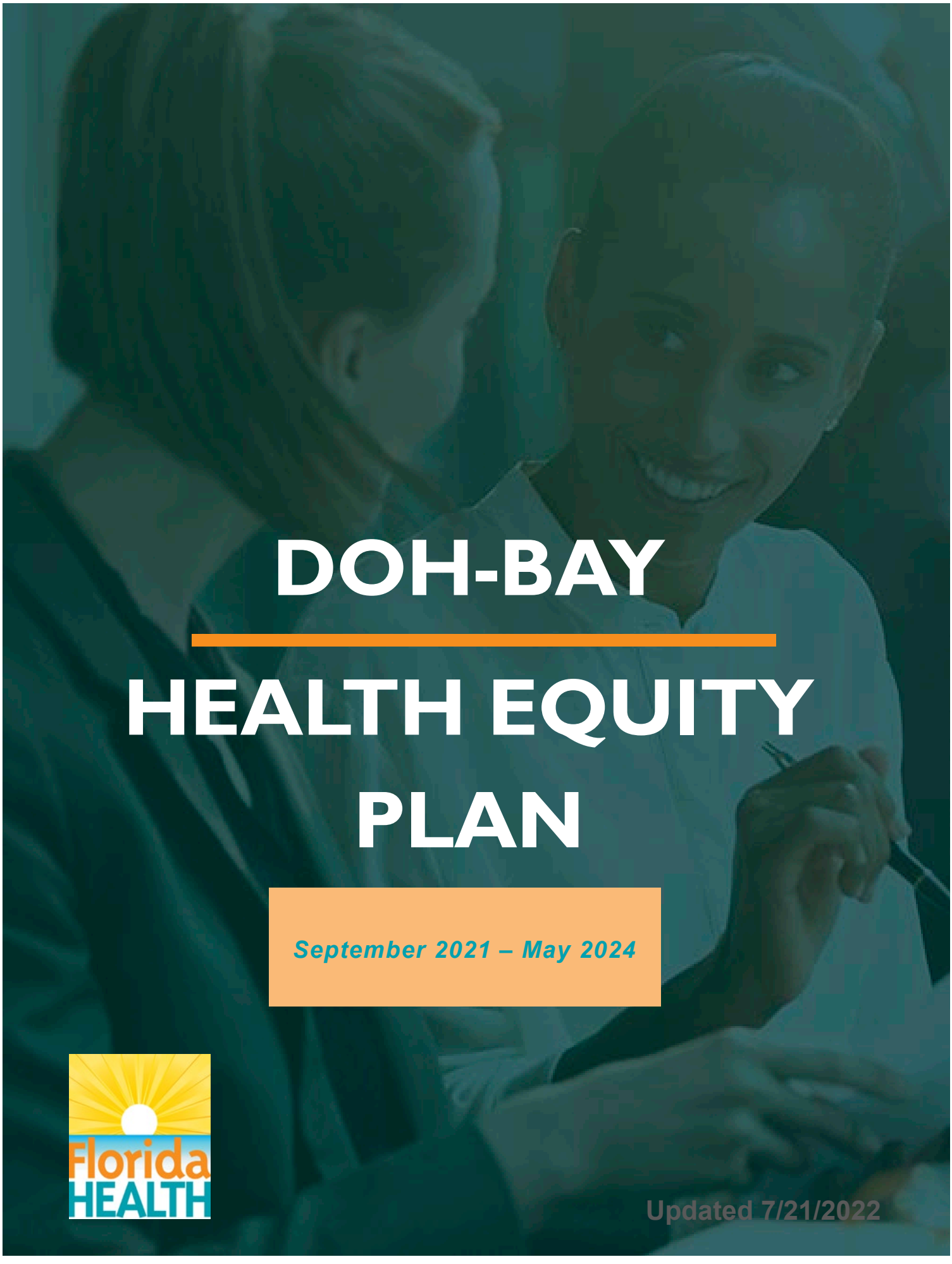

DOH-BAY

HEALTH EQUITY PLAN

September 2021 – May 2024

Florida HEALTH

Updated 7/21/2022

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I. VISION

The Health Equity Taskforce collaboratively determined a focus, purpose and direction utilizing the Mobilizing for Action Through Planning & Partnership (MAPP) process that resulted in a shared vision and corresponding value statements. The taskforce identified existing community visions that could inform or could be integrated into the MAPP process. They then discussed whether the existing visions, if applicable, represent the diverse views of community members and the local public health system through an interactive brainstorming session. This brainstorming session involved a broad representation from the community. The brainstorming focused on where the community wants to be in the future and asked a series of health equity visioning questions such as: What does an equitable community look like to you? In five years, if our community successfully worked towards achieving health equity, what would we have accomplished? Based on the feedback gathered, a vision statement and common values was formulated.

Vision:
To achieve health equity locally and nationally in which every resident, regardless of race, ethnicity, age, gender, sexual orientation, religion, income or other physical or social characteristic, has every opportunity to maximize their health and thrive.

Mission:
To preventing disease and injury and improving health through partnerships by educating and empowering communities to reduce health disparities.

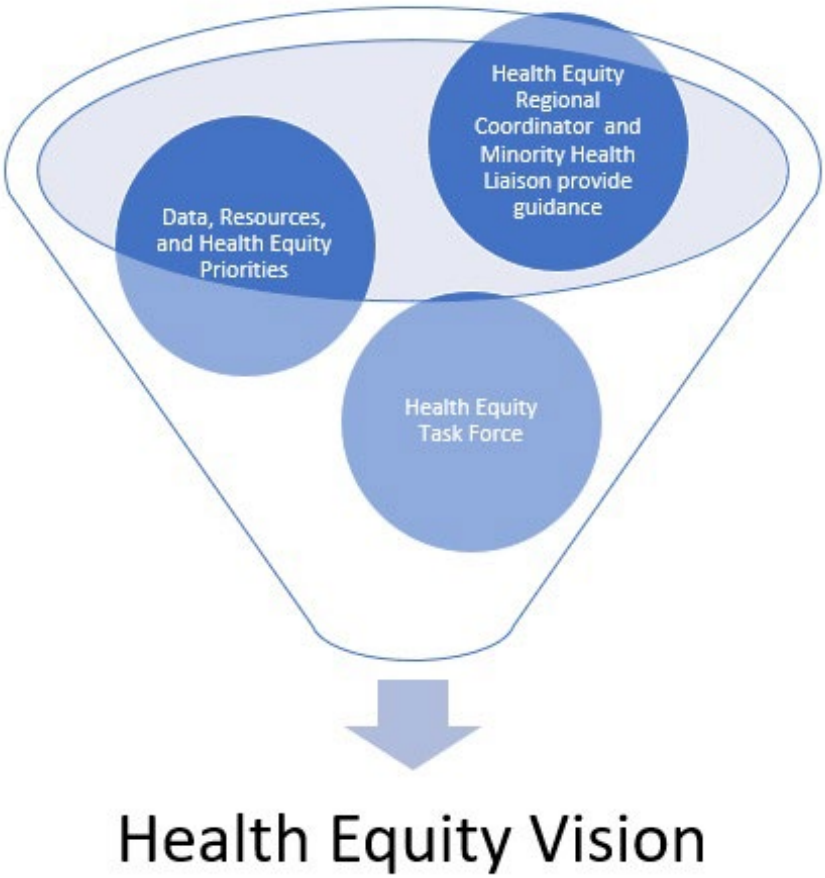
Goals:

- Increasing awareness of the significance of health inequities, their impact on Bay County, and the actions necessary to improve health outcomes for vulnerable and underserved populations;
- Moving toward eliminating health inequities through policy reform and strengthening and broadening leadership for addressing health inequities;
- Improving health and healthcare outcomes for racial, ethnic, and underserved populations;
- Improving data availability, coordination, utilization, and diffusion of research and evaluation outcomes;

- Building the capacity of Bay CHD to promote solutions to eliminate health disparities and achieve health equity.

Strategic Focus:

- Awareness
- Policy Development
- Leadership
- Health Systems and Wellness
- Cultural and Linguistic Competency
- Data, Research and Evaluation
- Community Capacity Building
- Sustainability



II. PURPOSE OF THE HEALTH EQUITY PLAN

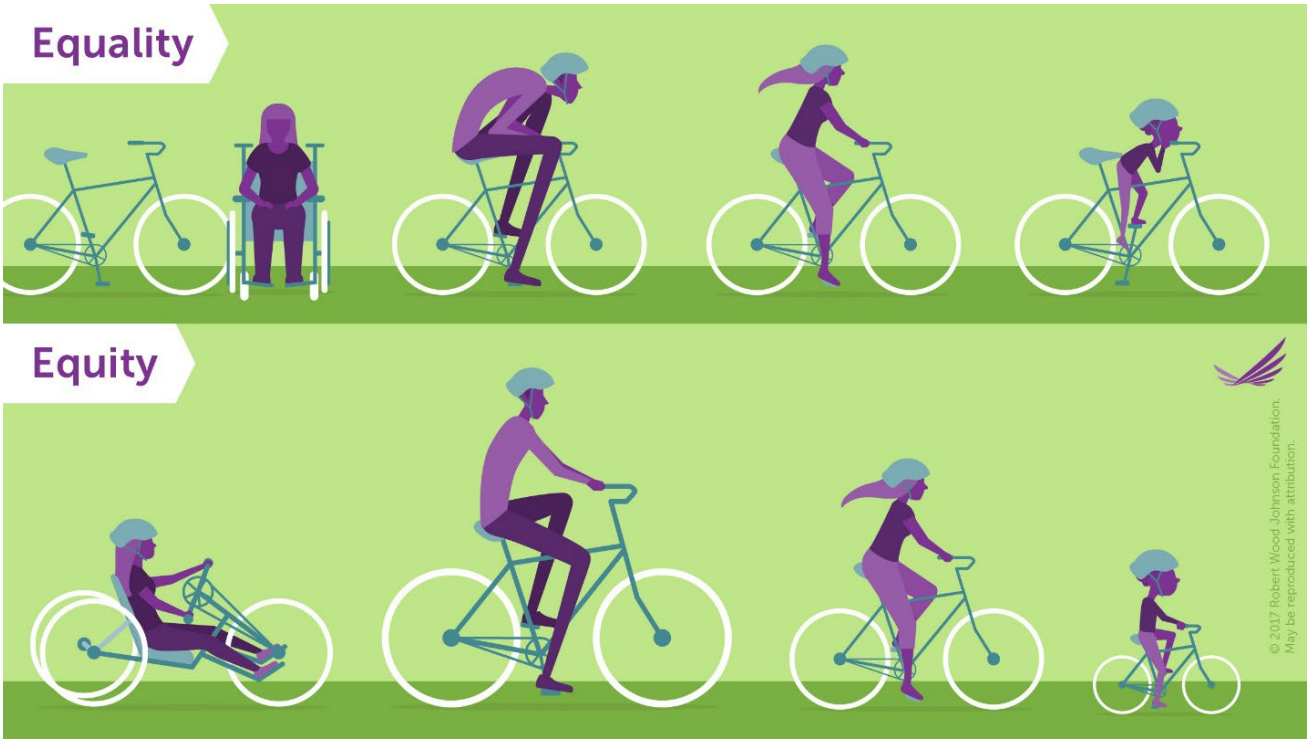
Health Equity is achieved when everyone can attain optimal health.

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 vulnerable populations. County organizations have a critical role in addressing the social determinants of health (SDOHs) by fostering multi-sector and multi-level partnerships, conducting surveillance, and integrating data from multiple sources, and leading approaches to develop upstream policies and solutions. This plan acknowledges that collaborative initiatives to address the SDOHs are the most effective at reducing health disparities.

The purpose of the Health Equity Plan is to increase health equity within Bay. To develop this plan, Bay 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 Bay. 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.

Bay CHD formed a diverse workgroup of community partners to oversee the Bay County Community Health Equity plan. The Health Equity workgroup is one of four subcommittees that contribute to the Bay County Community Health Improvement Plan. The Health Equity workgroup includes a wide range of community members and organizations, including state agencies, public-private partnerships, universities, health planning agencies, local nonprofits and community groups, and government officials. Members of the Health Equity workgroup are listed on pages 9 & 10 below.

The Health Equity workgroup's goal is to Increase awareness of the significance of health inequities, their impact on Bay County, and the actions necessary to improve health outcomes for vulnerable and underserved populations.

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: AnnJeanette Haro
Minority Health Liaison Backup: Brandy Mankin

B. Health Equity Team

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

Name	Title	Program
AnnJeanette Haro	Minority Health Liaison	Health Equity
Brandy Mankin	Quality Assurance	Administration
Kay Mulligan-Judah	WIC Director	WIC
Suzanne Schaefer	Mobile Dental Unit Coord.	Dental
Tricia Pearce	Comm Program Manager	Community Promotions
Chase Barrs	Health Program Educator	HIV/Re-Engagement
Tina Biddle	HIV Area 2A Regional Coord	HIV/Re-Engagement
Angela Bernard	PrEP Coordinator	Perinatal HIV Program
Victor Walsh	CHD Financial Administrator	Administration
Joy Griffin	Senior Health Educator	WIC
Christine Bartels	Director of Nursing	Clinic
Sandy McCroan	Breastfeeding Coordinator	WIC

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

Meeting Date	Topic/Purpose
2/11/22	Basic Overview and Introduction
3/3/22	Health Disparities selection Matrix
6/1/22	HE Plan review

C. Health Equity Taskforce

To form the Health Equity Taskforce and Coalition, the Health Equity team needed to consider a variety of factors during the recruitment process; identifying prospective partners within the community that share goals, networking to identify connections to those partners, calling or visiting to make a "warm introduction", holding a potential partner meeting and asking for a commitment. 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 Bay Health Equity Plan and oversaw the design and implementation of projects. Health Equity Taskforce members are listed below.

Name	Title	Organization	Social Determinant of Health
Tricia Pearce	Comm. Program Manager	Department of Health	Access to Healthcare
Dixie Williams	Diabetes Services Registered Nurse Specialist	Department of Health	Access to Healthcare
Michael Harris	Outreach Librarian	Bay County Public Library	Education
Janice Lucas	Executive Director	LEAD	Community and Social Impact
Sandy Culbreth	Operations Coordinator	Bay County Transportation	Built Environments
Kylee Trenholm	Parks and Recreation	Bay County	Built Environments

Melanie Taylor	Extension Agent	UFAS	Food
Liz Hunt	Gym Owner	Anytime Fitness	Exercise

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

Meeting Date	Organizations	Topic/Purpose
5/23/22	Various (see above list)	Introduction to health equity initiative
5/23/22	Various (see above list)	Brainstorm goals/objectives
6/6/22	Various (see above list)	Brainstorm goals/objectives Present health disparity data analysis
6/6/22	Various (see above list)	Finalize SDOH projects. Review and finalize HE plan

D. Coalition

The Coalition discussed strategies to improve the health of the community. The strategies focused on the social determinants of health: education access and quality, health care access and quality, economic stability, social and community context, and neighborhood and built environment. Membership includes community leaders working to address each SDOH, as well as any relevant sub-SDOHs. The Coalition assisted the Health Equity Taskforce by reviewing their Health Equity Plan for feasibility. See appendix A 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.

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

V. HEALTH EQUITY ASSESSMENT, TRAINING, AND PROMOTION

A. Health Equity Assessments

Bay County conducted a health equity assessment as part of the Community Health Assessment to examine the capacity and knowledge of DOH-Bay staff and county partners to address social determinants of health. With 844 Bay County resident responses, the health equity portion of the Community Health Assessment determined that due to their ethnicity and race, 12% felt they were discouraged by a teacher or advisor from seeking higher education, 16% felt they were denied a scholarship, 30% felt they were not hired for a job or were fired, 38% felt they were not given a promotion, 14% felt they were denied housing to include renting or buying, 6% moved from a neighborhood because they felt discriminated against, 10% felt unfairly targeted by police, 22% felt they were denied healthcare or provided inferior medical care, and 25% felt they were discriminated in public.

In addition, 50% of residents think the most important health issues in Bay County is Obesity/Excess Weight, whereas 60% at mental health, 22% substance use and diabetes, and 28% heart disease and stroke.

Below are the dates assessments were distributed and the partners who participated.

Date	Assessment Name	Organizations Assessed
5/1/2022-5/31/2022	Community Health Assessment	This assessment was distributed county-wide

B. County Health Equity Training

Assessing the capacity and knowledge of health equity should help the Minority Health Liaison identify knowledge gaps and create training plans for the Health Equity Taskforce, the Coalition, and other county partners. Therefore, a health equity assessment is scheduled to be conducted by the fall of 2023. The statewide health equity assessment survey tool will be utilized for data analysis. Once the data from this survey is aggregated, a training plan will be developed, and training opportunities facilitated.

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

Training Plan:

Date	Topics	Organization(s) receiving trainings
12/15/22	Cultural Awareness: Introduction to Cultural Competency and Addressing Health Equity: A Public Health Essential	All 172 DOH-Bay Employees
5/17/23	Centers for Disease Control: From Concepts to Practice: Health Equity, Health Inequities, Health Disparities, Social Determinants of Health	Any and all Bay County organizations to include those in the Bay County HE Coalition.
10/31/2023	NACCHO Roots of Health Inequity: The Roots of Health Inequity is designed for the public health workforce. Based on a social justice framework, the course introduces health organizations to concepts and strategies for taking action in everyday practice	Any and all Bay County organizations to include those in the Bay County HE Coalition.

12/31/23	A post training health equity assessment will be conducted by December 31, 2022, to determine the success of the trainings, and participation through training engagement surveys and an online questionnaire.	Any and all Bay County organizations to include those in the Bay County HE Coalition and DOH- Bay employees

C. County Health Department Health Equity Training

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

Completed Trainings:

Date	Topics	Number of Staff in Attendance
2/11/22	Health Equity, SDOH and health disparities and the differences between them.	11

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
11/8/21, 1/19/22, 2/23/22	Innovation Approaches to Tackle Public Health and Community Challenges: Stake Holder Mapping
1/25/22	Cultural Competency and Health Equity Training
2/22/22 – 2/24/22	Health Equity Strategies Process Planning and Technology of Participation (ToP) Facilitation Training.
3/8/22	Age-Friendly Public Health Systems: Social Isolation Summit
3/24/22	How to Assess Affordable Housing needs with Community Data
3/30/22	Meeting the needs of LGBTQIA+ Community at Community Health Centers in the South

E. National Minority Health Month Promotion

For Bay County's National Minority Health Month promotional event, Bay CHD partnered with Early Education & Care (EEC), Bay County Public Library, Bay County Free Library on Wheels (FLOW), Panama City Quality of Life, and Bay CHD programs such as: HIV, Abstinence, WIC, Tobacco, SNAP-ED, Diabetes and Dental. The event took place at Daffin Park in Panama City, Florida on Saturday, April 23, 2022, from 10a.m.-12p.m.

The purpose of the event was to promote health education and literacy (i.e., the importance of physical outdoor family activities and nutrition) to those vulnerable populations, namely the Hispanic communities, that are generally disadvantaged. About 55 residents in that community participated in the event, and about 27 staff members were present. The families engaged in fun activities such as a hula hoop relay activity, ball throwing, face painting, and bubble chasing activities. Refreshments and healthier food options such as fruits and other healthy snacks were provided and education on the importance of eating healthy and developing healthier lifestyles was provided as well.

Each family could visit the various booths and participate in contests where free prizes were handed out. In addition, families could take giveaways such as HIV home kits, antibacterial wipes, t-shirts, water bottles, and books.

Education on health equity, tobacco cessation, “rethink your drink”, USDA my plate, and WIC, were provided at each booth where families could engage in educational dialogue. Also, free dental screenings were provided by the “tooth fairy”, as well as the “know your number” free diabetes screenings.

The event flyer was promoted to our community partners and members through email and public forums.

As a result of this event, residents in these neighborhoods were introduced to available health options to include WIC provisions, free dental care for the children, learning how to eat healthier and the benefits of literacy and how to obtain free books. In addition, new partnerships were formed such as the LEAD Coalition, Parks & Recreation and UFAS Extension Office. These three (3) partnerships translated into new Bay County Health Equity Taskforce members.

VI. PRIORITIZING A HEALTH DISPARITY

The Health Equity Team identified and reviewed health disparities data in Bay. Data was pulled from multiple sources including but not limited to, FLCHARTS, Behavioral Risk Factor Surveillance System [BRFSS] and U.S. Department of Health and Human Services Office of Minority Health.

The following health disparities were identified in Bay County: diabetes and mental health. Using the NACCHO MAPP Multi-Voting Matrix, the Health Equity Team decided to work on Diabetes in the Health Equity Plan. Data concerning Diabetes and Chronic Disease is below. This process was used to help create the vision, values, and mission statements.

The data about adults who have ever been told they had diabetes come from a state-based telephone surveillance system called the Behavioral Risk Factor Surveillance System (BRFSS). BRFSS is the nation's premier system of health-related telephone surveys that collect state data about U.S. residents regarding their health-related risk behaviors, chronic health conditions, and use of preventive services. Florida is one of 50 states conducting the BRFSS with financial and technical assistance from the Centers for Disease Control and Prevention (CDC). In Florida, the BRFSS data is collected at the state level each year, and it is collected at the county level every three years.

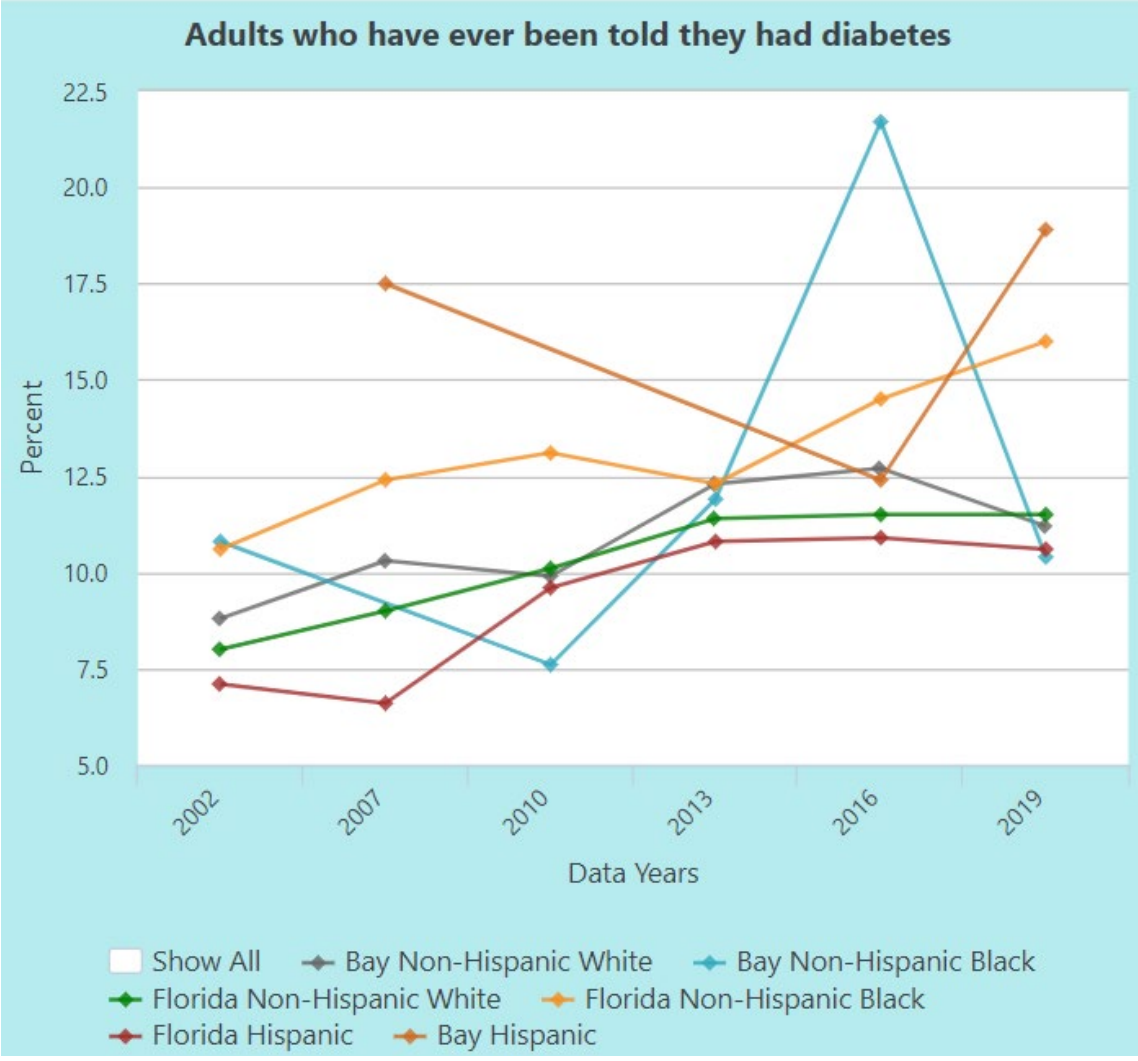
Since behaviors impact health, this knowledge is a powerful tool for targeting and building health promotion activities. It also provides a way to see change in population health behaviors before morbidity or disease is apparent.

In 2019, in Bay County, 11.6% of adults who have ever been told they had diabetes (Overall) can be compared to 11.7% statewide. The line graph shows change over time when there are at least three years of data.

Bay County is in the second quartile for this measure. This means that relative to other counties in Florida, the situation occurs more often in about half of the counties, and it occurs less often in about one quarter of the counties. The map

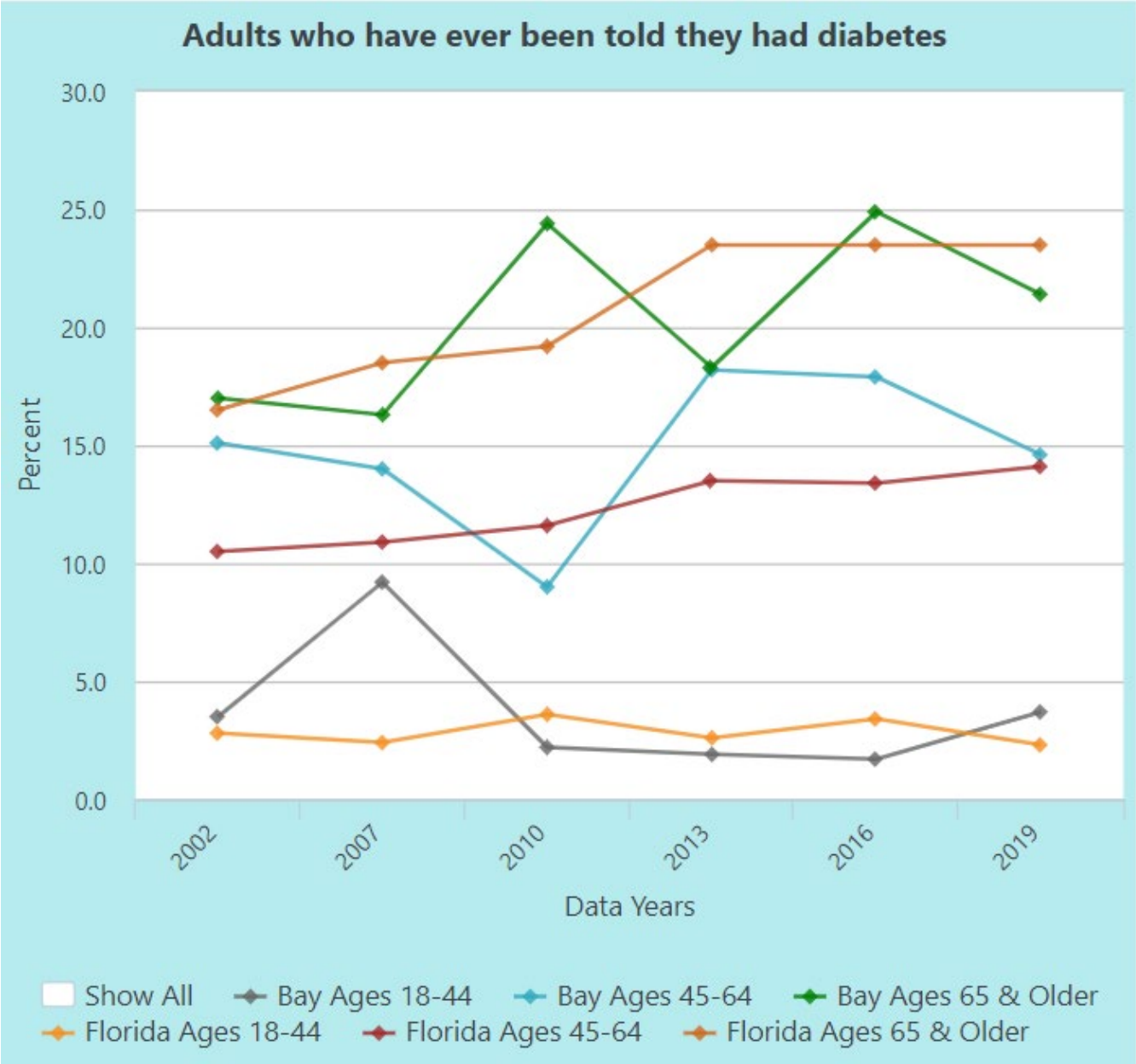
illustrates county data by quartile. It is shown when there are at least 51 counties with data for this measure.

Table 1: Adults who have ever been told they had diabetes by race/ethnicity (Source FLCHARTS, CDC & US Census Bureau) According to all three (3) data sources- other ethnicities not available for Bay County other than those on the below chart.



Adults who have ever been told they had diabetes						
	Bay			Florida		
Year	Non-Hispanic White	Non-Hispanic Black	Hispanic	Non-Hispanic White	Non-Hispanic Black	Hispanic
2019	11.2% (8.3% - 14.1%)	10.4% (3.7% - 17%)	18.9% (7.4% - 30.5%)	11.5% (10.5% - 12.4%)	16% (12.8% - 19.1%)	10.6% (8.2% - 13.1%)
2016	12.7% (8.8% - 16.5%)	21.7% (10.2% - 33.3%)	12.4% (3.9% - 20.8%)	11.5% (10.8% - 12.2%)	14.5% (12.3% - 16.8%)	10.9% (9.3% - 12.6%)
2013	12.3% (8.7% - 15.9%)	11.9% (0.8% - 23.1%)		11.4% (10.7% - 12.2%)	12.3% (10% - 14.6%)	10.8% (8.7% - 12.8%)
2010	9.9% (6.9% - 13%)	7.6% (0% - 15.9%)		10.1% (9.4% - 10.7%)	13.1% (10.7% - 15.5%)	9.6% (7.2% - 12.1%)
2007	10.3% (7.6% - 13.9%)		17.5% (3.3% - 56.7%)	9% (8.4% - 9.6%)	12.4% (10.4% - 14.8%)	6.6% (5.2% - 8.2%)
2002	8.8% (5.7% - 11.9%)	10.8% (1.3% - 20.4%)		8% (7.4% - 8.6%)	10.6% (8.2% - 13.1%)	7.1% (5% - 9.2%)

Table 2: Adults who have ever been told they had diabetes by age (Source: FLCHARTS)



Adults who have ever been told they had diabetes						
	Bay			Florida		
Year	Ages 18-44	Ages 45-64	Ages 65 & Older	Ages 18-44	Ages 45-64	Ages 65 & Older
2019	3.7% (1.1% - 6.3%)	14.6% (9.5% - 19.8%)	21.4% (15.8% - 27.1%)	2.3% (1.6% - 2.9%)	14.1% (12.1% - 16.2%)	23.5% (21.5% - 25.6%)
2016	1.7% (0% - 3.6%)	17.9% (11.8% - 24%)	24.9% (16.6% - 33.2%)	3.4% (2.7% - 4.1%)	13.4% (12.2% - 14.6%)	23.5% (21.8% - 25.1%)
2013	1.9% (0% - 4.4%)	18.2% (11.5% - 24.9%)	18.3% (12% - 24.5%)	2.6% (1.9% - 3.2%)	13.5% (12.1% - 14.9%)	23.5% (21.8% - 25.3%)
2010	2.2% (0% - 4.9%)	9% (4.7% - 13.2%)	24.4% (16.6% - 32.1%)	3.6% (2.8% - 4.5%)	11.6% (10.4% - 12.7%)	19.2% (17.9% - 20.5%)
2007	9.2% (2.9% - 25.5%)	14% (9.7% - 19.7%)	16.3% (10.8% - 23.9%)	2.4% (1.9% - 3.1%)	10.9% (9.9% - 12.1%)	18.5% (17.2% - 19.9%)
2002	3.5% (0.5% - 6.4%)	15.1% (8.8% - 21.3%)	17% (8.6% - 25.4%)	2.8% (2.2% - 3.4%)	10.5% (9.2% - 11.8%)	16.5% (14.9% - 18.1%)

Table 3: Diagnosed Cases of Diabetes/African Americans

Diabetes and African Americans

- In 2018, non-Hispanic blacks were twice as likely as non-Hispanic whites to die from diabetes.
- African American adults are 60 percent more likely than non-Hispanic white adults to be diagnosed with diabetes by a physician.
- In 2017, non-Hispanic blacks were 3.2 times more likely to be diagnosed with end stage renal disease as compared to non-Hispanic whites.
- In 2017, non-Hispanic blacks were 2.3 times more likely to be hospitalized for lower limb amputations as compared to non-Hispanic whites.

Diagnosed Cases of Diabetes

Age-adjusted percentage of persons 18 years of age and over with diabetes, 2018			
	Non-Hispanic Black	**Non-Hispanic White**	**Non-Hispanic Black / Non-Hispanic White Ratio**
Men	13.4	8.7	1.5
Women	12.7	7.5	1.7
Total	13.0	8.0	1.6

Source: CDC 2021. Summary Health Statistics: National Health Interview Survey: 2018. Table A-4a.
http://www.cdc.gov/nchs/nhis/shs/tables.htm

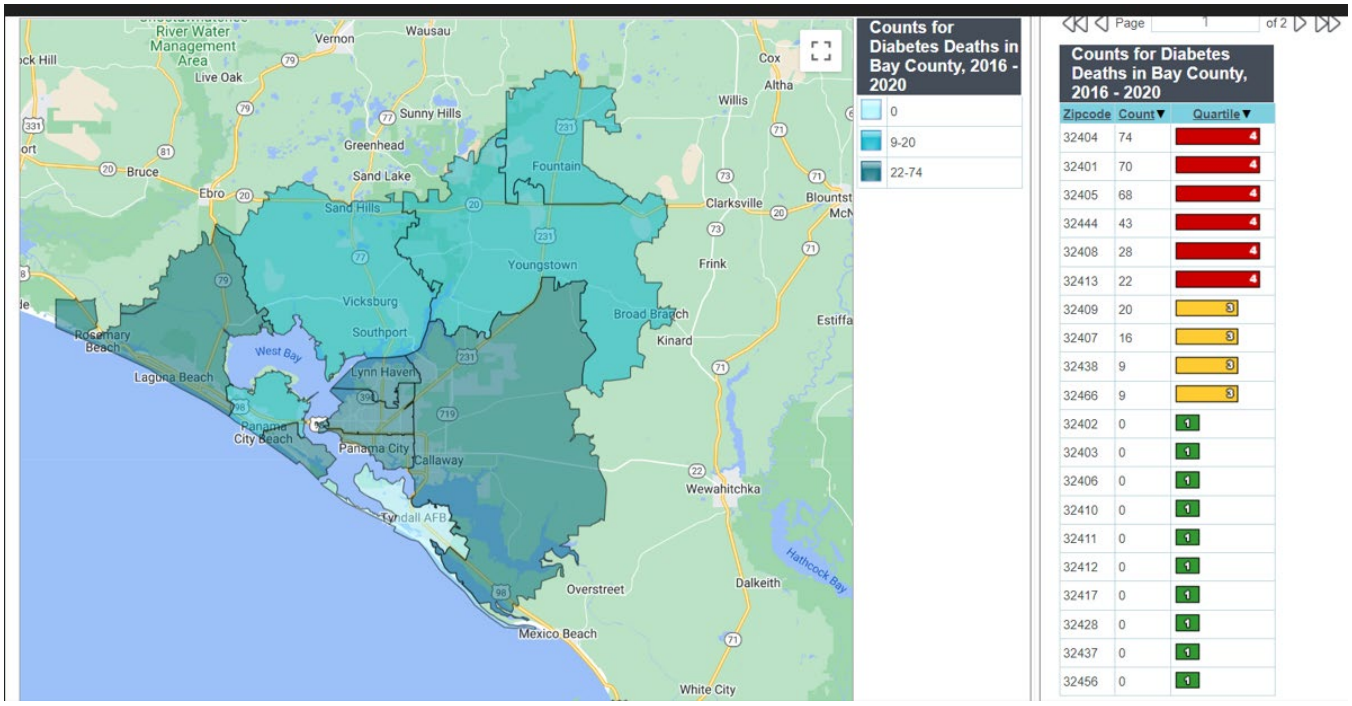
Age-adjusted percentage of adults age 18 and over diagnosed with diabetes, 2018		
Non-Hispanic Black	**Non-Hispanic White**	**Non-Hispanic Black / Non-Hispanic White Ratio**
12.4	7.8	1.6

Source: CDC 2021. National Diabetes Surveillance System.
https://gis.cdc.gov/grasp/diabetes/DiabetesAtlas.html

Age-adjusted percentage of diagnosed diabetes for adults age 18 and over, 2017-2018			
	Non-Hispanic Black	**Non-Hispanic White**	**Non-Hispanic Black / Non-Hispanic White Ratio**
Men	11.4	8.6	1.3
Women	12.0	6.6	1.8
Total	11.7	7.5	1.6

Source: CDC 2020. National Diabetes Statistics Report, 2020. Appendix Table 3.
https://www.cdc.gov/diabetes/data/statistics-report/index.html

Counts by Diabetes Death in Bay County



Source: FLCHARTS, 2016-2020; zip code

In **2020**, the **demographics by zip-code per 100,000 population of Deaths From Diabetes (All) in Bay** County was **359** compared to Florida at **583**. Since the oldest age at death varies, an ending age of 999 is used to retrieve all records up to and including the oldest age.

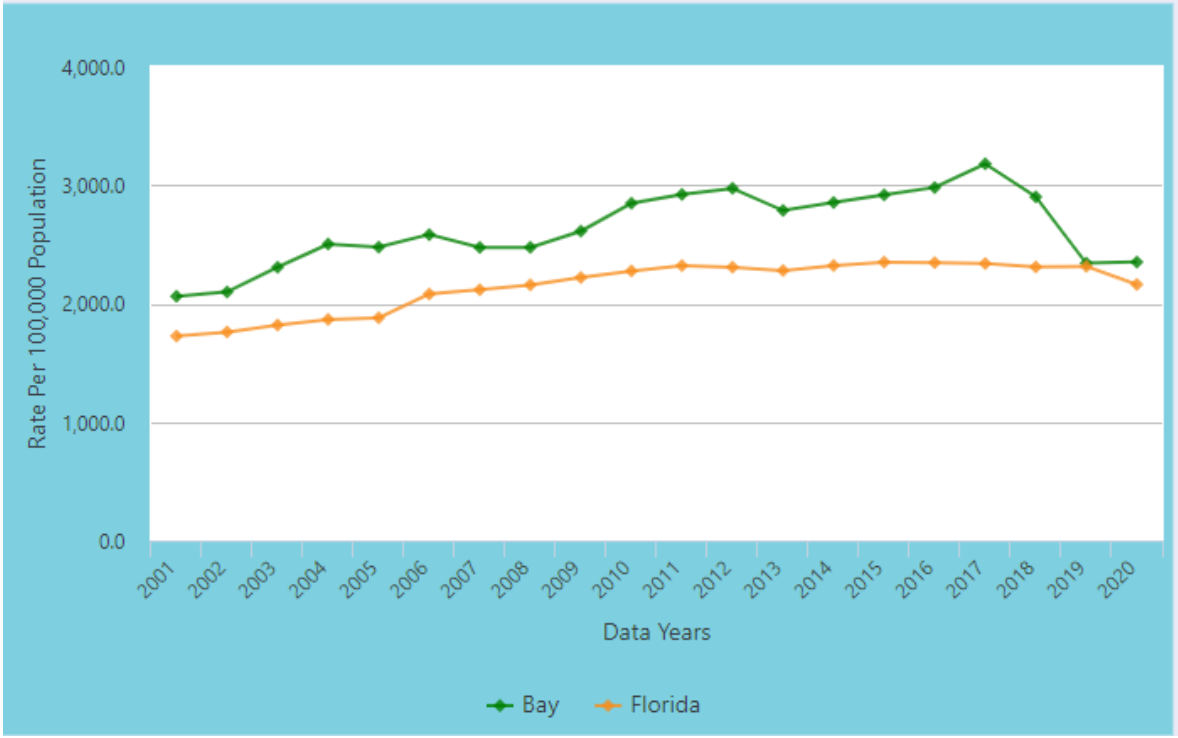
Bay County is in the **second** quartile for this measure. This means that relative to other counties in Florida, the situation occurs more often in about half of the counties, and it occurs less often in about one quarter of the counties. The map illustrates county data by quartile.

In **2019, in Bay County, 8.7% of adults who have ever been told they had pre-diabetes (Overall)** can be compared to **9.1%** statewide. The line graph shows change over time when there are at least three years of data.

Adults who have ever been told they had pre-diabetes, Overall		
Year	Bay	Florida
2019	8.7% (6.3% - 11.2%)	9.1% (8.2% - 10.1%)
2016	7.5% (5.1% - 9.9%)	9.4% (8.7% - 10%)
2013	6.1% (3.9% - 8.4%)	7.1% (6.6% - 7.7%)

Source: FLCHARTS

Age-adjusted Hospitalizations From or With Diabetes as Any Listed Diagnosis , Single Year



In **2020, the age-adjusted rate per 100,000 of Hospitalizations From or With Diabetes as Any Listed Diagnosis** in **Bay** County was **2350.9** compared to Florida at **2160.3**. The line graph shows change over time when there are at least three years of data.

Bay County is in the **third** quartile for this measure. This means that relative to other counties in Florida, **the age-adjusted rate per 100,000 of Hospitalizations From or With Diabetes as Any Listed Diagnosis** is less in about half of the counties, and more in about one quarter of the counties

Long-term complications of diabetes develop gradually. The longer you have diabetes — and the less controlled your blood sugar — the higher the risk of complications. Eventually, diabetes complications may be disabling or even life-threatening. Possible complications include:

- **Cardiovascular disease.** Diabetes dramatically increases the risk of various cardiovascular problems, including coronary artery disease with chest pain (angina), heart attack, stroke and narrowing of arteries (atherosclerosis). If you have diabetes, you're more likely to have heart disease or stroke.

- **Nerve damage (neuropathy).** Excess sugar can injure the walls of the tiny blood vessels (capillaries) that nourish your nerves, especially in your legs. This can cause tingling, numbness, burning or pain that usually begins at the tips of the toes or fingers and gradually spreads upward.

  Left untreated, you could lose all sense of feeling in the affected limbs. Damage to the nerves related to digestion can cause problems with nausea, vomiting, diarrhea or constipation. For men, it may lead to erectile dysfunction.

- **Kidney damage (nephropathy).** The kidneys contain millions of tiny blood vessel clusters (glomeruli) that filter waste from your blood. Diabetes can damage this delicate filtering system. Severe damage can lead to kidney failure or irreversible end-stage kidney disease, which may require dialysis or a kidney transplant.

- **Eye damage (retinopathy).** Diabetes can damage the blood vessels of the retina (diabetic retinopathy), potentially leading to blindness. Diabetes also increases the risk of other serious vision conditions, such as cataracts and glaucoma.

- **Foot damage.** Nerve damage in the feet or poor blood flow to the feet increases the risk of various foot complications. Left untreated, cuts and blisters can develop serious infections, which often heal poorly. These infections may ultimately require toe, foot or leg amputation.

- **Skin conditions.** Diabetes may leave you more susceptible to skin problems, including bacterial and fungal infections.

- **Hearing impairment.** Hearing problems are more common in people with diabetes.

- **Alzheimer's disease.** Type 2 diabetes may increase the risk of dementia, such as Alzheimer's disease. The poorer your blood sugar control, the greater the risk appears to be. Although there are theories as to how these disorders might be connected, none has yet been proved.

- **Depression.** Depression symptoms are common in people with type 1 and type 2 diabetes. Depression can affect diabetes management.

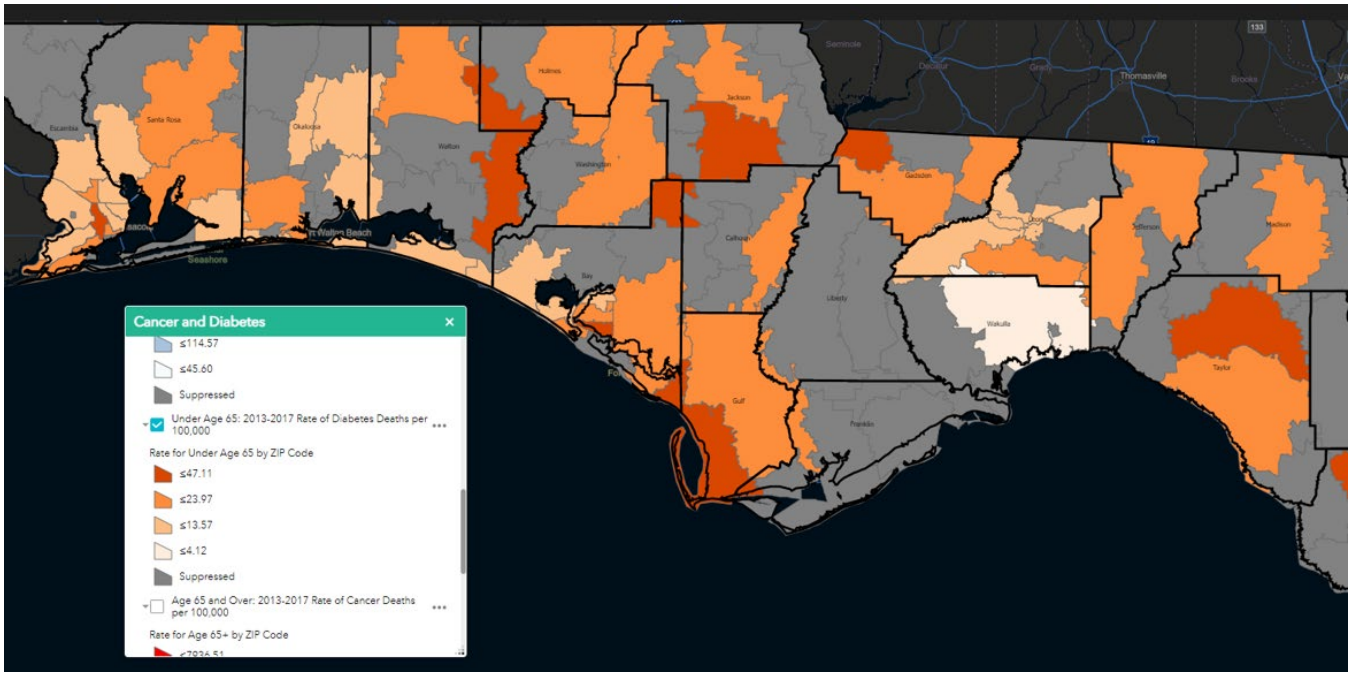
Diabetes can also increase your risk of developing certain types of **cancer**.

A July 2018 study confirmed that both type 1 and type 2 diabetes put people at greater risk of developing certain cancers, with the risk higher for women than for men. Researchers reviewed 47 studies worldwide that included health data for almost 20 million individuals.

The researchers from the University of Oxford in Great Britain and Johns Hopkins University in Baltimore reached the following conclusions about cancer and diabetes in men and women:

- Diabetic women have a 27 percent greater chance of developing cancer than healthy women.
- Diabetic men are 19 percent more likely to develop cancer than healthy men.
- Diabetic men have a 12 percent higher risk of liver cancer than diabetic women.
- Compared to diabetic men, diabetic women have a:
    - 15 percent higher risk of developing leukemia
    - 14 percent higher risk of stomach cancer
    - 13 percent higher risk of oral cancer
    - 11 percent higher risk of kidney cancer

People with type 2 diabetes, also known as adult-onset diabetes, may have an increased risk of breast, endometrial, pancreatic, liver, kidney and colon cancers.



Source :FLCHARTS

Vulnerable Populations:

In **2019, in Bay County, 8.7% of adults who have ever been told they had pre-diabetes (Overall)** can be compared to **9.1%** statewide. The below tables show by age, sex and ethnicity. (Source: FLCHARTS)

Adults who have ever been told they have pre-diabetes by age:

Adults who have ever been told they had pre-diabetes						
	Bay			Florida		
Year	Ages 18-44	Ages 45-64	Ages 65 & Older	Ages 18-44	Ages 45-64	Ages 65 & Older
2019	4.5% (1.7% - 7.3%)	12.4% (7.2% - 17.7%)	11.5% (6.6% - 16.4%)	4.7% (3.4% - 6%)	12.2% (10.2% - 14.2%)	11.8% (10.3% - 13.4%)
2016	3.6% (0.8% - 6.5%)	7.6% (3.6% - 11.5%)	12.1% (6.3% - 17.9%)	6.2% (5.2% - 7.3%)	11.5% (10.2% - 12.7%)	11.5% (10.3% - 12.7%)
2013	4.2% (0.6% - 7.8%)	6.9% (3% - 10.8%)	9% (4.7% - 13.3%)	4.9% (3.9% - 5.8%)	7.9% (7% - 8.8%)	9.6% (8.7% - 10.6%)

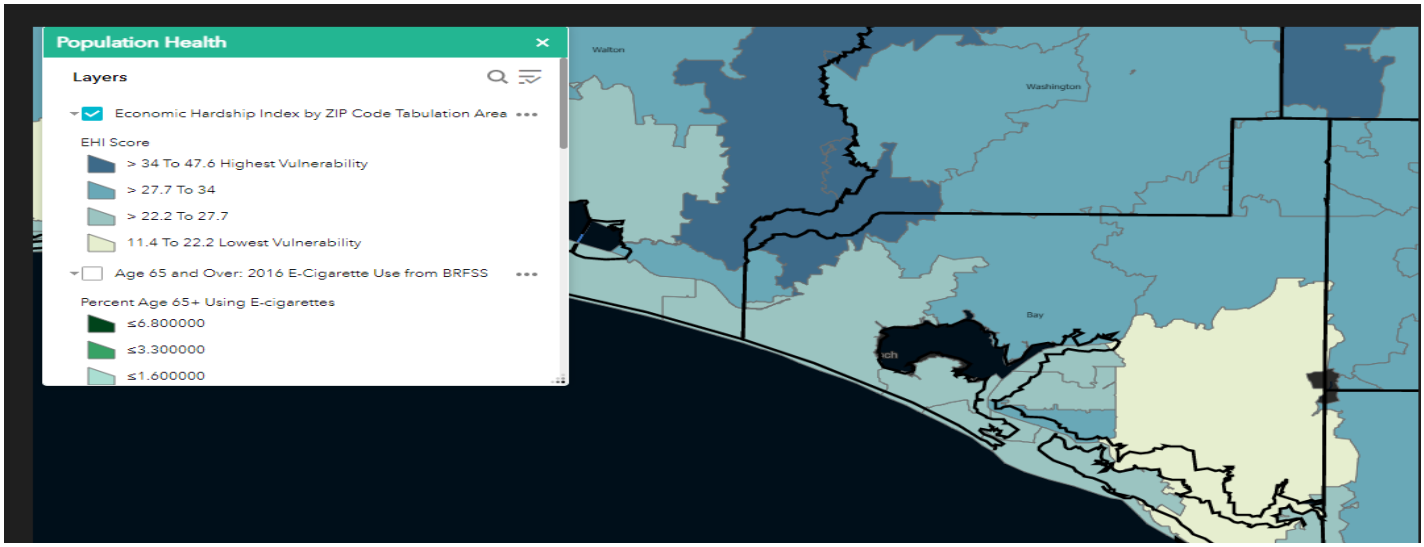
Adults who have ever been told they have pre-diabetes by sex:

Adults who have ever been told they had pre-diabetes				
	Bay		Florida	
Year	Men	Women	Men	Women
2019	9.6% (5.7% - 13.4%)	7.9% (4.9% - 10.9%)	8.9% (7.5% - 10.3%)	9.4% (8.1% - 10.6%)
2016	6.4% (3.5% - 9.4%)	8.5% (4.7% - 12.3%)	8.9% (8% - 9.9%)	9.7% (8.8% - 10.7%)
2013	4.6% (1.5% - 7.7%)	7.6% (4.3% - 10.9%)	7.4% (6.5% - 8.3%)	7% (6.3% - 7.6%)

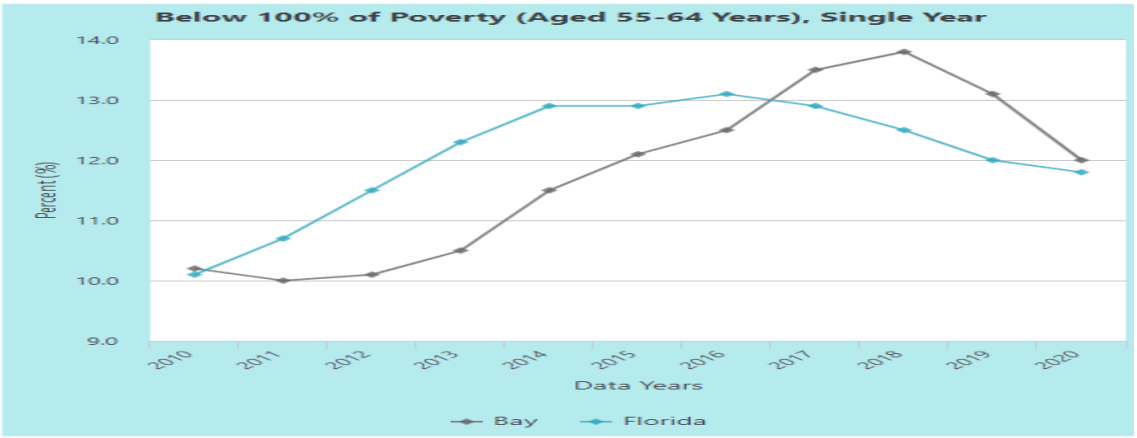
Adults who have ever been told they have pre-diabetes by ethnicity:

Adults who have ever been told they had pre-diabetes						
	Bay			Florida		
Year	Non-Hispanic White	Non-Hispanic Black	Hispanic	Non-Hispanic White	Non-Hispanic Black	Hispanic
2019	9.6% (6.7% - 12.5%)	10.4% (0.7% - 20.2%)	3.1% (0% - 6.6%)	10% (8.9% - 11%)	8.7% (5.9% - 11.5%)	7.9% (5.6% - 10.3%)
2016	8.3% (5.4% - 11.3%)	8% (0.1% - 15.9%)	5.2% (0% - 10.4%)	9.4% (8.7% - 10.1%)	11.8% (9.4% - 14.2%)	7.2% (5.8% - 8.5%)
2013	6.2% (3.7% - 8.7%)	4.7% (0% - 12.5%)		7.9% (7.3% - 8.5%)	8.3% (6.2% - 10.5%)	4.8% (3.5% - 6.2%)

In looking at the above data, it appears that adult, non-Hispanic, black males ages 45-64 are vulnerable at being dispositioned for diabetes. In addition, we can see that zip codes 32401 and 32404 (reference Counts by Diabetes Deaths graph, page 25), are the most vulnerable geographically for diabetes. These geographic areas are also considered food deserts within Bay County when it comes to healthier food options. (Reference Food Deserts, pages 35-39)

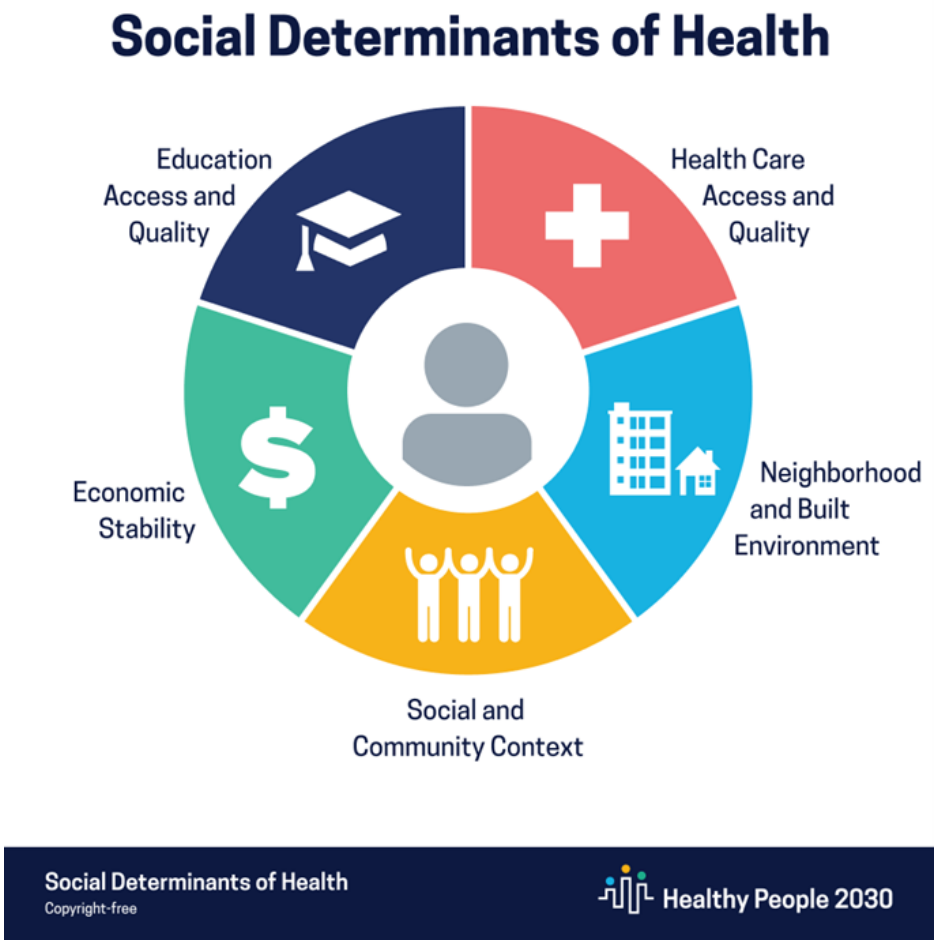


In **2020, the percentage of Below 100% of Poverty (Aged 55-64 Years)** in **Bay** County was **12** compared to Florida at **11.8**. The line graph shows change over time when there are at least three years of data. **Bay** County is in the **second** quartile for this measure. This means that relative to other counties in Florida, there are more **Below 100% of Poverty (Aged 55-64 Years)** in about half of the counties, and less in about one quarter of the counties.



VII. SDOH DATA

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



A. Neighborhood and Built Environment

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

Rural Areas/Vulnerable Populations

In 2021, a survey was conducted with all Bay County residents living in and/or near Florida's I-10 Corridor. Residents in the I-10 corridor can expect to live shorter lives than those in many other parts of the state (77 years and 80 years, respectively) making these residents part of Bay County's vulnerable population. The Big Bend2 Community Health Assessment (2020) cites heart disease, cancer, stroke, unintentional injury, and chronic lower respiratory disease as the five leading causes of death in the region. With the exception of unintentional injury, these causes are classified as cardiometabolic disorders, associated with smoking, poor nutrition, and lack of exercise and directly correlated with obesity (National Academies of Sciences Engineering and Medicine, 2021). Residents in the I-10 corridor are more likely to be smokers, have a depressive disorder, diabetes, and chronic obstructive pulmonary disease (COPD) than those in the rest of Florida (2013 and 2016 Behavioral Risk Factor Surveillance System [BRFSS] analyses). See specific exhibits extracted from the I-10 survey data analysis.

About the I-10 Corridor

When many Americans think of Florida, they envision retirement enclaves such as The Villages, Jimmy Buffet's Key West, Donald Trump's Palm Beach Mar-a-Lago, Orlando's theme parks, the panhandle's white beaches, and the sophistication of Miami Beach. Perceptions of Florida's I-10 corridor, with its world-renowned white beaches and a significant military population, are consistent with this idealized view of the state. However, these perceptions may overshadow parts of Florida—and the I-10 corridor—that do not fit these stereotypes.

Beyond the beaches and military bases, the history, demographics, and population density of this region most closely resemble Florida's southern rural neighboring states: Georgia, Alabama, and Mississippi. Understanding these similarities allows us to draw on research about "southern rural" American communities. This research can help us ask the right questions about public health in this region, understand how its context shapes behaviors and health, and help us make informed recommendations to improve health.

We conducted a preliminary analysis of BRFSS data in the I-10 counties to verify that the relationships between health behaviors, health conditions, and life expectancy were consistent with the published research. Not surprisingly, smoking, not using seatbelts, stroke, diabetes, dental problems, physical inactivity, COPD, and asthma were associated with lower life expectancy in the region. Other analyses (and the Community Health Assessments) identified multiple challenges to community health, including lack of access to healthcare, primary care and behavioral health provider shortages, sustainable employment, and economic and social determinants of health.

All of this suggests that we need to consider the social determinants of health in our analysis of public health in the I-10 corridor. We recognize that it is beyond the ability of the state and county public health systems to directly change many of these factors.; however, some of the associated barriers posed by them may be mitigated, community assets identified and leveraged, and public health implementation better focused. The framework for this approach already exists in the Florida Department of Health's Strategic Plan.

Exhibit 3. Vulnerability and Life Expectancy Vary Widely in the I-10 Corridor

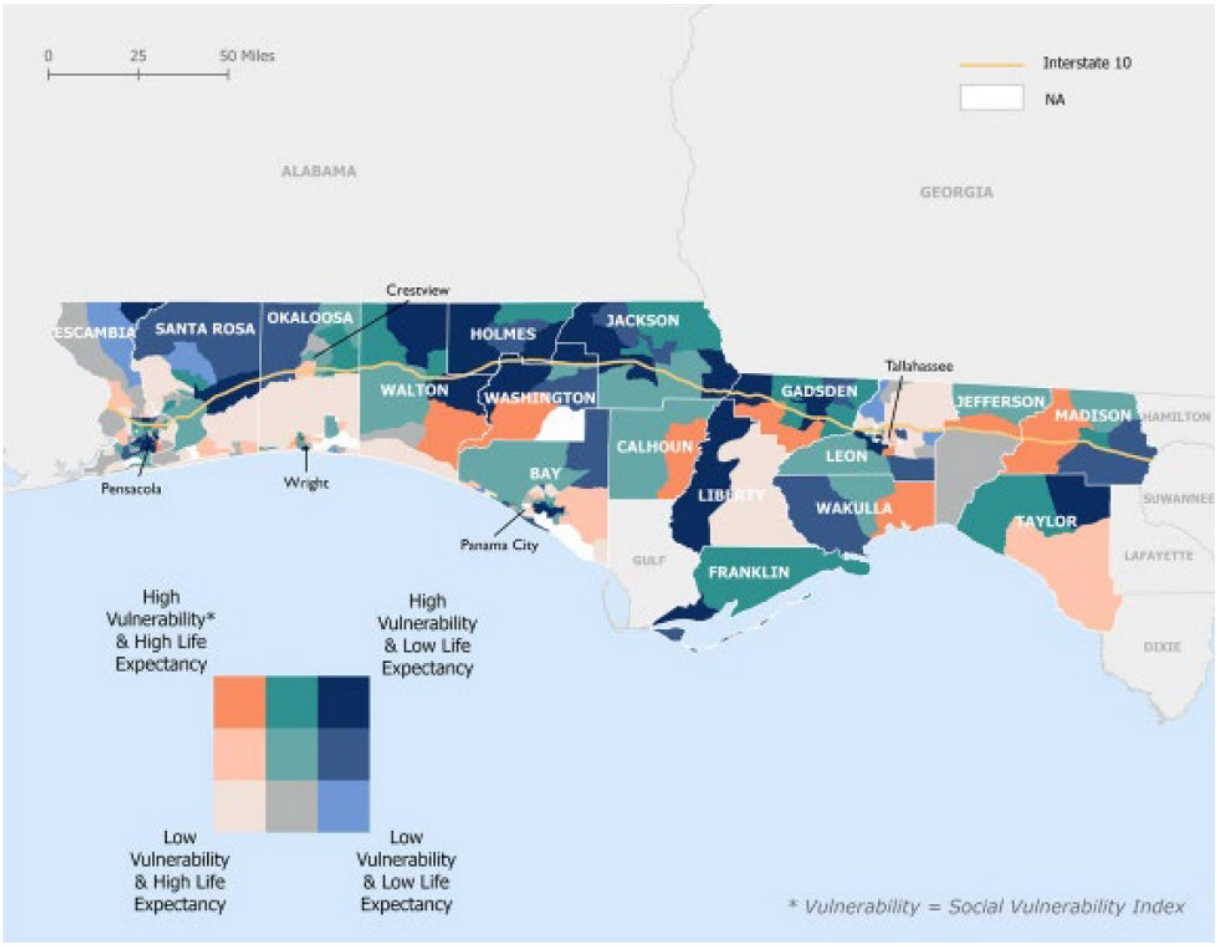


Exhibit 6. Health Behaviors and Conditions Associated with Lower Life Expectancy

Health Behaviors	Health Conditions
o Any exercise reported in the last 30 days o Current smoking status (some day or every day): defined as smoking at least 100 cigarettes and currently smoking some days or every day o Average hours of sleep per night	o Dental health (having had teeth extracted) o Arthritis o Depression o Diabetes o Asthma o Cancer o Chronic obstructive pulmonary disease (COPD) o Myocardial infarction or coronary health disease (MICHD or heart disease) o BMI: defined as weight divided by height

Healthy Lifestyle Choices

In 2013, in Bay County, 13.2% of adults Who Consumed Five or More Servings of Fruits or Vegetables per Day (Overall) can be compared to 18.3% statewide. The line graph shows change over time when there are at least three years of data.

Adults Who Consumed Five or More Servings of Fruits or Vegetables per Day, Overall		
Year	Bay	Florida
2013	13.2% (9.6% - 16.8%)	18.3% (17.3% - 19.4%)
2007	24.7% (19.3% - 31%)	26.2% (25.2% - 27.3%)

Food Deserts

In looking at the contributing causes of diabetes and chronic diseases, we also needed to research what foods residents in Bay County had access to. According to several data sources, 16.5% of Bay County residents have access to healthy food sources within a short drive, with the state at 27.7%: while 21.3%

of Bay County residents having access to unhealthier foods within a short drive, such as fast-food restaurants. (See tables below)

Table 1: Bay County Population living within ½ mile of a Healthy Food Source (Source: FLCHARTS)

Population Living within ½ mile of a Healthy Food Source, Percentage of Population, Single Year		
	Bay	Florida
Data Year	Percent (%)	Percent (%)
2019	16.5	27.7
2016	16.5	27.9

Table 2: Bay County Population living within ½ mile of a Fast Food Restaurant

Population Living within ½ mile of a Fast Food Restaurant, Percentage of Population, Single Year		
	Bay	Florida
Data Year	Percent (%)	Percent (%)
2019	21.3	27.7
2016	25.8	31.1

Table 3: Bay County Map of Fast Food Restaurants (Source: Google Maps)

Table 3: Bay County Grocery Stores/Panama City Beach (Source: Google Maps)

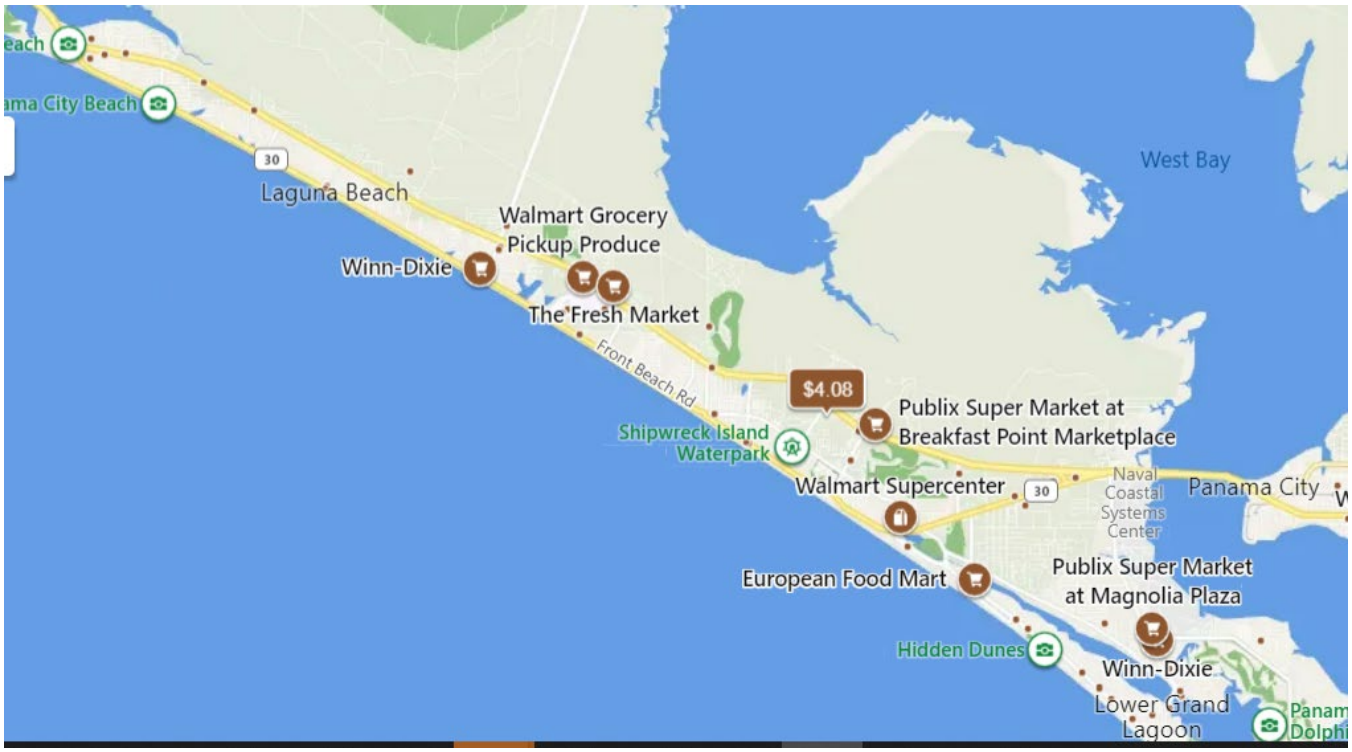
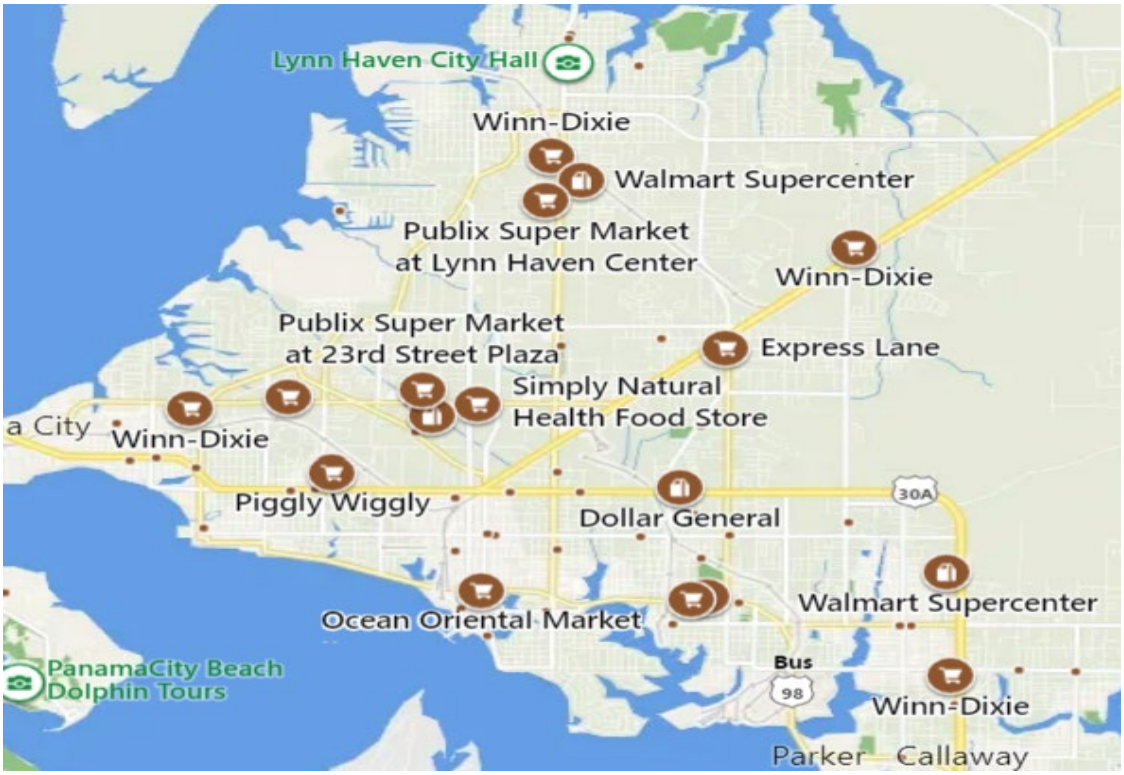
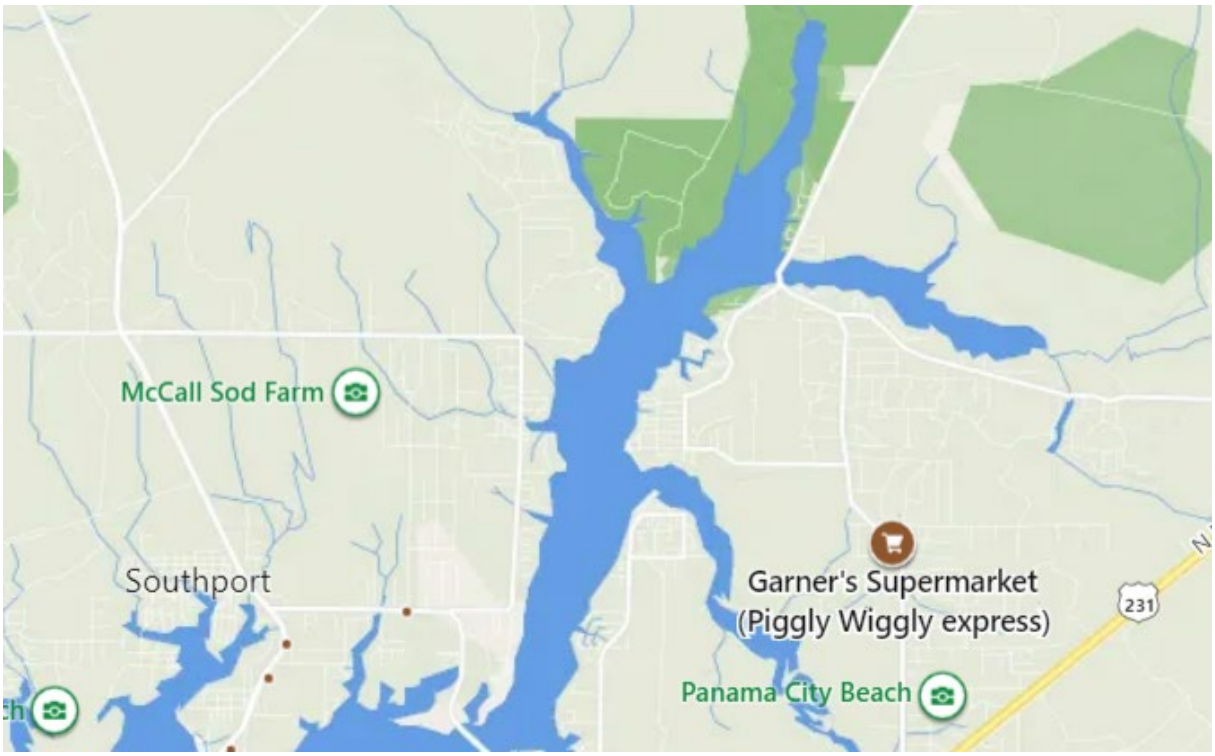


Table 4: Bay County Grocery Stores/Panama City & Outlying areas (Source: Google Maps)





Housing

According to the U.S. Census Bureau, as of April 1, 2020, Bay County's population is at 175,216 residents and of those residents, 139,727 are 18 years of age and older, with 104,768 housing units, and a median household income of $56,483. In 2019, the median property value was $178,400, with the median household price at $330,000, and 65.1% homeownership; the price of a home should be no more than 3x the annual gross income. There are 2.59 person per household and 79.8% of residents living in the same house, per a year ago and 14.9% of person in poverty. For low-income, vulnerable households there are challenges in creating a sense of home in a new tenancy which may have substantial effects on health and wellbeing. Thus, from the perspective of 'ontological security' the home is seen as providing a secure base from which people can develop confidence in self and social identity. [World Health Organization: Closing the gap; 2008]

Table 5: Housing population estimates (Source: US Census Bureau)

Housing	Bay County, Florida
Population Estimates, July 1 2021, (V2021)	NA
PEOPLE	
Housing	
Housing units, July 1, 2019, (V2019)	104,768
Owner-occupied housing unit rate, 2016-2020	67.3%
Median value of owner-occupied housing units, 2016-2020	$195,000
Median selected monthly owner costs -with a mortgage, 2016-2020	$1,399
Median selected monthly owner costs -without a mortgage, 2016-2020	$418
Median gross rent, 2016-2020	$1,099
Building permits, 2020	2,846

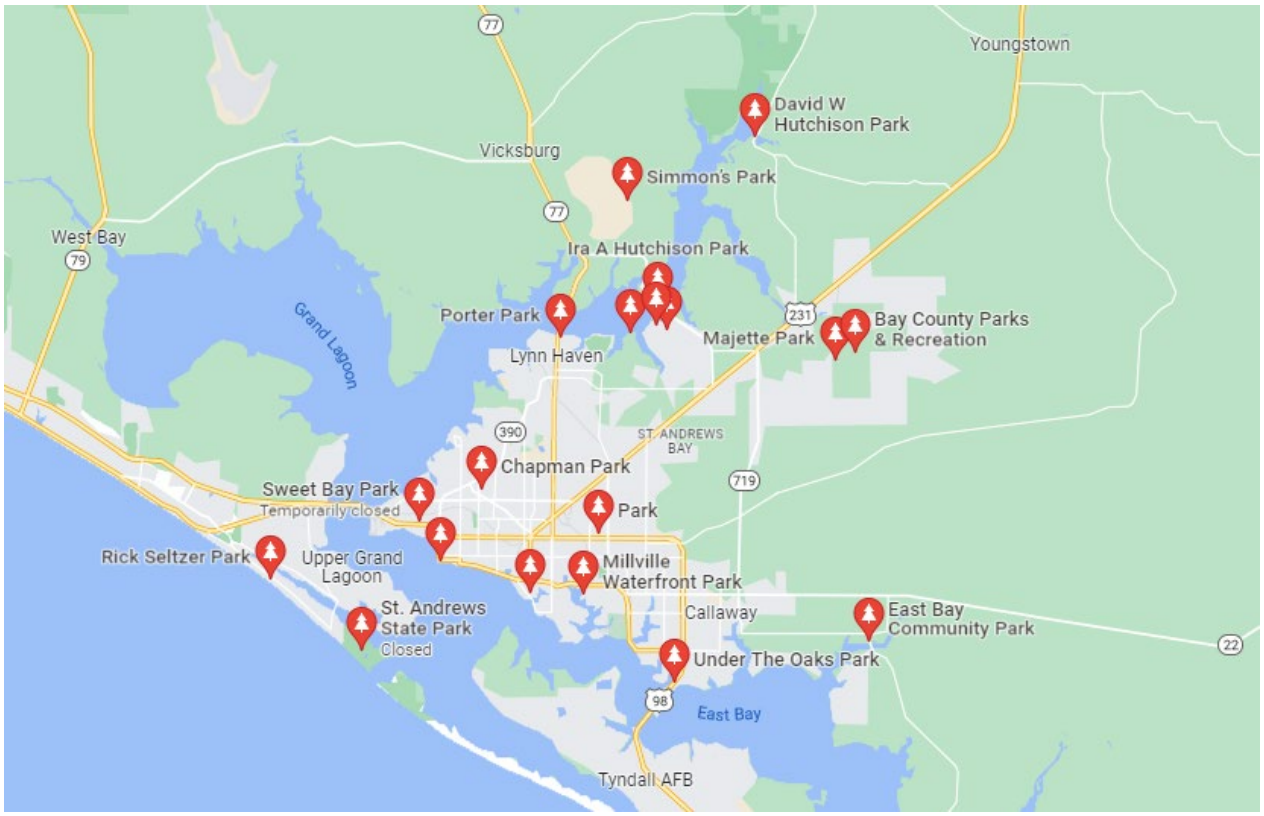
Walkability

When cities aren't designed for pedestrian traffic, people's health suffers in two ways. First, they may be less likely to get around by foot and to be physically fit. Several studies [World Health Organization] have found that having a place to walk or a more walkable neighborhood, featuring well-maintained sidewalks and walking paths, supports more exercise. Second, those who do choose to walk along roadways and shoulders without sidewalks are at greater risk of being hit by a motor vehicle.

Per the National Diabetes Prevention Program (NDPP) evidence-based lifestyle change program, creating a healthier environment that promotes walking and exercise can prevent obesity and diabetes.

In doing a “windshield tour” of both the municipal and rural areas, it is evidenced that public sidewalks either do not exist or need repair in many areas of Bay County. The table below lists all Bay County parks & recreation in both municipal and rural areas.

Table 6: Bay County current Parks & Recreation (Source: Google Maps)



Transportation

For local transportation needs, there are numerous options, including car rental, ride share such as Lyft and Uber, taxi services and both low-speed vehicle (LSV) and bicycle rentals.

Many of those traveling utilize the Bay County Transportation Services of Bay Town Trolley, which has a route system within the limits of Panama City, Panama City Beach, Callaway, and Springfield. The trolley offers services Monday through Saturday from 6 a.m. to 8 p.m. As the City continues with the Front Beach Road CRA (Community Redevelopment Area) project, both trolley

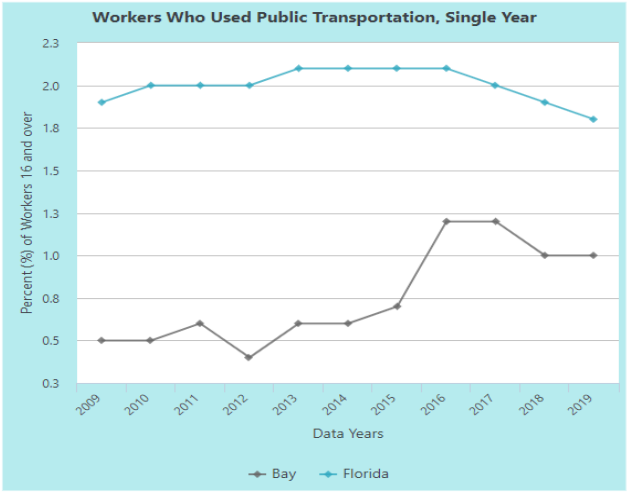
and bike lanes are being added to allow for a less congested and safer flow of traffic with multi-modal transportation options.

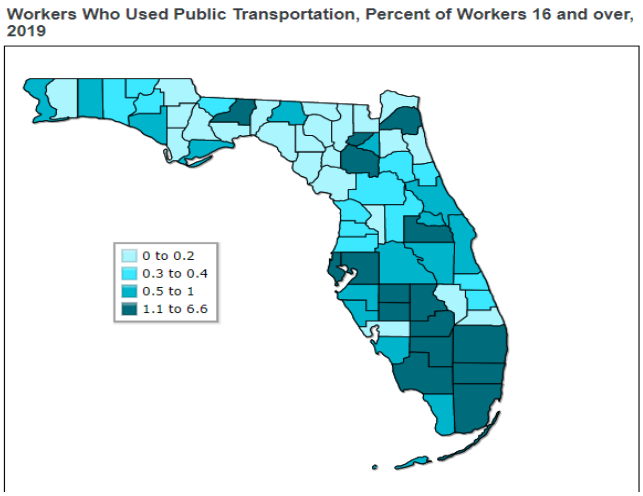
However, many Bay County residents living in the rural and outlying areas do not have access to public transportation. In addition, those that do have access to public transportation may have limited windows of access due to route system time constraints and cut-off times.

According to the U.S. Census Bureau, in 2019,the average commute time was 23.1 minutes, with the most common commute being those drivers that drive alone at 81.4%, those that carpool at 10.4% and those that worked from home at 4.05%; average car ownership- 2 per household.

In 2019, the percentage of Workers Who Used Public Transportation in Bay County was 1 compared to Florida at 1.8. The line graph shows change over time when there are at least three years of data.

Bay County is in the third quartile for this measure. This means that relative to other counties in Florida, there are less Workers Who Used Public Transportation in about one half of the counties, and more in about one quarter of the counties. The map illustrates county data by quartile. When fewer than 51 counties have data or zero values, no quartile map will be presented.





In 2019, the percentage of Workers Who Walked to Work in Bay County was 1.1 compared to Florida at 1.4. The below graph shows change over time when there are at least three years of data. The percentage of Workers Who Used Taxicab, Motorcycle, Bicycle, or Other Means to Work in Bay County was 2 compared to Florida at 2.3.

Workers Who Walked to Work, Percentage of Workers 16 and over, Single Year								
	Bay				Florida			
Data Year	Count	Denom	Percent (%)	MOV	Count	Denom	Percent (%)	MOV
2019	900	84,130	1.1*	0.1	134,920	9,383,111	1.4	0.0
2018	1,020	82,472	1.2*	0.1	129,987	9,140,393	1.4	0.0
2017	1,098	81,647	1.3*	0.1	129,801	8,907,171	1.5	0.0
2016	1,313	80,604	1.6*	0.1	127,822	8,649,800	1.5	0.0
2015	1,341	78,768	1.7*	0.1	125,170	8,432,513	1.5	0.0
2014	1,378	77,277	1.8*	0.1	126,128	8,228,557	1.5	0.0
2013	1,225	77,511	1.6	0.1	126,018	8,094,220	1.6	0.0
2012	1,499	78,601	1.9*	0.1	126,718	8,107,476	1.6	0.0
2011	1,435	79,334	1.8*	0.1	127,943	8,127,157	1.6	0.0
2010	1,335	78,809	1.7	0.1	132,455	8,165,401	1.6	0.0
2009	1,198	77,416	1.5*	0.1	131,024	8,062,375	1.6	0.0

- **The impact of neighborhood and built environment on Diabetes and Chronic Disease**

Neighborhood and Built Environment		
SDOH	**Vulnerable Populations Impacted**	**How the SDOH Impacts (Health Disparity)**
Housing	Low Income Families	Mental health and stability
Transportation	Low Income Families	Access to care
Safety	Low Income Neighborhoods	Crime rates, lighting
Parks/Playgrounds	Low Income Neighborhoods (East Bay County)	Hurricane Michael Rebuild
Walkability	Low Income Neighborhoods (East Bay County)	Lack of Sidewalks and lighting

Access to nutritional food	Rural & Low Income Neighborhoods	Food deserts

Vulnerable Populations- Disabled persons

Living with a disability is expensive and can require spending on medication and frequent health care visits, a wheelchair-accessible vehicle, in-home personal assistance, and adaptive devices and clothing, along with the usual costs of living. Living with serious illness only worsens these financial stresses.

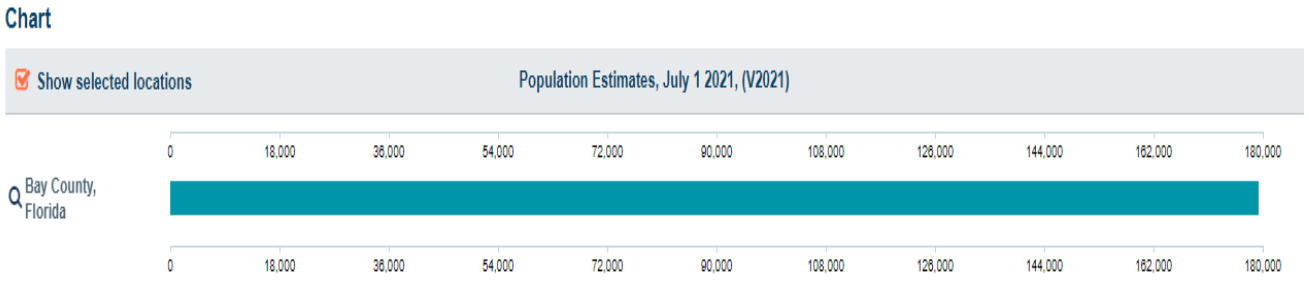
According to an analysis of the Health Disparities Among People living with Disability ages 18 to 65, conducted by the Knowli Data Science and FSU Claude Pepper Center, in Bay County, disabled veterans make up 12% (21,000 veterans) of the disabled population. In addition, immigrants are 6.7% of the population in Bay County living with disabilities, with the total disabled population at 14.9%.

B. Health Care Access and Quality

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

Health Coverage:

According to the U.S. Census Bureau, 14% of Bay County residents do not currently have health insurance. In addition, 12.4% of Bay County residents, are considered at poverty level. The chart below shows the health insurance inadequacies as of July 2021. (Source: US Census Bureau)

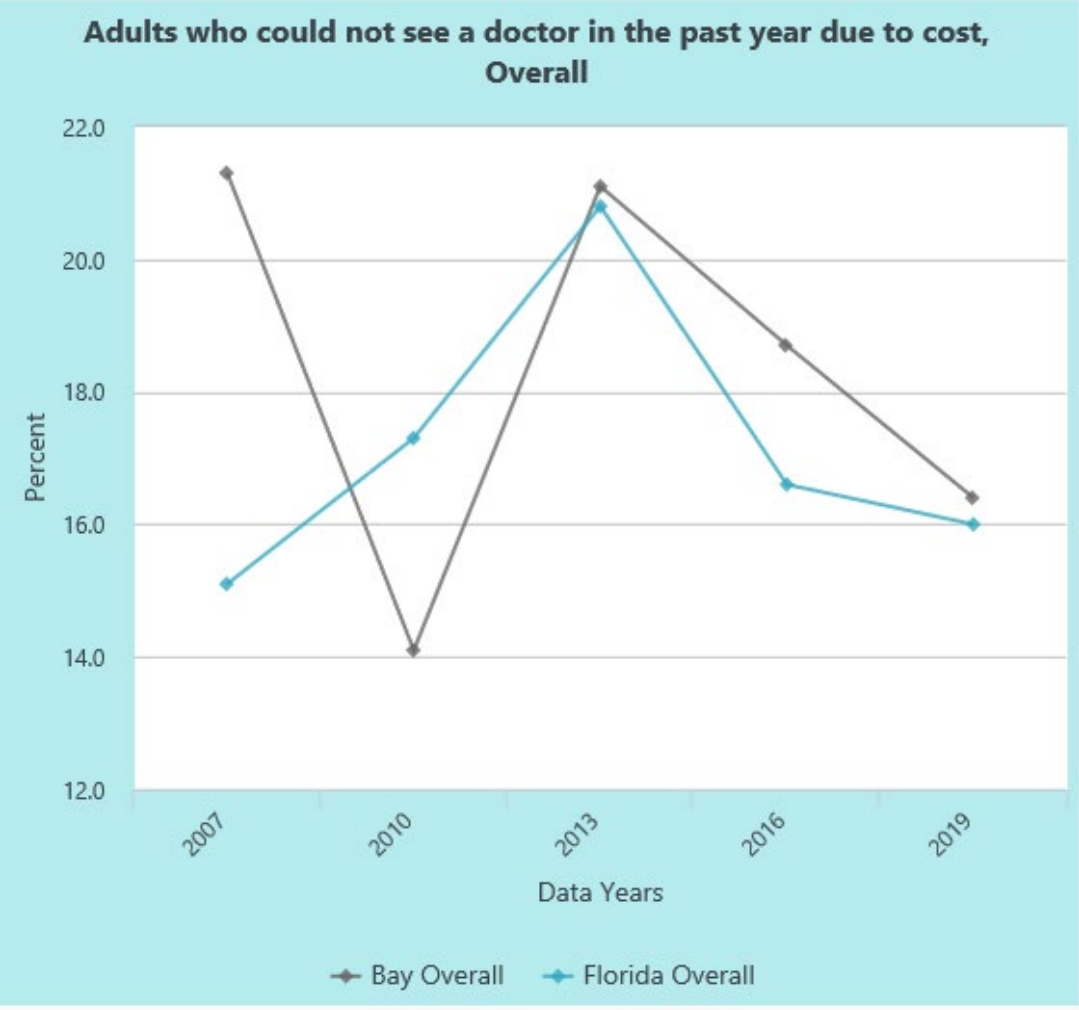


The data about **adults who could not see a doctor in the past year due to cost** came from a state-based telephone surveillance system called the Behavioral Risk Factor Surveillance System (BRFSS). BRFSS is the nation's premier system of health-related telephone surveys that collect state data about U.S. residents regarding their health-related risk behaviors, chronic health conditions, and use of preventive services. Florida is one of 50 states conducting the BRFSS with financial and technical assistance from the Centers for Disease

Control and Prevention (CDC). In Florida, the BRFSS data is collected at the state level each year, and it is collected at the county level every three years.

Since behaviors impact health, this knowledge is a powerful tool for targeting and building health promotion activities. It also provides a way to see change in population health behaviors before morbidity or disease is apparent.

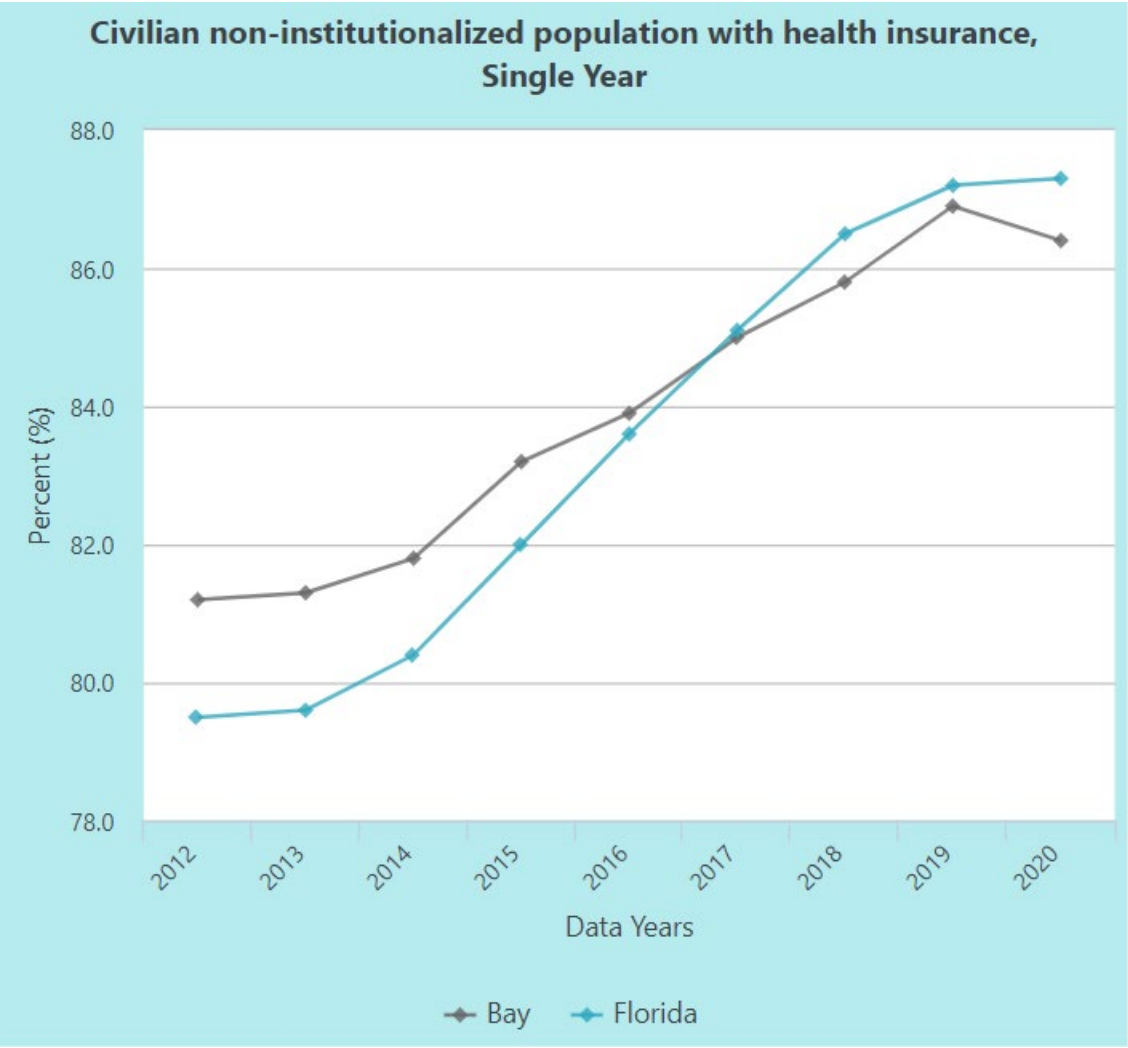
As of 2019, in Bay County, 16.4% of adults who could not see a doctor in the past year due to cost (Overall) can be compared to **16% statewide**. The line graph shows change over time. (Source: FLCHARTS)



Health insurance makes a difference in determining if and when people get necessary medical care, where they get their care, and ultimately, how healthy

they are. Uninsured people are far more likely than those with insurance to postpone health care or forgo it altogether.

In **2020, the percentage of Civilian non-institutionalized population with health insurance** in **Bay** County was **86.4%** compared to Florida at **87.3%**. The line graph shows change over time. (Source: FLCHARTS)

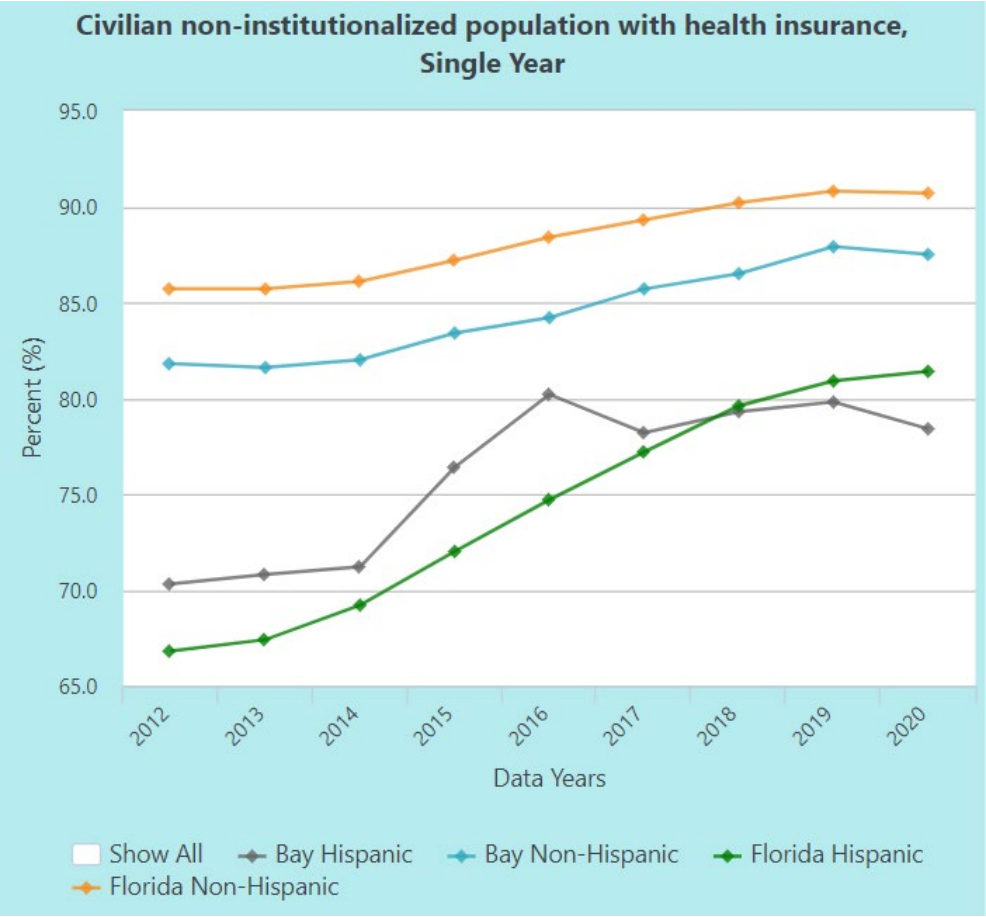


In 2020, in Bay County, the percentage of White Civilian non-institutionalized population with health insurance was 87.1% compared to Black Civilian non-institutionalized population with health insurance at 81.4%. However, we can see

a larger gap between Civilian non-institutionalized population with health insurance who identified as race type Other at only 73%. See the below chart comparing Bay County's White vs Other race and Florida's White vs Other race from 2012 - 2020. (Source: FLCHARTS)

Civilian non-institutionalized population with health insurance, Percentage of, Single Year				
	Bay		Florida	
	White	Other	White	Other
Data Year	Percent (%)	Percent (%)	Percent (%)	Percent (%)
2020	87.1	73.0	88.5	77.5
2019	87.3	78.8	88.1	75.8
2018	86.0	78.7	87.4	74.5
2017	85.2	80.5	86.1	72.2
2016	83.9	77.5	84.8	69.4
2015	83.1	68.5	83.4	65.8
2014	81.5	65.6	81.9	62.8
2013	81.1	69.5	81.2	60.5
2012	81.3	44.9	81.2	60.0

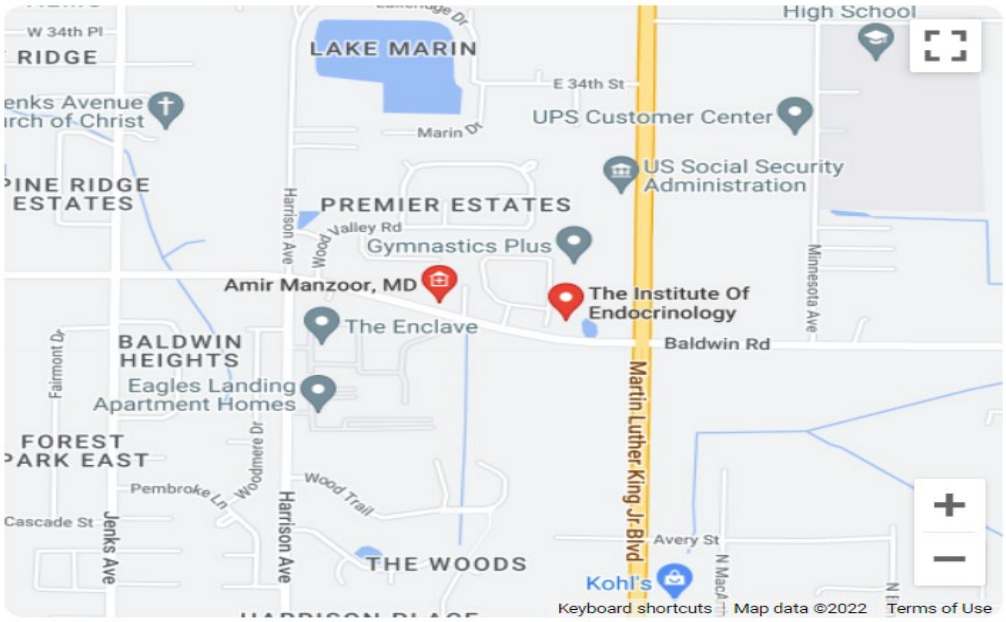
The data reported by ethnicity shows the percentage of civilian non-institutionalized population with health insurance identified as non-Hispanic is 87.5% compared to Hispanic which is 78.4%. See the blow line graph alongside statewide numbers for Civilian non-institutionalized population with health insurance by ethnicity. (Source: FLCHARTS)



Specialty Clinics

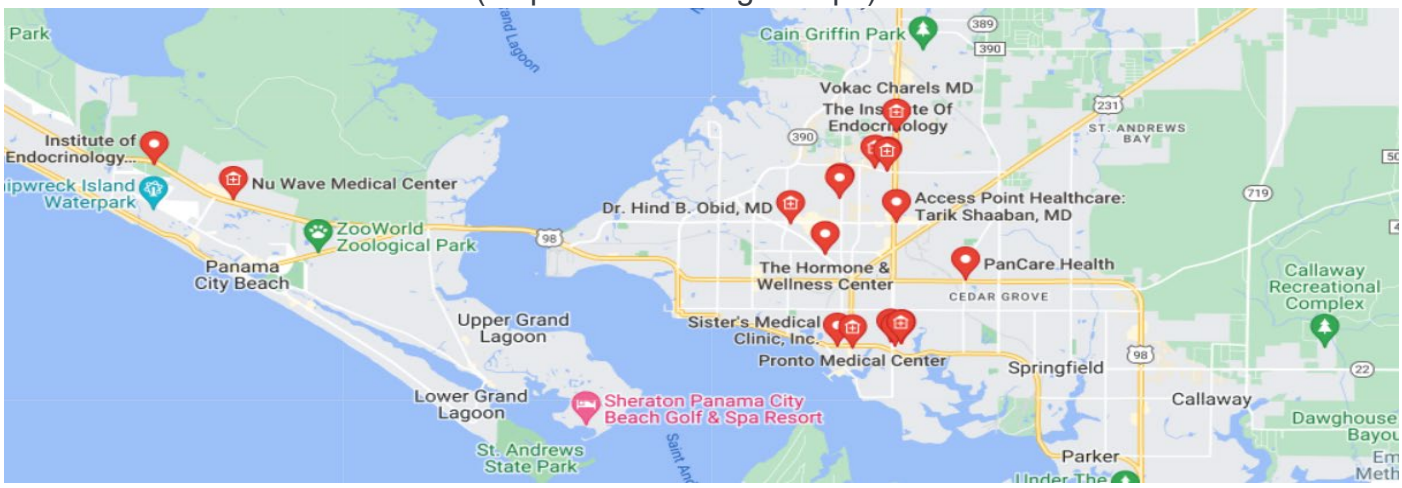
The map below indicates the only two (2) Endocrinologist providers located in Bay County. Both providers take private insurance but only one (1) is in network with Medicaid, Medicare and Tricare. (Source: https://www.iedhh.com/about-us-insurance-info.aspx and https://www.healthgrades.com/physician/dr-amir-manzoor-39vcd)

(Map Source: Google Maps)



The map below indicates doctors and clinics that provide diabetes services for Bay County residents, however, not all doctors are considered specialist in this field.

(Map Source: Google Maps)



2021 Physician Workforce Annual Report

Appendix C: Specialty Group Counts by County, 2020–21

This table represents a count of physicians by county and specialty[28].

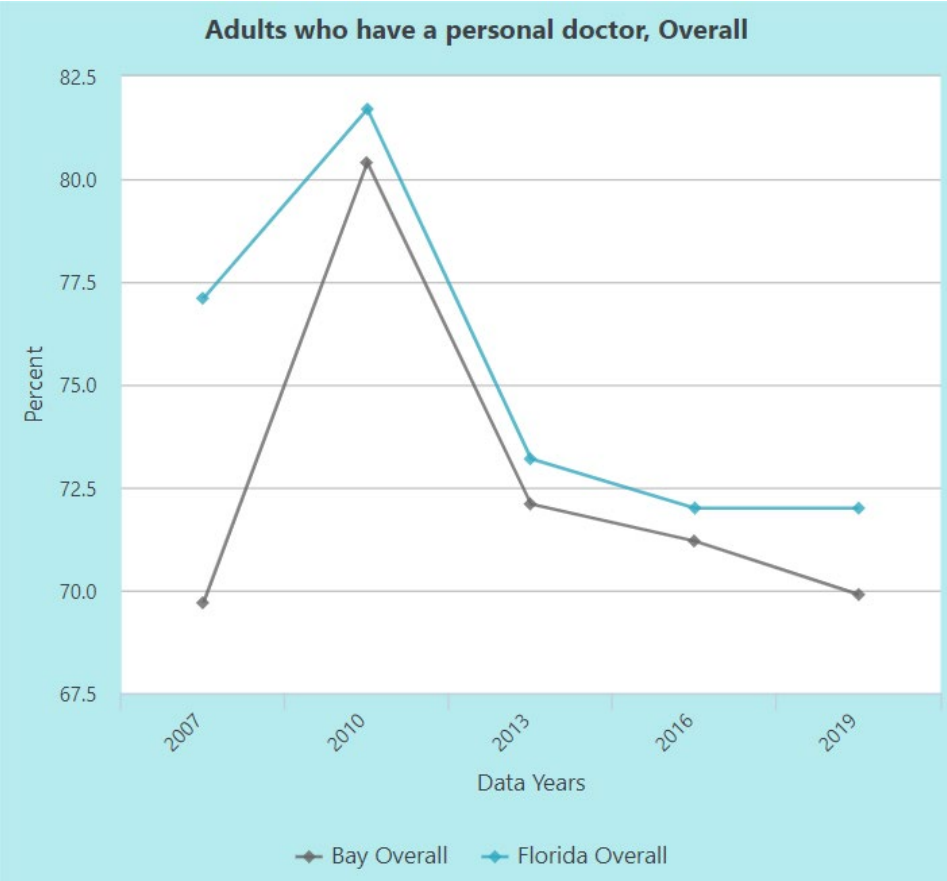
Specialty	Alachua	Baker	Bay	Bradford	Brevard	Broward
Anesthesiology	148	0	23	1	84	359
Dermatology	26	1	5	0	27	109
Emergency Medicine	89	6	32	3	82	292
Family Medicine	171	10	54	8	198	621
Internal Medicine	462	6	103	5	409	1,420
Medical Genetics	6	0	0	0	0	5
Neurology	61	0	12	2	45	119
Nuclear Medicine	2	0	1	0	2	5
Obstetrics & Gynecology	66	1	21	1	57	289
Ophthalmology	34	0	6	0	35	125
Orthopedic Medicine	21	0	15	0	31	125
Otolaryngology	28	0	6	0	21	59
Pathology	54	1	2	0	18	87
Pediatrics	167	1	24	3	80	433
Physical Medicine & Rehabilitation	21	0	1	0	23	73
Preventive Medicine	2	0	1	0	17	14
Proctology	0	0	0	0	0	2
Psychiatry	96	10	21	2	48	196
Radiology	112	0	20	0	76	225
Surgery	127	0	38	2	91	406
Urology	10	0	5	0	10	45
TOTAL	1,703	36	390	27	1,354	5,009

Provider Availability

The data about **Adults who have a personal doctor** comes from the state-based telephone surveillance system called the Behavioral Risk Factor Surveillance System (BRFSS).

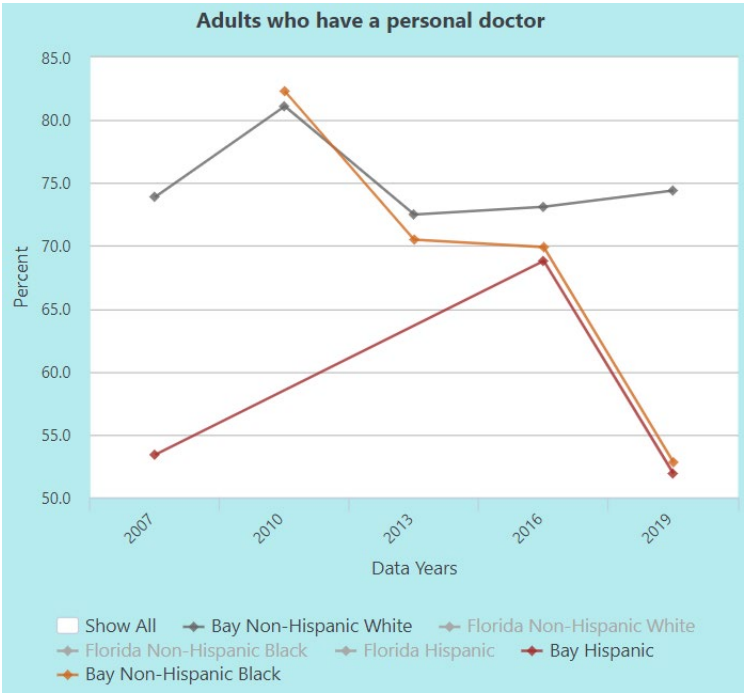
Since behaviors impact health, this knowledge is a powerful tool for targeting and building health promotion activities. It also provides a way to see change in population health behaviors before morbidity or disease is apparent.

As of **2019, in Bay County, 69.9% of adults who have a personal doctor (Overall)** can be compared to **72%** statewide. The line graph shows change over time. (Source: FLCHARTS)

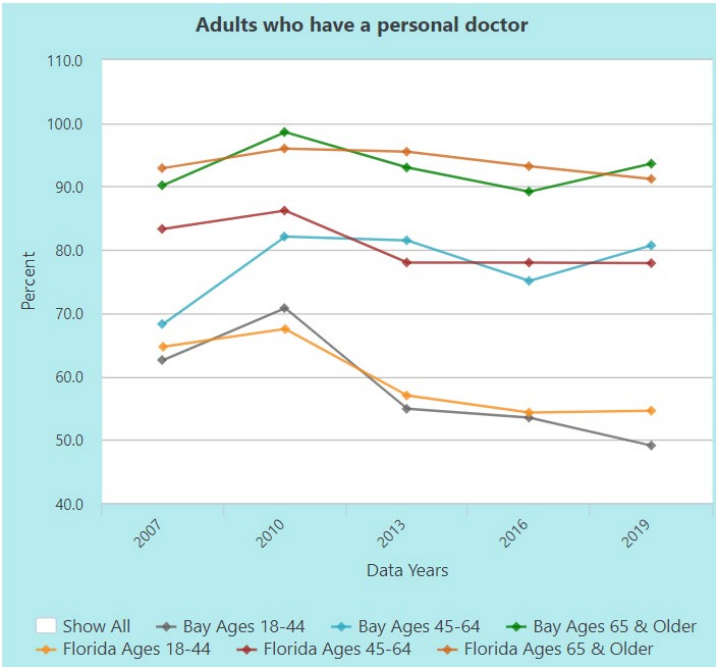


Studies show that men have a significantly lower percentage than women of having a personal doctor. In **2019, in Bay County, only 61.5% of men reported to have a personal doctor** which can be compared to **78.2% of women in Bay County**. This could be related to the availability of healthcare provided by employers who have a predominantly male workforce as compared to a predominantly female workforce.

Also, when comparing by race, Non-Hispanic White has a much higher percentage of having a personal doctor than Non-Hispanic Black or Hispanic. In **2019, in Bay County, 74.4% Non-Hispanic Whites** reported **having a personal doctor compared to 52.8% Non-Hispanic Blacks and 51.9% Hispanics** as shown in the graph below. (Source: FLCHARTS)



We can also see a disparity of access to care in the young to middle aged adults. In **2019, in Bay County, Adults who have a personal doctor were 49.1% for ages of 18-44, 80.7% for ages 45-64, and 93.6% for ages 65 & older.** These number are similar to the numbers report for the State of Florida as shown in the graph below. (Source: FLCHARTS)



Provider Linguistic, Health Literacy & Cultural Competency

According to the U.S. Census Bureau, ACS 5-year 2016-2020 report, there are 164,394 Bay County residents with the ability to speak English very well and 4,974 Bay County residents with the ability to speak English less than very well. In looking at the languages spoken at home, we see that 155,231 residents speak English, whereas 6,680 residents speak Spanish, 3,258 speak Asian-Pacific and 4,199 speak some other language other than English.

Callout in Bay County, FL

155,231
People
Language Spoken at Home - English Only
Bay County, FL

6,680
People
Language Spoken at Home - Spanish
Bay County, FL

3,516
People
Language Spoken at Home - Other Indo-European
Bay County, FL

3,258
People
Language Spoken at Home - Asian-Pacific Islander
Bay County, FL

683
People
Language Spoken at Home - Other
Bay County, FL

Sources: US Census Bureau ACS 5-year 2016-2020

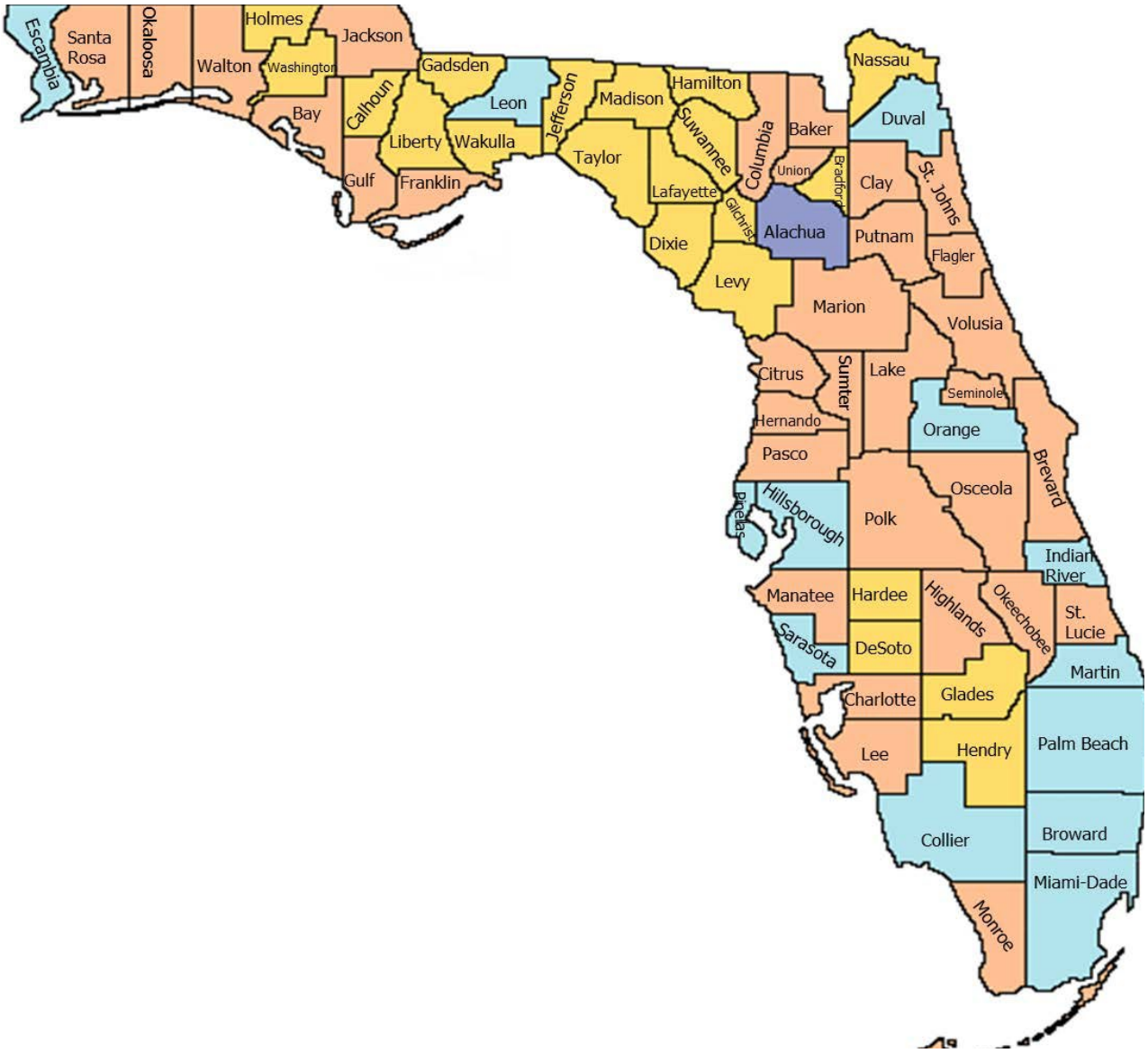
According to Zocdoc.com, there are 187 providers that have registered in Bay County that speak Spanish, Asian-Pacific or Mandarin. Also, according to the Department of Health 2021 Physician Workforce annual report, in 2020-2021 there were 403 practicing physicians with 46% of those practicing physicians speaking languages other than English.

Figure B-1: Number of Practicing Physicians by County by Year

* Rural Counties per 381.0406, Florida Statutes

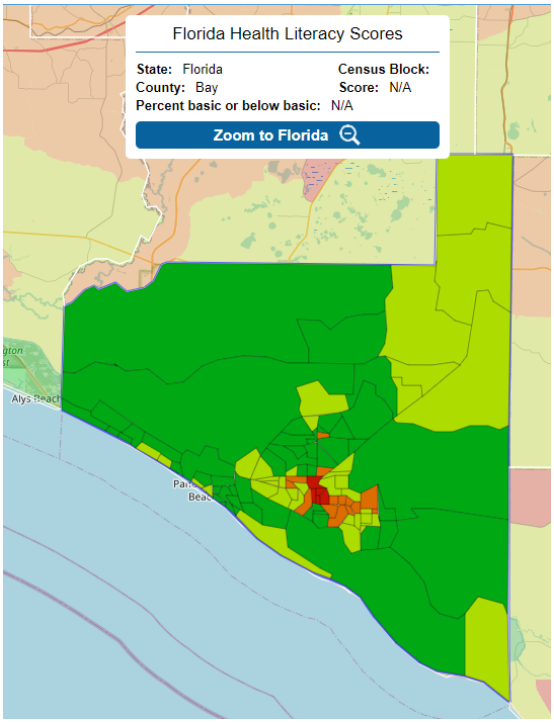
County	2013–14	2014–15	2015–16	2016–17	2017–18	2018–19	2019–20	2020–21
Alachua	1,370	1,426	1,443	1,429	1,615	1,666	1,707	1,754
Baker*	42	38	37	39	46	40	37	36
Bay	380	380	395	400	424	418	420	403

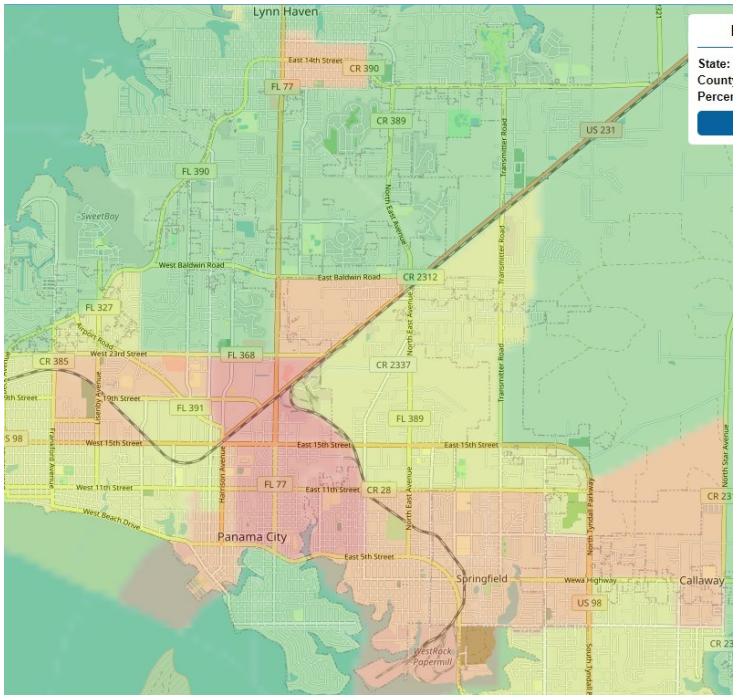
This map illustrates a per capita distribution of practicing physicians at the county level. Miami-Dade, Broward and Palm Beach Counties combined have almost one-third (31.8%) of all practicing physicians in Florida. Miami-Dade County alone has 14.4% of all practicing physicians. Even though these are the three most populous counties, when looking at the per capita distribution (number of physicians per 10,000 population) of physicians shown on the map below, the counties of Alachua (64.9), Duval (34.9), Sarasota (31.8), Escambia (31.6) and Pinellas (30.4) have the highest per capita rate. There are 21 counties (31.3%) to include Bay County, whose per capita rate is 10 or less.


Escambia
Santa Rosa
Okaloosa
Walton
Holmes
Washington
Jackson
Bay
Calhoun
Gadsden
Leon
Liberty
Wakulla
Jefferson
Gulf
Franklin
Madison
Taylor
Hamilton
Suwannee
Lafayette
Columbia
Baker
Union
Bradford
Nassau
Duval
Clay
St. Johns
Gilchrist
Alachua
Putnam
Flagler
Dixie
Levy
Marion
Volusia
Citrus
Sumter
Lake
Seminole
Hernando
Orange
Pasco
Brevard
Pinellas
Hillsborough
Polk
Osceola
Indian River
Manatee
Hardee
Highlands
Okeechobee
St. Lucie
Sarasota
DeSoto
Martin
Charlotte
Glades
Lee
Hendry
Palm Beach
Collier
Broward
Miami-Dade
Monroe

According to the national center for education statistics, through the (PIAAC) Program for International Assessment of Adult Health Literacy, Bay is at 18.4% that are at or below a level 1 literacy level. 5.7% are foreign born and 25.6% are 150% below poverty level. Education levels for Bay are as follows, 10.9% less than HS, 30.9% HS or GED, and 58.2% higher than HS education.

- **Level 1 skills** - having reading and writing abilities in the range of not being able to work with print material, to be able to read and understand short materials and do simple tasks, such as filling out forms.
- **Level 2 skills** - better, but still struggling with reading and writing abilities, including being able to read and understand print and digital materials and compare and contrast between materials with better understanding.
- **Level 3 skills** - considered proficient in reading and writing abilities, with the ability to understand complex materials and make inferences from them.





National Health Literacy Mapping to Inform Health Care Policy. Health Literacy Data Map. University of North Carolina at Chapel Hill, 2014. Web. 01 June 2015

5 census locations in Quartile 1. 14 census locations in Quartile 2.

- **The impact of health care access and quality on Diabetes and Chronic Disease**

Health Care Access and Quality		
SDOH	**Vulnerable Populations Impacted**	**How the SDOH Impacts (Health Disparity)**
Type of Insurance coverage	Uninsured Hispanic	Delaying and/or avoiding healthcare such as preventative care leads to chronic diseases affecting both the mental and physical well-being
Specialty clinics	Diabetic population	With only two endocrinologists in the area and only one of them accepting Medicaid, leaves a gap for opportunity when it comes to Diabetes. In addition, neither clinic is near a transportation route.
Health Coverage	Insured and underinsured	Whether insured or underinsured, the cost of health care coverage overall is too costly to pursue seeking medical care
Provider Linguistic and Cultural Competency	Hispanic and other non-English speaking communities	With 46% of physicians speaking another language other than English, is a positive change within our community
Provider Availability	Non-Hispanic Black; Hispanic; Men; young adults 18-44	Those without a personal doctor generally do not seek self-care, therefore resulting in the early development and prolonged development of chronic disease which may lead to morbidity.

Vulnerable Populations- Disabled persons

Living with a disability is expensive and can require spending on medication and frequent health care visits, a wheelchair-accessible vehicle, in-home personal assistance, and adaptive devices and clothing, along with the usual costs of living. Living with serious illness only worsens these financial stresses.

According to an analysis of the Health Disparities Among People living with Disability ages 18 to 65, conducted by the Knowli Data Science and FSU Claude Pepper Center, in Bay County, disabled veterans make up 12% (21,000 veterans) of the disabled population. In addition, immigrants are 6.7% of the population in Bay County living with disabilities, with the total disabled population at 14.9%.

VIII. SDOH PROJECTS

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

A. Data Review

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

The Health Equity Taskforce utilized the Community Health Assessment county-level data that was collected for 163 health status indicators and 28 demographic indicators. As a benchmark, individual performance of Bay County was compared to that of Florida state. To identify overall themes, results were analyzed using the County Health Rankings Model for population health that emphasized the impact of health factors, such as behavior, clinical care, socioeconomic and physical environment, on the health outcomes of mortality, length of life, morbidity and quality of life.

Bay County performed worse than the state in 105 of the 163 indicators: with 61 indicators showing a worsening trend. On June 6, 2022, a presentation of the assessment and indicator findings was provided to seven community partners which included the MAPP process, and the health indicators by performance. Following the presentation and discussion, the community partners selected Chronic Disease to include diabetes and obesity as the health priority. The Health Equity Plan was created based on these results to address the inequities in Bay County.

In Bay County, the Hispanic population, ages 45 and older, are 57 percent more at risk of diabetes, compared to Non-Hispanic White at 11.2% and Non-Hispanic Black at 10.4%; compared to Florida at a conglomerate 12.7%. African American adults are 60 percent more likely than non-Hispanic white adults to be diagnosed with diabetes by a physician. Please see table below for reference.

For additional diabetes disparities in relation to priority population, refer to pages 20-30.

Adults who have ever been told they had diabetes						
	Bay			Florida		
Year	Non-Hispanic White	Non-Hispanic Black	Hispanic	Non-Hispanic White	Non-Hispanic Black	Hispanic
2019	11.2% (8.3% - 14.1%)	10.4% (3.7% - 17%)	18.9% (7.4% - 30.5%)	11.5% (10.5% - 12.4%)	16% (12.8% - 19.1%)	10.6% (8.2% - 13.1%)
2016	12.7% (8.8% - 16.5%)	21.7% (10.2% - 33.3%)	12.4% (3.9% - 20.8%)	11.5% (10.8% - 12.2%)	14.5% (12.3% - 16.8%)	10.9% (9.3% - 12.6%)
2013	12.3% (8.7% - 15.9%)	11.9% (0.8% - 23.1%)		11.4% (10.7% - 12.2%)	12.3% (10% - 14.6%)	10.8% (8.7% - 12.8%)
2010	9.9% (6.9% - 13%)	7.6% (0% - 15.9%)		10.1% (9.4% - 10.7%)	13.1% (10.7% - 15.5%)	9.6% (7.2% - 12.1%)
2007	10.3% (7.6% - 13.9%)		17.5% (3.3% - 56.7%)	9% (8.4% - 9.6%)	12.4% (10.4% - 14.8%)	6.6% (5.2% - 8.2%)
2002	8.8% (5.7% - 11.9%)	10.8% (1.3% - 20.4%)		8% (7.4% - 8.6%)	10.6% (8.2% - 13.1%)	7.1% (5% - 9.2%)

Source: FLCHARTS

B. Barrier Identification

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

Partners	SDOH	Partner Barriers	Theme	Collaborative Strategies
Tricia Pearce/DOH	Community and Social Impacts	Overtaxed/overwhelmed partners	Financial & Resources	Bring resources together for a broader reach; no more silos
Dixie Williams/DOH	Community and Social Impacts Health Care Systems	Referrals for Care Community involvement Reach to target community Funding	Resources	Bring resources together for a broader reach; no more silos
Michael Harris/Bay County Public Library	Education	Connecting to Social Service Agencies Overtaxed/overwhelmed partners Connecting to target communities	Financial & Resources	Bring resources together for a broader reach; no more silos
Janice Lucas/ LEAD	Physical Environment Food	TBD	TBD	TBD

	Community and Social Impact			
Sandy Culbreth/Bay County	Physical Environment	Reduction in use Funding	Financial	Bring resources together for a broader reach; no more silos
Melanie Taylor/UFAS		TBD	TBD	TBD

C. Community Projects

The Health Equity (HE) 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. (Selection Matrix utilized to determine feasibility)

The Mobilizing for Action through Planning & Partnerships (MAPP) process was utilized to conduct the health equity assessments. The MAPP process is a community-driven strategic planning process for improving community health and is comprised of four individual assessments such as the Community Themes & Strengths, Forces of Change, the Local Public Health System Assessment and the Community Health Status Assessment. This process includes analysis of

health data that identifies factors and indicators contributing to disparities in health outcomes for Bay County residents.

The HE Taskforce also considered the Guide to Implementing the National CLAS Standards for racial, ethnic, and linguistic minorities, people with disabilities and sexual and gender minorities. The four Culturally and Linguistically Appropriate Services (CLAS) standard themes were used during the data gathering process: 1) Principal Standard; 2) Governance, Leadership and Workforce; 3) Communication and Language Assistance; 4) Engagement, Continuous Improvement and Accountability. Five (5) populations were targeted by these resources: people with disabilities, people with limited English proficiency, people with low health literacy, racial/ethnic minorities, and sexual and gender minorities. **Refer to pages 20-24, 28-30, 44,54, 57, 63-64 and 66-69 for correlated data sets**.

The assessment provided relevant information to community partners regarding the health status of all Bay County residents, and included results from resident knowledge, attitudes, beliefs, and behavior surveys as well as discussions of influences outside of the public health system that impact service provision. The HE Taskforce updated the HE Plan to provide expanded information on the health literacy and healthier lifestyle status of Bay County residents and geographical data by census tract. The HE Plan puts the community priorities into action by designing strategies with measurable outcomes.

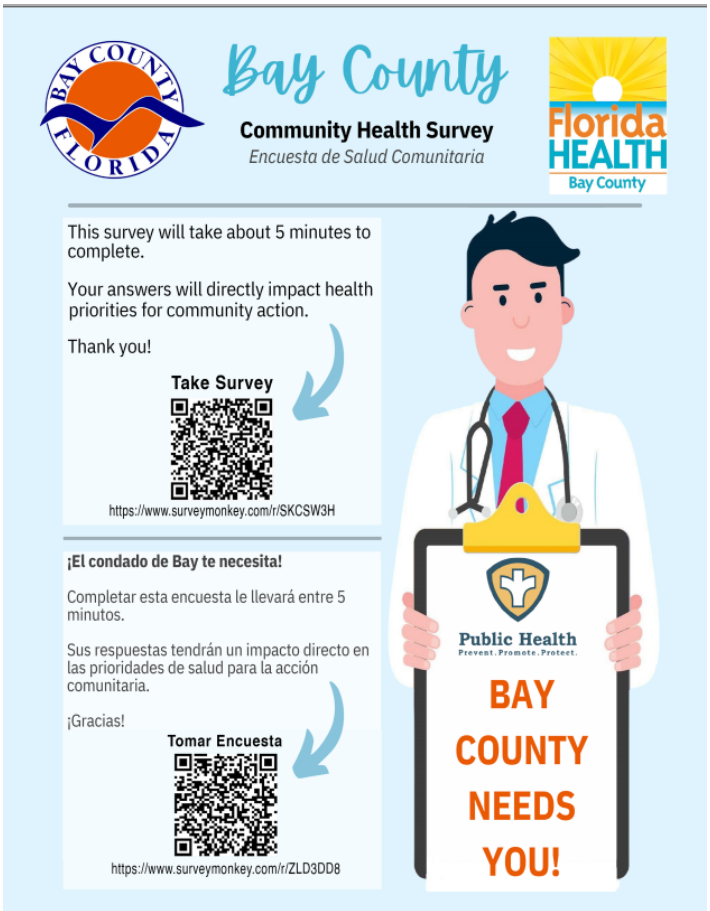
During development of the HE Plan, consideration was given to the social determinants of health, causes of higher health risks and health inequities. Strategies may include creating or expanding services provided by partnership member organizations, recommendations for policy changes that address social and economic conditions that influence health, and strategies to further engage stakeholders such as involving those priority populations in the development and review. Strategies and interventions are developed using evidence-based health interventions. (See appendix B for Forces of Change brainstorming matrix and Strengths, Weaknesses, Opportunities & Threats (SWOT) analysis, which indicates the basis for those recommended health interventions.)

In addition, the Florida Department of Health in Bay County formed a diverse workgroup of community partners to oversee the community health assessment as well as the four individual health analyses. Once the community health assessment was developed, Bay CHD formed four subcommittees (corresponding to the Bay County Community Health Improvement Plan's priority areas) with one of those subcommittees being the Health Equity Taskforce, which will continue to meet and assist in the annual review and update of the community health assessment plan. Each of the four (4) subcommittees have action items and indicators designed to meet committee goals which are directly linked to the Community health Improvement Plan (CHIP) and the Health Equity Plan. Through this process, multiple points of input are considered thereby allowing the health equity assessment to remain current.

The HE Taskforce recognizes that Bay's racial and ethnic populations correlate with health disparities. Despite progress in improving health status of Bay residents, gaps continue to exist in the health status of those with heart disease, diabetes and HIV/AIDS among White, Black and Hispanic races. Addressing the higher rates of death and disease in Bay's racial and ethnic minority groups requires understanding the underlying causes of these disparities and developing strategies to address these risk factors. Addressing these social determinants of health should improve these prioritized health disparities. (See Appendix D)

With diabetes being one of the prevalent health priorities in Bay County, the HE Taskforce looked at contributing factors such as food deserts, healthier food options, and language barriers. Using the countermeasures matrix of what objectives would be attainable (feasible), action items were created to set those objectives into motion. The below objectives table describes each objective to reach the overall goals.

To date, the HE Taskforce has translated plans, educational pamphlets, marketing tools and surveys into Spanish. Increased marketing strategies to broaden the reach into those vulnerable populated areas.



IX. HEALTH EQUITY PLAN OBJECTIVES

A. Neighborhood & Built Environments

- **Health Disparity Goal:** By December 31, 2025, reduce the number of adults who have ever been told they have diabetes from 11.6% to 10%. [data source: Florida Behavioral Risk Factor Surveillance System telephone survey conducted by the Centers for Disease Control and Prevention (CDC) and Florida Department of Health Division of Community Health Promotion]

- **Access to healthier food options: Table**

	Lead Entity and Unit	Lead Point Person	Data Source	Baseline Value	Target Value	Plan Alignment
Long-Term SDOH Goal: Improve community partnerships by combining resources						
Objective 3:1: By December 31, 2025, increase the number of farmers markets that accept SNAP (Florida EBT) from 0 to 5	Bay CHD	Denise Watson/A J Haro/	U.S. Department of Agriculture (USDA) Food and Nutrition Services Florida EBT Farmers Market report; Smarter Florida Farmers Markets that accept SNAP EBT online report	0 (July 2022)	5	Bay CHIP 1.1.3; SHIP Priority Area 2; ASP 1.1.2C
Objective 3:2: By December 31, 2025, expand the number of WIC locations that partner with the farmer's markets from 1 to 3	Bay CHD	Denise Watson/A J Haro	Florida Department of Agriculture Consumer Services/Community Farmers Market report by county, 2022	1 (July 2022)	3	Bay CHIP 1.1.3; SHIP Priority Area 2; ASP 1.1.2C
Medium-Term SDOH Goal: Increase access to healthier foods						
Objective 2:1: By December 31, 2024, increase the number of farmer's market locations in food desert areas from 3 to 5.	Bay CHD/ Bay CHD/Parks & Recs/Gyms	AJ Haro/ Kylee Trenholm/ Liz Hunt	Florida Department of Agriculture Consumer Services/Community Farmers Market report by county, 2022	3 (July 2022)	5	Bay CHIP 1.1.3; SHIP Priority Area 2; ASP 1.1.2C
Short-Term SDOH Goal: Improve food options						

Objective 1:1: By December 31, 2023, increase the number of community farmer's markets from 1 to 5 by incorporating more farmer's market vendors at existing location	Bay CHD/ Parks & Recreation	AJ Haro/ Kylee Trenholm	Florida Department of Agriculture Consumer Services/Community Farmers Market report by county, 2022	1 (July 2022)	5	Bay CHIP 1.1.3; SHIP Priority Area 2; ASP 1.1.2C
Objective:1:2: By December 31, 2023, increase the number of service days provided by farmer's markets from 3 days to 4 days at existing venues.	Bay CHD/	Denise Watson/AJ Haro/	Florida Department of Agriculture Consumer Services/Community Farmers Market report by county, 2022	3 (July 2022)	4	Bay CHIP 1.1.3; SHIP Priority Area 2; ASP 1.1.2C

- **Access to healthier food options funding sources: Health Disparities Grant and Bay CHD General Revenue**

B. Healthcare Access & Quality

- **Health Disparity Goal:** By December 31, 2025, Increase the number of adults with diabetes who ever had diabetes self-management education from 51% to 65%.
- **Education and Health Literacy**

	Lead Entity and Unit	Lead Point Person	Data Source	Baseline Value	Target Value	Plan Alignment
Long-Term SDOH Goal: Improve community partnerships by combining resources						
Objective 1:2: By December 31, 2024, provide cultural competence training to local physicians from 0 to 3	Bay CHD	AJ Haro	Bay CHD HE Plan	0 (July 2022)	3	Bay CHIP 1.1.3; SHIP Priority Area 2; ASP 1.1.2C
Medium-Term SDOH Goal: Increase access to healthier foods						
Objective:1:1: By December 31, 2024, partner with UFAS to conduct adult cooking classes on healthier cooking from 0 to 1 per quarter	Bay CHD/ UFAS	Dixie Williams/ Melanie Taylor	Florida Department of Agriculture Consumer Services/Team Nutrition report by county, 2022	0 (July 2022)	1	Bay CHIP 1.1.3; SHIP Priority Area 2; ASP 1.1.2C
Short-Term SDOH Goal: Improve food options						

Objective 1:2: By December 31, 2023, partner with the Bay County Public Library to provide accurate health resources to more public locations from 2 to 5	Bay County Public Library	Michael Harris	Bay County Public Library Free Library on Wheels reporting	2 (July 2022)	5	Bay CHIP 1.1.3; SHIP Priority Area 2; ASP 1.1.2C

- **Education and Health Literacy funding sources: Health Equity Grant and community partner funding**

X. PERFORMANCE TRACKING AND REPORTING

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

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

Health Liaison tracks and submits indicator values to the OMHHE within 15 days of the quarter end.

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

XI. REVISIONS

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

Revision	Revised By	Revision Date	Rationale for Revision
1	AJ Haro/Brandy Mankin	3/23/22	Input chosen SDOH and data
2	AJ Haro/Brandy Mankin	6/7/22	Input additional data, objectives, processes utilized, team assignments

Appendix A

Coalition Partner List

First Name	Last Name	Organization
Shonta	Covington	14th Judicial Circuit mental health court
Debbie	Edmondson	A New Day Transitional Resource Center, Communications Director
Barbara	Day	AARP , Chapter 1315 President
Terry	Gainer	After School Assistance Program (ASAP)
Nancy	King	Airman and Family Readiness, Center, TAFB
Leslie	Cochran	All About Women
Tonja	Haynes	All American Kids
Ron	Boyce	AMI Kids Panama City Marine Institute
Joel	Booth	Anchorage Children's Home, Executive Director
Teresa	Jones	Ascension Sacred Heart, Patient Experience Manager
Pamela	Williams	Basic of NWFL
Tommy	Hamm	Bay County Board of County Commissioners
Beth	Couliette	Bay County Council on Aging, Inc SEO
David	Morrison	Bay County Emergency Services, Deputy Chief
Frankie	Lumm	Bay County EOP
Bob	Majka	Bay County Government Office
Tammy	Harris	Bay County Housing
Rick	Anglin	Bay County Jail
Don	Myrray	Bay County Parks and Recreation
Dawn	Kirkland	Bay County Police Department
Kara	Mulkuksy	Bay County School District, Director of Student Services
Koren	Colbert	Bay County Sheriff's Department BCSD
Jeremy	Mathis	Bay County Sheriff's Office BCSO
Jessica	Laird	Bay County Tax Collector's Office
Suzanne	Cox	Bay County Teen Court
Lamar	Hobbs	Bay County Transportation
AnnJeanette	Haro	Bay-DOH
Pamm	Chapman	BDS Board
Nancy	Beaupre	Beach Care Service Office Manager
David	Daniels	Big Bend Community Based Care
Christa	Davis	Cardiovascular Instititue
Julie	Ramirez	Career Source, Royal American Management
Delbert	Horton	Chemical Addictions Recovery Effort Inc

Destiny &	Deveron	Global Art Society
Laurie	Combs	Grace Presbyterian Church, Chairman
Jennifer	Burkett	Gulf Coast Addiction Medicine
Lori	Allen	Gulf Coast Children's Advocacy Center
Morgan	Davis	Gulf Coast Regional Medical Center
Michael	Sparks	Gulf Coast Regional Medical Center
Greg	May	Gulf Coast State College Public Safety
Vickie	Johnson	Habitat for Humanity Bay County, program manager
Hang	Mai	HCA HealthCare
Adrienne	Bartle	HealthSouth
Sharon	Trainor	Healthy Start Coalition Bay, Frankiln. Gulf Counties, Inc, Executive Director
Terry	Duke	Holy Nativity Espiscopol School
Morgan	Burleson	Homeless Coalition of NWFL
Betty	Atkinson	Hope 29:11 Resources
M	Whitfield	Journey Pure
Janice	Lucas	LEAD Coalition of Bay
Lisa	Boer	Life Management Center
Carol	Justice	Merrick Industries HR
Shanta	Sapp	My Florida Families
Melissa	Beadle	MyGULFCare, Inc. Ascension, Population Health
Vence	Monlyn	Non Secure Programs, Inc./Keeton House
David	Tatom	North West Florida State College
Angela	Martin	Northstar Church
Ann	Wing	Northwest Florida Health Network Cordinator Circuit 14
Chris	Hockman	Oxford House, Inc.
Debbie	Ward	Panama City Beach Communications Director
Robert	Clarkson	Panama City Beach Police
J. Michael	Brown	Panama City Beach TDC
Billy	Rader	Panama City Commissioner Ward 3
Paul	Powell	Panama City Police Department, Deputy Chief
Steven	Fett	Panana City Rescue Mission
Kyle	Merritt	PanCare, Inc., marketing, communications, and Grant Management
Beach	Chamber	PCB Chamber of Commerce
Elizabeth	MacKenn	Rebuild Florida

Alisha	Townsend	Choose Covenant
Ben	Janke	City of Lynn Haven Economic Development Director
Toni	Shamplain	City of Panama City, CRA Manager
Vicki	Sandoval	City of Panama City, Manager of Utility Billing and Customer Service
Angelique	VanPatters	Commander, Health Care Operations Squadron
Christy	Evans	Community Health and Rehab
Jo	Schaffer	Community Resource Associates, Director and Managing Member
Janice	McEuen	Covenant Hospice
Wendy	Fletcher-Al	Department of Children and Families
Brian	Addison	Department of Environmental Protection
Julia	Robertson	Department of Juvenile Justice
Robert	Cox	Disability Resource Center, Inc., Exec. Director
Shelley	Frazier	Doorways/NAACP
Janice	Flowers	Early Education and Care Head Start Program
Toshiya	Connor	Early Education and Care, Inc.
Donna	Carnley	Early Learning Coalition
Jenice	Owens-Ada	Eastern Industries
Casey	Rogers	Emerald Coast Behavioral
Kimberly	Womack	Emerald Coast Forensic Services
Michelle	Flaat	Emerald Coast Medical Association
Jessica	Elkins Hoch	Emerald Coast Research
Regina	Becker	Emerald Shores Health and Rehab
Eric	Kunzman	Emergency Mangement Planner
Lora	Ponds	Encompass Health and Rehabilitation Hospital
Betty	Gehrken	Family Service Agency of Bay County, Inc Operations Manager
Dr. Melissa	Paris	First Baptist Church
Beth	Richardson	First United Methodist Church
Frederick	Womack	Fl Dept. of Juvenille Justice, Probation and Community Intervention Services
Martin	Sheffield	Florida Health Conncetor/Florida Blue President
Suzanne	Clark	Florida State University PC Campus, Social Work Professor
Drew	Hild	Florida Therapy
John Tory	Peek	FSU-PC/Public Health
Rebecca	Wade	Girls Inc. of Bay County Program Director

Bill	Swift	Glendwood Community
Jerry	Kindle	Red Cross of NWFL
Beverly	Brown	Renew
Jennifer	Anderson	Royal American Companies
Robert	Harned	SAIC Careers
Jayne	Fowler	Salvation Army Domestic Violence
Rhonda	Brannon	Sea Oaks Medical Clinic
Jone	Cupp	Second Chance of Northwest Florida, Inc
Deliliah	Dennis	Select Medical Director of QA
Amy	Blackburn	Select Specialty Hospital Panama City Quality Coordinator
Lisa	Bell	Signs Unlimited
Delbert	Summey	St. Andrews Community Medical Center, President, Board of Directors
Laurie	Hughes	State Attorney's Office Circuit 14
Gregory	Dossie	Student Advocacy Center, Inc
Robin	Smith	Sunshine Health (insurance) formally wellcare/staywell
Ron	Sharpe	The Arc of the Bay Executive Director
Patrick	McCreless	The Panama City News Herald
Cathy	Byrd	Titus 2 Partnership, Inc. Substance Abuse/ Lynn Haven Methodist Church
Darrell	Torbett	Treatment Center of Panama City
Christine	McGill	Tyndall Air Force Base Sexual Assualt Response Coordinator/Prgm manager
Rita	Miller	Unique Nourishment (Health Coach)
Littleton	Gina	United Way of NWFL
Marjorie	Moore	University of Florida IFAS Extension Extension Director
Catherine	Montfort	US Navy Fleet and Family Support Center, Sexual Assault Response Coordinator
Matthew	Standish	Vet Center
Dan	Rowe	Visit Panama City Beach TDC
Blaze	Maselli	Walgreens
Ronnie	Barnes	waterfront markets (farmers Market)
Donna	Bell	WJHG News Channel 7
Tom	Lewis	WMBB News Channel 13
Michael	Harris	Bay County Library

Appendix B-Strengths, Weaknesses, Opportunities & Threats (SWOT) Analysis

Directions: Please take a few minutes to share your feedback. Your input is important.

The three categories of Health Equity: Social Determinants of Health, Health inequities, and Health Disparties

Consider the following: Economic Stability (e.g., employment, food insecurity, housing instability, poverty); Neighborhood and Physical Environment (e.g., access to healthy foods, transportation, crime & violence, environmental conditions, quality of housing); Education (e.g., early childhood education & development, enrollment in higher education, high school graduation, language & literacy); Community and Social Context (e.g., civic participation, discrimination, incarceration, social justice); Health Care System (e.g., access to quality health care, access to primary care, health literacy)

Strengths	Weaknesses	Opportunities	Threats
Natural Resources	Community Involvement	Transporation directly to parks/J. Moody Harris Park Urban Ecology Center	Weather/Climate/Environmental conditions
Higher Education options(FSU, Troy, Gulf Coast)/Vocational Schools	Access to healthy affordable foods/Healthy fast-food options/food deserts	Improve outlook on the way the community looks at our hospitals/Changing attitudes/views of past experiences	Finances/Economy
Climate	Public Transportation	Increased enrollment in early education	Increase in area unemployment rate/Workforce
Public Library System	Lack of affordable housing/quality housing	Bring back "850strong" mentality	Wages not at a level where residents can fully integrate into society
Low Crime/Low Discrimination	Lack of effort to relocate/house the homeless	Central location for all information(each partner to reference one website)/Increased sharing of resources	Increased rates of health disparities/Underinsured/affordable health insurance
Social Service Organizations	Doctor availability/Specialty Care	Health literacy classes/Translation services	High costs for healthier foods
Outdoor recreational facilities	Mental Health workers/access	Multi-Sector Collaborated Community events	Discrimination/racism/gentrification
Large variety of community organizations/Hospital growth/ER on beach & 231/WI Clinics	Lack of concern/care for those that suffer from mental health	How federal funding from H. Michael are allocated/Data on employment opportunities & salaries	Lack of civic participation in helping to fix areas of weakness
Grant/Funding opportunities	Low Pay vs. cost of living/financial & economic instabilities due to H. Michael and COVID	Grocery stores in low income areas/Community gardening/hydroponic	Bad attitudes/frustration/exhaustion/ survival mode from H. Michael & Pandemic/lack of cleanup contributes
Public Transporation	Decreased education/graduation	New hospital built as training facility	Increased population puts more demand on current resources

Many grocery stores & farmer's markets	Increased crime rates/job opportunities for those with felonies	Increased population to bring in more resources	Unaffordable housing
New housing/building	Affordable healthcare	Bike lanes added to streets & education on how to utilize	High crime rates
Non-profit healthcare clinics/free clinics	Outdoor facility damage due to H. Michael	Clean damaged parks/hanging power lines/post H. Michael/Covid rebuild	Mental health due to multiple disasters/COVID/fires/H. Michael
Community acknowledgement of needs/Increased civic participation	Bilingual community professionals	Newly formed HE task force/New partnerships	Lack of specialty care
H. Michael cleanup and rebuild	Silos of organizations	Community education and engagement for civic & neighborhood involvement	
Forgotten communities/Millville/ Glenwood	Rural areas/Outlying areas		
Lots of job opportunities			
Communication/Promotion for health literacy			

Appendix C- Forces of Change Brainstorming Matrix

1	Question:	Answer:
2	What patterns of decisions, policies, investments, rules and laws affect the health of our community?	housing prices but reduced lot sizes, bringing in more people, housing shortages, not adding parks/green spaces, schools,limited trolley stops, landscaping, salary vs. cost of living ratio, war in other countries, bilingual care, unaffordable healthcare and insurance, priortizing the needs of vulnerable populatlions,
3	Who benefits from these decisions, policies, investments, rules and laws?	Youth, Children and infants, Workforce, city benefits through taxes, developers benefit, investors increasing rental prices (too high), material availability to those coming to area, those looking for better life outside of area, lack of enforcement only benefits those with status quo,
4	Whom do these decisions, policies, investments, rules and laws harm?	Those without the same support due to education or transportation, those working but underpaid, low income and cannot afford housing, rebuilding communities being flooded, families lack green space, safe areas to play, long wait times for healthcare appointments, those w/affordable insurance possibly penalized to cover the costs of low-income populations, unaware of policies,
5	Who or what institutions have the power to create, enforce, implement, and change these decisions, policies, investments, rules and laws?	Government agencies, lobbyists, county workgroups, boys and girls organizations, women's organizations, local businesses, school boards, developers, financial stress contributing to mental health, elected officials believe the market will correct itself, insurance companies, healthcare facilities, local/state/federal government,
6	What interests support or oppose actions that contribute to health inequity?	Too many fast food restaurants, transporation funding, support- private & non-proft orgs, city commissioners, developers, overall care to include healthier eating are too costly, public officials worried about spending too much/tax payer increases, decision-makers haven't the understanding why affordable ins/healthcare is important,

	A	B
7	What opportunities exist to influence decisions, policies, investments, rules and laws to benefit all groups?	Parks & Recreation, Petitioning county commissioners, educating communities to get involved through gov't meetings, look at community meeting hours, multicultural areas healthcare literacy, Data showing improvement, education on the true cost of healthcare/ins,
8	What forces now and in the future can reinforce health inequity in our community? How can we mitigate or prevent these forces?	Affordable and better housing, better paying jobs, grants, education, combining resources, educating local gov't & businesses, education on ordinances, translation services, acceptance of change, encourage good habits, education in general, climate/disasters, health literacy

Appendix D- SDOH Storyboards

PDCA Storyboard

Plan Do Check Act

Contact Information

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Goals and Objectives

Refer to the Tables in the Health Equity Plan (pages 54-57) for all project goals and objectives

Background

The HE Taskforce recognizes that Bay's racial and ethnic populations correlate with health disparities. Despite progress in improving health status of Bay residents, gaps continue to exist in the health status of those with heart disease, diabetes and HIV/AIDS among White, Black and Hispanic races. Addressing the higher rates of death and disease in Bay's racial and ethnic minority groups requires understanding the underlying causes of these disparities and developing strategies to address these risk factors. With diabetes being one of the prevalent health priorities in Bay County, the HE Taskforce looked at contributing factors such as food deserts, healthier food options, and language barriers. Using the countermeasures matrix of what objectives would be attainable (feasible), action items were created to set those objectives into motion

SDOH Addressed

Neighborhood and Built Environment

Baseline Data/Root Causes

Data Sources: Florida Behavioral Risk Factor Surveillance System telephone survey conducted by the Centers for Disease Control and Prevention (CDC) and Florida Department of Health Division of Community Health Promotion

Root Causes: In 2013, in Bay County, 13.2% of adults Who Consumed Five or More Servings of Fruits or Vegetables per Day (Overall) can be compared to 18.3% statewide. In looking at the contributing causes of diabetes and chronic diseases, we also needed to research what foods residents in Bay County had access to. According to several data sources, 16.5% of Bay County residents have access to healthy food sources within a short drive, with the state at 27.7%: while 21.3% of Bay County residents having access to unhealthier foods within a short drive, such as fast-food restaurants.

Results/Lessons Learned

To be determined upon project completion

AIM Statement

By December 31, 2025, reduce the number of adults who have ever been told they have diabetes from 11.6% to 10%.

Priority Population

Low Income Families, Low Income neighborhoods, Rural neighborhoods, Diabetic/Chronic Disease population

PDCA Storyboard

Plan Do Check Act

Contact Information

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DOH- Bay County, Bay County Public Library, LEAD Coalition, Parks & Recreation, Panama City Housing Authority, UF_IFAS

Goals and Objectives

Refer to the Tables in the Health Equity Plan (pages 54-57) for all project goals and objectives

Background

The Health Equity (HE) Taskforce researched evidence-based strategies to overcome the identified barriers and improve the SDOH that impact the prioritized health disparity. The Mobilizing for Action through Planning & Partnerships (MAPP) process was utilized to conduct the health equity assessments. This process includes analysis of health data that identifies factors and indicators contributing to disparities in health outcomes for Bay County residents. The assessment provided relevant information to community partners regarding the health status of all Bay County residents, and included results from resident knowledge, attitudes, beliefs, and behavior surveys as well as discussions of influences outside of the public health system that impact service provision. Bay County performed worse than the state in 105 of the 163 indicators: with 61 indicators showing a worsening trend. On June 6, 2022, a presentation of the assessment and indicator findings was provided to seven community partners which included the MAPP process, and the health indicators by performance. Following the presentation and discussion, the community partners selected Chronic Disease to include diabetes and obesity as the health priority

SDOH Addressed

Healthcare Access and Quality

Baseline Data/Root Causes

Data Sources: Florida Behavioral Risk Factor Surveillance System telephone survey conducted by the Centers for Disease Control and Prevention (CDC) and Florida Department of Health Division of Community Health Promotion

Root Causes: As of 2019, in Bay County, 16.4% of adults who could not see a doctor in the past year due to cost (Overall) can be compared to 16% statewide. In 2020, the percentage of Civilian non-institutionalized population with health insurance in Bay County was 86.4 and only 69.9% of adults have a personal doctor. In addition, there are only two endocrinologist providers located in Bay County. Therefore, those without a personal doctor generally do not seek self-care, therefore resulting in the early development and prolonged development of chronic disease which may lead to morbidity. Also, with only two endocrinologists in the area and only one of them accepting Medicaid, leaves a gap for opportunity when it comes to Diabetes. In addition, neither clinic is near a transportation route The Bay CHD Diabetes program is the only location that provides education to uninsured and underinsured patients.

Results/Lessons Learned

To be determined upon project completion

AIM Statement

By December 31, 2025, Increase the number of adults with diabetes who ever had diabetes self-management education from 51% to 65%.

Priority Population

Low Income Families, Low Income neighborhoods, Rural neighborhoods, Diabetic/Chronic Disease population