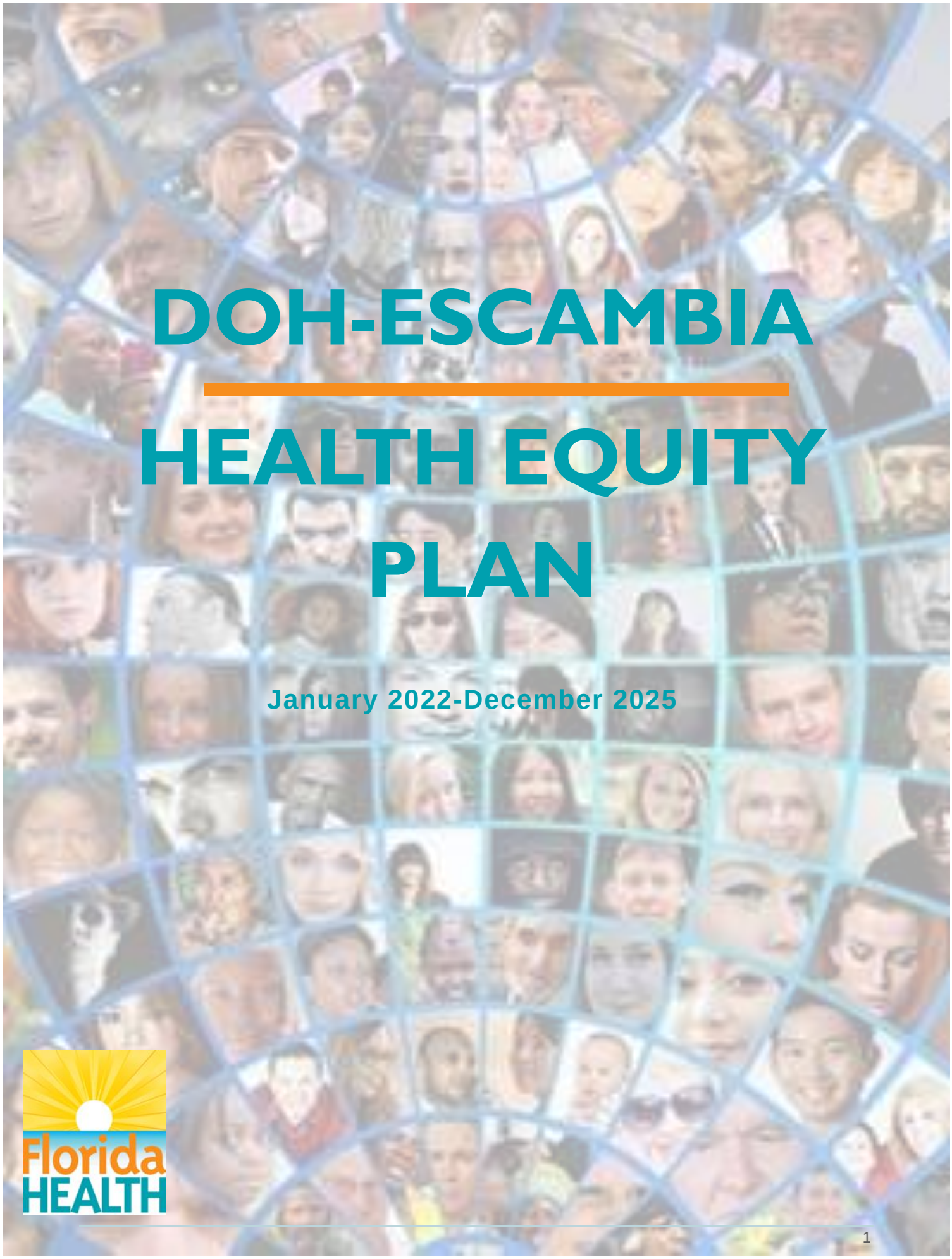


DOH-ESCAMBIA

HEALTH EQUITY PLAN

January 2022-December 2025

Florida HEALTH

Table of Contents

I. Vision 4

II. Purpose of the Health Equity Plan 6

III. Definitions 7

IV. Participation 8

A. Minority Health Liaison 10

B. Health Equity Team 10

C. Health Equity Taskforce 11

D. Coalition 14

E. Regional Health Equity Coordinators... 14

V. Health Equity Assessment, Training, and Promotion 15

A. Health Equity Assessments 15

B. County Health Equity Training 20

C. County Health Department Health Equity Training 22

D. Minority Health Liaison Training 23

E. National Minority Health Month Promotion 24

VI. Prioritizing a Health Disparity 28

VII. SDOH Data 35

A. Education Access and Quality 36

B. Economic Stability 38

C. Neighborhood and Built Environment .. 42

D. Social and Community Context……..45

E. Health Care Access and Quality 47

VIII. SDOH Projects 49

A. Data Review 49

B. Barrier Identification 55

C. Community Projects 56
IX. Health Equity Plan Objectives..... 59
A. (Prioritized Health Disparity)
X. Performance Tracking and Reporting 61
XI. Revisions 62
XII. References……..58
XIII. Appendix A…….66

I. VISION

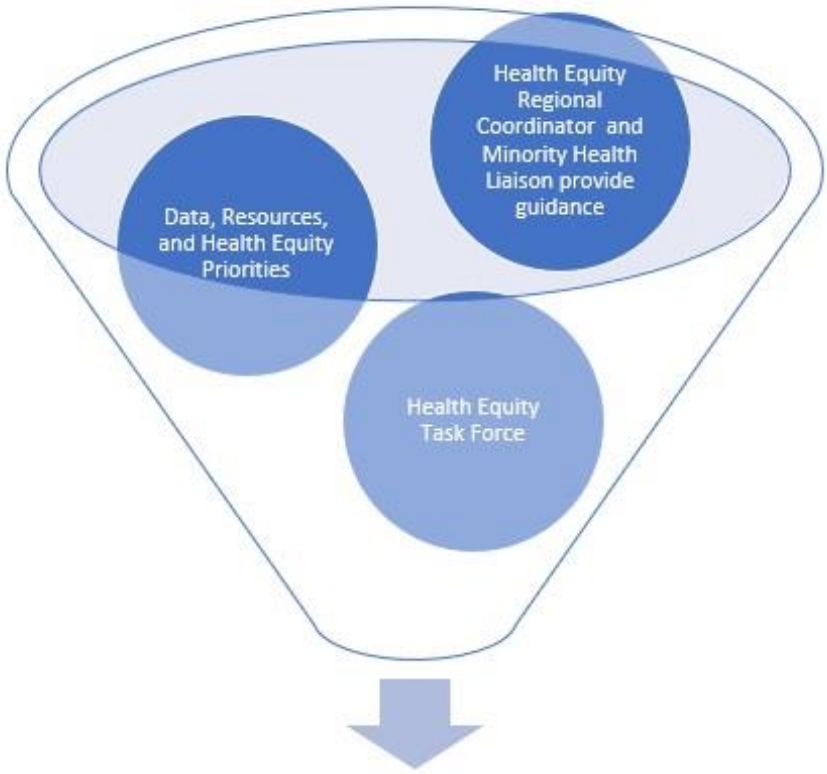
The Florida Department of Health in Escambia County worked with members of the Health Equity Task Force to create a vision statement. DOH-Escambia utilized members of the Achieve Healthy EscaRosa team as the Health Equity Task Force. Community leaders were utilized to form both groups since the 2022 CHNA cycle occurred near the same time as the development of the Health Equity Plan and the intended efforts closely align. Member Minority Health and Health Equity Team collaborated to create a vision to develop interventions to assist with health equity efforts.

Some social determinants of health affecting Escambia County residents include quality education, nutrition food, safe housing, affordable and reliable transportation, health insurance, access to healthcare, clean water, and individual unhealthy behaviors[20]. To create a plan to reduce barriers to addressing the social determinants of health, the team used a combination of brainstorming and identifying their personal and moral values about healthy communities. Throughout the brainstorming process, key group members sorted through and selected the most common responses from each question to develop the vision statement.

The questions below were divided between four charts, and questions were asked one at a time. Members used post-It notes to write their responses and affixed them to the respective charts. Once the chart was filled, the team discussed the commonalities of the responses. The questions asked were:

1. What do you believe about healthy communities?
2. What does a healthy Escambia County mean to you?
3. What are the important characteristics of a healthy community for all residents?
4. Who and what are we aspiring to change?

The team agreed on various social determinants of health that affect our community, such as access to healthcare, healthy foods, affordable housing, education, safe communities, transportation, and social services. Who and what we are aspiring to change includes community leaders, misinformation, system barriers, health literacy, and local policies.



Health Equity Vision

Florida Department of Health, Escambia County Minority Health & Health Equity Vision:

"Every resident has equal opportunity and knowledge to reach their full health potential."

II. PURPOSE OF THE HEALTH EQUITY PLAN

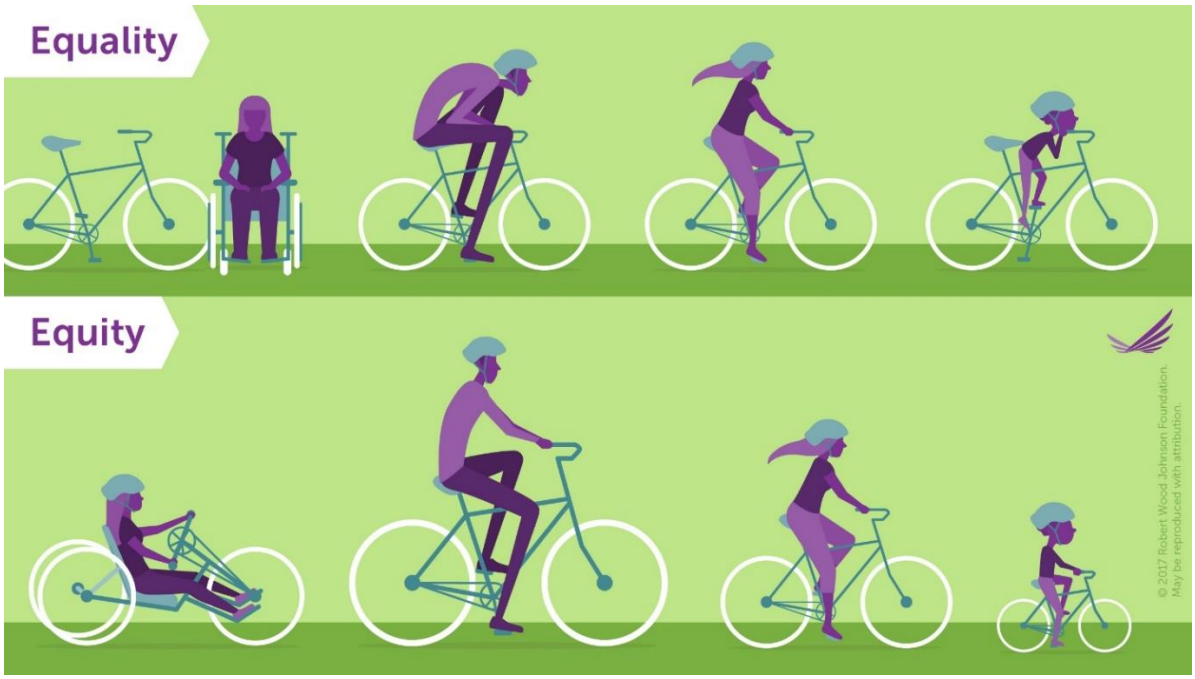
Health Equity is achieved when everyone can attain optimal health.

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

III. DEFINITIONS



Health equity is achieved when everyone can attain optimal health

Health inequities are systematic differences in the opportunity's 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.

Pictured above: DOH-Escambia and DOH-Santa Rosa County staff at the Achieve Healthy EscaRosa (AHER) Community Health Improvement Action Planning Workshop on February 22, 2022. AHER is a collective impact collaborative that works with healthcare providers, health departments, businesses, and non-profit organizations in both Escambia and Santa Rosa County, Florida to improve resident's health and well-being.

Achieve Healthy EscaRosa (AHER)

This partnership is comprised of the Florida Department of Health in Escambia and Santa Rosa counties, area hospitals and health providers, educational institutions, area health coalitions, nonprofit organizations, and others. Achieve Healthy EscaRosa (AHER) is a collective impact initiative created to unite and align resources to improve health equity and outcomes of the residents of Escambia and Santa Rosa Counties. AHER works by engaging businesses, civic leaders, non-profit, healthcare providers, education partners, and faith-based organizations across the two counties to identify a common agenda; establish shared measurements; foster mutually reinforcing activities; and encourage continued communication.

This broad-based collaborative has engaged hundreds of key stakeholders throughout the two-county area and is a collective impact effort that seeks to apply the following collective impact principles in the work[8]:

- Provide a common agenda
- Establish shared measurements, fosters mutually reinforcing activities
- Encourage continued communication
- Build strong community support across multiple sectors including health, business, military, education, faith, non-profit, government, and civic partners.

Every three years, community organizations in Escambia County and Santa Rosa County work collaboratively on a two-step process to understand and respond to health problems within our community. The first phase of this process involves identifying local health issues and resources through a Community Health Needs Assessment (CHNA). The second phase, which launched in early 2022, outlines the actions that the community will take to improve the health status of residents.

This Community Health Improvement Plan (CHIP) is a result of the continued efforts of both counties to address health issues that span across county lines. Although the collaboration has changed through the years, the goal to improve community health remains. The following Community Health Priorities have been adopted for both Escambia and Santa Rosa County: Diabetes, Behavioral Health, and Maternal and Child Health[7,8].

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: Tanisha Thompson, MS, CHES®
Minority Health Liaison Backup: Angel Bradley, DHSc, TTS, CWWS, CWWPM, CCHW

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 Escambia County to the Health Equity Task Force. The Minority Health Liaison guides these discussions and the implementation of initiatives. Members of the Health Equity Team were appointed by their Division Directors and serves as a lead community partner with Achieve Healthy EscaRosa (AHER).

Name	Title	Program
Christina Hutley	Area 1 HIV Linkage Coordinator	HIV/AIDS
Traci Baurberg	Senior Community Nurse	Clinic/STD
Sonya MacGregor	WIC Program Director	WIC
Amber Hanna	Human Services Program Analyst	Breast and Cervical Cancer Prevention
Barbara Shoulders	Senior Community Nursing Supervisor	Healthy Start
Kristopher Pickens	Planning Consultant	Public Health Preparedness
Kimberly Pace	Health Educator Consultant	CHA-CHIP-CHNA-Strategic Plan
Skye Owens	Public Health Nutritionist Supervisor	Healthiest Weight

The Health Equity Team met on the below dates during the health equity planning process.

Meeting Date	Topic/Purpose
January 31, 2022	Community Health Assessment, Health Rankings, OMHHE objectives and purpose, SDOH, Initiative overview, SOW, and FY-21-22 Budget Guidelines
February 14, 2022	Minority Health Month event planning, Brainstorm MHHE Team Vision, county health rankings
February 21, 2022	Inservice on differences between health equity and health disparities, vision brainstorm
March 7, 2022	Minority Health Month event planning, Data review, Discussion about choosing a priority health disparity
April 4, 2022	Finalized plans for the Minority Heath Month-Spring into Health event
April 18, 2022	Spring into Health Event hotwash, MHHE team next steps
May 16, 2022	Minority Heath and Health Equity Plan
June 20, 2022	Health Disparity Project planning

C. Health Equity Taskforce

The Health Equity Taskforce includes CHD staff and representatives from the AHER collaborative various organizations that provide services to address each SDOH. Members of this Taskforce brought their knowledge about community needs and SDOH. Collaboration within this group addresses upstream factors to achieve health equity.

Achieve Healthy EscaRosa

Name	Organization
Adrienne Maygarden	Ascension Sacred Heart
Amanda Bekolay	Lakeview Center
Bethany Miller	Ascension Florida and Gulf Coast
Brent Couch	Simply Healthcare Plans
Brianna Houston	Baptist Health Care
Chandra Smiley	Community Health Northwest Florida
Christina Krueger	Ascension Sacred Heart
Claire Kirchharr	Escambia County Healthy Start Coalition
Denise Manassa	CDAC Behavioral Healthcare, Inc.
Dr. Debra Vinci	University of West Florida
Dr. Patsy Barrington	University of West Florida
Jen Grove	Baptist Health Care
Joy Sharp	Baptist Health Care
Karen Croom	Florida Department of Health, Santa Rosa
Kathy Bowers	Baptist Health Care
Kimberly Pace	Florida Department of Health, Escambia
Laura Gilliam	United Way of West Florida
Mariah Kill	University of West Florida
Marie Mott	Florida Department of Health, Escambia
Mary Zaledonis	United Way of West Florida
Matt Dobson	Florida Department of Health, Santa Rosa
Nicholas Billings	University of West Florida
Nicole Gislason	University of West Florida Haas Center
Paula Bides	Ascension Florida and Gulf Coast
Rachelle Burns	Pensacola State College
Sandra Donaldson	Community Health Northwest Florida
Sandra Park-O'Hara	Florida Department of Health, Santa Rosa
Shawn Salamida	Lakeview Center
Tori Bennet	University of West Florida
Tricia Woodward	United Way of West Florida

The World Health Organization states “There is ample evidence that social factors, including education, employment status, income level, gender and ethnicity have a marked influence on how healthy a person is. In all countries and incomes there are wide disparities in the health status of different social, racial and ethnic groups.The lower an individual’s socioeconomic position, the higher their risk of poor health. Health inequities are reflected in differences in length of life; quality of life; rates of disease, disability, and death; severity of disease; and access to treatment.”

Health inequity affects many populations, including minorities, women, and children of various backgrounds. The COVID-19 pandemic had many significant impacts on public health. One of the major results was the exposure of health inequities across US communities[14]. The pandemic also helped to reveal the contributing factors to health inequity, identifying areas that can be addressed by community leaders. The U.S. Department of Health and Human Services reports that population-level factors, such as the physical, built, social, and policy environments, can impact health outcomes more than individual-level factors[20]. The Achieve Healthy EscaRosa CHNA report addresses some of the health equity issues so that the root causes can be addressed[8].

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
February 2, 2022	Achieve Healthy EscaRosa	Q1 SDOH Action Planning Workshop, Next Steps Post CHNA
April 22, 2022	Achieve Healthy EscaRosa	Q2 Community Health Focus Groups: Overweight and Obesity, Substance Abuse, Mental Health, Child Abuse, Access to Healthcare, Food Insecurity

D. Coalition

The Coalition discussed strategies to improve the health of the community. The strategies focused on these 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-SDOH. Community leaders and local politicians are invested in Achieve Healthy EscaRosa and Pensacola 2030 so we will continue to cross-collaborate with the community collective to increase health equity.

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
Ida Wright	North Central
Diane Padilla	Northeast
Rafik Brooks	West
Lesli Ahonkhai	Central
Frank Diaz-Gines	Southwest
Kimberly Watts	Southeast

V. HEALTH EQUITY ASSESSMENT, TRAINING, AND PROMOTION

A. Health Equity Assessments

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

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

Escambia County conducted health equity assessments to examine the capacity and knowledge of Escambia County staff and county partners to address Social Determinants of Health. A collaborative discussion identified the following priority health issues for Escambia County: Overweight and obesity; substance abuse; mental health; child abuse; access to healthcare; and food insecurity. Below are the dates assessments were distributed and the partners who participated.

Date	Assessment Name	Organizations Assessed
2019	Escambia-Santa Rosa Community Health Needs Assessment (CHNA)	FDOH-Escambia, FDOH-Santa Rosa, Community Action, Live Well, Community Health NWFL, Children's Home Society, Manna, Council for Aging, Sacred Heart Health System, Baptist Health Care, United Way of Escambia County, Santa Rosa Medical Centers, Emerald Coast Utilities Authority (ECUA), Santa Rosa County District Schools, University of West Florida (UWF), community residents, community stakeholders, faith-based organizations, social services, health, for-profit and non-profit businesses.
2021	Escambia-Santa Rosa Community Health Needs Assessment (CHNA)	Ascension Sacred Heart, Baptist Health, Simply Healthcare Plans, FDOH-Escambia, FDOH-Santa Rosa, University of West Florida (UWF), CDAC Behavioral Healthcare, Inc., United Way of West Florida, Community Health NWFL, Healthy Start Coalition, Pensacola State College, community residents, community stakeholders, faith-based organizations, health, for-profit and non-profit businesses.

A group of organizations known as Achieve Healthy EscaRosa conducted a Community Health Needs Assessment (CHNA) for Escambia County residents in Summer of 2021. This project aimed to sponsor a community health status assessment for Escambia and Santa Rosa counties and support and promote collaborative initiatives that address priority health challenges. In total, there were 2,937 viable survey respondents[19].

Community Health Needs Assessment (CHNA)

The Escambia and Santa Rosa County Community Health Needs Assessment (CHNA) process was launched in February of 2021. The mission for this project was to sponsor a community health status assessment for the two counties and to support and promote collaborative initiatives that address identified priority health challenges. The data collected for the CHNA includes both resident perceptions of and statistics concerning health status, community health needs, gaps, challenges, and assets. This report will be shared with key stakeholders and the community at large with the goal of mobilizing community members to work collaboratively towards building a healthier community.

Achieve Healthy EscaRosa (AHER), a group of local hospitals, FDOH-Escambia and FDOH-Santa Rosa, and local nonprofits, along with the University of West Florida, set out to better understand the health needs of all residents in Escambia and Santa Rosa counties, including those whose voices are underrepresented. To gather input, AHER conducted a Community Health Needs Assessment (CHNA) that is updated every three years. Two versions of the CHNA were administered – the CHNA Community Resident Survey and the CHNA Community Leader Survey.

Data Analysis Sources and Methodology

A comprehensive CHNA includes detailed examination of health and socioeconomic data. The primary data source for this CHNA was the Health Survey of Escambia and Santa Rosa Residents conducted in the summer of 2021. The Resident Survey was developed using the 2019 survey as a foundation. The survey items were reviewed by the CHNA committee and vetted for content. The majority of the 2019 survey items were retained. A few additional items on transportation, commute time, and delayed medical care were included to address the unique pandemic situation of 2020 and 2021[7,8]. The result of the collaborative effort was a 32-item survey that was distributed in electronic and paper format. In total, 3,051 community members participated in the Resident Survey, resulting in 2,937 viable surveys. There were 1,503 respondents from Escambia County and 1,434 respondents from Santa Rosa County**.**

Community Leader Survey

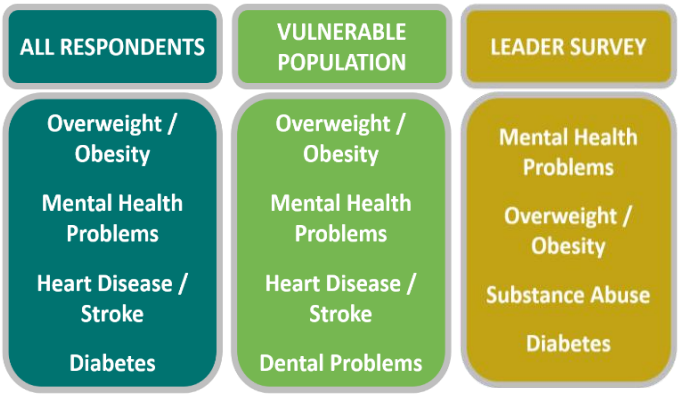
Community leaders were surveyed using a survey that was similar to the CHNA Community Residents survey. A total of 30 leaders participated in the online survey. The majority (55.56%) of respondents operate in Escambia County, and 27.67% operate in both Escambia and Santa Rosa counties[8]. 16.67% provide services in Santa Rosa County[8]. The 31.25 % of the respondents work in Healthcare and Social Assistance, with 12.50% from the areas of Educational Services, Professional, Scientific, and Technical Services, Public Administration, and Other Services[8]. Most (44.44%) of the respondents represented small organizations (1 to 49 employees), followed by an equal number from medium-sized organizations (50 to 199 employees) and large organizations (200 or more employees)[8]. 66.67% of the respondents had the position of Owner, CEO, COO, or Executive Director, followed by Vice President or other senior operations officer and Department Director or other managerial position at 11.1%[8].

A total of 33 leaders participated in the on-line survey[8]. The leaders shared many of the same concerns as voiced in the community survey. As with the community survey, leaders identified obesity, mental health, and diabetes as the most important health issues. Leaders also shared the community's concern that poor eating habits, lack of exercise and drug abuse were unhealthy behaviors. Leaders, however, differed from the community in ranking drug abuse in the top four most important health issues facing residents and in ranking tobacco use among the top unhealthy behaviors[8].

33 Community Leaders Surveyed[7,8]

24% Healthcare
24% Business
21% Social Service or Charitable
15% Government
12% Education
3% Faith-based
65% Serve both Escambia and Santa Rosa
21% Escambia only and 15% Santa Rosa only

Public and community leaders surveyed identified the following as the most important health concerns:



Community Health Needs Assessment, 2022

are often underrepresented. To gather the input from the community, AHER conducted a Community Health Needs Assessment (CHNA) that is updated every three years.

Gathering community input on their perception of health issues, concerns, and health services are a major portion of the CHNA. Trying to capture the voice of those we are intending to impact with policy and programs was a key driver for the process of conducting the survey and analyzing the results. Two versions of

B. County Health Equity Training

Assessing the capacity and knowledge of health equity, through the Community Health Needs Assessment, helped the Minority Health Liaison identify knowledge gaps and create training plans for the Health Equity Team.

The DOH-Escambia Minority Health and Health Equity Team and DOH staff completed Cultural Awareness and Health Equity Training as a part of the bi-annual training day requirements.

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

Date	Topics	Organization(s) receiving trainings
January 20, 2022	Community-wide focus groups for health disparities	FDOH-Escambia, FDOH-Santa Rosa, University of West Florida, For-profit and non-profit businesses, faith-based organizations, social services, health care
January 25, 2022	Cultural Competency and Health Equity Training	DOH-Escambia MHHE Liaisons
January 27, 2022	AHER 2022 CHNA Launch	FDOH-Escambia, FDOH-Santa Rosa, Community Action, Live Well, Community Health NWFL,

		Children's Home Society, Manna, Council for Aging, Sacred Heart Health System, Baptist Health Care, United Way of Escambia County, Santa Rosa Medical Centers, Emerald Coast Utilities Authority (ECUA), Santa Rosa County District Schools, University of West Florida (UWF), community residents, community stakeholders, faith-based organizations, social services, health, for-profit and non-profit businesses.
February 22, 2022	AHER Action Planning to address SDOH: Overweight and Obesity, Substance Abuse, Mental Health, Child Abuse, Access to Healthcare, Food Insecurity	FDOH-Escambia, FDOH-Santa Rosa, Community Action, Live Well, Community Health NWFL, Children's Home Society, Manna, Council for Aging, Sacred Heart Health System, Baptist Health Care, United Way of Escambia County, Santa Rosa Medical Centers, Emerald Coast Utilities Authority (ECUA), Santa Rosa County District Schools, University of West Florida (UWF), community residents, community stakeholders, faith-based organizations, social services, health, for-profit and non-profit businesses.

C. County Health Department Health Equity Training

The Florida Department of Health in (County) (DOH-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-(County) 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. Below are the topics of trainings that were completed prior to completing this plan.

Date	Topics	Number of Staff in Attendance
October 12, 2018	Social Determinants of Health and FDOH	98.5%
October 30, 2020	Cultural Awareness: Introduction to Organizational Cultural Competence	66%
April 29, 2022	Strength in Numbers: Replenishing as a team	90%

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
August 19, 2021	Intro to the OMHHE Office; FDOH Health Equity Efforts; MHHE Liaisons; Technical Assistant Support & Resources
September 16, 2021	OMHHE Scope of Work-State Funding Health Equity COVID-19-Federal Funding
October 21, 2021	Social Ecological Model; Health Disparities Workplan; HE Project Management Template; Technical Assistance Guidance Document; SharePoint
November 18, 2021	Health Equity Plan Template; HE Assessments; HE Partnership Overview; Next Steps
January 20, 2022	Health Equity Plan; HMS/EARS Coding; Budget Guidance; COVID-19 Health Disparities
March 17, 2022	SDOH Project Template; HE Plan Standards Tool; HE Taskforce Letter of Support; ClearPoint; Minority Health Month Events; HDG21 Health Disparities Updates and Reminders
April 12-13, 2022	Health Equity Liaison Onboarding Orientation
April 22, 2022	REDCH FY 22-23 Budget Guidance

E. National Minority Health Month Promotion

April represents National Minority Health Month. FDOH-Escambia's Minority Health and Health Equity team hosted the first annual Spring into Health community event. "Give Your Community a Boost!" was the 2022 theme. The event was named to highlight and reinforce the CDC's recommendations for preventing COVID-19 transmissions through vaccinations, boosters, wearing well-fitted face masks, proper handwashing, and getting tested.

The event sought to provide residents with health education to understand the importance of prevent health screenings and wellness visits with their primary care provider. Many screenings and tests can detect a disease in its early stages. Early detection leads to earlier treatment and better health outcomes for chronic health conditions like hypertension, diabetes, HIV, cardiovascular disease, stroke, eye diseases, and some cancers[13]. Health education leads to a better understanding of how to properly manage chronic health conditions through eating healthy, being active, quitting tobacco, limiting alcohol, and managing stress[16,49].

The following health screening services were offered at this event: COVID-19 vaccinations, boosters, and take-home tests, blood glucose and cholesterol

checks, blood pressure, body mass index (BMI), as well as health information and community resources.

Information about this event was spread through an official press release with local news media outlets, local minority radio outlets, digital billboard, and a radio interview with Dr. Vanessa Phillips, Director of Communications, Health Education, Nutrition, and Public Health Preparedness (CHENP). The agencies below participated in the event to provide information or health services to the residents in need. This event was free and open to the public.

Organization	Services Provided
Diabetes Prevention Program	Prediabetes screenings and health education
Women, Infants, and Children (WIC)	Maternal health information
Florida Breast and Cervical Cancer Early Detection Program (FBCCEDP)	Breast and cervical cancer health information
Public Health Preparedness	Free take home COVID-19 tests and disaster preparedness guides
HIV/AIDS	Free rapid HIV and Syphilis tests
Healthy Start	Information about safe sleeping protocols for babies
Healthy Families	Information about home visiting services for expectant parents and parents of newborns experiencing stressful life situations.
Simply Health Medicaid	Medicaid insurance provider
Health and Hope Clinic	Free COVID-19 testing, Body Mass Index, blood pressure
Real Women's Radio	Local minority radio outlet
90 Works	Provides supportive services for homeless veterans helping them to become self-sufficient in 90 days
Ambetter	Insurance
United Way of West Florida	Financial stability information

Vocational Rehabilitation	Helps people with disabilities gain their independence through finding and maintaining employment
Pensacola State College T.R.I.O.	Grant program to assist with admissions, financial aid, educational and career counseling, and referrals to support services
Pensacola State College	College information and registration
Goodwill Gulf Coast	Adult education, job training programs, digital skills, digital literacy skills, financial coaching, free medical equipment, and consumable products
Sickle Cell Disease Association	Sickle cell health and treatment resources
Sacred Heart Maternal Health	Health information for maternal health
Oasis Florida	HIV/AIDS information
AHEC Tobacco	Tobacco cessation information and class registration
AHEC Aging	Aging services information
Intelligent Retinal Imaging Systems	Free eye exams to check for diabetic retinopathy
Children's Home Society	Information and referral services
TFF-Escambia	Smoking cessation information
UWF School of Nursing	Blood pressure screenings, cholesterol screenings, blood glucose tests
Zeta's Cradle	Educational information
Agency for Persons with Disabilities	Resources for people with disabilities
Community Healthy Northwest Florida	Health screenings

The Spring into Health event was planned in an area where the target population resided, however, it was not well attended by residents due to multiple large community events occurring at the same time. The Minority Health and Health Equity Team completed a Hot Wash to identify barriers to the event's success. Areas of concern included the community center leased for the event had legal and COVID-19 issues at the time and incorporate more advanced marketing and social marketing techniques when advertising for the event. The team is dedicated to hosting this event again in 2023 in a different location.

VI. PRIORITIZING A HEALTH DISPARITY

Health within a community is affected by a wide range of factors, such as education level, safety of the neighborhood, quality of the air, poverty, and employment. These factors are called the social determinants of health. A collaborative effort between the Robert Wood Johnson Foundation and the University of Wisconsin Population with a community by looking at social determinants of health, access to and quality of health care and personal health behaviors. The framework, shown below, illustrates the strong influence that Health Factors have on illness and death, otherwise known as Health Outcomes.

Health Factors are the things that can be modified to improve the length and quality of life for community members[49].

Health Outcomes represent the overall health of a county, reflecting the physical and mental well-being of residents measured by length of life and quality of life. Health Outcomes are predictors of how healthy our communities can be in the future[14].

Policies and Programs, such as smoking ordinances or a diabetes prevention program hosted by a hospital or health department, can improve Health Factors, and thus lead to lower rates of disease and better Health Outcomes[26].

The County Health Rankings are based on a model of population health that emphasizes the many factors that, if improved, can help make communities healthier places to live, learn, work and play[19,20]. Achieve Healthy EscaRosa (AHER) has adopted the County Health Rankings framework that produces the CHNA.

This CHNA looks at health outcomes within our community to understand the causes of death, disease, and disability. The next step after the CHNA was to examine Health Factors contributing to Poor Health Outcomes and Policies and Programs that could be changed or put in place to improve our health[20]. The Health Outcomes and Health Factors provide a snapshot of our community health status. These issues are addressed in the Community Health Improvement Plans for both Santa Rosa and Escambia County.

From the 2022 CHNA report, the most important health issues identified in Escambia County were: Overweight and Obesity, Mental Health Issues, and Substance Abuse[26].

Since the assessments were complete, the summary of findings was distributed to community members who participated in the assessments and discussed at various community meetings to collect public input from a diverse group of community partners. Achieve Healthy EscaRosa conducted four-rounds of focus group meetings surrounding all five health priorities. These meetings were open to the public to review and discuss what is being done within the communities already. The gaps and barriers were also discussed giving the residents the opportunity to make recommendations.

The Achieve Healthy EscaRosa team met regularly to discuss the health issues and available resources to impact change. Seeking to develop a collaborative effort between public health officials, representatives from non-profits, and health service providers as subject matter experts for the health issues of both counties, the team formed a consensus around three priority areas[35]:

- Diabetes
- Behavioral Health (Mental Wellness & Substance Use)
- Maternal and Child Health

Through data analyses of CHNA Resident Survey and the CHNA Leader Survey informed the selection of the 2022 health priorities[8,46,47]:

• Overweight & Obesity

• Mental Health and Wellbeing

• Substance Abuse

• Food Insecurity

• Child Abuse

• Access to Healthcare

Over the past 20 years, the prevalence of diagnosed diabetes among Florida adults has more than doubled, increasing from 5.2 percent to 12.6 in 2018[1,11,12]. Nationally in 2018-2019, approximately 260,000 children and adolescents younger than age 20 had been diagnosed with type 1 or type 2 diabetes[15]. More than 20 percent of national health care spending is for people diagnosed with diabetes. In 2017, it is estimated that the total cost of diabetes in Florida was $25 billion, with $19.3 billion attributed to direct medical expenses for diagnosed and undiagnosed diabetes, prediabetes, and gestational diabetes[10].

Using the National Association of County and City Health Official's (NACCHO) Guide to Prioritization Techniques, the Health Equity Team chose to work on tackling overweight and obesity in adults utilizing the CDC's Prevent T2, Diabetes Prevention Lifestyle Change Program in the Health Equity Plan. The data revealed adults (both men and women), minorities, age 40 and older, had the highest rate of type 2 diabetes deaths and complications like lower extremity amputations. In 2019, in Escambia County, 9.1% adults have been told they had prediabetes, compared to 9.1% statewide[35,47].

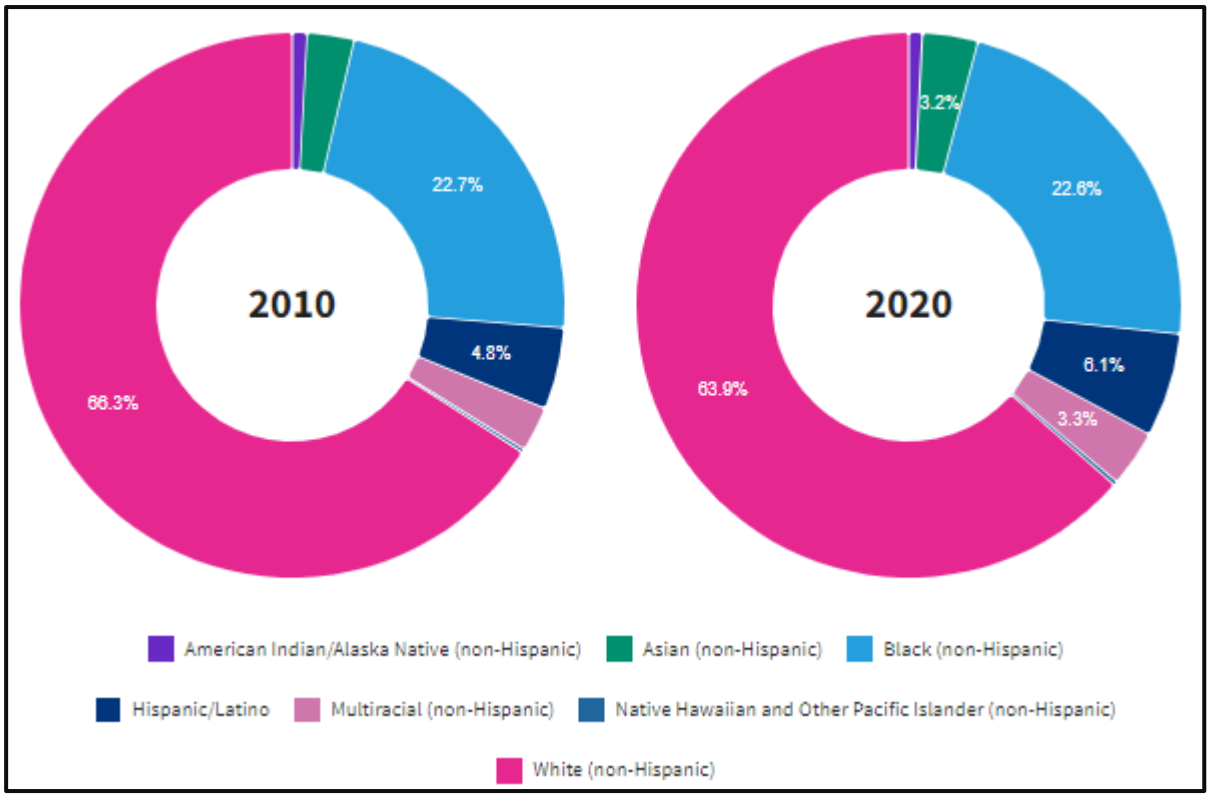
Background data was pulled from peer-reviewed research publications, Community Health Improvement Plan (CHIP), Community Health Needs Assessment (CHNA), U.S. Census 2020, Florida Charts, Behavioral Risk Factor Surveillance System (BRFSS), CDC, Escambia County Strategic Plan, Healthy People 2030, United States Diabetes Surveillance System (USDSS), and 2022 County Health Rankings.

The following zip codes in Escambia County between 2016-2020 account for the highest counts of deaths caused by type 2 diabetes and/or complications associated with prediabetes or type 2 diabetes: 32501, 32503, 32505, 32506, 32507, 32514, and 32526[7,15,25]. The Health Equity Team will work together to create projects to reduce the disparities and use county and state information to address data gaps in these high-risk areas.

Escambia County Population Demographics

There are an estimated 324,620 residents in Escambia County, Florida. According to the 2022 Florida County Health Rankings data, Escambia ranks 50th out of 67 counties[41]. Escambia is ranked in the lower middle range of counties for health outcomes[42]. Premature deaths, Years of Potential Life Lost (YPLL), has been increasing over the past 20 years[36]. In 2020, the average life expectancy in Florida is 79.7 years compared to 74.5 years in Escambia[34]. Focusing attention on premature mortality is helpful to identify negative health behaviors that led to deaths that might have been prevented[10].

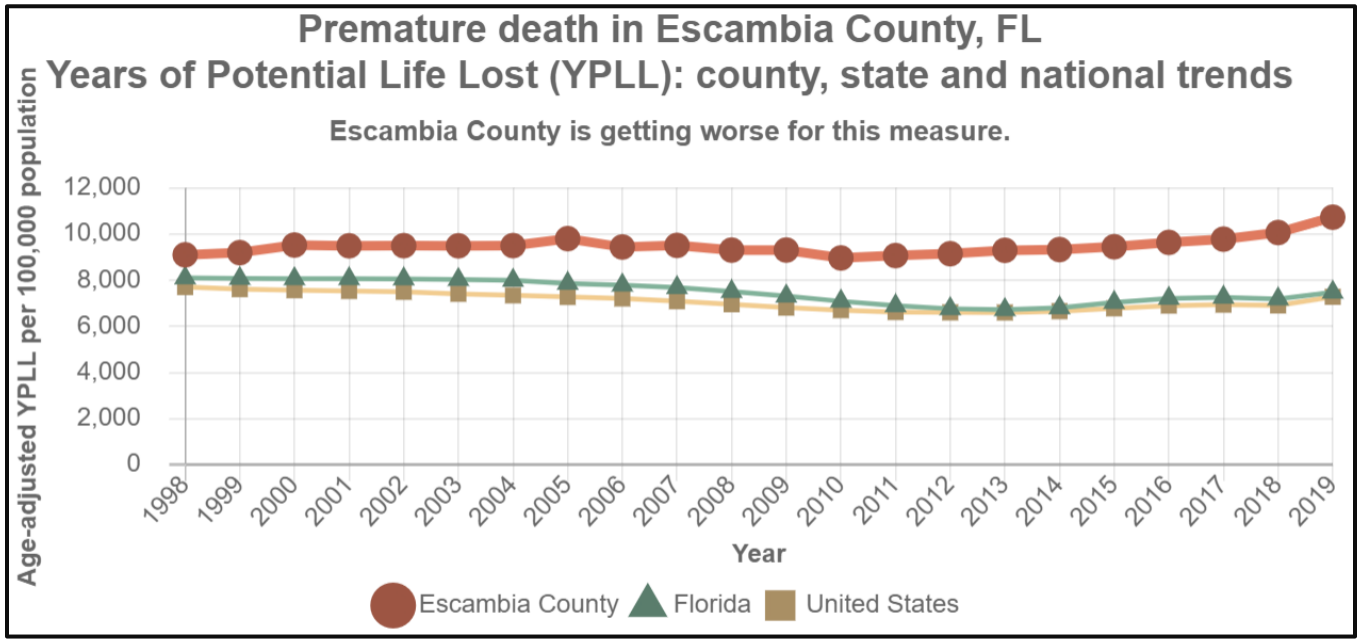
Escambia County Race and Ethnicity Growth 2010-2020



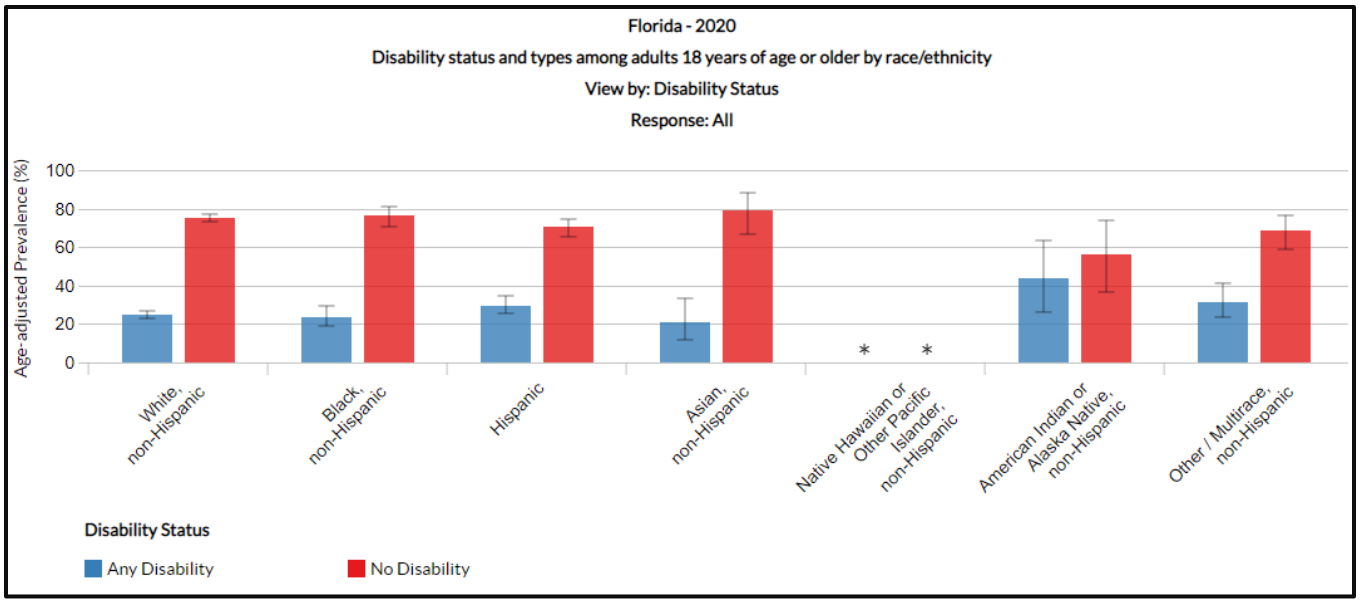
Data from 2022 County Health Rankings

Years of Potential Life Lost (YPLL) Escambia

Premature death is a measure of years of potential life lost due to death occurring before the age of 75[36]. Risk factors for premature death include obesity, smoking, and exposure to environmental hazards. High blood pressure, high cholesterol, and type 2 diabetes are preventable risk factors that can be modified through lifestyle behavior changes by eating healthy, getting active, and quitting tobacco[47].

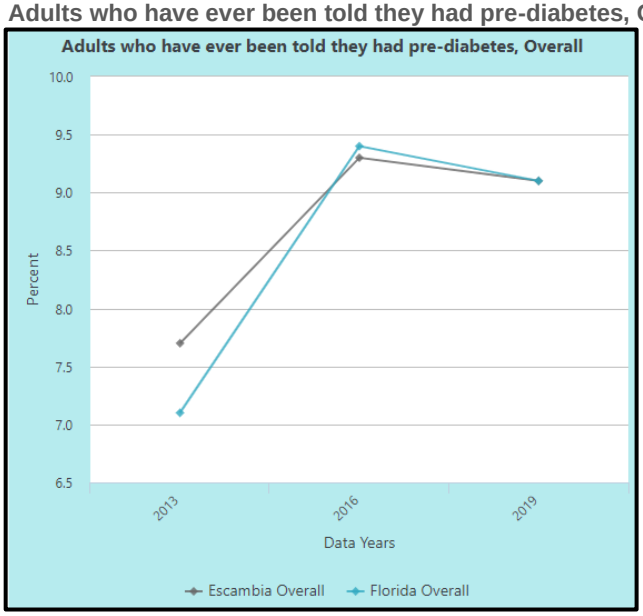


Data from 2022 County Health Rankings



Escambia County's 2022 CHNA report identified obesity and overweight as a top health issue[8]. Obesity and overweight increases a person's risk of developing chronic health conditions like cardiovascular disease, heart disease, and type 2 diabetes[10,14]. The Minority Health and Health Equity Team used the data collected to focus on unhealthy health behaviors to reduce eligible Escambia County's' residents' risk of developing type 2 diabetes. In 2019 in Escambia County, 12.8% of residents have ever been told they had pre-diabetes[33].

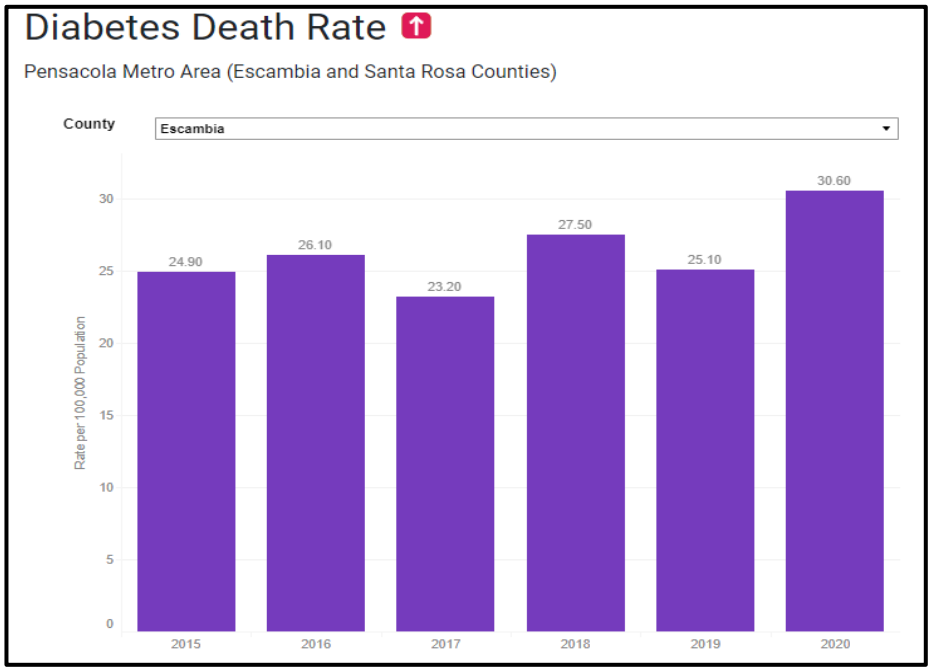
Adults who have ever been told they had pre-diabetes, Overall



Florida Health Charts, 2019

Diabetes Death Rate, Escambia County

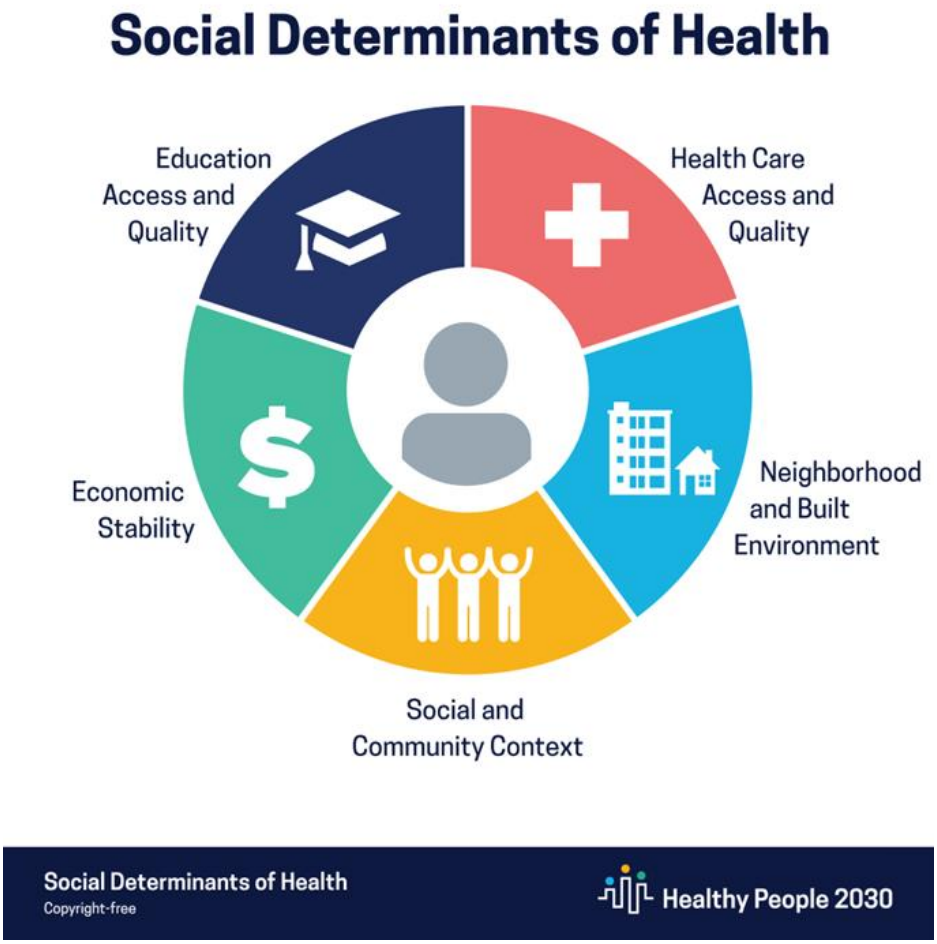
Premature deaths rates caused by diabetes are increasing. Without lifestyle changes, adults and children continue to be at risk for type 2 diabetes. Diabetes is a major cause of heart disease, strokes, blindness, neuropathy, kidney failure, and lower limb amputation. Diabetes is the 7th leading cause of death in the United States[50]. The Centers for Disease and Control Prevention Prevent T2 Lifestyle Change Program may be used to increase health equity by addressing the social determinants of health in a support group format.



Data Source: Florida Charts, 2020

VII. SDOH DATA

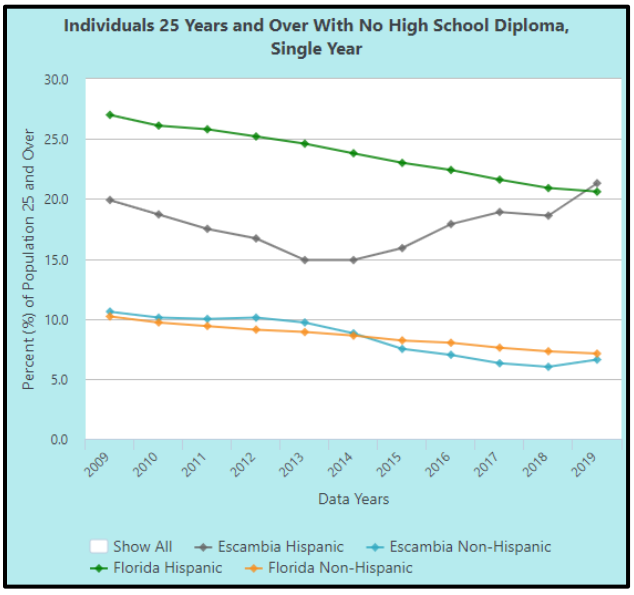
Social Determinants of Health (SDOHs) are conditions in the places where people live, learn, work, and play that affect a wide range of health and quality-of life-risks and outcomes. The SDOHs can be broken into the following categories: education access and quality, health care access and quality, neighborhood and built environment, social and community context, and economic stability. The Health Equity Team identified multiple SDOHs that impact type 2 diabetes. They are listed below.



A. Education Access and Quality

Individuals 25 Years and over with No High School Diploma by Ethnicity

In 2019, the percentage of individuals 25 years and over with no high school diploma in Escambia County was 9.5% compared to Florida at 11.8%[39]. The percentage of Hispanic individuals 25 years and over in Escambia County, with no high school diploma, was 21.3% compared to non-Hispanic individuals at 7.1%[50]. The line graph shows change over time. Low level of education was associated with at least a 50% higher risk of developing type 2 diabetes[53]. To reduce risk of type 2 diabetes, Escambia County is addressing ethnic disparities related to achieving a high school diploma.



Data Source: Florida Charts, 2020

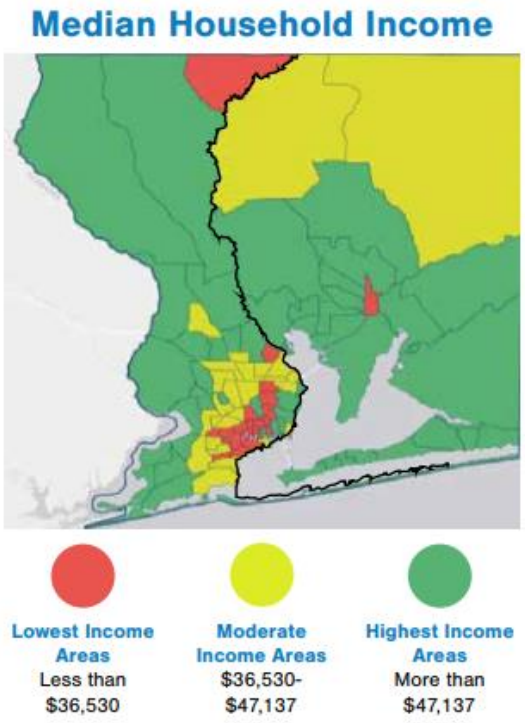
The impact of education access and quality on type 2 diabetes.

Education Access and Quality		
SDOH	**Vulnerable Populations Impacted**	**How the SDOH Impacts Diabetes**
Literacy	Black, White, American Indian, Alaskan Native, Asian, Hispanic, Latino, Elders (65+), People with disabilities, Veterans, LBGTQ	Low literacy is often associated with low health outcomes. Patients who have low literacy do not have the knowledge to obtain preventive health care services and may have poorer control of their chronic health conditions, leading to an increase in emergency room visits and hospitalizations. They may not understand their primary care providers instructions, or instructions for some medications.
Language	American Indian, Alaskan Native, Asian, Hispanic, Latino, LBGTQ	A patient who does not speak or understand English is a huge barrier in health care. Language barriers make it difficult for non-English speakers to understand where to go for care, and lack of understanding of their care plans.
Early Childhood Development	Black, White, American Indian, Alaskan Native, Asian, Hispanic, Latino, Elders (65+), People with disabilities, Veterans, LBGTQ	Health behaviors for children are learned at an early age. Children are more likely to adopt healthy and unhealthy behaviors and modeled by adults at an early age. The earlier they learn good health behaviors, the greater the health outcomes are in the future.
High School Diploma/GED	Black, White, American Indian, Alaskan Native, Asian, Hispanic, Latino, Elders (65+), People with disabilities, Veterans, LBGTQ	A person's income can enhance or limit their opportunities to earn a livable wage. Graduating high school or earning a GED is one of the first steps one can take to increase their earning potential.
Vocational Training	Black, White, American Indian, Alaskan Native, Asian, Hispanic, Latino, Elders (65+), People with disabilities, Veterans, LBGTQ	Vocational training provides low-income residents an opportunity to do hands-on training in various industries to increase their earning potential. Low income is commonly associated with higher stress, unhealthy behaviors, and other health disparities.
Higher Education	Black, White, American Indian, Alaskan Native, Asian, Hispanic, Latino, Elders (65+), People with disabilities, Veterans, LBGTQ	Families with less education may earn lower wages, have poor nutrition, unstable housing, or lack of medical insurance.

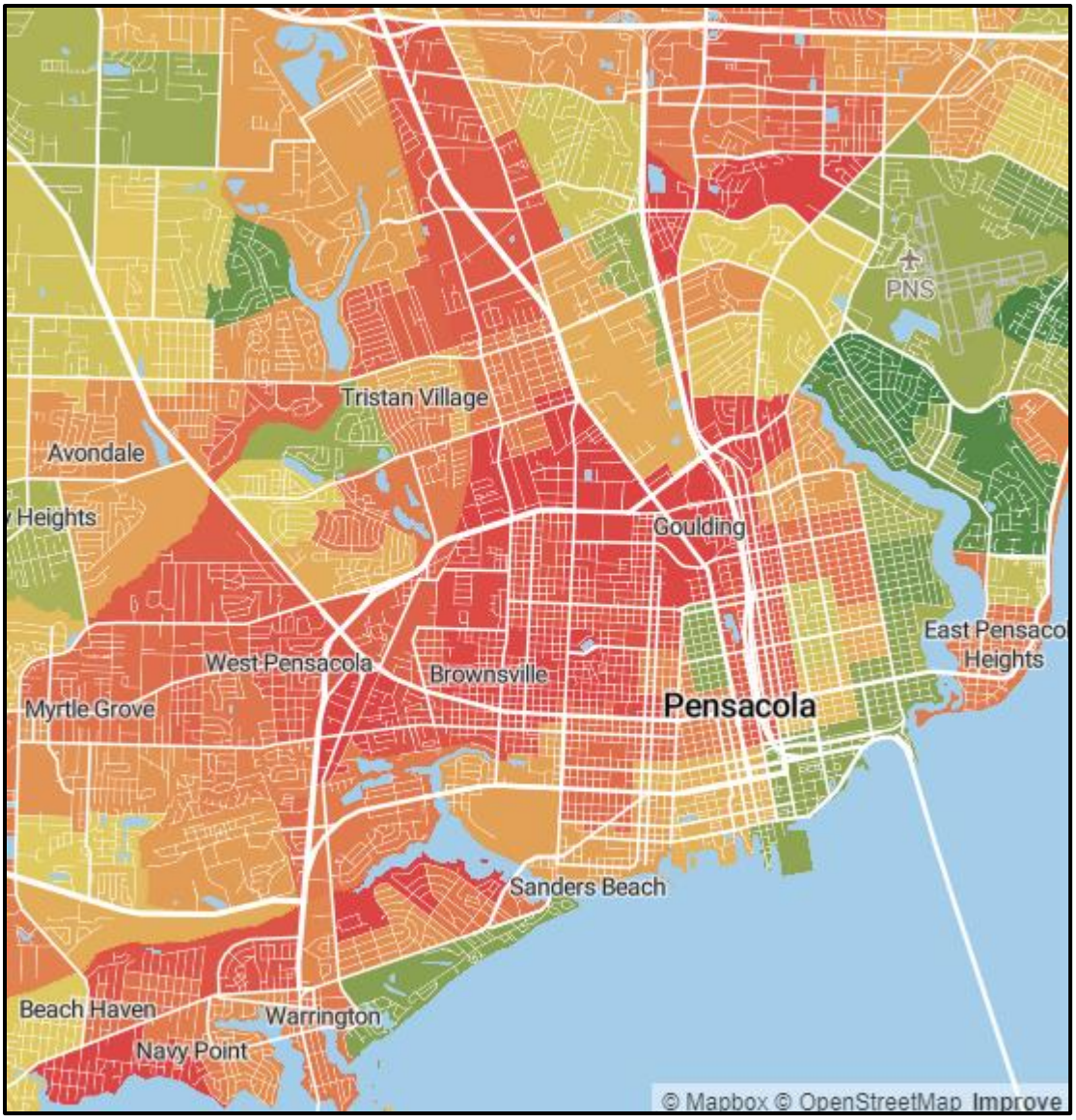
B. Economic Stability

Economic stability data for Escambia County

Median Household Income: Escambia County Residents



Data Source: Florida Charts, 2020



The following zip codes in red on this map are the areas identified as low-income: 32501, 32503, 32504, 32505, 32507, 32533. DOH-Escambia partners with local faith-based organizations, social services, career, and education service providers to extends outreach efforts in this area to educate the clients and to refer them to services.

Data Source: Florida Charts, 2020

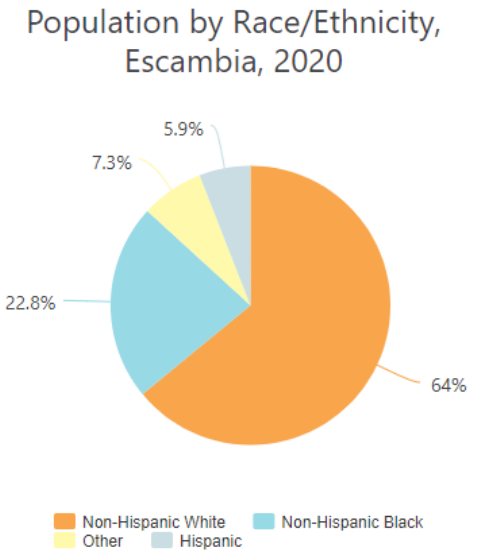
The impact of economic stability on type 2 diabetes

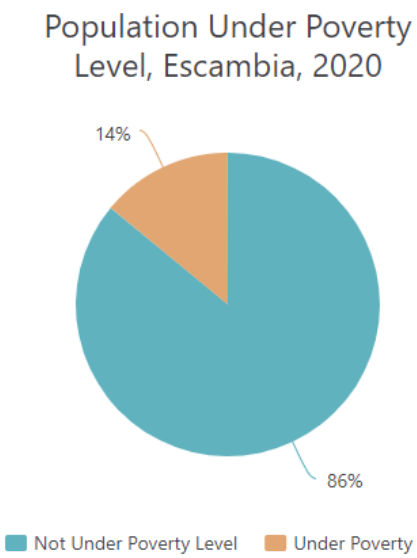
The cost of type 2 diabetes is over $300 billion dollars nationwide. The expenses are related to direct health care, excessive absenteeism from work, lack of physically activity, and unemployment due to disability[1,3]. Most of the cost for diabetes care in the U.S., 67.3%, is provided by government insurance (including Medicare, Medicaid, and the military)[3]. The rest is paid for by private insurance (30.7%) or by the uninsured (2%)[3].

People with diabetes who do not have health insurance have 60% fewer physician office visits and are prescribed 52% fewer medications than people with insurance coverage[35]. The other side is they also have 168% more emergency department visits than people who have insurance. Health care expenses are higher among men than women ($10,060 vs. $9,110)[28].

The cost of health is commonly lower among Hispanics ($8,050) and higher among non-Hispanic Blacks ($10,470) and among non-Hispanic whites ($9,800)[39]. Compared to non-Hispanic whites, hospital inpatient costs are 23% higher among non-Hispanic Blacks and 29% lower among Hispanics[3]. Non-Hispanic blacks also have 65% more emergency department visits than the population with diabetes[31,32].

Diabetes in Florida costs approximately $24.80 billion and is amongst the top five highest in the United States[11].





Data Source: Florida Charts, 2020

Economic Stability		
SDOH	**Vulnerable Populations Impacted**	**How the SDOH Impacts Diabetes**
Employment	Black, White, Asian, Hispanic, Latino, Elders (65+), People with disabilities, Veterans, LBGTQ	People who do not properly manage their health condition may suffer from excessive absenteeism due to sick days.
Income	Black, White, American Indian, Alaskan Native, Asian, Hispanic, Latino, Elders (65+), People with disabilities, Veterans, LBGTQ	Diabetes prevalence is high amongst middle and low-income people. For people who have low incomes, they may have housing insecurity or no means to pay for medications, or ability to pay for their basic needs to survive.
Expenses	Black, White, Asian, Hispanic, Latino, Elders (65+), People with disabilities, LBGTQ	Cost of diabetes is high for direct treatment such as medications and, urgent care, or emergency room visits.
Medical Bills	Black, White, Asian, Hispanic, Latino, Elders (65+), People with disabilities, Veterans, LBGTQ	Increased out-of-pocket expenses, inability to pay due to high co-pay, underinsured, or no insurance
Access to food	Black, White, Asian, Hispanic, Latino, Elders (65+), People with disabilities, Veterans, LBGTQ	Poverty affects diabetes because patients may not earn enough money or have access to eat healthy foods, housing, or medical care.

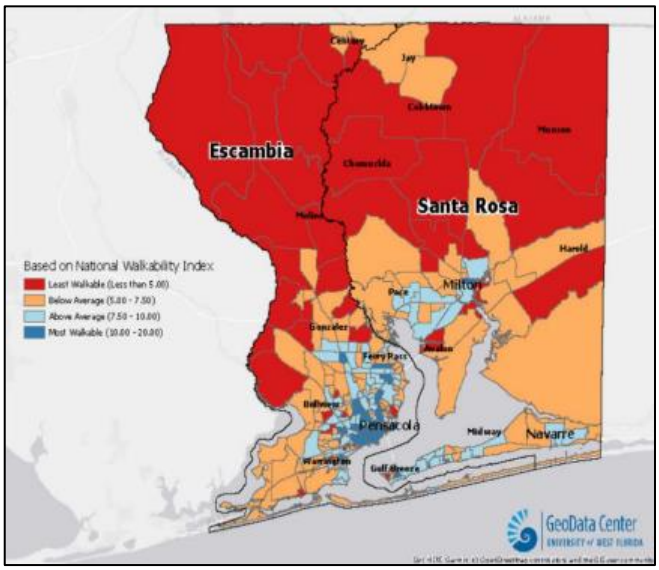
Data Source: Florida Charts, 2020, CDC, 2022

C. Neighborhood and Built Environment

Neighborhood and built environment data for Escambia County

The minorities who reside in Escambia County, Florida face historical and systemic barriers to health. Fourteen percent of residents live up to 200% below the poverty level, making it difficult to meet their physical, social, and health needs. People residing in these areas find barriers like traveling longer distances to purchase healthy foods, limits in public transportation access and bus routes, affordable adequate housing, and other environmental risks. Vulnerable populations include low-income young children under 5 years old, older adults aged 65 and older, adults living with a disability that prevents them from gainful employment, and people who do not speak English well.

Escambia County Walkability Index

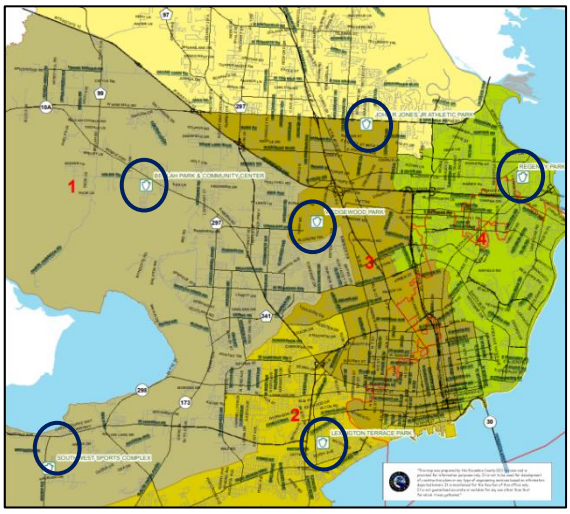


Data Source: Florida Charts, 2020

The impact of neighborhood and built environment on type 2 diabetes

Neighborhood and Built Environment		
SDOH	**Vulnerable Populations Impacted**	**How the SDOH Impacts Diabetes**
Housing	Black, White, Asian, Hispanic, Latino, Elders (65+), People with disabilities, Homeless Veterans, LBGTQ	Inadequate housing may increase illness due to lead, mold, and other environmental hazards. High population of homeless clients, low inventory of affordable housing
Transportation	Black, White, Hispanic, Latino, Elders (65+), People with disabilities, Veterans, LBGTQ	Limited mass public transportation available
Safety	Black, White, Hispanic, Latino, Elders (65+), People with disabilities, Veterans, LBGTQ	Increased amount of gun violence in young adults under 25 years old, black males
Parks	Black, White, American Indian, Alaskan Native, Asian, Hispanic, Latino, Elders (65+), People with disabilities, Veterans, LBGTQ	Limit's ability to be active in a safe environment
Playgrounds	Black, White, American Indian, Alaskan Native, Asian, Hispanic, Latino, Elders (65+), People with disabilities, LBGTQ	Limit's ability to play in a safe environment, residents living further than half a mile to a playground or park
Walkability	Black, White, Hispanic, Latino, Elders (65+), People with disabilities, LBGTQ	Limited sidewalks or damaged sidewalks limits walking access to shopping or community services creates a barrier. Area requires personal transportation.
Geography	Black, White, Hispanic, Latino, Elders (65+), People with disabilities, Veterans, LBGTQ	Rural counties have limited social support and services
Access to nutritional food	Black, White, Asian, Hispanic, Latino, Elders (65+), People with disabilities, LBGTQ	Lower-income neighborhoods have an increase in corner stores versus grocery stores leading to higher food costs and no access to nutritional foods.

Escambia County Parks and Recreation department has eight public parks that can accommodate persons with disabilities. The following parks have equipment that is conducive to persons challenged with motor and sensory skills.



- Beulah Regional Park
- Lexington Terrace Community Center and Regional Park
- Marie K. Young-Wedgewood Community Center and Park
- Miracle League of Pensacola
- Molino Community Center
- Old Ensley School Park
- Regency Park
- Southwest Escambia Sports Complex

Data Source: MyEscambia/Parks and Recreation

Many people in Escambia County live in neighborhoods with high rates of violence, unsafe air or water, and other health and safety risks. Racial and ethnic minorities and people who earn low incomes are more likely to live in places with these risks.

Interventions on the county, state, and federal level can help reduce the health and safety risks, while promoting health. Access to affordable, safe housing and public transportation can help to reduce some of the risks.

Obesity and being overweight are common risk factors for chronic diseases like type 2 diabetes and heart disease. Ensuring residents who reside in low-income neighborhoods have access to healthy nutritious foods is a critical step to promote healthy eating. Having access and eating the right foods can reduce hospitalizations from nutritional deficiencies. Having access to safe places to get active like a park or walking trails, may help people to get outside to get active.

D. Social and Community Context

Social and community context data for Escambia County

The relationships with friends, family, co-workers, and community members can have a major impact on health. Negative challenges such as unsafe neighborhoods, discrimination, or lack of support can have a negative impact on a person's well-being. According to the 2019 Behavioral Risk Factor Surveillance System (BRFSS), 23.2% of Escambia County adults reported their overall health was fair or poor compared to the State of Florida at 19.7%[29,35].

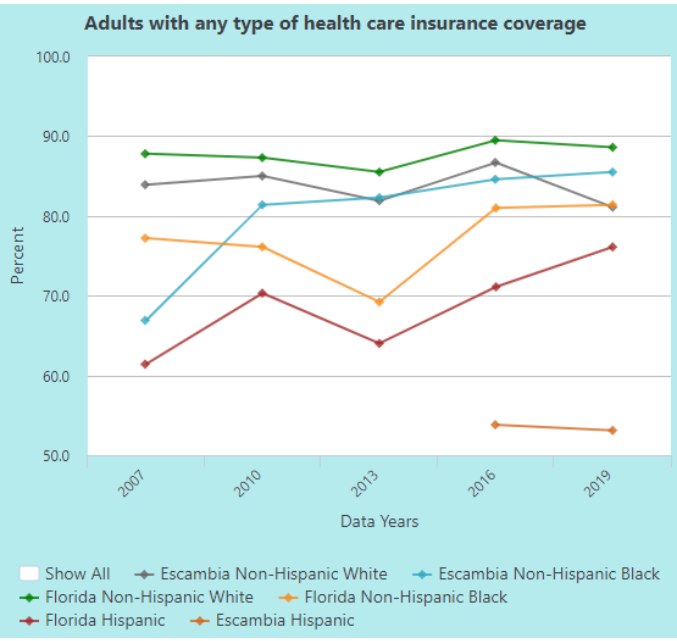
The impact of social and community context on type 2 diabetes

Social and Community Context		
SDOH	**Vulnerable Populations Impacted**	**How the SDOH Impacts Diabetes**
Social Integration	Black, White, Asian, Hispanic, Latino, Elders (65+), People with disabilities, Veterans, LBGTQ	Lack of social integration can negatively impact type 2 diabetes and can lead to poor health management. People with high social integration are more likely to incorporate good diabetes self-care behaviors such as eating well, being active, monitoring blood sugars, and seeing their healthcare provider regularly.
Support Systems	Black, White, Hispanic, Latino, Elders (65+), People with disabilities, LBGTQ	A lack of a family and community support systems can lead to increased stress. Increased stress makes it difficult for insulin to work properly causing spikes in blood sugar.
Community Engagement	Black, White, American Indian, Alaskan Native, Asian, Hispanic, Latino, Elders (65+), People with disabilities, Veterans, LBGTQ	People who are not engaged within their community (in-person or virtually), may have poorer glycemic levels
Discrimination	Black, American Indian, Alaskan Native, Asian, Hispanic, Latino, Elders (65+), People with disabilities, Veterans, LBGTQ	Discrimination has been linked to poor physical and mental health outcomes. Perceived discrimination is associated with increased stress and lower quality of life.
Stress	Black, White, American Indian, Alaskan Native, Asian, Hispanic, Latino, Elders (65+), People with disabilities, Veterans, LBGTQ	Increased stress levels can raise blood sugar levels. If left unmanaged, the increased blood sugar levels may lead to other diabetes-related complications.

E. Health Care Access and Quality

Health care access and quality data for Escambia County

Many people in the United States do not receive the health care services they need. Approximately 10.9 percent of Escambia County residents indicated that they do not have health insurance in 2020 (U.S. Census Bureau, 2022). People without health insurance often wait to seek treatment because of cost and do not have a primary care provider. Preventable health conditions are made worse because residents do not seek preventive health care like breast, cervical, or prostate screenings, and they may not be able to afford the health services and medications they need. Lack of health insurance and access to quality health care may lead to negative health outcomes[50].



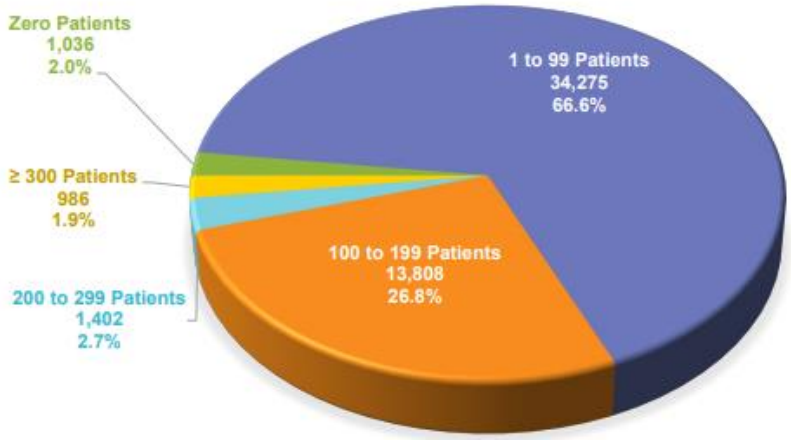
Data Source: Florida Charts, 2020

The impact of health care access and quality on type 2 diabetes

Health Care Access and Quality		
SDOH	**Vulnerable Populations Impacted**	**How the SDOH Impacts Diabetes**
Health Coverage	Black, White, American Indian, Alaskan Native, Asian, Hispanic, Latino, Elders (65+), People with disabilities, Veterans, LBGTQ	Lack of health insurance is a huge barrier to properly managing type 2 diabetes. People who have been diagnosed with type 2 diabetes health care costs are two times higher than those who had not been diagnosed. Without adequate health coverage, people may not be able to afford test strips, blood sugar monitors, medications, and treatments for complications.
Provider Linguistic and Cultural Competency	Black, White, American Indian, Alaskan Native, Asian, Hispanic, Latino, Elders (65+), People with disabilities, Veterans, LBGTQ	Escambia County still has a long way to go with requiring health care providers and health care organizations to be educated on the various races, cultures, and ethnicities in the area.
Provider Availability	Black, White, American Indian, Alaskan Native, Asian, Hispanic, Latino, Elders (65+), People with disabilities, Veterans, LBGTQ	When a patient must wait long times for an appointment, if they are uninsured or underinsured, it may increase their use of the emergency room and not see their primary care provider to follow-up.

Source**:** 2020 Physician Workforce Annual Report, November 2021, Florida Health

Figure 14: 2020–21 Average Number of Patients per Week at Primary Practice Location
n = 51,507



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.

Diabetes

Diabetes is the 7th leading cause of death in the United States and ranks high for healthcare costs for care of a person who has diabetes. Diabetes is a major health issue, that when unmanaged leads to high rates of hospitalizations, complications, and death. In Escambia County, Florida, death from diabetes disproportionately affects Blacks more than Whites. Diabetes is caused by poor diet and lack of physical activity. Death from diabetes is caused by poor management of the illness. There are several different factors that can affect a person's ability to manage their diabetes. Lack of knowledge of the health condition, access to health care, and an improper built environment to support healthy living activities are largely responsible for high rates of death.

Social and economic factors that limit a person's ability to be healthy include not having equitable access to good quality, affordable foods. If you were to cross-reference zip codes that high diabetes rates with grocery store access, you would find they have a negative correlation. This means, as you get higher

diabetes rates, you have lower access to grocery stores and good quality, affordable foods. Additionally, you find zip codes with high diabetes death rates often have lower health care access and use, and do not understand how to manage their disease.

Disparities in diabetes burdens exist mostly because of the social determinants of health (SDOH). Researchers and practitioners researched addressing health equity in diabetes. The research concluded addressing health equity disparities in people with diabetes should focus on individual behaviors or provide supportive approaches to addressing SDOH that are root causes for health inequity. The COVID-19 pandemic further revealed excess vulnerabilities on the target populations. To achieve health improvement amongst Escambia County residents who are at risk for diabetes, focus had to turn to the SDOH as a main contributor to diabetes inequities.

Food Access

Lacking consistent access to food is related to negative health outcomes such as weight-gain and premature mortality[13]. Food insecurity and a person's food choices are defined by the environment they live in, and food environments are not created equal. Fresh healthy foods are more likely to be at a higher price than processed foods. Additionally, people who work multiple jobs or that are otherwise time constrained are more likely to grab the quick and easy foods that may be less nutritious than buying the ingredients that are needed to prepare a whole meal.

The food environment index is a scale that weighs a neighborhood's average income and low access to grocery stores, and food insecurity rate in that same community. In 2019, 14.75% of Escambia County was food insecure, compared to Florida at 12%[21]. This means residents did not have consistent access to the amount of food they needed.

Income inequality and food deserts effect food choices. The obesity problem is partially fed by a system that does not allow people to easily make healthy choices.

Housing

Safe and stable housing has been associated with improved health and well-being. Housing instability has been associated with fair or poor health, maternal depressive symptoms, frequent hospitalizations, and food insecurity[50]. The Community Preventive Services Task Force (CPSTF), which provides guidance on available scientific evidence about community-based health promotion and disease prevention interventions, recommends tenant-based housing voucher programs to improve health and health-related outcomes[48]. Permanent supportive housing (PSH), a model which pairs affordable housing assistance with voluntary supportive services, has been shown to be effective in improving housing stability[50]. Existing evidence reviews have also found strong evidence of the benefits of providing supportive housing to individuals with chronic health conditions, including behavioral health conditions, with studies demonstrating reduced emergency department visits, hospitalization, and long-term care utilization, and in some cases, improved health outcomes or reduced overall healthcare costs[50]. Escambia County has implemented a Go Smoke-Free Program to reduce hazards caused by secondhand smoke. Secondhand smoke exposure increases the risk of developing diabetes by impairing the body's ability to process glucose properly[30]. Benefits of living in a smoke-free environment include lower risk of heart disease, stroke, some cancers, lower respiratory illness, and impaired lung function[30].

Infrastructure

Infrastructure broadly considers the systems and services that are needed for a community to function properly. Physical separation of races, often forced subconsciously or not, is an institutionalized form of racism that is often interwoven with things like location of food deserts, park access, and more. Low segregation rates build more community diversity and understanding. Walkability is critical for a community's ability to make healthy choices in the areas of exercise and play. Much of the northern parts of Escambia is somewhat unwalkable, with the most walkable areas often centered in higher income neighborhoods.

Violent crime in the community has been on a sharp incline between 2015 and 2020, and there is a rising number of murders in our community as compared to other crimes. In 2020, Escambia's murder rate in a single year was 9.9 compared to Florida at 5.9[40]. A community's violent crime rate is of critical importance in numerous ways. It is directly linked to how safe a parent feels to let their child out to play in the park, how many families go on evening walks, what the mental health of a child is when their parent is incarcerated. What people are witnessing on the streets then affects how they think, work, and play in the community.

Providing safe and reliable transportation options to eligible participants may reduce the barrier of feeling unsafe. Escambia communities can urge their elected officials to improve the walkability and accessibility of communities to promote more green spaces, sidewalks, and easier access to where they need to go.

Transportation

Transportation is a major barrier for participation in the Prevent-T2 program. Escambia County has public transportation to areas in the county. Not all areas in the county are assessable to public transportation or they only have one route that is provided. In 2019, data indicated that less people rode the public transportation than in 2018. Data provided indicated that a significant population walk. With no widespread public transportation available this can be a reason why we have many people walking. Individuals that have accounted their experience on the public transportation in Escambia County have made general statements: There are not always direct routes, and you must go to the main station to transfer. People may have to get to the first stop in the morning to get to an afternoon appointment. It can be an all-day event. If you work late there is no bus after 7:30pm. Transportation is often cited as barriers to healthcare access. Transportation barriers lead to rescheduled or missed appointments, delayed care, and missed or delayed medication use. These consequences may lead to poorer management of chronic illness and poorer health outcomes.

Transportation can also affect access social services, employment, and educational opportunities.

To address transportation as a social determinant of health, the Minority Health and Health Equity Team is researching ways to partner with Uber Health and other ride sharing programs supported by ECAT within the county. Uber Health is a healthcare partner organization that provides reliable, comfortable transportation for clients[51]. Uber Health offers flexible ride scheduling, access to services for clients who do not own a smartphone, and they observe HIPAA Compliance[51].

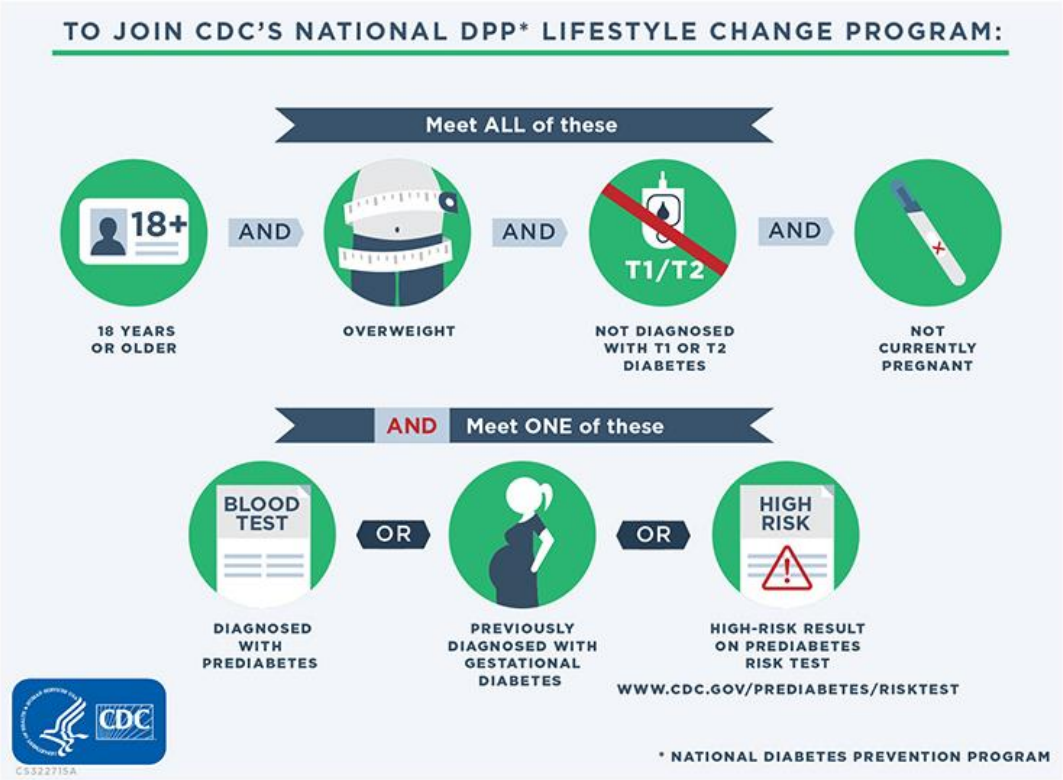
Marketing the Prevent T2 Program

One approach to the obesity and overweight issue in Escambia is to increase access and participation to the CDC's Prevent T2 Program, Diabetes Prevention Program. This one-year evidence-based lifestyle change program focuses on weight management to prevent or delay type 2 diabetes. Throughout the program, participants at higher risk or diagnosed as prediabetic will discover how to eat healthy and add more physical activity into their lifestyles[13]. Working with a trained Lifestyle Coach, program participants learn to make better food choices, be more physically active, and find ways to cope with problems and manage stress and quitting tobacco in a support group environment[13]. The target population for this program for minorities at highest risk are Blacks, Asian Americans, Hispanic or Latino, American Indian, Alaska Native, Pacific Islanders, people with disabilities, Veterans, LBGTQ, and Medicare beneficiaries[13].

DOH-Escambia is a CDC-recognized organization that currently has four trained lifestyle coaches to facilitate the program onsite, online, at faith-based organizations, community centers, businesses, health care organizations, universities, and public and private insurers. The program is currently free and available for participants who qualify for the program.

Efforts to market this program will include program advertising on the DOH-website, utilizing earned and paid media, social marketing, minority owned television and radio media, minority owned magazines and publications, churches, businesses, local television media, and local radio stations.

Prevent T2 Program Eligibility



Source: CDC, 2022

Diabetes Self-Management Program

People who have already been diagnosed with type-2 diabetes are disqualified from participating in the Prevent T2 program. DOH-Escambia is currently developing a plan to train registered dietitians and health educators to administer the evidence-based Diabetes Self-Management Program (DSMP). The DSMP has been proven to increase positive health behaviors and improved diabetes-related health outcomes. Participants in this program may have better utilization of primary care and preventive services, improved diet and physical activity, hemoglobin A1C levels, blood pressure, and cholesterol levels, higher rates of medication adherence, fewer diabetes-related complications, increased self-efficacy, and fewer emergency room visits, hospital admissions, and readmissions" [25].

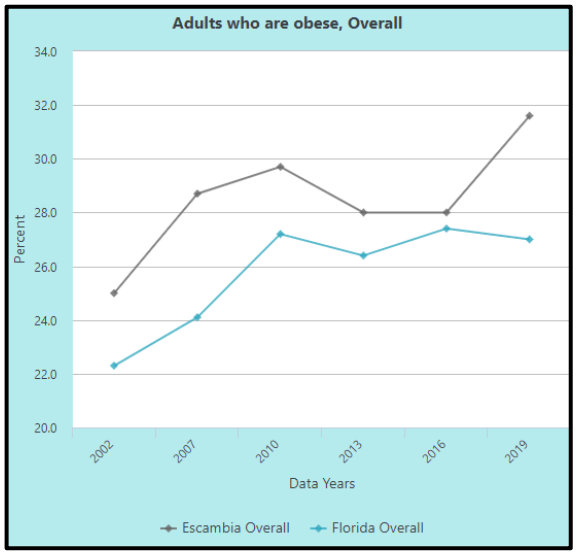
B. Barrier Identification

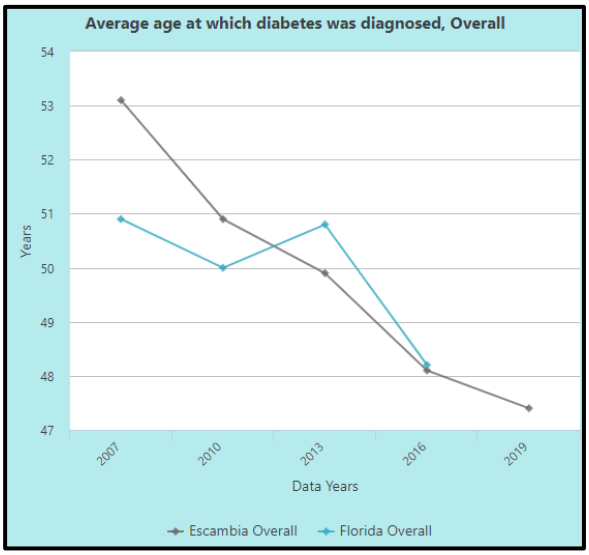
Members of the Health Equity Taskforce worked collaboratively to identify their organizations' barriers to fully addressing the SDOHs relevant to their organization's mission. Common themes were explored as well as collaborative strategies to overcome barriers.

Partners	SDOH	Partner Barriers	Theme	Collaborative Strategies
Ascension Sacred Heart, Baptist Health Care, West Florida Healthcare, Santa Rosa Medical Center, Community Health Northwest Florida, Health, and Hope Clinic	Access to healthcare	Limited health insurance coverage	Low provider knowledge of free programs, like the Diabetes Prevention Programs (DPP) and Diabetes Self-Management Education; Diabetes management and preventative education isn't a covered benefit for most	Educate physicians and staff about the effectiveness and benefits to DPP programs; Collaborate with partner agencies delivering free or low-cost diabetes prevention or diabetes management education to establish a new referral process with local physicians' offices and community agencies to refer to these programs
Same as above	Access to healthcare	Provider availability	Wait times for appointments are too long; doctor or clinic doesn't take all insurances; doctor or clinic isn't accepting new patients	Make telehealth a priority by offering more online DPP programs; Increase local offerings of free or low cost DSMES
Uber Health, Escambia County Area Transit	Provider availability Transportation	There is a need to measure and evaluate current processes	Establish policies for community sites and broadband transportation; consider using funding for ride services for patient appointments and classes; make telehealth a priority by offering more online DPP programs; Increase local offerings of DSMES	Media and marketing campaigns to raise awareness; Arrange for group and/or individual education sessions for physicians and supporting partner organizations; expand offerings of chronic disease prevention education in the community.
United Way Northwest Florida, Manna, Feed America, Faith-based organizations	Poor Built Environment	Access to Nutritious Foods	Negative correlation with grocery store access and good quality food with high diabetes rates	To make healthy foods more affordable, WIC gives clients Farmers Market vouchers that can be redeemed for fresh fruits and vegetables from local farmers. To increase access to nutritious foods, DOH-Escambia schedules and provides a space for farmers to set up their produce for sale right outside the health department every week.
DOH-Escambia	Education Access and Quality	Health Literacy	Need Provider, patient, and community education and communication about preventative health care services available; Low literacy of the disease, diabetes, and how to properly manage it	Media and marketing campaigns to raise awareness; Arrange for group and/or individual education sessions for physicians and supporting partner organizations; expand offerings of chronic disease prevention education in the community.

C. Community Projects

The Health Equity Team 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. Due to lack of staffing at the time of this report, the planning portion of the community project is still in progress. Below is a snapshot of the project.





Data Source: Florida Charts, 2019

Problem: Increase of diabetes diagnoses in Escambia County

Background: In 2019, 12.8% adults have been diagnosed with type 2 diabetes[11].

People with type 2 diabetes either doesn't make enough insulin or the body doesn't use the insulin as well as it should[10]. Too much sugar in the bloodstream may lead to serious health conditions like heart disease, kidney disease, vision loss, or limb amputation[10].

People with prediabetes may reverse or delay being diagnosed with type 2 diabetes by making small lifestyle changes like getting active, losing weight, and eating a healthy diet[13]. Nine out of 10 people have prediabetes and don't know they have it[13].

Prevent T2 is a Centers for Disease Control and Prevention (CDC) evidence-based lifestyle change program that helps people to make small manageable changes over time to reduce their risk of type 2 diabetes and other chronic health conditions. In 2022, DOH-Escambia Lifestyle Coaches received additional training in coaching and facilitation skills, promotional messaging, social marketing, and health equity through the adaption of the DPP curriculum to be inclusive of participants with disabilities from the National Association of Chronic Disease Directors (NACDD).

Scope: FDOH-Escambia is a CDC recognized site for administering the Prevent T2 program. There has been an issue with attendance and retainment of participants. This project will address the barriers and attempt to close the gap by collaborating with community organizations who may be able to assist with the transportation barriers. FDOH-Escambia will create a plan to market the program using mass media outlets to recruit and retain DPP participants through social marketing efforts.

Social Determinants of Health (SDOH): Time, staff, transportation, location, literacy, health literacy

Priority Populations: Black, White, American Indian, Hispanic, Latino, Asian Americans, American Indian, Alaskan Native, Veterans, Elderly, LBGTQ, and Persons with Disabilities at risk for type 2 diabetes

Stakeholders: Florida Department of Health Escambia, Escambia County Area Transit (ECAT), Uber Ride Share, Non-profit and for-profit community partners who may have access to transportation assistance such as United Way of Northwest Florida, and Community Health Northwest Florida, Achieve Healthy EscaRosa, and Pensacola 2030 with the Greater Pensacola Chamber Foundation. The effort to address locations, the City of Pensacola for access to the community centers in the areas of the high risk participants.

IX. HEALTH EQUITY PLAN OBJECTIVES

1. Diabetes

Diabetes Objective: By December 31, 2025, reduce the number of new cases of type 2 diabetes from 12.8% to 12.6%. (FL. Charts)

Healthy People 2030 Objective D-D01: Increase the proportion of eligible persons completing Centers for Disease Control and Prevention (CDC)-recognized lifestyle change programs[47].

Healthy People 2030 Objective D-02: Reduce the proportion of adults who don't know they have prediabetes[48].

Escambia County Strategic Plan Priority 2[7]: Our Community

Goal 2.1: Engage our partners and community to address needs and reduce poor health outcomes and disparities[2]

Strategy 2.1.1 Use data to feed community engagement

Strategy 2.1.3 Improve public health messaging about CHD services

Objectives **2.1.3B** Increase the number of marketing campaigns that use social marketing principles and campaign message development to educate Escambia County residents about CHD clinic services from 1 in October 2020 to 3 by December 31, 2023

Community Health Needs Assessment 2022 (CHNA)[8]:

Most important health issues[8]

1. Overweight and obesity
2. Mental health issues
3. Substance abuse (drugs or alcohol)

Behavioral Risk Factor Surveillance System (BRFSS), 2017-2019, Escambia County

Prevent T2 Participant Recruitment and Retainment Project (2022-2025)

	Lead Entity and Unit	Lead Point Person	Data Source	Baseline Value	Target Value	Plan Alignment
Long-Term SDOH Goal: To reduce the number of new adult diabetes diagnoses through promoting healthy eating, physical activity, and weight management for people at risk for prediabetes.						
Objective: By December 31, 2025, reduce the number of new diagnoses of type 2 diabetes for Escambia County residents	DOH-Escambia	Skye Owens	Centers for Disease Control and Prevention, Florida Charts	12.8%	12.6%	Strategic Plan, CHNA, CHIP, Healthy People 2030
Medium-Term SDOH Goal: To develop social marketing strategies to improve recruitment and retainment for virtual and in-person Prevent T2 program.						
Objective: By December 31, 2023, Increase the percentage of eligible participants who complete the Prevent T2 program.	DOH-Escambia	Jenea Wood	FL Charts, BRFSS, CDC	50% of participants successfully complete the Prevent T2 Program	Increase to 55% of participants complete the Prevent T2 Program	CDC, Strategic Plan, CHNA, CHIP, Healthy People 2030
Short-Term SDOH Goal: To provide transportation assistance options to qualified residents wanting to participate in the in-person Prevent T2 program.						
Objective: By December 31, 2022, partner with transportation organizations	Escambia County Area Transit	Christina Hutley	FL Charts, BRFSS, CDC	0% of DPP participants are using this service	At least 2 participants receive the service	Strategic Plan, CHNA, CHIP

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

XII. REFERENCES

1. Achieve Dashboard. (2019). Diabetes diagnosis. Retrieved from: https://www.achievedashboard.org/health/diabetes-diagnosis
2. Achieve Dashboard. (2019). Food insecurity rates. Retrieved from: https://www.achievedashboard.org/quality/food-insecurity
3. Achieve Dashboard. (2019). Health insurance coverage Pensacola metro area. Retrieved from: https://www.achievedashboard.org/health/health-insurance-coverage
4. Achieve Dashboard. (2020). Homelessness. Retrieved from: https://www.achievedashboard.org/quality/homelessness
5. Achieve Dashboard. (2019). Mean household income. Retrieved from: https://www.achievedashboard.org/workforce/income-levels-workforce
6. Achieve Dashboard. (2022). Occupied housing Pensacola metro area. Retrieved from: https://www.achievedashboard.org/workforce/housing-characteristics
7. Achieve Dashboard. (2022). Social characteristics table Pensacola metro area. Retrieved from: https://www.achievedashboard.org/workforce/social-characteristics
8. Achieve Healthy EscaRosa. (2022). Community health needs assessment.
9. Centers for Disease Control and Prevention. (2021). Awareness campaigns. Retrieved from: https://www.cdc.gov/diabetes/campaigns/index.html
10. Centers for Disease Control and Prevention. (2022). Diabetes. Retrieved from: https://www.cdc.gov/diabetes/basics/diabetes.html
11. Centers for Disease Control and Prevention. (2022) Diabetes data and statistics. Retrieved from: https://www.cdc.gov/diabetes/data/index.html
12. Centers for Disease Control and Prevention. (2022). Diabetes report card 2021. Retrieved from: https://www.cdc.gov/diabetes/library/reports/reportcard.html
13. Centers for Disease Control and Prevention. (2022). Increasing access to type 2 diabetes prevention. Retrieved from: https://www.cdc.gov/diabetes/health-equity/increase-type2-prevention.html
14. Centers for Disease Control and Prevention. (2021). Information for diabetes professionals. Retrieved from: https://www.cdc.gov/diabetes/professional-info/index.html
15. Centers for Disease Control and Prevention. (2022). Minority health and health equity. Retrieved from: https://www.cdc.gov/minorityhealth/
16. Centers for Disease Control and Prevention. (2022) National Diabetes Statistics Report. Retrieved from: https://www.cdc.gov/diabetes/data/statistics-report/index.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fdiabetes%2Fdata%2Fstatistics%2Fstatistics-report.html
17. Centers for Disease Control and Prevention. (2020). Nutrition, physical activity, and obesity: Data, trends, and maps. Retrieved from: https://nccd.cdc.gov/dnpao_dtm/rdPage.aspx?rdReport=DNPAO_DTM.ExploreByTopic&islClass=OWS&islTopic=&go=GO
18. Centers for Disease Control and Prevention. (2021). Prediabetes-Your chance to prevent type 2 diabetes. Retrieved from: https://www.cdc.gov/diabetes/basics/prediabetes.html
19. Centers for Disease Control and Prevention. (2020). Training and capacity building. Retrieved from: https://www.cdc.gov/diabetes/professional-info/training.html
20. County Health Rankings and Roadmaps. (2021). Escambia health factors. Retrieved from: https://www.countyhealthrankings.org/app/florida/2021/rankings/escambia/county/outcomes/overall/snapshot
21. County Health Rankings and Roadmaps. (2021). Escambia county health outcomes. Retrieved from: https://www.countyhealthrankings.org/app/florida/2021/rankings/outcomes/overall

22. County Health Rankings and Roadmaps. (2019). Food insecurity in Florida. Retrieved fromhttps://www.countyhealthrankings.org/app/florida/2022/measure/factors/139/dataCounty Health Rankings and Roadmaps. (2021). Preventable hospital stays. Retrieved from: https://www.countyhealthrankings.org/app/florida/2021/measure/factors/5/map
23. Deborah G. Duran and Eliseo J. Pérez-Stable, 2019: Novel Approaches to Advance Minority Health and Health Disparities Research. American Journal of Public Health 109, S8_S10, https://doi.org/10.2105/AJPH.2018.304931
24. Echouffo-Tcheugui JB, Selvin E. Prediabetes and What It Means: The Epidemiological Evidence. Annu Rev Public Health. 2021 Apr 1; 42:59-77. doi: 10.1146/annurev-publhealth-090419-102644. Epub 2021 Dec 23. PMID: 33355476; PMCID: PMC8026645.
25. Felicia Hill-Briggs, Nancy E. Adler, Seth A. Berkowitz, Marshall H. Chin, Tiffany L. Gary-Webb, Ana Navas-Acien, Pamela L. Thornton, Debra Haire-Joshu; Social Determinants of Health and Diabetes: A Scientific Review. Diabetes Care 1 January 2021; 44 (1): 258–279. https://doi.org/10.2337/dci20-0053
26. Florida Behavioral Risk Factor Surveillance System. (2019). 2017-2019 BRFSS Data Report. Retrieved from: https://www.floridahealth.gov/statistics-and-data/survey-data/behavioral-risk-factor-surveillance-system/2019county/EscambiaCombinedReport.pdf
27. Florida Department of Health. (2020). Community health improvement plan 2020-2023. Retrieved from: https://escambia.floridahealth.gov/programs-and-services/community-health-status/community-health-improvement-plan/_documents/escambia-chip.pdf
28. Florida Department of Health. (2021). Escambia county strategic plan January 1, 2021-December 31, 2023.
29. Florida Department of Health (2020). Physician Workforce Annual Report. Retrieved from: https://www.floridahealth.gov/provider-and-partner-resources/community-health-workers/physician-workforce-development-and-recruitment/2020DOHPhysicianWorkforceAnnualReport-10-28-20FINAL.PDF
30. Florida Department of Health. (2014). Residential building is in Escambia County, Florida go smoke-free. Retrieved from: https://newsroomarchive.floridahealth.gov/escambia/2014/09/2014-09-30-smokefree-housing-pensacola1.pdf.html
31. Florida Health Charts. (2019). Adults who are obese. Retrieved from: https://www.flhealthcharts.gov/ChartsReports/rdPage.aspx?rdReport=BrfssCounty.Dataviewer
32. Florida Health Charts. (2019). Adults who are overweight. Retrieved from: https://www.flhealthcharts.gov/ChartsReports/rdPage.aspx?rdReport=BrfssCounty.Dataviewer
33. Florida Health Charts. (2019). Adults who could not see a doctor in the past year due to cost. Retrieved from: https://www.flhealthcharts.gov/ChartsReports/rdPage.aspx?rdReport=BrfssCounty.Dataviewer
34. Florida Health Charts. (2019). Adults who have a personal doctor. Retrieved from: https://www.flhealthcharts.gov/ChartsReports/rdPage.aspx?rdReport=BrfssCounty.DataViewer&bid=12
35. Florida Health Charts. (2019). Adults who have ever been told they had diabetes. Retrieved from: https://www.flhealthcharts.gov/ChartsReports/rdPage.aspx?rdReport=BrfssCounty.Dataviewer
36. Florida Health Charts. (2020). County Chronic Disease Profile-2020. Retrieved from: https://www.flhealthcharts.gov/ChartsReports/rdPage.aspx?rdReport=ChartsProfiles.CountyChronicDiseaseProfile
37. Florida Health Charts. (2020). County health status summary profile-2020. Retrieved from: https://www.flhealthcharts.gov/ChartsReports/rdPage.aspx?rdReport=ChartsProfiles.CountyHealthSummary
38. Florida Health Charts. (2020). Deaths from Diabetes. Retrieved from: https://www.flhealthcharts.gov/ChartsDashboards/rdPage.aspx?rdReport=Death.Dataviewer
39. Florida Health Charts. (2020). Hospitalizations from or with diabetes as any listed diagnosis. Retrieved from: https://www.flhealthcharts.gov/ChartsDashboards/rdPage.aspx?rdReport=NonVitalInd.Dataviewer&cid=0334
40. Florida Health Charts. (2020). Hospitalizations from or with diabetes as any listed diagnosis which resulted in a diabetes-attributable amputation of a lower extremity. Retrieved from: https://www.flhealthcharts.gov/ChartsDashboards/rdPage.aspx?rdReport=NonVitalInd.Dataviewer&cid=0335
41. Florida Health Charts. (2020). Individuals below poverty level. Retrieved from: https://www.flhealthcharts.gov/ChartsDashboards/rdPage.aspx?rdReport=NonVitalInd.Dataviewer&cid=0294
42. Florida Health Charts. (2020). Median household income. Retrieved from: https://www.flhealthcharts.gov/ChartsReports/rdPage.aspx?rdReport=NonVitalIndGrp.Dataviewer

43. Florida Health Charts. (2020). Population by County by Year. Retrieved from:
44. https://www.flhealthcharts.gov/FLQUERY_New/Population/Count
45. Florida Health Charts. (2020). Population non-institutionalized civilians with health insurance. Retrieved from: https://www.flhealthcharts.gov/ChartsReports/rdPage.aspx?rdReport=NonVitalIndGrp.Dataviewer&cid=9835
46. Florida Health Charts. (2020). Population that speaks English less than very well (Aged 5 years and older). Retrieved from: https://www.flhealthcharts.gov/ChartsReports/rdPage.aspx?rdReport=NonVitalIndNoGrp.Dataviewer
47. Florida Health Charts. (2020). Unemployed civilian labor force. Retrieved from: https://www.flhealthcharts.gov/ChartsDashboards/rdPage.aspx?rdReport=NonVitalInd.Dataviewer&cid=0298
48. Gabarron E, Årsand E, Wynn R. Social Media Use in Interventions for Diabetes: Rapid Evidence-Based Review Journal of Medical Internet Research. 2018;20(8): e10303. doi: 10.2196/10303
49. Healthy People 2030. (2021). Diabetes prevention: Interventions engaging community health workers. Retrieved from: https://health.gov/healthypeople/tools-action/browse-evidence-based-resources/diabetes-prevention-interventions-engaging-community-health-workers
50. Healthy People 2030. (2020). Reduce the proportion of adults who don't know they have prediabetes. Retrieved from: https://health.gov/healthypeople/objectives-and-data/browse-objectives/diabetes/reduce-proportion-adults-who-dont-know-they-have-prediabetes-d-02
51. Robert Wood Johnson Foundation. (2021). Health disparities. Retrieved from: https://www.rwjf.org/en/our-focus-areas/topics/health-disparities.html
52. Uber Health. (2018). Introducing Uber health, removing transportation as a barrier to care. Retrieved from: https://www.uber.com/newsroom/uber-health
53. USA Facts. (2020). How has the population changed in Escambia County? Retrieved from: https://usafacts.org/data/topics/people-society/population-and-demographics/our-changing-population/state/florida/county/escambia-county?endDate=2020-01-01&startDate=2010-01-01

XIII. APPENDIX A

2021-2022 Health Equity Outreach Events in Escambia County

Hep A Vaccine Outreach

Mobile HIV Testing

In-Home HIV Test Kits

Parent University

Tobacco Free Florida SWAT