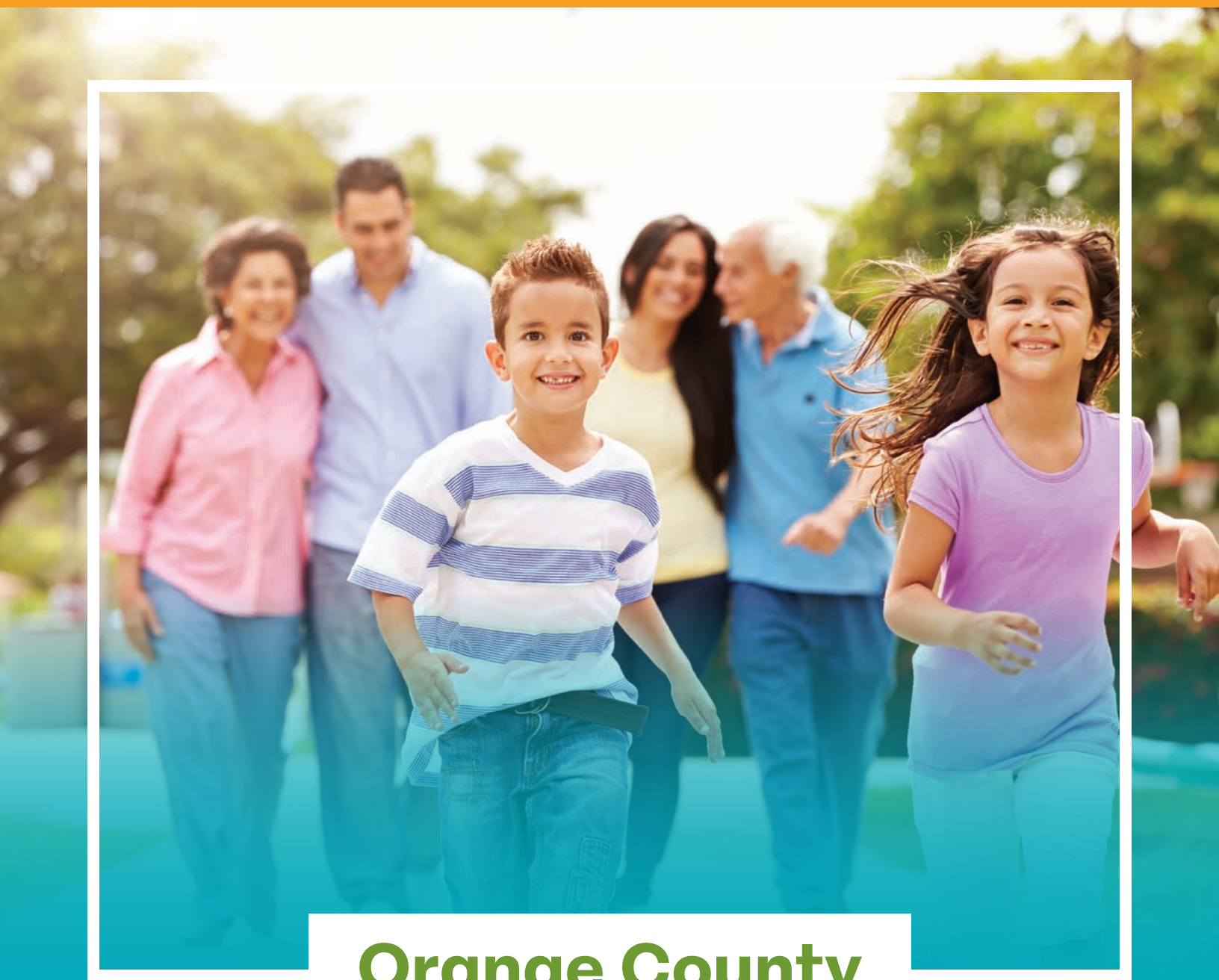


Orange County

Community Health Improvement Plan
2024-2026

OC Health Improvement Plan | Orange County California - Health Care Agency (ochealthinfo.com)

Table of Contents

EXECUTIVE SUMMARY

The Orange County Health Improvement Plan envisions a county where everyone can achieve health and optimal well-being in an environment of access, equity, and resilience. To achieve this vision, Orange County communities are working on eliminating health disparities by embracing community voice, establishing trusted partnerships, and implementing evidence-based strategies and best practices to achieve equitable health outcomes for all.

In 2023, collaborative efforts of community and organizational partners led by the OC Health Care Agency (HCA) created the Community Health Assessment (CHA), a comprehensive review of the current health status of our shared communities and our most pressing health needs. Background of the CHA can be found at: Orange_County_Community_Health_Assessment-Final.pdf (ochealthinfo.com).

The CHA's data-driven review identifies priority areas of focus for Orange County's Community Health Improvement Plan (OC CHIP). The CHA gathered recommendations from 174 participants for issue prioritization from individual community members, Community-Based Organizations, public health agencies and health care systems, and hospitals to inform the drafting and implementation of the OC CHIP. The six priority areas identified by the community included Mental Health, Substance Use, Diabetes/Obesity, Housing/Homelessness, Care Navigation, and Economic Disparities.

Once completed, the CHA provided a framework to gather structured feedback from subject matter experts, including individual community members, Community-Based Organizations, public health agencies, health care systems, and hospitals. This feedback was used to define the goals, objectives, strategies, measures, and outcomes that would form the foundation for the ongoing work of the OC CHIP. The OC CHIP is critical for creating a shared roadmap of strategies and actions to address the top health priorities for the region. It enables the region to track progress, celebrate achievements, and modify course as the work unfolds to achieve greater and more equitable health for our shared communities.

The identified priorities in this document are the result of months of community events, surveys, and engagement over the last two years (including Equity in OC events and other surveys). Through the unified commitment from multiple sectors across the county, we anticipate positive impacts on the issues the community finds relevant. The pandemic highlighted inequities that have systemically existed and the significant detrimental impacts on specific communities. We can and must do better collectively to improve the health of all in Orange County.







ORANGE
COUNTY






Summary of Priorities

Priority Area 1: Mental Health

1

Goals

Goal 1: Increase access to the continuum of quality mental health services for all Orange County community members

Goal 2: Decrease stigma surrounding mental health issues in Orange County

Priority Area 2: Substance Use

2

Goals

Goal 1: Decrease deaths for OC residents from opioids, including illicit fentanyl

Goal 2: Decrease the rate of substance use/misuse for OC residents

Priority Area 3: Diabetes and Obesity

3

Goals

Goal 1: Increase the proportion of community members who are at a healthy weight

Goal 2: Reverse the trend of increasing rates of diabetes

Priority Area 4: Housing and Homelessness

4

Goals

Goal 1: Broaden the Housing and Homelessness workgroup by incorporating members from various organizations involved in housing and homelessness initiatives throughout Orange County to work toward meaningful and sustainable solutions

Priority Area 5: Care Navigation

5

Goals

Goal 1: Improve access to the health care systems in a manner that is culturally and linguistically appropriate and accessible

Goal 2: Improve knowledge of common preventable health conditions and the health care system to promote informed health decisions through best practice care navigation

Priority Area 6: Economic Disparities

6

Goals

Goal 1: Increase economic investments and opportunities for people in Orange County impacted by economic disparities

Welcome to the Orange County Community Health Improvement Plan (OC CHIP)

Welcome Message

Dear Community Members, Partners, and Stakeholders,

On behalf of OC CHIP, we warmly welcome all who are joining us on this journey toward a healthier and thriving community. Your presence and participation are crucial as we work together to address the health needs and challenges that impact each of us.

In every community, health is a shared responsibility, and through collaboration and collective effort, we can create lasting and positive changes. The Orange County Community Health Improvement Plan (OC CHIP) is not just a document; it is a roadmap that reflects the aspirations of our community members and the commitment of diverse stakeholders to prioritize and enhance the well-being of everyone.

As we embark on this endeavor, we invite you to engage actively, share your insights, and contribute your unique perspectives. Your input is invaluable in shaping the strategies and actions to guide us toward healthier outcomes for all.

This CHIP is more than a plan; it is a testament to our dedication to fostering a healthier community for generations. Together, we will build a foundation for well-being, address health disparities, and create an environment where everyone can lead a healthy and fulfilling life.

Thank you for being an integral part of our community's health journey. Your commitment strengthens our shared vision for a healthier, happier, more resilient community.

Sincerely,

OC CHIP Steering Committee and Community Chairs




Mission and Vision

MISSION

To collaboratively design and implement a plan that addresses the diverse needs of our community, empowers individuals to make informed choices, and creates a culture of inclusivity, equity, compassion, and support where every individual has the opportunity to attain their highest level of health and well-being.

VISION

We envision an Orange County in which everyone has the opportunity to be healthy, not just through the absence of illness, but also with the presence of health and optimal well-being in an environment of opportunity, equity, and resilience.




Acknowledgements

The success of the OC CHIP is a testament to the collaborative spirit demonstrated by many organizations, health care systems, community-based organizations (CBOs), and individuals who participated in the various OC CHIP development activities, from the community assessments to the focus groups, to the thought leadership, the plan development, and so much more. Together, we have developed evidence-based techniques to affect long-lasting positive change to identify important health objectives. Moving forward, the groundwork laid with the collaboration of all those listed below will pave the way for improved health outcomes and increased community well-being. In gratitude, we list all those below for their unwavering commitment to our shared community's health, and we look forward to continuing this journey together toward an equitably healthier Orange County.

ORGANIZATIONS THAT CONTRIBUTED TO THE CHA AND OC CHIP

2-1-1 Orange County
Abrazar Inc
Abound Food Care
ACLU Southern California
Ada J. Hand Early Childhood Consulting
Advance Orange County
AltaMed Health Services
Altura MSO
Alzheimer's Association of Orange County
Alzheimer's Orange County
American Heart Association in Orange County
Anaheim Elementary School District
Anaheim Unified High School District
Asian American Senior Citizen's Service Center
Aurrera Health Group
Boys and Girls Club of Garden Grove
Boys and Girls Club of Laguna Beach
Buena Park Collaborative
California State University, Fullerton (CSUF)
California University of Science and Medicine
CalOptima Health
Cancer Kinship
Caravan 4 Justice
Casa Morales
Center for Asian Americans in Action
Center for Community Advancement (BPSOS – CCA)
Center for Family Health Initiative
Child Guidance Center
Children Now
Children's Hospital of Orange County
Coalition of Orange County Community Health Centers
CommunityHealthComm
Community Health Initiative of Orange County (CHIOC)
Community Voices
Council of Aging - Southern California
County of Orange Board of Supervisors
County of Orange Executive Office, Office of Care Coordination
County of Orange Health Care Agency
County of Orange Social Services Agency
CVS Health
Cypress College Black Student Union
Dayle McIntosh Center
Depression and Bipolar Support Alliance Orange County
EDU Work Partners
Family Solutions Collaborative
Friendly Center
First 5 Orange County
Global Hope 365
Good Hands Foundation

Health Equity for African American's League (HEAAL) Collaborative
Hoag Hospital
Hospital Association of Southern California
Housing for Health
Huntington Beach CERT
I5 Freedom Network
Illumination Institute
Institute for Healthcare Advancement John Henry Foundation
Kaiser Permanente
Kennedy Commission
Korean Community Services
La Habra Collaborative
Latino Health Access
Lestonnac Free Clinic
LGBT Center of Orange County
Lutheran Social Services of Southern California
MAT Connect
Mercy Health
Mercy Pharmacy Group
MIND Orange County
Mission Hospital Laguna Beach
Multi-Ethnic Collaborative of Community Agencies (MECCA)
MOMS Orange County
National Alliance on Mental Illness Orange County (NAMI OC)
NorthSTAR/ Rev Hub Orange County
Omid Multicultural Institute for Development
Orange County Aging Services
Orange County Asian and Pacific Islander Community Alliance (OCAPICA)
Orange County Children's Therapeutic Arts Center
Orange County Department of Education (OCDE)
Orange County Grant Makers
Orange County Labor Federation
Orange County Medical Association
Orange County Rapid Response Network
Orange County Sheriff's Department
Orange County Women's Health Project
Orange County United Way
Pacific Health Partners
Partner4Wellness
Peace and Justice Law Center
Public Health Foundation Enterprise (PHFE) Women, Infants, and Children
Planned Parenthood
Peer Voices of Orange County and Los Angeles
People for Housing
Poppy Life Care
Project Youth Orange County
Providence Mission Hospital
Providence St. Joseph Hospital and St. Jude Medical Center
Ready SET Orange County
Recovery Road
Regional Center of Orange County
Rossmoor Homeowner's Association
Saahas for Cause
Sabil USA
Sacred Path Indigenous Wellness Center
Second Baptist Church
Second Harvest Food Bank
Shanti Orange County
Sisters of St. Joseph Healthcare Foundation
Sonrise Community Church
Southland Integrated Services
Southwest Community Center
Start Well Orange County
Sullivan en Accion
The Cambodian Family
The Green Foundation
Thru Health
Time Zone LLC
Tustin Unified School District
United Across Borders Foundation
Unidos South Orange County
United American Indian Involvement
United Way Orange County
University of California, Irvine
University of California, Los Angeles
Urban Social Services and Advocacy
Viet Rainbow of Orange County
Vietnamese American Cancer Foundation
WayMakers Orange County
Welcoming Neighbors Home
Wellness and Prevention Center
Western University of Health Sciences
YMCA of Orange County

In addition to the organizations, several community members assisted with the CHA and OC CHIP. They include: Virginia Arizu-Sanchez, Nadia Atalah, Nancy Beltran, Helen Cameron, Helen Chen, Dianna Daly, Elizabeth Diaz, Rosemary Egkan, Bory Hok, Jonathan Lukoff, Carol McCann, Princess Osita-Oleribe, Maria Belen Ramirez, Karen Sarabia, Thary Sok, Jacqueline Tran, and Johnice Williams.

We extend special thanks to the following individuals and work groups who provided leadership and guidance in the planning process throughout 2023.

OC CHIP STEERING COMMITTEE

LaRisha Baker	Orange County Health Care Agency, Public Health Services (Care Navigation)
Douglas Becht	Orange County, County Executive Office (Housing/Homelessness)
Maridet Ibañez	Orange County Health Care Agency, Public Health Services (Diabetes/Obesity)
Travers Ichinose	Orange County Health Care Agency, Public Health Services (Economic Disparities)
Mark Lawrenz	Orange County Health Care Agency, Behavioral Health Services (Substance Use)
Anna Luciano-Acenas	Orange County Health Care Agency, Public Health Services (Diabetes/Obesity)
Zulima Lundy	Orange County, County Executive Office (Housing/Homelessness)
Michelle Smith	Orange County Health Care Agency, Behavioral Health Services (Mental Health)
Pauline Stauder	Orange County Health Care Agency, Behavioral Health Services (Substance Use)
Terri Styner	Orange County Health Care Agency, Behavioral Health Services (Mental Health)

OC CHIP COMMUNITY WORKGROUP CHAIRS

Mental Health	Dr. Heather Huszti, Children's Hospital of Orange County (CHOC)
	Deborah De Leon, National Alliance on Mental Illness (NAMI)
Substance Use	Mark Parades, Mercy Health
	Sevin Ataie, CVS Health
Diabetes/Obesity	Guillermo Alvarez, Latino Health Access (LHA)
Housing/Homelessness	Cesar Covarrubias, Kennedy Commission
	Carrie Buck, Family Solutions Collaborative (FSC)
Care Navigation	Guillermo Alvarez, Latino Health Access (LHA)
Economic Disparities	Mario Ortega, Abrazar Inc

Special thanks to the following staff of the Orange County Health Care Agency for their assistance in producing this plan:

Regina Chinsio-Kwong, DO	County Health Officer
Almaas Shaikh, MD MPH	Public Health Services
Sharon Boles, PhD	Strategy and Special Projects
Travers Ichinose, MS, MA	Public Health Services
Jenna Sarin, MSN, RN, PHN	Public Health Services
Tiffany Kalaitzidis, MPH	Strategy and Special Projects
Richard Chhuon, MPH	Strategy and Special Projects
Samane Zarebanadkoki, PhD	Strategy and Special Projects
Kelsy Bonnet, MPH, RD	Public Health Services
Amy Castro, PhD	Public Health Services
Anna Luciano-Acenas, RDN	Public Health Services
Hieu Nguyen, LCSW, MBA	Office of Population Health and Equity
Emmi Monsour, MPH	Office of Population Health and Equity
Wesley Shain, MHA	Office of Population Health and Equity
Karin Kalk, MHA	Strategy and Special Projects
Jenny Qian, MA	Strategy and Special Projects
Michael Tadros, BA	Strategy and Special Projects
Anthony Perera, MS	Strategy and Special Projects

Orange County Profile

Home to over 3 million residents, Orange County (OC) is one of California's most densely populated counties, comprising of 34 incorporated cities, including Anaheim, Irvine, and Santa Ana. OC has one of the largest and most diverse economies in the U.S. Three industries that employ the most people in Orange County are construction, tourism, and health services. The County also leads in industries including computer storage device manufacturing, dental laboratories, the production of surgical and medical instruments, and the production of biomass electric power generation sectors. Moving forward together, Orange County plans to drive towards resilient, equitable, healthy, and sustainable communities with an economy that delivers for all communities. Located between the counties of Los Angeles and San Diego, Orange County holds 8% of the state's population within 0.5% of its land area, making it the second most densely populated county in California, behind San Francisco County. As of 2021, the population was 3,167,809, making it the third most populous county in California, the sixth most populous in the United States, and more populous than 19 American states.

Known for its dynamic communities, Orange County's population grew 5.1% from 2010 to 2021 with a diverse population that is ever-changing and adding to the community's strengths. Nowadays, the bulk of the population does not belong to any one race or ethnic group. The county's population is 37.6% White, 34.1% Hispanic or Latino, 21.9% Asian, and less than 2% Black or African American. Over 30% of community members were born outside the US and almost 46% speak a language other than English, with Spanish, Vietnamese, Chinese, Korean, and Tagalog being the five most common non- English languages spoken.

The median age in Orange County is 39.2, which is older than California's overall median age (37.6 years). More than three-quarters of the community is comprised of adults ages 18 and older (77.6%), with children under 18 representing almost 16% of the population. Overall, Orange County's population has seen a decline over the years with generally slowing population growth. The only exceptions are older age individuals, who are part of the one segment expected to see population growth from 2022 to 2060. Military veterans are important members of the Orange County community and make up 3.7% of the population, compared to 4.4% in California.

What is the Orange County Community Health Improvement Plan (OC CHIP)?

A Community Health Improvement Plan (CHIP) is a long-term strategy and systematic effort to improve the public's health based on community input and collaboration, which is informed by the results of the Community Health Assessment (CHA), a local public health assessment (see Figure 1). The CHIP defines the community's vision for health, addresses community-identified weaknesses and challenges, leverages strengths, and optimizes opportunities to improve health across all our communities, particularly among those affected by health inequities.

The CHIP guides health, government, educational, and human services agencies along with community partners to align priorities, coordinate action plans, and target resources. The 2024-2026 Orange County Community Health Improvement Plan (OC CHIP), was created through a collaboration between the Orange County Health Care Agency and a diverse set of local agency and community partners. The development of the 2024-2026 OC CHIP brought together organizations and community members through many in-person and virtual meetings to co-design actionable goals, objectives, strategies, measures, and outcomes, which establish mutual support and encourage accountability. Orange County's CHIP is updated every three years. The 2024-2026 OC CHIP planning process was launched publicly in April 2023 and published the OC CHIP in March 2024. Implementation of the 2024-2026 OC CHIP will begin in April 2024 and end in December 2026. Previous Orange County CHIPs can be located at: OC Health Improvement Plan | Orange County California - Health Care Agency (ochealthinfo.com)

Figure 1: Community Health Improvement Planning Process

Why the OC CHIP?

The OC CHIP serves primarily as a guiding document for all the implementing partners in Orange County, defining our common priorities, presenting our key strategies, and laying out how our progress and outcomes will be measured. The goal of the OC CHIP is to provide interested members of the community with access to concrete outcomes that they can anticipate by the program's conclusion, in addition to information about ongoing efforts to improve Orange County's health.

The OC CHIP will function as a framework and strategic plan for communitywide action. Because the OC CHIP is meant for the entire community, it differs from the internal or departmental strategic plans of agencies or organizations. The OC CHIP helps align the work of our diverse partners and specific plans around common priorities, supports coordinated work on these priorities, enhances collaborative relationships between partners, and sets and tracks common progress indicators. The 2024-2026 OC CHIP is designed to use existing resources wisely, consider unique local conditions and needs, assess changes required to obtain goals, reduce health disparities, and drive collective action. The Orange County Health Care Agency is committed to providing ongoing support for the OC CHIP's collective health improvement strategies and to help maximize collaborative strategies by the many community and agency partners in Orange County.

How Was the OC CHIP Planned and Timed?

The Orange County Health Care Agency began planning for the 2024-2026 Orange County Community Health Improvement Plan (OC CHIP) using the Mobilizing for Action through Planning and Partnerships (MAPP) framework at the beginning of 2022. The table below shows the OC CHIP's timeline for the completion of this plan. As shown, various MAPP recommended assessments were conducted, and findings were reviewed through a series of community meetings to help guide the OC CHIP in determining goals, objectives, and strategies to be published in the final plan. In total, The Orange County Health Care Agency engaged over 400 community health partners and 40 organizations in the development of the 2024-2026 Orange County Community Health Improvement Plan.

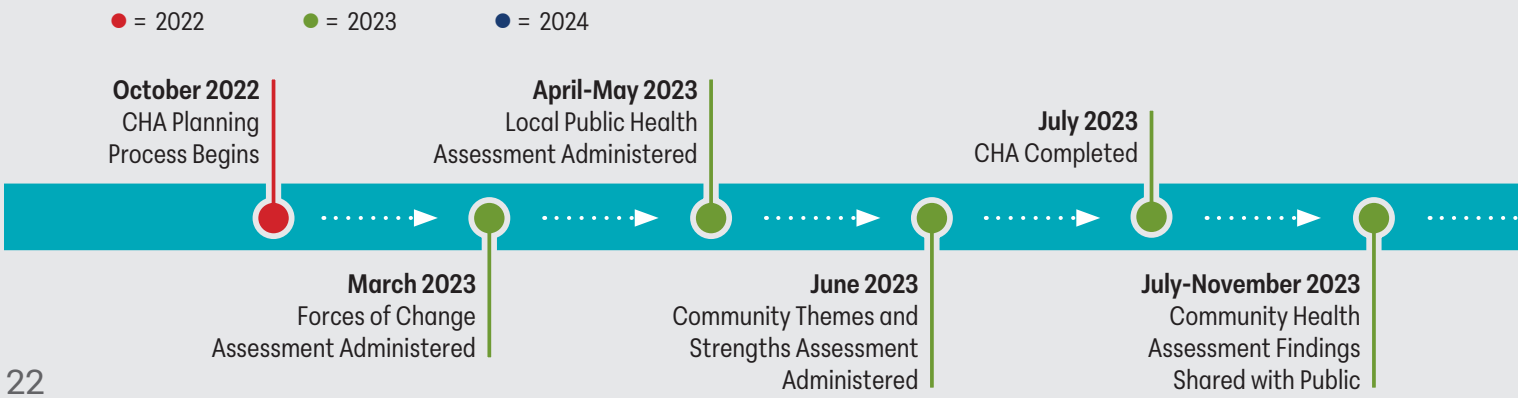
The Orange County Community Health Improvement Plan seeks to align the efforts of various parts of the public health system to improve health for all Orange County residents. MAPP was developed by the National Association of City and County Health Officials (NACCHO) and the Centers for Disease Control and Prevention (CDC) as a tool to bring together stakeholders to identify community health issues and to take action. MAPP is also among the evidence-based, community driven strategic planning models recommended by the Public Health Accreditation Board (PHAB). This framework helps communities prioritize public health issues, identify resources for addressing them, and take action to improve conditions that support healthy living.

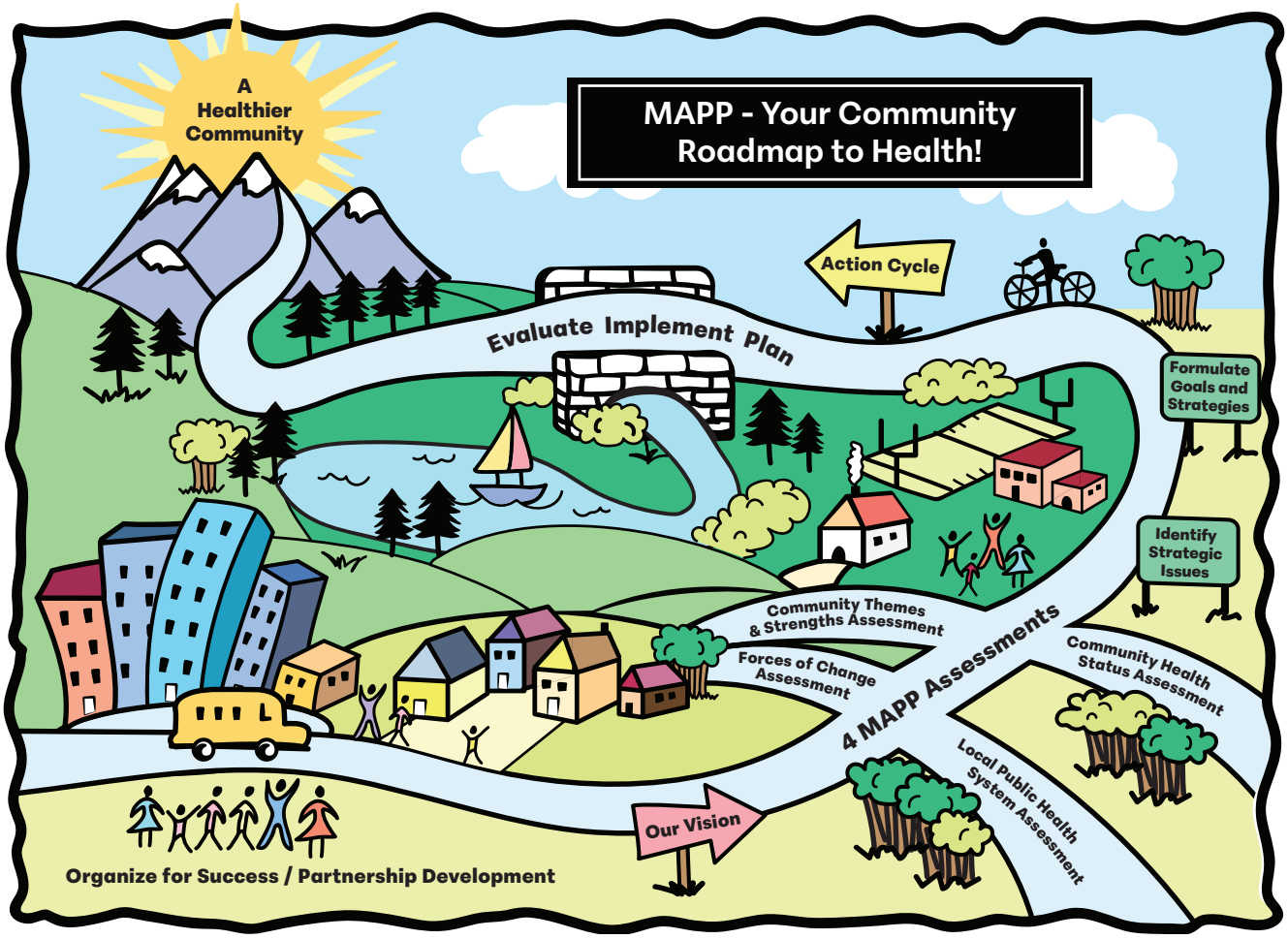
MAPP is generally led by one or more community organizations and is completed with the input and participation of many organizations and individuals who work, learn, live, and play in the community.

Key phases of MAPP include:

1) Organizing and Partnership Development
2) Visioning
3) Community Health Assessment (CHA)
4) Identifying Strategic Issues
5) Formulating Goals and Strategies
6) Acting

Orange County CHA and CHIP Timeline





MAPP brings together both qualitative and quantitative data to identify current public health and social determinants of health trends and opportunities for improvement. The MAPP model brings to bear four different assessments to get the clearest possible picture of community health issues and systems. These data include factors addressing health risk, quality of life, social determinants, disparities, mortality and morbidity, community assets, forces of change, threats and strengths of the community, and how well the public health system provides the 10 essential public health services.

September-November 2023
CHIP Priority Areas Selected

December 2023
First CHIP Workgroup Meeting Held

January 2024
Workgroups Created Priority Area Goals, Objectives and Strategies

March 2024
Synthesized Workgroup Findings and Disseminated for Public Comment

June 2024-2026
OC CHIP Published

The four MAPP assessments included in the CHA include:

Forces of Change (FoC)

Identifies forces that may affect a community and opportunities and threats associated with those forces.

1

Conduct focus groups to determine:

1. What is occurring or might occur that affects the health of our community?
2. What are the specific threats or opportunities generated by those occurrences?

Community Themes and Strengths Assessment (CTSA)

Identifies assets in the community and issues that are important to community members.

2

Consider **community focus groups** to determine:

1. What are our priorities for health?
2. What is working well in how we address health?
3. What are areas for improvement?

Local Public Health Assessment

Measures how well different local public health system partners work together to deliver the Essential Public Health Services.

3

Conduct **assessments with key public health stakeholders** to determine:

1. How responsive, accessible, and accountable is our system?
2. How well connected and coordinated is our system?
3. How data-driven and focused on best practices and quality is our system?
4. How well positioned to anticipate and respond to health impacts is our system?

Community Health Status Assessment (CHSA)

Provides quantitative data on community health conditions (i.e., data indicators).

4

Review **key health indicators with Health Improvement** Partnership to determine:

1. What does the health status of Orange County look like?
2. How healthy are our residents?

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: OC Health Improvement Plan | Orange County California - Health Care Agency (ochealthinfo.com)

How Were Indicators Chosen to Create a Baseline?

One of the first steps in bringing about change in the community is determining the extent to which the various problems and trends under evaluation were genuinely present in the first place. An important part of this process is to find out what conditions are like before the CHIP work begins, including how prevalent any problems are, how often these problems are happening, the duration and intensity of issues, and whether certain groups are more likely to be impacted by these issues. Combined with the four assessments from the MAPP, indicators from local, state, and national data were presented to the community to establish a baseline, which then will serve as the standard against which all subsequent changes after the CHIP are compared. By including baselines, we will be able to see whether our efforts are ultimately working and creating the changes we seek.

The indicators provide a general picture of health and answer the questions: "What does overall health in Orange County look like?" and "How Healthy are our residents?" The indicators used were taken from local, state, and national reports such as Healthy People 2030, the Conditions of Childrens Report, the California Health Interview Survey, and the American Community Survey. A full list of indicators utilized for the Community Health Improvement Plan can be accessed at OC Health Improvement Plan | Orange County California - Health Care Agency (ochealthinfo.com). An ad-hoc committee of researchers reviewed over 200 potential indicators selecting final indicators based on the following criteria:

1) alignment with the six priority areas identified
2) alignment with the criteria for core indicator selection
3) alignment with local, state and national reports (e.g., Healthy People 2030, Conditions of Children Report, etc.)
4) longitudinal data is available to conduct trend analyses

Orange County column: The value shows the most recent Orange County data in comparison to California and the United States (when available).

Trend column: Five or more consecutive data points in a single direction (i.e., run chart rules) are used to determine trends when there were at least 5 data points in order to determine if the data were following a positive or negative trend.

➡ is
- **Green** when Orange County is trending in a positive direction,
- **Yellow** when Orange County has not had a consistent trend,
- **Red** when Orange County is trending in the wrong direction,
- **Gray** when there are not enough data points to determine an Orange County trend.

Disparities column: Racial/ethnic, gender and geographic disparities are identified, where available. It should be noted that not all race/ethnicity data are available for all major groups, often due to low numbers (e.g., Black/African American, American Indian/Alaskan Native, Native Hawaiian/Pacific Islander) or classification issues (e.g., Middle Eastern, which is often combined with White/Caucasian).

INDICATOR	US VALUE	CA VALUE	OC VALUE	TREND	HEALTHY PEOPLE 2030 GOAL	DISPARITIES
Percent of Adults Who Smoke (CHIS)	11.7% (2021)	6.2% (2021)	7.1% (2021)	↓	6.1%	Asian: 4.4% Hispanic: 9.0% White: 6.8% Male: 10.2% Female: 3.9%

Criteria for Selection of Priorities

Given the range of information contained in the Community Health Assessment, it was essential that community stakeholders assist in setting agreed upon criteria by which community members would use these data to rate priorities across public health and social determinant of health areas. At a community meeting on August 23, 2023, community and organizational participants reviewed and proposed revisions to criteria for selection of priorities, ultimately setting the following criteria.

1

Health Impact

To what degree would action on this health issue improve overall health in Orange County?

2

Disparity

To what degree does addressing this health issue reduce health disparities within the county?

3

Trends

To what degree does addressing this health issue assist Orange County in intervening with a health indicator that is trending negatively or progressing too slowly?

4

Root Cause

To what degree does the health issue have a root cause that is modifiable at the individual, community, or institutional level?

5

Efficiency

To what degree can action on this health issue address multiple issues?

6

Economic Impact

To what degree would addressing this health issue decrease economic impact downstream?

7

Prevention

To what degree does the health issue benefit from primary prevention?

8

Early Intervention

To what degree does the health issue benefit from early intervention?

9

Collaboration

To what degree would collaborative or multi-sector approaches to address this health issue improve chances for success?

10

Under-Addressed Issue

To what degree is this health issue not addressed or is under-addressed in Orange County.

How Were the Community Priority Areas Chosen?

The CHA was used to identify the community's priorities across health conditions and social determinants of health. During this process, diverse community stakeholders reviewed the previously described local assessments to identify key health needs and issues, which were to be addressed through the Orange County Community Health Improvement Plan (OC CHIP).

Handouts summarizing the Forces of Change, Community Themes and Strengths, and Community Indicators were provided and referred to during prioritization sessions, which were structured by the selection criteria discussed previously. Subject-matter and data experts were on hand to assist in interpreting trends and populations at risk for over 100 key health indicators for Orange County. A summary of indicators that were presented as part of the Community Health Assessment are available in the Summary of Health Indicators section of this report. The most current indicators are available on: OC Health Improvement Plan | Orange County California - Health Care Agency (ochealthinfo.com).

Overall, 174 participants representing Orange County communities and organizations took part in the CHA prioritization process through in-person or virtual sessions. Consensus on topics was obtained using the Delphi scoring process, a widely accepted group-based prioritization method. Results of the process revealed the following three health conditions as priority issues for the upcoming 2024-2026 OC CHIP: Mental Health, Substance Use, and Diabetes/Obesity. Understanding that social determinants of health (such as housing, access to education, economic stability, etc.) affect a wide range of health outcomes and risks, community stakeholders also identified the following three health determinants as priority issues: Housing/Homelessness, Care Navigation, and Economic Disparities.

How Was the Orange County CHIP Developed?

Identifying OC CHIP Workgroups

An initial list of people who assisted with the previous OC CHIP activities or took part in the Community Health Assessment (CHA) process was used to determine who was invited to the OC CHIP workgroups. Organizational leads then recommended additional agencies, organizations, and community members for recruitment to the workgroups. Community members were encouraged to join the OC CHIP process and refer organizations known to be working in the priority areas.

Clarifying Goals and Objectives

Overall, 30 OC CHIP planning meetings were held over January 2024 across the Mental Health, Substance Use, Diabetes and Obesity, Housing/Homelessness, Care Navigation, and Economic Disparities workgroups to mutually create priority issue goals, objectives, strategies, measures, and outcomes. Goals, objectives, strategies, measures, and outcomes were refined by each workgroup based on the following considerations: 1) alignment to current initiatives and programs, 2) feasibility within the three-year OC CHIP, 3) availability of conveners and contributors to carry out the work, and 4) fit with best-practices and evidence-based approaches. Updated versions of priority issue goals, objectives, strategies, measures, and outcomes from workgroup discussions were vetted with participants and approved through electronic surveys. Drafts of goals, objectives, strategies, measures, and outcomes were then sent to the Steering Committee for editing, consolidation, and alignment across priority issues for inclusion in the larger OC CHIP.

The resulting priority area plans produced by the Mental Health, Substance Use, Diabetes and Obesity, Housing/Homelessness, Care Navigation, and Economic Disparities workgroups are provided in subsequent sections of this report.

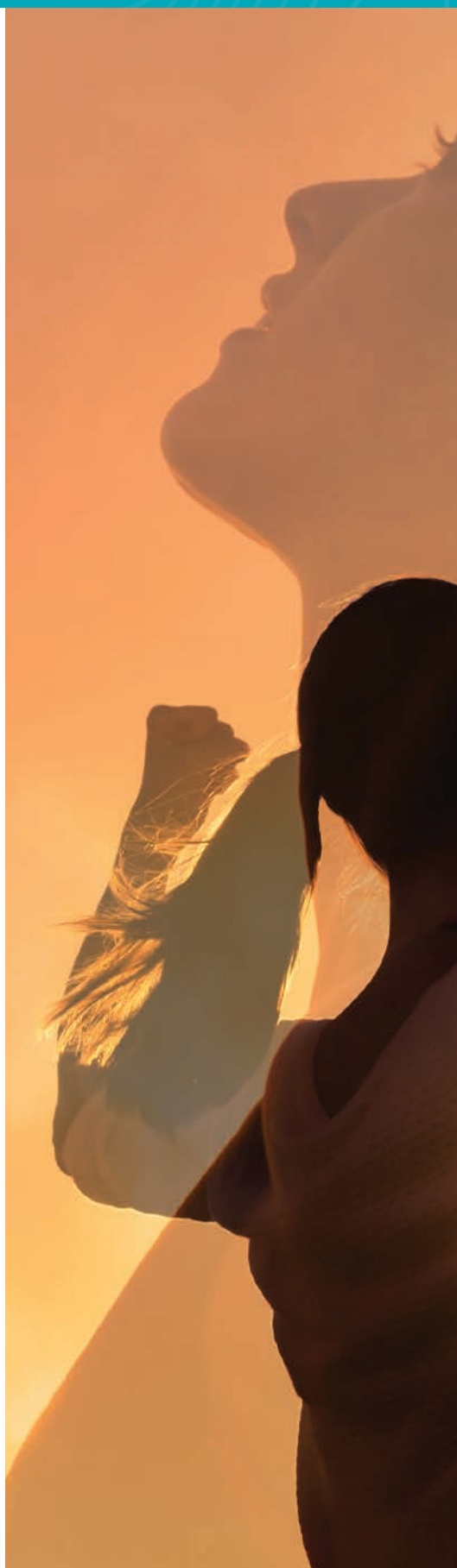
MENTAL HEALTH

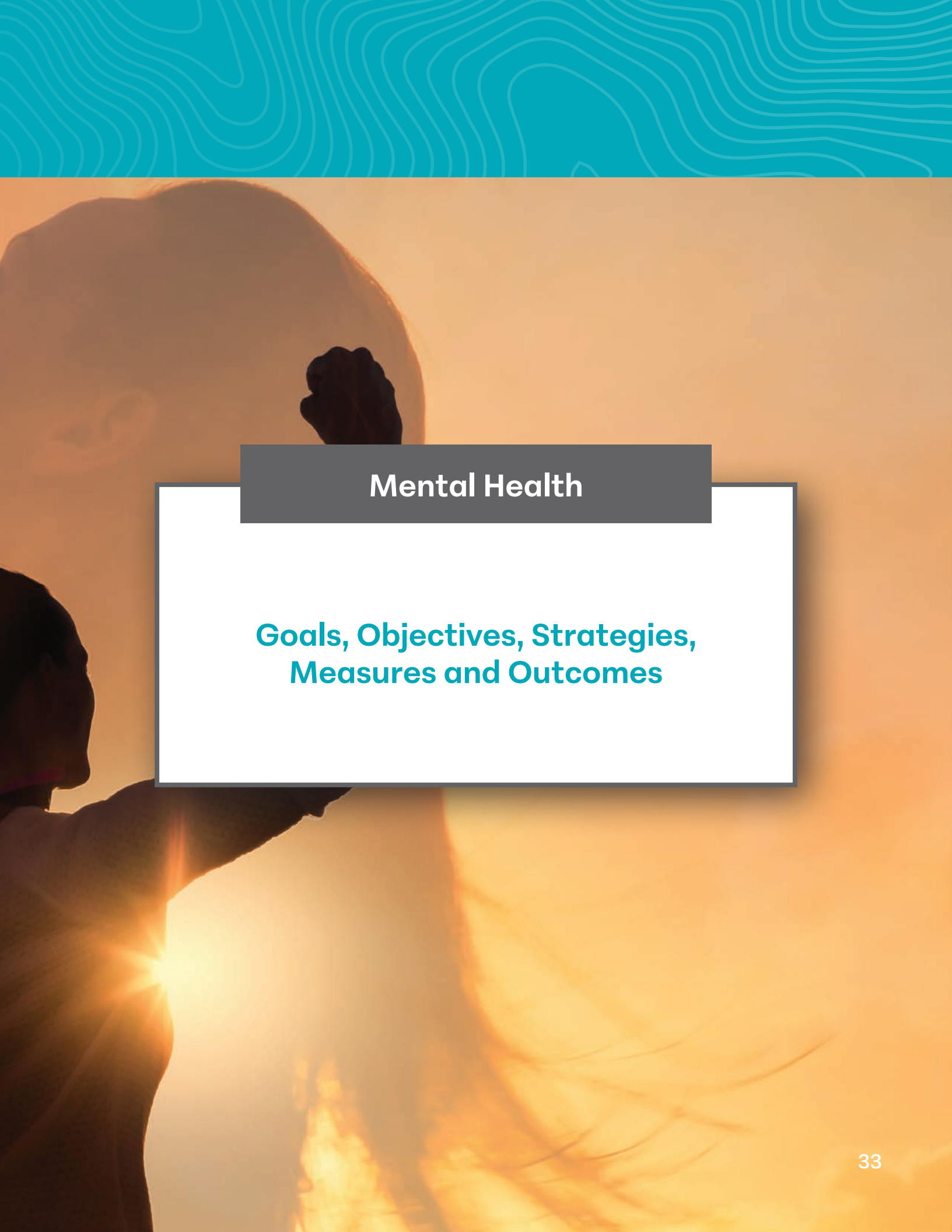
WHY IS THIS A PRIORITY ISSUE?

Nearly 1 in 2 US residents in their lifetime will develop a mental health disorder. Mental disorders can increase risk for some of the leading causes of death in the United States, such as heart disease, stroke, and diabetes. Anxiety and depression can be associated with drug misuse and smoking and can serve as barriers to healthy habits, such as eating well and exercise.

KEY FINDINGS

- According to the California Health Interview Survey, 14.6% of Orange County adults report experiencing likely serious psychological distress in the past year.
- 14.0% of Orange County 11th graders considered suicide in the past year (California Department of Education).
- Orange County teens (47.1%) were more likely than their peers statewide (36.7%) to need help with emotional or mental health problems (CHIS)





Mental Health

Goals, Objectives, Strategies, Measures and Outcomes

MENTAL HEALTH

Goal 1

Increase access to the continuum of quality public/private mental health services for all Orange County community members.

Objective 1

By December 2026, increase the number of diverse community members who are certified mental health para-professionals (including but not limited to, community health workers, peer support specialists, or wellness coaches) by 10%.

Objective 2

By December 2026, increase the number of diverse licensed and pre-licensed mental health providers from underserved/underrepresented communities (including but not limited to, social workers, marriage and family therapists, professional counselors, psychology interns, fellows, psychiatry residents) by 10%.

Strategies

1. Develop a countywide system for coordination of career pipelines, pathways, incentives, and retention for behavioral health professionals and paraprofessionals, with a particular focus on increasing representation from underrepresented communities.
2. Provide training in culturally and linguistically appropriate mental health education, services, and supports to service providers.
3. Establish shared data sets to track behavioral health professionals/paraprofessionals and to identify areas most underserved in Orange County.

Measures

1. Increase from baseline the numbers of individuals certified as behavioral health para-professionals (including but not limited to, community health workers, peer support specialists, or wellness coaches).
2. Increase from baseline the numbers of pre-licensed behavioral health providers who become licensed in the 3-year period (including but not limited to, social workers, marriage and family therapists, professional counselors, psychology interns and fellows, and psychiatry residents and fellows).

Outcomes

1. Increased numbers of diverse, qualified individuals entering behavioral health professions.
2. Increased numbers of behavioral health para/professionals able to provide prevention, early intervention, and clinical services in languages other than English.
3. OC Behavioral Health Workforce Collaborative established.

MENTAL HEALTH

Goal 2

Decrease stigma surrounding mental health issues in Orange County.

Objective 1

By December 2026, increase knowledge and awareness about mental health *conditions* in underserved/ underrepresented communities by 10%.

Objective 2

By December 2026, increase knowledge and understanding of mental health *services* in underserved/underrepresented communities by 10%.

Strategies

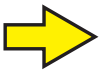
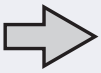
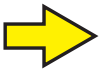
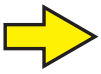
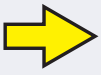
1. Promote effective communication channels to disseminate information about, and support linkages to, available mental health services, resources, and programs.
   a) Leverage existing infrastructure of the CBOs to assess knowledge, attitudes, and help seeking behaviors.
   b) Promote and advocate for CBOs to collaborate with health care and managed care organizations and other sectors, such as education and businesses to improve outreach, education, and stigma reduction.
   c) Explore sustainability and intersectionality models to support ongoing efforts (with all system partners) in providing mental health services in the community including but not limited to, outreach, education, and engagement.
2. Adopt a training curriculum that covers a wide range of topics relevant to mental health for each target demographic within our communities.

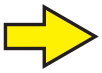
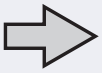
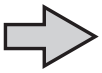
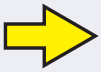
Measures

1. Develop a short baseline survey in multiple languages to increase knowledge and awareness about mental health and treatment options.
2. Increase the number of individuals from underserved/underrepresented communities who receive education or training.
3. Produce an evaluation of the effectiveness of outreach programs through feedback from participants, pre-and-post assessments and program outcomes.

Outcomes

1. Increased willingness to engage in help seeking behaviors.
2. Improved knowledge and awareness about mental health conditions.
3. Improved knowledge about how to access mental health services and supports in Orange County.

INDICATOR	US VALUE	CA VALUE	OC VALUE	TREND	HEALTHY PEOPLE 2030 GOAL	DISPARITIES
Percent of Adults <Who Report> Needing Help with Mental, Emotional, or Substance Use Problems (CHIS)	N/A	25.0% (2021)	22.0% (2021)		N/A	Asian: 15.4% Hispanic: 22.2% White: 24.1% Two or More: 41.2% Male: 17.5% Female: 24.7%
Percent of Teens <Who Report> Needing Help for Emotional/Mental Health Problems (CHIS)	N/A	36.7% (2021)	47.1% (2021)		N/A	Asian: 41.9% Hispanic: 52.5%* White: 46.0% Male: 38.3%* Female: 53.2%
Percent of Adults <Who Report> Needing and Receiving Behavioral Health Care Services (CHIS)	N/A	53.8% (2021)	47.9% (2021)		N/A	Asian: 39.3% Hispanic: 34.5% White: 58.7% Male: 47.0% Female: 48.5%
Percent of Adults <Who Report> Likely Psychological Distress During the Past Year (CHIS)	N/A	17.0%	14.6%		N/A	Asian: 15.7% Hispanic: 18.2% White: 12.1% Male: 9.9% Female: 19.4%
Percentage of Adults Reporting 14 or More Days of Poor Mental Health per Month (UWPHI)	14.0% (2020)	13.0% (2020)	13.0% (2020)		N/A	
Age-Adjusted Death Rate Due to Suicide per 100,000 (CDPH)	14.1 (2021)	10.5 (2018-2020)	9.9 (2018-2020)		12.8	

INDICATOR	US VALUE	CA VALUE	OC VALUE	TREND	HEALTHY PEOPLE 2030 GOAL	DISPARITIES
Percent of Adults Who <Report They> Thought Seriously About Committing Suicide (CHIS)	N/A	19.1% (2021)	17.0% (2021)		N/A	Asian: 13.5% Hispanic: 18.1% White: 16.4% Male: 15.4% Female: 18.6%
Percent of 11th Graders Who <Report They> Thought Seriously About Committing Suicide (CHIS)	N/A	16.0% (2017-2019)	14.0% (2019-2021)		N/A	Asian: 16.0% Hispanic: 13.0% White: 15.0% Black: 12.0%% American Indian: 7.0% Pacific Islander: 16.0% Two or More: 18.0% Other: 11.0% Male: 10.0% Female: 17.0%
Percent of Transgender 11th Graders Who <Report They> Thought Seriously About Committing Suicide (CDE)	N/A	51.0% (2017-2019)	49.0% (2019-2021)		N/A	
Ratio of Population to Mental Health Providers (UWPHI)	340:1 (2022)	236.1 (2022)	283:1 (2022)		N/A	

Note: *Statistically unstable.

FOR ADDITIONAL INFORMATION ON BEST PRACTICES

Mental Health and Mental Illness | The Community Guide

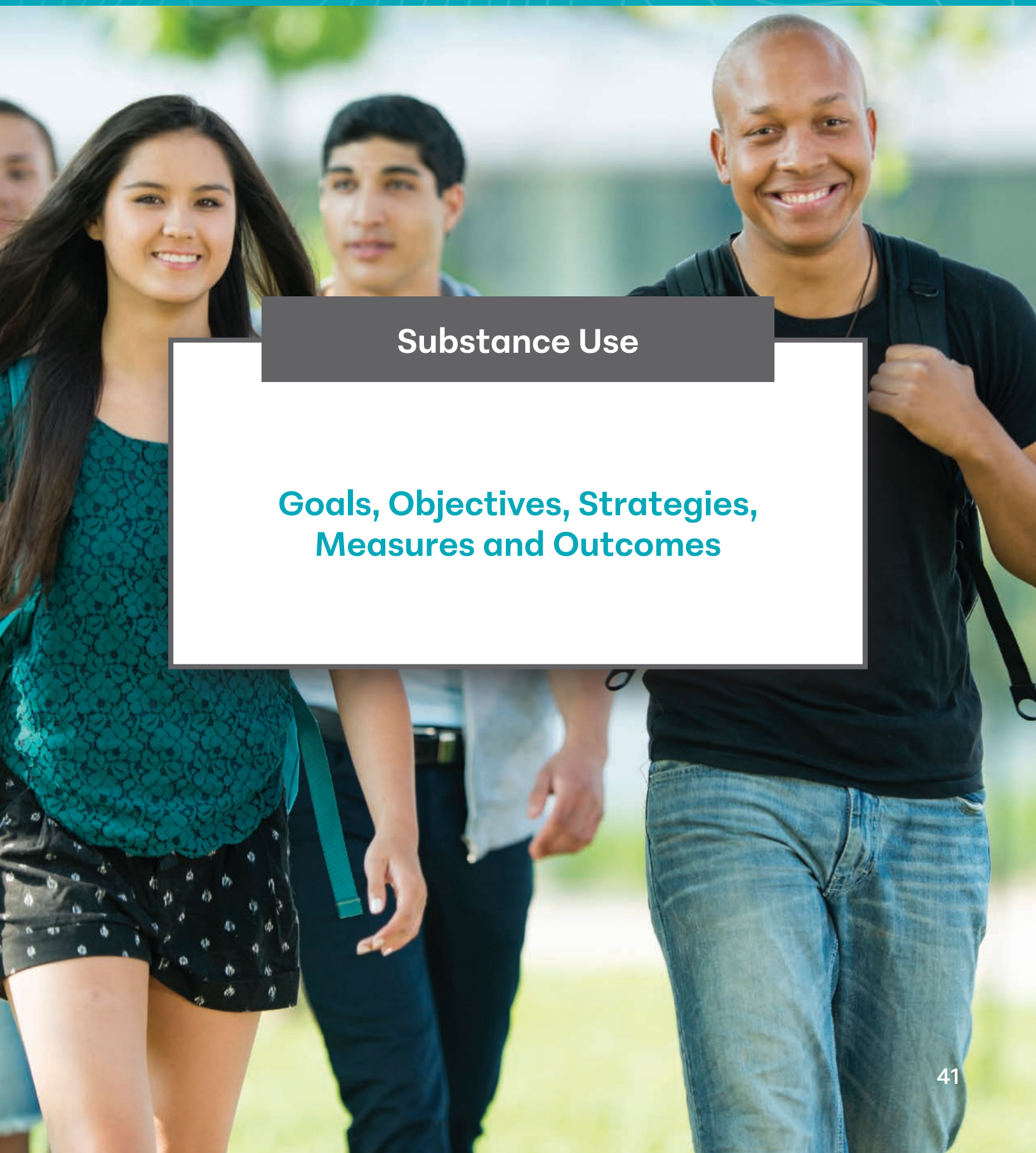
SUBSTANCE USE

WHY IS THIS A PRIORITY ISSUE?

Drug and alcohol use cause roughly 160,000 deaths annually in the United States, with increases in opioid and fentanyl related overdoses being of particular concern. Tobacco is the leading preventable cause of death and although smoking rates have decreased over the past decade, increased vaping among youth has put such public health gains at risk.

KEY FINDINGS

- According to the California Department of Education, 15.0% of Orange County 11th graders reported alcohol or drug use in the last 30 days.
- Although Orange County's drug induced death rate in 2018-2020 (15.6 per 100K) is lower than those of the State (17.8) and US (32.4) overall, there have been recent increases in this metric that are concerning.
- Areas of north and south Orange County experienced greater increases in drug and alcohol mortality rates from the 2010-2012 to 2019-2021 periods.



Substance Use

Goals, Objectives, Strategies, Measures and Outcomes

SUBSTANCE USE

Goal 1

Decrease deaths for OC residents from opioids, including illicit fentanyl.

Objective 1

By December 2026, reduce the rate of overdose deaths among youth (10-24 years of age) from illicit fentanyl by 20%.

Objective 2

By December 2026, reduce the rate of overdose deaths among adults (25-64 years of age) from illicit fentanyl by 20%.

Strategies

1	Implement community education and outreach efforts.
2	Increase accessibility to substance use disorder treatment by enhancing access points.

Measures

1	Increase the number of community events including town halls, social media with prevention messages, naloxone training and distribution.
2	Increase the reach of media campaign to reduce the stigma associated with treatment while promoting healthy behaviors.
3	Increase the number of parent/adults and youth educational workshops and prevention activities.
4	Increase the number of persons enrolled in substance use disorder treatment.

Outcomes

1	Increased public awareness and understanding of opioid and illicit fentanyl risks.
2	Enhanced protective factors among youth.
3	Increased engagement of youth in prevention efforts.
4	Increased awareness and recognition of the dangers of opioids amongst community members to aid in informed decision-making.
5	Increased utilization of treatment services.
6	Decreased stigma and improved support for those seeking help.
7	Increased community access to overdose reversal resources.
8	Increased awareness of available substance use disorder treatment resources.

SUBSTANCE USE

Goal 2

Decrease the rate of substance use/misuse for OC residents.

Objective 1

By December 2026, reduce the rate of 11th grade youth who report using alcohol in the past 30 days by 10%.

Objective 2

By December 2026, decrease self-reported Orange County 11th grade prevalence of cannabis use in the past 30 days by 10%.

Objective 3

By December 2026, decrease self-reported 11th grade vaping prevalence in Orange County by 20%.

Objective 4

By December 2026, increase the number of youth enrolled in a smoking/vaping cessation class in Orange County by 20%.

Objective 5

By December 2026, decrease the number of collisions related to impaired driving by 10%.

Objective 6

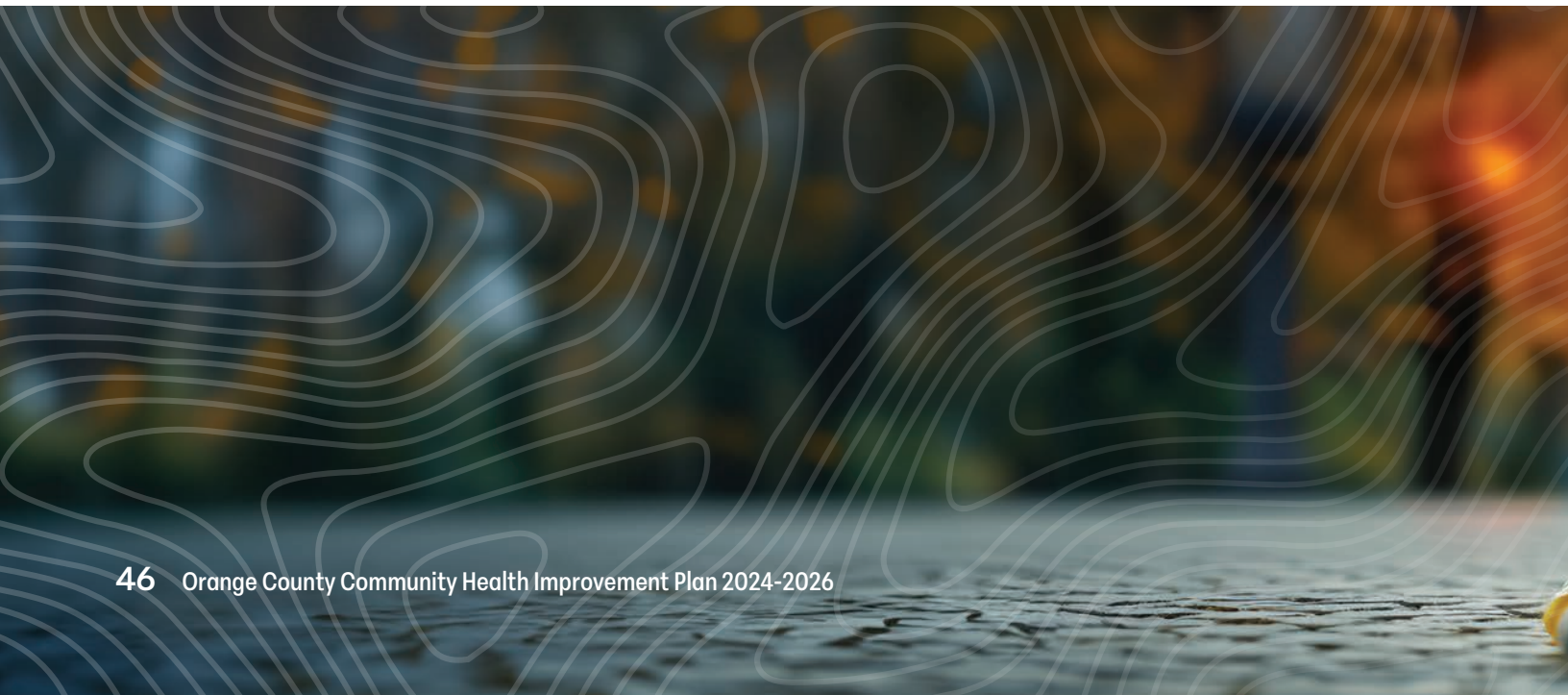
By December 2026, increase abstinence from alcohol among pregnant women by 10%.

Strategies

1	Implement social media campaigns.
2	Educate youth about the dangers and consequences of using alcohol, cannabis, and e-cigarette utilizing evidence- based, evidence-informed, and innovative practices through engagement activities, presentations, school campus events, and leadership-building projects.
3	Implement parent education and outreach interventions, such as educational workshops and community health and resource fairs.
4	Promote awareness and access to substance use disorder treatment.
5	Implement prenatal education on Fetal Alcohol Spectrum Disorders (FASD).
6	Advocate for policies and policy implemention on substance use prevention at school districts and municipalities.
7	Provide youth smoking and vaping cessation services and resources community-wide.
8	Establish an alternative-to-disciplinary action policy (diversion program) at additional schools to refer students to cessation services.
9	Implement impaired driving prevention campaigns in partnership with local law enforcement and the hospitality industry.

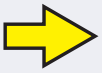
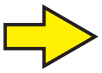
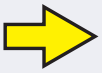
Measures

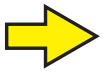
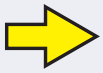
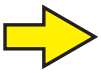
1	Increase the number of people reached by social media campaigns with prevention messages targeting youth and adults (e.g., impaired driving prevention, promoting healthy lifestyle, reducing the stigma associated with treatment, and educating).
2	Increase the number of youth educational workshops and prevention activities delivered.
3	Increase the number of parents participating in substance use prevention activities.
4	Increase the number of persons enrolled in treatment.
5	Increase the number of educational workshops on dangers of substance use during pregnancy.
6	Increase the number of educational touchpoints with decision makers on alternatives to disciplinary action.
7	Increase the number of youths enrolled in vaping cessation classes.
8	Increase the number of educational sessions on alternative action policies to schools and school districts.
9	Increase the number of persons reached by social ride share campaigns.

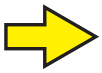
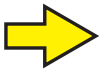


Outcomes

1	Improved awareness of substance uses related risks among OC residents.
2	Enhanced resilience, coping skills, and leadership among youth as a result of educational opportunities.
3	Improved parental skills to engage with their youth.
4	Increased policies and policy implementation to reduce youth substance use through supportive home and school environments.
5	Reduce the incidence of Fetal Alcohol Spectrum Disorders (FASD).
6	Improved access to treatment for substance use.
7	Decreased stigma and increased support for treatment.
8	Increased youth awareness and knowledge of risks of vaping.
9	Improved youth cessation rates of smoking and vaping.
10	Decreased collisions associated with impaired driving.
11	Increased awareness of available substance use disorder treatment resources.
12	Increased number of policies implemented to reduce substance use through substance use prevention at school districts and municipalities.
13	Increased number of alternatives to disciplinary action policies at schools or school districts.

INDICATOR	US VALUE	CA VALUE	OC VALUE	TREND	HEALTHY PEOPLE 2030 GOAL	DISPARITIES
Percent of Adults Who <Report Current> Smoking (CHIS)	11.7% (2021)	6.2% (2021)	7.1% (2021)		6.1%	Asian: 4.4% Hispanic: 9.0% White: 6.8% Male: 10.2% Female: 3.9%
Percent of Adults Who <Report> Binge Drinking (UWPHI)	19.0% (2020)	18.0% (2020)	17.0% (2020)		N/A	
Percent of 7th Graders Who <Report Currently Using> Alcohol or Drugs (CDE)	N/A	15.0% (2019-2021)	4.0% (2019-2021)		N/A	Asian: 2.0% Hispanic: 5.0% White: 2.0% Black: 4.0% American Indian: 2.0% Pacific Islander: 5.0% Two or More: 3.0% Other: 4.0% Male: 3.0% Female: 5.0%
Percent of 9th Graders Who <Report Currently Using> Alcohol or Drugs (CDE)	N/A	15.0% (2019-2021)	8.0% (2019-2021)		N/A	Asian: 3.0% Hispanic: 9.0% White: 8.0% Black: 5.0% American Indian: 4.0% Pacific Islander: 13.0% Two or More: 8.0% Other: 6.0% Male: 7.0% Female: 8.0%

INDICATOR	US VALUE	CA VALUE	OC VALUE	TREND	HEALTHY PEOPLE 2030 GOAL	DISPARITIES
Percent of 11th Graders Who <Report Currently Using> Alcohol or Drugs (CDE)	N/A	23.0% (2019-2021)	15.0% (2019-2021)		N/A	Asian: 6.0% Hispanic: 14.0% White: 21.0% Black: 17.0% American Indian: 14.0% Pacific Islander: 16.0% Two or More: 17.0% Other: 16.0% Male: 13.0% Female: 16.0%
Percent of 7th Graders Who <Report Currently Using> E-Cigarettes (CDE)	13.1%	2.0% (2019-2021)	2.0% (2019-2021)		10.5%	Asian: 0.0% Hispanic: 3.0% White: 1.0% Black: 2.0% American Indian: 3.0% Pacific Islander: 1.0% Two or More: 2.0% Other: 3.0% Male: 2.0% Female: 3.0%
Percent of 9th Graders Who <Report Currently Using> E-Cigarettes (CDE)	13.1%	6.0% (2019-2021)	4.0% (2019-2021)		10.5%	Asian: 1.0% Hispanic: 5.0% White: 4.0% Black: 3.0% American Indian: 2.0% Pacific Islander: 6.0% Two or More: 4.0% Other: 5.0% Male: 4.0% Female: 5.0%

INDICATOR	US VALUE	CA VALUE	OC VALUE	TREND	HEALTHY PEOPLE 2030 GOAL	DISPARITIES
Percent of 11th Graders Who <Report Currently Using> E-Cigarettes (CDE)	13.1%	10.0% (2019-2021)	7.0% (2019-2021)		10.5%	Asian: 3.0% Hispanic: 6.0% White: 10.0% Black: 10.0% American Indian: 9.0% Pacific Islander: 11.0% Two or More: 9.0% Other: 6.0% Male: 6.0% Female: 8.0%
Age-Adjusted Opioid Prescription Rates per 1,000 (CDPH COSD)	N/A	321.7 (2021)	287.4 (2021)		N/A	
Age-Adjusted Emergency Department Visit Rates Due to All Drug Overdoses (CDPH)	N/A	148.2	119.1 (2021)		N/A	Hispanic: 98.1 White: 185.1 Black: 239.7 Pacific Islander: 42.9 Hawaiian/Alaskan: 130.4
Age-Adjusted Drug Induced Death Rate per 100,000 (CDPH)	32.4 (2021)	17.84 (2021)	15.6 (2021)		20.7	

FOR ADDITIONAL INFORMATION ON BEST PRACTICES

Substance Use | The Community Guide


DRUG
FREE
ZONE

DIABETES AND OBESITY

WHY IS THIS A PRIORITY ISSUE?

Obesity increases the risk for many diseases and health conditions, including heart disease, Type 2 diabetes, cancer, hypertension, stroke, liver and gallbladder disease, respiratory problems, and arthritis. Obesity is the second leading preventable cause of death in the United States and Healthy People 2030 has established obesity among children and adolescents as a Leading Health Indicator. The main factor for the more than 30 million cases of diabetes that occur in the US each year is obesity, coupled with related poor diet and physical inactivity. Poorly controlled diabetes can lead to a range of complications, such as amputations, vision loss, and kidney damage.

KEY FINDINGS

- According to the California Health Interview Survey, 24.2% of adults in Orange County are obese.
- Orange County's death rate due to diabetes was 14.9 per 100,000 residents, which was higher than the Healthy People 2030 target of 13.7 per 100,000.
- Both diabetes and obesity are more prevalent in parts of north and central Orange County, suggesting important county disparities in these key public health challenges.

Diabetes and Obesity

Goals, Objectives, Strategies, Measures and Outcomes

DIABETES AND OBESITY

Goal 1

Increase the proportion of community members who are at a healthy weight.

Objective 1

By December 2026, increase the proportion of socioeconomically at-risk children and adolescents who are in a healthy weight by 10%.

Objective 2

By December 2026, decrease the proportion of socioeconomically at-risk adults who are obese by 10%.

Strategies

1	Implement family-based Interventions that combine activities with health education to increase physical activity.
2	Implement gardening Interventions in early care, education, school, afterschool, and/or community settings, with parent nutrition education supports, focused on increasing vegetable consumption in children.
3	Implement interventions to increase active travel to schools/parks.
4	Implement multicomponent interventions including policy, systems, and environmental change approaches, to increase healthy foods and beverages in schools and neighborhoods.
5	Implement social support and social network interventions in community settings to promote physical activity, healthy eating, and related policies.
6	Implement Worksite Programs, including informational, educational, behavioral and social strategies, along with policy and environmental approaches, to improve health-related behaviors and health outcomes.
7	Implement healthy and culturally sensitive home-delivered and congregate meal services for older adults tailored to independence levels and group setting.
8	Promote, build, or improve on areas encouraging safe physical activity, such as fitness centers, walking trails, while also increasing access to already existing amenities.

Measures

1	Increased number of participants attending family-based physical activity classes.
2	Increased number of community gardens in neighborhoods and schools with socioeconomic risk.
3	Increased number of schools in areas with socioeconomic risk engaging in active travel to school/park interventions.
4	Increased number of multicomponent interventions delivered to schools in areas with socioeconomic risk.
5	Increased number of participants in social support physical activity interventions in areas with socioeconomic risk.
6	Increased number of worksite fitness and/or nutrition programs or classes offered in areas with socioeconomic risk.
7	Increased home-delivered meals and congregate meals served in areas with socioeconomic risk.
8	Increased number of places for physical activity in areas with socioeconomic risk.

Outcomes

1	Increased proportion of children and adolescents in areas with socioeconomic risk who do the recommended amount of physical activity.
2	Increased vegetable consumption amongst children in areas with socioeconomic risk.
3	Increased proportion of children in areas with socioeconomic risk who walk or bike to school regularly.
4	Increased consumption of healthy food amongst children and adolescents at target schools and community sites.
5	Increased proportion of adults in areas with socioeconomic risk who do the recommended amount of physical activity.
6	Increased consumption of healthy food amongst older adults in areas with socioeconomic risk.

DIABETES AND OBESITY

Goal 2

Reverse the trend of increasing rates of diabetes.

Objective 1

By December 2026, hold Orange County adult diabetes prevalence under statewide rate (currently 10.5%).

Strategies

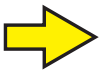
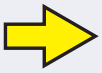
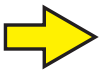
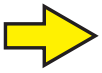
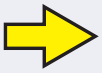
1	Implement combined diet and physical activity promotion programs to screen and prevent type 2 diabetes among people at increased risk, including but not limited to the use of trained providers, counseling, coaching, extended support systems, or multiple sessions.
2	Further engage community health workers for diabetes prevention or self-management, including patient education, coaching, and social support to improve diabetes testing and monitoring, medication adherence, diet, physical activity, or weight management.
3	Implement lifestyle interventions such as supervised exercise, diet and education counseling, physical activity education and counseling, or diet activity (e.g., meal plan, food diary, individualized support) to reduce the risk of gestational diabetes.
4	Implement park, trail, and greenway infrastructure interventions, in combination with strategic supports, to increase physical activity, relaxation, social interaction, and enjoyment.

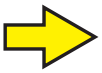
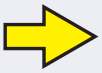
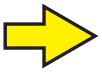
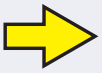
Measures

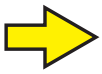
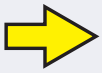
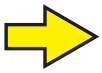
1	Increased participation of those with pre-diabetes in combined nutrition and physical activity programs.
2	Increased number of Community Health Workers certified for diabetes self-management and/or prevention.
3	Increased number of lifestyle intervention courses targeted towards pregnancies at high-risk for gestational diabetes.
4	Increased number of parks, trails, or greenways in areas with socioeconomic risk.

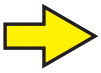
Outcomes

1	Increased proportion of people at high risk for diabetes who engage in recommended nutrition and physical activity practices.
2	Increased proportion of those with diabetes who have engaged in recommended disease self-management.
3	Decreased gestational diabetes amongst high-risk pregnancies.
4	Increased proportion of adults who reach recommended amount of physical activity.

INDICATOR	US VALUE	CA VALUE	OC VALUE	TREND	HEALTHY PEOPLE 2030 GOAL	DISPARITIES
Percent of Adults <Who Report Having> Diabetes (CHIS)	N/A	10.8% (2021)	8.4% (2021)		N/A	Asian: 8.3% Hispanic: 10.4% White: 7.2% Male: 9.8% Female: 7.0%
Age-Adjusted Hospitalization Due to Uncontrolled Diabetes per 10,000 (HCAI)	N/A	25.0 (2021)	24.6 (2021)		N/A	
Age-Adjusted Preventable Hospitalizations Due to Long-Term, Diabetes Complications (HCAI)	N/A	93.0 (2021)	88.9 (2021)		N/A	
Percent of Births Where Mother Had Diabetes (CDC)	N/A	9.5% (2021)	11.0% (2021)		N/A	Asian: 12.0% White: 7.8% Black: 2.8% Native Hawaiian/ Pacific Islander: 6.6% Multiracial: 6.4%
Age-Adjusted Death Rate Due to Diabetes per 100,000 (CDPH)	15.2 (2010-2015)	22.3 (2018-2020)	14.9 (2018-2020)		13.7	
Percent of Adults Who <Report as> Obese (CHIS)	41.8% (2021)	28.2% (2021)	24.2% (2021)		36.0%	Asian: 6.2% Hispanic: 33.6% White: 25.4% Male: 23.5% Female: 24.9%

INDICATOR	US VALUE	CA VALUE	OC VALUE	TREND	HEALTHY PEOPLE 2030 GOAL	DISPARITIES
Percent of Adults Who <Report as> Overweight or Obese (CHIS)	N/A	62.0% (2021)	58.1% (2021)		N/A	Asian: 34.9% Hispanic: 70.2% White: 59.3% Male: 63.5% Female: 52.7%
Percent of Adults 18+ Who Reported Being Physically Inactive (UWPHI)	22.0% (2020)	21.0% (2020)	21.0% (2020)		N/A	
Percent of 5th Graders Who Are Overweight or Obese (CDE)	N/A	41.3% (2019)	36.6% (2019)		N/A	Asian: 24.6% Hispanic: 48.5% White: 22.7% Black: 30.8% American Indian/ Alaskan: 31.7% Filipino: 28.7% Hawaiian/ Pacific Islander: 44.5% Two or More: 27.5% Male: 41.8% Female: 31.1%
Percent of 7th Graders Who Are Overweight or Obese (CDE)	N/A	40.0% (2019)	34.9% (2019)		N/A	Asian: 20.7% Hispanic: 46.1% White: 28.7% Black: 45.2% American Indian/ Alaskan: 44.7% Filipino: 26.6% Hawaiian/ Pacific Islander: 53.5% Two or More: 29.0% Male: 37.6% Female: 32.0%

INDICATOR	US VALUE	CA VALUE	OC VALUE	TREND	HEALTHY PEOPLE 2030 GOAL	DISPARITIES
Percent of 9th Graders Who Are Overweight or Obese (CDE)	N/A	37.8% (2019)	31.4% (2019)		N/A	Asian: 17.7% Hispanic: 42.4% White: 26.0% Black: 42.7% American Indian/ Alaskan: 25.0% Filipino: 26.6% Hawaiian/ Pacific Islander: 54.0% Two or More: 23.0% Male: 33.9% Female: 28.7%
Percent of 5th Graders Meeting All Fitness Standards (CDE)		23.1% (2019)	28.5% (2019)			Asian: 35.5% Hispanic: 18.2% White: 42.9% Black: 30.0% American Indian/ Alaskan: 25.8% Filipino: 35.9% Hawaiian/ Pacific Islander: 30.7% Two or More: 38.8% Male: 26.8% Female: 30.4%
Percent of 7th Graders Meeting All Fitness Standards (CDE)		28.2% (2019)	34.8% (2019)			Asian: 47.5% Hispanic: 23.7% White: 41.6% Black: 23.1% American Indian/ Alaskan: 30.9% Filipino: 45.3% Hawaiian/ Pacific Islander: 24.7% Two or More: 40.6% Male: 32.9% Female: 36.9%

INDICATOR	US VALUE	CA VALUE	OC VALUE	TREND	HEALTHY PEOPLE 2030 GOAL	DISPARITIES
Percent of 9th Graders Meeting All Fitness Standards (CDE)	23.2% (2019)	33.0% (2019)	42.2% (2019)		30.6%	Asian: 55.8% Hispanic: 31.4% White: 47.5% Black: 25.8% American Indian/ Alaskan: 48.8% Filipino: 48.7% Hawaiian/ Pacific Islander: 29.8% Two or More: 52.0% Male: 41.6% Female: 42.9%

FOR ADDITIONAL INFORMATION ON BEST PRACTICES

Diabetes Prevention and Control | The Community Guide
Obesity Prevention and Control | The Community Guide
Promoting Good Nutrition | The Community Guide
Increasing Physical Activity | The Community Guide
White-House-National-Strategy-on-Hunger-Nutrition-and-Health-FINAL.pdf (whitehouse.gov)

HOUSING AND HOMELESSNESS

WHY IS THIS A PRIORITY ISSUE?

Both homelessness and unstable housing are part of the framework of the social drivers of health described by Healthy People 2030 as those conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. As part of the neighborhood and built environment domain within the social determinants of health, homelessness, and unstable housing have a detrimental impact on one's physical and mental well-being and can significantly impact long-term health outcomes. Neighborhood and environmental conditions, including overcrowding, can contribute to the spread of infectious diseases and increase the risk of contracting infections such as COVID-19 or tuberculosis. Additional environmental and neighborhood issues, such as limited access to food and care, can also exacerbate several health conditions including asthma, depression, substance use, diabetes, hypertension, and heart disease. Individuals who are struggling to maintain housing, at risk of losing housing, or experiencing homelessness are part of the most vulnerable members of the county and require a collaborative, evidence-based, compassionate approach to address the complexities of the issue.

For the OC CHIP, the community workgroup convened to discuss the complexities of the unstable housing and homelessness issue while recognizing the complex needs and magnitude of the priority area. Given the magnitude and complexity of the topic, a broader engagement with stakeholders, ensuring all involved find a seat at the table for discussion, was identified as a priority. Specifically, a better understanding of existing resources addressing unstable housing and homelessness in Orange County while also thoroughly understanding ongoing challenges and existing gaps needed to be a critical starting point for any path forward. With that established foundation, the group can then aim to formulate goals and strategies that are both impactful and sustainable. By engaging additional stakeholders, we aim to harness combined efforts alongside existing groups, ensuring that the mission to address the significant challenges faced by the most vulnerable members of Orange County aligns with their specific needs.

Housing and Homelessness

KEY FINDINGS

Housing:

- 33% of Orange County Families are below Real Cost Measure and struggle to maintain or obtain housing. (United Ways of California; The Real Cost Measure 2023)*
- In 2022, the County of Orange identified the need to build 2,396 additional supportive housing units to impact homelessness.

Homelessness:

- In the fall of 2022, the Commission to End Homelessness directed the Office of Care Coordination to conduct a complementary services survey of 20% of the unsheltered homeless population to identify service gaps in the County's homeless system of care. The survey found that chronic homelessness and disabling conditions are increasing.

- Final survey findings from the recent Orange County Point in Time Count of 2024 are expected in April 2024.

Goal:

Broaden the Housing and Homelessness workgroup by incorporating members from various organizations involved in housing and homelessness initiatives throughout Orange County to work toward meaningful and sustainable solutions.**

*The Real Cost Measure was created by United way to factor in the costs of housing, food, health care, child care, transportation and other basic needs to reveal what it really costs to live in California.

**This group includes but is not limited to representatives from the Commission to End Homelessness, Continuum of Care, North OC Taskforce, and Orange County Housing Finance Trust, among others.

CARE NAVIGATION

WHY IS THIS A PRIORITY ISSUE?

Patients may experience significant issues accessing health care, including lack of transportation, cultural and language barriers, mistrust of the health care system, explicit and implicit biases in health care, financial barriers, and the digital divide. As a result, these patients face an increased risk of poor health outcomes, unnecessary disability, premature death, and health disparities. Patient care navigation can help address racial/ethnic disparities in health care access, access to clinical preventive services, disease screening, and treatment disparities.

KEY FINDINGS

- According to the California Health Interview Survey, 87.2% of interviewed Orange County residents had a usual source of care, which was higher than that observed nationally (76.0%) and higher than the Healthy People 2030 goal.
- Approximately 16.6% of Orange County adults reported delaying or having difficulty obtaining care, which was significantly higher than the Healthy People 2030 goal (5.9%).
- Among Orange County adults, 12.3% reported having difficulty finding specialty care.

Care Navigation

Goals, Objectives, Strategies, Measures and Outcomes

CARE NAVIGATION

Goal 1

Improve access to the health care systems in a manner that is culturally and linguistically appropriate and accessible.

Objective 1

By December 2026, increase the number of persons engaging with culturally, linguistically, and readily available appropriate health education or care navigation by 10%.

Objective 2

By December 2026, increase resource sharing and collaborative agreements amongst organizations with the community, including, but not limited to, CBOs, clinics, and systems of care by 10%.

Objective 3

By December 2026, increase the number of persons enrolled in Medi-Cal by 10% (emphasizing the expansion/redetermination age group among 26-to 49-year-olds).

Strategies

1	Promote the administration of individual holistic assessments that evaluate barriers to accessing care.
2	Creation of or collaboration with community sites to engage in conversations to discuss care navigation issues such as Medi-Cal expansion.
3	Support community health workers to continue to provide preventive health services and warm handoffs and reduce barriers to access to care.
4	Promote existing centralized resources directory to aid in appropriate and successful health care referrals, including but not limited to Medi-Cal.
5	Implement data sharing consent forms and waivers between agencies for closed-loop referrals and warm hand-offs (as is legally feasible)..
6	Hold outreach and engagement events including, but not limited to, education workshops (about Medi-Cal myths and eligibility, and FAQs), enrollment events, or campaigns to reduce access to care issues.

Measures

1. Increase the number of organizations promoting a care navigation assessment.
2. Increase the number of community sites and attendees that discuss Medi-Cal expansion and care navigation issues.
3. Increase the number of community health workers.
4. Increase the number of persons who engage with community health workers.
5. Increase the number of community organizations and service providers that promote the use of the centralized resource directory.
6. Increase the number of agencies participating in data sharing consent form or waivers for care navigation (as is legally feasible).
7. Increase the number of persons that engage in care navigation outreach and engagement events.

Outcomes

1. Increased understanding of needs, barriers, and gaps related to access of health-care.
2. Increased knowledge of Medi-Cal expansion and care navigation resources among persons engaging in care navigation resources discussions.
3. Increased number of persons with successful referrals to Medi-Cal.
4. Increased number of persons with successful referrals to care.
5. Increase number of persons referred using resource directory.
6. Increased number of clients with shared data for closed-loop referrals.
7. Increased number of persons that enroll in Medi-Cal during or after engagement events.

CARE NAVIGATION

Goal 2

Improve knowledge of common health conditions and the health care system to promote informed health decisions through best practice care navigation.

Objective 1

By December 2026, increase the number of community members by 10% who understand common health conditions, how they are detected, and how they should be managed through best practice care navigation.

Objective 2

By December 2026, increase the number of lasting partnerships/relationships by 10% within the community that support health education related to the early detection and management of common health conditions through best practice care navigation.

Strategies

1	Promote ongoing relationships with key care navigation partners.
2	Promote a needs assessment to identify the gaps and barriers in health knowledge and resources related to care navigation.
3	Conduct education workshops and media campaigns about common health conditions and how they may be addressed through best practice care navigation.

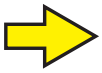
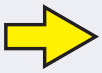
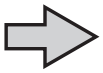
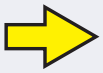
Measures

1	Increase the number of key care navigation partners.
2	Increase the number of participants in care navigation needs assessment.
3	Increase the number of care navigation workshops and/or participants.
4	Increase the number of people that engage with care navigation media campaign.

Outcomes

1. Improved relationships amongst key partner to address best practice care navigation.
2. Improved understanding of care navigation needs and gaps.
3. Improved awareness and knowledge of common health conditions and their best practice care navigation.

INDICATOR	US VALUE	CA VALUE	OC VALUE	TREND	HEALTHY PEOPLE 2030 GOAL	DISPARITIES
Percent of Adults <Who Report Having> Health Insurance (ACS).	87.8% (2021)	90.1% (2021)	90.4% (2021)	↑	92.4%	Asian: 94.1% Hispanic: 82.3% White: 93.9% Black: 90.4% American Indian/ Alaskan: 80.4% Native Hawaiian/ Pacific Islander: 89.6% Two or More: 86.2% Other: 79.9%
Percent of Children <Reported with> Health Insurance (ACS)	94.6% (2021)	96.5% (2021)	96.4% (2021)	→	N/A	Geographic
Percent of Adults 65+ <Who Report Having> Health Insurance (ACS)	99.2% (2021)	98.9% (2021)	99.0% (2021)	↑	N/A	
Percent of People <Who Report Having> a Usual Source of Care (CHIS)	76.0% (2021)	86.0% (2021)	82.7% (2021)	→	84.0%	Asian: 84.7% Hispanic: 74.1% White: 88.1% Male: 78.6% Female: 86.8%
Percent of People Who <Reported They> Delayed or Had Difficulty Obtaining Care (CHIS)	17.6% (2021)	19.9% (2021)	16.6% (2021)	→	5.9%	Asian: 10.7% Hispanic: 14.2% White: 21.6% Male: 15.1% Female: 18.1%
Percent of Adults Who <Report They> Had a Routine Check-Up in the Past 12 Months (CHIS)	N/A	60.2% (2021)	64.3% (2021	→	N/A	Asian: 66.4% Hispanic: 59.1% White: 67.7% Male: 57.8% Female: 70.9%

INDICATOR	US VALUE	CA VALUE	OC VALUE	TREND	HEALTHY PEOPLE 2030 GOAL	DISPARITIES
Percent of People Who <Report They> Had Difficulty Finding Primary Care (CHIS)	N/A	8.3% (2022)	13.6% (2022)		N/A	Asian: 12.3% Hispanic: 17.0% White: 10.6% Two or More: 14.6%* Male: 12.2% Female: 14.8%
Percent of People Who <Report They> Had Difficulty Finding Specialty Care (CHIS))	N/A	16.8% (2021)	12.3% (2021)		N/A	Asian: 9.5% White: 12.8% Male: 13.3% Female: 11.4%
Percent of Adults Who <Report They> Avoided Government Benefits Due to Concern Over Self or Family Member Disqualification from Green Card or Citizenship (CHIS)	N/A	18.8%	21.9% (2021)		N/A	Asian: 10.0% Hispanic: 36.2% White: 14.2%* Black: 0.0%* Male:15.5% Female: 28.8%
Ratio of Population to Health Care Providers (UWPHI)	1310:1 (2020	1234:1 (2020)	955:1 (2020)		N/A	

Note: *Statistically unstable.

FOR ADDITIONAL INFORMATION ON BEST PRACTICES

Patient Navigation | CDC
Patient Navigation | STEPS to Care | Treat | Effective Interventions | HIV/AIDS | CDC

ECONOMIC DISPARITIES

WHY IS THIS A PRIORITY ISSUE?

Those with fewer economic resources are more likely to be undereducated, live in poor housing conditions, have more dangerous and strenuous jobs, lack health insurance and a regular source of care, and live in unsafe neighborhoods. Such cumulative burdens make those who are economically challenged more likely to suffer from a range of diseases, suffer more severe forms of disease, and ultimately live shorter lives. Income inequality has been rising in the United States and is at the root of many important racial/ethnic disparities. For this reason, Per Capita Income is included in the Healthy People 2030 report.

KEY FINDINGS

- In Orange County, per capita income is substantially lower among Black ($41,000), (AIAN) ($28,000), Latino ($27,337), and Asian Americans ($46,000) than Whites ($62,000).

- In Orange County, approximately 13.1% of Blacks, 12.8% of AIAN's, 11.6% of Latinos, and 11.5% of Asian Americans live in poverty compared to 7.2% of non-Hispanic Whites.

- There are substantial socioeconomic disparities among Orange County communities across a range of indicators. Communities in the north and central parts of Orange County have been shown to have greater economic challenges through several Social Determinants of Health indices, such as the California Healthy Places Index.

Economic Disparities

Goals, Objectives, Strategies, Measures and Outcomes

ECONOMIC DISPARITIES

Goal 1

Increase opportunities for people in Orange County impacted by economic disparities.

Objective 1

By December 2026, increase enrollment levels in financial empowerment* programs by 10% among people impacted by economic disparities.

[*Financial empowerment includes a range of complementary activities, including but not limited to, financial coaching, credit score awareness and education; home buying, apartment rental, and tenant rights; budgeting; older adult financial wellness; and accessing public services.]

Objective 2

By December 2026, increase enrollment levels in training and skill development opportunities^ by 10% among people impacted by economic disparities.

[^Training and skill development includes a range of activities, including but not limited to vocational training; healthcare and public health training; skills development courses; STEM and emerging technology training; paid internships and apprenticeships.]

Objective 3

By December 2026, increase enrollment levels in free, or low cost, childcare programs by 10%.

Strategies

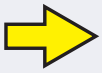
1	Inventory and assess existing Orange County programs focusing on financial empowerment, training and skill development, and childcare services.
2	Create or support existing multi-system social determinants of health collaborative to facilitate cross-sector training, awareness and relationship building among traditional public health, clinical, community, and social determinants partners, including those among financial empowerment, training and skill development, and childcare providers in Orange County.
3	Promote screening and assessment of individuals with economic hardship.
4	Support and advocate integration of coordinated, closed loop, warm handoff referrals of Orange County residents with economic disparities to financial empowerment, training and skill development, and childcare services by Orange County programs.
5	Build capacity and expand infrastructure of organizations serving communities with economic disparities that are providing financial empowerment, training and skill development, and childcare services.
6	Implement a coordinated campaign to educate and build awareness of resources and opportunities in the community related to financial empowerment, training and skill development, and childcare services.
7	Advocate for and promote pathways and investments for training and skills building, including but not limited to vocational, healthcare, public health, STEM, and emerging technology.
8	Advocate for paid internships and apprenticeships at County agencies, community organizations, and businesses with links to employment.
9	Advocate for universal basic income for families.
10	Advocate for intergenerational programs and childcare at senior centers.
11	Advocate for expansion of community program for certified childcare providers in partnership with community colleges.
12	Advocate to expand opportunities for residents to become childcare certified providers.

Measures

1	Increase the number of partners participating in a social determinants of health collaborative.
2	Assessment is performed of Orange County programs on financial empowerment, training and skills development, and childcare and related disparities.
3	Increase the number of providers screening for economic hardship.
4	Increase the number of Orange County programs referring clients in a closed loop manner to financial empowerment, training and skill development, and childcare services.
5	Increase number of Orange County programs engaging in trainings to provide financial empowerment, training and skill development, and childcare services.
6	Increase number of Orange County programs trained, using coordinated campaign materials, on those financial empowerment, training and skill development, and childcare services available in the community.
7	Increase number of coordinated advocacy touchpoints with key decision makers on issues related to financial empowerment, training and skills development, and childcare services.

Outcomes

1	Enhanced cross-sector collaborations across social determinants of health partners to address economic disparities.
2	Identified needs and gaps in services.
3	Increased proportion of those with economic hardship identified in provider settings.
4	Increased enrollment of those with economic hardship in financial empowerment, training and skill development, and childcare services.
5	Increased capacity of Orange County programs to provide financial empowerment, training and skill development, and childcare services.
6	Increased knowledge of Orange County programs on available financial empowerment, training and skill development, and childcare services.
7	Implementation of policy, systems, and/or environmental changes that promote financial empowerment, training and skills development, and childcare services.

INDICATOR	US VALUE	CA VALUE	OC VALUE	TREND	HEALTHY PEOPLE 2030 GOAL	DISPARITIES
Per Capita Income (ACS)	$38,332 (2021)	$42,396 (2021)	$47,334 (2021)		N/A	Asian: $46,136 Hispanic: $27,337 White: $62,278 Black: $40,976 American Indian/ Alaskan: $27,611 Hawiian/ Pacific Islander: $33,690 Two or More: $32,958 Other: $24,939
Percent of People Living Below Poverty Level (ACS)	12.8% (2021)	12.3% (2021)	9.9% (2021)		8.0% (2021)	Asian: 11.5% Hispanic: 11.6% White: 7.8% Black: 13.1% American Indian/ Alaskan: 12.8% Two or More: 8.7% Other: 13.7% Male: 8.8% Female: 10.9%
Percent of Children Living Below Poverty Level (ACS)	16.9% (2021)	15.8% (2021)	10.8% (2021)		N/A	Geographic^
Percent of Adults 65+ Living Below Poverty Level (ACS)	10.3% (2021)	11.1% (2021)	10.0%% (2021)		N/A	
Bachelor's Degree or Higher by Age 25 (ACS)	35.0% (2021)	36.2% (2021)	43.1% (2021)		N/A	

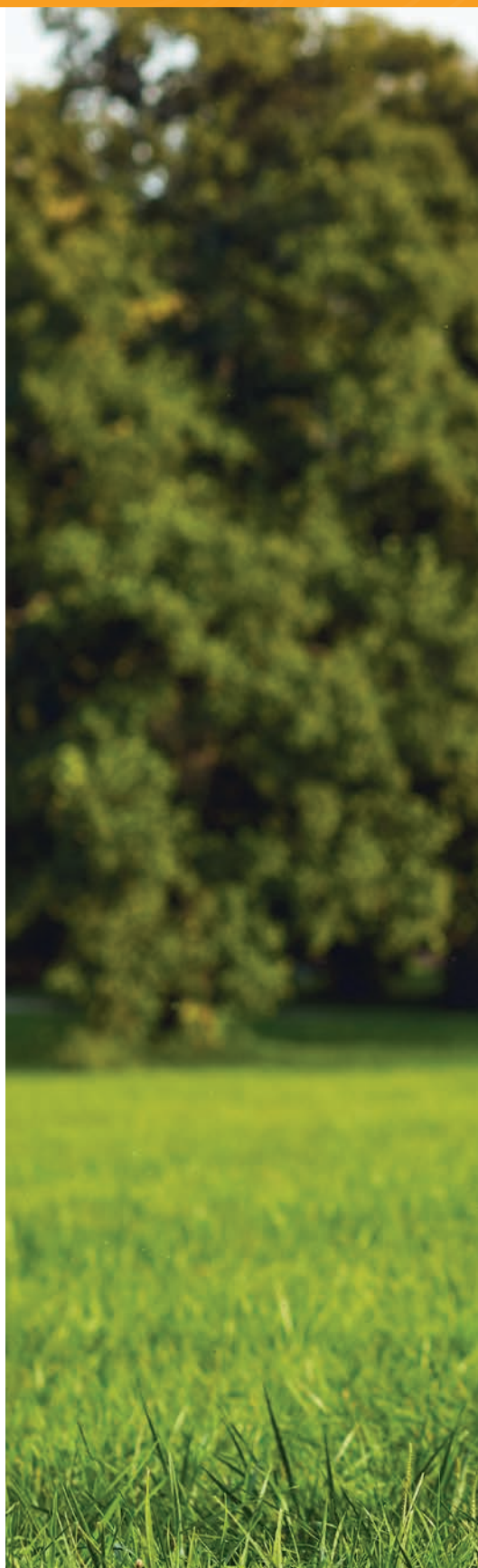
Note: ^Orange_County_Community_Health_Assessment-Final.pdf (ochealthinfo.com), page 176.

FOR ADDITIONAL INFORMATION ON BEST PRACTICES

Social Determinants of Health | The Community Guide
A Roadmap to Reducing Child Poverty - NCBI Bookshelf (nih.gov)
From Poverty to Prosperity: A National Strategy to Cut Poverty in Half - Center for American Progress

HOW WILL WE MONITOR OUR PROGRESS?

Public health leaders and community partners have a shared interest in ensuring the time, energy, and resources invested to improve community health are effective. The act of monitoring and revising the Community Health Improvement Plan (OC CHIP) is essential to make and keep the plan a living and meaningful document. A community health improvement plan can only be meaningful and effective if the entire community and vested stakeholders take ownership. Systematic and regular program evaluation is essential to assess, improve, and account for public health actions by engaging in strategies that are effective, practical, feasible, ethical and equity-driven. The evaluation and ongoing data-driven adaptation of the OC CHIP will be critical to its success and to the improvement of community health. Through use of the CDC's operating principles for guiding public health activities, which include a) using science as a basis for decisions making and public health action, b) expanding the quest for social equity through public health action, c) performing effectively as a collaborative, d) making efforts outcome oriented, and e) maintaining accountability, the OC CHIP is committed to developing clear plans, accountable processes, inclusive partnerships, and feedback systems that allow learning and ongoing improvement to occur. The development of routine evaluations will be key to ensuring that the OC CHIP honors these principles. The development of routine evaluations will provide information for management and improvement of the plan.



WHAT PART OF THE OC CHIP WILL BE MONITORED AND REVISED?

The health priority area goals and objectives are long-range, and data collected to determine the impact on these areas may not readily be available. Often, community health improvement plans must actively develop ongoing data sources for measures that support the evaluation of strategies, activities, and timelines that are linked to the objectives and health priority issues. While there may be times when the original health priorities, goals, and objectives need to be revised, the main focus of monitoring and revision will be on activities that make a substantial contribution to implementing a particular strategy and achieving a particular target or goal.

WHO SHOULD BE INVOLVED IN THE MONITOR AND REVISION PROCESS?

A key component of monitoring and updating the CHIP is keeping track of the advancements made possible by the efforts of agencies, community organizations, and other partners in addressing the top health objectives listed in the OC CHIP. While public health agencies such as the HCA are often the coordinator and convener of the work, the OC CHIP is, most fundamentally, a community health improvement plan and not an HCA plan. The community partners who are involved in implementing the strategies in the OC CHIP will play an active role in monitoring the progress of the work and recommending revisions. It is essential to have a clear plan in place for monitoring and revising the OC CHIP before the plan is implemented and it is important to communicate the roles and responsibilities of community partners at the onset to make engagement in the process more meaningful and successful.

WHAT DOES A CHIP MONITOR AND REVISE PROCESS LOOK LIKE?

Effectiveness and improved outcomes are the overarching goals of the OC CHIP. We all want to ensure that the time and resources dedicated to strategies and actions pay off for the hopes and efforts put into the plan. Community health improvement plans are more likely to be effective when there is consistent and transparent monitoring and revising as needed to better serve shared communities. The Minnesota Department of Public Health (2019) identifies elements of an effective monitoring and revising program include:

1. Involvement and active participation by community stakeholders and partners who have been implementing strategies in the OC CHIP.
2. Clear roles and responsibilities of community stakeholders and partners in the process (including what data or information they are expected to collect and share).
3. Scheduled meetings where monitoring and revising the CHIP are an intentional part of the agenda/discussion.
4. Ongoing data review, information sharing, and discussion regarding progress toward objectives and effectiveness of OC CHIP implementation.
5. An inclusive and fair decision-making process for revising the OC CHIP and approval of those revisions.
6. During the process of monitoring our OC CHIP, guiding questions will be used to facilitate discussions with community partners. Examples of some questions include:

In addition to the elements above, there are additional Health Priority, Objective and Strategy Issues to consider (Minnesota Department of Public Health).

- For **Health Priority Issues**, additional questions to consider include:
    1) Have there been resource or responsibility changes that impact the community's ability to address this health priority issue?
    2) Are there more urgent emerging health issues in the community?
- For the **Objectives**, additional questions to consider include:
    1) Has the objective been accomplished?
    2) Is the objective SMART (specific, measurable, achievable, relevant, and time-bound)?
- For the **Strategies**, the additional questions to consider include:
    1) Is this strategy still feasible?
    2) What is the progress made on this strategy?
    3) Do we want to continue with this strategy?

MONITORING WORKSHEET (EXAMPLE)

CHIP priority health issue: **Goal:**

OBJECTIVE IN OC CHIP	STRATEGIES WRITTEN IN THE OC CHIP	STRATEGIES STEPS BASELINE AND TARGET (WHERE DID WE START? WHERE DO WE WANT TO BE?)	PROGRESS (WHERE ARE WE NOW?)	REVISION DESCRIPTION	RATIONALE FOR REVISION
Objective 1:	Strategy 1:				
	Strategy 2:				
Objective 2:	Strategy 1:				
	Strategy 2:				
Objective 3:	Strategy 1:				
	Strategy 2:				

Context notes/next steps/other revisions:

BUILDING TOWARDS A HEALTHIER ORANGE COUNTY

The OC CHIP is a living plan created by community partners across multiple jurisdictions, sectors, and organizations that is founded in the understanding that collaboration is essential to maintain accountability and achieve success. CHIP partners also recognize that this plan is a continuous work in progress. Updates will be provided as major deliverables, such as logic models and measurable outcomes, are written and approved by the multi-sector steering committee, action teams, and the CHIP collaborative.

The OC CHIP is a vision and roadmap shaped by the core values of our community, which places the well-being and equity of all residents at its heart. Driven by inclusive community engagement, the plan reflects our shared aspirations for health and vitality. Grounded in respect, diversity, equity, and cultural sensitivity, the OC CHIP addresses identified needs with interventions that align with local aspirations, hopes, and values. Regular data collection, transparent communication, and collaborative decision-making help foster a sense of ownership and empowerment among community members. The plan remains a testament to the commitment to collective well-being, ensuring that every action reflects the values that make our Orange County community unique and resilient.

Glossary

Community-Based Organizations (CBOs): Community-based organizations are non-profit, non-governmental, or charitable organizations that represent community needs and work to help them. CBOs may be associated with a particular area of concern or segment of the community.

Community Health Assessment (CHA): A comprehensive and multi-faceted analysis of health conditions. Must be completed every three years for non-profit hospitals and every five years for accredited health department. Our county's CHA is on a three-year cycle.

Community Health Improvement Plan (CHIP): An action plan to address the priorities identified in the Community Health Assessment. CHIP goals and objectives should be feasible and achievable within the three-year window.

Health Disparity: Differences in health outcomes or related conditions across populations, which result from socioeconomic, biological, behavioral, psychological factors.

Local Public Health System: Collection of public, private and voluntary entities, as well as individuals and informal associations, that contribute to the public's health within a jurisdiction.

Mobilizing for Action through Planning and Partnerships (MAPP): A community-wide strategic planning process for improving public health created by the National Association of City and County Health Officials (NACCHO) and the Centers for Disease Control and Prevention.

Primary Data Collection: Data observed or collected from original sources, ranging from more scientifically rigorous approaches such as randomized controlled designs to less rigorous approaches such as focus groups or case studies.

Public Health: The science and the art of preventing disease, prolonging life, and promoting physical health and mental health and efficiency through organized community efforts toward a sanitary environment; the control of community infections; the education of residents in principles of personal hygiene; and the organization of medical and nursing service for the early diagnosis and treatment of disease.

Secondary Data Collection: Data collected by other parties, or result from combining data or information from existing data sources.

Social Determinants of Health (SDOH): The complex, integrated, and overlapping social structures and economic systems that include the social environment, physical environment, and health services; structural and societal factors that are responsible for most health inequities. SDOH are shaped by the distribution of money, power, resources at global, national, and local levels, which are themselves influenced by policy choices.

10 Essential Public Health Systems: Describe what public health seeks to accomplish and how it will carry out its basic responsibilities such as monitoring the health status, diagnosing and investigating health problems, and evaluating effectiveness, accessibility, and quality of person and population-based health services

Citations

GENERAL REFERENCES

National Association of County and City Health Officials. (July 2015). *Mobilizing for Action through Planning and Partnerships (MAPP): User's Handbook.*

Minnesota Department of Public Health (2019). *Monitoring and Revising the Community Health Improvement Plan: Process Guide and Worksheet. Retrieved from:* chip-monitor-revise-guide.docx (live.com).

SOCIAL DETERMINANTS OF HEALTH

U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion (n.d.). *Healthy People 2030*. Retrieved from: https://health.gov/healthy people.

POPULATION

U.S. Census Bureau (2021). Selected Population Profile in the United States, 2010-2021, *American Community Survey 1-Year Estimates*. Retrieved from B01003: TOTAL POPULATION - Census Bureau Table.

SOCIAL INDICATORS

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)

U.S. Census Bureau (2021) Education Attainment, 2010-2021, *American Community Survey 1-Year Estimates*. Retrieved May 1, 2023 from: S1501: EDUCATIONAL ATTAINMENT - Census Bureau Table.

MENTAL HEALTH

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.

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.

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.

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.

UCLA Center for Health Policy Research, Los Angeles, CA. AskCHIS 2011-2021. *Teen Need Help For Emotional/ Mental Health Problems (California, Orange)*. Retrieved from: http://ask.chis.ucla.edu.

University of Wisconsin, Population Health Institute (n.d.). *County Health Rankings and Roadmaps, 2010-2021*. Retrieved from: Rankings data & documentation | County Health Rankings & Roadmaps

SUBSTANCE ABUSE

California Department of Education, (n.d.). *California Healthy Kids Survey*. Retrieved from: The California School Climate, Health, and Learning Survey (CalSCHLS) System - Public Dashboards

California Department of Public Health (n.d.). *California Overdose Surveillance Dashboard*. Retrieved from: https://skylab.cdph.ca.gov/ODdash/?tab=CTY

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)

Orange County Health Care Agency (2022, June). *Drugs and Alcohol – Deaths, Emergency Department Visits, and Hospitalizations: Trends from 2009-2020*. Retrieved from: Drugs_Alcohol_Report_ED_Hosp_Death_All_Ages_2022-Final.pdf (ochealthinfo.com)

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

University of Wisconsin, Population Health Institute (n.d.). *County Health Rankings and Roadmaps, 2010-2021*. Retrieved from: Rankings data & documentation | County Health Rankings & Roadmaps

DIABETES AND OBESITY

California Department of Education (2020, January). *Physical Fitness Testing Research Files*. Retrieved from: Students Meeting All Fitness Standards, by Grade Level - Kidsdata.org

California Department of Education (2020, January). *Physical Fitness Testing Research Files*. Retrieved from: Students Who Are Overweight or Obese, by Grade Level - Kidsdata.org

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

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

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)

Centers for Disease Control and Prevention (n.d.). National Diabetes Statistics Report: *Estimates of Diabetes and its Burden in the United States*. Retrieved from: National Diabetes Statistics Report | Diabetes | CDC.

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.

UCLA Center for Health Policy Research, Los Angeles, CA. AskCHIS 2011-2021. *Delayed or Didn't Get Prescription Medicines (California, Orange)*. Retrieved from: http://ask.chis.ucla.edu.

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.

University of Wisconsin, Population Health Institute (n.d.). *County Health Rankings and Roadmaps, 2010-2021*. Retrieved from: Rankings data & documentation | County Health Rankings & Roadmaps

HOUSING AND HOMELESSNESS

Becht, D. (2023, October). *2023 Orange County Homeless Survey* [Power Point Slides] . Office of Care Coordination, Orange County Health Care Agency. https://ceo.ocgov.com/sites/ceo/files/2023-10/2023%20Homeless%20Survey%20Presentationl_Full%20Deck_10.23.2023.pdf.

United Ways of California. (2023, June). *How Much it Costs to Struggle: The Real Cost Measure in California 2023.* Available at: https://www.unitedwaysca.org/realcost.

ACCESS TO CARE

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.

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.

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.

UCLA Center for Health Policy Research, Los Angeles, CA. AskCHIS 2011-2021. *Had Preventive Care in the Past Year (California, Orange)*. Retrieved from: http://ask.chis.ucla.edu.

UCLA Center for Health Policy Research, Los Angeles, CA. AskCHIS 2011-2021. *Has Someone at Doctor's Office/Clinic Who Help Coordinate Care (California, Orange)*. Retrieved from: http://ask.chis.ucla.edu.

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.

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.

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.

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.

University of Wisconsin, Population Health Institute (n.d.). *County Health Rankings and Roadmaps, 2010-2021*. Retrieved from: Rankings data & documentation | County Health Rankings & Roadmaps.

ECONOMIC DISPARITIES

U.S. Census Bureau (2021). Per Capita Income in the Past 12 months, 2010-2021, *American Community Survey 1-Year Estimates*. Retrieved May 1, 2023 from: B19301: PER CAPITA INCOME IN THE ... - Census Bureau Table.

U.S. Census Bureau (2021). Poverty Status in the Past 12 Months, 2010-2021, *American Community Survey 1-Year Estimates*. Retrieved May 1, 2023 from: S1701: POVERTY STATUS IN THE PAST ... - Census Bureau Table.

ORANGE COUNTY
Community Health Improvement Plan
2024-2026