Rady Children's Health

Orange County

2025 Community Health Needs Assessment

Contents

Acknowledgments 3
Community Health Needs Assessment Partner Organizations 4
Glossary 5
Executive Summary 7
About Rady Children's Health Orange County Health Orange County 15
CHNA Methodology 27
Prioritization of Health Needs 38
Community Context 40
Health Priority 1: Behavioral Health 55
Health Priority 2: Access to Pediatric Healthcare Services 70
Social Driver of Health Priority 1: Safe Homes, Schools, and Neighborhoods 87
Social Driver of Health Priority 2: Connectedness 98
Social Driver of Health Priority 3: Healthy and Affordable Foods 106
Social Driver of Health Priority 4: Economic Stability 111
Orange County Demographic Profile 122
Assessment of Orange County's Resources Available to Meet the Social and Health Needs of Children and Families 128
Conclusion and Next Steps 137
Appendix A: Rady Children's Health Orange County List of Services 140
Appendix B: List of Zip Codes Included in Rady Children's Health Orange County PSA 143
Appendix C: Focus Group Discussion Guide 144
Appendix D: Focus Group Summary 146
Appendix E: Key Informant Discussion Guide 169
Appendix F: Key Informant Interview Summary of Findings 172
Appendix G: Survey Respondent Demographics 185
Appendix H: Secondary Data on Other Areas of Interest 187
Appendix I: Community Context Supporting Survey Data Tables 191

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Rady Children's Health Orange County Steering Committee

- Dr. Sharonne Herbert – GROW (Growth, Respect, Opportunity & Well-being) Officer
- Jena Jensen – Vice President and Chief Advocacy & Public Policy Officer
- Sumee Lee – GROW Health Equity Manager
- Dr. Prashanthinie Mohan – Director, Operational Transitions
- Rachel Rolnicki – Director of Government Affairs
- Jacqlyn Smith – Vice President Strategic Partnerships & Business Development

Community Advisory Committee

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- Dr. Ramin Baschi – Rady Children's Health Orange County/First 5 OC Board Member
- Dr. Coleen Cunningham, Rady Children's Health Orange County
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- Dr. Sameer Pathare – Rady Children's Health Orange County
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Research and Design Partners

- Health Management Associates, Inc.

This project was made possible because of their thoughtful contributions and steadfast dedication to improving child and family health in our region.

Community Health Needs Assessment Partner Organizations

We thank the following interest holders for their engagement and contributions:

- Access California Services
- American Academy of Pediatrics, OC Chapter
- CalOptima Health
- The Cambodian Family
- Capistrano Unified School District
- CHOC Health Alliance
- Community Action Partnership of Orange County
- Delphi Center for Teaching and Learning
- Disneyland
- First 5 OC
- Fountain Valley School District
- Fullerton Joint Union High School District
- Groundswell
- The Green Foundation
- Healthy Smiles for Kids by AltaMed
- Huntington Beach Union High School District
- Irvine Unified School District
- LGBTQ Center of Orange County
- Mariposa Center
- Orange County Business Council
- Orange County Health Care Agency
- Placentia-Yorba Linda Unified School District
- Santa Ana Chamber of Commerce
- Vision y Compromiso

Glossary

Community – Group of people with diverse characteristics who are linked by social ties, common perspectives, and who may be engaged in joint action in geographical locations or settings. This is but one definition. Community can be defined in multiple ways depending on the people asked and what groups have in common.

Community Commitment– Refers to unreimbursed goods, services, and resources that hospitals and health plans provide to improve health outcomes and access to care—especially for underserved populations—based on community-identified needs. Community commitment priorities were identified through a Children's Health Survey question asking survey respondents to select their top five issues and/or services they would like to see Rady Children's Health Orange County and the community Orange County work together to address.

Health Behaviors – Actions individuals take that affect their health.

Health Outcomes – Measure a change in the health status of an individual or a group that can be attributed to the intervention.

LGBTQ2IA+ – An inclusive acronym used to include people of all genders and sexualities that stands for lesbian, gay, bisexual, transgender, questioning/queer, intersex, asexual plus others such as pansexual.

Social Drivers of Health – The conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes.

Central Region – Includes Costa Mesa, Fountain Valley, Garden Grove, Huntington Beach, Midway City, Newport Beach, Santa Ana, Seal Beach, Tustin, and Westminster.

South Region – Includes Aliso Viejo, Dana Point, Irvine, Ladera Ranch, Laguna Beach, Laguna Hills, Laguna Niguel, Laguna Woods, Lake Forest, Mission Viejo, Rancho Santa Margarita, San Clemente, San Juan Capistrano, Silverado, and Trabuco Canyon.

North Region – Includes Anaheim, Brea, Buena Park, Cypress, Fullerton, La Habra, La Palma, Los Alamitos, Orange, Placentia, Stanton, Villa Park, and Yorba Linda.

Rady Children's Health Orange County (legacy CHOC) – Children's Hospital of Orange County (CHOC) and Rady Children's Hospital San Diego have united under one combined nonprofit health system: Rady Children's Health. Rady Children's Health Orange County is a pediatric healthcare system based in Orange County, CA, and was established in 1964.

Interest Holder – Any person, group, or entity that has a recognized interest in the outcomes, processes, or decisions of the CHNA whether they have the power to directly influence it. For this CHNA, interest holders include the key informant interviewees, focus group participants, members of the CHNA advisory and steering committees.

Provider Survey Respondent – The results of the Children's Health Survey were presented to reflect the perspectives of respondents who identified as provider survey participants. This includes individuals who indicated they were responding in the capacity of either social services providers or healthcare professionals.

Parent/Caregiver Survey Respondent – The results of the Children's Health Survey were presented to reflect the perspectives of respondents who identified as either a caregiver of child(ren) living in Orange County or as a young adult (18-24 years). This includes individuals who also indicated they were a foster parent.

Children and Youth with Significant Healthcare Needs – Children (0-24 years) who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.

Children's Health Survey Top Five Priority Selections – The purpose of the CHNA was to identify and rank health needs, issues, or factors. The Children's Health Survey included questions asking respondents to choose their top five health needs, issues, or factors. In some cases, the difference between the fifth most selected item and the next was not statistically significant. As a result, the CHNA reports health issues, needs and factors that were tied with the fifth selected option, as the frequency of selections varied only slightly. As a result, more than five selections are reported.

Pediatric Population – Defined to include ages 0-18 years and children with significant health care needs (0-24 years).

Pediatric Age Groups – Age groups are used throughout the CHNA and are defined in the following ways:

- Prenatal, Perinatal and Infants: Caregivers who are pregnant or caring for infants less than one year.
- Early Childhood: Ages 1-5 years
- Middle Childhood: Ages 6-10 years
- Adolescence: Ages 11-17 years
- Young adults: Ages 18-24 years
- Children with Significant Health Care Needs: Ages 0-24 years

Executive Summary

Rady Children's Health Orange County completed a Community Health Needs Assessment to pinpoint priorities and direct resources for improving pediatric health in its primary service area. The results will shape Rady Children's Health Orange County strategic plans and investments to better meet health-related needs for children and families. California and federal law require that private nonprofit hospitals conduct a Community Health Needs Assessment (CHNA) every three years.

The 2025 CHNA, which will cover 2025–2027, has four objectives:

1. **Identify critical health issues for children and families in Orange County**
2. **Identify available resources**
3. **Identify significant gaps** that hinder the provision of pediatric primary and specialty services
4. **Assist Rady Children's Health Orange County Board of Directors and leadership team** in setting priorities and allocating resources

Methodology

Rady Children's Health Orange County engaged Health Management Associates, Inc. (HMA), to design and implement a comprehensive CHNA process. Using a mixed-methods approach grounded in the Mobilizing for Action through Planning and Partnerships (MAPP) 2.0 framework, Rady Children's Health Orange County assessed pediatric health needs across Orange County. MAPP 2.0 provides a structured, community-driven approach that ensures the assessment is comprehensive, inclusive, and actionable.[1] Data collection methods include a survey, focus groups, key informant interviews, and secondary data analysis.

The methodology emphasized robust community engagement. Primary data were gathered through direct outreach to community members and parents/caregivers; secondary data included public health and socioeconomic indicators from publicly available sources.

- **Children's Health Survey:** Rady Children's Health Orange County launched an online survey to gather perspectives on health in Orange County to better understand the experiences of children and families**.** The survey was available from April 15 to May 21, 2025, and was written at a fifth grade reading level and offered in nine languages, including English. A variety of strategies were used to disseminate the survey throughout Orange County, resulting in a total of 1,149 complete responses from parents/caregivers, young adults, and/or health and social service providers about their priority pediatric health issues and factors, and experiences with accessing and/or providing pediatric care.

[1] National Association of County and City Health Officials (NACCHO). (2025). Mobilizing for Action through Planning and Partnerships (MAPP) 2.0 Framework.

- **Focus Groups:** Seven focus groups with parents/ caregivers, community health workers, and school nurses were held. These discussions involved the voices of 80 individuals who shared either their personal experience or those of the parents/caregivers and families they serve. Through these conversations, Rady Children's Health Orange County gained deeper insight into the realities, challenges, and strengths of children and families throughout Orange County.
- **Key Informant Interviews**: Twenty-one key informant interviews with a diverse group of community service leaders were held. These interviews were designed to elicit expert insights into the health needs and personal experiences of children and families, representing a range of perspectives including those of behavioral health, social services, education, oral health, and focus populations (e.g., LGBTQ2IA+, Asian Pacific Islander, children with significant healthcare needs, Middle Eastern, and African American).
- **Rady Children's Health Orange County Patient and Family Advisory Council**: Composed of parents/caregivers of patients were engaged to provide input on both the Children's Health Survey questions and interpretation of preliminary survey results.

Prioritization of Health Needs

A list of health issues were identified because both of the following were found to be true for Orange County:

- Community members expressed concern about the issue
- Secondary data pointed to either significant differences in Orange County compared with the State of California or indicated a concerning or worsening trend regarding the issue

Health issues from this list were then prioritized based on the responses to the following questions:

- Can Rady Children's Health Orange County influence the issue?
- Does Rady Children's Health Orange County already have a strategic focus or initiative on the issue?
- Is there community will or opportunity to leverage or influence the issue?
- Is measurable change possible within three years?

Additionally, community members were asked to prioritize ***"****Potential Areas to Commit and/or see Rady Children's Health Orange County and the Community Together to Address"* which served to inform preliminary recommendations for commitments.

Health Priority: *Behavioral Health*

Concerns Identified by the CHNA	Areas to Commit and/or See Rady Children's Health Orange County and the Community Come Together to Address

• Mental health conditions
  • Depression
  • Anxiety
  • Stress
  • Eating disorders
  • Suicidal ideation
	• Expand access to mental health services (which include culturally and linguistically appropriate therapists, and improve timely and affordable mental healthcare)

• Substance use	• Education about behavioral health issues with a focus on engaging adolescents and young adults, and perinatal, prenatal, and parents of infants
	• Programs to prevent substance use or addiction

Health Priority: *Access to Pediatric Healthcare Services*

Concerns Identified by the CHNA	Areas to Commit and/or See Rady Children's Health Orange County and the Community Come Together to Address
• Ability to access healthcare services (preventive, mental, and primary care; services for children with significant healthcare needs)	• Expand access to primary healthcare services
• Availability of appointments during times that are convenient for parents or caregivers	• Make appointments available during times that are convenient for the patient
• Long wait times and providers not taking new patients	• Teamwork between healthcare organizations and community-based organizations
• Complex navigation systems	• Tools to assist patients and families in navigating the healthcare system
• Lack of access to culturally and linguistically appropriate services (e.g., providers who speak the patient's language and understand the patient's culture)	

The health priorities identified in this CHNA are those Rady Children's Health Orange County and many community partners have been working to address for years. Analysis of secondary data indicates that while certain aspects of these two pediatric health priorities have shown improvement, other areas need continued improvement.

Areas Demonstrating Improvement Since the 2022 CHNA

Behavioral Health

- More Orange County youth ages 12–17 were receiving psychological/ emotional counseling.
- Binge drinking and vaping rates declined across grade levels, especially among non-traditional school-based students.

Access to Pediatric Healthcare Services

- The percentage of uninsured orange County children dropped by 20% from 2019 to 2023.
- More children were receiving standardized developmental and behavioral screenings.
- Fewer children were experiencing delays or barriers in accessing prescription medications.

Areas That Need Continued Improvement Since the 2022 CHNA

Behavioral Health

- A significant portion of students continue to report depression-related feelings, with rates rising over the past decade.
- Unintentional injury deaths and drug overdose mortality among youth increased.

Access to Pediatric Healthcare Services

- A recent uptick in uninsured rates from 2022 to 2023 suggests emerging gaps in coverage.
- Uninsured rates remained disproportionately high among American Indian/Alaska Native and Hispanic/Latino children.
- Many children lack a regular source of healthcare, with some relying on emergency departments or urgent care centers for routine needs.

Social Drivers of Health Priorities

Social drivers of health (SDOH) like economic stability, education, access to healthcare, and neighborhood safety — affect health outcomes at the community level. To effectively commit to activities that improve population health, it is necessary to identify and understand which factors or drivers are influencing health outcomes in a community. This CHNA identified four SDOH priorities to consider when developing strategies to respond to the two health priorities of Behavioral Health and Access to Pediatric Health Services.

Social Driver of Health Priorities	Priority Risk and Protective Factors Identified by Community
Connectedness	• Absence of positive adult role models for children, including gaps in modeling good lifestyle habits by family members, lack of family engagement in children's care, families overwhelmed with care needs of aging family members • Social media contributing to setting unrealistic expectations for both children and caregivers/parents
Economic Stability	• Increasing costs of living, including housing, childcare, and food • Access to affordable extracurricular activities (e.g., youth sports, art, camps, afterschool programming)
Healthy & Affordable Foods	• Cost and proximity to nutritious foods • Access to education about nutritious food
Safe Homes, Schools & Neighborhoods	• Low-crime and safe neighborhoods • Injury prevention • Community violence • Bullying, including cyberbullying • Domestic abuse

Below presents data from secondary sources showing that while some of these SDOH indicators are improving, others still require focused attention and continued effort:

Areas Demonstrating Improvement Since the 2022 CHNA

Connectedness

- The percent of opportunity youth (ages 16–19 not in school or working) declined, and rates in Orange County were lower than state and national averages
- Fewer Orange County teens report being online “almost constantly,” suggesting healthier digital habits

Economic Stability

- Joblessness remained relatively low in Orange County, supporting economic stability

Healthy & Affordable Foods

- Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) enrollment and participation in CalFresh among households living in poverty recently increased
- Fewer food-insecure children were income-eligible for nutrition programs, suggesting better access and coverage

Safe Homes, Schools & Communities

- Cyberbullying rates among grade 9 and 11 students in Orange County were lower than the state average and were decreasing. However, rates among grade 7 students were rising and exceeded the state average

Areas That Need Continued Improvement Since the 2022 CHNA

Connectedness

- Students reported feeling less connected to their schools compared to previous years, with older students feeling the least connected

Economic Stability

- Over one-third of Orange County households were ALICE (Asset Limited, Income Constrained, Employed), highlighting challenges in affording basic needs despite employment
- Median home prices rose 33% while median household income remained the same, deepening the affordability crisis
- Over 30,000 Orange County public school students were housing-insecure, with most living in overcrowded conditions—affecting health, stability, and academic outcomes

Healthy & Affordable Foods

- Over 73% of eligible low-income households were not enrolled in CalFresh in Orange County, indicating persistent barriers
- Food insecurity rates increased among both youth and the general population since 2019 in Orange County

Safe Homes, Schools & Communities

- Fewer students in Orange County public schools felt safe at school compared to previous years, with only 57–63% of grade 7, 9, and 11 students reporting their school as safe or very safe
- While Orange County's overall child mortality rate remained lower than the statewide average, injury-related deaths increased significantly, driven largely by a tripling in unintentional injury deaths between 2019 and 2023
- Although substantiated child abuse and neglect rates in Orange County declined slightly since 2019, they remained higher than the statewide average, and the county's rate of improvement was slower than California's overall progress

Report Organization

This CHNA is organized in the following way:

2025 CHNA Approach & Process	Outline the purpose and rationale for conducting the CHNA	Pages 27-54
	Describe the methodology used, including data sources and community engagement strategies	
	Introduce the key pediatric health issues identified and summarize community perspectives	
Understanding CHNA Findings	Examine each health issue in depth, presenting both prevalence data and contributing factors	Pages 55-121
	Integrate primary data (e.g., insights from healthcare professionals, service providers, and parents/caregivers) with secondary data (e.g., public health statistics and trend analyses) to highlight disparities and underlying causes	
Orange County Community & Available Resources	Describe the demographic characteristics of Orange County	Pages 122-139
	Identify existing assets and services in Orange County that address pediatric health needs	
	Highlight gaps in services and opportunities for program expansion or new initiatives to improve pediatric health outcomes	

Interpretation of the CHNA Findings

The CHNA is not an evaluation of Rady Children's Health Orange County services, but an assessment of pediatric health needs and priorities across Orange County. Addressing the health priorities identified in this CHNA is the collective responsibility of many interest holders across Orange County.

Conclusion and Next Steps

Rady Children's Health Orange County will use the findings from this CHNA to inform decisions regarding its programming that targets significant health issues, key populations, and related protective and risk factors. Rady Children's Health Orange County will also work with community partners to address health concerns, including those outside its main areas of expertise. This report lays the groundwork for future efforts to improve child and family health across Orange County.

About Rady Children's Health Orange County

Children's Hospital of Orange County (CHOC) and Rady Children's Hospital San Diego have united under one combined nonprofit health system: Rady Children's Health. Together, both organizations strive to build healthier futures for every child who depends on pediatric healthcare.

Building on a combined legacy of more than seventy years of clinical excellence, Rady Children's Health is dedicated to advancing children's health through leading-edge research, innovative treatments and compassionate care. Rady Children's Health remains steadfast in its commitment to serving the local communities while providing the benefits of this enhanced relationship.

Patients and families in Orange County and San Diego will continue receiving care from the same trusted medical providers they know. Care teams remain unchanged, and the same high-quality, personalized services will continue — now supported by expanded resources and expertise through our unified health system.

Rady Children's Health Orange County (legacy CHOC) is a pediatric healthcare system based in Orange County, California, and was established in 1964. Rady Children's Health Orange County growing enterprise includes two state-of-the-art hospitals in Orange and Mission Viejo and a regional network of primary and specialty care clinics serving children and families in five counties. It offers several clinical programs of excellence, which provide the highest levels of care for the most severe pediatric illnesses and injuries, both physical and mental. Rady Children's Health Orange County research and innovation institutes focus on translating patient needs into real-world treatments so every child can enjoy a healthy and happy life.

Rady Children's Health Orange County at Orange is a licensed 388-bed tertiary/quaternary children's hospital with 44 locations and more than 6,000 employees. The organization provides care to people ranging in age from prenatal and neonatal (newborns) through 21 years old and up to age 25 for patients diagnosed with certain rare conditions. **Appendix A** provides a list of programs and capabilities.

The hospital's commitment to the highest standards of patient care and safety, as well as performance excellence, earned the organization the following accolades: ranked as one of the nation's best children's hospitals by *U.S. News & World Report*; Magnet designation, the highest honor bestowed to hospitals for nursing excellence; and presentation of the Pediatric Beacon Award for Critical Excellence to Rady Children's Health Orange County pediatric intensive care unit (PICU).

Rady Children's Health Orange County at Mission is a California nonprofit public benefit corporation formed in 1991 and operates a 54-bed acute pediatric hospital located in Mission

Viejo. Rady Children's Health Orange County at Mission is located on the fifth floor of Mission Hospital, a member of the Providence/St. Joseph Health System.

Rady Children's Health Orange County Mission Statement

To nurture, advance, and protect the health and well-being of children

Rady Children's Health Orange County Vision

To be the leading destination for children's health by providing exceptional and innovative care

Rady Children's Health Orange County Core Values

Excellence	Setting and achieving the highest standards in all we do
Innovation	Advancing children's healthcare by leading with new ideas and technology
Service	Delivering unmatched personal experience
Collaboration	Working with our colleagues and partners to achieve our mission
Compassion	Caring with sensitivity and respect
Accountability	Serving as dedicated stewards of the lives and resources entrusted to us

Rady Children's Health Orange County Primary Service Area

Rady Children's Health Orange County primary service area (PSA) is Orange County, based on the place of residence of most of the patients it serves (**Figure 1**). Statewide inpatient data were used to define Rady Children's Health Orange County PSA. Orange County has a total pediatric population of 758,107 children and youth (0 – 19 years).[2]

The Primary Service Area encompasses Orange County. Significant cities in this area include Orange, Santa Ana, Anaheim, Fullerton, and Garden Grove in the north, as well as Mission Viejo, Laguna Niguel, Rancho Santa Margarita, Laguna Hills, Lake Forest, San Clemente, and San Juan Capistrano in the south.

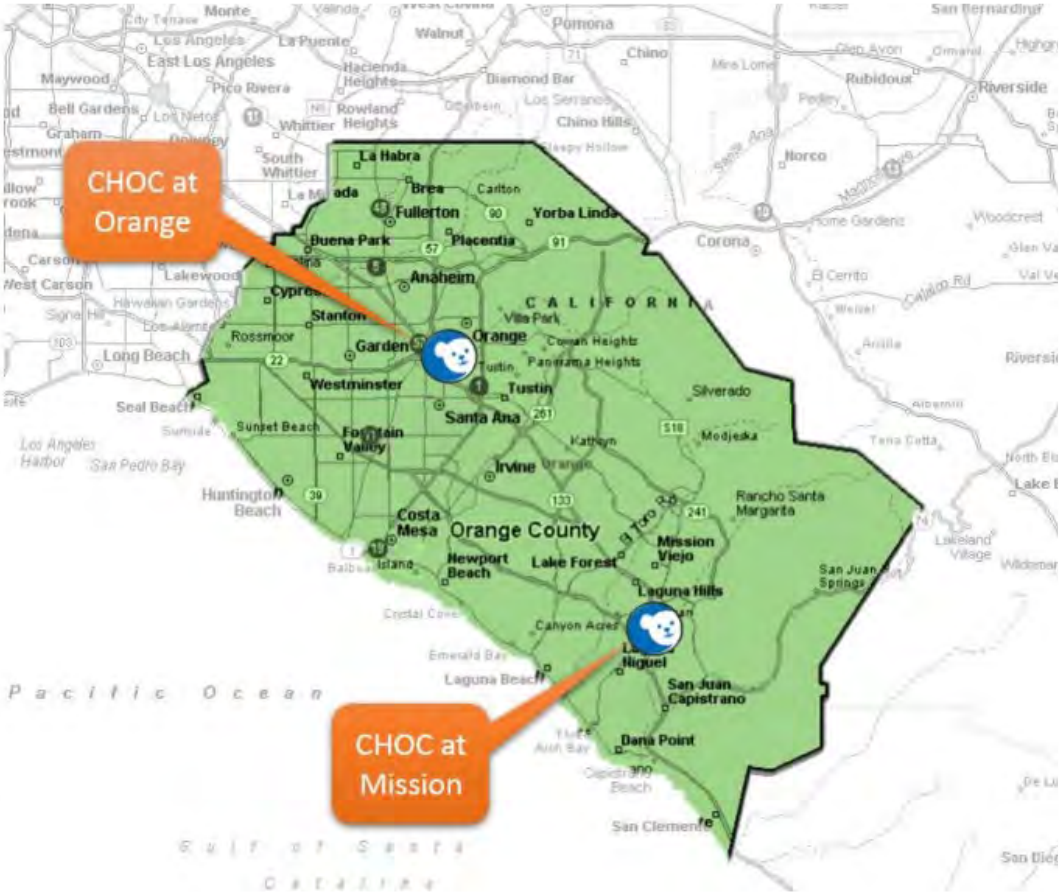
The Secondary Service Area includes portions of southern Los Angeles County, Riverside County, and San Bernardino County.

The Tertiary Service Area includes portions of Los Angeles County.

As previously noted, Rady Children's Hospital San Diego and Children's Hospital of Orange County have come together under a unified nonprofit parent organization, Rady Children's Health. While Rady Children's Hospital San Diego encompasses San Diego, southern Riverside, and Imperial counties, this Community Health Needs Assessment is focused exclusively on the Orange County PSA. Cities and ZIP codes are provided in **Appendix B**.

[2] U.S. Census Bureau. American Community Survey, 2023 One-year Estimate, Table S0101

Figure 1. Rady Children's Health Orange County Service Area Map



Programs and Services

Rady Children's Health Orange County offers primary, secondary, tertiary, and quaternary services across its network of inpatient, outpatient, and ancillary centers, including, but not limited to:

- 18 Primary care locations
- 13 Specialty care locations
- 3 Neonatal Intensive Care Unit (NICU) locations
- 15 NICU partner locations
- 5 Urgent care locations
- 2 Hospitals
- 4 Community clinics

The following is a list of Rady Children's Health Orange County major primary care, inpatient, and outpatient services.

- Adolescent Medicine
- Allergy / Immunology
- Autism
- Behavioral Health Services
- Blood and Donor Services
- Breast Milk Donations
- Cardiology
- Child Life
- Cord Blood Bank
- Orthodontics
- Critical Care
- Dentistry
- Dermatology
- Developmental and Behavioral Pediatrics
- Eating Disorders Program
- Emergency Medicine
- Endocrinology and Diabetes
- Fetal Care Center
- Gastroenterology
- General and Thoracic Surgery
- Genetics
- Hematology
- Immunizations
- Infectious Disease
- Integrative Health
- Laboratory Services
- Lactation Services
- Mental Health
- Metabolic Disorders
- Neonatology / Perinatology
- Nephrology
- Neurology / Neurosurgery Neuroscience Institute
- Newborn visits
- Nutrition Services
- Oncology
- Ophthalmology
- Orthopedics
- Otolaryngology (Ear, Nose and Throat)
- Palliative Care
- Pharmacy
- Physical Medicine and Rehabilitation
- Plastic Surgery
- Primary Care
- Psychology / Psychiatry
- Pulmonology
- Radiology / Imaging
- Rehabilitation Services
- Research Institute
- Rheumatology
- Social Services
- Screenings
- Spiritual Care
- Well-Child, Routine & Sick Care
- Urology

Background on a Community Health Needs Assessment

The Community Health Needs Assessment (CHNA) serves as a strategic resource to inform community benefit investment funding, policy development, advocacy priorities, and program planning efforts. To better understand and respond to the health needs of our communities, the Affordable Care Act (ACA) requires nonprofit hospitals to listen to the voices of the people they serve. Every three years, hospitals must conduct a CHNA and create a plan, called a Community Benefit Implementation Strategy (CBIS), to address the most pressing issues identified. This process ensures that hospitals remain accountable to their communities while continuing to qualify for tax-exempt status. The CHNA proces was designed to meet federal and California Department of Health Care Access and Information (HCAI) requirements each year as listed in **Table 1**.

Table 1. Federal and State Requirements for Nonprofit Hospitals

IRS & ACA | Community Benefit Requirement	
Every 3 Years	Conduct a CHNA
With CHNA	Adopt a Community Benefit Implementation Strategy (CBIS) to meet identified/prioritized needs
With CHNA	Widely publicize the CHNA, CBIS, Community Benefit programs and services, and Financial Assistance Policy (FAP)
Every Year	File an IRS Form 990, Schedule H, to report Community Benefit Activities and other information related to tax-exemption
State-Level Community Benefit Requirements | CA SB 697	
Every 3 Years	Collaborate with the community to conduct a CHNA
Every Year	Collaborate with the community to develop a comprehensive CBIS
Every Year	Submit the SB 697 Plan (indicates CHNA & CBIS) to HCAI within 120 days of adopting the CHNA
State-Level Community Benefit Plan Requirement | CA AB 204	
Every 3 Years	Collaborate with the community to conduct a CHNA
Every Year	Collaborate with the community to develop a comprehensive CBIS
Every Year	Submit the SB 697 Plan (indicates CHNA & CBIS) to HCAI within 120 days of adopting the CHNA
State-Level Community Benefit Reporting Requirement | CA AB 1204	
Every Year	Provide more detailed reporting of Community Benefit activities, including services for specific groups, to promote transparency and accountability

Written Public Comments on the Prior CHNA

To offer the public a means to provide written input on the CHNA reports, Rady Children's offers a public email for direct contact: CommunityComments@choc.org

At the time the 2025 CHNA report was completed, Rady Children's Health Orange County did not receive any written comments about the 2022 CHNA report. It will continue to accept submissions and ensure that all relevant feedback is reviewed and addressed by appropriate hospital staff.

Rady Children's Health Orange County Community Benefit Program CHNA

Rady Children's Health Orange County is dedicated to working cooperatively to expand existing services and develop innovative programs to benefit the families of Orange County. Community benefits include free or subsidized programs and services designed to meet identified community needs and to serve the public interest. More than two million children across five counties rely on Rady Children's Health Orange County to provide needed care, regardless of their families' ability to pay.

In fiscal year 2023–2024, Rady Children's Health Orange County invested $12.3 million in community benefits—programs or activities that provide treatment and promote health and healing as a response to identified community needs. Rady Children's Health Orange County continues to Table in 68 different services that address the following six goals:

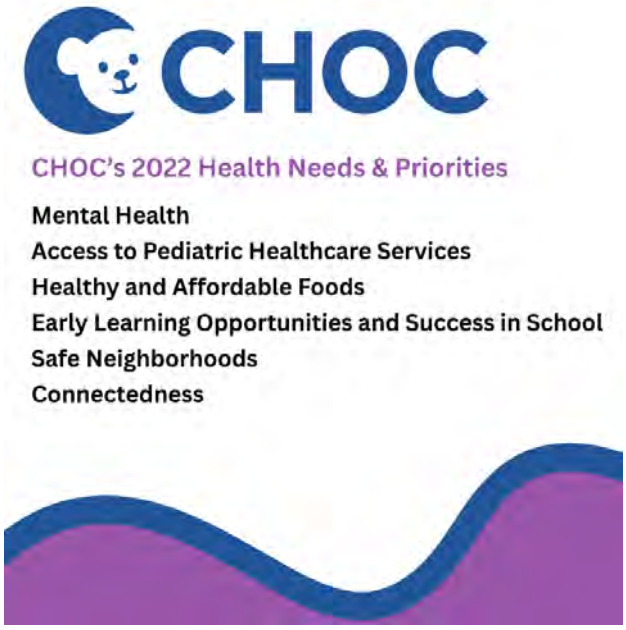
1. **Healthcare Access:** Increasing access to quality pediatric healthcare resources and information to low-income and medically underserved families throughout Orange County
2. **Behavioral Health Access:** Enhancing community access to behavioral health information and social and emotional services, with a focus on medically underserved populations
3. **Disease Prevention:** Increasing awareness of disease prevention and promoting early intervention of major diseases that affect the community
4. **Information Resource:** Providing the community with resources for information and education on health risk behaviors
5. **Injury Prevention:** Actively contributing to reductions in the number of unintentional injuries to young children, especially low-income, diverse, and medically underserved populations
6. **Community Action:** Actively recruiting, recognizing, and advocating for volunteer leadership and community assistance in providing care for children

Rady Children's Health Orange County Community Benefit Plan for 2023–2024 can be viewed here.

2022 Health Needs and Priorities

CHOC's 2022 CHNA identified several key pediatric health needs and priorities across Orange County, as illustrated in **Figure 2**. The assessment aimed to understand the health status of children and families, identify gaps in care, and highlight areas of health inequity. Below is a detailed overview of the health priorities identified in the 2022 CHNA.

Figure 2.
CHOC's 2022 Health Needs and Priorities



Mental Health

- Increase in depressive symptoms among students
- Increase in hospitalizations for mental illness in 2020, despite the overall decrease in hospitalizations due to the COVID-19 Public Health Emergency
- Need for prevention, early intervention, and treatment for substance use among youth

Access to Pediatric Healthcare Services

- Need for improved access to pediatric services (including pediatric specialists) from a diverse group of healthcare professionals who understand the racial, cultural, and linguistic needs of children and families living in the county
- Geographic disparity in access to pediatric healthcare

Activities Since Last CHNA

Rady Children's Health Orange County developed an implementation plan to address the most pressing issues, including mental health challenges, access to pediatric healthcare services, and disparities rooted in social drivers of health. Rady Children's Health Orange County implemented several recommendations listed in the implementation to address the community health needs identified in the 2022 CHNA. Descriptions of selected activities that were implemented by Rady Children's Health Orange County in response to these needs are described below.

WellSpaces

Rady Children's Health Orange County has partnered with the Orange County Department of Education (OCDE) to expand its WellSpaces, with the goal of improving youth mental health. WellSpaces are dedicated areas in schools, kindergarten through grade 12, focused on the mental and emotional well-being of students.

WellSpaces offer students a calming place on campus where they can practice mindfulness, meditate, practice yoga, and learn about self-care. The partnership with OCDE has led to the expansion of this program, leading to over 50 WellSpaces in 17 school districts across Orange County. In 2024, 53 WellSpaces logged 31,800 student check-ins.

Rady Children's Health Orange County is expanding the initiative by creating WellCorners in K-8 schools in 2025. These smaller, classroom-based spaces will focus on teaching younger children coping mechanisms and social-emotional learning skills.

Mental Health Crisis Clinic

The Mental Health Crisis Clinic (MHCC) is an outpatient mental health program for youth. The clinic provides short-term therapy services to youth ages 3+ who present with suicidal thoughts/behaviors and are not currently linked to or in active mental health treatment. The clinic is intended as a step down from the emergency department or inpatient units, and for patients whose needs are urgent but who do not require immediate stabilization or emergency care. Reasons for referral are suicidal thoughts, suicidal behaviors, and non-suicidal self-injury. MHCC focuses on developing adaptive coping strategies to maintain safety and promote recovery on this step of the journey.

Clinic services include:

- Initial 90-minute mental health assessment to determine fit for clinic and next steps
    - Clinical Evaluation
    - Suicide Risk Assessment
    - Safety Planning

Benefits of Mental Health Crisis Clinic

- ✓ Afterschool hours
- ✓ Program run by experienced, licensed clinicians who specialize in working with youth
- ✓ DBT-adherent program, means that the program has all aspects of treatment considered by research to be most effective
- ✓ Board-certified adolescent psychiatrist for consultation and medication management as needed
- ✓ Case coordination with other providers and school

- Dialectical Behavior Therapy (DBT) Crisis Skill: If the patient meets criteria, they will receive up to three additional follow-up one-hour therapy sessions that focus on distress tolerance and emotion regulation skills from DBT
- Support with connection to long-term mental health services
- Telehealth and in-person appointments are available to reduce obstacles to care

Expected outcomes include significant reduction in symptoms of depression and anxiety, improved functioning at home, better interactions in school and with friends, new skills to cope with stress, and a decrease in unsafe thoughts and behaviors. In the first six months of the program (November 2022-May 2023) the Mental Health Crisis Clinic treated 88 patients.

Middle School Intensive Outpatient Program (IOP)

The Rady Children's Health Orange County middle school IOP teaches Dialectical Behavior Therapy (DBT) skills to middle school teens and their primary caregivers. The program aims to reduce teens' suicidal thoughts, suicidal attempts, self-harm urges & actions by helping them better regulate their emotions, control impulses, think and behave more flexibly, and have healthier relationships. IOP best serves teens that either are not progressing in outpatient therapy, have worsening symptoms despite outpatient therapy, or have not received prior therapy and symptoms indicate a need for a higher level of care than typical outpatient therapy.

Families complete an initial evaluation to determine eligibility for the program. Upon admission, teens attend the program in-person for 10 weeks, coming in four days a week after school for three hours each day. Primary caregivers are also required to participate. Groups include skills groups, mindfulness/meditation practices, art therapy, and recreational therapy. Groups are open and new enrollment takes place every two weeks. Psychiatry services are offered to those teens who are either on medication or recommended medication to improve progress. The middle school IOP was adapted from the high school program to attend to developmental differences and unique needs of pre-adolescents.

Mental Health Education Program (MHEP)

The school-based mental health team provides mental health and wellness programming for schools that receive WellSpaces (which are project-managed by Rady Children's Health Orange County population health and OCDE). Using these WellSpaces as vehicles for programming delivery, the school-based mental health team provides a number of activities, events, and presentations to students, teachers/staff, and caregivers. Examples of such programming include wellness activities for students and staff (i.e., art-based expressive activities that are modeled after DBT and cognitive behavioral therapy (CBT) oriented coping skills), "parenting power hour" (a series of presentations for parents on parenting their children using DBT principles), trauma-informed care training for the classroom, cognitive-behavioral intervention for trauma in schools, and a many other offerings. All educational materials are designed, peer-reviewed, and presented by working mental health experts at Rady Children's Health Orange County, so families and community members are receiving the same skills and resources that our clinicians use every day with patients.

To date, MHEP has created over 300 unique educational materials on topics ranging from picky eating in early childhood to how to prepare for your child to return home after a suicide attempt. In the 2024-2025 fiscal year, MHEP's online engagements (for webinars, articles, etc.) topped 350,000 and the program reached more than 2,700 individuals through live community education.

Universal Screening for Suicidal Ideation

As a part of the Zero Suicide Initiative, Rady Children's Health Orange County began universal suicide risk screening for youth ages 12+ in specific pilot specialty and primary care clinics. The Suicide Assessment Team is a remote service that deploys in response to patients who have screened positive for suicide risk during a specialty or primary care clinic visit. The assessment is conducted at their current healthcare visit. It includes the completion of the Columbia Suicide Screening Rating Scale, a mental health safety and coping plan, and referrals to ongoing mental healthcare as needed. Through this initiative, the Suicide Assessment Team can identify youth at risk of suicide, provide brief assessments, connect them promptly to care, and ensure that care teams are collaborating to support the family. Using the Suicide Assessment Team allows families to avoid an intensive emergency department visit and leave their scheduled medical appointment with a clear safety plan for their child.

ONE Number for the Community: 1-844-Get-CHOC

To ensure easy access to pediatric services, Rady Children's Health Orange County implemented ONE Number for the Community which is a single phone number (1-844-GET-CHOC) patients can call to get access to Rady Children's Health Orange County healthcare system. Essentially, it is an access point Rady Children's Health Orange County is using to triage phone calls, initiate telehealth visits and connect patients to Rady Children's Health Orange County primary care network and specialty clinics.

Building on 2023's success in merging nurse triage teams and integrating telemedicine, One Number for the Community expanded its services to include Saturday and Sunday hours, 6:00 am–6:00 pm, achieving a 100% increase in completed telehealth visits in 2024. The nurse advice line expanded its services to 15 specialty clinics for after-hours calls. In 2024, more than 80,000 calls were received, and more than 34,000 nurse advice encounters were completed.

Access and Capacity

Rady Children's Health Orange County opened a new nine-story ambulatory services building in June 2025. The Southwest Tower (SWT) is an outpatient "one stop shop" with over 25 specialties and an outpatient radiology suite serving patients in one location. The 9th floor of the SWT is dedicated to research, both clinical and translational.

Concierge Care Program

Rady Children's Health Orange County launched a concierge program providing patients and families with personalized emotional and environmental support during their visits at Rady Children's Health Orange County. The Patient and Family Experience Team oversee this program, which aims to tailor services to address the individual needs of each child and family. The team has introduced two services: Hospital Kind Concierge Services and Emergency Department Concierge Services.

Hospital Kind Concierge Service

Kind Concierge volunteers visit inpatient rooms to assess the needs of Rady Children's Health Orange County patients, improve communication and assist families with resources and information about the amenities and services available to them. The goal of the program is to reduce stress, promote healing and wellness, and improve patient and family experience.

Emergency Department Concierge Services

The Emergency Department (ED) Concierge Services team of liaisons partnered closely with medical staff to deliver an exceptional patient and family experience throughout the ED. Liaisons visited the ED lobby to answer questions from patients and families and provided clear, timely communication during their visit. They also offered comfort items such as blankets and refreshments, along with distraction tools like coloring books and activity kits.

Wellness on Wheels

Wellness on Wheels (WoW), a mobile multilingual clinic focused on testing, diagnosing, treating, and managing asthma and related health conditions in children, conducted 2,965 patient visits—a 5.6% increase over the previous year. Rady Children's Health Orange County retrofitted the former Breathmobile with advanced medical equipment, connecting Rady Children's Health Orange County electronic health record, pulmonary function equipment, and audio-visual education and training devices.

WoW actively takes part in community engagement, education and outreach, aiming to empower all families with the resilience, knowledge and ability to navigate healthcare in Orange County. The diverse team takes pride in reflecting and representing the very people served, which is key to building these lasting connections. WoW staff are fluent in English, Spanish and Tagalog. Additional translation services are also available for Korean, Vietnamese, Mandarin, Cantonese and all other languages.

WoW visits many Orange County Rady Children's Health Orange County clinics, schools, school districts, community organizations, family resource centers, wellness events and other sites throughout the region.

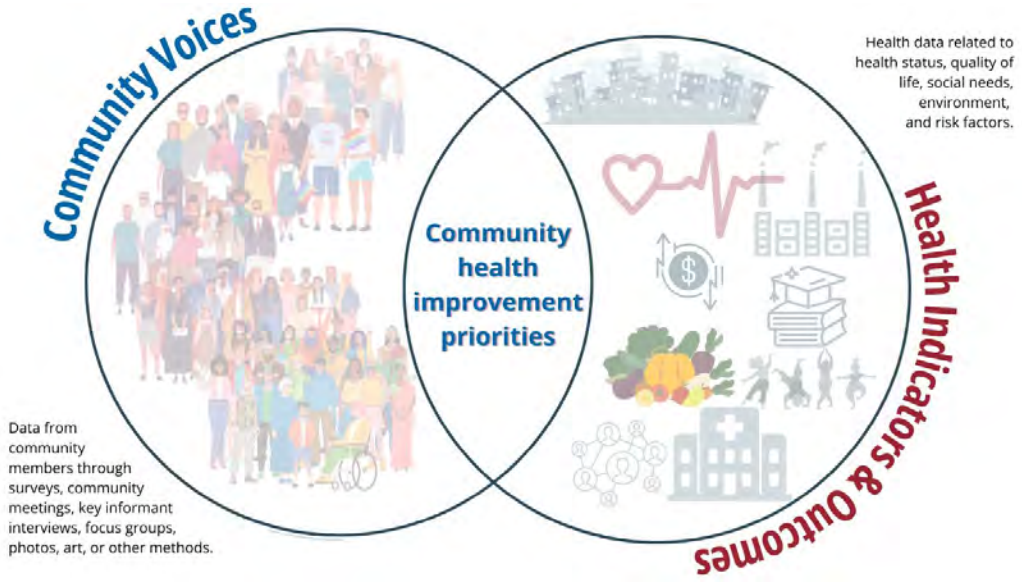
2025 CHNA Approach & Process

- Outline the purpose and rationale for conducting the CHNA.
- Describe the methodology used, including data sources and community engagement strategies.
- Introduce the key pediatric health issues identified and summarize community perspectives.

CHNA Methodology

Health Management Associates, Inc. (HMA), in collaboration with Rady Children's Health Orange County, conducted the CHNA using a mixed-methods approach to gain a comprehensive understanding of community health needs. The CHNA was carried out between December 2024 and July 2025 using an adapted process from the Mobilizing for Action through Planning and Partnerships (MAPP) 2.0 framework.[3] This model is widely used to conduct CHNAs. It focuses on community engagement, partnership development, and participation from people who are historically excluded from community decision-making processes. This process does not rely on any one source of information; rather multiple data sources are analyzed before arriving at findings (**Figure 3**).

Figure 3. CHNA Approach



[3]National Association of County and City Health Officials. (2023). Mobilizing for action through planning & partnerships: MAPP 2.0 user's handbook. Centers for Disease Control and Prevention, Office of State, Tribal, Local, and Territorial Support.

CHNA Goals

The CHNA aims to identify pediatric health needs, challenges, and resources for children in Orange County through comprehensive data collection and analysis. It assesses pediatric health priorities countywide, not solely Rady Children's Health Orange County services. Broadly, the objectives of this CHNA include:

- **Define** the **population** Rady Children's Health Orange County serves and the **communities** from which this population originates
- **Determine community health needs and resources**, including those related to pediatric inpatient and outpatient care
- **Identify significant gaps** that hinder the provision of pediatric primary and specialty services
- **Identify community assets** that promote the health and well-being of community members
- **Mitigate barriers** to meet the health and social needs of the community
- **Meaningfully engage** the Orange County community and build relationships with a broad and diverse group of key interest holders.

The following questions were answered:

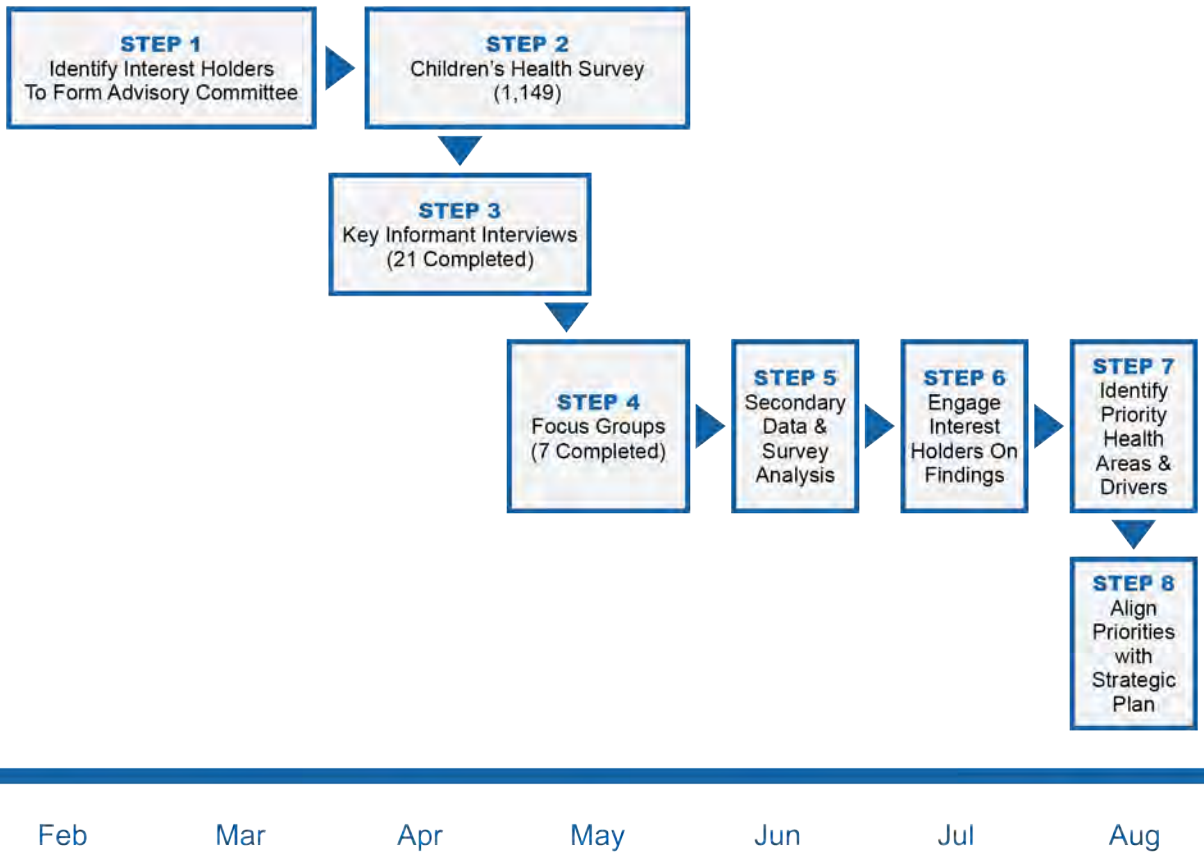
- What are the key factors that contribute to a healthy community for children and families in Orange County?
- What are the most critical health issues for children and families in Orange County?
- What factors drive these health issues for children and families in Orange County?
- What resources are available to address these health issues?

The CHNA team gathered data from diverse sources in Orange County for broad community input (**Figure 4**). By combining primary and secondary data, they ensured a thorough analysis of health needs. This assessment leverages the following data sources:

- A countywide Children's Health Survey
- Information gathered through community focus groups that included Orange County school nurses, community health workers, parents and caregivers
- Key informant interviews with community health leaders
- Secondary data or information that had already been collected, analyzed, and published by others—such as census data, public health records, academic studies, or government reports—and was used to support or compare findings from new, primary data collection efforts.

Findings from data collection and analysis will guide Rady Children's Health Orange County CHNA Community Benefit Implementation Strategy (CBIS), ensuring resources are focused on the county's most pressing pediatric health and healthcare needs.

Figure 4. 2025 CHNA Community Engagement Process



Children's Health Survey

Rady Children's Health Orange County launched an online Children's Health Survey to gather perspectives on health in Orange County to better understand the experiences of children and families**.** The survey was available from April 15 to May 21, 2025, and was written at a fifth grade reading level. It was available in the nine threshold languages in Orange County–Spanish, Arabic, Farsi, Simplified Chinese, Traditional Chinese, Korean, Russian, Vietnamese, and English. To maximize outreach across Orange County, Rady Children's Health Orange County collaborated with its marketing team, 42 Orange County interest holders (i.e., members of the CHNA Advisory Committee, CHNA Steering Committee as well as key informants) and a diverse network of community partners to promote the online survey. A variety of dissemination strategies were deployed to ensure broad community engagement and participation, including:

1. **Email Blasts:** Sent to community–based organizations and collaboratives such as Illumination Foundation, Be Well OC, Family Resource Centers, Health Equity Coalition, Local Community Clinics, First 5 Orange County programs and others
2. **Social Media:** Twitter, LinkedIn, Facebook, and Instagram
3. **Healthcare and Medical Networks:** Sent to University of California, Irvine Department of Pediatrics, Orange County Perinatal Council, Orange County Medical Association and American Academy of Pediatrics and others

4. **Clinic Sites:** Rady Children's Health Orange County outpatient specialty clinics, mobile clinics, and urgent care centers
5. **Professional Channels:** Email blasts to OC legislative Offices, Orange County Business Council, Santa Ana Chamber of Commerce and Santa Ana businesses
6. **Engagement with Participants** of Rady Children's Health Orange County Patient and Family Advisory Committee
7. **Participants of Focus Groups:** Parents and caregivers, community health workers, and school nurses
8. **Event and Location Based Promotion:** Promoted at the Rady Children's Health Orange County Wellness Fair and local events like Dia Del Niño, posted at local supermarkets, Town Hall events, and texting campaigns

The Children's Health Survey was started 1,906 times. A total of 757 surveys were excluded from analysis because less than 75% of the questions were completed or failed bot detection. As a result, the survey yielded **1,149 valid and unique responses** from across Orange County. As **Table 2** indicates, most survey respondents received the survey by email (29%), workplace (21%), and other places not listed in the survey (10%). The most common responses for "other" were LinkedIn, Rady Children's Health Orange County, community-based organizations (CBOs), hospitals, regional center, and doctor's office or urgent care.

Table 2. How Respondents Received the Community Health Survey

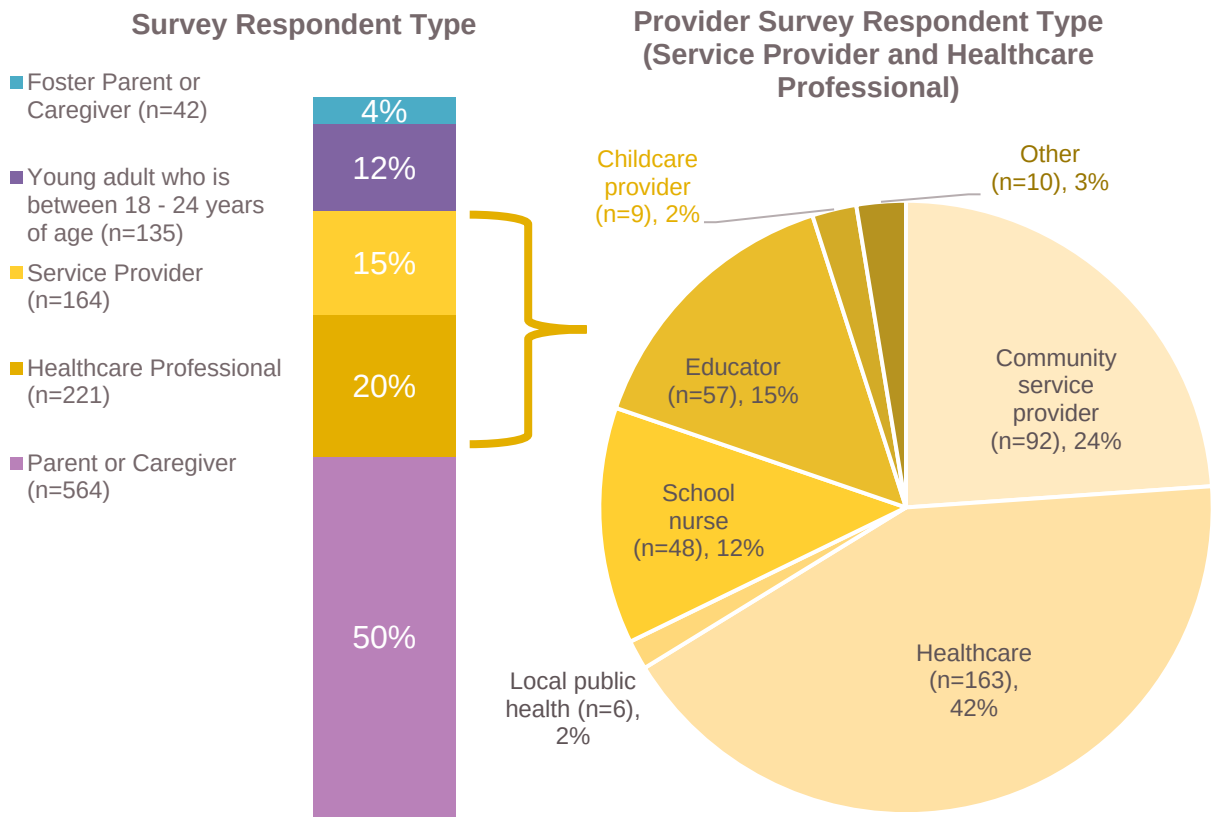
Method	Count	%
Email	335	29%
Workplace	235	21%
Other, please describe	111	10%
Community Meeting	75	7%
School	71	6%
Healthcare Provider	62	5%
Facebook	57	5%
Personal Contact (e.g., friends or family)	33	3%
X (Twitter)	28	3%
Newsletter	27	2%
I prefer not to say	25	2%
Instagram	25	2%
Next Door	20	2%
Faith-based setting (e.g., church, synagogue, mosque)	18	2%

Note: Retailer, (8), grocery store (3), newspaper (3), and library (2) were selected by a total of 10% of survey respondents. Source: Children's Health Survey, 2025

At the beginning of the survey, respondents were asked to identify their role in the community. As **Figure 5** shows, most were parents/caregivers (49%), young adults aged 18–24 (12%), and foster parents/caregivers (4%). The remaining 385 respondents identified as providers, including healthcare professionals (19%) and service providers such as social workers, school nurses, and educators (14%).

Respondents who identified as providers were asked to further specify their role. **Figure 5** also outlines the breakdown of provider types, with the largest group being healthcare professionals (42%), followed by community service providers (24%), and educators (15%). Those who selected "healthcare professional" were asked to describe their specialty. The most common specialties were physician (36%) and behavioral health professional (32%).

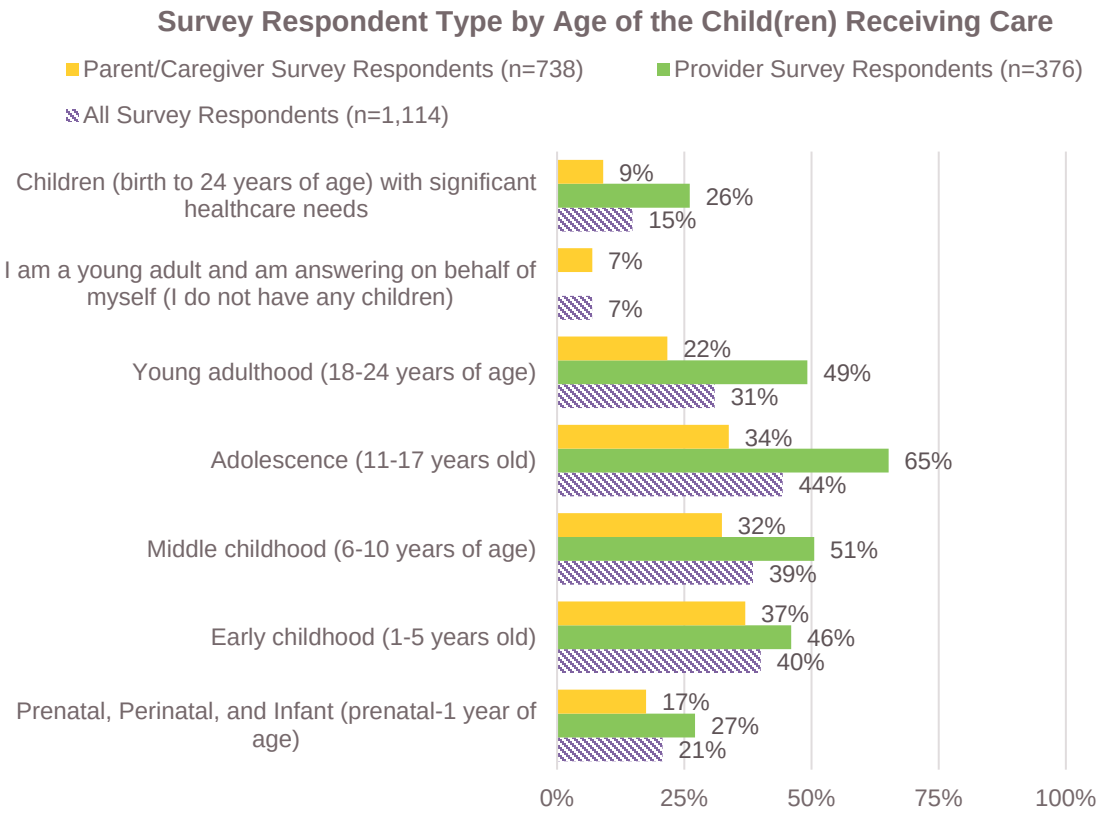
Figure 5. Survey Respondents by Type



Source: Children's Health Survey, 2025

The most frequently selected age groups receiving care among survey respondents were adolescents (11–17 years) at 44%, early childhood (1–5 years) at 40%, and middle childhood (6–10 years) at 39%. Additionally, 15% of survey respondents reported working with children with significant healthcare needs, while 21% cared for prenatal, perinatal, and infant populations (**Figure 6**). Most provider respondents primarily cared for adolescents (ages 11–17, 65%), while parent/caregiver respondents more often cared for young children (ages 1–5, 37%).

Figure 6. Percentage of Survey Respondents by Age of the Child(ren) Receiving Care

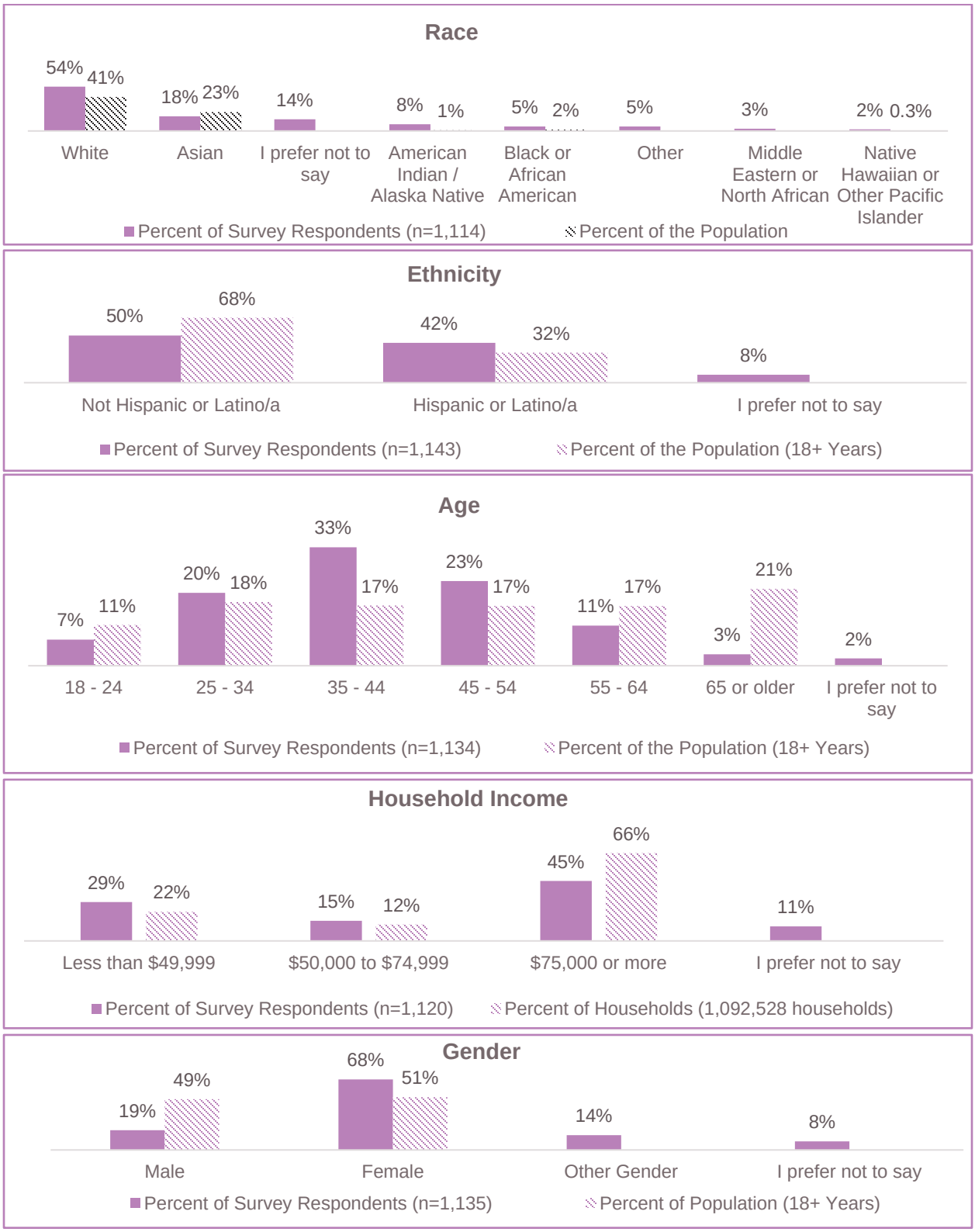


Source: Children's Health Survey, 2025

Survey Respondent Demographics

Survey respondents were asked nine demographic questions. Survey respondent demographics were compared with U.S. Census data to assess how representative they are of Orange County adults ages 18 and older (**Figure 7**).

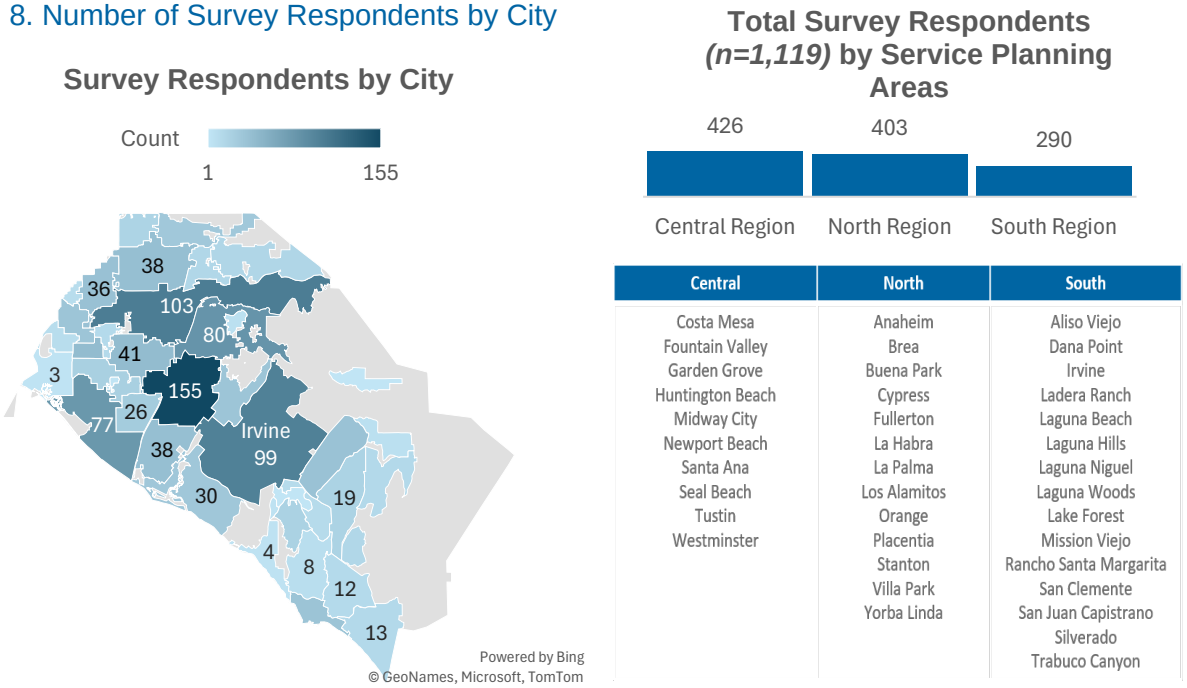
Figure 7. Survey Respondent Demographics



Note: Medicaid eligibility is income at or below 138% of the federal poverty level (FPL)—$21,597 per year for an individual or $44,367 per year for a family of four. U.S. Census tables referenced include Table S0101 (Age), S1901 (income), S0101 (Gender, Ethnicity, DP03 (Race).

Survey respondents were asked which Orange County city they live in. **Figure 8** illustrates the number of respondents per city and service planning area.

Figure 8. Number of Survey Respondents by City



Source: Children's Health Survey, 2025

The survey data were analyzed using Stats iQ, a built-in statistical analysis tool within the Qualtrics platform.[4] Using the responses to the demographic questions, survey respondent subgroups were established—based on respondent type, community of residence, or age of the child(ren) receiving care—to support meaningful conclusions while maintaining confidentiality. These categorizations enabled an examination of correlations between self-reported needs, experiences and outcomes and survey respondent attributes. The statistical significance of relationships between variables was examined and reported. This approach ensured that the findings presented in this report are both statistically sound and reflective of the diverse perspectives captured in the survey.

Key Informant Interviews

As part of its 2025 CHNA, 21 key informant interviews with a diverse group of community service providers across Orange County were held (**Table 3**). These interviews were designed to obtain expert insights into the health needs and reflect the experience of children and families, representing a spectrum of perspectives, including behavioral health, social services, education, oral health, and priority populations such as Asian Pacific Islander, Black/African American, Middle Eastern, LGBTQ2IA+, and individuals with developmental disabilities. Interviews were scheduled and completed in late April 2025. Participants were selected based

[4] Qualtrics. (2024). Qualtrics Stats iQ [Computer software]. Qualtrics. https://www.qualtrics.com

on their leadership roles, subject matter expertise, and deep community engagement. Many interviewees lived or worked in Orange County. The three central questions that guided these discussions included:

1. What do you think are the major health-related challenges facing communities in Orange County?
2. What do you think are the major risk factors associated with those health concerns?
3. What are Orange County's greatest strengths and assets with respect to these health concerns?

Table 3. Number of Key Informant Interview by Sector/Focus Area

Sector/Focus Area	Number of Interviewees
Behavioral Health	1
Children 0-5	1
Community, Health Centers, Community Violence	3
County Health/Physical Health	2
Health Insurance/Access	1
Education	1
Oral Health	1
Other - Corporate	1
Priority Populations (African American, Asian Pacific Islander, LGBTQ2IA+, Middle Eastern, People with Disabilities)	5
School Nurse	1
Social Service	1
Vaccines for Pregnant Women/Neonatal Care	1
Workforce and Economic Development	2
Total	21

All discussion notes from the 21 Key Informant interviews were analyzed to identify key informants' top three identified health issues affecting children and families in Orange County. **Appendix F** provides a detailed analysis of the key informant discussions. **Figure 9** provides a summary of the leading health issues prioritized by key informant interviewees.

Figure 9. Leading Health Issues Prioritized by Key Informant Interviewees

1. Mental Health
Anxiety and depression among youth

2. Economic Instability
Driven in part by housing instability and high costs of living

3. Accessing Healthcare
Such as long wait times and difficulty navigating the system

Community Member Focus Groups

A series of focus groups was conducted to validate findings from the Children's Health Survey. First 5 Orange County, CalOptima, and the Orange County Department of Education supported the recruitment of focus group participants. All focus groups were conducted virtually. Through these conversations, deeper insights into the experiences of children and families, challenges, and strengths of families across Orange County was gained. **Table 4** summarizes focus group participation.

Table 4. Focus Group Participation

Focus Group	Total Number of Focus Groups	Total Participants
Community Health Workers	2	18
School Nurses	3	45
Parents and Caregivers–English	1	5
Parents and Caregivers– Spanish	1	12

Four central questions guided the focus group discussions:

1. What are the primary health concerns for children and families in Orange County?
2. What are some of the biggest barriers to maintaining good health for children and families?
3. What resources do children and families need to achieve their goals?
4. What could the community improve in supporting children and families?

The discussions explored the complex landscape of child and family health in Orange County, examining challenges, barriers, health concerns, community assets, service gaps, needed resources, and health disparities affecting diverse populations. **Appendix D** provides a detailed analysis of the focus group discussions. **Figure 10** lists the leading health priorities among focus group participants.

Figure 10. Leading Health Issues Prioritized by Focus Group Participants

1. Mental Health and Emotional Well-Being
Anxiety and depression, and positive mental health and being stress free

2. Nutrition and Physical Activity
Lack of adequate exercise, access to affordable nutritional foods, and limited education on nutrition driving prevalence obesity and diabetes among children

4. Social Drivers of Health and Impact on Care Access and Health Outcomes
Housing, transportation, economic stability, and access to healthy foods

Secondary Data Analysis

Data from several local, state, national databases and public health sources provided a comprehensive picture of Orange County children and family health, including:

- Population characteristics, such as race/ethnicity, education level, income level, and employment statistics
- Health outcomes, including chronic disease prevalence and mortality rates
- Health behaviors, including physical activity, nutrition, and alcohol, drug, and tobacco use
- Healthcare utilization, including hospital inpatient and outpatient data
- Access-to-care indicators, such as population-to-provider ratios and health professional shortage area designations
- SDOH indicators, including affordable housing, food security, and access to childcare

Secondary data used in this CHNA came from local, state, and national sources such as vital statistics and records from the California Department of Public Health and Environment, the U.S. Census Bureau, the Behavioral Risk Factor Surveillance System, the California Department of Education's California Healthy Kids Survey, and the University of California, Los Angeles (UCLA) Center for Health Policy Research, California Health Interview Survey.

Once information from these data sources was collected and compiled, it was analyzed to compare health needs in Orange County to California. Results were then presented to and reviewed by interest holders in the community and by the CHNA Steering Committee and Advisory Committee. This multifaceted approach ensured that our findings and interpretation were informed by a range of interest holders.

Prioritization of Health Needs

Health priorities were determined because both of the following were found to be true for Orange County in the CHNA:

- Community members expressed concern about the priority.
- Secondary data pointed to either significant differences in Orange County compared with California or indicated a worrisome or worsening trend.

Health priorities were selected using the following criteria:

- Can Rady Children's Health Orange County influence the issue?
- Is there existing Rady Children's Health Orange County strategic focus and/or initiative on the issue?
- Is there community will and opportunity to leverage or influence the issue?
- Is measurable change possible within three years?

Additionally, the column ***"****Potential Areas to Commit and/or see Rady Children's Health Orange County and the Community Together to Address"* outlines preliminary recommendations prioritized by the community through the survey, focus groups and key informant interviews.

Health Priorities	Concerns Identified By the CHNA	Areas to Commit and/or see Rady Children's Health Orange County and the Community Together to Address
Behavioral Health	• Mental Health Conditions o Depression o Anxiety o Stress o Eating disorders o Suicidal ideation • Substance use	• Expand access to mental health services (which include culturally and linguistically appropriate therapists, and improve timely and affordable mental healthcare) • Education about behavioral health issues with a focus on engaging adolescents and perinatal, prenatal, and new parents of infants • Substance use or addiction prevention
Access to Pediatric Healthcare Services	• Ability to access healthcare services • Availability of appointments during times that are convenient for parents or caregivers • Long wait times and providers not taking new patients • Complex navigation systems • Lack of access to cultural and linguistically appropriate services	• Expand access to primary healthcare services • Make appointments available at times that are convenient for the patient • Teamwork between healthcare organizations and community-based organizations • Tools to assist patients and families in navigating the healthcare system

The way communities and individuals experience health and healthcare is based on more than physical access to medical services; it is impacted by other factors that may support or create barriers to health and well-being referred to as social drivers of health (SDOH). This CHNA identified four drivers of health to consider when developing strategies to respond to the two health priorities.

Social Driver of Health Priorities	Priority Risk and Protective Factors Identified by Community
Connectedness	• Absence of positive adult role models for children, including gaps in modeling good lifestyle habits by family members, lack of family engagement in children's care, families overwhelmed with care needs of aging family members • Social media contributing to setting unrealistic expectations for both children and caregivers/parents
Economic Stability	• Increasing costs of living, including housing, childcare, and food • Access to affordable extracurricular activities (e.g., youth sports, art, camps, afterschool programming)
Healthy & Affordable Foods	• Cost and proximity to nutritious foods • Access to education about nutritious food
Safe Homes, Schools & Neighborhoods	• Low-crime and safe neighborhoods • Injury prevention • Community violence • Bullying, including cyberbullying • Domestic abuse

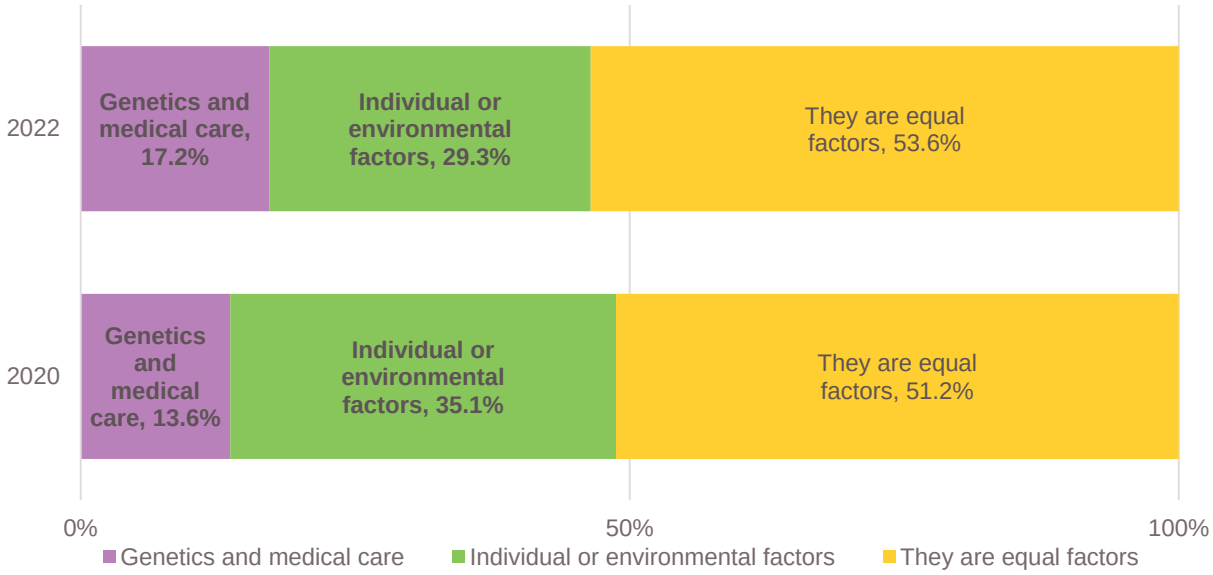
Community Context

Social and community factors significantly influence healthcare access and outcomes, affecting the availability and quality of medical services across different communities. The findings presented in this CHNA are derived from an assessment of children's health, incorporating insights from key informant interviews, focus groups, and the Children's Health Survey. This multifaceted approach allowed for a deep dive into the experiences, perceptions, and priorities of young adults, parent/caregivers, health and social service providers, school administrators and teachers, and other community members.

These voices expressed a range of concerns, including challenges related to finding stable housing, achieving financial stability, accessing nutritious and healthy foods, paying for amenities needed for health and wellness, locating mental and physical healthcare and safe outdoor spaces for children to play and exercise. For example, school nurses highlighted the economic stress families experience daily to make difficult choices between basic needs and healthcare or those who need to navigate the benefits system that is perceived to create traps that discourage economic progress. As illustrated by the quote, ***"They're afraid to take a raise because they'll lose childcare."*** The economic barriers in Orange County trap families in cycles that prevent health improvement, causing structural disincentives in the benefits system known as the "benefits cliff." Community health workers (CHWs) in focus groups reported severe living conditions, with one stating, ***"We have families living in cars with babies… they're on waitlists [for supportive services] for years."*** Statements like these underscore the critical nature of social and community factors in determining the accessibility and affordability of healthcare. Additionally, the lack of access to pediatric specialists creates additional delays in obtaining necessary evaluations and services creating delays in care.

Rarely, if ever, does one factor determine the health of a community and its residents. In 2022, the California Health Interview Survey found that 17.2% of Orange County adults reported the most important factor for sound health was genetics and medical care (higher than 13.6% in 2020), while 29.3% reported it was individual or environmental factors (lower than 35.1% in 2020). In 2022, more than half (53.6%) of the adult respondents said that these factors are equal, reflecting an increasingly holistic view of health (**Figure 11**).

Figure 11. Most Important Factor to Health



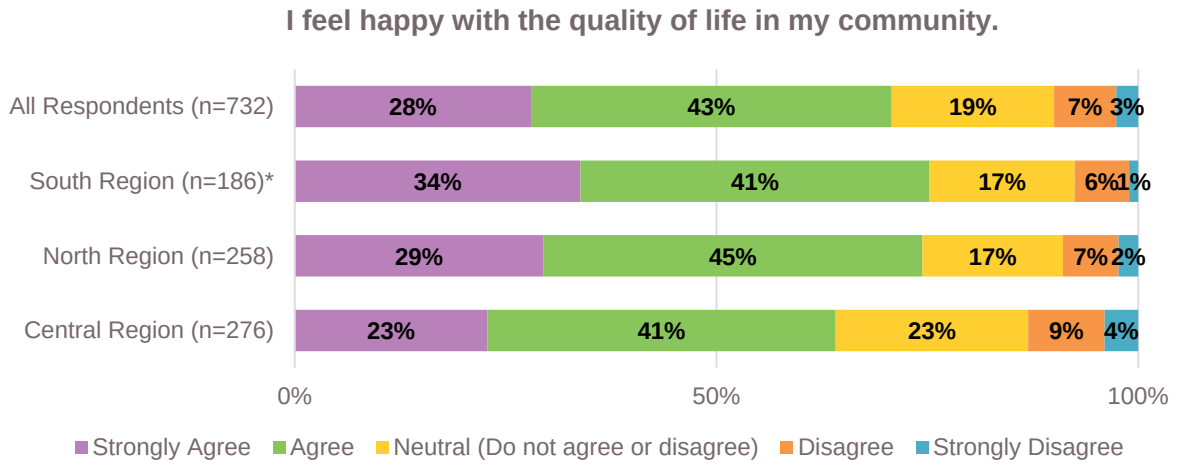
Source: UCLA Center for Health Policy Research, California Health Interview Survey, 2022

Quality of life is a powerful driver of health because it reflects the overall well-being of individuals—physically, mentally, and socially. People with higher life satisfaction tend to engage in healthier behaviors, experience less stress, and have stronger social connections, all of which contribute to lower risks of chronic disease and premature death. Conversely, inadequate quality of life can lead to increased vulnerability to illness, reduced resilience, and higher mortality rates.[5]

Parents and caregivers of the Children's Health Survey respondents were asked about whether they were happy with the quality of life in their community. Most parents/caregivers survey respondents indicated satisfaction with their community's quality of life, with 71% agreeing or strongly agreeing (**Figure 12**). Analysis by region shows that the survey respondents living in the South Orange County Region had the highest satisfaction levels, as 75% of respondents expressed agreement or strong agreement.

[5] Centers for Disease Control and Prevention. Health-Related Quality of Life (HRQOL). Available at: https://archive.cdc.gov/#/details?url=https://www.cdc.gov/hrqol/index.htm.

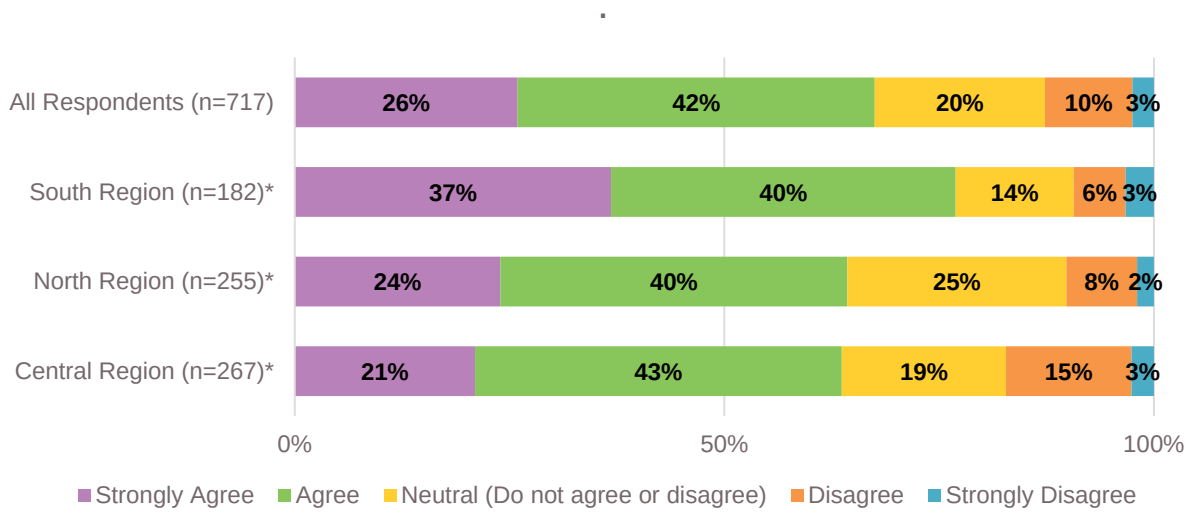
Figure 12. Community Strengths: Quality of Life (Parents/Caregivers)



*South Region "strongly agree" responses were significantly higher than those in the Central Region. Source: Children's Health Survey, 2025

Most parents/caregivers survey respondents view their community positively for raising children, with 68% agreeing or strongly agreeing. South Region reported the highest agreement (77%). Central Region reported the highest disagreement rate at 18% (**Figure 13**).

Figure 13. Percentage of Parent/Caregiver Survey Respondents by Level of Agreement with a Quality of Life Statement about Raising Children



*South Region "strongly agree" responses were significantly higher than other regions. North Region respondents were more likely to give a "neutral" rating than people in the South Region. Central Region "disagree" rates were significantly higher than the other regions. Source: Children's Health Survey, 2025

The Children's Health Survey asked all respondents to indicate the most important risk factors, protective factors, and health problems in their community. The three prompts were as follows:

1. **Most Important Protective Health Factors:** Below is a list of things that can make a community healthy for kids and families. Pick up to FIVE of the most important ones for the children and families you know.
2. **Most Important Risk Factors:** Here is a list of things that research has shown can lead to injuries, violence, and poor health. Choose up to FIVE things that you believe most harm the health of children and families you know.
3. **Most Important Health Problems:** Every community has health problems. Below is a list of common problems. Pick up to FIVE problems that most affect the children and families you know.

The following section describes the top five selections among all survey respondents for each prompt, as well as the top five priorities selected by caregivers/parents, providers, and by the region respondent lives in. Detailed data tables regarding responses to these questions are provided in **Appendix I**.

Most Important Protective Health Factors

Protective health factors are conditions or characteristics—biological, psychological, familial, or community-level—that reduce the likelihood of negative health outcomes.[6] Survey respondents were asked to select the top five most important protective health factors, and prioritized access to healthcare providers (59%), access to mental health services (47%), low-crime and safe neighborhoods (41%), and healthy food and nearby grocery stores (39%). The fifth highest priorities–all similarly ranked as the fifth most selected option - were affordable housing (34%), ability to access dental care (31%), and services for children and youth with significant healthcare needs (27%). Notable differences in how protective health factors were prioritized were that parents/caregivers placed greater emphasis on the ability to get dental care (34%) than providers (25%). Providers placed greater emphasis on access to mental health services (61%) and affordable housing (40%) than parents/caregivers (41% and 34%, respectively). Protective health factors were similarly prioritized across all regions.

Most Important Protective Health Factors

1. Able to get healthcare providers (59%)
2. Able to get mental health services (47%)
3. Low-crime and safe neighborhoods (41%)
4. Healthy food and close grocery stores (39%)
5. Affordable housing (34%)

Able to get dental care (31%)
Services for children with significant health care needs (25%)

Source: Children's Health Survey, 2025

[6] Centers for Disease Control and Prevention. (n.d.). Risk and protective factors. U.S. Department of Health & Human Services.

Focus Group Insights on Protective Health Factors

Focus group findings underscore that access to primary and mental healthcare providers is a key protective factor.

Focus group participants overwhelmingly identified limited access to mental health services as a major barrier to family wellbeing.

School nurses reported that many children receive only brief interventions and are then discharged without follow-up, leaving families without ongoing support or prevention.

Chronic absenteeism was highlighted as a significant consequence, as students miss large portions of the school year due to unmet mental health needs.

The shortage of providers and long wait times exacerbated issues with access to care, making timely care nearly impossible and forcing families to wait until crises arise.

School nurses and community health workers described feelings of isolation from medical systems, emphasizing the importance of their role in children's daily lives and a need for this role to be recognized among medical community.

School nurses and community health workers called for better integration with primary care, noting that effective collaborations can result in prompt, consistent services.

Key Informant Insights on Protective Health Factors

A recurring theme was the direct connection between housing stability and utilization of health services.

Interviewees noted that individuals worrying about their housing situations often prioritized meeting basic needs over seeking medical or mental health care.

Navigating the healthcare system poses challenges for families, particularly for those with private insurance.

Interviewees reported families struggled to find providers who accepted their insurance plans or who were located within a reasonable distance. Additionally, the complexity of insurance networks, combined with frequent changes in provider availability, often forced families to spend excessive time searching for appropriate healthcare providers. These processes delayed access to care and compounded existing barriers to timely services.

Most Important Risk Factors

Risk factors are conditions or characteristics that increase the likelihood of negative health outcomes such as injury, illness, or violence.[7] Survey respondents were asked to select the top five most important risk factors and prioritized the absence of positive adult role models (47%), bullying (including cyberbullying) (37%), poor dietary habits (31%), and community violence (26%). The fifth highest priorities–all similarly ranked as the fifth most selected option–were not getting regular health screening (24%), social media (22%), discrimination or racism (20%), not getting vaccinates (19%), and homelessness (14%).

Most Important Risk Factors

1. Absence of positive adult role models for children (47%)
2. Bullying, including cyberbullying (37%)
3. Poor eating habits (e.g., fast food, junk food) (31%)
4. Community violence (e.g., gang violence, homicide) (26%)
5. Not getting regular health screening (24%)

- Social media, including excessive or inappropriate use (22%)
- Discrimination or racism (20%)
- Not getting vaccinated (19%)
- Homelessness (14%)

Source: Children's Health Survey, 2025.

Notable differences in how health factors were prioritized between parents/caregiver and provider survey respondents included:

- Providers were more likely than parents/caregivers to emphasize the impact of social media use (27% and 19%, respectively) and homelessness (19% and 12%, respectively)
- In contrast, parents/caregivers were more likely than providers to prioritize discrimination or racism (22% and 15%, respectively) and gaps in vaccination (21% and 16%).

Notable differences in the prioritization of risk factors depending on the region the respondent lives included:

- Respondents living in the North Region prioritized the absence of positive adult role models for children at the highest rate (53%) over respondents living in the Central (45%) and South (39%) regions.
- Respondents living in the Central Region prioritized community violence (31%) more than respondents living in the South Region (18%).

[7] Centers for Disease Control and Prevention. (n.d.). Risk and protective factors. U.S. Department of Health & Human Services

Focus Group Insights on Risk Factors

Focus group participants emphasized housing instability, immigration fears, system fragmentation, social media and bullying and poor nutrition as risk factors harmful to the health of children and families.

School nurses noted that the absence of positive role models at home—often due to competing parental priorities—can lead to reduced engagement in children's health and well-being.

Digital literacy and social media education emerged as needed, with a suggestion to develop strategies that use social media platforms to educate parents and counter misinformation.

Key Informant Insights on Risk Factors

Key informants discussed how historical exclusion and discrimination have led to a deep mistrust of healthcare systems among some low-income and immigrant populations, deterring them from seeking necessary care.

Most Important Health Problems

Community survey respondents were asked to identify the most common health problems affecting children and families they know, prioritizing developmental disabilities (62%), poor mental health (40%), diabetes (36%), and cancer (32%) (Error! Reference source not found. **5**). The fifth most prioritized health conditions - all similarly ranked as the fifth most selected option - were breathing problems/lung disease (29%), drug addiction (26%), alcohol addiction (22%), eating disorders (21%), suicide (17%), and injuries (physical or emotional) from domestic violence (DV) or abuse (15%).

Notable differences in how parents/caregivers and provider survey respondents prioritized health conditions included:

- Providers expressed significantly greater concern about poor mental health (56%) than parents/caregivers (32%). Providers also placed greater emphasis on suicide than parents/caregivers (22% and 15%, respectively) and injuries from DV or abuse (22% and 12%, respectively).
- Parents/caregivers were more likely to prioritize cancer (35%) compared to providers (23%).

Notable differences between how health conditions were prioritized depending on the region the respondent lives included:

- Diabetes was prioritized in the North and Central regions (40% and 37% of survey respondents, respectively).
- Injury from DV or abuse was prioritized in the Central (18%) and North (17%) regions.
- Breathing problems/lung disease were prioritized in the North Region (33%).
- Alcohol addiction and suicide were prioritized in the Central Region (26% and 22%, respectively).
- Eating disorders were prioritized in the South Region (28%).

Table 5. Health Problems by Respondent Type

	Health Problem		Notable Differences Between Parent/Caregiver and Providers		Notable Differences Between Regions		
		All	Caregivers	Providers	South	North	Central
1	Developmental disabilities (e.g., autism, ADHD)	62%	59%	68%	59%	65%	61%
2	**Poor mental health**	40%	**32%**	**56% +**	41%	36%	42%
3	Diabetes	36%	36%	37%	30%	**40%***	37%
4	**Cancer (all types)**	32%	**36% +**	**23%**	30%	31%	34%
5	**Breathing problems/lung disease**	29%	29%	30%	23%	**33%***	28%
	Drug addiction	26%	23%	30%	22%	25%	29%
	Alcohol addiction	22%	21%	23%	22%	18%	**26%***
	Eating disorders	21%	21%	23%	**28%***	21%	19%
	Suicide	17%	**15%**	**22% +**	13%	15%	**22% ***
	Injuries (physical or emotional) from DV or abuse	15%	**12%**	**22% +**	10%	**17%***	**18% ***

+Significant difference between parent/caregiver and provider survey respondents.
*Significantly higher than other regions. Source: Children's Health Survey, 2025

Focus Group Insights on Health Problems

Focus group participants most often mentioned mental health concerns, followed by nutrition and exercise-related conditions like obesity and diabetes, and concerns for children with developmental delays and the wait times for diagnoses and services. School nurses and community health workers concentrated more on mental health, whereas parents/caregivers expressed more concern about physical health conditions.

Mental Health

Mental health emerged as the most frequently cited health problem.
Community health workers emphasized how multiple stressors compound mental health issues, noting **"compounding effects of housing instability, economic stress, immigration fears, and social media pressure."**
The lack of family follow-through with mental health care was attributed to competing family priorities and limited understanding of the importance of ongoing treatment.

Diabetes and Obesity

Diabetes was discussed as a growing health concern, particularly among younger children, reflecting broader nutritional and lifestyle challenges.
Parents/caregivers directly linked childhood obesity and diabetes to poor nutrition, limited physical activity, and time constraints that prevent preparation of healthy meals.
The concern extends to school food programs, with parents/caregivers expressing worry about the quality and nutritional balance of school meals.

Key Informant Insights on Health Problems

Autism

Early childhood leaders expressed concern that access to autism care remains a complex and delayed process.

Mental Health

Stigma remains a barrier to mental health care, and recent laws have increased stress for vulnerable groups. Climate anxiety and disaster trauma are growing concerns.	Increased anxiety and depression among children driven in part by family financial instability and/or uncertainty with the changing Federal administration.

Most Important Areas for Community Commitment

A fourth question was asked of all Children's Health Survey respondents: What are the top FIVE issues and/or services you'd like to see Rady Children's Health Orange County and the community of Orange County work together to address? The issues and/or services selected by survey respondents are referred to as priorities for "community commitment" in this CHNA.

Survey findings revealed that the top four areas for community commitment identified by all respondents were education about behavioral health issues (52%), affordable housing (44%), improved teamwork between healthcare and community organizations (35%), and jobs that pay enough money to themselves and their family (33%). Several community commitments ranked fifth.

Community Commitment Priorities: Issue or Service Priorities for Rady Children's and the Orange County Community to Work Together to Address

1. Education about behavioral health issues (52%)
2. Affordable housing (44%)
3. Teamwork between healthcare organizations and community organizations to help families meet their needs (35%)
4. Jobs that pay enough money to support me and my family (33%)
5. Affordable, healthy, and nutritious food (31%)

- Programs to prevent substance use or addiction (29%)
- Positive activities, services, resources, and programs for youth (27%)
- Quality and affordable childcare (23%)
- Assistance for families switching to new healthcare providers or finding providers they need (21%)
- Help managing disease or chronic health conditions (21%)
- School health and wellness programs (20%)
- Resources to help families create consistent routine and stable home lives that build child resilience (19%)

Note: The Children's Health Survey included questions asking respondents to choose their top five health needs, issues, or factors. In some cases, the difference between the fifth most selected item and the next was not statistically significant. As a result, the CHNA reports health issues, needs and factors that were tied with the fifth selected option, as the frequency of selections varied only slightly. As a result, more than five selections are reported. Source: Children's Health Survey, 2025.

Notable differences in how community commitments were prioritized between parents/caregivers and provider survey respondents included:

- Parent/caregiver survey respondents placed greater emphasis on behavioral health education (58%) compared to providers (49%).
- Provider survey respondents were more likely to prioritize inter-organizational collaboration (40%) than parents/caregivers (33%).

- Providers focused more on building child resilience at home than parent/s caregivers (28% and 14%, respectively), while parents/caregivers prioritized navigating access to care over providers (24% and 15%, respectively).

Regional differences in the selected priorities for community commitment included:

- Affordable housing was prioritized among survey respondents living in the Central Region (51%) than in North (42%) and South (35%) regions.
- The South Region prioritized help for families that are switching healthcare providers (26%).

Focus Group Insights on Priorities for Community Commitment

The priorities highlighted in focus group discussions include expanded and continuous mental health services, expanding access to nutritious foods, nutrition education (providing families with information, resources, and skills to make healthy food choices, prepare nutritious meals, and understand the importance of diet for children's growth and development improve nutrition and family engagement etc.), early intervention and developmental services, health education and parent empowerment, and improved communication and coordination between healthcare and community organizations. The parents/caregivers who participated in the focus groups emphasized more services, whereas providers placed greater emphasis on system coordination.

Expand Culturally and Linguistically Responsive Mental Health Services

Increase the availability of therapists who are culturally & linguistically responsive to meet the diverse needs of the community.

Expand Mental Health Service Across All Age Groups, Including Preschoolers

The need extends beyond crisis response to include accessible, long-term mental health care, as students often receive only five sessions before being left without follow-up, even when needs persist.

Mental Health Drop-In Services

Parents/caregivers specifically expressed interest in drop-in mental health spaces, mindfulness programs, and ongoing support that recognizes the interconnected nature of family mental health.

Improve Quality of Virtual Therapy

Families expressed a desire for virtual therapy that is not only accessible and affordable, but also culturally and linguistically responsive, with providers who can build trust and continuity of care. Addressing these gaps will require investments in technology, training, and service models that prioritize relationship-building, engagement, and high-quality, personalized care ensuring that virtual therapy is a meaningful and effective option for all families in Orange County.

Quick, Easy, and Affordable Mental Health Care

Community health workers emphasized that families need timely, affordable, and culturally appropriate mental healthcare for both children and parents, with long waitlists and limited pediatric mental health providers representing major obstacles.

Key Informant Insights on Priorities for Community Commitment

Key Informants highlighted collaboration among community partners, including nonprofit organizations, grassroots advocates, and culturally competent service providers as a current asset and strength within the community. Examples of these partnerships include:

Community Health Worker Initiative by CalOptima, which facilitates home visits for preventive care education.

Public health promotion networks and behavioral health initiatives like Be Well OC providing mental health and substance use support.

Robust safety nets, particularly in North and Central regions.

Although partnerships exist, strengthening teamwork between health care organizations and community organizations to help families meet their needs was acknowledged as a crucial next step, with lack of adequate funding to support essential programs and initiatives being a major gap. This includes resources for health education, workforce compensation, and comprehensive services.

The four questions were then analyzed by the age group of children receiving care from providers and caregivers, revealing unique priorities across developmental stages. **Table 6** shows the top five priorities for each age group of the child(ren) receiving care by the survey respondent, meaning that there was a priority they selected that differed from the priorities among all survey respondents. The four questions were:

1. **Protective Health Factors:** Below is a list of things that can make a community healthy for kids and families. Pick up to FIVE of the most important ones for the children and families you know.
2. **Risk Factors:** Here is a list of things that research has shown can lead to injuries, violence, and poor health. Choose up to FIVE things that you believe most harm the health of children and families you know.
3. **Health Problems:** Every community has health problems. Below is a list of common problems. Pick up to FIVE problems that most affect the children and families you know.
4. **Community Commitment:** What are the top FIVE issues and/or services you'd like to see Rady Children's Health Orange County and the community of Orange County work together to address?

Table 6. Children's Health Survey Findings: Priority Areas for Children's Health

	Protective Health Factors	Risk Factors	Health Problems	Community Commitments
All Respondents	• Access to health care • Access to mental health services • Affordable housing • Healthy food and nearby grocery stores • Safe neighborhoods	• Absence of positive adult role models • Bullying • Community violence • Not getting regular health screenings • Poor eating habits	• Breathing problems • Cancer • Developmental disabilities • Diabetes • Poor mental health	• Affordable housing • Food security • Education about behavioral health issues • Jobs • Teamwork between healthcare and community organizations
Prenatal, Perinatal & Infant	• Able to get dental care	• Not getting vaccinated		• Positive youth activities, services, resources and programs • Programs to prevent substance use
Early Childhood (Ages 1-5)				
Middle Childhood (Ages 6-10)		• Social media		
Adolescence (Ages 11-17)		• Social media		
Young Adulthood (Ages 18-24)	• Violence within the home, including child abuse and intimate partner violence	• Social media	• Drug addiction	
Young Adults Answering on Behalf of Themselves			• Alcohol addiction • Eating disorders	• Programs to prevent substance use or addiction
Children with Significant Healthcare Needs (Birth-Age 24)	• Services for children and youth with special healthcare needs	Social media		• Positive activities, services, resources and programs for youth

Source: Children's Health Survey, 2025

Elevating CHNA Findings Across All Data Sources

To ensure a nuanced understanding of community health needs, a cross-source analysis was conducted by aggregating findings from the four prioritization survey questions and cross-referencing them with insights from focus groups (FG) and key informant interviews (KII). This approach allowed for the identification of areas with strong alignment across data sources, reinforcing the validity and urgency of the identified priorities. By linking quantitative survey data with qualitative narratives from FG and KII, nuanced patterns and community –specific concerns that might otherwise be overlooked were surfaced.

Table 7 lists the top 5 risk and protective factors, health problems, and community commitments reported through the Children's Health Survey and each with an icon to highlight thematic alignment with the health and the driver of health priorities. Insights from the FG ( ) and KII ( ) are included to show where there were areas of alignment across data sources.

1. **Health Priority 1 - Behavioral Health ( ):** This includes poor mental health and substance use, and the need for behavioral health education. These issues were frequently cited across all data sources, underscoring the need for expanded behavioral health services and community-based prevention programs.

2. **Health Priority 2 - Access to Healthcare ( ):** Barriers to seeing healthcare providers and obtaining mental health services were prominent and navigating the healthcare system were repeatedly mentioned. The data emphasized the importance of improving access to both general and specialized care, especially for children with significant healthcare needs.

3. **Driver of Health Priority 1 - Safe Schools, Homes, and Neighborhoods ( ):** Safety concerns such as bullying, community violence, and domestic abuse were identified as critical risk factors. These findings point to the need for community safety initiatives and trauma-informed support systems.

4. **Driver of Health Priority 2 - Connectedness: ( ):** A sense of belonging, support, and meaningful relationships within their families, communities, schools, and broader social networks was identified as both a strength and a need.

5. **Driver of Health Priority 3 - Access to Healthy Foods and Grocery Stores ( ):** Poor eating habits, obesity, diabetes, and lack of nutritious food options were linked to broader issues of food insecurity. The data calls for interventions that improve food access and promote healthy eating.

6. **Driver of Health Priority 4 - Economic Stability ( ):** Challenges such as affordable housing, living wage jobs, and childcare were frequently mentioned. These economic drivers of health are foundational to long-term community wellness and require coordinated policy and service responses.

Table 7. Summary of Health Factors, Priorities, Risks, and Services Aligned Across Survey, Focus Groups, and Key Informants

	Protective Health Factors	Risk Factors	Health Problems	Community Commitments
1	Able to see a healthcare provider	Absence of positive adult role model for children	Developmental disabilities	Education about behavioral health issues
2	Able to get mental health services	Bullying, including cyberbullying	Poor mental health	Affordable housing
3	Access to low crime and safe neighborhoods	Poor eating habits	Diabetes	Teamwork between healthcare and community organizations
4	Healthy food and close grocery stores	Community violence	Cancer (all types)	Affordable and nutritious foods
5	Affordable housing Services for children with significant healthcare needs	Not getting regular health screenings Social media Discrimination or racism Not getting vaccinated	Breathing/Lung disease Drug & alcohol use Eating disorders Suicide Injuries from DV or abuse	Programs to prevent substance use Affordable childcare Navigating healthcare system

Icon Key

- Behavioral Health
- Access to Pediatric Healthcare Services
- Safe Schools, Homes and Neighborhoods
- Aligned with Focus Group Findings
- Connectedness
- Healthy and Affordable Foods
- Economic Stability
- Aligned with Key Informant Interview Findings

Understanding the CHNA Findings

- Examine each health issue in depth, presenting both prevalence data and contributing factors.
- Integrate primary data (e.g., insights from healthcare professionals, service providers, and caregivers) with secondary data (e.g., public health statistics and trend analyses) to highlight disparities and underlying causes.

Health Priority 1: Behavioral Health

According to the Centers for Disease Control and Prevention (CDC), behavioral health is a broad term that encompasses both mental health and substance use issues.[8] It refers to the connection between behaviors and the well-being of the body, mind, and spirit. This includes how individuals cope with stress, relate to others, and make choices that affect their overall health.

- Mental health involves emotional, psychological, and social well-being. It affects how people think, feel, and act, and includes conditions such as depression, anxiety, and bipolar disorder.
- Substance use refers to the misuse of alcohol, drugs, or other substances that can impact physical and mental health, often co-occurring with mental health disorders.

Together, behavioral health addresses the interplay between mental health conditions and substance use, recognizing that these issues often overlap and influence one another. Integrated behavioral health approaches treat both conditions simultaneously to improve overall outcomes for individuals and communities.

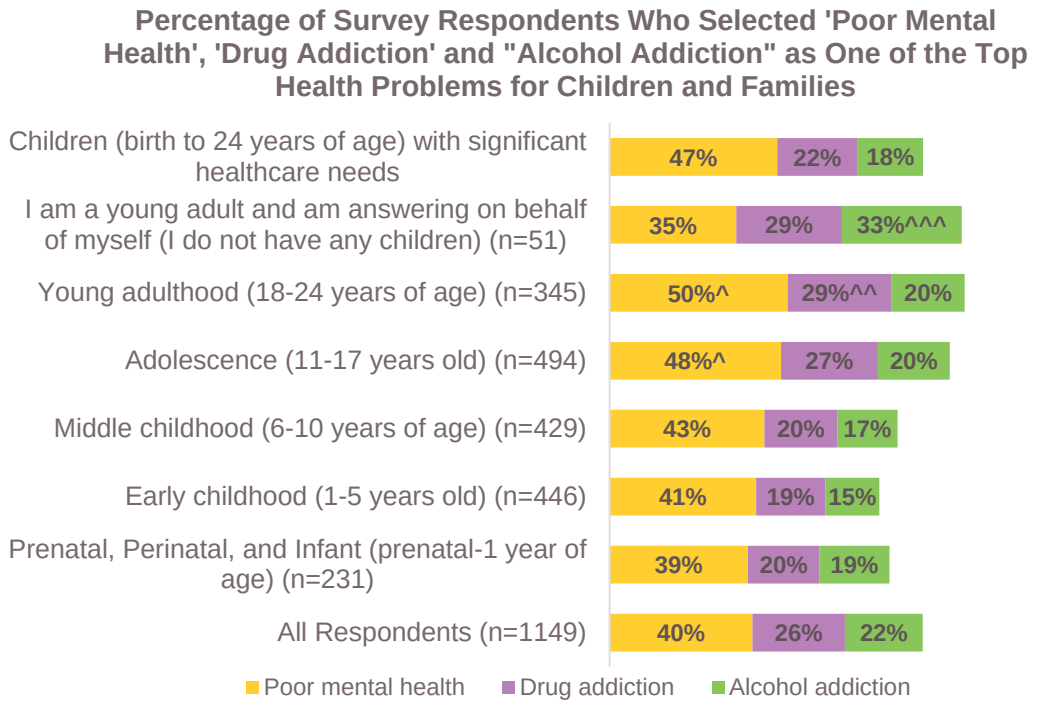
Respondents to the Children's Health Survey selected up to five health problems from a list of 23. **Figure 14** shows how survey respondents prioritized mental health and substance use concerns by the age of the child(ren) receiving care. Poor mental health was most frequently chosen (40%), followed by drug addiction (26%), and alcohol addiction (22%). Additional findings highlighted the prominence of these behavioral health problems among adolescents and young adults.

- Poor mental health emerged as the second most prioritized issue overall, after developmental disabilities (e.g., autism, ADHD), with half (50%) parents/caregivers and provider survey respondents caring for young adults and nearly as many survey respondents care for adolescents (48%) identifying it as a major concern.

[8] Centers for Disease Control and Prevention. About Behavioral Health. June 9, 2025. Available at: https://www.cdc.gov/mental-health/about/about-behavioral-health.html.

- Drug addiction, ranked sixth, was prioritized by survey respondents providing care to young adults (29%) and among young adult survey respondents themselves (29%).
- Alcohol addiction, which ranked seventh overall, was most frequently prioritized by young adults (33%) and by respondents providing care to adolescents (20%), underscoring that substance use issues and poor mental health were pressing concerns for adolescents and young adults in the community.

Figure 14. Prioritization of Behavioral Health Problems by the Age of Child(ren) Receiving Care

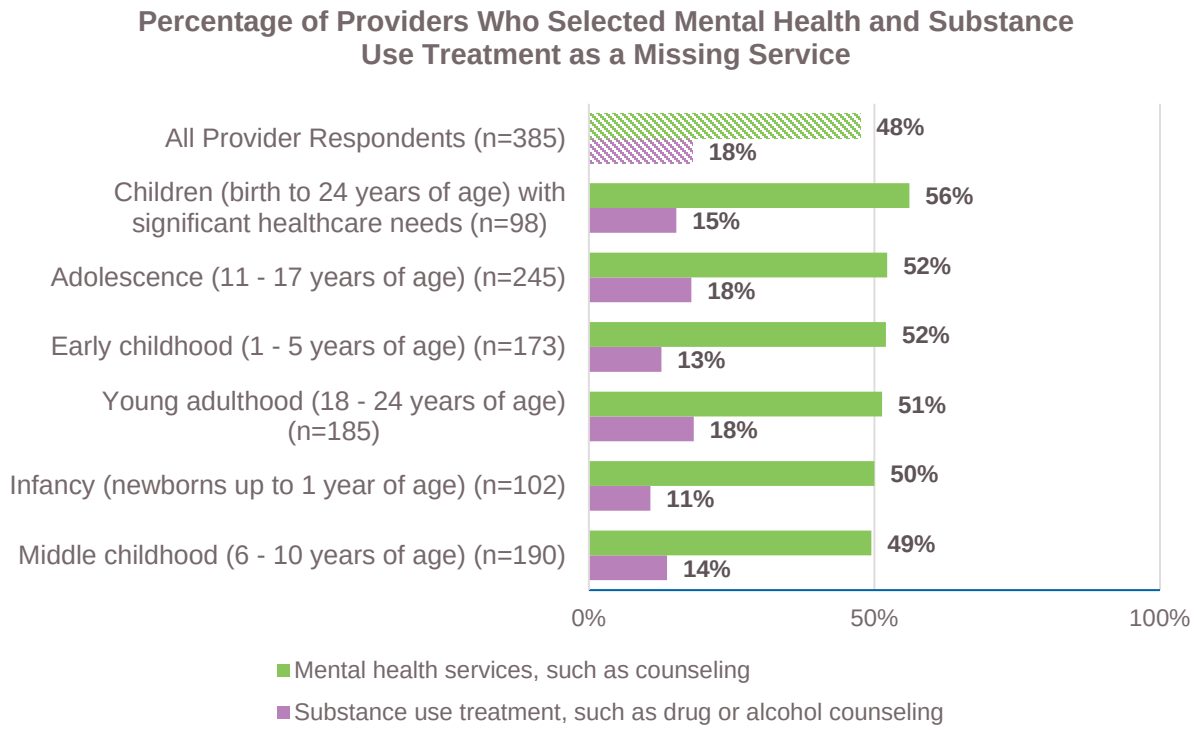


^Survey respondents caring for adolescents and young adults were significantly more likely to select poor mental health. ^^Survey respondents caring for young adults was significantly more likely to select drug addiction. ^^^Young adults answering on behalf of themselves were significantly more likely to select alcohol addiction respondents caring for middle childhood and/or early childhood. Source: Children's Health Survey, 2025

When asked to identify gaps in services for children and families in the Children's Health's Survey, provider survey respondents—regardless of the age group they provide care to—overwhelmingly pointed to mental health services such as counseling as the most critical unmet need, ranking it first out of 34 service categories provided in the survey as response options. Provider survey respondents emphasized the need for enhanced services for children with significant healthcare needs (56%), adolescents (52%), early childhood (52%), young adults (51%), and infants (50%), and middle childhood (49%)—underscoring the universal demand for mental health resources regardless of age group (**Figure 15Error! Reference source not found.**).

In addition to mental health services, substance use disorder (SUD) treatment was identified as a significant issue, ranking sixth out of 34 service categories provided in the survey as response options, including drug and alcohol counseling services. Though the overall concern was lower for SUD than for mental health, the data still indicates a meaningful demand for SUD services across age groups. Among provider survey respondents, 18% cited SUD treatment as a missing service. This prioritization was regardless of the age of the child(ren) receiving care.

Figure 15. Provider Perspective on Missing Services: Mental Health and Substance Use Treatment by Age of Child(ren) Receiving Care

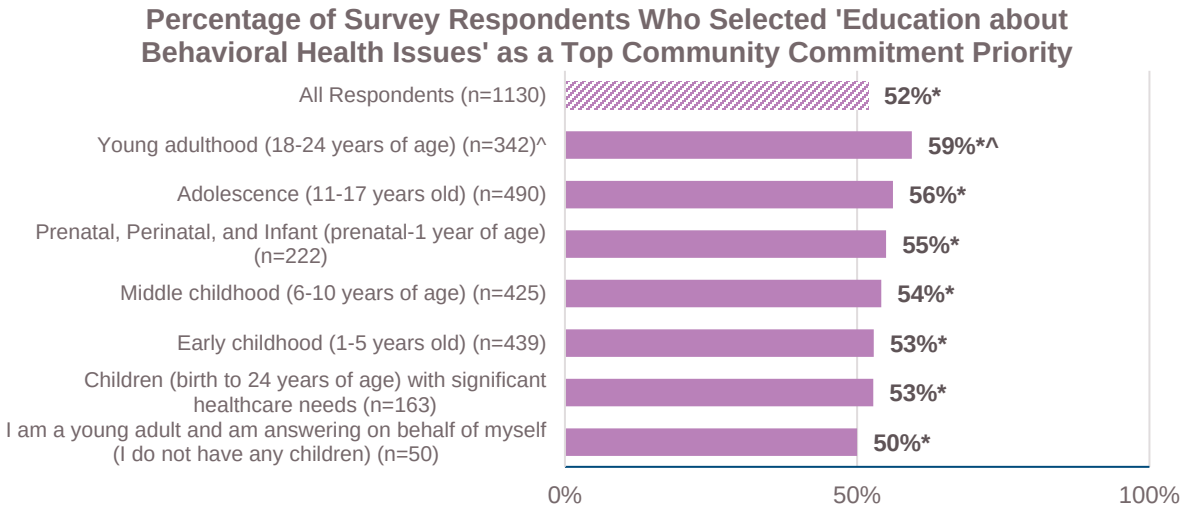


Note: No statistical difference among the groups. Source: Children's Health Survey, 2025

Health promotion and prevention services for behavioral health were prioritized by survey respondents when asked to select the top five issues and/or services they'd like to see Rady' Children's and the community of Orange County work together to address as a community commitment. Education about behavioral health issues—including topics such as substance use, suicide prevention, and mental health diagnoses like anxiety, depression, and bipolar disorder—were identified as the number one priority community commitment. More than half of all participants (52%) selected behavioral health education as a priority community commitment (**Figure 16**).

Respondents caring for young adults (18-24 years) ranked community education on behavioral health as their top investment priority (59%), followed by those serving adolescents (56%) and providers for prenatal, perinatal individuals, and infants (55%) suggesting education should be aimed at pregnant families and parents of children under one as well as adolescents and young adults.

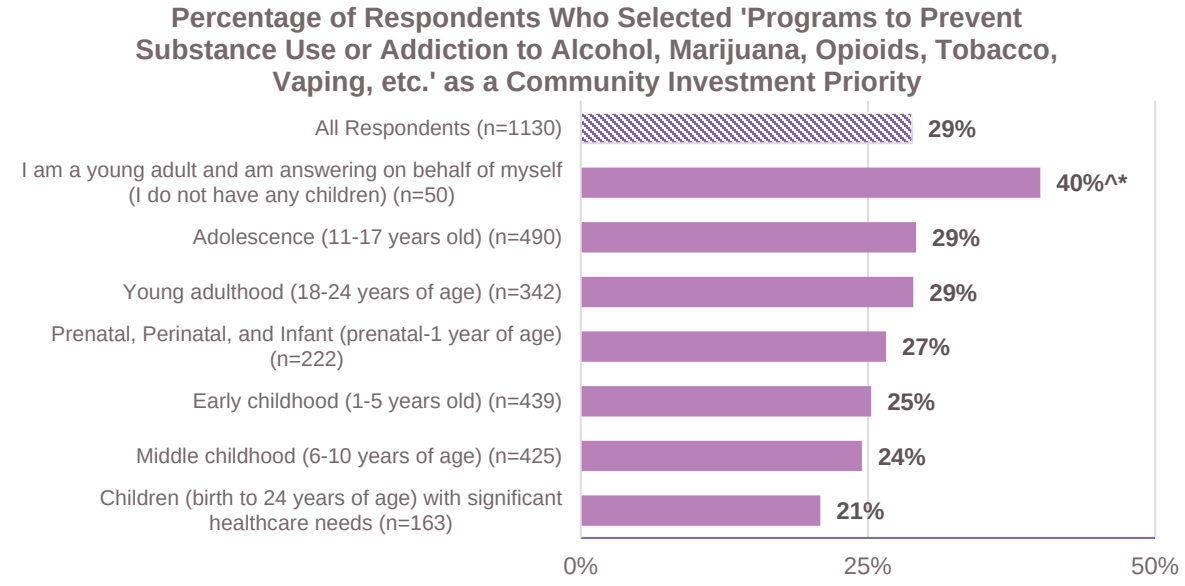
Figure 16. Community Commitment Priorities: Education About Behavioral Health by Age of Child(ren) Receiving Care



^Rates among all survey respondents who provide care to young adults was significantly higher than survey respondents providing care to other age groups. *Ranked among the top five priorities. Source: Children's Health Survey, 2025

Substance use prevention programs ranked sixth among community commitment options, with 29% of respondents highlighting this need. Prioritization was highest among survey respondents who are young adults and answering the survey on behalf of themselves (40%) (**Figure 17**).

Figure 17. Community Commitment Priorities: Programs to Prevent Substance Use or Addiction by Age of Child(ren) Receiving Care



^Young adults answering on their own behalf were most likely to rank substance use as a top investment priority. *Ranked among the top five priorities. Source: Children's Health Survey, 2025

Mental Health

Mental health issues emerged as the most frequently cited health concern, affecting both children and parents across all age groups and communities. Participants described anxiety, depression, and toxic stress as pervasive conditions.

School nurses noted that mental health concerns create cascading effects on educational outcomes. One nurse explained, ***"we just can't get them the services that they need, and they miss 30–40% of the school year."***

Postpartum depression and anxiety were highlighted, where new mothers are found to experience isolation and lack of support, contributing to their own mental health challenges.

Parents/caregivers emphasized the unique emotional toll of parenting under stress, with ongoing effects from the pandemic continuing to affect family mental health.

Substance Use Disorder

Key Informants raised concerns around the rise in people with substance use disorders, including increased use of vape, marijuana, alcohol, fentanyl, and party drugs.

Key informants reported a concern about the link between the rise in vaping among teens and nicotine addiction and respiratory issues.

Marijuana was thought to be increasing due to its use serving as a coping mechanism for stress and mental health challenges, whereas alcohol use was linked to social pressures and economic stress.

In summary, the community–as shared through the Children's Health Survey, key informant interviews and focus groups–believe behavioral health conditions were widespread or worsening, and there was a need for more services and resources, including upstream prevention and early intervention. Below is a summary of the secondary data that reveals both positive trends and areas for improvement in the prevalence of pediatric behavioral health conditions and access to behavioral health services in Orange County.

Positive Trends in Behavioral Health from the Secondary Data

1. **Access to Counseling** The percentage of youth ages 12–17 receiving psychological/emotional counseling increased from 18.6% in 2022 to 22.8% in 2023, indicating improved access to mental health support.
2. **Binge Drinking** Binge drinking among students decreased across all grade levels in 2017–2019 and 2021–2023, with the most significant drop occurring among non-traditional school-based students (from 24% to 9%) [1].
3. **Suicidality** The percentage of students seriously considering suicide declined slightly across all grade levels since 2017–2019, reflecting potential improvements in awareness and support.
4. **Vaping and Cigarette Use** E-cigarette use declined but remained higher than cigarette use: In 2023, 6% of grade 11 students and 4% of grade 9 students reported vaping, compared with 13% and 9% in 2017.

Areas for Improvement in Behavioral Health from the Secondary Data

1. **Emotional Maturity** From 2015 to 2025, Orange County's Early Development Index (EDI) data shows improvement in school readiness across four of five developmental domains, with the greatest gains in language and cognitive development. However, emotional maturity declined.
2. **Depression-Related Feelings** Between 30% and 39% of students reported depression-related feelings in 2021–2023. These rates have increased since 2011–2013, when they ranged from 23% to 34%.
3. **LGBTQ2IA+ Youth Mental Health** Students identifying as gay, lesbian, or bisexual were more than twice as likely as their heterosexual peers to report depression-related feelings (64.8% vs. 27.3%).
4. **Unintentional Injury Deaths** The rate of unintentional injury deaths among youth increased to 5.9 per 100,000 in 2023, up from a 10-year low of 1.6 deaths per 100,000 in 2019. In 2023, forty-four percent of these deaths resulted from poisoning, including drug overdoses.
5. **Drug Overdose Mortality** Drug overdose death rates among youth (15–24 years) showed a steady increase over the past decade, more than doubling from 6.2 in 2012-2014 to 15.9 deaths per 100,000 in 2022-2023.

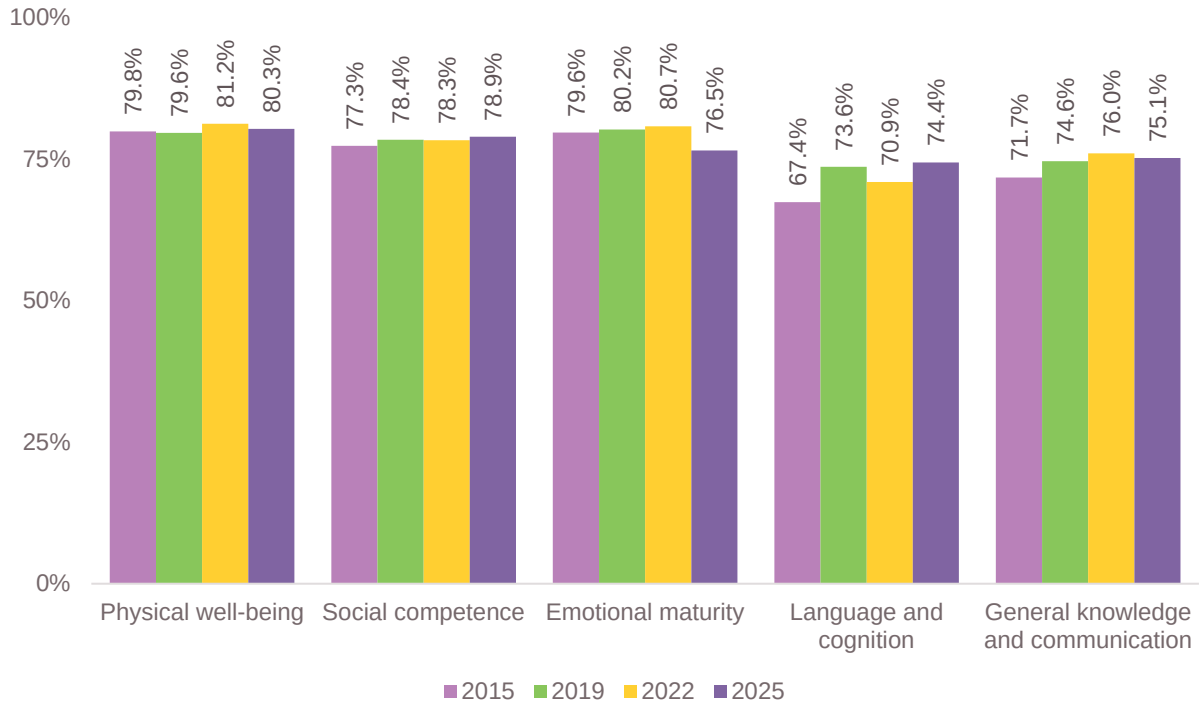
Sources: Detailed data estimates and data sources are provided in the text below.

The following section provides detailed data tables and/or figures behind the positive trends and areas for improvement in behavioral health from the secondary data.

Emotional Health and Mental Wellbeing Among Children and Youth

Orange County uses the Early Development Index (EDI) to measure children's readiness for school.[9] The EDI, conducted during the second half of the kindergarten year, assesses children's development by using an online questionnaire filled out by kindergarten teachers for every child in their class. It tracks five areas of a child's development: language and cognitive development; communication skills and general knowledge; social competence; emotional maturity; and physical health and well-being. From 2015 to 2025, four out of five EDI developmental domains for children showed improvement, with language and cognition increasing the most by 7.0 percentage points (from 67.4% in 2015 to 74.4% in 2025). However, emotional maturity declined by 3.2 percentage points (from 79.6% in 2015 to 76.5% in 2025), making it the only domain to experience a decrease over the decade (**Figure 18**).

Figure 18. Percentage of Children Ready for Kindergarten by Domain, 2015 to 2025

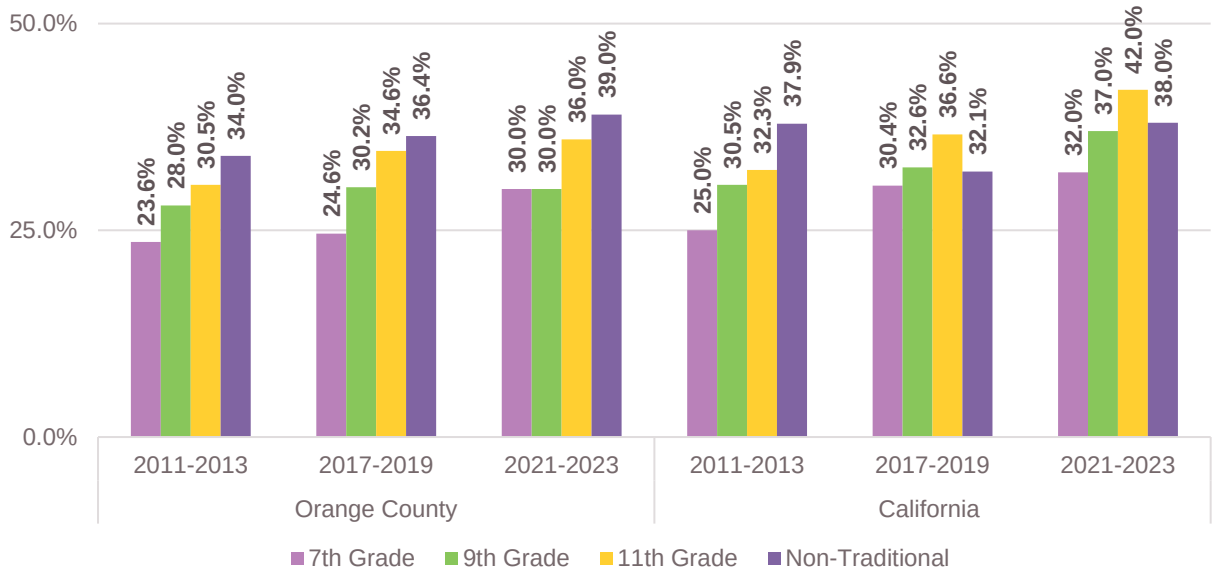


Note: 2015 includes data collected in 2013, 2014, and 2015; 2019 includes data collected in 2018 and 2019. The 2022 and 2025 data collection included participation of all the districts and schools in the same year. The four waves each reflect 100% school participation. Source: Early Development Index, 2015 to 2025

[9] First 5 Orange County. (n.d.). Early Development Index (EDI). Retrieved from https://first5oc.org/resources/edi/

The California Healthy Kids Survey estimates that in 2021–2023, the percentage of Orange County students who reported experiencing depression-related feelings ranged from 30.0% among grade 7 and 9 students, to 36.0% among grade 11 students, and 39.0% for non-traditional school-based students (**Figure 19**). Orange County rates have trended lower than in California, except for non-traditional school-based students.[10] The percentage of students in grades 7, 9, and 11 who reported experiencing depression-related feelings increased between 2015-2017 and 2021 – 2023.

Figure 19. Students Who Reported Experiencing Depression-Related Feelings by Grade Level

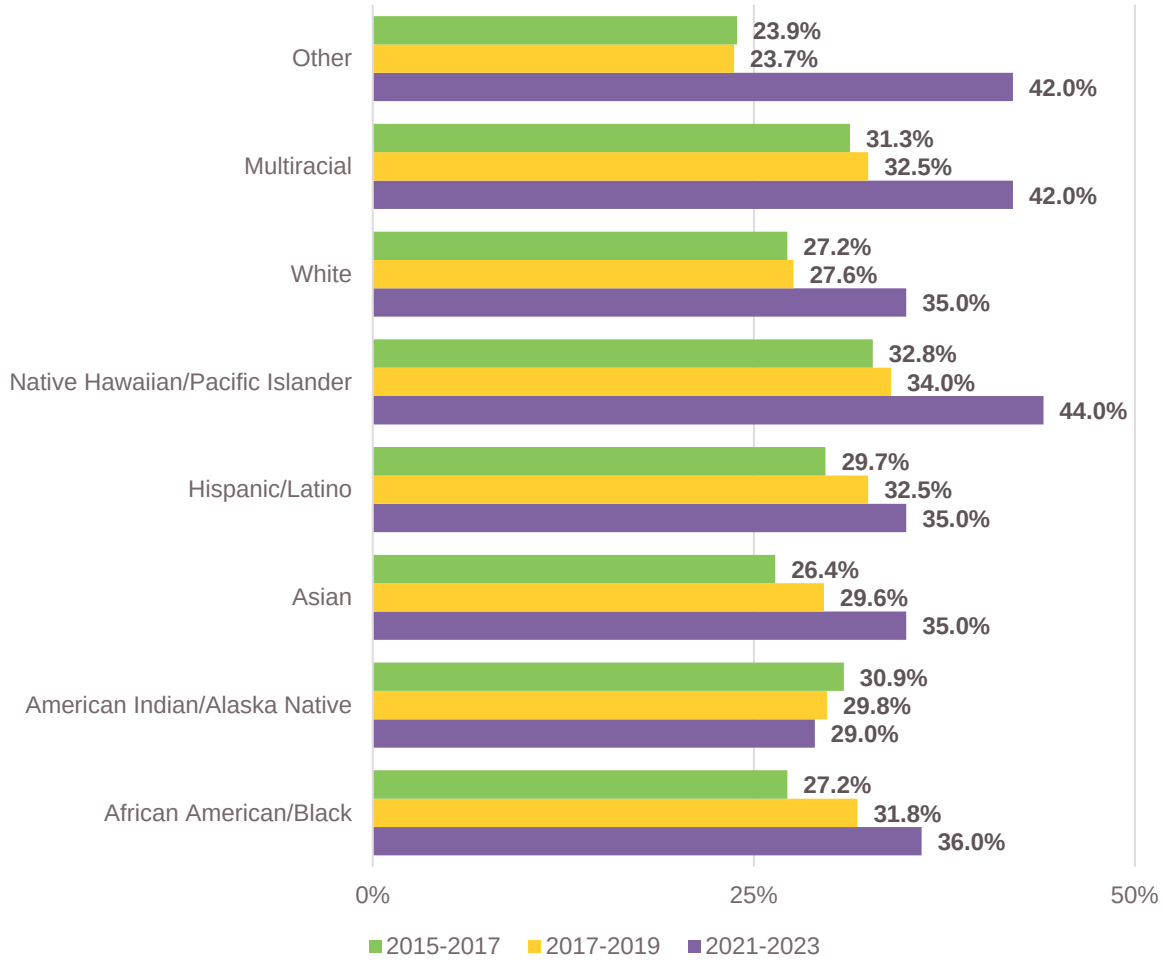


Note: Estimated percentage of public school students in grades 7, 9, 11, and non-traditional programs who, in the previous year, felt so sad or hopeless almost every day for two weeks or more that they stopped doing some usual activities. Years presented comprise two school years (e.g., 2017-18 and 2018-19 school years are shown as 2017-2019). Source: California Deaprtment of Education, California Health Kids Survey

As **Figure 20** indicates, between 2015–2017 and 2021–2023, rates of reported depression-related feelings increased for most racial/ethnic groups, except American Indian/Alaska Native students in Orange County. During this same time, Native Hawaiian/Pacific Islander students in Orange County had higher rates of depressed mood compared with their peers.

[10] Non-traditional school base students include students who attend Continuation High Schools, County Community Schools, District Community Day Schools, Juvenile Court Schools, Opportunity Schools, or Special Education Schools, as defined by the California Department of Education.

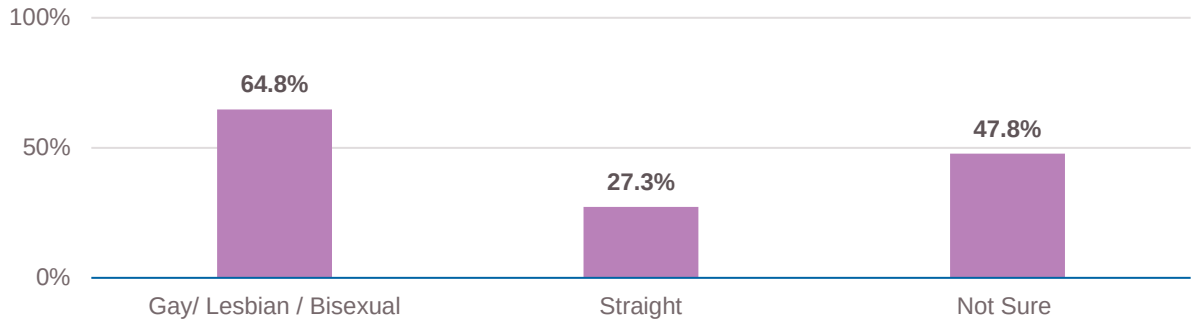
Figure 20. Percentage of Students Who Reported Experiencing Depression-Related Feelings by Race and Ethnicity, Orange County



Note: Estimated percentage of public school students in grades 7, 9, 11 and non-traditional programs who, in the previous year, felt so sad or hopeless almost every day for two weeks or more that they stopped doing some usual activities. Source: California Department of Education, California Healthy Kids Survey, 2021–2023

As shown in **Figure 21**, students who identified as gay, lesbian, or bisexual (as defined by California Health Kids Survey) were more than twice as likely to report depression-related feelings than their heterosexual classmates (64.8% to 27.3%) in 2021-2023.

Figure 21. Percentage of Students Who Reported Experiencing Depression-Related Feelings, By Sexual Orientation, Orange County, 2021-2023



Note: Depression-related feelings were defined as when a student felt so sad or hopeless almost every day for two weeks or more that they stopped doing some usual activities. Source: California Department of Education, California Healthy Kids Survey, 2021–2023

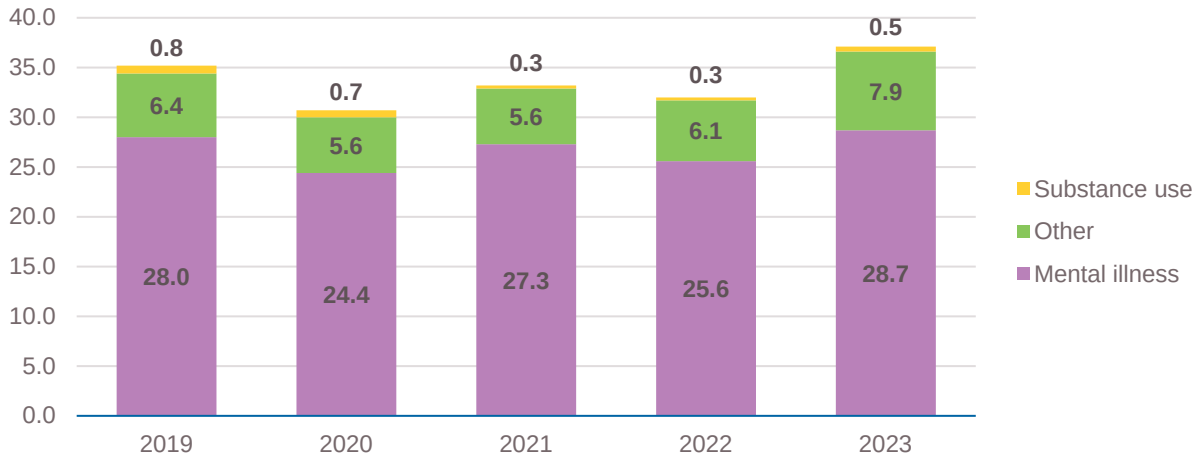
Hospitalizations for Mental Health

Mental health is one of the leading health indicators in Healthy People 2030 (HP2030). The primary mental health objective in HP2030 is to increase the proportion of adolescents with major depressive episodes who receive treatment. The sooner young people are treated for depression, the more effective it can be in preventing more severe, long-term problems in adulthood. In 2023, 22.8% of youth (12–17 years old) in Orange County reported receiving psychological/emotional counseling in the past year, an increase from 2022 when 18.6% of these individuals indicated they received counseling.[11]

As **Figure 22** indicates, the combined hospitalization rate for serious mental illness and substance use for children and youth (0–17 years) increased by 5.7%, from a low of 30.7 per 10,000 children in 2015 to 2019 to 37.0 per 10,000 children in 2023. The hospitalization rate for serious mental illness increased 17.6%, from 24.4 in 2019 to 28.7 per 10,000 children in 2023. It is important to remember that changes in hospitalization discharge data may be the result of multiple factors, including changes in capacity and access to these services, as well as changed stigma about help seeking. Therefore, the increase cannot be interpreted solely as a change in prevalence in mental health issues.

[11] UCLA Center for Health Policy Research. California Health Interview Survey, 2023

Figure 22. Mental Health and Substance Abuse-Related Hospitalization Rates in Orange County per 10,000 Youth (0–17 years), 2019 to 2023



Note: “Other” includes mental disorders such as other unspecified mood disorders, conduct disorders, and disorders related to sleep, eating, elimination, and pain. Source: Orange County Health Care Agency, 2023

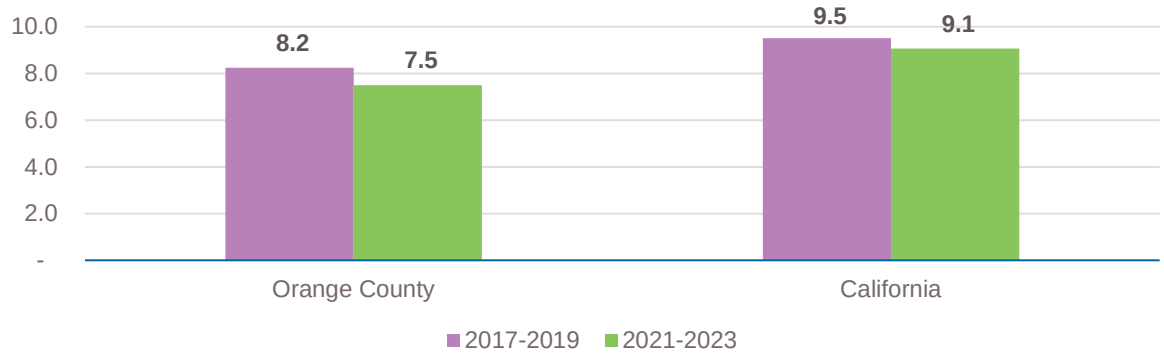
Suicidality and Suicide

Suicide is one of the leading causes of death and major public health problems in the United States for people 10 years and older, responsible for over 49,000 deaths in 2023 (up from 46,000 deaths in 2020), according to the Centers for Disease Control and Prevention.[12] From 2000–2020, the national overall rate (for all ages) of suicide increased 30%.[13] Suicide is the second leading cause of death for 10–24 year olds in the U.S. and is a global public health issue, with a recent declaration of a National State of Emergency in Children’s Mental Health by the American Academy of Pediatrics, American Academy of Child and Adolescent Psychiatry, and Children’s Hospital Association.[14]

As **Figure 23** shows, from 2017–2019 to 2021–2023, suicide rates among youth and young adults (15–24 years) in Orange County experienced no significant change, decreasing slightly from 8.2 (109 deaths) to 7.5 deaths per 100,000 (94 deaths). California's suicide rate of youth and young adults was slightly higher in both periods (9.5 to 9.1 deaths per 100,000 or 1,539 deaths and 1,431 deaths, respectively). Orange County consistently accounted for approximately 7% of youth suicides statewide.[15]

[12] National Center for Health Statistics. (2024, May 15). Provisional mortality data — United States, 2023 (Report No. VSRR-034). Centers for Disease Control and Prevention.
[13] Garnett, M. F., & Okoro, C. A. (2022). Suicidal thoughts and behaviors among adults aged 18 and over: United States, 2020 and 2021 (NCHS Data Brief No. 433). National Center for Health Statistics.
[14] Liwei L. Hua, Janet Lee, Maria H. Rahmandar, Eric J. Sigel, COMMITTEE ON ADOLESCENCE, COUNCIL ON INJURY, VIOLENCE, AND POISON PREVENTION; Suicide and Suicide Risk in Adolescents. Pediatrics January 2024; 153 (1): e2023064800. 10.1542/peds.2023-064800
[15] California Department of Public Health, Center for Family Health, Maternal, Child and Adolescent Health Division, Youth Suicide Deaths Dashboard.

Figure 22. Suicide Death Rate per 100,00 Population for Children (15-24 years old), 2017–2019 to 2021–2023



Note: The youth suicide rate is the number of deaths from suicide per 100,000 people ages 15–24. Source: California Department of Public Health, Center for Family Health, Maternal, Child and Adolescent Health Division, Youth Suicide Deaths Dashboard. Last modified April 2025

Suicide deaths, however, are only part of the problem. Suicidality, which refers to a spectrum of thoughts, plans, or actions related to ending one's own life, including suicidal ideation or serious thinking about suicide, is far more prevalent. The number of people who experience these thoughts or attempt suicide is much higher than the number of actual deaths. In fact, for every death by suicide in the U.S. in 2022, approximately 32 people attempted suicide and more than 250 people seriously considered it.[16]

Children and adolescents often live in environments shaped by adults, especially parents and caregivers. Adult suicidality, including ideation and attempts, can:

- Create emotional instability and trauma in children.
- Increase the risk of intergenerational transmission of mental health issues.
- Lead to neglect or inconsistent caregiving, which are known risk factors for youth mental health problems.

In 2023, an estimated 12.8 million adults in the U.S. seriously considered suicide, 3.7 million adults developed a plan to end their lives, and 1.5 million adults attempted suicide. Those who survive suicide may have serious injuries, in addition to experiencing depression and other mental health problems.[17]

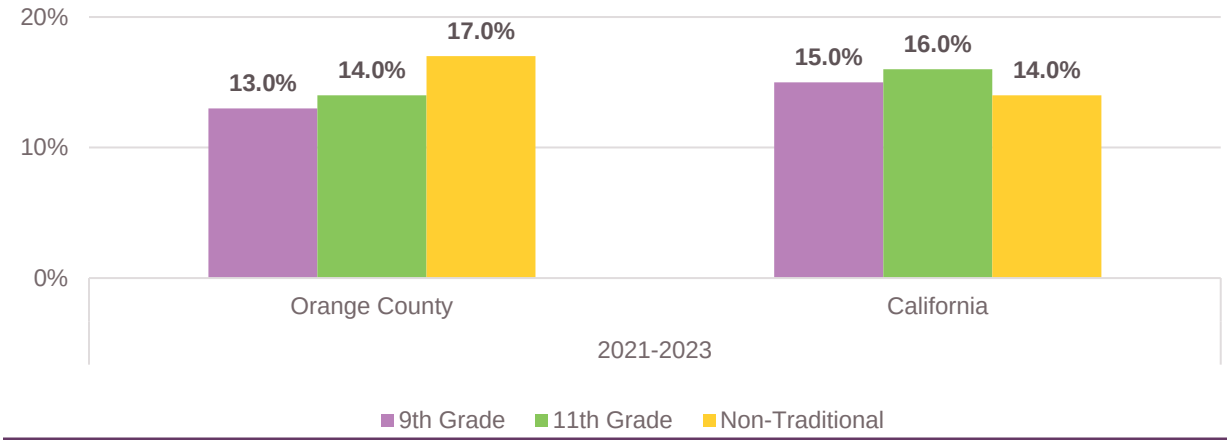
[16] Pew Charitable Trusts. (2024, September 30). U.S. national trends and disparities in suicidal ideation, suicide attempts, and healthcare use.

[17] Substance Abuse and Mental Health Services Administration. Key Substance Use and Mental Health Indicators in the United States: Results from the 2024 National Survey on Drug Use and Health (HHS Publication No. PEP25-07-007, NSDUH Series H-60). Center for Behavioral Health Statistics and Quality. 2025. Available at: https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health/national-releases/2024.

According to The Substance Abuse and Mental Health Services Administration's (SAMHSA) 2024 National Survey on Drug Use and Health, about 12.6% of young adults (ages 18-25) reported that they have had serious thoughts about suicide in the past year, and 2% reported a suicide attempt during the prior year.[18] Nationally, according to the 2023 Youth Risk Behavioral Survey, these numbers were higher among high school students – nearly 20% reported seriously considering attempting suicide.[19]

In Orange County, the percentage of students who seriously considered suicide during the past 12 months ranged from 13.0% among grade 9 students to 17.0% among non-traditional school-based students in 2021–2023. Except for non-traditional school-based students, Orange County rates for grade 9 and grade 11 students were lower (**Figure 24**).

Figure 24. Percentage of Public School Students Who Seriously Considered Suicide in the Previous year, by Grade Level, 2021-2023



Note: Estimated percentage of public school students in grades 9, 11 and non-traditional programs who seriously considered attempting suicide in the previous year. Years presented comprise two school years.Source: California Department of Education, California Healthy Kids Survey

Substance Use

Adolescents experiencing emotional distress may engage in alcohol or drug use to manage challenging feelings. While substance use may initially alleviate symptoms such as hopelessness, anxiety, irritability, and negative thoughts, it poses significant risks to mental health, especially given the ongoing development of the adolescent brain. Consequently, youth are more susceptible to substance use and dependence, and these behaviors can intensify underlying mental health concerns over time.**Error! Bookmark not defined.**

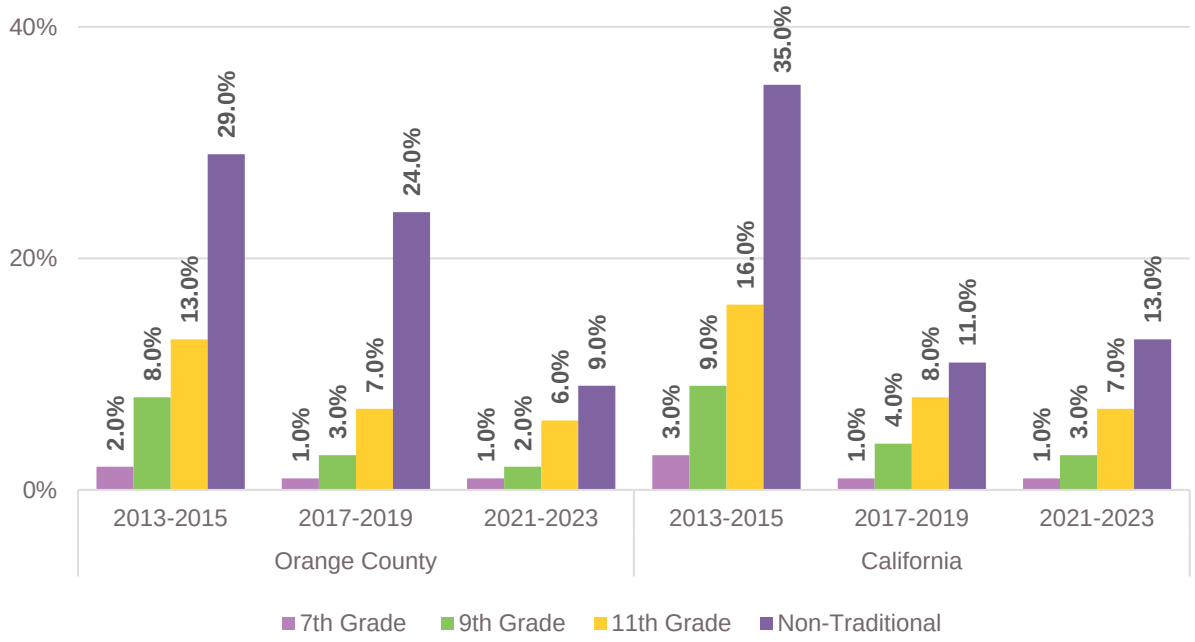
[18] Ibid

[19] Verlenden JV, Fodeman A, Wilkins N, et al. Mental Health and Suicide Risk Among High School Students and Protective Factors — Youth Risk Behavior Survey, United States, 2023. *Morbidity and Mortality Weekly Report: Surveillance Summaries*. 2024;73(Suppl. 4):1–20. Centers for Disease Control and Prevention. Available at: https://www.cdc.gov/mmwr/volumes/73/su/pdfs/su7304a9-H.pdf.

Alcohol

As part of the California Health Kids Survey, self-reported binge drinking rates decreased between 2017–2019 and 2021–2023 in Orange County (**Figure 25**). In Orange County, grade 9 and grade 11 students were less likely to binge drink than students in non-traditional school-based students. Non-traditional school-based students had the largest decrease in binge drinking rates (down from 24.0% to 9.0%) in Orange County. In 2021–2023, students in Orange County had lower binge drinking rates than their peers in California.

Figure 25. Percentage of Students Who Binge Drank In The Past 30 Days



Note: Estimated Percentage of public-school students in grades 7, 9, 11 and in non-traditional school-based students who have consumed five or more drinks of alcohol within a couple of hours over the past 30 days. Years presented comprise two school years.Source: California Department of Education, California Healthy Kids Survey

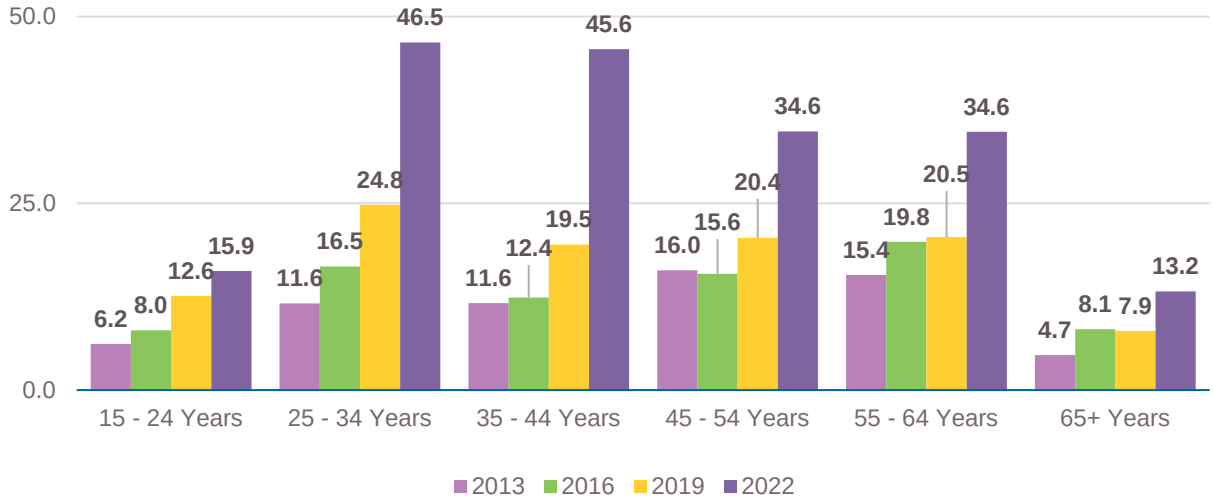
Vaping and Cigarette Use

From 2021 to 2023, 1.0% of Orange County grade 9 and 11 students reported cigarette use in the past 30 days, down from 2.1% in 2017–2019. E-cigarette use also declined but remained higher than cigarette use: in 2023, 6% of grade 11 students and 4% of grade 9 students reported vaping, compared with 13% and 9% in 2017.

Drug Overdose and Mortality

Mortality from drug overdose among youth and young adults (15-24 years) was on the rise between 2012 and 2023; however, the largest increases occurred in the 25–34 and 35–44 age groups, with rates almost doubling from 2018–2020 to 2021–2023: for ages 25–34, nearly doubling to 46.5 from 24.8, and for ages 35–44, more than doubling to 45.6 from 19.5 deaths per 100,000. Adult drug overdose—especially involving opioids—can profoundly affect children through unintentional exposure, increased risk of child abuse by poisoning, and the trauma of losing a caregiver. These events contribute to adverse childhood experiences (ACEs), which are linked to long-term physical and mental health issues.[20] Children in households with substance use are more likely to enter foster care, require mental health services, and face developmental challenges.[21] The age group 15–24 years steadily increased, more than doubling from 6.2 in 2012-2014 to 15.9 deaths per 100,000 in 2021-2023 (**Figure 26**).

Figure 26. Trend in Crude Death Rate per 100,000 Population of Drug Overdose (Poisoning/SUD) in Orange County by Age Group, 2012–2014 to 2021–2023



Note: Years represent three-year estimates including 2012-2014, 2015-2017, 2018-2020, and 2021-2023. Source. California Department of Public Health, California Community Burden of Disease Engine

Unintentional injury was the cause of most injury-related mortality among youth in Orange County. In 2023, the unintentional injury rate among youth in Orange County was 5.9 deaths per 100,000, up from a 10-year low of 1.6 deaths per 100,000 in 2019. In 2023, among these deaths resulting from unintentional injury, 44% were a result of poisoning, including drug overdoses.[22]

[20] Wisdom, A. C., Govindu, M., Liu, S., Meyers, C., Mellerson, J., Gervin, D., DePadilla, L., & Holland, K. (2022). Adverse childhood experiences and overdose: Lessons from Overdose Data to Action. Centers for Disease Control and Prevention.
[21] Hulsey EG, Li Y, Hacker K, Williams K, Collins K, Dalton E. Potential Emerging Risks Among Children Following Parental Opioid-Related Overdose Death. JAMA Pediatr. 2020;174(5):503–50
[22] Orange County Health Care Agency, Public Health Services

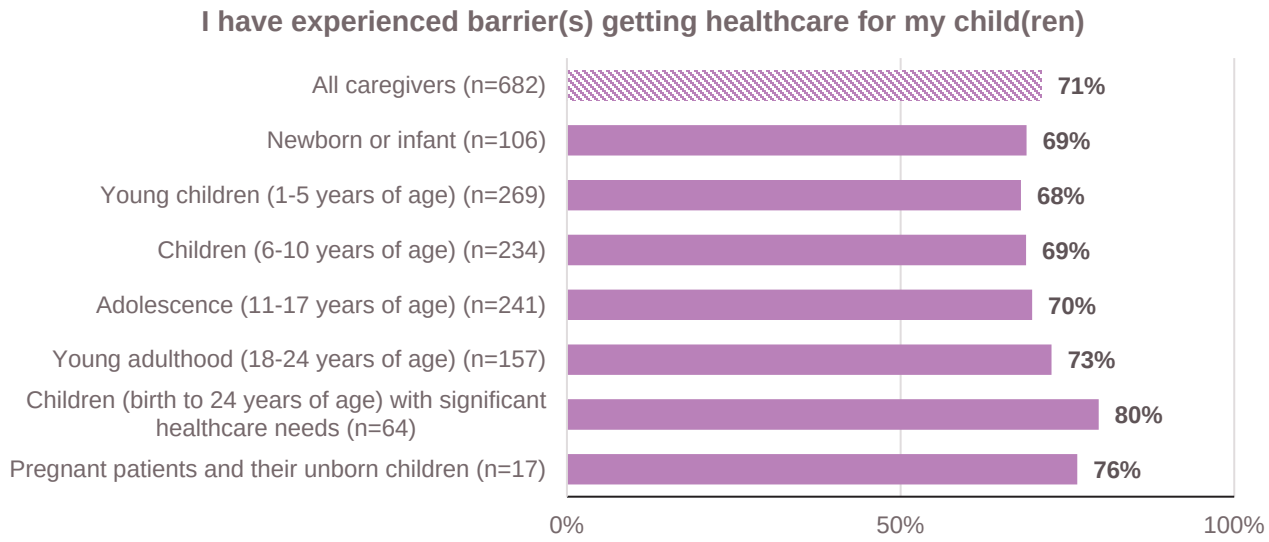
Health Priority 2: Access to Pediatric Healthcare Services

Access to care allows people to enter the healthcare system, find care easily and locally, pay for care, and get their health needs met. Lack of health insurance, poor access to transportation, and limited healthcare resources (e.g., physician shortages) are examples of barriers to care. Experiencing these barriers may mean inconsistent access to healthcare, longer wait times, and delays in care.[23]

Access to pediatric healthcare is a top priority for community members, who view the ability to see healthcare professionals and receive mental health services as essential to a healthy environment for children and families.

Despite this importance, a majority of parent/caregiver respondents (71%) reported experiencing barriers to care (**Figure 27**). Parents/caregivers of children with significant healthcare needs (80%), young adults (73%), and pregnant patients (76%) face slightly more barriers.

Figure 27. Barriers Experienced Among Parent/Caregivers by the Age of the Child(ren) Receiving Care

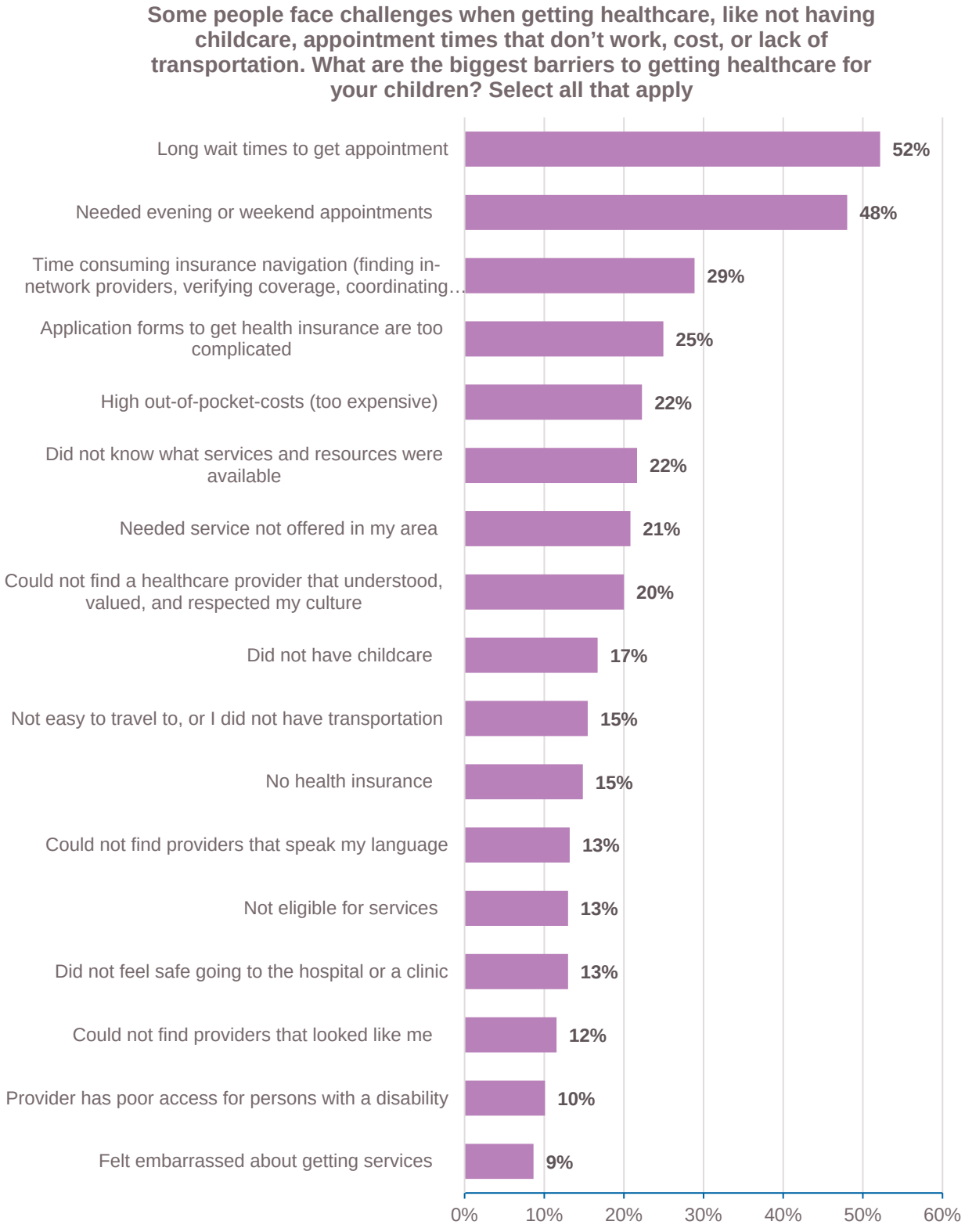


Source: Children's Health Survey, 2025

Barriers to care include long wait times (52%), limited appointment availability during evenings or weekends (48%), challenges with insurance navigation (29%), application complexity (25%), and out-of-pocket costs (22%) (**Figure 28**). Other obstacles included navigating insurance networks (29%), complicated application forms (25%), and high out-of-pocket costs (22%).

[23] Office of Disease Prevention and Health Promotion. (n.d.). Healthcare access and quality. Healthy People 2030. U.S. Department of Health and Human Services.

Figure 28. Percentage of Parent/Caregiver Survey Respondents Who Selected Barriers to Getting Healthcare for Children



Source: Children's Health Survey, 2025

Barriers vary by the age of the child(ren) receiving the care, with cultural responsiveness, transportation, and affordability emerging as key concern (**Table 8**).

- Prenatal, perinatal, and infant: Could not find a healthcare professional that understood, valued, and respected their culture
- Early childhood (1-5 years old): Application forms to get health insurance are too complicated
- Middle childhood (6-10 years old): Could not find a healthcare professional that understood, valued, and respected their culture and high out-of-pocket-costs (too expensive)
- Pregnant patients and their unborn children: Not easy to travel to, or I did not have transportation, did not know what services and resources were available, and application forms to get health insurance are too complicated

Table 8. Top Three Barriers With Accessing Care by Age of Child(ren) Receiving Care

	1	2	3
All Respondents (n=485)	Long wait times to get an appointment	Needed evening or weekend appointments	Time consuming insurance navigation (finding in-network providers, verifying coverage, coordinating referrals, etc.)
Prenatal, Perinatal & Infant (n=86, Parents/Caregivers only)	Could not find a healthcare provider that understood, valued and respected my culture		
Pregnant Patients & Their Unborn Children (n=13, Providers only)	Not easy to travel to, or I did not have transportation	Did not know what services and resources were available	Application forms to get health insurance too complicated
Early Childhood (Ages 1-5) (n=183)	Application forms to get health insurance too complicated		
Middle Childhood (Ages 6-10) (n=161)	Could not find a healthcare provider that understood, valued and respected my culture	High out-of-pocket costs (too expensive)	

Note: The barriers listed for each age group of the child(ren) receiving care are those uniquely in the top three barriers for that age group. For instance, survey respondents who were either prenatal, perinatal, or cariving for an infant, “Could not find a healthcare provider that understood, valued, and respected my culture” as a top three barrier. Age groups adolescence, young adulthood, or children with significant health care needs did not differ in their responses compared to other survey respondents and are not included in this table. Source: Children’s Health Survey, 2025.

Focus Group Insights on Access to Pediatric Healthcare Services

Healthcare access and navigation challenges proved equally problematic, with families facing extended wait times and complex navigation systems that can lead to the abandonment of care.

A nurse described the lengthy referral process: **"It's a six-week wait just to get into Ear, Nose and Throat Doctor. Then you wait for a sleep study, then results, then maybe surgery. It's months."**

The fragmentation of services overwhelms families, with one community health work explaining, **"They have to retell their story over and over again… takes too long to get connected to care… they just give up."**

Language challenges further complicate access. As one nurse noted, **"Many of my families speak Spanish only or communicate in American Sign Language only... They come back and don't know what the doctor said,"** leaving families unable to understand medical instructions or communicate effectively with the physician.

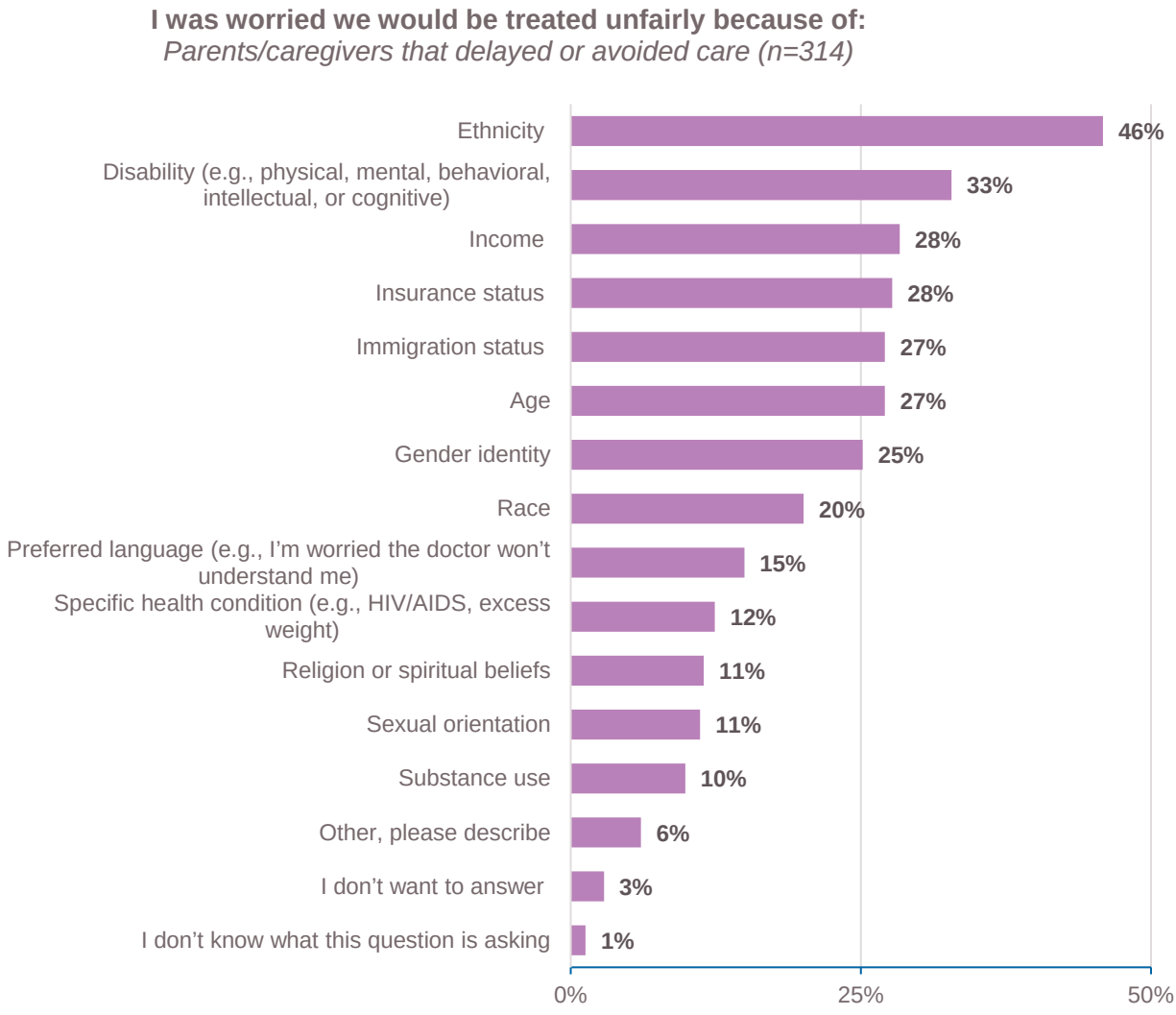
Other Challenges

Ability to establish primary care relationships, leaving families without consistent medical homes.	Limited provider hours that conflict with work schedules create additional access barriers, preventing working families from attending appointments.
Even when families can access care, complex navigation requirements create barriers to follow-through.	There is a pressing need for culturally competent therapists who can provide linguistically and culturally appropriate care. This is especially important for LGBTQ2IA+ individuals and people of color.
Administrative barriers, including extensive paperwork and repeated intake processes, overwhelm families with limited literacy or time.	Families reportedly often abandon care when navigation becomes too complex, leading to incomplete treatment and worsening conditions.

Personal Experience: Parents/Caregivers Experience with Discrimination and Racism

Notably, 43% of parent/caregiver survey respondents reported delaying or avoiding care due to fear of discrimination, with nearly half citing concerns about being treated unfairly based on ethnicity (46%), defined in the survey as discrimination based on cultural identity, including culture, religion, dress, customs, nationality, or ancestry such as Hispanic, Latino/a, or Spanish. Additional common reasons were concerns about unfair treatment based on disability (33%), income level (28%), and insurance status (28%) (**Figure 29**).

Figure 29. Percentage of Parent/Caregiver Survey Respondents by the Reasons Healthcare was Delayed or Avoided



Source: Children's Health Survey, 2025

Focus Group Insights on Parent/Caregiver Experience with Discrimination and Racism

Focus group participants explained that immigration-related fears create barriers for families in accessing healthcare.

Misinformation about public charge policies and eligibility requirements creates additional barriers, deterring families from seeking care even when they are legally entitled to services.

The climate of fear affects not only undocumented families but also mixed-status families and those with temporary legal status.

Community health workers noted that even providing education on individual rights, it has limited effectiveness against deep-seated fears, as the emotional impact of fear often overrides rational information about legal protections.

Community health workers described how Immigration and Customs Enforcement (ICE) activity may be creating fear in immigrant communities, with one explaining, **"They're afraid to come to events or answer the door because of ICE."**

School nurses also encountered this barrier, with one sharing, **"They shut the door on us after ICE visited… they thought we brought them."**

This fear extends to healthcare settings, with a community health worker noting, **"We're seeing a lot of anxiety and stress in immigrant communities… they're afraid to even go to the doctor."**

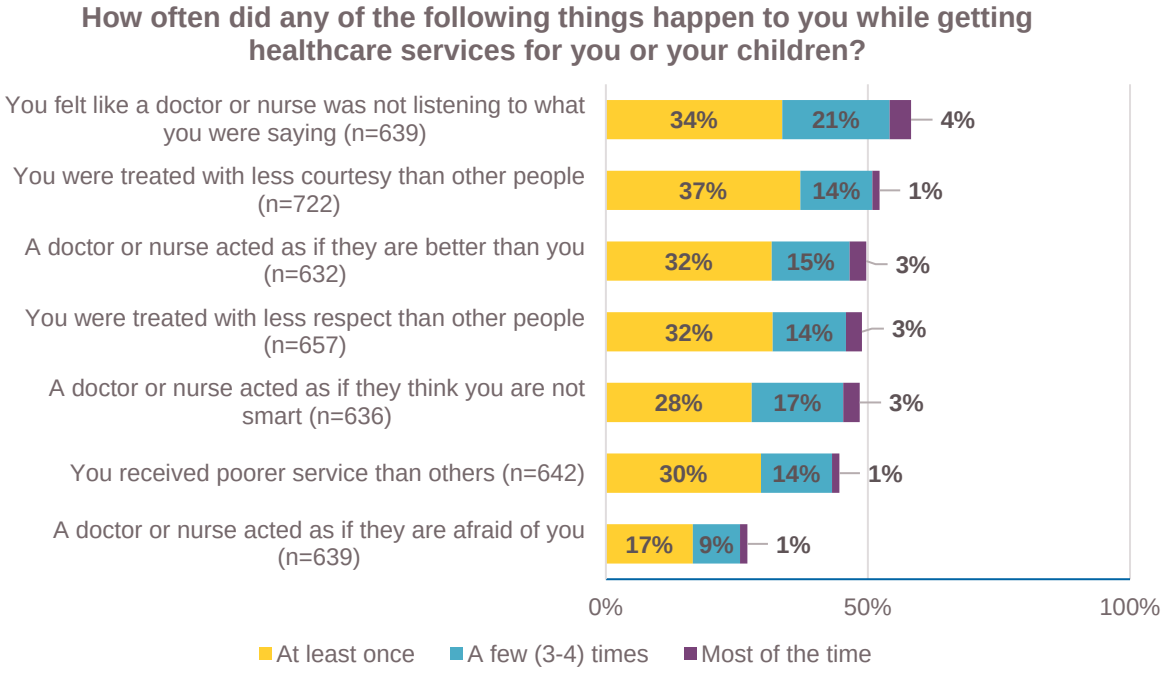
Personal Experience: Parent's/Caregiver's Healthcare Visits

The survey explored parent's/caregiver's experiences with healthcare services, revealing that many have encountered moments of disrespect, bias, or poor communication. Parent/caregiver survey respondents shared troubling experiences with healthcare services: many felt disrespected, unheard, or judged, with over half reporting being treated with less courtesy or feeling looked down upon, specifically:

- 59% who were not listened to at least once
- 52% felt as though they were treated with less courtesy than other people
- 50% felt looked down on by healthcare professionals
- 48% felt judged as not smart
- 45% received poorer service than others
- 27% felt healthcare professionals were afraid of them

Figure 30 shows the frequency of which parent/caregiver survey respondents experienced these negative encounters while receiving healthcare:

Figure 30. Experience with Getting Healthcare Services Among Parent/Caregiver Survey Respondents

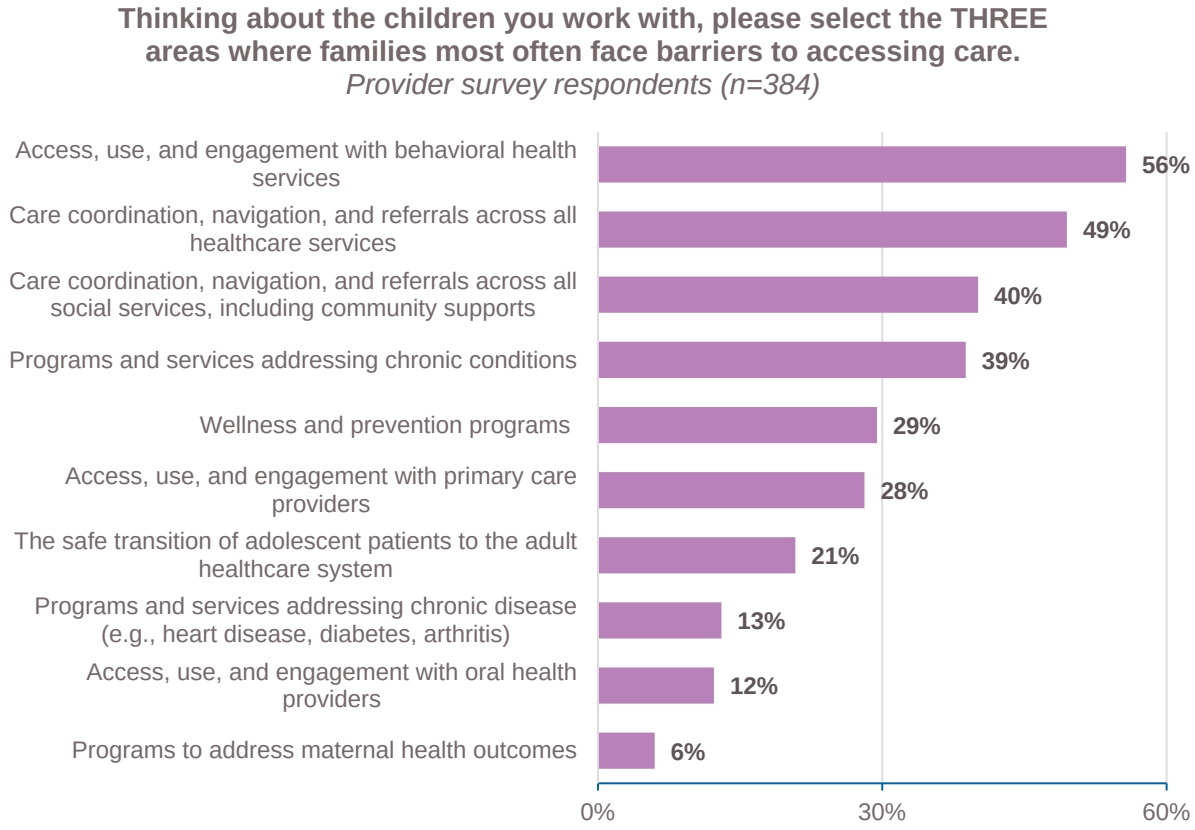


Source: Children's Health Survey, 2025

Provider Perspective on Access to Care

From the perspective of provider survey respondents, the most significant barriers families face include accessing behavioral health services (56%), coordinating care and referrals (49%), and obtaining social services (40%) (**Figure 31**).

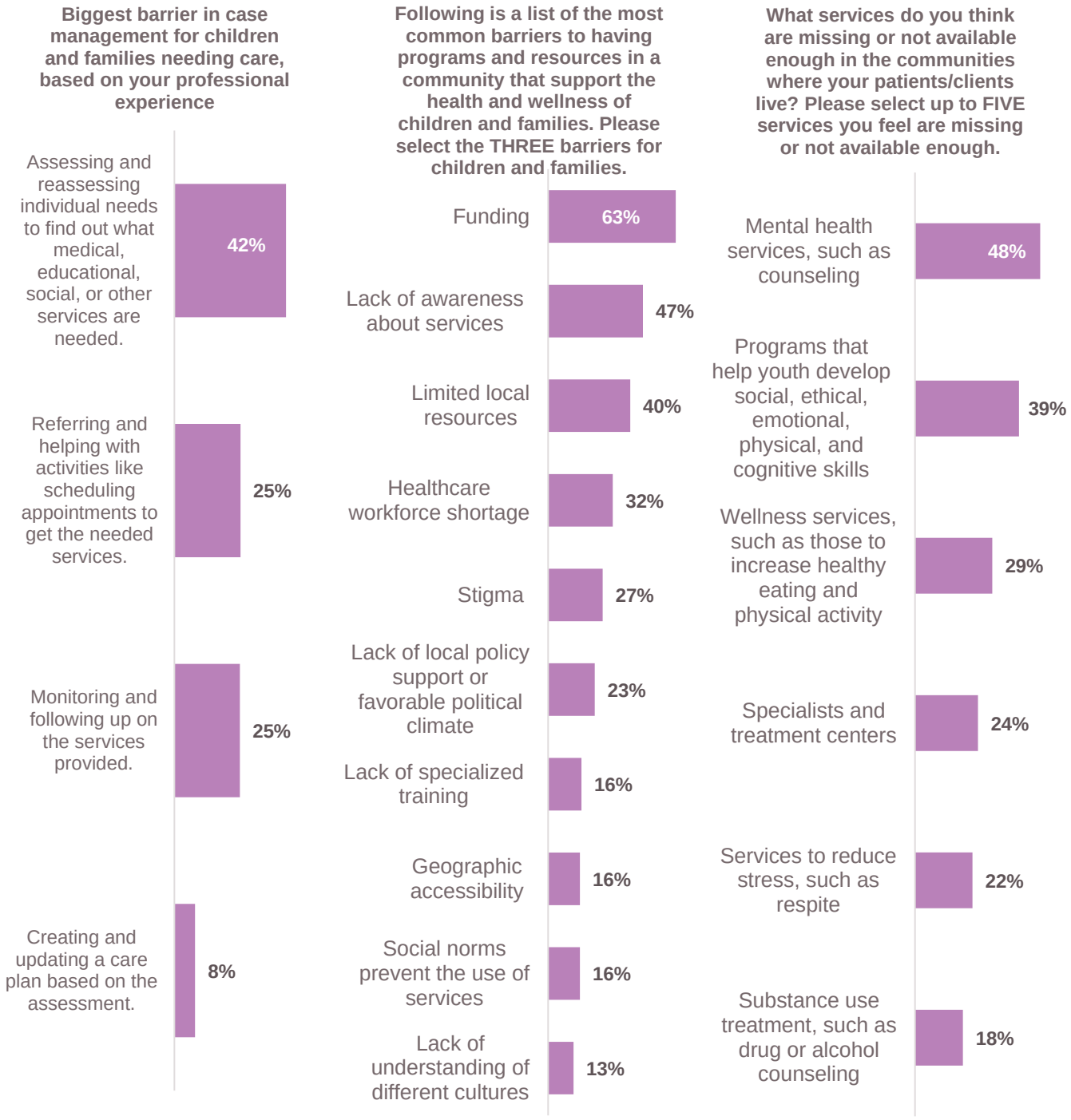
Figure 31. Percentage of Provider Survey Respondents on Where Families Face Barriers in Accessing Care



Source: Children's Health Survey, 2025

In terms of systemic barriers, healthcare providers pointed to funding limitations (63%), lack of awareness about available services (47%), shortages in local resources (40%), and limited healthcare workforce (32%). Stigma emerged as another notable concern (27%). The most cited service gap was mental health services, such as counseling, with 48% of the provider survey respondents identifying this as a top concern. Additionally, 39% of provider survey respondents pointed to a lack of programs that help youth develop social and emotional skills, while 29% noted a need for wellness services that promote healthy eating and physical activities (**Figure 32**).

Figure 32. Provider Perspectives on Barriers to Care for Children and Families



Among provider survey respondents (n=383). Source: Children's Health Survey, 2025

Key Informant Insights on Access to Pediatric Healthcare Services

Access to pediatric healthcare services was among the top three most frequently mentioned topics by key informants noting that navigating the healthcare system poses challenges, particularly for people with private insurance. Long wait times, difficulty finding providers, and geographic disparities in healthcare services contribute to this issue. Specific barriers include:

Long Wait Times

One of the most significant problems faced by patients is the lengthy wait times for appointments. This can be particularly frustrating for those seeking specialized care or urgent medical attention. The shortage of healthcare professionals in certain areas exacerbates this issue, leading to delays in receiving necessary treatments and interventions.

Difficulty Finding Providers

Patients often struggle to find providers who accept their insurance plans or who are located within a reasonable distance. This issue is compounded by the complexity of insurance networks and the frequent changes in provider availability. Many patients find themselves spending an inordinate amount of time searching for a suitable healthcare provider, which can delay access to care.

Geographic Disparities

There are significant geographic disparities in healthcare services, with urban areas typically offering better access to medical facilities and professionals compared to rural regions. This disparity means that individuals living in less populated areas may have to travel long distances to receive care, which can be especially challenging for those without reliable transportation. Additionally, the concentration of specialized services in urban centers leaves rural populations at a disadvantage when seeking advanced medical treatments.

Healthcare System Navigation

The complexity of the healthcare system itself poses a significant barrier. Patients often experience difficulties understanding their insurance coverage, obtaining necessary authorizations, and navigating the referral process for specialized services. Health literacy plays a crucial role in this context; individuals with lower health literacy may struggle more to advocate for their healthcare needs and to utilize available services effectively.

Economic Disparities

Economic disparities further complicate access to healthcare. High out-of-pocket costs, co-pays, and deductibles can deter patients from seeking timely medical attention. Families with limited financial resources may prioritize immediate survival needs such as housing and food over healthcare, leading to untreated conditions and poor health outcomes.

Transportation Barriers

Transportation is another critical issue affecting access to health care. Inadequate public transportation options and long travel times can prevent individuals from attending medical appointments. This is particularly problematic in regions with limited healthcare facilities, where patients may need to travel significant distances to receive care.

In summary, community members shared through the Children's Health Survey, key informant interviews, and focus groups, access to pediatric healthcare services, including both physical and mental health services, as essential to a healthy environment for children and families. Despite the importance of healthcare access, 71% of parents/caregiver's report facing barriers to care, most commonly long wait times, limited appointment availability, and challenges with insurance and affordability. These barriers vary by the age of the child(ren) receiving care and include cultural responsiveness, transportation, and complex insurance processes. Additionally, many parents/caregivers report delaying or avoiding care due to fears of racism and discrimination, with nearly half citing concerns about unfair treatment based on ethnicity. Personal experiences of disrespect and bias further compound these challenges among parents/caregivers. Provider survey respondents echo these concerns, identifying behavioral health access, care coordination, and social services as key areas where families struggle. Below is a summary of secondary data that reveal both positive trends and areas for improvement in access to pediatric healthcare services in Orange County.

Positive Trends in Access to Pediatric Healthcare Services from the Secondary Data

1. **Uninsured Rates** In 2023, 3.4% of children were uninsured, down from 4.0% in 2019, representing a 20% decrease in the number of uninsured children over four years.
2. **Developmental Screenings** The percentage of children receiving standardized developmental and behavioral screenings rose from 42.8% in 2020 to 45.5% in 2023, indicating improved early detection efforts.
3. **Prescription Medication Access** Only 2.4% of children (0-17 years) experienced delays or were unable to access prescription medications in 2023, down from 3.3% in previous years.

Areas for Improvement in Access to Pediatric Healthcare Services from the Secondary Data

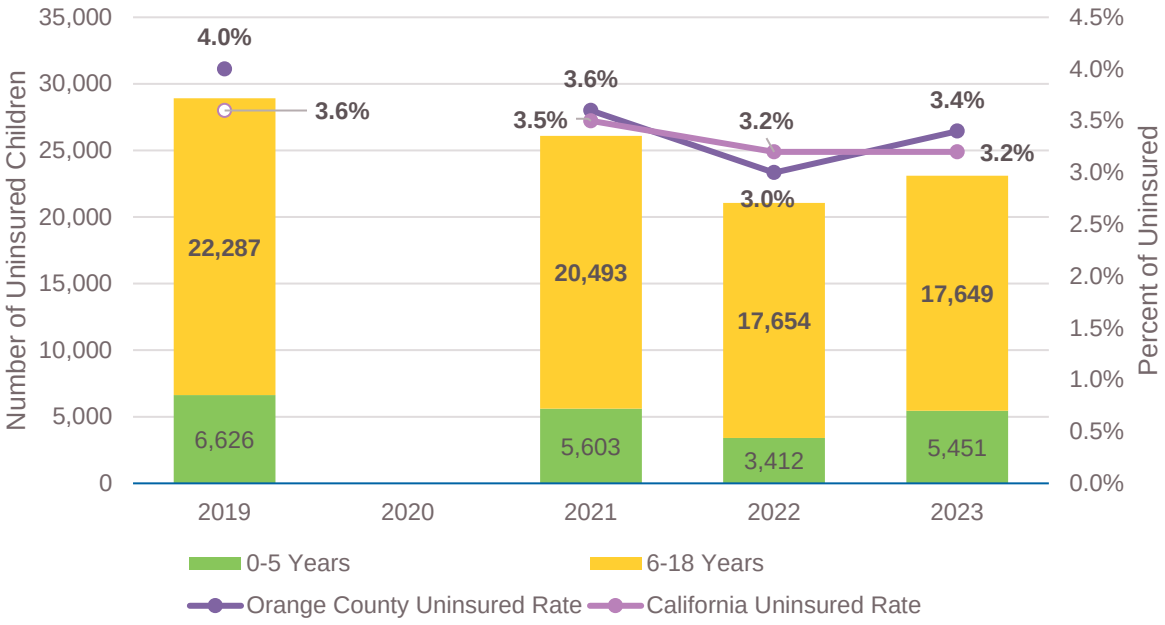
1. **Racial and Ethnic Disparities** Uninsured rates remain highest among American Indian/Alaska Native (11.4%) and Hispanic/Latino/a (4.9%) children, compared with White (2.2%), Asian (3.0%), and Black (1.9%) children.
2. **Usual Source of Care** Fourteen percent (14.2%) of children lacked a regular place to go for healthcare, and 9.1% experienced delayed or unmet medical care.
3. **Emergency Department (ED) Use** Among children without a usual source of care, 17.2% relied on EDs or urgent care centers, indicating limited access to primary care.

Sources: Detailed data estimates and data sources are provided in the text below.

The following section provides detailed data tables and/or figures supporting the positive trends and areas for improvement in access to pediatric healthcare services identified based on secondary data.

Access to pediatric healthcare services in Orange County showed mixed progress over the past decade. In 2023, 3.4% of children under 18 (23,100 children) were uninsured, a 20% decrease from 2019 (4.0%, 28,913 children). However, this rate (non-significantly) increased from 3.0% (21,066 children) in 2022, suggesting a recent reversal in progress. In 2023, Orange County's youth uninsured rate remained slightly higher than California's at 3.2% (**Figure 33**). By age group, in 2023, children ages 0–5 years accounted for 24% of uninsured children (5,451 children), compared to 23% (6,626) among uninsured children ages 0–5 years in 2019.

Figure 33. Number and Percentage of Uninsured Children, 0–17 Years, Orange County

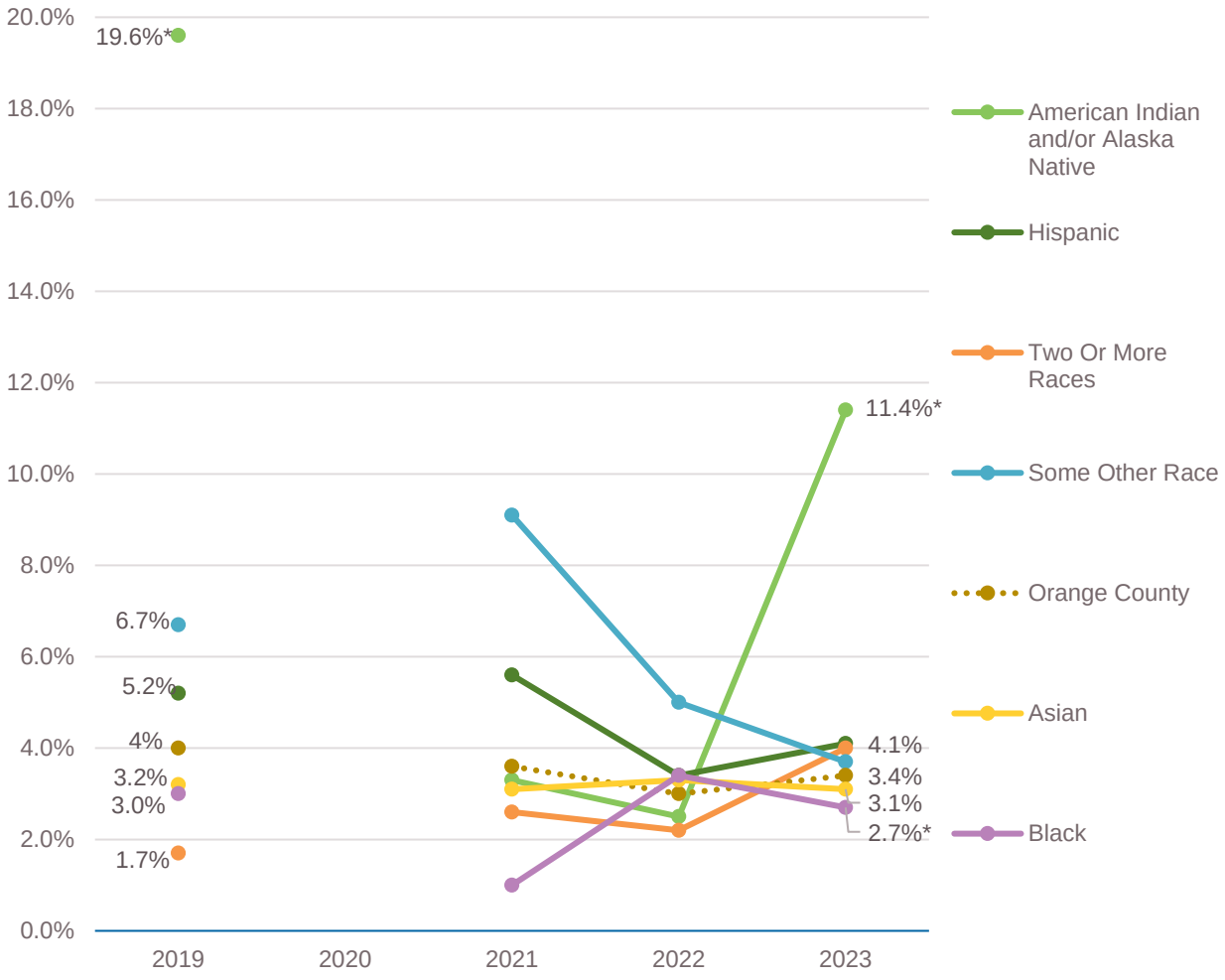


*Due to disruptions in data collection caused by COVID-19, one-year population estimates for this topic are not available from the American Community Survey in 2020. For more on the limitations of one-year 2020 estimates, see https://www. census.gov/newsroom/press-releases/2021/changes-2020-acs-1-year.html Source: U.S. Census Bureau. American Community Survey, One-year Estimates, Table 2701 and Table B27001.

In Orange County, shown in **Figure 34**, disparities in uninsured rates persist across racial and ethnic groups:

- American Indian/Alaska Native children had the highest uninsured rate at 11.4% (should be interpreted with caution due to a small population size).
- Between 2022 and 2023, the rate among Hispanic children increased to 4.1% and children of two or more races increased to 4.0%, while rates for Black (2.7%), White (2.6%), and Asian (3.1%) children declined.

Figure 34. Orange County Percentage of Children Uninsured, by Race/Ethnicity, 2019 to 2023



Note: Estimates among Black and American Indian/Alaska Native populations have wide margins of error and large variability year to year due to their small population size in Orange County. For that reason, the estimates of uninsured in these populations should be interpreted with caution. Source: U.S. Census Bureau, American Community Survey, One-year Estimates, Tables B27001 A-I and C27001 A-E.

Despite improvements in insurance coverage, in 2023, 10.8% of children had no usual source of care, and 7.0% had delayed or unmet medical needs.[24] Most children with the usual source of care visited a doctor's office (68.4%), while 17.2% of those without regular care relied on EDs or urgent care centers. An additional 14.4% went to a clinic or community hospital.[25]

[24] UCLA Center for Health Policy Research. California Health Interview Survey, 2023
[25] Ibid

Access to Care for Children with Significant Healthcare Needs and Children Enrolled in Special Education, Also Known as Individualized Education Services/Supports

Developmental disabilities emerged as the most frequently cited health condition affecting children and families, with 62% of all survey respondents selecting it as a top concern. This issue was especially emphasized by provider respondents, 68% of whom identified it as a priority, compared to 59% of parents/caregivers. Additionally, approximately one in four respondents (27%) indicated that services for children and youth with significant healthcare needs are critical to building a healthy community.

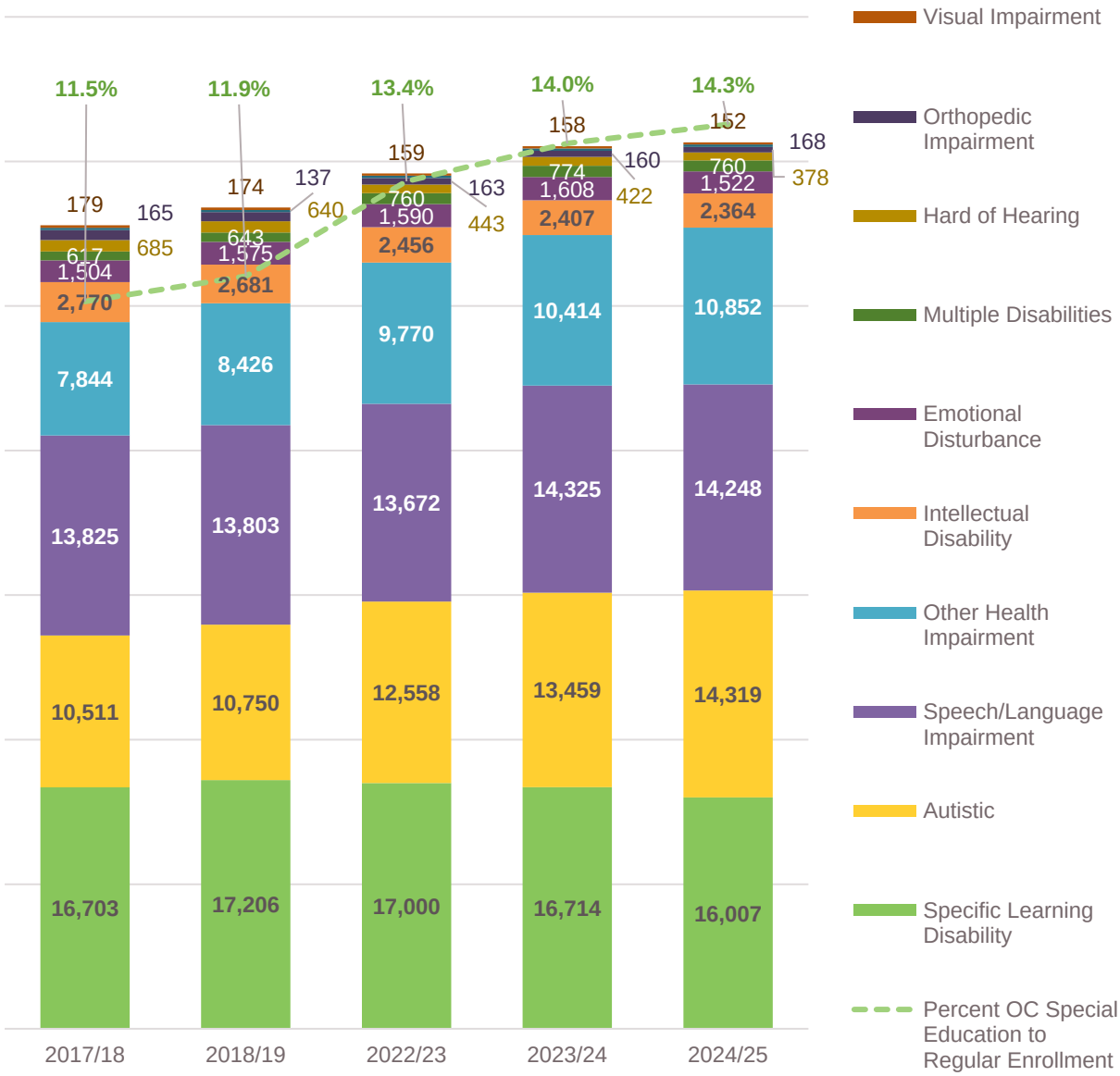
Nearly one out of every five children in the U.S. have a significant healthcare need. Children and youth with significant healthcare needs require more care for their physical, developmental, behavioral, or emotional differences than their typically developing peers.[26] The percentage of Orange County youth with a disability, defined as one or more sensory disabilities or difficulties with everyday tasks, was 5.0%, which was lower than California at 5.6%.[27]

Screening for development disabilities was improving between 2020 and 2023. Among Orange County children (one year or older) in 2023, 45.5% of parents completed a Standardized Development and Behavioral Screening (SDBS) tool. This percentage increased from 42.8% in 2020.[28]

Special education refers to specially designed instruction and related services at no cost to the parent that meets the unique needs of individuals whose educational needs cannot be met with modification of the regular instruction program. In 2024-2025, 14.3% (61,404 students) were enrolled in special education, which was increasing since 2017-2018 when it was 11.5% (55,908 students). Learning disability was the most prevalent disability among students throughout this period, followed by autism and speech/language impairment (**Figure 35**).

[26] Abdi, F. M., Seok, D., & Murphey, D. (2020, December 10). Children with special health care needs are more likely to have adverse childhood experiences. Child Trends.
[27] U.S. Census Bureau. 5-Year Combined Estimate, 2019–2023, Table S1810.
[28] Percentage of children who have received a developmental screening, Orange County, UCLA Community Health Interview Survey

Figure 35. Number and Percentage of K-12 Students Receiving Special Education Services, by Type of Disability, Orange County, 2017-2018 to 2024-2025



Source: California Department of Education

Focus Group Insights on Access to Care for Children with Significant Healthcare Needs

Students with disabilities and who are medically fragile emerged as the populations experiencing the most explicitly identified health disparities, with participants across all focus groups noting significant challenges in accessing appropriate care and support.

School nurses identified delays in diagnosis and access to specialists for conditions including autism and Ear Nose and Throat (ENT) concerns, along with lack of coordination between medical professionals and schools that leaves families navigating complex systems alone. The inadequate support for students with complex medical needs has become more pronounced as the number of medically fragile students increases.

Community health workers noted that families seeking autism diagnoses face long wait times, while some pediatricians dismiss parental concerns about potential developmental delays, preventing timely referrals. As one community health worker explained, **"Sometimes pediatricians aren't concerned [about potential for autism or developmental delays], so families don't get referred."**

Parents/Caregivers described challenges accessing speech therapy and developmental services, noting increased prevalence of communication delays among children in their communities.

The analysis of survey responses, focus groups, key informant interviews, and secondary data identified behavioral health and access to pediatric healthcare services as the two leading health priorities in this CHNA. Behavioral health concerns, including mental health, substance use, and limited access to services, were most prominent among respondents caring for adolescents and young adults. Health promotion and prevention efforts on the topic of behavioral health were also identified as a need for both these age groups and for perinatal, prenatal, and parents of infant. Access to pediatric healthcare services emerged as a second priority, with barriers such as long wait times, insurance complexities, and cultural or language challenges. Community members engaged in the CHNA process emphasized the need to improve access to care, with an emphasis on mental health care, care coordination, and address experiences of racism and discrimination within the healthcare system.

Health outcomes are deeply influenced by social drivers of health such as safe homes, economic stability, healthy and affordable foods, and social connection, all which shape patients' ability to engage in care and maintain wellness. The next section of the report will provide a deep dive into the key drivers of health that were identified through this CHNA.

Social Driver of Health Priorities

Social Driver of Health Priority 1: Safe Homes, Schools, and Neighborhoods

Survey respondents ranked low-crime and safe neighborhoods among the top three factors for a healthy community for children and families. Key concerns identified were bullying (including cyberbullying) and community violence.

The priority area of Safe Homes, Schools, and Neighborhoods focuses on the safety of the environments where people live, learn, work, and play. Error! Reference source not found. **9** below describes how these community priorities align.

Table 9. Alignment of Community Priorities with Safe Homes, Schools and Neighborhoods as a SDOH

Community Priority	SDOH Connection	Health Implications
Low-crime and safe neighborhoods	Community safety and trust	Affects mental health, stress levels, and children's ability to play and learn freely
Bullying and community violence	Social cohesion and exposure to trauma	Linked to anxiety, depression, and long-term health risks

Safety

Safe environments, whether in homes, schools, or neighborhoods, are essential for promoting community health. They support physical and mental well-being, strengthen social ties, and minimize exposure to harmful conditions. Enhancing housing quality and neighborhood safety can reduce injuries, illnesses, and fatalities, while also lowering chronic disease rates, improving mental health outcomes, and boosting academic achievement.[29]

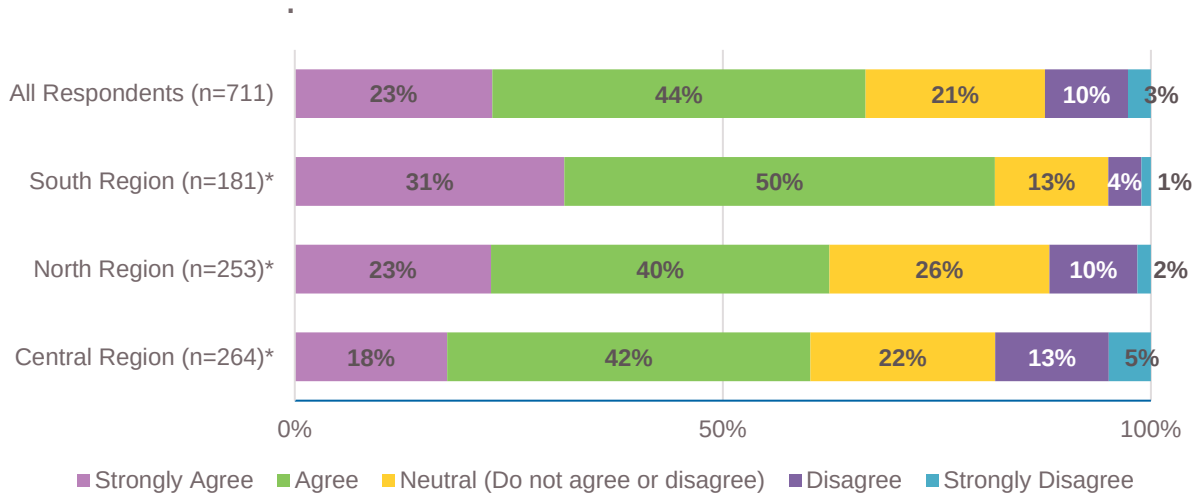
Perceived Neighborhood Safety

Perceptions of community safety vary across regions, though most respondents expressed a positive view. Overall, 67% of all Children's Health Survey respondents agreed or strongly agreed that their community was a safe place to live (**Figure 36**).

[29] Health Impact Assessment. Housing and Health Sector Spotlight. Available at: https://hia.communitycommons.org/learn/health-in-all-policies/housing-and-health/.

Survey respondents living in the South Region reported the highest sense of safety (81%) expressing agreement. Survey respondents living in the North Region showed a more mixed response, with 63% agreeing and the highest proportion of neutral responses (26%) among the regions. The Central Region had the lowest rate of agreement (60%) that their community is a safe place to live along with the highest combined disagreement rate (18%).

Figure 36. Percentage of Parent/Caregiver Survey Respondents by Level of Agreement with a Quality of Life Statement about Safety

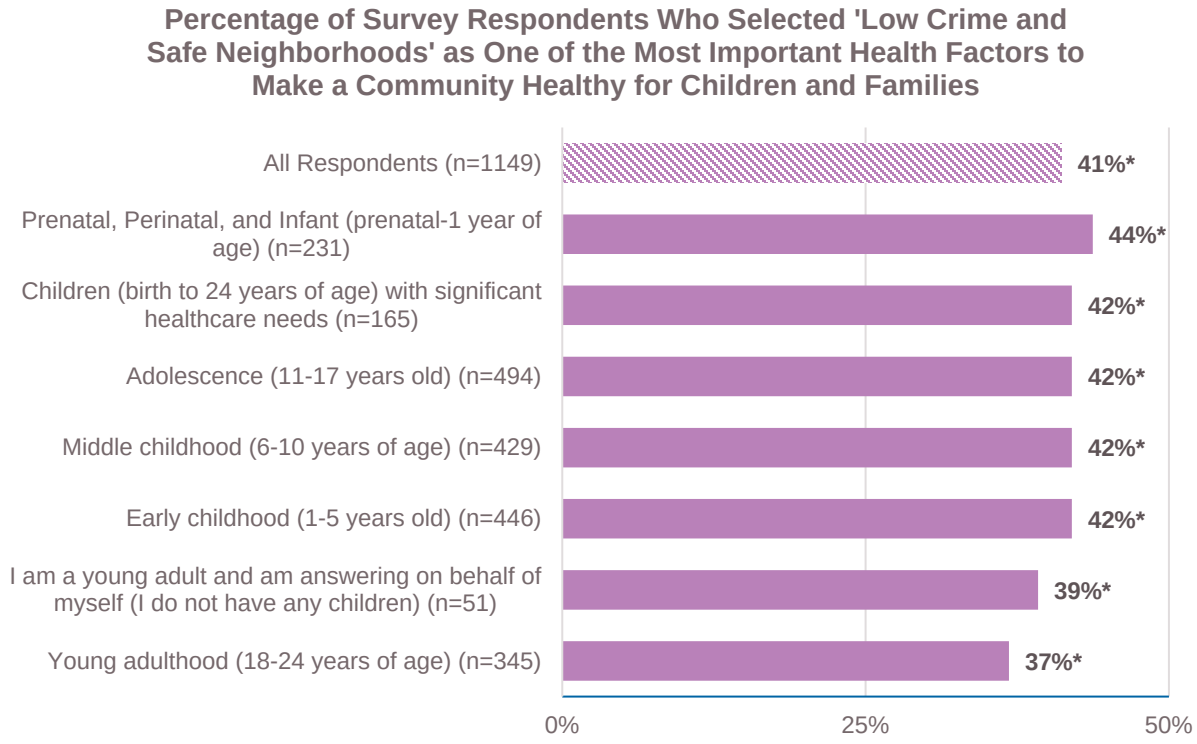


Note: *South Region significantly higher than Central Region for “strongly agree” and significantly lower than all regions and all respondents for “disagree.” North Region significantly higher than South Region for “neutral.” Central Region significantly higher than South Region for “disagree.” Source: Children’s Health Survey, 2024

Safe Neighborhoods as an Important Health Factor

In the Children’s Health Survey question regarding health factors that contribute to a healthy community for children and families, low-crime and safe neighborhoods ranked third out of 28 options, with approximately 41% of respondents selecting it. **Figure 37** presents responses by the age group of child(ren) receiving care. Survey respondents caring for children in the prenatal to infant stage were most likely to prioritize safe neighborhoods (44%), followed by those caring for children with significant healthcare needs (42%), middle childhood (42%), early childhood (42%), and adolescence (42%). These differences compared to all respondents, however, were not statistically significant, indicating that perceptions of neighborhood safety as a health factor were relatively consistent across groups.

Figure 37. Health Factors: Low-Crime and Safe Neighborhoods, by Age of Child(ren) Receiving Care

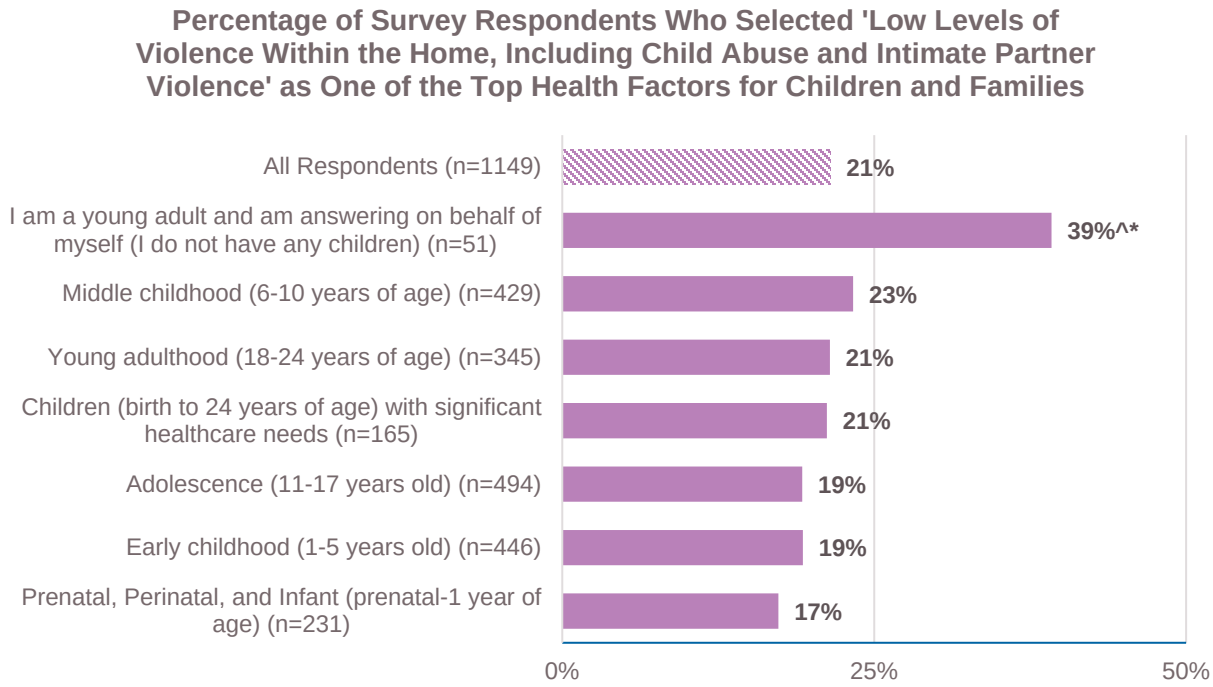


Note: No statistically significant differences were found among groups. *Ranked among the top five health factors for respondents. Source: Children's Health Survey, 2025

Safe Homes as an Important Health Factor

In the Children's Health Survey, low violence in the home, including child and intimate partner violence, ranked eighth of 28 health priorities, with 21% of respondents selecting it. **Figure 38** shows that, at 39%, young adults themselves prioritized this issue the most. This difference was statistically significant, with young adults expressing more concern for this issue compared to all other survey respondents.

Figure 38. Survey Respondents Perceived Importance of Low Levels of Violence by Age of Child(ren) Receiving Care



^Young adults answering on behalf of themselves was significantly higher than all age groups and all respondents. *Ranked among the top five health factors for respondents. Source: Children's Health Survey, 2025

Community Violence and Bullying as An Important Health Factor

In the Children's Health Survey, 26% of respondents identified community violence (i.e., gang violence, homicide) as one of the most harmful risk factors for children and families, ranking it fourth out of 33 options. Young adult respondents reported the highest concern (29%), though the differences between the groups were not statistically significant.

Bullying, including cyberbullying, was ranked as the second most harmful risk factor to children and families in the Children's Health Survey with 37% of respondents naming it a priority. Concern was notably higher among those responding on behalf of children in middle childhood (41%), adolescence (39%), and young adulthood (39%), underscoring the widespread impact of bullying across developmental stages.

Focus Group Insights on Safe Homes, Schools and Neighborhoods

During the focus groups, parents/caregivers expressed some concern about the safety of parks, with a reported need for more security.

Community health workers who participated in a focus group emphasized that families need safe parks and community spaces for physical activity and social interaction, noting that families avoid using some parks due to safety concerns.

“You don’t see families using the parks anymore…they don’t feel safe.”

“More security in parks ... there are homeless people, or people doing drugs or drinking."

Focus group participants note the impact on health behaviors, for example, **“Families lack access to safe parks, walkable neighborhoods and recreational spaces. This limits physical activity and contributes to obesity and isolation.”**

Another parent/caregiver mentioned a lack of park infrastructure saying, **“Some parks have no shade or the games and structures for kids are broken.”**

One school nurse participant, though, shared a differing perspective, saying, **“Irvine Parks and Rec does a really nice job providing programs from infancy through seniors. There’s a lot of open space for outdoor sports and hiking.”**

Related to school safety, parents/caregivers expressed some concern about unvaccinated children in homeschooling environments, and illnesses spreading in schools.

“Some parents prefer homeschooling because they don't want vaccination.”

Below is a summary of the secondary data that reveals both positive trends and areas for improvement in Safe Homes, Schools, and Neighborhoods in Orange County.

Positive Trends in Safe Homes, Schools and Neighborhoods in Orange County from the Secondary Data

1

Cyberbullying

Orange County grade 9 and 11 students had slightly lower rates of cyberbullying, defined as having had mean rumors or lies spread about them on the internet by other students at least once in the previous year, compared to California. The rates were decreasing. However, the rate for Orange County grade 7 students was increasing and was higher than California.

Areas for Improvement in Safe Homes, Schools and Neighborhoods in Orange County from the Secondary Data

1

School Safety

The percentage of children who reported that their school was safe or very safe ranged from a low of 57.0% of students in grade 7 to a high of 63.0% among grade 11 students. Across grades 7, 9, and 11, students were less likely to feel safe at school in 2021–2023 compared to 2013–2015 and 2017–2019.

2

Disparities in School Safety

Between 2021 and 2023, 44.3% of gay, lesbian, and bisexual students in Orange County felt their school was safe, compared to 62.3% of heterosexual students — a trend reflected statewide. Perceived safety declined for these groups and all students of color since 2017–2019, with Native Hawaiian/Pacific Islander and Black/African American students reporting the lowest safety rates at about 51%.

3

Bullying

Data from 2021–2023 show that 55.3% of gay, lesbian, and bisexual students in Orange County reported experiencing bullying in the past year, compared to 22.0% of students identifying as heterosexual. Bullying rates in Orange County remained below California averages across all sexual orientations.

4

Injury Mortality

While Orange County's overall child mortality rate remained lower than the statewide average, injury-related deaths increased significantly, driven largely by a tripling in unintentional (accidental) injury deaths between 2019 and 2023, with poisoning and drug overdoses and motor vehicle accidents as large contributors.

5

Child Abuse and Neglect Rates

Although substantiated child abuse rates in Orange County declined slightly since 2019, they remain higher than the statewide average, and the county's rate of improvement has been slower than California's overall progress.

Note: Detailed data estimates and data sources are provided in the text below.

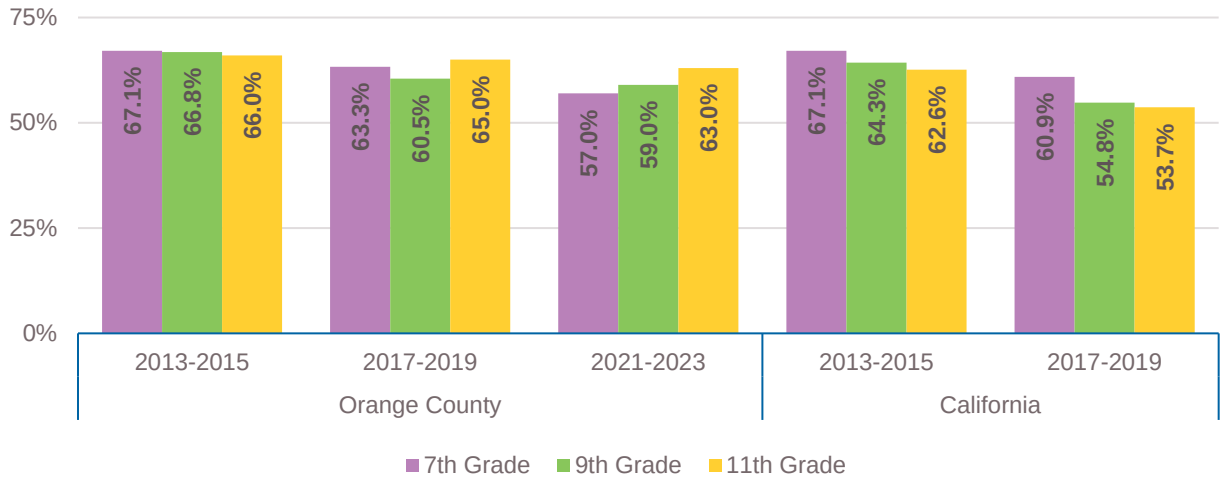
The following section provides detailed data tables and/or figures supporting the positive trends and areas for improvement in safe homes, schools and neighborhoods identified based on secondary data.

Perceived School Safety

Indicators of school safety are based on student reports regarding their perceived level of safety when at school. In the California Health Kids Survey, students identify their level of safety from very safe, safe, neither safe nor unsafe, unsafe, and very unsafe.

As shown in **Figure 39**, the percentage of children who reported that their school was safe or very safe ranged from a low of 57.0% of grade 7 students to a high of 63.0% among grade 11 students. Perceived rates of school safety were higher in Orange County compared to California in 2017–2019.[30] In Orange County, grade 7, 9, and 11 students were less likely to feel safe at school in 2021–2023 compared to 2013–2015.

Figure 39. Percentage of Student who Reported That School was Perceived as Safe or Very Safe



Source: California Department of Education, California Healthy Kids Survey

Bullying

Bullying is any type of repeated, aggressive behavior that one person (or a group of people) directs at someone else with the goal of causing physical or emotional pain. While accidents happen and may result in physical harm, bullying behaviors are purposeful and intentional.[31]

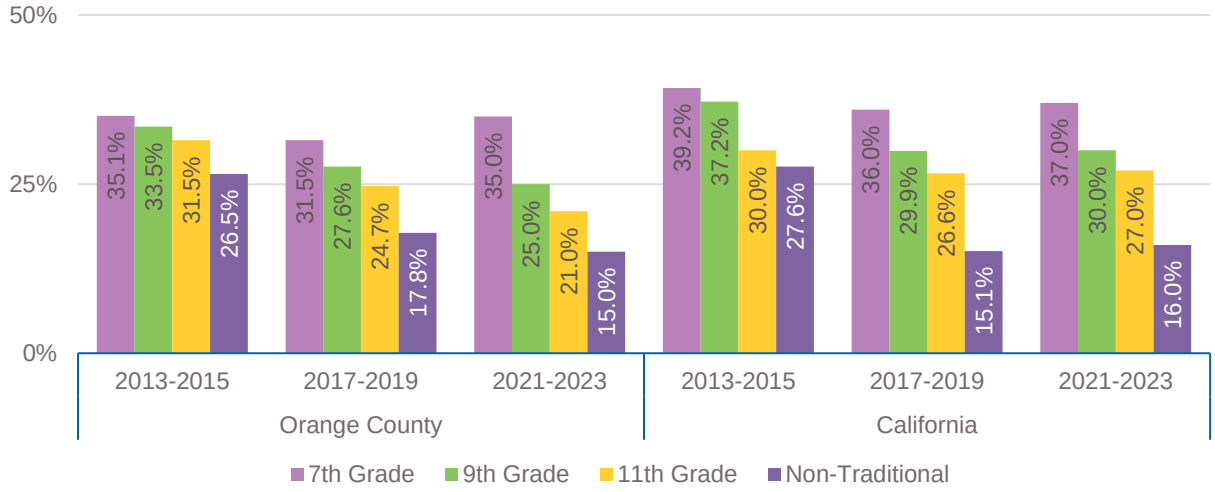
Self-reported rates of being on the receiving end of bullying at least once in the past 12 months were lower in Orange County compared to California. As shown in **Figure 40** grades 9 and 11

[30] The perceived rates of school safety cannot be compared between Orange County and California for 2021–2023 because California data are unavailable.

[31] Centers for Disease Control and Prevention. (2024, October 28). Bullying, Youth Violence Prevention. U.S. Department of Health & Human Services.

and non-traditional school-based students self-reported rates of bullying had decreased between 2013–2015 and 2021–2023, except for grade 7 students. Most recently, between 2017–2019 and 2021–2023, the rates of bullying for grade 7 students increased.

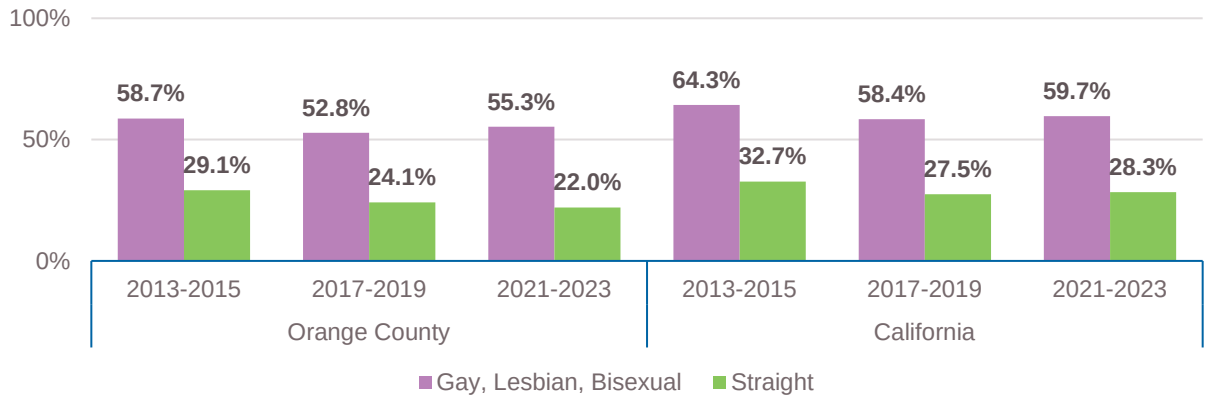
Figure 40. Percentage of Students Who Experienced Any Harassment or Bullying at School at Least Once in the Past 12 Months, by Grade Level



Source: California Department of Education, California Health Kids Survey

Data from 2021–2023 show that 55.3% of gay, lesbian, and bisexual students in Orange County reported experiencing bullying in the past year, compared to 22.0% for students identifying as straight (**Figure 41**). The rates for gay, lesbian, and bisexual students increased from 52.8% in 2017–2019 to 55.3% in 2021–2023, following a period of decline since 2013–2015. Bullying rates in Orange County remained below California's state average across all sexual orientations.

Figure 41. Percentage of Students Who Experience Any Harassment or Bullying at School at Least One Time in the Past 12 Months, by Sexual Orientation



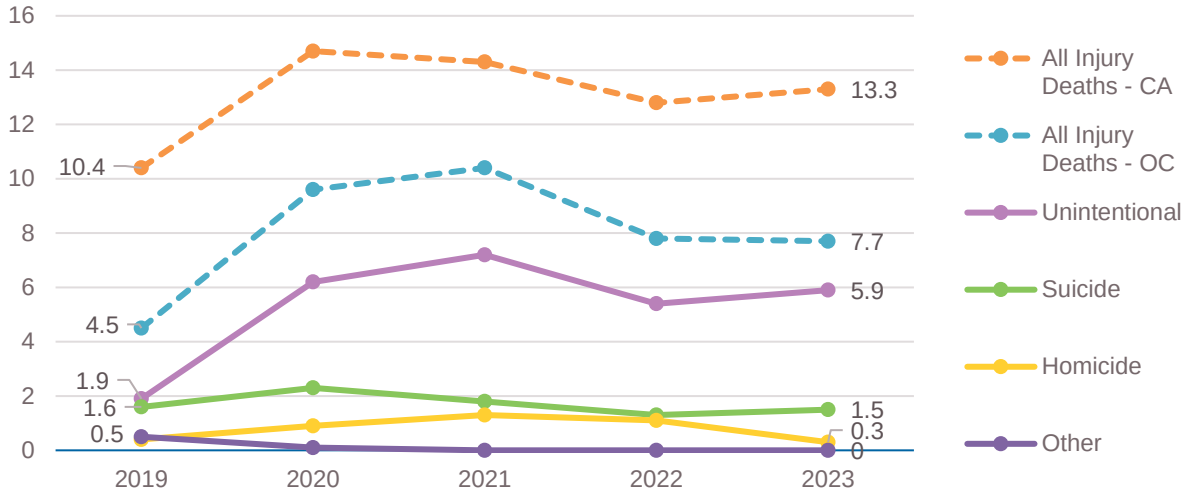
Source: California Department of Education, California Healthy Kids Survey

Death From Injury

Many child and adolescent deaths stem from injuries often preventable through safety measures. These include firearm injuries, motor vehicle crashes, drug overdoses, and suicide.[32] Each of these causes is tied to environmental, behavioral, and systemic safety factors, much of which are described in this needs assessment.

In 2023, Orange County reported 113 deaths among children ages 1-19, with a mortality rate of 15.4 per 100,000, which remained lower than the statewide rate of 13.3 per 100,000 for injury-related deaths. As shown in **Figure 42**, from 2019 to 2023, Orange County's overall injury death rate increased from 4.5 to 7.7 deaths per 100,000. Nearly half (49.6% or 59 deaths) of all child and youth deaths in 2023 were injury-related, though this marked a 9.6% decrease from 2022 (54.6% or 79 deaths). Unintentional (accidental) injury deaths were the most significant contributor to this increase, tripling from 1.9 to 5.9 deaths per 100,000 during this same period. Among injury-related deaths, unintentional injury represented the higher proportion of deaths (73% or 43 deaths). Poisoning (including drug overdoses) accounted for the highest number (19 deaths), followed by motor vehicle incidents, including both bicycle and pedestrian incidents (16 deaths), drowning (4 deaths), and other causes (4 deaths).

Figure 42. Injury, Unintentional Injury, Suicide, and Homicide Rate Per 100,000 Children, 1–19 Years Old, 2019–2023.



Source: Orange County Health Care Agency

As shown in **Figure 43,** the leading causes of death varied by age group: unintentional (accidental) injuries were the top cause for children ages 1–4 and teens ages 15–19, while cancer was the leading cause for children ages 5–14. Suicide emerged as the second leading cause of death among children ages 10–19, with 35 deaths reported between 2021 and 2023. Homicide was also a significant contributor among teens (ages 15–19) (18 deaths).

[32] Centers for Disease Control and Prevention. (2025, July 15). FastStats - Adolescent Health. National Center for Health Statistics.

Figure 43. Leading Causes of Death for Children 1-19 Years Old, by Age Group and Number of Deaths, 2021–2023

	1–4 Years	5–9 Years	10–14 Years	15–19 Years	1–19 Years
First Leading Cause	Unintentional Injuries (13)	Cancer (11)	Cancer (13)	Unintentional Injuries (110)	Unintentional Injuries (139)
Second Leading Cause	Cancer (6)	Unintentional Injuries (7)	Suicide (13)	Suicide (22)	Cancer (48)
Third Leading Cause	Conditions originating in the perinatal period (3)	Congenital Anomalies (6)	Unintentional Injuries (9)	Cancer (18)/ Homicide (18)	Suicide (35)

Note: Three-year total number of deaths. Source: Orange County Health Care Agency

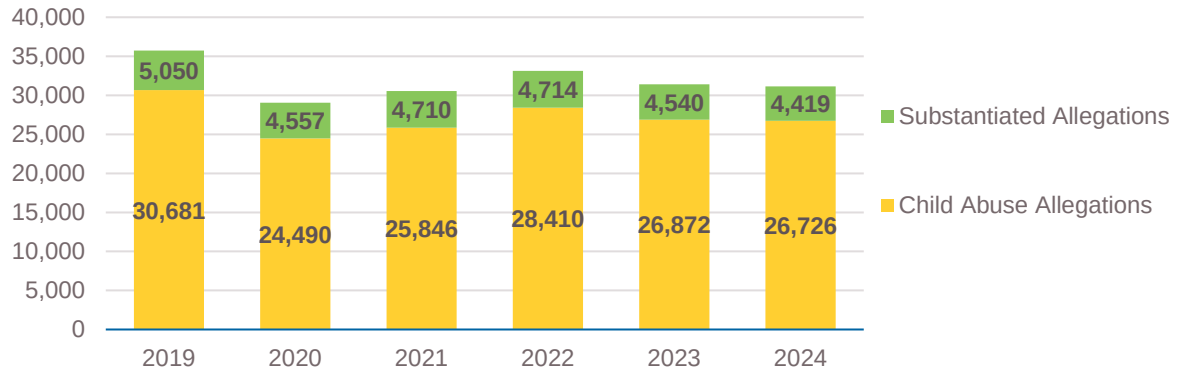
Among unintentional injury related deaths, 44% were due to poisoning, including drug overdose followed by motor vehicles (37%), drowning (10%) and other causes, including events with undetermined intent (9%). Additionally, older teens (ages 15–19) accounted for 57.5% of all child deaths. While male mortality rates decreased slightly (from 18.0 to 16.8 deaths per 100,000 children ages one to 10 years), female rates increased from 2022–2023 (from 10.3 to 14.0 per 100,000 children ages 1-10 years).

Racial and ethnic disparities were evident, with Hawaiian/Pacific Islander children experiencing the highest mortality rate (54.6 per 100,000), followed by White (17.5), Hispanic (16.9), and Asian (12.2) youth. Rates for Black youth were lower (9.3), though estimates for Hawaiian/Pacific Islander and Black youth should be interpreted with caution due to small population sizes.

Child Abuse and Neglect

In 2024, there were 32,913 children and youth (ages 0–17) in Orange County who were the subject of one or more child abuse allegations (**Figure 44**). Of these, 13.4% (4,419 children) of the allegations were substantiated.[33] Since 2019, the number of children subject to one or more child abuse allegations decreased 12% from 38,916 children.

Figure 44. Total Number of Children with Child Abuse Allegations and Substantiated Allegations, 2019-2024



Note: Numbers are based on an unduplicated count of children. Source: California Department of Finance; Child Welfare Services / Case Management System 2024 Quarter 4 Extract, County of Orange Social Services Agency

In 2024, the rate of substantiated child abuse in Orange County was 6.8 per 1,000 children under 18 years, which was higher than California's rate of 5.4 per 1,000 children. Since 2019, substantiated abuse rates fell by 4.2% in Orange County (from 7.1 to 6.8 per 1,000 children), while California saw a larger 28.9% drop (from 7.6 to 5.4 per 1,000).[34]

Children under six years old accounted for the largest share of substantiated cases, with infants under one year comprising 11.5% and children ages 1-5 making up 28.4% of substantiated cases. Children ages 6-10 represented 27.7%, those ages 11-15 made up 24.3%, and youth ages 16-17 accounted for 8.1%.[35] Most substantiated allegations were due to general neglect (69.4%). Other reasons included risk of sibling abuse (9.2%), severe neglect (8.5%), physical abuse (4.9%), sexual abuse (3.9%), caretaker absence or incapacity (2.9%), exploitation (0.6%), and emotional abuse (0.5%).[36]

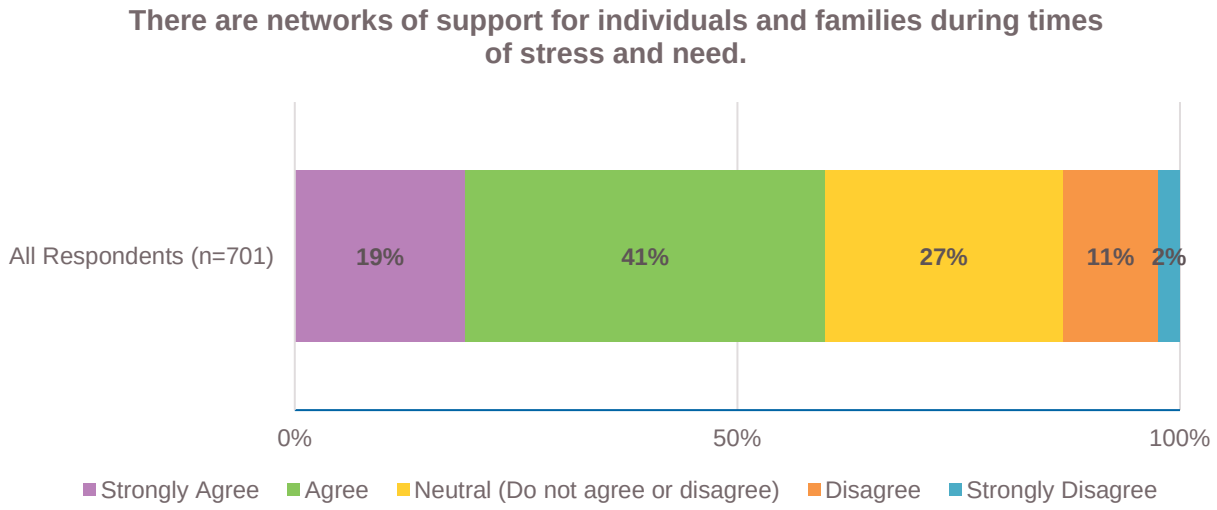
[33] Allegations refer to the nature of abuse or neglect that a child experiences (e.g., sexual or physical). A substantiated child abuse allegation is determined by the investigator based upon evidence that makes it more likely than not that child abuse or neglect occurred as defined in Penal Code (PC) 1165.6. A substantiated allegation does not include a report where the investigator later found the report to be false, inherently improbable, to involve accidental injury or to not constitute child abuse or neglect as defined in PC 1165.6.
[34] California Department of Finance; Child Welfare Services / Case Management System 2024 Quarter 4 Extract, County of Orange Social Services Agency.
[35] Ibid.
[36] Ibid

Social Driver of Health Priority 2: Connectedness

Connectedness is a vital component of pediatric health. High-quality relationships and supportive environments help individuals manage stress, adopt healthier behaviors, increase life expectancy, and improve overall well-being. Communities that foster trust and provide safe, accessible spaces for connections play a key role in reducing isolation and strengthening resilience.[37]

A key community strength identified in the Children Health Survey was the presence of support networks for individuals and families during times of stress and need. Overall, 60% of all respondents agreed or strongly agreed that such networks exist in their communities, while 27% were neutral and 13% expressed disagreement. Regional responses were consistent overall, with no significant differences. Respondents living in the South Region had the highest level of agreement (64%), suggesting a more positive perception of support systems in that area compared to respondents living in the Central and North regions. However, these regional differences were not significantly different (**Figure 45**).

Figure 45. Percentage of Parent/Caregiver Survey Respondents by Level of Agreement with a Quality of Life Statement on Networks of Support



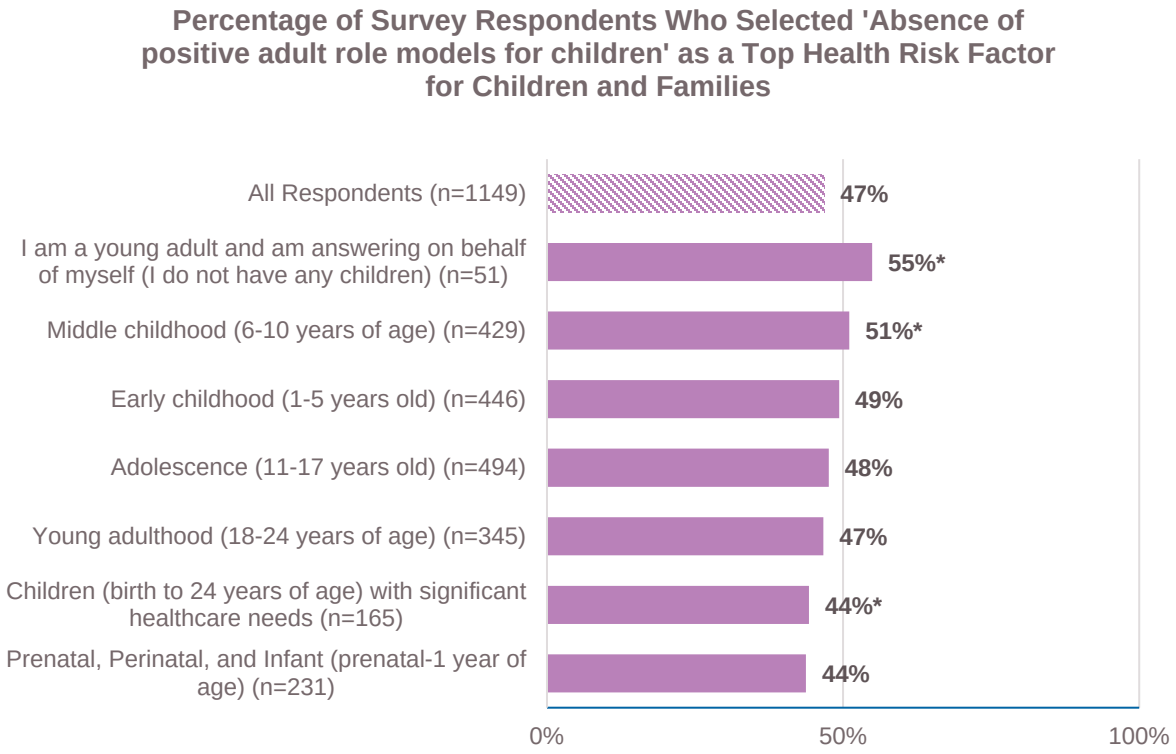
Note: No statistical difference between regions. Source: Children's Health Survey, 2025

[37] Centers for Disease Control and Prevention. Social Connectedness. Available at: https://www.cdc.gov/social-connectedness/about/index.html.

Having one or more caring adult in a young person's life is an important protective factor against negative social and health outcomes. In many cases, these caring adults are the child's parents, but other relatives, neighbors, friends of parents, teachers, coaches, religious leaders, and others can play this role.[38] The absence of positive adult role models for children was identified as the most significant health-related risk factor among all 33 options presented in the community survey (**Figure 46**). Nearly half (47%) of survey respondents selected the absence of a positive adult role model for children as the most significant risk factor.

This prioritization was most common among young adults responding on their own behalf (55%), followed by children in middle childhood (51%), early childhood (49%), and adolescence (48%). These differences were not statistically significant, suggesting broad agreement across groups about the critical role of adult influences in shaping children's health and development.

Figure 46. Health Risk Factors: Absence of Positive Adult Role Models for Children, by Age of Child(ren) Receiving Care



No statistically significant differences were found among survey respondents who provide care for different age groups. *Absence of positive adult roles models for children was ranked in the top five risk factor for all groups. Source: Children's Health Survey, 2025

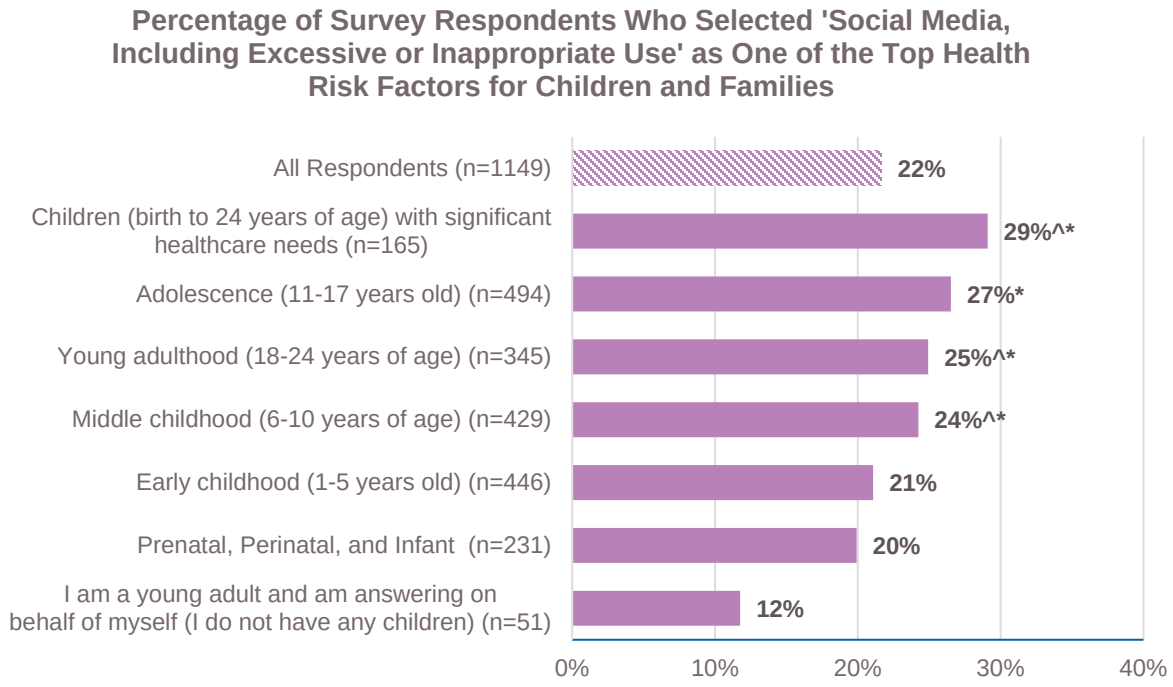
[38] Raimon, M.L., "Interactive Guide: Using the Protective and Promotive Factors to Support Youth Well-Being." Center for the Study of Social Policy.

Screen time and social media may affect children's social relationships. This impact can be both positive and negative. Social media plays a major part in our everyday lives, and most young people spend a large part of their day engaging on one or more social media platforms. Social media can have many positive aspects such as:

- Helping connect with loved ones who may be scattered around the world
- Connecting with people who have similar interests or passions
- Providing a platform to share stories and experiences
- Connecting with people who are exploring their identities and accessing resources not made available at home or school

In the Children's Health Survey, 22% of all respondents listed excessive or inappropriate social media use as a top concern, ranking it sixth out of 33 risks to child and family health (**Figure 47**). Figure 4Survey respondents caring for children with significant healthcare needs (29%), adolescents (27%), young adults (25%) and children in middle childhood (24%) were more likely than other survey respondents to view social media use as a risk.

Figure 47. Risk Health Factor: Social Media Use, by Adult Role Models for Children, by Age of Child(ren) Receiving Care



^Responses were statistically significantly higher than other age groups receiving care by caregiver and provider survey respondents.*Ranked among the top five health risk factors.
Source: Children's Health Survey, 2025

Focus Group Insights on Connectedness and Social Media

Focus group participants highlighted a different impact of social media–not only on the child, but also on their parents and caregivers.

Participants shared that inadequate access to mental health services is exacerbated by social media pressure, with parents reportedly feeling inadequate after comparing themselves to unrealistic online portrayals.

One participant noted, **"Parents are stressed… they're seeing so much on social media… they feel like they're not doing enough."**

Focus group participants also explained that social media is contributing to health misinformation and creating barriers to establishing trust between families and healthcare providers.

School nurses reported increasing difficulty in countering misinformation and rebuilding trust with families who have been exposed to conflicting information online.

Below is a summary of the secondary data that reveals both positive trends and areas for improvement in connectedness in Orange County.

Positive Trends in Connectedness from the Secondary Data

1. **Opportunity Youth**
   In Orange County, from 2015–2019, 4.0% of youth ages 16–19 were neither working nor enrolled in school, otherwise known as Opportunity Youth. This statistic decreased since 2010–2014, when it was 6.2%. Opportunity youth rates in Orange County were lower than California and the U.S.

2. **Screen Time**
   In Orange County in 2022, 33.9% of teens (13–17 years) reported that they “almost constantly” use the internet. This decreased from 49.9% of teens in 2020.

3. **Social Media Use**
   In 2022, in Orange County, 27.4% of teens reported they “almost constantly” used a computer/mobile device for social media, which was an increase from 24.4% in 2020.

Areas for Improvement in Connectedness from the Secondary Data

1 **School Connectedness**
Orange County students were less likely to report that they "strongly agree" or "agree" that there was school connectedness in 2021–2023 as compared to 2017–2019. The higher the grade level, the less school connectedness was reported among students.

2 **Disparity in School Connectedness**
Gay, lesbian, and bisexual students reported lower levels of school connectedness (47.5%) compared to straight students (57.8%) in 2021–2023. Students of color were less likely to feel connected to school than their peers, but this gap was closing, decreasing from an 18% to 9% gap.

Note: Detailed data estimates and data sources are provided in the text below.

The following section provides detailed data tables and/or figures supporting the positive trends and areas for improvement in connectedness identified based on secondary data.

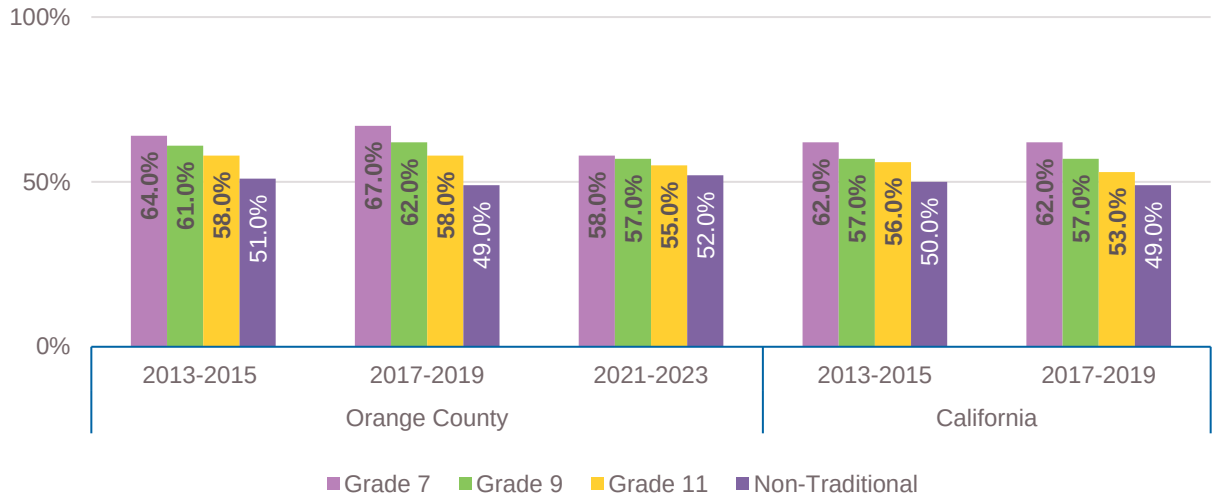
Youth School Connectedness

School connectedness is the belief students hold that adults and peers at school care about their learning and about them as individuals. This sense of connection is a key protective factor, shown to reduce the likelihood of risky behaviors such as early sexual activity, substance use, violence, and gang involvement. Connection has shown to improve the likelihood of academic achievement, defined by higher grades and test scores, school attendance, and completing school.[39]

School connectedness is measured on the California Healthy Kids Survey with five questions about feeling safe, feeling close to people, feeling included at school, being happy at school, and teachers treating students fairly. Orange County students, including students in grades 7, 9, and 11, were less likely to report that they strongly agree or agree with these measures of school connectedness in 2021–2023 as compared to both 2013–2015 and 2017–2019 (**Figure 48**). Non-traditional school-based students generally remained stable during this time at approximately 50% of students. School connectedness declined as grade levels increased.[40]

[39] Centers for Disease Control and Prevention. (2023). *School connectedness and risk behaviors and experiences among high school students—Youth Risk Behavior Survey, United States, 2021*. Morbidity and Mortality Weekly Report, 72(Suppl-1), 13–21.
[40] Orange County could not be compared with California because those data were unavailable in 2021–2023.

Figure 48. Percentage of Students with High Level of School Connectedness, by Grade



Source: California Department of Education, California Healthy Kids Survey. Data for 201-2023 was unavailable for California.

Youth Connectedness with Adults

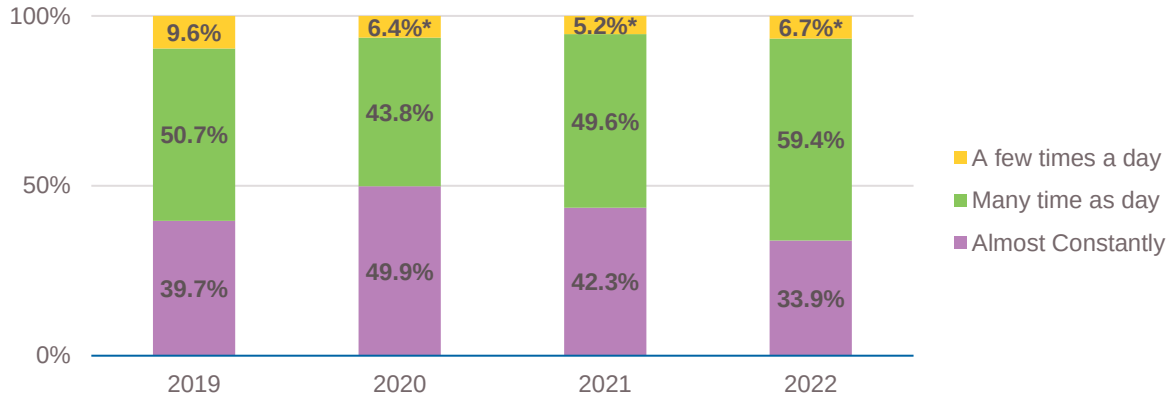
The California Healthy Kids Survey measures connectedness with an adult in school through student self-reports on three statements: having a teacher or other adult at school who cares about them, notices when they are absent, and listens when they have something to say. In 2023, the percentage of grade 7, 9, and 11 students who reported they had a caring relationship with an adult was 57.0%, 55.0%, and 58.0%, respectively.

The percentage of students that had a caring adult relationship varied by race or ethnicity and sexual orientation. In 2021–2023, 67.5% of White/Caucasian students reported having caring adult relationships compared to 57.3% of Hispanic or Latino/a and American Indian students. Connectedness to adults at school among gay, lesbian and bisexual students was slightly lower compared to straight students, at 55.5% versus 58.8%, respectively. Trends in Orange County were like California's; however, connectedness was slightly higher in Orange County for all race groups**.**

Social Media and Screen Time

In 2022, in Orange County, 33.9% of teens (13-17 years) reported they "almost constantly" use the internet. This is compared to a four year high of 49.9% in 2020 (**Figure 49**).

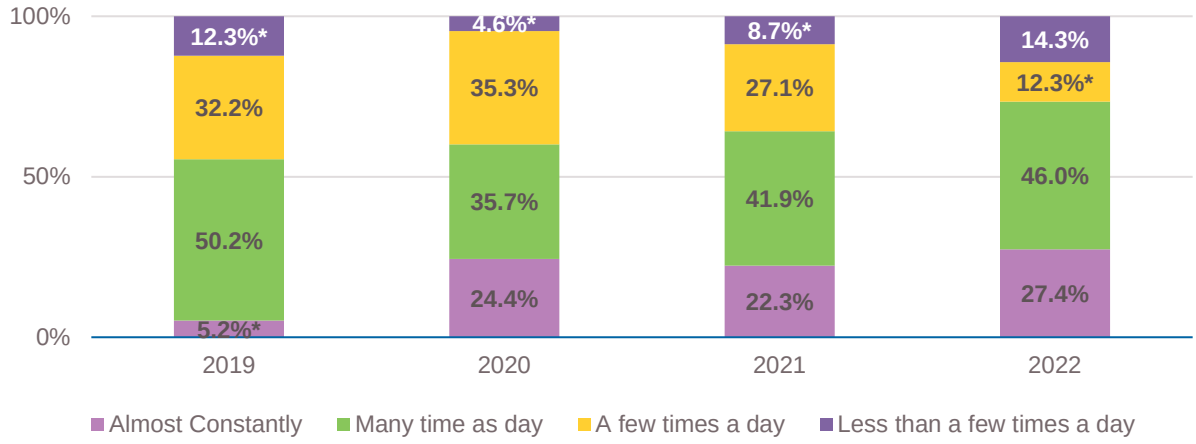
Figure 49. Percentage of Orange County Teens (13-17 years) by How Often They Use the Internet



*Estimate may not reliably represent the population and should be interpreted with caution.
Source: UCLA Center for Health Policy Research, California Health Interview Survey

In 2022, in Orange County, 27.4% of teens reported they "almost constantly" used a computer/mobile device for social media, which was a slight increase from 24.4% in 2020 (**Figure 50**).

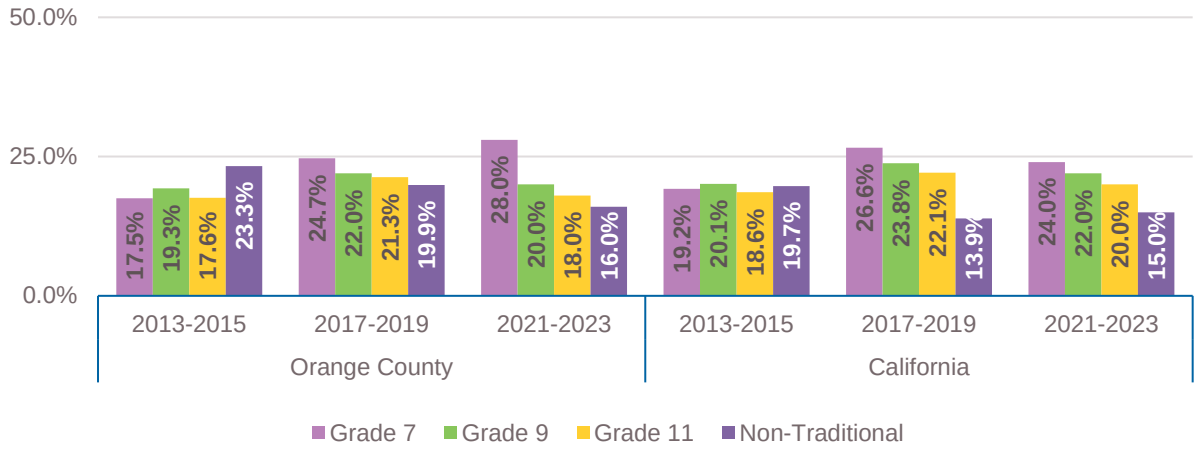
Figure 50. Percentage of Orange County teens (13-17 years) by How Often They Use a Computer or Mobile Device for Social Media



*Estimate may not reliably represent the population and should be interpreted with caution.
Source: UCLA Center for Health Policy Research, California Health Interview Survey

According to the Centers for Disease Control and Prevention (CDC), approximately 33% of middle school and 30% of high school students nationally have experienced cyberbullying, defined as having had mean rumors or lies spread about them on the internet by other students at least once in the previous year.[41] Orange County grade 9 and 11 students had slightly lower rates of cyberbullying, compared to California, and these rates were decreasing. However, the rates for Orange County grade 7 students increased from 17.5% in 2013–2015 to 28.0% in 2021–2023 (**Figure 51**).

Figure 51. Percentage of Public School Students Who Had Other Students Spread Mean Rumors or Lies About Them on the Internet at Least Once in the Past Year, by Grade Level



Source: California Department of Education, California Health Kids Survey

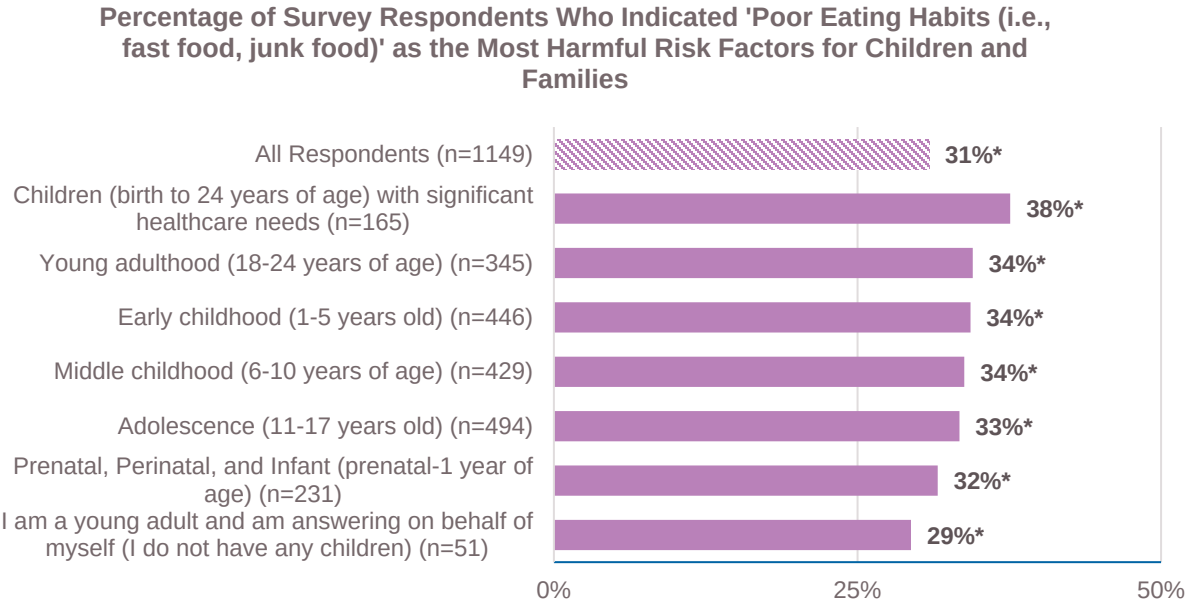
[41] Centers for Disease Control and Prevention. (2019). Preventing Bullying. National Center for Injury Prevention and Control.

Social Driver of Health Priority 3: Healthy and Affordable Foods

Access to foods that support healthy dietary patterns contribute to lifelong health.[42] Unfortunately, there are barriers and disparities in the accessibility and availability of foods that support healthy eating habits. Low-income and minority communities often lack convenient sources of affordable, healthier foods. When healthy foods are unavailable, people may settle for foods higher in calories and lower in nutritional value.[43]

Poor eating habits were ranked third out of 33 risk factors for children and families, with 31% of respondents selecting it (**Figure 52**). The concern was higher among survey respondents caring for children with significant healthcare needs (38%), as well as those representing early childhood, middle childhood, and young adulthood (each at 34%). No statistically significant difference was noted among the groups, highlighting that concerns about poor eating habits were consistent across the age groups being cared for.

Figure 52. Health Risk Factors: Poor Eating Habits, by Age of Child(ren) Receiving Care



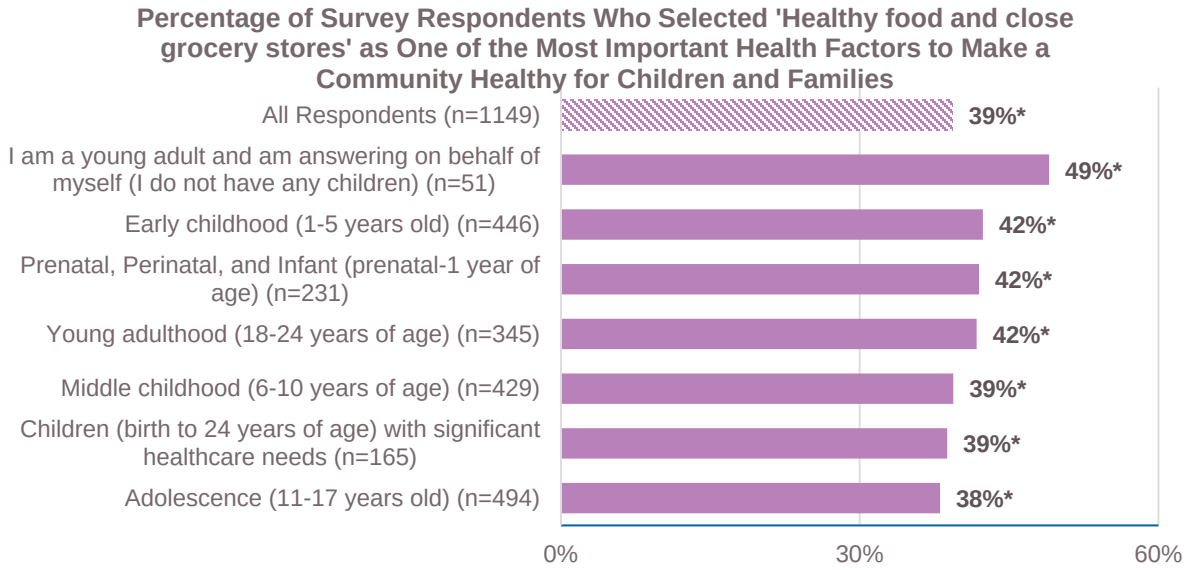
Note: No statistically significant differences were found among groups receiving care. *Ranked among the top five risk factors for respondents. Source: Children's Health Survey, 2025.

Access to healthy food and nearby grocery stores was ranked fourth overall out of 28 health factors, selected by 39% of all respondents as one of the most important elements for a healthy community. **Figure 53** reveals notable variation among age groups cared for, however, the differences were not statistically significant. Among survey respondents, those that care for

[42] Office of Disease Prevention and Health Promotion. (n.d.). Nutrition and healthy eating. Healthy People 2030. U.S. Department of Health and Human Services.
[43] Haynes-Maslow, L., Parsons, S. E., Wheeler, S. B., & Leone, L. A. (2013). A qualitative study of perceived barriers to fruit and vegetable consumption among low-income populations, North Carolina, 2011. Centers for Disease Control and Prevention. Preventing Chronic Disease, 10, 120206.

young adults (49%) expressed the strongest concern, followed by those providing care for children in early childhood, prenatal/infant care, and young adulthood (each at 42%).

Figure 53. Health Factors: Healthy Foods, by Age of Child(ren) Receiving Care



Note: No statistically significant differences were found among groups *Ranked among the top five health factors for respondents. Source: Children's Health Survey, 2025

Focus Group Insights on Healthy and Affordable Foods

Community health workers emphasized that families need access to affordable, nutritious food combined with education on healthy eating, highlighting the importance of food banks, Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), CalFresh, and nutrition education programs.

The rising prevalence of obesity and diabetes underscores the urgency of addressing nutrition-related needs. Proposed approaches include utilizing surplus cafeteria produce to support families and expanding programs such as Nutrition Network to reach older student populations.

Below is a summary of the secondary data that reveals both positive trends and areas for improvement in Healthy and Affordable Foods in Orange County.

Positive Trends in Healthy and Affordable Foods from the Secondary Data

1. **WIC Participation**
   After hitting a 10-year low in 2021/2022, WIC participation in Orange County increased slightly to over 59,000 participants in 2023/2024, showing signs of renewed engagement.
2. **Eligibility Among Food-Insecure Children for Nutrition Programs**
   The percentage of food-insecure children who were income-eligible for nutrition programs dropped from 73% in 2019 to 63% in 2023, suggesting improved coverage and access.
3. **Meal Cost**
   Although meal costs were rising, the rate of increase slowed.

Areas for Improvement in Healthy and Affordable Foods from the Secondary Data

1. **Participation in CalFresh**
   In 2023, over 73% of low-income households in Orange County were not receiving CalFresh, significantly higher than the 61% statewide rate. This persistent gap suggests barriers in outreach, enrollment, or eligibility verification.
2. **Food Insecurity**
   Both youth and general population food insecurity rates increased since 2019 to 12.9% of youth and 11.4% of the full population in Orange County in 2023.

Note: Detailed data estimates and data sources are provided in the text below.

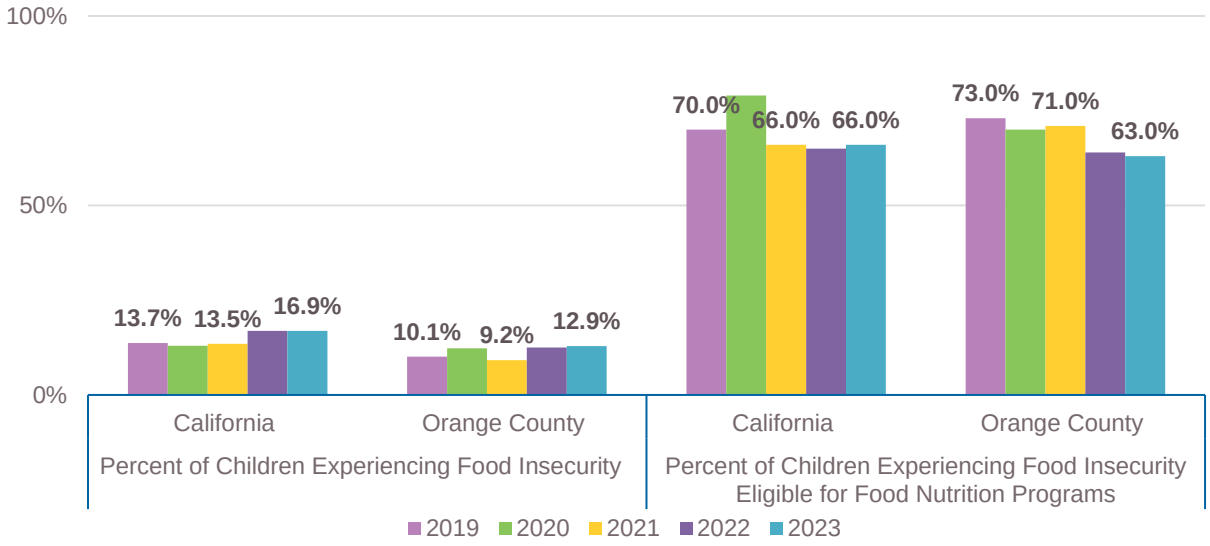
The following section provides detailed data tables and/or figures supporting the positive trends and areas for improvement in healthy and affordable foods identified based on secondary data.

Food Insecurity Rates

From 2019–2023, food insecurity rates in both California and Orange County increased across both youth and the general population, though Orange County consistently reported lower rates than the state overall. For the full population, California's rate grew from 10.2% to 13.7%, and Orange County's rate increased from 8.3% to 11.4%

Among youth ages 0–17, California saw a rise from 13.7% in 2019 to 16.9% in 2023, while Orange County's youth food insecurity increased slightly less from 10.1% in 2019 to 12.9% in 2023, with a notable dip to 9.2% in 2021 (**Figure 54**). Of those children experiencing food insecurity, 63% were income-eligible for federal nutrition programs (incomes at or below 18% of poverty) in 2023 (compared to 66.0% of food-insecure children in California). The percentage of children experiencing food insecurity who were also eligible for food nutrition programs decreased in Orange County between 2019 and 2023, from 73.0% to 63.0% of children.

Figure 54. Percentage of Children Experiencing Food Insecurity and Eligibility for Food Nutrition Programs

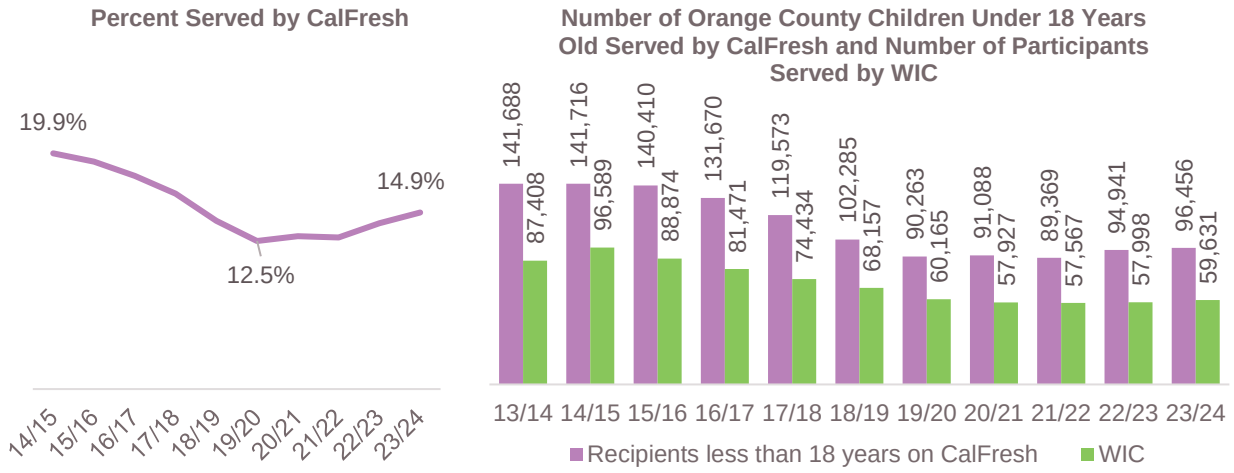


Source: U.S. Department of Department of Agriculture, Map the Meal Gap.

Participation in Food Assistance Programs

The CalFresh Program, known nationally as the Supplemental Nutrition Assistance Program (SNAP), and the Supplemental Nutrition Program for Women, Infants, and Children (WIC), provide nutrition assistance to people in low-income households by increasing their food-buying power. Income-eligible children can receive both forms of nutrition assistance. With these benefits, families can purchase more nutritious foods, such as fruits, vegetables, and other healthy foods. Between 2014–2024, participation in supplemental nutrition programs such as CalFresh and WIC in Orange County has fluctuated, reflecting both economic conditions and outreach efforts. In 2023-2024, 14.9% of children under 18 in Orange County received CalFresh benefits, down from a 10-year high of 19.9% in 2014/2015, yet still representing over 96,000 children (**Figure 55**). This rate remained lower than the statewide average of 22.4%. WIC participation also increased slightly, from a 10-year low of 57,567 in 2021–2022 to 59,631 in 2023–2024, though still below its peak of 96,589 in 2015.

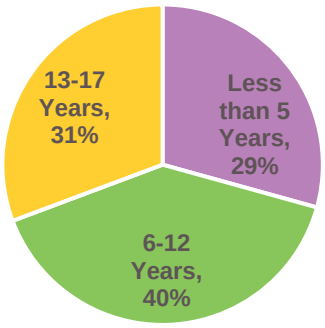
Figure 55. Number and Percentage of Children Under 18 Years Old Served by CalFresh and Number of Participants Served by WIC



Note: WIC data represents the number of participants served in September of each year. Cal Fresh data represents fiscal Year (July–June) monthly averages. Source for CalFresh: County of Orange Social Services Agency. Source for WIC: Orange County Health Care Agency/Nutrition Services-WIC

As shown in **Figure 56**, the largest share of child CalFresh Orange County recipients in January 2025 were aged 6–12 years (39.9%), followed by 13–17 years (30.2%) and 0–5 years (29.8%).

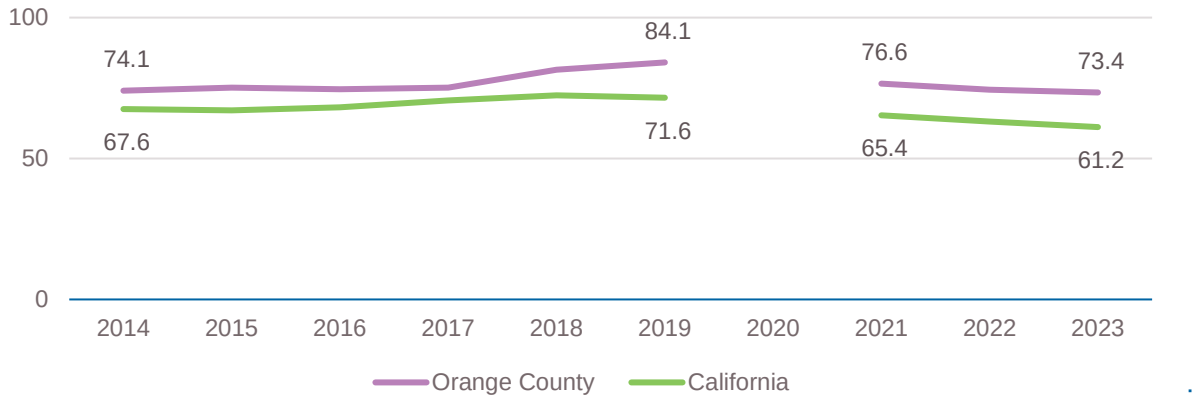
Figure 56. Percentage of Orange County Children Receiving CalFresh, by Age Group, July 2023–June 2024



Source: California Department of Social Services, CalFresh County Data Dashboard, 2024

From 2014 to 2023, Orange County consistently had a higher percentage of households in poverty not receiving CalFresh compared to the statewide average. In 2014, 74.1% of low-income households in Orange County were not enrolled in CalFresh, compared to 67.6% statewide (**Figure 57**). This gap persisted and widened over time, peaking in 2019 when 84.1% of Orange County's low-income households were not participating, versus 71.6% of households in California. Although both regions saw a decline in nonparticipation after 2019, Orange County's rate remained significantly higher. By 2023, 73.4% of eligible households in Orange County were still not receiving CalFresh, compared to 61.2% statewide.

Figure 57. Percentage of Households in Poverty Not Receiving CalFresh

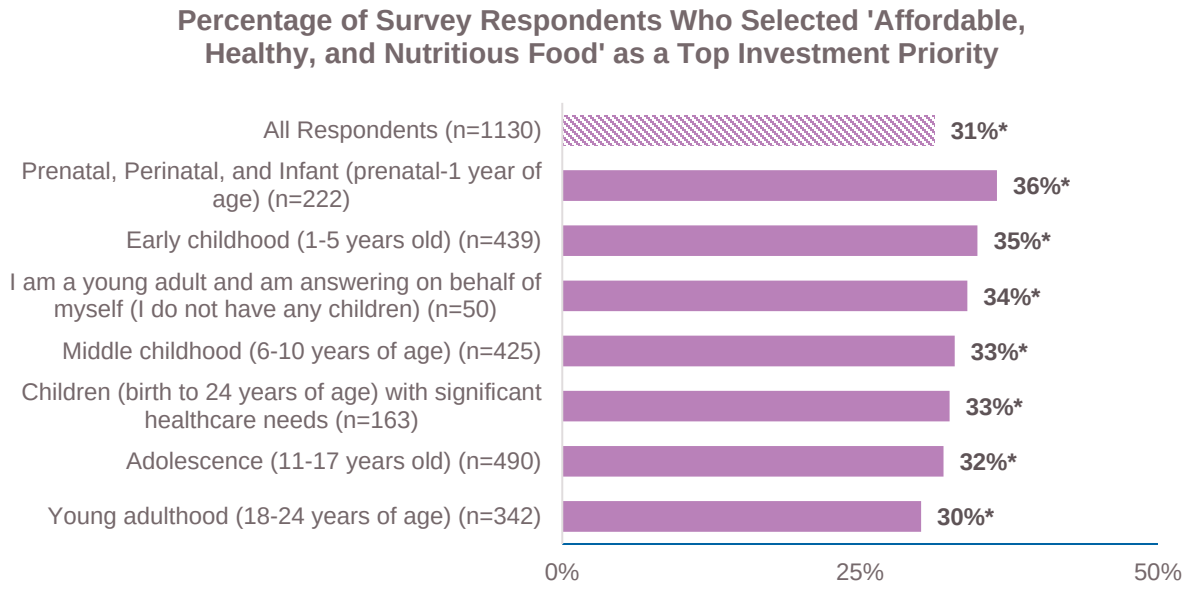


Source: U.S. Census Bureau, American Community Survey, One-year Estimates, Table B22003

Food Affordability

Affordable, healthy, and nutritious food ranked fifth among 24 health priorities, chosen by 31% of Children Health Survey respondents. The issue was identified across all age groups (**Figure 58**). Survey respondents providing care to prenatal individuals or infants (36%) and early childhood (35%) were most often to prioritize affordable, healthy, and nutritious food, followed by young adults (34%) and respondents caring for middle childhood and children with significant healthcare needs (33%). There was no statistically significant variation between groups, indicating that the concern is common among all respondents.

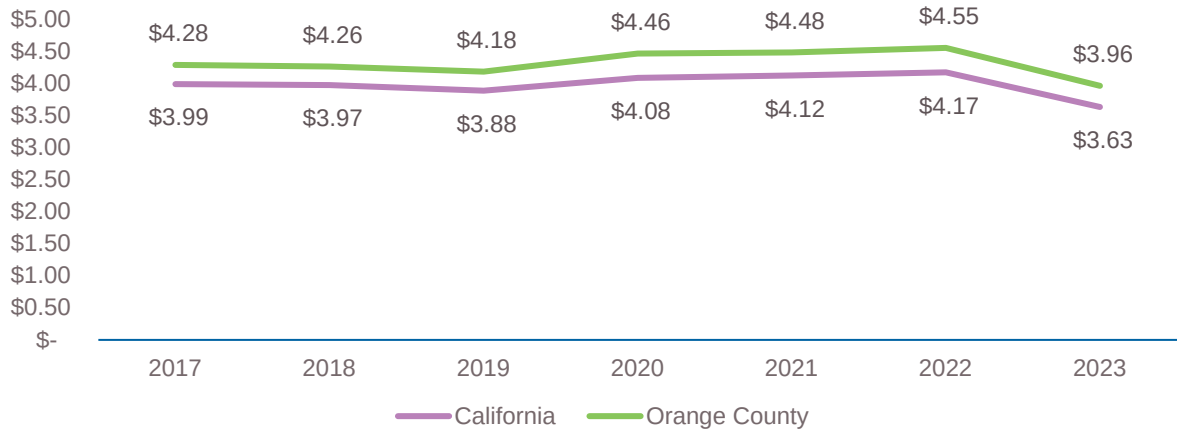
Figure 58. Community Commitment Priorities: Affordable, Healthy, and Nutritious Food, and Age of Child(ren) Receiving Care



Note: No statistically significant differences were found among groups.*Ranked among the top five health priorities for respondents. Source: Children's Health Survey, 2025

The average meal cost in Orange County ($3.51) was higher than in California as a whole ($3.26). The average meal cost was generally increasing in both Orange County and California between 2017 and 2022, with a small decrease by 2023 (**Figure 59**).

Figure 59. Average Meal Cost

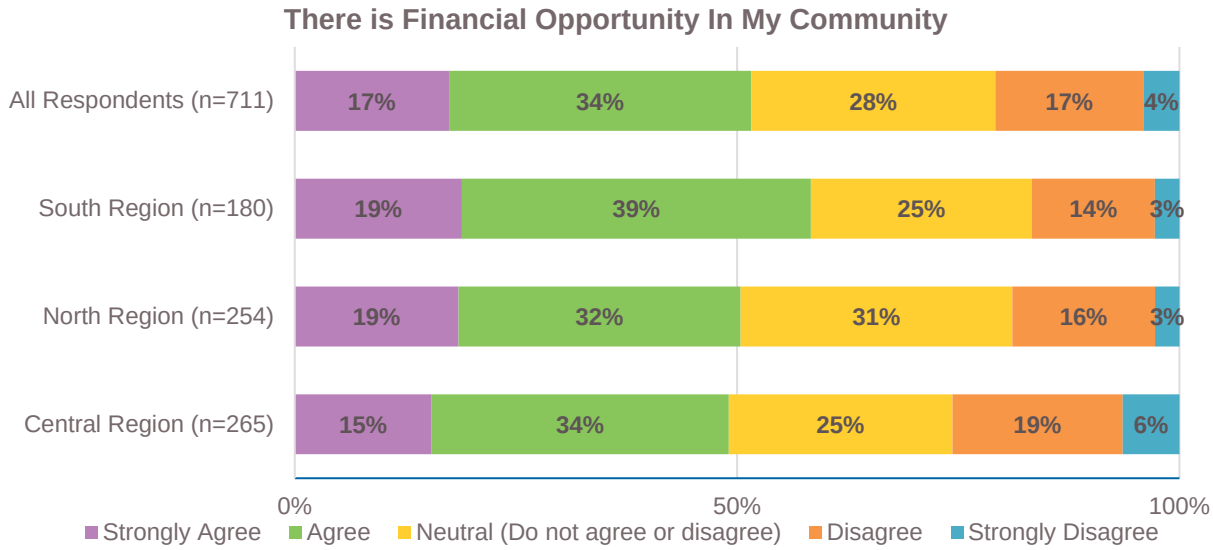


Source: U.S. Department of Agriculture. Map the Meal Gap

Social Driver of Health Priority 4: Economic Stability

The Children's Health Survey findings were mixed among parents/caregivers about financial opportunities in their communities. While 51% of all respondents agreed or strongly agreed that such opportunities exist, 28% were neutral and 21% disagreed. Regional differences were minor; survey respondents living in the South Region had the highest agreement at 58%, the North Region matched the overall average at 51%, and the Central Region showed 49% agreement and the most disagreement at 25% (**Figure 60**).

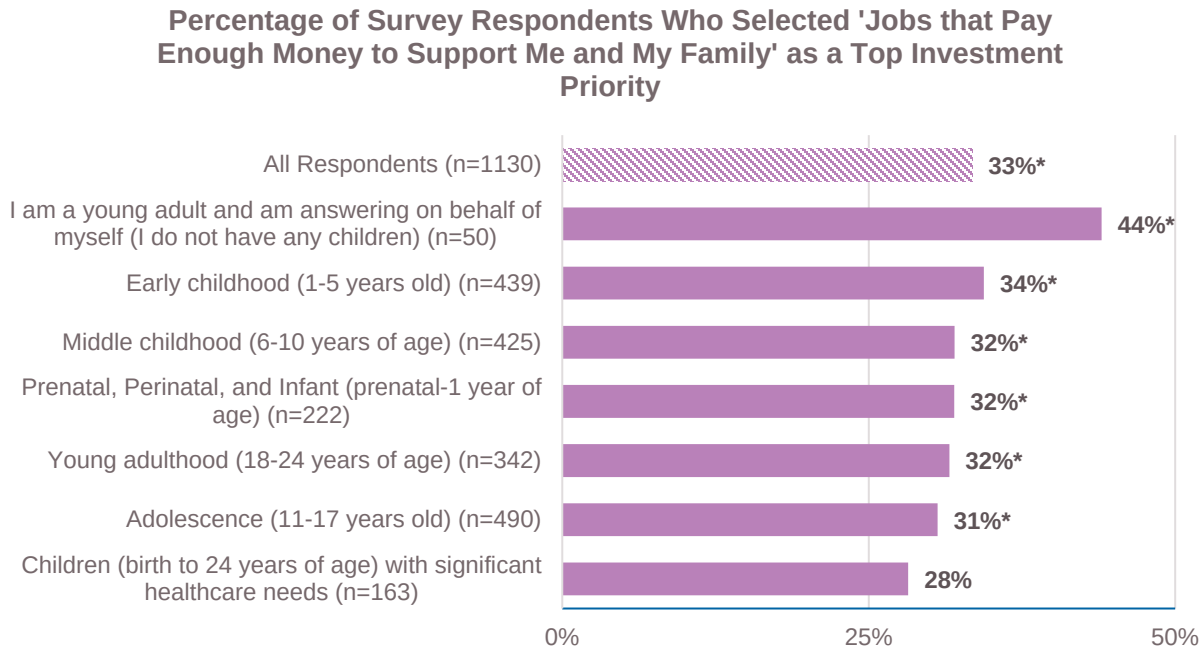
Figure 60. Percentage of Parent/Caregiver Survey Respondents by Level of Agreement with a Quality of Life Statement about Financial Opportunity



Note: No statistical significance between the regions. Source: Children's Health Survey, 2025

Furthermore, jobs that pay enough to support families were ranked as the fourth-highest health priority, selected by 33% of all respondents, and even more frequently by young adults (44%) highlighting the financial pressures faced by individuals early in their careers. Survey respondents providing care to children across all developmental stages consistently prioritized this issue, with rates ranging from 28% to 34% (**Figure 61**).

Figure 61. Community Commitment Priorities: Jobs that Pay Enough Money by Age of Children Receiving Care

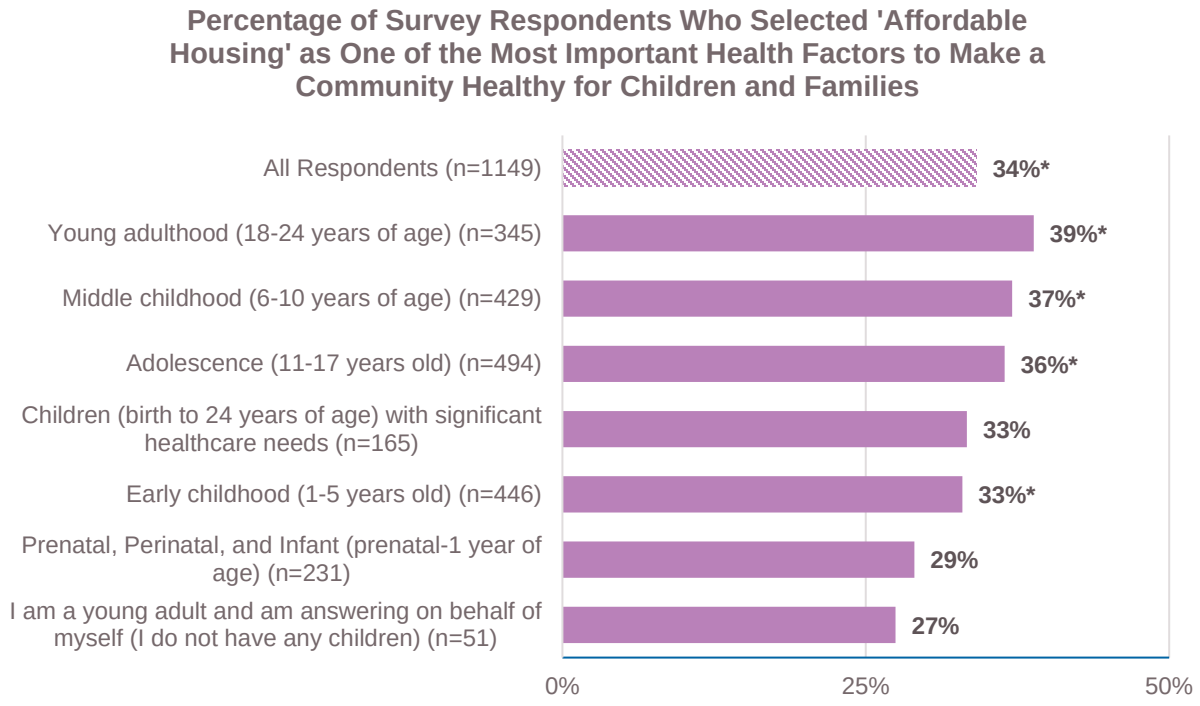


Note: No statistically significant differences were found among providers and caregivers provide care for different age groups.*Ranked among the top five health priorities for respondents.
Source: Children's Health Survey, 2025

Affordable housing consistently emerged as a top concern in the Children's Health Survey. It was identified as the second most important protective factor for Rady Children's Health Orange County and Orange County to address collaboratively, with 44% of all respondents selecting it. The issue was especially prominent among young adult parents/caregivers, nearly half of whom (48%) cited it as a priority. However, differences across age groups were not statistically significant, indicating broad concern across the population.

Similarly, when asked to identify the most important health factor for creating healthy communities for children and families, 34% of all respondents selected affordable housing, ranking it fifth overall. Concern was highest among survey respondents caring for young adults (39%), though only 27% of young adults responding on their own behalf selected it—lower than the average across all survey respondents (**Figure 62**).

Figure 62. Health Factors: Affordable Housing by Age of Child(ren) Receiving Care



Note: No statistically significant differences were found among providers and caregivers who provide care for different age groups. Source: Children's Health Survey, 2025

The issue of affordable childcare also surfaced. One in four (24%) survey respondents selected the issue of quality and affordable childcare as an issue or service that should be prioritized for community commitment. Furthermore, more than half of survey respondents said they needed childcare/daycare assistance, with 25% reporting they needed it but did not receive this assistance.

These findings highlight how limited income affects access to essential services, including housing and childcare, and contributes to broader health inequities. Together, these insights suggest a need to consider income, employment, housing, and childcare as interconnected drivers when designing and implementing strategies to address family and community health.

Below is a summary of the secondary data that reveals both positive trends and areas for improvement in Economic Stability in Orange County.

Positive Trends in Economic Stability from the Secondary Data

1. **Unemployment**
   Unemployment remained relatively low.

2. **Homeownership**
   Despite rising costs, homeownership continued to be a key indicator of housing stability with 60% of the population getting mortgage approvals.

Areas for Improvement in Economic Stability from the Secondary Data

1. **Economic Stability**
   While stable, the fact that over one-third of households were ALICE – Asset Limited, Income Constrained, Employed—and nearly half of the households statewide – indicates a widespread struggle to afford basic needs, even among employed families.

2. **Housing Costs**
   From 2019 to 2024, median home prices increased by 33%, while median household income declined by 3.7%, widening the affordability gap.

3. **Mortgage Approval Disparities**
   Approval rates for Black (47.6%), Native American (53.5%), and Hispanic/Latino (52.9%) applicants lag the regional average, pointing to systemic barriers in homeownership access.

4. **Youth Housing Insecurity**
   Over 30,000 students (6.7% of enrollment) were identified as housing-insecure in 2023–2024, the highest in a decade and well above the statewide rate of 4.8%. Nearly 90% of affected students live in overcrowded housing situations.

5. **Housing Insecurity for Students of Color**
   Hispanic/Latino (11.6%), American Indian/Alaska Native (9.8%), and Black/African American (7.3%) students experience significantly higher rates of housing insecurity than their peers.

Note: Detailed data estimates and data sources are provided in the text below.

The following section provides detailed data tables and/or figures supporting the positive trends and areas for improvement in economic stability identified based on secondary data.

Economic Status

Approximately 35% of households in Orange County were classified as ALICE–Asset Limited, Income Constrained, Employed. These are working families who earn above the federal poverty level but do not earn enough to afford necessities such as housing, childcare, food, transportation, and healthcare. The proportion of ALICE households in Orange County had remained relatively stable over the past several years, hovering around one-third of all households. In California, the percentage of ALICE households was higher at 49%.

As of June 2025, Orange County's unemployment rate was 4.5%, up from 2.9% in June 2019.[44] While relatively low compared to historical highs, this increase may reflect growing economic pressures, including rising housing costs and stagnant wages.

Despite employment, many residents still live in poverty. In 2023, 11.3% of working adults in Orange County were living in poverty, including 8% of those employed full-time.[45] This statistic highlights the disconnect between employment and economic stability. Many jobs do not pay enough to meet the high cost of living in the region. In California, poverty rates were especially high among workers in:

- Food preparation and serving (22.4%)[45]
- Personal care (20.8%)[45]
- Construction and extraction (17.4%)[45]
- Healthcare support (16.4%)[45]

While Orange County shows signs of economic resilience through low unemployment and high workforce participation, many families remained economically unstable. Rising housing costs, stagnant wages, and racial disparities in mortgage approval and working poverty contributed to a growing affordability crisis.

Housing Costs

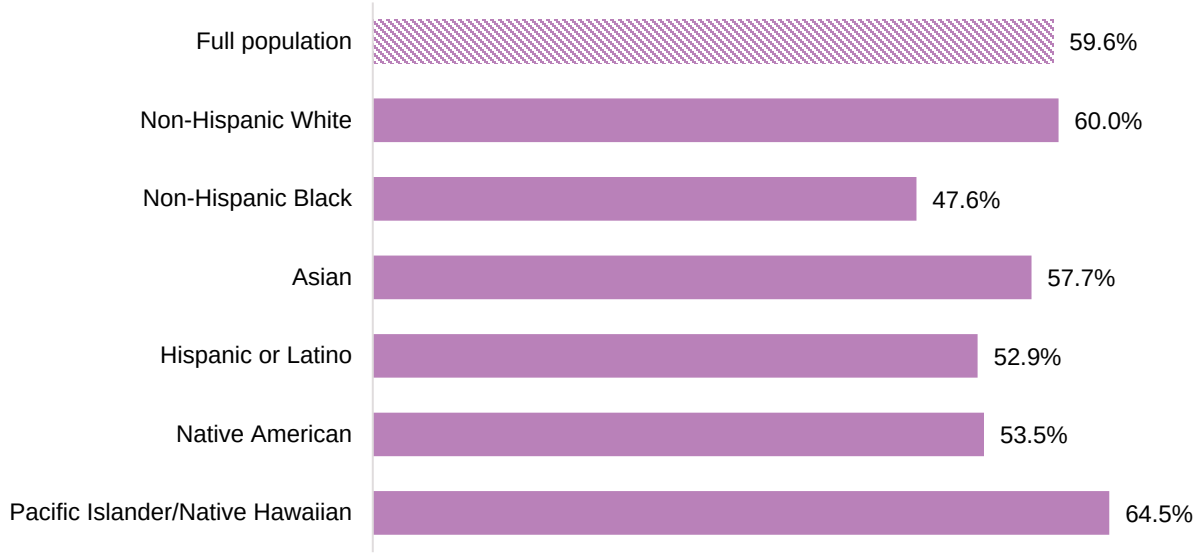
The monthly median rent was $2,382 in Orange County in 2023, significantly up 3.7% from $2,298 in 2019.[46] The median regional home sale price was $849,075 in 2019, increasing 33% to $1,125,150 in 2024[47] while the median household income decreased 3.7% (from $114,273 in 2019 to $110,042 in 2023).[48]

[44] Federal Reserve Bank of St. Louis. Unemployment Rate in Orange County, CA. Available at: https://fred.stlouisfed.org/series/CAORAN7URN.
[45] Bohn S, Danielson C, Kimberlin S, Malagon P, Stevens C, Wimer C. Poverty Among California's Workers. Public Policy Institute of California. Available at: https://www.ppic.org/publication/poverty-among-californias-workers/.
[46] Per the United States Census Bureau. American Community Survey (ACS), Table B25064, Median Gross Rent is defined as total rent paid by renter-occupied housing units paying cash rent. Gross rent includes the contract rent (the asking rent price for the unit) as well as any utilities or fuel that the tenant must pay.
[47] Redfin Data Center via Metopio
[48] United States Census Bureau. American Community Survey (ACS) Table B19013: Median Household Income in the Past 12 Months (in 2023 Inflation-Adjusted Dollars) (Black or African American Householder). Available at: https://data.census.gov/table/ACSDT5Y2021.B19013?q=b19013&g=040XX00US50$0600000&codeset=p~true&t.

Elevated rates of homeownership are frequently used as a proxy indicator for housing stability. Homeownership is commonly associated with building wealth and fostering long-term community investment. However, homeowners may still encounter instability due to factors such as foreclosure, unemployment, or increasing property taxes. Regional Orange County data on mortgage loan approval rates highlight notable disparities by race and ethnicity. The overall approval rate for the full population in 2024 is 59.6% (**Figure 63**). However, when broken down by group, significant gaps emerge:

- Non-Hispanic White applicants have an approval rate of 60.0%, closely aligning with the regional average
- Non-Hispanic Black applicants have the lowest approval rate at 47.6%
- Asian (57.7%,), Native American (53.5%), and Hispanic or Latino (52.9%) applicants have lower approval rates than the regional average

Figure 63. Orange County Mortgage Approval Rate by Race and Ethnicity, 2024

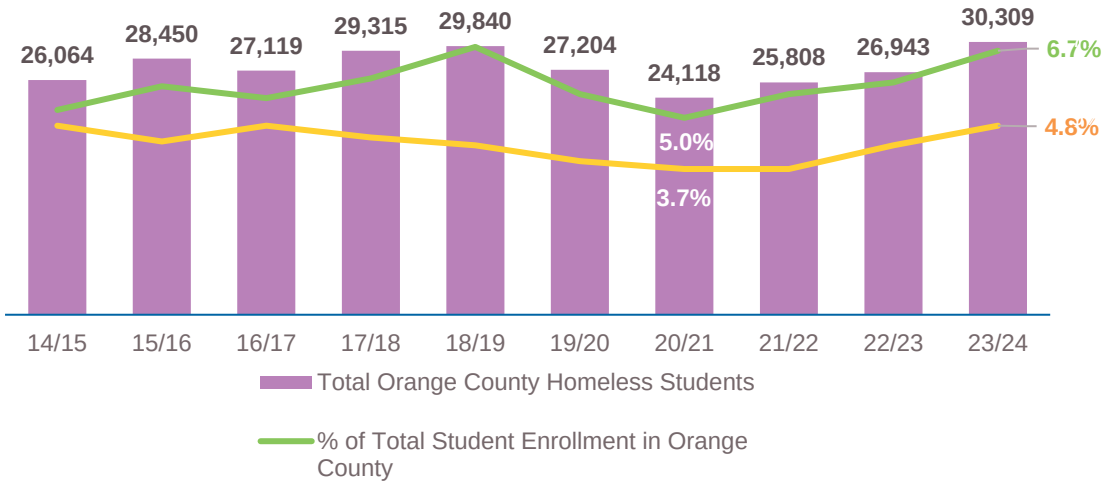


Source: HMDA (Home Mortgage Disclosure Act) Data Browser; Federal Financial Institutions Examination Council via Metopio

Housing Insecurity

In the 2023–2024 school year, more than 30,000 students in Orange County were identified as experiencing housing insecurity, the highest number in the past decade (**Figure 64**). This represents 6.7% of the county's student population, a notable increase from 5.2% in 2014–2015, and significantly higher than the statewide rate of 4.8%.

Figure 64. Number and Percentage of Students with Insecure Housing, Orange County and California

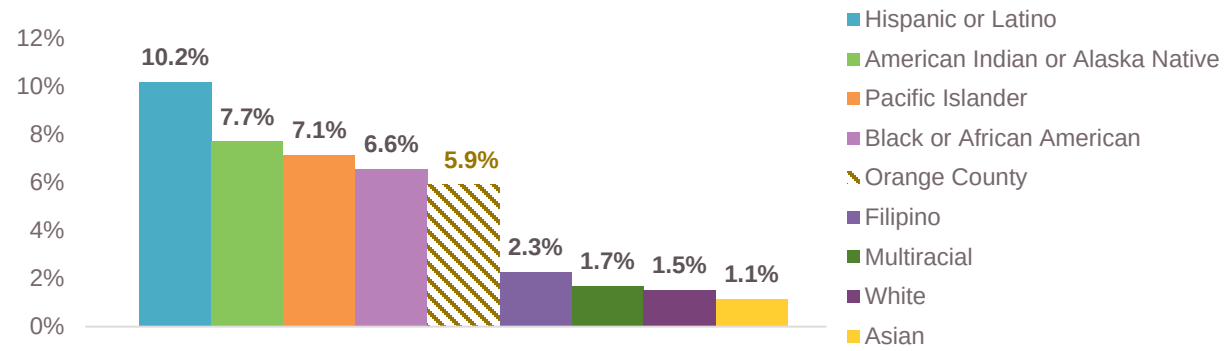


Note: Data from 2014–2015 is lower due to a statewide data system error at the California Department of Education that likely resulted in underreported counts. Source: California Department of Education

Most of these students (89.6%) were living in doubled-up housing situations, while smaller percentages were in motels (4.5%), shelters (4.3%), or unsheltered (1.6%). Elementary students (Transitional kindergarten through grade 6) made up the largest share of those affected (7.3%).

Housing insecurity affects students of color differently. In 2023–2024, Hispanic or Latino students had the highest rate (10.2%), followed by American Indian or Alaska Native (7.7%), Pacific Islander (7.1%), and Black or African American (6.6%) students. In contrast, Filipino (2.3%), Multiracial (1.7%), White (1.5%) and Asian (1.1%) had the lowest rates (**Figure 65**).

Figure 65. Percentage of Orange County Enrolled Students with Insecure Housing, by Race and Ethnicity, 2022/2023



Source: California Department of Education, DataQuest

Focus Group Insights on Economic Stability

Poverty and Housing

Focus group participants consistently linked housing instability and poverty to health outcomes among youth, particularly chronic conditions like asthma and diabetes. Families living in overcrowded or unsanitary environments face heightened health risks, and school nurses emphasized that poverty is a root cause of poor health, concluding " **“Housing instability represents the most fundamental disparity with families living in conditions that directly undermine health, including overcrowded rooms, garages, or cars.”**

Economic Instability, Food, Housing and Healthcare

Economic instability was seen as a barrier to accessing basic needs, including food, housing, and healthcare. Nutrition support services—such as food banks and culturally appropriate meal programs—were described as essential lifelines, especially for homeless families. These services help mitigate the effects of poverty but do not address its underlying causes.

Insecurely Housed Students as a Priority Population

Students protected under the McKinney-Vento Act were identified as experiencing the most severe housing-related health disparities. Long wait times for housing assistance, frequent school changes, and lack of stable addresses disrupt both education and healthcare access. Participants noted that economic instability compounds these challenges, creating chronic stress and undermining both physical and mental health.

Key Informant Insights on Economic Stability

High Cost of Living

The high cost of living in Orange County forces many families to choose between essentials like rent, food, and healthcare. Key informants noted:

- Out-of-pocket costs, co-pays, and deductibles deter families from seeking timely care.
- Lack of insurance or undocumented status further limits access to preventive and ongoing treatment.
- Transportation and childcare barriers make attending appointments difficult, especially for low-income families without paid leave.

Families in low-income communities reside in healthcare deserts, with few culturally competent providers and long wait times

Scarcity of Housing Resources

The scarcity of housing resources was a common theme. One respondent noted **"With most resources, we can provide some referrals, except for affordable housing; any affordable housing resources we find have significant waitlists. It feels disrespectful to provide someone with an affordable housing resource with a one-to-two-year waitlist."**

Housing Stability and Health Outcomes

Informants emphasized that housing stability is directly tied to healthcare access and outcomes. When families are focused on survival—finding shelter, food, and safety—they are less likely to seek medical or mental health care, leading to untreated conditions and worsening health outcomes saying, **"Many families are living in households that are overcrowded that often leads to the deterioration of their physical health/mental health."**

Orange County Community and Available Resources

- Describe the demographic characteristics of Orange County
- Identify existing assets and services in Orange County that address pediatric health needs
- Highlight gaps in services and opportunities for program expansion or new initiatives to improve child health outcomes

Orange County Demographic Profile

Tucked between San Diego and Los Angeles Counties, this region is known for popular beaches and “The Happiest Place on Earth,” Disneyland Resort. Anaheim, the theme park’s home, offers an energetic vibe in a refurbished downtown. Newport Beach has dazzling yachts, Huntington Beach has iconic surfing, and Costa Mesa beckons with top shopping.

There are significant political, demographic, economic and cultural distinctions between North and South Orange County, divided by the Costa Mesa Freeway.

North Orange County, including Anaheim, Fullerton, and Santa Ana, was the first part of the county to be developed and is culturally closer to Los Angeles County. This region is more diverse and densely populated, and includes more renters, fewer homeowners, and more registered Democrats than Republicans, compared to South Orange County. There are notable exceptions to these general trends, such as the presence of more Republican registered voters in Yorba Linda, and higher-income residents in Anaheim Hills and Villa Park.

South Orange County is more residential, wealthier, more Republican, less racially diverse, and more recently developed. Irvine, the largest city in the region, is an exception to some of these trends, being a major employment center and having an Asian plurality (Irvine's Asian population is predominantly East Asian, compared with Westminster’s which is predominantly Southeast Asian).

The demographic characteristics of a population are important in understanding the health risks, challenges, strengths, and opportunities of Orange County. Aspects such as age, race, and ethnicity are linked to health outcomes. Socioeconomic factors such as income, language, and education are likewise associated with health risk and protective factors, and outcomes. This section of the report highlights select Orange County demographics.

Population Change

Assessing the shifting population is important in identifying potential impacts on healthcare providers, healthcare access, and utilization of community resources. In 2023, there were approximately 3.1 million people living in Orange County among which 758,107 were children (0-19 years).[49]

In 2023, there were 29,866 births in Orange County. No significant change occurred in the birth rate per 1,000 women ages 15–50 in Orange County and California from 2014–2018 to 2019–2023.

Table 10. Birth Rate per 1,000 Women Ages 15–50

Year	Orange County	California
2014–2018	46.9	49.1
2019–2023	45.5	48.4

Source: U.S. Census, Five-year Estimate 2019–2023, S0101

Age

The median age in Orange County and California both increased significantly from 2014–2018 to 2019–2023. In 2019–2023, Orange County's median age at 39.1 years was higher than California's at 37.6. The percentage of the population who were children (0-19 years) was 24.0% in 2019-2023.

Table 11. Pediatric Population by Age

Population Cohort by Age	Orange County		California	
	2014-2018	2019-2023	2014-2018	2019-2023
0–5	5.4%	5.4%	6.3%	5.4%
5–9	5.6%	5.6%	6.4%	5.8%
10–14	6.4%	6.4%	6.5%	6.5%
15–19	6.6%	6.6%	6.6%	6.7%
All pediatrics (0–17)	21.3%	24.0%	23.2%	21.7%
Median Age	37.8	39.1	36.3	37.6

Source: U.S. Census, American Community Survey, Five-year Estimate, S0101

[49] U.S. Census, American Community survey, One-year Estimate, 2023

Race and Ethnicity

Understanding race and ethnicity composition can help reveal health disparities, including higher rates of chronic disease, healthcare access, premature death, and other factors that affect the health of the community's population.[50] In 2019-2023, Orange County's largest racial group was White or Caucasian, representing 41.2% of the total population and 33.2% of the pediatric population. This was followed by the full and pediatric populations for Asian (22.9% and 20.4%, respectively), Multiracial (18.2% and 26.7%, respectively), and Some Other Race (14.7% and 16.9%, respectively). Smaller population groups included Black or African American, American Indian or Alaska Native, and Native Hawaiian or Other Pacific Islander individuals representing less than 2.0 percent of both the full and pediatric population. Individuals who were Hispanic or Latino of any race represented 34.2% of the full population and 44.2% of the pediatric population.

Table 12. Population by Race and Ethnicity, 2023

Year	Pediatric Population	Full Population
White	33.2%	41.2%
Asian	20.4%	22.9%
Multiracial	26.7%	18.2%
Some other race	16.9%	14.7%
Black or African American	1.7%	1.7%
American Indian and Alaska Native	0.8%	0.9%
Native Hawaiian and Other Pacific Islander	0.3%	0.3%
Hispanic or Latino (of any race)	44.2%	34.2%

Source: U.S. Census, American Community Survey, One-year Estimate, 2023, Tables S0901 and DP05.

International Residents

Orange County is home to approximately 967,323 foreign-born residents as of 2023, among which 3.8% were ages 0-17.[51] There were 411,695 households with foreign-born residents among which 30.7% households included children. Approximately 39.0% of foreign-born residents were enrolled in preschool (1.2%), kindergarten (0.8%), elementary school (21.2%), or high school (15.8%).

[50] Artiga, S., & Hill, L. (2022, October 6). Understanding racial and ethnic identity in federal data impacts health disparities. KFF.
[51] U.S. Census, American Community Survey, One-year Estimate, 2023, Table S0201

Language Spoken

Limited English Proficiency (LEP) is a term used to describe individuals who do not speak English as their primary language and have a limited ability to read, speak, write, or understand English.[52] About half of Orange County households (214,041) with children ages birth to 17 years speak at least one language other than English.

In Orange County, 57.6% of households spoke English only, slightly less than California's 58.8%. Orange County had 10.5% of households that speak Asian and Pacific Islander languages, nearly twice as high as California's 5.7% of households. Just under one in three households (27.8%) speak Spanish, slightly lower than California's 31.3%.

Table 13. Children (0–17 years) by Household Language

Household Language Spoken	California		Orange County	
	Number	Percent	Number	Percent
English only	3,830,458	58.8%	290,577	57.6%
Spanish	2,037,515	31.3%	140,408	27.8%
Asian and Pacific Islander languages	1,650,553	5.7%	52,881	10.5%
Other Indo-European languages	214,883	3.3%	15,621	3.1%
Other languages	178,833	1.0%	5,131	1.0%

Source: U.S. Census, American Community Survey, Five-year Estimate, 2019-2023, Table B16004.

Among Orange County households, where the primary language was not English, 7.9% or 39,847 households speak English less than “very well.” This rate was similar, but slightly lower compared to California at 8.0%. Language influences access to services and is an increasingly important consideration for service delivery.

Table 14. Children (0–17 years) by Household Language, Limited Fluency in English

Household English Proficiency	Orange County		California	
	Number	Percent	Number	Percent
Spanish	23,942	4.7%	386,962	5.9%
Asian and Pacific Islander languages	13,781	2.7%	87,489	1.3%
Other languages	558	0.1%	11,025	0.2%
Other Indo-European languages	1,566	0.3%	36,050	0.6%
Percentage of all households who speak a second language who speak English less than “very well”	39,847	7.9%	521,526	8.0%

Source: U.S. Census Data, American Community Survey, Five-year Estimate, 2019–2023, Table B16004.

[52] Office for Civil Rights, U.S. Department of Health & Human Services. (2025, July 18). Limited English Proficiency HHS.gov.

Poverty

Child poverty has various negative effects on the physical and mental health of children.[53] Poverty is linked to substandard housing, homelessness, inadequate nutrition, food insecurity, inadequate childcare, lack of access to healthcare, and generally unsafe neighborhoods. The implications for children living in poverty include greater risk for poor academic achievement, school dropout, abuse and neglect, behavioral and socioemotional problems, physical health problems and developmental delays.[54] In Orange County, approximately 15.1% of children aged 0–17 live in poverty, and 4.9% (32,566) of children live in deep poverty.

Table 15. Orange County Children (0–17 years) Living in Poverty

Children Living below the Federal Poverty Level (FPL)	Orange County		California
	Number	Percent	Percent
Poverty (<125% FPL)	100,356	15.1%	20.2%
Deep poverty (<50% FPL)	32,566	4.9%	6.7%

Source: U.S. Census Bureau, American Community Survey, Five-year Estimate, 2019–2023, Table S1703

Health Insurance Coverage

In 2023, 36.5% of residents were publicly insured, which was significantly lower than California at 40.3%. Since 2019, the percentage of residents publicly insured increased in both Orange County (from 32.5%) and California (from 37.8%). Among residents publicly insured, in 2023, 22.0% were insured through Medicaid (Medi-Cal) in Orange County compared to 27.2% in California. In 2023, among youth (under 19 years) 35.6% were publicly insured, with nearly all being Medicaid coverage.

Educational Attainment

Educational attainment is one of the most influential drivers of health and is known to impact health outcomes, mental health, and care access.[55] As reported in the 2021 America's Health Rankings report, health disparities in mental and behavioral health are evident between those without a high school diploma and those who have graduated from college. Both in Orange County and California, high school graduation rates among adults 25 years or older increased between 2014-2018 (85.1% and 82.9%, respectively) to 2019–2023 (86.9% and 85.6%, respectively).

[53] American Psychological Association. (n.d.). Effects of poverty, hunger and homelessness on children and youth.
[54] Office of Disease Prevention and Health Promotion. (n.d.). Poverty. Healthy People 2030. U.S. Department of Health and Human Services.
[55] Agency for Healthcare Research and Quality. (2021). *2021 National healthcare quality and disparities report*. U.S. Department of Health and Human Services.

Household Characteristics

The average household size in 2023 was 2.9 people. Nearly 84% of children living in Orange County were a biological son or daughter to the householder, followed by 7.5% (50,671) who were grandchildren. There were 11,325 households with a foster child and 8,795 households with an adopted child.

Table 16. Children (0-17 years) in Households By Relationship To Householder

Household Relationships	California		Orange County	
	Number	Percent	Number	Percent
Biological son or daughter	7,100,758	81.5%	563,342	83.6%
Grandchild	806,572	9.3%	50,671	7.5%
Other relative	322,726	3.7%	25,303	3.8%
Stepson or stepdaughter	205,405	2.4%	14,183	2.1%
Adopted child	120,959	1.4%	8,795	1.3%
Foster child	155,571	1.8%	11,325	1.7%

Source: U.S. Census Bureau, American Community Survey, Five-year Estimate, 2019–2023, Table B09018.

Adults and children in single-parent households are at risk for adverse health outcomes, including mental illness (e.g., substance use, depression, suicide) and unhealthy behaviors (e.g., smoking, excessive alcohol use, food insecurity). Children in single-parent households are at greater risk of severe morbidity and mortality than their peers in two-parent households.[56] Mortality risk is also higher among single parents.

In 2019–2023, about one in four Orange County households (18.3% or 122,802) with children birth to 17 years were single-parent households. Among all households, 14.1% were households with a single mother or female caregiver.

Table 17. Children (0–17 years) by Household Type

Single-Parent Households	California		Orange County	
	Number	Percent	Number	Percent
Households	8,711,991	99.1%	673,619	100%
Married-couple household	5,951,486	68.3%	505,645	75.1%
Single-mother household	1,531,629	17.6%	94,658	14.1%
Single-father household	428,483	4.9%	28,144	4.2%
Non-married household	800,393	9.2%	45,172	6.7%

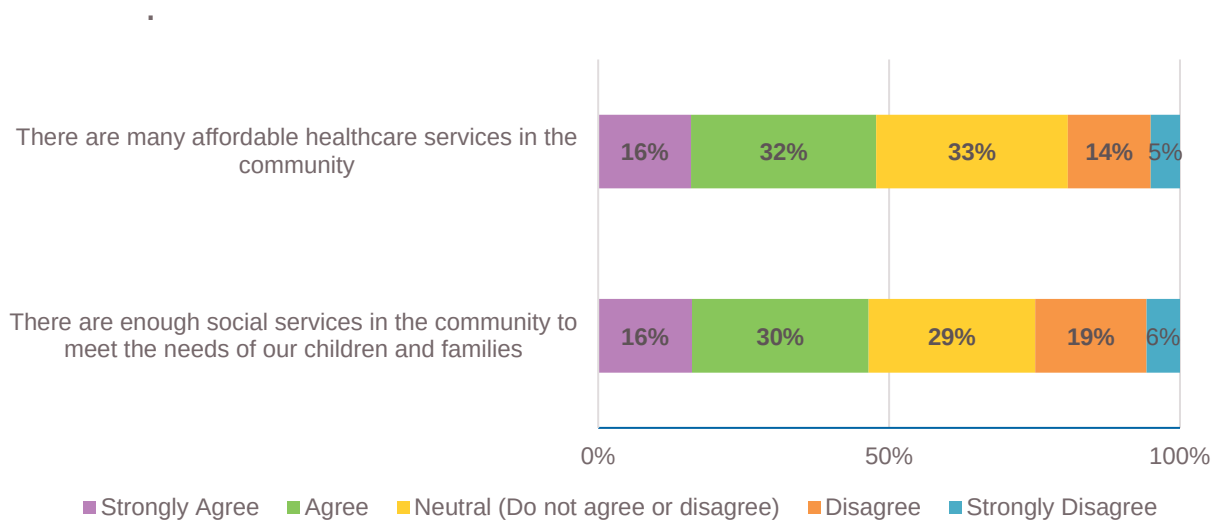
Source: U.S. Census Bureau, American Community Survey, Five-year Estimate, 2019–2023, Table B09005

[56] University of Wisconsin Population Health Institute. (2025). *Children in single-parent households*. County Health Rankings & Roadmaps.

Assessment of Orange County's Resources Available to Meet the Social and Health Needs of Children and Families

Community strengths are essential to understanding how residents perceive the quality of life in their area. These strengths reflect the resources, services, and conditions that support the well-being of children and families. In the Children's Health Survey, respondents were asked whether there are enough social services in the community to meet the needs of children and families and whether there are many affordable healthcare services in their community. Overall, just under half of all respondents agreed or strongly agreed (46%) with the statement, while 19% disagreed and 6% strongly disagreed, and 29% remained neutral (**Figure 66**). Similarly, nearly half (48%) agreed or strongly agreed that their community offers many affordable healthcare options, while 33% remained neutral and 19% expressed disagreement (**Figure 66**).

Figure 66. Percentage of Parent/Caregiver Survey Respondents by Level of Agreement with a Quality of Life Statement about Healthcare and Social Services

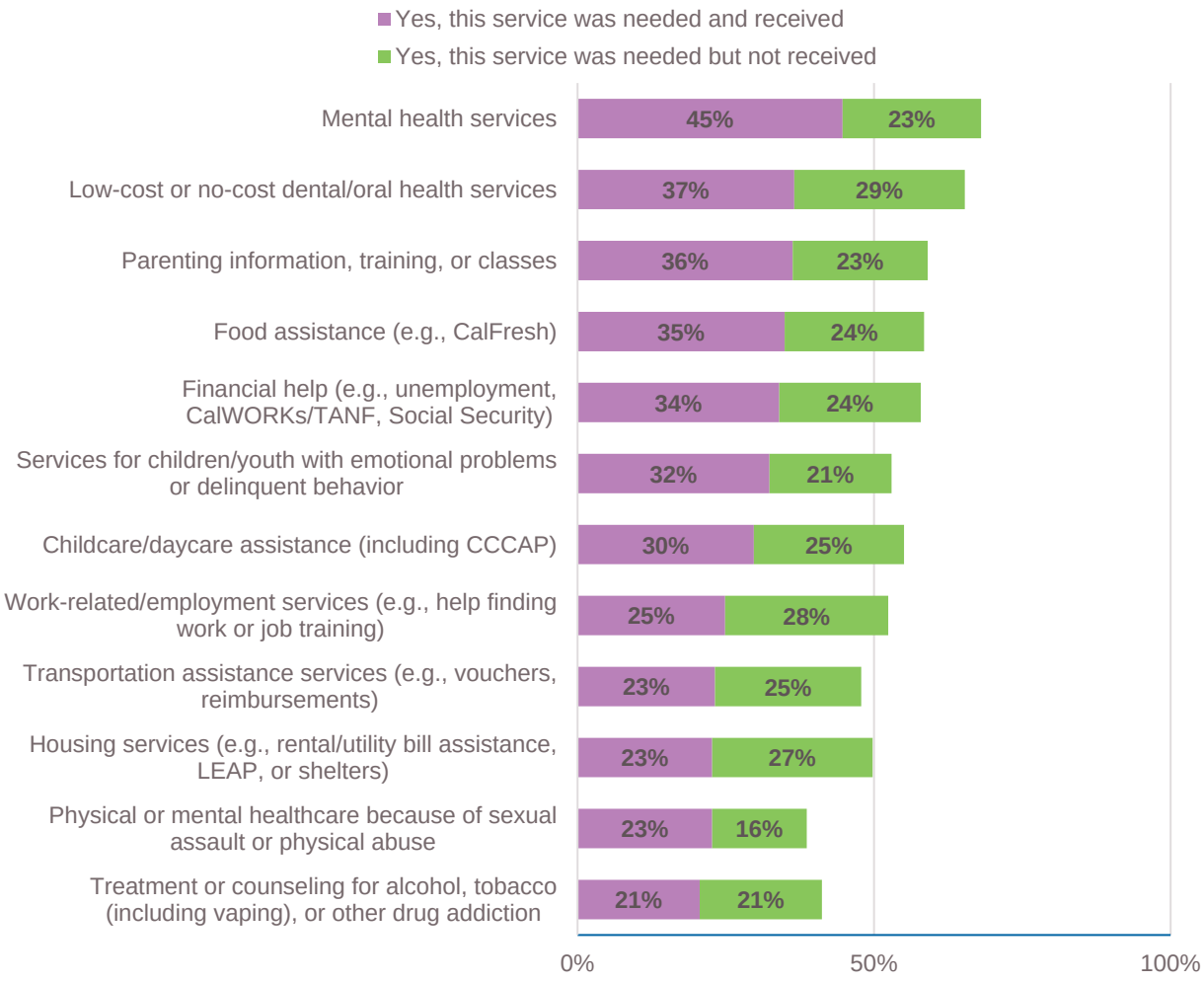


Source: Children's Health Survey, 2025

The Children's Health Survey also explored access to essential services, revealing both areas of strength and gaps in both healthcare and social care (**Figure 67**). Mental health services were the most needed, with 68% of respondents indicating a need — 45% received the service, while 23% reported that they did not receive the mental health services they needed. Similarly, nearly two-thirds (66%) of respondents reported they needed low-cost or no-cost dental services, among which 29% were unable to access low-cost or no-cost dental services. Low-cost or no-cost dental services were the most common service needed but not received, followed by work-related/employment services (28%) and housing services (27%).

Figurre 67. Services Needed in the Community

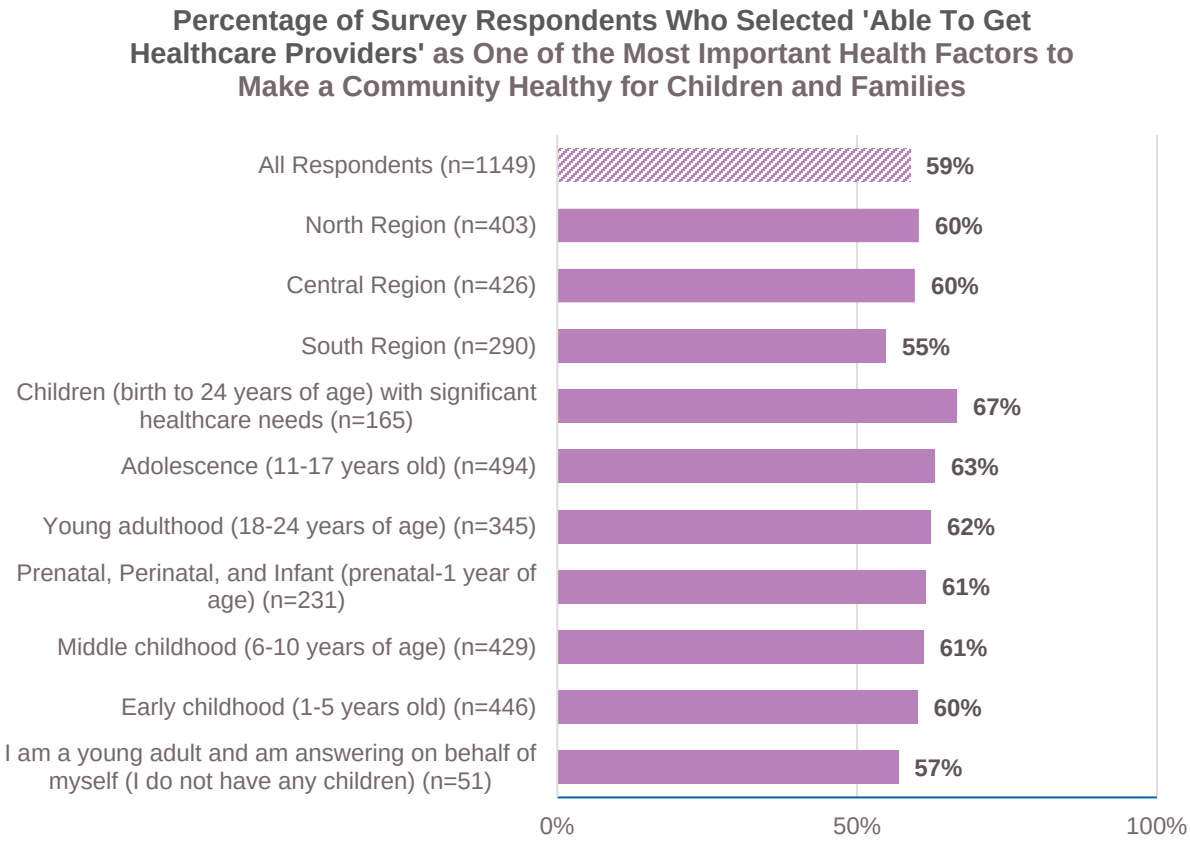
In The Past 12 months, Did You or Anyone In Your Home Need Any of These Services? Not All Services Will Apply to Your Personal Lived Experience. If It Does Not Apply, Please Select "Not Applicable."
Parent/caregiver survey respondents (n=520-613)



Source: Children's Health Survey, 2025

As reported previously, access to healthcare professionals emerged as the number one health priority among survey respondents with 59% of all respondents identifying this factor as one of the most important for the health and well-being of children and families. The issue was especially pronounced among those caring for children with significant healthcare needs, with 67% of respondents in this group selecting it as a top concern. This underscores the critical importance of accessibility for families managing complex health conditions. Concern remained consistently high with no statistical difference across age groups receiving care (**Figure 68**)**.**

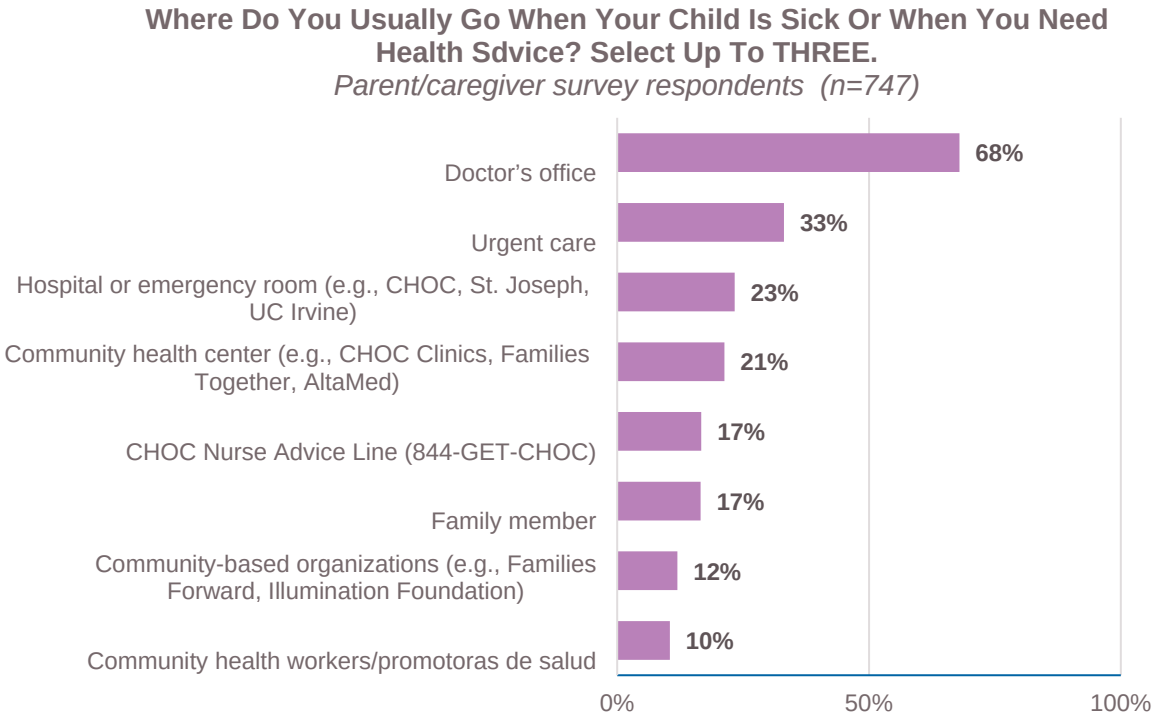
Figure 68. Health Factors: Ability to Get Healthcare Providers, by Service Planning Area and Age of Child(ren) Receiving Care



Note: No statistical difference among the groups. Source: Children's Health Survey, 2025

The Children's Health Survey asked parents/caregivers where they typically seek care or health advice when their child is sick. The majority (68%) of all respondents reported going to a doctor's office, making it the most common source of care. Urgent care centers (33%) and hospital emergency rooms (23%) were also frequently used (**Figure 69**). Notably, 21% of parents/caregivers turned to community health centers, and 17% relied on the Rady Children's Health Orange County Nurse Advice Line or family members for guidance. While formal healthcare settings were dominant, a meaningful portion of all respondents also accessed support through community-based organizations, community health workers, and informal networks, highlighting the importance of diverse and accessible care pathways for families.

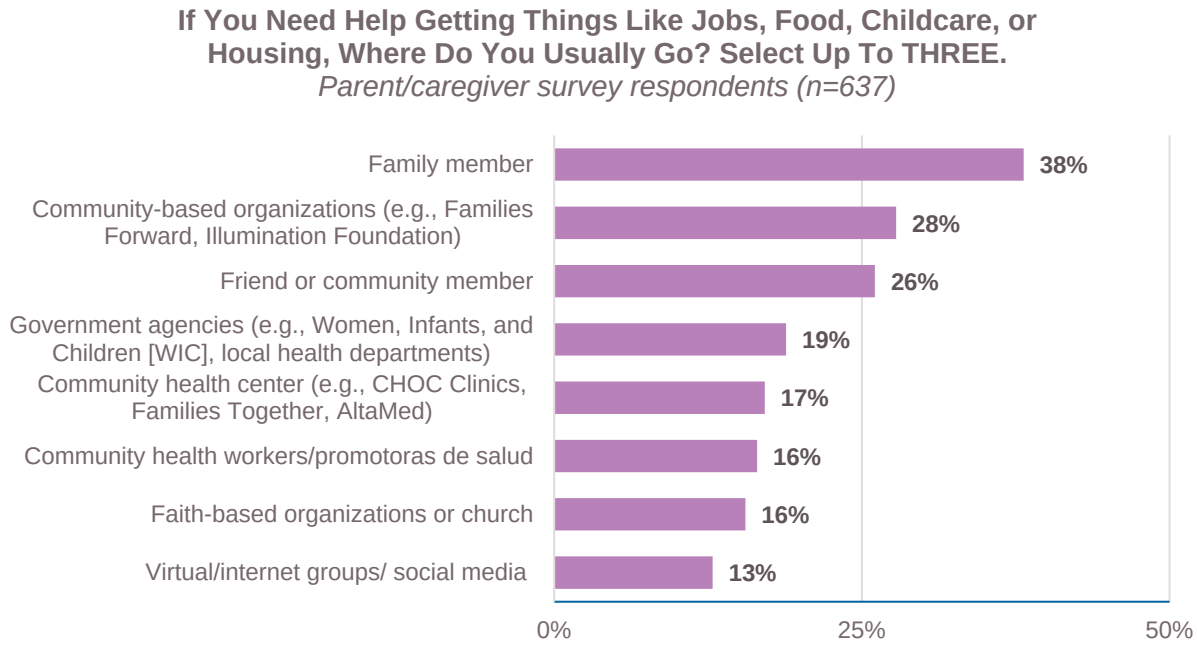
Figure 69. Locations when Child is Sick or Need Health Advice



Note: Less than 10% of parent/caregiver survey respondents selected 911, friend or community members, groups that support and speak up for people, government agencies, virtual resources, cultural centers, 211, faith-based organizations or church, retail store or minute health clinic, peer health support, schools, libraries. Source: Children's Health Survey, 2025

Parents/caregivers responding to the Children's Health Survey were asked where they typically seek help for essential needs such as jobs, food, childcare, or housing. The most common source of support was family members, selected by 38% of all respondents, followed by community-based organizations (28%) and friends or community members (26%). Formal systems such as government agencies (19%), community health centers (16%), and faith-based organizations or church were less frequently cited (**Figure 70**).

Figure 70. Locations for Jobs, Childcare, or Housing



Note: Less than 10% of all survey respondents selected schools, groups that support and speak up for people, cultural centers, 211, Hospital, peer health support, and libraries, Source: Children's Health Survey, 2025

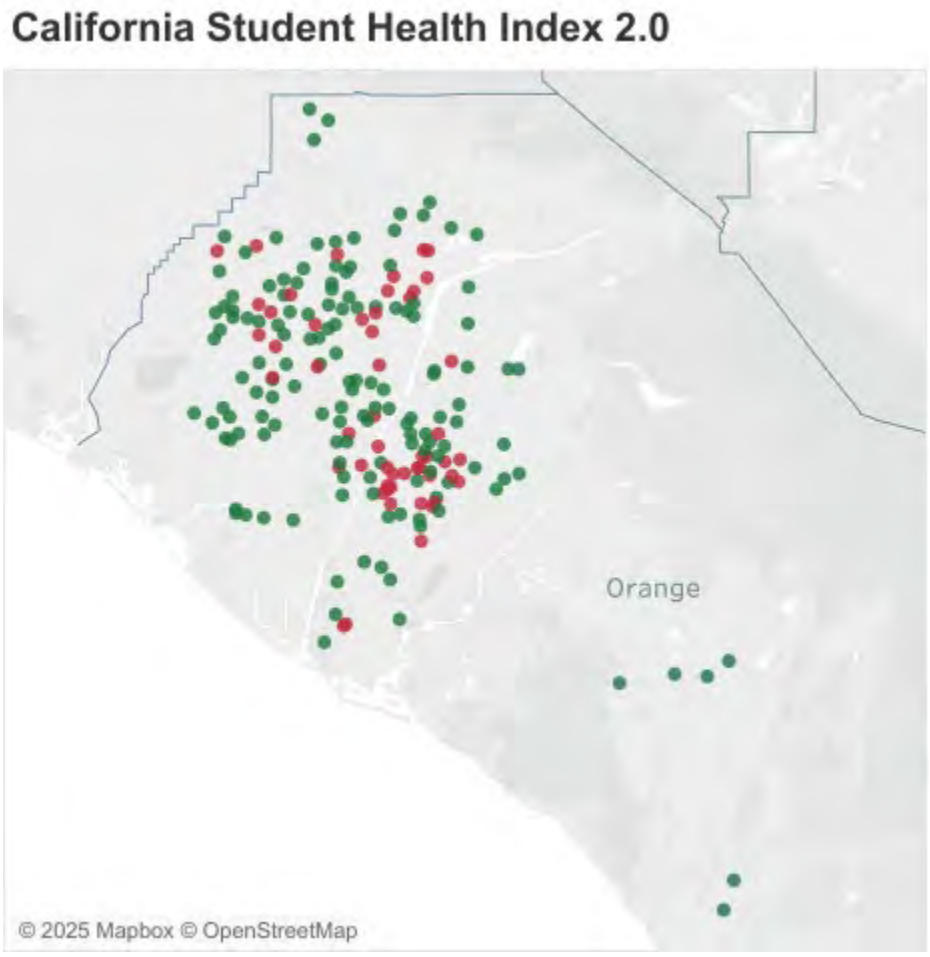
Access to School-Based Health Centers

School-based health centers (SBHCs) are uniquely situated to bring healthcare professionals and educators together to address the multifaceted needs of children, youth, and families. Some SBHCs only serve students, while others also serve family members or the broader community surrounding the school. According to California School-Based Health Alliance, there are nine SBHCs in Orange County of the 300 located throughout California.

The California School-Based Health Alliance has made available the Student Health Index — newly updated in 2023—to identify the counties, districts, and schools where new SBHCs will have the greatest return on investment for improving student health and education equity.[57] **Figure 71** below shows a map of Orange County and the school locations of where there is the "highest" or "higher" need for a school-based health center.

[57] California School-Based Health Alliance. California Student Health Index. Available at: https://www.schoolhealthcenters.org/school-based-health/student-health-index/.

Figure 71. California Student Health Index 2.0



Note: Red Dot “Highest Need” Green Dot “Higher Need”. Source: California School-Based Health Alliance

Population to Provider Ratios

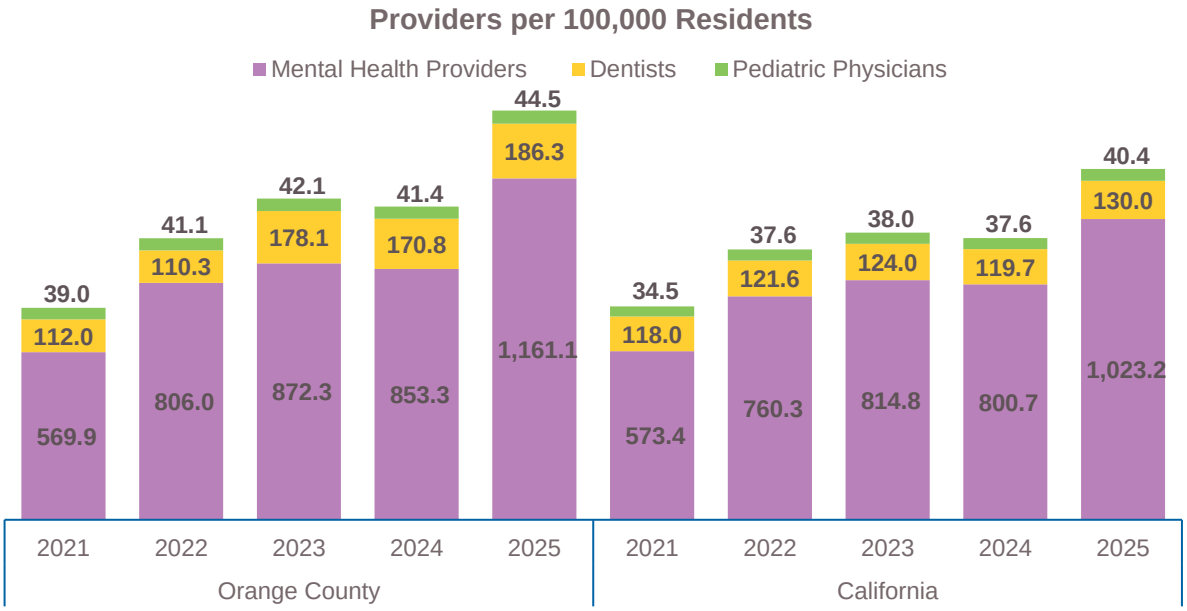
Access to timely and appropriate healthcare is influenced by the availability of qualified providers. According to 2024 data from Health Resources and Services Administration (HRSA), Orange County continues to experience notable shortages in dental, mental health, and primary care providers. These shortages are measured in full-time equivalent (FTE) practitioners needed to meet the recommended population-to-provider ratios. Orange County faces the most acute shortages in primary care (deficit of 43.5 FTEs), followed by mental healthcare professionals (shortage of 5.3 FTEs). There is no reported dental care shortage in Orange County.

Provider shortages are not just a workforce issue -- they directly affect the health of thousands of residents across the region. According to the HRSA Health Professional Shortage Area (HPSA) data, Orange County’s unmet care needs across all major service areas include:

- Primary care: Over 130,343 people are estimated to lack access to adequate primary care.
- Mental health: An estimated 71,393 people are not receiving needed mental health services.

Figure 72 below shows a summary of the trends in provider per 100,000 resident ratios from 2021–2025 in Orange County and California. Generally, the provider ratios were improving between 2021–2024 and were higher in Orange County compared to California. It is important to note that the population was decreasing in Orange County, with 3.167 million people in 2021 down to 3.135 million people in 2023.

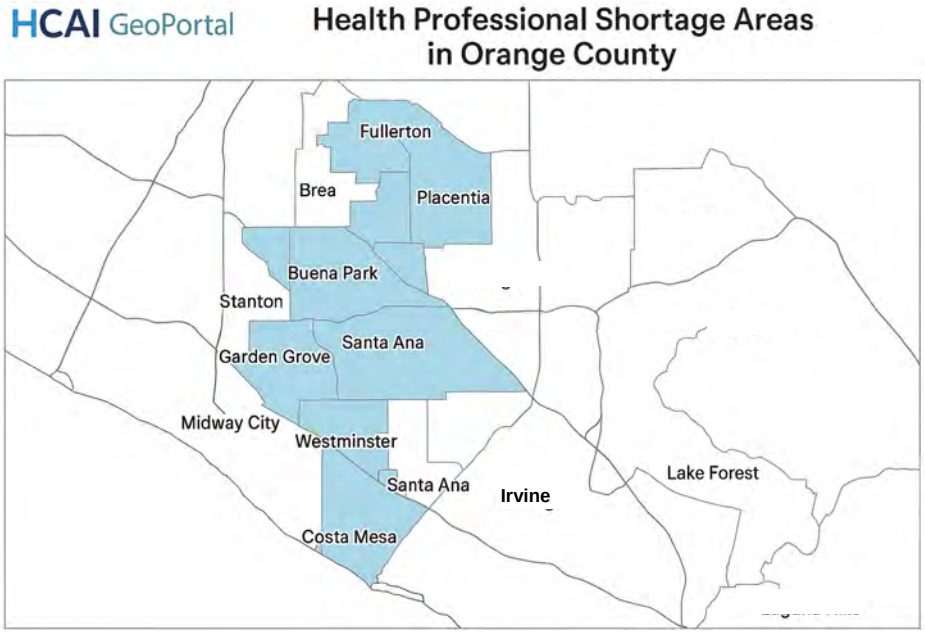
Figure 72. Providers per 100,000 Residents



Source: Health Resources and Services Administration. Health Professional Shortage Area.

Cities in Orange County have historically been designated as Health Professional Shortage Areas (HPSA), including Santa Ana, Anaheim (parts of the city, especially west and central areas), Garden Grove, Midway City, and Parts of Fullerton and Westminster (**Figure 73**). These areas have historically faced provider shortages in primary care, mental health, or dental health, based on California Department of Health Care Access and Information (HCAI) and Health Resources and Services Administration (HRSA) data.

Figure 73. Health Professional Shortage Areas within Orange County



Source: California Department of Health Care Access and Information

Healthcare Workforce Diversity

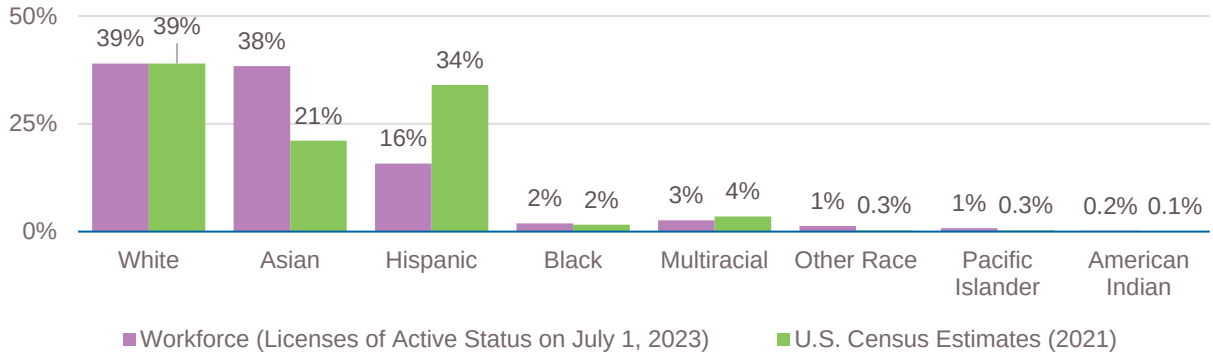
Racial and Ethnic Representation

Statewide, Hispanic or Latino individuals were significantly underrepresented in the health workforce compared to their share of the population. They make up 39% of California's population but were underrepresented across all six major health workforce groups (**Figure 74**).[58] In Orange County, this underrepresentation was even more pronounced where 15.8% of the workforce is Hispanic (any race) compared to the county's Hispanic population share, which is 34%.[59]

[58] Department of Health Care Access and Information. (2025). *Health Workforce Research Data Center annual report to the legislature: April 2025*. Reference to page 7

[59] Department of Health Care Access and Information, Race and Ethnicity of California's Health Workforce Dashboard, Retrieved from https://hcai.ca.gov/visualizations/race-ethnicity-of-californias-health-workforce/

Figure 74. Orange County Healthcare Workforce by Race and Ethnicity

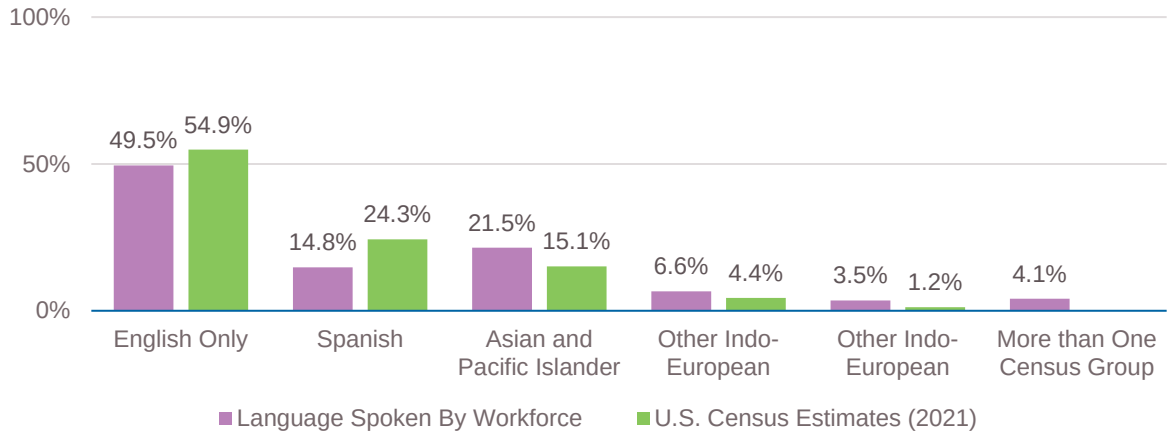


Source. California Department of Health Care Access and Information, Race and Ethnicity of California's Health Workforce Dashboard

Language Diversity

California shows a mismatch between the languages spoken by providers and the preferred languages of patients. Spanish is the most common non-English language spoken by patients, but not all providers are equipped to communicate Spanish (**Figure 75**). Statewide, over 11% (1.9 million) of the patients seeking medical care in California-licensed hospitals and ambulatory surgery clinics[60] preferred to speak Spanish, and 2.6% of the patients (over 400,000) preferred to speak a language other than English or Spanish. Orange County reflects this trend, with a high demand for Spanish-speaking providers (10.6% of encounters), but a shortage of bilingual professionals (14.8% of bi-lingual Spanish-speaking providers).

Figure 75. Orange County Language Diversity Among Healthcare Workforce



Source HCAI, Language Diversity of California's Health Workforce Dashboard, Retrieved from https://hcai.ca.gov/visualizations/preferred-languages-spoken-in-california-facilities/

[60] Physician-owned ambulatory surgery clinics do not report their data to Department of Health Care Access and Information and are not included here.

Conclusion and Next Steps

Rady Children's Health Orange County implemented a mixed methods approach with a strong emphasis on robust community engagement to assess the pediatric health needs across Orange County. Data collection methods included surveys, focus groups, key informant interviews, and secondary data analysis. A list of health issues was identified because both of the following were found to be true for Orange County:

- Community members expressed concern about the issue
- Secondary data pointed to either significant differences in Orange County compared with the State of California or indicated a concerning or worsening trend regarding the issue

Health issues from this list were then prioritized based on the responses to the following questions:

- Can Rady Children's Health Orange County influence the issue?
- Does Rady Children's Health Orange County already have a strategic focus or initiative on the issue?
- Is there community will or opportunity to leverage or influence the issue?
- Is measurable change possible within three years?

Health Priorities

Health Priorities	Concerns Identified By the CHNA	Potential Areas to Commit and/or see Rady Children's Health Orange County and the Community Together to Address
Behavioral Health	• Mental Health Conditions o Depression o Anxiety o Stress o Eating disorders o Suicidal ideation • Substance use	• Expand access to mental health services (which include culturally and linguistically appropriate therapists, and improve timely and affordable mental healthcare) • Education about behavioral health issues with a focus on engaging adolescents and perinatal, prenatal, and new parents of infants. • Substance use or addiction prevention
Access to Pediatric Healthcare Services	• Ability to access healthcare services • Availability of appointments during times that are convenient for parents or caregivers • Long wait times and providers not taking new patients • Complex navigation systems • Lack of access to cultural and linguistically appropriate services	• Expand access to primary healthcare services • Make appointments available at times that are convenient for the patient • Teamwork between healthcare organizations and community-based organizations • Tools to assist patients and families in navigating the healthcare system

Social Driver of Health Priorities

This CHNA identified four SDOH to consider when developing strategies to respond to the two health priorities of Behavioral Health and Access to Healthcare Services.

Social Driver of Health Priorities	Priority Risk and Protective Factors Identified by Community
Connectedness	• Absence of positive adult role models for children, including gaps in modeling good lifestyle habits by family members, lack of family engagement in children's care, families overwhelmed with care needs of aging family members • Social media contributing to setting unrealistic expectations for both children and caregivers/parents
Economic Stability	• Increasing costs of living, including housing, childcare, and food • Access to affordable extracurricular activities (e.g., youth sports, art, camps, afterschool programming)
Healthy & Affordable Foods	• Cost and proximity to nutritious foods • Access to education about nutritious food
Safe Homes, Schools & Neighborhoods	• Low-crime and safe neighborhoods • Injury prevention • Community violence • Bullying, including cyberbullying • Domestic abuse

Rady Children's Health Orange County will use the results of this CHNA to guide decisions on priority programs, focusing on the most pressing health issues, key populations, and associated risk factors. Specifically, the CHNA findings will inform:

1. Rady Children's Health Orange County strategic planning process
2. How Rady Children's Health Orange County directs community benefit investment funds
3. Opportunities to work with partners on issues outside Rady Children's Health Orange County expertise
4. Setting advocacy priorities
5. Fundraising and philanthropy work

This report is one of many steps toward improving child and family health outcomes throughout Orange County. It is anticipated that organizations, networks, and residents will be mobilized to act collectively on the priority issues identified. The CHNA will serve as a foundational resource for ongoing community health improvement efforts.

Appendix A: Rady Children's Health Orange County List of Services

The following is a list of Rady Children's Health Orange County inpatient and outpatient services:

- Adolescent Medicine
  - Eating disorders
  - Reproductive Health
  - Mental Health
  - Adolescent Healthcare
- Allergy / Immunology
  - Asthma Education Programs
  - Breathmobile
  - Eosinophilic Esophagitis Clinic
- Autism
- Blood and Donor Services
- Breast Milk Donations
- Cardiology / Heart Institute
  - Cardiac Catheterization Laboratory
  - Cardio-diagnostics
  - Cardiovascular Intensive Care Unit (CVICU)
  - Electrophysiology (EP) Program
  - Healthy Lifestyle Classes
  - Heart Surgery
  - Interventional Cardiology Program
  - Lipid Clinic
  - Pacemaker and Implantable Cardioverter Defibrillator Program
  - Pulmonary Hypertension Clinic
  - Sports Cardiology Program
- Child Life
- Cord Blood Bank
- Craniofacial Orthodontics
- Critical Care
  - Cardiovascular Intensive Care Unit (CVICU)
  - Extracorporeal Life Support Program (ECMO)
  - Neonatal Intensive Care Unit (NICU)
  - Pediatric Intensive Care Unit (PICU)
  - Transport Services
- Dentistry
- Dermatology
- Developmental and Behavioral Pediatrics
  - Developmental Services
- Emergency Medicine
  - Injury Prevention
  - Safety Tips
  - Transport Services
  - Trauma Center
- Endocrinology and Diabetes
  - Healthy Lifestyle Classes
- Fetal Care Center of Southern California
- Gastroenterology
  - Colorectal/Bowel Management Program
  - Eosinophilic Esophagitis Clinic
  - Feeding Program
  - Functional Abdominal Pain Program
  - Gastrointestinal Motility Program
  - Inflammatory Bowel Disease (IBD) Program
  - Intestinal Rehabilitation Program
- General and Thoracic Surgery
- Genetics
- Hematology
  - Vascular Anomalies Center

- Infectious Disease
- Integrative Health
- Laboratory Services
- Lactation Services
- Metabolic Disorders
    - Metabolic Lab
- Neonatology/Perinatology
    - Neonatal Intensive Care Unit (NICU)
    - Neurocritical NICU
    - Small Baby Unit
    - Surgical NICU
    - High-Risk Infant Follow-Up Clinic
- Nephrology
- Neurology/Neuroscience Institute
    - Concussion Program
    - Developmental Services
    - Down Syndrome Program
    - Epilepsy Program
    - Muscular Dystrophy Association Clinic
    - Neuro-diagnostics
    - Neuromuscular Disease Program
    - Sleep Disorder Center
    - Spasticity Clinic
    - Spina Bifida Clinic
- Neurosurgery / Neuroscience Institute
    - Brachial Plexus Program
    - Concussion Program
    - Epilepsy Program
    - Neuro-oncology Program
    - Plagiocephaly Clinic
    - Spasticity Clinic
    - Spina Bifida Clinic
- Nutrition Services
- Oncology / Hyundai Cancer Institute
    - Adolescent and Young Adult Cancer Program
    - After Cancer Treatment Survivorship Program
    - Blood and Marrow Transplant Program
    - Bone and Soft Tissue Sarcoma Program
    - Histiocytosis Program
    - Leukemia Program
    - Lymphoma Program
    - Neuro-oncology Program
    - Recurrent and Refractory Cancer Program
    - Solid Tumor Program
- Ophthalmology
- Orthopedics/Orthopedic Institute
    - Clubfoot and Foot Disorder Program
    - Fracture Clinic
    - Hand Program
    - Infant and Adolescent Hip Disorder Program
    - Limb Program
    - Muscular Dystrophy Association Clinic
    - Musculoskeletal Tumor Program
    - Neuromuscular Disease Program
    - Orthopedic Surgery
    - Spasticity Clinic
    - Spina Bifida Clinic
    - Spine Center
    - Sports Medicine Program
- Otolaryngology (Ear, Nose and Throat)
    - Cleft and Craniofacial Program
    - Cochlear Implant Program
    - Vascular Anomalies Center
- Palliative Care
- Pharmacy
- Physical Medicine and Rehabilitation
    - Rehabilitation Services
    - Physical Therapy
    - Occupational Therapy
    - Speech and Language Pathology
    - Developmental Therapy
- Plastic Surgery
    - Brachial Plexus Program

- Cleft and Craniofacial Program
- Vascular Anomalies Center

- Primary Care
- Psychology / Psychiatry
  - Mental Health Services
- Pulmonology
  - Severe Asthma Program
  - Chronic Lung Disease
  - Cystic Fibrosis Center
  - Interstitial Lung Disease
  - Respiratory Syncytial Virus (RSV) Prevention Program
  - Sleep Disorder Center
  - Tracheostomy and Mechanical Home Ventilation
- Radiology / Imaging
- Rehabilitation Services
- Research Institute
- Rheumatology
- Social Services
- Spiritual Care
- Surgical Services
- Thoracic Surgery
- Urology
  - Bedwetting and Daytime Incontinence Program
  - Disorders of Sexual Differentiation Program
  - Hypospadias Program
  - Spina Bifida Clinic

Appendix B: List of Zip Codes Included in Orange County PSA

Zip Code	Community Name
92656	Aliso Viejo
92801, 92802, 92804, 92805, 92806, 92807, 92808	Anaheim
92821, 92823	Brea
90620, 90621	Buena Park
92624	Capistrano Beach
92625	Corona del Mar
92626, 92627	Costa Mesa
90630	Cypress
92629	Dana Point
92610	Foothill Ranch
92708	Fountain Valley
92831, 92832, 92833, 92835	Fullerton
92840, 92841, 92843, 92844, 92845	Garden Grove
92646, 92647, 92648, 92649	Huntington Beach
92602, 92603, 92604, 92606, 92612, 92614, 92617, 92618, 92620, 92697	Irvine
90631	La Habra
90623	La Palma
92694	Ladera Ranch
92651	Laguna Beach
92653	Laguna Hills
92677	Laguna Niguel
92637	Laguna Woods
92630	Lake Forest
90720	Los Alamitos
92655	Midway City
92691, 92692	Mission Viejo
92660, 92661, 92662, 92663	Newport Beach
92657	Newport Coast
92865, 92866, 92867, 92868, 92869	Orange
92870	Placentia
92688	Rancho Santa Margarita
92672, 92673	San Clemente
92675	San Juan Capistrano
92701, 92703, 92704, 92705, 92706, 92707	Santa Ana
90740	Seal Beach
92676	Silverado
90680	Stanton
90742	Sunset Beach
92679	Trabuco Canyon
92780, 92782	Tustin
92861	Villa Park
92683	Westminster
92886, 92887	Yorba Linda

Appendix C: Focus Group Discussion Guide

Discussion Questions

Note: While interview questions will be customized for each focus group based on the nature of the data strategy or approach under examination, the following set of questions will be used by interviewers as guide. Interviewers can use their discretion in how they verbalize questions to best align with the interviewee and the flow of the conversation.

Explain the purpose of the focus group: To gather parent/caregiver perspectives on how to utilize regional resources to address gaps in youth and family wellness and develop collaborative solutions following the Community Health Needs Assessment (CHNA).

Review Guidelines for Discussion: respect, confidentiality, one person speaking at a time, utilizing Zoom chat

Rady Children's Health Orange County is conducting a Community Health Needs Assessment (CHNA). The purpose of the CHNA is to create a report that uplifts the health needs and experiences of communities in Orange County through systematic, comprehensive data collection and analysis. We are conducting a Focus Group with community health workers to get your perspectives and concerns regarding health issues based on their own personal experiences and provide a nuanced understanding that may not be captured through quantitative data alone. Your input will help identify priority health needs and tailor interventions to the specific community context.

Introductions:

Please introduce yourself by sharing your name, your role and one thing you love about Orange County

Icebreaker: What helps you and your family stay healthy in your community?

Identifying Top Health Issues

1. **What are the biggest challenges facing children and families in Orange County?** *Probe: What factors make it difficult for families to raise healthy children here? What types of supports or services would have made a significant difference?*

2. **What are some primary health concerns for children and families in Orange County?** *Probe: Why do you think these issues or health conditions are prevalent? How do these concerns affect the well-being of families in the community?*

2. **What are some of the biggest barriers to maintaining good health for children and families?** *Probe: What factors make it difficult for families to ensure proper nutrition, physical activity, and mental healthcare?*

Addressing Top Health Issues

4. **What is the community doing well to support the overall health and well-being of children and families?** *Probe: Which programs or services do you think are most effective in providing support?*

5. **What could the community improve in supporting children and families?** *What gaps exist, and what additional resources or services would be most beneficial?*

6. **What resources do children and families need to achieve their goals?** *What specific supports are needed for children to thrive in areas like education, personal development, and overall well-being?*

Conclusion

Is there anything else you want to talk about? Do you have any questions for us?

Appendix D: Focus Group Summary

Focus Groups Discussions

Focus group discussions were held with school nurses, community health workers (CHWs), and caregivers as part of the community engagement framework for the CHNA. The discussions explored the complex landscape of child and family health in Orange County, examining challenges, barriers, health concerns, community assets, service gaps, needed resources, and health disparities affecting diverse populations. Through the voices of frontline professionals and family members, this analysis provides critical insights into both the obstacles preventing optimal health outcomes and the solutions that could transform health equity for Orange County's children and families.

Mental Health Issues

Mental health issues emerged as the most frequently cited primary health concern, affecting both children and parents across all age groups and communities. Participants described widespread anxiety, depression, and toxic stress as pervasive conditions requiring ongoing clinical attention.

- School nurses noted that mental health concerns create cascading effects on educational outcomes and require significant resources within school settings. In the focus groups conducted among nurses, mental health was the most frequently cited concern across all school districts and age groups.
- Community health workers emphasized how multiple stressors compound mental health issues, noting the *"compounding effects of housing instability, economic stress, immigration fears, and social media pressure."* The lack of follow-through with mental healthcare was attributed to competing family priorities and limited understanding of the importance of ongoing treatment.
- Caregivers emphasized the unique emotional toll of parenting under stress, with ongoing effects from the pandemic continuing to impact family mental health

School nurses and community health workers reported that families cannot access adequate mental health services due to severe provider shortages and month-long waitlists. As one nurse explained, *"We just can't get them the services that they need, and they miss 30–40% of the school year." The shortage of providers creates waitlists that make timely intervention impossible, forcing families to wait until crises occur.*

The crisis is exacerbated by social media pressure, with parents reportedly feeling inadequate after comparing themselves to unrealistic online portrayals, leading one participant to note that *"Parents are stressed… they're seeing so much on social media… they feel like they're not doing enough."* The system's reactive rather than preventive approach compounds the problem, with a nurse stating, *"We're very reactive with mental health. We respond when it's a crisis, but we're not doing enough screening or early intervention."*

Access to mental health service emerged as the most significant obstacle to family well-being, with participants describing how families cannot access adequate mental health services despite widespread need. School nurses noted that children often receive only brief interventions before being discharged without follow-up care. The system's focus on crisis response rather than prevention creates additional barriers to early intervention and ongoing support. Mental health issues create cascading effects on school attendance, with chronic absenteeism becoming a significant problem when students cannot access needed services

Topic I: Primary Health Concerns

Focus group participants identified the specific health conditions and concerns that are most prevalent among children and families in Orange County. These primary health concerns represent the clinical manifestations of broader systemic challenges, showing how social drivers, access barriers, and structural inequities translate into specific health conditions affecting children's development, learning, and overall well-being. Health pertains to concerns physical, mental, and developmental conditions, with many interconnected through common underlying factors such as poverty, housing instability, and limited access to preventive care.

Mental Health Support Programs provide essential services addressing the widespread mental health challenges previously identified. Rady Children's Project Health and Western Youth Services offer therapy and wraparound services that help bridge gaps in school-based mental healthcare. These programs demonstrate innovation in service delivery by providing comprehensive support rather than isolated interventions. Community health workers acknowledged the availability of mental health services including counseling at Family Resource Centers and referrals through Help Me Grow, with programs like Adverse Childhood Experiences (ACEs) screening and "stress busters" providing helpful tools for families. Caregivers recognized the availability of free therapy services through CalOptima and other programs, including school-based mental health counselors and support groups.

Nutrition and Adequate Exercise

Nutrition and physical activity were identified as key health concerns, with obesity noted as a specific issue impacting children and families. The following was specifically noted:

- School nurses report high obesity prevalence but lack referral resources. Children experience both obesity and malnutrition, with families relying on fast food due to affordability and time constraints
- Community health workers described a paradoxical situation where children experience both obesity and malnutrition simultaneously, with families relying on fast food due to affordability, lack of kitchen access, and time constraints.
- Caregivers linked childhood obesity and diabetes to poor nutrition, limited physical activity, and time constraints that prevent preparation of healthy meals. The concern

extends to school food programs, with caregivers expressing worry about the quality and nutritional balance of school meals.

Diabetes represents a growing health concern, particularly among younger students, reflecting broader nutritional and lifestyle challenges facing families.

- School nurses noted increasing prevalence and described significant management challenges including inconsistent glucose monitoring, limited parental understanding of the condition, and insurance barriers that prevent access to emergency medications.
- Community health workers identified prediabetes in children as an emerging concern, particularly in the context of poor nutrition and limited access to healthy food options.

The condition reflects the intersection of multiple systemic issues, including food insecurity, limited physical activity opportunities, and inadequate health education about nutrition and diabetes prevention. Poor nutrition and limited physical activity, linked to housing conditions and economic constraints, contribute to these health problems, with one community health worker noting, *"We're seeing more kids with asthma and obesity… but they're also malnourished."*

It was noted among participants that housing instability and poverty worsen chronic illnesses like asthma and diabetes, with families in overcrowded or unsanitary conditions facing specific health challenges. School nurses identified poverty as a fundamental root cause of poor health outcomes, with one stating that *"poverty is one of the biggest challenges."* Food banks and nutrition support play a critical role, providing food pantries and meal programs, particularly for homeless families, with some partnering to offer culturally appropriate food boxes.

Food Banks and Nutrition Support represent a critical community asset addressing food insecurity challenges. School districts and local churches provide food pantries and meal programs, with some districts operating their own food banks specifically for McKinney-Vento homeless families and others in need. The programs show strength in their accessibility and cultural responsiveness, with community health workers highlighting partnerships that provide culturally appropriate food boxes delivered directly to families. As one community health worker explained, *"We have CHWs who gather food from the food bank and deliver it to families."* Caregivers acknowledged nutrition workshops, food distribution, and school-based meal programs as helpful resources, though they also noted areas for potential improvement in these services.

Community-Based Recreation and Education Programs provide important opportunities for physical activity, learning, and family engagement. Irvine's Parks and Recreation Department exemplifies effective municipal programming by offering free or low-cost after-school programs, tutoring, and outdoor activities along with open spaces for walking, hiking, and sports. Community health workers described community events like "Family Fun Days" that combine health screenings, education, and recreation as effective ways to engage families while providing multiple services simultaneously. Caregivers highlighted specific recreational opportunities such as splash pads, summer park events, 5K runs, and library programs that provide accessible family activities.

Social Drivers of Health

Focus group participants emphasized the impact of Social Drivers of Health noting that families lacking basic amenities, such as safe outdoor spaces for children to play and exercise, facing significant barriers to achieving health and wellness.

Families experiencing economic stress reportedly face difficult choices between basic needs and healthcare, and those who need to navigate a benefits system that is perceived to create traps that discourage economic progress. as illustrated by the quote, *"They're afraid to take a raise because they'll lose childcare."* The economic barriers in Orange County trap families in cycles that prevent health improvement, causing structural disincentives in the benefits system known as the "benefits cliff." Families fear losing essential healthcare coverage and support services with any slight increase in income, forcing them to choose between economic progress and maintaining access to healthcare. Work schedule barriers also prevent attending appointments during regular hours, and lack of paid sick leave adds further obstacles.

Housing instability emerged as a dominant issue:

- *"Whole families live in a rented room. Kids come home and sit on a bed with an iPad. There's no place to play outside."*

- Community health workers reported even more severe conditions, with one stating, *"We have families living in cars with babies… they're on waitlists [for supportive services] for years."*

Chronic condition management barriers prevent families from effectively managing ongoing health needs. Insurance barriers limit access to necessary medical supplies, devices, and medications, forcing families to choose between financial stability and health management. The increasing complexity of pediatric medical needs creates barriers for families who lack the training, resources, or support systems to manage complex care plans effectively. Poor access to nutritious food and safe exercise opportunities creates barriers to managing conditions like diabetes, asthma, and obesity. Families often struggle to balance the demands of managing chronic conditions with work schedules and other responsibilities, leading to inconsistent care and worsening health outcomes.

Education Access and Quality

Developmental Delays

Developmental delays, including autism, have become increasingly prominent health concerns, with participants noting both rising prevalence and significant barriers to timely diagnosis and intervention.

- School nurses reported long delays in diagnosis due to referral bottlenecks, while early intervention efforts are hindered by waitlists and limited coordination between schools and healthcare providers.
- Community health workers working with early childhood populations identified speech delays and autism diagnoses as high-priority concerns, with one noting that *"a lot of families are seeking autism diagnoses... but the waitlists are extensive."* The lack of pediatric specialists creates additional delays in obtaining necessary evaluations and services.
- Caregivers reported observing increased numbers of children needing speech therapy and described significant challenges in navigating the complex system of developmental services.

Student Health

Medically fragile students represent a growing category of complex health concerns requiring specialized care within school settings. School nurses reported an increase in students with tracheostomies, G-tubes, and other complex medical needs. This trend is attributed to both advances in medical technology that allow more children with complex conditions to survive and thrive, and greater inclusion policies that bring these students into mainstream educational settings. The presence of medically fragile students in schools requires significant resources and specialized training for school health staff.

A school nurse observed, *"We have more kids with G-tubes now than in the past six years."* Insurance limitations prevent families from accessing necessary medical supplies, with one

example being, *"The student didn't have emergency glucose because insurance wouldn't cover it. The parent just didn't get anything."*

Educational and systemic disconnects emerged as a significant challenge, with fragmentation between healthcare, education, and social services systems creating difficulties for both families and providers. School nurses expressed frustration about being undervalued and excluded from care coordination, with one stating, *"We're not seen as real nurses. Even physicians and other nurses don't understand what we do."* The lack of system integration leaves families struggling to navigate multiple agencies independently, as a community health worker explained, *"The systems don't talk to each other. Families are stuck in the middle."* School nurses, despite their daily contact with students, feel disconnected from the broader healthcare system, with one advocating, *"We need to be part of the medical home. We're the ones seeing these kids every day."*

Professional silos prevent effective communication between schools, healthcare providers, and social services, creating gaps in care coordination. School nurses face barriers to participating in medical decision-making despite their unique position and daily contact with students. The lack of integrated systems forces families to navigate multiple agencies independently, often leading to duplicated efforts or missed opportunities for comprehensive care. Information sharing barriers prevent providers from having complete pictures of family needs and circumstances.

Regional Center for Early Intervention provides critical services for children with developmental delays and disabilities. School nurses noted the value of these services in addressing autism and developmental concerns, while caregivers acknowledged their importance despite ongoing challenges with waitlists and access. The Regional Center represents a specialized resource that addresses specific needs that might otherwise go unmet in the broader healthcare system.

Neighborhood and Built Environment:

Asthma

Asthma emerged as a significant respiratory health concern with clear environmental and geographical patterns.

- School nurses noted that asthma is particularly prevalent in areas near freeways and with higher pollution levels, specifically mentioning Westminster and Garden Grove. They observed a direct correlation between asthma prevalence and environmental exposures including cigarette smoke and traffic emissions.
- Community health workers reported a high prevalence of asthma, especially in children, and linked it directly to environmental conditions such as substandard housing and poor air quality. The condition represents a clear example of how environmental factors and

housing conditions translate into chronic health conditions requiring ongoing medical management.

Food Allergies

Food allergies represent an emerging health concern that appears to vary by geographic and socioeconomic factors within Orange County.

- School nurses noted that food allergies are particularly prevalent in more affluent areas like Irvine, raising questions about potential overdiagnosis and the psychological impact of these diagnoses on students. The geographic variation suggests different factors may be contributing to food allergy prevalence or recognition across different communities.
- Caregivers discussed recurring allergy issues in children and expressed dissatisfaction with the quality of care and education they receive about managing these conditions.

Environmental and infrastructure barriers prevent families from maintaining healthy lifestyles through limited access to safe spaces for physical activity.

- Community safety concerns create barriers to using available recreational facilities, with families avoiding parks and outdoor spaces due to perceived dangers.
- Housing conditions that lack adequate space for physical activity create additional environmental barriers to healthy development.
- Transportation barriers prevent families from accessing recreational facilities that might be available in other parts of the community.

Mobile Health Services represent an innovative approach to overcoming access barriers by bringing healthcare directly to where families are located. School nurses noted that multiple districts benefit from mobile clinics including dental vans, vision vans, and CHOC's Wellness on Wheels, which reduce the need for transportation and time off work for families. As one nurse explained, *"We have the mobile dental clinic, a vision van, CHOC Wellness on Wheels, and a different medical mobile van that comes. We try to make access to those things easy for our families."* The mobile model demonstrates how creative service delivery can address many of the logistical barriers that prevent families from accessing care.

Several additional health concerns were identified by participants, including

1. Overuse injuries in school-age children reflecting changing patterns of physical activity and sports participation.
2. Parental mental health and intergenerational conflict that affects entire family systems.
3. Fear-driven avoidance of healthcare prevents families from seeking necessary medical care.
4. Frequent illness patterns that contribute to chronic school absenteeism.
5. Limited access to providers and telehealth services.

6. Health literacy and education gaps.
7. Administrative burden and system complexity.
8. Language and cultural barriers affect communication with providers.
9. Lack of human connection and navigation support in healthcare settings.
10. Transportation and logistical barriers.
11. System fragmentation creates gaps in coordinated care.

These findings demonstrate that primary health concerns in Orange County reflect not only biological and genetic factors but also the complex interplay of social, environmental, and systemic factors that shape children's health outcomes and families' ability to maintain wellness.

Topic II: Challenges Facing Children and Families

The focus group discussions revealed a complex web of interconnected challenges that make it difficult for families to raise healthy children. Participants described families struggling with multiple, compounding stressors that affect every aspect of child and family well-being. The conversations highlighted systemic gaps in services, fragmented care coordination, and structural inequities that leave vulnerable families overwhelmed and underserved.

Challenges Facing Providers Serving Children and Families

Health Misinformation and Vaccine Hesitancy

Health misinformation and vaccine hesitancy emerged as a growing concern, particularly among school nurses who reported that parents increasingly reject professional medical advice in favor of information from social media influencers. One nurse shared a specific example: *"Parents are coming in and telling us stuff that is just not true. They're getting it from influencers. There's a new push for raw milk."* This trend undermines healthcare professionals' credibility and expertise, with nurses reporting that *"Parents often reject professional advice in favor of what they read online."*

Health misinformation barriers prevent families from making informed health decisions and following medical advice. The proliferation of health misinformation through social media and online influencers creates barriers to establishing trust between families and healthcare providers. Parents increasingly question professional medical recommendations, creating barriers to evidence-based care and treatment compliance. This erosion of trust creates fundamental barriers to effective patient-provider relationships and adherence to treatment plans. Healthcare providers report increasing difficulty in countering misinformation and rebuilding trust with families who have been exposed to conflicting information online.

Immigration status and fear

Immigration status and fear created significant challenges to healthcare access, with families avoiding services due to fears about immigration enforcement.

- Community health workers described how Immigration and Customs Enforcement (ICE) activity creates pervasive fear in immigrant communities, with one explaining, *"They're afraid to come to events or answer the door because of ICE."*
- School nurses also encountered this barrier, with one sharing, *"They shut the door on us after ICE visited… they thought we brought them."* This fear extends to healthcare settings, with a community health worker noting, *"We're seeing a lot of anxiety and stress in immigrant communities… they're afraid to even go to the doctor."*

Immigration-related barriers prevent families from accessing services due to pervasive fears about immigration enforcement. Misinformation about public charge policies and eligibility requirements creates additional barriers, deterring families from seeking care even when they are legally entitled to services. The climate of fear affects not only undocumented families but also mixed-status families and those with temporary legal status. Community health workers noted that even providing rights education has limited effectiveness against deep-seated fears, as the emotional impact of fear often overrides rational information about legal protections.

Structural barriers to Community Health Worker Effectiveness

Structural barriers to community health worker effectiveness limit the ability of these frontline workers to support families effectively. Community health workers face systemic challenges including low wages, lack of billing infrastructure, and limited professional recognition. One community health worker explained, *"We can't bill for outreach, but that's how we build trust."* Many community health workers live in similar precarious conditions to the families they serve, with one participant noting, *"Community health workers are living in the same conditions as the families they support."* The precarious employment conditions of many community health workers create additional barriers to providing consistent support to families over time.

Culturally and Linguistically Responsive Services represent an important community strength in addressing the diverse needs of Orange County's population. Community health workers and caregivers highlighted programs that provide services in multiple languages and incorporate cultural understanding into service delivery. These services recognize that effective health support requires more than just translation and must incorporate cultural competency to be truly accessible to diverse communities.

Challenges Facing Children and Families

Healthcare Access and Navigation Challenges

Healthcare access and navigation challenges proved equally problematic, with families facing extensive waitlists and complex navigation systems that often lead to the abandonment of care. A nurse described the lengthy referral process: *"It's a six-week wait just to get into Ear Nose and Throat (ENT). Then you wait for a sleep study, then results, then maybe surgery. It's months."* The fragmentation of services overwhelms families, with one community health worker explaining, *"They have to retell their story over and over again… they just give up."* Language

challenges further complicate access, as noted by a nurse: *"Many of my families speak Spanish only or communicate in American Sign Language only... they come back and don't know what the doctor said."*

- Provider shortages and closed panels prevent families from establishing primary care relationships, leaving them without consistent medical homes. Even when families can access care, complex navigation requirements create barriers to follow-through.
- Administrative barriers, including extensive paperwork and repeated intake processes, overwhelm families with limited literacy or time.
- Limited provider hours that conflict with work schedules create additional access barriers, preventing working families from attending appointments.

Families often abandon care when navigation becomes too complex, leading to incomplete treatment and worsening conditions. Language barriers compound these challenges, with families unable to understand medical instructions or communicate effectively with providers.

Strong Collaboration with CHOC and Cross-Sector Partnerships emerged as the most frequently cited community strength, demonstrating the value of healthcare institutions working closely with schools and community organizations. School nurses consistently praised CHOC's partnership approach, particularly highlighting innovations in information sharing and coordination of care. The collaboration includes sharing medical records through a secure portal, supporting students with chronic conditions like diabetes, and offering Project Health, which provides mental health therapy and collaborates with IEP teams. As one nurse noted, *"CHOC has a really great relationship with Orange County nurses. They've started to do more information sharing to make access to medical records so much easier for school nurses."* Community health workers also emphasized the effectiveness of mobile clinics that bring care directly to families, particularly those facing transportation or scheduling barriers. These partnerships demonstrate how cross-sector collaboration can overcome many of the access barriers that families face.

Family Resource Centers (FRC) serve as trusted, accessible hubs for comprehensive wraparound services including case management, counseling, basic needs support, and referrals to other services. Community health workers repeatedly cited FRCs as effective because they co-locate multiple services and focus on building long-term relationships with families rather than providing one-time interventions. The approach of centralizing services reduces navigation burden on families while creating opportunities for more comprehensive support. Programs like those at Mira Loma Center provide essential items like diapers and food while connecting families to additional resources, with one caregiver noting, *"They provide diapers and food for us moms and help with referrals to other services."*

Vision and Dental Resources address critical healthcare needs through innovative service delivery models. Programs like Healthy Smiles, Family Health Matters, and Serve the People provide free or low-cost glasses and dental care, with mobile services bringing care directly to schools to eliminate transportation barriers. School nurses particularly praised these programs for their accessibility, with one noting, *"Family Health Matters has been very positive. They have a van that comes out to the school and gets kids free glasses."* While caregivers acknowledged that access remains limited overall, they recognized the value of occasional free or low-cost vision and dental services offered through school screenings and community clinics.

CalOptima Nurse and Dental Navigator Programs provide specialized support to help families navigate complex insurance and healthcare systems. These programs specifically address navigation barriers by providing dedicated staff to help families understand and access Medi-Cal and dental care systems. School nurses expressed enthusiasm about these services and planned to share them more widely with families, with one noting, *"I heard CalOptima has a nurse navigator program… I think it's a great service that I'll be sharing with the nurses and families I work with."* The navigator model recognizes that access to insurance does not automatically translate to access to care without additional support.

Topic III: Service Gaps and Areas for Improvement

While participants identified valuable community assets and strengths, they also highlighted significant service gaps and areas requiring improvement to better support children and families' health and well-being. These gaps represent missed opportunities and systemic deficiencies that prevent the community from fully addressing the needs identified in previous discussions. The areas for improvement provide a roadmap for strengthening existing services and developing new approaches to better serve Orange County's diverse families. Addressing these gaps could significantly enhance the effectiveness of current community assets while expanding access and improving outcomes for vulnerable populations.

Limited Access to Timely and Specialized Healthcare

Limited access to timely and specialized healthcare emerged as the most critical service gap, affecting families' ability to receive appropriate care when needed. School nurses emphasized the lack of direct access to providers for school-based health concerns, particularly for urgent or complex cases that require immediate professional consultation.

- There is a clear need for telehealth or on-call providers to support school nurses in real time, with one nurse stating, *"School nurses need to have direct access to a provider—telehealth—for challenging cases."* Long wait times for referrals to specialists including ENT, autism evaluations, and mental health services significantly delay diagnoses and treatment, creating cascading effects on children's development and educational outcomes.
- Community health workers identified particularly problematic waitlists for pediatric mental health and developmental services, while also noting closed provider panels and limited availability of culturally competent providers.
- Caregivers described experiencing long wait times, difficulty securing appointments, and limited provider availability, especially for pediatric, allergy, and speech therapy services.

Underutilization and Poor Awareness of Available Services

Underutilization and poor awareness of available services represent a significant gap where existing resources fail to reach families who could benefit from them. School nurses noted that families often do not follow through with appointments or services even when resources are available, due to competing responsibilities, lack of understanding, and system complexity. The problem extends to professional awareness, with programs like CalOptima's nurse navigator and mobile health vans existing but not being widely known or used according to participants. As one nurse observed, even school nurses were unaware of some services until recently, highlighting the broader communication and outreach challenges. Community health workers emphasized that families are often unaware of what services exist or how to access them, with immigration fears and misinformation about eligibility further reducing service uptake. Caregivers confirmed this pattern, noting that *"some benefits people don't know about... sometimes people have Medi-Cal and they don't even know they have it."*

Fragmented Communication Between Schools and Healthcare Providers

Fragmented communication between schools and healthcare providers creates a significant gap in coordinated care for children who spend much of their time in educational settings. School nurses specifically identified a lack of coordination between schools, healthcare providers, and community services, noting that CalOptima and other systems are not well integrated with school-based health efforts. School nurses are often excluded from care coordination despite their unique position and daily contact with students, and struggle to get timely responses from providers when they need consultation or support. This fragmentation prevents comprehensive care planning and leaves gaps in understanding children's complete health picture across settings.

Lack of Continuity in Mental Health Services

Lack of continuity in mental health services represents a critical gap, particularly given the widespread mental health challenges identified by participants. School nurses reported that students often receive only a few sessions before being left without long-term support, creating discontinuity that undermines treatment effectiveness. The gap is particularly problematic after inpatient care, when parents are left to navigate complex systems alone without adequate transition support. Caregivers raised concerns about the quality and consistency of school-based mental health counselors, with some positions being temporary or rotating, asking, *"How do the schools guarantee quality of the [mental health] counselors?"* This instability prevents the development of therapeutic relationships necessary for effective mental health treatment.

Barriers to Vision and Dental Care

Barriers to vision and dental care persist despite some existing programs, indicating that current resources are insufficient to meet community needs. School nurses noted that programs like ARCHES have ended, leaving families with limited or hard-to-access alternatives. Transportation and cost remain major obstacles, especially for families on Medi-Cal who still face significant out-of-pocket expenses. Caregivers described high costs for glasses and limited access to affordable vision services even with insurance coverage, with one stating, *"Even with Medi-Cal... they're still charging me $200 for my daughter's glasses."* These financial barriers prevent families from addressing vision problems that can significantly impact children's educational success.

Health Misinformation and Vaccine Hesitancy

School nurses noted that newly documented families are particularly afraid to access services due to the political climate and fear of immigration enforcement, stating that *"newly documented families have extensive fear" of accessing services."* The problem extends beyond immigration concerns, with parents increasingly relying on social media for health information, leading to mistrust of professional recommendations and poor health decisions. School nurses struggle to counter misinformation and rebuild trust with families who have been influenced by unreliable online sources. Caregivers expressed concerns about unvaccinated children in homeschooling environments and the potential spread of illness in school settings.

Insufficient School Nurse Staffing and Recognition

High student-to-nurse ratios limit the ability to provide adequate care and follow-up, while some school nurses feel undervalued and misunderstood by healthcare providers and the public. This staffing gap is particularly problematic given the increasing complexity of student health needs and the critical role school nurses play in identifying and addressing health concerns during the school day. The lack of recognition also affects recruitment and retention of qualified school health professionals.

Lack of Culturally and Linguistically Appropriate Services

School nurses identified language diversity as a major barrier, with 48 languages spoken in some districts while many families cannot access services in their preferred language due to limited translation support. Many services are only available in English or lack live interpreters, causing families with limited English proficiency to struggle with accessing and understanding care. Beyond language, cultural barriers also exist, with caregivers noting mental health stigma in Hispanic communities as a significant obstacle and emphasizing the need for culturally sensitive outreach approaches.

Lack of Real-Time Data Sharing and Interdisciplinary Coordination

School nurses identified the need for better systems that allow real-time sharing of health information and coordinated care planning across providers and settings. Without these systems, important health information may not reach all relevant caregivers, leading to duplicated efforts or missed opportunities for intervention.

Transportation and Logistical Barriers

Families still struggle with transportation to appointments and services, particularly for specialized care that may not be available through mobile programs. These logistical challenges are compounded by work schedule conflicts and other competing responsibilities that make traditional service delivery models inaccessible for many families.

Topic IV: Needed Resources

Building on their identification of challenges, barriers, health concerns, community assets, and service gaps, focus group participants articulated specific resources that children and families need to achieve their goals and thrive in areas like education, personal development, and overall well-being. These resources represent participants' vision for what would most effectively address the challenges they identified, offering concrete recommendations for strengthening community support systems. The resources span immediate service needs as well as longer-term systemic changes that would create more supportive environments for healthy child and family development.

Expanded and Continuous Mental Health Services emerged as the most critical resource need, reflecting the widespread mental health challenges identified throughout the discussions.

- School nurses emphasized the difficulty finding culturally and linguistically appropriate therapists and noted that virtual therapy lacks the personal connection and quality needed for effective treatment. Mental health issues are widespread across all age groups, including preschoolers, requiring more comprehensive service availability. The need extends beyond crisis response to include accessible, long-term mental healthcare, as students often receive only five sessions before being left without follow-up even when needs persist.
- Community health workers emphasized that families need timely, affordable, and culturally appropriate mental healthcare for both children and parents, with long waitlists and limited pediatric mental health providers representing major obstacles.
- Caregivers specifically expressed interest in drop-in mental health spaces, mindfulness programs, and ongoing support that recognizes the interconnected nature of family mental health.

Nutrition and Family Engagement represent a multifaceted resource need addressing both immediate food access and longer-term health education.

- School nurses identified the need for support with healthy eating habits and family-based wellness approaches, recognizing that many families rely on fast food due to time, cost, or employment in food service industries. They suggested expanding nutrition education programs and family engagement initiatives that address the root causes of poor nutrition.
- Community health workers emphasized that families need access to affordable, nutritious food combined with education on healthy eating, highlighting the importance of food banks, WIC, CalFresh, and nutrition education programs. The rising prevalence of obesity and diabetes creates urgency around this need, with suggestions including cafeterias donating leftover produce to families and expanding programs like Nutrition Network to serve older students.
- Caregivers highlighted the importance of family meals, physical activity, and screen time boundaries while noting the need for affordable healthy food and cooking education.

Early Intervention and Developmental Services represent critical resources for addressing developmental delays and ensuring children receive timely support for optimal development.

- School nurses emphasized the need for early identification and support for developmental delays, noting that delays in diagnosis, particularly for autism, prevent access to essential services and interventions.
- Community health workers working with early childhood populations reported high concern regarding speech delays and autism diagnoses, with long waitlists and lack of pediatric specialists creating significant obstacles to timely intervention. The loss of effective programs like HeadStart due to funding cuts highlights the need for sustained investment in early intervention services.

- Caregivers noted that speech delays and developmental concerns are common, and while they value peer referrals and community-based navigation, they emphasized that access to services remains difficult and needs improvement.

Health Education and Parent Empowerment address the critical need for families to understand available resources and develop skills to support their children's health and development.

- School nurses identified the need for clear, accessible information about what schools and nurses can provide, noting that parents are often unaware that schools can administer medications, provide nebulizer treatments, or offer other health services.
- Community health workers emphasized that parents need workshops and resources to support their children's social-emotional development and manage behavioral concerns, particularly given the stress parents experience because of social media pressure and unrealistic expectations. The need for health education extends from early childhood or even prenatal periods, as parents often lack understanding of preventive care and long-term health impacts.
- Caregivers expressed a strong desire for more education on nutrition, parenting strategies, and how to support children's learning at home, especially with evolving academic standards.

Safe Transportation and Access to Activities address fundamental logistical needs that affect families' ability to access healthcare, education, and enrichment opportunities.

- School nurses identified the need for safe, affordable transportation to school and community programs, recognizing that transportation obstacles limit access to healthcare, enrichment activities, and even basic school attendance. They suggested expanding transportation support programs, using models like Anaheim Union High School District's bus pass program.
- Community health workers emphasized that families need safe parks and community spaces for physical activity and social interaction, noting that families avoid using some parks due to safety concerns.
- Cost and logistics represent major obstacles to extracurricular participation, with caregivers calling for more affordable, accessible sports and enrichment programs that do not create additional financial burden for families already struggling with basic needs.

Improved Communication and Coordination with Healthcare Providers address the fragmentation that prevents effective care coordination across settings where children spend their time.

- School nurses identified the need for real-time, two-way communication between school nurses and medical providers, citing delays in receiving medical orders, lack of updates on medication changes, and exclusion from care coordination despite their daily contact with students. They specifically mentioned the value of Rady Children’s Health Orange County doctors who have been helpful through conferences and Q&A sessions, suggesting expansion of these collaborative approaches.

- Community health workers emphasized that families need help navigating fragmented systems and maintaining continuity of care across providers and programs, as families currently must retell their stories repeatedly across different systems, leading many to give up on seeking care.

Vision and Dental Care Access represents ongoing needs for specialized healthcare services that significantly impact children's educational success and overall well-being.

- School nurses identified the need for reliable, affordable access to glasses and dental services, noting that programs like ARCHES have ended while Medi-Cal coverage remains limited. They suggested expanding mobile services like Family Health Matters and creating more accessible options for families. The lack of prioritization of dental and vision care, combined with insufficient follow-up and limited knowledge about available services, creates gaps in essential care.
- Caregivers described ongoing difficulty affording glasses and accessing vision care even with insurance coverage, requesting more frequent, community-based screenings that would make these services more accessible.

Culturally and Linguistically Responsive Services address the diverse needs of Orange County's population and the importance of culturally competent care and support. With 48 languages spoken in some school districts, as mentioned previously, the need for linguistically appropriate services is critical. Community liaisons providing services in languages like Russian and Mandarin have proven highly effective, suggesting the value of expanding these positions.

- Community health workers noted the broader need for culturally responsive approaches that go beyond translation to include cultural understanding and appropriate service delivery methods.
- Caregivers emphasized the need for mental health and parenting resources that are culturally relevant and available in Spanish, noting cultural barriers that affect utilization of mental health services in Hispanic communities.

Additional Resources Identified by participants include more school nurses and recognition of their professional role in supporting student health, with nurses needing better resources to assess and refer students effectively.

- Digital literacy and social media education emerged as needs, with suggestions for Rady Children’s Health Orange County to use social media platforms to educate parents and counter misinformation. Stable and affordable housing was identified as a fundamental resource need affecting all other health outcomes.
- Community health navigators and liaisons represent important resources for helping families navigate complex systems and access appropriate services. Trust and relationship building with schools was highlighted as essential for effective family engagement and service utilization.

Several specialized resource needs were also identified, including guaranteed income and financial stability programs that would address root causes of family stress, immigration support

and legal resources to help families access services without fear, school-based primary care access that would bring healthcare directly to where children are located, affordable in-person tutoring and academic support to address educational needs, and integrated family resource centers that could provide comprehensive, co-located services.

Topic VI: Health Disparities Among Specific Populations

Focus group participants identified significant health disparities affecting multiple vulnerable populations throughout Orange County, revealing how social drivers, systemic barriers, and inadequate resources create unequal health outcomes for different groups of children and families. While participants discussed disparities affecting various populations, their observations demonstrate that health inequities are not randomly distributed but systematically affect certain groups due to structural and institutional factors. These disparities reflect the complex interplay between individual circumstances, community conditions, and systemic failures that prevent equitable access to health resources and optimal health outcomes.

Students with Disabilities and Medically Fragile Youth emerged as the population experiencing the most explicitly identified health disparities, with participants across all focus groups noting significant challenges in accessing appropriate care and support. School nurses identified delays in diagnosis and access to specialists for conditions including autism and ENT concerns, along with lack of coordination between medical providers and schools that leaves families navigating complex systems alone. The inadequate support for students with complex medical needs has become more pronounced as the number of medically fragile students increases. Community health workers noted that families seeking autism diagnoses face long waitlists, while some pediatricians dismiss parental concerns about potential developmental delays, preventing timely referrals. As one community health worker explained, *"Sometimes pediatricians aren't concerned [about potential for autism or developmental delays], so families don't get referred."* Caregivers described challenges accessing speech therapy and developmental services, noting increased prevalence of communication delays among children in their communities.

Immigrant and Undocumented Families experience pervasive health disparities that affect their ability to access and utilize healthcare services across all areas of need. Fear-driven avoidance of healthcare services due to immigration enforcement concerns creates systematic barriers to care, with families avoiding services even when legally entitled to them. Community health workers emphasized that newly documented families have extensive fear about accessing services, particularly in the current political climate. The fear extends beyond individual healthcare encounters to community participation, with families reluctant to engage with any services or community programs. Language barriers compound these disparities, with participants noting the challenge of providing services across dozens of languages spoken in Orange County communities. Cultural barriers, particularly around mental health services, create additional disparities for immigrant families who may not access needed care due to stigma or cultural misunderstandings about mental health treatment.

Low-Income Families and Those in High-Poverty Areas face health disparities rooted in economic circumstances that create cascading effects on all aspects of health and well-being.

Housing instability represents the most fundamental disparity, with families living in conditions that directly undermine health, including overcrowded rooms, garages, or cars. Food insecurity creates nutritional disparities that contribute to both malnutrition and obesity, with families relying on fast food due to economic constraints and limited access to healthy options. Geographic disparities in environmental health exposures disproportionately affect low-income families, with participants noting higher rates of asthma in areas near freeways, particularly in Westminster and Garden Grove. Economic traps, including benefits cliffs, create disparities by preventing families from improving their economic circumstances without losing essential healthcare coverage.

Working Parents experience health disparities related to employment constraints that prevent them from accessing healthcare services and prioritizing health activities for their families. The inability to attend appointments during regular business hours creates systematic disparities in access to care. Working parents, particularly those in low-wage jobs, lack paid sick leave and flexibility to prioritize health appointments without putting their income or jobs at risk. Multiple job responsibilities and caregiving demands create time-related disparities that prevent follow-through on care plans and health-promoting activities like preparing nutritious meals. The competing demands on working parents create disparities in their ability to manage complex healthcare needs, particularly when they must balance caring for both children and elderly relatives simultaneously.

Non-English Speaking Families face systematic health disparities due to language barriers that affect all aspects of healthcare access and quality. Communication barriers prevent families from understanding medical instructions and care plans, creating significant obstacles to effective healthcare utilization. Limited access to services in preferred languages creates disparities in service quality and effectiveness, while language lines and interpretation services are often inadequate or not trusted by families. Health literacy disparities are compounded by language barriers, preventing families from understanding preventive care concepts and long-term health management strategies. The lack of cultural and linguistically appropriate services creates disparities in mental health and behavioral healthcare, where nuanced communication is particularly important for effective treatment.

Families Living in Overcrowded or Substandard Housing experience health disparities related to their living conditions that affect both immediate health outcomes and long-term health trajectories. Housing conditions create environmental health disparities through increased exposure to allergens, toxins, and poor air quality that contribute to higher rates of asthma and other respiratory conditions. Limited space for physical activity and healthy development creates disparities in childhood obesity and physical fitness, with children having nowhere to play outside safely. Overcrowding affects mental health and family dynamics, creating stress-related health disparities that impact both children and parents. The instability of substandard housing creates additional disparities through frequent moves that disrupt healthcare relationships and educational continuity. Challenges with medication storage and basic hygiene in inadequate housing create disparities in managing chronic conditions and preventing illness.

Multigenerational and Young Parent Households face unique health disparities related to family structures and competing caregiving responsibilities. Multigenerational caregiving responsibilities create disparities in health prioritization, with parents caring for both children and elderly relatives simultaneously, preventing focus on preventive care and health maintenance. Intergenerational conflicts in immigrant families create mental health disparities that affect family dynamics and healthcare decision-making. Young parents may lack the knowledge, resources, and support systems necessary for optimal child health outcomes, creating disparities in early childhood development and health management. Cultural conflicts between generations regarding healthcare decisions and parenting practices create additional stress and barriers to accessing appropriate care.

Students in Affluent Areas represent a different type of health disparity that demonstrates how socioeconomic status can create both advantages and unique health challenges. School nurses noted that food allergies are particularly prevalent in more affluent areas like Irvine, raising questions about potential overdiagnosis and the psychological impact of these diagnoses on students. While these students may have better access to healthcare services, they may also experience different types of mental health pressures related to achievement expectations and social pressures that create their own set of health disparities.

Homeless and Housing-Insecure Students under McKinney-Vento protections face the most severe housing-related health disparities, with families experiencing extreme housing instability while waiting extended periods for housing assistance. These students experience educational instability that compounds health disparities through frequent school changes and interrupted healthcare relationships. The lack of stable addresses creates barriers to accessing consistent healthcare and maintaining medical records. Basic needs insecurity affects their ability to focus on health and educational outcomes while also creating chronic stress that affects both physical and mental health.

Several additional populations experience notable health disparities including

- Deaf and hard of hearing students with additional disabilities who face communication barriers compounded by other needs
- Families experiencing system instability who struggle with constantly changing services and providers that prevent the development of consistent care relationships.

These health disparities collectively demonstrate that in Orange County, health outcomes are significantly influenced by social position, immigration status, economic circumstances, housing conditions, language, and family structure, creating systematic advantages for some populations while placing others at significant disadvantage in achieving optimal health and well-being.

Overarching Themes and Cross-Cutting Focus Group Findings

Analysis across all focus group discussions reveals several overarching themes that transcend individual topics and consistently emerge throughout participants' responses about challenges, barriers, health concerns, community assets, service gaps, needed resources, and health

disparities. These cross-cutting themes represent fundamental issues that shape the health and well-being of children and families in Orange County. Understanding these themes is critical for developing comprehensive strategies that address root causes rather than isolated symptoms.

The Interconnectedness of Health and Social Drivers emerged as the most pervasive theme across all discussions. Participants consistently described how housing instability, economic stress, immigration status, and family structure create cascading effects that influence every aspect of health outcomes. Mental health challenges cannot be separated from housing conditions, chronic diseases are linked to food insecurity, and educational success is affected by health status. This interconnectedness means that addressing any single health issue requires consideration of multiple social and economic factors. Housing emerged as particularly foundational, with participants linking stable housing to better nutrition, improved mental health, reduced asthma, enhanced educational outcomes, and stronger family functioning.

System Fragmentation and Poor Coordination represent a critical cross-cutting barrier that affects every aspect of service delivery and health outcomes. Participants described this fragmentation in multiple contexts: healthcare providers not communicating with schools, families having to retell their stories across multiple agencies, services operating in silos without awareness of each other's work, and children receiving care from multiple providers who do not coordinate treatment plans. This fragmentation creates burden for families, leads to duplicated efforts and missed opportunities, prevents comprehensive care planning, and results in gaps where children and families fall through cracks between systems.

The central role of fear and trust influences families' willingness and ability to access services across all domains. Immigration-related fears affect not only undocumented families but also mixed-status families and those with temporary legal status. Fear of losing benefits prevents economic advancement and service utilization. Mistrust of institutions, often based on past negative experiences or cultural differences, creates barriers to engagement with schools, healthcare providers, and community organizations. Conversely, trusted relationships with community health workers, school nurses, and culturally responsive programs emerged as critical factors in successful service delivery and health outcomes.

Professional isolation and under recognition affect key frontline workers who serve as bridges between families and formal healthcare systems. School nurses feel excluded from medical decision-making despite their daily contact with students and unique insights into children's health needs. Community health workers face structural barriers including low wages, limited billing options, and lack of professional recognition that prevent them from maximizing their effectiveness. Both groups described feeling undervalued by healthcare providers and health systems, despite their critical roles in identifying health concerns, providing ongoing support, and connecting families to resources.

Time poverty and competing priorities create universal challenges that affect families across socioeconomic levels, though the impacts are most severe for low-income families. Parents working multiple jobs cannot attend appointments during regular business hours. Families caring for multiple generations have competing demands that prevent health prioritization.

Complex systems requiring extensive navigation time create an additional burden for families already stretched thin. Even when services are available and accessible, time constraints often prevent families from following through on care plans or maintaining consistent engagement with health-promoting activities.

Cultural and linguistic responsiveness as essential, not optional emerged as critical for effective service delivery across all populations. With dozens of languages spoken in Orange County communities, translation is just the beginning of accessibility. Cultural understanding affects mental health service utilization, influences healthcare decision-making, shapes parenting practices, and determines family engagement with schools and community programs. Services that incorporate cultural responsiveness are more effective and better utilized, while those that do not often fail to reach the families who most need support.

The power of relationship-based care and services consistently emerged as a distinguishing factor between successful and unsuccessful interventions. Programs that prioritize building long-term relationships with families, such as Family Resource Centers and community health worker programs, were most highly valued by participants. In contrast, services that provide one-time interactions or constantly changing providers were described as less effective and more frustrating for families. The importance of relationships was particularly evident in mental health services, where continuity of care and therapeutic relationships are essential for effectiveness.

Technology as both solution and barrier represents a complex theme that emerged across multiple discussions. While telehealth and digital services offer potential solutions for access barriers, they also create new forms of exclusion for families lacking digital literacy, reliable internet access, or appropriate devices. Virtual mental health services were described as lacking the personal connection necessary for effectiveness, while digital-only educational support was seen as insufficient for many children's learning needs. Technology solutions must be implemented thoughtfully to avoid exacerbating existing disparities.

Prevention versus crisis response highlighted a fundamental tension in current service delivery approaches. Participants consistently described systems that respond to crises rather than prevent problems, from mental health services that intervene only after emergencies to educational support that begin only after children are already struggling. The emphasis on crisis response creates more expensive, less effective interventions while missing opportunities for early intervention that could prevent more serious problems from developing.

Community assets exist but are underutilized representing both a challenge and an opportunity identified across focus group discussions. Orange County has significant resources including mobile health services, Family Resource Centers, cultural organizations, and innovative partnerships between institutions like Rady Children’s Health Orange County and schools. However, many families do not know about available services, face barriers to accessing them, or find them inadequately coordinated with other supports they need. The challenge is not just creating new resources but better connecting families to existing assets and improving coordination between services.

Conclusion on Focus Group Findings

The focus group findings reveal that children and families in Orange County face complex, interconnected challenges that require comprehensive, coordinated responses addressing both immediate needs and underlying systemic issues. While significant community assets and innovative programs exist, substantial gaps remain in accessibility, coordination, and responsiveness to the diverse needs of Orange County's population.

The voices of school nurses, community health workers, and caregivers provide crucial insights into both the barriers preventing optimal health outcomes and the solutions that could address these challenges. Their recommendations emphasize the need for culturally responsive services, better coordination between systems, increased attention to social drivers of health, and recognition of the expertise that frontline workers bring to understanding community needs.

Most importantly, these findings demonstrate that achieving health equity for all children and families in Orange County requires moving beyond individual interventions to address the structural and systemic factors that create and perpetuate health disparities. Success will require sustained commitment to cross-sector collaboration, community-driven solutions, and policies that address the root causes of health inequities while building on the considerable strengths and assets that already exist within Orange County's diverse communities.

Appendix E: Key Informant Discussion Guide

Interview Protocol

1. Invitation –HMA will send an introductory email to the key informant group
2. All interviews will be confidential. Quotes from participants may be used for illustrative purposes without attribution.
3. Interviews will include two representatives from HMA: one lead and one support consultant who will take notes. We will inquire with interviewees if they are comfortable with our recording the session (for internal review purposes only).

Invitation Email

Rady Children's Health Orange County Health Orange County is conducting a Community Health Needs Assessment (CHNA). The purpose of the CHNA is to assess the health needs and experiences of children and their families in Orange County through a comprehensive evidence-based data collection and analysis process. The data are collected in many ways, by talking with community leaders, families, and conducting a community health survey. Additionally, we will analyze existing data from hospitals, education systems, local community-based reports, as well as county and state data.

Rady Children's Health Orange County will use the findings from the CHNA to help identify the health needs and the factors that influence the health of Orange County children and families. Rady Children's Health Orange County will use CHNA results to guide its community health improvement plan, ensuring resources are focused on the most pressing pediatric healthcare needs identified by the community.

You have been identified as a community leader with a perspective needed for the CHNA. <<Describe perspective>>

Would you be available for a 1-hour discussion? Your perspective and input are very valuable.

Please respond to the following poll to confirm your availability by Wednesday 3/19/25 and we will follow up with more details. Please select as many dates as possible that you are available.

Doodle Pool Link:

We will send a calendar invite and the discussion guide in advance of the interview.

Please reach out if you have any questions. Thank you so much for your time; we look forward to speaking with you soon.

Questions

Note: While interview questions will be customized for each interviewee based on the nature of the data strategy or approach under examination, the following set of questions will be used by interviewers as a guide. Interviewers can use their discretion in how they verbalize questions to best align with the interviewee and the flow of the conversation.

1. Which area of expertise do you represent? Out of these categories:
    a. Behavioral Health
    b. Child Trafficking
    c. Children 0-5
    d. Community Health Centers
    e. Community of Interest
    f. Community Violence
    g. County Health
    h. Education
    i. Health Insurance and Access
    j. Oral Health
    k. Other
    l. Physical Health
    m. Priority Population-African American
    n. Priority Population- Asian Pacific Islander
    o. Priority Population- People with Developmental Disabilities
    p. Priority Population- LGBTQ2IA+
    q. School Nurse
    r. Social Service
    s. Vaccines for Pregnant Women/Neonatal Care
    t. Workforce and Economic Development

Probe: What is your organization's/agency's mission? What communities do you work in?

Identifying Top Health Issues

2. Based on your area of expertise, what are some of the major health-related challenges facing communities within Orange County?

3. What do you feel are the major health concerns for Orange County children and families?

Probe: Which populations do you think are most vulnerable or at risk for these conditions/issues? In what way?

4. What factors do you think contribute most to these specific health concerns in Orange County?

5. Do you think there are any emerging threats to the health of Orange County children and residents that might not yet be major issues, but have the potential to become more important?

Probe: What are these? Why do you think these are important?

Addressing Top Health Issues

6. Thinking about the top health issues you've mentioned, what are the community's greatest strengths or assets around these issues?

7. Thinking about the top health issues you've mentioned, in what ways does the community have gaps in addressing those issues?

8. Thinking about the top health issues you've mentioned, what is currently being done to address those issues?

9. Thinking about the top health issues you've mentioned, what key barriers make it difficult to implement solutions and drive meaningful change?

10. What do you think leaders and decision-makers can do to help improve the health of Orange County children and families?

Children's Health Survey:

11. Can you help disseminate the Children's Health Survey? If yes, how can you disseminate the survey?

Focus Groups:

12. Can you help recruit participants into our focus groups?

Conclusion

Thank you for taking the time to talk with us.

Appendix F: Key Informant Interview Summary of Findings

Twenty-one key informant interviews with a diverse group of community service providers across Orange County were held. These interviews were designed to obtain expert insights into the health needs and reflect the experience of children and families, representing a spectrum of perspectives, including behavioral health, social services, education, oral health, and priority populations such as Asian Pacific Islander, Black/African American, Middle Eastern, LGBTQ2IA+, and individuals with developmental disabilities. Interviews were scheduled and completed in late April 2025. Participants were selected based on their leadership roles, subject matter expertise, and deep community engagement. Many interviewees lived or worked in Orange County.

Health Issues

The Top Three Noted Health Issues *(most frequently discussed)*

1. Mental Health: Anxiety and depression are prevalent, especially among children and adolescents. The COVID-19 pandemic has exacerbated these issues, leading to increased rates of suicide and substance use.
2. Housing Instability: The high cost of living in Orange County leads to housing insecurity, which affects overall health and well-being. Overcrowded living conditions and homelessness are significant stressors impacting families.
3. Access to Healthcare: Navigating the healthcare system poses challenges, particularly for those with private insurance. Long wait times, difficulty finding providers, and geographic disparities in healthcare services contribute to this issue.

All the Health Issues Identified by Key Informants

- Substance use disorders, including vaping, marijuana, alcohol, fentanyl, and party drugs. The rise in vaping among teens is particularly alarming, leading to nicotine addiction and respiratory issues. Marijuana use has increased as a coping mechanism for stress and mental health challenges. Alcohol abuse remains prevalent, often exacerbated by social pressures and economic stress. The use of fentanyl and party drugs presents severe risks, with instances of overdoses and fatalities highlighting the need for robust intervention programs.
- Obesity and diabetes.
- Injury prevention, including e-bike accidents, nitrous oxide injuries, and traumatic injuries.
- Respiratory issues such as asthma and allergies.
- Access to mental health services, including the need for culturally competent care.
- Housing instability and its impact on health.
- Vaccination concerns, including vaccine hesitancy.

- Coordination of care between primary care providers and specialized services is improving but still facing gaps.
- Burnout among healthcare providers.
- Navigation of the healthcare system and understanding of insurance processes
- Food accessibility and nutritional challenges.
- Environmental concerns, including the impact of wildfires, and their contribution to respiratory issues and stress, affecting both physical and mental health.
- Maternal and child health, including postpartum depression and anxiety. New mothers often experience isolation and lack of support, contributing to mental health challenges.
- Oral health remains a critical issue, especially post-COVID-19, as many families deferred dental care due to economic hardships and fear of the virus.

More on Mental Health as a Top Issue:

- One of the primary concerns is the difficulty in accessing mental health services. Long wait times, particularly for autism evaluations and therapy, are significant barriers, as well as a shortage of qualified mental health professionals.
- There is a pressing need for culturally competent therapists who can provide linguistically and culturally appropriate care. This is especially crucial for the diverse population of Orange County, including people of color and ibutio individuals.
- Mental Health stigma associated with mental health conditions remains a substantial barrier to seeking help. This stigma is particularly prevalent in certain communities where mental health issues are considered signs of weakness or shame.
- The COVID-19 pandemic has exacerbated mental health issues across all age groups, with a notable rise in anxiety, depression, and suicidality among children and adolescents.
- Navigating insurance processes and securing sufficient funding for mental health programs are persistent issues that hinder access to necessary services.
- There is an urgent need for early identification and intervention for mental health conditions. However, long waitlists and inadequate funding for early intervention services, particularly for children, pose significant challenges.
- Mental health issues, such as anxiety and depression, are prevalent among students. Schools require more support to address these concerns effectively, including additional mental health resources and programs.
- Factors such as housing instability, food insecurity, and economic stressors significantly impact mental health. Addressing these social drivers is essential to improve overall mental health outcomes.
- Substance use disorders, including vaping and drinking, are prevalent among the youth. The use of substances is often a coping mechanism for stress, family conflicts, and economic worries.

More on Housing Instability as a Top Issue:

- High cost of living and limited availability of affordable housing contribute to financial instability. This financial strain forces many families into overcrowded and substandard living conditions, exacerbating mental health challenges and increasing stress levels.
- A recurring theme was the direct connection between housing stability and access to health services. Interviewees noted that individuals worrying about their housing situations often prioritize immediate survival needs over seeking medical or mental healthcare. This displacement of priorities can lead to untreated health conditions and a decline in overall community health.
- The housing crisis impacts families at risk of or experiencing homelessness. Long-term solutions are needed, including more affordable housing units and supportive services.
- Interviewees also discussed the impact of socioeconomic factors on housing stability, such as employment and transportation. They emphasized that without access to stable housing, families are unable to prioritize health or follow through with care recommendations. These factors contribute significantly to long-term health outcomes for children and their families.

More on Access to Care as a Top Issue:

- One of the most significant problems faced by patients is the lengthy wait times for appointments. This can be particularly frustrating for those seeking specialized care or urgent medical attention. The shortage of healthcare professionals in certain areas exacerbates this issue, leading to delays in receiving necessary treatments and interventions.
- Patients often struggle to find providers who accept their insurance plans or who are located within a reasonable distance. This issue is compounded by the complexity of insurance networks and the frequent changes in provider availability. Many patients find themselves spending an inordinate amount of time searching for a suitable healthcare provider, which can delay access to care.
- There are significant geographic disparities in healthcare services, with urban areas typically offering better access to medical facilities and professionals compared to rural regions. This disparity means that individuals living in less populated areas may have to travel long distances to receive care, which can be especially challenging for those without reliable transportation. Additionally, the concentration of specialized services in urban centers leaves rural populations at a disadvantage when seeking advanced medical treatments.
- The complexity of the healthcare system itself poses a significant barrier. Patients often experience difficulties understanding their insurance coverage, obtaining necessary authorizations, and navigating the referral process for specialized services. Health literacy plays a crucial role in this context; individuals with lower health literacy may struggle more to advocate for their healthcare needs and to utilize available services effectively.
- Economic disparities further complicate access to healthcare. High out-of-pocket costs, co-pays, and deductibles can deter patients from seeking timely medical attention.

Families with limited financial resources may prioritize immediate survival needs such as housing and food over healthcare, leading to untreated conditions and poor health outcomes.

- Transportation is another critical issue affecting access to healthcare. Inadequate public transportation options and long travel times can prevent individuals from attending medical appointments. This is particularly problematic in regions with limited healthcare facilities, where patients may need to travel significant distances to receive care.

Issues Identified related to Social Drivers of Health

- Health education levels influence health outcomes, with a lack of awareness and understanding about preventive health measures leading to late diagnoses. Gap in communication between healthcare providers and patients, noting that patients often feel they are not given enough information unless they ask probing questions. This lack of communication can lead to late-stage diagnoses and poorer health outcomes.
- Issues like wildfires contribute to stress and health hazards, particularly for children and families living in affected areas.

Population Identified that Experience Disproportionate Impact of these Health Issues/Topics

The most frequently noted populations include:

1. Low-income individuals and families
2. Immigrant populations
3. LGBTQ2IA+ community

All the populations described/discussed across the key informant interviews:

- Low-income children and families
- Teenagers (ages 11-17)
- Non-English speakers
- LGBTQ2IA+ youth and their families
- People of color
- Residents of urban areas (especially Santa Ana and Anaheim)
- Neurodivergent individuals
- Residents who depend on public transportation
- Undocumented individuals and mixed-status families
- Housing-insecure families
- Racial and ethnic minority groups
- Children experiencing food insecurity
- Asian and Pacific Islander communities
- Immigrant and refugee populations
- Youth and young adults

- Pregnant and parenting women
- Arabic and Farsi speaking families
- Children with autism
- Children facing acute mental health crises
- People with disabilities

More on Low-Income individuals and families:

- Financial constraints severely limit their ability to afford essential healthcare services. Many low-income families lack adequate health insurance, which restricts their access to preventive care, timely medical treatments, and necessary medications. This financial barrier often results in delayed diagnoses and treatment of medical conditions, leading to more severe health issues over time.
- High cost of living, particularly in regions like Orange County, exacerbates these health disparities. Families living paycheck to paycheck must prioritize necessities such as food, shelter, and utilities over healthcare expenses. This economic strain contributes to housing instability and food insecurity, both of which have direct negative impacts on physical and mental health.
- Transportation and childcare issues further complicate access to healthcare for low-income families. Limited public transportation options and inflexible work schedules make it difficult for these individuals to attend medical appointments. Many parents do not have paid leave, so seeking medical care often means losing income, which they cannot afford.
- Low-income communities frequently reside in areas with fewer healthcare facilities and providers. This lack of accessible and culturally competent healthcare services means that even when individuals attempt to seek care, they face long wait times and difficulty finding providers who understand and respect their cultural and linguistic needs.
- Systemic barriers, including a shortage of providers equipped to meet the specific needs of marginalized families, further compound these challenges. Historical exclusion and discrimination have led to a deep mistrust of healthcare systems among some low-income and immigrant populations, deterring them from seeking necessary care.

More on Immigrant Families

- Historical exclusion and past experiences of discrimination or neglect have led to a deep mistrust of healthcare systems among many immigrant families.
- Language barriers, including non-English spoken languages and limited health literacy, further exacerbate these issues, making it difficult for immigrants to navigate the healthcare system and access necessary services.
- Significant gap between the services that are technically available and what is accessible or trusted in immigrant communities.
- lack of representation within the service provider workforce, which can result in culturally insensitive care and a lack of understanding of immigration-related trauma. Immigrant families may encounter providers who are unfamiliar with their cultural norms, leading to a sense of alienation and underutilization of vital health programs.

More on LGBTQ2IA+ Children and families:

- Face barriers such as discrimination, stigma, and a lack of culturally competent healthcare providers, which can deter them from seeking necessary medical care.
- Healthcare providers may lack the necessary training to understand and address the specific health needs of LGBTQ2IA+ patients, including hormone therapy for transgender individuals, HIV prevention and treatment, and the unique aspects of sexual health. This lack of understanding can lead to inadequate care and poorer health outcomes.
- LGBTQ2IA+ individuals, especially those from low-income backgrounds or marginalized communities, may encounter the same systemic barriers that affect other disadvantaged groups, such as inadequate access to health education, preventive care, and supportive services. For example, an LGBTQ2IA+ person with limited financial resources may struggle to afford gender-affirming treatments or face challenges in finding a provider who respects their gender identity.

Emerging Threats

The top three emerging threats *(most frequently discussed)*

1. Climate Change: The impact of climate change on health, including extreme weather events like wildfires and snowstorms, and its influence on the spread and prevalence of infectious diseases.
2. Mental Health: The increasing prevalence of mental health issues, particularly among children and adolescents, exacerbated by the COVID-19 pandemic and socioeconomic disparities.
3. Political Climate: The current political climate is creating barriers to improving public health, with concerns over potential decreases in funding, changes in healthcare policies, and anti-LGBTQ legislation affecting mental and physical health.

All the emerging threats described across the key informant interviews:

- Impact of fentanyl and drug issues
- Mental health impacts from the pandemic
- State budget issues affecting public resources for healthcare services
- Potential changes in education regulations regarding vaccinations; Uncertainty surrounding vaccinations and public health impact; Vaccine hesitancy and misinformation
- Political climate and anti-LGBTQ2IA+ legislation
- Reduction in funding for HIV testing and gender-affirming care
- Changes in Medicaid and Medi-Cal systems
- Loss of funding for prevention and early intervention programs
- Wildfires and their health implications
- Homelessness among students
- Food insecurity
- Economic and political instability

- Healthcare funding cuts
- Nitrous oxide misuse
- Type 2 diabetes among students
- Fear of accessing services in mixed immigration households
- Unemployment or underemployment
- Childcare access issues
- Mistrust in medical advice
- Long waitlists for autism evaluations
- Misconceptions about autism treatments
- Environmental hazards like lead in soil
- Proximity to freeways and asthma cases
- Workforce shortages in healthcare
- Climate change and its health impacts
- Cyber attacks on healthcare systems
- High travel increases risk of infectious diseases
- Rollback of COVID-19 safety protocols
- Worsening housing crisis

More on Climate Change as an Emerging Threat

- Spread of Infectious Diseases: Concerns expressed about how climate patterns can alter the distribution of vectors like mosquitoes and ticks, potentially leading to an uptick in diseases such as malaria, dengue, and Lyme disease.
- Extreme Weather Events: The increasing frequency and intensity of wildfires, hurricanes, and heatwaves pose direct threats to human health, safety, and infrastructure.
- Air Quality: Higher temperatures and changes in weather can worsen air pollution, exacerbating respiratory issues like asthma and other chronic pulmonary diseases, especially in vulnerable populations.
- Water Quality and Supply: Climate change can disrupt water systems, leading to both shortages and contamination issues. This can have profound effects on both rural and urban communities, affecting drinking water, agriculture, and sanitation.
- Mental Health: The psychological impact of climate-related disasters and the anxiety associated with climate change predictions can lead to increased stress, depression, and other mental health issues.
- Food Security: Changes in weather patterns can affect crop yields and food production, leading to food shortages and increased prices, which disproportionately impact low-income populations.
- Displacement and Migration: Rising sea levels and environmental degradation can lead to displacement and forced migration, creating additional social and health challenges for affected populations.

More on Mental Health as an Emerging Threat:

- Mental health has emerged as a critical issue, particularly in the wake of the COVID-19 pandemic. The isolation, financial instability, and general uncertainty brought by the pandemic have exacerbated pre-existing mental health conditions and triggered new ones in many individuals.
- Noted a significant increase in anxiety, depression, and other mental health disorders across all age groups, but particularly among children and adolescents. They highlighted the urgent need for accessible mental health services and resources to address this growing crisis
- Stigma surrounding mental health remains a considerable barrier, preventing many from seeking the help they need.
- Concerns about the mental health impacts of recent political and social changes, including anti-LGBTQ2IA+ legislation and policies. These changes have created additional stress and fear among LGBTQ2IA+ individuals, further highlighting the need for inclusive and supportive mental health services.
- Socioeconomic disparities were cited as a major contributor to the mental health crisis, with vulnerable and underserved populations experiencing higher rates of mental health problems and limited access to care. The lack of affordable and reliable transportation further complicates access to mental health services for these groups.
- The shortage of mental health professionals and the long waitlists for services were identified as significant obstacles.

More on the Political Climate:

- Politicization of health issues, particularly vaccinations, has created barriers to improving child and family health. They noted the need to depoliticize these issues to achieve better public health outcomes. Informants pointed out that the discourse around vaccinations has become highly polarized, leading to decreased vaccination rates and heightened risk of preventable diseases. They stressed the importance of addressing misinformation and fostering trust in medical advice to counteract these negative trends.
- Potential reductions in healthcare funding and changes to essential programs like Medicaid. They emphasized that cuts to Medicaid would have severe consequences for vulnerable populations, who rely on these services for their survival. The uncertainty surrounding these changes creates fear and anxiety among individuals who depend on consistent healthcare support.
- Contributed to an increase in anti-LGBTQ2IA+ legislation, which informants identified as a growing threat to mental and physical health. Policies aimed at restricting gender-affirming care have caused significant stress and fear among LGBTQ2IA+ youth, highlighting the need for stable and inclusive healthcare policies.

County Assets or Strengths

The Top Three Assets and Strengths *(most frequently discussed)*

1. Strong Collaboration and Partnerships: The collaborative efforts between various organizations, including community-based organizations, healthcare providers, and public agencies, are frequently highlighted as a significant strength. These partnerships and coalitions work together to address community needs effectively.
2. Community Engagement and Involvement: The active involvement and engagement of community members in identifying their own health needs and participating in health initiatives are seen as crucial assets. This engagement leads to more sustainable and effective health interventions.
3. Diverse and Culturally Competent Service Providers: The presence of a passionate network of nonprofit organizations, grassroots advocates, and culturally competent service providers deeply embedded in the communities they serve is recognized as a major strength. These providers offer mental health support, food distribution, health navigation, and culturally relevant outreach.

All the assets and strengths described across the key informant interviews:

- Strong collaboration among community partners, including nonprofit organizations, grassroots advocates, and culturally competent service providers.
- Highly engaged resident groups in cities like Santa Ana, Garden Grove, and Anaheim.
- Trusted organizations such as Latino Health Access, Cambodian Family, Abrazar, Samina, Radiant Health (LGBTQ2IA+ focus), and the Kennedy Commission on Housing.
- Public health promotion networks and behavioral health initiatives like Be Well OC providing mental health and substance use support.
- Community Health Worker Initiative by CalOptima facilitating home visits for preventive care education.
- Programs focus on building social connections and providing comprehensive support like the transitional age youth drop-in center.
- CalOptima's Enhanced Care Management (ECM) and funding support initiatives including school district initiatives and campus clinics providing healthcare information.
- Strong ties and collaborative efforts between local businesses and nonprofits.
- Healthcare Institutions like Rady Children’s Health Orange County and their outreach initiatives.
- Improved data sharing and utilization among schools, hospitals, and other organizations.
- Collaborative efforts focused on increasing developmental screenings, improving access to well-child visits, and addressing substance use in families.
- Strong collaboration among county, CalOptima, Kaiser, and other public institutions, including experienced health professionals with institutional and historical knowledge.
- Robust safety nets, particularly in North and Central regions.
- High level of managed care settings (both Medicaid and commercial HMO).
- Strong coalitions and collaborative efforts in health arenas.
- Significant philanthropic base raising millions of dollars for health programs.

- Community recognition and identification of health needs driving effective health interventions.
- State support for public health initiatives beneficial for health program implementation.
- Emphasis on using data and scientific evidence to inform health policies.
- Strong dedication and commitment from hospital systems to public health agencies.
- Presence of major healthcare assets like Rady Children's Health Orange County and the Orange County Health Care Agency.

More on Strong Collaboration and Partnerships:

- Community groups and advocacy organizations work together effectively to address health concerns, enabling better support and resources for health issues.
- There is significant emphasis on collaboration between county agencies, community-based organizations, and healthcare providers, allowing for comprehensive support.
- Collaborations between local health centers and LGBTQ2IA+ organizations have resulted in more comprehensive care services.
- There are formal and informal networks among health providers, the Health Department, and community-based organizations that facilitate the sharing of resources and information. These networks are crucial for coordinating efforts and ensuring that services reach those in need efficiently.
- The county's efforts to improve access to healthcare services, including through partnerships with local health centers and schools, have been pivotal. Initiatives like school-based health programs and mobile health units ensure that healthcare is accessible to all community members.
- The involvement and participation of Rady Children's Health Orange County in these collaborative efforts have been crucial for improving health outcomes.
- Engagement and awareness among the Board of Supervisors and legislators about the importance of behavioral health have been pivotal.
- Strong partnerships with community organizations like the Illumination Foundation and Boys and Girls Clubs facilitate the provision of health services directly within communities.
- Numerous collaborative partnerships with health organizations, community based organizations, nonprofits, and places of worship enhance support efforts.
- Engagement in community events and promoting education, awareness, and visibility are key strategies in these collaborative efforts.

More on Community Engagement and Involvement:

- The collective resilience of the community, particularly among communities of color, was acknowledged. Despite facing numerous challenges, these communities demonstrate a remarkable capacity to mobilize, advocate for their rights, and implement strategies for wellness and health improvement.

More on Diverse and Culturally Competent Service Providers:

- The informants highlighted several examples of successful culturally competent initiatives. For instance, community health workers who are members of the communities they serve are invaluable in promoting health education, preventive care, and early intervention. These workers understand the specific challenges and barriers their communities face and can tailor their approaches accordingly.
- Noted the commitment to diversity and cultural competence among service providers in Orange County as a cornerstone of the county's strategy to improve health outcomes and ensure equitable access to care for all its residents.

County Gaps Discussed

The Top Three County Gaps (most frequently discussed)

- **Funding Limitations:** A recurring challenge is the lack of adequate funding to support essential programs and initiatives. This includes resources for health education, workforce compensation, and comprehensive services.
- **Workforce Shortages:** There is a critical shortage of healthcare and public health professionals, particularly those who are bilingual, bicultural, or disability competent. This shortage impacts the delivery of quality care and the ability to meet diverse community needs.
- **Cultural and Linguistic Competency:** There is a significant need for cultural and linguistically appropriate care to adequately serve the diverse populations within the county. This includes providing translation services, culturally relevant health education materials, and engaging trusted community figures.

All County Gaps Described Across the Key Informant Interviews

- Inadequate financial resources to support necessary programs and initiatives.
- Lack of skilled healthcare and public health workers, leading to high turnover and burnout.
- Difficulty in finding and accessing healthcare services, especially for those not in crisis.
- Inefficiencies in data sharing and integration among different agencies and healthcare providers.
- Need for more culturally and linguistically appropriate care and services.
- Heavy administrative burden due to increasing regulatory requirements.
- Impact of political decisions and policies creating fear and anxiety among immigrant communities.
- Lack of effective collaboration among various agencies, leading to redundant efforts.
- Challenges in accessing services due to limited transportation options.
- Over-surveying the community without providing meaningful feedback or action.
- Need for ongoing education, particularly in culturally competent care.

More on Funding Limitations

- Expressed concerns over the uncertainty of federal and state budgets, which significantly impacts the availability and accessibility of healthcare services. This financial constraint makes it difficult to meet the growing needs of the community and hampers efforts to provide comprehensive care.
- Noted a significant funding disparity between general medical services and behavioral health services. Behavioral health services receive much less funding despite the increasing demand, leading to unsustainable caseloads and insufficient resources for mental healthcare.
- Interviewees also highlighted that funding for prevention programs is often short-term, which undermines their effectiveness. There is a need for sustained investment in these programs to ensure long-term benefits.
- Many community organizations and coalitions struggle with limited financial resources to support their initiatives. This lack of funding affects their ability to purchase health education materials, provide culturally competent care, and address transportation, housing, and economic disparities.
- The allocation of funds is sometimes misaligned, with excessive resources devoted to immediate medical care rather than addressing social drivers of health such as housing, food, and education. Correcting this imbalance is crucial for providing holistic care and improving overall health outcomes.

More on Workforce Shortages:

- One of the most pressing concerns was the difficulty in finding and retaining qualified frontline workers. The low wages and lack of sustainability in positions contribute significantly to high turnover rates, making it challenging for agencies to maintain a stable workforce.
- Informants pointed out the need for more uniform training and expertise among community-based organizations. Gaps in training can lead to inconsistencies in service delivery, which affects the overall quality of care provided to the community. There is a call for comprehensive educational frameworks to ensure all healthcare providers, including front office staff, are adequately trained and understand the importance of their roles.
- The shortage of specialized healthcare professionals, such as mental health providers, nurses, and culturally competent staff. This shortage limits the capacity to address diverse healthcare needs effectively. Informants stressed the importance of investing in culturally and linguistically appropriate care to serve the diverse populations adequately.
- Bureaucratic processes and non-competitive salaries are significant barriers to hiring and retaining experienced professionals. The increasing regulatory requirements and the need to demonstrate compliance place a heavy administrative burden on the behavioral health system, diverting resources away from direct patient care.
- Shortage of credentialed school nurses in districts like Capistrano Unified was specifically mentioned, leading to an over-reliance on less qualified personnel and higher

911 call rates. This situation underscores the urgent need for more skilled healthcare workers in educational settings to ensure the safety and well-being of students.

- Informants emphasized the necessity of long-term investment in prevention programs and sustainable funding for nonprofits working on the ground. Short-term funding undermines the effectiveness of these programs and contributes to workforce instability. Sustainable investment and commitment to prevention are vital for addressing workforce shortages and improving community health outcomes.

More on Cultural and Linguistic Competency

- One of the main points raised during the interviews was the urgent need for healthcare providers to offer culturally appropriate care. This involves understanding and respecting the diverse cultural backgrounds of patients, which can significantly influence their health beliefs and behaviors. Informants emphasized that culturally appropriate care is not just about language translation but also about understanding cultural nuances, traditions, and values.
- More healthcare materials should be available in multiple languages, and interpretation services should be more than just word-for-word translations; they should also be culturally sensitive. The need for more bilingual and bicultural healthcare providers was strongly emphasized, as this helps bridge the communication gap and builds trust between patients and providers.
- Despite the recognized importance of cultural and linguistic competency, informants pointed out several challenges in implementing these programs. One major challenge is the lack of funding and resources to train healthcare providers adequately. Additionally, there is often a shortage of qualified interpreters and bilingual staff, which can lead to miscommunication and dissatisfaction among patients.

Appendix G: Survey Respondent Demographics

Table A. Survey Respondent Types

Respondent Type	Count	%
Caregivers (n=741)		
Parent or Caregiver	564	49.1%
Young adult who is between 18 - 24 years of age	135	11.7%
Foster Parent or Caregiver	42	3.7%
Providers (n=385)		
Healthcare Professional (physical/medical, behavioral/mental, oral/dental)	221	19.2%
Service Provider (social worker, school nurse, home visitor, school-based professional, etc.)	164	14.3%
No response	23	2.0%
Total	**1,149**	

Source: Children's Health Survey, 2025

Table B. Survey Provider Respondent Types

Provider type (PH, medical, childcare, etc.)	Count	%
Community service provider (e.g., social worker, home visitor, infant-toddler specialist)	92	24%
Healthcare professional (e.g., physical/medical, behavioral/mental, oral/dental)	163	42%
Physician	56	36%
Advanced Practice Nurse Practitioner	10	6%
Behavioral Health Professional	57	32%
Dental Provider	3	2%
Other, please describe.	37	24%
Local public health department	6	2%
School nurse	48	13%
Educator (e.g., administrator, teacher, school-based preschool/after school care, Head Start, or other school-based professional)	57	15%
Childcare provider	9	2%
Other, please describe	10	3%
Total	385	24%

Note: Healthcare professionals were asked to clarify their specific role as designated in blue. The blue text is not included in the total count. Source: Children's Health Survey, 2025

Table C. Respondent Age of Child(ren) Cared for by Survey Respondent Type

Combined Provider and Caregiver Age Groups	**Count**	**%**
Early childhood (1-5 years old)	446	40%
Adolescence (11-17 years old)	494	44%
Prenatal, Perinatal, and Infant (prenatal-1 year of age)	231	21%
Young adulthood (18-24 years of age)	345	31%
Middle childhood (6-10 years of age)	429	39%
I am a young adult and am answering on behalf of myself (I do not have any children)	51	5%
Children (birth to 24 years of age) with significant healthcare needs	165	15%
Provider: Age Groups	**Count**	**%**
Adolescence (11 - 17 years of age)	**245**	**65%**
Middle childhood (6 - 10 years of age)	190	51%
Young adulthood (18 - 24 years of age)	185	49%
Early childhood (1 - 5 years of age)	173	46%
Infancy (newborns up to 1 year of age)	102	27%
Children (birth to 24 years of age) with significant healthcare needs	98	26%
Caregiver: Age Groups	**Count**	**%**
Young children (1 - 5 years of age)	**273**	**37%**
Children (11 - 17 years of age)	249	34%
Children (6 - 10 years of age)	239	32%
Young adults (18 - 24 years of age)	160	22%
Newborn or infant (birth up to 1 year of age)	111	15%
Children (birth to 24 years of age) with significant healthcare needs	67	9%
I am a young adult and am answering on behalf of myself (I do not have any children)	51	7%
Pregnant patients and their unborn children	18	2%

Appendix H: Secondary Data on Other Areas of Interest

Table A. Early Learning Opportunities and Success in School

Academic Achievement	• Third Grade Academic Achievement: In 2023, 56% of third graders met or exceeded math standards and 52.7% met or exceeded English Language Arts (ELA) standards, both higher than the statewide averages. • Achievement Disparities by Economic Status: Only 40% of socioeconomically disadvantaged third graders met ELA standards and 38% met math standards, compared to 75% and 71% of their more advantaged peers. • Highschool Dropout Rates: Orange County's high school dropout rate decreased from 5.3% in 2017 to 4.8% in 2023, remaining well below the state average of 8.2%. • Highschool Dropout Rates Among Vulnerable Groups: Students in foster care (16.9%), migrant education (14.6%), and homeless youth (10.7%) had significantly higher dropout rates than the county average, and these rates have increased since 2022.
Early Learning	• Preschool Enrollment: While Orange County's preschool enrollment rate (53.7%) remains higher than California's (44.4%), it has not improved since 2014–2018 and is significantly lower than desired. • Kindergarten Readiness: The percentage of children developmentally ready for kindergarten increased from 48.2% in 2013–2015 to 53.0% in 2025, showing progress in early childhood development. • Kindergarten Readiness Race/Ethnicity Gaps: In 2025, Hispanic/Latino (42.8%) and Black/African American (45.7%) children had the lowest kindergarten readiness rates, compared to Asian (64.9%) and White (61.9%) children.
Chronic Absenteeism	• Chronic Absenteeism: Chronic absenteeism rose to 20.5% in 2023, more than doubling since 2021 (9.2%). Rates are highest among kindergarteners, high school students, and vulnerable groups like foster youth (39%) and insecurely housed youth (33.2%).

Sources include California Department of Education, DataQuest; First 5 Orange County Early Development Index (EDI), U.S. Census, American Community Survey.

Maternal, Infant, and Child Health

According to Healthy People 2030, improving the well-being of mothers, infants, and children is an important public health goal for the United States. Monitoring their well-being helps to predict future challenges in community health. Access to maternal and infant healthcare can help mitigate health risks and promote positive outcomes.[61]

Table B: Maternal and Infant Health

Births	In 2023, there were 29,866 births to residents in Orange County, which is a 17.0% drop from 34,963 in 2019. The largest proportion of births were among people ages 30–34 years (36.2%), followed by 35-30 years (24.9%), 25–29 years (20.9%), and 20-24 years (9.1%). Births to teens ages 15–19 years was 2.0%.
Prenatal Care	In 2023, Orange County's rate of infants born to people who received early prenatal care was 90.2%. This rate was higher than the previous 10-year high of 88.7% in 2011 and remained higher than California (84.5%) in 2023.
	Among infants born to people who received early prenatal care, 93.8% of White/Caucasian, followed by Asian (92.8%), Other race (91.6%), Hispanic or Latino (87.1%), Black/African American (86.0%), and Native Hawaiian or other Pacific Islander (75.8%) infants received early prenatal care.
Low Weight Births	In 2023, there were 29,866 births to residents in Orange County, of which 7.4% (2,212) were low birth weight infants, the highest percentage in the last 10 years.
	Overall, the Orange County low birth weight rate remained lower than the 2023 rates for California (7.5%) and the U.S. (8.6%). Preterm births were at a 10-year high in both California and the U.S.
	By race/ethnicity, the percent of low birth weight infants within each group were: Black (13.6%), Native Hawaiian or Other Pacific Islander (10.8%), Asian (8.5%), Hispanic (7.7%) and White (6.0%) infants. Percent of low birth weight infants increased for all race/ethnicities between 2022 and 2023.
Pre-term Births	Preterm births accounted for 8.8% of births to Orange County residents in 2023. By comparison, the rate for the United States was higher at 10.4% as was the rate for California (9.2%).

[61]All Maternal, Infant and Child Health data were provided by the Orange County Health Care Agency, Family health Division unless otherwise noted.

	The percentage of preterm births in Orange County was highest among Native Hawaiian or Other Pacific Islander infants (15.4%), followed by Black infants (11.3%), Hispanic (10.1%), Asian (7.8%) and White (7.8%) infants. The percentages increased for infants across all races compared to 2022 except Black infants and Asian infants, which both decreased.
Breastfeeding	In 2022, 67% of Orange County women were exclusively breastfeeding at time of hospital discharge compared to 68.5% of women in California. The rate was similar compared to 2020 (67.6%)
	Exclusive breastfeeding at time of discharge was highest among White/Caucasian women at 79.9%, followed by multiracial (74.5%), Black (72.6%), Hispanic or Latino/a (61.6%), Asian (59.3%), and Pacific Islander (56.8%) women.
	Exclusive breastfeeding three months after delivery decreased in 2021-2022 to 26.0%, compared to a rate of 38.8% in 2018/19.
Child Immunization	In 2023, 99.0% of Orange County children in childcare centers had up-to-date immunizations (4:3:1 schedule) at their time of enrollment, compared to 87.6% in 2013.
	In 2023, 95.6% of Orange County kindergartners had up-to-date immunizations, a 7.8% increase from the 10-year low of 88.7% in 2013.
	Capistrano School District had the lowest % of kindergartners with up-to-date immunization levels at 92.5% in 2023, followed by La Habra School District (94.2%). Cypress School District had the highest % of kindergartners with up-to-date immunization levels at 98.7%.
Oral Health	Among Orange County youth ages 3 to 11 years, in 2023, 77.8% had visited a dentist within the previous 6 months. In 2020, this rate was lower, at 62.7%.
Infant Mortality	In 2023, there were 102 infant deaths in Orange County. The infant mortality rate was 3.2 deaths per 1,000 births in 2023, a decrease from recent years, but an overall increase from 3.0 in 2014. This rate was lower than California's 2023 rate of 4.12 and the United States' rate of 5.6.
	Average infant mortality rates in 2021-2023 decreased from 2018-2020 in Native Hawaiian or Other Pacific Islander (4.6%) and Black (4.5%) infants but increased in Hispanic (4.1%), Non-Hispanic White (3.1%), and Asian (2.2%) infants.

Child Mortality	There were 113 deaths for children and adolescents ages one to 19 years in Orange County in 2023. The mortality rate was 15.4 deaths per 100,000 children and adolescents.
	In 2023, the rate of overall deaths related to injury for Non-Hispanic White children and adolescents was 8.6 per 100,000 children. For Hispanic children and adolescents, the rate was 8.3 and for Asian it was 7.2. The rate for Native Hawaiian or Other Pacific Islander and African American/Black children and adolescents was unstable due to the small number of deaths.

Sources include Orange County Health Care Agency, California Department of Public Health, Immunization Branch, UCLA California Health Interview Survey, California Department of Public Health, Center for Family Health, Maternal, Child and Adolescent Health Division, Breastfeeding Initiation Dashboard, August 2024.

Teen Sexual Health

The World Health Organization defines sexual health as a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. In 2017-2018, 87.1% of California teens had never had sex. This increased from 81.7% in 2011-12. Orange County estimates are not available.

Table C. Teen Sexual Health

Teen Birth	In 2023, 2.0% (599) Orange County births were to teens ages 19 years and younger, a 16.5% decrease from 698 births in 2020.
	In 2023, 91.9% of California teens had never had sex and 91.6% Orange County teens. This was an increase from 2020 for both 87.9% and 83.0% respectively.
	At 6.2 births per 1,000 teens (ages 15-19), Orange County has a lower teen birth rate than California (8.1) in 2023. Both rates have decreased since 2020, from 6.9 and 11.0 births per 1,000 teens, respectively.
	In 2023, Hispanic or Latina/o teens had the highest birth rate (11.7 births per 1,000 teen females), followed by Black/African American (7.8), White/Caucasian (1.9), and Asian (0.4) teens in Orange County. Teen birth rates in Orange County have increased for all races and ethnicities compared to 2022, except Native Hawaiian or Other Pacific Islander and Asian infants.
Sexually Transmitted Infections	In 2023, there were 175.8 cases of chlamydia per 100,000 youth ages 10-17 years, which was a 5.5% increase from a rate of 166.7 per 100,000 youth in 2020. The number of cases in 2023 was 563, up from 544 cases in 2020.
	In 2023, there were 34.7 cases of gonorrhea per 100,000 youth ages 10-17 years, which was a 2% decrease from a rate of 35.4 per 100,000 youth in 2021. There were 111 cases of gonorrhea in 2023, down from 114 in 2021. All gonorrhea cases were among youth ages 15-17 years.

Sources include Orange County Health Care Agency

Appendix I: Community Context Supporting Survey Data Tables

Table A. Most Important Protective Factor by Survey Respondent Type

	Protective Factors		Notable Differences Between Caregiver and Provider Survey Respondents		Notable Differences Between Regions		
		All	Caregivers	Providers	South	North	Central
1	Able to get healthcare providers	59%	58%	62%	55%	60%	60%
2	**Able to get mental health services**	47%	**41%**	**61% +**	44%	49%	48%
3	Low-crime and safe neighborhoods	41%	42%	39%	41%	39%	42%
4	Healthy food and close grocery stores	39%	40%	38%	34%	40%	43%
5	**Affordable housing**	34%	**31%**	**40% +**	29%	34%	37%
	Able to get dental care	31%	**34% +**	**25%**	29%	33%	31%

+Significant difference between caregiver and provider respondents. Source: Children's Health Survey, 2025

Table B. Most Important Risk Factors by Survey Respondent Type

	Risk Factors		Notable Differences Between Caregiver and Provider Survey Respondents		Notable Differences Between Regions		
		All	Caregivers	Providers	South	North	Central
1	Absence of positive adult role models for children	47%	43%	54%	39%	**53%***	45%
2	Bullying, including cyberbullying	37%	38%	37%	38%	39%	35%
3	Poor eating habits (e.g., fast food, junk food)	31%	29%	34%	27%	30%	35%
4	**Community violence (e.g., gang violence, homicide)**	26%	25%	29%	18%	25%	**31%***
5	Not getting regular health screenings	24%	25%	21%	21%	25%	26%
	Social media, including excessive or inappropriate use	22%	**19%**	**27% +**	26%	19%	20%
	Discrimination or racism	20%	**22% +**	**15%**	22%	18%	21%
	Not getting vaccinated	19%	**21% +**	**16%**	24%	19%	17%
	Homelessness	14%	**12%**	**19% +**	13%	13%	16%

+Significant difference between caregiver and provider respondents.
*Significantly higher than the South Region.
Source: Children's Health Survey, 2025

Table C. Priorities for Community Commitment by Survey Respondent Type

	Priorities for Community Commitment		Notable Differences Between Caregiver and Provider Survey Respondents		Notable Differences Between Regions		
		All	Caregivers	Providers	South	North	Central
1	**Education about behavioral health issues**	52%	49%	**58%+**	49%	51%	55%
2	**Affordable housing**	44%	45%	43%	35%	42%	**51%***
3	**Teamwork between healthcare organizations and community organizations to help families meet their needs**	35%	33%	**40%+**	37%	35%	35%
4	Jobs that pay enough money to support me and my family	33%	36%	29%	27%	32%	40%*
5	Affordable, healthy, and nutritious food	31%	34%	30%	27%	34%	32%
	Programs to prevent substance use or addiction	29%	30%	27%	30%	28%	30%
	Positive activities, services, resources, and programs for youth	27%	27%	29%	26%	28%	28%
	Quality and affordable childcare	23%	24%	22%	22%	23%	24%
	Assistance for families switching to new healthcare providers or finding providers they need	21%	**24%+**	15%	26%	20%	19%
	Help managing disease or chronic health conditions	21%	20%	23%	19%	23%	20%
	School health and wellness programs	20%	19%	23%	19%	22%	20%
	Resources to help families create consistent routine and stable home lives that build child resilience	19%	14%	**28%+**	18%	21%	17%

+Significant difference between caregiver and provider respondents. *Significantly higher than in the South Region. Source: Children's Health Survey, 2025