ALACHUA COUNTY

HEALTH EQUITY PLAN

JULY 2022 – JUNE 2027

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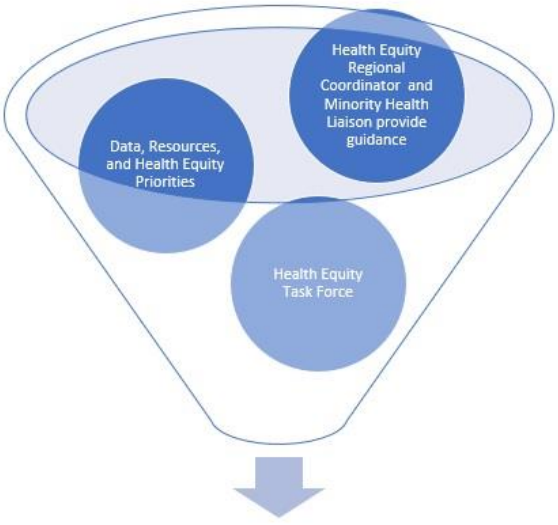
I. VISION

The Alachua County Health Equity Team, Task Force, and Coalition have come together to work across sectors to confront factors that create barriers to health, dismantle discriminatory practices, and promote equitable care and outcomes for all. When trying to develop the Health Equity Vision statement, using the same statement as the CHIP and Age Friendly Alachua County plans, “A Community Where Everyone Can Be Healthy.” However, there was concern that this was not reflective of the focus and efforts related to the Alachua County Health Equity Plan in that the members acknowledge and pledge to address the barriers that prevent everyone from being healthy. Everyone can be healthy if appropriate resources exist, and they are able to utilize the needed resources. The original members of the Health Equity Team, Taskforce, Coalition blended several ideas into the final Vision Statement for the Alachua County Health Equity Plan.



An Alachua County in which every resident, regardless physical or social characteristics, has the opportunity and ability to maximize their health and thrive.

II. PURPOSE OF THE HEALTH EQUITY PLAN

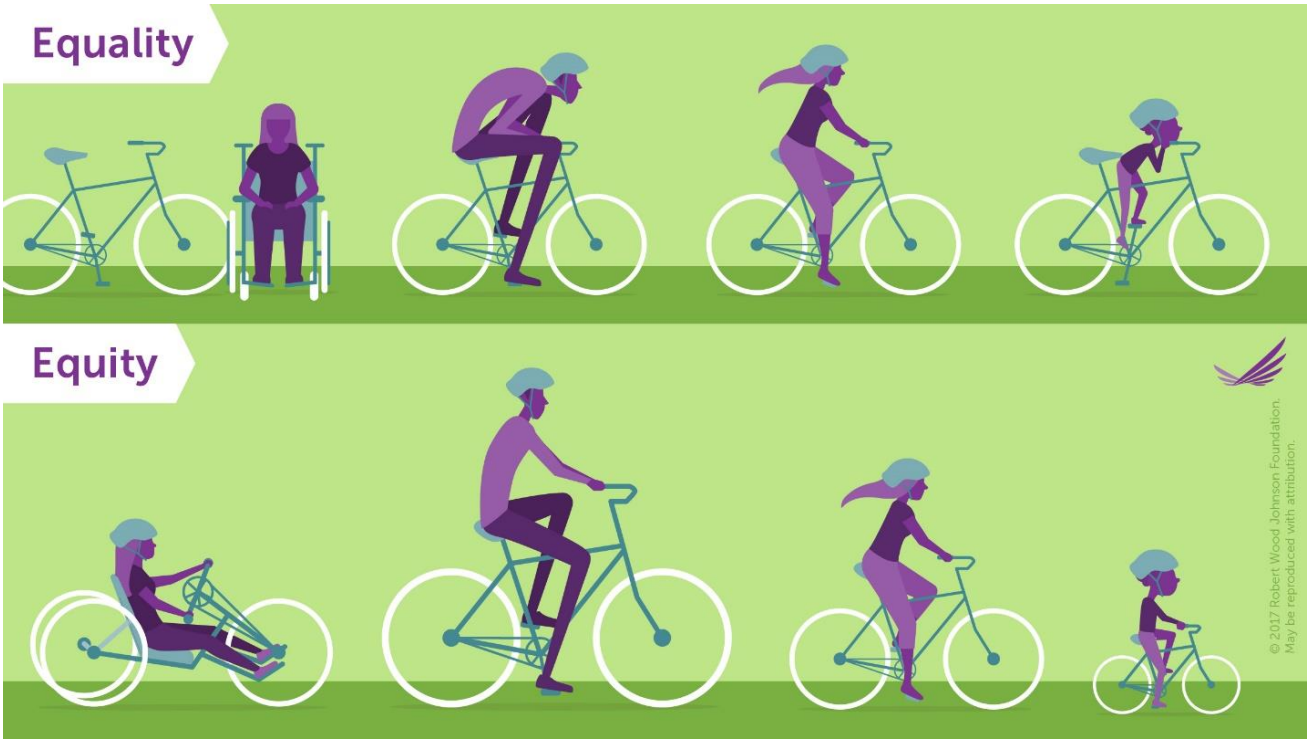
Health Equity is achieved when everyone can attain optimal health.

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 2021-1700 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 priority 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, 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 Alachua County. To develop this plan, Alachua 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 Alachua 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.

Photo Courtesy of http://farm2schoolalachua.com/

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: Terri Hutchinson
Minority Health Liaison Backup: Erica Barnard

B. Health Equity Team

The Health Equity Team includes individuals that each represent a different program within the CHD. The Minority Health Liaison determined which departments within the CHD provided services to the community. The supervisors of the selected departments were informed of the purpose of the recruitment and expectations of their representative. Each representative interacts with the community on a regular basis; each addressing different health issues. The members of the Health Equity Team are diverse in their age, gender, race, and ethnicity and all are passionate about improving the health of the Alachua County residents. The Minority Health Liaison will continually evaluate the Team and incorporate additional members, if appropriate, to ensure the inclusivity and capacity of the Team.

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 program and strategize ways to improve it. The Health Equity Team also relays information and data concerning key health disparities and SDOH in Alachua County to the Health Equity Taskforce. The Minority Health Liaison guides these discussions and the implementation of initiatives. The members of the Health Equity Team and is listed below.

Name	Title	Program
Erica Barnard	Program Administrator	Diabetes Health Network
Nykki Barnes	ER Diversion/Medial Home Coordinator	Medical Home / ER Diversion
Marize Farag	Regional Minority AIDS Program Coordinator	Area 3/13 Minority HIV/AIDS Program
Terri Hutchinson	County Minority Health Liaison	Alachua County Minority Health and Health Equity
Brittany Kingery	Hygienist and Program Administrator	Dental
Mandy Ledwith	WeCare Network Oral Health Care Coordinator	WeCare – Dental WeCare – Florida Breast and Cervical Cancer Program
Johnny Lloyd	Program Consultant	Epidemiology
Candi Morris	Administrative Assistant/Community Outreach	WIC - Alachua
Larissa Cantlin-Plemmons	Program Manager	Area 3/13 STD Program
Jaime Walker	Community Health Nurse	Family Planning- DOH Alachua

The Health Equity Team met on the below dates during the health equity planning process. As the Health Equity Plan is a living document, the Health Equity Team will continue to meet monthly to track progress.

Meeting Date	Topic/Purpose
1/14/22	Establish the Health Equity Team, discuss purpose/deliverables of Health Equity Team, Address internal/external equity concerns
2/11/22	Discuss current programs in community and need for communication/marketing
3/11/22	Choose health disparity and SDOH of concern using consensus workshop method, discuss agencies who should be on Task Force
4/8/22	Choose additional agencies/organizations to invite to Task Force, discuss desired information from Knowli
5/13/22	Minority Health Month Event recap and discussion of additional partners for Task Force and Coalition
6/14/22	Discussed objectives for projects
7/8/22	Discussed concepts and expectations of SDOH-focused health assessment

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 Alachua County Health Equity Plan and oversaw and will continue to review the design and implementation of projects. Health Equity Taskforce members are listed below.

Name	Title	Organization	Social Determinant of Health
Cynthia Nazario-Leary, PhD.	Extension Agent II	IFAS – Environmental Horticulture	Economic Stability /Neighborhood and Built Environment
Martha Maddox, MS	Extension Agent IV	IFAS – Family and Consumer Sciences	Economic Stability / Neighborhood and Built Environment
Francis Donahue	Transit Planner	Gainesville Regional Transit System	Neighborhood and Built Environment
Courtney Puentes, RN, CDCES	Program Manager	UF Health Diabetes Education and Nutrition	Health Care Access and Quality / Social and Community Context
Erica Barnard, CDCES	Program Manager	DOH-Alachua Diabetes Health Network	Health Care Access and Quality / Social and Community Context
Leanne Hibbitts	Executive Director	NAMI Gainesville	Social and Community Context
Karissa Raskin	Civic Collaboration Specialist	City of Gainesville Food System Coalition	Economic Stability /Neighborhood and Built Environment
Adriana Mendez/Nicole Diaz	Social Service Coordinator	Rural Women's Health Project	Education Access and Quality

Grace Gardner	Insurance Navigator	Suwanee River AHEC	Economic Stability/Health Care Access and Quality
David Rodriguez	Insurance Navigator	Suwanee River AHEC	Economic Stability/Health Care Access and Quality

The Health Equity Taskforce met on the below dates during the health equity planning process. The Health Equity Taskforce will continue to meet as needed to track progress, evaluate the projects for any needed modifications, assess the need for new partnerships, and evaluate any community feedback on the projects.

Meeting Date	Organizations	Topic/Purpose
12/7/21	UF Department of Physical Therapy, DOH-Alachua Diabetes Health Network	Increasing engagement in the Gaitor Challenge walks being held on the eastside of Gainesville
12/20/21	City of Gainesville/Food System Coalition	Evaluating ways to expand services to more of the disparate communities
1/6/22	Rural Women's Health Project, DOH-Alachua Diabetes Health Network	Discussing current resources and opportunities to expand services
4/30/22	NAMI, DOH-Alachua Diabetes Health Network	Discussed need for specialized mental health resources for those dealing with chronic diseases, SDOH data

5/27/22	UF Health Diabetes Education and Nutrition Center, DOH-Alachua Diabetes Health Network	Discussed current barriers and potential projects for resolution, SDOH Data
6/1/22	IFAS Environmental Horticulture & Family and Consumer Sciences, DOH-Alachua Diabetes Health Network	Discussed current barriers and potential projects for resolution, SDOH data
6/13/22	NAMI, UF Health Diabetes Education and Nutrition Center, DOH-Alachua Diabetes Health Network	Discussed issues seen by UFHealth Diabetes and DOH-Alachua Diabetes Health Network regarding mental health issues of our patients and ideas of how to more directly address them
6/14/22	UF Health Diabetes Education and Nutrition Center, DOH-Alachua Diabetes Health Network	Discussed objectives for projects
7/7/22	Gini Language Access Institute, DOH-Alachua Diabetes Health Network	Development of language access plan
7/8/22	Knowli	Discussed concepts and expectations of SDOH-focused health assessment
7/18/22	UF Health Diabetes Education and	Discuss timeline for Diabetes Support Group development

	Nutrition Center, DOH-Alachua Diabetes Health Network	
7/19/22	NAMI, DOH-Alachua Diabetes Health Network	Discussed finding of research related to chronic disease and mental health resources/programs
7/21/22	GINI Language Access Institute, DOH-Alachua Diabetes Health Network	Continued development of language access plan
7/22/22	SRAHEC	Project plans for increased insurance enrollment

D. Coalition

The Coalition will continue to be built as the Health Equity Plan evolves and projects are implemented and the need for additional input is assessed. The Coalition will continue to discuss strategies to improve the health of the community and evaluate current issues and data. The strategies will continue to focus 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. Some members of the Coalition assisted the Health Equity Taskforce by reviewing their Health Equity Plan for feasibility and effectiveness. See Addendum 1 for a list of Coalition members.

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. The Health Equity Coordinators review the county plans and assist with the continued evolution of the plans and evaluation.

Name	Region
Carrie Rickman	Emerald Coast
Quincy Wimberly	Capitol
Ida Wright	Northeast
Diane Padilla	North Central
Rafik Brooks	West
Lesli Ahonkhai	Central
Frank Diaz-Gines	Southwest
Fatima Mohamed	Southeast

V. HEALTH EQUITY ASSESSMENT, TRAINING, AND PROMOTION

A. Health Equity Assessments

To improve health outcomes in Florida, it is critical to assess the knowledge, skills, organizational practices, and infrastructure necessary to address health inequities. Health equity assessments are needed to achieve the following:

- Establish a baseline measure of capacity, skills, and areas for improvement to support health equity-focused activities
- Meet Public Health Administration Board (PHAB) Standards and Measures 11.1.4A which states, “The health department must provide an assessment of cultural and linguistic competence.”
- Provide ongoing measures to assess progress towards identified goals developed to address health inequities
- Guide CHD strategic, health improvement, and workforce development planning
- Support training to advance health equity as a workforce and organizational practice

Alachua County will be conducting a health equity assessment(s) to examine the capacity and knowledge of DOH-Alachua staff to address social determinants of health. Information about the administration and participation in the assessments(s) will be added to this document when completed.

B. County Health Equity Training

Assessing the capacity and knowledge of health equity, is necessary to identify knowledge gaps. DOH-Alachua will be creating training plans for the Health Equity Taskforce, the Coalition, and other county partners.

Information about the administration and participation in the trainings will be added to this document when completed.

Date	Topics	Number of Staff in Attendance
3/11/22	Basic concepts of SDOH https://www.youtube.com/watch?v=Lf4lFF7HlXI	7 Health Equity Task Force members
November 2022	Addressing Health Equity: A Public Health Essential	
November 2022	Cultural Awareness: Introduction to Cultural Competency	

C. County Health Department Health Equity Training

The Florida Department of Health in Alachua recognizes that ongoing training in health equity and cultural competency are critical for creating a sustainable health equity focus. At a minimum, all DOH-Alachua staff receive the *Cultural Awareness: Introduction to Cultural Competency* and *Addressing Health Equity: A Public Health Essential* training. This training is in the process of approval as a part of the staff's annual training. In addition, the Health Equity Team will provide regular training to staff on health equity and cultural competency. The information regarding these trainings will be added to this document when completed.

Date	Topics	Number of Staff in Attendance
3/11/22	Basic concepts of SDOH https://www.youtube.com/watch?v=Lf4lFF7HlXI	7
November 2022	Addressing Health Equity: A Public Health Essential	
November 2022	Cultural Awareness: Introduction to Cultural Competency	

D. 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
1/26/22	Cultural Competency and Health Equity Training
2/22-2/24/2022	Health Equity Coordinator Training (developing partnerships, developing plans) ToP Training (facilitation methods and consensus training)
7/26-7/27/2022	2022 Florida Public Health Association Annual Education Conference

E. National Minority Health Month Promotion

The First Annual Minority Health Month Event, “Boost Your Community,” was held on Saturday, April 30, 2022, at the Bo Diddley Community Plaza from 10am – 2pm.

Our “Boost Your Community” event included vendors who help address the Social Determinants of Health that lead to health disparities in the minority communities. The event was promoted to the Hispanic Community through the Rural Women’s Health Project and to the Black community through strategic flyer placement, mailed flyers to the historically Black churches in the community and an email blast to several community partners.

Many free health screenings were provided for diseases/disorders including Hypertension, Diabetes, STD/HIV, Cervical Cancer, and Colon Cancer. Education on Breast Cancer Detection using self-breast exam models was provided as well as information regarding dental, mental health, and health insurance. Free COVID-19 vaccines and influenza vaccines were provided. Information regarding emergency preparedness, the Gainesville Bike and Pedestrian program, WIC, family resources, the Human Rights Coalition, and Spanish community resources were available. Spanish translators were on site and all vendors were asked to bring materials in Spanish, and other languages if available.

A local dance group encouraged physical activity and a bounce house was available for kids and a food truck was on site as well. The attendees who completed the event passport by visiting all the vendors were provided a small reward and a bag of produce.

The event was attended by approximately 100 people of all ages, races, and ethnicities. Over 60 A1c screenings and 12 HIV tests were provided and 15 COVID19 vaccines administered.

Feedback from the post-event vendor survey was overwhelmingly positive regarding the number of attendees, the services offered, the ability to network with other agencies. Suggestions were made regarding the inclusion of translators for other languages and more community agencies.

The event will continue to be held annually during the month of April, National Minority Health Month.

Vendors representing various agencies addressing SDOHs were introduced to the County Health Equity Plan and invited to be members of our Health Equity Task Force. The intentions, findings, and goals of the plan were discussed, and several representatives indicated desire to be on the Health Equity Task Force or Coalition.

BOOST YOUR COMMUNITY

NATIONAL MINORITY HEALTH MONTH EVENT

SATURDAY, APRIL 30TH
10 A.M.– 2 P.M.
BO DIDDLEY PLAZA

FREE PRIZES!

FREE SCREENINGS

- Diabetes
- Blood Pressure
- Breast and Colon Cancers
- STD/HIV Testing

CONNECT TO RESOURCES

- Dental Health
- Mental Health
- Physical Activity
- Vaccines
- Early Childhood Health & more!

Come out for a great day full of entertainment, food trucks, and prizes for the whole family!

Florida HEALTH

Contact Info:
352-225-4176
352-225-4354

V. PRIORITIZING A HEALTH DISPARITY

According to the 2020 US Census, Alachua County had a population of 278,468 with the majority, 141,085, residing in Gainesville or the surrounding area. Most other residents live in the towns of Alachua, High Springs, Hawthorne, Newberry, and Lacrosse.

RACE & ETHNICITY

The figure below demonstrates the demographic makeup of Alachua-county according to the 2020 Decennial Census.

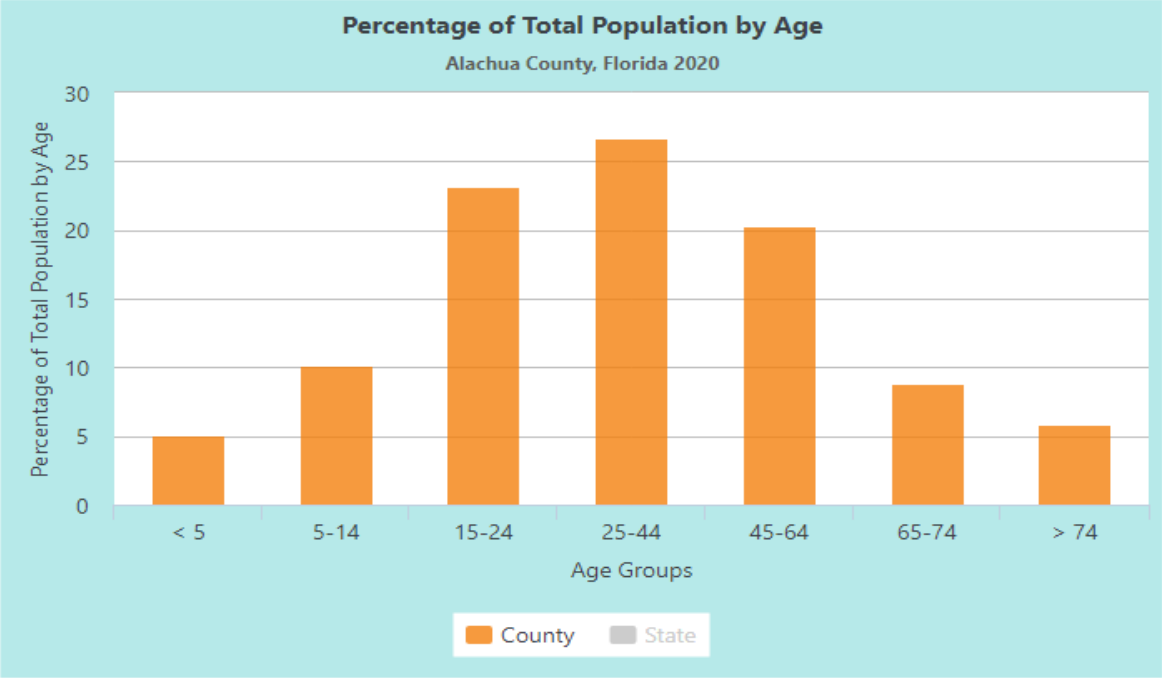
White	57.60%
Black	18.70%
Hispanic	12%
American Indian/Alaskan Native	0.30%
Hawaiian or Pacific Islander	0.04%
Asian	6.50%
2 or more races	9.87%
Other	3.4%

Additional data from the 2020 Census indicates that approximately 6.8% of the county population identifies as a Veteran, and 10.8% identify as Foreign Born. According to Florida Health Charts (2019), 21.3% of the county population identified as having any disability. Questions included in the 2017-2019 Behavioral Risk Factor Surveillance System (BRFSS) indicate that there are residents in the county who identify as LGBTQ+ but it is unclear what percent of the population this includes.

It is relevant to view some of the county data through the lens created by the influence the University of Florida (UF) and Santa Fe College (SFC) have on the demographic picture of Alachua County. Most data sources available do not differentiate between those who are students versus established residents of the county.

AGE AND GENDER

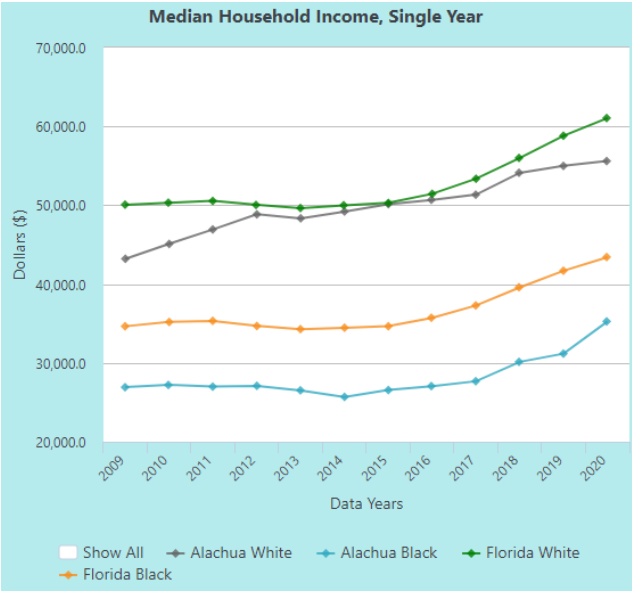
Residents in the age range of 15-44 years old make up 49.9% of the population, with those aged 65 years and older making up 14.6% of the population. Approximately 48.3% of the population identifies as male while 51.7% identify as female.

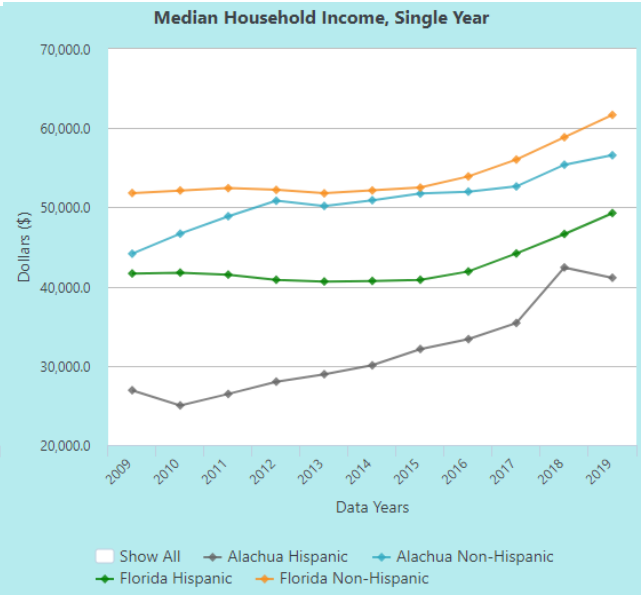


County Health Profile (flhealthcharts.gov)

INCOME AND POVERTY

In 2020, the Mean Household Income in Alachua County was $50,089.00 compared to Florida at $57,703.00 *Median Household Income - Florida Health CHARTS - Florida Department of Health (flhealthcharts.gov)* According to the same data, not only did Black residents in Alachua County have a lower Mean Household Income ($35,264.00) compared to Black residents in the state ($43,418.00) but also compared to White Alachua County residents ($55,619.00) and Hispanic Alachua County residents ($41,109.00) as shown in the figures below.





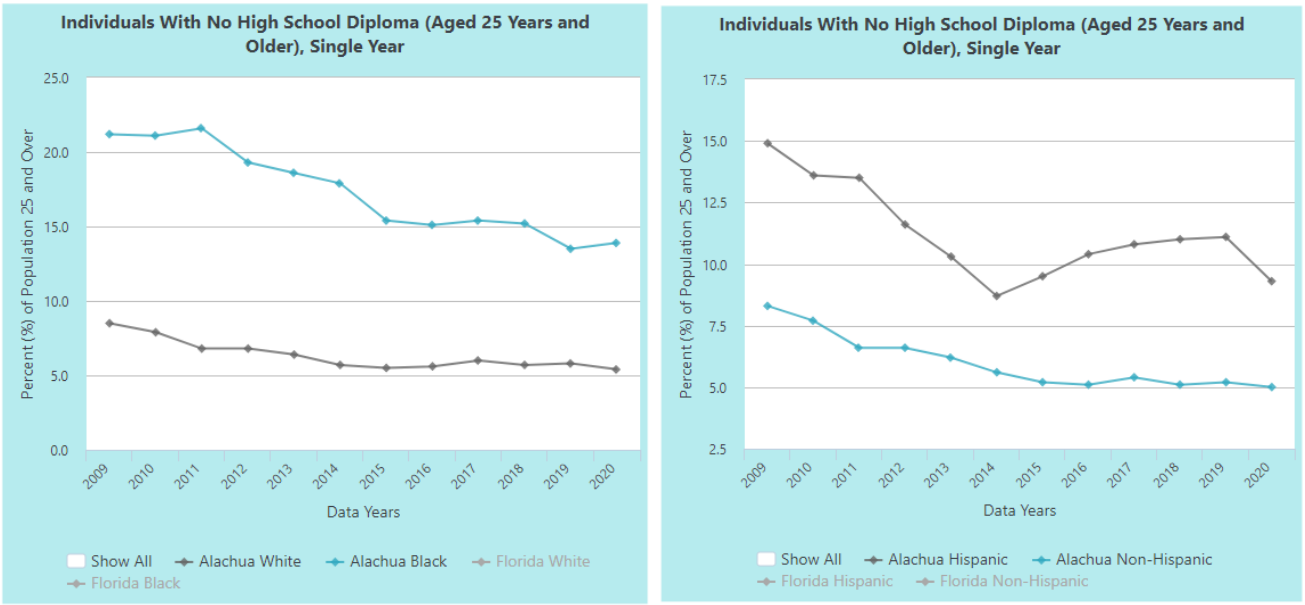
There was limited county-level data on Veterans. However, national data indicates that Veterans have a median income of $44,241 in 2019. *Median income of Veterans - USAFacts* The limited responses of the 2017-2019 BRFSS data suggest that most county residents who identify as having a disability may make a similar or slightly less mean income when compared to the Black residents. The data regarding those who identify as LGBTQ+ is limited and does not yield a statically significant difference when compared with the total population.

Approximately 20.7% of individuals report being under the poverty level while 9.4% of families report the same. Of the individuals living under the poverty level, 28.7% identify as Black, 17.7% identify as White, and 27.3% identify as Hispanic. *Individuals Below Poverty Level - Florida Health CHARTS - Florida Department of Health | CHARTS (flhealthcharts.gov).* There is limited county-level data on Veterans. However, the U.S.

Department of Veterans Affairs reports in 2015 that Veterans have a lower overall rate of poverty than non-Veterans. *Veteran Poverty Trends (va.gov)*. According to the limited relevant responses in the 2017-2019 BRFSS, those who identified as LGBTQ+ reported a similar rate of those living under the poverty level when compared to the Black and Hispanic population. Those who identified as having at least 1 disability had a slightly higher rate for those living under the poverty level.

EDUCATION

According to the 2020 American Community Survey, of the residents over 25 years of age, 7.2% report having not completed high school with another 20.2% reporting their highest level of education as high school graduation or completion of a GED. The FlHealthCharts.gov figure below indicates that there is a higher rate of 25+ year old Black residents (13.9%) who do not have a high school diploma when compared to both White (5.4%) and Hispanic residents (9.3%).



Individuals With No High School Diploma (Aged 25 Years and Older) - Florida Health CHARTS - Florida Department of Health (flhealthcharts.gov).

Data indicates that Black residents experience the highest rate of not having a high school diploma or equivalent (13.9%) when compared to White residents

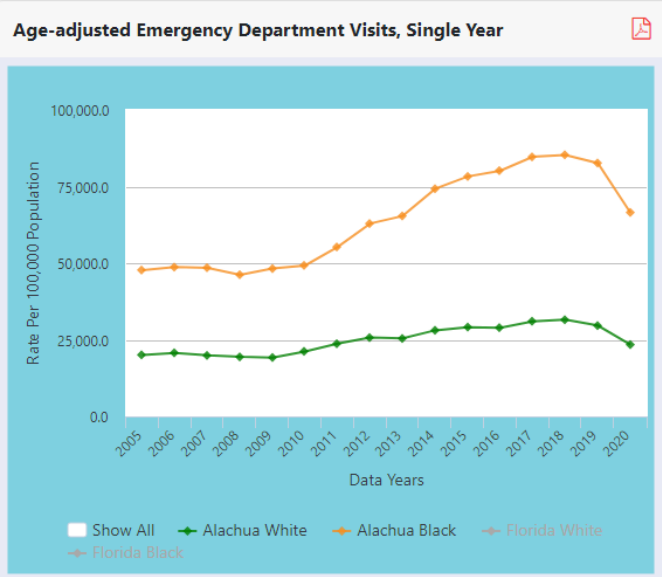
According to the 2020 American Community Survey estimates for Alachua County, 5.9% of those who identify as American Indian/Alaskan Native, 3.2% of those who identify as Asian, and 0% of those who identify as Native Hawaiian and other Pacific Islander report not having at least a high school diploma or equivalent. Although there is limited or no county data available, the Bureau of Labor Statistics suggests that only 4.8% of Veterans do not have at least a high school diploma on a national level. *A closer look at Veterans in the labor force: Career Outlook: U.S. Bureau of Labor Statistics (bls.gov)* The 2017-2019 BRFSS data regarding high school graduation rates for those with disabilities suggests that they may have a 14% rate of not completing high school. There is limited data regarding LBGTQ+ residents as they relate to this indicator, as well as high school graduation rates.

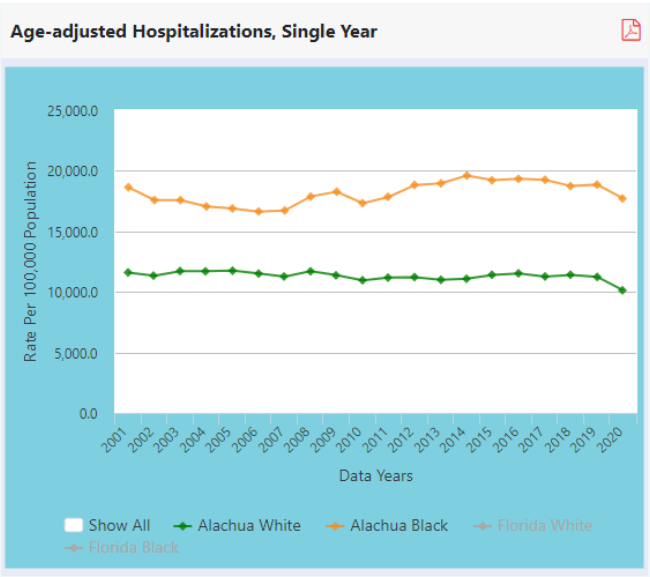
The Health Equity Team reviewed multiple health data sources and identified and reviewed health disparities data in Alachua County. Data was pulled from sources including:

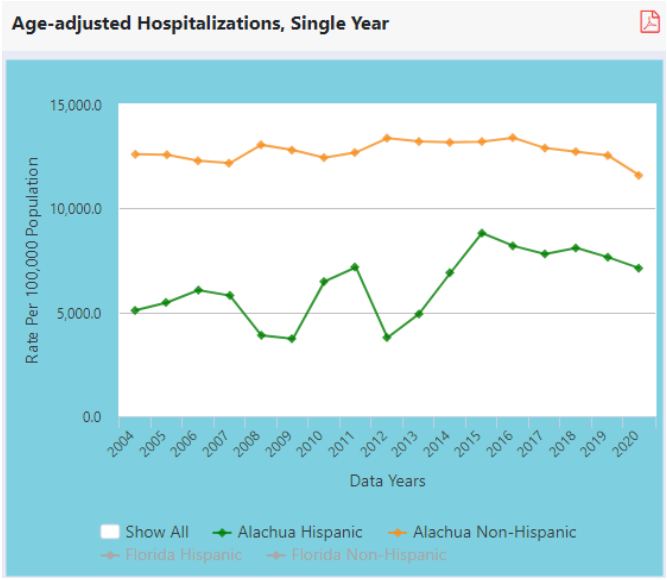
- FLHEATHCHARTS.gov
- United States Census Bureau
- CDC.gov
- America's Health Rankings.org
- Current Population Survey

There was an overwhelming absence or limitation of data regarding other minority groups including the disabled, Veterans, LGBTQ+, and other nationalities/ethnicities. This issue will be addressed through one of the Health Equity projects as the goal will be a more comprehensive community SDOH assessment that is inclusive and reflective of the Alachua County residents.

Of all the health disparities present in Alachua County, one that created a significant concern was that, despite representing only 20.1% of the county population, Black residents have historically had higher rates of Emergency Department visits and hospitalizations compared to their White and Hispanic counterparts as shown in the figures below. *(FLHEALTHCHARTS.gov)*

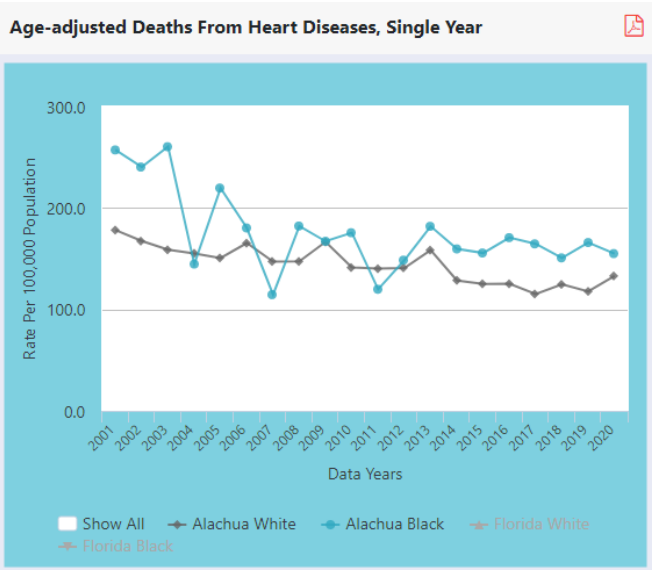


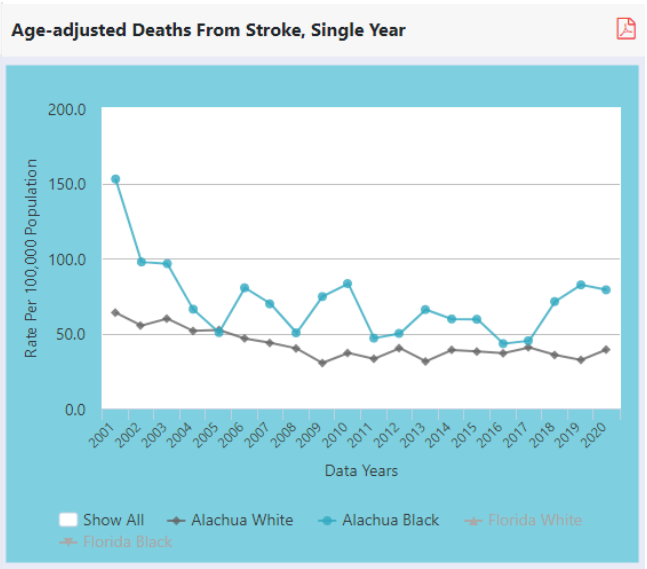


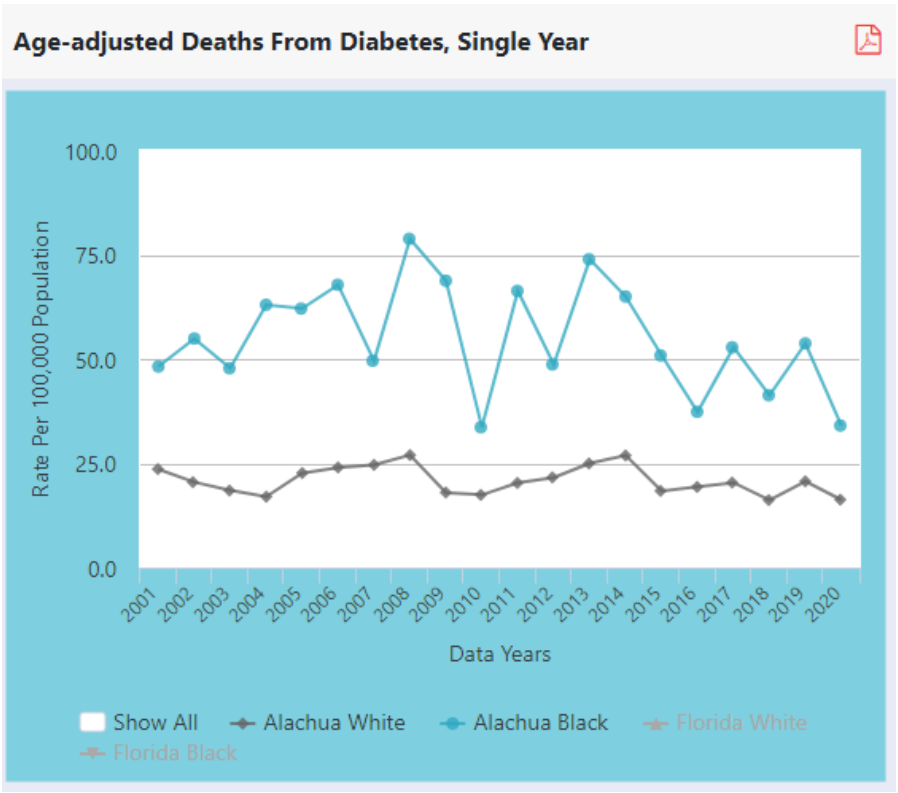


Furthermore, Black residents have not only had higher rates of hospitalization related to diabetes, hypertension, heart disease, but also generally higher rates

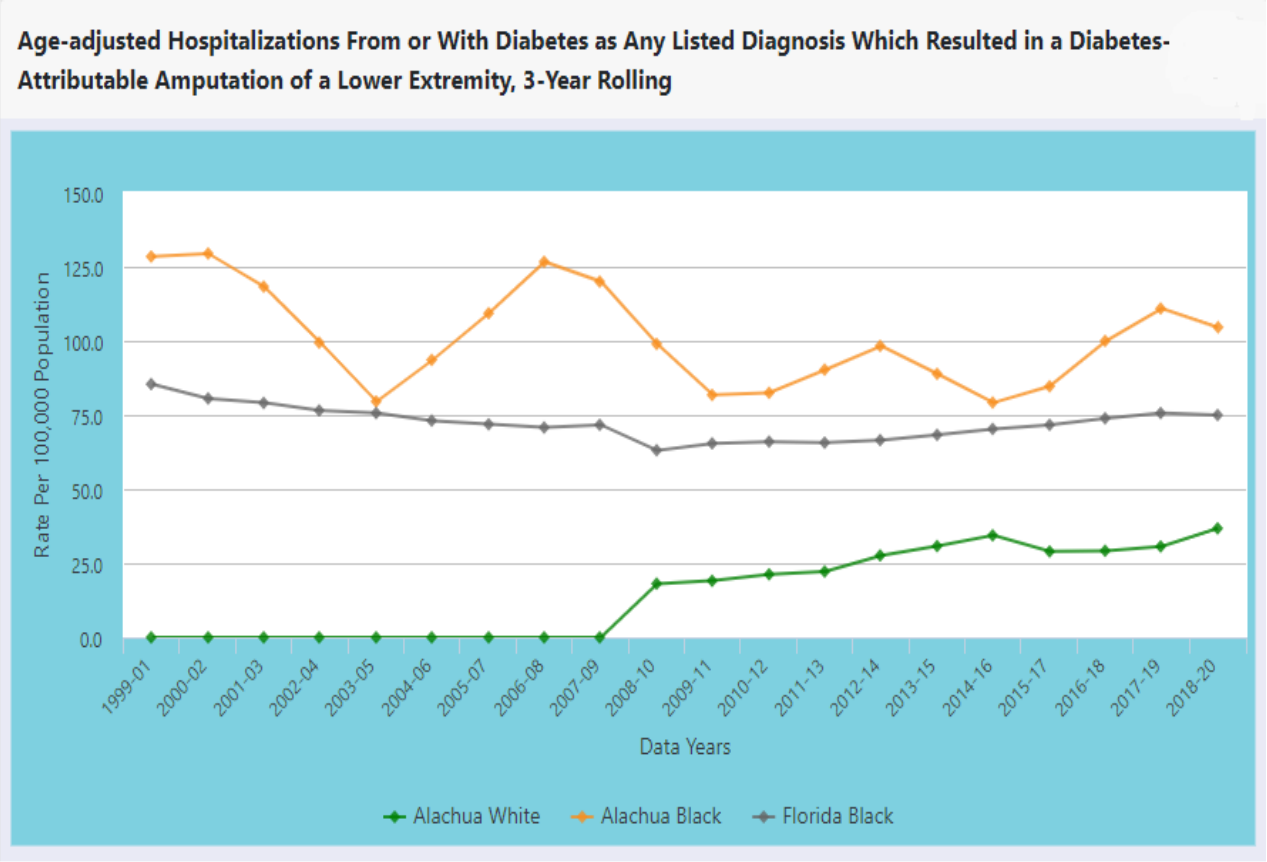
of death from Stroke, Heart Disease, and Diabetes compared to both their White and Hispanic counterparts as shown in the figures below. *(FLHEALTHCHARTS.gov)*







Of concern, was the sustained historically significant difference that exists between Black residents, White residents, and Hispanic residents regarding diabetes-related deaths per 100,000 at 34, 16.2, and 5.9 respectively in 2020. Moreover, the figure below shows that Black residents have also continuously had a rate of diabetes-related amputation that is double or triple the rate of those with diabetes who are White (87.1 vs.39.9/100,000).



Hospitalizations From or With Diabetes as Any Listed Diagnosis Which Resulted in a Diabetes-Attributable Amputation of a Lower Extremity - Florida Health CHARTS - Florida Department of Health | CHARTS (flhealthcharts.gov)

Upon further review of data, it was found that Diabetes was the 6th leading cause of death for Black residents of Alachua County versus being ranked 8th for White residents and 7th for Hispanic residents. Heart Disease was the 2nd leading cause, COVID-19 the 3rd leading cause, and Stroke as the 4th leading cause of death for Black residents.

Leading Causes of Death Profile, Black, Alachua County, Florida - 2020					
Causes of Death	Deaths	Percent of Total Deaths	Crude Rate Per 100,000	Age-Adjusted Death Rate Per 100,000	YPLL < 75 Per 100,000 Under 75
ALL CAUSES	493	100.00	883.8	1,077.4	10,989.9
CANCER	81	16.43	145.2	155.3	1,635.5
HEART DISEASE	70	14.20	125.5	155.0	915.7
COVID-19	62	12.58	111.1	135.6	1,143.2
STROKE	33	6.69	59.2	79.0	302.1
UNINTENTIONAL INJURY	28	5.68	50.2	54.2	1,624.3
DIABETES	16	3.25	28.7	34.0	317.0
NEPHRITIS, NEPHROTIC SYNDROME & NEPHROSIS	12	2.43	21.5	26.5	186.5

Leading Causes of Death (flhealthcharts.gov)

It is important to acknowledge that diabetes is a known risk factor for both heart disease and Stroke and is also a risk factor for complications in the setting of COVID-19. Therefore, addressing diabetes could potentially impact those diseases in a positive way.

Despite the limited health indicator data for all the minorities in Alachua County, the Health Equity Team and Taskforce looked for state and national data that could possibly shed light on the potential implications for those same minorities who reside in Alachua County.

Knowing of a diagnosis can have significant implications regarding health outcomes. There is limited county-level data regarding diagnosis of diabetes within certain races and ethnicities. According to America's Health Rankings, the Florida state trend indicates that 14.9% of American Indian/Alaska Native, 10.3% of Asian, and 0% of Native Hawaiian and Other Pacific Islander populations report being told they have diabetes. *Explore Diabetes in Florida | 2021 Annual Report | AHR (americashealthrankings.org)* Of concern is the rate of diabetes within the Asian community as it is suspected to be severely underdiagnosed due to a lower BMI threshold for risk when compared to non-Asian people. *Diabetes and Asian American People | CDC* According to the U.S. Department of Veterans Affairs, "Diabetes affects nearly 25 percent of VA's patient population," suggesting that this population may experience diabetes-related disparities. Diabetes (va.gov) The data regarding residents with disabilities and those who identify as LGBTQ+, was found in the 2017-2019 BRFSS which asks respondents if they have ever been told that they have diabetes. The data indicates that 19% of those identifying as

disabled had been told they have diabetes while the limited number of LGBTQ+ respondents did not yield a statistical difference when compared to the non-LGBTQ+ residents.

FLHealthCharts.gov provided information regarding the White, Black, and Hispanic residents. The figure below shows a similar rate for both White and Black residents who report having been told they had diabetes,10.8% and 10.2% respectively, but a higher rate for Hispanic residents at 18.7%, which aligns with the national trend indicating Hispanics have a higher rate of diabetes.

Health Equity Profile (flhealthcharts.gov)

Despite an apparent disparity regarding diabetes, there is limited data regarding people with disabilities, and Asians and their diabetes-related ER, hospitalization, and death rates. However, the data does show that Black residents have a significantly higher rate of ER visits, hospitalizations, and death due to diabetes compared to White residents and Hispanic residents as shown in the figure below.

			RACE/ETHNICITY					
Indicator	Measure	Year(s)	Total	White	Black	Other Race	Hispanic	Non-Hispanic
Diabetes								
Adults who have ever been told they had diabetes	Percent	2019	11.2	10.8	10.2		18.7	
Emergency room visits due to diabetes	Per 100,000 population	2020	151.7	88.8	378.7	129.2	113.5	155.9
Preventable hospitalizations under 65 from diabetes	Per 100,000 population	2020	116.5					
Hospitalizations from or with diabetes	Per 100,000 population	2020	2662.8	1900	5756.5	2720	2022.5	2671.1
Diabetes age-adjusted death rate	Per 100,000 population	2020	19.9	16.2	34	28.6	5.9	21

This data is concerning as it causes question as to whether Black residents are not being informed of, or understanding, their diagnosis and are possibly not receiving appropriate care and education after diagnosis.

While there is intention to also address the high rate of Diabetes within the community of those with disabilities, Asians, and Veterans, there currently is no data regarding the indicators that would measure the effect of any projects or interventions, such as diabetes-related hospitalizations, amputations, and deaths. Because of the abundance of limited data on all the minorities in the

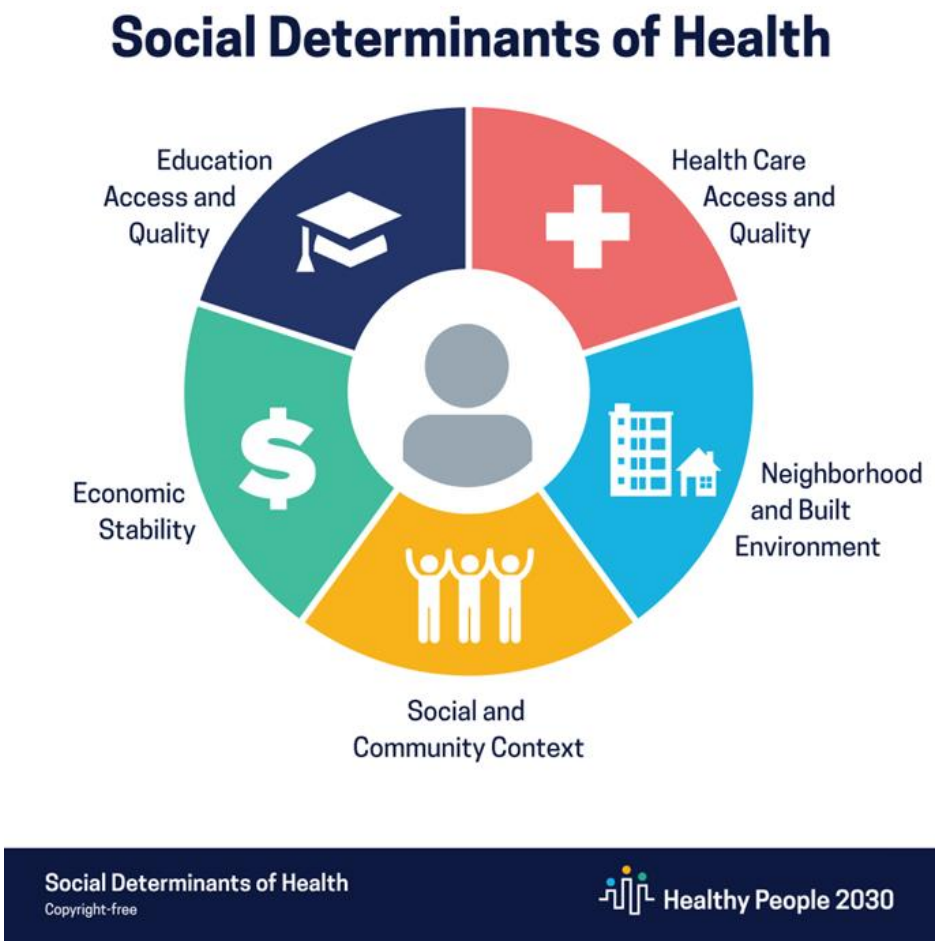
county, one of this plan's projects is to create, administer, and analyze a more inclusive county health assessment and provide the missing data for all the residents who are not adequately represented in the current data.

Considering the data that was available at the time of the original version of the Alachua County Health Equity Plan, and the potential to positively affect the indicators related to not just diabetes, but also heart disease, stroke, and COVID-19, the Health Equity Team agreed that the targeted health disparity should be diabetes within the Black adult community. When determining the geographic location of the high-risk residents, several zip codes were in the 4th quartile for Diabetes-related deaths. Upon review of those zip codes, it was determined that 32641 and 32609 have some of the highest rate of Diabetes-related deaths *Community Social and Economic Factors Report (flhealthcharts.gov)* and a high population of Black residents with 32641 at 65.5% Black and 32609 at 38.6% Black. *DP05: Census Bureau Table.*

It is the intention of the 2022 Alachua County Health Equity Plan to address the Social Determinants of Health (SDOH) that may be the source of the diabetes-related disparities for not just the Black residents, but for all minorities in the county who may be disparately affected by diabetes. Although there is anticipation that the results of the plan's SDOH projects may improve other health indicators, the data point that will be used to measure the impact of this plan's projects will be the Diabetes-related hospitalization rate for Black Alachua County residents: By June 2027, reduce the rate of Diabetes-related hospitalizations for Black residents by 10% from 494.6/100,000 (2020) to 445.14/100,000.

VI. 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 disparity regarding diabetes. They are listed below.



A. Education Access and Quality

Education Access and Quality data for Alachua County.

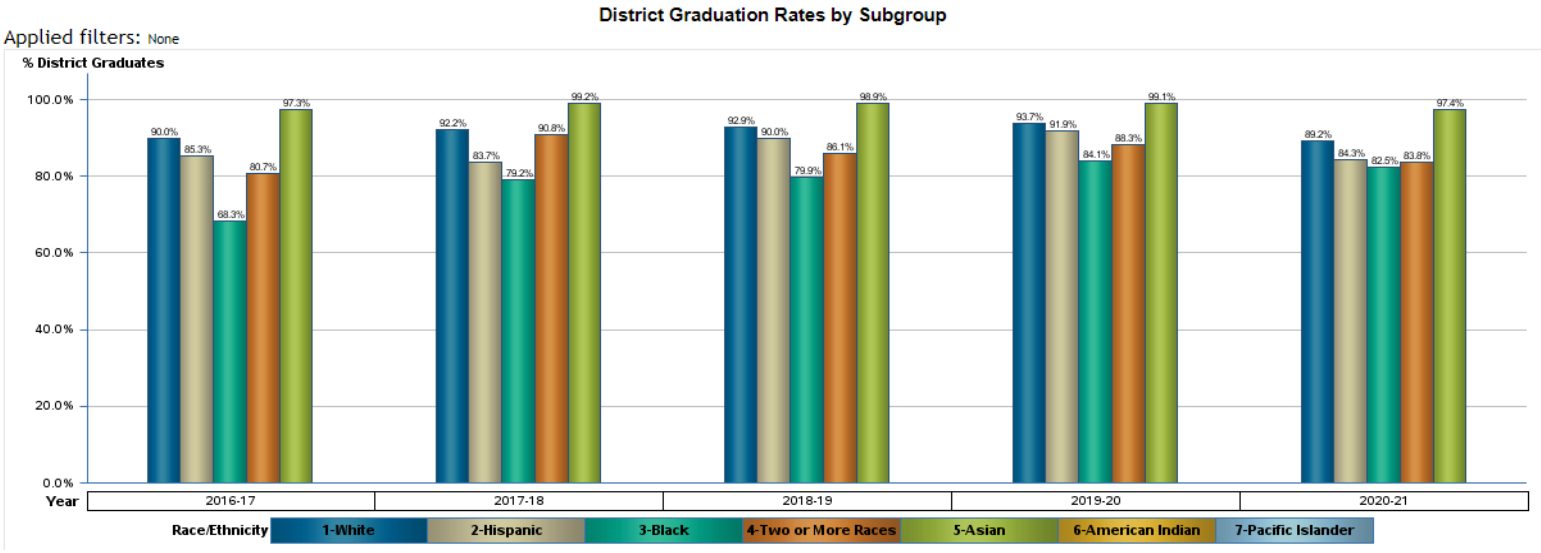
Education is a vital component to an adult's ability to secure employment, financial stability, and health. Without it, the potential to thrive in the mentioned arenas is significantly reduced.

In the year 2020-2021, Alachua County saw a total high school graduation rate of 86.6%, compared to the state of Florida rate of 90.0%. Additional data shows that since at least 2012, Black Alachua County students have had lower graduation rates (82.5%) when compared to White Alachua County students (89.2%), as well as both White (91.8%) and Black (87.1%) students at the state level. A clear disparity in high school graduation rates can also be seen for residents with disabilities (77.7%) compared to those without disabilities (87.5%) in Alachua County as shown in the figures below.

High School Graduation Rate - Florida Health CHARTS - Florida Department of Health (flhealthcharts.gov)

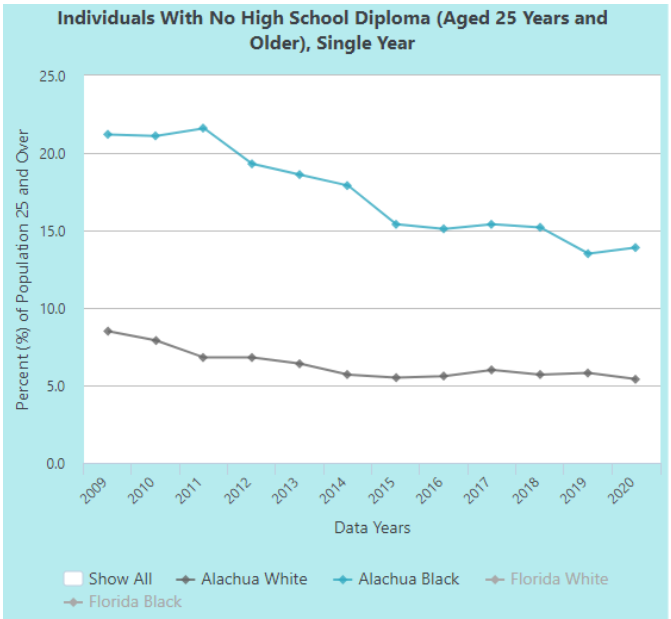
There was limited data regarding residents identifying as LGBTQ+ and high school graduation rates. However, according to www.pride.com, 96.6% of LGBTQ+ students surveyed nationally indicated that they planned to finish high school. Although there is limited data on Alachua County Veterans, the Bureau of Labor Statistics suggests that only 4.8% of Veterans do not have at least a high school diploma on a national level.

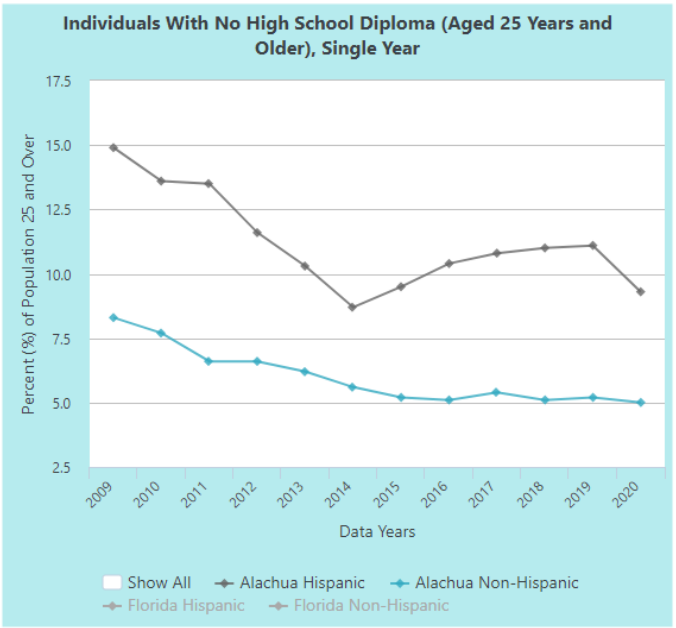
Data from the Department of Education indicates that Alachua County's Black students have had lower high school graduation rates compared to all other measured races and ethnic groups for multiple years as shown in the figure below.



[FL Department of Education: View Report (fldoe.org)]

Furthermore, data regarding adults 25 years and older without a High School diploma suggests that Black residents are less likely than their White and Hispanic counterparts to finish their high school/GED education leaving them with a lower education level as an adult as shown in the figures below.



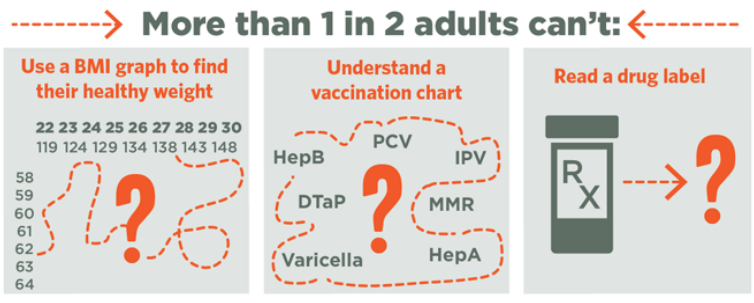


[Individuals With No High School Diploma (Aged 25 Years and Older) - Florida Health CHARTS - Florida Department of Health (flhealthcharts.gov)]

There is limited data regarding all other minority groups regarding this indicator.

In accordance with the rate of high school diplomas, Black Alachua County residents have the lowest rate of post-secondary enrollment in a Florida college or university with a 2019-2020 rate of 39.9% for Black students versus 61.3% for White students. *Alachua School District Report Card (fldoe.org)*

According to the 2003 National Assessment of Adult Literacy (NAAL), 55% of those who did not graduate from high school had a Prose Literacy level below basic – indicating that they mastered no more than the most simple and concrete literacy skills. The Program for the International Assessment of Adult Competencies (PIAAC) indicates, that out of 5 literacy levels, Literacy Level 1 is associated with those who do not graduate from high school and a Literacy Level of 2 is associated with those who do graduate. *Program for the International Assessment for Adult Competencies (PIAAC)-PIAAC Proficiency Levels for Literacy (ed.gov)* The connection between literacy and health is clear as research has shown, "Low literacy is associated with several adverse health outcomes." *Literacy and health outcomes: a systematic review of the literature - PubMed (nih.gov)* When literacy skills are subpar, the individual may not be able to understand the directions provided regarding health behaviors and, when numeracy skills are equally subpar, they may not be able to properly execute dosing and timing of their medication. This deficit in education can be a significant barrier when trying to live with diabetes as diabetes is a dynamic disease that requires frequent changes to the treatment regimen over a lifetime. Instructions on handling emergencies, sick days, monitoring, and other behaviors can be misunderstood or neglected altogether out of frustration related to the disconnect created by their literacy deficit.



change4health.org

Furthermore, the daily interaction with numbers as they relate to blood sugar readings, medication dosing, and dietary portioning, can leave a person with lower literacy and numeracy vulnerable to mistakes with, or even omission of, important steps in diabetes management. Consequently, the individual may experience a higher rate and severity of complications, more frequent hospitalizations, and even death at an earlier age from not just diabetes, but potentially heart disease or stroke.

The fact that Black Alachua County residents have a low rate of those indicating they have been told they have diabetes, yet a high rate of diabetes-related hospitalizations, amputations, and death may in fact be an indicator that they are not understanding what they are supposed to do.

			RACE/ETHNICITY					
Indicator	Measure	Year(s)	Total	White	Black	Other Race	Hispanic	Non- Hispanic
Diabetes								
Adults who have ever been told they had diabetes	Percent	2019	11.2	10.8	10.2		18.7	
Emergency room visits due to diabetes	Per 100,000 population	2020	151.7	88.8	378.7	129.2	113.5	155.9
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Diabetes age-adjusted death rate	Per 100,000 population	2020	19.9	16.2	34	28.6	5.9	21

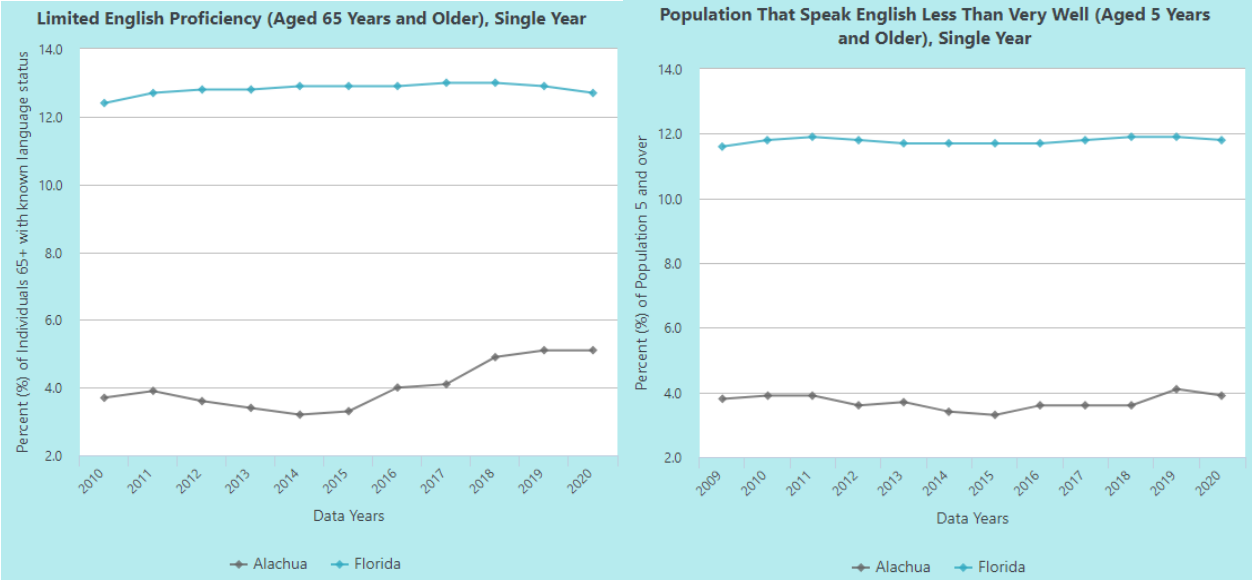
Health Equity Profile (flhealthcharts.gov)

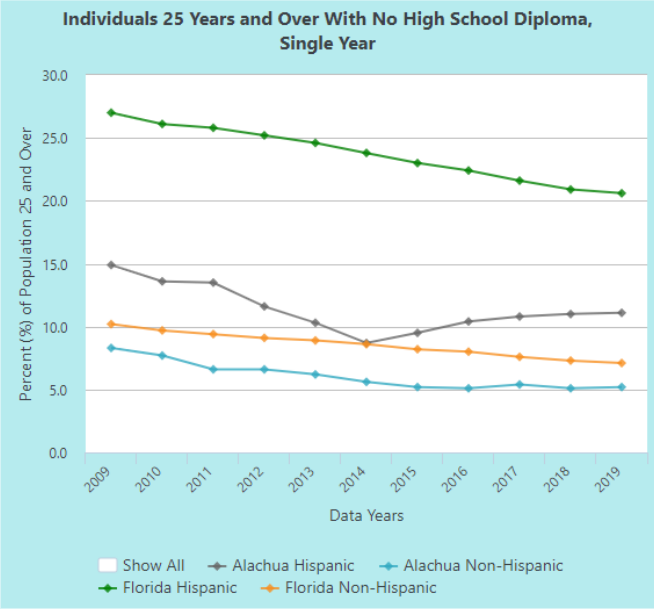
Another factor that can be layered with literacy is language. Research shows that among patients who do not speak the local language,

> "49% had trouble understanding a medical situation, 34.7% were confused about how to use medication, 41.8% had trouble understanding a label on medication, 15.8% had a bad reaction to medication due to a problem understanding their healthcare provider's instructions,[20] 66.7% faced a barrier when accessing healthcare, and 20% did not seek healthcare services if these were not readily available for fear of not understanding their healthcare provider.[14]" *(Implications of Language Barriers for Healthcare: A Systematic Review - PMC (nih.gov).*

To thrive in a predominantly English setting, those whose first language is not English need to have ample access to opportunities to learn English. In addition, research suggests that there should be integration of health topics and numeracy skills into English language instruction to enhance the learner's ability to fully participate in their health management. *PIAAC Numeracy Skills and Home Use Among Adult English Learners | Adult Education and Literacy | U.S. Department of Education*

Alachua county has a relatively small population of those who don't speak English well as indicated in the figures below. However, data suggests, that at least in the Hispanic community, there is a higher rate of those without a high school diploma (9.3%, 2020), compared to the non-Hispanic population (5%, 2020). *(FLHEALTHCHARTS.gov)*





Compounding the effects of both a language barrier and literacy deficiency puts the English learner population in Alachua County at an even higher risk for poor health outcomes as they may experience a significantly lower chance of being provided health information in a native language. Having diabetes in the setting of language barriers further creates the potential for an increase in diabetes-related hospitalizations, amputations, and early death.

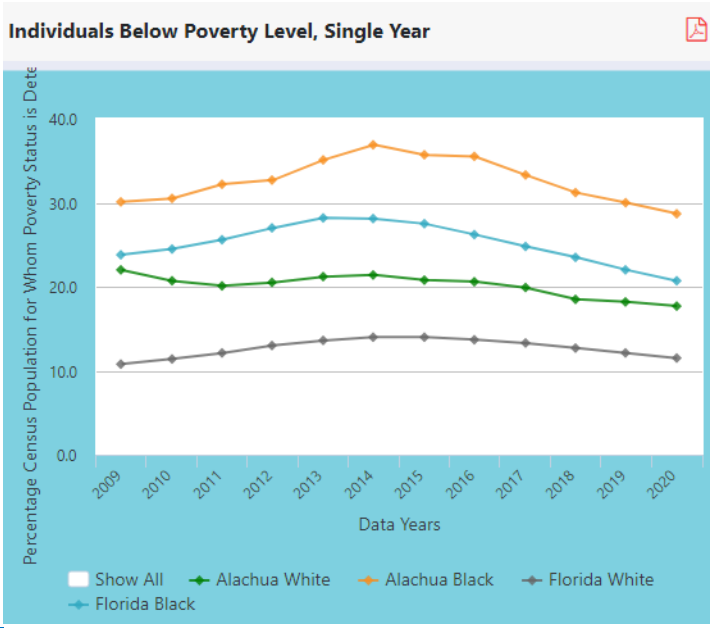
The impact of education access and quality on Diabetes

Education Access and Quality		
SDOH	**Vulnerable Populations Impacted**	**How the SDOH Impacts Diabetes**
Literacy	Black and Hispanic residents, people with disabilities	Individuals with low literacy can struggle with information related to managing a chronic disease. This is even more of an issue regarding diabetes due to the depth of education and numeracy that is required to manage it well. Those who have low literacy may be more vulnerable to mistakes and omissions regarding components of their care that can lead to poorer health outcomes.
Language	Hispanic residents and immigrants	Managing diabetes in the setting of a language barrier compounds the potential for confusion, misunderstandings, and mistakes, for not only the patient but the provider. Cultural differences may also lead to an incomplete understanding of how to apply expected health behaviors. This leaves the patient with a significantly increased potential for poor health outcomes.

B. Economic Stability

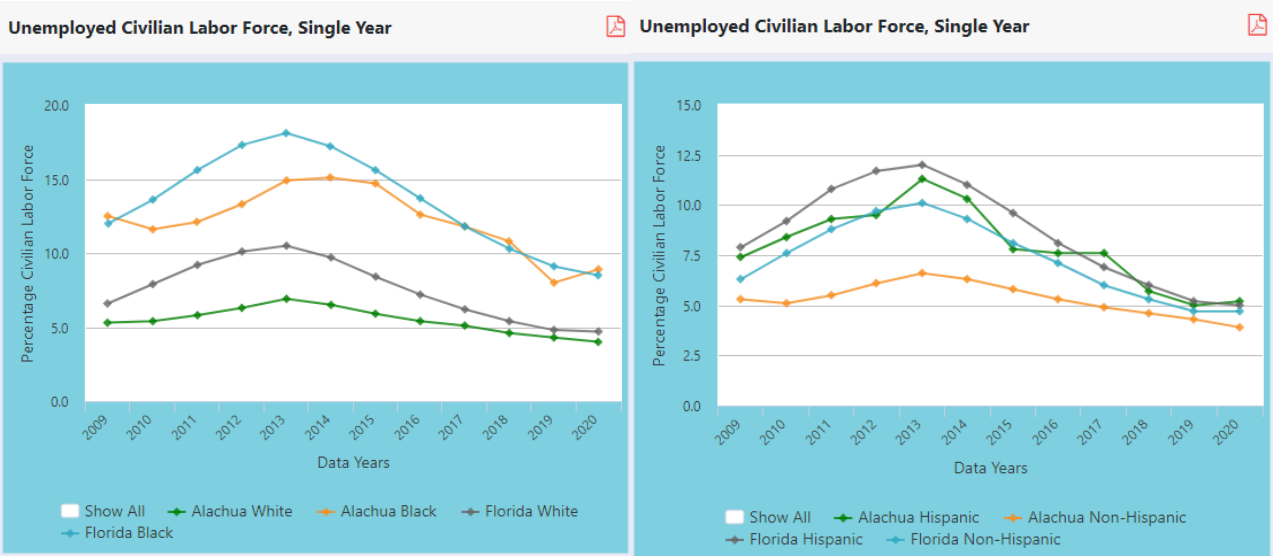
Economic stability data for Alachua County

Economic stability can be described in many ways, one of which is that it is the ability to access and afford the resources essential to one's basic needs and well-being. According to the Child Welfare League of America, "The federal poverty level is the standard proxy measure to indicate whether individuals or families are poor or unable to meet their basic economic needs. *SDOH-One-Pager-EconomicStability.pdf (cwla.org)* As of 2020, one in five Alachua County residents lived under the poverty level (20.7%).



Individuals Below Poverty Level - Florida Health CHARTS - Florida Department of Health | CHARTS (flhealthcharts.gov).

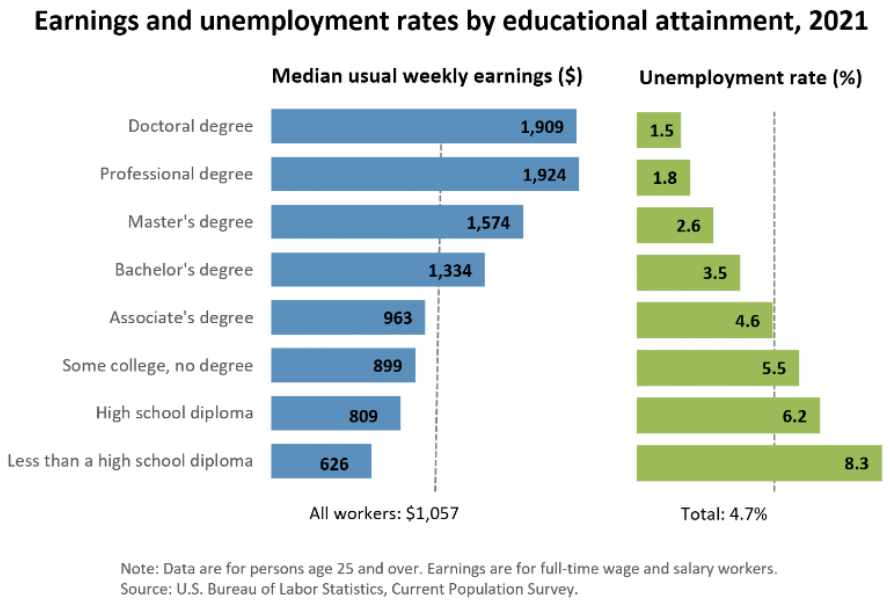
One of the many factors that affect the potential for poverty is employment. Historically, the Black residents, in both the state of Florida and in Alachua County, have had almost double the rate of unemployment compared to their White counterparts with a 2020 unemployment rate of 8.9% versus 4.0% respectively in Alachua County as seen in the figures below. The Hispanic residents of Alachua County have historically had a lower unemployment rate (5.2%) than Black residents (8.9%) and have had a rate much closer to the state rate for Hispanic residents as seen in the figures below.



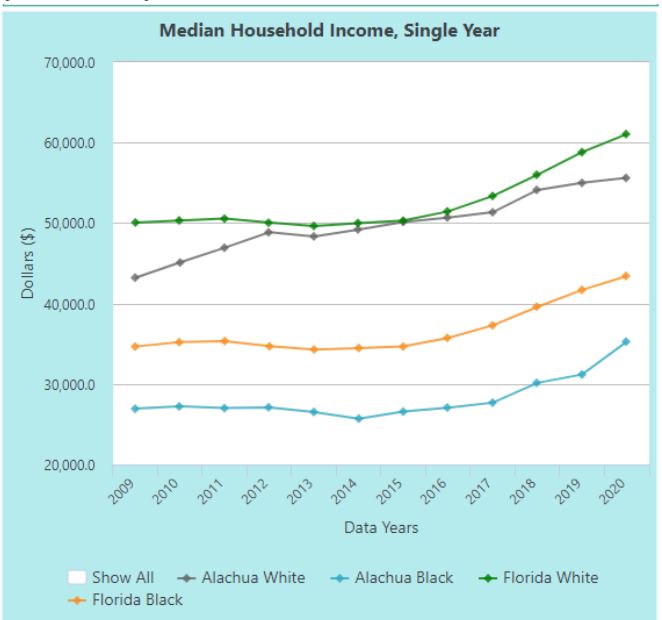
Unemployed Civilian Labor Force - Florida Health CHARTS - Florida Department of Health | CHARTS (flhealthcharts.gov)

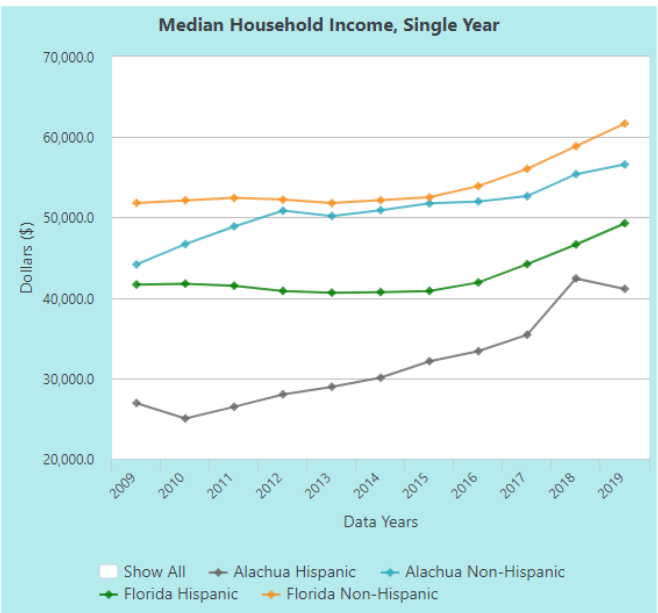
The 2020 Decennial Census indicates that Asian, American Indian/Alaska Native, and Native Hawaiian and Other Pacific Islander residents experience an unemployment rate lower than that of the Black residents in Alachua County. Although there is limited county data regarding Veterans, the Bureau of Labor Statistics reports, “Across all levels of education in 2021, persons with a disability were much less likely to be employed than were their counterparts with no disability” at the national level. *Persons with a Disability: Labor Force Characteristics - 2021 (bls.gov)*. There was limited data on LGBTQ+ residents.

Ideally, employment should yield a reasonable income that allows for an individual or family to meet their basic needs. However, the figure below shows that research indicates a lower education level usually leads to lower income.



According to the Literacy Cooperative, Level 2 literacy skills (associated with only attaining high school graduation) are likely to be excluded from all but minimum wage work. *https://literacycooperative.org/* The data regarding income in Alachua County supports these findings. Considering the high school graduation data, and the associated literacy level, it is not surprising that from the years 2016 – 2020, Black households in Alachua County reported approximately 37% less income ($35,264) than their White counterparts ($55,619) and Hispanic counterparts ($41,109).



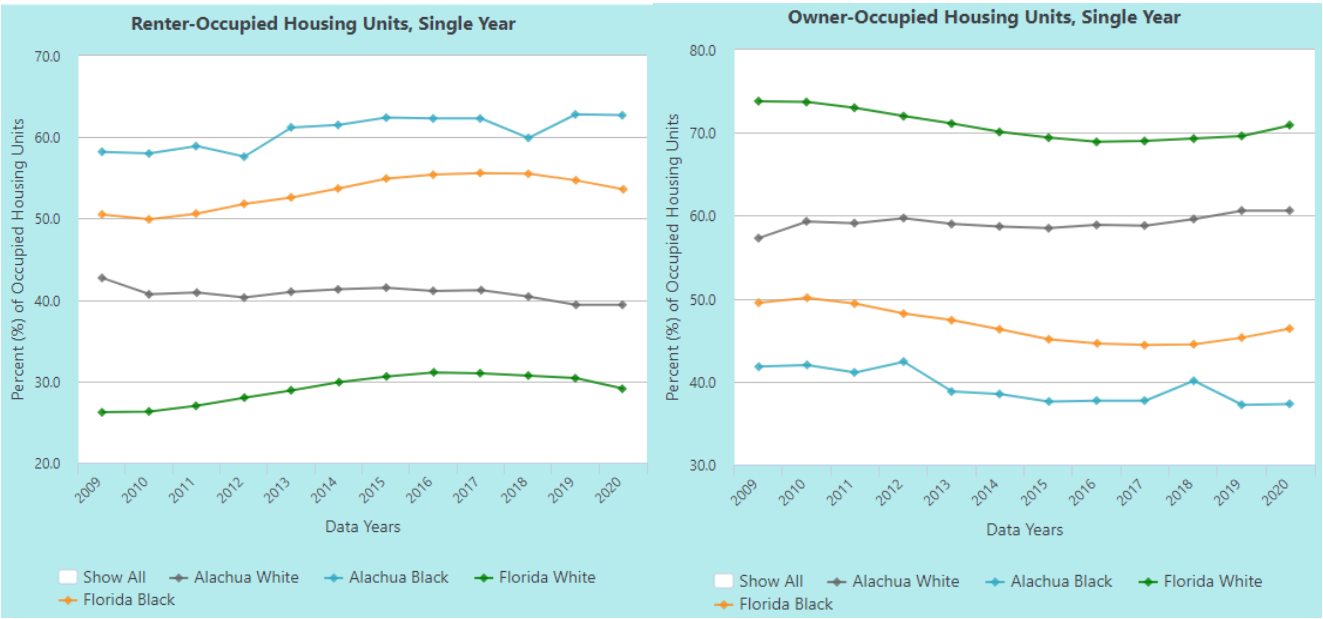


Median Household Income - Florida Health CHARTS - Florida Department of Health (flhealthcharts.gov)

Nationally, Veterans have a median income of $44,241 in 2019. *Median income of Veterans - USAFacts* . However, “workers with a disability were more likely to be employed part time than those with no disability,” and 29% of those with disabilities did so in 2021 compared to 16% for those without disabilities. *Persons with a Disability: Labor Force Characteristics - 2021 (bls.gov)* Consequently, people with disabilities may likely have lower household income. There was limited data on household income and those who identify at LGBTQ+.

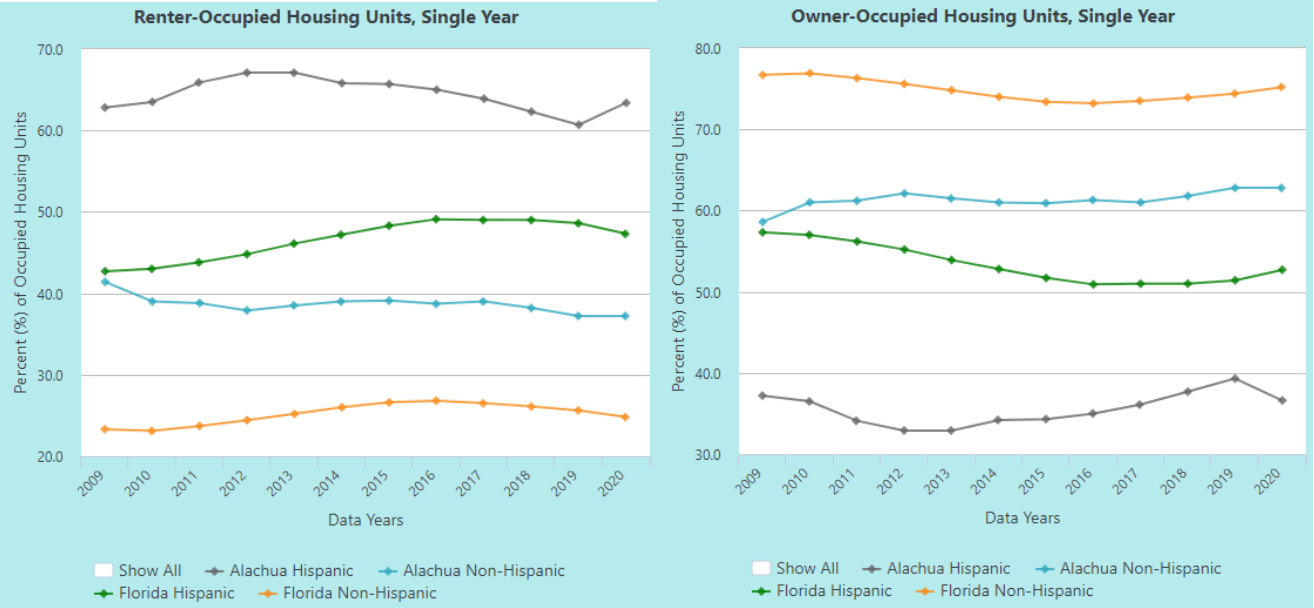
One of the basic expenses that is expected to be covered by income is housing. According to research done by Drexel University, “Low-income households are more likely to rent their homes.” *Minimum Wage is Not Enough - Home (drexel.edu)* In Alachua County, the 2020 housing data is as follows:

Own Housing Unit: 37.3% of Black residents
60.6% of White residents
Rent Housing Unit: 62.7% of Black residents
39.4% of White residents *Health Equity Profile*



(flhealthcharts.gov)

The figures below show that the Hispanic residents of Alachua County experienced a slightly less favorable housing rental and ownership rate when compared to the county’s Black residents with 63.4% of the Hispanic residents renting and only 36.6% owning their housing unit in 2020.



[Owner-Occupied Housing Units - Florida Health CHARTS - Florida Department of Health (flhealthcharts.gov)]

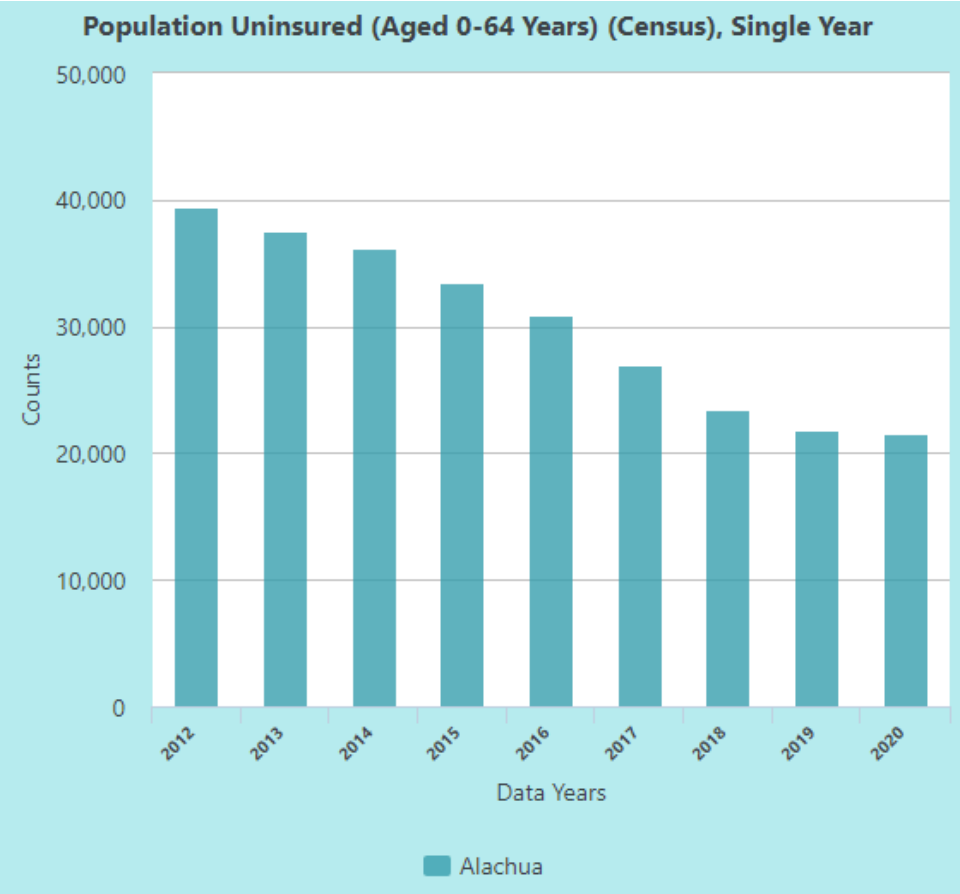
Although there is limited county-level data regarding Veterans and home ownership, a study by the Urban Institute provides national data. The study suggested that "78.2% of Veteran households were homeowners in 2017." However, there were racial disparities within the Veteran community as they found that "White Veterans have the highest homeownership rates, with 46% of active servicemen owning homes and 82% of Veterans being homeowners. Those numbers drop to 35% and 63% for African American homeowners." [Veteran Homeownership Rate Surpasses That of Overall Population - DSNews] There was limited data regarding other races, ethnicities, the LGBTQ+ population, and those who have disabilities.

The research by Drexel University also found that lower income households "spend a higher percentage of their earned income on housing." More importantly,

> "Rent prices increased an average of 8.86 percent each year since 1980, consistently and significantly outpacing wages. In 2021, a worker receiving minimum wage would be unable to afford housing anywhere in the U.S. In many locations, two full-time minimum wage workers would still be unable to afford a fairly priced two-bedroom apartment." [Minimum Wage is Not Enough - Home (drexel.edu)]

This potential lack of income after housing expenses can significantly limit the ability to afford medications, medical visits, and education related to proper management of diabetes.

Another anticipated benefit of employment is health insurance. The United States is unique regarding its model of employment-based health insurance and, in 2020, 54.4% of the national population was covered by employment-based insurance. *Health Insurance Coverage in the United States: 2020 (census.gov)* To insure those who cannot work due to disability or age, there are programs such as Medicare, Medicaid, and the Children's Health Insurance Program for which they may qualify. However, not all employers offer health insurance coverage, or offer coverage that is affordable for those who do work. In fact, "Many members of lower-income families are not eligible for public insurance, yet they are not offered—nor can they afford to buy—employment-based or individual health insurance. *Measuring the Affordability of Employer Health Coverage | KFF.* Kaiser Family Foundation suggests that employment-based coverage is considered unaffordable if the out-of-pocket premium exceeds 9.5% of the employee's income. Although the number of Alachua County residents without insurance has steadily declined, there were still over 21,000 residents without some form of health insurance as of 2020. According to the 2020 American Community Survey estimates, this includes 6.7% of Asian residents, 12% of Hispanic residents, 6.7% White residents, 8.85% of Black residents, 17.5% of American Indian/Alaska Native residents, and 23.1% of Native Hawaiian and Other Pacific Island residents of Alachua County. Although there is no county data, www.census.gov reports that only 5.5% of Veterans were uninsured nationally in 2016. With data suggesting that 29% of people with disabilities work part-time nationally, there is a significant potential that they are not able to afford health insurance. In fact, prior to the 2010 enactment of the Affordable Care Act, an estimated 3.5 million people with disabilities were uninsured due to many of the prohibitive enrollment parameters. *Key Statistics on Disability and Healthcare Coverage | National Disability Navigator Resource Collaborative* Per the 2017-2019 BRFSS data, 63.8% of Alachua County respondents who identify as LGBTQ+ had some type of health care insurance.



Population Uninsured (Aged 0-64 Years) (Census) - Florida Health CHARTS - Florida Department of Health (flhealthcharts.gov)

Without adequate health insurance, residents may be less likely to seek medical attention in a timely manner, need urgent or emergent care for a typical primary care issue, be unable to afford medications, and may not be able to afford services from necessary specialists. Furthermore, diabetes is an expensive disease to have and not having health insurance can mean that management extremely challenging. According to the American Diabetes Association, research released in 2018 indicated that those with diabetes have medical expenditures that are 2.3 times higher than those without diabetes. *The Cost of Diabetes | ADA* Also, it was found that uninsured people with diabetes "have 60% fewer physician office visits and are prescribed 52% fewer medications than people with insurance coverage—but they also have 168% more emergency department visits than people who have insurance." The cost of testing supplies, diabetes-related medication, specialists for complications, and complication-related medication can directly impede on a person's budget and finances as

they address other necessary costs related to housing, utilities, and food. Consequently, many individuals may forgo expenses related to proper management of diabetes and other chronic diseases, and in fact a report by cnbc.com indicates that this is the current choice many Americans are making,

> "22% of Americans say they have steered clear of some sort of medical care — including doctor visits, medications, vaccinations, annual exams, screenings, vision checks and routine blood work — because of the expense, according to a recent online survey of roughly 2,500 U.S. adults conducted on behalf of Bankrate." *Nearly 1 in 4 Americans are skipping medical care because of the cost (cnbc.com).*

According to Kaiser Family Foundation,

> "(29%) of all adults report not taking their medicines as prescribed at some point in the past year because of the cost. This includes about one in five who say they didn't fill a prescription (19%) or took an over-the counter drug instead (18%), and about one in 10 (12%) who say they cut pills in half or skipped a dose. Three in ten of those who report not taking their medicines say their condition got worse as a result." *Poll: Nearly 1 in 4 Americans Taking Prescription Drugs Say It's Difficult to Afford Their Medicines, including Larger Shares Among Those with Health Issues, with Low Incomes and Nearing Medicare Age | KFF*

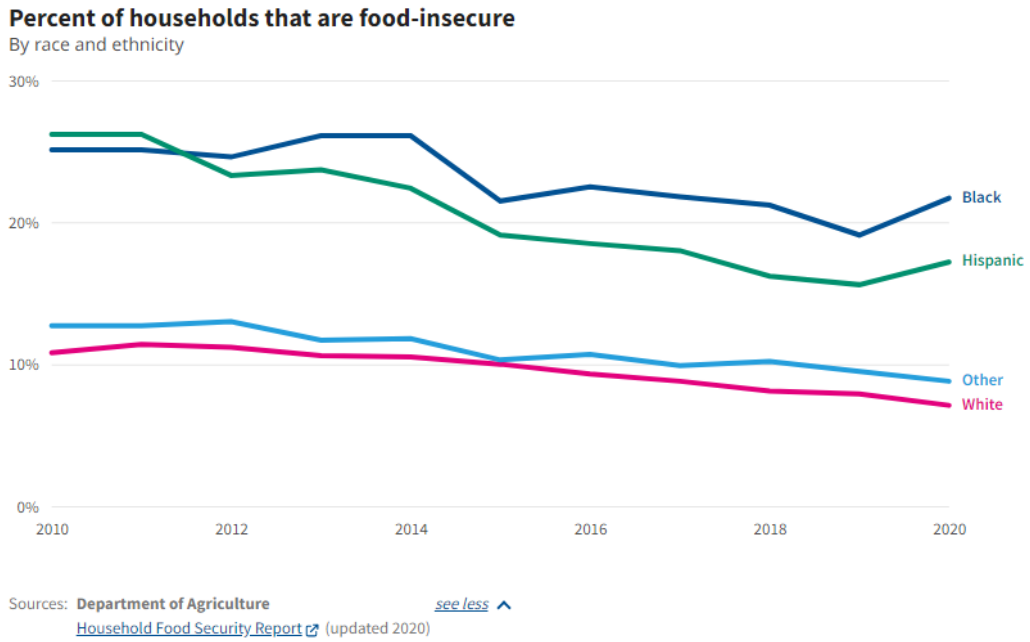
Making these choices in the setting of Diabetes can be dangerous in both the short term and long term. The rationing of medications is a significant issue, especially for people with diabetes who are taking insulin. Yet, research by Yale Diabetes Center found that up to 1 in 4 patients may be rationing their insulin due to expense. *Gathering Evidence on Insulin Rationing: Answers and Future Questions (ajmc.com)* . This research also indicated that "Deaths from insulin rationing are the outer edge of a continuum that includes patients who are risking blindness, amputations, and hospital stays. For these patients, rationing could erode their health…. It can hasten disability (e.g., blindness and kidney failure) and early death." The higher rate of diabetes-related complications and death among the Black Alachua County residents supports the data that the expense related to diabetes, especially the uninsured, is a burden that many cannot bear and can consequently lead to poor health outcomes.

The ability to buy an adequate amount of food is yet another anticipated benefit of employment. According to FeedingAmerica.org, "Food insecurity can be defined as "a lack of consistent access to enough food for every person in a household to live an active, healthy life." Alachua County has historically had a

higher rate of food insecurity when compared to the state at 13.4% and 12% respectively in 2019.

Food Insecurity Rate - Florida Health CHARTS - Florida Department of Health | CHARTS (flhealthcharts.gov)

Research by Drexel University found that nationally, “more than half of African American workers and almost 60 percent of Latinx workers make less than $15. Black (21.7 percent) and Latinx (17.2 percent) households experienced food insecurity at rates triple and double that of White (7.1 percent) households in 2020.” *Minimum Wage is Not Enough - Home (drexel.edu)* National data supports the connection between employment/income and food insecurity as the Black and Hispanic population have higher rates of food insecurity.



Percent of households that are food-insecure - USAFacts

Although at the time of the original draft of this Health Equity Plan, there was limited population-specific data on food insecurity, reasonable assumptions can be made. Since most of the population with lower education levels and lower income levels are predominantly Black and Hispanic residents and those with disabilities, it may be reasonable to extrapolate that most of the Alachua County residents that experience food insecurity are from the same demographic groups. In fact, according to FeedingAmerica.org, “an estimated 24% of the Black community experienced food insecurity in 2020.” *Food Insecurity in Black Communities | Feeding America* National data indicates that “estimates of food insecurity among Veterans vary widely, ranging from 65 – 24%.” Food Insecurity Among Veterans: Resources to Screen and Intervene - PMC (nih.gov)The 2017-2019 BRFSS data showed that 50% of Alachua-county residents who have disabilities reported food insecurity. The same survey data showed that there was not a statistically significant difference between residents who identify as LGBTQ+ and those who do not.

Food insecurity can leave those affected by it vulnerable to a multitude of poor health outcomes. According to research, “not only is food insecurity associated with clinical evidence of hypertension and diabetes, it may in fact be a risk factor for hypertension and diabetes among nonelderly adults.” Food Insecurity Is Associated with Chronic Disease among Low-Income NHANES Participants - PMC (nih.gov) According to an article in The Journal of Nutrition,

> “Food insecurity also appears to be more strongly associated with diabetes than with hypertension, particularly at the most severe levels of food insecurity. There are a number of reasons why this stronger association may exist. First, diabetes may be more highly sensitive to diet, whereas hypertension and hyperlipidemia may be more highly sensitive to medication adherence. Second, an extension of the thrifty gene hypothesis suggests that peripheral insulin resistance, a precursor to diabetes, may be adaptive in association with food insecurity insofar as it allows for the preservation of muscle tissue during food restriction (47). Third, food insecurity is a highly stressful state, both emotionally and physiologically (48). The elevated cortisol associated with such stress is frequently linked to adiposity, particularly the visceral adiposity that is a strong risk factor for diabetes. Finally, replacement of dietary fruits and vegetables with relatively inexpensive carbohydrates, such as refined starches, increases dietary glycemic load and may increase the risk of developing diabetes in predisposed individuals (49–51). *Food Insecurity Is Associated with Chronic Disease among Low-Income NHANES Participants - PMC (nih.gov)*

The layered effect of lower education, lower employment rate, lower income, less potential to afford health insurance, and reduced chances at consistent access to food can snowball into a lifestyle that is not conducive to management of diabetes, or any other chronic disease for that matter. The inherent need to make healthy food choices, understand diabetes education, and actively participate in one’s self-management of diabetes can be completely derailed by this snowball of disparities leaving those affected at a significantly higher risk for diabetes-related mortality and morbidity.

The impact of economic stability on Diabetes

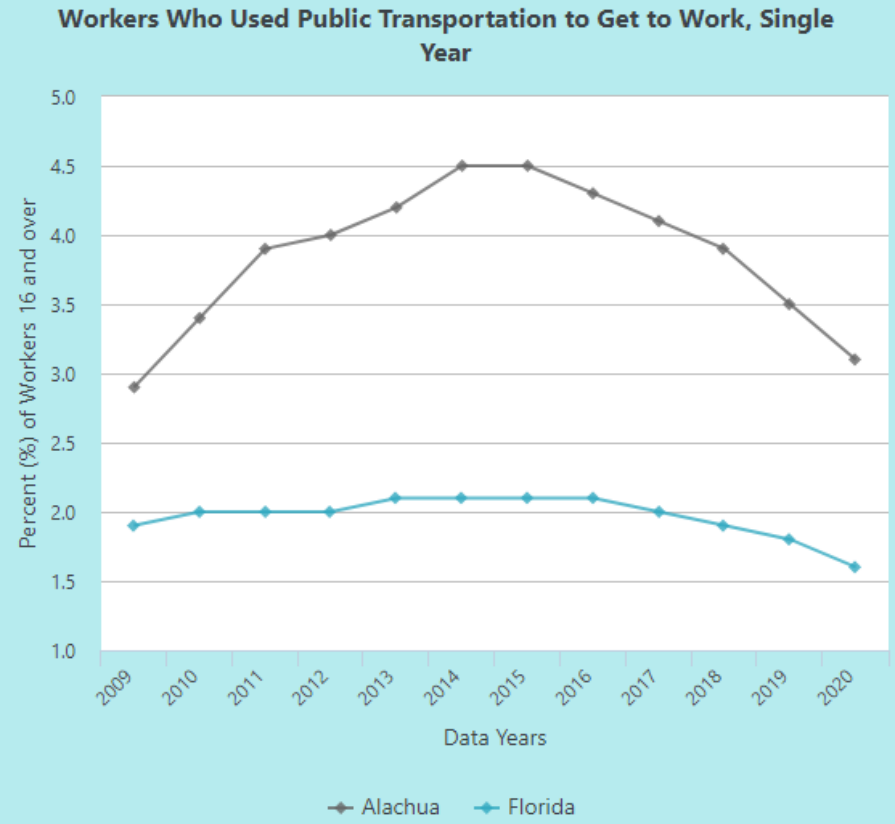
Economic Stability		
SDOH	**Vulnerable Populations Impacted**	**How the SDOH Impacts Diabetes**
Employment	Racial Minorities Ethnic Minorities, People with Disabilities	Lack of employment can put the vulnerable populations at a higher risk for lack of insurance and inadequate income that then affects the ability to seek timely medical care and have consistent access to food. This raises the potential for diabetes-related complications and death
Income	Racial Minorities Ethnic Minorities People with Disabilities	Lack of adequate income can lead to choices regarding finances that leaves the individual without adequate food or the ability to afford insurance
Expenses	Racial Minorities Ethnic Minorities People with Disabilities, Veterans	The expenses related to housing costs, in particular renters, can leave individuals with little to no income to dedicate to food, medication, or monitoring supplies for those who have diabetes. Due to the cost of monitoring supplies and medications, Diabetes can be an expensive disease to manage.
Health Insurance	Racial Minorities Ethnic Minorities, People with Disabilities	The lack of health insurance can completely change the treatment regimen for someone with diabetes as they may not be able to access appropriate and comprehensive care, have a limited medication options due to cost, and may not be able to afford Diabetes-Self-Management Education. All these factors can lead to poor health outcomes.
Hunger	Racial Minorities Ethnic Minorities People with disabilities, Veterans	Inability to eat meals at a proper frequency and with an appropriate balance of food groups hinders the ability to better regulate diabetes. Diabetes is a disease that is significantly influenced by diet and those who do not have consistent access to food can experience detrimental effects from their medication and the lack of stability of their blood sugar.

C. Neighborhood and Built Environment

Neighborhood and built environment data for Alachua County

Diabetes is a chronic medical condition that often requires frequent health care visits to manage it. Reliable transportation is an absolute when it comes to accessing appropriate care in a timely manner. However, in 25 separate studies, “10–51 % of patients reported that transportation was a barrier to health care access.” *Traveling Towards Disease: Transportation Barriers to Health Care Access - PMC (nih.gov)* “Collectively, these studies suggest that lack or inaccessibility of transportation may be associated with less health care utilization, lack of regular medical care, and missed medical appointments, particularly for those from lower economic backgrounds.” In fact, a study in Texas found that 50% of those who missed appointments cited transportation problems while another study in Atlanta found that “65% of patient felt transportation assistance would improve medication use after discharge.” *Traveling Towards Disease: Transportation Barriers to Health Care Access - PMC (nih.gov)* Moreover, the studies evaluated suggest that the lack or inaccessibility of transportation is more of an issue for ethnic minorities than Whites even after controlling for socio-economic status.

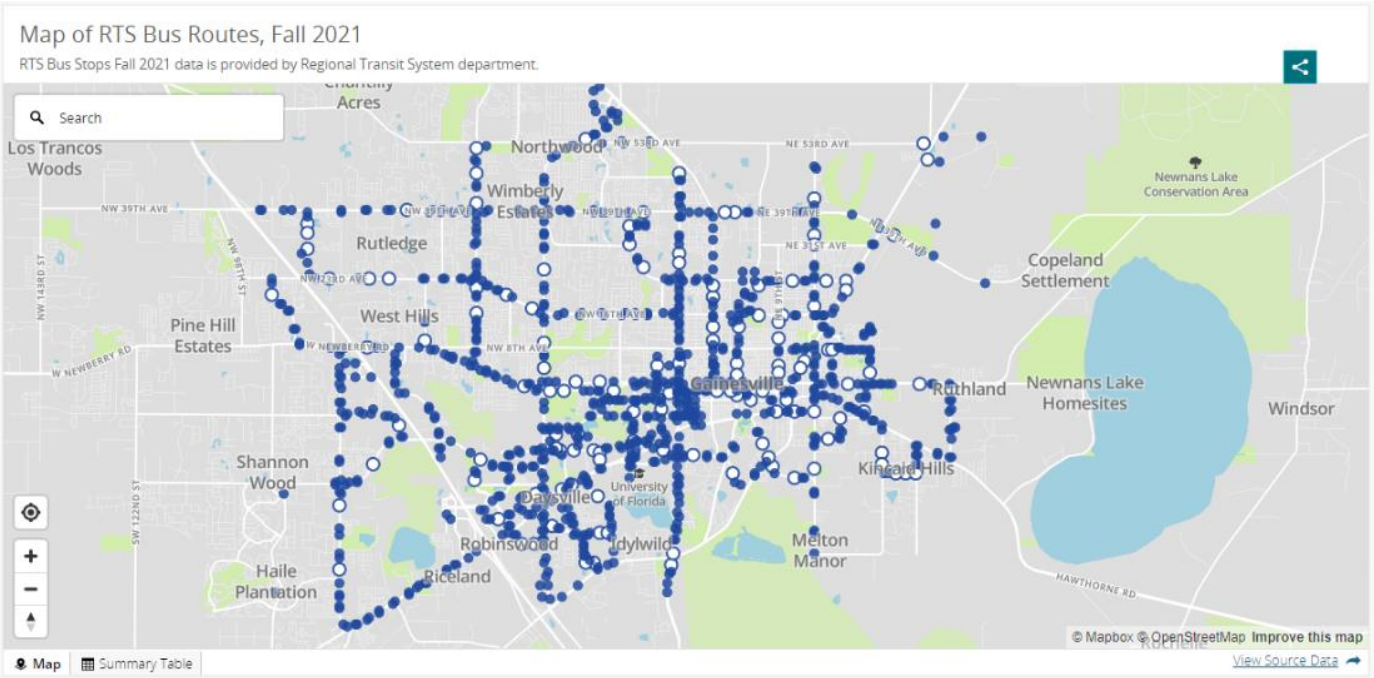
Alachua County has a much higher rate of workers who use public transportation when compared to the state rate.



Workers Who Used Public Transportation to Get to Work - Florida Health CHARTS - Florida Department of Health (flhealthcharts.gov)

Of note is that the current BRFSS asks only about use of public transportation to get to work, which excludes those who do not work, those who may only need public transportation for other reasons like medical visits or grocery shopping, and those for whom the bus system is inaccessible. A report from the University of Florida's Program for Resource Efficient Communities, showed that Black Alachua County households may have had to use a personal vehicle to commute to work despite having lower rates of vehicle ownership versus White households. *ri2_housing_transportation_neighborhood_baselines.pdf (ufl.edu)* This research may support the concern that not all of those who need the public transportation system are able to use it, and possibly for various reasons.

Gainesville's Regional Transit System (RTS) routes typically run within Gainesville City limits, except for a few routes that wander into areas just outside of the city limits.

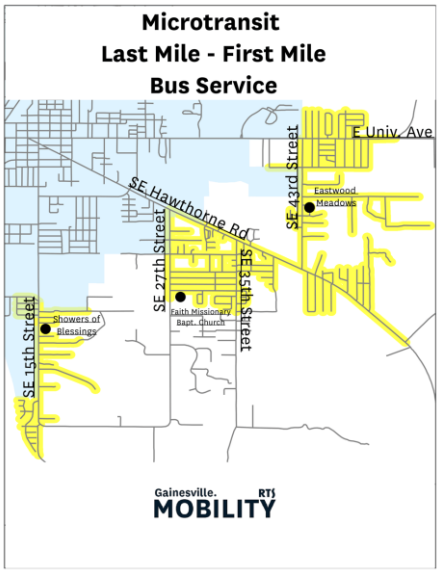


data.cityofgainesville.org

That leaves approximately 138,840 residents living outside of the bus system, *U.S. Census Bureau QuickFacts: Alachua County, Florida.*, some of them living in the 32609 and 32641 zip codes. For many residents, they may have a 10–15-minute walk before they can get to a bus stop. This can be a deterrent for those whose health condition makes it more difficult to walk those distances, let alone in the hot and humid weather that is often experienced in Alachua County. Being exposed to higher temperatures and heat indices, can cause complications with several chronic diseases including hypertension and diabetes. The heat outside can cause someone with diabetes to become more dehydrated which can lead to a rise, sometimes rapid, in blood sugar. To make things worse, some of the medications used to treat hypertension and/or diabetes act like diuretics and dehydrate the recipient. *Managing Diabetes in the Heat | Diabetes | CDC* In addition, the equipment used to monitor diabetes is temperature sensitive as are many of the diabetes medications, in particular insulin. A person who takes insulin multiple times a day will most likely have to carry their insulin when they travel to/from work or when running errands. Having to walk, bike, or wait for a bus in the heat can prove to be detrimental to the potency of their insulin, and potentially the

function and accuracy of their testing supplies. According to the CDC, “the heat index can be up to 15 degrees higher when in full sunlight.” *Managing Diabetes in the Heat | Diabetes | CDC.* Therefore, it is important that those who need to use public transportation, can access it safely without prolonged exposure to heat and humidity. Not only is safely getting to a bus stop important, but ideally there should be shelter from the sun while waiting for the bus.

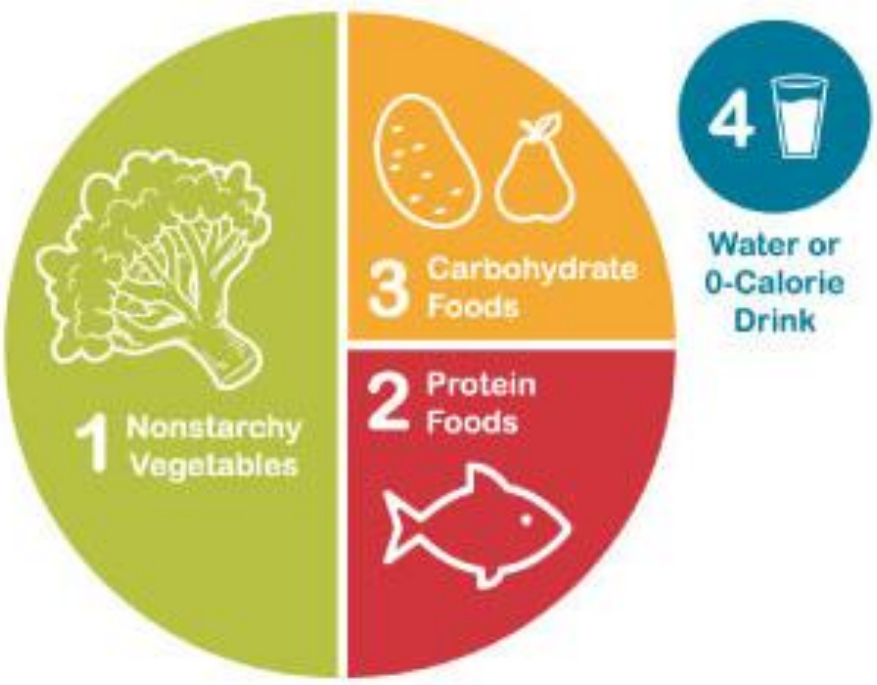
Gainesville’s Regional Transit System (RTS) has a Mobility Bus that is intended to take riders from locations outside the bus routes into the bus route system – a first mile/last mile service.



(Route 600) Eastwood Meadows Area to Rosa Parks Transfer Station - Go-RTS

This service was originally intended to service those living just outside of the southeast margin of the city limits where there is a higher rate of minority residents. Unfortunately, there is concern that the service, as well as how to access it, is not understood by the community for which it was intended. Additionally, there are many bus stops that do not have shelter, some do not even have seating. There is a lack of comprehensive data regarding Alachua County residents and their reasons for using/not using public transportation. Additional information would be beneficial in driving future decisions made by RTS.

Access to healthy foods, not just access to food in general, is necessary for appropriate management of most chronic diseases. Successful management of diabetes is absolutely influenced by food choices. Traditionally, diabetes education would include nutrition label reading, calculating, and carb counting. However, studies suggest that those with lower literacy and numeracy skills are "associated with poorer portion size estimation, understanding of food labels, diabetes-related-self-management abilities, diabetes control, and increased body mass index." *www.ncbi.nim.nih.gov/pmc/articles/PMC6731880* Fortunately, in addition to the traditional methods of creating balanced meals, the American Diabetes Association favors what is known as the Diabetes Plate Method.

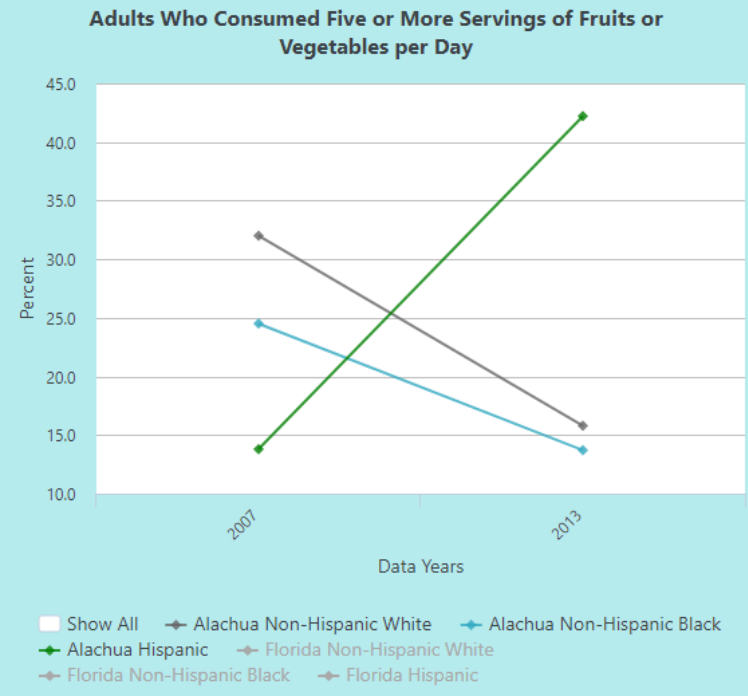


This is a variation of the MyPlate.gov plate method in that is encourages a meal that is ½ non-starchy vegetables, which lends itself to a smaller portion of starches. Using this vegetable-forward method provides a reasonable way to create a balanced meal and appropriate portions without having to depend so often on carb counting, calculating, or weighing foods – all of which can be

intimidating to those with lower literacy and numeracy levels, or burdensome to those who do not feel they have the time to do so. Additionally, this method provides a more visual and less literacy-based option for those with lower literacy levels.

Learning how to apply this method, and others, is best learned in a Diabetes Self-Management Education program to ensure the appropriate knowledge regarding the food groups and their value. Results from a meta-analysis study found that "higher fruit or GLV *(green leafy vegetable)* intake is associated with a significantly reduced risk of T2D." *Fruit and vegetable intake and risk of type 2 diabetes mellitus: meta-analysis of prospective cohort studies - PMC (nih.gov)* Unfortunately, research shows "starchy vegetables make up a large proportion of daily vegetable consumption per day, likely due to the ease of preparation and consumption (e.g., boiled and mashed potatoes)." *Disparities in State-Specific Adult Fruit and Vegetable Consumption — United States, 2015 - PMC (nih.gov).* Over consumption of starchy vegetables can hinder the ability to manage diabetes.

According to FLHEALTHCHARTS.gov, less than 20% of both the White and the Black non-Hispanic residents in Alachua County consume the recommended 5 or more servings of fruits or vegetables per day while over 40% of Hispanic residents reported consuming the recommended amounts.



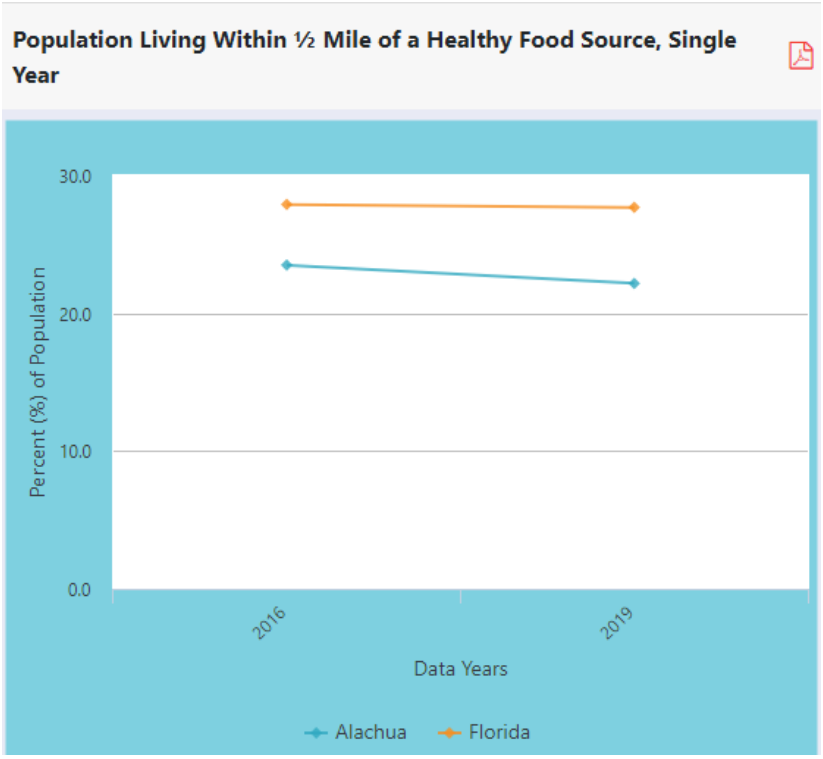
Florida Behavioral Risk Factor (BRFSS) Data - Florida Health CHARTS - Florida Department of Health (flhealthcharts.gov)

From 2003 – 2016, Veterans scored "slightly lower" than non-Veterans nationally regarding fruit and vegetables consumption. *An Examination of Veterans' Diet Quality (usda.gov)* There is limited data on people with disabilities and those who identify as LGBTQ+ regarding this indicator.

Data from the US Census categories indicates "African Americans are less likely to meet recommended intake of fruits and vegetables than non-Hispanic Whites and Hispanics/Latinos." and these disparities continue in old age. *Disparities in State-Specific Adult Fruit and Vegetable Consumption — United States, 2015 - PMC (nih.gov).* The same research concluded that,

> "Racial/ethnic differences are partly due to individual and neighborhood-level socioeconomic status [85-88]; however, research studies suggest that this relationship remains even after taking socioeconomic status into consideration [45,74,89]. Fruit and vegetable consumption is particularly low among African Americans in minority-segregated neighborhoods [87,90,91]. Further, living in an economically deprived neighborhood is a particularly strong predictor of inadequate fruit and vegetable intake for African Americans compared to other racial/ethnic groups [63,85]. Fruit and vegetable access is limited in minority-segregated neighborhoods relative to availability in predominantly White and racially integrated neighborhoods, largely due to differences in the food retail environments [87,91,92].

When examining access to food stores for residents in Alachua County, the figure below shows that Alachua County has a relatively low percentage of people living within ½ mile of a grocery store.



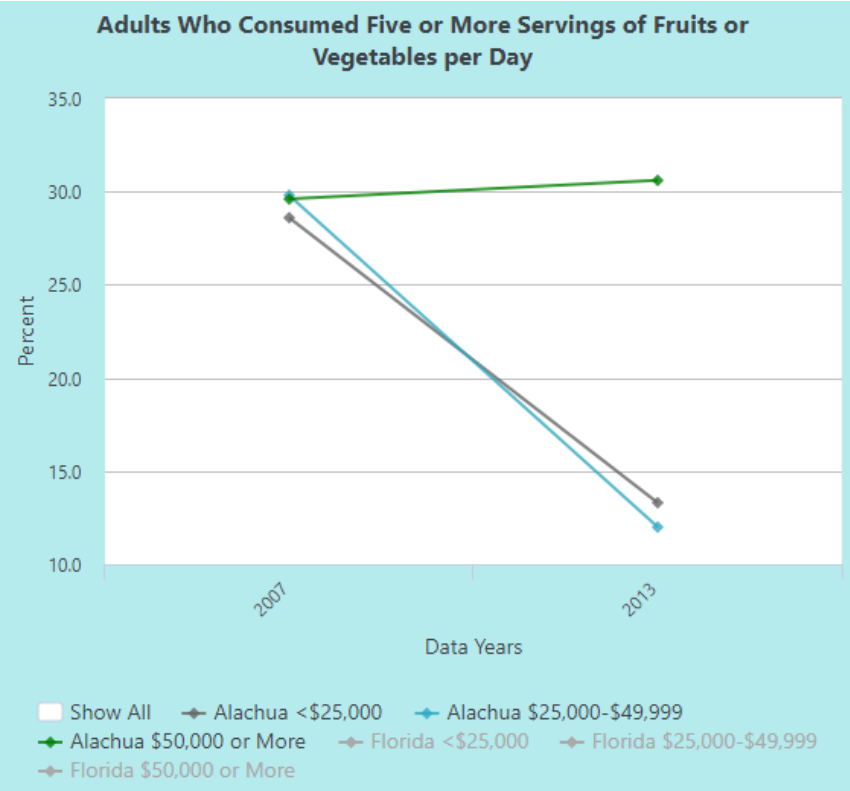
Population Living Within ½ Mile of a Healthy Food Source - Florida Health CHARTS - Florida Department of Health | CHARTS (flhealthcharts.gov)

> "Individuals with fewer resources are more likely to live in poorer neighborhoods, while people who live in poorer neighborhoods consume fewer fruits and vegetables [85-87]. Resource-deprived neighborhoods typically have fewer large grocery stores available and instead have smaller stores with fewer fruit and vegetable options [62,65-67,98,99].
> *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3713183/*

Upon further review, the zip codes 32641 and 32609, totaling 161.45 square miles, are serviced by one Super-Walmart, and several drug stores, discount stores, gas station stores, and small family markets, many of which do not sell produce.

The ability to afford produce is a significant driver for consumption. "In addition to being less available, fruits and vegetables in poorer neighborhoods usually cost more than they do in socially advantaged neighborhoods [64]."
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3713183/ In Alachua County, less than 15% of those making less than $50,000 annually consume the recommended amount of

fruits and vegetables. Whereas over 30% of those making more than $50,000 annually consume the recommended amounts as shown in the figure below.



Florida Behavioral Risk Factor (BRFSS) Data - Florida Health CHARTS - Florida Department of Health (flhealthcharts.gov)

To provide guidance on improving produce consumption on a national level, the CDC developed strategies to guide communities.

> "The CDC Guide to Strategies to Increase the Consumption of Fruits and Vegetables[¶] identifies 10 strategies to increase access to and improve the availability of fruits and vegetables. Examples include starting or expanding farm-to-institution programs in childcare, schools, hospitals, workplaces, and other institutions; improving access to retail stores and markets that sell high quality fruits and vegetables; and ensuring access to fruits and vegetables in cafeterias and other food service venues in worksites, hospitals, and universities. To address cost, the U.S. Department of Agriculture Food Insecurity Nutrition Incentive (FINI) grant program[**] supports projects to increase the purchase of fruits and vegetables among low-income consumers participating in the

> Supplemental Nutrition Assistance Program, by providing incentives at the point of purchase; FINI projects are currently underway in 26 states.††"" *Disparities in State-Specific Adult Fruit and Vegetable Consumption — United States, 2015 - PMC (nih.gov)*

Evaluation of programs in Alachua County aligning with these strategies is ongoing. However, county data via BRFSS, does not indicate how the chosen strategies are utilized by the community. The current data that indicates a less than desirable consumption of fruits and vegetables implies that current strategies may need to be modified to better address the barriers the community is experiencing.

The impact of neighborhood and built environment on Diabetes

Neighborhood and Built Environment		
SDOH	**Vulnerable Populations Impacted**	**How the SDOH Impacts (Health Disparity)**
Housing	Black residents, Hispanic residents, Lower income residents, People with disabilities, Veterans	Lack of affordable housing can leave residents struggling to afford other basic needs. The additional costs related to the management of diabetes can lead to having to make the choice between paying for housing or healthcare.
Transportation	Lower income residents, People with disabilities, Black residents	Those who are unable to get to their primary, specialist, or health education appointments can experience more complications due to delay in care. In addition, their complications can be more severe as they are unable to seek care or pick up their medications in a timely manner.
Access to nutritional food	Black residents, Hispanic residents, People with disabilities, Veterans, those living in lower socio-economic areas	A diet with an inappropriate balance of nutrients and food groups can significantly hinder the ability to manage diabetes leading to an increase in complications, hospitalizations, and death.

D. Social and Community Context

Social and community context data for Alachua County

Managing any chronic disease can be stressful. However, diabetes presents issues unlike most other chronic diseases. According to the CDC, people with diabetes are 2 to 3 times more likely to have depression than those who do not have diabetes and only 25-50% of them get diagnosed and receive treatment. *Diabetes and Mental Health | CDC* The constant self-assessment of what to eat and drink, the need to increase activity, having to check one's blood sugar daily, sometimes multiple times a day, and having to manage medication, especially insulin, can become very overwhelming. Fear of fluctuations in blood sugar, and the related physical and mental consequences, can lead to anxiety and depression. Having to, in essence, hurt yourself to monitor the disease and hurt yourself to manage it, if your taking insulin, makes diabetes a disease with quite a significant psychological component. In addition to all the internal pressure to do right is the external pressures and influence provided by friends and family that, although are well-intentioned, are often ill-placed and sometimes contradictory to what the person with diabetes has been taught by their medical team.

At the crossroads of all these requirements, consequences, and influences are conditions called Diabetes Distress and Diabetes Burnout. It is estimated that 40% of people with diabetes will experience Diabetes Distress at some point in their journey with diabetes. *Diabetes Distress Assessment & Resource Center* When a person is experiencing Diabetes Distress, they often feel alone, angry, anxious and will often make choices that put them at risk of complications such as avoiding doctor appointments, regularly eating foods that they know will negatively affect their blood sugar and avoiding checking their blood sugar. *What is diabetes distress and burnout? | Wellbeing | Diabetes UK* Diabetes Burnout can be even more dangerous as many times people will stop taking care of their diabetes all together by skipping medicine and sometimes even stop taking care of their other conditions.

Proper support when living with diabetes can make a difference with one's ability to thrive with diabetes instead of just surviving. Support groups, both in-person and online, are a great asset to people living with diabetes as having others share their struggles and successes allows those in the group to see life with diabetes from another's perspective. Being encouraged by others sharing their journey with diabetes can reduce feelings of isolation and anxiety. Furthermore, seeing people at different stages of their journey with diabetes, and how they are thriving, allows for those that are struggling to contemplate that same result for themselves. *Type 2 diabetes support groups and their benefits (medicalnewstoday.com)*

Currently there are no known diabetes support groups actively meeting in Alachua County. Previously the Diabetes Health Network at the Department of Health in Alachua and the UFHealth Diabetes Program were facilitating a support group at a local facility. However, attendance was low despite participants indicating that they appreciated the platform and looked forward to the meetings. Although participation was low, those who did participate indicated that they were more compliant with their medications and made better choices regarding diet and exercise because of their engagement in the support group.

The impact of social and community context on Diabetes

Social and Community Context		
SDOH	**Vulnerable Populations Impacted**	**How the SDOH Impacts Diabetes**
Support Systems	Black and Hispanic residents, Lower-income residents, People with disabilities, LGBTQ, Veterans	Good support systems allow individuals with diabetes to cope with their diagnosis. Strong support systems improve health outcomes as these individuals may be more motivated to adhere to treatment. Support systems are necessary to share lived experiences and help these priority population's improve rates of diabetes management.
Stress	Black and Hispanic residents, Lower-income residents, People with disabilities, LGBTQ, Veterans	Diabetes and Stress are Linked...stress can contribute to and be a consequence of diabetes. It's a known fact that various life events (stressors) can increase the risk of developing diabetes. Also, high levels of stress may cause one to engage in unhealthy lifestyle habits (I.e., eating a poor-quality diet and low exercise regimen). Moreover, stress can negatively affect blood sugar control.

E. Health Care Access and Quality

Health care access and quality data for Alachua County

"Health Care Access" can be defined in many ways. According to the Agency for Healthcare Research and Quality (AHRQ), health care access means having "the timely use of personal health services to achieve the best health outcomes." *Access to Care | Agency for Healthcare Research and Quality (ahrq.gov)* In addition, AHRQ indicates that access to health care consists of four components: coverage, services, timeliness, and qualified workforce. The University of Missouri School of Medicine indicates that "Health care access is the ability to obtain healthcare services such as prevention, diagnosis, treatment, and management of diseases, illness, disorders, and other health-impacting conditions. For healthcare to be accessible it must be affordable and convenient." *Health Care Access - MU School of Medicine (missouri.edu)*

Oftentimes, health insurance is seen as the primary way to access the health care system. However, it is not just having insurance, but also the type of insurance, that influences the potential for positive health outcomes. Review of current data shows that the census tracts that have a higher percentage of Black

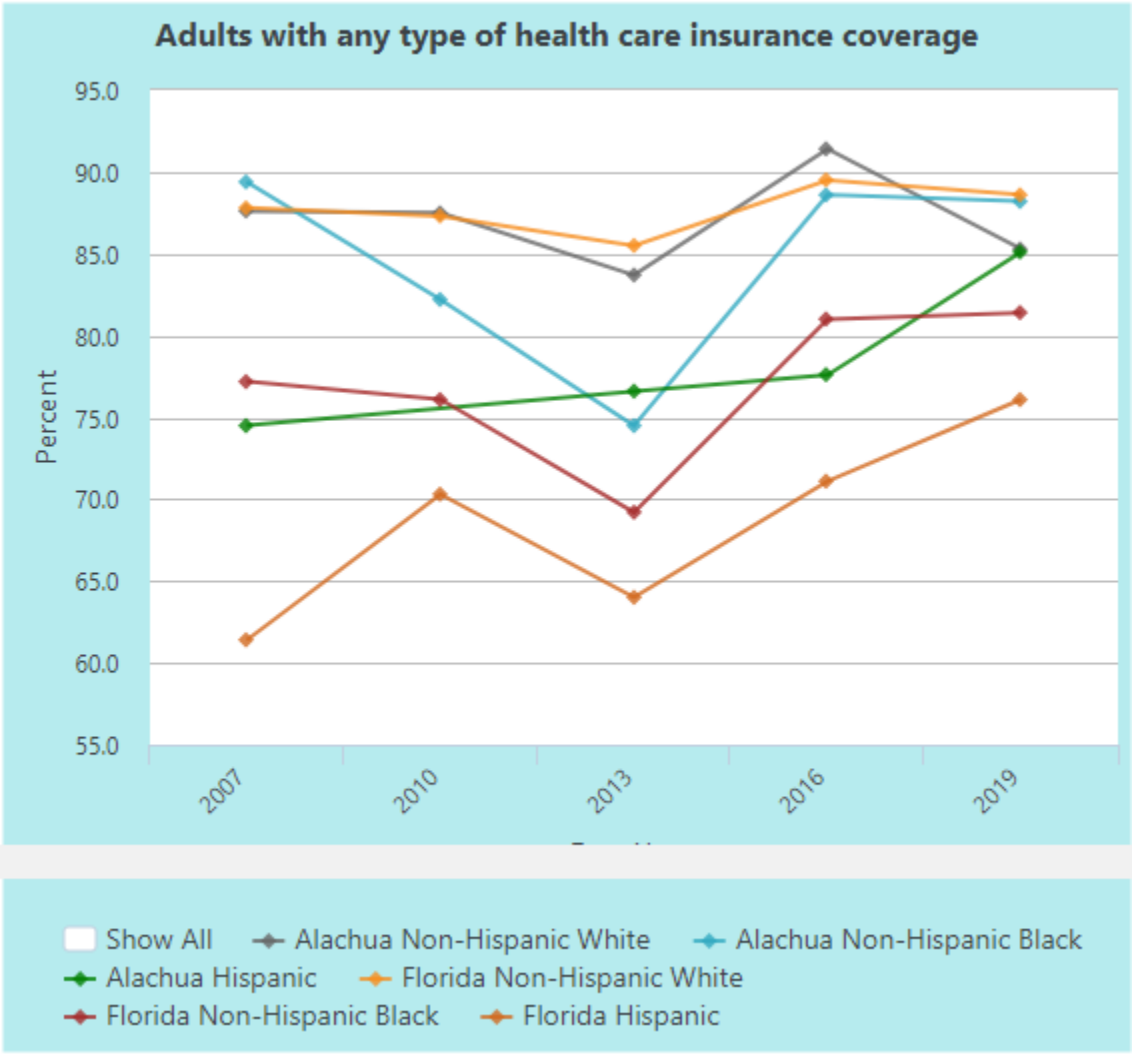
residents also have a higher percentage of those 19-64 years of age who are using public insurance like Medicaid.

Alachua County, 2016-20							
	Census Tract Codes						
Indicator	State	County	6	7	14	19.02	22.17
TOTAL POPULATION	21216924	268105	5343	6854	4915	3701	5524
RACE, OF ANY ETHNICITY							
White (%)	71.6	67.2	4.9	34.1	35.8	41.2	43.0
Black or African American (%)	15.9	20.1	91.7	61.9	58.4	54.8	43.6
HISPANIC OR LATINO AND RACE							
Hispanic or Latino, of any race (%)	25.8	10.2	1.4	6.8	2.4	4.5	17.9
POVERTY							
People whose poverty status is known	20793628	254198	5309	6854	3613	3627	5524
People under 185% of poverty (%)	29.9	36.2	64.1	57.6	49.7	77.4	43.2
HEALTH INSURANCE COVERAGE							
Civilian noninstitutionalized population	20897188	265609	5338	6854	3623	3640	5524
With private health insurance (%)	62.9	75.1	43.4	51.0	49.8	37.0	55.5
With public coverage (%)	36.9	27.4	53.7	45.7	43.3	65.1	31.6
No health insurance coverage (%)	12.7	8.3	13.3	16.1	15.9	11.6	18.0
Employed 19 to 64 years	8877117	118648	1643	2740	1280	1295	2557
With private health insurance (%)	78.1	86.3	67.7	71.0	77.8	49.8	78.8
With public coverage (%)	7.7	5.8	13.8	11.8	7.0	39.7	6.7
No health insurance coverage (%)	16.8	9.8	20.0	21.9	17.9	25.7	16.7

Community Social and Economic Factors Report (flhealthcharts.gov)

"In the United States Medicaid is a government sponsored program to help poor people pay for healthcare. But Medicaid is poorly funded and not all healthcare providers are willing to accept its low rate of reimbursement for services. Medicaid as administered in any particular state does not necessarily cover all needed services, such as bone marrow transplants." *Health Care Access - MU School of Medicine (missouri.edu)* In Florida, Diabetes Self-Management Education is not covered by Medicaid. *Health Insurance Coverage Laws for Diabetes Self-Management Education and Training (lawatlas.org)*

Per Flhealthcharts.gov, 14.7% of White residents, 11.8% of Black residents, and 14.9% of Hispanic residents do not have some form of health insurance.



According to the 2020 American Community Survey estimates, other ethnicities in Alachua County experience being uninsured as follows: 6.7% of Asian residents, 12% of Hispanic residents, 6.7% White residents, 8.85% of Black residents, 17.5% of American Indian/Alaska Native residents, and 23.1% of Native Hawaiian and Other Pacific Island residents. Although there is no county data, www.census.gov reports that only 5.5% of Veterans were uninsured nationally in 2016. With data suggesting that 29% of people with disabilities work part-time nationally, there is a significant potential that they are not able to afford health insurance. Prior to the 2010 enactment of the Affordable Care Act, an estimated 3.5 million people with disabilities were uninsured due to many of the prohibitive enrollment parameters. *Key Statistics on Disability and Healthcare Coverage | National*

Disability Navigator Resource Collaborative Per the 2017-2019 BRFSS data, 63.8% of Alachua County respondents who identify as LGBTQ+ had some type of health care insurance.
In Alachua County, there are several healthcare options for those without health insurance. However, these options often have limited availability regarding either their days and/or hours of operation. These options, albeit very helpful at reaching the at-risk population, can leave residents without assistance if they need care outside of those clinics' schedules. There are also community clinics such as the Department of Health in Alachua County and its 3 locations, UF Health Eastside, Main Street and Archer clinics, Palms Medical Group and others who are available at least Monday – Friday with reasonable hours. Some facilities offer sliding fee scale while others require a flat fee before services. Aside from those options, residents can participate in direct primary care services, otherwise known as concierge doctors. With this option, the patient pays a flat monthly rate to receive services as often as needed or simply just accepts cash only. However, in Alachua County, most of these providers are located outside of the areas that have higher uninsured rates and their rates may not be affordable. Although many of the afore-mentioned programs and facilities offer linkage to care, Alachua County has a unique program, WeCare, that assists with the need for indigent and uninsured residents to receive care from necessary specialists, including, but not limited to, cardiology, orthopedics, neurology, pulmonology, and podiatry. However, the patient must have some source for the referral and appointments may be limited as practitioners agree to a certain amount of pro-bono care. In addition, the Gainesville Fire Rescue department established a Community Resource Paramedicine Program who addresses the barriers to care that lead to inappropriate use of the 911 system.

Many of these options assist with primary care services but may not offer chronic disease management education. At the time of the original version of this plan, there were only 3 Diabetes Self-Management Programs listed on either the America Diabetes Association recognition list or the Association of Diabetes Care and Education Specialists list of accredited programs. The typical cost without insurance, or qualification for support, is ~$1,000, which may be too high an expense for many. Unfortunately, this leaves many residents with diabetes without the necessary and beneficial education needed to help manage their diabetes.

Furthermore, it is usually with insurance that a resident has the most options for their medication regimen. In fact, many of the medications for diabetes can be hundreds of dollars per month without insurance. Examples of the classes of medications included in the standard of care algorithm are GLP-1 Receptor Agonists, Long-Acting Insulin, SGLT2 Inhibitors, DPP-4 Inhibitors, Second-generation Sulfonylureas, and Biguanides. According to GoodRx.com, the approximate out-of-pocket cost, without insurance, for medications in these classes of drugs are as follows:

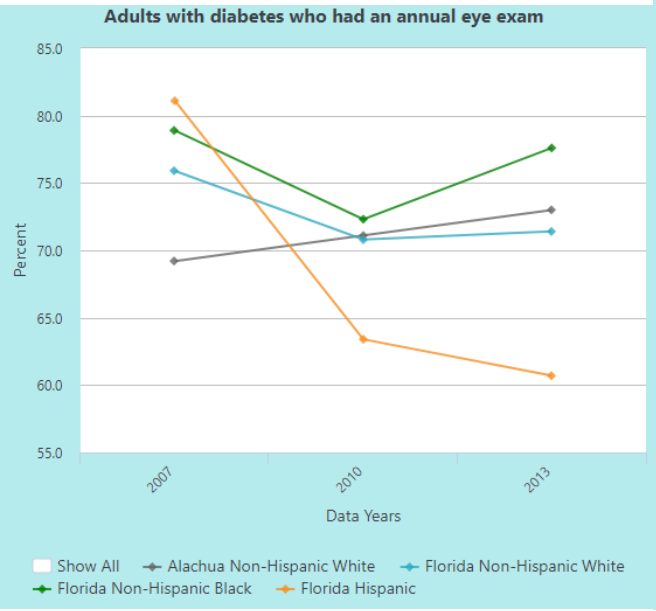
Long-Acting Insulin*	**$194.82/vial**
Intermediate Acting Insulin*	**$70.43/vial**
Short Acting Insulin*	**$66.22/vial**
Rapid Acting Insulin*	**$43.43/vial**
GLP-1 Agonists*	**$884.04/pen**
DPP-4 Inhibitors	**$542.21/30-day supply**
SGLT2 Inhibitors	**$592.13/30-day supply**
2nd Generation Sulfonylureas	**$4.00/30-day supply**
Biguanides	**$4.00/30-day supply**

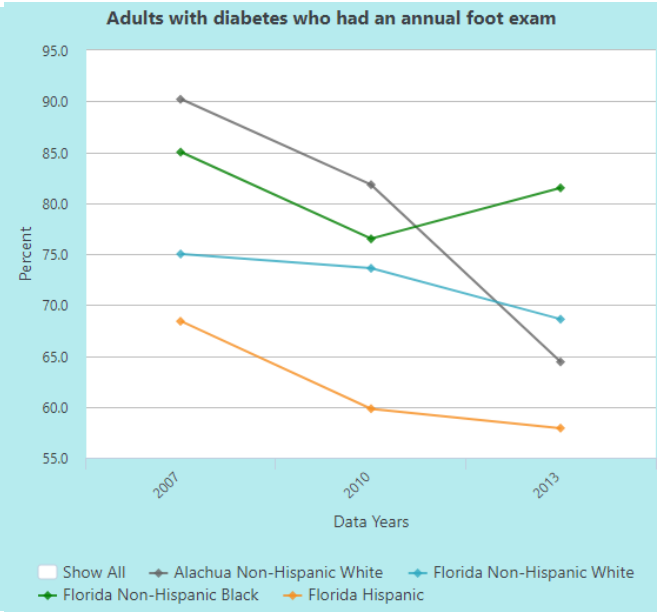
**Note: oftentimes a monthly regimen may require multiple vials or pens*

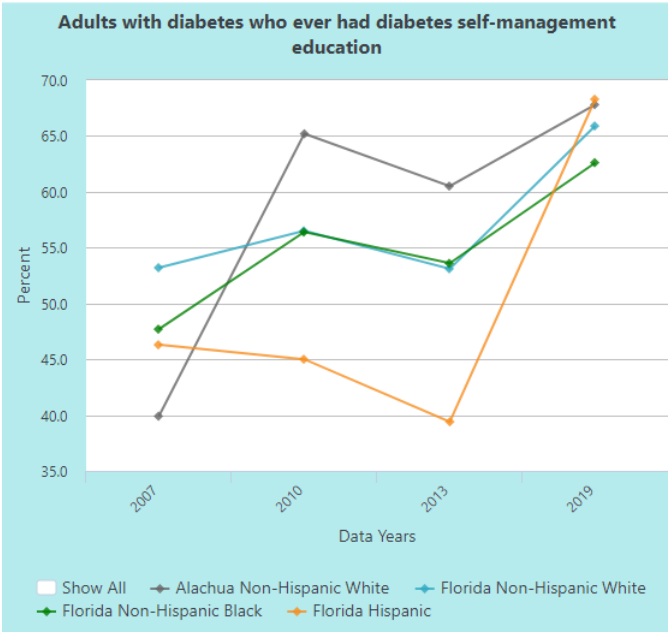
Without insurance, these medications are often not a feasible option. Consequently, patients are often put on lower cost medications with a less than desirable result. Although there are Prescription Assistance Programs for many medications, not every medical provider or practice can store and/or dispense the medications that do not get sent directly to the patient's home. Additionally, manufacturers that offer assistance for the uninsured may have a maximum duration for the benefit. The data regarding income for Alachua County residents shows that Black residents may be more vulnerable to the expenses related to a favorable diabetes medication regimen.

the BRFSS questions, there are no specifications that help differentiate between seeing primary care versus a specialist versus going to the emergency department as it relates to getting a medical checkup. There is concern that this data may be skewed by the respondents' interpretation. As mentioned before, there is also a similar concern about the respondents' interpretation of what

Diabetes Self-Management Education is as there is a much higher rate than expected of residents who indicated they've received it, especially when considering the hospitalization, amputation, and death rates. However, the data does not differentiate between racial and ethnic groups regarding this indicator. At the time of the original version of this Health Equity Plan, there was very little data regarding DSME or annual foot and eye exams for the minority populations in Alachua County.

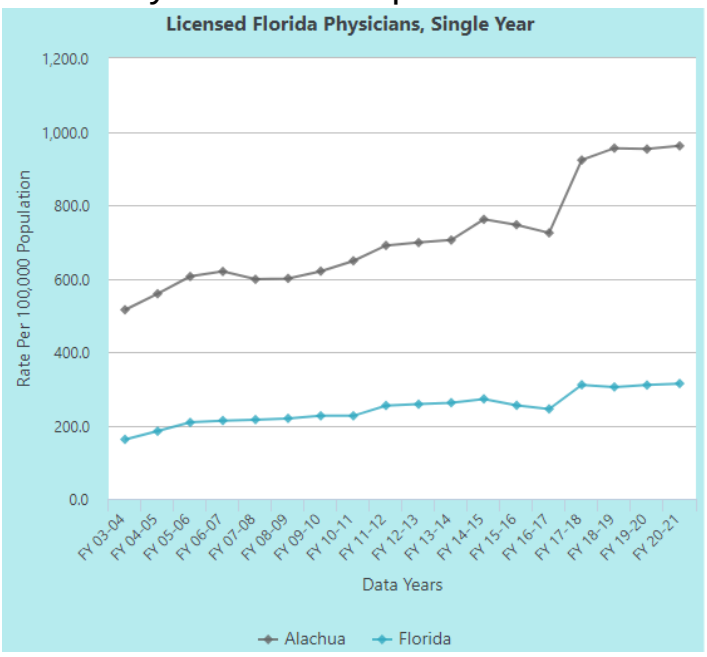






All 3 of these indicators reflect key steps that those with diabetes should take to mitigate the potential for diabetes-related complications. These steps in self-care are especially important to those who are more at risk for diabetes and diabetes-related complications such as Black residents, Hispanic residents, Veterans, and those with disabilities.

Provider availability is a key variable to access to care. Alachua County has much higher rates of Family Practice and Internal Medicine providers compared to the state, per FLHEALTHCHARTS.GOV. This is most likely due to The University of Florida saturating the county, more so the city of Gainesville, with medical students and recently credentialed providers.



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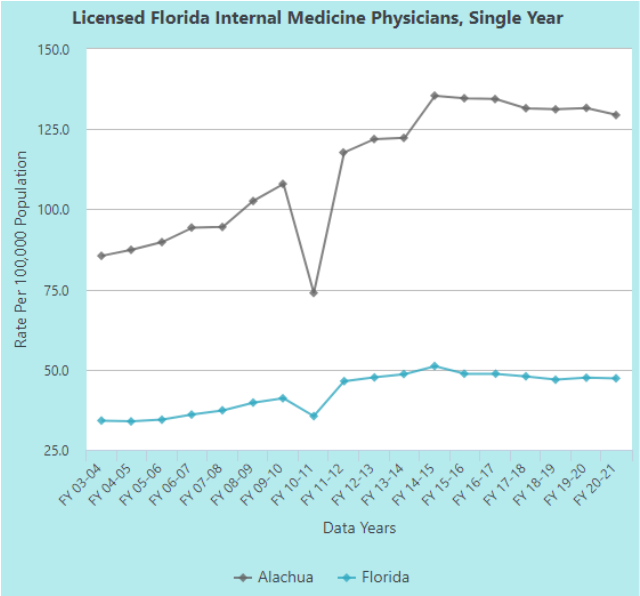

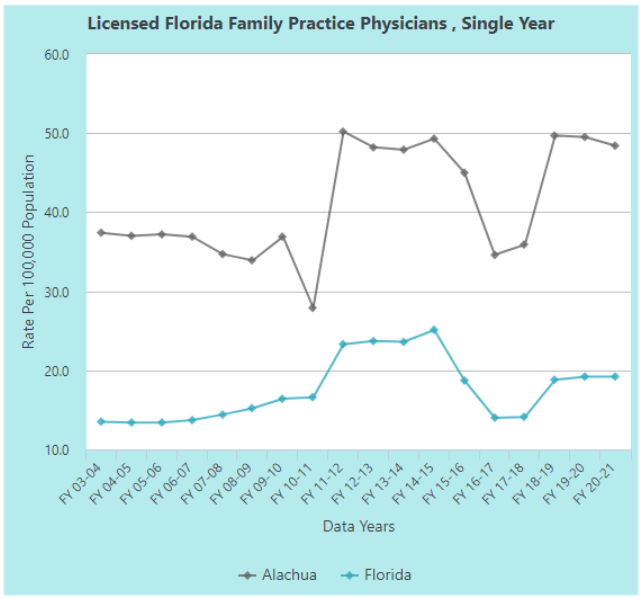

(flhealthcharts.gov)

Having a medical provider who speaks your first language reduces the risk for misunderstandings and mistakes. At the time of the original version of the Health Equity Plan, there were no reliable resources regarding the number of medical providers who speak Spanish, or any other language, in Alachua County. It is important that, at the least, there are comprehensive and appropriate education materials available for those whose first language is not English. Additionally, the literacy level should be low and there should be visual aids to assist those that may have lower literacy levels in their first language.

The impact of health care access and quality on Diabetes

Health Care Access and Quality		
SDOH	**Vulnerable Populations Impacted**	**How the SDOH Impacts (Health Disparity)**
Health Coverage	Black and African American, Hispanic, and Latino, Immigrants, People with Disabilities	Those without healthcare coverage are less likely to be seen by a physician in a timely manner and they are less likely to afford participation in a diabetes self-management program, be seen by specialist, and be able to afford the most appropriate medications.
Provider Linguistic and Cultural Competency	Black and African American, Hispanic, and Latino, Immigrants, and LGBTQ+, People with disabilities	Culturally competent diabetes care improves adherence to treatment among priority populations. Primary care physicians and providers must be aware of cultural differences and beliefs among their patients. Greater cultural competency among providers will help them form treatment plans that their patients are more comfortable with. Acknowledging implicit bias and being aware of health disparities that affect priority populations will also enable providers to provider greater quality healthcare. Speaking the first language of their patients, allows for both the provider and patient to create and implement a successful plan of care and helps ensure that the patient has a better chance at understanding it.
Provider Availability	Black and African American, Hispanic, and Latino, Immigrants, and LGBTQ+, People with disabilities	Providers who offer quality and comprehensive services at an affordable rate for those without insurance can improve the chance for diabetes management for those who would otherwise be unable to participate in care.

VII. 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	Collaborative Strategies
Health Equity Team, Taskforce, Coalition	All	There is limited comprehensive data on SDOHs for the county, as well as racial and ethnic minorities, Veterans,	DOH-Alachua Health Equity Task Force will contract with Knowli to develop and administer a more in depth and inclusive Community SDOH Assessment

		people with disabilities, LGBTQ+	
DOH-Alachua Diabetes Health Network and UFHealth Diabetes Education Program	Social and Community Context	Patient mental health can hinder the development of proper self-management behaviors	Partner together to hold a Diabetes Support Group on a monthly basis to bring together those who may be experiencing diabetes distress or burnout.
DOH-Alachua Diabetes Health Network and UFHealth Diabetes Education Program	Education Access and Quality	Much of the education available is not at an appropriate literacy level for those who are challenged, not all education resources are in Spanish or other languages that reflect the diversity of the community	Partner together to create education materials that are low grade level, available in multiple languages and have informative pictures. These materials will be given to local providers to give to patients as needed.

RTS	Neighborhood and Built Environment	Less than ideal community awareness of Mobility Bus	Partner with DOH-Alachua Diabetes Network and UFHealth Diabetes Education Program to promote RTS service to residents in priority zip codes
IFAS	Neighborhood and Built Environment, Economic Stability	Presence and direct contact with the at-risk community where they live and shop.	Partner with store located in priority zip codes to promote produce of the month
NAMI	Social and Community Context	Not much experience dealing with specific chronic disease related mental stress	Working with national chapter to research/develop curriculum to help bolster Diabetes Support Group
SRAHEC	Economic Stability and Health Care Access and Quality	Presence and direct contact with the at-risk community where they live and shop.	Partner with local churches, libraries, and agencies to offer insurance navigation
DOH-Alachua Diabetes Network	Health Care Access and Quality	Patients who work during normal business hours and may	DOH-Alachua Diabetes Health Network and UF Health Diabetes will offer DSME outside of normal

		not be able to attend DSME during that time	business hours. DOH-Alachua Diabetes Network will partner with local churches to offer DPP

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.

1. PROJECT: ALL ABOARD!

Team: Gainesville Regional Transit System (RTS) and DOH- Alachua Diabetes Health Network

Background

- Many of the residents experiencing diabetes-related health disparities depend on public transportation or live in locations where accessing it is very difficult.
- Review of current bus routes shows gaps in accessibility and the reduction of routes during the summer enhances the issue.
- RTS does have a Mobility Bus, or route 600, that was intended to be a first mile/last mile service and get riders from their home and into the bus route system.
- However, there are concerns that the community awareness of and knowledge of how to access the Mobility Bus is not what was expected.

Description and Deliverables

- The project will focus on the residents in the 32641 and 32609 zip codes
- RTS's Marketing department will work on new methods of community education.
- The Diabetes Health Network and UFHealth Diabetes will promote the service to their patients.
- The Health Equity Task Force and Coalition will share the information with their customers.
- DOH-Alachua will also share the information with their multiple departments and programs
- Knowli will help collect more detailed data about community use of public transportation
- RTS will evaluate the need for expanded routes and/or schedules
- Addition of more detailed transportation questions to the CHA will be considered

Progress

- Describe the progress made on this project to date.
- Once completed, report if the project led to improved performance. Document lessons learned.
- Display new graphs or data tables.

2. PROJECT: IT'S GREAT TO EDUCATE

Team: DOH-Alachua Diabetes Health Network and UFHEALTH Diabetes Education Program

Background

- Diabetes Self-Management Education (DSME) is a necessary tool regarding the successful management of Diabetes. DSME is a structured education program addressing 7 key health behaviors, meets the National Standards for Diabetes Self-Management Education, and is accredited by the Association of Diabetes Care and Education Specialists or recognized by the American Diabetes Association.
- Currently, Alachua County data shows that 64% of adults with diabetes have had diabetes-self-management education.
- The agencies who offer this service are concerned that the public may not know what DSME is and are assuming any conversation or education handout they received qualified as DSME when answering the question.
- Furthermore, the low rate of those indicating they were told they had diabetes and the high rate of hospitalization, amputation and death further support the concerns as a low diagnosis rate and high rate of complications may indicate that appropriate education is not being received.

Description and Deliverables

- DOH-Alachua Diabetes Health Network and the UFHealth Diabetes Education Program will work together to create a universal tool for providers to give patients diagnosed with diabetes that will include ways to enroll in DSME.
- DOH-Alachua Diabetes Health Network will find feasible locations for the provision of DSME within the 32641 and 32609 zip codes
- Both programs will work on arranging and delivering a free diabetes education class that will cover the 7 Self-Health Care Behaviors in a modified version at least once a quarter.

Progress

- Describe the progress made on this project to date.
- Once completed, report if the project led to improved performance. Document lessons learned.
- Display new graphs or data tables.

3. PROJECT: GETTING TO KNOW YOU

Team: Health Equity Task Force and Knowli

Background

- Most data regarding SDOH in Alachua County is from the County Health Assessment (CHA) and the CDC Behavioral Risk Factor Surveillance System (BRFSS).
- Although these tools yield valuable information, it omits information that would complete the picture of the community's perspective on several resources as well as provide a more comprehensive assessment of the community's health behaviors.
- As the Health Equity Taskforce and Coalition continues to develop and implement projects, it would be beneficial to be driven by data that is more comprehensive and inclusive of all populations.

Description and Deliverables

- Knowli will be contracted to create a community SDOH assessment.
- The questions included will be developed with the input of the Health Equity Team, Health Equity Task Force, and Health Equity Coalition.
- The assessment will be administered using strategic methods that incorporate a percentage of the population, to be determined, and inclusion of all minority populations
- The data will be analyzed and shared with the Health Equity partners and relevant agencies and organizations
- The assessment questions and data will be shared with the committee responsible for developing the CHA

Progress

- Describe the progress made on this project to date.
- Once completed, report if the project led to improved performance. Document lessons learned.
- Display new graphs or data tables.

4. PROJECT: SWEET SUPPORT

Team: NAMI, DOH-Alachua Diabetes Network, UFHealth Diabetes Network

Background

- Research shows that those with diabetes are at least 40% more likely to suffer from depression.
- Diabetes Distress and Diabetes Burnout can be detrimental to one's ability to manage diabetes.
- Diabetes can often feel very overwhelmed by the constant obligations of monitoring, making choices about food and exercise, and taking medication as directed.
- Some people with diabetes experience additional stress from external sources such as family and friends.
- A Diabetes Support Group would provide an outlet for those struggling with diabetes management to learn coping skills

Description and Deliverables

- DOH-Alachua Diabetes Health Network and the UFHealth Diabetes Education Program will work together to develop the structure of the support group.
- Healthstreet will initially host the support group, as their facility offers other resources that may be needed by the targeted population.
- The teams will work together to promote the support group to appropriate providers in the county and targeted resources within the Black community.
- The support group will be offered monthly at a scheduled date and time at Healthstreet.
- NAMI will research and provide evidence-based curriculum to bolster the effectiveness of the support group

Progress

- Describe the progress made on this project to date.
- Once completed, report if the project led to improved performance. Document lessons learned.
- Display new graphs or data tables.

5. PROJECT: PRODUCE PROMOTION

Team: IFAS, DOH-Alachua Diabetes Health Network

Background

- Research shows that racially segregated neighborhoods have less access to fruits and vegetables
- Black Alachua County residents have a fruit and vegetable consumption below recommendations.
- UF/IFAS has a produce promotion program that is currently available on their website and podcast. This may not be accessible to the minority communities
- Many times, lower income families will by the lower cost produce which is often starchy and can lead to challenges when managing diabetes

Description and Deliverables

- IFAS will work with one of the main stores that provides produce to the 32609 and 32641 zip codes
- The goal will be to provide education at the store on at least a quarterly basis that promotes a produce through tabling and providing education on how to grow, store, prepare the produce
- IFAS will partner with DOH-Alachua Diabetes Health Network to develop another method of indirect promotion of produce

Progress

- Describe the progress made on this project to date.
- Once completed, report if the project led to improved performance. Document lessons learned.
- Display new graphs or data tables.

VIII. HEALTH EQUITY PLAN OBJECTIVES

A. Higher rates of Diabetes-related hospitalizations for Black residents compared to White residents

Health Disparity Objective: By June 2027, reduce the rate of Diabetes-related hospitalizations for Black residents by 10% from 494.6/100,000 (2020) to 445.14/100,000

Since the Health Equity Task Force was unable to find reliable data regarding the other populations that may experience diabetes-related disparities, in particular hospitalizations, a contracted agency will be tasked with determining if there is reliable data available for this indicator as it relates to Alachua County residents with disabilities and Veterans. Developing data regarding the potential for Hispanic residents with diabetes having limited education access will also be considered. Any additional indicators that are deemed to be an appropriate measure of progress within a minority population will be considered and related projects developed if approved by the Heath Equity Team, Task Force and Coalition.

The Health Equity Team and Task Force developed the following projects to affect the desired changes. These projects are dynamic and will be influenced by the Health Equity Coalition, other community partners and residents, and evolving data.

PROJECT It's Great to Educate

	Lead Entity and Unit	Lead Point Person	Data Source	Baseline Value	Target Value	Plan Alignment
Long-Term SDOH Goal: Have referral to DSME be an absolute for all providers servicing residents who have diabetes.						
Objective: By 2027, those who have had DSME will increase by 5%	DOH-Alachua Diabetes Health Network	Erica Barnard	Flhealthcharts.gov	67.8%	72.%	CHIP, SHIP
Medium-Term SDOH Goal: Increase access to DSME by providing free quarterly classes in targeted zip codes						
Objective: By 2027, those who have had DSME will increase by 5%	DOH-Alachua Diabetes Health Network	Erica Barnard	Flhealthcharts.gov	67.8%	72.%	CHIP, SHIP
Short-Term SDOH Goal: Improve provider and community knowledge of DSME resources						
Objective: By 2027, those who have had DSME will increase by 5%	DOH-Alachua Diabetes Health Network	Courtney Puentes	Flhealthcharts.gov	67.8%	72.%	CHIP, SHIP

PROJECT Produce Promotion

	Lead Entity and Unit	Lead Point Person	Data Source	Baseline Value	Target Value	Plan Alignment
Long-Term SDOH Goal: The community is more engaged in their produce consumption						
Objective: By June 2026, the percent of Black residents who consume 5 servings of fruits and vegetables will increase by 10%	IFAS	Dr. Cynthia Nazario-Leary	BRFSS	13.7%	23.7%	CHIP, SHIP
Medium-Term SDOH Goal: Increase awareness of various produce, how to buy it, store it, and prepare it by providing education at primary grocery store in targeted zip code						
Objective: By June 2026, the percent of Black residents who consume 5 servings of fruits and vegetables will increase	IFAS	Dr. Martha Maddox, Dr. Cynthia Nazario-Leary	BRFSS	13.7%	23.7%	CHIP, SHIP
Short-Term SDOH Goal: Increase awareness of current IFAS resources regarding home-grown produce, farmer's markets, produce promotion, promoting Plant of the Month						
Objective: By June 2026, the percent of Black residents who consume 5 servings of fruits and vegetables will increase	IFAS	Dr. Cynthia Nazario-Leary	BRFSS	13.7%	23.7%	CHIP, SHIP

PROJECT All Aboard!

	Lead Entity and Unit	Lead Point Person	Data Source	Baseline Value	Target Value	Plan Alignment
Long-Term SDOH Goal: Have busses running early morning and later evening, and/or to have additional routes servicing the communities that use the bus for transportation to work, medical appointments, and errands.						
Objective: Increase ridership of Mobility Bus by at least 10% by June 2025	RTS	Francis Donahue	RTS	Average monthly ridership rate of 1,498 in FY 2021	10% increase	CHIP
Medium-Term SDOH Goal: Increase ridership of Mobility Bus. Evaluate additional SDOH data regarding use of public transportation						
Objective: Increase ridership of Mobility Bus by at least 10% by June 2025	RTS	Thomas Idoyaga	RTS	Average monthly ridership rate of 1,498 in FY 2021	10% increase	CHIP
Short-Term SDOH Goal: Increase awareness of Mobility Bus service by implementing 1 additional method of marketing						
Objective: Increase ridership of Mobility Bus by at least 10% by June 2025	RTS	Francis Donahue	RTS	Average monthly ridership rate of 1,498 in FY 2021	10% increase	CHIP

PROJECT Sweet Support

	Lead Entity and Unit	Lead Point Person	Data Source	Baseline Value	Target Value	Plan Alignment
Long-Term SDOH Goal: Include questions regarding chronic disease and mental health/support groups included in the CHA						
Objective: By January 2026, survey questions regarding chronic disease support groups will be included in the CHA	DOH-Alachua Diabetes Health Network	Terri Hutchinson	CHA	0	at least 1 question	CHIP
Medium-Term SDOH Goals: 1) Increase provider and community knowledge of Support Group and 2) Have measurable data regarding the impact of Diabetes Support Groups						
Objective 1: By July 2025 the selected DSME programs will have a 5% increase in referrals compared to July 2024 – June 2025	DOH-Alachua Diabetes Health Network	Terri Hutchinson	Program data	unknown	5% increase	CHIP, SHIP
Objective 2: By February 2024, Survey participants in Support Group and at least 30% of DSME enrollees for the period of	UFHealth Diabetes Education Program	Taylor Wooten	Program data	0	~30 Support Group attendees and ~ 50 DSME enrollees	CHIP

February 2023 – February 2024						
Short-Term SDOH Goal: Create an opportunity for those with diabetes to gain support to manage life with diabetes						
Objective 1: By September of 2022, a Diabetes Support Group will be established and host a meeting once a month.	UFHealth Diabetes Education Program, DOH-Alachua Diabetes Health Network	Erica Barnard	Attendance document	0	1 meeting/month	CHIP

PROJECT Getting to Know You

	Lead Entity and Unit	Lead Point Person	Data Source	Baseline Value	Target Value	Plan Alignment
Long-Term SDOH Goal: The inclusion of additional SDOH and Health Equity questions in the future Community Health Assessments and BRFSS						
Objective: By January 2026, more inclusive data will be available regarding multiple health indicators and SDOHs	Knowli	Emily Saras	Knowli	Number of current CDC BRFSS addressing SDOHs	1. Inclusion of at least 1 question regarding each of the SDOH categories to be included in the next CHA 2. Future CHAs can analyze data with inclusion of a more inclusive racial and ethnic representation as well as that of those with disabilities, Veterans, and LGBTQ+	CHIP, Age Friendly Plan, SHIP
Medium-Term SDOH Goal: Increased engagement of residents and community perspective in the development of community assessment						
Objective: By June 2023, SDOH Assessment data analyzed	Knowli	Emily Saras	Knowli	0	At least 30% of all minority groups represented in	CHIP, Age Friendly Plan, SHIP

					SODH assessment	
Short-Term SDOH Goal: Engagement of relevant agencies in developing questions about the community's perspective on the services they provide						
Objective: By March 2023, Knowli will have administered SDOH assessment tool.	Knowli	Emily Saras	Knowli	0	1 comprehensive community assessment that focuses on SDOHs	CHIP, Age Friendly Plan, SHIP

IX. 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, monitoring and reporting progress achieved on the goals and objectives of the Health Equity Plan. 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.

X. 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

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HEALTH EQUITY COALITION

Healthiest Weight Florida	Kourtney Oliver
Bread of the Mighty Food Bank	Sherah English
UFHealth Diabetes Education Program	Courtney Puentes
WeCare Network	Melissa Laliberte
DOH-Alachua Dental	Brittany Kingery
UF/IFAS Environmental Horticulture	Dr. Cynthia Nazario-Leary
UF/IFAS Family and Consumer Sciences	Dr. Martha Maddox
UF/IFAS Family Nutrition Program	Ebony Griffin
DOH-Alachua Diabetes Health Network	Erica Barnard
Alachua County Social Services	Claudia Tuck
City of Gainesville Food Recovery	Karissa Raskin
UF Department of Physical Therapy	Dr. Kim Dunleavy
Suwannee River Area Health Education Center	Sarah Catalanotto
DOH-Alachua HIV/STD	Gay Koehler-Sides
Alachua County Community Support Services	Cindy Bishop
Gainesville Regional Transit System Transit Service Community Specialist	Thomas Idoyaga
Gainesville Regional Transit System Planning	Francis Donahue
DOH-Alachua	Paul Myers
DOH-Alachua	Roger Dolz
DOH-Alachua Medical Home Program	Ashanti Barnes
Archer Family Health Care	Denise Schentrup
National Alliance on Mental Illness	Leanne Hibbitts
Helping Hands	Brendan Shortley
City of Gainesville Fire Rescue	Krista Ott