Franklin County

HEALTH EQUITY PLAN

January 2023—June 2025

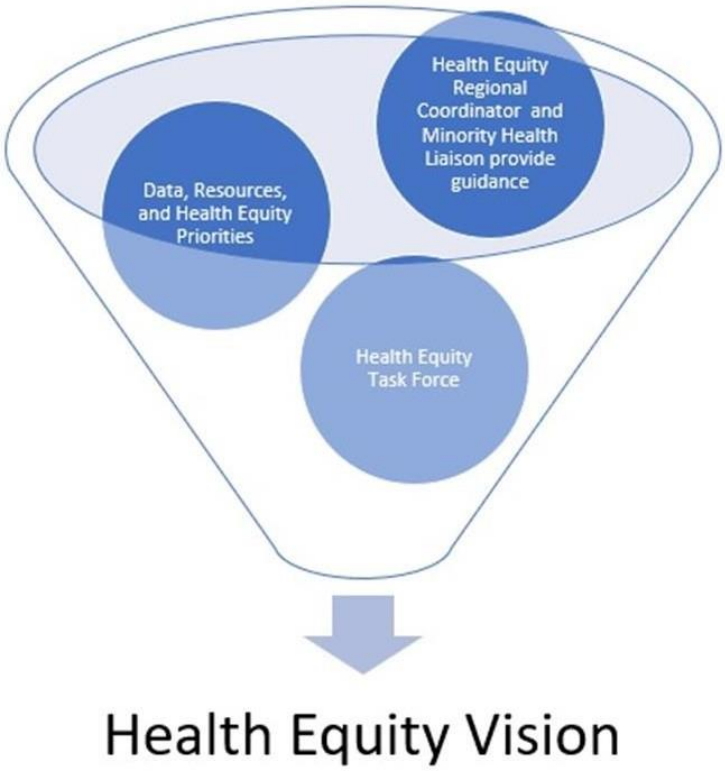
Updated 12/28/2022

Submitted by
the Health Equity Taskforce

Table of Contents

I. VISION

The vision statement provides focus, purpose, and direction to the health equity planning process. Visioning guides the community through a collaborative process that leads to a shared community aspiration. As a part of the Community Health Assessment (CHA) Franklin County used the National Association of County and City Health Officials (NACCHO), Mobilizing for Action through Planning and Partnerships (MAPP) guidance. The Health Equity Vision was written by the Health Equity Taskforce under the guidance of the Health Equity Regional Coordinator and the Minority Health Liaison. Visioning was conducted at the beginning of the planning process to provide the framework throughout the stages of planning and unite around a shared vision.



The Regional Coordinator and Minority Health Liaison facilitated the shared vision. Ascendant Healthcare Partners facilitated the MAPP assessments as well as additional primary research. The Community Health Improvement Plan (CHIP) identified the Health Equity Taskforce as a subset of the Community Health Improvement Team.

A UNITED, HEALTHY, AND PROSPEROUS FRANKLIN COUNTY.

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 (SDOH) by fostering multi-sector and multi-level partnerships, conducting surveillance, integrating data from multiple sources, and leading approaches to develop upstream policies and solutions. This plan acknowledges that collaborative initiatives to address the SDOH are the most effective at reducing health disparities.

The purpose of the Health Equity Plan is to increase health equity within DOH-Franklin. To develop this plan, Franklin 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 DOH-Franklin. 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 which impact health and well-being in the county.

III. DEFINITIONS

Health equity is achieved when everyone can attain optimal health.

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

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

Equality is when 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.

The Florida Department of Health in Franklin County strives to provide the support needed to attain optimal health for vulnerable populations on a consistent basis. The image above was taken at the Improving Access to Care event which brought together residents and visitors in Franklin County to heighten awareness across all priority populations and organizations. DOH-Franklin are the champions of the community for providing a broad arrangement of health and safety education to all communities and populations. Over the past ten years, DOH-Franklin has grown and continues to evolve while learning more about adequately providing health and safety education in an equitable manner to Franklin County citizens and visitors. DOH-Franklin partnered in the event with Elder Care Community Council, CareerSource Gulf Coast, Ascension Sacred Heart Gulf and Refuge House.

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: Alma Pugh
Minority Health Liaison Backup: DT Simmons

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 Franklin County to the Health Equity Taskforce. The Minority Health Liaison guides these discussions and the implementation of initiatives. The membership of the Health Equity Team is listed below.

Name	Title	Program
Bennefield, Megan M	CHOICES Health Educator	CHOICES
Cash, Stephanie A	Program Supervisor	Healthy Families
Hogan, Lisa	Nursing Director	Clinical Services
Jones, Tasia L	SWAT Coordinator	Tobacco Prevention
Lenhart, Karey	Environmental Health Specialist	Environmental Health
Pippin, Jessie W	Program Supervisor	Health Education
Pugh, Alma	Minority Health Liaison	Minority Health
Quinn, Evette	SWAT Coordinator	Tobacco Prevention
Rickards, Patricia L	Family Support Worker	Healthy Start
Robinson, Talitha L	CHOICES Health Educator	CHOICES
Simmons, Deanna T	Minority Health Liaison	Accreditation

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

Meeting Date	Topic/Purpose
March 8, 2022	Team purpose, roles, responsibilities, and review of Social Determinants of Health and Health Equity
June 7, 2022	

August 24, 2022	Discussed how priority populations access our services and our facility
October 19, 2022	Discussed barriers to service. Reviewed reports from teams on how to make our facility more accessible of all.

C. Health Equity Taskforce

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

Name	Title	Organization	Social Determinants of Health
Alma Pugh	Minority Health Liaison	DOH-Franklin	Healthcare
Angela Webster	Case Manager	Capital Area Community Action Agency	Economic
David Walker	CEO	Weems Memorial	Healthcare
DT Simmons	Minority Health Liaison	DOH-Franklin/Gulf	Healthcare
John Griggs	Nurse Educator	Sacred Heart Hospital	Healthcare
Sarah Quaranta	Administrator	DOH-Franklin/Gulf	Healthcare
Stephanie Turrell	Executive Director	Apalachicola Housing Authority	Neighborhood
Terrence Watts	Administrator	DCF – Circuit 2	Social
Charles Elliot	Coordinator	Franklin County Veterans Administrations	
Cheyenne Martin	Community Resource Development	FAMU Extension Cooperative Program	Education
Ciara Holloman	Statewide Health Agent	FAMU Extension Cooperative Program	Education
Valentina Webb		CareerSource	Economic/Employment
Elinor Mount-Simmons	President	H'COLA	
Selina Peet	Program Supervisor	Apalachee Center, Inc.	Healthcare
Lisa Sherry	Community Outreach Coordinator	DISC Village	Social/Community Networks
Myrtis Wynn	Member	North Florida African American Corridor Project	Social/Community Network
Chelsea Marshall	Specialist	UF Extension Office (IFAS)	Education

The Health Equity Taskforce met on the below date 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	Organizations	Topic/Purpose
3/17/2022	HE Taskforce	Taskforce purpose, roles, responsibilities, and review of Social Determinants of Health, and Health Equity
09/14/2022	HE Taskforce	Discussed prioritized health disparity. Identified populations impacted by our health disparity. Examined data gaps Discussed social determinants of health
10/27/2022	HE Taskforce	Created (short, med, and long-term) goals. Discussed community needs, highlighted upcoming events and opportunities to collaborate with each other.
11/22/2022	Objectives Subcommittee	Reviewed short-term, med-term, and long-term goals. Discussed how to build quality objectives. Created objectives to support each goal.
12/28/2022	HE Taskforce	Reviewed (including but not limited to: overall priority, priority populations, identified social determinants of health, selected goals & objectives) the plan and projects and approved.

D. Coalition

The Coalition discussed strategies to improve the health of the community. The strategies focused on the following 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. The Coalition assisted the Health Equity Taskforce by reviewing their Health Equity Plan for feasibility. See Appendix A for a list of Coalition members.

E. Regional Health Equity Coordinators

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

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

V. HEALTH EQUITY ASSESSMENT, TRAINING, AND PROMOTION

A. Health Equity Assessments

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

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

Franklin County conducted health equity assessments to examine the capacity and knowledge of DOH-Franklin staff and county partners to address social determinants of health. The DOH-Franklin County staff were surveyed to identify the baseline of understanding their role in health equity. Franklin County utilized MAPP assessments in combination with the Mobilizing and Organizing Partners to Achieve Health Equity Tool (April 2021). The full results of the assessments below can be found in the 2022 Franklin County's Community Health Assessment. Below are the dates assessments were distributed and the partners who participated.

Date	Assessment Name	Organizations Assessed
2/26/2022	Social Determinants of Health and Health Equity Training	Day of Dialogue Committee and Participants
3/8/2022	Community Health Status Assessment	Primary data community
3/10/2022	Community Themes & Strengths Assessment	Community-wide
3/17/2022	Social Determinants of Health and Health Equity Training	Health Equity Coalition
3/19/2022	Social Determinants of Health and Health Equity Training	Pioneer Bay Community Development Cooperation
3/30/2022	Health Equity Survey: Baseline Understanding to Identify Future Training Needs	DOH-staff

4/7/2022	Social Determinants of Health and Health Equity	Franklin & Gulf County Retired Teacher Association
4/28/2022	Forces of Change Assessment	Community Partners
5/18/2022	Local Public Health Assessment	Community Partners & Health Equity Taskforce

Community Health Status Assessment

The Community Health Status Assessment (CHSA) identifies priority health and quality of life issues. Questions include: “How healthy are our residents?” and “What does the health status of our state look like?” The CHSA is a crucial component in the MAPP process, and it is during this stage that specific health issues (e.g., high cancer rates or low immunization rates) are identified. A broad range of data serves as the foundation for analyzing and identifying community health issues and determining where the community stands in relation to peer communities, state data and national data. To better communicate findings, the County Health Rankings and Roadmaps model was used to group and frame information for the health status assessment. The County Health Rankings measure the health of nearly all counties in the nation and rank them within the state.[1] The 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.

Health Equity Lens

In addition to considering what the social determinants of health are, it is important to understand how they disproportionately affect underserved populations. Health equity is defined as all people having the opportunity to ‘attain their full health potential and no one is disadvantaged from achieving this potential because of their social position or other socially determined circumstance.[2] A robust assessment of the larger social and economic factors affecting a community (e.g., housing, employment status, the built environment, etc.) should capture the disparities and inequities that exist for traditionally underserved groups. According to Healthy People 2030, a science-based platform that provides 10-year national objectives for

[1] Robert Wood Johnson Foundation. (2017). County Health Rankings and Roadmaps. Retrieved from http://www.countyhealthrankings.org/our-approach.
[2] Braveman, P.A., Monitoring equity in health and healthcare: a conceptual framework. Journal of Health, Population, and Nutrition, 2003. 21(3): p. 181

improving the health of all Americans and achieving health equity requires focused efforts at the societal level to address avoidable inequalities, especially among those who have experienced socioeconomic disadvantage or historical injustices. A health equity lens guided the community health assessment process to ensure the data comprised a range of social and economic indicators and was presented for specific population groups. Within the CHSA strategies were used to identify patterns of health inequity within the community.

In Franklin County, the leading causes of death identified were types of chronic disease: heart disease and cancer. The analysis shows that 35% of Franklin County adults were obese. The identified priority populations were Hispanics, African American, and elderly (65+). The County maps showed that a significant proportion of the identified priority populations reside in Port St. Joe and Apalachicola.

Community Themes and Strengths Assessment

The County Themes and Strengths Assessment (CTSA) answers key questions, drawing from a cross-section of the public health system that includes local county health departments, state and community public health partners, and residents. This assessment results in a strong understanding of community issues and concerns, perceptions about quality of life and a listing of assets. The table below highlights the health disparities that were identified.

	White		Black		Hispanic/Latino		Asian-Pacific Islander		Native Indian/ Alaska Native	
	Male	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
Access to Care	12	41	0	9	0	1	0	0	0	0
Education (did not graduate High School)	0	3	0	0	0	0	0	0	0	0
Food Insecurities	21	77	1	9	0	2	0	0	0	0

Forces of Change

The partners of Franklin County identified opportunities within access to care to be a new hospital opening, opportunities for further collaboration in partnerships and health education. The challenges identified were the funding to meet the specific needs of the community and the breakdown between services available and the priority populations in need.

Local Public Health Status Assessment (LPHSA)

Franklin County used a combination of leadership and community stakeholders to engage in the survey. This assessment has been useful as a learning tool to assess Franklin County's readiness to address agencies strengths and weaknesses as well as how they acknowledge and address health equity in the near future. The assessment emphasizes alignment with the essential public health services - those that experts agree will be most critical to protecting and promoting the health of the public in the future. The LPHSA showed partners in Franklin County are aware of health equity and it illustrated the need to further improve partners knowledge in this area.

When the Franklin County Health Department completed the Local Public Health System Assessment (LPHSA) using the National Public Health Performance Standards (NPHPS) Instrument, the questions about essential service delivery identified how well the local public health system acknowledges and addresses health inequities.

The diverse group of partners and public health professionals represented a wide spectrum of expertise which were surveyed to assess the performance and capacity of Franklin's public health system. The survey provided the Essential Service description, activities, and model standard for each group of indicators. Utilizing the survey, participants then cast votes ranging from no activity to optimal activity. Voting results were presented virtually.

Responses for all ten Essential Public Health Services (EPHS) were entered into a standardized CDC-developed tool from which results were obtained.

Health Equity Employee Survey

On March 30, 2022, a Health Equity Employee survey was completed by all employees of the DOH-Franklin. The 26-question survey instrument provided the opportunity to choose one of the following options: aware, functional, proficient, and expert.

Overall, the results showed that employees of DOH-Franklin had a functional understanding of health equity, health inequities, and disparities. This survey provides the baseline for training opportunities that will increase their awareness of cultural competency training to improve staff skills in working with diverse populations.

All members of the DOH-Franklin identified that it is very important for public health professionals to have the skills to identify health equity and social determinants of health expertise. The Health Equity Survey identified additional training requirements to provide optimum understanding of health equity, disparities, and the need for community investment.

B. County Health Equity Training

Assessing the capacity and knowledge of health equity helped the Minority Health Liaison identified knowledge gaps and created cultural awareness training for the Health Equity Taskforce and the Coalition. DOH-Franklin provided an online training to our partners which is outlined below.

Date	Topics	Organization(s) receiving trainings
2/26/2022	Social Determinants of Health and Health Equity Training	Day of Dialogue Committee and Participants
3/17/2022	Social Determinants of Health and Health Equity Training	Health Equity Coalition
3/19/2022	Social Determinants of Health and Health Equity Training	Pioneer Bay Community Development Cooperation
4/7/2022	Social Determinants of Health and Health Equity	Franklin & Gulf County Retired Teacher Association

C. County Health Department Health Equity Training

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

Date	Topics	Number of Staff in Attendance
11/15/2021	Health Equity Training	DOH-Franklin/Gulf Staff
3/8/2022	Social Determinants of Health and Health Equity Training	DOH-Franklin/Gulf Staff

DOH-Franklin's Health Equity Team developed a shared understanding of health equity in Franklin County through training and dissemination of resources. Recently, the Cultural Competency Health Equity training was shared with organizations in the community.

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
April 12-13, 2022	Minority Health and Health Equity Liaison Orientation
May 3-5, 2022	Health Equity Conference

E. National Minority Health Month Promotion

"The National Minority Health Month promotional event was held on Saturday, April 30, 2022. The event focused on improving access to care with an emphasis on chronic disease awareness, prevention, and management. This event took place at the Holy Family Senior Center, a community center in the heart of Apalachicola's historically black neighborhood.

At this event, residents visited vendors offering support services and receive free screenings. Those with diabetes and/or other chronic disease or pre-disease status

were connected to wrap around services within the community, including diabetes self-management, tobacco cessation support and other family support services.

This event started with a diabetes lecture, followed by a round table discussion on the importance of mental health and finished with a large group exercise activity, highlighting easy exercises that can be done at home with little to no equipment. Partners provided healthy refreshments, information on local health services, and free seasonal produce accompanied by healthy recipe cards.

VI. PRIORITIZING A HEALTH DISPARITY

Franklin County, Florida shows that the health disparity with the highest priority is diabetes. Data was pulled from multiple sources including Florida Charts, Healthy People 2030, 2022 Franklin County's Community Health Assessment, and mySidewalk.

The risk for diabetes differs based on whether or not you've completed high school, your income, and whether you come from a group that has historically faced discrimination such as Native Americans, indigenous people, African Americans, and people of Hispanic heritage. Risk also differs based on access to affordable care and quality care. These are all factors that are independently associated with diabetes prevalence. Because these are conditions in which one is born and lives, social determinants of health have an impact across the full continuum of diabetes outcomes.

Diabetes is a chronic, metabolic disease characterized by elevated levels of blood sugar which can over time led to serious damage to the heart, blood vessels, eyes, kidneys, and nerves. The fact that in 2019, 9.9% of all Franklin County adults had been told that they had diabetes and that three of their priority populations, elderly residents, African American residents, and Hispanic residents had higher percentages, further confirms this selection.

There are several priority populations that have to be addressed including African Americans, Hispanics, and the elderly based on their significance in the County's population. African Americans are the largest priority group in Franklin County with 13.5% of the total population. In 2019, 22.5% of the non-Hispanic Franklin County African American residents had ever been told that they had diabetes as compared to the State of Florida's percentage of 16%. The median household income for Franklin County African American residents from 2016 to 2019 was $31,310 which is almost 30% below the like number for Florida. Also, only 34.4% own their homes which results in unstable housing which is associated with an increased risk of diabetes. As is in 2019 only 65.4% of Franklin County's African American residents had a personal doctor and less than 70% of the non-institutionalized residents had health insurance. With the high school graduation rate for Franklin County African American residents at 65%

and only 6.4% of them having bachelor's degree or higher, many of the social determinants that put residents at risk are in place for Franklin County African American residents.

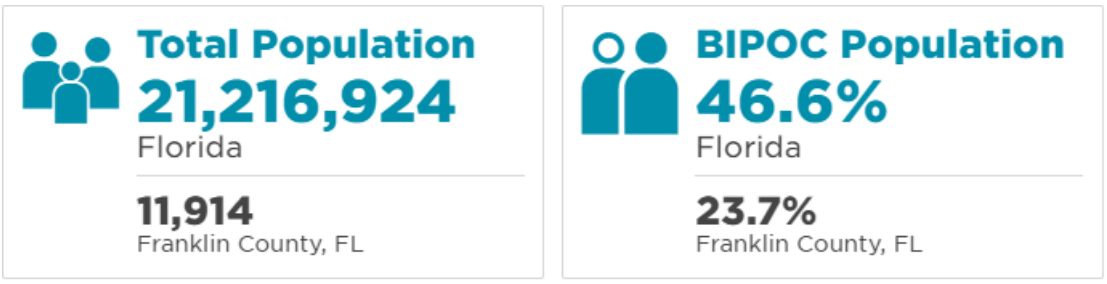
Another priority population which needs to be addressed are the Hispanic residents who make up 5.6% of Franklin County's population. In 2019, 10.4% of Hispanic residents had been told that they had diabetes. Only 33% of them had a personal doctor. Concerns voiced by the Franklin and Gulf Health Equity Task Force was that clients were not receiving the best follow up post diabetes diagnosis. If this continues to be an issue overall, given the low percentage of the Hispanic adults with a personal doctor, this could really be an issue for the Hispanic population.

Additionally, the priority population of the elderly which is defined as a resident at least 65 years old. In 2019, 23% of the elderly in Franklin County had been told that they had diabetes. That compares to 23.5% statewide. The elderly population's median household income was about 10% below the State of Florida average from 2016 to 2020. Although the elderly can usually obtain good health insurance coverage, lack of public transportation and lack of certain specialized types of doctors who can treat diseases such as diabetes and related diseases can cause problems to this population.

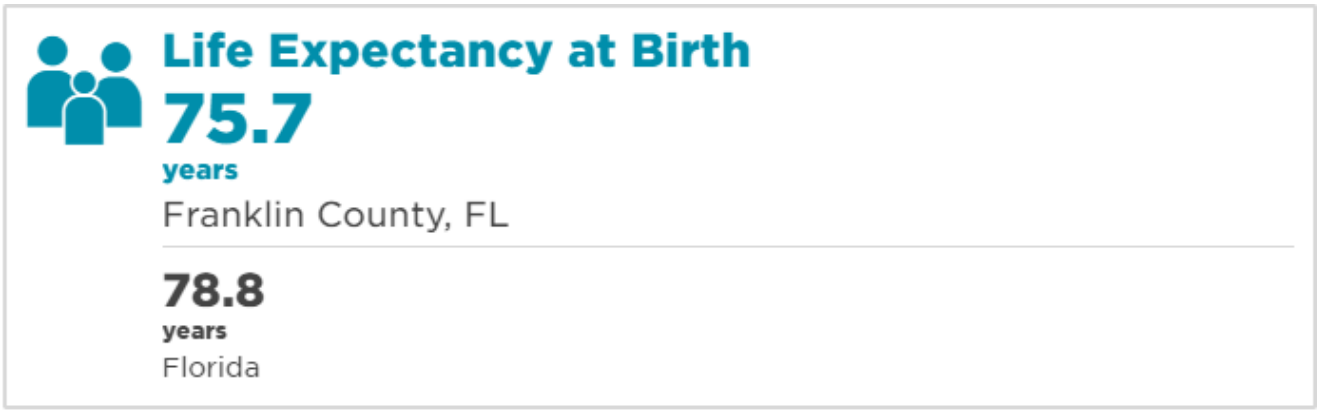
Franklin County has set a Health Equity Plan objective of reducing the African American/White diabetes death disparity from 5.4 to 1 in 2022 using the following Social Determinants of Health goals:

1) Improving access to healthcare resulting in the rate of African American diabetes deaths from 70.3 to 65 (per 100,000). This is a long-term goal;
2) Improving access to healthcare resulting reducing the percentage of African American residents diagnosed with diabetes from 20.7% to 18%. This is a medium-term goal;
3) Improving access to housing in Franklin County by increasing by June 2023 the African American owner-occupied housing from 34.4% to 36% in Franklin County. This is a short-term goal;
4) Improving health equity by improving baseline knowledge of partners in Franklin County from by October 2022 by using Ascendant Healthcare Partner's survey instrument. This is a short-term goal.

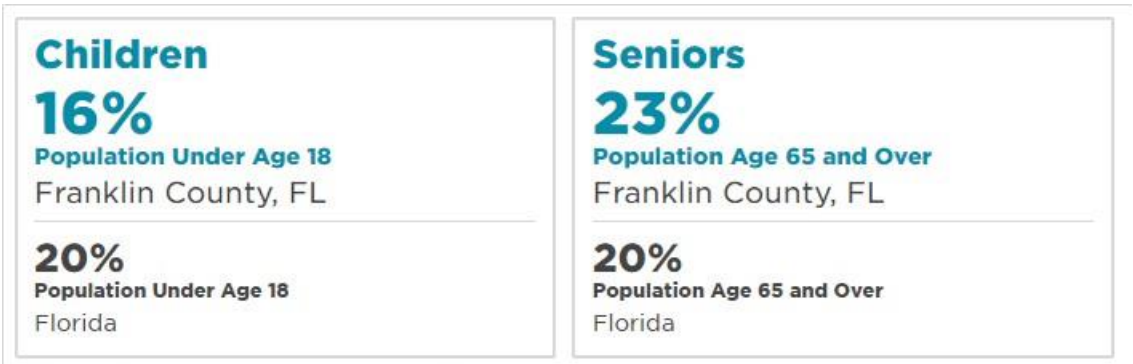
The populations in the following groups were too low to establish a baseline to be identified as a priority population within Franklin County: American Indian, Alaskan Native, Asian, Native Hawaiian, Other Pacific Islander, veterans, disabled, or immigrants and LGBTQ+. Furthermore, the proportion of infants and toddlers (0-5yrs) that are type 2 diabetes is atypical.



Sources: US Census ACS 5-yearNote: BIPOC Population is calculated by taking the total population minus the white (not Latino, not Hispanic) population.



Sources: CDC NCHS USALEEP 2010-2015

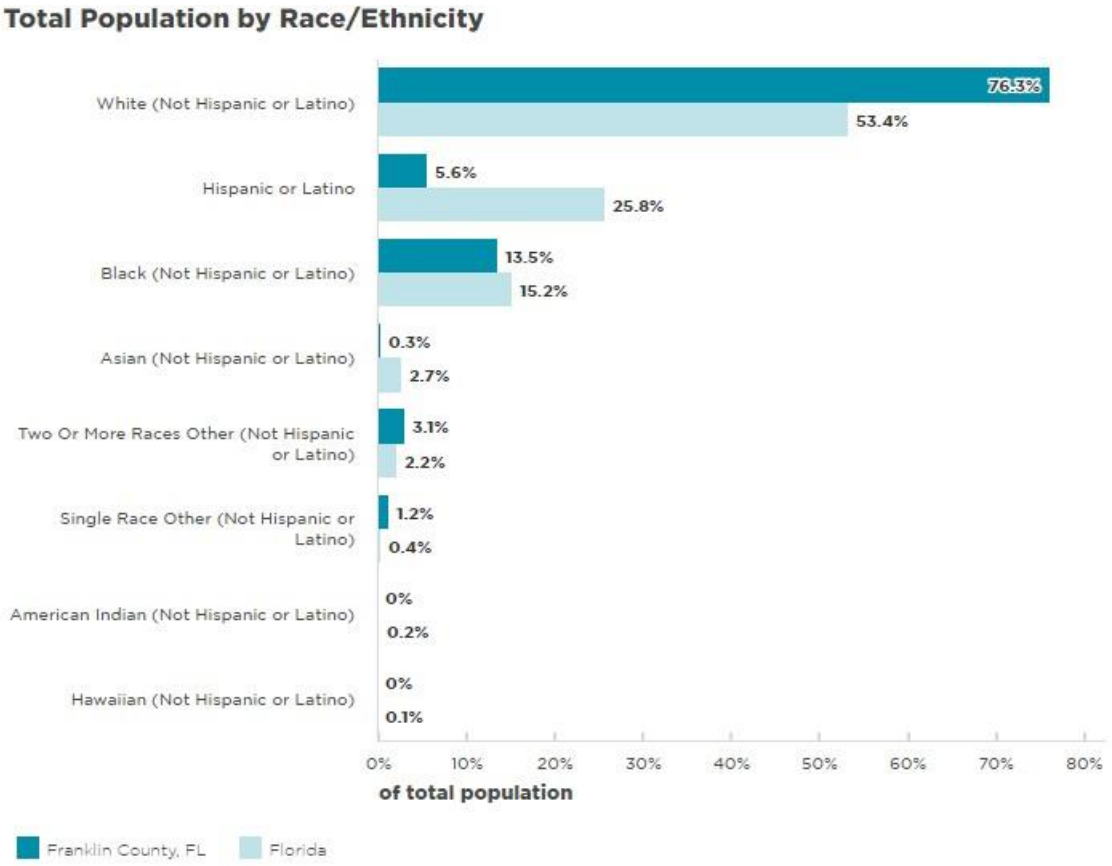


Sources: US Census Bureau ACS 5-year 2016-2020

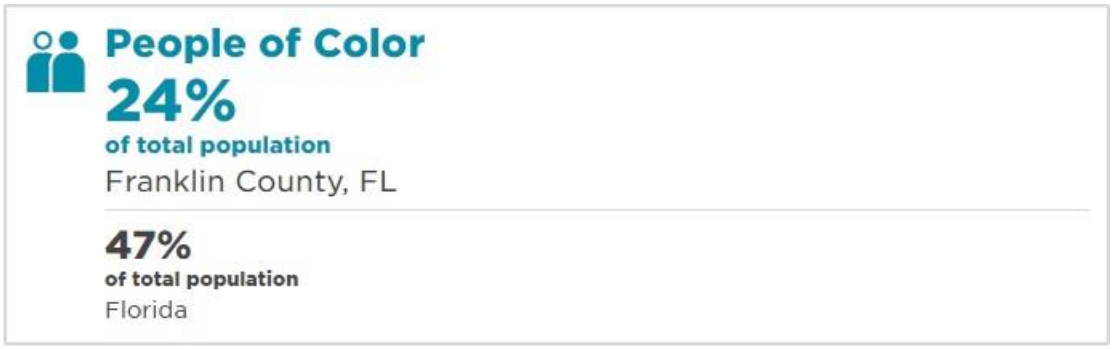
Vulnerable Populations

	People
Population Age Under 5	479
Population Age 65 and over	2,753
Population Living with a Disability	2,167

Educational Attainment: Less than 9th Grade	665
Ratio of Income to Poverty Level: 150% and Under - Very Low-Income Population	3,601
Ability to Speak English - Less Than Very Well	182
Veteran Population	998
Veteran Population 65+	585
Foreign Born Population	358



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



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

Hispanic Population

5.6%
of total population
Franklin County, FL

25.8%
of total population
Florida

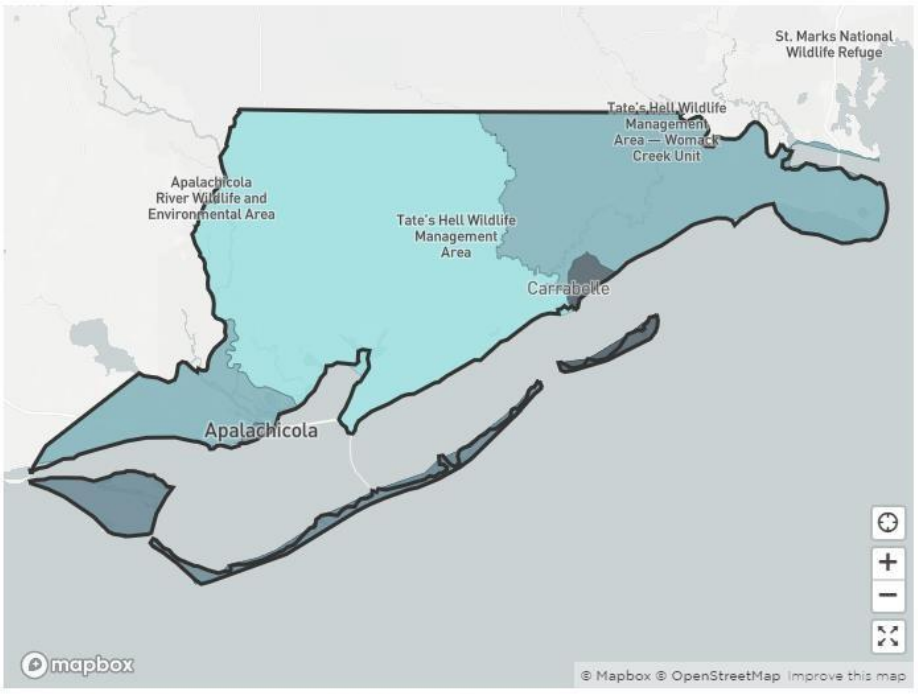
Hispanic or Latino/Not Hispanic or Latino Dissimilarity Index

0.07
out of 1
Franklin County, FL

0.49
out of 1
Florida

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

Note: This dataset represents the dissimilarity index between two populations. Values near 0 represent less segregation where the selected geography's ratio of two race/ethnicities is very similar to the contained Census Tracts. Values near 1 represent more segregation where the select geography's distribution is much different from the Census Tracts.



Sources: EPA Smart Location Database 2019; US Census Bureau ACS 5-year 2016-2020

Sources: US Census ACS 5-year

Black (non-Hispanic) Population

13.5%
of total population
Franklin County, FL

15.2%
of total population
Florida

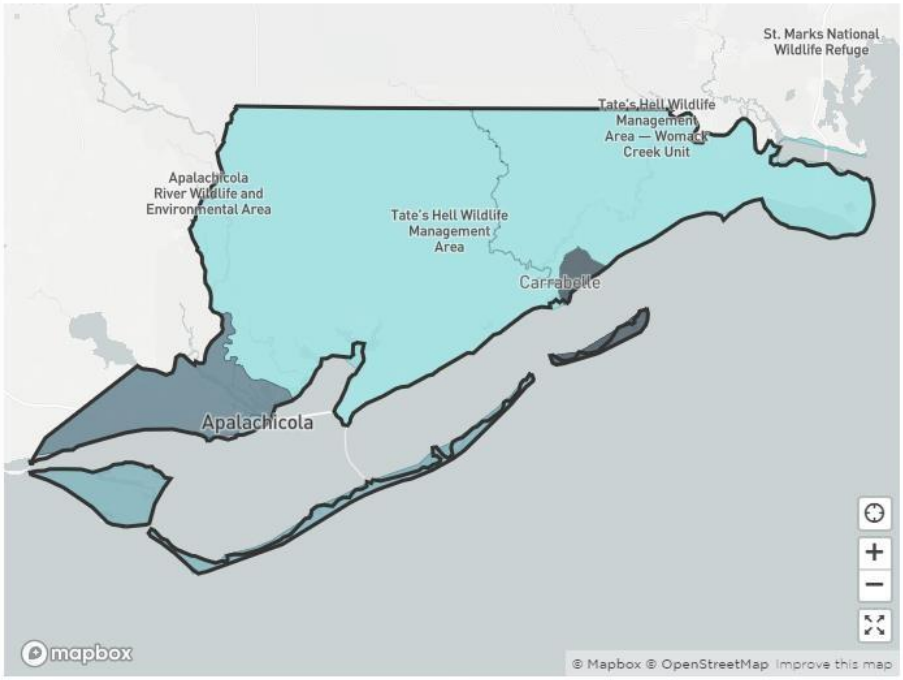
Black/White Dissimilarity Index

0.57
out of 1
Franklin County, FL

0.59
out of 1
Florida

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

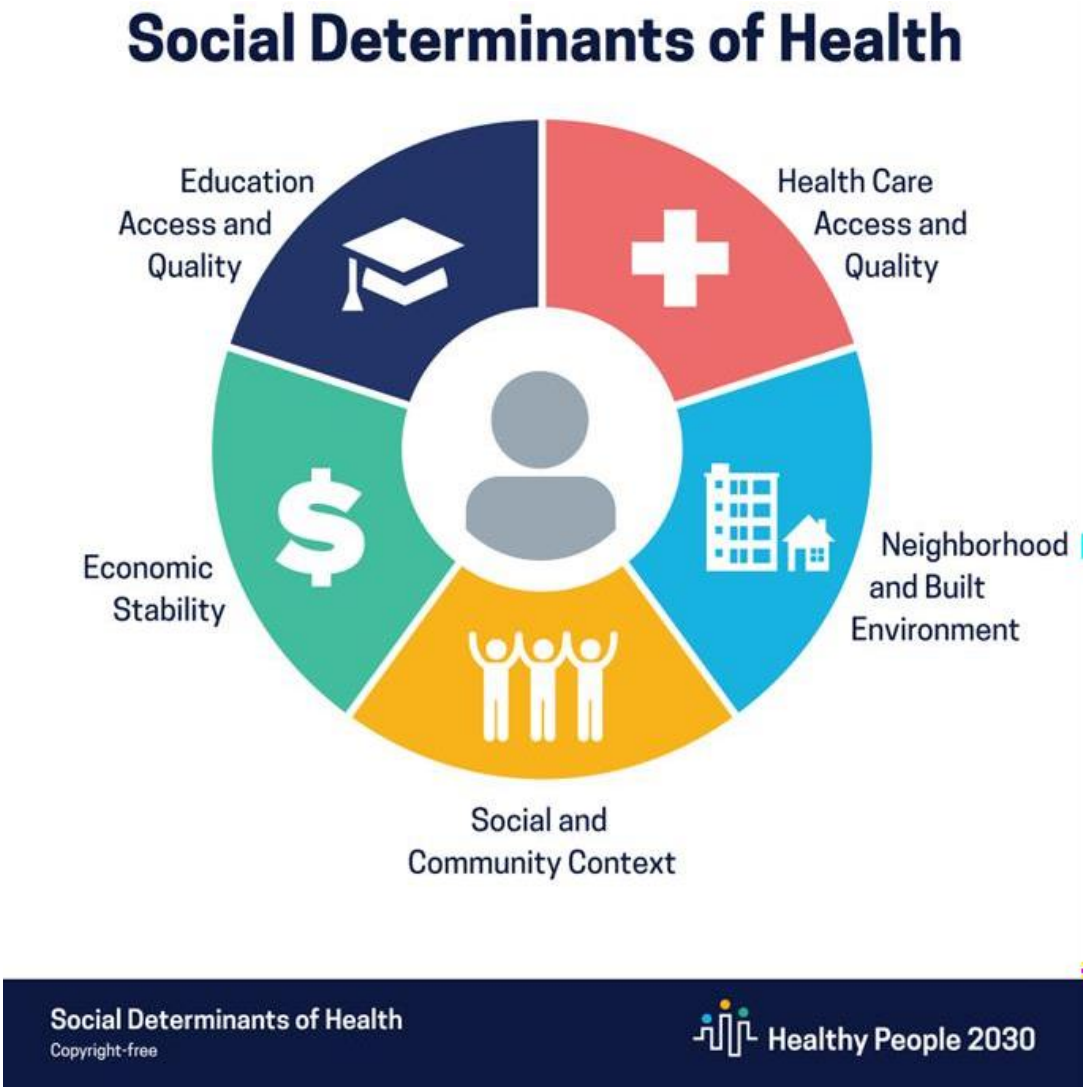
Note: This dataset represents the dissimilarity index between two populations. Values near 0 represent less segregation where the selected geography's ratio of two race/ethnicities is very similar to the contained Census Tracts. Values near 1 represent more segregation where the select geography's distribution is much different from the Census Tracts.



Sources: EPA Smart Location Database 2019; US Census Bureau ACS 5-year 2016-2020

Sources: US Census ACS 5-year

VII. SDOH DATA



The Social Determinants of Health (SDOH) 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 SDOH 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. Some of the conditions which affect the five SDOH relative to type 2 diabetes in Franklin County are outlined below:

A. Education Access and Quality

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

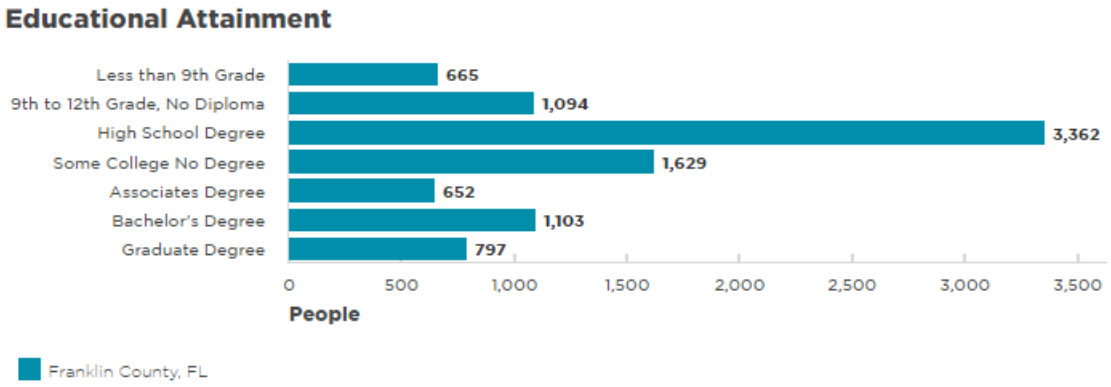
How many residents have access to educational opportunities?

It is commonly known that good habits like eating well, maintaining a good weight, not smoking, and getting regular checkups can lead to better health. What is not as widely known is that access to quality education has been correlated to better health outcomes and possibly a longer life. In fact, individuals who graduate college live up to five years longer than those who did not graduate from high school. For this reason, the CDC considers education one of the top five social determinants of health (SDOH).[3]

Education improves nearly every factor impacting an individual's health. Literacy and the ability to understand health information is correlated with longer lifespans, greater educational attainment improves economic opportunity, and high school graduation is a critical predictor for whether an individual will be exposed to violent crime in their lifetime. Lifelong educational outcomes begin in preschool. Enrollment in a high-quality preschool or nursery school often predicts lifelong educational and health outcomes.

[3] Social Determinants of Health: Education Access and Quality - myNEXUS® (mynexuscare.com)

A more educated community builds a stronger foundation for economic success, and directly impacts the overall well-being of a place. Educational attainment shows the knowledge and skills of residents and identify areas where efforts to increase educational attainment would be most impactful.

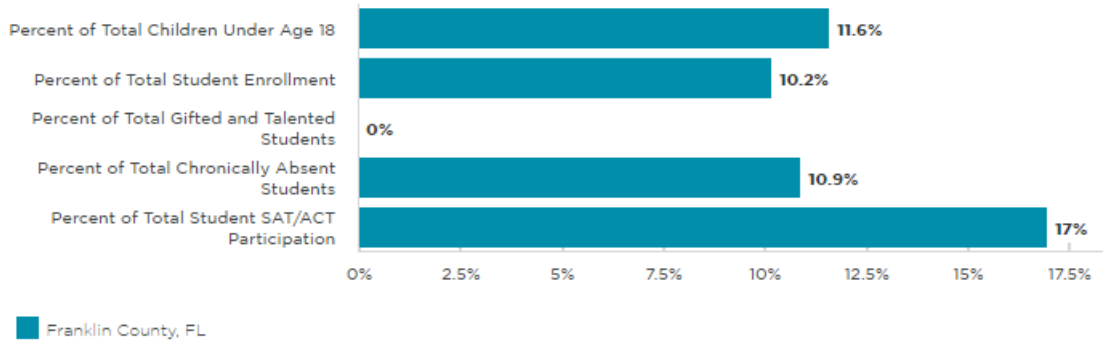


Sources: US Census Bureau ACS 5-year 2016-2020

High School Graduate or Higher (2020-21) https://data.census.gov/cedsci/table?q=high%20School%20diploma&t=Populations%20and%20People&g=0500000US12037&tid=ACSST5Y2020.S1501&moe=false				
	Total	**65+**	**Black**	**Hispanic**
Franklin	81.1%	87.3%	64.9%	69.7%
State of Fla	88.5%	86.1%	83.7%	80.4%

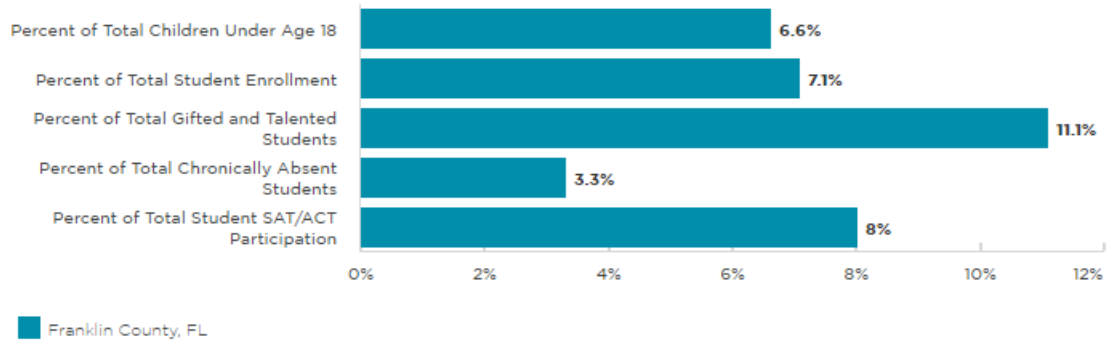
Bachelor's Degree or Higher (2016-2020) https://data.census.gov/cedsci/table?q=high%20School%20diploma&t=Populations%20and%20People&g=0500000US12037&tid=ACSST5Y2020.S1501&moe=false				
	Total	**65+**	**Black**	**Hispanic**
Franklin	20.4%	29.7%	6.4%	10.5%
State of Fla	30.5%	28.5%	19.3%	24.6%

Black Students At-A-Glance



Sources: CRDC 2017-2018; US Census Bureau ACS 5-year 2016-2020

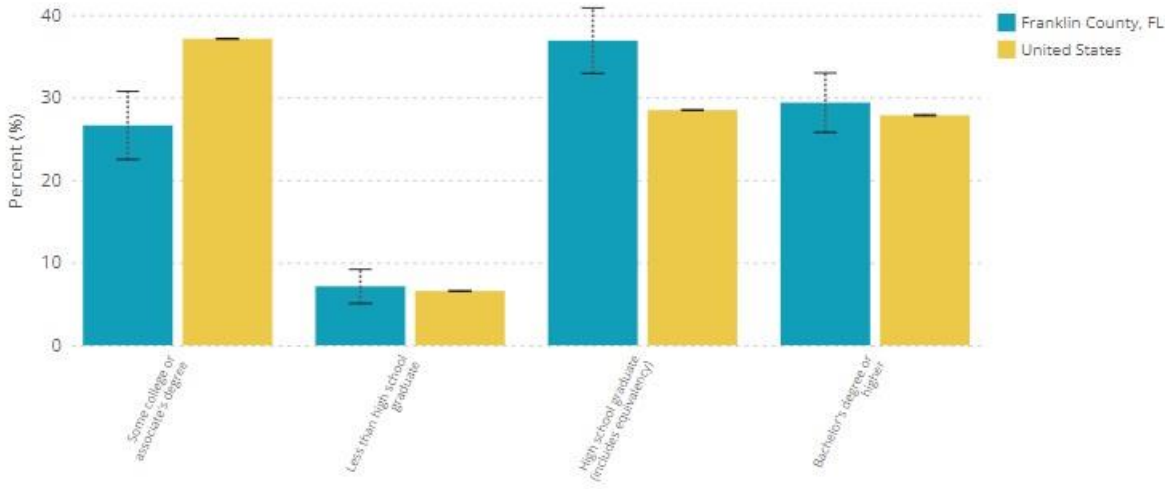
Hispanic Students At-A-Glance



Sources: CRDC 2017-2018; US Census Bureau ACS 5-year 2016-2020

What is the highest level of schooling attained by the veteran population in Franklin County?

Veteran Population: by Educational Attainment (2013-2017)



About the Data

Data is from the U.S. Census Bureau's American Community Survey (ACS), 5-year estimates, Table B21003. The population considered in this data only includes people who are 25 years and older. LiveStories calculated the percentages.

- **The impact of education access and quality on Type 2 Diabetes**

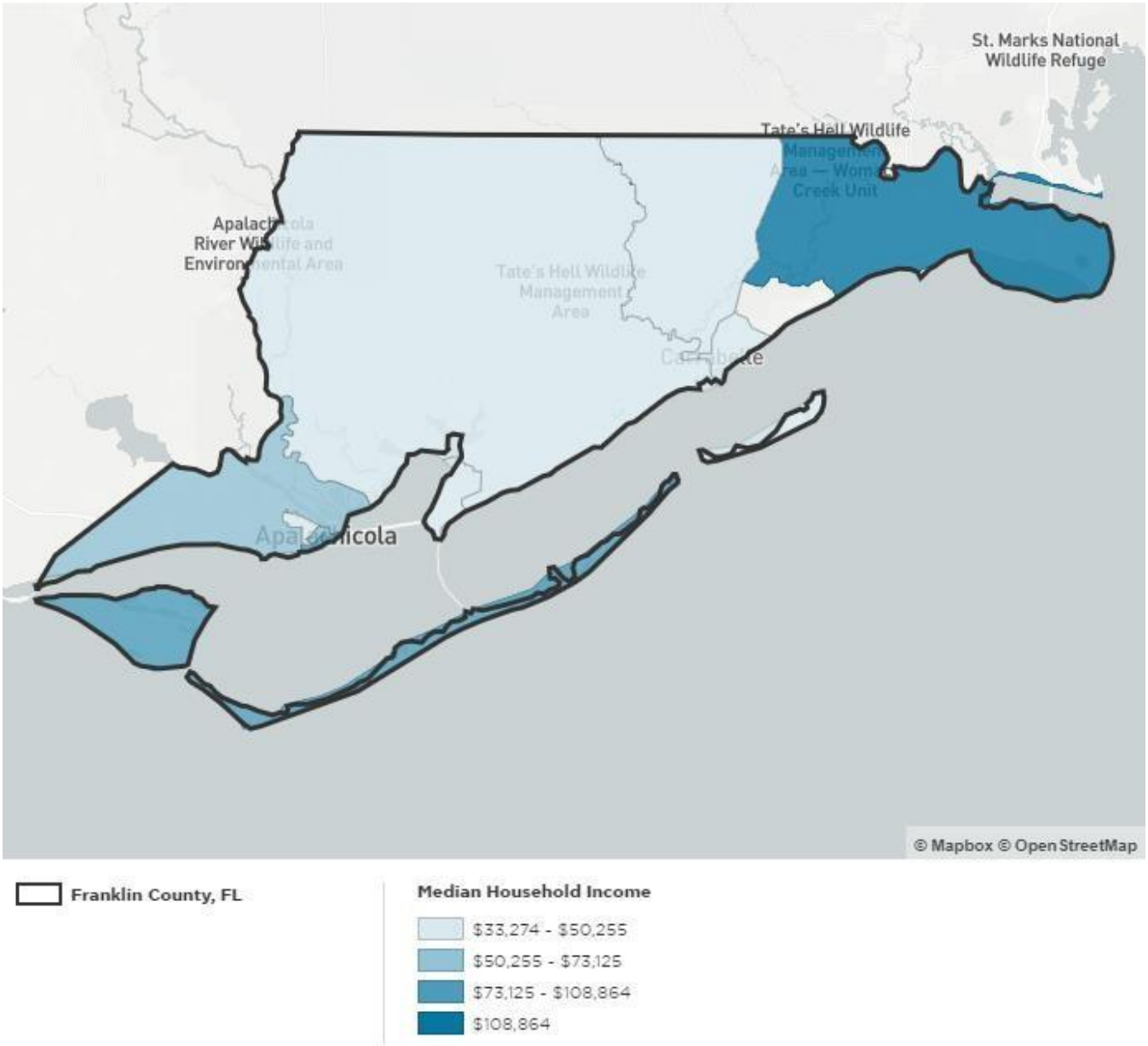
Education Access and Quality: The risk for diabetes differs based on whether or not you've completed high school, your income, and whether you come from a group that has historically faced discrimination such as Native Americans, indigenous people, African Americans, and people of Hispanic heritage. Programs which help students finish high school should lower the residents being diagnosed with type 2 diabetes later in life. Risk also differs based on access to affordable care and quality care.

B. Economic Stability

- **Economic stability data for Franklin County**

People with steady employment are less likely to live in poverty and more likely to be healthy, but many people have trouble finding and keeping a job. People with disabilities, injuries, or conditions like arthritis may be especially limited in their ability to work. In addition, many people with steady work still don't earn enough to afford the things they need to stay healthy.

Median household Income. (2016-2020) https://www.flhealthcharts.gov/ChartsReports/rdPage.aspx?rdReport=ChartsProfiles.HealthEquityMergeMHProfile				
	Total	**65+**	**Black**	**Hispanic**
Franklin	$48,814	$42,254	$31,310	$44,054
State of Fla	$57,703	$46,182	$43,418.	$52,092



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

Unemployment

Employment is the very foundation of economic opportunity. Unemployment makes it difficult, if not impossible, to meet life's basic needs and even a brief period of unemployment can negatively impact an individual's earnings for up to 20 years. Middle skill jobs often provide better wages than lower skill jobs, but also often require training or education beyond high school.

4,565
Labor Force Population
Franklin County, FL

7.8%
Unemployment Rate
Franklin County, FL

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

3,241
Jobs by workplace location
Total Jobs
Franklin County, FL

No data
Jobs
Jobs within 1/2 Mile of Transit Stop
Franklin County, FL

7.8%
of total labor force
Unemployment Rate
Franklin County, FL

$48,814
USD
Median Household Income
Franklin County, FL

25.3%
of total jobs
Low Wage Jobs
Franklin County, FL

46.2%
of total population
Low Income Residents
Franklin County, FL

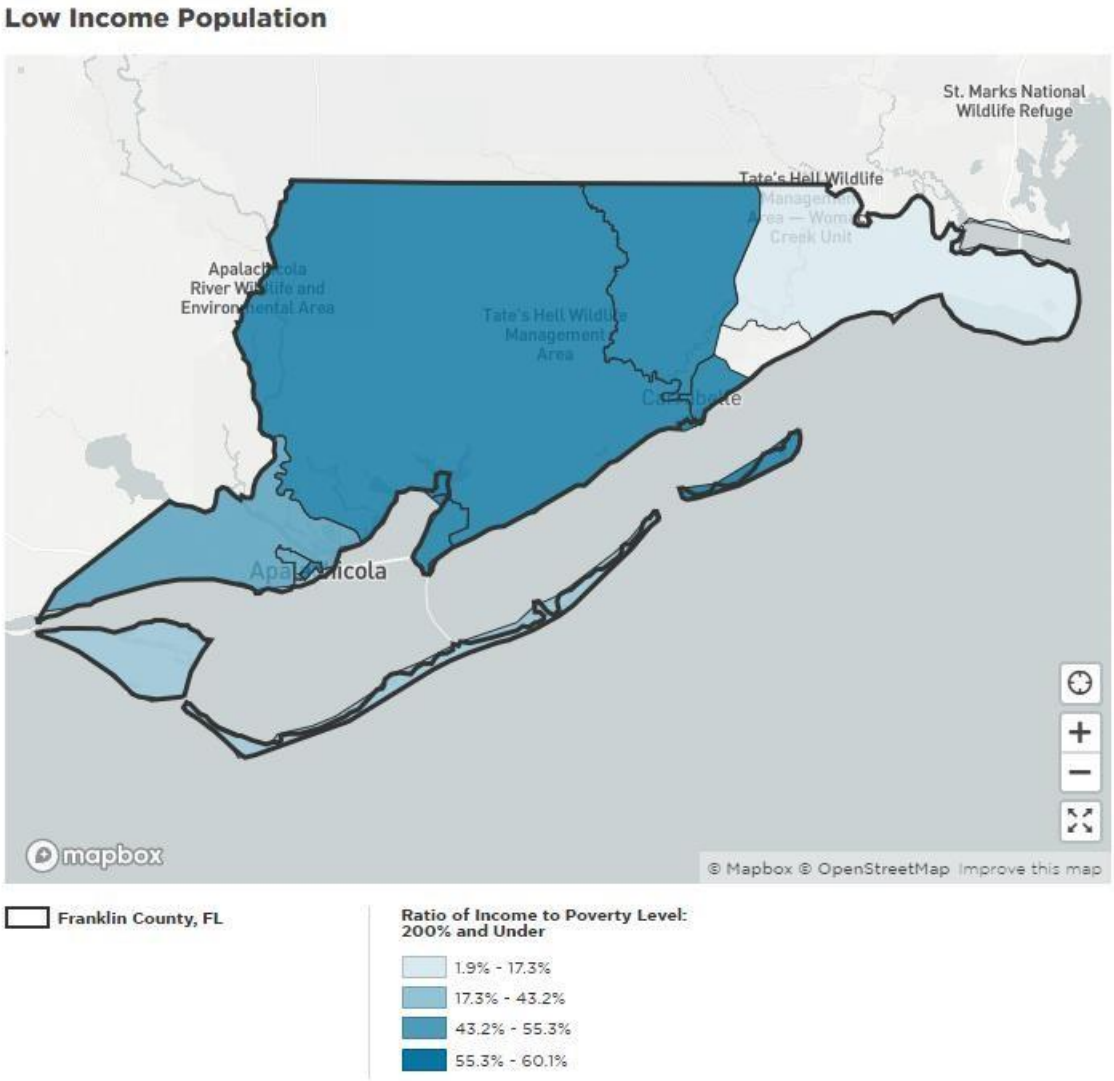
Sources: EPA Smart Location Database 2019; US Census Bureau ACS 5-year 2016-2020

Note: Low wage jobs are as those where workers earn $1250/month or less. Low income residents is defined as the population that is living 200% or below poverty level.

Poverty Levels

The U.S. Census identifies individuals with a household income of up to 200% of the poverty level as low income. Low-income residents in communities with high income inequality face greater health risks. They are more likely to face barriers to healthy choices,

such as longer distances to healthy food or affordable healthcare and are more likely to be exposed to environmental risks, such as low-quality housing.



The incidence and prevalence of Type 2 diabetes appear to be socially graded, as individuals with lower income and less education are 2 to 4 times more likely to develop diabetes than more advantaged individuals.

46.2%
Ratio of Income to Poverty Level: 200% and Under - Low Income Population
Franklin County, FL

20.4%
Percent of Population Below Poverty Level
Franklin County, FL

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

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

Owner-occupied housing units (2016-2020). https://www.census.gov/quickfacts/fact/table/franklincountyflorida,gulfcountyflorida,FL/PST045221				
	Total	**65+**	**Black**	**Hispanic**
Franklin	75.8%	N/A	34.4%	74.1%
State of Fla	66.2%	N/A	46.4%	52.7%

4,691
Occupied housing units
Occupied Housing Units
Franklin County, FL

522
Vacant housing units
Vacant Housing Units
Franklin County, FL

22.4%
Cost Burdened Homeowners
Franklin County, FL

41.6%
Cost Burdened Renters
Franklin County, FL

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

Note: Vacant housing units includes those for reasons of foreclosure, personal/family reasons, held in legal proceedings, preparing to rent/sell, held for storage of household furniture, needs repairs, currently being repaired/renovated, specific use housing, extended absence, abandoned/possibly to be demolished/possibly condemned, and reason for vacant unknown

Asset Limited Income Constrained Employed (ALICE). (2018) https://www.unitedforalice.org/state-overview-mobile/Florida				
	Total	**65+**	**Black**	**Hispanic**
Franklin	41%	45%	41%	N/A
State of Fla				

Income Spent on Housing and Transportation

64.6%
of income for median income families
Income Spent on Housing and Transportation (2012)
Franklin County, FL

66.4%
of income for median income families
Income Spent on Housing and Transportation (Current)
Franklin County, FL

Sources: US HUD & DOT LAI V2.0 2012; US HUD & DOT LAI V3.0 2016

- **The impact of economic stability on Type 2 Diabetes**

Type 2 diabetes affects millions of individuals and their families, workplaces, and the US health care system. In 2017, the total cost of medical care and lost productivity for people with diagnosed diabetes was $327 billion, up 33% over a 5-year period.[4]

Unstable housing is common and associated with increased risk of diabetes-related emergency department and inpatient use. Addressing unstable housing in clinical settings may help improve health care utilization for vulnerable individuals with diabetes.

Franklin County's African American and the elderly have low median incomes. For the African American population provide better training and job referral services so they can stabilize their income. This would improve their ability to get access to health care. For the elderly provide transportation services to doctors and stores which sell healthy food.

C. Neighborhood and Built Environment

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

Walkability is a measure used to indicate the ease of pedestrian travel in an area. Scores start out at 1 and go up to 20, with scores closer to 1 indicating lower walkability and scores closer to 20 indicating higher walkability. Once you know which areas of your community are walkable and which are struggling, you can make more informed decisions about what

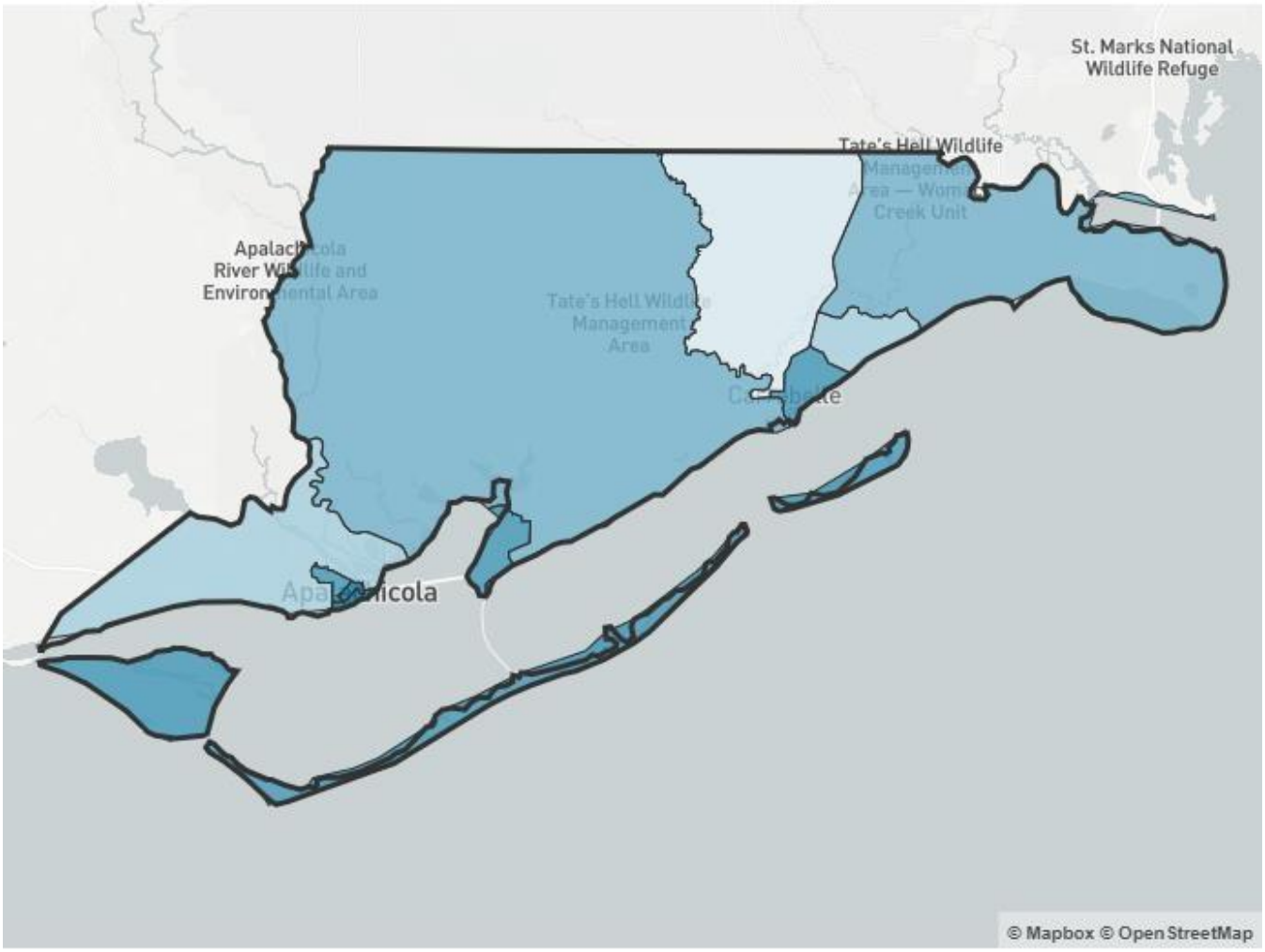
[4] https://www.cdc.gov/diabetes/prevention/how-type2-affects-workforce.htm#:~:text=Type%202%20diabetes%20affects%20millions,over%20a%205%2Dyear%20period.

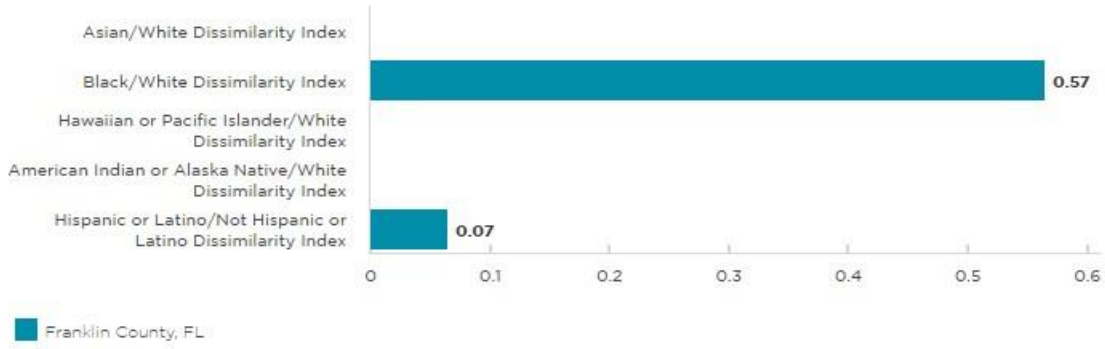
kind of pedestrian improvements are needed and where. Franklin County has a walkability index score of 7.3.

Walkability has a relationship with health benefits (by providing the active lifestyle), sustainable environment (by decreasing air pollution from less driving), and lead to efficiency in time and cost (residents of mixed-use walkable communities spend less time commuting to the shopping, dining, recreation, entertainment and even work destinations when they have the option of walking wherever they need to go).The factors that make a neighborhood walkable are:

- **A center**: Walkable neighborhoods have a center, whether it's the main street or a public space.
- **People**: Enough people for businesses to flourish and for public transit to run frequently.
- **Mixed-income, mixed-use:** Affordable housing located near businesses.
- **Parks and public space**: Plenty of public places to gather and play.
- **Pedestrian design:** Buildings are close to the street and parking lots are relegated to the back.
- **Schools and workplaces:** Close enough that most residents can walk from their homes.
- **Complete streets:** Streets mostly designed for cyclists, pedestrians, and transit.

Walkability Index

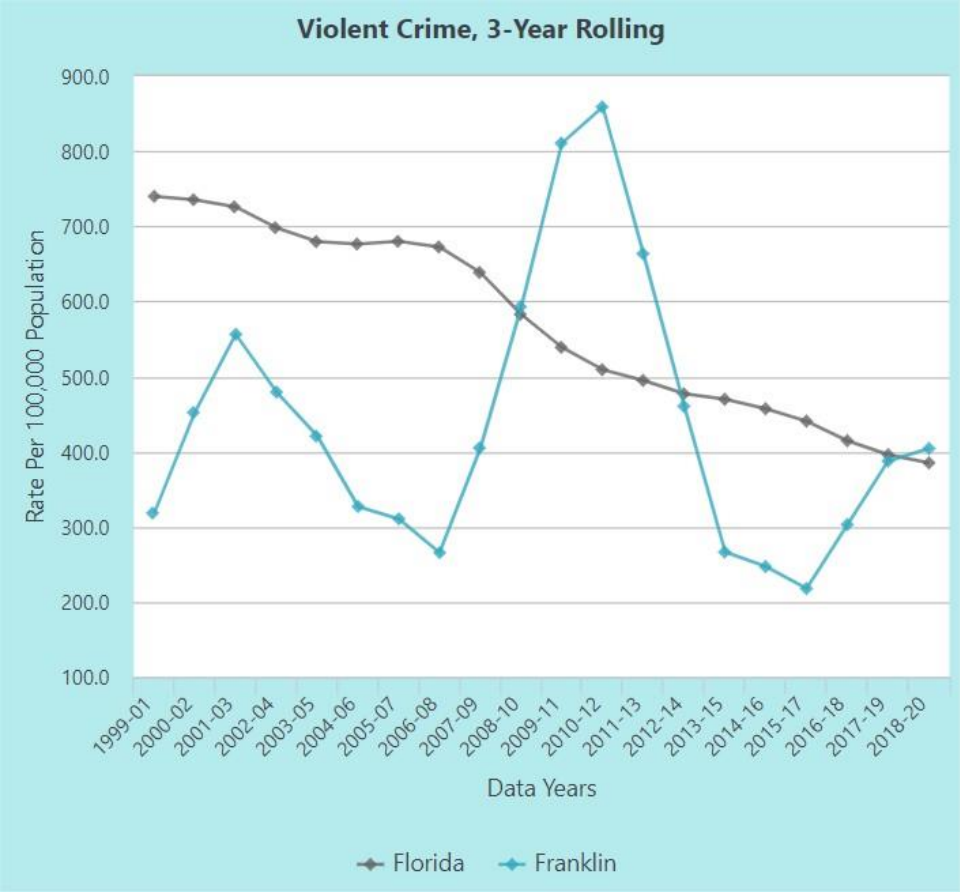




Sources: US Census Bureau ACS 5-year 2016-2020

Note: Data values are between 0 and 1 and can be interpreted as the proportion of one group that would need to move in order to achieve uniform distribution in a given geography. So values near 0 are when the two race/ethnicities are even distributed within the contained Census Tracts and the ratio matches the selected geography. Values near 1 means the ratio of the two race/ethnicities varies between Census Tracts.

There is a correlation between inactivity associated with violent crime. The rate of crime has remained consistent average of around 200 instances per year.



- **The impact of neighborhood and built environment on Type 2 Diabetes**

Walkability is an important factor in livability because it promotes active forms of transport. Increasingly physically inactive and sedentary lifestyles contribute to around 3.2 million preventable deaths a year.

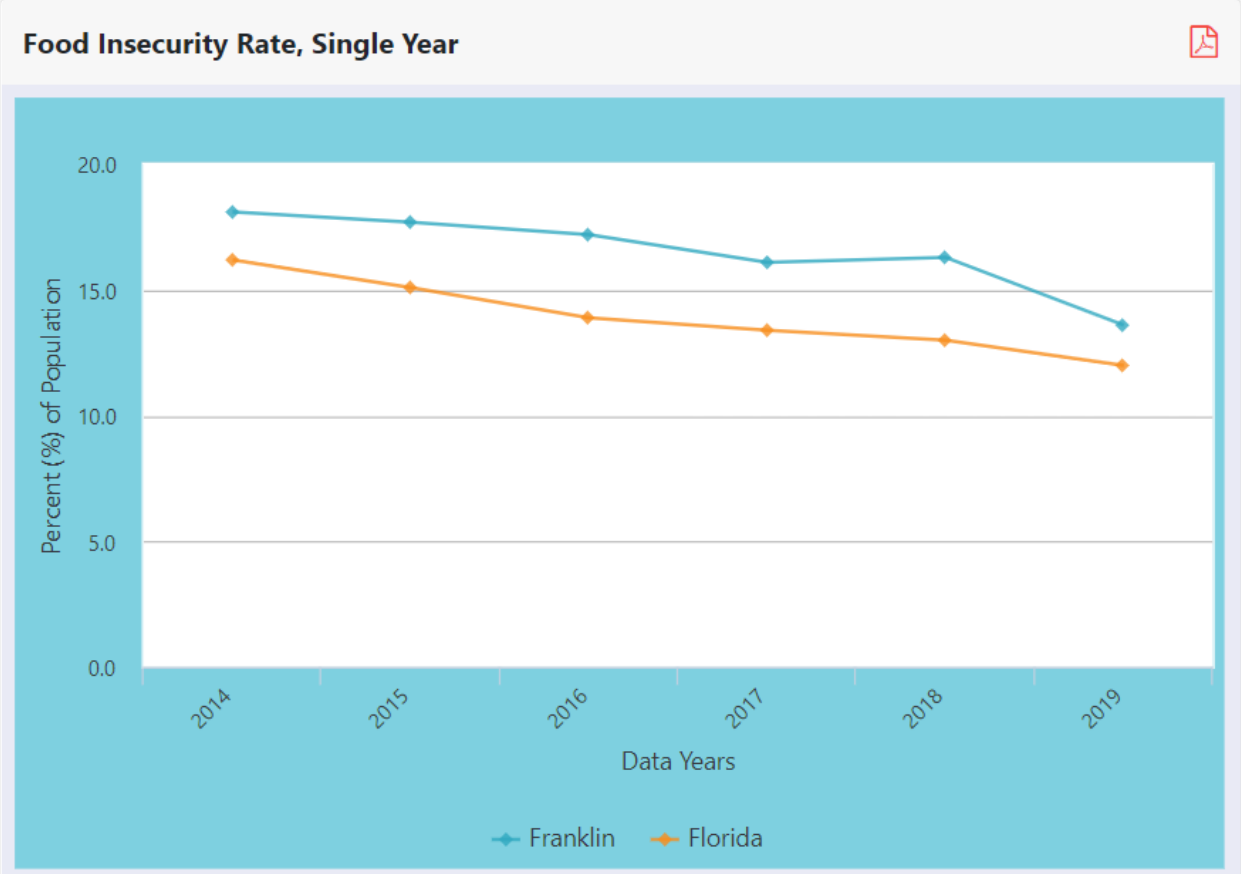
Development of type 2 diabetes mellitus is influenced by built environment, which is, 'the environments that are modified by humans, including homes, schools, workplaces, highways, urban sprawls, accessibility to amenities, leisure, and pollution.' Built environment contributes to diabetes through access to physical activity and through stress, by affecting the sleep cycle.[5]

[5] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2878692/

D. Social and Community Context

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

The social and community context in which people live includes the relationships formed between neighbors and their social and civic connections. People who live in the south and southeast part of the county consider it to be the safest.



Access to Healthy Food

3.3%
of total population
People with Low Access to Healthy Food
Franklin County, FL

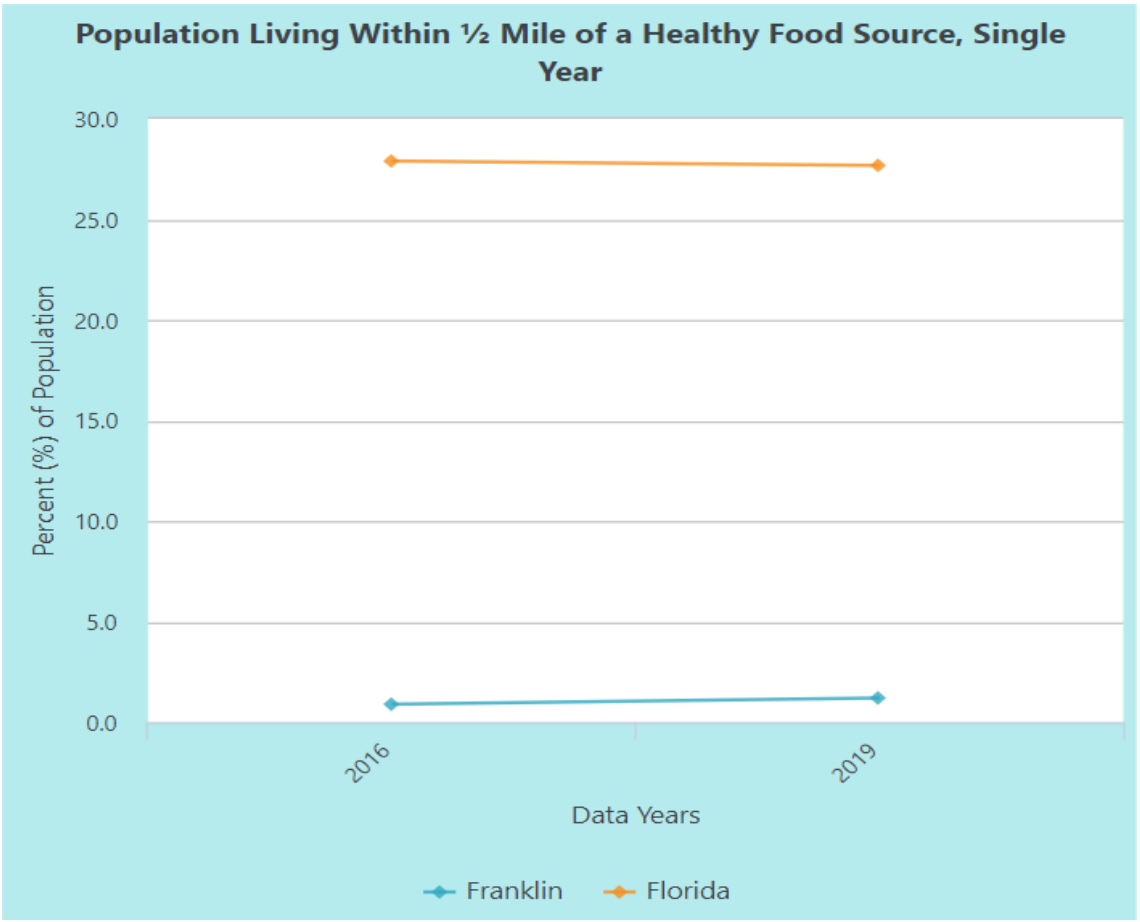
1.8%
of low income people
Low Income People with Low Access to Healthy Food
Franklin County, FL

6.1%
of seniors age 65 and over
Seniors with Low Access to Healthy Food
Franklin County, FL

2%
of children age 17 and under
Children Low Access to Healthy Food
Franklin County, FL

Sources: USDA ERS 2019

Note: Low access is defined as people living 1 miles from access point in urban areas and 10 miles in rural areas.

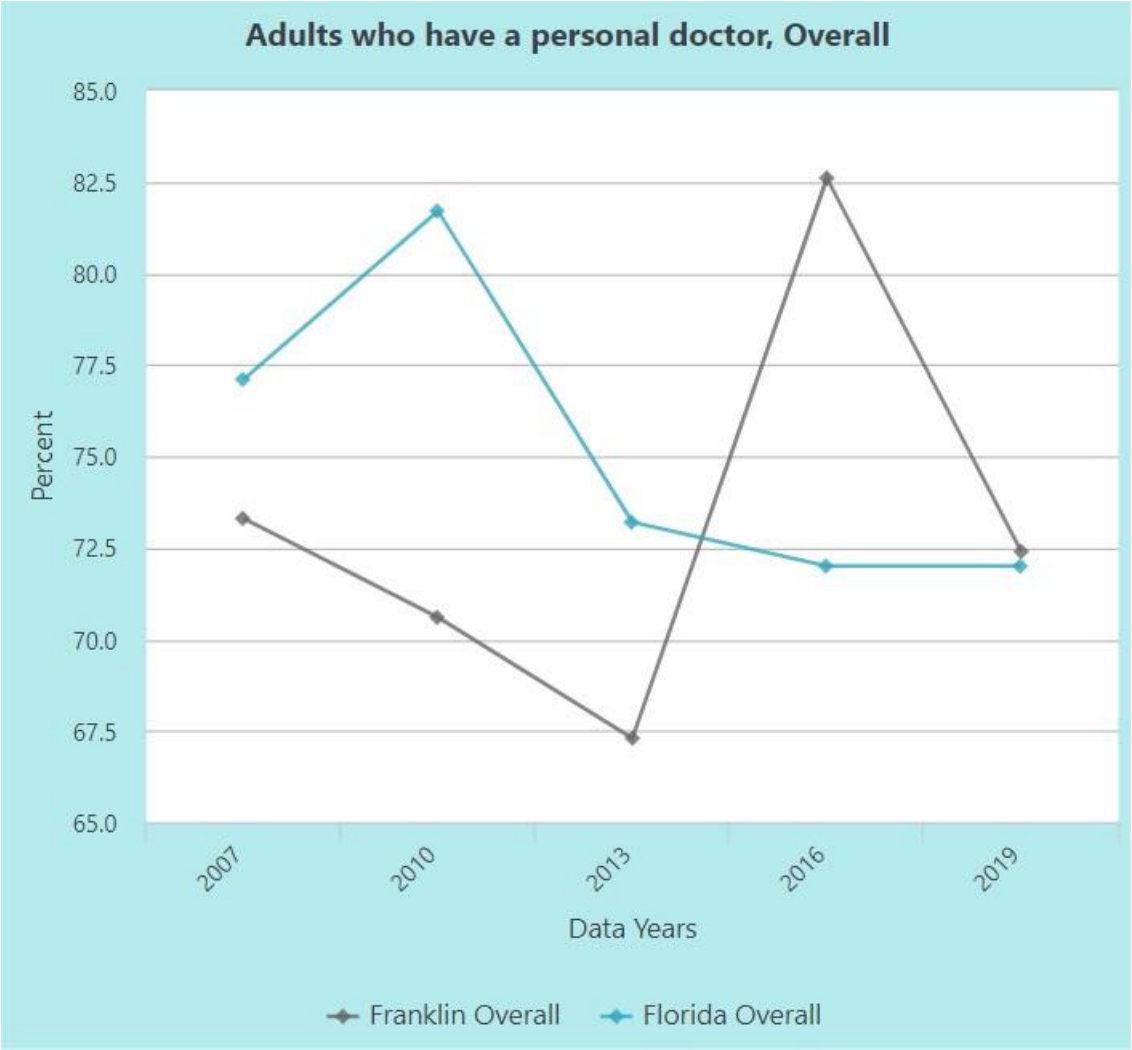


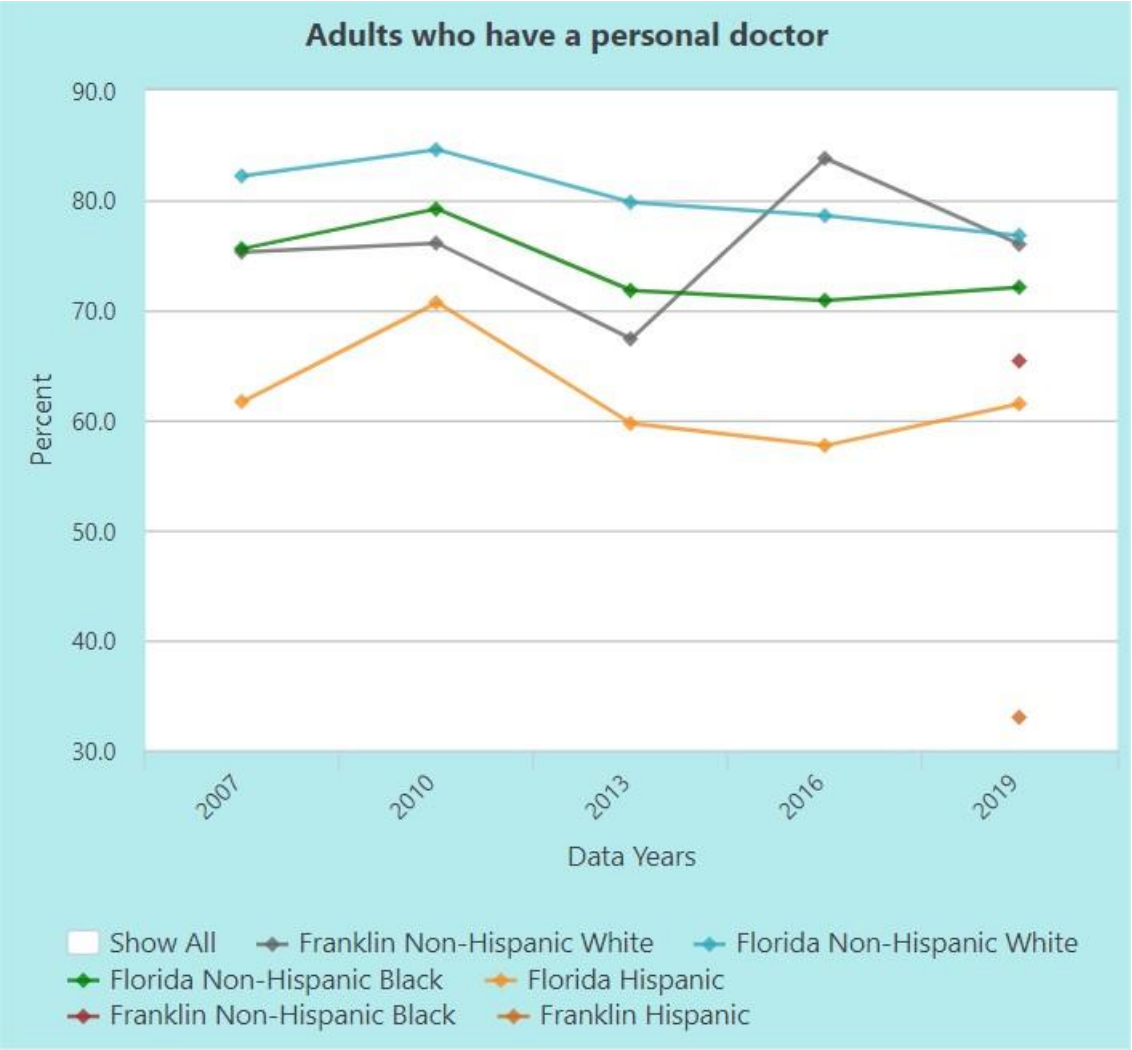
- **The impact of social and community context on Franklin County**

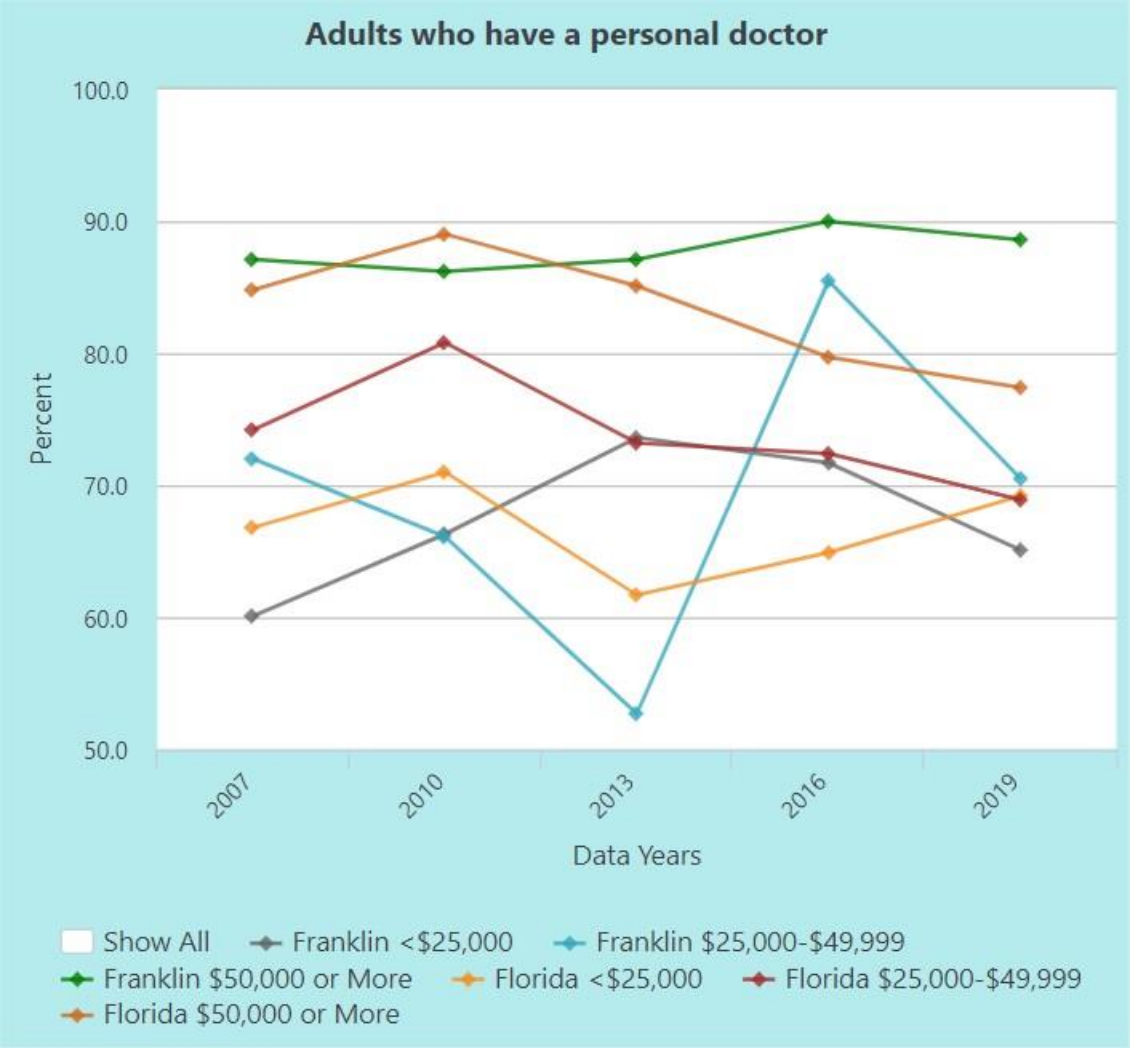
Focusing on the interrelated social causes that are at the root of health inequalities (Type 2 diabetes disproportionately affecting those with low socioeconomic status) is one approach that can be used to mitigate health disparities.

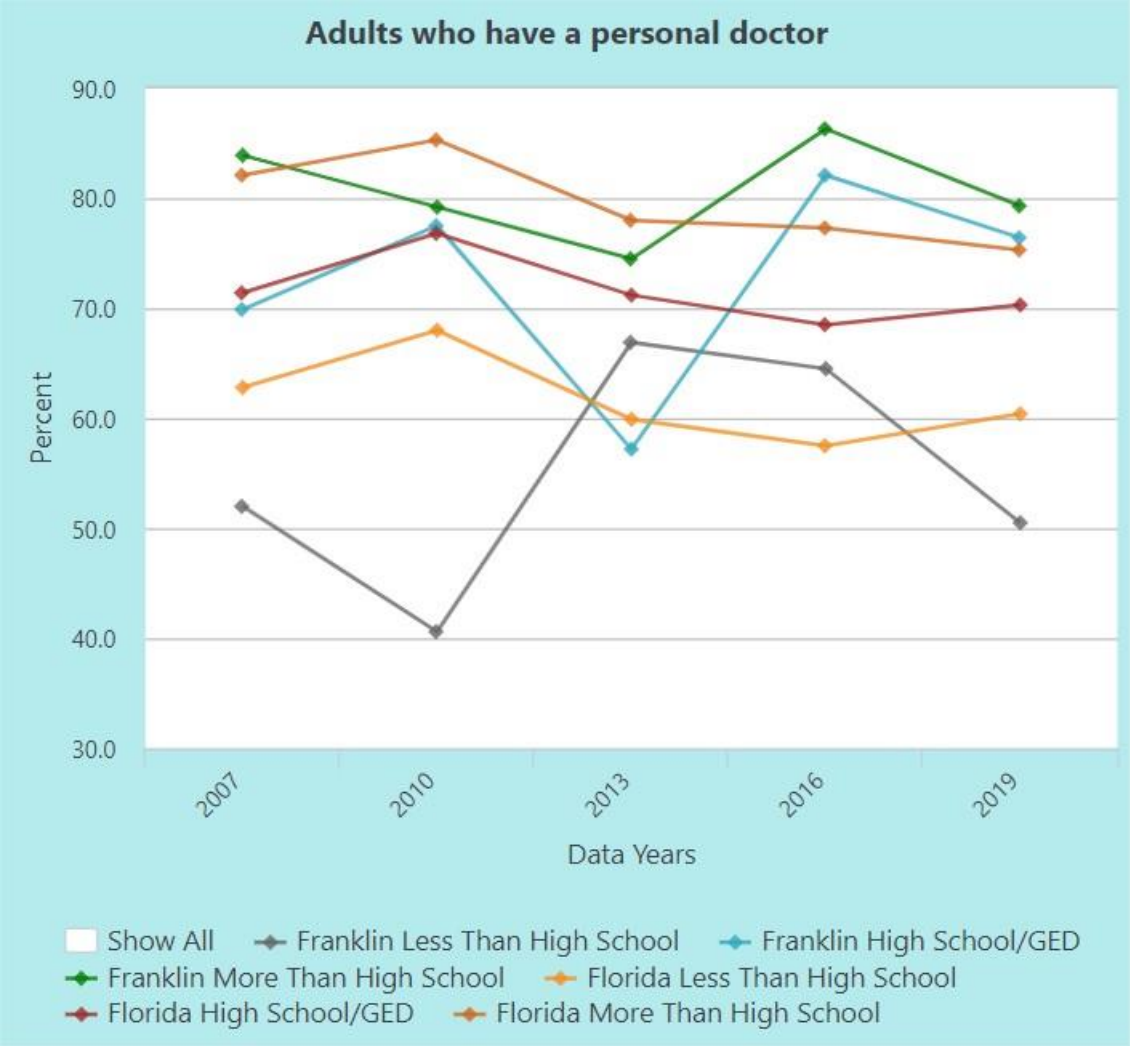
E. Health Care Access and Quality

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


Adults who have a personal doctor, Overall
85.0
82.5
80.0
77.5
75.0
72.5
70.0
67.5
65.0
Percent
2007
2010
2013
2016
2019
Data Years
Franklin Overall
Florida Overall


Adults who have a personal doctor
90.0
80.0
70.0
60.0
50.0
40.0
30.0
Percent
2007
2010
2013
2016
2019
Data Years
Show All
Franklin Non-Hispanic White
Florida Non-Hispanic White
Florida Non-Hispanic Black
Florida Hispanic
Franklin Non-Hispanic Black
Franklin Hispanic


Adults who have a personal doctor
100.0
90.0
80.0
70.0
60.0
50.0
Percent
2007
2010
2013
2016
2019
Data Years
Show All
Franklin <$25,000
Franklin $25,000-$49,999
Franklin $50,000 or More
Florida <$25,000
Florida $25,000-$49,999
Florida $50,000 or More



Clinical Care. (2020) https://www.countyhealthrankings.org/app/florida/2020/rankings/franklin/county/factors/overall/snapshot			
	Primary Care Physicians	**Mental Health Providers**	**Preventable Hospital Stays**
Franklin	3,910:1	1,470:1	4,514
State of Fla	1,380:1	620:1	5,086

Non-institutionalized population with health insurance. (2016-2020) https://www.flhealthcharts.gov/ChartsReports/rdPage.aspx?rdReport=ChartsProfiles.HealthEquityMergeMHProfile				
	Total	**65+**	**Black**	**Hispanic**
Franklin	81.2%	N/A	69.8%	89.7%
State of Fla	87.3%	N/A	85.1%	81.4%

Adults who have a personal doctor. (2019) https://www.flhealthcharts.gov/ChartsReports/rdPage.aspx?rdReport=ChartsProfiles.HealthEquityMergeMHProfile				
	Total	**65+**	**Black**	**Hispanic**
Franklin	72.4%	87.4%	65.4%	33.0%
State of Fla	72.0%	91.2%	72.1 %	61.5 %

Adults ever told they have diabetes. (2019) https://www.flhealthcharts.gov/ChartsReports/rdPage.aspx?rdReport=ChartsProfiles.HealthEquityMergeMHProfile https://www.flhealthcharts.gov/ChartsReports/rdPage.aspx?rdReport=AgingInFlorida.Dashboard								
	Total	**Age 65+**	**Black**	**Hispanic**	**LGBTQ***	**National Origin***	**Disabilities***	**Veterans***
Franklin	9.9%	22.7%	20.7%	10.4%	N/A	N/A	N/A	N/A
State	11.7 %	23.5%	16.0 %	10.6%	N/A	N/A	N/A	N/A

Diabetes age adjusted death rate per 100,000. (2020) https://www.flhealthcharts.gov/ChartsReports/rdPage.aspx?rdReport=ChartsProfiles.HealthEquityMergeMHProfile					
	Total	**Hispanic**	**White**	**Black**	**B/W Ratio**
Franklin	15.7	N/A	13	70.3	5.4 to 1
State of Fla	23.2	N/A	20.0	47.2	2.4 to 1

- **The impact of health care access and quality on Type 2 Diabetes**

In 2010, Type 2 diabetes accounted for more than 95% of the 25 million patients with diabetes in the US, and an additional 79 million individuals were estimated to be prediabetic. In 2007, the annual economic burden of diabetes was estimated at $174 billion, with $116 billion in excess medical expenditures and $58 billion in reduced productivity. Diabetes also takes a toll on the health care system, as 1 in 10 health care dollars is attributed to it. Average medical expenses for patients with diabetes are nearly twice as high as those for patients who do not have diabetes. Additionally, Type 2 diabetes is more prevalent in minority races and ethnicities, as evidenced by Hispanics having a 66% greater risk, and non-Hispanic African American having a 77% greater risk for developing it than non-Hispanic whites.[6]

[6] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3662286/

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 Health Equity Taskforce reviewed data, discussed current health needs, and identified local assets and resources and collectively decided to adopt diabetes as a priority. The Minority Health Liaison took into consideration the prioritized health disparity and the impactful SDOH identified by the Health Equity Team during recruitment.

A. Data Review

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

The 2022 Franklin County's Community Health Assessment identified the leading causes of death that were identified were types of chronic disease: heart disease and cancer. The analysis shows that 35% of Franklin County adults were obese. The identified priority populations were Hispanics, African American, and elderly (65+). The County maps showed that a significant proportion of the identified priority populations reside in Port St. Joe and Apalachicola.

B. Barrier Identification

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

C. Community Projects

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

Social Determinants of Health	Barriers and Themes	Collaborative Strategies
Neighborhood and Lived Environment	Health Equity Taskforce members discussed the housing disparity between black and whites in Franklin. Taskforce also discussed that the county has shown great interest in increasing opportunities for homeownership in Franklin County. The same interest has been shown in Gulf County, but the data did not demonstrate a housing disparity in target populations.	Strategies include collaborating with FAMU's Extension Office and the SHIP program to reduce barriers to homeownership in Franklin and Gulf Counties.
Health Care Access and Quality	Health Equity Taskforce members discussed the stark diabetes death rate disparity and the barriers that clients face post diabetes diagnosis. Clients are not receiving the best follow up by primary care physicians post diagnosis. The community has already shown an interest in receiving more screening services, and education on advancing their health.	Health Equity Taskforce members discussed the need to increase access to diabetes resources and education programs within target populations.
Education	This SDOH is not focused on formal institutions of learning. This SDOH revolves around access to information. There seems to be barriers when it comes to accessing education on available services within the community, nutrition and diabetes health education, and homebuyer education.	Collaborate with MyGulfCare and other health partners to increase access to information.
Food Access	Both Gulf and Franklin Counties have limited access to grocery stores. The taskforce discussed potential barriers (cost, availability, education on matter, etc) that keep people from accessing healthier food options.	Strategies include partnering with the PAC, Farmacy, and MyGulfCare to reduce barriers to healthy food access and promote and advocate for healthier food options and accessibility amongst target populations.

IX. HEALTH EQUITY PLAN OBJECTIVES

A. Type 2 Diabetes

- **Health Disparity Objective:** By June 2025, the rate of black diabetes death will decrease from 70.3 to 65 (per 100,000) in Franklin County.

Goals & Objectives	Lead Entity & Unit	Lead Point Person	Data Source	Baseline Value	Target Value	Plan Alignment
Long-Term SDOH Goal: Reduce social determinant of health disparities in Franklin County						
Objective: By the end of December 2025, community wide health literacy will increase from (TBD) in 2023 to (TBD)	DOH Franklin	Alma Pugh	TBD	TBD	TBD	None
Medium-Term SDOH Goal: Improve access to healthcare in Franklin County						
Objective: By the end of December 2024, the number of monthly diabetes education class in Apalachicola will increase from 0 (December 2022) to 24 (once monthly class)	My Gulf Care	John Griggs	CHIP Plan	0	24	CHA CHIP
Short-Term SDOH Goal: Improve access to housing in Franklin County.						
Objective: By June 2023, the number of financial literacy workshop targeted towards priority populations will increase from 0 to 2.	H'COLA	Elinor Mount-Simmons	TBD	0	2	PACE-EH
Short-Term SDOH Goal: Create a health equity Community Health Improvement Plan subcommittee.						
Objective: By June of 2023, the number of subcommittees focused on improving health equity via closing the disparities in SDOH will increase from 0 to 1.	DOH Franklin	Alma Pugh	CHIP Plan	0	1	CHA CHIP
Short-Term SDOH Goal: Improve health equity by understanding baseline knowledge of partners in Franklin County.						
Objective: By October 2022 will utilize AHP's survey instrument to obtain a baseline knowledge of partners from 0 to 20.	AHP	Alma Pugh	Survey instrument	Partner Baseline	# of completed surveys	CHA 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
1	HE Taskforce	12/28/2022	Updated taskforce members/agencies, goals & objectives

XII. APPENDIX A HEALTH EQUITY PLAN COALITION

Name*	Title	Organization	Social Determinants of Health
Alma Pugh	Minority Health Liaison	DOH-Franklin	Healthcare
Angela Webster	Case Manager	Capital Area Community Action Agency	Economic
David Walker	CEO	Weems Memorial	Healthcare
DT Simmons	Minority Health Liaison	DOH-Franklin/Gulf	Healthcare
John Griggs	Nurse Educator	Sacred Heart Hospital	Healthcare
Sarah Quaranta	Administrator	DOH-Franklin/Gulf	Healthcare
Stephanie Turrell	Executive Director	Apalachicola Housing Authority	Neighborhood
Terrence Watts	Administrator	DCF – Circuit 2	Social
Charles Elliot	Coordinator	Franklin County Veterans Administrations	
Cheyenne Martin	Community Resource Development	FAMU Extension Cooperative Program	Education
Ciara Holloman	Statewide Health Agent	FAMU Extension Cooperative Program	Education
Valentina Webb		CareerSource	Economic/Employment
Elinor Mount-Simmons	President	H'COLA	
Selina Peet	Program Supervisor	Apalachee Center, Inc.	Healthcare
Lisa Sherry	Community Outreach Coordinator	DISC Village	Social/Community Networks
Myrtis Wynn	Member	North Florida African American Corridor Project	Social/Community Network
Chelsea Marshall	Specialist	UF Extension Office (IFAS)	Education

*Currently the HE Coalition and the HE Taskforce are one. This HE Plan has a current goal/objective to officially separate the two, by incorporating the coalition into the CHIP, which will make the general CHIP partnership the coalition.

XIII. MINORITY HEALTH MONTH AD

APRIL IS NATIONAL MINORITY HEALTH MONTH

NATIONAL MINORITY HEALTH MONTH

MES NACIONAL DE LA SALUD DE LAS MINORÍAS

Please Join Us!
Community Health Fair
Saturday, April 30 . 9am - Noon

Historic Holy Family Senior/Community Center
203 Dr. Frederick Humphries St., Apalachicola

Free Health Screenings, Give-a-ways and Healthy Refreshments

Guest Speakers and Topics

Chronic Health Diseases and Mental Health

Florida HEALTH

Hosted by the Florida Department of Health and the Following Community Sponsors

Phoenix Family Medical Clinic — Where Patients Come First
WEEMS MEMORIAL — GEORGE E. WEEMS MEMORIAL HOSPITAL
Refuge House — Stop the Violence!
Ascension Sacred Heart
We Are The Bridge — ECCC — Elder Care Community Council
FAMU — Florida A&M University Cooperative Extension

For additional information contact Valentina Webb (850-653-4981) or Alma Pugh (850-653-2111)

XIV. HE TASKFORCE MEETING AGENDAS

Florida Department of Health (FDOH)
Franklin/ Gulf
County Health Department Health Equity Team
Meeting Agenda
Wednesday, August 24, 2022
11:00 AM – 12:00 PM

Meeting Objective: The purpose of this meeting is to discuss Minority Health Liaison, CHD Health Equity Team and the Health Equity Coalition's roles, the priority populations, the Health Equity Plan and monthly meeting scheduling.

Time	Topic	Lead
11:00-11:05	**Welcome**	Marquita Thompkins FDOH-Gulf MHL
11:05-11:10	**Minority Health Liaison (MHL)**	Alma Pugh FDOH-Franklin MHL
11:10-11:25	**CHD Health Equity Team (CHD HE Team)** **Health Equity Coalition**	Alma Pugh FDOH-Franklin MHL
11:25- 11:35	**Priority Populations**	Jessie Pippin FDOH-Franklin/Gulf Operation Manager
11:35-11:55	**Health Equity Plan**	DT Simmons FDOH-Franklin/Gulf Operation Manager
11:55-12:00	**Monthly Meeting/ Final Remarks/ Assignments**	DT Simmons FDOH-Franklin/Gulf Operation Manager

Florida Department of Health
Franklin County Health Equity Coalition Meeting
Wednesday, September 13, 2022
12:00p.m. – 1:00p.m.

Meeting Objective: The purpose of this meeting is to identify the prioritized health disparity and the populations it impacts, and to collaborate with community partners on addressing Social Determinants of Health (SDOH) to reduce these health disparities in the target populations.

Topic	Lead
Welcome & Introductions ▪ Introduction of new partners ▪ What representation is our Taskforce missing? o Community representation	Alma Pugh, DOH-Franklin County Minority Health Liaison

Health Disparity Data Review and Updates
▪ Our prioritized health disparity.
Diabetes
▪ Populations impacted by our health disparity:
  o Racial/ethnic minorities
  o People living with a disability
  o Age groups
▪ Data gaps
  o LGBTQ+
  o Veterans
  o Infants
▪ Who else?
	DT. Simmons,
	DOH-Franklin County
	Operations Manager

Social Determinants of Health *Indicators impacting our health disparity* ▪ Economic Stability ▪ Education Access and Quality ▪ Healthcare Access and Quality	DT. Simmons, DOH-Franklin County. Operations Manager
Partnership Development ▪ What projects is your organization already doing or planning? ▪ What are some barriers your organization is facing in trying to support your community? ▪ What opportunities to collaborate to make our activities more efficient, effective, and comprehensive to our community's needs?	Jessie Pippins, DOH-Gulf County Operations Manager
Resources Events Grant Opportunities Trainings	Alma Pugh, DOH-Franklin Minority Health Liaison Cheryl Steindorf, ???????

DOH-Franklin Healthy Equity Coalition Meeting
Thursday, October 27, 2022
2:00PM-3:00PM Via Zoom

Meeting Objective: The purpose of this meeting is to collaborate with community partners on goals and upcoming events that address social determinants of health to reduce the health disparity of diabetes in Franklin County.

Topic	Lead
Welcome & Introductions	Marquita Thompkins DOH-Gulf County Minority Health Liaison
September Health Equity Coalition Meeting Overview ➢ Our prioritized health disparity ➢ Populations impacted by our health disparity ➢ Data gaps ➢ Social Determinants of Health	Marquita Thompkins DOH-Gulf County Minority Health Liaison
Review Goals ➢ Long-Term Goal- Improve access to healthcare in Franklin County ➢ Medium-Term Goal-Improve access to healthcare in Franklin County ➢ Short-Term Goal- Improve access to housing in Franklin County ➢ Short-Term Goal- Improve Health Equity by understanding baseline knowledge of partners in Franklin County	DT Simmons, DOH-Franklin County Operations Manager
Upcoming Events and Opportunities to Collaborate ➢ Gulf County Health Fair ➢ Franklin County Mental Health Awareness Event	Jessie Pippin, DOH-Gulf County Operations Manager
What's Missing? ➢ Partners	Alma Pugh, DOH-Franklin Minority Health Liaison
Survey ➢ Link	Alma Pugh, DOH-Franklin Minority Health Liaison
Closing Remarks	Anyone

DOH-Franklin Healthy Equity Taskforce
Objective Committee Meeting
Tuesday, November 22, 2022
10am – 11am Via Zoom

https://us06web.zoom.us/j/84269792882
Meeting ID: 842 6979 2882

Meeting Objective: This is a subcommittee of the Health Equity Coalition. The purpose of this meeting is to set objectives to the selected goals of the Health Equity Coalition.

Topic	Lead
Welcome	Alma Pugh, DOH-Franklin Health Equity Liaison
Review Goals ✓ **Long-Term Goal:** Reduce social determinant of health disparities in Franklin County **OBJECTIVE: (TBD)**By the end of December 2025, we will collaborate with stakeholders (churches, schools, community agencies/organizations, ….and media) to educate our community on available resources. ✓ **Medium-Term Goal:** Improve access to healthcare in Franklin County **OBJECTIVE:** By the end of December 2024, we will collaborate with local healthcare organizations to host monthly diabetes education class in Franklin County. ✓ **Short-Term Goal:** Improve access to housing in Franklin County **OBJECTIVE:** By June 30, 2023, we will partner with local organizations to host 2 financial literacy workshops.	Alma Pugh, DOH-Franklin Health Equity Liaison
What are Ojectives?	DT Simmons, DOH-Franklin Operations Manager
Setting Objectives for Selected Goals	Everyone
Closing Remarks	Anyone

DOH-Franklin Healthy Equity Taskforce Meeting
Wednesday, December 28, 2022
10am – 11am

Zoom Link: https://us06web.zoom.us/j/81171679725?pwd=b1MSdGJWVmRG82IHZy9vMG9OczR2Zz09
Meeting ID: 811 7167 9725
Passcode: Health

Meeting Objective: The purpose of this meeting is to review Franklin County's goals and objectives, and to present Franklin County's health equity plan to the coalition for discussion and revisions.

Topic	Lead
Welcome	Alma Pugh, DOH-Franklin Health Equity Liaison
Review Goals and Objectives • **Long-Term Goal:** Reduce social determinant of health disparities in Franklin County **OBJECTIVE:** By the end of December 2025, community wide health literacy will increase from (TBD) in 2023 to (TBD) . • **Medium-Term Goal:** Improve access to healthcare in Franklin County **OBJECTIVE:** By the end of December 2024, we will collaborate with local healthcare organizations to host monthly diabetes education class in Franklin County. • **Short-Term Goal:** Improve access to housing in Franklin County **OBJECTIVE:** By June 30, 2023, we will partner with local organizations to host 2 financial literacy workshops.	Alma Pugh, DOH- Franklin Health Equity Liaison
Franklin County's Health Equity Plan	DT Simmons DOH-Franklin Operational Manager
Health Equity Plan Discussion & Revisions	Everyone
Up -Coming Community Events	Anyone