THE 21ST ANNUAL REPORT ON THE
CONDITIONS OF CHILDREN
IN ORANGE COUNTY
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SPECIAL THANKS TO:

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ABOUT THE ORANGE COUNTY CHILDREN’S PARTNERSHIP

MISSION STATEMENT
Orange County Children’s Partnership is a unified voice that champions health, education, safety and economic stability by advancing more responsive services that effectively meet the needs of children and families in Orange County communities.

This report is sponsored by the Orange County Children’s Partnership (OCCP), a 22-member advisory body made up of public agencies, community agencies and individuals. The OCCP addresses community needs and determines the best return on investment from government funding to improve the conditions of children.

The responsibilities of the OCCP include sharing information on services for wards, dependents and seriously emotionally and/or behaviorally disturbed children; identifying gaps in the service system for high-risk children and their families; and recommending collaborative programs to better serve this population.

The OCCP carries out its work through subcommittees and task forces. In 2015, these included: Emancipation Services; Child Welfare Services Redesign Planning Council; Infant Safe Sleep Collaborative; Foster Youth Education; and High School Completion.

For more information about the priorities, important work and public meetings of the OCCP, please visit: http://ochealthinfo.com/phs/about/family/occp.

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As of 10/2015
The Annual Report on the Conditions of Children marks the 21st consecutive year of examining Orange County through the interrelated and interdependent lenses of health, the economy, education, and public safety. As with past reports, the indicators are presented in four sections – Good Health, Economic Well-Being, Educational Achievement, and Safe Homes and Communities – that contain 24 indicators in total. The definition, findings, and trends of each indicator are presented, along with a discussion of why the indicator is important.

This published report is part of a larger document, which includes an online version with a Quick Guide, and extensive supplemental data and indicators. Together, they provide powerful tools to identify, understand, and highlight trends in the conditions of children in Orange County. The economic and racial diversity within the county underscores the complexity of its population and the conditions under which its children are living and growing up. Conditions are improving in some areas, while in others, problems have deepened and enormous need remains. The good news is that of 24 measures, 13 measures with trend data show signs of improvement. In many cases, however, racial, ethnic, and geographic disparities persist.

Among the 11 measures of Good Health, five reveal improvement, with a notable 46.0% decrease in the teen birth rate since 2004. In contrast, the hospitalization rate for mental illness and substance abuse increased 25.6% in the last 10 years to nearly one in four hundred children.

Among measures of Economic Well-Being, only one of the five measures, child support distribution, shows signs of improvement. It is important to note that while these measures, such as the number of beneficiaries of CalWORKs, CalFresh, and Free and Reduced Price Lunch Price Programs, positively reveal that more children are accessing these benefits, they are used in this report as an indicator of poverty and thus have been identified as needing improvement due to the increasing number of beneficiaries. Notably, the percent of current child support distributed in Orange County has increased 23.7% to 66.7% in 2014/15, surpassing California at 64.9%. One area of concern is the increase in students insecurely housed, which has increased eightfold since 2004/05 to 6.5% of students.

Both measures within Educational Achievement are improving across all races and ethnicities. The percent of high school dropouts has decreased by nearly half (45.5%) since the 2009/10 school year to a current low of 6.7%, and college readiness among high school graduates has increased 26.4%. Despite these improvements, a deeper look reveals that disparities among different race and ethnic groups persist. For example, among students who are deemed college-ready, despite having the largest proportion of graduates, Hispanic students were least likely to be college-ready.

Among the six measures of Safe Homes and Communities, five are improving, indicating that Orange County is becoming a safer place for children to live. Again, while there is measurable improvement, the racial and ethnic divide persists. For example, Hispanic youth comprised 75.0% of juveniles who were arrested and received a formal court hearing.

In summary, this report makes data about children, youth and families of Orange County accessible and relevant to the public for use in research, as a call to action and to strengthen the collaborative efforts of the OCCP to improve conditions for children in Orange County. By shining a light on the status of children and families, it highlights issues that need to be addressed, measures progress toward healthier outcomes, and allows celebration of victories along the way.
THE WORK OF THE ORANGE COUNTY CHILDREN’S PARTNERSHIP

The OCCP is working to draw attention to and address areas of need in Orange County. In 2015, OCCP focused on several specific needs, including:

The Commercially Sexually Exploited Children [CSEC] population is a focus of OCCP because the children most at risk of exploitation, or those who are currently being exploited, often go unnoticed. OCCP is a part of a multidisciplinary collaboration that includes the Orange County Human Trafficking Task Force, the State of California, Orange County Social Services Agency, and other partners to ensure a holistic, victim-centered approach to serve the CSEC population via the development of a new protocol and plan. Among many tactics, the approach requires developing education and training of front-line responders, including law enforcement and school professionals, to identify those youth at risk or those youth experiencing sexual exploitation. OCCP is also contributing to the discussion on how best to measure the scope of the problem of CSEC in Orange County, as statistical data on victims, arrests, and convictions need to be more consistent, particularly among youth. OCCP is also working to expand existing data collection protocols to be more inclusive of all at-risk youth and to encourage early detection and prevention.

Mental health transition for youth experiencing serious emotional and mental health issues is an area of focus due to Orange County’s low capacity to house and treat these youth (including juvenile dependents and wards of the courts). All too often, youth are sent out of state to receive treatment, when they would have improved outcomes if closer to family and home. Working with community partners, including Orange County Health Care Agency, Orange County Juvenile Court, Orange County Social Services Agency, Orange County Alliance for Children and Families, and Orange County Probation Department, the OCCP is fostering the development of a new residential treatment facility employing an innovative program model where Health Care Agency staff work on-site to treat youth in an environment where they reside and feel comfortable. While the need for this facility is apparent, the magnitude of the need is unknown. Data collection protocols that expand across youth populations are needed to determine the extent to which youth access, or are in need of, high intensity residential treatment programs.

Increasing child immunization rates in Orange County is one of the most important interventions in preventing a number of infectious and dangerous diseases. The recent measles outbreak in Orange County was a call to action to address the decreasing immunization rates via policy, programmatic, and research and evaluative approaches. A new state law requiring almost all California school children to be fully vaccinated in order to attend public or private school, regardless of their parents’ personal or religious beliefs, will likely spur an increase in rates. Still, OCCP sees a great need for provider and parental education on immunizations to support the law’s implementation. OCCP is working to promote pro-immunization messaging and provide resource materials to those that work with parents to educate parents about the importance of immunizing their child. Additionally, OCCP is promoting Orange County’s immunization registry to ensure health care providers are familiar with and support use of the registry.

Sudden Unexpected Infant Death [SUID] is a focus area led by the Orange County Safe Sleep Collaborative [the Collaborative], a collaboration between OCCP and a number of key community perinatal stakeholders. According to 2010 U.S. data, unintentional suffocation during sleep is by far the leading cause of injury deaths for children under age one. Infant bed-sharing in an adult bed is an identified, increasingly prevalent risk factor for SUIDs. The Collaborative has worked since 2013 to identify opportunities to promote safe infant sleep practices and ultimately reduce infant deaths associated with bed-sharing and other risk factors. An initial area of focus is the development of a new parent and caregiver educational resource that clearly shows what a safe infant sleep environment looks like and identifies avoidable risk factors for SUIDs. This resource is widely available in English, Spanish, and Vietnamese.
Demographics

According to California’s Department of Finance, in January 2015 Orange County’s population numbered 3,147,655, making it the third largest county in California, trailing Los Angeles County (10,136,559) and San Diego County (3,227,496), and ranking as the sixth most populated county in the nation. Orange County has more residents than 20 states, including Mississippi, Utah, and Nevada. Since 2010, Orange County’s population increased by 4.6%. The average annual increase slowed considerably to 1.1% between 2013 and 2014. The population growth is expected to continue at a slower rate with population projections reaching just over 3.4 million by the year 2035.

While natural population increase (births minus deaths) has outpaced migration as the county’s principal source of growth, international immigration – largely from Asia and Latin America – has contributed significantly to Orange County’s growth in the last 30 years, shifting the county’s proportion of foreign born residents from 6% in 1970 to 30.4% in 2013. Between 2013 and 2014, Orange County added 19,219 residents through natural increase and 14,176 residents through net immigration.

Ethnicity and Age

Orange County’s youth population is similarly diverse, albeit with somewhat different proportions than the overall population, according to 2013 American Community Survey estimates. In 2013, Hispanic or Latino youth comprised 47.0% of the total youth population; White youth comprised 31.2%; Asian youth comprised 15.7%; Black youth comprised 1.4%, and All Others at 4.7%.

In 2013, 30.4% of people living in Orange County were foreign born. Among those residents who were at least five years or older, 45.4% spoke another language other than English at home; the majority spoke Spanish (26.3%) followed by Asian/Pacific Islander languages (14.0%).

The median age has risen from 35 years old in 2003 to 36.4 years old in 2013, with 24% of the population under 18 years of age.

Education

In the 2014/15 school year, Orange County public school enrollment was 497,116. The largest racial/ethnic student group in the county was Hispanic or Latino, representing 49.0% of school enrollment, a 7.1% increase since 2004/05. White students comprised the second largest racial/ethnic group, representing 28.0% of students in 2014/15, a decrease of 25.7% since 2004/05. In 2014/15, Asian, Pacific Islander or Filipino students represented 17.7%; Black, 1.4%; American Indian or Alaska Native, 0.4%; and “Other” represented 3.5% of the student population.
Economy
Orange County has a stronger than average regional economy with a Gross County Product reaching $210.9 billion in 2014. The most recent Census data (2013) show that the median family income is $74,163, a 9% decrease from 2012. As of May 2015, the largest labor markets were Professional and Business Services (18.4%), Trade, Transportation and Utilities (16.6%), Leisure and Hospitality Services (12.8%), Educational and Health Services (13.0%) and Manufacturing (10.5%). The five largest employers in Orange County are Walt Disney Company (27,000), University of California, Irvine (22,835), St. Joseph Health (12,227), Kaiser Permanente (7,000), and Boeing (6,890).

Socioeconomics
In February 2015, the unemployment rate for Orange County was 4.7%, lower than California (6.8%) and the national average (5.5%). Poverty, on the other hand, increased in both number and proportion in recent years. As of 2013, 16.9% of children ages 0-17 lived in poverty in Orange County. An estimated 6.5% (32,510) children in the 2013/14 school year were considered homeless according to the statistics prepared by the Orange County Department of Education as required by the McKinney-Vento Homeless Education Assistance Act, an eight-fold increase from 2004/05. In addition, in 2014/15, 49% (243,432) of Orange County’s public school children participated in the Free and Reduced Price Lunch (FRL) program. In order to be eligible for the FRL program, families must not exceed 185% of the Federal Poverty Level. In 2015, the Federal Poverty Level for a household of four was $24,250 compared to $18,850 in 2004. Orange County continues to be among the most inaccessible places to live for low- and moderate-income earners. In April 2015, the median sale price of an existing single-family home in Orange County was approximately $705,190, an increase of 3.7% since April 2014. The minimum household income needed to purchase a median-priced single family home in Orange County is approximately $135,920. Less than half (45%) of households in Orange County can afford an entry-level home in 2015. At 41%, a smaller proportion of Orange County households are renters than California at 45%. Rental housing remains more expensive than that of neighboring counties. In 2015, the fair market rent in Orange County was $1,283 for a one-bedroom apartment, $1,608 for a two-bedroom apartment and $2,250 for a three-bedroom apartment. The hourly wage needed for a household to afford the fair market rent of a one-bedroom apartment was $24.67; for a two-bedroom, $30.92; a three-bedroom, $43.27; and for a four-bedroom, $48.17. A minimum wage earner in Orange County must work 110 hours per week to afford a one-bedroom apartment, compared to the state average of 92 hours per week.

Orange County is considered one of the most densely populated areas in the United States, ranking 19th out of 3,143 counties in the nation. In 2015 the average household size in Orange County was 3.1 persons, larger than California (2.95) and the United States (2.63). The city of Santa Ana had the highest household size in the county at 4.5 persons per household. In addition to Santa Ana, 11 Orange County cities had an average household size higher than the county average, including Garden Grove (3.8), Stanton (3.6), Westminster (3.5), and Anaheim (3.5). Orange County’s population density is 3,942 persons per square mile, an increase of 4.6% since 2010.

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ORANGE COUNTY SNAPSHOT

Economy
- 4.7% unemployment
- Median family income is $74,163
- 16.9% of children live in poverty (123,845)
- 49.0% of public school students receive free and reduced price lunch

Housing
- Median home price is $705,190
- Average apartment rental rate is $1,713
- 6.5% of students enrolled in public schools have insecure housing

UNEMPLOYMENT

<table>
<thead>
<tr>
<th>Year</th>
<th>Unemployment Rate</th>
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<tr>
<td>2005</td>
<td>5.4%</td>
</tr>
<tr>
<td>2015</td>
<td>4.7%</td>
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MEDIAN HOME PRICE AND AVERAGE RENTAL RATE

<table>
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<tr>
<th>Year</th>
<th>Home Price</th>
<th>Rental Rate</th>
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<tr>
<td>2005</td>
<td>$525,000</td>
<td>$1,217</td>
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<tr>
<td>2015</td>
<td>$705,190</td>
<td>$1,713</td>
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Health
- 7.6% of children are uninsured
- Infant mortality rate is 3.3 per 1,000 live births
- 90.0% of children are adequately immunized by kindergarten

% ADEQUATELY IMMUNIZED

<table>
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<tr>
<th>Year</th>
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<tbody>
<tr>
<td>2005</td>
<td>92.7%</td>
</tr>
<tr>
<td>2014</td>
<td>90.0%</td>
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</tbody>
</table>

Population
- 37,256 children are born
- 24.0% of Orange County’s total population are children under age 18 (732,814)
- More than 3.1 million people live in Orange County
- Median age is 36.4

% CHILDREN IN ORANGE COUNTY

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>2005</td>
<td>27%</td>
</tr>
<tr>
<td>2015</td>
<td>24%</td>
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NUMBER OF BIRTHS IN ORANGE COUNTY

<table>
<thead>
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<th>Year</th>
<th>Number of Births</th>
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<tbody>
<tr>
<td>2005</td>
<td>44,065</td>
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<tr>
<td>2013</td>
<td>37,256</td>
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ORANGE COUNTY DEMOGRAPHICS

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>% of Total Population</th>
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<tbody>
<tr>
<td>White</td>
<td>42.6%</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>34.2%</td>
</tr>
<tr>
<td>Asian</td>
<td>19.2%</td>
</tr>
<tr>
<td>Black</td>
<td>2.1%</td>
</tr>
<tr>
<td>All Other</td>
<td>1.9%</td>
</tr>
</tbody>
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Note: Current data reflect the most recent year of data available, ranging from 2013 to 2015.
## Good Health Indicators

### Access to Health Care
- **Percent of Uninsured Children**
  - 2008: 10.9%
  - 2013: 7.6%

### Preterm Births
- **Percent of Preterm Births**
  - 2004: 9.8%
  - 2013: 7.8%

### Obstetric Health
- **Percent of Women Who Received Early Prenatal Care**
  - 2004: 91.7%
  - 2013: 88.3%

### Infant Mortality
- **Rate of Infant Mortality per 1,000 Live Births**
  - 2004: 4.0
  - 2013: 3.3

### Breastfeeding
- **Percent Exclusive Breastfeeding at Time of Hospital Discharge**
  - 2012: 63.1%
  - 2014: 64.6%

### Physical Fitness and Nutrition
- **Percent of 5th Grade Students with Health Risk Due to Body Composition**
  - 2010/11: Data not comparable
  - 2013/14: 18.3%
- **Percent of 5th Grade Students with Health Risk Due to Aerobic Activity**
  - 2010/11: Data not comparable
  - 2013/14: 5.8%

### Infant Mortality
- **Birth Rate per 1,000 Females 15 to 19 Years of Age**
  - 2004: 30.9
  - 2013: 16.7

### Behavioral Health
- **Hospitalization Rate for Serious Mental Illness and Substance Abuse**
  - 2004: 18.0
  - 2013: 22.6

### Low Birth Weight
- **Percent of Infants with Low Birth Weight**
  - 2004: 6.2%
  - 2013: 6.3%

### Immunizations
- **Percent of Children Adequately Immunized by Kindergarten**
  - 2005: 92.7%
  - 2014: 90.0%
Why is this Important?

Improving health care access for all children helps to improve prevention, early diagnosis and treatment of health problems. Children with health insurance are more likely to get timely medical care and prescription medications when they are sick or injured; are more likely to get preventive care (including immunizations, dental care and vision screenings); and, overall, have better health outcomes.

Findings

- In 2013, 7.6% of children were uninsured, a 30.3% decrease from a high of 10.9% of children in 2008.
- With a rate of 10.3% in 2013, Hispanic children are two to three times more likely to be uninsured than children from other racial/ethnic groups, including Asian (7.1%), White (4.7%), and Other (3.0%) groups.
- Uninsured rates of very young children (0-5 years old) have dropped by 37.1% from 8.9% in 2009 to 5.6% in 2013. Similarly, rates of uninsured 6-17 year olds have dropped by 23.2% from 11.2% in 2009 to 8.6% in 2013.
- In addition, the 2014 California Health Interview Survey (pooled estimate for 2011 through 2014):
  - An estimated 59,000 (7.7%) Orange County children annually did not have a usual source of care to go to when they were sick or needed health advice.
  - Approximately 24,750 children (3.3%) experienced a delay or lack of medical care and 31,250 children (4.1%) experienced a delay or lack of needed prescription medications.
  - Most children who had access to a usual source of care went to a doctor’s office (71.6%), while 19.6% went to a clinic or community hospital. The proportion of children who regularly visited an Emergency Department, urgent care center or other location is unknown.¹

¹ Pooled estimates using 2011, 2012, 2013, and 2014 data are used because it resulted in statistically stable percentages. A population average was used to estimate the number of children.
GOOD HEALTH

Percent of Children Uninsured, by Race/Ethnicity
2010 to 2013

Note: Other category includes Black.

Percent of Children Under 18 Years Old Who Were Uninsured, by Race/Ethnicity
2010 to 2013

Note: Other category includes Black.

Percent of Children Under 18 Years Old Who Were Uninsured, by Community of Residence, 5 Year Average, 2013

Source: U.S. Census Bureau, Tables S2701 (2009-2013 data) and B27001 (2008 data)

Source: American Community Survey, 2009-2013, 5 Year Average

Source: American Community Survey, 2009-2013
EARLY PRENATAL CARE

EARLY PRENATAL CARE CONTINUES TO DECLINE AS DISPARITY BETWEEN ETHNICITIES AND RACES WIDENS.

DESCRIPTION OF INDICATOR
This indicator tracks the number and percent of infants born to women whose prenatal care began during the first trimester (the first three months) of pregnancy.

Why is this Important?
Getting early and regular prenatal care improves the chances of a healthy pregnancy, which is one of the best ways to promote a healthy birth. This care can begin even before pregnancy with a preconception care visit to a health care provider. Achieving a healthy birth weight baby is also a preventive and cost-effective approach for reducing health care costs associated with providing neonatal intensive care services for low birth weight babies.¹

Findings
• Overall, the percent of women receiving early prenatal care in Orange County decreased 3.7% in 10 years, dropping from 91.7% in 2004 to 88.3% in 2013. The decrease was reflected among all racial and ethnic groups.
• In 2013, 88.3% of pregnant women in Orange County received early prenatal care, greater than California (82.1%)², and the United States (74.1%)³.
• In Orange County, 92.2% of White women received early prenatal care followed by Asian (88.9%), Hispanic (85.6%), and Black (83.3%) women.
• The disparities between racial/ethnic groups was most pronounced between White women and Black women. In 2004, the difference was 6.1% (95.1% versus 89.0%) and by 2013, the difference increased to 8.9% (92.2% versus 83.3%).

¹ National Institute of Child Health and Human Development, 2013. ² State of California, Center for Health Statistics, Birth Files. ³ Center for Disease Control and Prevention, National Center for Health Statistics. 2012 Nativity File. Data are from D.C. and 38 states that implemented the 2003 revision of the birth certificate as of January 1, 2012, representing 86% of all U.S. births.
Percentage of Women who Received Early Prenatal Care, by Race/Ethnicity
2004 to 2013
- White
- Asian
- Hispanic
- Black

Source: Orange County Health Care Agency

Percent of Women who Received Early Prenatal Care
Orange County and California, 2004 to 2013
- California
- Orange County

Source: Orange County Health Care Agency

Percent of Women who Received Early Prenatal Care, by Community of Residence, 2013

* Laguna Woods had fewer than five births. Rates based on less than five events are unstable and should be interpreted with caution.

Source: Orange County Health Care Agency Family Health Division
INFANT MORTALITY

INFANT MORTALITY RATES DECLINE.

DESCRIPTION OF INDICATOR
This indicator tracks deaths of infants under one year of age. The number of deaths and rate of infant mortality are calculated per 1,000 live births per year.

Why is this Important?
The infant mortality rate is a widely used indicator of societal health because it is associated with maternal health, quality of and access to medical care, socioeconomic conditions and public health practices. Improvements in the infant mortality rate may reflect progress in medical technology, hygiene and sanitation systems, economic well-being and the availability and use of both preventive and clinical health services. Despite the overall declines in infant mortality since 2004, there remain significant disparities among Blacks and Hispanics in Orange County, which remain higher than the overall county rate. In the past, these disparities had been only partially explained by factors such as adequacy and quality of prenatal care.

Findings
• In 2013, there were 123 infant deaths in Orange County.
• The infant mortality rate was 3.3 deaths per 1,000 births in 2013, lower than California’s rate of 4.7 and the United States’ rate of 6.0, and a 17.5% decrease since 2004.
• Leading causes of infant mortality were: other conditions of the perinatal period (33.3%), congenital anomalies or birth defects (21.1%), maternal causes (16.3%), and short gestation/low birth weight (8.9%).
• Disparities persist; infant mortality rates (per 1,000 live births) was highest among Hispanic infants (4.5), and lowest among White (2.2), and Asian (2.2) infants.

1 MacDorman, M F, Mathew, MS, 2013. 2 State of California, Center for Health Statistics, Vital Statistics Query System. 3 Centers for Disease Control, CDC Wonder, 2015.
Rate per 1,000 Live Births Suffering Infant Mortality
Orange County and California, 2004 to 2013
- Orange County
- California

Note: Rates based on less than five deaths are unstable, and therefore should be interpreted with caution. Black infant mortality rates are not included because the relatively low numbers of Black infant births and deaths in Orange County yield unreliable statistics for annual comparison.
Source: Orange County Health Care Agency

Rate per 1,000 Live Births Suffering Infant Mortality, by Race and Ethnicity 2004 to 2013
- Hispanic
- White
- Asian

Percent of Infant Deaths, by Cause, 2013

<table>
<thead>
<tr>
<th>Causes</th>
<th>Percent of Infant Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Conditions of Perinatal Period*</td>
<td>33.3%</td>
</tr>
<tr>
<td>Congenital Anomalies (Birth Defects)</td>
<td>21.1%</td>
</tr>
<tr>
<td>Maternal Causes</td>
<td>16.3%</td>
</tr>
<tr>
<td>Short Gestation/Low Birthweight</td>
<td>8.9%</td>
</tr>
<tr>
<td>Other Symptoms, Signs, and Abnormal Laboratory Findings</td>
<td>3.3%</td>
</tr>
<tr>
<td>Complications of Placenta, Cord, and Membranes</td>
<td>3.3%</td>
</tr>
<tr>
<td>Respiratory Distress Syndrome (RDS)</td>
<td>2.4%</td>
</tr>
<tr>
<td>Accidents and Adverse Effects</td>
<td>2.4%</td>
</tr>
<tr>
<td>Other and Unspecified Diseases of the Respiratory System</td>
<td>1.6%</td>
</tr>
<tr>
<td>Meningitis</td>
<td>1.6%</td>
</tr>
<tr>
<td>Sudden Infant Death Syndrome (SIDS)*</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

*Includes: newborn affected by noxious influences transmitted via placenta or breast milk, intrapartum hypoxia, birth asphyxia, chronic respiratory disease originating in the perinatal period, neonatal hemorrhage, hydrops fetalis not due to hemolytic disease, newborn affected by other complications of labor and delivery, bacterial sepsis of newborn, necrotizing enterocolitis of newborn, pulmonary hemorrhage originating in the perinatal period, atelectasis, and all other infections specific to the perinatal period.

The remaining 4.1% of causes include heart disease, diarrhea and gastroenteritis of infectious origins, other and unspecified viral diseases, In situ, benign, and neoplasms of uncertain or unknown behavior, certain disorders involving the immune mechanism, other diseases of the nervous system, and other external causes.

Source: Orange County Health Care Agency

* In 2013, there were eight sleep related deaths, referred to as Sudden Unexpected Infant Deaths (SUIDs), in Orange County, which are included in other categories.
Source: Orange County Coroner Division
LOW BIRTH WEIGHT

LOW BIRTH WEIGHT VARIES BY RACE AND ETHNICITY AND GEOGRAPHY.

DESCRIPTION OF INDICATOR

This indicator reports the total number of low birth weight infants and very low birth weight infants as a proportion of the total number of births. Low birth weight is defined as infants born weighing less than 2,500 grams (5 pounds, 8 ounces). Very low birth weight infants are a subset of low birth weight infants born weighing less than 1,500 grams (3 pounds, 5 ounces).

Why is this Important?

Infants weighing less than 2,500 grams at birth have an increased risk of experiencing developmental problems. In addition, these low birth weight infants are at higher risk for serious illness, disability, developmental delays, lifelong health difficulties and are more likely to die before their first birthday.\(^1\)

The primary causes of low birth weight are premature birth and fetal growth restriction. Risk factors for low birth weight include smoking, alcohol/drug use during pregnancy, multiple births, poor nutrition, maternal age, socioeconomic factors, domestic violence and maternal or fetal infections.

Findings

- In 2013, there were 37,256 births of which 6.3% (2,347) were low birth weight infants, an increase of 1.6% from 6.2% in 2004 but a 6% decrease from the high of 6.7% in 2011.
- Overall, the Orange County rate is lower than California (6.8%)\(^2\) and the United States (8.2%)\(^3\) in 2013.
- Very low birth weight infants comprised 1.0% (385) of the total births.
- When assessed by race/ethnicity, the highest percentage of low birth weight infants was Black (9.5%), followed by Asian (7.2%), Hispanic (6.0%), and White (5.9%) infants.

GOOD HEALTH

Percentage of Infants with Low Birth Weight, by Race/Ethnicity
2004 to 2013

- Black
- Asian
- White
- Hispanic

Source: HCA Family Health Division

Percent of Infants with Low Birth Weight
Orange County and California, 2004 to 2013

- Orange County
- California

Source: HCA Family Health Division

Percentage of Infants with Low Birth Weight, by Community of Residence, 2013

Note: NA is no data available. * Laguna Woods rate is based on fewer than five births. Rates based on less than five events are unstable and should be interpreted with caution.

Source: HCA Family Health Division
PRETERM BIRTHS DROP TO 7.8% OF BIRTHS – THE LOWEST LEVEL OVER THE PAST DECADE.

DESCRIPTION OF INDICATOR
This indicator reports the percentage of total annual births which are preterm. Preterm birth is defined as the delivery of an infant at less than 37 weeks of gestation, the period of time between conception and birth. Late preterm births (occurring between 34 to 36 weeks of gestation), moderate preterm births (occurring between 32 to 33 weeks of gestation), and very preterm births (occurring less than 32 weeks of gestation) are subsets of preterm births.

Why is this Important?
Preterm birth is an important public health issue requiring sustained focus on its causes, consequences, and prevention strategies.\(^1\) Compared to infants born at term, preterm infants are more likely to suffer lifelong neurologic, cognitive and behavioral problems.\(^2,3\) Prematurity and low birth weight are often, but not always, associated. In 2010, infants born preterm accounted for two-thirds of all low birthweight infants, and 46% of preterm births were low birthweight. Nationally, preterm-related causes of death together accounted for 35% of all infant deaths in 2010, more than any other single cause. Preterm births cost the United States health care system more than $26 billion each year.\(^4\)

Findings
- Preterm births accounted for 7.8% of the 37,256 births to Orange County residents in 2013, dropping 24.8% from 9.8% in 2004. By comparison, the rate for California was higher at 8.8%\(^5\) (20% decrease since 2004) and the United States was higher at 11.4%\(^6\) (8.8% decrease since 2004) in 2013.
- Disparities persist with Black infants at 10.1%, followed by Hispanic (8.1%), White (7.5%), and Asian (7.1%) infants (the percentages decreased for all race/ethnicities, compared to 2004).
- Percent of preterm births was highest among women less than 15 years old (22.2%), followed by women older than 40 years of age (12.1%), 35-39 years (8.8%), 15-19 years (7.8%), 30-34 years (7.3%), 25-29 years (7.1%), and 20-24 years (6.9%).
### Percent of Preterm Births

**Orange County, California, and United States, 2004 to 2013**

- **United States**
- **California**
- **Orange County**

*Source: Orange County Health Care Agency and Program Development Branch, Maternal Child and Adolescent Health (MCAH) Program, Martin JA, Hamilton BE, Osterman JK, et al., 2015*

### Percent of Preterm Births, by Race/Ethnicity

**2004 to 2013**

- **Black**
- **Hispanic**
- **White**
- **Asian**

*Source: Orange County Health Care Agency*

### Percent of Preterm Births, by Community of Residence, 2013

- **ALISO VIEJO**: 7.1
- **ANAHEIM**: 8.4
- **BREA**: 5.7
- **BUENA PARK**: 8.6
- **COSTA MESA**: 8.8
- **COTO DE CAZA**: 15.1
- **CYPRUS**: 9.0
- **DANA POINT**: 5.5
- **FOUNTAIN VALLEY**: 4.4
- **FULLERTON**: 7.7
- **GARDEN GROVE**: 7.5
- **HUNTINGTON BEACH**: 7.2
- **IRVINE**: 6.7

*Source: Orange County Health Care Agency Family Health Division*

### Note

- NA is no data available.
- *Laguna Woods rate is based on fewer than five births. Rates based on less than five events are unstable and should be interpreted with caution.*

*Source: Orange County Health Care Agency Family Health Division*
BIRTHS TO TEENS

THE TEEN BIRTH RATE CONTINUES TO IMPROVE, DECLINING 46% FROM 2004 ALTHOUGH DRAMATIC DISPARITIES EXIST.

DESCRIPTION OF INDICATOR

This indicator reports the percent of total annual births occurring among females ages 19 years and under and the teen birth rate, which is a calculation of teen births per 1,000 females ages 15 to 19 years per year.

Why is this Important?

Giving birth as a teen can have profoundly negative consequences for both the teen parents and the infant. Teen births also have negative consequences for society. Teen mothers are less likely to get or stay married, and less likely to complete high school or college. They are more likely to require public assistance and live in poverty than their peers who are not mothers. Infants born to teen mothers are at greater risk for low birth weight, preterm birth, and death in infancy. These infants have a lower probability of obtaining the emotional and financial resources they need throughout childhood to develop into independent, productive, well-adjusted adults. For society, teen births in the United States cost taxpayers an estimated $9.4 billion in 2010. Estimated taxpayer costs were $870 million for California and $53 million for Orange County in 2010 (societal costs are estimated to be even higher). Teen birth rates have declined significantly since 1991, representing an estimated annual U.S. taxpayer savings of $12 billion in 2010 alone.

Findings

- In 2013, 4.8% (1,801) of total annual births were to females ages 19 years and younger, a 12.7% decrease from 5.5% in 2012.
- The teen birth rate in 2013 was 16.7 births per 1,000, a decrease of 46% from 30.9 births per 1,000 in 2004.
- Overall, Orange County has a lower teen birth rate per 1,000 females than California (22.7) and the United States (26.5).
- When assessed by race and ethnicity, Hispanic teens had the highest birth rate per 1,000 females (32.8), followed by Black (11.4), White (4.2), and Asian (2.6) teens.

Birth Rate per 1,000 Females 15 to 19 Years of Age
Orange County, California, and United States 2004 to 2013

- United States
- California
- Orange County

2004, 2009, and 2013 Birth Rate per 1,000 Females 15 to 19 Years of Age, by Race/Ethnicity

2004, 2009, and 2013 Birth Rate per 1,000 Females 15 to 19 Years of Age, by Community of Residence, 2009 to 2013, 5 Year Average

Source: Orange County Health Care Agency
26.9% OF WOMEN EXCLUSIVELY BREASTFEED THREE MONTHS AFTER DELIVERY, A SLIGHTLY IMPROVING TREND.

DESCRIPTION OF INDICATOR

This indicator reports the prevalence of breastfeeding using two California Department of Public Health data sources. The In-Hospital Newborn Screening Program documents feeding practices at the time of hospital discharge. The Maternal Infant Health Assessment (MIHA) is an annual statewide-representative survey of women with a recent live birth in California. In-Hospital Newborn Screening data are presented as the percentage of mothers breastfeeding (any or exclusive) in the hospital after birth; MIHA data are presented as the percentage of mothers who reported breastfeeding (any or exclusive) at one month after delivery and at three months after delivery.

Why is this Important?

Human milk is the optimal source of nutrition for an infant and provides many benefits for healthy growth and development. Breastfeeding reduces infant risks for infections (including ear and respiratory infections and diarrhea) and thus infants require fewer visits to the doctor and medications than infants who are formula fed. Evidence also demonstrates that breastfeeding reduces the risk for cardiovascular disease, asthma, and diabetes later in life, and that exclusive breastfeeding can reduce the risk of childhood obesity.

Breastfeeding can provide protective health benefits for the mother. The breastfeeding mother may experience less postpartum bleeding, decreased menstrual blood loss (which conserves iron in the body), decreased risk for osteoporosis and hip fracture in the post-menopausal period, earlier return to pre-pregnancy weight, and decreased risks of breast and ovarian cancers. Breastfeeding also benefits the entire family and community. It improves household food security because families need not use income to buy formula, food, and bottles.

Findings

- In 2014, 64.6% of Orange County women were exclusively breastfeeding at time of hospital discharge, lower than California at 66.6%.
- Exclusive breastfeeding at time of discharge was highest among White women at 78.0%, followed by multiracial (75.1%), Black (65.9%), Hispanic (61.1%), Asian (48.8%), and Pacific Islander (46.9%) women.
- In 2012/13, 50.1% of Orange County women were exclusively breastfeeding one week after delivery, an increase from 45.6% in 2011/12, and lower than women in California at 53.4%.
- One month after delivery, 36.9% of Orange County women in 2012/13 were exclusively breastfeeding, an increase from 34.6% in 2011/12, and lower than women in California at 41.4%.
- Three months after delivery, 26.9% of Orange County women in 2012/13 were exclusively breastfeeding, an increase from 25.0% in 2011/12, and similar to California’s rate in 2012/13 of 26.2%.

Note: The American Academy of Pediatrics and the World Health Organization recommend exclusive breastfeeding for the first six months of life; and continued breastfeeding along with the introduction of safe and appropriate complementary foods until at least 12 months of age.

An infant is “exclusively breastfed” when fed only with human milk and no other supplements such as water, formula, non-human milk, food or juice. “Any breastfeeding” is defined as feeding with both human milk and infant formula. Bartick M, Reinhold A., 2010. 1 Gartner LM, et al., 2005.
Hospital Discharge Breastfeeding Percentages in Orange County and California, 2012 to 2014

- Orange County Any Breastfeeding
- California Any Breastfeeding
- Orange County Exclusive Breastfeeding
- California Exclusive Breastfeeding

** Source:** California Department of Public Health. Genetic Disease Screening Program, Newborn Screening Data, 2016. NBS Form Version (D) Revised 12/2008. Maternal, Child, and Adolescent Health Program.

**Note:** Rate for infants born in Orange County Hospitals, including to both resident and non-resident mothers.

Hospital Discharge Breastfeeding Percentages, by Race/Ethnicity, 2014

- Exclusive Breastfeeding
- Any Breastfeeding

** Source:** California Department of Public Health. Genetic Disease Screening Program, Newborn Screening Data, 2016. NBS Form Version (D) Revised 12/2008. Maternal, Child, and Adolescent Health Program.

**Note:** Breastfeeding percentages include only mothers who are Orange County residents.

Breastfeeding Percentages at One Week, One Month and Three Months After Delivery, 2011/12 to 2012/13

- 2011/12
- 2012/13

** Note:** MIHA is an annual population-based survey of California resident women with a live birth. The total sample size was 6,853 in 2011, 6,810 in 2012, and 7,011 in 2013. The Orange County sample size was 390 in 2011, 387 in 2012, and 187 in 2013. The data are weighted to represent all women with a live birth in California. More information on MIHA and the indicators above is on the MIHA website.

**Sources:** Sacramento: California Department of Public Health, Maternal, Child, and Adolescent Health Program, 2015.
IMMUNIZATIONS

OVERALL, ABOUT ONE IN 10 CHILDREN ARE NOT ADEQUATELY IMMUNIZED UPON ENROLLING IN SCHOOL, WITH EVEN HIGHER RATES IN SOME COMMUNITIES.

DESCRIPTION OF INDICATOR
This indicator reports the percentage of children who received all of the doses of specific vaccines recommended by their 2nd birthday and required at kindergarten entry. Data at the 2nd birthday are based upon annual retrospective reviews of a sample of randomly selected schools’ kindergarten immunization records and therefore represent vaccination trends three years prior.

Why is this Important?
The widespread use of safe, effective childhood vaccinations has been one of the most successful and cost-effective public health interventions in the United States and globally. Many serious and once-common childhood infections have been dramatically reduced through routine immunizations. The success of immunization programs depends upon appropriate timing and on a high rate of vaccine acceptance, particularly among parents of young children.

Over the past decade, increasing numbers of children with delayed or refused vaccinations have led to reduced levels of vaccine coverage. Studies have found that children whose parents delay or refuse vaccines are more likely to be White and reside in well-educated, higher income areas. Many communities are below the protective level needed to prevent the spread of disease. In December 2014, Orange County experienced a measles outbreak initiated at Disneyland theme park.

Findings
• In 2014, 78.9% of children entering kindergarten had been adequately immunized (4:3:1 schedule) at age two, similar to the rate of 78.1% in 2011.
• In 2014, 90.0% of kindergartners had up-to-date immunizations, an increase from the 10-year low at 88.7% in 2013, but down from 92.7% in 2005.
• These percentages and trends are similar to those among kindergartners throughout California at 90.4% in 2014, and down from 92.8% in 2005.
• Five school districts had fewer than 85% of their kindergartners with up-to-date immunization levels, including Capistrano, Huntington Beach, Laguna Beach, Newport-Mesa, and Saddleback Valley. This correlates with higher percentages of personal belief exemptions and conditional enrollments in these districts.

A new California law goes into effect January 1, 2016, requiring that private or public child care centers, preschools, elementary schools and secondary schools cannot admit children unless they are immunized against 10 diseases: diphtheria, Haemophilus influenza type b (bacterial meningitis), measles, mumps, pertussis (whooping cough), polio, rubella, tetanus, hepatitis B and chicken pox. The law overrides an allowance for a religious exemption to vaccinations, but permits medical, special education, and homeschooling or independent study exemptions.

Sources: California Department of Public Health
GOOD HEALTH

Percent of Adequately Immunized Children Enrolling in School Between 2005 and 2014 in Orange County and California

- Up-To-Date at Kindergarten Entry California
- Up-To-Date at Kindergarten Entry Orange County
- Up-To-Date at 2nd Birthday Orange County
- Up-To-Date at 2nd Birthday California

Source: Orange County Health Care Agency

Note: After 2010, California data are no longer being collected for percent of up-to-date immunized children after their 2nd birthday. 2004 to 2010 Orange County data include other Southern California counties (Imperial, Orange, Riverside, San Bernardino, and San Diego). 2011-2014 data include a small, random sample of schools for Orange County only.

Immunization Coverage Among Kindergarten Students at Two Years of Age, by Immunization, Kindergarten Retrospective Survey, 2011 to 2014

<table>
<thead>
<tr>
<th>Year</th>
<th>Number</th>
<th>DTaP (4+)</th>
<th>Polio (3+)</th>
<th>MMR (1+)</th>
<th>Hepatitis B (3+)</th>
<th>Varicella (1+)</th>
<th>4:3:1</th>
<th>4:3:1-3</th>
<th>4:3:1-3:1</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>1,449</td>
<td>81.7%</td>
<td>91.9%</td>
<td>91.9%</td>
<td>92.0%</td>
<td>89.4%</td>
<td>78.1%</td>
<td>76.0%</td>
<td>73.6%</td>
</tr>
<tr>
<td>2012</td>
<td>1,887</td>
<td>80.1%</td>
<td>90.5%</td>
<td>89.7%</td>
<td>90.5%</td>
<td>88.8%</td>
<td>75.7%</td>
<td>73.3%</td>
<td>70.9%</td>
</tr>
<tr>
<td>2013</td>
<td>1,966</td>
<td>78.6%</td>
<td>88.3%</td>
<td>87.6%</td>
<td>87.8%</td>
<td>86.5%</td>
<td>73.6%</td>
<td>70.9%</td>
<td>68.9%</td>
</tr>
<tr>
<td>2014</td>
<td>1,800</td>
<td>82.7%</td>
<td>92.1%</td>
<td>90.9%</td>
<td>90.8%</td>
<td>90.2%</td>
<td>78.9%</td>
<td>77.1%</td>
<td>75.3%</td>
</tr>
</tbody>
</table>

Source: Orange County Health Care Agency

Percent of Up-to-Date Immunizations at Kindergarten Enrollment, Private and Public Schools within Each School District, 2014

<table>
<thead>
<tr>
<th>District</th>
<th>% of Immunizations</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 ANAHEIM</td>
<td>96.0</td>
</tr>
<tr>
<td>2 BREA-OLINDA</td>
<td>91.4</td>
</tr>
<tr>
<td>3 BUENA PARK</td>
<td>95.6</td>
</tr>
<tr>
<td>4 CAPISTRANO</td>
<td>79.7</td>
</tr>
<tr>
<td>5 CENTRALIA</td>
<td>94.1</td>
</tr>
<tr>
<td>6 CYPRESS</td>
<td>89.2</td>
</tr>
<tr>
<td>7 FOUNTAIN VALLEY</td>
<td>93.9</td>
</tr>
<tr>
<td>8 FULLERTON</td>
<td>96.7</td>
</tr>
<tr>
<td>9 GARDEN GROVE</td>
<td>94.8</td>
</tr>
<tr>
<td>10 HUNTINGTON BEACH</td>
<td>83.8</td>
</tr>
<tr>
<td>11 IRVINE</td>
<td>87.9</td>
</tr>
<tr>
<td>12 LA HABRA</td>
<td>96.9</td>
</tr>
<tr>
<td>13 LAGUNA BEACH</td>
<td>76.9</td>
</tr>
<tr>
<td>14 LOS ALAMITOS</td>
<td>95.2</td>
</tr>
<tr>
<td>15 MAGNOLIA</td>
<td>94.3</td>
</tr>
<tr>
<td>16 NEWPORT MESA</td>
<td>82.4</td>
</tr>
<tr>
<td>17 OCEAN VIEW</td>
<td>92.0</td>
</tr>
<tr>
<td>18 ORANGE</td>
<td>98.2</td>
</tr>
<tr>
<td>19 PLACENTIA-YORBA LINDA</td>
<td>91.5</td>
</tr>
<tr>
<td>20 SADDLEBACK</td>
<td>80.8</td>
</tr>
<tr>
<td>21 SANTA ANA</td>
<td>93.9</td>
</tr>
<tr>
<td>22 SAYANNA</td>
<td>85.1</td>
</tr>
<tr>
<td>23 TUSTIN</td>
<td>90.9</td>
</tr>
<tr>
<td>24 WESTMINSTER</td>
<td>96.3</td>
</tr>
</tbody>
</table>

Source: Orange County Health Care Agency
OBESITY

NEARLY ONE IN FIVE 5TH GRADE STUDENTS ARE AT RISK FOR OBESITY.

DESCRIPTION OF THE INDICATOR

This indicator reports data from the California Physical Fitness Test on the percent of 5th grade students who are classified as having health risk due to their body composition.

Why is this Important?

Excess weight acquired during childhood and adolescence may persist into adulthood and increase the risk for chronic diseases, such as sleep apnea, diabetes, cardiovascular disease and hypertension. Obese adolescents have a 70% chance of becoming obese adults.1 Excess weight can be prevented and treated through proper nutrition and physical activity (reported on page 28-29 of this report), especially during the critical periods of infancy, two to four years of age, and adolescence.

Findings

- During the 2013/14 school year, 18.3% of 5th graders were classified “at health risk due to body composition,” lower than California at 21% of 5th graders.
- Among race and ethnic groups, Pacific Islander (28.6%) and Hispanic (27.3%) 5th graders had the highest percentages of students classified at health risk due to their body composition, followed by Black (17.9%), American Indian (16.6%), Filipino (16%), 2 or more race (9.9%), White (9.3%), and Asian (8.6%) 5th graders.

California Physical Fitness Test uses the Cooper Institute’s FITNESSGRAM approach to classify 5th grade students at “Health Risk” due to body composition when they had a body fat percentage or a body mass index (BMI) that could result in health issues. “Health Risk” classifications for body composition are defined using criterion-referenced, age-specific standards. In 2010/11 and 2013/14 school years, changes to the FITNESSGRAM methodology prevents comparison across multiple years. Changes accommodate the widely accepted CDC defined BMI weight classifications.

1 The Surgeon General, 2000.
GOOD HEALTH

Percent of 5th Grade Students at Health Risk Due to Body Composition, by Race/Ethnicity
2010/11 to 2013/14

Source: California Department of Education, DataQuest, 2015

Obese adolescents have a 70% chance of becoming obese adults.¹

Percent of 5th Grade Students at Health Risk Due to Body Composition, by School District, 2013/14

Source: California Department of Education, DataQuest, 2015
PHYSICAL FITNESS AND NUTRITION

RACIAL DISPARITY EXISTS FOR STUDENTS’ PHYSICAL FITNESS.

DESCRIPTION OF INDICATOR

To assess physical fitness, this indicator reports data from the California Physical Fitness Test on the percent of 5th grade students who are classified as having health risk due to their aerobic capacity.

For nutrition, this indicator reports the proportion of youth (ages 2 to 17) who ate fast food one or more times in the past week and ate less than two fruit servings in the past day.

Why is this Important?

Both healthy eating and regular physical activity are essential to achieving and keeping a healthy weight. The habitual intake of too many calories, including from the consumption of sugary beverages, without enough physical activity, can result in obesity. Those who eat a healthy diet rich in fruits and vegetables and incorporate aerobic physical activity and cardio-respiratory fitness into a daily routine are less likely to develop many types of disease, including heart disease, high blood pressure, Type 2 diabetes, and oral disease. Additionally, these behaviors when developed at a younger age are associated with similar behaviors in adulthood.

Findings

• During the 2013/14 school year, 5.8% of 5th graders were classified “at health risk due to aerobic capacity,” and lower than California at 6.5% of 5th graders.
• The percentage of 5th graders at health risk due to aerobic capacity was highest among Hispanic 5th graders (9.1%), followed by Pacific Islander (7.2%), Black (5.6%), American Indian (5.6%), Filipino (5.0%), White (2.7%), Multi Race (2.3%), and Asian (2.1%) 5th graders.
• According to the 2013/14 California Health Interview Survey:
  – 77.8% of children (2 to 17 years old) reported eating fast food one or more times in the past week, an increase of 5.4% from 73.8% in 2011.
  – 41.2% of children (2 to 17 years old) reported eating less than two fruit servings the previous day, an increase of 26.0% from 32.7% in 2011.


Note: California Physical Fitness Test uses the Cooper Institute’s FITNESSGRAM approach to classify 5th graders aerobic capacity at health risk when their VO2max, a measure of maximum oxygen consumption, fell within certain limits after participation in structured aerobic exercises, such as the Progressive Aerobic Cardiovascular Endurance Run (PACER), one-mile run, or walk test, which deemed them at likely risk for future health problems. The definition of aerobic capacity categories was modified in 2010/11 to improve classification agreement between the PACER and one-mile run approaches. Another modification in 2013/14 no longer requires height and weight information to estimate VO2max from the PACER test. Because of these adjustments, California Physical Fitness Test data collected prior to the 2013/14 school year are not comparable to those collected under the current standards.
GOOD HEALTH

Percent of 5th Grade Students at Health Risk Due to Aerobic Capacity, by Race/Ethnicity in Orange County
2010/11 to 2013/14

- Hispanic
- Pacific Islander
- Multi Race
- Black
- Filipino
- American Indian
- White
- Asian
- California
- Orange County

Source: California Department of Education, DataQuest, 2015

Percent of Children Ages 2 to 17 Years Old who Ate Fast Food One or More Times in the Past Week
2011 to 2014

Note: Data for 2013 is statistically unstable.
Source: California Health Interview Survey, 2013/14

Percent of Children Ages 2 to 17 Years Old who Ate Less than Two Fruit Servings the Previous Day
2011 to 2014

Source: California Health Interview Survey, 2013/14

Percent of 5th Grade Students at Health Risk Due to Aerobic Capacity, by School District, 2013/14

1. ANAHEIM CITY
11.3%
2. BREA-OLINDA UNIFIED
2.3%
3. BUENA PARK ELEMENTARY
10.1%
4. CAPISTRANO UNIFIED
2.8%
5. CENTRALIA ELEMENTARY
7.0%
6. CYPRESS ELEMENTARY
4.7%
7. FOUNTAIN VALLEY ELEMENTARY
3.2%
8. FULLERTON ELEMENTARY
6.3%
9. GARDEN GROVE UNIFIED
5.8%
10. HUNTINGTON BEACH CITY ELEMENTARY
3.0%
11. IRVINE UNIFIED
2.6%
12. LA HABRA CITY ELEMENTARY
7.8%
13. LAGUNA BEACH UNIFIED
0.0%
14. LOS ALAMITOS UNIFIED
3.2%
15. MAGNOLIA ELEMENTARY
6.9%
16. NEWPORT-MESA UNIFIED
3.5%
17. OCEAN VIEW
4.4%
18. ORANGE UNIFIED
5.8%
19. PLACENTIA-YORBA LINDA UNIFIED
7.2%
20. SADDLEBACK VALLEY UNIFIED
1.0%
21. SANTA ANA UNIFIED
11.2%
22. SAVANNA ELEMENTARY
11.4%
23. TUSTIN UNIFIED
6.6%
24. WESTMINSTER
5.1%

Orange County: 5.8%
California: 6.5%

% of Students
- 10.1 - 11.4
- 6.1 - 10.0
- 3.1 - 6.0
- 0.0 - 3.0

Source: California Department of Education, DataQuest, 2015
Why is this Important?

The presence of behavioral health disorders can have a profound impact on individuals and families, as well as systems within the community, such as schools or the juvenile justice system. By tracking hospitalization rates related to behavioral health disorders, health officials can more readily identify trends and monitor the needs of the community while directing resources (e.g., training, education, counseling, outreach, etc.) to areas in need. For example, an increase in hospitalization rates due to heroin use may signal a serious trend in a local community and may lead to resource allocation to combat the increase of this illicit and harmful drug.

Findings

- The overall hospitalization rate for serious mental illness and substance abuse conditions for children increased by 25.6% since 2004, with a low of 16.7 in 2008 and moving to a high of 22.6 per 10,000 children in 2013.
- The hospitalization rate for serious mental illness has increased 66%, from a low of 11.3 in 2008 to 18.8 per 10,000 children in 2013.
- Major Depression and Mood Disorders accounted for over half (59%) of all hospitalizations, followed by Bipolar (19%), Schizophrenia/Psychoses (5%), and Schizoaffective Disorders (1%).
- Hospitalizations for substance related diagnoses accounted for 3% of all such admissions for children in 2013, and has decreased 59% over the past decade to 0.7 per 10,000 population in 2013.
- In 2012, 9% of adolescents ages 12 to 17 years old had at least one major depressive episode in both California and the United States.1
- While males accounted for the majority (63%) of substance related hospitalizations, females accounted for 61% of mental illness hospitalizations (and 60% of all admissions).
- White youth accounted for over half (51%) of all mental illness and substance abuse-related hospitalizations and Hispanic children accounted for over one third (35%).

---

GOOD HEALTH

Mental Health and Substance Abuse Related Hospitalization Rates, Rate per 10,000 Children
2004 to 2013

- Total
- Mental Illness
- Other
- Substance Abuse

Source: Orange County Health Care Agency
Notes: Rates for Black children are not included due to unstable and unreliable estimates for small populations. Other includes mental disorders such as other unspecified mood disorders, conduct disorders, and disorders related to sleep, eating, elimination, and pain.

Mental Health Hospitalization Rates per 10,000 Children, by Race/Ethnicity 2013

- White
- Hispanic
- Asian/Pacific Islander

Source: Orange County Health Care Agency
Notes: Rates for Black children are not included due to unstable and unreliable estimates for small populations. Other includes mental disorders such as other unspecified mood disorders, conduct disorders, and disorders related to sleep, eating, elimination, and pain.

Rate of Orange County Hospitalizations for Mental Health and Substance Abuse per 10,000 Children, 2013

Source: Orange County Health Care Agency Research and Planning
Notes: Rates for Black children are not included due to unstable and unreliable estimates for small populations. Other includes mental disorders such as other unspecified mood disorders, conduct disorders, and disorders related to sleep, eating, elimination, and pain.
ECONOMIC WELL-BEING INDICATORS

**CHILD POVERTY**
- Percent of students receiving free and reduced lunch:
  - 2005/06: 38.4%
  - 2014/15: 49.0%

**CALWORKS**
- Percent of children receiving Calworks:
  - 2004/05: 4.5%
  - 2013/14: 6.0%

**HOUSING**
- Percent of students insecurely housed:
  - 2004/05: 0.7%
  - 2013/14: 6.5%

**CHILD SUPPORT**
- Percent of current support distributed:
  - 2005/06: 53.9%
  - 2014/15: 66.7%

**SUPPLEMENTAL NUTRITION**
- Percent of children receiving CalFresh:
  - 2004/05: 6.9%
  - 2013/14: 19.7%
CHILD POVERTY

AN INCREASE IN FREE AND REDUCED PRICE LUNCH PROGRAM BENEFICIARIES REFLECTS THAT NEARLY 17 OUT OF EVERY 100 ORANGE COUNTY CHILDREN LIVE IN POVERTY.

DESCRIPTION OF INDICATOR
This indicator reports the number and percent of students participating in the National School Free and Reduced Price Lunch program, considered to be an indicator of children living in poverty or of working poor families. Eligibility is based on income of the child’s parent or guardian, which must be below 185% of the Federal Poverty Level.

Why is this Important?
Research has demonstrated that living in poverty has a wide range of negative effects on the physical and mental health and well-being of children. Poverty is linked with negative conditions such as substandard housing, homelessness, inadequate nutrition, food insecurity, inadequate child care, lack of access to health care, unsafe neighborhoods and under-resourced schools. These conditions mean school districts face many challenges serving low-income families, particularly those school districts with more than 65% of students enrolled in the Free and Reduced Price Lunch program. 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.

Findings
• In 2014/15, 49.0% (243,432) of students qualified for the Free and Reduced Price Lunch Program in Orange County, lower than California at 58.6% (3,655,624).
• Between 2005/06 and 2014/15, there was a greater increase (27.6%) among Orange County students qualifying for the Free and Reduced Price Lunch Program than among students throughout California (14.7%).
• According to the United States Census, 16.9% of Orange County’s children were living in poverty in 2013; an increase from 13.6% in 2010, while remaining lower than California (22.1%) and the United States (21.6%).
• When cost of housing is factored in, poverty among Orange County’s children jumps to 27.8%, surpassing California at 24.9%, with a threshold income needed to maintain a basic standard of living for a family of four at $33,842.
• Orange County has the fourth highest child poverty rate (27.8%) in California. Monterey/San Benito has the highest rate of 32.4%, followed by Los Angeles (29.9%) and Tulare (29.6%) counties.

1 American Psychological Association, 2014. 2 California Poverty Measure. 2013. California Poverty measure (CPM) incorporates the changes in costs and standards of living since the official poverty measure was devised in the early 1960s – and accounts for geographic differences in the cost of living across the state. It also factors in tax credits and in-kind assistance that can augment family resources and subtracts medical, commuting, and child care expenses. 2011 Census Bureau data is used to estimate the CPM.
**ECONOMIC WELL-BEING**

### Percent of Students Receiving Free and Reduced Price Lunch
2005/06 to 2014/15
- Orange County
- California
- United States

*Source: Department of Education, DataQuest, 2015*

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<thead>
<tr>
<th>Year</th>
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<th>California</th>
<th>United States</th>
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### Percent of Children Under 18 Years Old, Living in Poverty, Orange County, California, and United States
2010-2013
- United States
- California
- Orange County

*Source: U.S. Census Bureau, 2009-2013 American Community Survey, 5 Year Estimates. Data for 2009 is unavailable*

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### Percent of Children Under 18 Years Old Living in Poverty, by City
2013

*Source: U.S. Census Bureau, 2009-2013 American Community Survey, 5 Year Estimates*
Why is this Important?

The percent of children benefiting from CalWORKs is an indicator of Orange County’s capacity to successfully meet welfare reform priorities and help families achieve self-sufficiency through employment income. CalWORKs provides financial and employment assistance to needy children and families in Orange County. CalWORKs has multiple goals, including reduced welfare dependency, increased self-sufficiency, and improved child well-being. Services include employment preparation, various job training programs and placements in subsidized and unsubsidized job opportunities. Elements that focus on child well-being include school attendance requirements, child immunizations and assisting with paternity and child support enforcement activities.

Findings

- In 2013/14, 6.0% (42,877) of Orange County’s children received CalWORKs assistance, lower than California at 11.0%, and an 18.3% increase from 4.5% in 2004/05.
- Young children (zero to five years of age) accounted for 34% of the youth population receiving CalWORKs assistance.
- The highest percentages of children receiving CalWORKs are in the cities of Santa Ana at 11.8% (11,760), Anaheim at 10.9% (10,059), Stanton at 8.3% (855), Garden Grove at 7.2% (3,122) and Buena Park at 7.2% (1,445).
- Cities with the lowest percentage of children receiving CalWORKs are Seal Beach at 1.2% (37), Aliso Viejo at 1.1% (137), Rancho Santa Margarita at 1.0% (130), Newport Beach at 0.8% (119), and Laguna Beach at 0.6% (25).
6.0% (42,877) of Orange County’s children receive CalWORKs assistance.

Percent Receiving CalWORKs, by City
2014

<table>
<thead>
<tr>
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<td>5.8</td>
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<tr>
<td>YORBA LINDA</td>
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</tr>
</tbody>
</table>

Source: Orange County Social Services Agency
SUPPLEMENTAL NUTRITION

ONE IN FIVE CHILDREN UNDER 18 YEARS OLD BENEFIT FROM CALFRESH, NEARLY TWICE THE NUMBER OF CHILDREN 10 YEARS AGO.

DESCRIPTION OF INDICATOR

This indicator reports the number and percent of recipients of the CalFresh Program, federally known as the Supplemental Nutrition Assistance Program (SNAP), and the number and percent of recipients in the Supplemental Nutrition Program for Women, Infants and Children (WIC). As an indicator of poverty, the increase in children receiving these benefits is one that needs improvement. However, the increase may also be viewed as an improvement in that more eligible children are receiving these benefits.

Why is this Important?

Data shows that there is a relationship between a family’s food security and assurance of a healthy life. Households with food insecurity are more likely to experience reduced diet quality, anxiety about their food supply, increased use of emergency food sources or other coping behaviors, and hunger. CalFresh and WIC programs provide nutrition assistance to people in low-income households by increasing their food-buying power so they are able to purchase more nutritious foods, such as fruits, vegetables and other healthy foods. Income eligible children can receive both forms of nutrition assistance.

Findings

- In 2013/14, 19.7% (141,688) of children under 18 years old received CalFresh, a 158% increase in the number of children since 2004/2005 at 6.9%. Orange County had a lower rate than California at 24.9% (2,305,000) of children receiving CalFresh (SNAP).  
- In December 2014, the largest age group of CalFresh beneficiaries in Orange County were six to 12 year olds (43% or 61,224), followed by zero to five year olds (34% or 49,062), and 13 to 17 year olds (23% or 32,308).  
- In 2013/14, 87,408 participants were served by the WIC program, a decrease of 11.4% from 98,635 in 2004/05.  
- In September 2014, there were 70,057 WIC beneficiaries in Orange County ages zero to five years old.

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1 USDA Food and Nutrition Service, WIC Program Total Participation. Data as of May 8, 2015. WIC provides nutrition services to pregnant and postpartum women, infants and children (ages 0 to 5 years). Participants must meet eligibility and income guidelines (at or below 185% of the federal poverty level). WIC participants are reported as the number of prenatal, breastfeeding and postpartum women, infants and children up to five years old who receive food vouchers in the month of September each year. The CalFresh Program, federally known as the Supplemental Nutrition Assistance Program (SNAP), helps income-eligible families put healthy and nutritious food on the table. The program issues monthly electronic benefits that can be used at grocery stores and participating farmers markets. The amount of the benefit is based on household size, income and housing expenses. Children under 18 years are reported annually through CalWIN. December figures are used to define the service population for a given federal fiscal year (Oct. 1, 2012 to Sept. 30, 2013). 2 United States Department of Agriculture, Food and Nutrition Service, SNAP 2014.
Nearly 20% of Orange County children (141,688) receive CalFresh.
The data is collected from the Local Education Agency (school district) and reported to the California Department of Education (CDE) at the end of each academic year, by June 30. Beginning 2010-2011, CDE began collecting the data directly via California Longitudinal Pupil Achievement Data System.  

Why is this Important?

The high mobility, trauma, and poverty associated with homelessness and unstable housing creates educational barriers, low attendance, developmental, physical and emotional problems, and challenges for students. Lacking a fixed, regular night-time place to stay increases the chances that a student will require additional support services associated with their developmental and academic success. A homeless student or one living in a crowded environment may experience a greater tendency for stress and anxiety not knowing where they are going to sleep each night nor having a consistent, quiet permanent place to study or do their homework. Homelessness can be associated with lower standardized test scores in all areas. Thus, students with insecure housing often require supports beyond what is typically offered to achieve academic success.

Findings

• In 2013/14, 6.5% [32,510] of students in Orange County were considered homeless, higher than California at 4.8%, and more than eight times greater than the percent of Orange County students homeless in 2004/05, at 0.7% [9,671].

• With regard to primary nighttime residence, in 2013/14:
  - 90.0% of homeless students were doubled-or tripled-up in housing, a 10% percent increase from 81.6% in 2004/05.
  - 5.3% of homeless students were housed in shelters, a 26% increase from 4.2% in 2004/05.
  - 3.8% of homeless students were in hotels or motels, a 69% decrease from 12.2% in 2004/05.
  - 0.7% of homeless students were unsheltered, a 75% increase from 0.4% in 2004/05.

• Of those students who were homeless in 2013/14, elementary age students (pre K-5th grade) had the highest percentage of homelessness at 43.7%, followed by high school students (grades 9-12) at 34.2% and middle school students (grades 6-8) at 22.1%.  

DESCRIPTION OF INDICATOR

This indicator reports the number of students identified by school districts as homeless (as qualified by the McKinney-Vento Homeless Education Assistance Act), meaning they are living in motels, shelters, parks and doubling-or tripling-up in a home.

6.5% OF STUDENTS HAVE INSECURE HOUSING, MORE THAN EIGHT TIMES THE PERCENTAGE 10 YEARS AGO.
Number and Percent Homeless Students, Orange County and California, 2004/05 to 2013/14

Source: California Department of Education

* ACCESS (Alternative, Community, and Correctional Schools and Services) student population is unique in that it encompasses a wide range of youth, including students in group homes or incarcerated in institutions, students on probation or homeless, students who are parents or working full-time, students participating in a home schooling program, and students who are referred by local school districts.

Primary Nighttime Residency of Homeless Students, 2004/05 and 2013/14

Source: California Department of Education

Percent of Enrolled Students Who Are Homeless, by School District, 2013/14

ECONOMIC WELL-BEING

Orange County: 14.0 and Greater

California: 4.8

3.0 - 9.9

0.0 - 2.9

Source: California Department of Education
CHILD SUPPORT

SINCE 2005/06, THE DOLLAR AMOUNT OF CHILD SUPPORT DISTRIBUTED PER CASE HAS INCREASED BY 44.9%.

DESCRIPTION OF INDICATOR

This indicator reports the Distributed Net Collections divided by the average monthly caseload for the Federal Fiscal Year. Improvements in collections per case indicate more dollars available for children’s basic necessities.

Why is this Important?

The number of Orange County children living in poverty has risen by 24.3% since 2010 (presently 123,845).¹ Research shows that child support payments help to lift more than one million Americans above the poverty line each year and assist families with incomes above the poverty line to make ends meet.² Child Support Services (CSS) builds partnerships with parents, develops community linkages, and cultivates existing relationships with other county agencies. CSS has implemented a family-centered approach that connects customers to local resources for family essentials (e.g., clothing and food), parental success (e.g., parenting classes and financial workshops) and individual services (e.g., adult education and job training). Expected results are increased collections and improved performance, which yield increased financial support to meet the needs of children and families. Child support collections pay for essentials such as food, shelter, child care, and medical support.

In the last 10 years, the number of Orange County CSS cases have decreased while services to customers have increased along with the collections per case.

Findings

- Total cases decreased by 30.5% throughout the last 10 years from 97,425 in 2005/06 to 67,735 in 2014/15. Over the same time period, net collections remained steady with an average of $178.5 million annually. The per case collection has increased 44.9% from $1,815 in 2005/06 to $2,630 in 2014/15.

- Cases with a court order established improved by 1.6% to 90.0% (2014/15) compared to 88.6% (2013/14).³

- The percent of current support distributed during 2014/15 was 66.7%, which is higher than the California rate of 64.9%, and represents a continuous improvement since 2005/06 when the rate was 53.9% (a 23.7% increase).⁴
Total Child Support Cases and Per Case Collections 2005/06 to 2014/15

- **Case Count**
- **Per Case Collection**

Source: Orange County Department of Child Support Services

Note: Total cases each year is a 12-month average from July to June. All 2014/15 cases and collections were projected through June using actual data through May 2015.

### Percent of Child Support Distributed, Orange County and California, 2005/06 to 2014/15

- **Orange County**
- **California**

Source: Orange County Department of Child Support Services

### Total Support Distributed and Number of Cases, by City, 2014/15

#### Total Support (in Millions)
- 5.0 - 19.0
- 3.0 - 4.9
- 2.0 - 2.9
- Under 2.0

**Cases**

**5.0 - 19.0**

- Fullerton: $3,249,800.43 (1,607 cases)
- Garden Grove: $7,865,315.43 (2,295 cases)
- Huntington Beach: $7,762,398.90 (1,958 cases)
- Irvine: $6,325,551.86 (1,264 cases)
- Los Alamitos: $1,017,186.25 (1,019 cases)

**3.0 - 4.9**

- Mission Viejo: $3,181,406.65 (715 cases)
- Newport Coast: $2,399,334.49 (429 cases)
- Orange: $5,928,464.20 (1,681 cases)
- Placentia: $2,299,334.49 (429 cases)
- San Clemente: $2,321,403.35 (489 cases)

**2.0 - 2.9**

- Rancho Santa Margarita: $2,289,736.49 (429 cases)
- San Juan Capistrano: $2,389,736.49 (429 cases)
- Santa Ana: $17,550,302.70 (5,390 cases)

**Under 2.0**

- Stanton: $1,697,674.62 (532 cases)
- Sunset Beach: $2,133,044.06 (480 cases)
- Trabuco Canyon: $943,180.61 (199 cases)
- Villa Park: $100,577.78 (1,063 cases)
- Yorba Linda: $2,249,626.78 (513 cases)

**Total Support Distributed and Number of Cases, by City, 2014/15**

- **Orange County:** $128.2 million (34,207 cases)
- **California:**
  - 5.0 - 19.0
  - 3.0 - 4.9
  - 2.0 - 2.9
  - Under 2.0
EDUCATIONAL ACHIEVEMENT INDICATORS

HIGH SCHOOL DROP OUT RATES

**PERCENT HIGH SCHOOL DROPOUTS FOR GRADES 9-12 COHORT**

- **2009/10**: 12.3%
- **2013/14**: 6.7%

COLLEGE READINESS

**PERCENT OF GRADUATES WITH UC/CSU Eligible Requirements**

- **2004/05**: 38.7%
- **2013/14**: 48.9%

**UPWARD TREND**
- Needs Improvement

**DOWNWARD TREND**
- Needs Improvement

**DIFFICULT TO ASSESS DUE TO THE NATURE OF THE DATA.**
HIGH SCHOOL DROPOUT RATES

DROPOUT RATES DECREASE FOR FIVE CONSECUTIVE YEARS, WITH DECLINES SEEN ACROSS ALL RACES AND ETHNICITIES.

DESCRIPTION OF INDICATOR

This indicator measures high school dropout rates for Orange County school districts, including detail by race/ethnicity and by program. Beginning in 2008, a student is considered a dropout if he or she was enrolled in grades 9 to 12 during the previous year and left before completing the current school year, or did not attend the expected school or any other school by October of the following year. Students who received a diploma, General Education Diploma (GED), or California High School Proficiency Exam certificate; transferred to a degree-granting college; died; had a school-recognized absence; or were known to have left the state are not counted as dropouts.¹

Why is this Important?

Education provides benefits to both individuals and society. Compared to high school graduates, dropouts earn lower wages, pay fewer taxes, are more likely to commit crimes, are more likely to be on welfare and are far less healthy.²

Findings

- The Orange County dropout rate was 6.7% for 2013/14, and was lower than the California dropout rate of 11.5% in 2013/14 and the United States dropout rate of 7.1% in 2011.²
- In 2013/14, 2,750 students in Orange County dropped out.
- While rates across all race and ethnicities are declining, dropout rates for the 2013/14 school year continued to be highest among Black students (10.2%), followed by Hispanic (10.0%), two or more races (5.3%), American Indian (4.5%), White (3.9%), and Asian (3.1%) students.
- By program, in 2013/14, dropout rates were highest among students enrolled as English Learners (16.0%), followed by Migrant Education (11.7%), Special Education (10.7%), and Socioeconomically Disadvantaged (10.5%) programs.⁴

¹ California Department of Education, Educational Demographics Office, 2013. ² Belfield, C. and Levin, H. (2007). The Economic Losses from High School Dropouts in California. ³ National Center of Education Statistics, 2011. Last available data set. ⁴ Socioeconomically Disadvantaged is a student whose parents have not received a high school diploma or is eligible for the free or reduced-price lunch program. English Learner is a student identified as English learner based on the results of the California English Language Development Test or is a reclassified fluent-English-proficient student (RFEP) who has not scored at the proficient level on the California English-Language Arts and Mathematics Standards Tests. Student with Disabilities is a student who receives special education services and has a valid disability code or was previously identified as special education but who is no longer receiving special education services for two years after exiting special education. Migrant is a student who changes schools during the year, often crossing school district and state lines, to follow work in agriculture, fishing, dairies, or the logging industry.
Percent of Grade 9-12 Cohort Dropouts, by Race/Ethnicity
2009/10 to 2013/14

- Hispanic
- Black
- Overall Orange County
- American Indian
- Asian
- White
- Two or more races, not Hispanic

Source: California Department of Education, DataQuest, 2015

Percent of Grade 9-12 Cohort Dropouts, by Program
2009/10 to 2013/14

- English Learners
- Migrant Education
- Special Education
- Socioeconomically Disadvantaged

Source: California Department of Education, DataQuest, 2015

Percent of Grade 9-12 Cohort High School Dropouts, by School District, 2013/14

1. ANAHEIM UNION HIGH
2. BREA-OLINDA UNIFIED
3. CAPISTRANO UNIFIED
4. FULLERTON JOINT UNION HIGH
5. GARDEN GROVE UNIFIED
6. HUNTINGTON BEACH UNION HIGH
7. IRWINE UNIFIED
8. LAGUNA BEACH UNIFIED
9. LOS ALAMITOS UNIFIED
10. NEWPORT-MESA UNIFIED
11. ORANGE UNIFIED
12. ORANGE COUNTY: 6.7
13. PLACENTIA-YORBA LINDA UNIFIED
14. SADDLEBACK VALLEY UNIFIED
15. SANTA ANA UNIFIED
16. SANTA ANA COUNTY: 4.1
17. TUSTIN UNIFIED

% Dropouts
- 0.0 - 2.0
- 2.1 - 4.0
- 4.1 - 8.0
- 8.1 - 12.0

Source: California Department of Education, DataQuest, 2015
COLLEGE READINESS

COLLEGE READINESS RISES OVERALL; HISPANIC STUDENTS ARE UNDERREPRESENTED AMONG THOSE READY FOR COLLEGE.

DESCRIPTION OF INDICATOR

This indicator tracks the number and percent of students who graduate from high school having completed the course requirements to be eligible to apply to a University of California (UC) or California State University (CSU). The UC/CSU eligibility requirements are presented below.

Why is this Important?

The UC/CSU minimum course requirements are centered on a well-rounded curriculum that fosters content mastery and ensures that students are ready to take college courses without remediation. The comprehensiveness of the courses includes an applied learning component which gives the opportunity to prove comprehension and practice critical thinking skills. The more students master the content in conjunction with these skills, the more likely they are to pursue and succeed in college, as well as in the workforce.¹

Findings

• In 2013/14, Orange County had 37,499 high school graduates, of which 48.9% were UC/CSU eligible, higher than California’s eligibility rate of 41.9%.²
• UC/CSU eligibility increased 26.4% in 10 years, from 38.7% of graduates in 2004/05 to 48.9% in 2013/14.
• At 75.4%, Asian students comprised the greatest proportion of graduates who were UC/CSU eligible, followed by White (55.0%), American Indian (45.8%), Black (38.4%) and Hispanic (33.6%) graduates.
• While the disparity continues to narrow, Hispanic graduates comprise the largest group of total graduates (42.7%), they accounted for only 33.6% of those UC/CSU eligible, lower than Asian (16.2% of total graduates accounting for 75.4% of UC/CSU eligible) and White (33.4% of total graduates accounting for 55.0% of UC/CSU eligible) graduates.
• Since 2006/07, the eligibility rates for graduates increased the most among students in the Socioeconomically Disadvantaged program (70.3% increase), followed by students in the Migrant Education (50.3% increase) program. The eligibility rate for graduates of the English Learner program declined 67.7% between 2006/07 and 2013/14, with a recent 25.9% increase between 2011/12 and 13/14.³

UC/CSU Requirements

• 4 years of English approved by the UC/CSU
• 3 years of Math, including Algebra, Geometry, and Intermediate Algebra
• 2 years of History/Social Studies, including one year of United States History or one-half year of United States History and one-half year of Civics or American Government; and one year of World History, Cultures, and Geography
• 2 years of Science with lab required chosen from Biology, Chemistry, and Physics
• 2 years of Foreign Language and must be the same language for those two years
• 1 year of Visual and Performing Arts chosen from Dance, Drama/Theater, Music, or Visual Art
• 1 year of Electives

¹ University of California, Office of the President (UCOP). ² California Department of Education, DataQuest, 2015. ³ See footnotes on page 46 for program descriptions.
Percent of Graduates in Orange County and California Meeting UC/CSU Entrance Requirements, 2004/05 to 2013/14

Source: California Department of Education, DataQuest, 2015

Percent of Graduates Meeting UC/CSU Entrance Requirements, by District, 2013/14

Source: California Department of Education, DataQuest, 2015

Number of Graduates and Percent Graduates Meeting UC/CSU Entrance Requirements, 2013/14

Source: California Department of Education, DataQuest, 2015
SAFE HOMES AND COMMUNITIES INDICATORS

PREVENTABLE CHILD AND YOUTH DEATHS

UNINTENTIONAL INJURY DEATH RATE PER 100,000 YOUTH 1 TO 19 YEARS OLD

<table>
<thead>
<tr>
<th>Year</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>6.4</td>
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<tr>
<td>2013</td>
<td>6.0</td>
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</table>

JUVENILE ARRESTS

JUVENILE ARREST RATE PER 100,000 YOUTH 10 TO 17 YEARS OLD

<table>
<thead>
<tr>
<th>Year</th>
<th>Rate</th>
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</thead>
<tbody>
<tr>
<td>2004</td>
<td>3,588</td>
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<tr>
<td>2013</td>
<td>2,076</td>
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</table>

SUBSTANTIATED CHILD ABUSE

SUBSTANTIATED CHILD ABUSE ALLEGATIONS RATE PER 1,000 CHILDREN 0 TO 17 YEARS OLD

<table>
<thead>
<tr>
<th>Year</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>11.0</td>
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<tr>
<td>2014</td>
<td>7.5</td>
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</tbody>
</table>

JUVENILE SUSTAINED PETITIONS

SUSTAINED PETITIONS PER 100,000 YOUTH 10 TO 17 YEARS OLD

<table>
<thead>
<tr>
<th>Year</th>
<th>Rate</th>
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</thead>
<tbody>
<tr>
<td>2003</td>
<td>1,048</td>
</tr>
<tr>
<td>2013</td>
<td>800</td>
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</tbody>
</table>

CHILD WELFARE

MEDIAN MONTHS IN FOSTER CARE TO REUNIFICATION (EXIT COHORT)

<table>
<thead>
<tr>
<th>Year</th>
<th>Rate</th>
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<tr>
<td>2004/05</td>
<td>8.7</td>
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<tr>
<td>2013/14</td>
<td>12.7</td>
</tr>
</tbody>
</table>

GANG MEMBERSHIP

JUVENILE GANG MEMBERS PER 100,000 YOUTH

<table>
<thead>
<tr>
<th>Year</th>
<th>Rate</th>
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<tbody>
<tr>
<td>2005</td>
<td>261</td>
</tr>
<tr>
<td>2014</td>
<td>139</td>
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</table>

UPWARD TREND

UPWARD TREND NEEDS IMPROVEMENT

DOWNWARD TREND

DOWNWARD TREND NEEDS IMPROVEMENT

DIFFICULT TO ASSESS DUE TO THE NATURE OF THE DATA.
PREVENTABLE
CHILD AND
YOUTH DEATHS

DESPITE A RECENT INCREASE, OVERALL DEATHS DUE TO INJURY HAVE DECLINED SINCE 2003.

DESCRIPTION OF INDICATOR
This indicator reports the number of deaths from unintentional and intentional injuries, including suicide and homicide. Leading causes of death by age group are identified.

Why is this Important?
The death of any child is a tragedy for family and friends, and a loss to the community. Along with the direct impact of a child’s death, the child death rate in a community is an important indicator for public health advocates and policymakers. A high rate can point to underlying problems, such as violent neighborhoods or inadequate child supervision. Unintentional childhood mortality due to injury is strongly inversely related to median income and thus, a solid indicator of poverty. It can also point to inequities, for example, in access to health care or safe places to play. Because children are much more likely to die during the first year of life (infancy) than they are at older ages, trends in infant mortality are discussed separately (pages 14-15).

Findings
• Orange County’s overall injury death rate for children decreased 38% from a peak rate of 12.9 (per 100,000 children one to 19 years) in 2006 to 8.0 in 2013 (115 deaths), lower than California’s rate of 10.9 in 2013.
• The unintentional injury death rate (e.g., accidental poisoning, motor vehicle accident, or drowning) decreased 20% from a peak rate (per 100,000 children one to 19 years) of 7.5 in 2006 to 6.0 in 2013.
• Despite the long term decline, unintentional injury death rates increased 36.4% between 2012 and 2013, driving a one-year increase of 9.6% in the overall injury death rate.
• In contrast, homicide and suicide death rates have remained relatively level during the past 10 years.
• Unintentional injury deaths accounted for the highest average number (39.2 per year) and rate (5.0 per 100,000) of all injury deaths to children one to 19 years of age between 2011 and 2013, followed by cancer (17.7 per year), suicide (10.7 per year), homicide (10.0 per year), and congenital anomalies (8.3 per year).
• Younger children and teens (ages one to 14) tended to have higher average number of deaths for unintentional injuries such as accidental poisoning, drowning, and motor vehicle occupant deaths.
• Older teens (ages 15 to 19) tended to have higher average number of deaths per year due to suicide (9.3 per year) and homicide (8.3 per year) in addition to unintentional injury deaths (23.3 per year) which primarily included accidental poisoning and motor vehicle incidents.

1 Infant, Child and Teen Mortality, updated June 2013.
Injury, Unintentional Injury, Suicide and Homicide, Rate per 100,000 Children, One to 19 Years Old, 2004 to 2013

- Unintentional Injury
- Suicide
- Homicide
- All Injury Deaths

Source: Orange County Health Care Agency

Injury Death Rates Per 100,000 Children, One to 19 Years Old 2004 to 2013

- California
- Orange County

Source: Orange County Health Care Agency

Leading Causes of Death for Children One to 19 Years Old, by Age Group and Number of Deaths, (2011-2013)

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<tbody>
<tr>
<td>1-4 Years</td>
<td>26</td>
<td>10</td>
<td>7</td>
<td>12</td>
<td>9</td>
<td>12</td>
<td>9</td>
<td>12</td>
<td>9</td>
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<tr>
<td>5-9 Years</td>
<td>10</td>
<td>7</td>
<td>12</td>
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<tr>
<td>10-14 Years</td>
<td>15</td>
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<tr>
<td>15-19 Years</td>
<td>70</td>
<td>45</td>
<td>30</td>
<td>20</td>
<td>55</td>
<td>30</td>
<td>20</td>
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<tr>
<td>1-19 Years Total</td>
<td>118</td>
<td>90</td>
<td>118</td>
<td>90</td>
<td>118</td>
<td>90</td>
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</table>

HIGHEST

Unintentional Injuries (26)
Drowning/Submersion (11)
Cancer (7)
Congenital Anomalies (3)
Influenza/Pneumonia (2)

LOWEST

Cancer (9)
Diseases of the heart (4)
Congenital Anomalies (3)
Homicide (4)
Suicide (4)

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

SUBSTANTIATED CHILD ABUSE ALLEGATIONS DROP 37% BETWEEN 2005 AND 2014.

DESCRIPTION OF INDICATOR
This indicator reports the unduplicated count of children with substantiated child abuse allegations. Allegations refer to the nature of abuse or neglect that a child is experiencing (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.

Why is this Important?
Studies indicate that victims of child abuse are more likely to use drugs and alcohol, become homeless as adults, engage in violence against others and be incarcerated. The identification of a family in which a substantiated incident of abuse or neglect has occurred is important because it provides an opportunity for intervention to assure child safety. Once a child abuse referral is substantiated by the investigating social worker and safety threats for the child(ren) are identified, a social worker works with the family to develop a safety plan.

Findings
- In 2014, 29,578 children were the subject of one or more child abuse allegations. Of these, 18.1% (5,370) of children had substantiated allegations of child abuse with a 37.6% decrease from 39.0% (8,611) of children in 2005.¹
- In 2014, substantiated allegations occurred at a rate of 7.5 per 1,000 children, a 31.8% decrease from 11.0 in 2005, and lower than California (8.7), with a 24.3% decrease from 11.5 in 2005.¹
- In 2013, there were approximately 679,000 maltreated children in the United States, a rate of 9.1 per 1,000 children, higher than Orange County and California.²
- At 29.6%, children six to 10 years of age comprised the most child abuse reports, followed by children 11 to 15 (27.2%), one to five (26.3%), 16 to 17 (10.8%), and less than one year of age (6.1%).
- In 2014, general neglect made up the largest type of substantiated child abuse allegations at 44.2%, followed by at-risk/sibling abuse (26.0%), physical abuse (16.2%) and sexual abuse (10.8%) allegations. Severe Neglect (1.3%), Caretaker Absence (0.9%) and Emotional Abuse (0.6%) made up the remaining types.

Substantiated Child Abuse Allegations, Rate per 1,000 Children Under 18 Years Old
2005 to 2014
- Orange County
- California

Note: Rates are based on unduplicated count of children.
Source: County of Orange, Social Services Agency, 2014

Total Number of Children with Child Abuse Allegations and Substantiated Allegations
2005 to 2014
- Child Abuse Allegations
- Substantiated Allegations

Note: Rates are based on unduplicated count of children.
Source: CWS/CMS 2015 Quarter 1 Extract, Orange County Social Services Agency

Substantiated Child Abuse Allegations, Rate per 1,000 Children, by City, 2014

Rate Per 1,000 Children
- 10.0 and Greater
- 6.0 - 9.9
- 3.0 - 5.9
- 0.0 - 2.9
- Unincorporated

* The rate is not reported due to the small number of children living in Laguna Woods.
Why is this Important?
The placement of children in out-of-home care is an indicator of when a parent is unable to provide a safe environment. Child abuse and neglect is a serious problem that crosses socioeconomic and race-ethnic boundaries and has a profound effect on the safety and well-being of the children. The number of children growing to maturity in out-of-home care has gained considerable national, statewide and local attention. Too often these children experience multiple placements, which can be related to attachment disorders, poor educational outcomes, mental health and behavioral problems, poor preparation for independent living and negative adult outcomes, and can lead to the inability to reunite with their families or attach to a new permanent family.

Findings
• In 2013/14, the median time to reunification was 12.7 months for children in foster care in Orange County, higher than California at 8.7 months. The national goal is 5.4 months.
• Only 5.8% of children in Orange County reentered foster care within 12 months of reunification, a decrease of 18.3% from 2003/04 to 2012/13. Orange County is lower than California at 12.1%.
• In 2013/14, 32.6% of children who were in foster care for more than two years were placed in a permanent home by the end of the year, a 47.5% increase since 2004/05 (22.1%).
• Most recently, Orange County (32.6%) surpassed California (24.7%) in finding a permanent home for children in foster care for more than two years.

1 Exits to Permanency measures children who were in foster care for 24 months or longer on the first day of the year, who were then transitioned to a permanent home at the end of the year. Permanency is defined as achieved when the child is reunited with the family, placed with a legal guardian, or adopted. ² University of California, Berkley, Center for Social Services Research, 2013.
Median Time in Months to Reunifications (Exit Cohort) 2004/05 to 2013/14

- Orange County
- California

Source: CWS/CMS 2015 Quarter 1 Extract, UC Berkley, Center for Social Services Research

Percent of Children Reentering Foster Care within 12 months of Reunification, Orange County and California 2003/04 to 2012/13

- California
- Orange County

Note: Due to the methodological differences, the reporting period for no reentry following reunification will always be one year behind what is reported for the other measures.

Source: CWS/CMS 2014 Quarter 4 Extract, UC Berkley, Center for Social Services Research. Latest data available

Percent of Children in Foster Care, 24+ Months, Placed in a Permanent Home 2004/05 to 2013/14

- Orange County
- California

Note: Permanency is defined as achieved when the child is reunited with the family, placed with a legal guardian, or adopted.

Sources: CWS/CMS 2015 Quarter 1 Extract, UC Berkley, Center for Social Services Research
Why is this Important?

An arrest is usually the first formal encounter a youth has with the juvenile justice system. It is particularly important that at this onset of criminal activity, a pattern of juvenile delinquency does not continue into adulthood. More importantly, the flow of youthful offenders into the justice system should be prevented. By getting involved in children’s lives early, later crime can be effectively reduced.\(^1\) Prevention programs positively impact the general public because they stop this crime from happening in the first place.\(^2\) Various cost-benefit analyses show that early prevention programs provide value for money and can be a worthwhile investment of government resources compared with prison and other criminal justice responses.\(^3\)

Findings

- In 2013, there were 6,892 juvenile arrests in Orange County, and 96,718 in California.
- Since 2004 there was a 47% decrease in the total number of juvenile arrests in Orange County from 12,989 to 6,892 arrests.
- In 2013, Orange County’s juvenile arrest rate was 2,076 per 100,000 youth 10 to 17 years old, a decrease of 42% from 2004, compared to California’s rate of 2,370, a decrease of 51% since 2004.
- In Orange County, felonies accounted for 27% [1,866] and misdemeanors accounted for 57% [3,902] of arrests among youth ages 17 years and under in 2013.
- In 2013, 8.6% [102] of fatal and injury collisions due to driving under the influence (DUI) of alcohol involved youth under the age of 21 years; 80% of those youth were male.
- Among 18 to 20 year olds, DUI convictions have increased by 4% since 2004 with a peak of 1,226 convictions in 2009. Among youth under 18 years, there was a 12% decrease since 2004, with a peak of 84 convictions in 2008.

---

1 Zagar, R.J., Busch, K.G., and Hughes, J.R., 2009.  
Juvenile Arrest Rate per 100,000 Youth 10 to 17 Years Old
Orange County and California, 2004 to 2013

- Orange County
- California

Note: 2004 to 2012 figures were based on population projections as of 2007 while 2013 figures were based on revised projections as of Dec 2014

Sources: Criminal Justice Statistics Center, California Department of Justice
Demographic Research Unit, California State Department of Finance

Percent Youth 0-20 Years in Fatal and Injury Collisions by “Had Been Drinking Drivers,” by Age
2011 to 2013

DUI Convictions in Orange County, by Age
2004 to 2013

Note: Information on crash involvement is maintained and produced by the California Highway Patrol; 2013 crash data is the most recent available. Data includes all youth involved whether driver or passenger.

Source: California Highway Patrol, Information Services Unit Statewide Integrated Traffic Records System, Table 5J

Percent of Juvenile Arrests, by City, Youth 10 to 17 Years Old
2013

Note: 2013 figure for OC Sheriffs may include Yorba Linda.

Sources: Criminal Justice Statistics Center, California Department of Justice, Demographic Research Unit, California State Department of Finance

SAFE HOMES & COMMUNITIES
JUVENILE SUSTAINED PETITIONS

JUVENILE SUSTAINED PETITION RATES DECLINE; RACIAL DISPARITIES PERSIST.

DESCRIPTION OF INDICATOR

This indicator reports the number and percent of juvenile sustained petitions. After a juvenile arrest, a referral is typically made by the arresting officer to the Probation Department for further processing. The probation officer decides whether a referral is dismissed, the juvenile is placed on informal probation or a petition will be sought for a formal court hearing. When a petition is sustained by the court, the juvenile becomes a ward of the court. A ward is either allowed to go home under the supervision of a probation officer or ordered for detention in a juvenile institution.

Why is this Important?

Sustained juvenile petitions are similar to an adult criminal conviction. They indicate where and what types of crimes are occurring among youth. Many agencies have a role to play in helping to meet California’s goal of rehabilitation for youth who have a sustained petition, including schools, social services agencies, and community-based organizations. Knowledge about sustained juvenile petitions can help provide strategic direction to prevention, early intervention, and rehabilitation efforts in Orange County.

Findings

- In 2013, there were 2,657 juvenile sustained petitions, a 14% decrease from 2012 (3,078).
- The rate of sustained petitions per 100,000 youth ages 10 to 17 years old was 800 in 2013, a 9.4% decrease from 2012 (883 per 100,000), and a 23.7% decrease from 2003 (1,048 per 100,000).
- Sustained petitions were highest among youth 15 to 17 years old who comprised 86.9% of total sustained petitions, followed by youth 12 to 14 years old (12.9%) and youth 11 years and younger (0.2%).
- When assessed by race and ethnicity, Hispanic youth (75.0%) comprised the greatest proportion of sustained petitions, followed by White (16.4%), Black (3.7%), Asian (2.7%), and Other (2.2%) youth in 2013.
- Across genders, the vast majority of sustained petitions were on juvenile males (83.0%), with juvenile females accounting for 17.0% of sustained petitions in 2013.
Juvenile Sustained Petitions, Rate per 100,000 Youth 10 to 17 Years Old, Orange County, 2003, 2012, and 2013

Percent of Juvenile Sustained Petitions, Rate per 100,000 Youth 10 to 17 Years Old, by City, 2013

Source: Orange County Probation, Research Division

Percent of Juvenile Arrests with a Sustained Petition, Youth 10 to 17 Years Old, by Age, 2013

1. 11 and under
2. 12-14 Years of Age
3. 15-17 Years of Age

Source: Orange County Probation, Research Division

Juvenile Sustained Petitions, Rate per 100,000, Youth 10 to 17 years old, by City, 2013

Source: Orange County Probation, Research Division

Rate of Sustained Petitions
1. 850.0 - 1,500.0
2. 501.0 - 849.9
3. 251.0 - 500.9
4. 0.0 - 250.9

GANG MEMBERSHIP

GANG MEMBERSHIP DECREASES NEARLY 50% IN 10 YEARS.

DESCRIPTION OF INDICATOR
This indicator reports the number and percent of known gang members 10 to 17 years of age.

Why is this Important?
Data consistently shows that gang members are responsible for a disproportionately high number of crimes committed by youth offenders. Compared to other delinquent youth, gang members are more extensively involved in serious and violent criminal behavior. Juvenile gang members commit serious and violent offenses at a rate several times higher than non-gang adolescents. From a societal standpoint, the issue of juvenile gangs is one that requires swift action both for the well-being and safety of communities and the youth who get caught up in this dangerous lifestyle.

Findings
• There was a 48.9% decrease in the total number of known gang members ages 10 to 17 years old, from 963 in 2005 to 460 individuals in 2014.
• Since 2005, there was a 64.3% decrease in the total known gang members ages 10 to 14 years old (115 in 2005 to 41 in 2014) and a 50.6% decrease in gang members ages 15 to 17 years old (848 in 2005 to 419 in 2014).
• The rate of known gang members was 139 per 100,000 for 10 to 17 year olds in 2014.
• Broken down by age, 10 to 14 year old juvenile gang members decreased from 27 to 12 per 100,000 from 2004 to 2014. For 15 to 17 years old, the rate decreased from 227 to 127 per 100,000 from 2004 to 2014.
• Across ethnicities, Hispanic youth represented the highest proportion of juvenile gang members (90%), followed by Other (8%), Asian (1%), White (1%) and Black (0%) youth.
• Nationally, in 2012, there were an estimated 30,700 gangs (an increase from 29,900 in 2011) and 850,000 gang members (an increase from 782,500 in 2011) throughout 3,100 jurisdictions with gang problems (down from 3,300 in 2011). The number of reported gang-related homicides increased 20% from 1,824 in 2011 to 2,363 in 2012.\(^1\)

Percent of Total Juvenile Gang Members, by Race/Ethnicity 10 to 17 Years Old
2005 and 2014

- **Asian**
- **Black**
- **Hispanic**
- **White**
- **Other/Unknown**

2005:
- 92%

2014:
- 90%

Source: Orange County District Attorney’s Office
Note: In 2014, 0% of black youth were gang members.

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Gang membership continues to disproportionately affect Hispanic youth.

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Total Number of Known Juvenile Gang Members 10 to 17 Years Old, by Age
2005 to 2014

- **10 to 14 years old**
- **15 to 17 years old**
- **Rate per 100,000**

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<td>90</td>
<td>72</td>
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Source: Orange County District Attorney’s Office
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