7%	6%	5%	4%	3%	4%
White	12%	4%	4%	3%	2%	1%	3%
Black	20%	10%	8%	7%	7%	5%	6%
Hispanic	30%	16%	12%	9%	7%	6%	6%
Asian	19%	7%	2%	8%	7%	4%	7%

Source: Pew Research Center

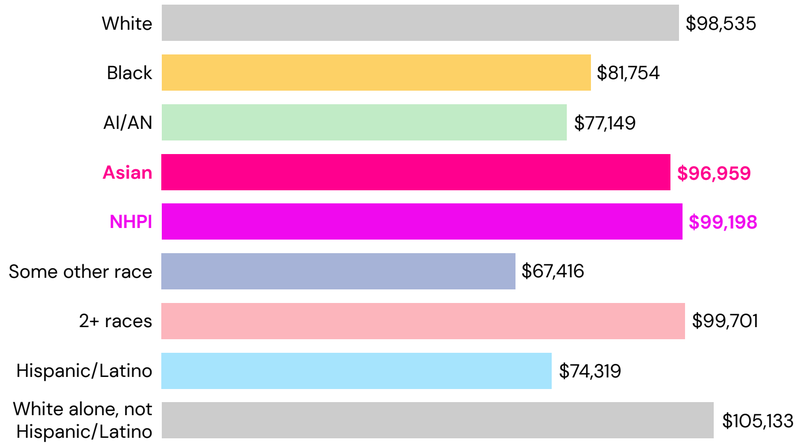
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Wide disparities in income exist in the Asian community. Asian households in the US had a median annual income of $85,800 in 2019 and is higher than the $61,800 among all US households. Two Asian subgroups had household incomes that exceeded the median for Asian Americans overall: Indians ($119,000) and Filipinos ($90,400). Most of the Asian subgroups were below the national median for Asian Americans, including the two lowest median household incomes: Burmese ($44,400) and Nepalese ($55,000).

Median Household Income by Race/Ethnicity in Orange County

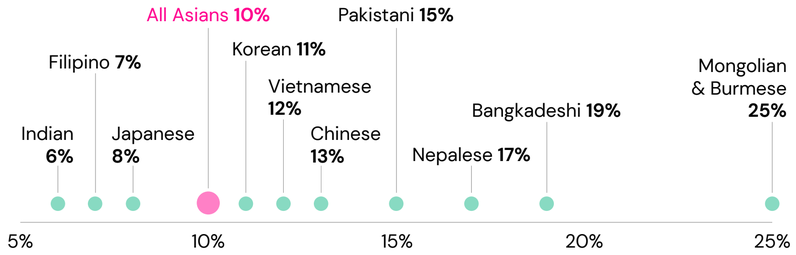
2020



Source: Steven Ruggles, Sarah Flood, Ronald Goeken, Megan Schouweiler and Matthew Sobek. IPUMS USA: Version 12.0 [dataset]. Minneapolis, MN: IPUMS, 2022. https://doi.org/10.18128/D010.V12.0

Asian Americans in Poverty by Origin Group Nationally

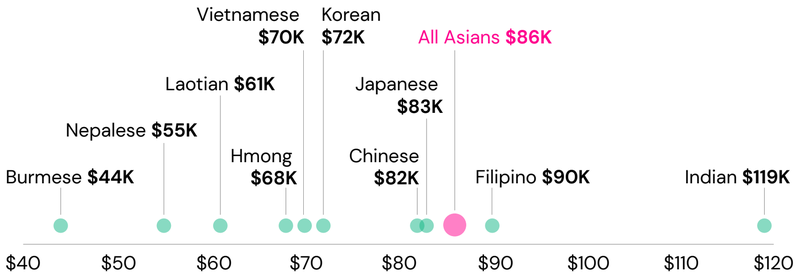
2020



Source: Pew Research Center

Median Household Income by Origin Group Nationally

2020



Source: Pew Research Center

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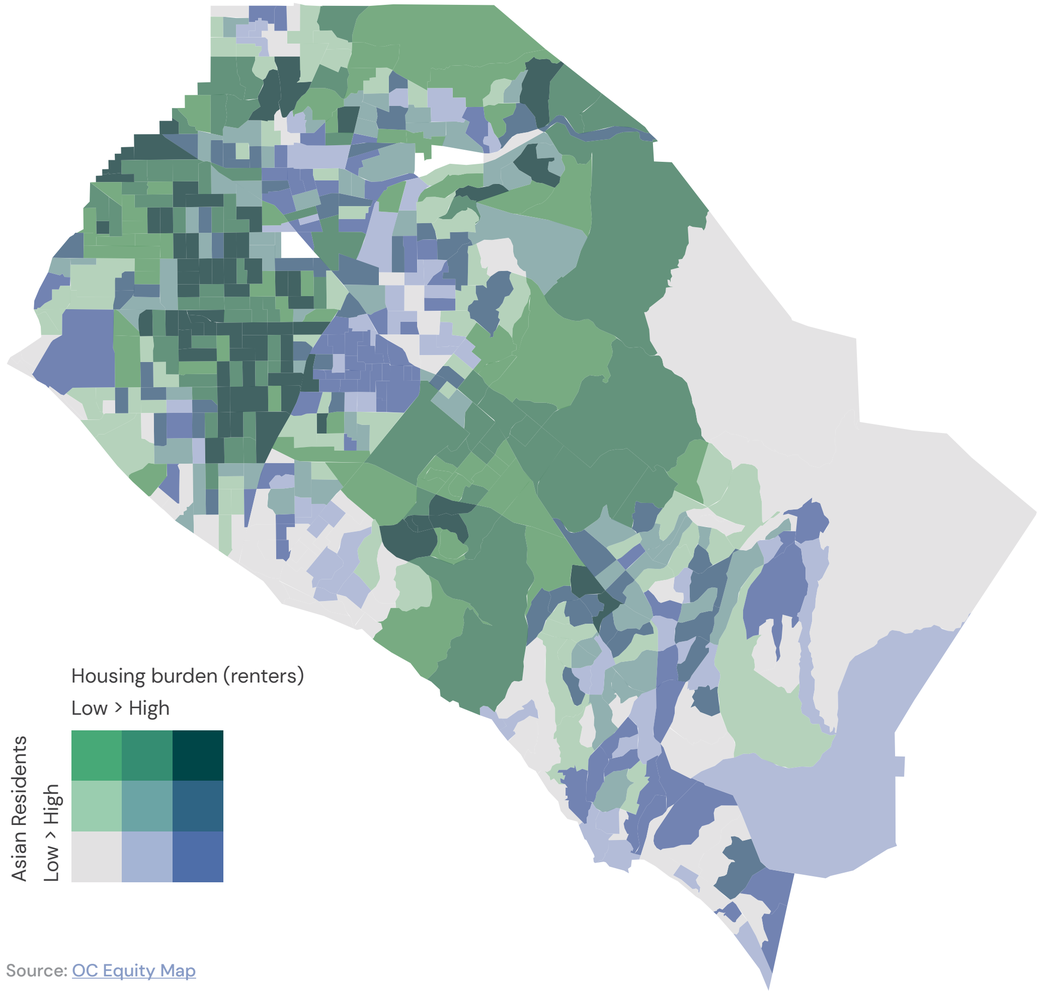
Built Environment and Social Context

Asians, Native Hawaiians, and Pacific Islanders (ANHPI) struggle to find stable and affordable housing. Nearly half of Asians in Orange County pay more than 30% of their income on housing. Vietnamese and Koreans are most likely to spend more of their income on housing costs than the ANHPI population. Nearly half of NHPI homeowners in the county struggle to manage housing costs. By dedicating so much of their incomes to housing, these groups may have difficulty affording necessities, such as food and medical care. When they do seek medical care, they may already be in worse health situations.

Asian business owners sometimes operate exclusively in cash. Some first-generation Asian immigrants also "under bank." Since they don't trust financial systems, they tend to hoard cash in their household. This lack of traceable income can make it difficult to get financial assistance for their business or when trying to find housing.

Housing Burdened for Renters and the Asian Population in Orange County

2019



Source: OC Equity Map

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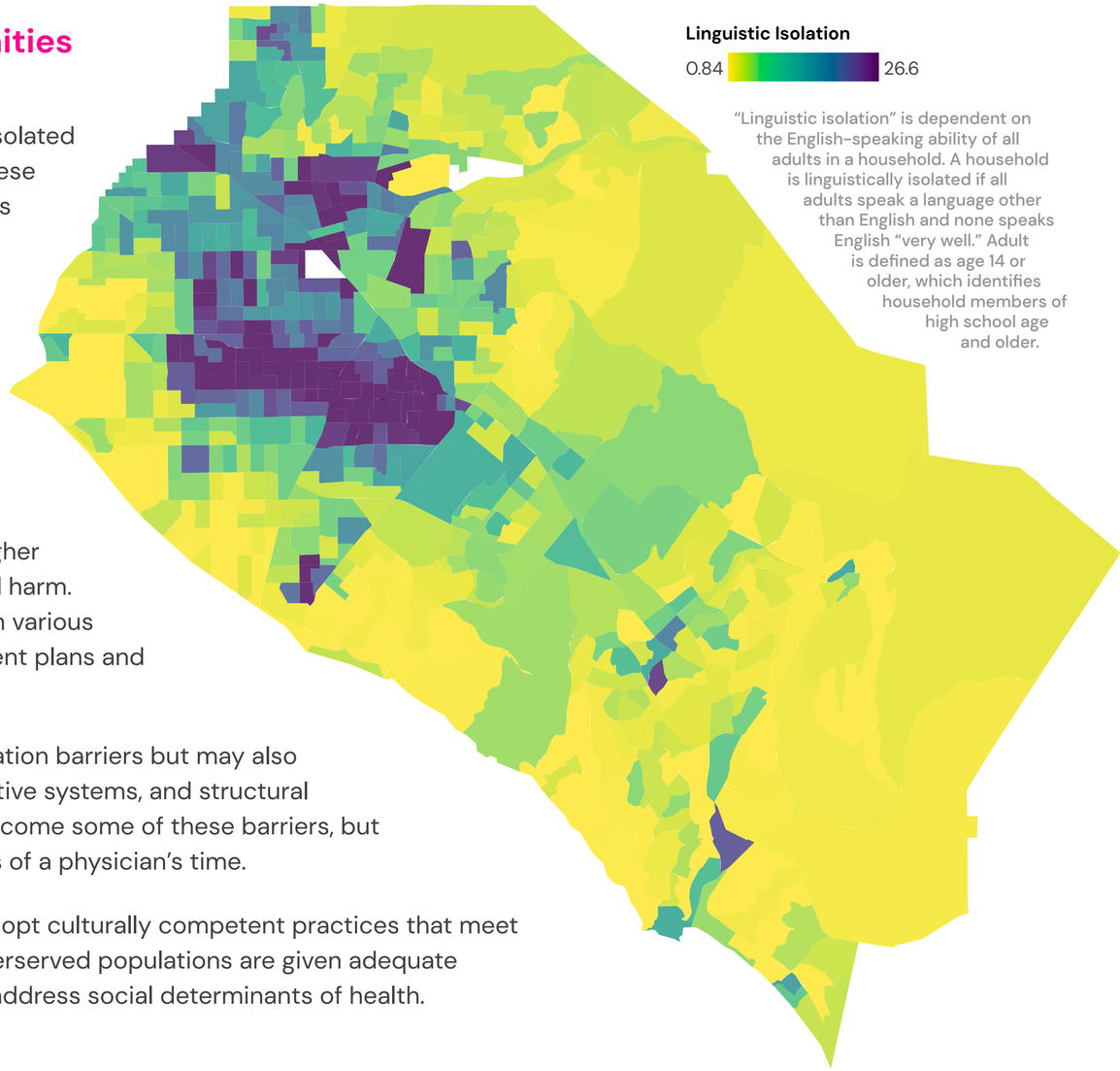
Orange County Language Opportunities and Services

Orange County residents who live in linguistically isolated communities are often from immigrant families. These immigrant families tend to gather in ethnic enclaves as a means of survival because of discriminatory practices or due to being shunned from other parts of the county.

People with limited English proficiency (LEP) are defined by the US Census as those who speak English less than "very well." In 2020, 8.7% of Orange County residents are LEP. They experience high rates of medical errors with worse clinical outcomes than English-proficient patients. This higher incidence of medical errors could result in physical harm. LEP individuals also receive lower quality of care on various measures and are less likely to understand treatment plans and disease processes.

These disparities are rooted in obvious communication barriers but may also reflect cultural differences, clinician biases, ineffective systems, and structural barriers. Medical interpreter services can help overcome some of these barriers, but they have associated costs financially and in terms of a physician's time.

We must strive to remove language barriers and adopt culturally competent practices that meet residents where they are. This will ensure that underserved populations are given adequate resources to access healthcare and services that address social determinants of health.



Source: OC Equity Map, AdvanceOC

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Built Environment and Social Context (continued)

Air Pollution Exposure in Orange County

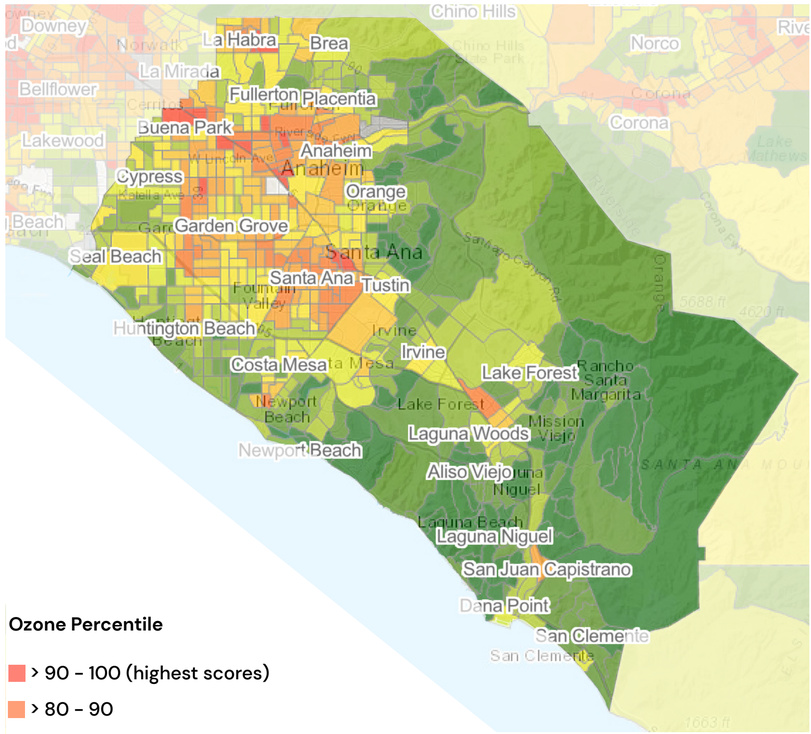
In California, environmental quality has improved over the last few decades. This is seen in improved water quality, reduced air pollution, decrease in pesticide use, continued cleanup of hazardous waste sites, increased recycling, and reduction of solid waste going into landfills. However, pollution reduction and the resulting health and environmental benefits are not uniformly distributed across the state, within a region, or among all population segments. Many communities continue to bear a disproportionate burden of pollution not only from multiple nearby sources but also from pollution in various forms, such as air and water.

Ozone pollution causes adverse health effects including respiratory irritation and worsening of lung disease. Adverse effects of ozone have been studied extensively since the late 1960s, and ongoing exposure to ozone shows inflammation and cell and tissue injury. People with asthma and chronic obstructive pulmonary disease (COPD) are considered sensitive to the effects of ozone. Studies also show that long-term ozone exposure affects respiratory and cardiovascular mortality. A 2019 study estimates 13,700 deaths in California in the year 2012 were due to long-term ozone exposure.

Of these deaths, 7,300 were from respiratory causes, and 6,400 were from cardiovascular causes. The CalEnviroScreen 4.0 draft ozone map of Orange County shows high levels of ozone pollution scores in north and central Orange County. In the OC Equity Map, these communities have low Social Progress Index scores.

Ozone Levels by Pollution Score

2021



Source: CalEnviroScreen

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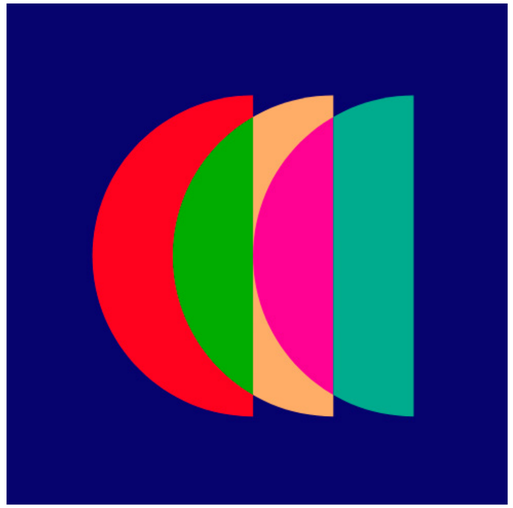
Health is a shared value. Your involvement will help create a healthier, more resilient, and equitable Orange County.

Here's how you can get involved:



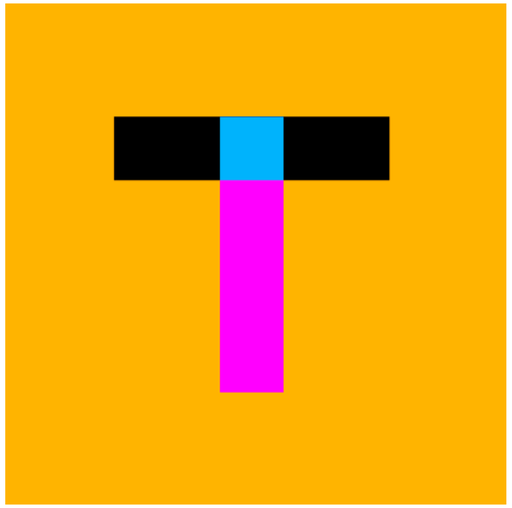
Participate in the EiOC Action and Learning Community

Learn More



Join a Population Health Equity Collective

Learn More



Make your voice heard at EiOC Taskforce Meetings

View Events



An Initiative of OC health CARE AGENCY

EquityinOC.com

EQUITY IN OC

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Addressing health inequities across Orange County by enabling system change.



Achieving Equity in Orange County

Health inequities are differences in health status or in the distribution of health resources among various populations. This is due to the social conditions in which people are born, grow, live, work, and age. Across Orange County (OC) we see differences in the length and quality of life; rates of disease, disability, and early death; severity of disease; and access to treatment because of these inequities.

Equity in OC is an OC Health Care Agency (HCA) initiative in collaboration and partnership with local Orange County community partners. Funded by a grant from the Centers for Disease Control and Prevention (CDC), the Equity in OC Initiative is a community-informed and data-driven initiative to address health inequities and disparities in Orange County by laying the foundation for creating a healthier, more resilient, and equitable Orange County.

Why Create Population Overviews?

These population overviews are snapshots of available data for various populations in Orange County. By laying out population-specific data in these overviews, we can identify systemic changes that can improve the quality of life within these communities. Since these population overviews are only the start of democratizing community-level data, we welcome feedback and input to further refine and improve this living document.

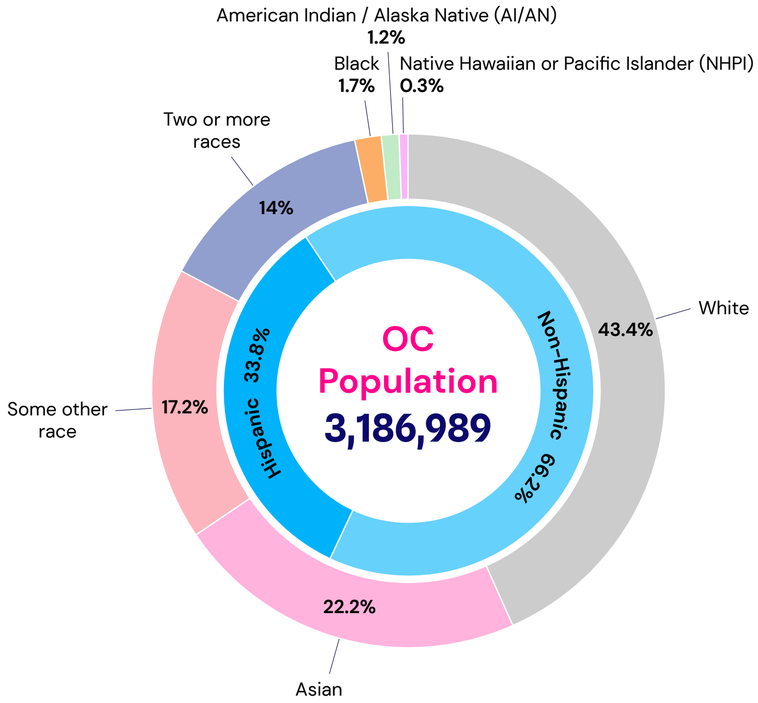
For more information go to www.equityinoc.com.

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Orange County at a Glance



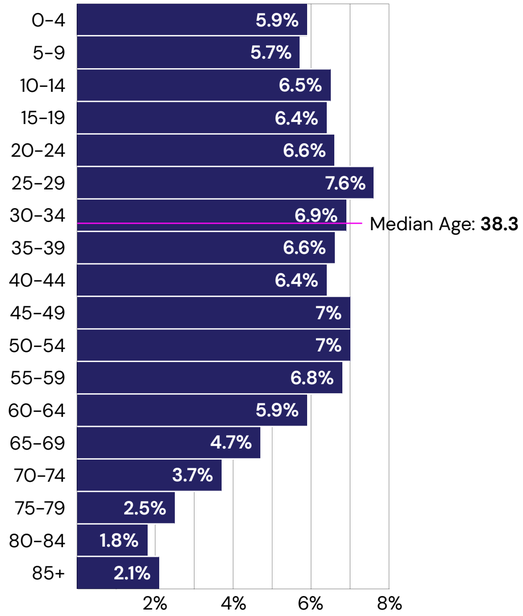
The United States (US) Census Bureau collects racial data according to guidelines by the US Office of Management and Budget (OMB), and these data are based on self-identification.

Racial categories in the census survey reflect a social definition of race in the US. It is not an attempt to define race biologically, anthropologically, or genetically. Also, categories of race include national origin or sociocultural groups. People who identify their origin as Hispanic, Latino, or Spanish may be of any race.

About the Topic of Race (census.gov)

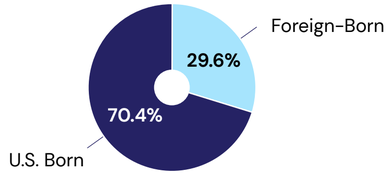
Source: 2020 Decennial Census

Population by Age Group



Source: 2020 ACS 5-Year Data, U.S. Census Bureau

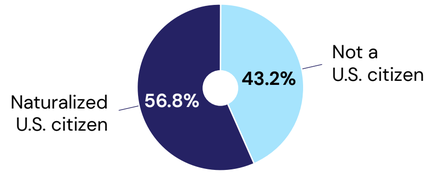
Population by Birth Origin



Source: 2020 ACS 5-Year Data, U.S. Census Bureau

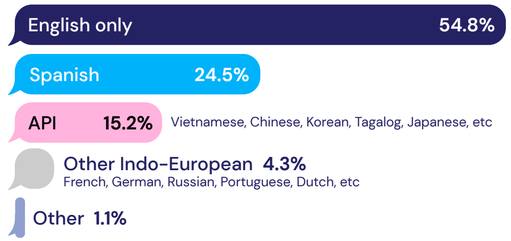
Population by Citizenship

of foreign-born residents



Source: 2020 ACS 5-Year Data, U.S. Census Bureau

Languages Spoken at Home



Source: 2020 ACS 5-Year Data, U.S. Census Bureau

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$94,441

Median Household Income

2020

Source: 2020 ACS 5-Year Data, U.S. Census Bureau



56.9%

Home Ownership Rate

as of March 2022

Source: U.S. Bureau of Labor Statistics



1,129,785

Total Housing Units

2020

Source: 2020 ACS 5-Year Data, U.S. Census Bureau



41.2%

Bachelor's Degree or Higher

2020

Source: 2020 ACS 5-Year Data, U.S. Census Bureau



10.1%

Persons in Poverty

2020

Source: 2020 ACS 5-Year Data, U.S. Census Bureau



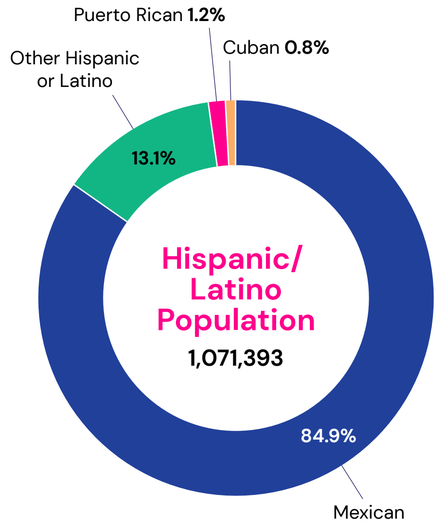
3.1%

Unemployment Rate

as of March 2022

Source: U.S. Bureau of Labor Statistics

Hispanic/Latino Population Overview in OC



Source: 2020 ACS 5-Year Data, U.S. Census Bureau

Understanding Hispanic, Latino, Chicano and other terms

When referring to people who identify as Hispanic, Latino (or Latinx, etc.), Chicano, or another related designation, community members should consult with individuals to figure out the appropriate choice. Note that "Hispanic" is not necessarily an umbrella term, and the labels "Hispanic" and "Latino" have different meanings. The term "Latino" (and its related forms) might be preferred by those originating from Latin America, including Brazil. Some use the word "Hispanic" to refer to those who speak Spanish; however, not every group in Latin America speaks Spanish (for example, in Brazil, the official language is Portuguese). The word "Latino" is gendered, ("Latino" is masculine and "Latina" is feminine). Recently, gender-

Hispanic/Latino Population by Ethnicity

Alone and in other combinations for Orange County, 2020, and percentage change since 2015

Mexican	909,158	-2.6%
Salvadoran	30,536	-6.7%
Guatemalan	20,334	+1.2%
All other Hispanic/Latino	16,604	+42.5%
Puerto Rican	12,581	-10.7%
Spaniard	11,781	+0.7%
Peruvian	9,072	-18.8%
Cuban	9,051	+21.9%
Spanish	8,929	+8.1%
Colombian	8,671	-5.9%
Argentinean	6,581	+112.6%
Honduran	4,065	+10.1%
Costa Rican	3,591	+412.3%
Ecuadorian	3,565	-38.7%
Nicaraguan	3,441	-44.5%
Bolivian	2,811	+35.7%
Venezuelan	2,551	+756.0%
Chilean	2,241	+1.3%
Other Central American	1,573	+173.6%
Other South American	1,412	+7.5%
Uruguayan	959	+8.1%
Panamanian	888	-30.1%
Dominican	760	-37%
Spanish American	167	-57.3%

Source: 2020 ACS 5-Year Data, U.S. Census Bureau

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inclusive terms have gained popularity, using “Latin@” to mean both. “Latinx” can also be a gender-neutral or nonbinary term, inclusive of all genders. Chicano is terminology used to identify people of Mexican descent born in the United States. The term became popular among Mexican Americans as a symbol of pride and activism during the Chicano Movement of the 1960s.

After talking with community members and organizations serving this community, we will use **Hispanic/Latinos** in this document to be inclusive. It will be our preference to refer to a nation or region of origin when data are available (for example, Bolivian, Salvadoran, or Costa Rican is more specific than Latino, Latinx, Latin American, or Hispanic).

Top Cities of Hispanic/Latino Residents

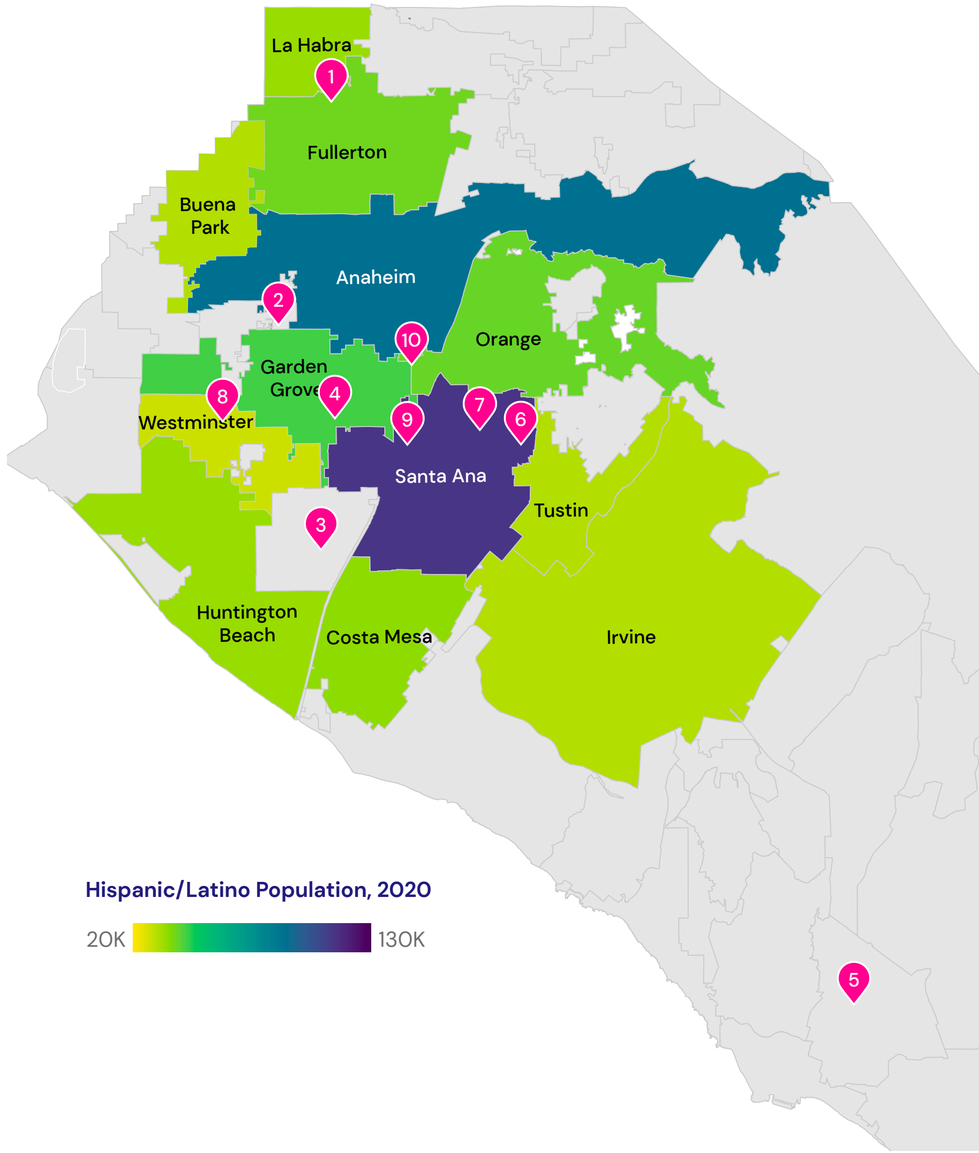
2020, with percentage changes since 2015

City	2020	
Santa Ana	252,762	-3.1%
Anaheim	188,179	+2.6%
Garden Grove	63,289	-1.3%
Orange	53,160	+0.7%
Fullerton	51,901	+6.0%
Costa Mesa	41,070	+2.4%

City	2020	
Huntington Beach	38,116	-0.2%
La Habra	36,869	-1.8%
Tustin	31,572	-0.4%
Buena Park	31,128	-0.5%
Irvine	29,184	+21.7%
Westminster	20,832	-1.9%

Geographical Markers

1. Bastanchury Ranch
2. Colonia Independencia
3. Colonia Juarez
4. Colonia La Paz + Colonia Manzanillo
5. Mission San Juan Capistrano
6. Mexican Consulate
7. Chepa’s Park
8. The Mendez Tribute Monument Park and Freedom Trail
9. Sariñana’s Tamale Factory
10. Christ Cathedral



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Hispanic/Latino Population: A Historical Context

Mexican Americans come from a culture steeped in rich history in the Americas. For thousands of years, Mexico was already the cultural center of America with a concentration of highly advanced cultures and empires: Aztec, Maya, Toltec, and many more. The Aztec empire was the largest and most powerful nation in the Americas, and only the Inca, in South America, could rival it. In later years, colonization was an unfortunate consequence of Spanish interaction, resulting as generational trauma among native and indigenous communities. Before that, the territory was inhabited exclusively by American Indians. Mexican Americans are, therefore, the second oldest component of American society.

Before 1840, California, Nevada, Texas, New Mexico, Colorado, Utah, and Arizona — about one-third of the United States today — was Mexican territory. In 1846, the United States invaded California, which was then part of the Republic of Mexico. This event, which is one aspect of the 1846-1848 US-Mexican War, led to US annexation of California through the 1848 Treaty of Guadalupe Hidalgo. Mexican American history in California shows that instead of Mexican Americans crossing the border, the border crossed Mexican Americans. That led to the saying among Mexican Americans that "we didn't cross the border, the border crossed us."

According to OC History, the Mexican revolution in 1910 significantly led to increased migration of Mexican families moving north to the United States to escape economic turmoil and violence taking place south of the border. Based on this migration, the Mexican American population in Orange County doubled, making up 14% of the county's total population.

During World War II, much of the US workforce was lost to military and defense work, resulting in shortages of farmworkers. In July 1942, the governments of the United States and Mexico negotiated an agreement called the Mexican Farm Labor Program. Unofficially, it was called the Bracero Program (one definition of bracero is "day laborer"). The program continued until 1964, nearly 20 years after the war's end, largely at the insistence of employers who benefited from it.

Nevertheless, migrant workers earned significantly lower wages than nearly all other American laborers and faced much harsher working conditions. In the 1960s, some migrant workers in the Southwest began to form labor unions under the leadership of activists such as Cesar Chavez and Larry Itliong. Unionization helped improve conditions for migrant workers, but their standard of living still remained much lower compared to the average American worker.

Comparing the city of Santa Ana, where many Hispanic/Latinos reside, and the largely White rich cities that surround it, reveals extreme and persistent segregation and inequality. The Hispanic/ Latino population has grown tremendously in Orange County but still experiences high levels of segregation. Residential segregation is also an issue in other cities in Orange County, such as Irvine. Residents work hard to maintain their property values by using their homeowner's associations to keep Hispanic/Latinos out.

Source: MDPI Journal

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Hispanic/Latinos also faced inequalities in education throughout California. The 1931 decision in the *Roberto Alvarez v. the Board of Trustees of the Lemon Grove School District* case desegregated Mexican American students in San Diego. Years later, Mexican Americans living in Westminster, Garden Grove, Santa Ana, and El Modena school districts of Orange County challenged the practice of school segregation.

The 1946 court case, *Mendez, et al. v. Westminster School Dist. of Orange County, et al.*, demanded an end to the segregation of 5,000 Mexican students in Orange County school districts. Segregation prevented Mexican students' capacity to learn English and increased occurrence of antagonism and inferiority against students of Mexican descent. This lawsuit led to the end of school segregation in California in 1947 and served as precedent for *Brown v. Board of Education of Topeka* in 1954.

As immigrants continued to expand in Orange County, a small group of activists organized against what they perceived as a threat of illegal immigration. They created an initiative called Save Our State (SOS) that was supported by the governor and passed as California Proposition 187 in November 8, 1994. This proposition restricted undocumented immigrants from the state's public services, including access to public education and healthcare. Proposition 187 challenged immigrants, especially the Hispanic/Latino community. Although Proposition 187 was declared unconstitutional, it created fear and anger in Hispanic/Latino and immigrant communities. This proposition also led to the rise of the Hispanic/Latino vote through persistent organizing that transformed politics and policymaking in California.

While Mexicans are the largest group of Hispanic/Latinos in Orange County, they are among a diverse community that make up the Hispanic/Latino population. Orange County is also home to residents with origins from El Salvador, Guatemala, Puerto Rico, Peru, Cuba, Colombia, and other countries. The rich tapestry of Hispanic/Latino heritage is embedded in Orange County's food, businesses, history, and vernacular. We encourage you to explore more of this diaspora by pursuing ethnic studies, engaging with different cultural organizations, and participating in activities celebrating Hispanic/Latino heritage locally and nationally.

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Hispanic/Latinos and COVID-19 in OC

According to the OC Health Care Agency as of May 10, 2022, over 500,000 cases and over 7,000 deaths have occurred in Orange County due to COVID-19.

Among the 500,000 cases reported in Orange County, most of the COVID-19 cases are "unknown" since they did not have racial or ethnic classification. Unknown cases include those who did not identify with a particular racial or ethnic classification or may not have been asked for this information. With many unknown COVID-19 cases, generalizations about the impact of COVID-19 among various racial and ethnic groups should be avoided. According to the California Immunization Registry, 76.3% of Orange County residents older than 5 years are fully vaccinated. The vaccination rate of California is 75.1%.

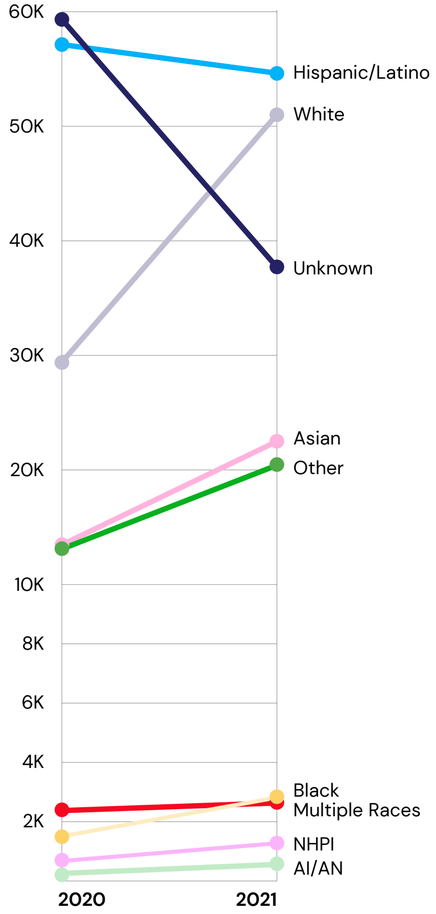
The Hispanic/Latino community had the lowest vaccination rate among all racial and ethnic groups in Orange County.

This can be explained by a number of different factors, including vaccine hesitancy, systemic lack of resources to conduct targeted outreach and counter misinformation, and long-standing structural determinants of health.

To understand the impact of COVID-19 on the various populations of Orange County, a specific public health measurement is used: case or death rates per 100,000 people, which are the total number of cases

Total Cases

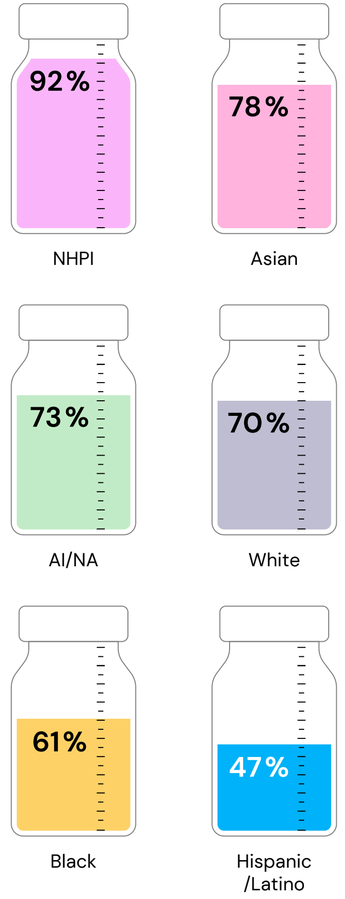
by race/ethnicity, 2020-2021



Source: OC Health Care Agency

Vaccination Rate

per 100K population, 2021



Source: OC Health Care Agency

Hispanic/Latinos and COVID-19 in OC (continued)

or deaths divided by the total population of a specific group and multiplied by 100,000.

For data collection on COVID-19 cases, information is under-reporting among Hispanic/Latinos because of fear of sharing identifiable information about their ethnicity and possibly risking deportation.

The impact of COVID-19 on the Hispanic/Latino community was disproportionately adverse, with some families being impacted by both health and financial loss.

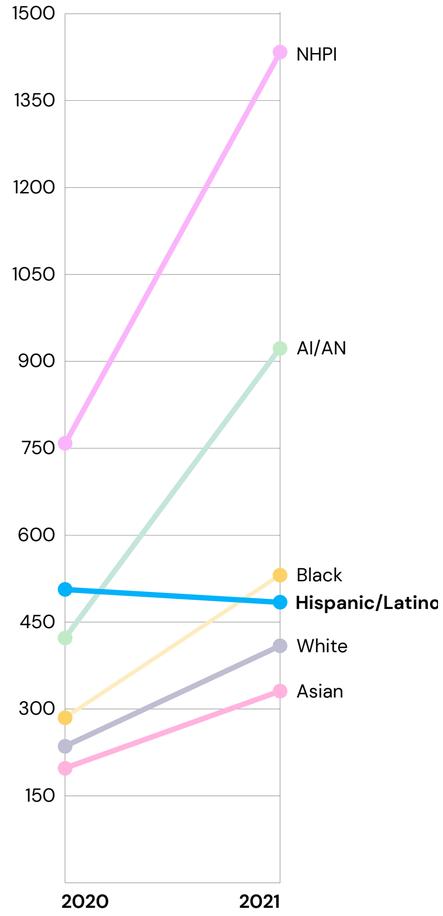
Despite the many structural factors impacting this community, such as housing overcrowding, lack of childcare, and the dependence on public transit, Hispanic/Latinos continue to have the highest incidence and lowest vaccination rates for COVID-19. Their socioeconomic roles as front line workers prevented their ability to socially distance and seek a primary care physician.

The Hispanic/Latino community was heavily dependent on concerted outreach by a broad-based coalition of community-based organizations, faith-based groups, and local clinics to counter historical mistrust, fear, and misinformation.

Ongoing investments to address health literacy, social determinants of health, and organizational capacity building is needed to tackle health barriers for the Hispanic/Latino community.

Case Rate

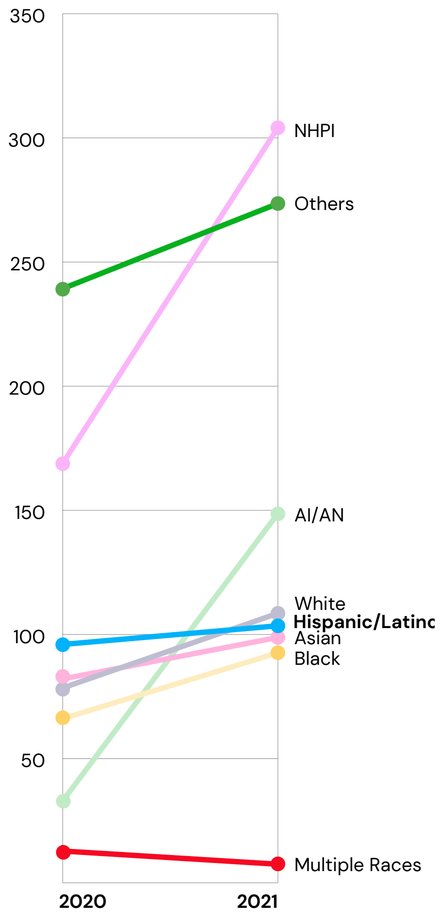
per 100K population, 2020-2021



Source: OC Health Care Agency

Death Rate

per 100K population, 2020-2021



Source: OC Health Care Agency

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Health and Mortality

According to the 2022 County Health Rankings, Hispanic/Latinos in Orange County have a life expectancy of 83.2 years, which is the second highest among racial and ethnic groups in the county.

Hispanic/Latinos in the United States typically live longer than Whites — a phenomenon commonly referred to as the "Hispanic Paradox" or "Latino Mortality Advantage."

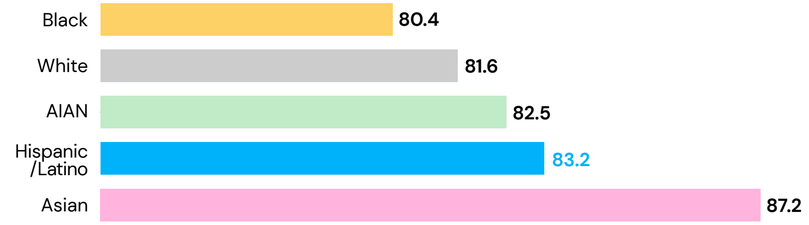
While not totally understood, these epidemiological findings have interested scholars, mostly because Hispanic/Latinos, on average, have lower socioeconomic status than Whites. This is typically associated with higher death rates and worse health outcomes.

Current health trends suggest the gap between US Hispanic/Latinos and Whites may soon be shrinking. Princeton University research points to higher obesity rates, higher incidence of diabetes, and significant disability issues as potential downfalls for Hispanic/ Latinos. While Hispanic/Latinos still smoke less than Whites in the United States, this may not be enough to counteract other negative health trends.

Researchers have posed several explanations for the survival advantage: better health among those who immigrate to the United States, better health-related behaviors, particularly lower rates of smoking, and better social support from their families and peer networks. Currently, the strongest explanation for this survival advantage is that Hispanic/Latinos have had and continue to have lower rates of smoking than non-Hispanic/Latino Whites. Based on this fact, Hispanic/Latino immigrants have reported better health outcomes than US-born individuals despite their limited access to health care services and education.

Life Expectancy at Birth in Orange County

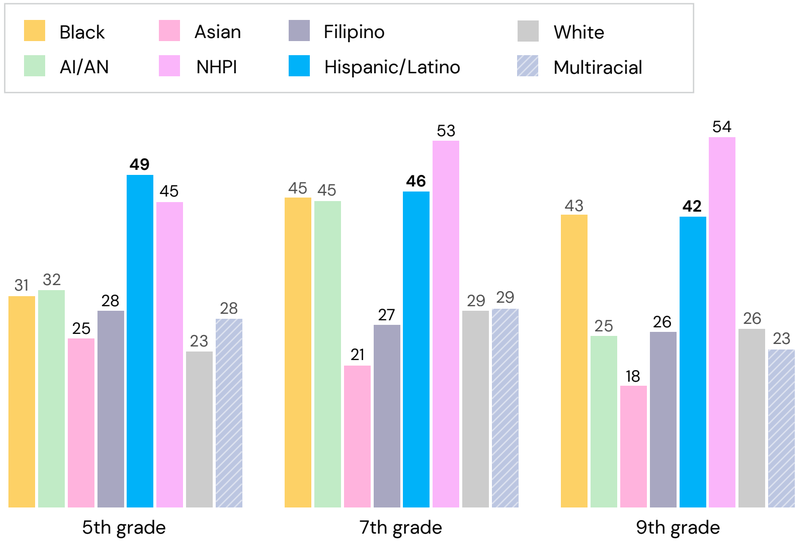
2020



Source: County Health Rankings

Childhood Obesity in Orange County

Percentage by Race/Ethnicity and Grade Level, 2019



Source: Kidsdata.org

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Health and Mortality (continued)

Further research suggests that the Hispanic Paradox is explained by the Healthy Migrant Hypothesis and Salmon Bias Hypothesis.

The Healthy Migrant Hypothesis describes the pattern of migration into the United States of individuals and families seeking a better life for themselves. These migrants tend to be in better health than those who remain in their country of origin.

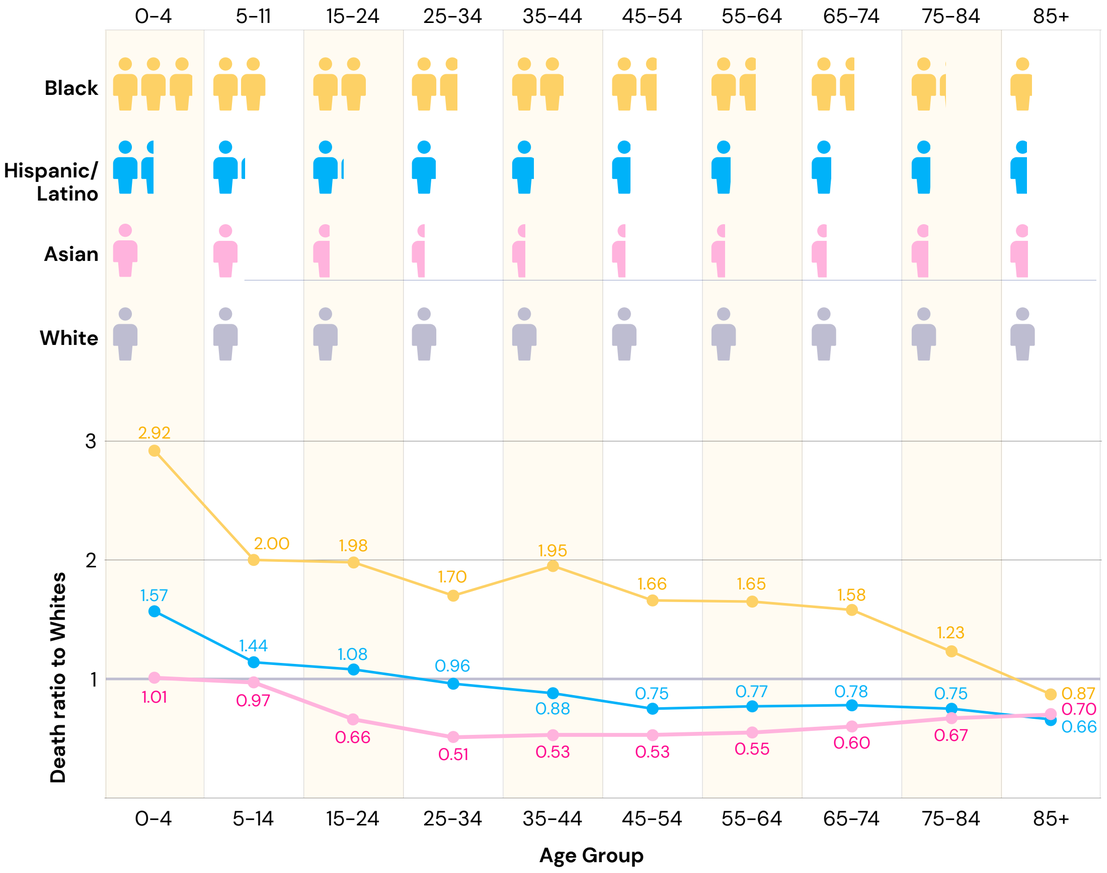
On the other hand, the Salmon Bias Hypothesis explains that the health advantage of Hispanic/Latinos is because those who are less healthy return to their country of origin. Usually, they return home to be with family or seek more affordable healthcare.

On July 21, 2021, the CDC released the report, *Provisional Life Expectancy Estimates for 2020*, which recorded a decline in overall life expectancy of 1.5 years from 2019 to 2020, the lowest level since 2003.

The decline in life expectancy between 2019 and 2020 can primarily be attributed to deaths from the pandemic, as COVID-19 deaths contributed to nearly three-fourths or 74% of the decline.

California Deaths by Age Group

Ratio of the age-specific Asian, Black, and Hispanic/Latinos rates to White rates.
A ratio of 1.0 means the rates are the same.



Source: California State of Public Health Report 2021

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Health and Mortality (continued)

Though US Hispanic/Latinos have longer life expectancy than non-Hispanic/Latino Blacks or Whites nationwide, they had the largest decline in life expectancy of these groups during 2020. Hispanic/Latino life expectancy dropped three years from 81.8 years in 2019 to 78.8 years in 2020. Hispanic/Latino males had the largest decline in life expectancy in 2020. COVID-19 was responsible for 90% of the decline in life expectancy for the Hispanic/Latino population.

The California State of Public Health Report 2021 reports all-cause death rates and rate ratios of Asian, Black, Hispanic/Latinos, and White residents. Whites are the reference group since they have been historically the largest group in the state. A rate ratio of 1.0 means that the rates are the same for both groups.

Hispanic/Latinos have worse mortality outcomes than Whites in younger age groups, specifically in the 0-4 age range.

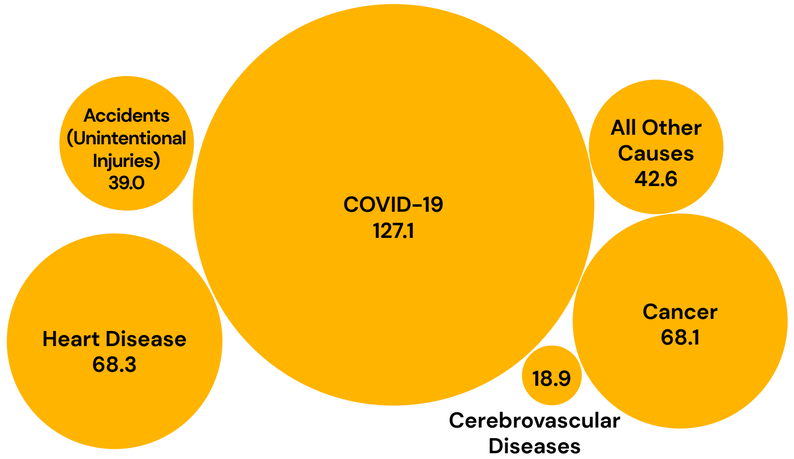
In Orange County, the five leading causes of death in 2021 among Hispanic/Latinos are COVID-19, heart disease, cancer, unintentional injuries, and stroke.

It is significant to note that Hispanic/Latinos have the highest uninsured rates of any racial or ethnic group within the United States. In 2019, the Census Bureau reported that 50.1% of Hispanic/Latinos had private insurance coverage, as compared to 74.7% for non-Hispanic/Latino Whites.

Those without health insurance coverage varied among Hispanic/Latino subgroups: 20.3% of Mexicans, 8.0% of Puerto Ricans, 14.0% of Cubans, and 19.4% of Central Americans. In 2019, 18.7% of the Hispanic/Latino population was not covered by health insurance, as compared to 6.3% of the non-Hispanic/Latino White population.

Top 5 Leading Causes of Death Among Hispanic/Latinos in Orange County

2021, and crude rate per 100,000 Hispanic/Latino population



Source: OC Health Care Agency

In Orange County, 13.3% of residents who identified as Hispanic/Latinos (of any race) are uninsured versus 3.5% of non-Hispanic/Latino Whites.

According to a Kaiser Family Foundation report dated November 2020, 73.7% of uninsured adults were uninsured because the cost of coverage was too high. Many people do not have access to coverage through a job, and some people remain ineligible for financial assistance for coverage.

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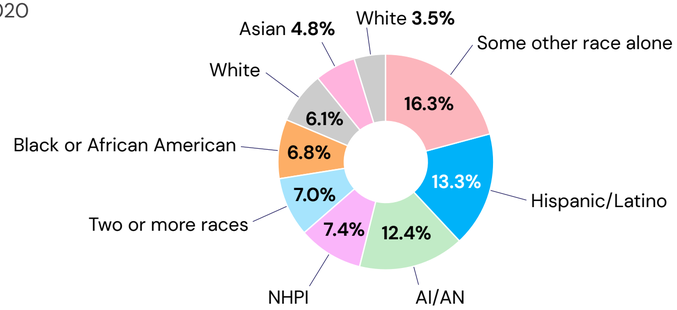
Health and Mortality (continued)

People without insurance coverage have worse access to care than people who are insured. Three in ten uninsured adults in 2019 went without medical care due to cost. Studies repeatedly demonstrate that uninsured people are less likely than those with insurance to receive preventive care and services for major health conditions and chronic diseases.

Hispanic/Latino adults with health insurance are 28 percentage points more likely than those without health insurance to see a doctor or other health care provider in the last 12 months (77% versus 49%). Half of Hispanic/Latino adults without health insurance have not seen a provider within the last year. Those who do not have health insurance are more likely to say the process of getting care is hard to understand (55%, compared with 47% of those insured). Language and cultural barriers, as well as higher levels of poverty, particularly among recent Hispanic/Latino immigrants, are among the socioeconomic dynamics that contribute to disparate health outcomes for Hispanic/Latino Americans.

Uninsured Population by Race/Ethnicity in Orange County

2020



Source: 2020 ACS 5-Year Data, U.S. Census Bureau

Public Charge

2022

Public Charge Definition and Programs Considered Under2019 Rule and 2022 Proposed Rule

	2019 Rule	2022 Proposed Rule
Public Charge Definition	More likely than not at any time in future to receive one or more public benefits for more than 12 months in the aggregate within any 36-month period (such that, for instance, receipt of two benefits in one month counts as two months)	Likely to become primarily dependent on the federal government as demonstrated by use of cash assistance programs or government-funded institutionalized long-term care
Programs Considered in Public Charge Determinations	• Supplemental Security Income (SSI) • Temporary Assistance for Needy Families (TANF) • Federal, state or local cash benefit programs for income maintenance • Non-emergency Medicaid for non-pregnant adults over age 21 • Supplemental Nutrition Assistance Program (SNAP) • Housing assistance	• Supplemental Security Income (SSI) • Temporary Assistance for Needy Families (TANF) • State/local cash assistance program • Long-term institutionalization at government expense (including Medicaid coverage for institutional services)
Heavily Weighted Negative Factors	• Has received one or more public benefits for more than 12 months in the aggregate within the prior 36 month • Not a full-time student and is authorized to work but is unable to demonstrate employment, recent employment, or a reasonable prospect of future employment • Has a medical condition that requires extensive treatment or institutionalization and is uninsured and does not have sufficient resources to pay for medical costs related to the condition • Previously found inadmissible or deportable on public charge grounds	Not specified. Statutory minimum factors (age, family status, health, education, income, and resources) must be considered in their totality
Heavily Weighted Positive Factors	• Household has financial assets/ resource of at least 250% of the federal poverty level (FPL) Authorized to work or employed with an income of at least 250% of the federal poverty level (FPL) • Individual has private insurance that is not subsidized by Affordable Care Act tax credits	

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Health and Mortality (continued)

Access to Substance Use/Abuse Services

The current opioid crisis is one of the most widespread drug epidemics in US history for all racial and ethnic groups. In 2017, a national public health emergency was declared, with 47,600 reported deaths from opioid-related overdoses, which accounted for the majority of overdose drug deaths.

Recently, a demographic shift has been observed in the epidemic with dramatic increases in opioid misuse and overdose deaths among Hispanic/Latino*, Black/African American, and American Indian/Alaska Native populations.

National data from multiple sources specific to high school-aged youth indicate that Hispanic/Latino youth are using drugs at rates that are equivalent or higher compared to their racial and ethnic peers. In 2019, the CDC Youth Risk Behavior Survey (YRBS) reported that high school Hispanic/Latino youth had the highest prevalence of illicit drug use (15.5%) and prescription opioid misuse (16.0%) compared to the total high school youth population (14.8% for illicit drug use and 14.3% for opioid use).

Access to Mental Health Services

The CDC YRBS also show 40% of Hispanic/Latino youth nationwide report persistent feelings of sadness and hopelessness, more than any other racial and ethnic group. This aligns with data reported in Orange County where one-third of Hispanic/Latino youth in grades 9 and 11 report these feelings.

Source: *The Opioid Crisis and the Hispanic/Latino Population: An Urgent Issue.* a report by Substance Abuse and Mental Health Services Administration, Office of Behavioral Health Equity

Drug and Alcohol Deaths Among 10-17 year olds

	Percent	Rate per 100,000 Popluation*
Gender		
Male		
2020	67%	3.5
2021	55%	6.5
Female		
2020	33%	1.9
2021	45%	5.6
Race		
Non-Hispanic White		
2020	67%	6.0
2021	35%	6.9
Hispanic/Latino		
2020	33%	1.9
2021	40%	5.1
Asian/Pacific Islander		
2020	0%	0.0
2021	20%	7.7
Other/Unknown		
2020	0%	0.0
2021	5%	6.7
Black/African American		
2020	0%	0.0
2021	0%	0.0

*Rates in this table are unstable, based on counts <20.

Source: Orange County Health Care Agency

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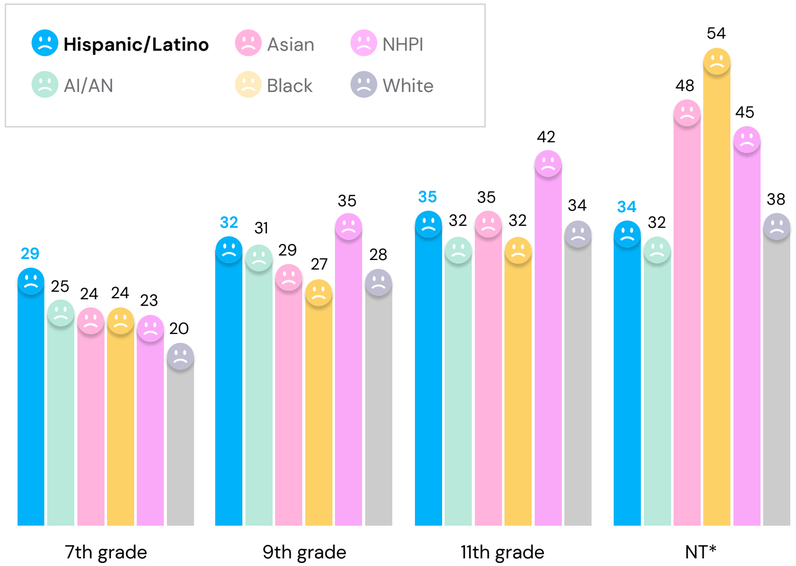
For the Hispanic/Latino community, mental health and mental illness are often stigmatized topics, resulting in prolonged suffering in silence. This silence compounds with experiences that may include immigration, acculturation, trauma, and generational conflicts. Additionally, the Hispanic/Latino community faces unique institutional and systemic barriers that may prevent access to mental health services and result in reduced help-seeking behaviors.

Religion can be a protective factor for mental health in the Hispanic/Latino community (for example, faith, prayer) but can also contribute to stigma against mental illness and treatment (for example, lack of faith, sinful behavior). Working with religious institutions to encourage mental health and treatment and services is important.

Also, older Hispanic/Latino individuals feel that discussing mental health problems can create embarrassment and shame for the family, resulting in fewer people seeking treatment.

Chronic Sadness or Hopelessness in Orange County Schools

Percentage in the past 12 months by grade level, 2017-2019



Percentage of students who felt so sad or hopeless almost every day for two weeks or more that they've stopped doing some usual activities during the past 12 months

7th grade	9th grade	11th grade	NT
25%	30%	35%	36%

Percentage of students who seriously considered attempting suicide during the past 12 months

7th grade	9th grade	11th grade	NT
13%	15%	15%	19%

* NT includes continuation, community day, and other alternative school types
Source: California Healthy Kids Survey

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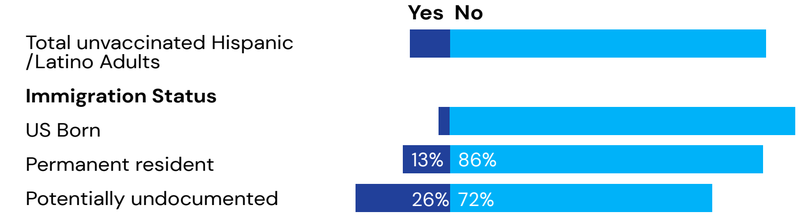
Hispanic/Latinos have been reluctant to seek care for mental health problems. Several health providers have mentioned that reluctance has increased since the 2016 presidential election. People who are undocumented and others who are citizens with family members without legal status worry that contact with a public health clinic will result in their information with be shared with immigration authorities even though their information is protected. The "public charge" rule — a proposal currently on hold but, if implemented, would penalize Green Card applicants for using certain public benefits — is scaring many legal citizens from seeking mental health care for themselves or their US citizen children.

However, the Biden administration sought to restore rules that had been in place since 1999, which did not consider use of non-cash benefits like Supplemental Nutrition Assistance Program (SNAP)/food stamps, health services, and transportation vouchers when determining Green Card eligibility. Programs considered in public charge determinations under the 2022 proposed rule are Supplemental Security Income (SSI), Temporary Assistance for Needy Families (TANF), cash assistance programs, and long term institutionalization at government expense (including Medicaid coverage for institutional services). This will go into effect on December 23, 2022 and will allow citizens to enroll in non-cash public programs, including Medicaid and CHIP, without the fear of being denied Green Card, if eligible. These changes are intended to reduce fears of accessing programs.

Potentially Undocumented Adults and Assistance Program Participation

One Quarter of Potentially Undocumented Hispanic/Latino Adults Say They or a Family Member Did Not Participate in an Assistance Program Due to Immigration Fears

Was there a time in the past 3 year when you or a family member in your household decided not to apply for or stopped participating in a government program that provides assistance with food, housing, or health care, because you were afraid it might negatively affect your or a family member's immigration status?



Source: KFF COVID-19 Vaccine Monitor (April 15-29, 2021)

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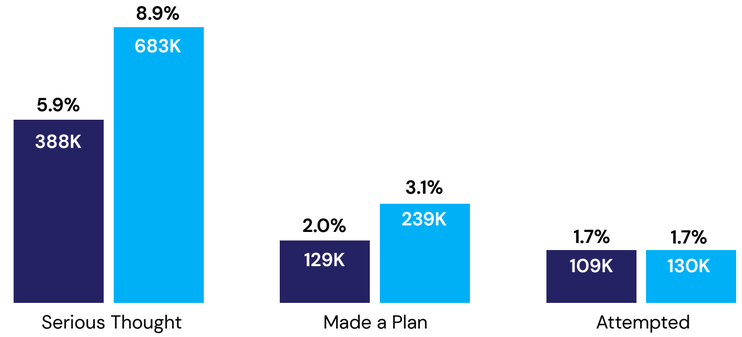
Health and Mortality (continued)

A study in the *Journal of the American Medical Association* Pediatrics, which looked at nearly 400 US-born Hispanic/Latino teens with immigrant parents, found they had higher levels of anxiety, higher blood pressure, and more trouble sleeping. Another study found an unexpected increase in preterm birth rates among Hispanic/Latina mothers. Other surveys by The Children's Partnership and California Immigrant Policy Center showed greater anxiety and fearfulness among Hispanic/Latino parents and their children. These fears are causing immigrants and their children to isolate themselves, further undermining their mental well being.

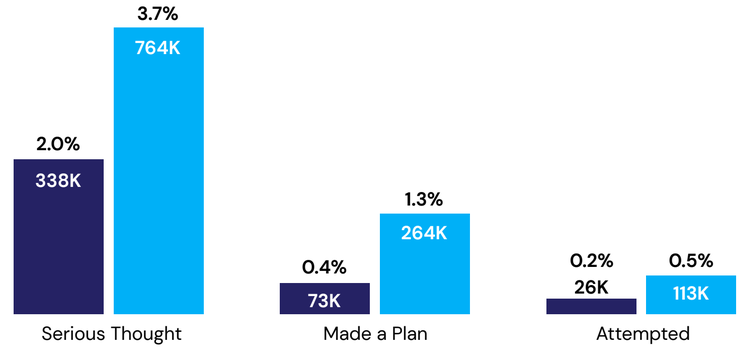
Suicidal Thoughts, Plans, and Attempts for Hispanic/Latino Young Adults Nationally

2010 vs 2020

Ages (18-25)



Ages (26-49)



Source: Hispanics Slides for the 2020 National Survey on Drug Use and Health (samhsa.gov)

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What are Social Determinants of Health?

The World Health Organization (WHO) defines social determinants of health (SDoH) as the conditions in which people are born, live, learn, work, play, worship, and age that impact health outcomes of a person or community. These circumstances are shaped by the distribution of money, power, and resources at the global, national, and local levels. These forces are outside the control of an individual or community and can greatly affect their overall health and well-being. Addressing these SDoH requires collective community action on a systemic level. The following pages highlight the status of the Hispanic/Latino population in Orange County across three social factors:

Health and Mortality

Comparing how long a group lives and determining their quality of life to the population at large can be a baseline for whether systemic disparities exist and how these disparities impact the community.

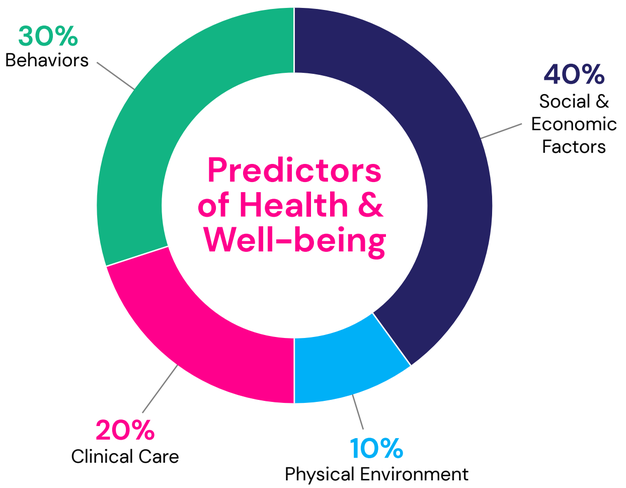
Economics and Education

Education does more than determine one's income. Individuals with higher education are more likely to be healthier and live longer. Improving education in various communities can bring significant health benefits to everyone.

Built Environment and Social Context

Where someone lives, how an individual gets around, and what is going on a person's community can greatly impact both individual and community health and well-being. Things like neighborhood walkability, cleanliness of air and water, and even the age of buildings in the community can affect quality of life.

> *It is unreasonable to expect that people will change their behavior easily when so many forces in the social, cultural, and political environment conspire against such change.*
>
> **National Academy of Medicine**



Source: County Health Rankings

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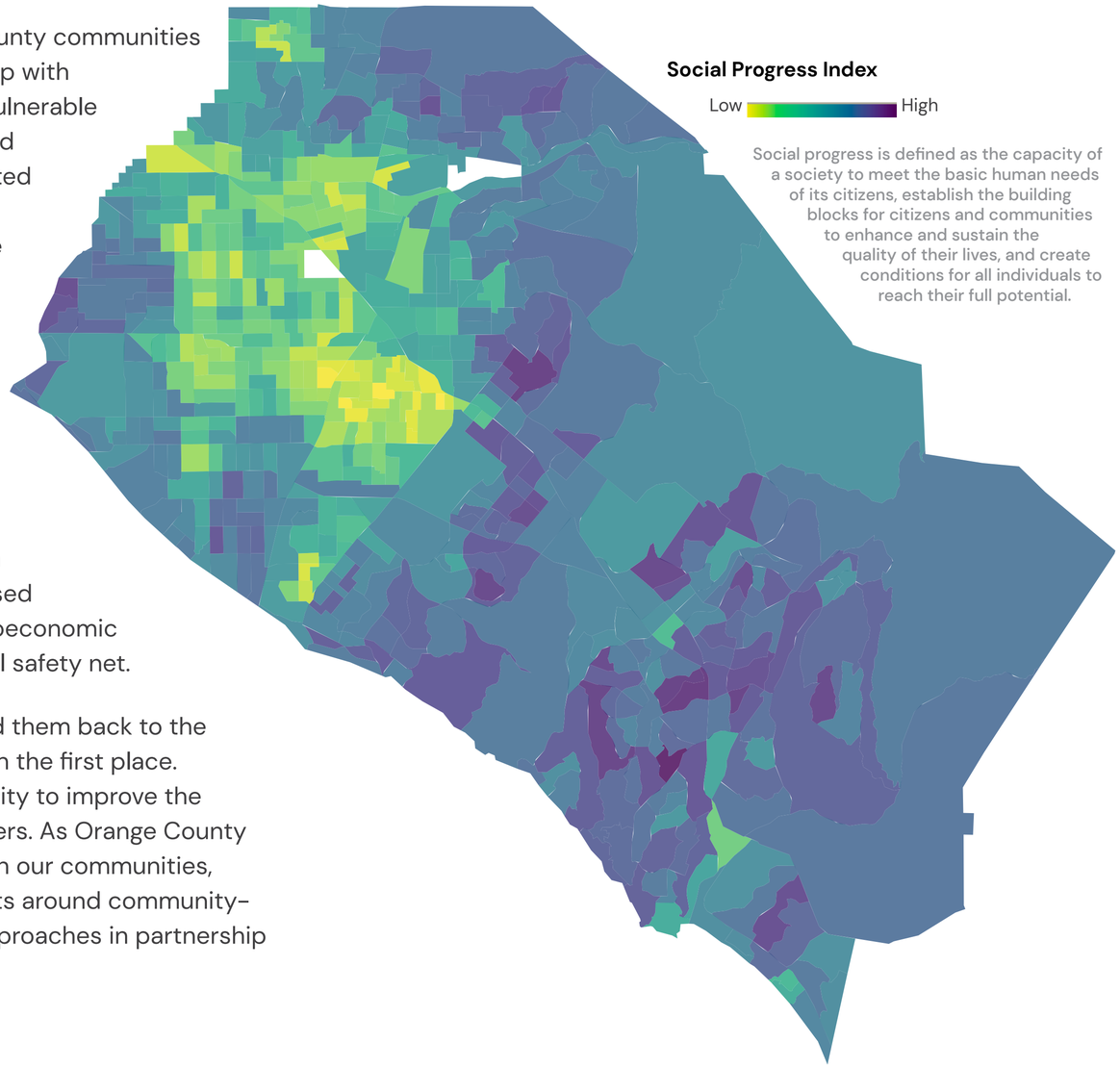
Mapping the Disparity

The COVID-19 pandemic impacted Orange County communities unequally and disproportionately. In partnership with AdvanceOC, a local non-profit, we identified vulnerable communities using comorbidity risk factors and social vulnerability. This rigorous analysis resulted in the Orange County Equity Map and guided the county's response and management of the pandemic.

What We Learned

The OC Equity Map measures social progress in various census tracts of the county. Analyzing and layering COVID-19 cases in Orange County showed that higher concentrations of COVID-19 cases occurred in low social progress areas. The pandemic exposed and magnified existing racial, gender, and socioeconomic inequities, including flaws in the county's social safety net.

We cannot treat and heal individuals then send them back to the systems and conditions that made them sick in the first place. Orange County sees COVID-19 as an opportunity to improve the health and well-being of all community members. As Orange County charts a path forward to rebuild and strengthen our communities, the Health Care Agency will center these efforts around community-informed, data-driven, and equity-oriented approaches in partnership and collaboration with community members.



Source: OC Equity Map, AdvanceOC

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SDoH Impacting Hispanic/ Latino Community

The Hispanic/Latino population is the largest minority group in the United States and, after Asians, they are the fastest growing. At 62 million, Hispanic/Latinos accounted for 51% of US population growth from 2010 to 2020. Newborns are driving much of this Hispanic/ Latino population growth, as immigration declined between 2010 and 2019. This is a reversal of historical trends.

In Orange County, over one third of residents identify as Hispanic/ Latino in the 2020 Census survey, equating to over 1 million people. Heart disease and cancer in Hispanic/Latinos are the two leading causes of death, accounting for about 2 out of 5 deaths, which is similar to Whites. According to the CDC, Hispanic/Latinos have lower deaths than Whites from the 10 leading causes of death with two exceptions—more deaths from diabetes and chronic liver disease.

In clinics, hospitals, or doctor offices, discrimination can include dismissing a patient's symptoms or health concerns, offering different treatment based on a patient's type of insurance, or not providing care in a patient's preferred language.

Language fluency varies among Hispanic/Latino subgroups who reside within the mainland United States. Currently, 91% of US-born Hispanic/Latinos are English proficient versus 72% in 1980. Increasingly, less US-born Hispanic/Latinos speak Spanish at home today than in 1980. Compared to foreign-born Hispanic/Latinos where trends did not show changes over the same time period. Hispanic/Latinos with limited English proficiency (LEP) may hesitate to seek care because of fear that their language barrier can result in unequal treatment. LEP individuals do not speak English as their primary language and have limited ability to read, speak, write, or understand English. Hispanic/Latinos, especially older adults, with lower acculturation reported lower access to care.

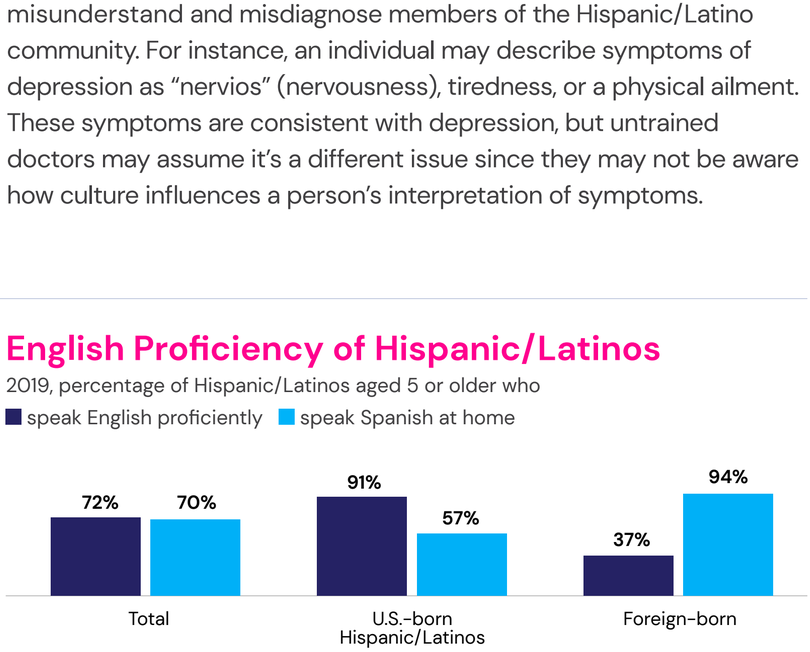
People in the Hispanic/Latino community can often be private and may not want to talk publicly about challenges at home. This can lead to a lack of information and continued stigma about mental health within the community, as talking about it can be taboo.

Many in the Hispanic/Latino community are familiar with the phrase "la ropa sucia se lava en casa" (similar to "don't air your dirty laundry in public"). Some people do not seek treatment for mental illness out of fear of being labeled as "locos" (crazy) or bringing shame or unwanted attention to their families.

Cultural differences may lead mental health providers to misunderstand and misdiagnose members of the Hispanic/Latino community. For instance, an individual may describe symptoms of depression as "nervios" (nervousness), tiredness, or a physical ailment. These symptoms are consistent with depression, but untrained doctors may assume it's a different issue since they may not be aware how culture influences a person's interpretation of symptoms.

English Proficiency of Hispanic/Latinos

2019, percentage of Hispanic/Latinos aged 5 or older who



Source: Pew Research Center

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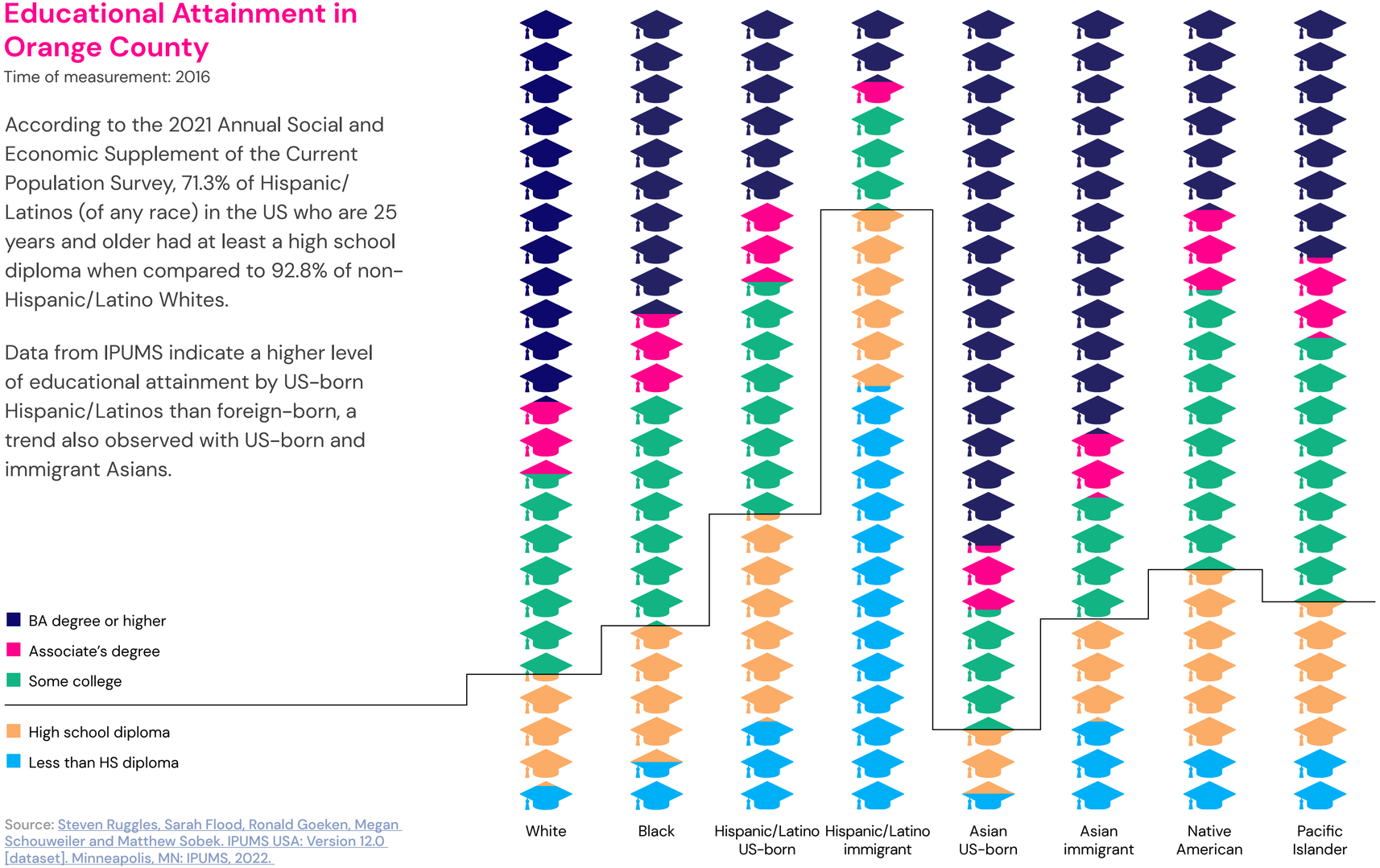
Economics and Education

Educational Attainment in Orange County

Time of measurement: 2016

According to the 2021 Annual Social and Economic Supplement of the Current Population Survey, 71.3% of Hispanic/ Latinos (of any race) in the US who are 25 years and older had at least a high school diploma when compared to 92.8% of non-Hispanic/Latino Whites.

Data from IPUMS indicate a higher level of educational attainment by US-born Hispanic/Latinos than foreign-born, a trend also observed with US-born and immigrant Asians.



Source: Steven Ruggles, Sarah Flood, Ronald Goeken, Megan Schouweiler and Matthew Sobek. IPUMS USA: Version 12.0 [dataset]. Minneapolis, MN: IPUMS, 2022. https://doi.org/10.18128/D010.V12.0

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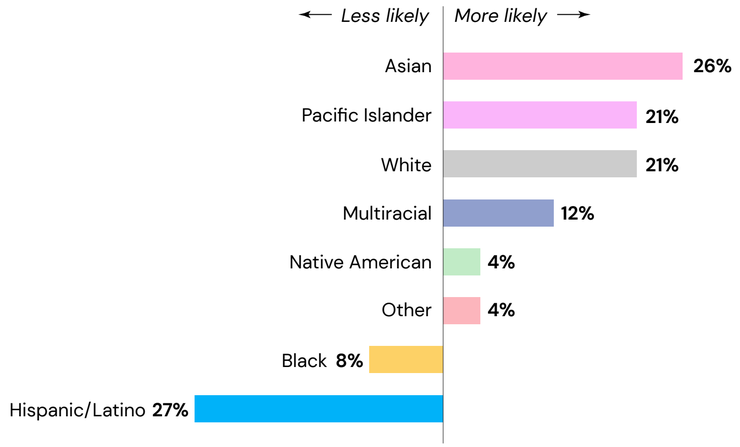
In a recent report by First 5 OC, Hispanic/Latino children were 27% less likely to be ready for kindergarten than other racial and ethnic groups. Black children are 8% less likely to be ready for kindergarten. White children are 21% more likely to be ready for kindergarten, and Asian are 26% more likely to be ready.

Disparity in kindergarten readiness of Hispanic/Latino children can be explained by a variety of factors, including lack of access to preschool facilities in predominant Hispanic/Latino neighborhoods, lack of educational resources for monolingual parents, and inability of working class Hispanic/Latino families to access early childhood development and childcare services.

Child care responsibilities among Hispanic/Latino parents with young children have been more difficult during the COVID-19 pandemic due to the lack of access to full-time childcare. Research shows that 42% of Hispanic/Latino children live in "child care deserts" with no or overfull early care and education centers. Only 40% of Hispanic/Latino children participate in preschool education programs as compared to 53% of non-Hispanic/Latino Whites. Lack of participation in a preschool program is a main contributor to poor school readiness. Another study found that when starting kindergarten, children who completed preschool programs were significantly more advanced in key areas of development: language and literacy, creativity, music and movement, initiative, and social skills.

Children's Likelihood for Being Ready for Kindergarten by Race and Ethnicity

2019



Source: First 5 Orange County, Early Development Index, Equity Ratio

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Education disparity is widespread in the Hispanic/Latino community. According to the College Campaign, 53% of Hispanic/Latino men and 65% of Hispanic/Latina women who enroll in post-high school education complete their degree in 4 years.

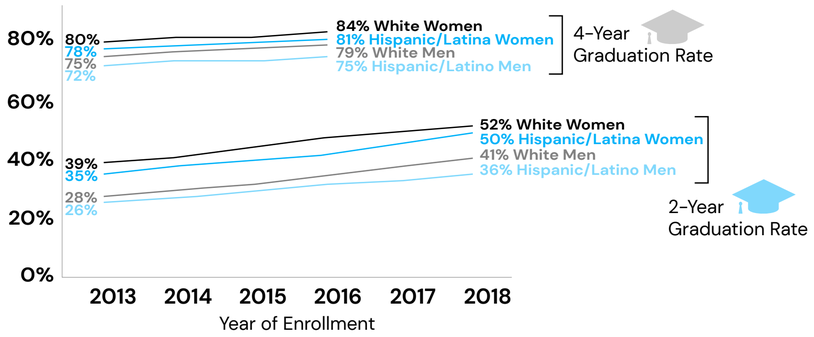
Hispanic/Latino students require additional support to achieve college success. Studies show that many students drop out to provide financial help to their immediate family, due to a lack of funds to continue their education, or because they do not "belong" in a campus culture where they lack a peer group or faculty support.

In addition, early academic problems increase the chances of truancy, dropping out, risky health behaviors, and delinquency. The COVID-19 pandemic has exacerbated many of these inequities. Also, Hispanic/Latino students are more likely than non-Hispanic/Latino Whites to experience remote learning arrangements, yet they have less access to the tools necessary to succeed, such as broadband and computer access.

During the pandemic, the digital divide has emerged as a reinforcing mechanism of education through wealth and of future wealth through education. Nationwide, Black and Hispanic/Latino households have less reliable internet and devices available. This goes along with fewer hours children spend on remote learning. The lack of internet and devices is associated with less wealth and is reflected in lower homeownership rates and greater housing instability. Black and Hispanic/Latino households, in particular, are more likely to be renters and face housing instability.

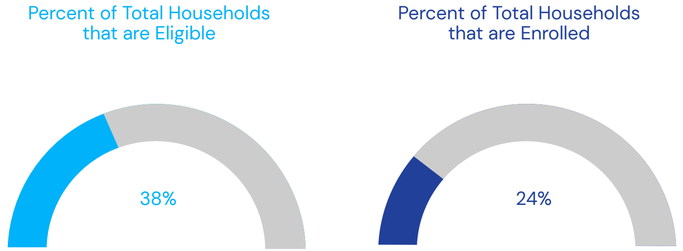
According to data collected by the state, roughly 400,000 Orange County households qualify for free or discounted high-speed internet service through a federally funded initiative called the Affordable Connectivity Program. However, only 24% of eligible households have enrolled.

Graduation Rates for First Time Freshman



Source: University of California. (n.d.) Undergraduate graduation rates.

California Affordable Connectivity Program (ACP) Enrollment



Source: California Affordable Connectivity Program (ACP) Enrollment

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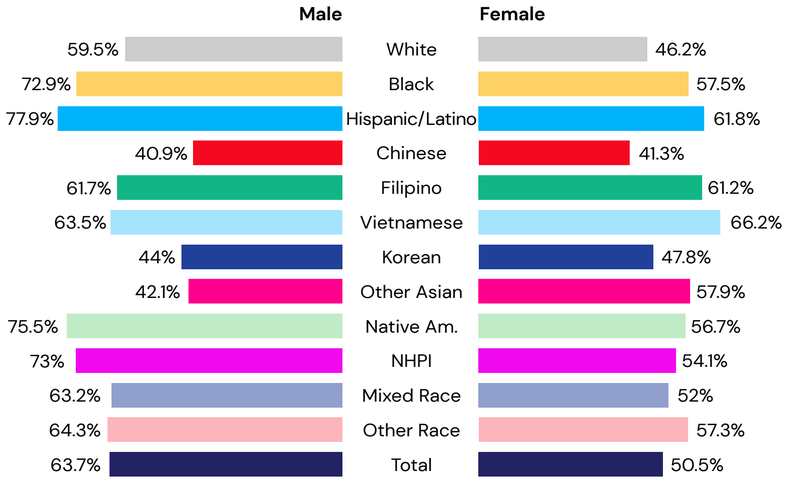
Employment in frontline occupations varies considerably across racial and ethnic groups. For both men and women, Hispanic/ Latinos are most likely workers to hold frontline occupations.

Hispanic/Latino, Black, Native American, and Pacific Islander men are most likely to have frontline occupations – more than 70% of male workers in each of these groups are classified as frontline. In addition, Vietnamese, Latina, and Filipina women are most likely female workers to hold frontline occupations.

A recent Pew Research Center survey shows more adults turning to the "gig work economy." 30% of Hispanic/Latinos performed short-term contract work, compared to 16% of US adults as a whole. The majority of these jobs involved making deliveries, performing household tasks, or running errands. In total, more Hispanic/Latinos performed these types of jobs than any other subgroup.

Frontline Workers

Percentage in recent workers by race/ethnicity, 2018



Source: 2018 American Community Survey

Gig Workers by Race/Ethnicity Nationally

Percentage of adults who say they have ever earned money by...

	Doing any gig platform work	Making deliveries from a restaurant or store for a delivery app	Performing household tasks or running errands	Driving for a ride-hailing app	Shopping or delivering groceries or household items	Using a personal vehicle to deliver packages via an app or website	Doing something else
U.S. adults	16%	7%	6%	5%	4%	3%	4%
White	12%	4%	4%	3%	2%	1%	3%
Black	20%	10%	8%	7%	7%	5%	6%
Hispanic	30%	16%	12%	9%	7%	6%	6%
Asian	19%	7%	2%	8%	7%	4%	7%

Source: Pew Research Center

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Median household income for Hispanic/Latino families in Orange County is estimated to be $74,319 in 2020, the lowest for any identified racial and ethnic group. This number can be misleading because multiple generations of income earners can be in the same household or some income earners work at cash-paying jobs that may not be reported on a W-2 or to the US Census. Therefore, the income gap between Hispanic/Latino families and other racial and ethnic groups can be potentially wider than what is reported in federal data.

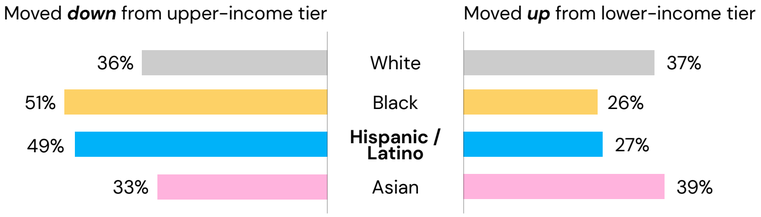
Economic mobility for the Hispanic/Latino community is challenging. The Pew Research Center recently released a study showing the movement of different racial and ethnic groups between different income tiers in the last 20 years. 49% of Hispanic/Latinos moved down from an upper income tier to a lower income tier, compared to only 36% of White adults.

In contrast, only 27% of Hispanic/Latino adults moved up from a lower income tier to a higher income tier in the same period. This is compared to 37% of White adults and 39% of Asian adults nationally.

The uninsured rate among Hispanic/Latino people is alarmingly high, according to a Center on Budget and Policy Priorities analysis. In 2019, 38% of uninsured people under age 65 were Hispanic/Latinos nearly double the 20% Hispanic/Latino share of the non-elderly population. Between 2018 and 2019, the uninsured rate for non-elderly Hispanic/Latinos increased from 17.9% to 18.7%, the largest increase of any major racial and ethnic group and an erosion of earlier gains under the Affordable Care Act (ACA).

Income Tier Movement Nationally

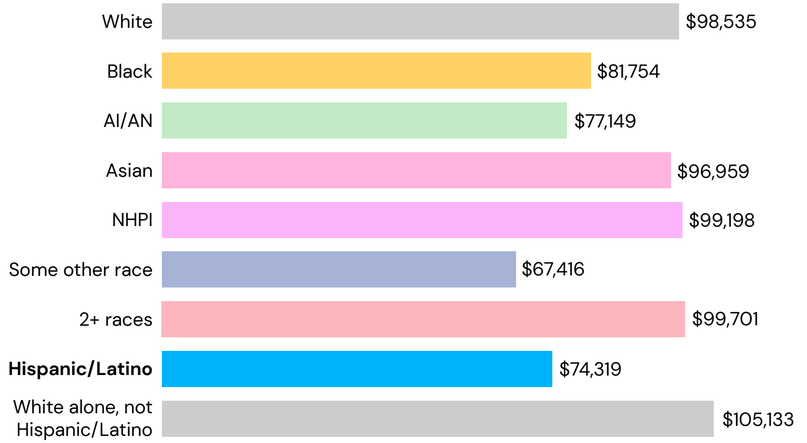
Percentage of adults who moved up from the lower-income tier or down from the upper-income tier, average of annual turnovers from 2000-2001 to 2020-2021



Source: Pew Research Center

Median Household Income by Race/Ethnicity in Orange County

2020



Source: Steven Ruggles, Sarah Flood, Ronald Goeken, Megan Schouweiler and Matthew Sobek. IPUMS USA: Version 12.0 [dataset]. Minneapolis, MN: IPUMS, 2022. https://doi.org/10.18128/D010.V12.0

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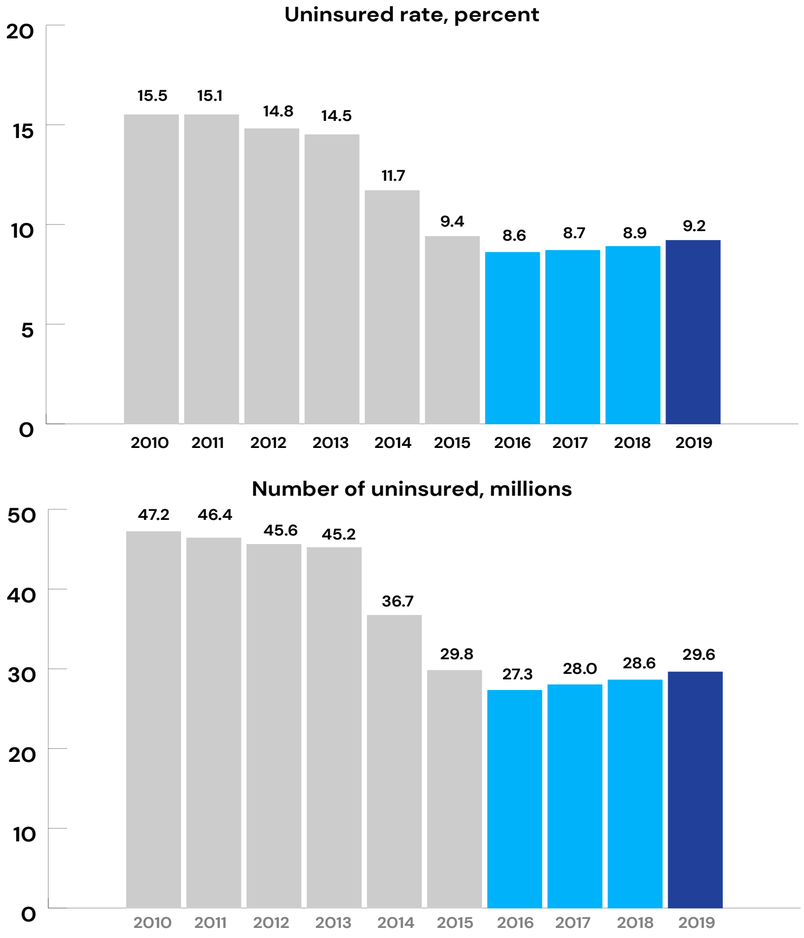
The high Hispanic/Latino uninsured rate reflects several factors. Hispanic/Latinos are less likely to have coverage through their jobs than the overall non-elderly population. Additionally, they often face barriers to enrolling in health insurance affordability programs such as Medicaid, Children's Health Insurance Program (CHIP), and ACA marketplaces. Strict immigration-related eligibility restrictions block some Hispanic/Latinos from enrolling, while others may not know these programs exist or fear that enrolling would negatively affect their families. Others may have tried to enroll but encountered procedural hurdles.

CalOptima was formed in 1995 in response to a healthcare system that was struggling to meet the needs of vulnerable Orange County residents. Today, CalOptima has grown to be the single, largest health insurer in Orange County, providing coverage for one in four residents through four programs: Medi-Cal, OneCare Connect, OneCare, and PACE. CalOptima is a health care program that pays for some medical services of children and adults with limited income and resources. It covers families with children, adults, seniors, people with disabilities, foster care children, pregnant women, and people with specific diseases. Currently, CalOptima provides Medi-cal coverage for 925,756 Orange County residents, including 43% of Santa Ana's citizens, and serves 27% of Spanish speakers. Since 2016, CalOptima has increased its participation in public events serving the Hispanic/Latino community. CalOptima also launched an initiative to strengthen relationships with Hispanic/ Latino community organizations and holds monthly meetings called "Cafecito" to connect with other Hispanic/Latino community-based service providers.

Sources: https://ssa.ocgov.com/health-care-services
https://caloptima.org/en/ForMembers/Medi-Cal/HowToEnroll.aspx
https://www.ochealthinfo.com/providers-partners/county-partnerships/caloptima

Progress on Health Coverage is Eroding

2022



Source: Census Bureau, American Community Survey

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In 2017, Santa Ana recognized CalOptima's involvement in the Hispanic/Latino community and honored CalOptima with a Certificate of Recognition for Outstanding Outreach.

Low-income, undocumented Hispanic/Latino young adults were at risk of losing coverage under California's Medicaid program. This required the state to extend health coverage to people between the ages of 26 and 49, which kept Hispanic/Latino young adults covered and healthier. Undocumented Hispanic/Latino immigrants ages 50 and older are much less likely to have health insurance (51%), compared to documented immigrants (91%). Furthermore, undocumented immigrants cannot buy insurance plans through Covered California, the state's insurance marketplace, and are less likely to have insurance through employers. Although undocumented workers are eligible for employer coverage, cost and availability can be barriers.

As of September 2019, Senate Bill (SB) 104 enacted the Young Adult Expansion, which provides full-scope Medi-Cal benefits for individuals between the ages of 19 and 25, who do not have satisfactory immigration status, or unable to receive citizenship verification but meet all other eligibility requirements for the Medi-Cal program. Beginning in 2020, California extended full-scope Medi-Cal to all children and adults, regardless of their immigration status. The California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) and the Statewide Automated Welfare System (SAWS) implemented the Older Adult Expansion. It was modeled after the Young Adult Expansion and provides full-scope Medi-Cal benefits for those 50 years and older. Older adults will have access to these benefits in 2022.

CalOptima Health Membership Data

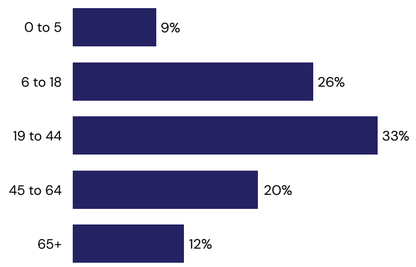
2022

925,756

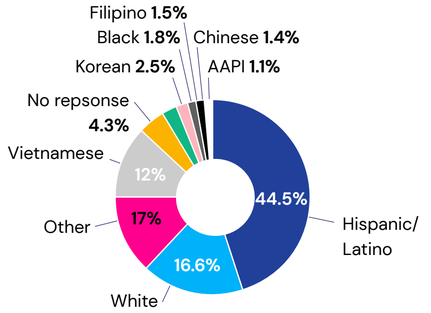
Total CalOptima Health Membership

2022

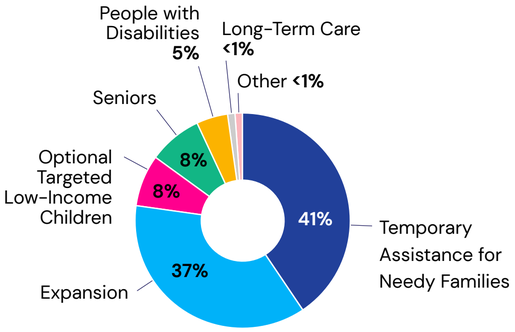
Member Age



Enrollment Rates by Race/ Ethnicity



Medi-Cal Aid Categories



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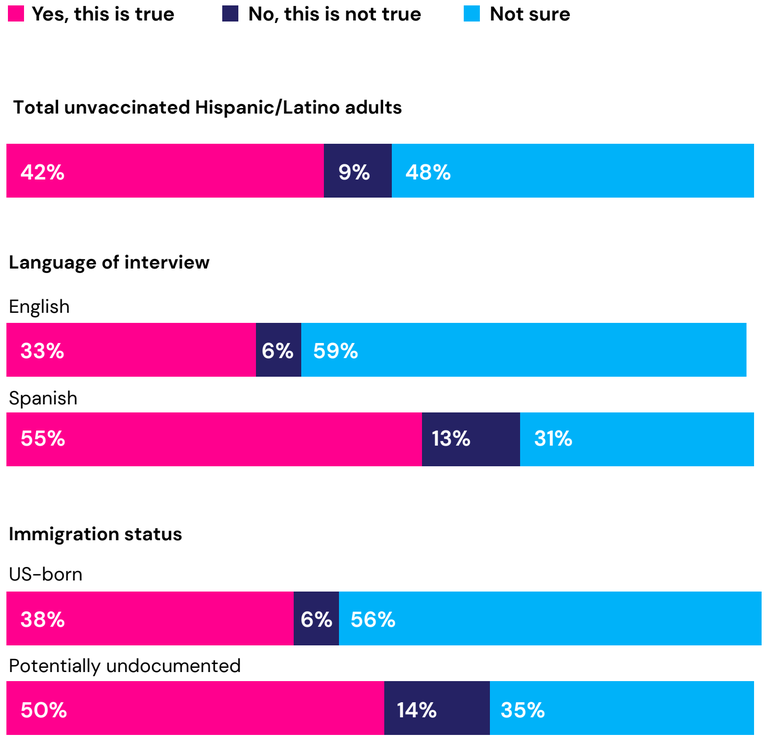
In addition to structural barriers, undocumented immigrants may fear that seeking health care could lead to detection by immigration officials or using government services might prevent them from obtaining legal status. They may also fear being turned away or being mistreated by health care providers. As a result, undocumented immigrants are less likely to have regular sources of care, seek preventive services, or have access to specialty care. This increases their risk for poor overall health. Due to the lack of insurance coverage and limited financial means, many undocumented immigrants rely on safety-net, health care providers for their care.

During the pandemic, half of unvaccinated Hispanic/Latino adults were unsure whether immigrants are eligible to get the COVID-19 vaccine, according to a recent survey by the Kaiser Family Foundation.

Half of Unvaccinated Hispanic/Latino Adults Unsure Whether Immigrants Are Eligible To Get COVID-19 Vaccine

2022

As far as you know, are adults living in the US eligible to get the COVID-19 vaccine, regardless of their immigration status?



Source: KFF COVID-19 Vaccine Monitor (April 15-29, 2021)

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Hispanic/Latinos struggle to find stable and affordable housing. The map on the right highlights neighborhoods in Orange County and the housing vulnerability experienced by the Hispanic/Latino community.

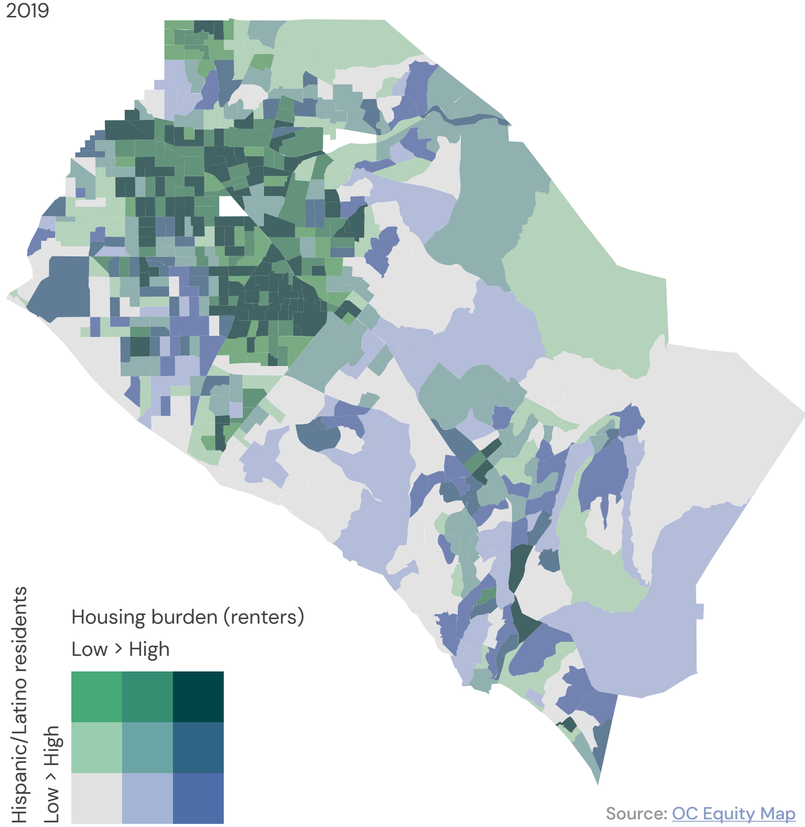
Housing burden is defined as spending 30% or more of one's monthly income on rent. A 2018 study found that housing instability was linked to poor health outcomes in both children and their caregivers. In this study of urban renter families, being behind on rent at any time in the past 12 months, moving more than twice in the past 12 months, or having any history of homelessness was defined as "housing insecurity." Compared with children in stable housing, children with any form of housing insecurity were more likely to have been in the hospital or have fair and/or poor health at any point in their life. Caregivers who face housing insecurity were more likely to have fair and/or poor health or maternal depressive symptoms.

Across counties in the US, every 10% increase in households severely cost burdened is linked to 29,000 more children in poverty, 86,000 more people who are food insecure, and 84,000 more people in fair or poor health, according to the 2019 County Health Rankings.

Overcrowding, defined as a housing situation in which there is more than one person per room, is also more common among Hispanic/ Latinos than among any other racial and ethnic group. This disparity is driven by non-US citizens and especially undocumented Hispanic/ Latinos. Hispanic/Latinos are denied mortgages at disproportionately high rates and were targeted for high-cost, high-risk mortgages in the years leading up to the housing crisis in 2008. This contributed to worse outcomes for these groups. Hispanic/Latinos are shown fewer housing units than White home-seekers who are identical in every respect besides race or ethnicity. This results in Hispanic/Latino households steered toward lower-income neighborhoods with poorer quality housing stock. Despite the challenges they face, Hispanic/ Latinos appear to underuse government housing assistance. Hispanic/ Latinos also underuse homelessness services, leading to the concept of "hidden homelessness" in the community.

Housing Burden for Renters of Hispanic/Latino Residents in Orange County

2019



Source: OC Equity Map

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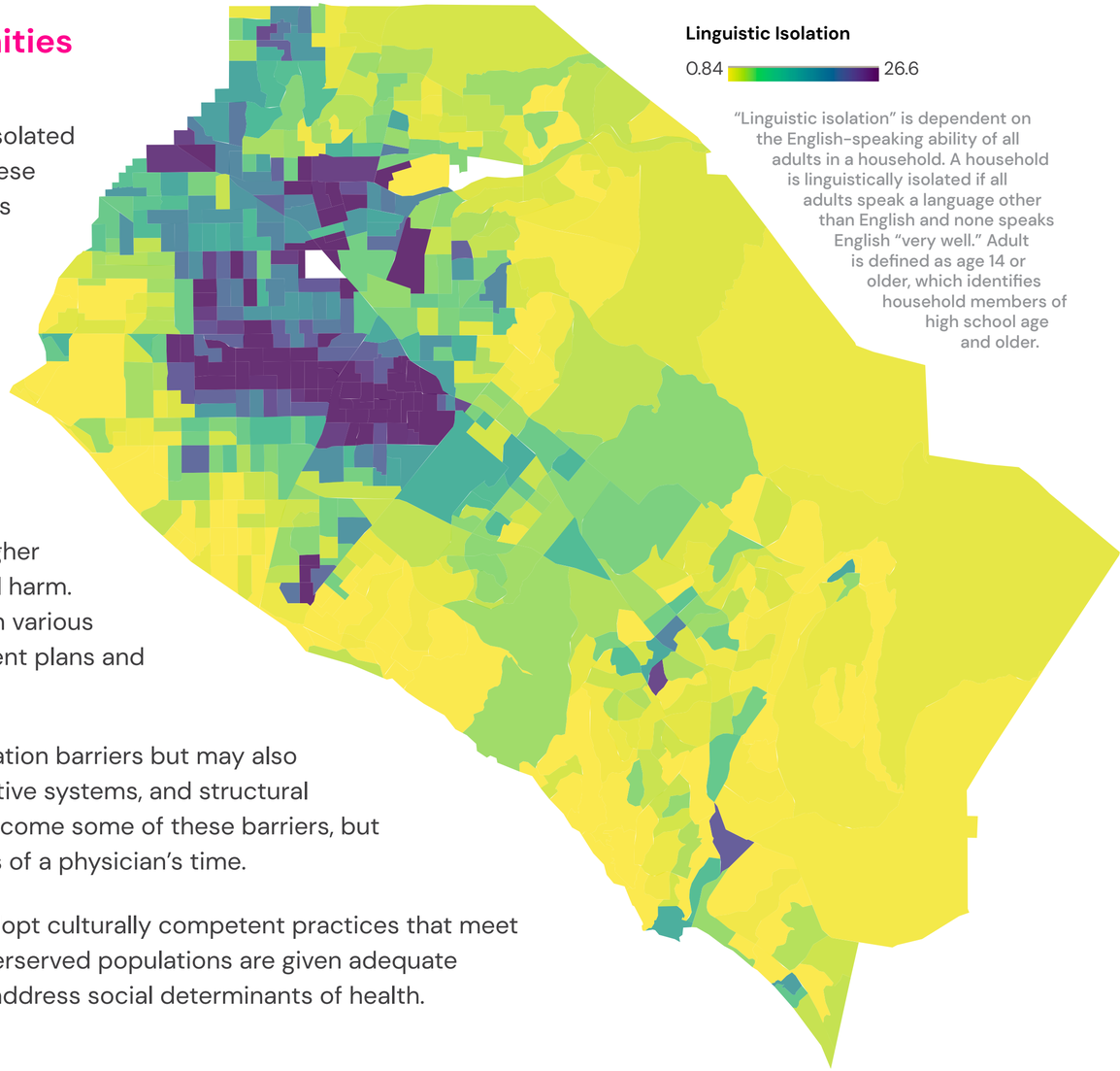
Orange County Language Opportunities and Services

Orange County residents who live in linguistically isolated communities are often from immigrant families. These immigrant families tend to gather in ethnic enclaves as a means of survival because of discriminatory practices or due to being shunned from other parts of the county.

People with limited English proficiency (LEP) are defined by the US Census as those who speak English less than "very well." In 2020, 8.7% of Orange County residents are LEP. They experience high rates of medical errors with worse clinical outcomes than English-proficient patients. This higher incidence of medical errors could result in physical harm. LEP individuals also receive lower quality of care on various measures and are less likely to understand treatment plans and disease processes.

These disparities are rooted in obvious communication barriers but may also reflect cultural differences, clinician biases, ineffective systems, and structural barriers. Medical interpreter services can help overcome some of these barriers, but they have associated costs financially and in terms of a physician's time.

We must strive to remove language barriers and adopt culturally competent practices that meet residents where they are. This will ensure that underserved populations are given adequate resources to access healthcare and services that address social determinants of health.



Source: OC Equity Map, AdvanceOC

Built Environment and Social Context (continued)

Air Pollution Exposure in Orange County

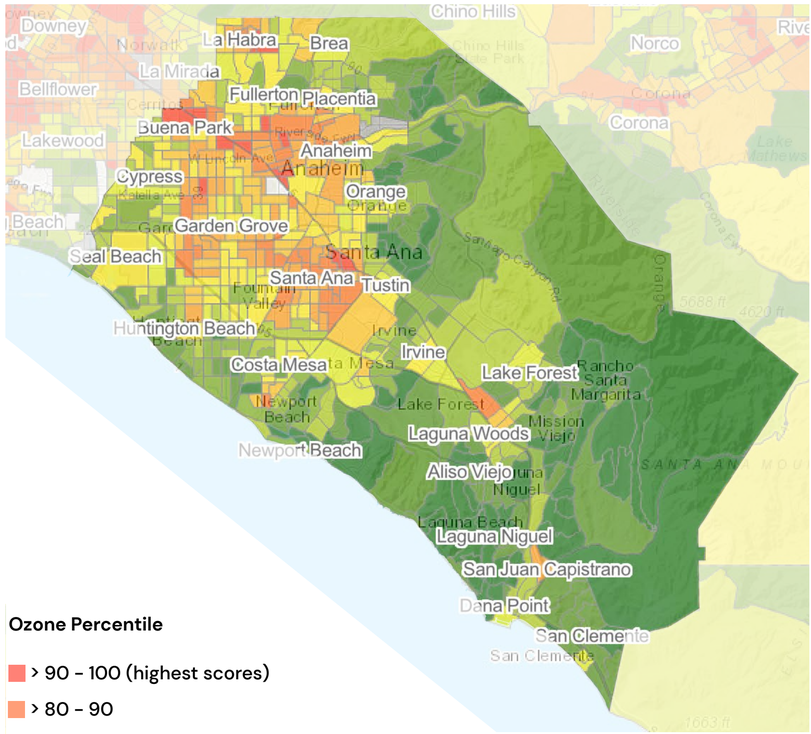
In California, environmental quality has improved over the last few decades. This is seen in improved water quality, reduced air pollution, decrease in pesticide use, continued cleanup of hazardous waste sites, increased recycling, and reduction of solid waste going into landfills. However, pollution reduction and the resulting health and environmental benefits are not uniformly distributed across the state, within a region, or among all population segments. Many communities continue to bear a disproportionate burden of pollution not only from multiple nearby sources but also from pollution in various forms, such as air and water.

Ozone pollution causes adverse health effects including respiratory irritation and worsening of lung disease. Adverse effects of ozone have been studied extensively since the late 1960s, and ongoing exposure to ozone shows inflammation and cell and tissue injury. People with asthma and chronic obstructive pulmonary disease (COPD) are considered sensitive to the effects of ozone. Studies also show that long-term ozone exposure affects respiratory and cardiovascular mortality. A 2019 study estimates 13,700 deaths in California in the year 2012 were due to long-term ozone exposure.

Of these deaths, 7,300 were from respiratory causes, and 6,400 were from cardiovascular causes. The CalEnviroScreen 4.0 draft ozone map of Orange County shows high levels of ozone pollution scores in north and central Orange County. In the OC Equity Map, these communities have low Social Progress Index scores.

Ozone Levels by Pollution Score

2021



Source: CalEnviroScreen

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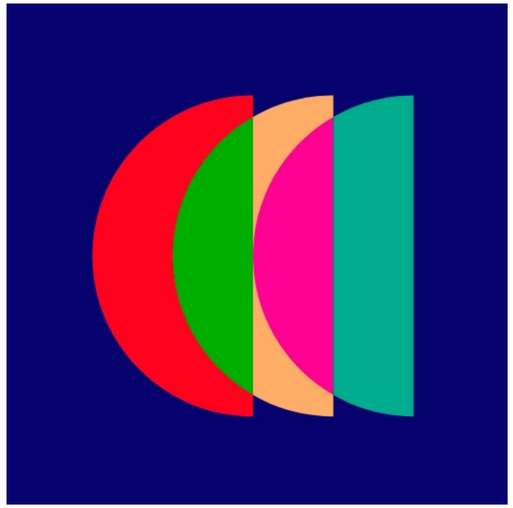
Health is a shared value. Your involvement will help create a healthier, more resilient, and equitable Orange County.

Here's how you can get involved:



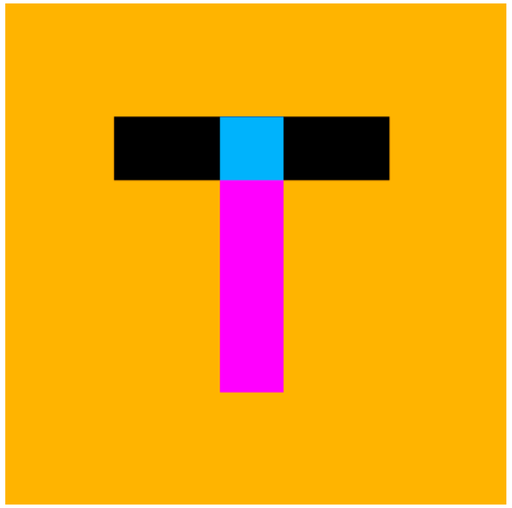
Participate in the EiOC Action and Learning Community

Learn More



Join a Population Health Equity Collective

Learn More



Make your voice heard at EiOC Taskforce Meetings

View Events



An Initiative of OC health CARE AGENCY

EquityinOC.com

EQUITY IN OC

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OC health CARE AGENCY

An initiative of OC health CARE AGENCY

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Addressing health inequities across Orange County by enabling system change.



Achieving Equity in Orange County

Health inequities are differences in health status or in the distribution of health resources among various populations. This is due to the social conditions in which people are born, grow, live, work, and age. Across Orange County (OC) we see differences in the length and quality of life; rates of disease, disability, and early death; severity of disease; and access to treatment because of these inequities.

Equity in OC is an OC Health Care Agency (HCA) initiative in collaboration and partnership with local Orange County community partners. Funded by a grant from the Centers for Disease Control and Prevention (CDC), the Equity in OC Initiative is a community-informed and data-driven initiative to address health inequities and disparities in Orange County by laying the foundation for creating a healthier, more resilient, and equitable Orange County.

Why Create Population Overviews?

These population overviews are snapshots of available data for various populations in Orange County. By laying out population-specific data in these overviews, we can identify systemic changes that can improve the quality of life within these communities. Since these population overviews are only the start of democratizing community-level data, we welcome feedback and input to further refine and improve this living document.

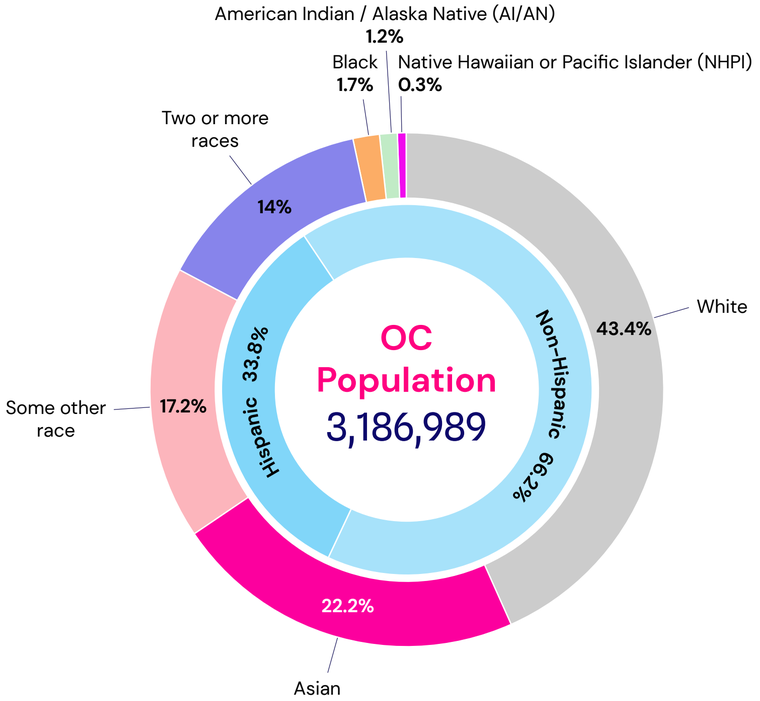
For more information go to www.equityinoc.com.

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Orange County at a Glance



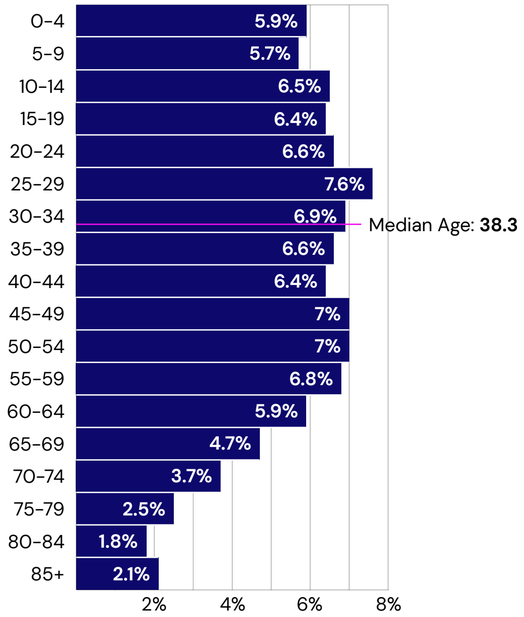
The United States (U.S.) Census Bureau collects racial data according to guidelines by the U.S. Office of Management and Budget (OMB), and these data are based on self-identification.

Racial categories in the census survey reflect a social definition of race in the U.S. It is not an attempt to define race biologically, anthropologically, or genetically. Also, categories of race include national origin or sociocultural groups. People who identify their origin as Hispanic, Latino, or Spanish may be of any race.

About the Topic of Race (census.gov)

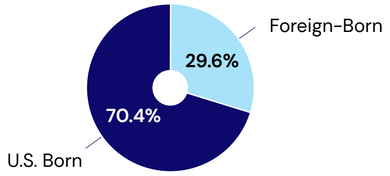
Source: 2020 Decennial Census

Population by Age Group



Source: 2020 ACS 5-Year Data, U.S. Census Bureau

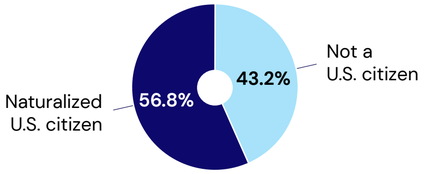
Population by Birth Origin



Source: 2020 ACS 5-Year Data, U.S. Census Bureau

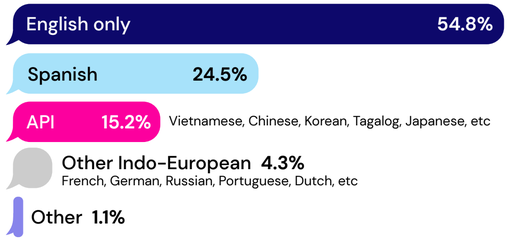
Population by Citizenship

of foreign-born residents



Source: 2020 ACS 5-Year Data, U.S. Census Bureau

Languages Spoken at Home



Source: 2020 ACS 5-Year Data, U.S. Census Bureau

An initiative of OC health CARE AGENCY

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Orange County at a Glance



$94,441

Median Household Income

2020

Source: 2020 ACS 5-Year Data, U.S. Census Bureau



56.9%

Home Ownership Rate

as of March 2022

Source: U.S. Bureau of Labor Statistics



1,129,785

Total Housing Units

2020

Source: 2020 ACS 5-Year Data, U.S. Census Bureau



41.2%

Bachelor's Degree or Higher

2020

Source: 2020 ACS 5-Year Data, U.S. Census Bureau



10.1%

Persons in Poverty

2020

Source: 2020 ACS 5-Year Data, U.S. Census Bureau



3.1%

Unemployment Rate

as of March 2022

Source: U.S. Bureau of Labor Statistics

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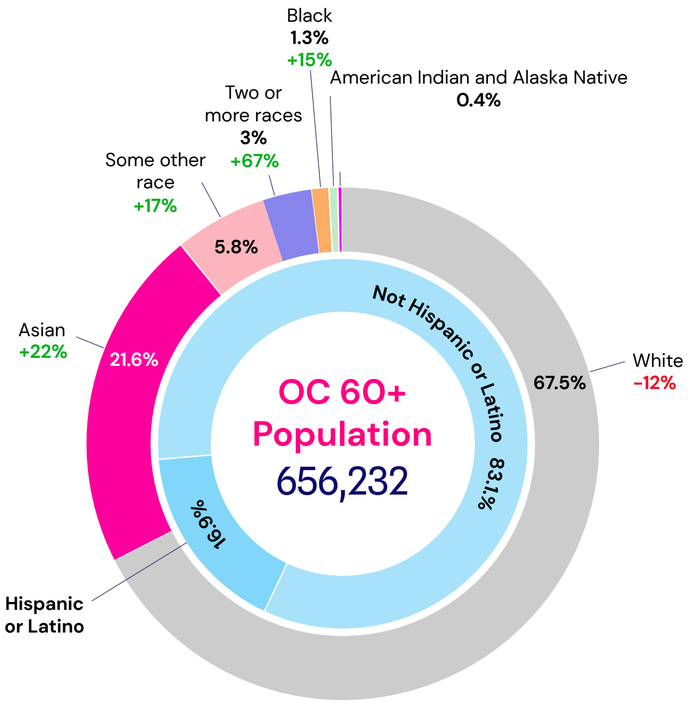
Older Adult Population Overview in OC

Understanding the Term Older Adult

In June 2017, the Journal of the American Geriatrics Society (JAGS) adopted language recommendations to describe older people. Based on the work of the American Geriatrics Society (AGS) with leaders of aging organizations and the FrameWorks Institute, these recommendations are grounded in building better public perceptions of aging. They made clear "that words like (the) aged, elder(s), (the) elderly, and seniors should not be used . . . because [they] connote discrimination and certain negative stereotypes." JAGS adopted "older adult(s)" and "older person/people" as preferred terms and opposed using "the elderly," "senior(s)," and/or "senior citizen(s)."

The precise age of an "older adult" is not universal. Medicare collects the health information of adults aged 65 and older. Social Security is available to those who are 62 years old. The American Association of Retired Persons (AARP) is dedicated to people over 50, but there is no minimum age to join. The U.S. Department of Housing and Urban Development's (HUD) Housing for Older Persons Act (HOPA) manages older adult housing and 55-and-over communities.

In this population overview, we will use the term Older Adults to be as respectful as possible. We are also adopting the California Master Plan for Aging's definition of Older Adults in which the phrase "Older Adult population" is inclusive of people 60 years and older. We will showcase data for this population segment where it is available.



Sex and Age

Adults aged 60+ in Orange County, 2020, and percentage change since 2010

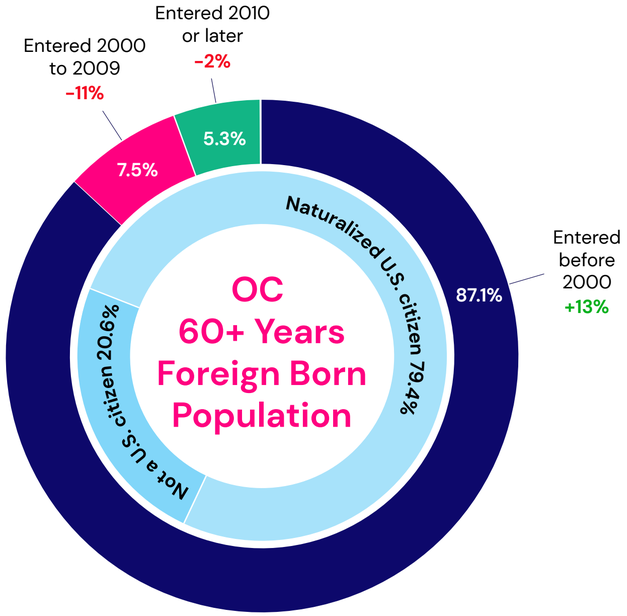


Source: 2020 American Community Survey 5-year Estimates

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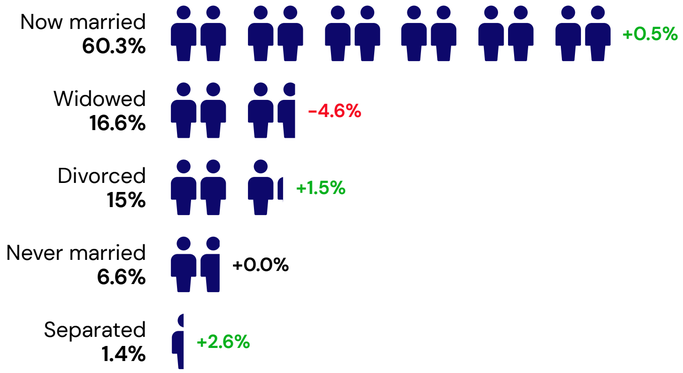
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Marital Status

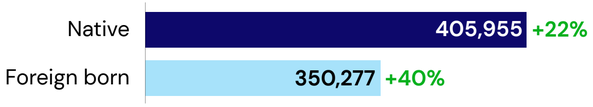
Adults aged 60+ in Orange County, 2020, and percentage change since 2010



Source: 2020 American Community Survey 5-year Estimates

Place of Birth

Adults aged 60+ in Orange County, 2020, and percentage change since 2010



Source: 2020 American Community Survey 5-year Estimates

Older Adults by Veteran Status

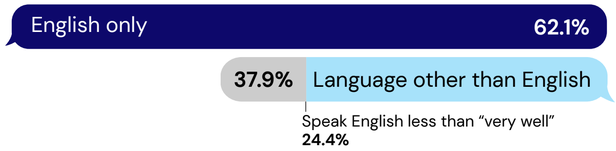
Adults aged 60+ in Orange County, 2020



Source: 2020 American Community Survey 5-year Estimates

Language

Adults aged 60+ in Orange County, 2020



Source: 2020 American Community Survey 5-year Estimates

With Disabilities

Adults aged 60+ in Orange County, 2020



Source: 2020 American Community Survey 5-year Estimates

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Older Adult: A Historical Context

According to the Orange County Historical Society, Orange County was formed in 1889. As early as 1870, local residents tried to break away from Los Angeles to form their own county, but it was not until 1889 that the California Legislature passed a bill to allow a vote on county division. By the mid-1950s, Orange County's farms were being replaced by tract housing. Existing cities began annexing territory in every direction, and new cities incorporated almost every year. Between 1953 and 1962, ten cities, from Buena Park to San Juan Capistrano, voted to incorporate. In 1963, Orange County's population topped one million. More cities arose between the 1960s and 1990s, including Mission Viejo and Ladera Ranch. By the 1950s, Orange County had developed a variety of industries. They included tourism, manufacturing, and service, all attracting residents and job-seekers. Orange County is also home to Laguna Woods, formerly known as Leisure World. It is originally a community built by Ross W. Cortese to meet the needs of those 55 years and older. Today, Orange County is home to more than three million residents with 34 incorporated cities and several unincorporated areas.

In 2020, the median age of Orange County was 38 years old, with Older adults representing one of the fastest growing segments. According to the OC Health Care Agency, approximately 25% of people in Orange County will be 60 years old or older by 2040. This newfound, growing population has resulted in the need for local government agencies and community organizations to re-evaluate and understand the changing health and social dynamics that their constituents face.

This demographic trend is reflected on the national level, too. The older adult population is growing at such a rapid rate in the U.S. that ten years from now, California will be home to 10.8 million people aged 60 and over, which is nearly twice as many older adults in 2010. In 2019, Governor Gavin Newsom ordered a statewide master plan on the issue. The Master Plan for Aging states that soon one out every four Californians will be older adults, a demographic shift that will change structures of families and communities as well as the drivers of the California economy. The next generation of older adults in California will be significantly more diverse, will have a higher life expectancy, and will contribute in new ways to make the state a more vibrant place.

Orange County is developing its own version of an aging plan, and it's a collaboration between the Social Services Agency, Community Resources' Office on Aging, OC Health Care Agency, and the County Executive Office. The aim is to create a local aging plan specific to the needs of Orange County older adults. It will focus on the five goals in the state's master plan: housing, access to health care, equity, caregiving, and economic security. In 2019, the county performed a public outreach on the aging plan. A public information workshop called "Mastering the Master Plan" was sponsored by the Orange County Strategic Plan for Aging. As California and Orange County age, we will also experience new challenges—more people staying in the workforce, more neighbors living alone, and many individuals enjoying less economic security than before.

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Top 10 Cities of Older Adult Residents

Top Cities With Populations of Older Adults (60+)

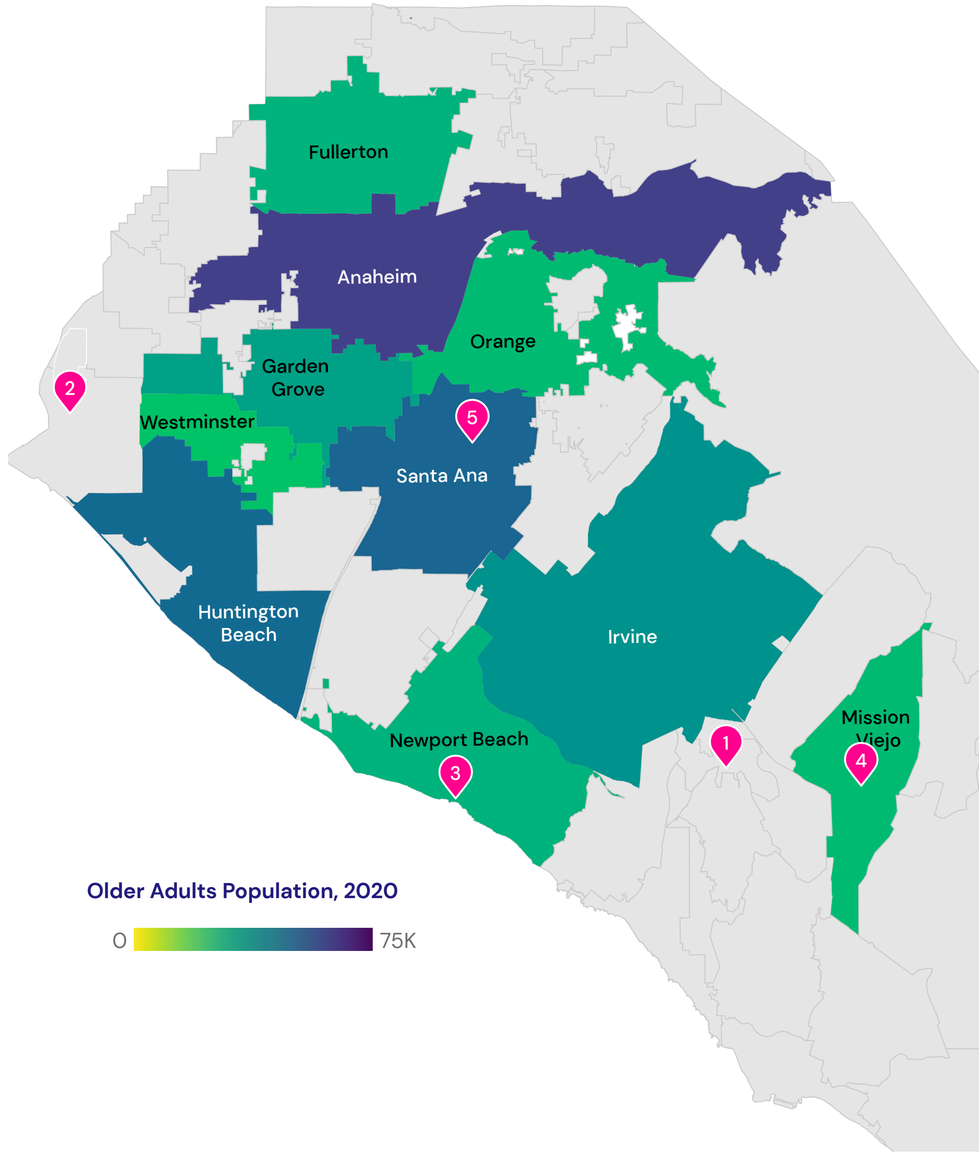
2020, with percentage changes since 2015

City	2020	
Anaheim	60,434	+17.7%
Huntington Beach	49,734	+17.7%
Santa Ana	47,240	+28%
Irvine	37,961	+7.9%
Garden Grove	35,028	+16.8%

City	2020	
Fullerton	27,089	+15.9%
Newport Beach	27,058	+15.1%
Mission Viejo	26,808	+19.8%
Orange	26,714	+17.2%
Westminster	21,298	+6.7%

Geographical Markers

1. Laguna Woods Village
2. Leisure World
3. Oasis Senior Center
4. Norman P. Murray Community and Senior Center
5. Asian American Senior Citizens Service Center



Source: 2020 American Community Survey 5-year Estimates

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Older Adults and COVID-19 in OC

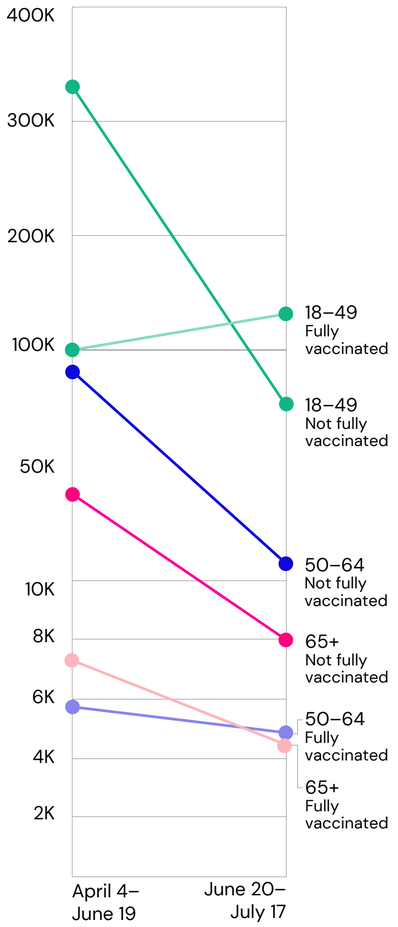
According to the OC Health Care Agency, as of May 10, 2022, over 500,000 cases and over 7,000 deaths have occurred in Orange County due to COVID-19.

Most of the 500,000 COVID-19 cases in Orange County did not include the patient's racial or ethnic data. This gap in data occurred for a variety of reasons. Some patients did not identify with a particular racial or ethnic classification, while some were not asked. As a result, we recommend avoiding generalizations about the impact of COVID-19 among various racial and ethnic groups.

According to the California Immunization Registry, 76.3% of Orange County residents older than 5 years are fully vaccinated. The vaccination rate of California is 75.1%.

Total Cases

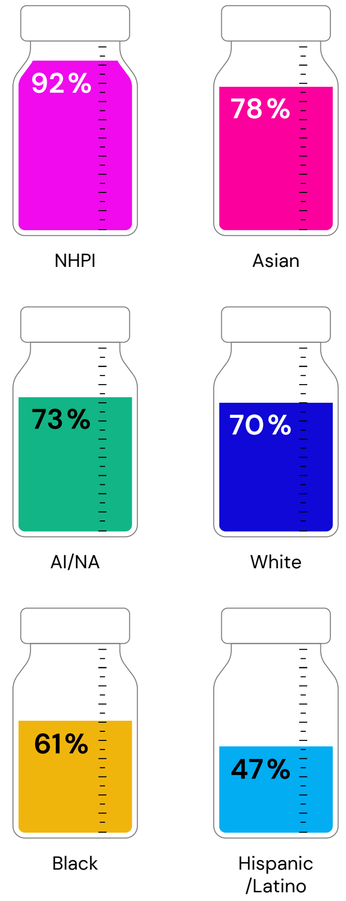
by age and vaccination status, 2021



Source: OC Health Care Agency

Vaccination Rate

per 100K population, 2021



Source: OC Health Care Agency

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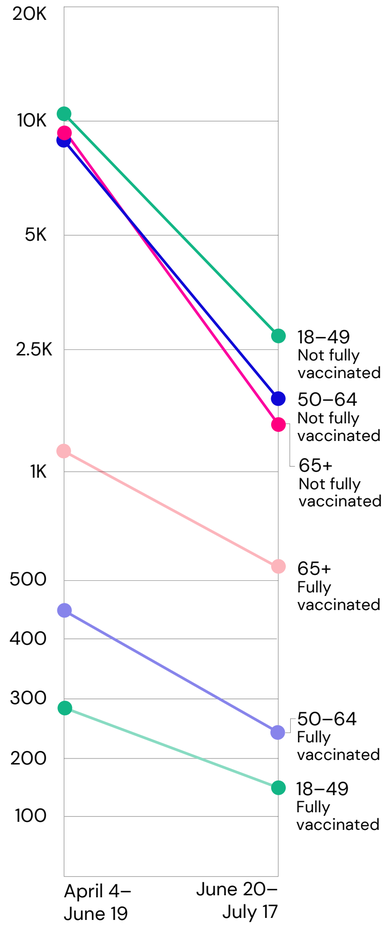
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Older Adults and COVID-19 in OC (continued)

Data show that older adults are getting vaccinated at similar rates to younger Orange County residents. From April to July 2021, the number of vaccinated people who were hospitalized and had COVID-19-related deaths were lower when compared to the non-vaccinated population. In 2021, the number of COVID-19 cases among the older adult population was lower than younger age groups. Despite this, they faced the highest death rate and were among the most hospitalized. This suggests that COVID-19 disproportionately affected the older adult population, even among the vaccinated.

Hospitalizations

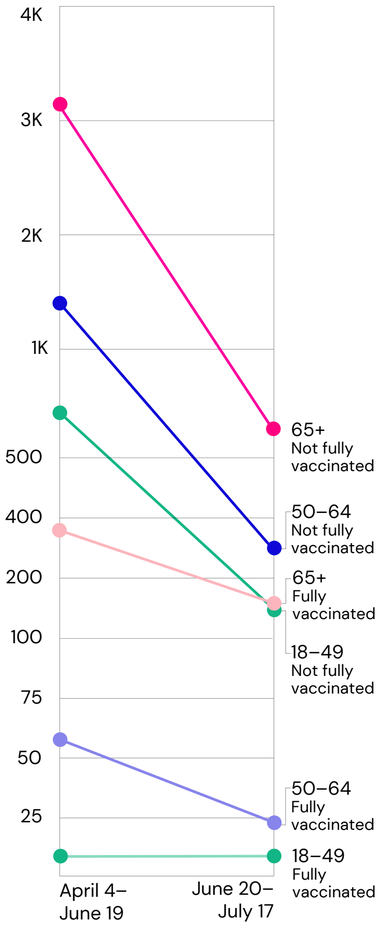
by age and vaccination status, 2021



Source: OC Health Care Agency

Death Rate

by age and vaccination status, 2021



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Health and Mortality

According to the National Institute on Aging, 80% of adults 65 and older have at least one chronic condition, while 68% have two or more. The 10 most common chronic conditions are: hypertension, high cholesterol, arthritis, coronary heart disease, diabetes, chronic kidney disease, heart failure, depression, Alzheimer's disease and dementia, and chronic obstructive pulmonary disease (COPD).

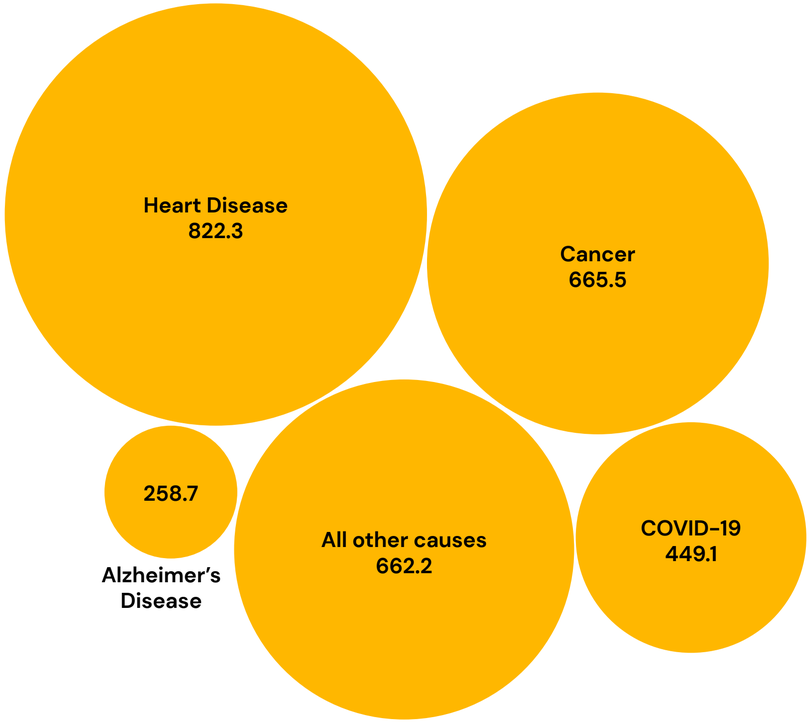
To address health disparities related to aging, the National Institute on Aging has supported Alzheimer's disease research. Research shows that Alzheimer's disease is more prevalent among Blacks and Latinos than other ethnic groups in the U.S. Although Alzheimer's disease affects some ethnic groups and genders at disproportionate rates, it is currently the seventh leading cause of death in the U.S. and is more common in older adults.

Lack of access to care can worsen health disparities in older adults. Enrolling in the Medicare program and accessing its benefits can be complex and is often confusing for older adults. The process can be even more challenging for older immigrants since they might not have work history in the U.S., not be citizens, or have limited English proficiency.

The Orange County health status profile for 2019 shows that the leading causes of death are cancer, Alzheimer's disease, and coronary heart disease. These data are similar to the top leading causes of death in the older adult population in the U.S. An exception is respiratory diseases, which affects more older adults in Orange County.

Top 5 Leading Causes of Death Among Older Adults in Orange County

2021, and crude rate per 100,000 older adult population



Source: CA Department of Public Health

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Health and Mortality (continued)

Living with Reduced Physical, Mental, and Medical Capacity

A strong relationship exists between disability and health, which can impact quality of life. How a person is limited by disability is dependent on the social and economic environment in which they live. As people get older, there are many physical, financial, and medical considerations which can cause or increase the severity of disability. The disability rate of those between 65 and 74 years old is about 18%. The disability rate more than doubles to 46% for those older than 75.

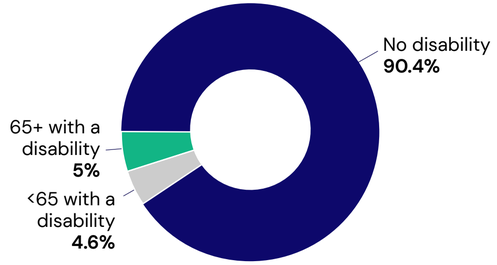
It is not uncommon for older adults to be caregivers for family members with disabilities, especially when it is their own children. These individuals may be affected by Down syndrome, amyotrophic lateral sclerosis (ALS), mental health issues, and/or mobility impairment due to accident or injury. In the U.S., an estimated 800,000 to a million adults over the age of 60 are caregivers for a loved one with a disability. This puts a physical strain on the parents as they age and also causes additional anxieties regarding who will care for their children when they are no longer able to. Available options for caregiving include independent living programs and group homes, which can be fully funded by insurance. Some resources available in Orange County include Independent Living Center of Southern California, OC Health Care Agency, and Easterseals Southern California.

Disabilities can be categorized into three main types:

- Lifelong or congenital
- Due to trauma (for example, accidents, injuries, lived experiences, etc.)
- Related to age (for example, arthritis, reduced eyesight or hearing, chronic diseases, etc.)

Older Adults with Disabilities in Orange County

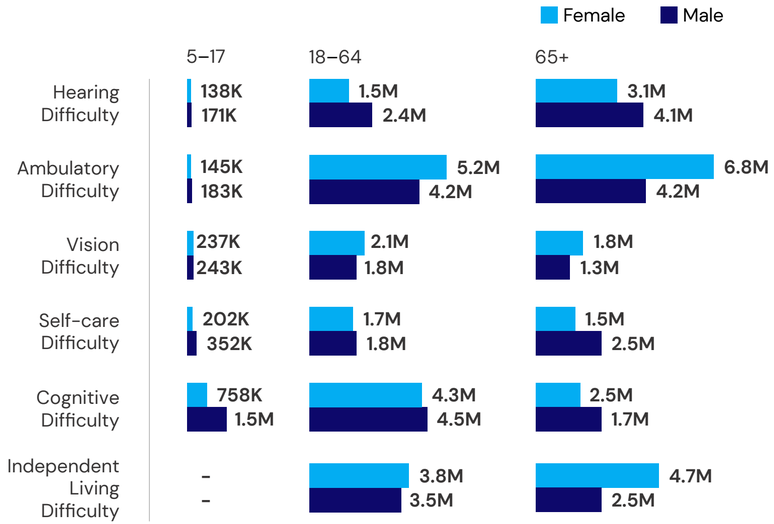
Number of Americans with a disability by age, sex, and disability type in 2018.



Margin of Error: Disability Compendium figure = 8.5% of the county are disabled = 270,894
Error: 36,689 people = 1.15%

Americans with a Disability

Number of Americans with a disability by age, sex, and disability type in 2018.



Source: 2018 American Community Survey

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Older Adult Care and Support

Over 7 million Americans aged 65 and older experience difficulty with independent living. Some terms describing various degrees of independent living difficulty among older adults are:

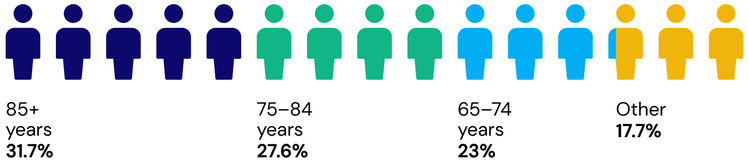
- **Conservatorship (or older adult guardianship)** is when a representative appointed by a judge is responsible for another individual who is unable to care for themselves or manage their own finances. Probate conservatorships are the most common types of conservatorships. Probate conservatorships "are established for individuals who are unable to care for themselves or are subject to physical, mental, or financial abuse where no other alternative exists." Conservatorships are most common among individuals who suffer from dementia, traumatic brain injury, or other cognitive impairments.

- **Power of attorney (POA)** gives a representative, often a close family member, the right to manage the affairs of another individual. A general POA usually happens when an individual still has the capability to handle their affairs (legal, financial, etc.) but would rather someone else do it. This right can be revoked at any time and is automatically canceled once the individual is incapacitated. If the individual wants to continue the POA after they can no longer make decisions, they can pursue a durable POA. A durable POA allows the representative to act on behalf of the individual when the individual is unable to handle their affairs. This can include paying bills, managing investments, and receiving medical care. A durable POA is often recommended for the older adult population because of the higher likelihood of health emergencies.

- **Assisted living** is when an individual needs help with activities of daily living (ADLs) to maintain their health and safety. Assisted living does not include constant attention or skilled care by a licensed nurse. This type of care is also called "Residential Care for the Elderly (RCFE)," or "Board and Care." While some long-term care insurance policies cover this type of care, older adults or their families generally must pay for it out of pocket. In Orange County, this care can cost between $3,000 to $10,000 or more per month, which has created a "forgotten middle." The forgotten middle are older adults who are unlikely to qualify for Medi-Cal but lack the resources to pay for the housing and care options that they need or want. By 2033, an estimated 16 million older adults in the U.S. will experience this gap.

Age in Long-term Care Facilities

Older adults 65+ in California in 2019



Source: County Health Rankings

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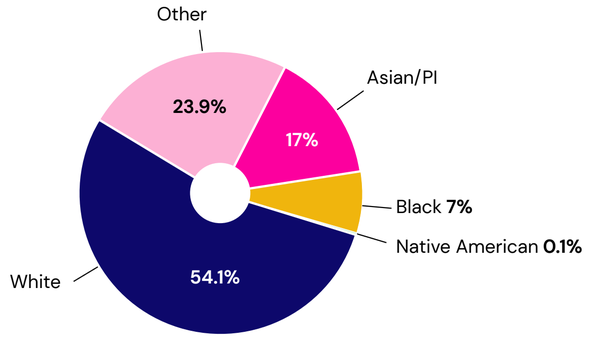
Long Term Care Facilities

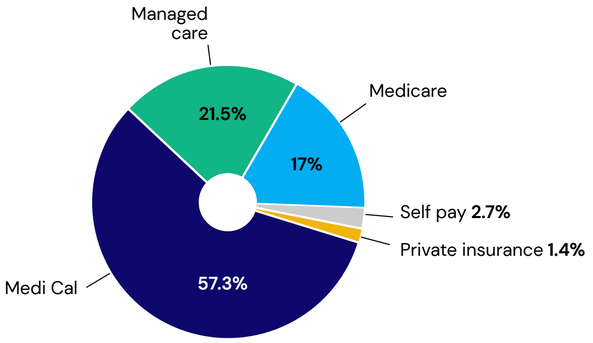
A study of older adults who use long-term care facilities shows that non-Hispanic Whites are more likely to use these facilities than other groups. Cultural factors play a role in these differences. Filial piety, a concept of respect and obligation to older adults in the family, is prevalent in Asian, Pacific Islander, and Native Hawaiian (ANHPI) cultures. Many studies connect filial piety to ANHPI caregiver beliefs, attitudes, and behaviors across multiple ethnicities. Filial piety may explain certain caregiver relations, such as when adult children share a home with their parents. Additionally, familism (a strong identification with and prioritizing of family over personal needs), is common among Latino cultures. It is an obligation to care for the older adults in the family (abuelas, padres, tias, and tios), and those who provide care often do not identify as caregivers.

Studies show that older adults of many racial minorities (Blacks, Native Hawaiians and Pacific Islanders, and American Indians and Alaska Natives) often have self-care difficulties. A notable trend is the increased independent and self-care living difficulties among other Asians (15.3%) and Native Hawaiians and Pacific Islanders (9%). Another trend is the higher proportion of older adults with independent living difficulty (12%), compared to self-care difficulty (7.5%). This suggests that most older adults are provided care, so they can remain at a level of living with assistance.

Long-term Care Facility Use

Older adults 65+ in California in 2019





Source: County Health Rankings

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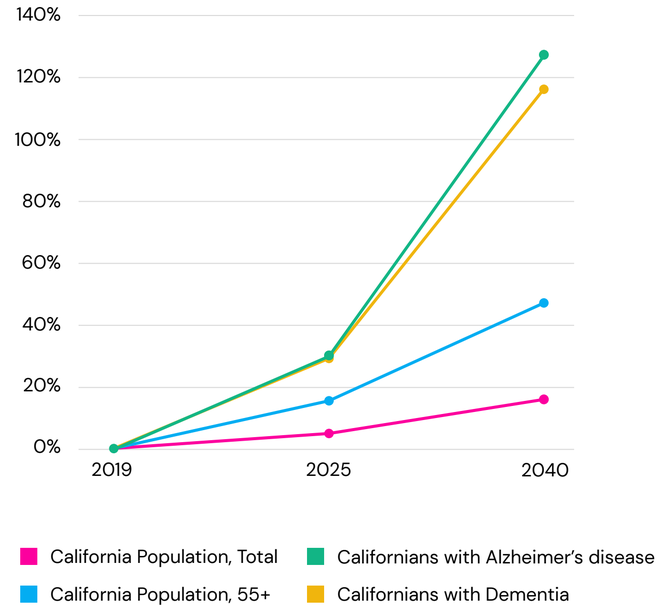
Dementia and Alzheimer's Disease

Cognitive decline in older adults is defined as difficulty in thinking, memory, concentration, and other brain functions beyond what is expected because of aging. These changes can come suddenly or gradually and can be permanent or temporary. Some signs of cognitive decline can include forgetfulness, losing one's train of thought, becoming more impulsive, or increased poor judgment. Many health conditions, including mental health diagnoses, can affect the brain and can be a risk to cognitive function. Depression and anxiety can lead to confusion or attention problems that could be linked to dementia.

Many older adults are at risk of developing dementia, which is an umbrella term to describe symptoms associated with severe cognitive decline. While many older adults often experience memory loss and difficulties associated with age, dementia is not a "normal" process of aging. Dementia can be much more severe, and those as young as 40 years of age can be diagnosed with dementia. Dementia can impact other areas of cognition that can affect day-to-day activities. This includes decision-making, problem-solving, and moderation of mood and behavior.

Estimated Percent Increase in Dementia or Alzheimer's Disease

Population of California and in Californians Age 55+



Source: 2021 Alzheimer's Disease and Related Dementias Facts and Figures in California: Current Status and Future Projections

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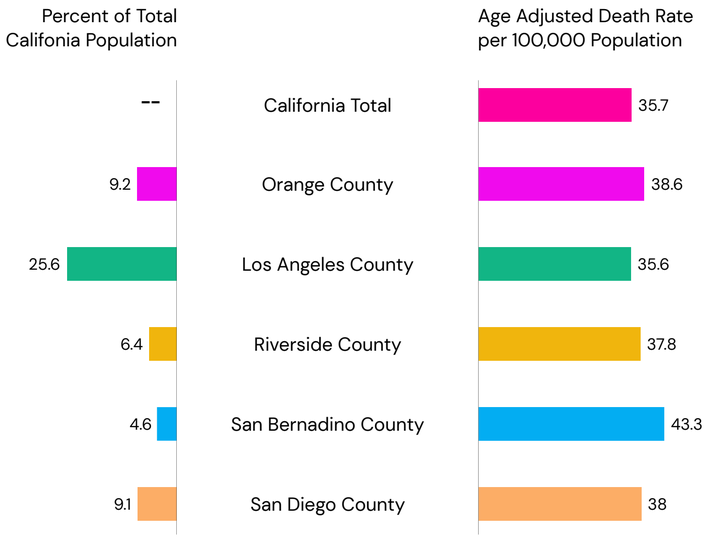
Health and Mortality (continued)

One of the most common causes of dementia is Alzheimer's disease, and it accounts for 60% to 80% of cases. Those diagnosed with Alzheimer's disease experience gradual cognitive decline because of cellular damage to the brain. Loss of brain cells is irreversible and can lead to changes in brain structure and function, eventually resulting in cognitive impairment. Early symptoms may be mild, but their severity increases as time progresses. Eventually, it can become difficult to live and function without in-home assistance or palliative care.

Very little is known about the onset of Alzheimer's disease. Age increase is the largest risk factor, which makes the older adult population most vulnerable. Although therapeutics on the market target Alzheimer's disease, current medicine is mainly concerned with slowing the progression of the disease rather than preventing it. Therefore, it is critical to have an early diagnosis to ensure that treatment can begin as soon as possible. Prevalence of Alzheimer's disease in California will increase in the next 20 years. In Orange County, an estimated 84,000 people are currently living with or are at risk for Alzheimer's disease, which is a leading cause of death in the county. As of 2018, Orange County experienced nearly 40 deaths per 100,000, a higher rate than California or the U.S.

Three-Year Average Number of Alzheimer's Disease Deaths in California Counties

2015–2017



Source: 2021 Alzheimer's Disease and Related Dementias Facts and Figures in California: Current Status and Future Projections

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Mental Health Among Older Adults

Psychological distress can affect all aspects of our lives. For older adults, they may experience the loss of independent living, limited mobility, chronic pain, or other mental or physical problems. Older adults are also more likely to experience loss of loved ones, socioeconomic status change because of retirement, or disability.

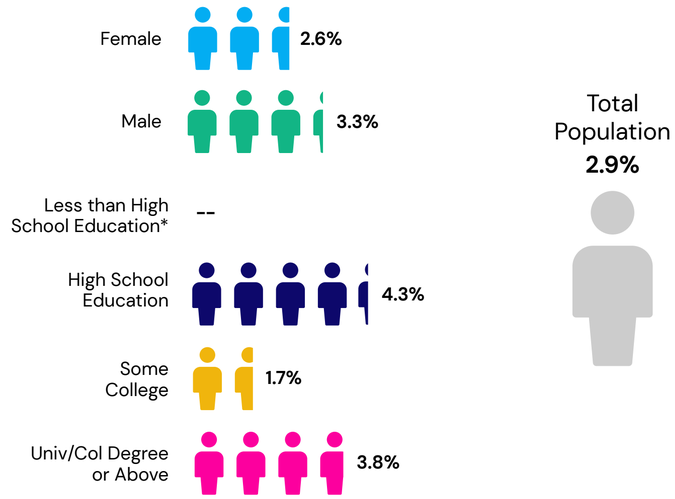
Depression is one of many mental health issues that older adults encounter and can lead to impaired functioning in daily life. Unfortunately, its symptoms are often overlooked and untreated because they can occur alongside other problems. Older adults with symptoms of depression may have poorer functioning compared to those with chronic medical conditions. This can increase perceptions of poor health and cause greater use of health care services. All of these can prevent the older adult population from seeking the resources they need.

Several studies show the negative effects of loneliness and social isolation on mental health and wellbeing. Loneliness is a source of silent suffering for older adults and can lead to other major risk factors. According to a 2020 study on social isolation and loneliness, having less social connections increases the risk for premature death. This is because isolation increases the risk of cognitive decline, dementia, depression, high blood pressure, and negative health factors.

Older adults had difficulty managing the challenges brought by the COVID-19 pandemic. High transmissibility of COVID-19 and dangerous complications associated with pre-existing health conditions meant that older adults needed protection from potential exposure. Social distancing forced older adults into isolation, which increased loneliness. Some families were unable to see their loved ones, and everyone had to adjust how they interacted with the community. In 2020, 2.9% of adults aged 60 years or older (approximately 20,000 Orange County residents) reported experiencing psychological distress in the past year. Psychological distress includes feelings of nervousness, hopelessness, restlessness, depression, demotivation, and worthlessness.

Psychological Distress of OC Adults

Percent of OC Adults Age 60 or Older Who Experienced Psychological Distress in 2020



*Groups with 500 members or less were excluded.

Source: Let's Get Healthy California

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Health and Mortality (continued)

Suicide Risk Among Older Adults

A troubling public health issue associated with older adults is suicide. Between 2000 and 2018, the suicide death rate increased 30%, then decreased in 2019 and 2020. 46,000 deaths by suicide took place in 2020, which made it the 12th leading cause of death in the U.S. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), that same year, 12.2 million adults seriously thought about suicide, 3.2 million made a plan, and 1.2 million attempted suicide in the past year.

Recorded suicide attempts among older adults are usually more lethal than those among the younger age groups. Older adults are nearly twice as likely to use firearms as a means of suicide, compared with adults younger than 60. Older adults may also exhibit passive self-harm behaviors that can result in death, such as refusing food, medications, or liquids. These are rarely recorded as suicide attempts or suicide deaths.

Suicide among adults ages 65 years and older cost more than $1.8 billion in combined medical and work-loss related expenses in 2013. This averages between $66,218 and $243,883 per deceased individual among older adults. The suicide rate of older adults is higher among:

- Men (when compared with women)
- Individuals aged 85 and older (when compared with those aged 65-74 and 75-84)
- White adults (when compared with American Indian and Alaska Native, Asian, Native Hawaiian and Pacific Islander, and Black adults)
- LGBTQ adults (when compared with straight adults; lifetime discrimination and victimization based on sexual orientation may contribute to this higher suicide rate)

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What are Social Determinants of Health?

The World Health Organization (WHO) defines social determinants of health (SDoH) as the conditions in which people are born, live, learn, work, play, worship, and age that impact health outcomes of a person or community. These circumstances are shaped by the distribution of money, power, and resources at the global, national, and local levels. These forces are outside the control of an individual or community and can greatly affect their overall health and well-being. Addressing these SDoH requires collective community action on a systemic level. The following pages highlight the status of the Older Adult population in Orange County across three social factors:

Health and Mortality

Comparing how long a group lives and determining their quality of life to the population at large can be a baseline for whether systemic disparities exist and how these disparities impact the community.

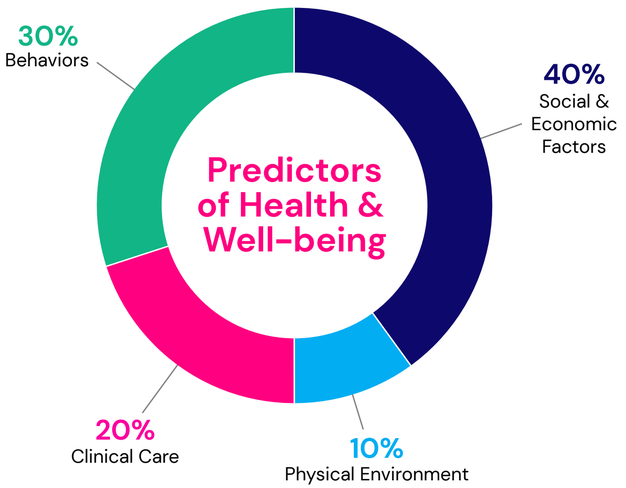
Economics and Education

Education does more than determine one's income. Individuals with higher education are more likely to be healthier and live longer. Improving education in various communities can bring significant health benefits to everyone.

Built Environment and Social Context

Where someone lives, how an individual gets around, and what is going on in a person's community can greatly impact both individual and community health and well-being. Things like neighborhood walkability, cleanliness of air and water, and even the age of buildings in the community can affect quality of life.

> *It is unreasonable to expect that people will change their behavior easily when so many forces in the social, cultural, and political environment conspire against such change.*
>
> **National Academy of Medicine**



Source: County Health Rankings

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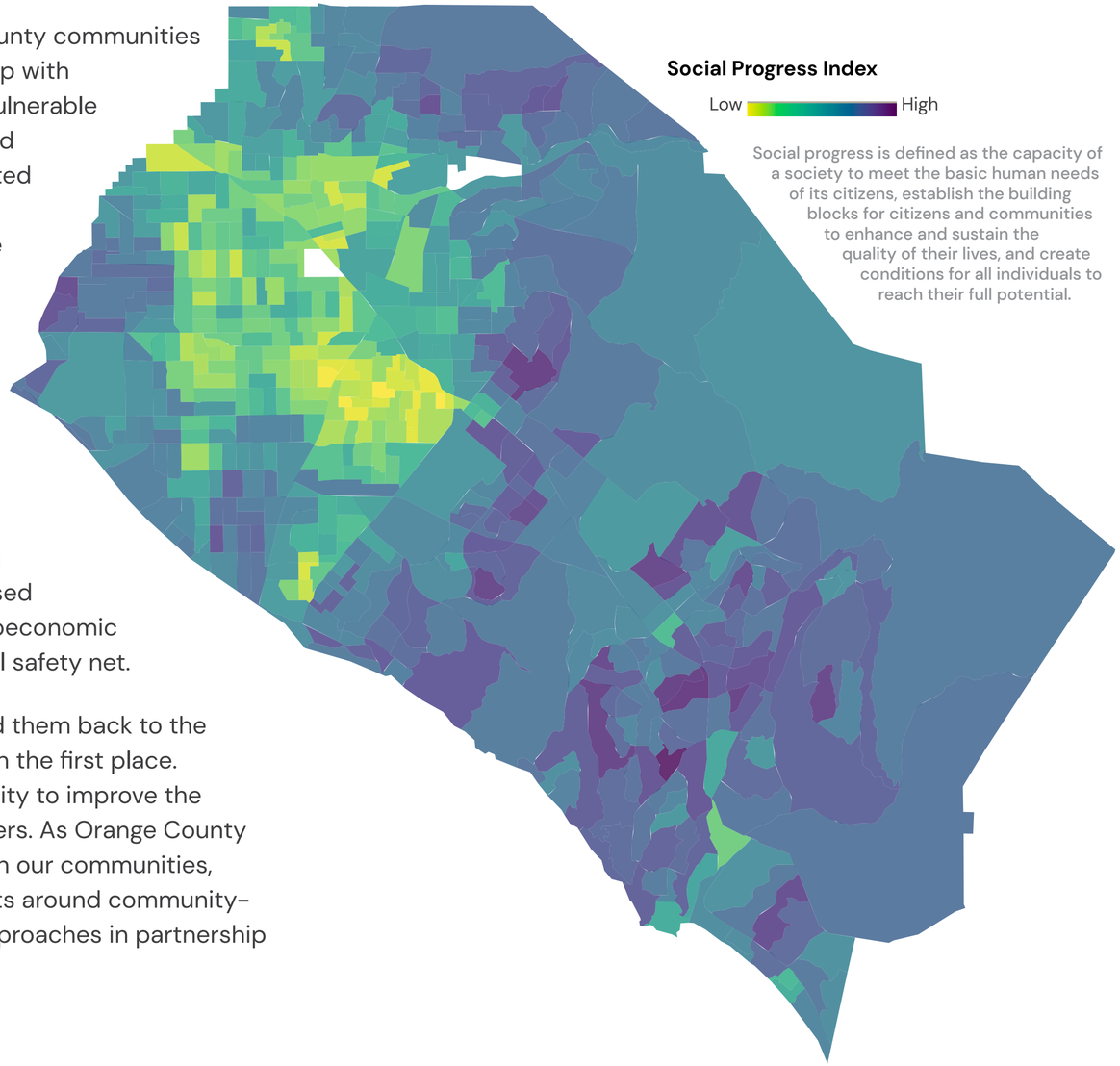
Mapping the Disparity

The COVID-19 pandemic impacted Orange County communities unequally and disproportionately. In partnership with AdvanceOC, a local non-profit, we identified vulnerable communities using comorbidity risk factors and social vulnerability. This rigorous analysis resulted in the Orange County Equity Map and guided the county's response and management of the pandemic.

What We Learned

The OC Equity Map measures social progress in various census tracts of the county. Analyzing and layering COVID-19 cases in Orange County showed that higher concentrations of COVID-19 cases occurred in low social progress areas. The pandemic exposed and magnified existing racial, gender, and socioeconomic inequities, including flaws in the county's social safety net.

We cannot treat and heal individuals then send them back to the systems and conditions that made them sick in the first place. Orange County sees COVID-19 as an opportunity to improve the health and well-being of all community members. As Orange County charts a path forward to rebuild and strengthen our communities, the Health Care Agency will center these efforts around community-informed, data-driven, and equity-oriented approaches in partnership and collaboration with community members.



Source: OC Equity Map, AdvanceOC

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SDoH Impacting Older Adults

Food Insecurity

In pre-pandemic Orange County (2016-2018), the California Health Interview Survey (CHIS) estimated the food insecurity rate for low-income adults aged 65 years and over to be 29.4%. Low-income individuals are those living 200% below the Federal Poverty Level. It is estimated that in Orange County, somewhere around 113,000 to 200,000 older adults may not have enough to eat. COVID-19 has worsened this problem. Second Harvest, Orange County's largest distributor of food to the needy, gave away 7 million pounds of food in July 2020. By February 2021, the volume was reduced to 5 million pounds, an amount still twice the pre-pandemic level. Figures from the Orange County Office on Aging show a 63% increase in senior meals between the periods of 2019-2020 and 2020-2021. The Feeding America report "The Impact of the Coronavirus on Food Insecurity" in 2020 and 2021 says, "After the Great Recession, it took nearly ten years, until 2018, for food insecurity to return to pre-recession levels, and even then, 37 million people were still at risk of hunger."

Elder Abuse and Victimization

Abuse of older adults, also known as elder abuse, can be a single or repeated act. It may also be a failure to act. It can occur within any relationship where there is an expectation of trust and causes harm or distress to an older person. Individuals aged 65 and older often experience the same crimes as the rest of the population, but they may be less likely to recover from their victimization. Worse yet, older adults are often sought out because of their age and decreased likelihood of the crime being reported.

According to The World Health Organization, approximately 10% of older adults over the age of 60 have experienced elder abuse. The seven most common types of elder abuse are physical abuse, emotional abuse, financial abuse, sexual abuse, neglect, self-neglect, and abandonment. Studies show that crimes against older adults are highly underestimated since some older adults are not included in surveys. This includes individuals with degenerative diseases or cognitive disabilities like dementia, Alzheimer's disease, and Parkinson's disease.

While older adults most often face mistreatment by family members or acquaintances, nearly half are perpetrated by strangers. Abuse rates are high in places where people have entrusted their loved ones to be cared for, such as nursing homes and long-term care facilities. Two in three staff have reported committing abuse in the past year. In 2020, 5,568 confirmed cases of elder abuse were reported in Orange County, according to data from the OC Health Care Agency. Elder abuse cases have been increasing since 2005.

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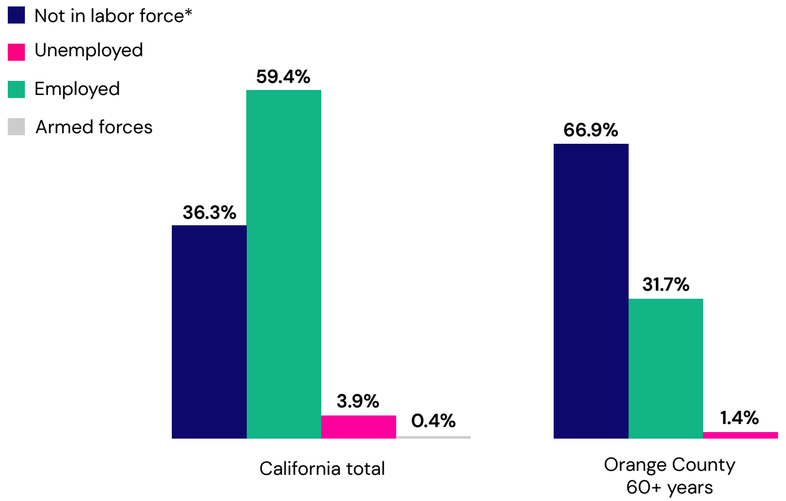
Economics and Education

Educational Attainment for Older Adults

The percentage of older adults with a high school degree or General Educational Development (GED) has dropped 4% in the last ten years. On the other hand, the number of older adults with a bachelor's degree or higher and the number of older adults with some college or associate degree has increased.

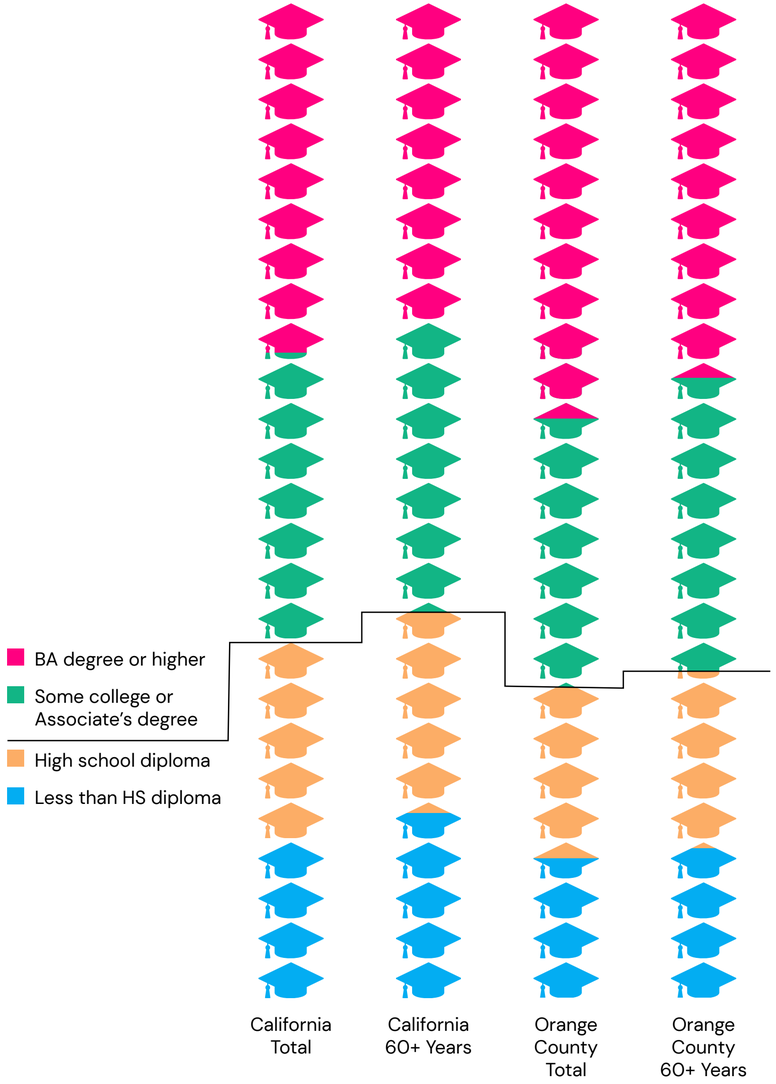
Employment

In 2020



*People who are not in the labor force include retired people, students, those taking care of children or other family members, and those who are neither working nor seeking work.

Source: 2020 American Community Survey 5-year Estimates



Source: 2020 American Community Survey 5-year Estimates

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Income

Older adults make a living in a variety of ways. They can be part of the workforce. They can also receive assistance through Social Security (68.3%) and Supplemental Security Income (7.3%). Retirement income (41.8%) is also an important part of many older adults' finances. Increases in retirement income has increased the average yearly income of older adults to $40,449. This has increased over $12,500 since 2010.

Poverty and Housing

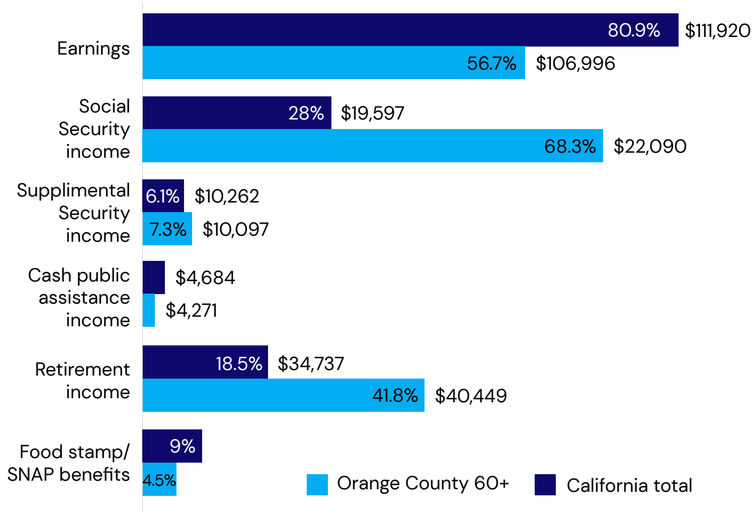
The Elder Economic Security Index considers local costs for housing, health care, food, and transportation. It can provide a more complete estimate of the financial state of older adults. According to the 2019 California Health Interview Survey (CHIS) estimates, 25.6% (124,236) of older adults in Orange County have a household income below the Elder Economic Security Standard Index. This percentage has increased compared to estimates from 2015, where 9% of single older adults and 9.6% of older adult couples in Orange County living were below the Elder Economic Security Index.

The number of low income older adults is increasing. California Health and Human Services data estimate that 70,900 adults over age 60 living in Orange County were 'low income' in 2020. It was an increase from 68,900 adults in 2019. This is calculated by comparing income to a standard expenditure like housing cost.

Housing affordability is defined as paying no more than 30% of income toward housing cost. Orange County's median housing burden is 44%, which exceeds affordability standards. The cost of living in Orange County is among the highest in the state.

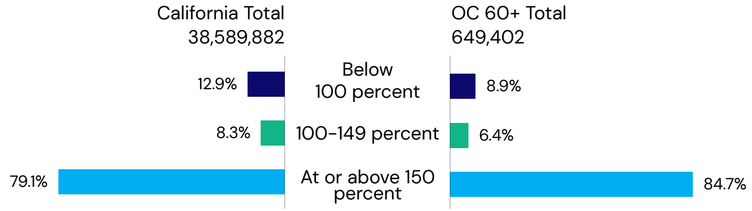
Income for Older Adults

Income in the past 12 months in 2020, percent of population with income and mean income amount



Poverty Status

Percent of poverty level



Source: 2020 American Community Survey 5-year Estimates

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For older adults on a fixed income, the growing cost of housing, medical, and other basic expenses presents a challenge and often results in worsened physical and mental health.

Of the 239,853 older adult-occupied housing units, 75.9% are owner-occupied, and 24.1% are renter-occupied. According to the American Community Survey, Orange County has a large proportion of households with older adults. With an estimated total of 1,044,280 households, the proportion of older adults is as follows:

- 9.5% (99,207) are individuals aged 65 and older who live alone
- 42.4% of all households in Orange County (442,385) have at least one person who is aged 60 and older
- 48.2% (143,210) of non-family households have at least one member who is aged 60 and older
- Of the 297,117 non-family households, 33.6% are 65 and older who lives alone

9.5%
Older Adults 65+ who live alone
2020

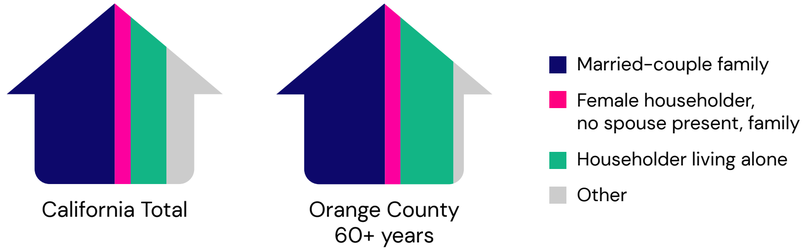
42.4%
Households with at least one person 60+
2020

Homelessness Among Older Adults

From the 2018 CES Point-in-Time Count: "In 2015, the median age of the homeless population within Orange County was 50 years, which is higher than the county median age of 38.3, indicating an aging trend in homelessness in the county. Currently, older adults make up about 7.1% of the homeless population, and much of this group is disabled (81.9%)." According to the 2022 Point-in-Time Count Summary of United to End Homelessness, 5,718 homeless people were in Orange County, and 3,057 of them were unsheltered. Of these homeless individuals, 718 were adults aged 62 and older, and 300 of them were unsheltered.

Households by Type

For 2020



Source: 2020 American Community Survey 5-year Estimates

Racial and Ethnic Differences in Economic Security

Single Asian older adults have lower rates of economic insecurity (5.2%) when compared to Asian older adult couples (12.8%). Black single older adults face higher rates of economic insecurity (16.4%) when compared to Black older adult couples (7.6%). Latino single older adults and older adult couples have similar rates of economic insecurity (14.4% and 14.2%, respectively). These are higher than the rate of other racial/ethnic groups and the overall rate (9% and 9.6%, respectively). White single older adults and older adult couples have similar rates of economic insecurity (7.6% and 6%, respectively) that are lower than the rate of other racial/ethnic groups and the overall rate (9% and 9.6%, respectively).

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Social Isolation/Loneliness

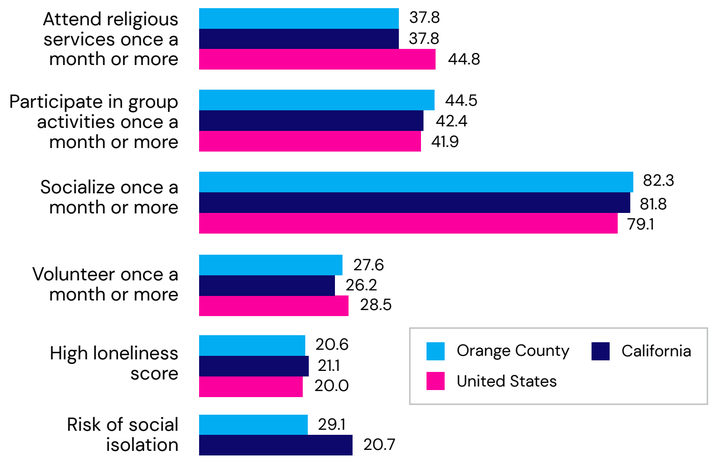
Loneliness is the feeling of isolation, not belonging, or lacking companionship. Social isolation and loneliness can occur for many reasons, including, but not limited to, language barriers, immigration status, health conditions affecting mobility or cognition, depression, and lack of social support. These factors can lead to depression, self-neglect, and increased diagnoses of chronic conditions.

Loneliness in older adults can lead to other risk factors that may increase health concerns and early death within this population. According to the National Academies of Sciences, Engineering, and Medicine (NASEM), more than one-third of adults aged 45 and older feel lonely, and nearly one-fourth of adults aged 65 and older are socially isolated. Older adults are also at increased risk for loneliness and social isolation because they are more likely to live alone, experience the loss of family or friends, or have chronic illness and/or hearing loss. In Orange County in 2019, 22% of adults aged 65 and older lived alone and may be at risk for social isolation.

In Orange County, close to 100,000 older adults live alone. The loneliness score (as reported by AARP*), which measures how left out or isolated a group feels, is slightly higher than the national average. This is a public health concern because higher scores indicate greater feelings of isolation and because social isolation and loneliness can increase a person's risk of death. Loneliness has been linked to a greater risk of heart attack, metastatic cancer, stroke, depression, dementia, and neurodegenerative diseases. Research from UCLA shows that lonely adults are 25% more likely to die prematurely. Also, older adults who are lonely die at twice the rate as those who are socially connected. Chronic loneliness was associated with higher numbers of chronic illness and higher depression scores.

Social Isolation

Percent of population 50 or above in 2022



Loneliness Score

Population 50 and older in 2022.



1.2 OC

1.2 CA

1.1 U.S.

Source: Report on Aging in Orange County 2022

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Studies show that chronic loneliness can affect memory, mental and physical health, and longevity. In Orange County, the percentage of householders living alone is higher among individuals 60 years and older (33.3%) when compared to the county's total population (21.2%). These numbers are consistent with the overall 60 and older population in the state.

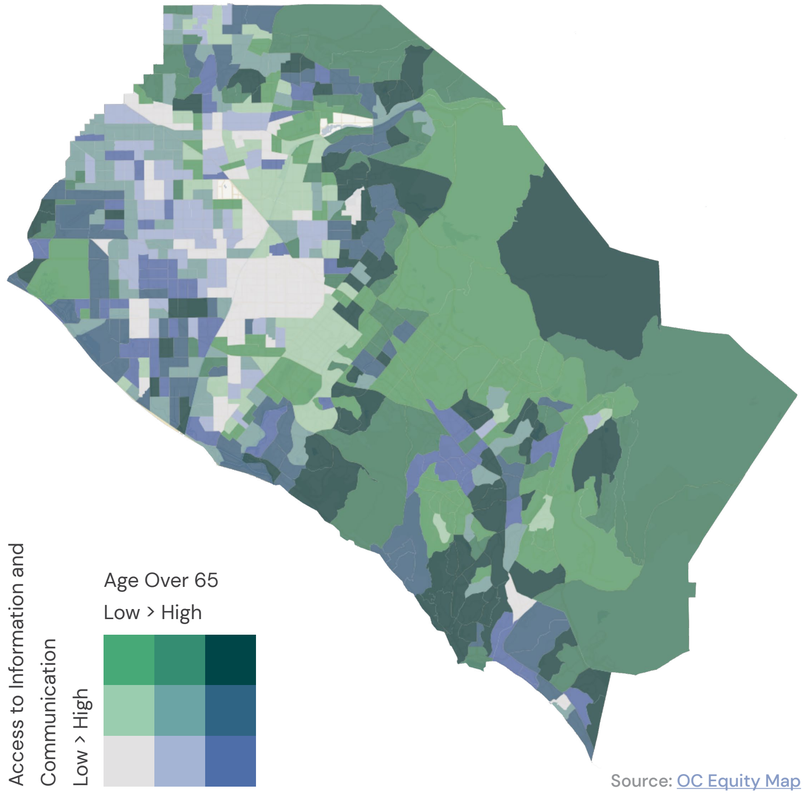
In addition, older adults who are socially isolated are more likely to have a poor diet, use tobacco, and lack physical activity. This can increase health risks since socially isolated individuals have an increased risk of developing depression, anxiety, and dementia. They are also more vulnerable to physical abuse. Social isolation can make older adults more susceptible to financial abuse since perpetrators of such crimes can more easily take advantage of an isolated older adult.

It is important to consider how the pandemic impacted the overall wellbeing of older adults. Loneliness and limited social contact during the pandemic were strongly associated with symptoms of depression among older adults. Regarding loneliness in the older adult population, the National Council on Aging states that "they are no longer in the workforce, are more likely to live alone, and have fewer social connections over time. In addition, their extended families may be more geographically dispersed than in past generations, making it difficult to maintain in-person familial contact."

During the pandemic, older adults were often unable to be visited by family. Many also lost social connections due to the closing of community programs. While the rest of the world pivoted to an online setting during COVID-19, the older adult population struggled to adapt. Studies show that only 38% of older adults feel comfortable using the internet and under half have broadband access. This also increased loneliness and isolation in the older adult population, since many had difficulties communicating with others using technology.

Access to Information

2021



Source: OC Equity Map

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Built Environment and Social Context (continued)

Digital Divide

Older adults face a digital divide, which is the unequal access to digital technology (smartphones, computer, the internet, etc.). According to an AARP survey, 6% of older adults in Orange County do not have internet and 13.1% do not have a computer. While both are lower than the California and U.S. averages, specific pockets in Orange County (Laguna Woods, Laguna Hills, Lake Forest, Seal Beach, and La Habra) are more impacted by the digital divide.

This is an issue because older adults do not have lifelong exposure to digital media, which forces them to adapt later in life. As a result, they risk being isolated from new digital solutions, including telehealth, online shopping and banking, and digital communication. Their technological inexperience has also led to a higher likelihood of being scammed. Adults over 65 are 34% more likely to lose money because of a financial scam than those in their 40s.

Orange County has attempted to bridge the digital divide by providing iPads for older adults. The initiative was approved by the Orange County Board of Supervisors in 2021. Older adults were provided iPads along with data plans, training, technology support, and subscriptions to virtual classes. This Orange County effort to combat social isolation in older adults was a response to COVID-19.

Transportation

Orange County offers two resources for older adults in need of assistance. One resource that OCTA offers is the Senior Mobility Program (SMP). It is designed to cover the gaps between the bus routes and ADA para-transit. Unfortunately, this service is only available in participating cities. The second resource available for older adults is the Orange County Go Senior Non-Emergency Medical Transportation (SNEMT) Program. This provides transportation for older adults who need low-cost transportation from their home to their destination.

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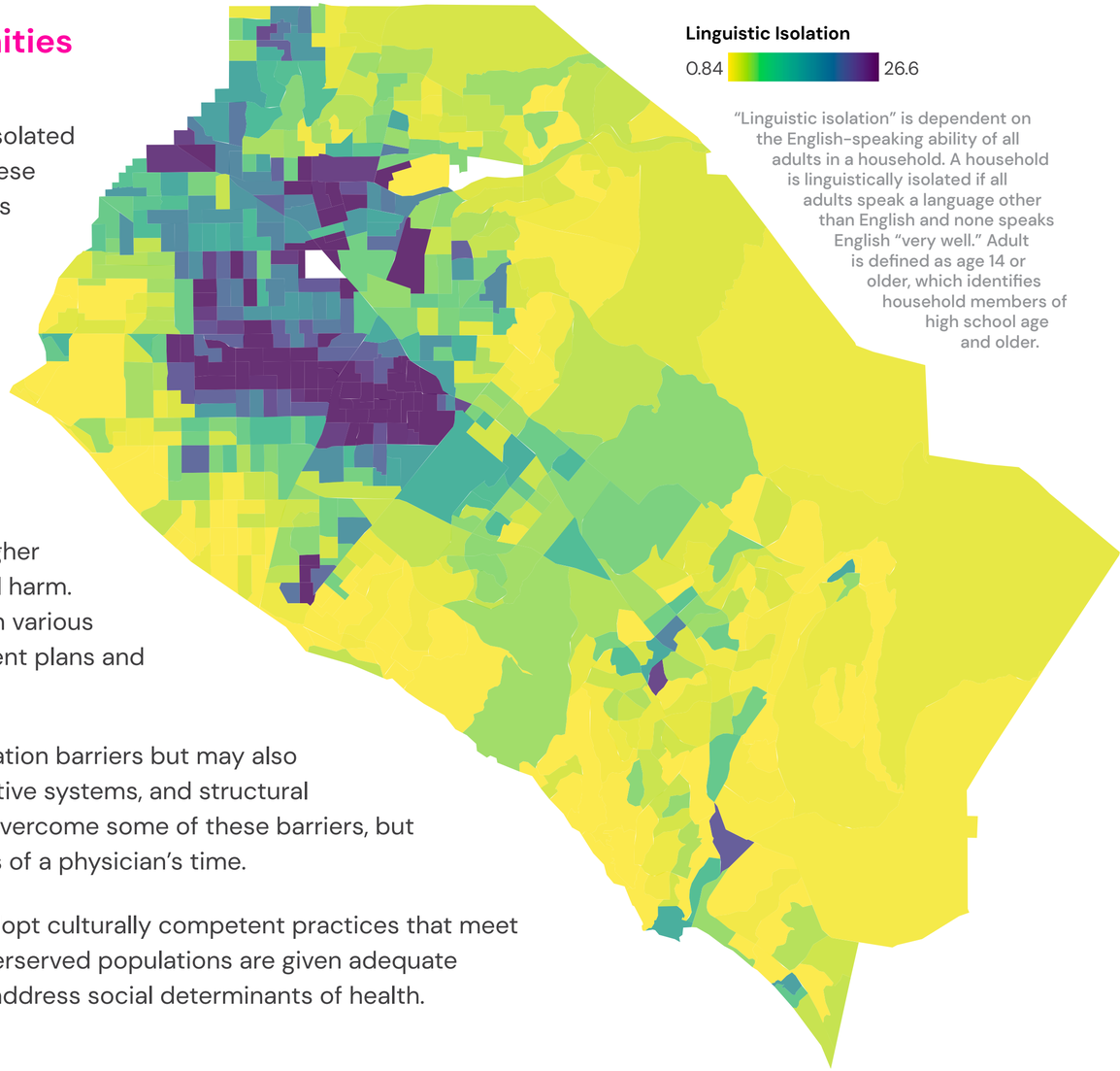
Orange County Language Opportunities and Services

Orange County residents who live in linguistically isolated communities are often from immigrant families. These immigrant families tend to gather in ethnic enclaves as a means of survival because of discriminatory practices or due to being shunned from other parts of the county.

People with limited English proficiency (LEP) are defined by the U.S. Census as those who speak English less than "very well." In 2020, 8.7% of Orange County residents are LEP. They experience high rates of medical errors with worse clinical outcomes than English-proficient patients. This higher incidence of medical errors could result in physical harm. LEP individuals also receive lower quality of care on various measures and are less likely to understand treatment plans and disease processes.

These disparities are rooted in obvious communication barriers but may also reflect cultural differences, clinician biases, ineffective systems, and structural barriers. Medical interpretation services can help overcome some of these barriers, but they have associated costs financially and in terms of a physician's time.

We must strive to remove language barriers and adopt culturally competent practices that meet residents where they are. This will ensure that underserved populations are given adequate resources to access healthcare and services that address social determinants of health.



Source: OC Equity Map, AdvanceOC

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Built Environment and Social Context (continued)

Air Pollution Exposure in Orange County

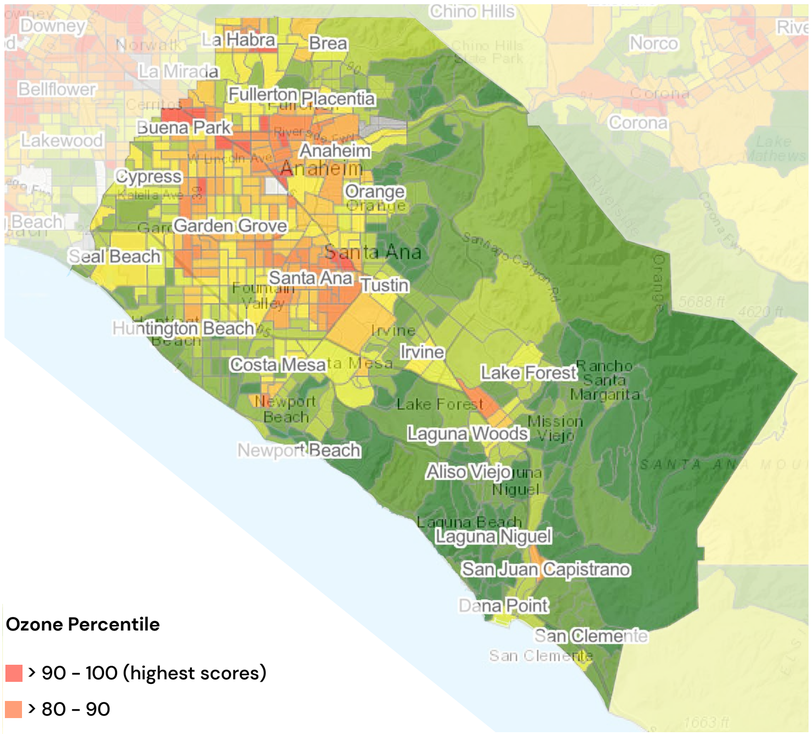
In California, environmental quality has improved over the last few decades. This is seen in improved water quality, reduced air pollution, decrease in pesticide use, continued cleanup of hazardous waste sites, increased recycling, and reduction of solid waste going into landfills. However, pollution reduction and the resulting health and environmental benefits are not uniformly distributed across the state, within a region, or among all population segments. Many communities continue to bear a disproportionate burden of pollution not only from multiple nearby sources but also from pollution in various forms, such as air and water.

Ozone pollution causes adverse health effects including respiratory irritation and worsening of lung disease. Adverse effects of ozone have been studied extensively since the late 1960s, and ongoing exposure to ozone shows inflammation and cell and tissue injury. People with asthma and chronic obstructive pulmonary disease (COPD) are considered sensitive to the effects of ozone. Studies also show that long-term ozone exposure affects respiratory and cardiovascular mortality. A 2019 study estimates 13,700 deaths in California in the year 2012 were due to long-term ozone exposure.

Of these deaths, 7,300 were from respiratory causes, and 6,400 were from cardiovascular causes. The CalEnviroScreen 4.0 draft ozone map of Orange County shows high levels of ozone pollution scores in north and central Orange County. In the OC Equity Map, these communities have low Social Progress Index scores.

Ozone Levels by Pollution Score

2021



Source: CalEnviroScreen

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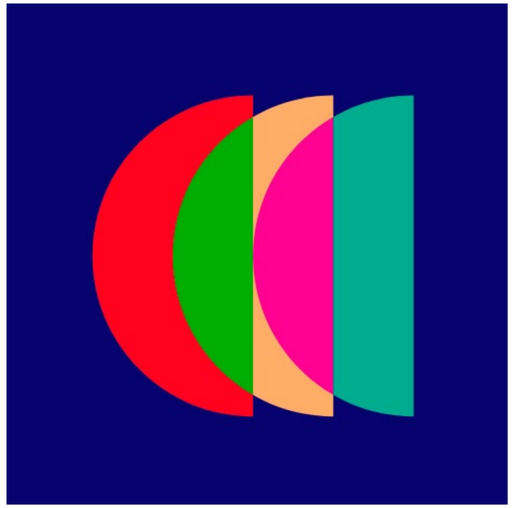
Health is a shared value. Your involvement will help create a healthier, more resilient, and equitable Orange County.

Here's how you can get involved:



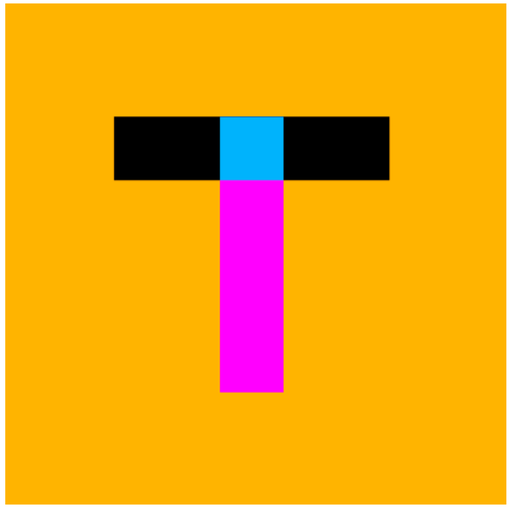
Participate in the EiOC Action and Learning Community

Learn More



Join a Population Health Equity Collective

Learn More



Make your voice heard at EiOC Taskforce Meetings

View Events



An Initiative of OC health CARE AGENCY

EquityinOC.com

ORANGE COUNTY COMMUNITY RESOURCES

Health, Wellness, and Other Resources

1. OC Navigator: OC Navigator (contains Orange County resources for mental health, housing, family safety, basic needs, money, legal help, medical, transportation, learning, kids and families, and substance use)
2. OC LGBTQ Resources: OC Navigator

Provider and Partner Resources

1. Provider r\Resources: Provider Resources | Orange County California - Health Care Agency (ochealthinfo.com)
2. Education and Training Programs: Education & Training | Orange County California - Health Care Agency (ochealthinfo.com)

Health Equity Community Resources

1. COVID-19 Health Equity Playbook for Communities: COVID-19 Health Equity Playbook for Communities (ca.gov)
2. Beyond the Blueprint: Targeted Equity Investment Plans: Beyond the Blueprint: Targeted Equity Investment Plans (ca.gov)
3. The Public Health Alliance Regional Equity Learning Collaborative: Collaborative (thepublichealthalliance.org)
4. Health Equity Resources: Health Equity Resources | DNPAO | CDC
5. Equity Mapping Tools-100 Million Healthier Lives Advancing Equity Tools: 100 Million Healthier Lives Advancing Equity Tools | IHI - Institute for Healthcare Improvement

Population Health Resources

1. COVID-19 Case Counts and Testing Figures: Vaccines Administered in OC | Novel Coronavirus (COVID-19) (ochealthinfo.com)
2. Institute for Exceptional Care: Institute for Exceptional Care (ie-care.org)

Diversity, Equity, Inclusion, and Accessibility Resources

1. 2021 Truth and Transformation Conference: 2021 Truth and Transformation Conference | Ash Center (harvard.edu)

Additional Community Resources

1. OC Health Data Portal: OC Health Data
2. Additional Community Resources: Additional Resources | OC Health Data

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