FDOH JACKSON

HEALTH EQUITY PLAN

June 2022– June 2027

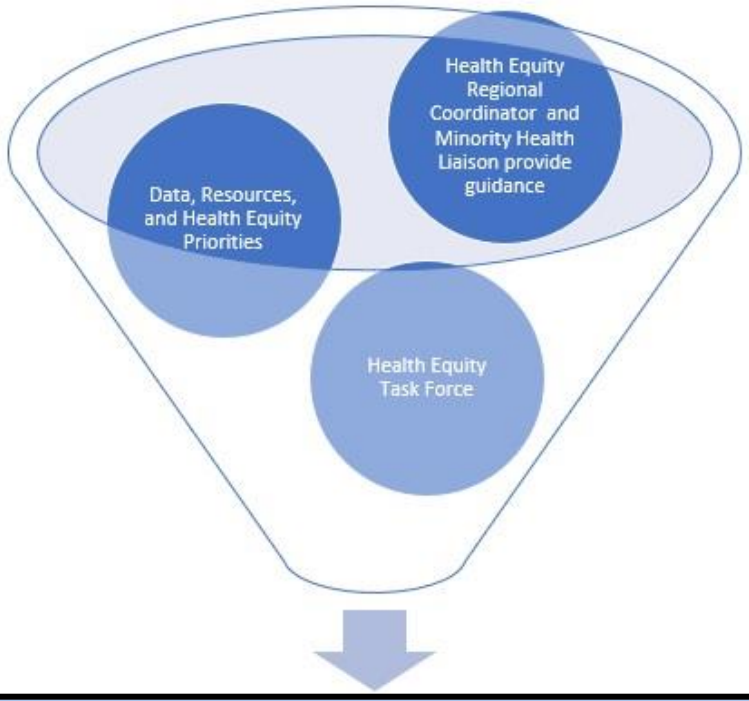
Florida HEALTH
Jackson County

Updated 06/22

Table of Contents

I. VISION

As a response to Chapter 2021-117: Office of Minority Health and Health Equity, the Florida Department of Health in Jackson County (FDOH-Jackson) was able to build its capacity to obtain a Minority Health Liaison to form partnerships and promote health equity in the community. In February 2022, an internal Health Equity Team consisting of representation from all departments within FDOH-Jackson was established and the concept of health equity was quickly accepted and integrated throughout all program areas in FDOH-Jackson. The Health Equity Team met multiple times in order to learn about health equity, health disparities, the Social Determinants of Health, and what these concepts mean for Jackson County. The Health Equity Team discussed the Jackson County Community Health Assessment, other data from the county, community resources and organizations that work within the different Social Determinants of Health, and what our vision for the county would be. In April 2022, the Health Equity Team and Task Force members agreed on the below vision after considering all facets and what they wish to see in Jackson County regarding Health Equity.



Vision: To improve the health of all Jackson County residents by addressing the Social Determinants of Health and minimizing health disparities.

II. PURPOSE OF THE HEALTH EQUITY PLAN

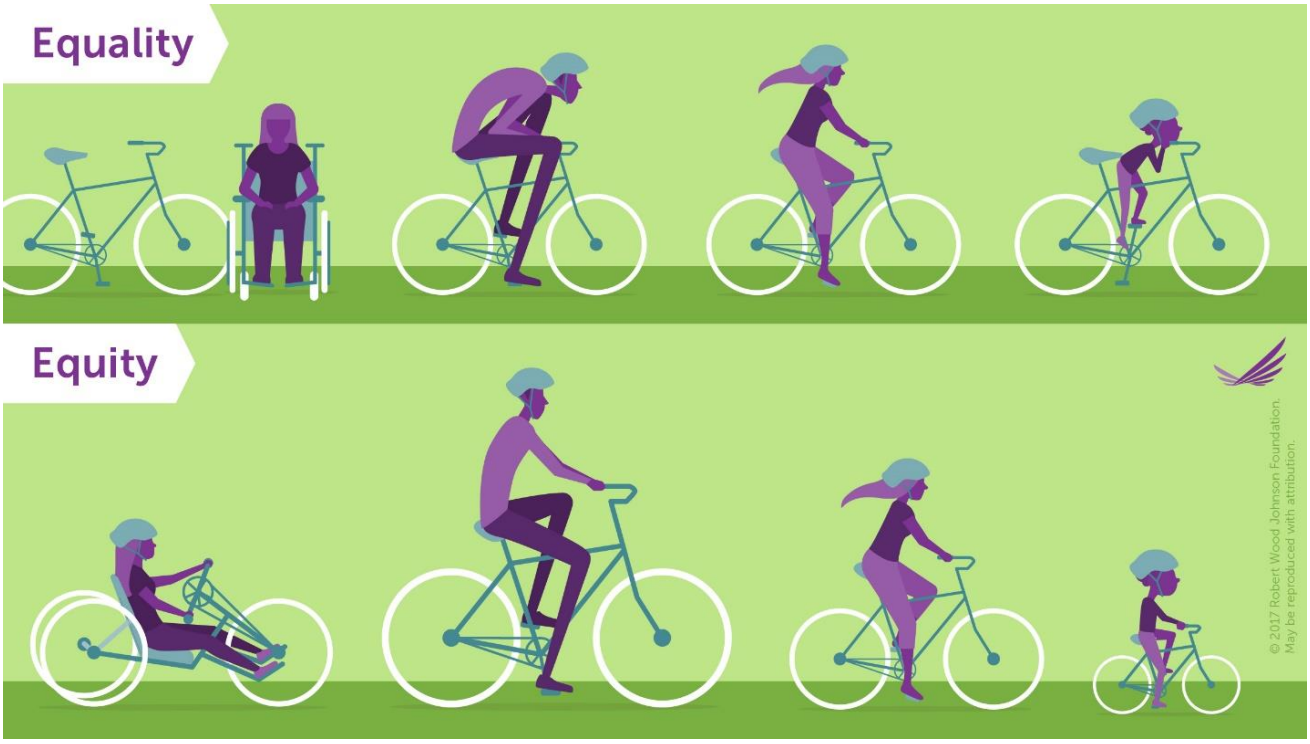
Health Equity is achieved when everyone can attain optimal health.

The Florida Department of Health's Office of Minority Health and Health Equity (OMHHE) works with government agencies and community organizations to address the barriers inhibiting populations from reaching optimal health. A focus on health equity means recognizing and eliminating the systemic barriers that have produced disparities in achieving wellness. In response to Chapter 2021-117 of the Florida Statute, effective July 1, 2021, each county health department (CHD) has been provided resources to create a Health Equity Plan to address health disparities in their communities.

The Health Equity Plan should guide counties in their efforts to create and improve systems and opportunities to achieve optimal health for all residents, especially vulnerable populations. County organizations have a critical role in addressing the social determinants of health (SDOHs) by fostering multi-sector and multi-level partnerships, conducting surveillance, and integrating data from multiple sources, and leading approaches to develop upstream policies and solutions. This plan acknowledges that collaborative initiatives to address the SDOHs are the most effective at reducing health disparities.

The purpose of the Health Equity Plan is to increase health equity within Jackson County. To develop this plan, Jackson County Health Department followed the Florida Department of Health's approach of multi-sector engagement to analyze data and resources, coordinate existing efforts, and establish collaborative initiatives. This plan addresses key SDOH indicators affecting health disparities within Jackson County. This Health Equity Plan is not a county health department plan; it is a county-wide Health Equity Plan through which the Health Equity Taskforce, including a variety of government, non-profit, and other community organizations, align to address the SDOH impact health and well-being in the county.

III. DEFINITIONS



Health equity is achieved when everyone can attain optimal health

Health inequities are systematic differences in the opportunities groups have to achieve optimal health, leading to avoidable differences in health outcomes.

Health disparities are the quantifiable differences, when comparing two groups, on a particular measure of health. Health disparities are typically reported as rate, proportion, mean, or some other measure.

Equality each individual or group of people is given the same resources or opportunities.

Social determinants of health are the conditions in which people are born, grow, learn, work, live, worship, and age that influence the health of people and communities.

IV. PARTICIPATION

Cross-sector collaborations and partnerships are essential components of improving health and well-being. Cross-sector collaboration uncovers the impact of education, health care access and quality, economic stability, social and community context, neighborhood and built environment and other factors influencing the well-being of populations. Cross-sector partners provide the range of expertise necessary to develop and implement the Health Equity Plan.

Community Partners present at Minority Health Fest in April

Jackson County is unique in that its rural nature affords rich cross-sector collaborations and partnerships with multiple community partners, as we all work together to promote health and wellness to our very rural community. FDOH Jackson takes pride in their involvement in many community partnerships, coalitions, and task forces, including but not limited to the Healthy Start Coalition, J-Trans Coalition, Jackson County Strong Families Coalition, Jackson County

Opioid Prevention Task Force, UF/IFAS Extension Partnership, FAMU Extension Partnership, Tobacco Prevention Partnership, and School Health Advisory Board. A prime example of the rich partnerships in Jackson County is the Minority Health Fest event held in April, where 22 community vendors came together to educate the community on the services and resources available to them. FDOH Jackson communicates regularly with community partners in a variety of ways, whether by face-to-face or a virtually, in order to strengthen these existing relationships and develop new cross-sector partnerships. Their input was invaluable during the Health Equity Plan process.

A. Minority Health Liaison

The Minority Health Liaison supports the Office of Minority Health and Health Equity in advancing health equity and improving health outcomes of racial and ethnic minorities and other vulnerable populations through partnership engagement, health equity planning, and implementation of health equity projects to improve social determinants of health. The Minority Health Liaison facilitates health equity discussions, initiatives, and collaborations related to elevating the shared efforts of the county.

Minority Health Liaison: Emily Bass
Minority Health Liaison Backup: Katrice Davis

B. Health Equity Team

The Health Equity Team includes individuals that each represent a different program within the CHD. The Health Equity Team explores opportunities to improve health equity efforts within the county health department. Members of the Health Equity Team assess the current understanding of health equity within their programs and strategize ways to improve it. The Health Equity Team also relays information and data concerning key health disparities and SDOH in Jackson to the Health Equity Taskforce. The Minority Health Liaison guides these discussions and the implementation of initiatives. The membership of the Health Equity Team is listed below.

Name	Title	Program
Emily Bass	Minority Health Liaison	Minority Health/Health Equity
Carrie Rickman	Regional Coordinator	Minority Health/Health Equity
Katrice Davis	Program Specialist	Chronic Disease
Candice Hudson	Clinical Supervisor	Clinic
Karen Edwards	Tobacco Prevention Specialist	Tobacco Prevention
Whitney Merritt	Health Educator	Diabetes Prevention Program
Sarah Ford	Nutritionist	WIC
Cortelia Thornton-Olds	Health Educator	SnapEd
Sharron Jones	Health Educator	SnapEd
Tara Peterson	Nurse	Covid Operations

The Health Equity Team met on the below dates during the health equity planning process. Since the Health Equity Plan was completed, the Health Equity Team has met at least quarterly to track progress.

Meeting Date	Topic/Purpose
February 7, 2022	Health Equity Overview/Team Roles & Responsibilities
February 15, 2022	CHA Review/Health Disparity Prioritization
March 15, 2022	Task Force Brainstorming /Identifying Resources in Community Regarding Health Disparity (Diabetes)/ SDOH impacts/ Health Equity Vision
June 3, 2022	HEP Review, Program updates

C. Health Equity Taskforce

The Health Equity Taskforce includes CHD staff and representatives from various organizations that provide services to address various SDOH. Members of this Taskforce brought their knowledge about community needs and SDOH. Collaboration within this group addresses upstream factors to achieve health equity. The Health Equity Taskforce wrote the Jackson Health Equity Plan and oversaw the design and implementation of projects. Health Equity Taskforce

members are listed below. Please note that recruitment efforts are ongoing, as the Community Health Improvement Plan workgroup will resume meetings again near the end of 2022. New members will be added in future revisions to this plan.

Name	Title	Organization	Social Determinant of Health
Katrice Davis	Chronic Disease Prevention Supervisor	Florida Department of Health	Access to Quality Education
Karen Edwards	Tobacco Prevention Specialist	Tobacco Prevention program	Access to Quality Education
Whitney Merritt	Health Educator	Diabetes Prevention Program	Access to Quality Education
Sean Golder	Lead Outreach	PanCare Health	Access to Quality Healthcare
Kevin Yoder	Pastor	Rivertown Community Church	Social Context – Neighborhood/Built Environment –Faith Based
Reverend Ron Mizer	Reverend	St. James AME Church	Neighborhood/Built Environment – Social Context – Faith Based
David Taylor	Prevention Program Director	Healthy Start	Access to Quality Education
David Taylor	Prevention Program Director	C.A.R.E.	Access to Quality Education

The Health Equity Taskforce met on the below dates during the health equity planning process. These recorded meetings were the initial recruitment and overview meetings with community organizations. The first in-person meeting for all current members is planned for July 2022. While there has not been an in-person meeting to date, communication with these organizations has been ongoing and their input and insight has helped to develop this plan. This plan

was submitted to the Task Force via email and feedback was requested, gathered, and included in the final version of this plan.

Meeting Date	Organizations	Topic/Purpose
4/29/22	FDOH Jackson, PanCare Health	HEP Overview/Objectives/Project Vision
5/5/22	FDOH Jackson	HEP Overview/Objectives/Project Vision
5/12/22	FDOH Jackson, St. James AME Church	HEP Overview/Objectives/Project Discussion
5/25/22	FDOH Jackson, Rivertown Community Church	HEP Overview/Objectives/Project Brainstorming
5/26/22	FDOH Jackson, Healthy Start, C.A.R.E.	HEP Overview/Objectives/Project Discussion
6/7/22	FDOH	HEP Final Review, Revisions

D. Coalition

The Coalition discussed strategies to improve the health of the community. The strategies focused on the social determinants of health: education access and quality, health care access and quality, economic stability, social and community context, and neighborhood and built environment. Membership includes community leaders working to address each SDOH, as well as any relevant sub-SDOHs. The Coalition assisted the Health Equity Taskforce by reviewing their Health Equity Plan for feasibility. See Page 64 for a list of Coalition members. Please note that the current list is fluid and new members are being identified and added frequently. New members will be added on future revisions of this plan. This plan was submitted to the Coalition via email and a meeting was held to review and discuss edits or revisions needed to be made. They have been incorporated into the final version of this plan.

E. Regional Health Equity Coordinators

There are eight Regional Health Equity Coordinators. These coordinators provide the Minority Health Liaison, Health Equity Team, and Health Equity Taskforce with technical assistance, training, and project coordination.

Name	Region	Expertise
Carrie Rickman	Emerald Coast	Technical Assistance, Training, and Project Coordination
Quincy Wimberly	Capitol	Technical Assistance, Training, and Project Coordination
Diane Padilla	North Central	Technical Assistance, Training, and Project Coordination
Ida Wright	Northeast	Technical Assistance, Training, and Project Coordination
Rafik Brooks	West	Technical Assistance, Training, and Project Coordination
Lesli Ahonkhai	Central	Technical Assistance, Training, and Project Coordination
Frank Diaz	Southwest	Technical Assistance, Training, and Project Coordination
Kimberly Watts	Southeast	Technical Assistance, Training, and Project Coordination

V. HEALTH EQUITY TRAINING AND PROMOTION

A. County Health Equity Training

Below are the dates, SDOH training topics, and organizations who attended training.

Date	Topics	Organization(s) receiving trainings
4/29/22	Health Equity overview, Jackson's Health Disparity data, SDOHs impact on health outcomes, Health Equity Plan objectives	FDOH Jackson, Jackson Hospital, Women's Pregnancy Center, Healthy Families, Healthy Start, C.A.R.E., FAMU extension office, Bay CHD HIV section, Prestige Adult Care services, Florida Caverns State Park, Marianna Woman's Club, PanCare Health, BASIC NWFL, CareerSource Chipola,

B. County Health Department Health Equity Training

The Florida Department of Health in DOH-Jackson County recognizes that ongoing training in health equity and cultural competency are critical for creating a sustainable health equity focus. At a minimum, all DOH-Jackson Health Equity staff receive the *Cultural Awareness: Introduction to Cultural Competency* and *Addressing Health Equity: A Public Health Essential* training. In addition, the Health Equity Team provides regular training to staff on health equity and cultural competency. The training is recorded below.

Date	Topics	Number of Staff in Attendance
1/25/22	Cultural Awareness: Introduction to Cultural Competency and Addressing Health Equity: A Public Health Essential	3
2/7/22	Health Equity and Social Determinants of Health Overview	8
2/17/22	Poverty Simulation: Cultural Competency in Poverty	65 (All Staff)

C. Minority Health Liaison Training

The Office of Minority Health and Health Equity and the Health Equity Regional Coordinator provide training and technical support to the Minority Health Liaison on topics such as: the health equity planning process and goals, facilitation and prioritization techniques, reporting requirements, and taking a systems approach to address health disparities. The Minority Health Liaison training is recorded below.

Date	Topics
1/20	Monthly Minority Health Liaison Meeting
1/25/22	Cultural Competency and Health Equity Training
2/17/22	Monthly Minority Health Liaison Meeting
2/22/22	Regional Coordinator and MHL Training in Tallahassee, FL

2/23/22-2/24/22	ToP Facilitation Methods
3/4/22	Minority Health Liaison SDOH Diabetes Work Group with Kelly Grove
3/17/22	Monthly Minority Health Liaison Meeting
3/22/22	Clearpoint Training
4/21/22	Monthly Minority Health Liaison Meeting
4/22/22	Covid-19 Outreach Health Equity Coordination with Mauricio Palacio
5/10/22 – 6/14/22	Grant Writing Training provided by OMHHE
5/19/22	Monthly Minority Health Liaison Meeting
6/2/22	Emerald Coast MHL Check-In
6/16/22	Monthly Minority Health Liaison Meeting

D. National Minority Health Month Promotion

Flyer for Event

Emerald Coast Regional Coordinator Carrie Rickman, Chronic Disease Supervisor Katrice Davis, MHL Emily Bass

Jackson County held their first “Health Fest: In Celebration of National Minority Health Month” event on April 29, 2022 at a local city park in the heart of Marianna. There were 22 community organizations on site to hand out information on local health resources, as well as free health screenings provided by our local FQHC (PanCare Health) in their mobile bus. Two local food vendors, The Ice Box and Leola’s Crab Shack were on site. These vendors are incredibly popular among Jackson County citizens and minority populations. The Master of Ceremonies, DJ Diamond D, played music and read off health statistics and program information provided to him by Jackson County organizations. He is a well-known and admired community member and gatekeeper within the black community of Jackson County, so many came out to hear his music. The event was advertised by the local newspaper, on social media, and by 500 flyers handed out to approximately 30 local businesses. Emily Bass, MHL, spoke on the importance of health equity among minority populations and introduced the Health Equity Plan. She also spoke on Diabetes (Jackson’s health disparity) and the ways that it was being addressed through the plan. Approximately 100 people attended the event.

VI. PRIORITIZING A HEALTH DISPARITY

The Health Equity Team identified and reviewed health disparities data in Jackson County. Data was pulled from multiple sources including the current Community Health Assessment, Florida Health Charts, Healthy People 2030, FDOH Bureau of Vital Statistics, and CDC's National Vital Statistics System.

The following health disparities were identified in Jackson County: heart disease, cancer, and diabetes. Using NACCHO's Multi-voting Technique, the Health Equity Team prioritized diabetes as Jackson's health disparity to include in the Health Equity Plan, specifically Type 2 diabetes. Many priority populations were researched within Jackson County. However, due to Jackson County's rural nature and small population, there were data gaps within certain populations, including LGBTQ+ and those identifying themselves as "Other" race.

In addition to the data sources above, information supporting this plan was also gathered from CDC.gov, peer reviewed publications, and research journal publications. The references for information pulled from these publications can be found at the end of this document. Data pulled from Florida Health Charts concerning diabetes among Jackson County's priority populations can be found below.

Jackson County:

Jackson County is a rural county in Northwest Florida with a population of 47,319 residents[1]. The county is incredibly uniform, meaning there is little diversity among the population. According to the Census Bureau, 69.6% of the county is White, 26.3% is Black or African American, 4.9% is Hispanic or Latino, and "Other" is 4%. "Other" for Jackson County includes 0.9% American Indian and Alaska Native, 0.7% Asian, 0.3% Native Hawaiian and Other Pacific Islander, and 2.2% Two or More Races[2]. It is also important to note that according to County Health Rankings, Jackson County is among the bottom ranked counties in Florida when it comes to Health Outcome Ranks[3].

In 2019, the percentage of adults who have ever been told that they have diabetes in Jackson County was 18.8% compared to Florida at 11.7%. This puts Jackson County in the fourth quartile, meaning that the percentage of adults who have ever been told that they have diabetes is smaller in the remaining counties in Florida.

Jackson County's elderly population make up 20.6% of the county's residents. In 2019, 34.5% of those 65 and older have been told that they have diabetes, compared to the 45-64 age group at 28.9% and the 18-44 age group at 3.5% (Florida Health Charts). Individuals living with disabilities make up 13.3% of the Jackson County population, and of those individuals, approximately 112 have a diabetes diagnosis (OMHHE). There are approximately 3,831 veterans living in Jackson County. While diabetes data specific to Jackson County veterans could not be located, it is estimated that nearly 25% of veterans enrolled in the VA have diabetes, and diabetes is more prevalent among veterans compared to the general population[4].

When broken down by Race/Ethnicity in Jackson County, the percentage of Non-Hispanic Black adults who have ever been told that they have diabetes is 19.5% compared to Non-Hispanic White adults at 18.9%. The health disparity is discovered when this is broken down further and the rate of hospitalizations and deaths among these populations are considered.

From 2018-2020, the rate of Jackson County Black residents who were hospitalized from diabetes was 229.4 compared to Jackson County White residents at 179.5. Similarly, from 2018-2020, the rate of Jackson County Black residents who died from diabetes was 42.4 compared to Jackson County White residents at 26.4.

The percentage of Hispanic adults who have ever been told that they have diabetes is 7.4% compared to non-Hispanic whites at 18.9% and non-Hispanic blacks at 19.5%. It is interesting to note that the data for Jackson County Hispanic adults who have ever been told that they have diabetes is only available from the years 2016 and 2019 in Florida Health Charts, suggesting that the Jackson County Hispanic population has not adequately been evaluated when it comes to this health outcome. This could explain why their percentages

regarding diabetes are much lower than the non-Hispanic population percentages. Similarly, there is no data for Jackson County Hispanic deaths from diabetes available. Furthermore, it should be noted that the Hispanic population in Jackson County has the highest percentage of individuals without a high school diploma (Figure 15), a higher poverty rate (Figure 20), the lowest percentage of health insurance coverage (Figure 28), and the highest percentage of individuals who couldn't see a doctor in the past year due to cost (Figure 29). Based on the data below, these indicators put an individual at a higher rate for a Diabetes diagnosis. It is also important to note that according to the Office of Minority Health, Hispanics are 1.3 times more likely to die from diabetes than non-Hispanic whites, 70% more likely to be diagnosed with diabetes than non-Hispanic whites, and twice as likely to be hospitalized for treatment of end-stage renal disease related to diabetes than non-Hispanic whites (2018)[5]. For this reason, they are included as a priority population in this plan.

In Jackson County, the data shows that a diabetes diagnosis among those with a lower income and a lower education level is significantly higher than those with a higher income and education level. In 2019, in Jackson County, the percentage of adults who have been told that they have diabetes and make less that $25,000 a year was 23.9% compared to those who have been told that they have diabetes and made more than $50,000 a year at 14%. Similarly, the percentage of adults who have been told that they have diabetes and have less than a high school education was 21.7%, compared to those with more than a high school education at 16.6%.

From the data reviewed, it is apparent that the disparity among the Black and Hispanic population involves the aftercare and management of a diabetes diagnosis, while the actual diagnosis itself more greatly affects the lower educated and lower income populations of Jackson County (from this point they will be referred to as the low socioeconomic population). Specific Census Tracts regarding these disparities can be found in the SDOH Data section of this plan. This Health Equity Plan attempts to delve into this health disparity to discover and confront the social determinants of health related to this chronic disease.

Further data pulled from Florida Health Charts, FDOH's data system, can be found below.

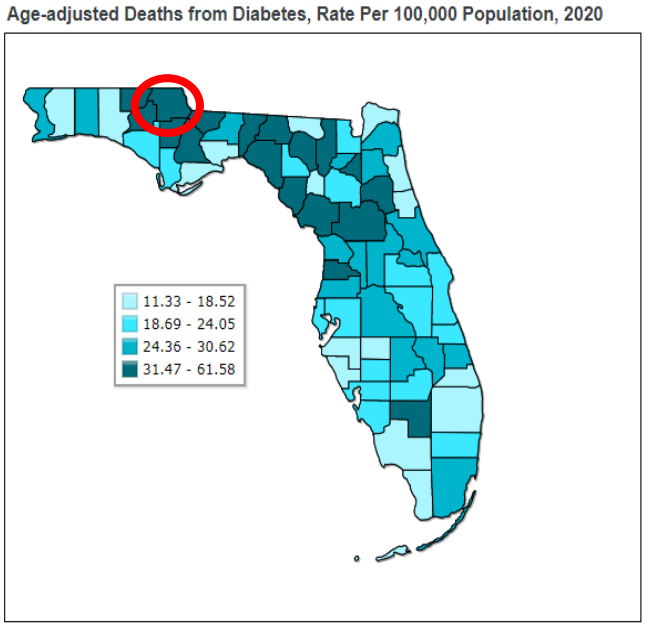


***Figure 1**: Age-adjusted deaths from Diabetes, Rate per 100,00 Population, 2020 / Source: FLHealthCharts.gov*

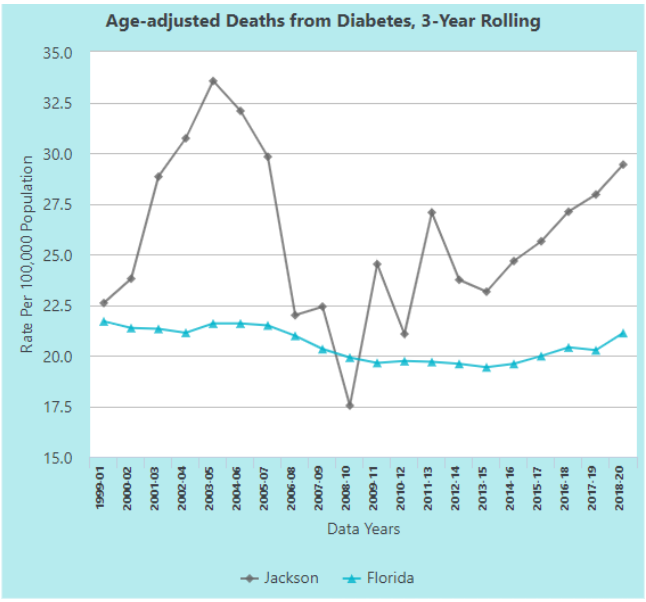


***Figure 2**: Age-adjusted deaths from Diabetes, 3 Year Rolling, Jackson County vs. Florida / Source: FLHealthCharts.gov*

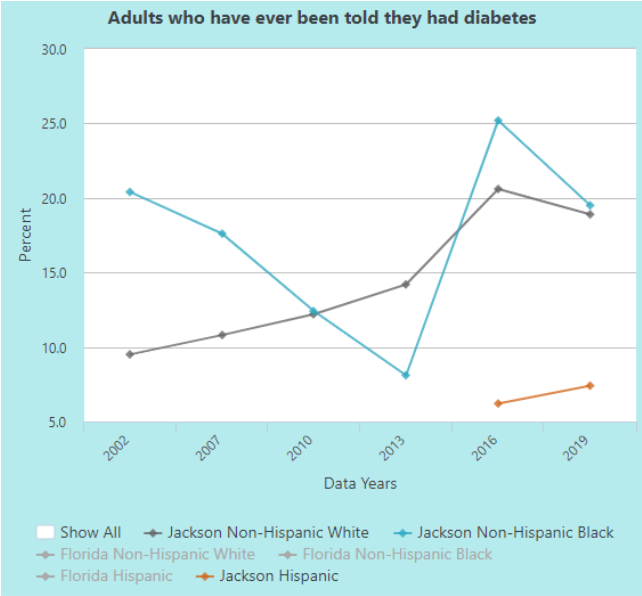


***Figure 3**: Adults who have ever been told they have Diabetes by Race/Ethnicity, Jackson County, 2019 / Source: FLHealthCharts.gov*

Adults who have ever been told they had diabetes						
	Jackson			Florida		
Year	Non-Hispanic White	Non-Hispanic Black	Hispanic	Non-Hispanic White	Non-Hispanic Black	Hispanic
2019	18.9% (14.5% - 23.3%)	19.5% (12.3% - 26.6%)	7.4% (0% - 15.3%)	11.5% (10.5% - 12.4%)	16% (12.8% - 19.1%)	10.6% (8.2% - 13.1%)
2016	20.6% (15.9% - 25.2%)	25.2% (16.5% - 33.9%)	6.2% (0% - 13.7%)	11.5% (10.8% - 12.2%)	14.5% (12.3% - 16.8%)	10.9% (9.3% - 12.6%)
2013	14.2% (9.1% - 19.2%)	8.1% (2.4% - 13.7%)		11.4% (10.7% - 12.2%)	12.3% (10% - 14.6%)	10.8% (8.7% - 12.8%)
2010	12.2% (8.9% - 15.5%)	12.4% (4.8% - 20.1%)		10.1% (9.4% - 10.7%)	13.1% (10.7% - 15.5%)	9.6% (7.2% - 12.1%)
2007	10.8% (7.6% - 15.1%)	17.6% (9.7% - 29.8%)		9% (8.4% - 9.6%)	12.4% (10.4% - 14.8%)	6.6% (5.2% - 8.2%)
2002	9.5% (6.3% - 12.8%)	20.4% (10.7% - 30.1%)		8% (7.4% - 8.6%)	10.6% (8.2% - 13.1%)	7.1% (5% - 9.2%)

***Figure 4**: Adults who have ever been told they have Diabetes by Race/Ethnicity, Jackson County vs. Florida / Source: FLHealthCharts.gov*

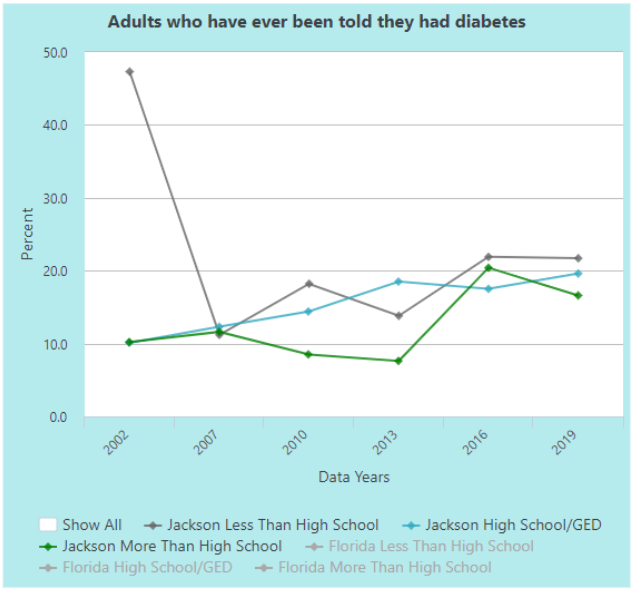


***Figure 5:** Adults who have ever been told they have Diabetes by Education level, Jackson County, 2019 / Source: FLHealthCharts.gov*

Adults who have ever been told they had diabetes						
	Jackson			Florida		
Year	Less Than High School	High School/GED	More Than High School	Less Than High School	High School/GED	More Than High School
2019	21.7% (12.9% - 30.5%)	19.6% (13.5% - 25.7%)	16.6% (12% - 21.3%)	20.3% (16.4% - 24.2%)	12.4% (10.7% - 14.2%)	9.5% (8.5% - 10.5%)
2016	21.9% (13% - 30.7%)	17.5% (11.4% - 23.7%)	20.4% (14.9% - 25.8%)	18.6% (15.9% - 21.3%)	12.6% (11.3% - 13.8%)	9.7% (8.9% - 10.4%)
2013	13.8% (4.6% - 22.9%)	18.5% (10.2% - 26.9%)	7.6% (3.3% - 11.9%)	18% (14.9% - 21.1%)	11.5% (10.3% - 12.6%)	9.2% (8.4% - 9.9%)
2010	18.2% (7.6% - 28.7%)	14.4% (9.2% - 19.6%)	8.5% (5.1% - 12%)	15.4% (12.8% - 18.1%)	11.7% (10.5% - 13%)	9.3% (8.5% - 10.1%)
2007	11.2% (6% - 19.9%)	12.3% (7.6% - 19.3%)	11.6% (7.2% - 18.2%)	14.4% (12.3% - 16.7%)	9.5% (8.4% - 10.7%)	7.5% (6.9% - 8.1%)
2002	47.3% (11.8% - 82.8%)	10.1% (5.5% - 14.7%)	10.2% (5.7% - 14.7%)	13.9% (11.1% - 16.7%)	8.6% (7.4% - 9.7%)	7% (6.3% - 7.8%)

***Figure 6:** Adults who have ever been told they have Diabetes by Education Level, Jackson County vs. Florida / Source: FLHealthCharts.gov*

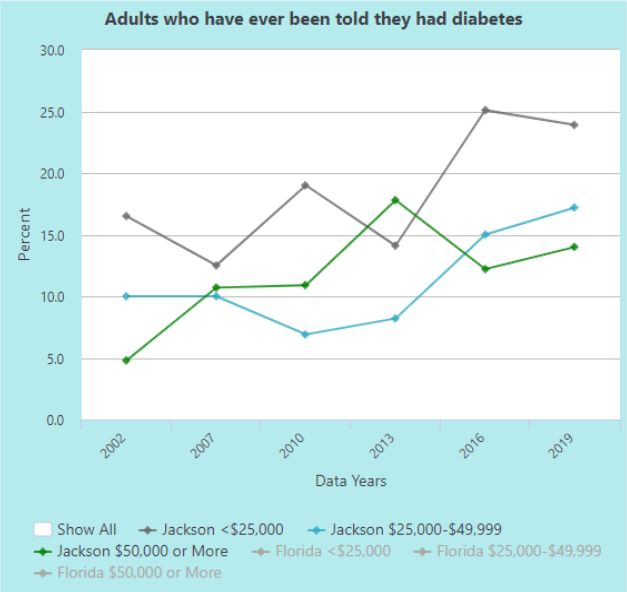


***Figure 7**: Adults who have ever been told they had Diabetes by Income Level, Jackson County, 2019 / Source: FLHealthCharts.gov*

Adults who have ever been told they had diabetes						
	Jackson			Florida		
Year	<$25,000	$25,000-$49,999	$50,000 or More	<$25,000	$25,000-$49,999	$50,000 or More
2019	23.9% (16.7% - 31.2%)	17.2% (10.6% - 23.8%)	14% (8.5% - 19.5%)	16.1% (13.8% - 18.4%)	12.7% (10.3% - 15.1%)	7.9% (6.8% - 9.1%)
2016	25.1% (18.5% - 31.7%)	15% (8% - 22%)	12.2% (5.2% - 19.3%)	16.6% (15.1% - 18.2%)	11.9% (10.5% - 13.4%)	8% (7% - 8.9%)
2013	14.1% (7.4% - 20.8%)	8.2% (2.5% - 13.8%)	17.8% (8.2% - 27.5%)	14.8% (13.1% - 16.4%)	11.9% (10.4% - 13.4%)	7.5% (6.6% - 8.4%)
2010	19% (12.8% - 25.3%)	6.9% (3.1% - 10.7%)	10.9% (4.9% - 16.9%)	14.8% (13.3% - 16.2%)	11.2% (9.7% - 12.7%)	7.3% (6.4% - 8.3%)
2007	12.5% (7.2% - 20.8%)	10% (6.1% - 15.9%)	10.7% (5.4% - 20.1%)	13.3% (11.9% - 14.9%)	8.5% (7.6% - 9.5%)	5.9% (5.2% - 6.7%)
2002	16.5% (10.1% - 22.9%)	10% (4.6% - 15.4%)	4.8% (0.9% - 8.8%)	11.5% (10% - 12.9%)	7.5% (6.4% - 8.7%)	4.9% (4% - 5.8%)

***Figure 8**: Adults who have ever been told they have Diabetes by Income Level, Jackson County vs. Florida / Source: FlHealthCharts.gov*

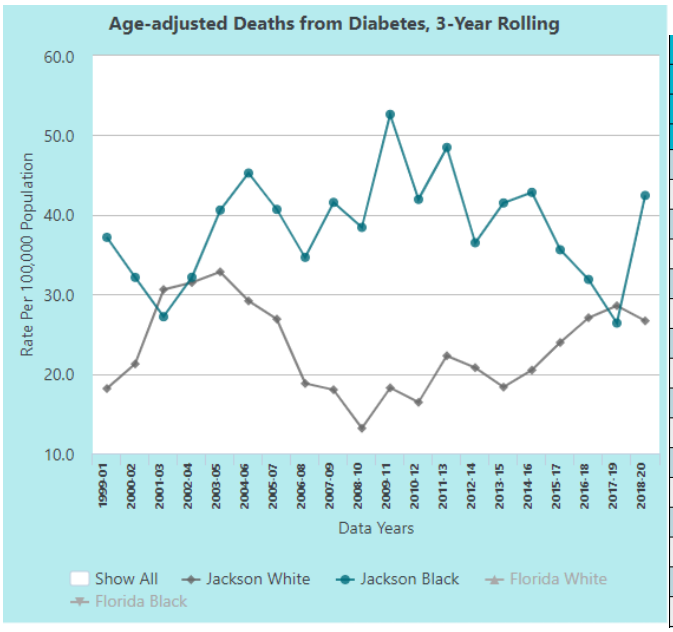


***Figure 9**: Age-adjusted Deaths from Diabetes, 3-year Rolling by Race, Jackson County / Source: FLHealthCharts.gov*

Age-adjusted Deaths from Diabetes, Rate Per 100,000 Population, 3-Year Rolling				
	Jackson		Florida	
	White	Black	White	Black
Data Year	Rate	Rate	Rate	Rate
2018-20	26.7	42.4	18.6	41.1
2017-19	28.6	26.4	18.0	38.8
2016-18	27.1	31.9	18.2	38.8
2015-17	23.9	35.6	17.7	38.9
2014-16	20.5	42.8	17.4	38.5
2013-15	18.3	41.5	17.1	40.0
2012-14	20.8	36.5	17.4	40.5
2011-13	22.3	48.5	17.4	41.4
2010-12	16.4	41.9	17.6	40.5
2009-11	18.2	52.6	17.6	40.6
2008-10	13.2	38.4	17.9	40.6
2007-09	18.0	41.6	18.3	42.6
2006-08	18.8	34.6	18.8	45.2
2005-07	26.9	40.7	19.2	47.3
2004-06	29.2	45.2	19.3	49.1
2003-05	32.8	40.6	19.2	50.8

***Figure 10**: Age-adjusted Deaths from Diabetes, Rate per 100,00 Population, 3-Year Rolling by Race, Jackson County vs. Florida / Source: FLHealthCharts.gov*

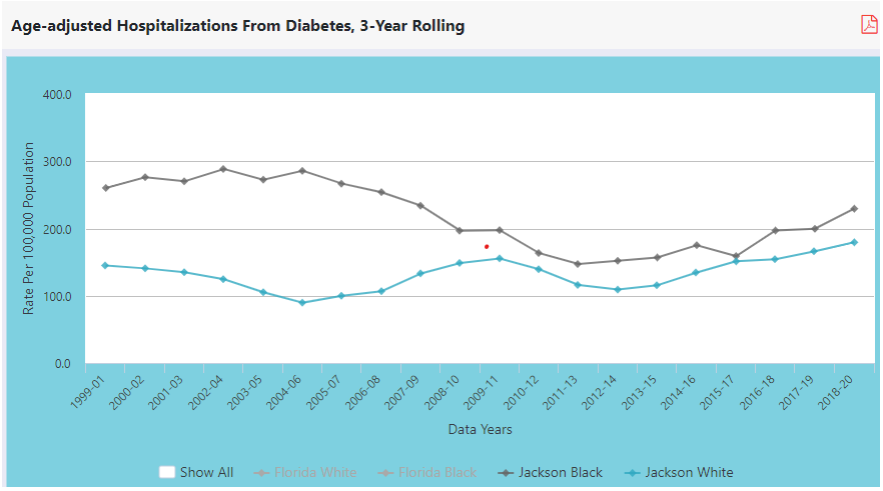


***Figure 11**: Age-adjusted Hospitalizations From Diabetes, 3-Year Rolling by Race, Jackson County / Source: FLHealthCharts.gov*

Age-adjusted Hospitalizations From Diabetes, Rate Per 100,000 Population, 3-Year Rolling

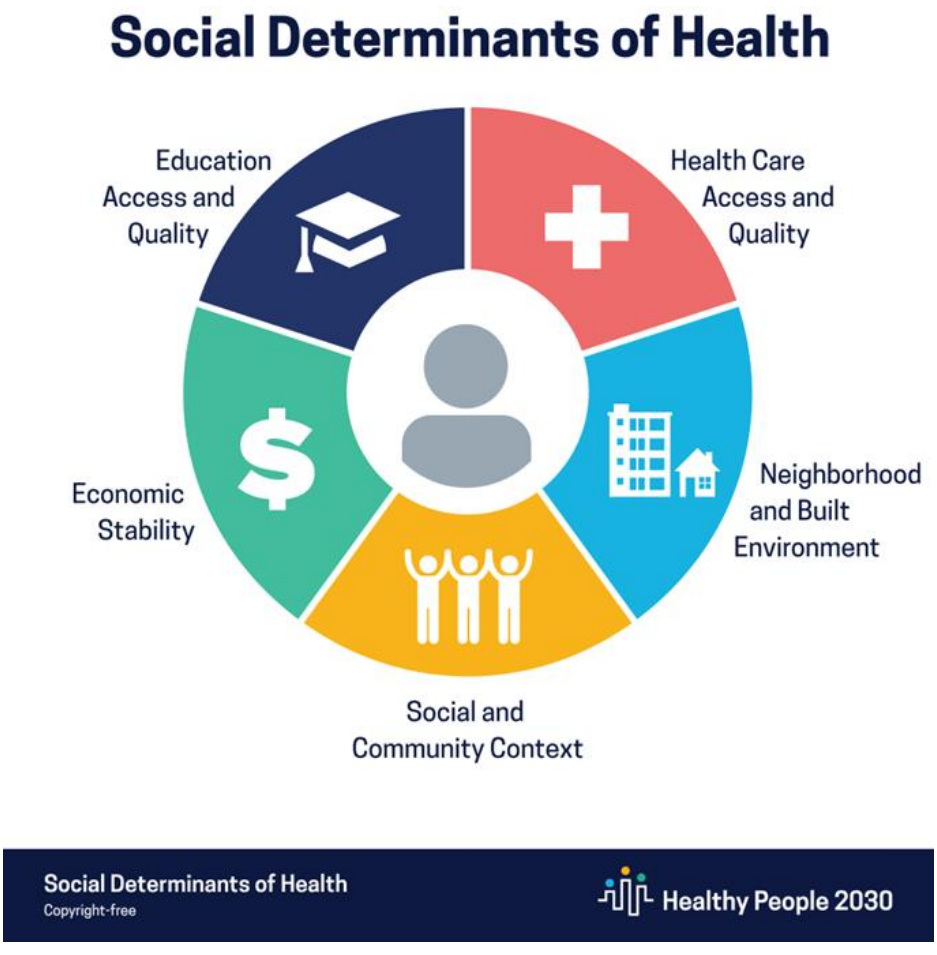
	Jackson		Florida	
	White	Black	White	Black
Data Year	Rate	Rate	Rate	Rate
2018-20	179.5	229.4	166.5	429.6
2017-19	166.1	199.7	171.5	444.0
2016-18	154.3	197.0	165.7	438.1

***Figure 12:** Age-adjusted Hospitalizations from Diabetes by Race, Rate per 100,000 Population, 3-Year Rolling, Jackson County vs. Florida / Source: FLHealthCharts.gov*

VII. SDOH DATA

Social Determinants of Health (SDOHs) are conditions in the places where people live, learn, work, and play that affect a wide range of health and quality-of life-risks and outcomes. The SDOHs can be broken into the following categories: education access and quality, health care access and quality, neighborhood and built environment, social and community context, and economic stability. The Health Equity Team identified multiple SDOHs that impact the rate and severity of a Diabetes diagnosis. They are listed below.

Data gathered for prioritized populations: Black, Hispanic, and lower socioeconomic population



A. Education Access and Quality

- **Education Access and Quality data for Jackson County**

In 2019, the percentage of individuals 25 years and over with no high school diploma in Jackson County was 19.5% compared to Florida at 11.8%. The percentage of Black individuals 25 years and over in Jackson County, with no high school diploma, was 25.6% compared to White individuals at 16.9%. The percentage of Hispanic individuals 25 years and over in Jackson County, with no high school diploma, was 44.1% compared to non-Hispanic individuals at 15.6%. Data shows that in 2019, the percentage of adults who have been told that they have diabetes and had less than a high school education was 21.7%, compared to adults who have been they have diabetes with more than a high school diploma at 16.6%. This suggests that education level has an assessable impact on a person's health outcomes. In the EPIC-InterAct study, it is suggested that individuals with a high education level may be more open to prevention education, have a better ability to change their health choices, and are prone to use better health care systems[6]. This would indicate the opposite for those with lower education. In Jackson County, the specific Census Tracts with the highest percentages of individuals with less than a 9th grade education are 2102, 2105, and 2111. According to the data, we can conclude that there is a higher risk a of diabetes diagnoses among these census tracts. See data below.

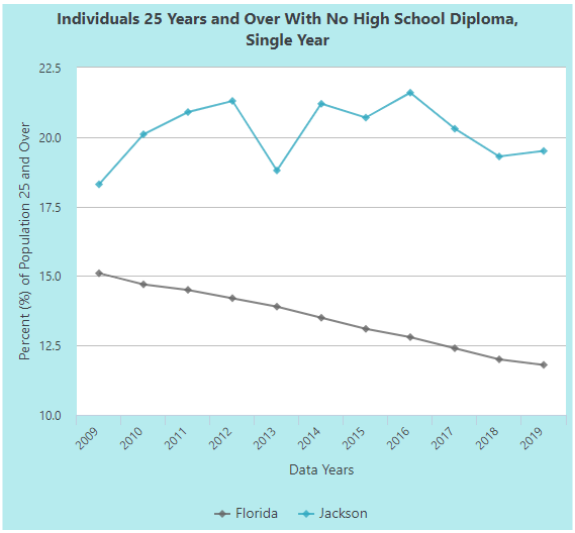


***Figure 13**: Individuals 25 Years and Over with No High School Diploma, Single Year, Jackson County vs. Florida, 2019 / Source: FlHealthCharts.gov*

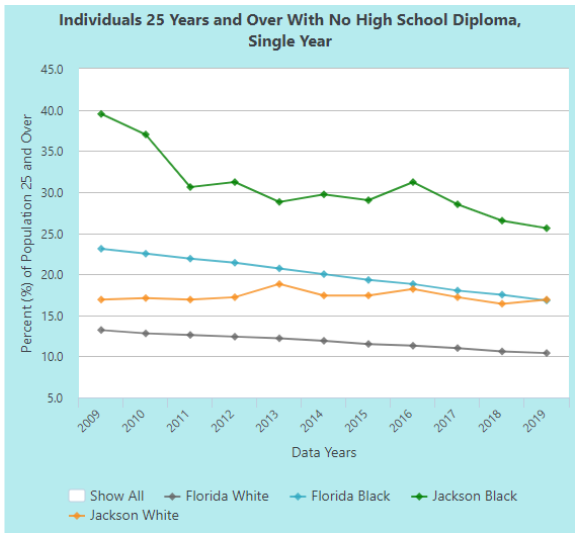


***Figure 14**: Individuals 25 Years and Over with No High School Diploma by Race, Single Year, Jackson County vs. Florida, 2019 / Source: FLHealthCharts.gov*

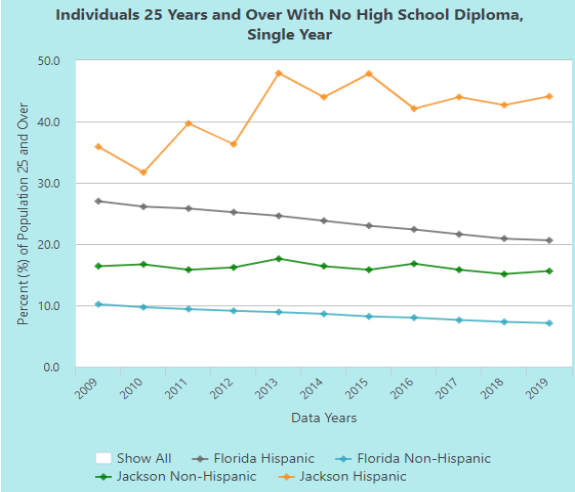


***Figure 15**: Individuals 25 Years and Over with No High School Diploma By Ethnicity, Single Year, Jackson County vs. Florida, 2019 / Source: FLHealthCharts.gov*

Adults who have ever been told they had diabetes						
	Jackson			Florida		
Year	Less Than High School	High School/GED	More Than High School	Less Than High School	High School/GED	More Than High School
2019	21.7% (12.9% - 30.5%)	19.6% (13.5% - 25.7%)	16.6% (12% - 21.3%)	20.3% (16.4% - 24.2%)	12.4% (10.7% - 14.2%)	9.5% (8.5% - 10.5%)
2016	21.9% (13% - 30.7%)	17.5% (11.4% - 23.7%)	20.4% (14.9% - 25.8%)	18.6% (15.9% - 21.3%)	12.6% (11.3% - 13.8%)	9.7% (8.9% - 10.4%)
2013	13.8% (4.6% - 22.9%)	18.5% (10.2% - 26.9%)	7.6% (3.3% - 11.9%)	18% (14.9% - 21.1%)	11.5% (10.3% - 12.6%)	9.2% (8.4% - 9.9%)

***Figure 16**: Adults who have ever been told they had diabetes by Education Level, Jackson County vs. Florida; Source: FLHealthCharts.gov*

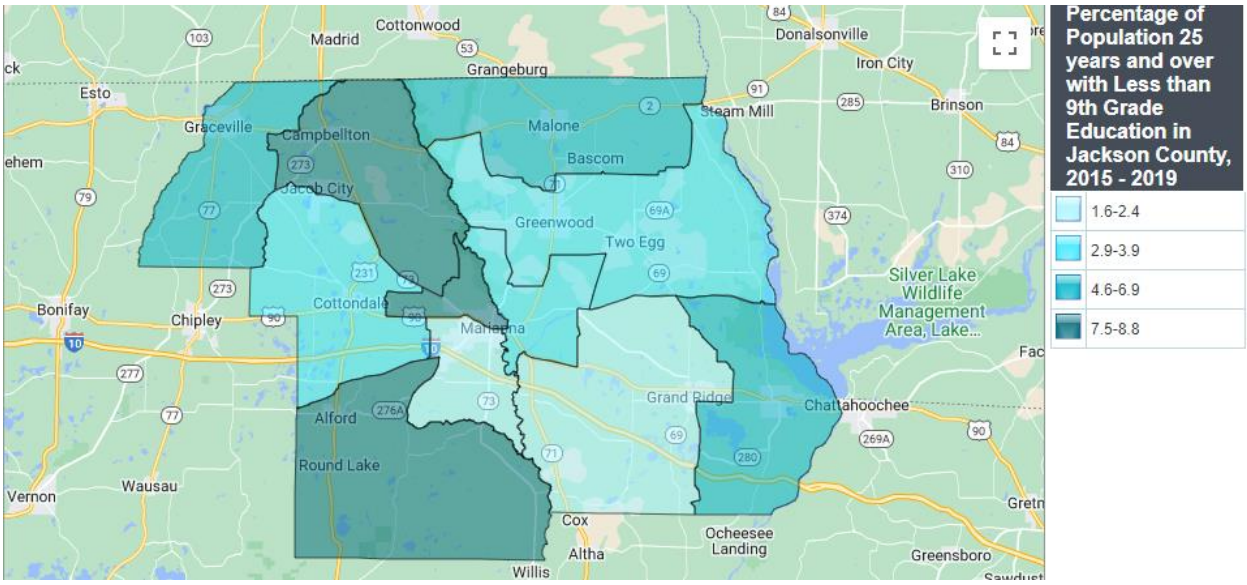


***Figure 17**: Census Tract Map for Jackson County showing Percentage of Population 25 years and over with Less than a 9th Grade Education, 2015-2019; Source: FLHealthCharts.gov*

Education Access and Quality		
SDOH	**Vulnerable Populations Impacted**	**How the SDOH Impacts Diabetes**
Literacy	Low socio-economic populations	There are direct links between low literacy levels and low socio-economic populations. It's estimated that some 43% of adults living in poverty have low literacy levels[7]. Without proper literacy, individuals may not be able to learn for themselves ways to prevent/manage health issues including diabetes.
Language	Hispanic Population	There are many language barriers among English speakers vs. Non-English speakers. If education is only provided in English, many non-English speakers will not properly be taught diabetes education. Therefore, it is important to include Spanish/Creole/etc. information as well and to always be mindful of these populations in education.
Higher Education	Low socio-economic populations, Black population, Hispanic population	Individuals who receive higher education often have a higher income, accessible transportation, and solid understanding of the importance of managing their health. Without higher education, an individual may not learn the skills or have the resources to manage their health properly. One study found that individuals with higher educational levels have a higher rate of adherence to dietary advice and better awareness of diabetes complications.[8]

B. Economic Stability

- **Economic stability data for Jackson County**

Unemployment in Jackson County

In 2020, the overall unemployment rate in Jackson County was 7.7% compared to Florida's unemployment rate of 5.4%. The rate of unemployed White residents was 4.6, compared to Black residents at 10.2, meaning the Black unemployment rate is more than doubled the White unemployment rate. The Jackson County Hispanic unemployment rate was just 4.8 compared to the non-Hispanic rate of 4.6. The specific Census Tracts where the highest rates of unemployed Jackson County residents reside are tracts 2106, 2108, and 2109. Interestingly, Census Tract 2106 is also one of the tracts with the highest rate of deaths from diabetes in Jackson County. Census Tract 2106 is 61.5% Black or African American, 32.3% White, 0.3 other race, and 5.8% Two or more races.

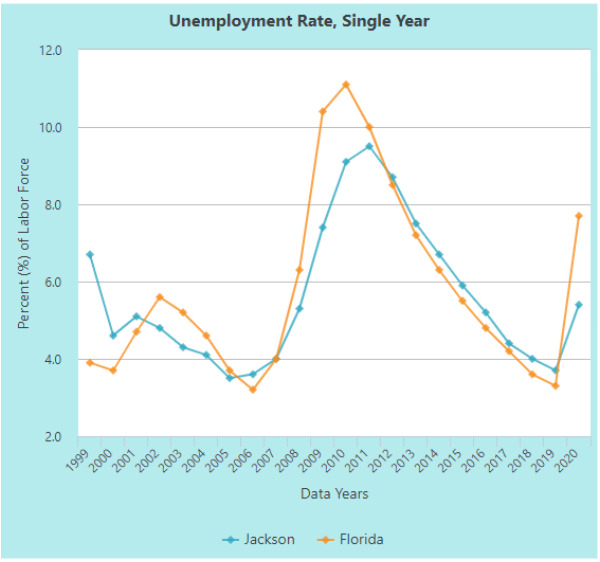


Figure 18: *Unemployment Rate, Single Year, Jackson vs. Florida, 2019 / Source: FLHealthCharts.gov*

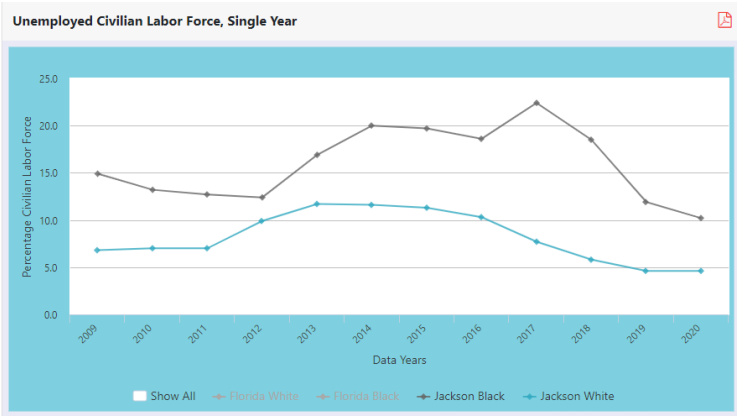


Figure 19: *Unemployment Rate, Single Year by Race, Single Year, 2019 / Source: FLHealthCharts.gov*

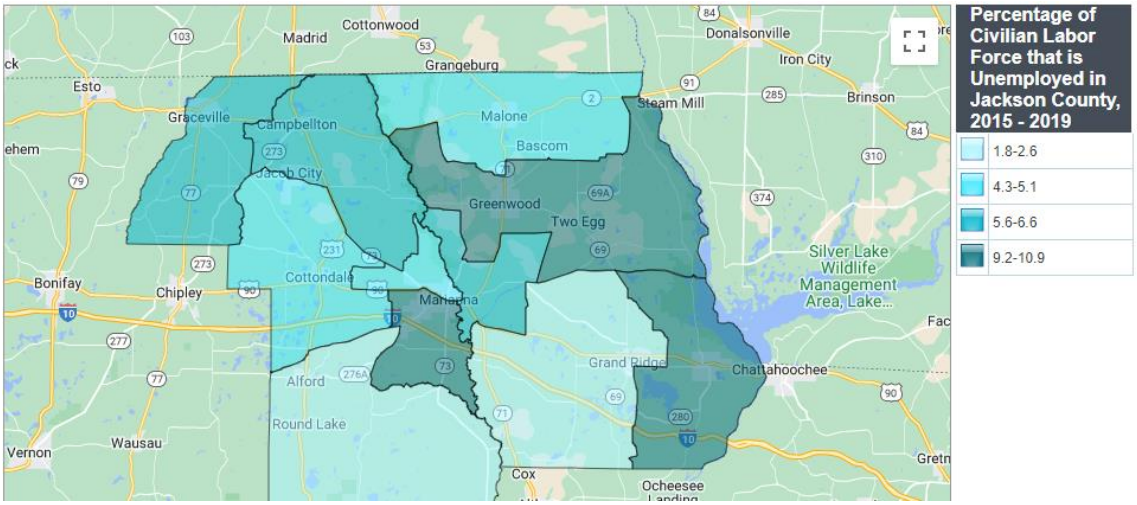


***Figure 20**: Percentage of Civilian Labor Force that is Unemployed in Jackson County, 2015-2019 / Source: FLHealthCharts.gov*

Poverty in Jackson County

In 2019, the total percentage of families below poverty level in Jackson County was 14.9% compared to Florida at 10%. The current poverty income level for a family of four in Florida is $27,750[9]. The percentage of Black families in Jackson County living below the poverty level was 27.7% which is more than double the percentage of White families at 11.4%. The percentage of Hispanic families living below the poverty level in Jackson County was 31.7%, compared to non-Hispanic families at 10.7%. Unfortunately, poverty data on other populations in Jackson County could not be identified. The specific Census Tracts where the highest percentages of families living below 100% of the poverty level in Jackson County are Tracts 2103, 2105, and 2106.

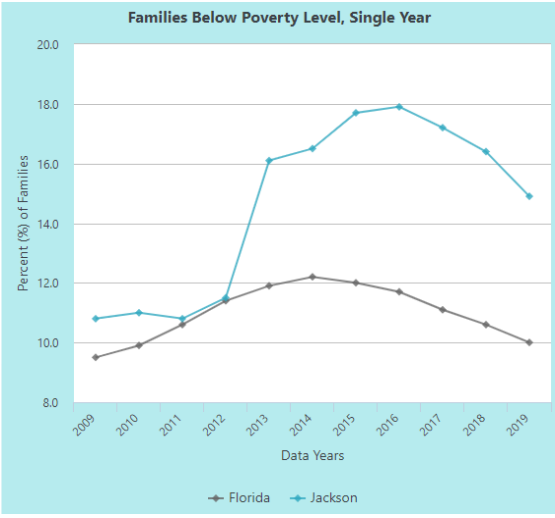


***Figure 21**: Families Below Poverty Level, Single Year, Jackson Vs. Florida, 2019 / Source: FLHealthCharts.gov*

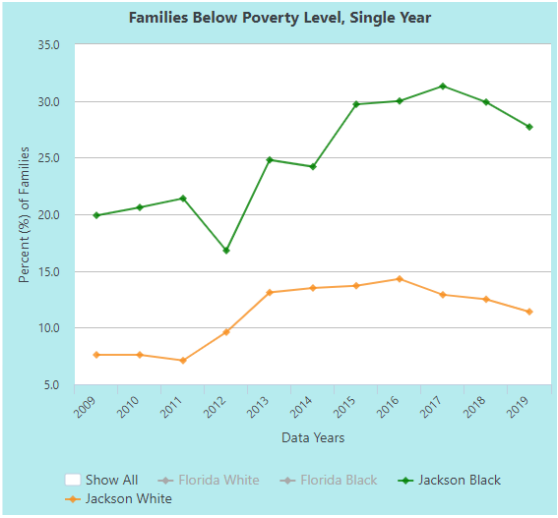


***Figure 22:** Families Below Poverty Level by Race, Single Year, 2019, Jackson County / Source: FLHealthCharts.gov*

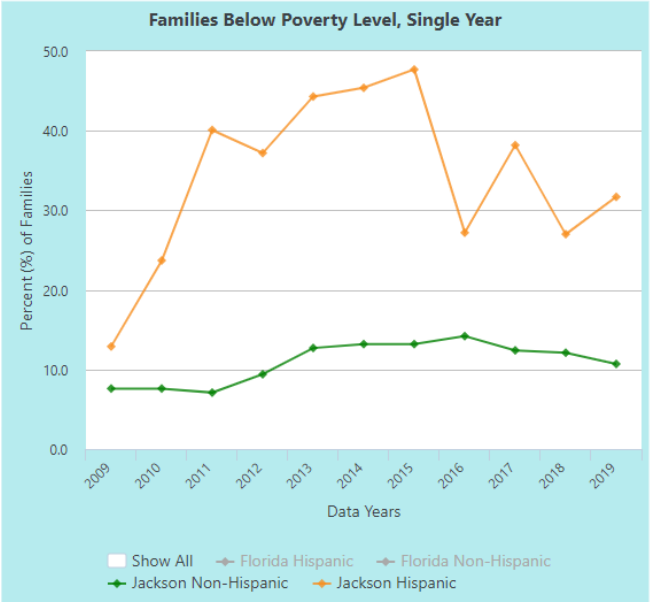


***Figure 23**: Families Below Poverty Level by Ethnicity, Single Year, 2019, Jackson County / Source: FLHealthCharts.gov*

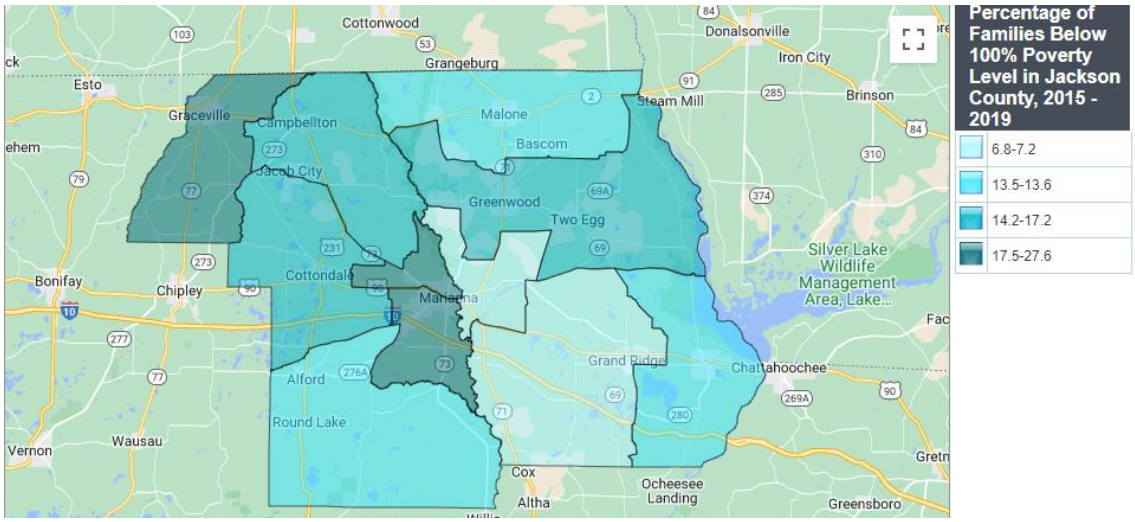


***Figure 24**: Census Tract of Percentage of Families Below 100% of Poverty Level in Jackson County, 2015-2019 / Source: FLHealthCharts.gov*

Food Insecurity in Jackson County

Food insecurity is defined as a lack of consistent access to enough food for an active, healthy lifestyle[10]. In 2019, the food insecurity rate in Jackson County was 12.8% compared to Florida at 12%. Food insecurity greatly affects the low-income families of Jackson County, as many times issues such as transportation, housing, and medical costs take precedence over nutrient-dense diets. Limited income among food-insecure families leads to purchasing cheaper and higher calorie foods, which can cause weight gain and make an individual more susceptible to chronic illnesses, including diabetes[11]. While there is no data on specific areas of higher food insecurity in Jackson County, it can be concluded that it falls within the areas of highest poverty. Census Tracts 2103, 2105, and 2106 have the highest percentages of families living below 100% of the poverty level in Jackson County.

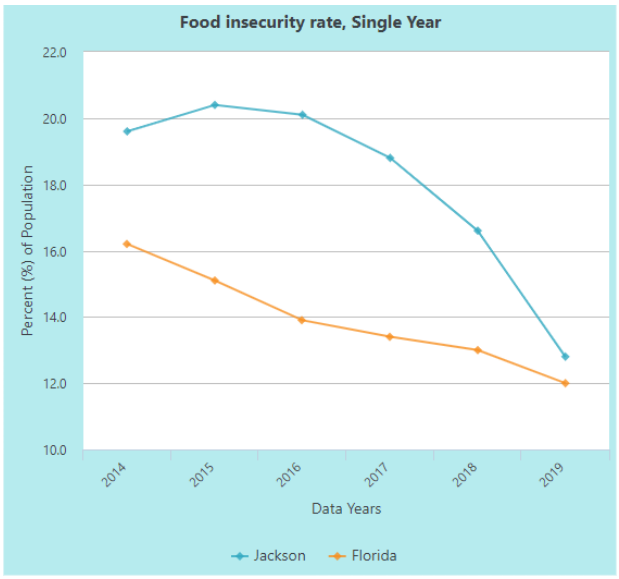


***Figure 25**: Food Insecurity Rate, Single Year, Jackson County vs. Florida, 2019 / Source: FLHealthCharts.gov*

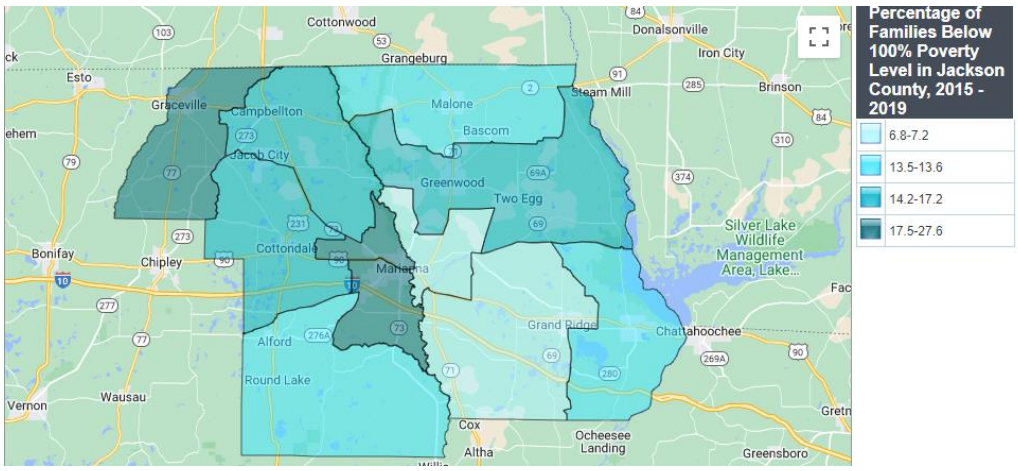


***Figure 26**: Census Tract of Percentage of Families Below 100% of Poverty Level in Jackson County, 2015-2019 / Source: FLHealthCharts.gov*

Economic Stability		
SDOH	**Vulnerable Populations Impacted**	**How the SDOH Impacts Diabetes**
Employment	Black population, Hispanic Population, Low socioeconomic population	Employment provides individuals with the means to potentially have better health outcomes, including transportation, money, better health care services, and better social integration.
Income	Black population, Hispanic Population, low socioeconomic population	Low-income individuals many times do not have the means to protect their health, meaning less healthy foods, less doctor's visits, less trips to parks/other outdoor activities, etc. These all have negative effects on health outcomes.
Food Insecurity	Low socioeconomic population	Healthy food options are many times not affordable for those with limited income. Low income leads to buying less nutritious foods because they are cheaper, which has a direct link to poor health outcomes.

C. Neighborhood and Built Environment

- **Neighborhood and built environment data for Jackson County**

Transportation in Jackson County

In 2019, the number of Jackson County residents who walked to work due to lack of transportation was 289, or 1.7%, compared to Florida's 1.4%. While data could not be identified on the exact population that was most likely to walk to work, Census Tracts 2103 and 2109 have the highest percentages of workers who walked to work in Jackson County in 2015-2019. Interestingly, Census Tract 2103 also has one of the highest percentages of families living under the poverty level and is among the census tracts with the highest percentages of deaths from diabetes. It could be suggested from this correlation that those who walk to work and the low socioeconomic population are the same. The same year, the percentage of Jackson County residents who used Public Transportation was 0.1%, compared to Florida at 1.8%. This percentage is so low because there is only one public transportation option available in Jackson County and it is for older adults with Medicaid/Medicare, or those who can

pay a substantial fee. A ride must be arranged at least 3 days in advance for this public transportation option as well, making it unfeasible for most people. Young people who simply lack transportation do not have any public transportation options. Lack of transportation in a community prohibits an individual's quality of life in many ways, but perhaps most importantly it takes away the ability to receive routine medical checkups, preventative, and specialty care. In fact, in 2017, 5.8 million people living in the U.S. delayed medical care because they did not have any transportation[12].

Figure 27: *Workers Who Walked to Work, Single Year, Jackson County, 2019 / Source: FLHealthCharts.gov*

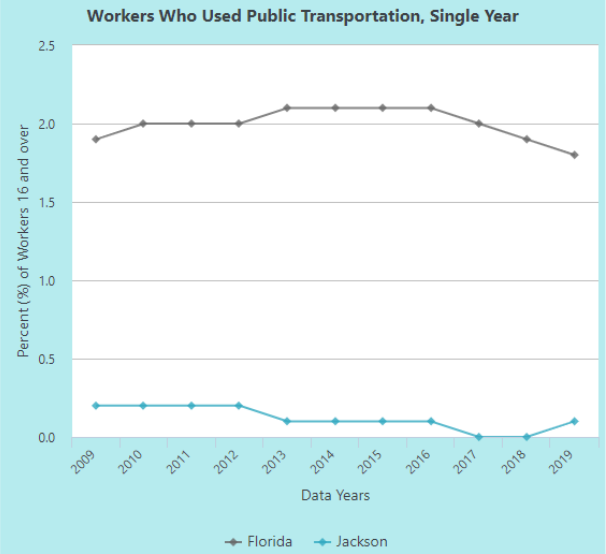


Figure 28: *Workers Who Used Public Transportation, Single Year, Jackson County vs. Florida, 2019 / Source: FLHealthCharts.gov*

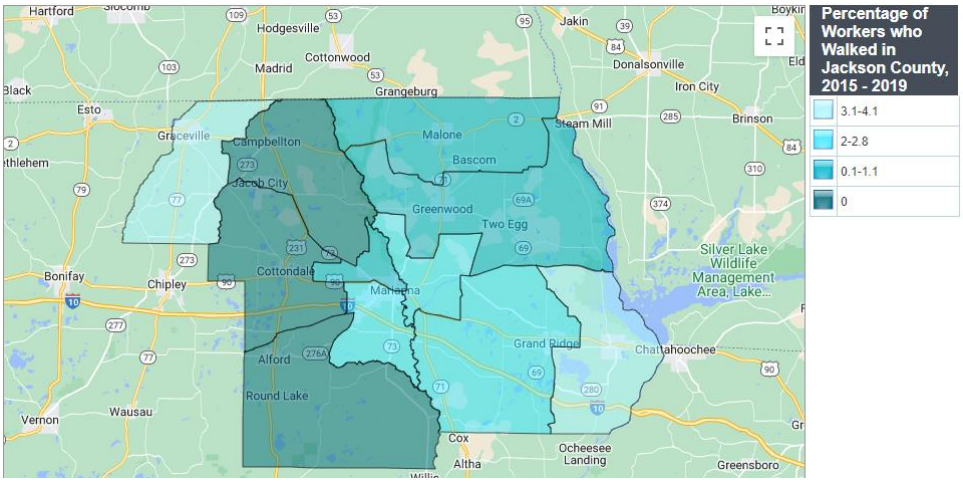


Figure 29: *Census Tracts for Percentage of Workers who Walked to Work in Jackson County, 2015-2019 (Please note that lighter areas make up higher percentages in this graphic) / Source: FLHealthCharts.gov*

Food Access in Jackson County

Additionally, the percentage of Jackson County residents who lived within ½ mile of a healthy food source in 2019 was just 1.1%, compared to Florida at 27.7%. While the exact populations this affects could not be found, it can be conferred that the population most impacted by this are extremely rural Jackson County residents who make up Census Tracts 2102, 2109.01, and 2103.02. Jackson County residents who lived ½ from a fast-food restaurant was slightly higher at 1.6% in 2019. This means that more people in Jackson County have walking access to less nutritional food options than healthy food options. Living in neighborhoods with walkable access to healthier food options, like supermarkets, can protect an individual against developing diabetes. However, living within walkable distance to a fast-food restaurant may increase a person's odds of a diabetes diagnosis[13]. While both percentages are incredibly low in Jackson County, it is telling that more residents live closer to a fast-food restaurant than a healthy food source.

Population Living Within ½ Mile of a Healthy Food Source, Percentage of Population, Single Year		
	Jackson	Florida
Data Year	Percent (%)	Percent (%)
2019	1.1	27.7
2016	1.2	27.9

***Figure 30**: Population Living Within ½ Mile of a Healthy Food Source, Percentage of Population, Jackson County vs. Florida, 2019 / Source: FLHealthCharts.gov*

Population Living within ½ mile of a Fast Food Restaurant, Percentage of Population, Single Year		
	Jackson	Florida
Data Year	Percent (%)	Percent (%)
2019	1.6	27.7
2016	1.5	31.1

***Figure 31:** Population Living Within ½ mile of a Fast Food Restaurant, Percentage of Population, Jackson County vs. Florida, 2019 / Source: FLHealthCharts.gov*

Parks and Outdoor Environments in Jackson County

According to minority population feedback from community partners, there is a lack of parks, sidewalks, and walkability in parts of the county (specifically Census Tract 2106) which also plays a large part in unequal health burdens among minority populations. Census Tract 2106 has one of the highest concentrations of Black residents out of the county. In this tract there was previously a community park that was destroyed by Hurricane Michael in 2018 and has yet to be rebuilt. The community utilized this park for events, physical activity, and softball games. Community feedback has been resounding that this Census Tract does not have proper sidewalks, outdoor areas, street lighting, and signage, which all impacts an individual's ability to get outside and exercise. Interestingly, this is also one of the Census Tracts that had the highest number of deaths from diabetes in Jackson County from 2016-2020. In 2019, the percentage of individuals in Jackson County living within ½ mile of a park was 5.9% compared to Florida at 40.1%. That means only approximately 2,800 residents have walkable access to a Jackson County Park. While there is no specific data to show who exactly these individuals are, it can be suggested that extremely rural and low socioeconomic residents do not live within a walkable distance to a park. This is critical because we know that parks and outdoor green spaces promote active lifestyles that can help reduce the risk of a diabetes diagnosis[14]. Jackson County's lack of accessible parks or areas where physical activity can safely be conducted could be contributing to this health disparity.

Population Living Within ½ Mile of a Park, Percentage of Population, Single Year

	Jackson	Florida
Data Year	Percent (%)	Percent (%)
2019	5.9	40.1
2016	5.0	38.8

Figure 32: *Population Living Within ½ mile of a park, Jackson County vs. Florida, Single Year, 2019 / Source: FLHealthCharts.gov*

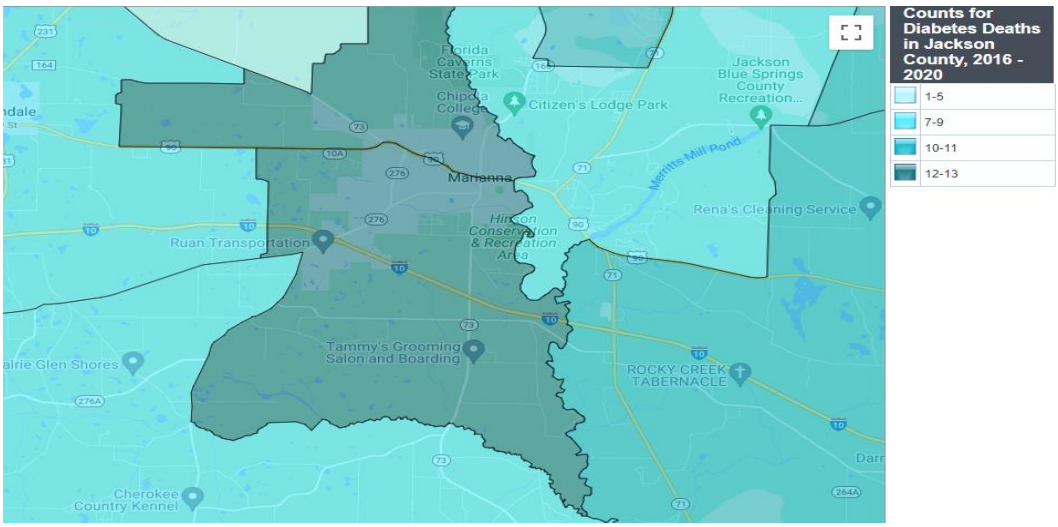


Figure 33: Census Tract Map 2106, Counts for Diabetes Deaths in Jackson County, 2016-2020 / Source: FLHealthCharts.gov

Neighborhood and Built Environment		
SDOH	**Vulnerable Populations Impacted**	**How the SDOH Impacts Diabetes**
Transportation	Black population, Hispanic Population, Low Socioeconomic population	Lack of transportation directly affects health outcomes like diabetes because individuals are not able to travel to doctor's appointments, grocery stores with nutritious foods, community resources centers, parks, etc.
Safety	Black Population, Low Socioeconomic population	Lack of proper safety (unsafe sidewalks, inadequate street lighting, lack of benches, etc.) in a neighborhood causes isolation. There is concern among Census Tract 2106 that safety is an issue for many. These individuals prohibit outside activities due to safety concerns. This

		causes inactivity which can have numerous detrimental health outcomes, including diabetes.
Parks	Black Population, Hispanic population, Extremely rural residents	Parks provide a safe space to be active. Without this valuable resource, many communities remain inactive. Not getting enough physical activity raises a person's chances of developing chronic diseases, including diabetes[15].
Walkability	Low socioeconomic population	Areas of poor walkability and inadequate sidewalks have higher rates of inactivity. Lower neighborhood walkability is associated with more sedentary behaviors, like driving and watching TV[16]. Sedentary behaviors lead to worse health outcomes.
Geography	Black population, Hispanic population, Low socioeconomic population	Rural communities tend to have much less resources than urban communities. Jackson County is incredibly rural so many residents without proper transportation are unable to walk to healthy food sources, parks, or engage in safe outside activities.
Access to nutritional food	Black population, Hispanic population, Low Socioeconomic population	Without access to nutritional foods, families tend to settle for less nutrient-dense food, which has a direct effect on a person's health outcomes. From the data we see that just 1.1% of Jackson County residents have walkable access to a healthy food source, putting Jackson in the fourth quartile for this measure.

D. Social and Community Context

- **Social and community context data for Jackson County**

There is little data available on social and community context in Jackson County. However, information gathered from community partners and minority populations suggest that lack of social cohesion is a large issue among minority populations and the elderly in Jackson County.

Jackson County is a historically white county with a noted history of racial segregation and violence[17]. For this reason, it can be suggested that there is a sense of isolation among minority populations. In addition, a CDC review suggests that nearly one-fourth of adults aged 65 and older are considered to be socially isolated, as they face factors like living alone, loss of loved ones, hearing loss, and chronic illnesses. There is a direct link between high-quality social relationships and living a healthier and longer life[18].

Social and Community Context		
SDOH	**Vulnerable Populations Impacted**	**How the SDOH Impacts Diabetes**
Social Integration	Black population, Elderly population	Social integration has been found to have direct impacts on a person's psychological well-being[19]. Without meaningful relationships at an individual level, a person may fall into social isolation which has been proven to have detrimental effects on health outcomes.
Support Systems	Black population, Elderly population,	People with good social support systems that are mutually beneficial are more likely to depend on their support to stick to a certain mindset, i.e. healthy eating, exercising, not smoking, etc. Without social support systems, people are more likely to be isolated and not motivated to follow certain healthy habits. Social support also reduces stress and anxiety, which can also lead to adverse health outcomes.
Discrimination	Black population, Hispanic population, Elderly population, Low Socioeconomic population	Discrimination in all forms tend to cause damage to one's emotional and physical health. Discrimination in the healthcare system contributes to disparities in quality of care and adverse health outcomes.

E. Health Care Access and Quality

- **Health care access and quality data for Jackson County**

Access to quality health care in Jackson County has many different barriers, including transportation issues and medical costs. From the data, it is apparent that those that suffer the most in Jackson County from access to healthcare are the Hispanic population, low socioeconomic population, and residents aged 18-44. In 2019, in Jackson County, the percentage of Hispanics with health insurance was just 26.2%, compared to the percentage of non-Hispanic Blacks with health insurance at 90.8% and non-Hispanic Whites at 84.4%. Research shows that uninsured adults suffer from more health disadvantages, including inadequate access to quality care and preventative services[20]. Similarly, the percentage of Hispanic residents in 2019 who could not see a doctor due to cost was 35.5%, compared to White residents at 16.2% and Black residents at 13.4%.

In 2019, the percentage of adults who made under $25,000 and could not see a doctor due to cost was 23.7% compared to those who made over $50,000 at 8.9%. Similarly, in 2019, the percentage of adults who could not see a doctor due to cost and had less than a high school education was 21% compared to those who had more than a high school education at 15.4%. This suggests that income and education level play a large role within access to quality health care in Jackson County.

Finally, Jackson residents between the ages of 18-44 have the most barriers when it comes to health care access. Residents aged 18-44 with health insurance was 73.9% in 2019 compared to adults 65 and older who's percentage was 98.6%. Similarly, residents aged 18-44 who could not see a doctor in the past year due to cost was 22.4% compared to those 65 and older at 6.9%. Additionally, residents between the ages of 18-44 who had a medical checkup in the past year was 59.3% compared to adults 65 and older at 92.7%. From this data, it is apparent that the younger population of Jackson County are less likely to have quality care access. It is important to note that the average age of a diabetes diagnosis in Jackson County is 51, so just 7 years outside of this age group. Preventative care and education are invaluable to those that fall within the 18-44 age group.

Adults with any type of health care insurance coverage						
	Jackson			Florida		
Year	Non-Hispanic White	Non-Hispanic Black	Hispanic	Non-Hispanic White	Non-Hispanic Black	Hispanic
2019	84.4% (79.8% - 88.9%)	90.8% (85.9% - 95.6%)	26.2% (10.8% - 41.6%)	88.6% (87.4% - 89.7%)	81.4% (77.3% - 85.4%)	76.1% (72.7% - 79.6%)
2016	86.9% (83.3% - 90.5%)	84.5% (77.5% - 91.6%)	48.6% (32.7% - 64.6%)	89.5% (88.8% - 90.3%)	81% (78.1% - 83.8%)	71.1% (68.7% - 73.5%)
2013	77.6% (69.6% - 85.5%)	75.6% (58.2% - 93.1%)		85.5% (84.6% - 86.3%)	69.2% (65.4% - 73%)	64% (60.6% - 67.4%)
2010	82% (75.9% - 88.1%)	86.7% (76.3% - 97.1%)		87.3% (86.3% - 88.2%)	76.1% (71.7% - 80.4%)	70.3% (66.1% - 74.6%)
2007	83.7% (76.4% - 89%)	76.7% (62.7% - 86.6%)		87.8% (86.9% - 88.7%)	77.2% (72.9% - 81.1%)	61.4% (57.6% - 65%)

Figure 34: *Adults with any type of health care insurance coverage by Race/Ethnicity, Jackson County vs. Florida, 2019 / Source: FLHealthCharts.gov*

Adults who could not see a doctor in the past year due to cost						
	Jackson			Florida		
Year	Non-Hispanic White	Non-Hispanic Black	Hispanic	Non-Hispanic White	Non-Hispanic Black	Hispanic
2019	16.2% (12% - 20.3%)	13.4% (6.9% - 19.9%)	35.5% (18.2% - 52.7%)	13.5% (12.3% - 14.7%)	16.8% (13% - 20.7%)	22.7% (19% - 26.3%)
2016	17.4% (13.3% - 21.5%)	14.5% (7.7% - 21.2%)	32.2% (16.9% - 47.5%)	14.1% (13.2% - 14.9%)	19.3% (16.3% - 22.2%)	21.3% (19.1% - 23.4%)

Figure 35: *Adults who could not see a doctor in the past year due to cost by Race/Ethnicity, 2019, Jackson County vs. Florida; Source: FLHealthCharts.gov*

Adults who could not see a doctor in the past year due to cost						
	Jackson			Florida		
Year	<$25,000	$25,000-$49,999	$50,000 or More	<$25,000	$25,000-$49,999	$50,000 or More
2019	23.7% (17.6% - 29.7%)	20% (11.1% - 28.9%)	8.9% (3.2% - 14.5%)	25.7% (22.8% - 28.6%)	19.6% (16.4% - 22.8%)	9.2% (7.4% - 11%)
2016	24.4% (17.9% - 30.8%)	16.6% (9.7% - 23.4%)	10.6% (4.9% - 16.3%)	27.7% (25.8% - 29.7%)	16.8% (15.1% - 18.5%)	8.4% (7.3% - 9.6%)
2013	22.7% (13.1% - 32.4%)	21.4% (3.1% - 39.8%)	10.5% (0% - 24.5%)	35.2% (32.9% - 37.4%)	21.3% (19.1% - 23.5%)	8.9% (7.5% - 10.3%)

Figure 36: *Adults who could not see a doctor in the past year due to cost by Annual Income, Jackson County vs. Florida; Source: FLHealthCharts.gov*

Adults who could not see a doctor in the past year due to cost						
	Jackson			Florida		
Year	Less Than High School	High School/GED	More Than High School	Less Than High School	High School/GED	More Than High School
2019	21% (11.9% - 30.2%)	16.1% (11.2% - 21.1%)	15.4% (10% - 20.8%)	21.4% (17.7% - 25%)	16.9% (14.6% - 19.3%)	14.5% (12.8% - 16.2%)
2016	25.8% (16% - 35.6%)	16.2% (10.5% - 21.9%)	16.8% (12% - 21.6%)	26.8% (23.6% - 29.9%)	18.1% (16.5% - 19.7%)	13.4% (12.5% - 14.4%)
2013	27.9% (7% - 48.8%)	23.4% (10.3% - 36.5%)	6.5% (2.3% - 10.7%)	30% (26.3% - 33.7%)	22.4% (20.3% - 24.5%)	17.3% (16.1% - 18.5%)

Figure 37: *Adults who could not see a doctor in the past year due to cost by Education Level, 2019, Jackson County vs. Florida; Source:*

Adults with any type of health care insurance coverage						
	Jackson			Florida		
Year	Ages 18-44	Ages 45-64	Ages 65 & Older	Ages 18-44	Ages 45-64	Ages 65 & Older
2019	73.9% (66.5% - 81.2%)	84% (79.1% - 89%)	98.6% (97.4% - 99.8%)	75.4% (73.1% - 77.7%)	83.5% (81.1% - 85.9%)	98.1% (97.4% - 98.8%)
2016	65.7% (58.1% - 73.4%)	85.1% (80% - 90.2%)	97% (93.8% - 100%)	74.5% (72.8% - 76.1%)	84.3% (82.9% - 85.6%)	98.1% (97.6% - 98.6%)
2013	71.3% (56.7% - 85.9%)	75.7% (67% - 84.3%)	98.3% (95.2% - 100%)	66.5% (64.4% - 68.5%)	76.4% (74.6% - 78.3%)	97.5% (96.7% - 98.2%)

Figure 38: *Adults with any type of health care insurance coverage, Age group, Jackson County vs. Florida; Source: FLHealthCharts.gov*

Adults who had a medical checkup in the past year						
	Jackson			Florida		
Year	Ages 18-44	Ages 45-64	Ages 65 & Older	Ages 18-44	Ages 45-64	Ages 65 & Older
2019	59.3% (50.5% - 68.2%)	78.1% (72.6% - 83.7%)	92.7% (89.6% - 95.8%)	65.5% (62.8% - 68.2%)	82.3% (80.2% - 84.5%)	94.1% (92.8% - 95.3%)
2016	70.9% (63.8% - 77.9%)	81.4% (76.3% - 86.6%)	91.7% (86.6% - 96.8%)	63.9% (62.1% - 65.7%)	78.9% (77.4% - 80.4%)	94.2% (93.4% - 94.9%)

Figure 39: *Adults who had a medical checkup in the past year, Age group, Jackson County vs. Florida; Source: FLHealthCharts.gov*

Health Care Access and Quality		
SDOH	**Vulnerable Populations Impacted**	**How the SDOH Impacts Diabetes**
Health Coverage	Hispanic population, Residents aged 18-44	If a person does not have proper health coverage, they will many times forego all types of doctor's visits. Without proper health care, people are put at risk for adverse health outcomes, including a Diabetes diagnosis.
Provider Linguistic and Cultural Competency	Black population, Hispanic population, low socioeconomic population	Providers who are not linguistically/culturally competent are many times unable to properly communicate important health topics (prevention/management) to patients of different cultural/ethnical/racial backgrounds. Without proper education, a patient may experience adverse health outcomes, including a higher risk of Diabetes.
Quality of Care	Black population, Hispanic population, low socioeconomic population	If a patient receives poor quality of care, they are put at a higher risk of adverse health outcomes. Whether the information they received is incomplete or incorrect, this leads to misinformed care, which the patient many times does not question. Additionally, a patient many times will not come back/follow up with the provider whose quality of care was poor, meaning the patient is vulnerable to adverse health outcomes like Diabetes.

VIII. SDOH PROJECTS

The Minority Health Liaison recruited and engaged members across the county, including government agencies, nonprofits, private businesses, and community organizations, to join the Health Equity Taskforce. The Minority Health Liaison took into consideration the prioritized health disparity and the impactful SDOHs identified by the Health Equity Team during recruitment.

A. Data Review

The Health Equity Taskforce reviewed data, including health disparities and SDOHs provided by the Health Equity Team. The Health Equity Taskforce also researched evidence-based and promising approaches to improve the identified SDOHs. The Health Equity Taskforce considered the policies, systems and environments that lead to inequities.

B. Barrier Identification

Members of the Health Equity Taskforce worked collaboratively to identify their organizations' barriers to fully addressing the SDOHs relevant to their organization's mission. Common themes were explored as well as collaborative strategies to overcome barriers.

Partners	SDOH	Partner Barriers	Theme	Collaborative Strategies
Chronic Disease Prevention	Access to Quality Education	Obesity, Healthy Food deserts, literacy issues	Chronic Disease	-Market programs that promote increase of fruit and veggie servings per day -Target adult population to

				provide physical activity in rural areas
Tobacco Prevention Program	Access to Quality Healthcare/Education	Transportation, Literacy issues, lack of internet access	Access to Services	Virtual classes offered to reduce burden of transportation
Diabetes Prevention Program	Access to Quality Education	Program Recruitment, Cultural Differences, Differing Community member priorities	Access to Services/Assistance	-Provide Health Education Resources -CHIP established to promote strategies that provide support and improve programs and services related to Chronic Disease prevention

C. Community Projects

The Health Equity Taskforce researched evidence-based strategies to overcome the identified barriers and improve the SDOH that impact the prioritized health disparity. The Health Equity Taskforce used this information to collaboratively design community projects to address the SDOHs. During project design, the Health Equity Taskforce considered the policies, systems and environments that lead to inequities. Projects included short, medium, and long-term goals with measurable objectives. These projects were reviewed, edited, and approved by the Coalition to ensure feasibility.

*SEE ADDENDUM FOR PROJECT STORYBOARDS

IX. HEALTH EQUITY PLAN OBJECTIVES

A. Diabetes

- **Health Disparity Objective: By June 2027, decrease the death rate from Diabetes among Black individuals in Jackson County from 68.7 (2020) to 63.** ***(Data Source: Florida Department of Health, Bureau of Vital Statistics; Retrieved from FLHealthCharts.gov)***
- **Health Disparity Objective: By June 2027, decrease the percentage of diabetes diagnosis among those making less than $25,000 a year from 23.9% (2019) to 21%.** ***(Data source: Florida Department of Health, Bureau of Vital Statistics; Retrieved from FLHealthCharts.gov)***

Diabetes Prevention Program Physical Activity Classes

	Lead Entity and Unit	Lead Point Person	Data Source	Baseline Value	Target Value	Plan Alignment
Long-Term SDOH Goal: Improve Access to Quality Education						
Objective: By June 2027, provide free physical activity and diabetes education classes to 200 participants.	Diabetes Prevention Program	Whitney Merritt/ Katrice Davis	Tracked by FDOH Jackson	0	200	N/a
Medium-Term SDOH Goal: Improve Social/Community Context						
Objective: By Dec 31, 2024, increase participation among older adults in physical	Diabetes Prevention Program	Whitney Merritt/ Katrice Davis	CHA/ CHIP	142	160	CHIP Objective 1.3

activity programs from 142 to 160.						
Short-Term SDOH Goal: Improve Neighborhood/Built Environment						
Objective: By August 1, 2022, increase community spaces where classes can be held in minority areas from 0 to 5.	Diabetes Prevention Program	Whitney Merritt/ Katrice Davis	Tracked by FDOH Jackson	0	5	N/a

PanCare Health Rural Mobile Clinics

	Lead Entity and Unit	Lead Point Person	Data Source	Baseline Value	Target Value	Plan Alignment
Long-Term SDOH Goal: Improve Access to Quality Health Care						
*Objective: By June 2027, increase the percentage of adults who had a medical checkup in the past year from 73.8% to 76% (County average). *Objective: By June 2027, increase the percentage of Black adults who	PanCare Health	Sean Golder	CHARTS	73.8% 83.1% 39.8%	76% 86% 43%	N/a

had a medical checkup in the past year from from 83.1% to 86% *Objective: By June 2027, increase the percentage of Hispanic adults who had a medical checkup in the past year from 39.8% to 43%.						
Medium-Term SDOH Goal: Improve Access to Quality Health Care						
Objective: By December 31, 2024, increase the percentage of individuals with or without diabetes who have had two A1C tests in the past year from 89% to 92%.	PanCare Health	Sean Golder	CHARTS	89%	92%	N/a
Short-Term SDOH Goal: Improve Neighborhood/Built Environment						
Objective: By August 1, 2022, identify at least 6 specific locations where residents have limited access to health	FDOH Jackson	Emily Bass	Tracked by FDOH Jackson	0	6	N/a

care due to cost/transportation in the county.						

Jackson Community Gardens

	Lead Entity and Unit	Lead Point Person	Data Source	Baseline Value	Target Value	Plan Alignment
Long-Term SDOH Goal: Improve Neighborhood/Built Environment						
Objective: By June 1, 2027, increase the number of Black residents who consume five or more servings of fruit or vegetables per day from 14.3% (2013) to 19% (FLCharts)	TBD	TBD	CHARTS	14.3%	19.0%	Chip Objective 1.2
Medium-Term SDOH Goal: Improve Economic Stability						
*Objective: By July 1, 2024, increase the number of community gardens in Census Tract 2103 from 0 to 1. *Objective: By July 1, 2024, increase the number of community gardens	TBD	TBD	Tracked by FDOH Jackson	0	3	N/a

in Census Tract 2105 from 0 to 1. *Objective: By July 1, 2024, increase the number of community gardens in Census Tract 2106 from 0 to 1.						
Short-Term SDOH Goal: Improve Economic Stability						
Objective: By September 1, 2022, increase funds dedicated to the creation of community gardens from $200 to $4,500.00	FDOH Jackson	Emily Bass	Tracked by FDOH Jackson	$200.00	$4500.00	N/a

X. PERFORMANCE TRACKING AND REPORTING

Ongoing communication is critical to the achievement of health equity goals and the institutionalization of a health equity focus. The successes of Health Equity Plan projects are shared with OMHHE, partners, other CHDs, CHD staff, and the Central Office through systematic information-sharing, networking, collecting, and reporting on knowledge gained, so that lessons learned can be replicated in other counties and programs. Regional Health Equity Coordinators facilitate systematic communication within their region.

The Minority Health Liaison serves as the point of contact in their county for sharing progress updates, implementation barriers, and practices associated with the Health Equity Plan. The Minority Health Liaison is responsible for gathering data and monitoring and reporting progress achieved on the goals and objectives of the Health Equity Plan. At least quarterly, the Minority Health Liaison meets with the Health Equity Taskforce to discuss progress and barriers. The Minority Health Liaison tracks and submits indicator values to the OMHHE within 15 days of the quarter end.

Annually, the Minority Health Liaison submits a Health Equity Plan Annual Report assessing progress toward reaching goals, objectives, achievements, obstacles, and revisions to the Regional Health Equity Coordinator and Coalition. The Regional Health Equity Coordinator and Coalition leaders provide feedback to the Minority Health Liaison and the Health Equity Taskforce from these annual reports. The Minority Health Liaison then submits the completed report to OMHHE by July 15th annually.

XI. REVISIONS

Annually, the Health Equity Taskforce reviews the Health Equity Plan to identify strengths, opportunities for improvement, and lessons learned. This information is then used to revise the plan as needed.

Revision	Revised By	Revision Date	Rationale for Revision
Edits to spelling/wording, missing information added	Emily Bass	6/2/22	Task Force Feedback
Edits to titles/employees	Emily Bass	6/7/22	Coalition Feedback

XII. ADDENDUM

SDOH PROJECT STORYBOARD

DPP COMMUNITY PHYSICAL ACTIVITY/LIFESTYLE CHANGE CLASSES

"Jump N' Jackson" (name pending)

PROBLEM:

Background: There is little opportunity for community physical activity among Jackson's minority and elderly populations. According to the CDC, physical activity "helps control blood sugar, weight, and blood pressure, as well as raise good cholesterol and lower bad cholesterol". This leads to positive health outcomes, including the delay or prevention of Type 2 Diabetes. Due to the rural nature of Jackson County, Covid-19 restrictions over the past 2 years, and the state of our county after Hurricane Michael, physical activity opportunities in the county have decreased significantly. Prior to these events, in 2016, the percentage of Black adults who met aerobic recommendations was 33.2 %. The percentage of Hispanic adults who met aerobic recommendations was 37.2%, while Non-Hispanic White adults were at 38.7%. Jackson County's overall percentage of adults who met aerobic recommendations was 37.6% compared to Florida at 44.8% (FLCharts) (See Figure 1). It is imperative that this is addressed now, as it drastically impacts Jackson County Residents' quality of life and has a direct link to Diabetes particularly in our minority and elderly populations.

Scope: Specific areas include Census Tract 2103, 2105, and 2106 as these have the highest deaths from diabetes according to FLCharts. (See Figure 2). Those who will benefit are the priority minority population (Black residents), as well as elderly residents in hopes to increase social context among them.

Priority populations: Black adults, elderly adults, and extremely rural residents. Data was reviewed for different populations and there is a dramatic increase in diabetes deaths and hospitalizations among this population compared to Non-Hispanic White residents. In 2020, the rate of Deaths from diabetes for Black individuals was 68.7, compared to White individuals at 28 in Jackson County (See Figures 3 & 4).

Long -Term Goal: Improve Access to Quality Education

By attending these classes, not only will physical health improve but providing quality education among residents regarding diabetes prevention and management will empower

residents to take care of their health, leading to a decrease of Diabetes diagnoses and better management of the illness among the Black community and Jackson County overall. Diabetes education has been associated with lower rates of diabetes complications during management[21].(See Objective 1.1)

Medium-Term Goal: Improve Social/Community Context

By attending these classes and increasing participation in classes, elderly and Black residents will hopefully gain positive relationships, community support, and a sense of accountability regarding their health among their inner circle (See Objective 1.2).

Short-Term Goal: Improve Neighborhood/Built Environment

By choosing specific areas in priority neighborhoods where classes will be held, the hope is that residents will learn about important venues and resources in their community where physical activities can be held safely, which will improve health and quality of life overall (See Objective 1.3).

Team Leaders:

Whitney Merritt, Diabetes Prevention Program Health Educator; Florida Department of Health in Jackson County

Katrice Davis, Chronic Disease Prevention Supervisor; Florida Department of Health in Jackson County

Long-Term Objective 1.1: By June 2027, By June 2027, provide free physical activity and diabetes education classes to 200 participants. (Tracked by FDOH Jackson)

Medium-Term Objective 1.2: By December 31 2024, increase participation among older adults in physical activity programs from 142 to 160. (Jackson CHIP, 2019-2024 objective 1.3)

Short-Term Objective 1.3: By August 1 2022, increase and identify community spaces where classes can be held in minority areas from 0 to 5. (Tracked by FDOH Jackson)

CURRENT PERFORMANCE:

Adults who meet aerobic recommendations						
	Jackson			Florida		
Year	Non-Hispanic White	Non-Hispanic Black	Hispanic	Non-Hispanic White	Non-Hispanic Black	Hispanic
2016	38.7% (32.7% - 44.7%)	33.2% (23% - 43.4%)	37.2% (19.2% - 55.2%)	50% (48.7% - 51.4%)	40.1% (36.1% - 44.1%)	35.6% (32.7% - 38.5%)
2013	42.2% (33.8% - 50.5%)	43.3% (14.7% - 71.9%)		53.8% (52.5% - 55.1%)	46.8% (42.5% - 51.1%)	45% (41% - 49%)

Figure 1: Adults who meet aerobic recommendations by Race/Ethnicity, Jackson County, 2019, Single Year; Source: FLHealthCharts.gov

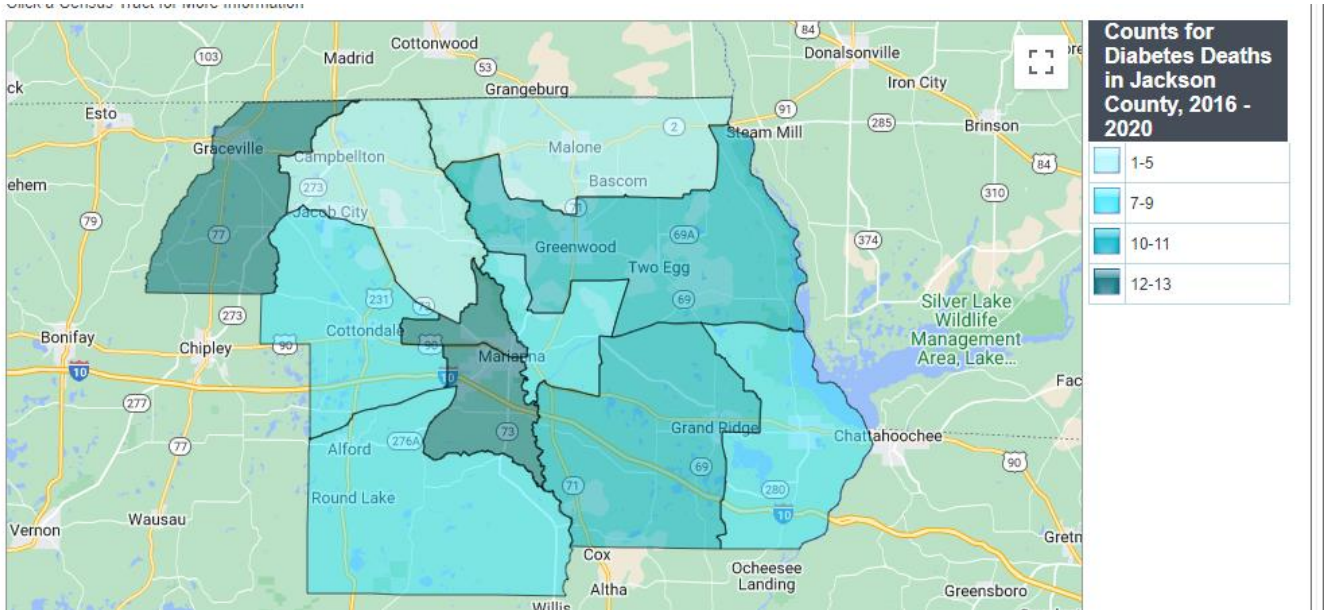


Figure 2: Census Tract Map for Jackson County showing Deaths from Diabetes, 2016-2020; Source: FLHealthCharts.gov

Age-adjusted Deaths From Diabetes, Rate Per 100,000 Population, Single Year

	Jackson		Florida	
	White	Black	White	Black
Data Year	Rate	Rate	Rate	Rate
2020	28.0	68.7	20.0	47.2
2019	33.4	21.8	17.5	37.6
2018	19.0	36.7	18.3	38.1
2017	32.9	20.2	18.3	40.8
2016	29.3	39.1	17.9	37.6
2015	9.5	47.4	16.9	38.2

Figure 3: Deaths from Diabetes by Race, Rate, Jackson County, 2020, Single Year; Source: FLHealthCharts.gov

Age-adjusted Hospitalizations From Diabetes, Rate Per 100,000 Population, Single Year

	Jackson		Florida	
	White	Black	White	Black
Data Year	Rate	Rate	Rate	Rate
2020	208.6	257.6	155.8	413.5
2019	188.6	190.2	173.3	432.5
2018	143.1	242.5	170.6	443.8
2017	166.6	166.9	170.4	456.1
2016	154.0	180.5	155.7	413.4

Figure 4: Hospitalizations from Diabetes by Race, Rate, Jackson County, 2020, Single Year; Source: FLHealthCharts.gov

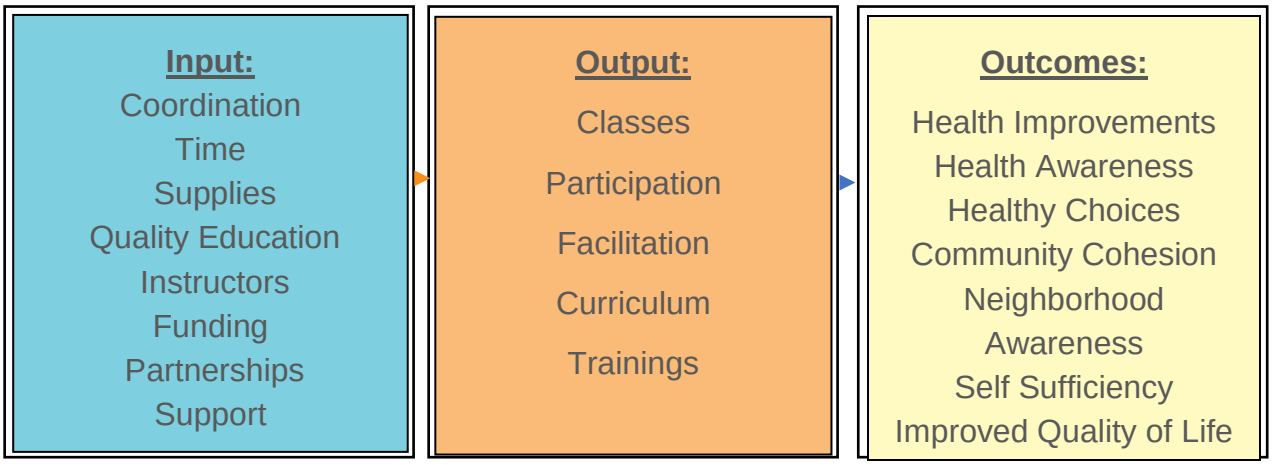
Adults who have ever been told they had diabetes						
	Jackson			Florida		
Year	Non-Hispanic White	Non-Hispanic Black	Hispanic	Non-Hispanic White	Non-Hispanic Black	Hispanic
2019	18.9% (14.5% - 23.3%)	19.5% (12.3% - 26.6%)	7.4% (0% - 15.3%)	11.5% (10.5% - 12.4%)	16% (12.8% - 19.1%)	10.6% (8.2% - 13.1%)
2016	20.6% (15.9% - 25.2%)	25.2% (16.5% - 33.9%)	6.2% (0% - 13.7%)	11.5% (10.8% - 12.2%)	14.5% (12.3% - 16.8%)	10.9% (9.3% - 12.6%)
2013	14.2% (9.1% - 19.2%)	8.1% (2.4% - 13.7%)		11.4% (10.7% - 12.2%)	12.3% (10% - 14.6%)	10.8% (8.7% - 12.8%)

Figure 5: Adults who have ever been told they had diabetes by Race/Ethnicity, Jackson County vs. Florida, 2019; Source: FLHealthcharts.gov

ROOT CAUSES AND BARRIERS:

In the Census Tracts that the Diabetes Prevention Program specifically wants to target (2106, 2110, and 2103), there is a known lack of sidewalks, parks, and other outside recreational facilities where safe and efficient physical activity can be performed. In tract 2106, there was previously a community park that was destroyed by Hurricane Michael and has not been rebuilt as of 2022. Sidewalks and bicycle lanes are non-existent or considered unsafe. Other areas of Jackson County (tracts 2110 & 2103) are so rural that physical activity facilities are unreachable unless there is proper transportation. Social isolation among our minority communities and elderly population also prevents them from garnering a sense of trust from those outside of their community. Covid restrictions have limited in person activities since March 2020, and many are still wary about meeting together in smaller spaces. The classes will be held in outside areas or large indoor areas that have plenty of room for social distancing.

Barriers: Transportation, Cost, Social Isolation, Covid weariness, Unsafe Conditions, Lack of education on importance of physical activity



PROJECT:

Many things were taken into consideration while designing this project. These classes will be integrated as part of the CDC-recommended Lifestyle Change Program which has been proven to prevent or delay type 2 diabetes. The American Diabetes Association recommends at least 150 hours a week of moderate activity to prevent or delay the diagnoses of diabetes. The Community Preventative Services Task Force (CPSTF) found that economic evidence indicates a combined diet and physical activity promotion program for those at risk of Type 2 Diabetes are effective at the reduction of new-onset diabetes (https://www.thecommunityguide.org/findings/diabetes-combined-diet-and-physical-activity-promotion-programs-prevent-type-2-diabetes).

This project will operate as 1 hour (60 minute) classes, with 45 minutes of moderate to vigorous activity and 15 minutes of diabetes prevention education (timeframe pending). The project will be held in different community centers, parks, or buildings around Jackson County, with specific emphasis on Census Tracts 2106, 2110, and 2103. These will be held twice monthly at to be determined locations. Local community trainers and exercise instructors will be brought in to teach an array of classes, including but not limited to Yoga, Hip Hop fitness, Zumba, Dance classes, etc. Whitney Merritt, DPP Health Educator is the responsible party for this project and is working to collaborate with trainers/exercise instructors and the local hospital's Diabetes Self-Management instructor for further coordination. She is also identifying and coordinating the rental of community spaces to hold these classes with backup help from Katrice Davis, Chronic Disease Prevention Supervisor at FDOH Jackson County. The Chronic Disease Outreach Program at FDOH Jackson County has agreed to advertise to the community and spread the word about these classes. The class schedule and agenda is being drafted but is planned to begin in September 2022. DPP has monies available for certain items, but the Minority Health Liaison is looking into additional funding sources including state and federal funds to contract instructors or rental space to hold classes. (Still in progress).

Results:	**Next Steps:**
TBD	TBD

SDOH PROJECT STORYBOARD

JACKSON COMMUNITY GARDENS

PROBLEM:

Background: Access to healthy foods is a problem for many Jackson County residents, but specifically Black individuals, low-income families, and extremely rural residents. In fact, in the year 2019, the percentage of all residents living within ½ mile of a healthy food source in Jackson County was 1.1% compared to Florida's percentage of 27.7% (See figure 1). This puts Jackson County in the fourth quartile for the entire state, meaning that more people live within ½ mile of a healthy food source in the remaining three quarters of Florida counties. While a portion of this percentage is due to the size, distance, and rural nature of Jackson County, it is also due to a lack of healthy food options within certain close-knit communities. According to the CDC, "managing blood sugar is the key to living with diabetes, and eating well is the key to managing blood sugar". It is a known fact that diet directly affects a diabetes diagnosis. The most highly recommended food groups for healthy living are vegetables and fruits. There is a lack of free, accessible community gardens in Jackson County.

Scope: Specific areas include Census Tracts 2106, 2105, and 2103 which has the highest percentage of families living below 100% of the poverty level according to FLCharts (see Figure 2). Those who will benefit are the minority population (Black individuals), as well as extremely rural and impoverished residents.

Priority populations: Black adults (18+) and low-income individuals. Data was reviewed for different populations and there is a dramatic increase in Diabetes deaths and hospitalizations among this population compared to Non-Hispanic White residents. In 2020, the rate of Deaths from Diabetes for Black individuals was 68.7, compared to white individuals at 28 in Jackson County (See Figures 3 & 4). Similarly, in 2019, the percentage of adults who have been told they have diabetes and make less that $25,000 a year is 23.9%, compared to those who make $50,000 or more a year at 14% (See Figure 5).

Long -Term Goal: Improve Neighborhood/Built Environment

By establishing these community gardens, not only will fruit and vegetable intake among residents increase but the neighborhood and community in which they live will also see positive impact. The hope is that by learning about community gardening and cultivating the skill, residents will take it back to their own homes and improve their individual environments that will positively impact the neighborhood in which they live. (See Objective 2.1)

Medium-Term Goal: Improve Economic Stability

By establishing these community gardens in impoverished and minority communities, the attainment of these fruits and vegetables will hopefully offset food costs for the individuals by reducing the financial burden of groceries. In addition, the gardens will hypothetically bring in productivity to previously vacant land. (See Objective 2.2)

Short-Term Goal: Improve Economic Stability

By increasing funds to establish a community garden, economic stability will improve among the community.

Team Members:

Sharron Jones, SnapED Health Educator; Florida Department of Health in Jackson County

Cortelia Thornton-Olds, SnapED Health Educator; Florida Department of Health in Jackson County

Master Gardeners, UF-IFAS

Friends of the Farmer's Market

TBD

Long-Term Objective 2.1: By June 1, 2027, increase the number of Black residents who consume five or more servings of fruit or vegetables per day from 14.3% to 19% (See Figure 6).

Medium-Term Objectives 2.2: By July 1, 2024, increase the number of community gardens in Census Tract 2103 from 0 to 1.

By July 1, 2024, increase the number of community gardens in Census Tract 2105 from 0 to 1.

By July 1, 2024, increase the number community gardens in Census Tract 2106 from 0 to 1.

Short-Term Objective 2.3: By July 1, 2022, increase funds dedicated to the creation of a community garden from $200.00 to $4,500.00.

CURRENT PERFORMANCE:

Population Living Within ½ Mile of a Healthy Food Source, Percentage of Population, Single Year

	Jackson	Florida
Data Year	Percent (%)	Percent (%)
2019	1.1	27.7
2016	1.2	27.9

Figure 1: Population Living Within ½ mile of a Healthy Food Source, Jackson County vs. Florida, Single Year, 2019; Source: FLHealthCharts.gov

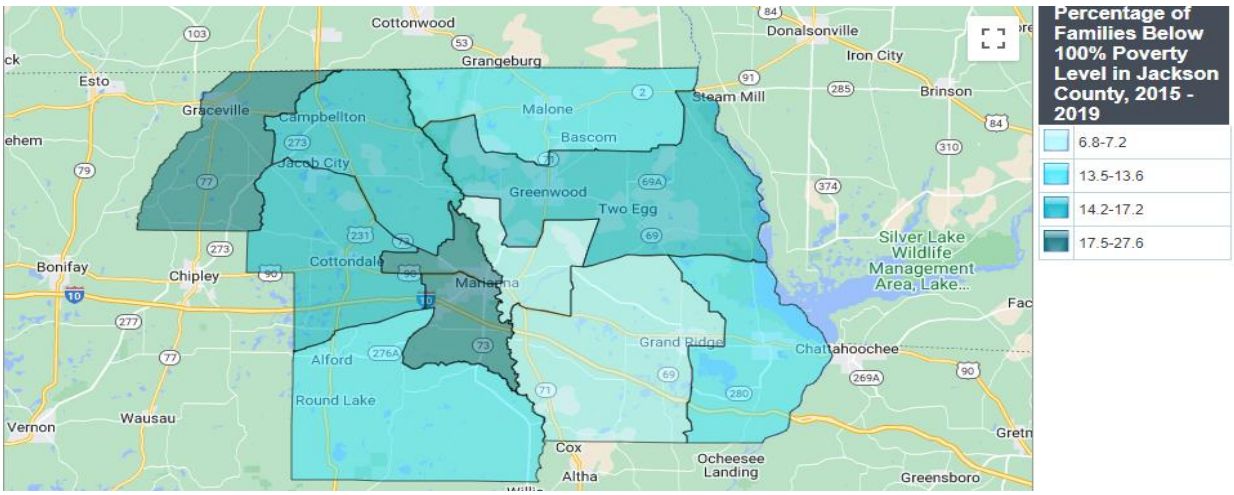


Figure 2: Census Tract Map for Jackson County showing Percentage of Families living below 100% of Poverty level, 2015-2019 (most recent data available); Source: FLHealthCharts.gov

Age-adjusted Deaths From Diabetes, Rate Per 100,000 Population, Single Year

	Jackson		Florida	
	White	Black	White	Black
Data Year	Rate	Rate	Rate	Rate
2020	28.0	68.7	20.0	47.2
2019	33.4	21.8	17.5	37.6
2018	19.0	36.7	18.3	38.1
2017	32.9	20.2	18.3	40.8
2016	29.3	39.1	17.9	37.6
2015	9.5	47.4	16.9	38.2

Figure 3: Deaths from Diabetes by Race, Rate, Jackson County, 2020, Single Year; Source: FLHealthCharts.gov

Age-adjusted Hospitalizations From Diabetes, Rate Per 100,000 Population, Single Year

	Jackson		Florida	
	White	Black	White	Black
Data Year	Rate	Rate	Rate	Rate
2020	208.6	257.6	155.8	413.5
2019	188.6	190.2	173.3	432.5
2018	143.1	242.5	170.6	443.8
2017	166.6	166.9	170.4	456.1
2016	154.0	180.5	155.7	413.4

Figure 4: Hospitalizations from Diabetes by Race, Rate, Jackson County, 2020, Single Year; Source: FLHealthCharts.gov

Adults who have ever been told they had diabetes						
	Jackson			Florida		
Year	<$25,000	$25,000-$49,999	$50,000 or More	<$25,000	$25,000-$49,999	$50,000 or More
2019	23.9% (16.7% - 31.2%)	17.2% (10.6% - 23.8%)	14% (8.5% - 19.5%)	16.1% (13.8% - 18.4%)	12.7% (10.3% - 15.1%)	7.9% (6.8% - 9.1%)
2016	25.1% (18.5% - 31.7%)	15% (8% - 22%)	12.2% (5.2% - 19.3%)	16.6% (15.1% - 18.2%)	11.9% (10.5% - 13.4%)	8% (7% - 8.9%)
2013	14.1% (7.4% - 20.8%)	8.2% (2.5% - 13.8%)	17.8% (8.2% - 27.5%)	14.8% (13.1% - 16.4%)	11.9% (10.4% - 13.4%)	7.5% (6.6% - 8.4%)

Figure 5: Adults who have ever been told they have diabetes by income level, Jackson vs. Florida, 2019; Source: FLHealthCharts.gov

Adults Who Consumed Five or More Servings of Fruits or Vegetables per Day						
	Jackson			Florida		
Year	Non-Hispanic White	Non-Hispanic Black	Hispanic	Non-Hispanic White	Non-Hispanic Black	Hispanic
2013	12.6% (6.9% - 18.2%)	14.3% (3% - 25.6%)		16.3% (15.4% - 17.3%)	22.4% (18.9% - 26%)	19.8% (16.8% - 22.9%)
2007	24.1% (18.8% - 30.4%)	20.9% (12.2% - 33.6%)		26.9% (25.8% - 28.1%)	28.2% (24.6% - 32.1%)	22.1% (19.1% - 25.4%)

Figure 6: Adults Who Consumed Five or More Servings of Fruits and Vegetables per Day by Race, Jackson County vs. Florida, 2013 (most recent data); Source: FLHealthCharts.gov

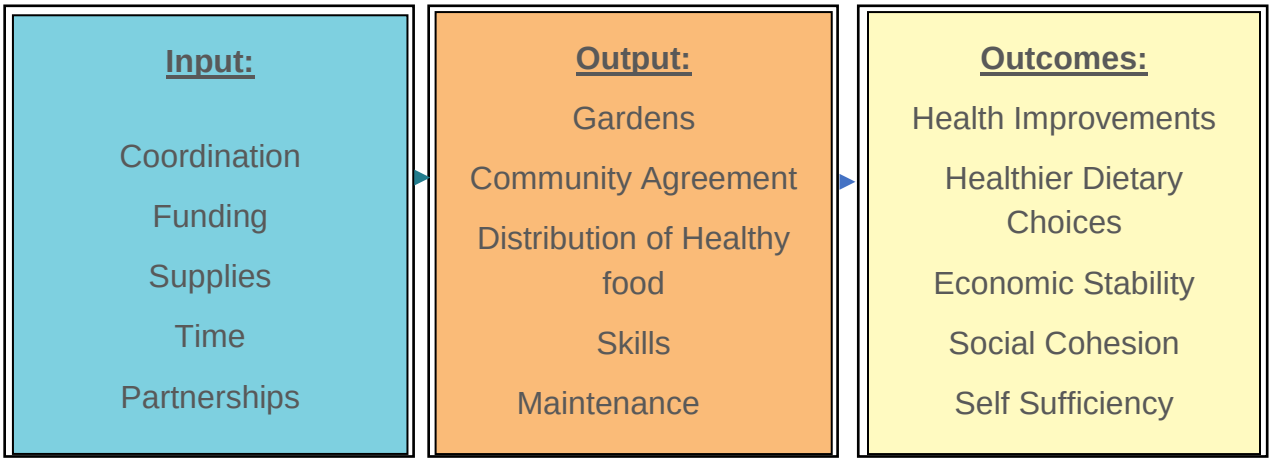
Adults Who Consumed Five or More Servings of Fruits or Vegetables per Day						
	Jackson			Florida		
Year	<$25,000	$25,000-$49,999	$50,000 or More	<$25,000	$25,000-$49,999	$50,000 or More
2013	11.1% (3.9% - 18.3%)	14.4% (3.2% - 25.6%)	18.5% (3.9% - 33.1%)	17.7% (15.6% - 19.8%)	19% (16.8% - 21.2%)	19.7% (18.1% - 21.3%)
2007	14.4% (8.5% - 23.4%)	28.2% (18.6% - 40.2%)	27.9% (18.4% - 40%)	24.8% (22.7% - 27.1%)	25.6% (23.6% - 27.6%)	27.3% (25.6% - 29%)

Figure 7: Adults Who Consumed Five or More Servings of Fruits and Vegetables per Day by Income Level, Jackson County vs. Florida, 2013 (most recent data); Source; FLHealthCharts.gov

ROOT CAUSES AND BARRIERS:

In the Census Tracts that this project is specifically wanting to target (2106, 2105, and 2103), a large and concentrated amount of families are living 100% below the Federal Poverty Level. In 2022, this amount is equal to or less that $18,310.00 a year for a family of two (Poverty Guidelines | ASPE (hhs.gov). One of the largest barriers to healthy eating is income level. Fruits and vegetables are at an all time high cost in the USA according to the USDA, which further discourages the community from spending their money on these healthy food options. In 2013 (most recent FLCharts data available), the percentage of adults making less than $25,000 a year who consumed five or more servings of fruits and vegetables per day was 11.1%, compared to those who made $50,000 or more a year at 18.5% (See Figure 7). Additionally, as has already been stated, transportation in Jackson's very rural community plays a large part in an individual's ability to obtain healthy food.

Barriers: Transportation, Cost, Social Isolation, Rural Geography, Lack of education on importance of healthy diet, Hurricane damage



PROJECT:

Many things were considered during the design of this project. Extensive research was reviewed regarding community gardens' positive impact on neighborhoods, economic stability, and most importantly – one's health. According to the CDC's website, "Eating a diet rich in fruits and vegetables can help reduce the risk of many leading causes of illness and death, such as cardiovascular disease, diabetes … "(Only 1 in 10 Adults Get Enough Fruits or Vegetables | DNPAO | CDC). The American Diabetes Association recommends beans, dark green leafy vegetables, citrus fruit, berries, and tomatoes as diabetes superfoods. Additionally, the CDC suggests that community gardens "may offer physical and mental health benefits by providing opportunities to eat healthy fresh fruits and vegetables, engage in physical activity, skill building, and creating green space, revitalize communities in industrial areas, decrease violence in some neighborhoods, and improve social well-being through strengthening social connection…" (CDC - Healthy Places - Healthy Food - Community Gardens).

This project is yet to have a church/organization to take ownership, but new options are being explored every day. Funding up to $4500.00 has already been secured by SnapEd monies to establish gardens and purchase raised garden beds, seeds, soil, tools, fertilizer, and any other necessary items. The organizations that agree to oversee this project will be connected with the UF/IFAS Extension Office's Master Gardener program, which is an outreach program where volunteer gardeners teach the skills necessary to maintain a garden. In addition, additional support will be provided by the local Farmer's Market organization. While not all steps and details have been operationalized, the hope is that the gardens will run yearlong OR be planted once every summer and distributed to the minority population and low-income residents efficiently. The hope is also that it builds a sense of social cohesion among community members while improving individual environments, economic stability, and the neighborhoods in which the gardens are planted. (Draft Form)

Results:	**Next Steps:**
TBD	TBD

SDOH PROJECT STORYBOARD

PanCare Health Rural Mobile Clinics

PROBLEM:

Background: There is a lack of Access to Quality Health Care in Jackson County. While many reasons contribute to this, the top three that were identified for Jackson County were transportation, medical costs, and lack of health insurance. In 2020, the rate of adults who walked to work in Jackson County was 1.9, compared to Florida at 1.4 (See Figure 1). The rate of 1.9 is higher than the previous rates from the past five years, suggesting that the issue of transportation in Jackson County is only getting worse. Health care is often neglected by those who do not have reliable transportation. In 2019, the amount of adults who could not see a doctor due to costs was 16.9% in Jackson County, compared to Florida at 16%. (See Figure 2). When this is broken down further, the disparity among this social determinant of health becomes more evident. In Jackson County, the percentage of adults making $25,000 or less a year and couldn't see a doctor in the year 2019 due to cost was 23.7%, compared to those who made $50,000 or more at 8.9% (See Figure 3). For the year 2019, the amount of Hispanic adults who could not see a doctor due to cost was 35.5%, compared to the Non-Hispanic White population at 16.2%. The Non-Hispanic Black population percentage was 13.4% (See Figure 4). In 2019, Jackson County residents who had less than a high school diploma and couldn't see a doctor due to cost was 21%, compared to those who had more than a high school degree at 15.4% (See Figure 5). Finally, the percentage of Jackson County Hispanic residents who had health care insurance coverage in the year 2019 was 26.2%, compared to Non-Hispanic White individuals at 84.4% (See Figure 6). From this data, we can concur that the residents who have the least access to Quality Health Care in Jackson County are the uninsured, low income, and lower educated residents, with a focus on Hispanic residents.

Scope: Specific areas include Census Tracts include 2106, 2110, and 2111, which has the highest percentage of individuals with no health insurance coverage in Jackson County from 2015-2019 (See Figure 7). Additionally, Census Tract 2102 will also be included as it joins Tracts 2111 and 2106 in having the lowest median household income (in dollars) in Jackson County from 2015-2019 (See Figure 8). Finally, Census Tracts 2105 will be included as it joins Tracts 2102 and 2111 in having the highest percentage of population over 25 years old with less than a 9th grade education in Jackson County from 2015-2019 (See Figure 9).

Priority populations: Based on gathered data, priority populations for this SDOH project are low-income residents, uninsured residents, and less educated Jackson County residents.

Long -Term Goal: Improve Access to Quality Health Care

By providing residents with mobile clinics and taking away the burden of transportation, costs, and insurance requirements, this project will greatly improve access to Quality Health Care. (See objective 3.1).

Medium-Term Goal: Improve Access to Quality Health Care

Much like the long-term goal, the hope is that by providing our priority populations with medical care, specifically A1C tests for Hispanic residents, access to quality health care will improve for all of Jackson County (See Objective 3.2).

Short-Term Goal: Improve Neighborhood/Built Environment

By choosing specific areas in priority neighborhoods where clinics will be held, the hope is that residents will learn about important venues and resources in their community where activities can be held safely, which will improve health and quality of life overall (See Objective 3.3).

Team Members:

Sean Golder, PanCare Health Lead Outreach Coordinator

Emily Bass, Minority Health Liaison, Florida Department of Health in Jackson County

PanCare Translation Services

Long-Term Objective 3.1: By June 2027, increase the percentage of adults who had a medical checkup in the past year from 73.8% to 76% (overall).

By June 2027, increase the percentage of Hispanic residents who had a medical checkup in the past year from 39.8% to 43%.

By June 2027, increase the percentage of Black residents who had a medical checkup in the past year from 83.1% to 86%. (See Figure 10).

Medium-Term Objective 3.2: By December 31, 2024, increase the rate of individuals with or without diabetes who have had two A1C tests in the past year from 89% to 92%. (2013-Most recent FLCharts data). (See Figure 11).

Short-Term Objective 3.3: By August 1, 2022, identify at least 6 specific locations with highest population of low income/low education level/uninsured residents where mobile clinics can be held.

CURRENT PERFORMANCE:

Workers Who Walked to Work, Percentage of Workers 16 and over, Single Year		
	Jackson	Florida
Data Year	Percent (%)	Percent (%)
2020	1.9*	1.4
2019	1.7*	1.4
2018	1.3	1.4
2017	1.3	1.5
2016	1.1*	1.5
2015	1.4	1.5

Figure 1: Workers Who Walked to Work, Percentage of Workers 16 and over, Single Year, Jackson County vs. Florida; Source: FLHealthCharts.gov

Adults who could not see a doctor in the past year due to cost, Overall		
Year	Jackson	Florida
2019	16.9% (13.4% - 20.3%)	16% (14.8% - 17.3%)
2016	18.1% (14.7% - 21.6%)	16.6% (15.8% - 17.4%)
2013	16.2% (9.3% - 23.2%)	20.8% (19.7% - 21.8%)
2010	17.8% (13.1% - 22.4%)	17.3% (16.2% - 18.3%)

Figure 2: Adults who could not see a doctor in the past year due to cost, Overall; Source: FLHealthCharts.gov

Adults who could not see a doctor in the past year due to cost						
	Jackson			Florida		
Year	<$25,000	$25,000-$49,999	$50,000 or More	<$25,000	$25,000-$49,999	$50,000 or More
2019	23.7% (17.6% - 29.7%)	20% (11.1% - 28.9%)	8.9% (3.2% - 14.5%)	25.7% (22.8% - 28.6%)	19.6% (16.4% - 22.8%)	9.2% (7.4% - 11%)
2016	24.4% (17.9% - 30.8%)	16.6% (9.7% - 23.4%)	10.6% (4.9% - 16.3%)	27.7% (25.8% - 29.7%)	16.8% (15.1% - 18.5%)	8.4% (7.3% - 9.6%)
2013	22.7% (13.1% - 32.4%)	21.4% (3.1% - 39.8%)	10.5% (0% - 24.5%)	35.2% (32.9% - 37.4%)	21.3% (19.1% - 23.5%)	8.9% (7.5% - 10.3%)

Figure 3: Adults who could not see a doctor in the past year due to cost by Annual Income, Jackson County vs. Florida; Source: FLHealthCharts.gov

Adults who could not see a doctor in the past year due to cost						
	Jackson			Florida		
Year	Non-Hispanic White	Non-Hispanic Black	Hispanic	Non-Hispanic White	Non-Hispanic Black	Hispanic
2019	16.2% (12% - 20.3%)	13.4% (6.9% - 19.9%)	35.5% (18.2% - 52.7%)	13.5% (12.3% - 14.7%)	16.8% (13% - 20.7%)	22.7% (19% - 26.3%)
2016	17.4% (13.3% - 21.5%)	14.5% (7.7% - 21.2%)	32.2% (16.9% - 47.5%)	14.1% (13.2% - 14.9%)	19.3% (16.3% - 22.2%)	21.3% (19.1% - 23.4%)

Figure 4: Adults who could not see a doctor in the past year due to cost by Race/Ethnicity, 2019, Jackson County vs. Florida; Source: FLHealthCharts.gov

Adults who could not see a doctor in the past year due to cost						
	Jackson			Florida		
Year	Less Than High School	High School/GED	More Than High School	Less Than High School	High School/GED	More Than High School
2019	21% (11.9% - 30.2%)	16.1% (11.2% - 21.1%)	15.4% (10% - 20.8%)	21.4% (17.7% - 25%)	16.9% (14.6% - 19.3%)	14.5% (12.8% - 16.2%)
2016	25.8% (16% - 35.6%)	16.2% (10.5% - 21.9%)	16.8% (12% - 21.6%)	26.8% (23.6% - 29.9%)	18.1% (16.5% - 19.7%)	13.4% (12.5% - 14.4%)
2013	27.9% (7% - 48.8%)	23.4% (10.3% - 36.5%)	6.5% (2.3% - 10.7%)	30% (26.3% - 33.7%)	22.4% (20.3% - 24.5%)	17.3% (16.1% - 18.5%)

Figure 5: Adults who could not see a doctor in the past year due to cost by Education Level, 2019, Jackson County vs. Florida; Source: FLHealthCharts.gov

Adults with any type of health care insurance coverage						
	Jackson			Florida		
Year	Non-Hispanic White	Non-Hispanic Black	Hispanic	Non-Hispanic White	Non-Hispanic Black	Hispanic
2019	84.4% (79.8% - 88.9%)	90.8% (85.9% - 95.6%)	26.2% (10.8% - 41.6%)	88.6% (87.4% - 89.7%)	81.4% (77.3% - 85.4%)	76.1% (72.7% - 79.6%)
2016	86.9% (83.3% - 90.5%)	84.5% (77.5% - 91.6%)	48.6% (32.7% - 64.6%)	89.5% (88.8% - 90.3%)	81% (78.1% - 83.8%)	71.1% (68.7% - 73.5%)

Figure 6: Adults with any type of health care insurance coverage by Race/Ethnicity, Jackson County vs. Florida, 2019; Source:FLHealthCharts.gov

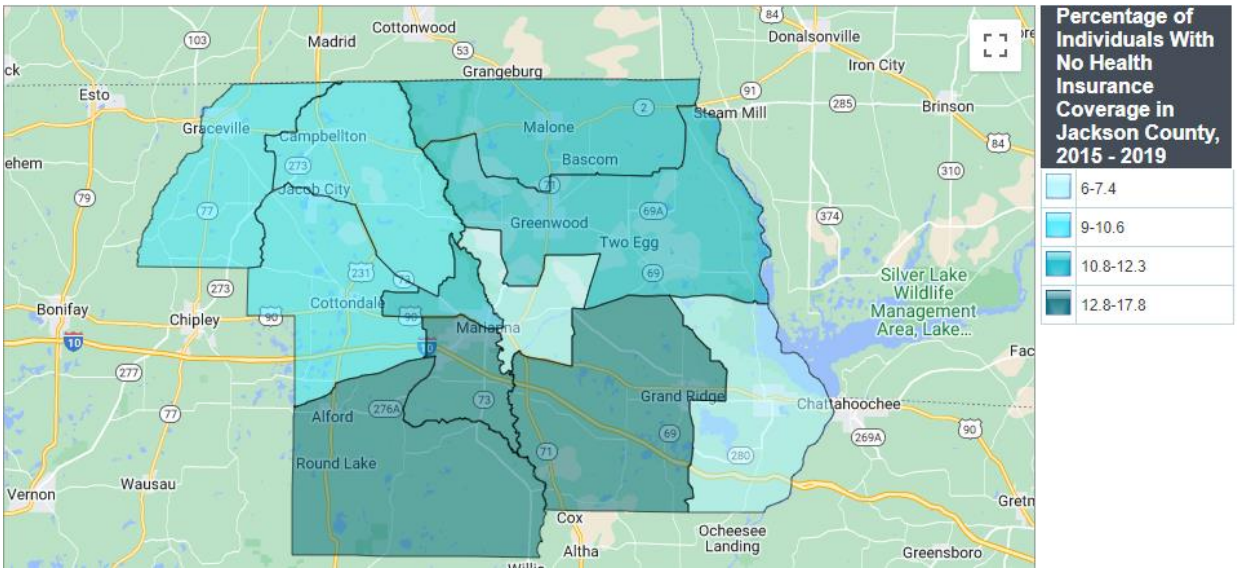


Figure 7: Census Tract Map for Jackson County showing Percentage of Individuals with No Health Insurance Coverage, 2015-2019; Source: FLHealthCharts.gov

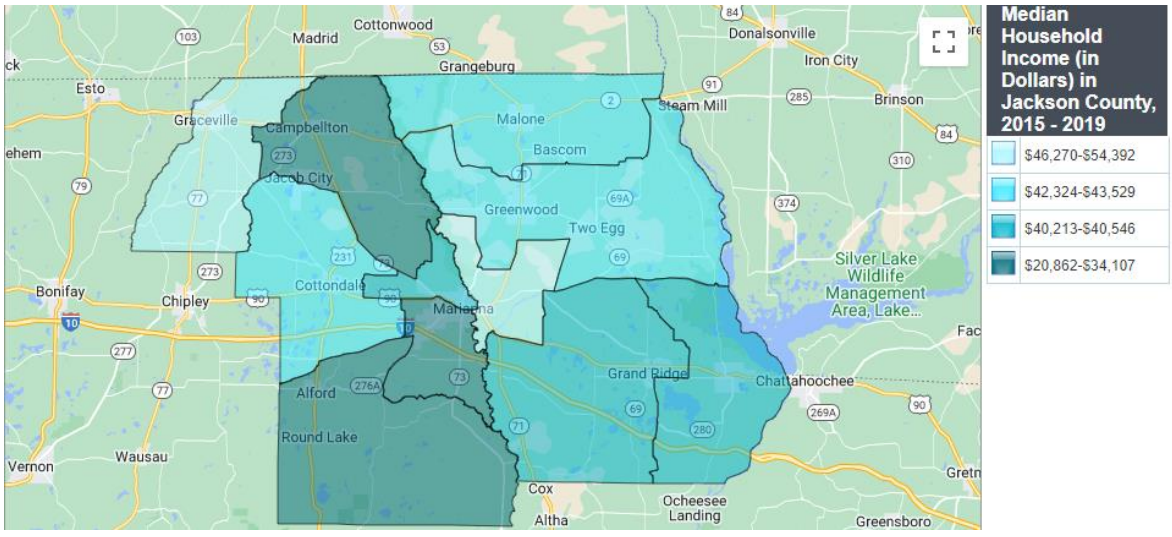


Figure 8: Census Tract Map for Jackson County showing Median Household Income (in dollars) in Jackson County, 2015-2019; Source: FLHealthCharts.gov

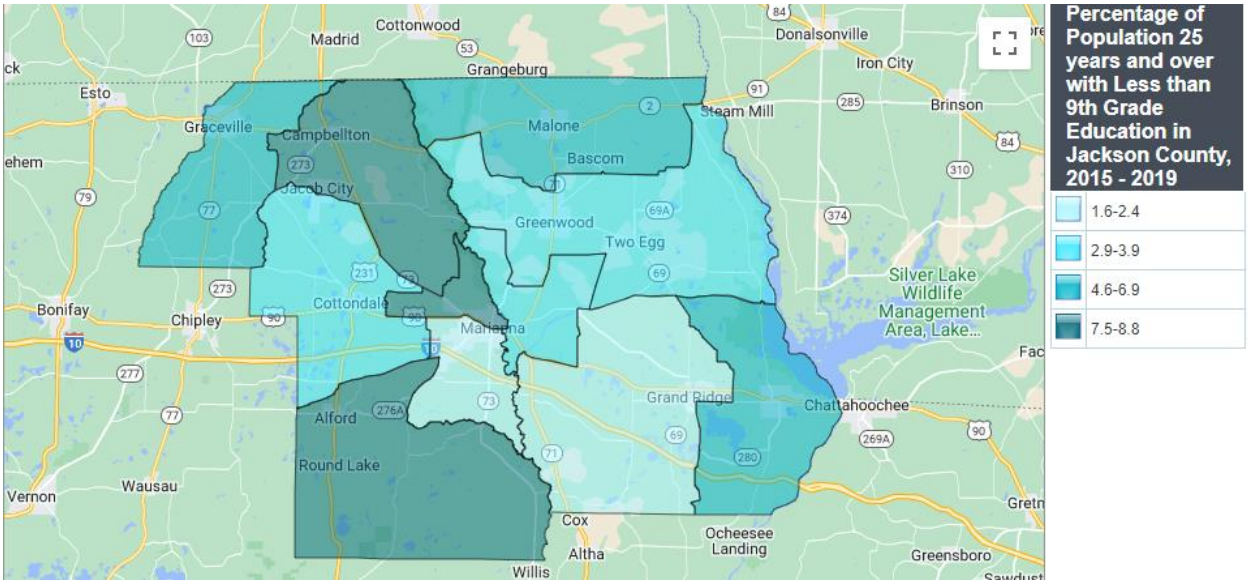


Figure 9: Census Tract Map for Jackson County showing Percentage of Population 25 years and over with Less than a 9th Grade Education, 2015-2019; Source: FLHealthCharts.gov

Adults who had a medical checkup in the past year						
	Jackson			Florida		
Year	Non-Hispanic White	Non-Hispanic Black	Hispanic	Non-Hispanic White	Non-Hispanic Black	Hispanic
2019	71.9% (66.7% - 77.1%)	83.1% (74.3% - 91.9%)	39.8% (21.4% - 58.3%)	80.6% (79.2% - 81.9%)	82.7% (78.9% - 86.4%)	73% (69.2% - 76.7%)
2016	80.9% (76.9% - 84.8%)	84.9% (77.4% - 92.3%)	72.6% (58.6% - 86.5%)	77.7% (76.6% - 78.7%)	80.4% (77.4% - 83.3%)	71.9% (69.5% - 74.4%)

Figure 10: Adults who had a medical checkup in the past year by Race/Ethnicity, Jackson County; Source: FLHealthCharts.gov

Adults with diabetes who had two A1C tests in the past year, Overall		
Year	Jackson	Florida
2013	89% (81.1% - 96.8%)	69.3% (65.8% - 72.9%)
2010	73.6% (60.9% - 86.4%)	75.6% (72.6% - 78.6%)
2007	82.4% (71.1% - 89.9%)	71.2% (67.7% - 74.4%)

Figure 11: Adults who had two A1C tests in the past year, Overall, Jackson County vs. Florida, 2013; Source: FLHealthCharts.gov

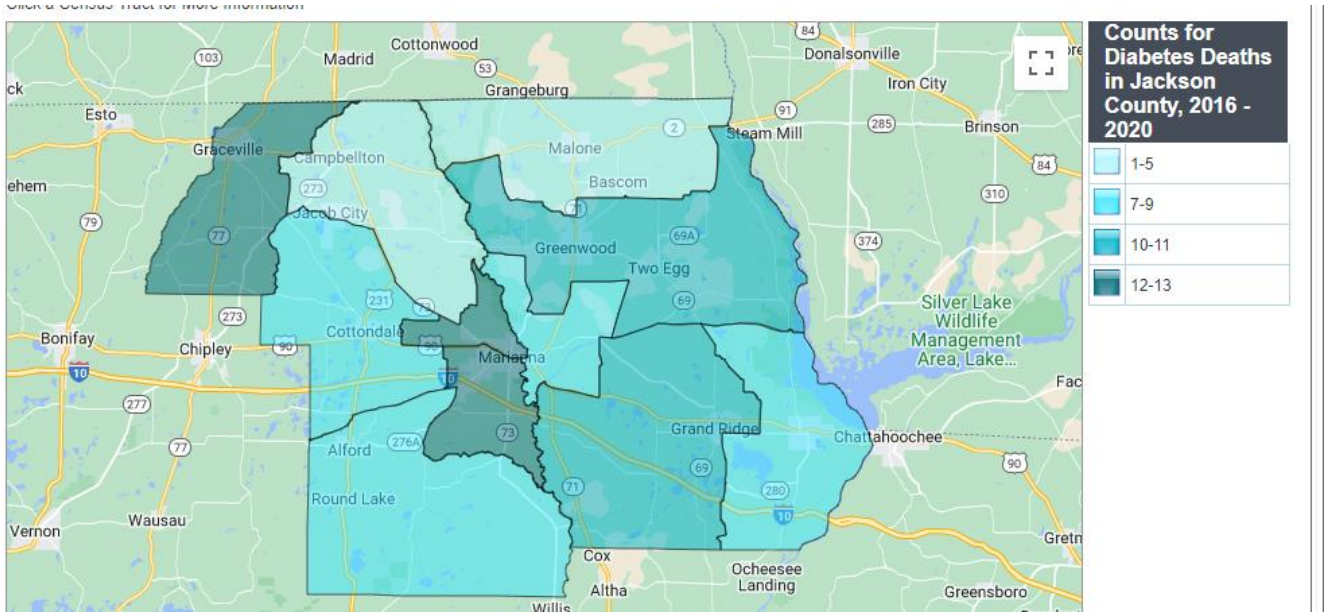
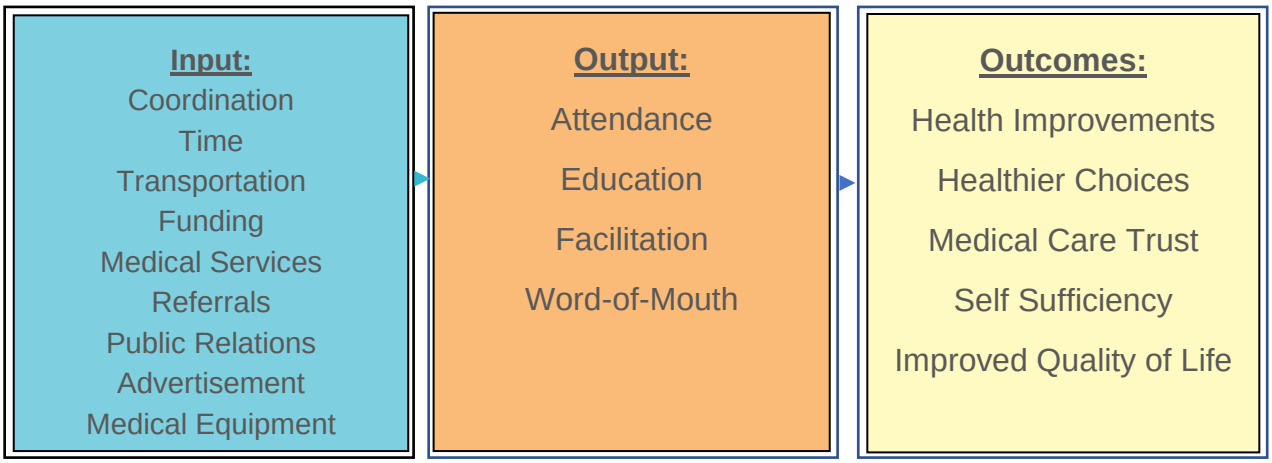


Figure 12: Census Tract Map for Jackson County, Counts for Diabetes Deaths, 2016-2020; Source: FLHealthCharts.gov

ROOT CAUSES AND BARRIERS:

In the Census Tracts that this project is particularly wanting to target (2106, 2110, 2111, 2102, and 2105), there is the highest concentration of low income, lesser educated, and uninsured residents in Jackson County. Among tracts 2105 and 2106 is where there is the highest number of deaths and hospitalizations from chronic disease in the years 2016-2020 (see Figure 12). From this information alone, there is an obvious correlation between lack of care and socioeconomic status. There are many barriers to care among this population, specifically transportation, medical costs, and lack of insurance. Many people are still distrustful of medical care after the Covid pandemic. The goal is to gain back trust, eliminate transportation and medical costs, and address insurance needs for these underserved residents.

Barriers: Transportation, Medical Costs, Lack of Insurance, Distrust, Lack of Education on Importance of Medical Care, Language Barriers, Availability of Services



PROJECT:

Many things were considered while designing this project. PanCare is a local FQHC with 12 buses fully equipped for community health clinics. They provide services at a very discounted or free price to uninsured and insured individuals. According to Stephanie Yu, “Mobile Health Clinics (MHCs) are an innovative model of healthcare delivery that could help alleviate health disparities in vulnerable populations and individuals with chronic diseases. Indeed, some studies have concluded that MHCs are particularly impactful in the following contexts: offering urgent care, providing preventative health screenings, and initiating chronic disease managements. By opening their doors directly into communities and leveraging existing community assets, MHCs can offer tailored, high-impact and affordable health care that responds dynamically to the community’s evolving needs” (Yu, Stephanie W Y et al. “The scope and impact of mobile health clinics in the United States: a literature review.” *International journal for equity in health* vol. 16,1 178. 5 Oct. 2017, doi:10.1186/s12939-017-0671-2).

The focus of these mobile clinics will be primary care, preventative care, and chronic disease management among the census tracts previously identified as Jackson’s underserved population. PanCare has the staff, resources, and funding available to do so and has expressed a great need to be more hands on in the community. The goal is to set up a clinic twice a month or as needed in these identified census tracts. They will partner with FDOH-Jackson to advertise these clinics and gather as many patients as possible. Translation services are available through PanCare and will be utilized when working with the Hispanic population. Not all details have been planned or considered and this project is in the draft stages, so changes and more information are forthcoming.

Results:	**Next Steps:**
TBD	TBD

Coalition Members:

Name	Title	Organization	Social Determinant of Health
Katrice Davis	Chronic Disease Prevention Supervisor	Florida Department of Health	Access to Quality Education
Karen Edwards	Tobacco Prevention Specialist	Tobacco Prevention program	Access to Quality Education
Whitney Merritt	Health Educator	Diabetes Prevention Program	Access to Quality Education
Sean Golder	Lead Outreach	PanCare Health	Access to Quality Healthcare
Elizabeth McDonald	Director of Nursing	Florida Department of Health	Access to Quality Healthcare
Kevin Yoder	Pastor	Rivertown Community Church	Social and Community Context – Neighborhood & Built Environment – Faith Based
Reverend Ron Mizer	Reverend	St. James AME Church	Social and Community Context – Neighborhood & Built Environment – Faith Based
Sandy Martin	Administrator	Florida Department of Health	Access to Quality Healthcare/Access to Quality Education
David Taylor	Prevention Program Director	C.A.R.E.	Access to Quality Education
TBD	Prevention Program Director	Healthy Start	Access to Quality Healthcare/Education
Shann Layne	Business Manager	Florida Department of Health	Economic Stability

XIII. REFERENCES

[1] . United States Census Bureau 2020. Jackson County, Florida. Retrieved from https://www.census.gov/quickfacts/fact/table/jacksoncountyalabama,mariannacityflorida,jacksoncountyflorida/POP010220.
[2] United States Census Bureau 2020. Jackson County, Florida. Retrieved from https://www.census.gov/quickfacts/fact/table/jacksoncountyalabama,mariannacityflorida,jacksoncountyflorida/POP010220.
[3] County Health Rankings. 2022 Florida State Report. Retrieved from https://www.countyhealthrankings.org/reports/state-reports/2022-florida-state-report.
[4] U.S. Department of Veterans Affairs. Diabetes Information. Retrieved from https://www.nutrition.va.gov/diabetes.asp.
[5] US Department of Health and Human Resources, Office of Minority Health. Diabetes and Hispanic Americans. Retrieved from https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=63.
[6] Oxford University Press. Lower Educational level is a predictor of incident type 2 diabetes in European countries: The EPIC-InterAct Study. Retrieved from https://watermark.silverchair.com/dys091.pdf?.
[7] Regis College. Child Illiteracy in America: Statistics, Facts and Resources. Retrieved from https://online.regiscollege.edu/blog/child-illiteracy/.
[8] Al-Rasheedi AA. The Role of Educational Level in Glycemic Control among Patients with Type II Diabetes Mellitus. Int J Health Sci (Qassim). 2014;8(2):177-187. doi:10.12816/0006084. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4166990/.
[9] ASPE. Poverty Guidelines for 2022. Retrieved from https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines.
[10] US Department of Agriculture. Hunger and Health, Feeding America. Retrieved from https://hungerandhealth.feedingamerica.org/understand-food-insecurity/.
[11] Gucciardi E, Vahabi M, Norris N, Del Monte JP, Farnum C. The Intersection between Food Insecurity and Diabetes: A Review. Curr Nutr Rep. 2014;3(4):324-332. doi:10.1007/s13668-014-0104-4.
[12] Mary K. Wolfe, Noreen C. McDonald, and G. Mark Holmes, 2020:
Transportation Barriers to Health Care in the United States: Findings From the National Health Interview Survey, 1997–2017
American Journal of Public Health 110, 815_822, https://doi.org/10.2105/AJPH.2020.305579.
[13] Health Day: News for Healthier Living. More Fast-Food Outlets, More Diabetes in Your Neighborhood. Retrieved from https://consumer.healthday.com/10-29-more-fast-food-outlets-more-diabetes-in-your-neighborhood-2655363693.html.
[14] American Diabetes Association. Diabetes Care. Astell-Burt T, Kolt G, Ziaoqi F. Is Neighborhood Green Space Associated With a Lower Risk of Type 2 Diabetes? Evidence from 267,072 Australians. Diabetes Care 2014;37(1):197–201. https://doi.org/10.2337/dc13-1325.
[15] CDC. National Center for Chronic Disease Prevention and Health Promotion. Physical Inactivity. Retrieved from https://www.cdc.gov/chronicdisease/resources/publications/factsheets/physical-activity.htm#:~:text=Not%20getting%20enough%20physical%20activity%20can%20raise%20a%20person%27s%20risk,and%20lower%20%E2%80%9Cbad%E2%80%9D%20cholesterol.

[16] Kozo, J., Sallis, J. F., Conway, T. L., Kerr, J., Cain, K., Saelens, B. E., Frank, L. D., & Owen, N. (2012). Sedentary behaviors of adults in relation to neighborhood walkability and income. Health Psychology, 31(6), 704–713. https://doi.org/10.1037/a0027874
[17] Dunn History. A History of Florida through Black Eyes. The Jackson County War (1869-1870) by Dr. Marvin Dunn. Retrieved from https://dunnhistory.com/the-jackson-county-war/.
[18] CDC. Alzheimer's Disease and Health Aging. Loneliness and Social Isolation linked to Serious Health Conditions. Retrieved from https://www.cdc.gov/aging/publications/features/lonely-older-adults.html.
[19] Wong YL, Matejkowski J, Lee S. Social integration of people with serious mental illness: network transactions and satisfaction. J Behav Health Serv Res. 2011;38(1):51-67. doi:10.1007/s11414-009-9203-1
[20] America's Health Rankings. Uninsured statistics. Retrieved from https://www.americashealthrankings.org/explore/annual/measure/HealthInsurance/state/FL.
[21] Fan MH, Huang BT, Tang YC, Han XH, Dong WW, Wang LX. Effect of individualized diabetes education for type 2 diabetes mellitus: a single-center randomized clinical trial. Afr Health Sci. 2016;16(4):1157-1162. doi:10.4314/ahs.v16i4.34