HARDEE COUNTY

HEALTH EQUITY PLAN

July 2022 – July 2027

Florida HEALTH

DRUG FREE HARDEE
Positive Community Change

Healthy Hardee

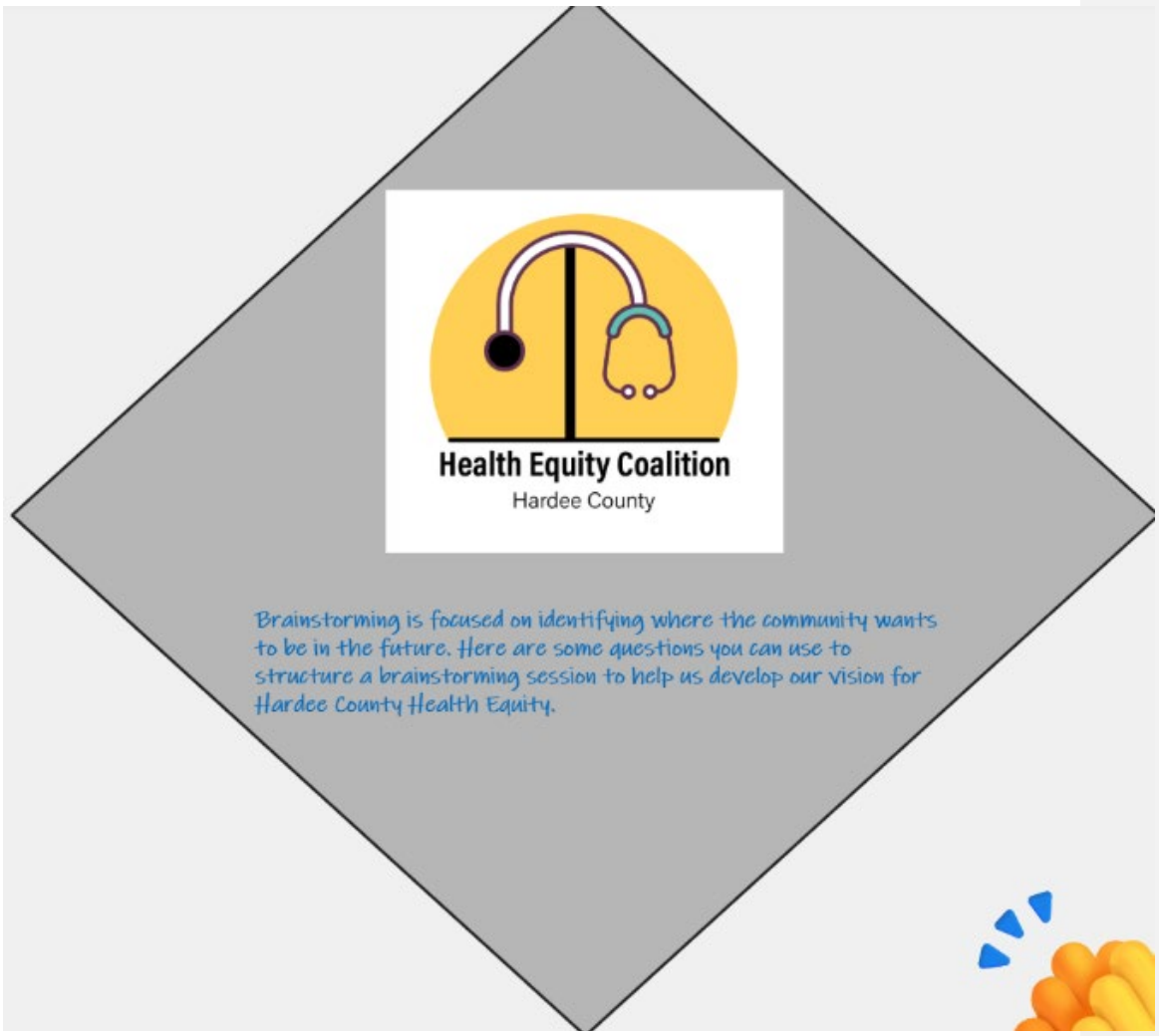
Tobacco Free Hardee

Updated 1/19/22

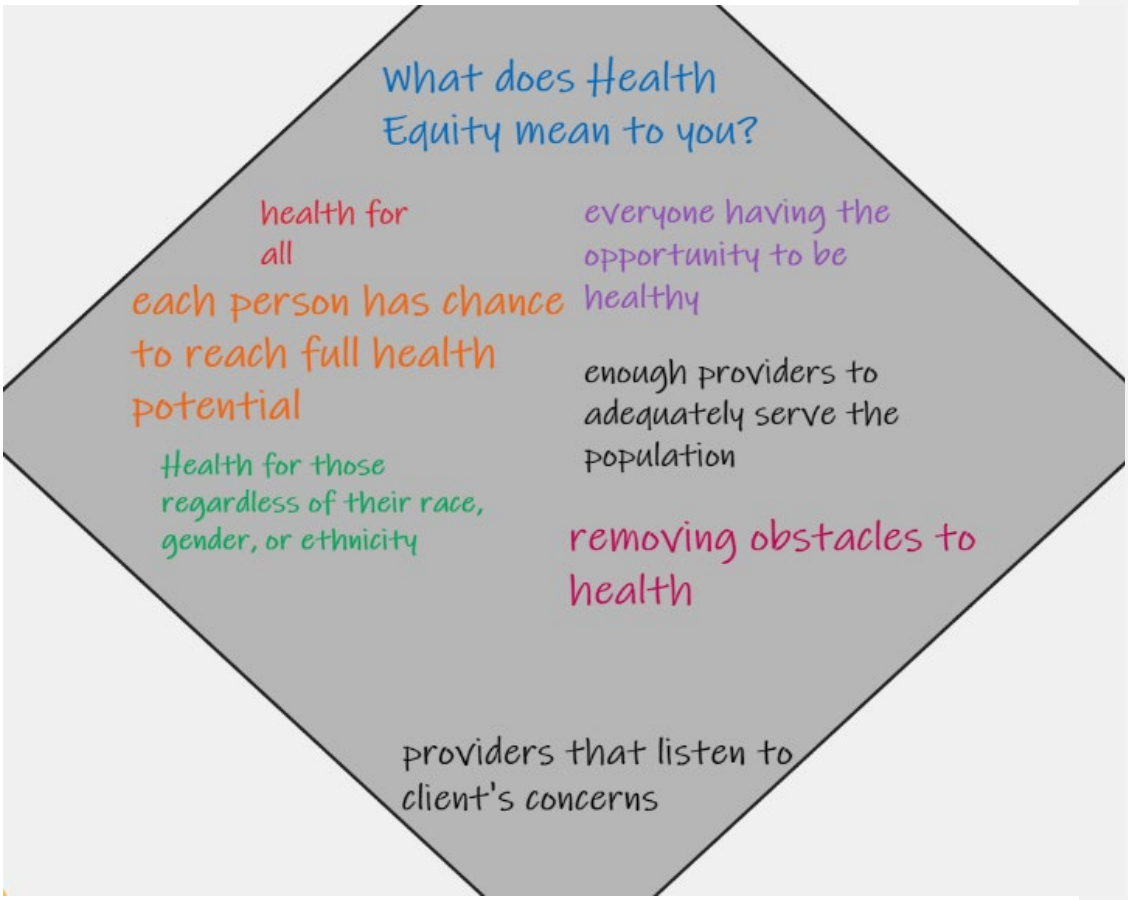
Table of Contents

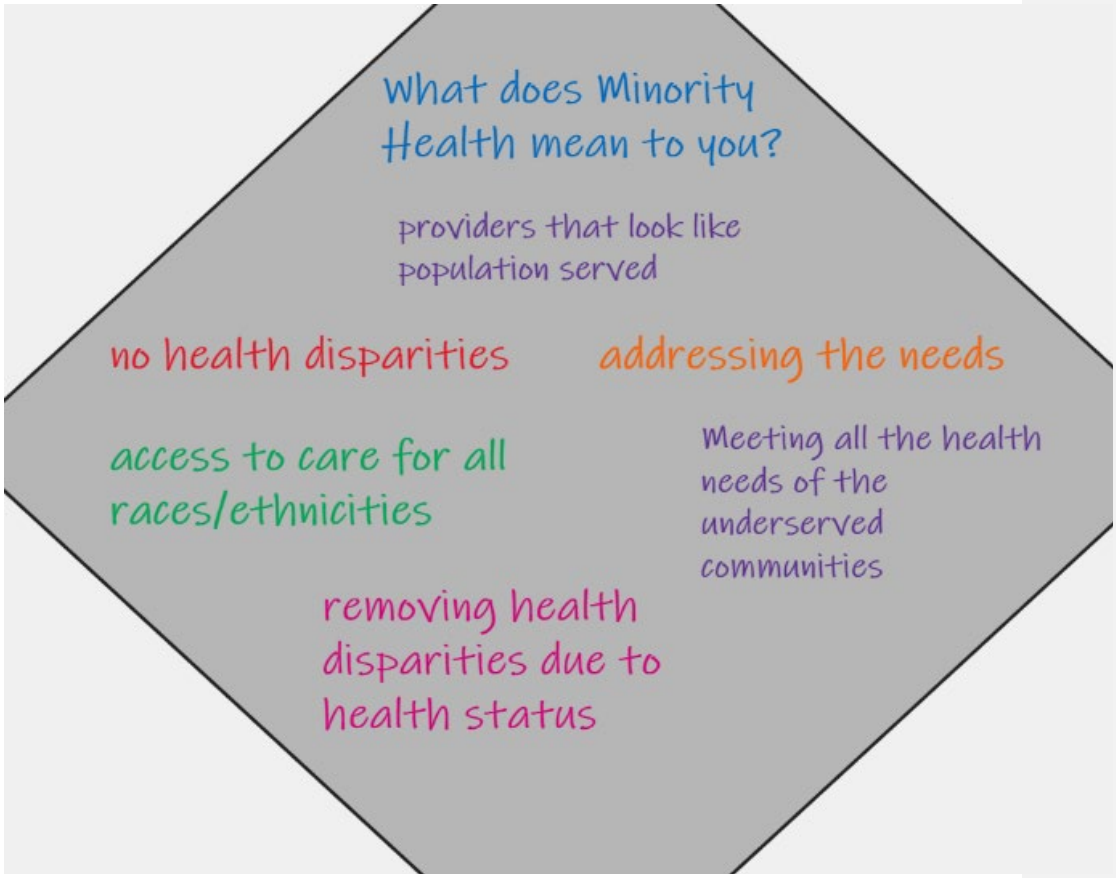
I. VISION

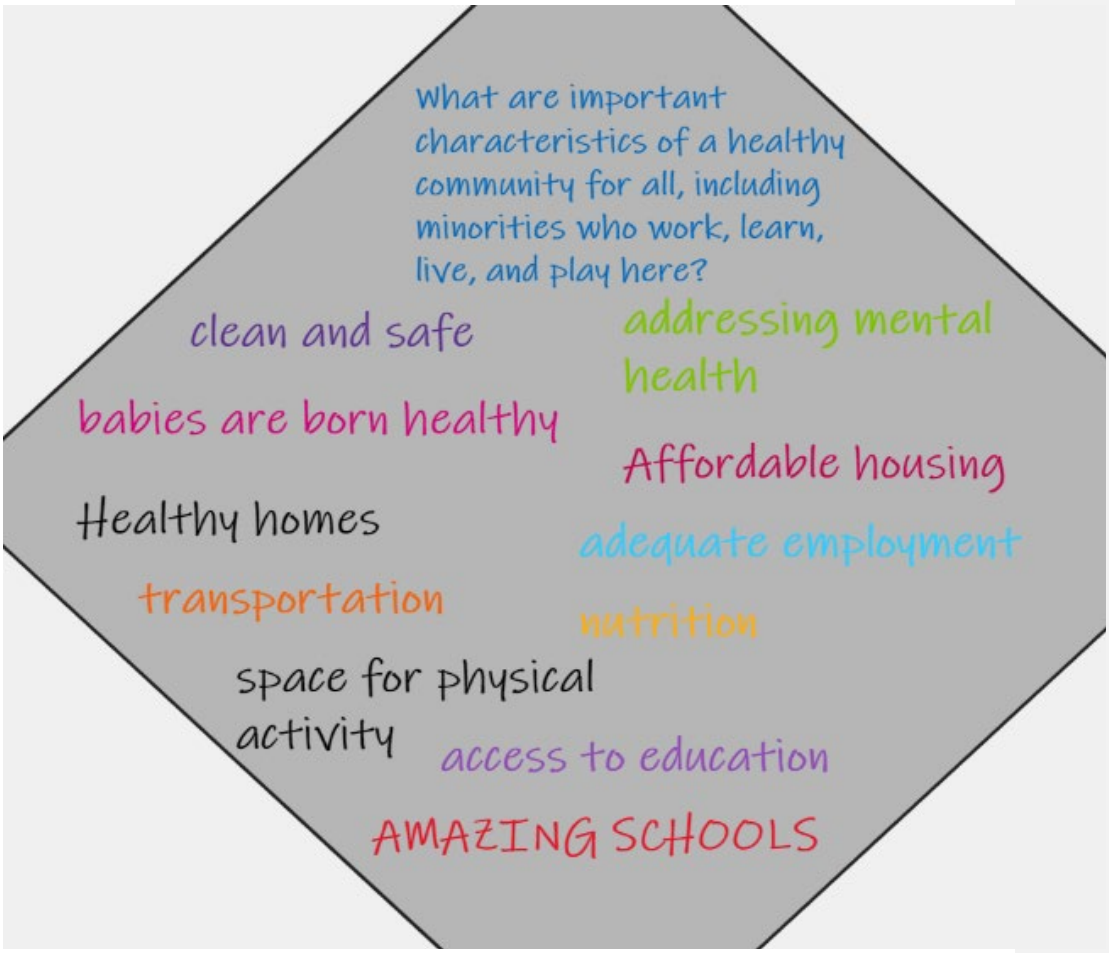
VISION: "Create the healthiest Hardee for everyone which includes eliminating health disparities and addressing the needs of the community."

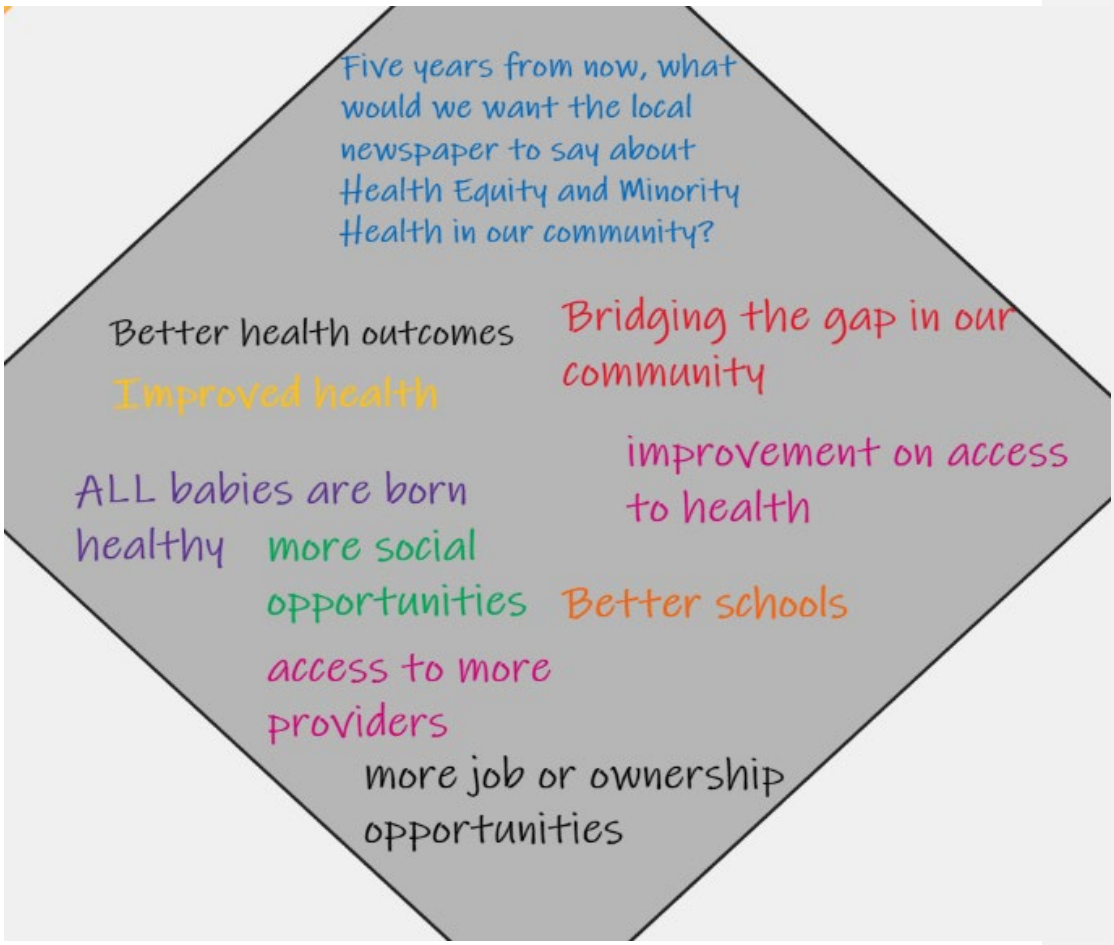


During our last HE meeting, our Health Equity Team brainstormed various questions that focused on identifying where the community wants to be in the future. Through majority vote, the health equity team was able to identify goals and changes that our county is needing.

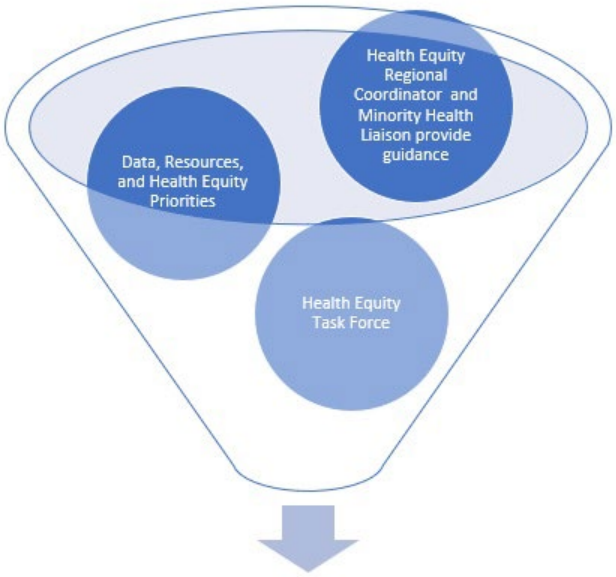



What does Minority Health mean to you?
providers that look like population served
no health disparities
addressing the needs
access to care for all races/ethnicities
Meeting all the health needs of the underserved communities
removing health disparities due to health status


What are important characteristics of a healthy community for all, including minorities who work, learn, live, and play here?
clean and safe
addressing mental health
babies are born healthy
Affordable housing
Healthy homes
adequate employment
transportation
nutrition
space for physical activity
access to education
AMAZING SCHOOLS


Five years from now, what would we want the local newspaper to say about Health Equity and Minority Health in our community?
Better health outcomes
Improved health
Bridging the gap in our community
improvement on access to health
ALL babies are born healthy
more social opportunities
Better schools
access to more providers
more job or ownership opportunities

Health Equity Coalition
Hardee County



II. PURPOSE OF THE HEALTH EQUITY PLAN

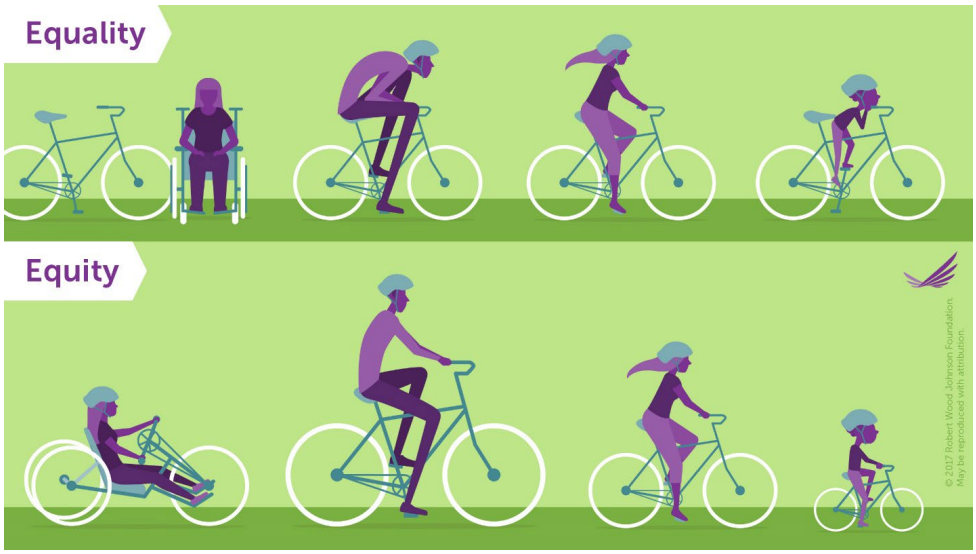
Health Equity is achieved when everyone can attain optimal health.

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 (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 Hardee County. To develop this plan, Hardee 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 Hardee County. This Health Equity Plan is not a county health department plan; it is a county-wide Health Equity Plan through which the Health Equity Taskforce, including a variety of government, non-profit, and other community organizations, align to address the SDOH impact health and well-being in the county.

III. DEFINITIONS



Health equity is achieved when everyone can attain optimal health

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

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

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

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

IV. PARTICIPATION

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

In January of 2022, community partners conducted a virtual open house in which the Hardee County Health Equity Coalition participated and recruited members.

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: Rosa Ontiveros
Minority Health Liaison Backup: Stefania Sweet

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 Hardee 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
Brenda Farmer	Director of Nursing	Clinical
Joy L. Jackson	CHD Director	Administration
Scott Sjoblom	Assistant CHD Director	Administration
Stefania Sweet	Community Health Programs Manager	Community Health

Deja Sparkman	Community Health Liaison	Community Health
LaToya Hinson	Tobacco Prevention Program Manager	Tobacco Prevention
Nikki Atchley	Staff Assistant	Environmental Health

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
4/26/2022	During this meeting the MHHE Liaison introduced the program to present members. The health equity plan was discussed along with the due date of June 15, 2022. Florida health terms were presented to further public health discussions along with our official Health Equity logo. Our county health disparity was established and approved.
5/27/2022	The MHHE Liaison created an interactive activity where present members were asked to participate in various questions regarding Hardee County Health Equity. These questions were intended to direct members into brainstorming ideas focused on identifying where the community wants to be in the future. MHHE Liaison informed members regarding the SDOH project and the outcomes expected. Members were given rural project examples, a member suggested reaching out to existing projects in motion and moving forward with the outcomes to meet our SDOH's. Present members reviewed

	minutes and gave brief updates regarding events, trainings, and future meetings.

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 Hardee Health Equity Plan and oversaw the design and implementation of projects. Health Equity Taskforce members are listed below.

Name	Title	Organization	Social Determinant of Health
Lenora White	Regional Center Branch Manager	Career Source Heartland	Economic Stability
Alison Grooms	Community Health Coordinator	Advent Health	Healthcare Access and Quality
Ivy Gonzalez	Director	Tri County Human Services	Social and Community Context/ Prevention
Katrina Blandin	Student Services Advisor	South Florida State College	Education Access and Quality
Maria Pearson	Director	Drug Free Hardee	Social and Community Context/ Prevention
Brenda Farmer	Director of Nursing	FDOH	Healthcare Access and Quality
Vivian Hartzell	Preparedness Planner	FDOH	Social and Community Context

Latoya Hinson	Tobacco Programs Manager	FDOH	Social and Community Context
Kristin Casey	Operations Manager	FDOH	Social and Community Context
Deja Sparkman	Community Health Liaison	FDOH	Social and Community Context
Charlene Edwards	Executive Director	Healthy Start Coalition of Hardee, Highlands and Polk Counties, Inc.	Social and Community Context
Dottie Robinett	Executive Assistant to Vice President/Administrator	Advent Health	Healthcare Access and Quality
Joy L. Jackson	Director	FDOH	Social and Community Context
Maria Magowan		Florida Center for Early Childhood	Education Access and Quality

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. The health equity task force is working to identify partners that represent vulnerable populations to include in further planning.

Meeting Date	Organizations	Topic/Purpose
4/26/2022	Tobacco Free Hardee, FDOH, Healthy Start Coalition, Career Source Heartland, & Advent Health.	During this meeting the MHHE Liaison introduced the program to present members. The health equity plan was discussed along with the due date of June 15, 2022. Florida health terms were presented to further public health discussions along with our official Health Equity logo. Our county health disparity was established and approved. During this meeting 11 Florida

		Department of Health staff were present.
5/27/2022	Tobacco Free Hardee FDOH, Healthy Start Coalition, Career Source Heartland, & Advent Health.	The MHHE Liaison created an interactive activity where present members were asked to participate in various questions regarding Hardee County Health Equity. These questions were intended to direct members into brainstorming ideas focused on identifying where the community wants to be in the future. MHHE Liaison informed members regarding the SDOH project and the outcomes expected. Members were given rural project examples, a member suggested reaching out to existing projects in motion and moving forward with the outcomes to meet our SDOH's. Present members reviewed minutes and gave brief updates regarding events, trainings, and future meetings.

D. Coalition

The Coalition discussed strategies to improve the health of the community. The strategies focused on the social determinants of health: education access and quality, health care access and quality, economic stability, social and community context, and neighborhood and built environment. Membership includes community leaders working to address each SDOH, as well as any relevant sub-

SDOHs. The Coalition assisted the Health Equity Taskforce by reviewing their Health Equity Plan for feasibility. See (IV. C Health Equity Task Force) for a list of Coalition members. The Task Force and the Coalition consist of the same members, as we are a small rural community.

E. Regional Health Equity Coordinators

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

Name	Region	Expertise
Carrie Rickman	Emerald Coast	Technical assistance, training, project coordination
Quincy Wimberly	Capitol	Technical assistance, training, project coordination
Diane Padilla	North Central	Technical assistance, training, project coordination
Ida Wright	Northeast	Technical assistance, training, project coordination
Rafik Brooks	West	Technical assistance, training, project coordination
Lesli Ahonkhai	Central	Faith-Based Engagement
Frank Diaz	Southwest	Technical assistance, training, project coordination
TBA	Southeast	Technical assistance, training, project coordination

V. HEALTH EQUITY ASSESSMENT, TRAINING, AND PROMOTION

A. Minority Health Liaison Training

The office of Minority Health and Health Equity and the Health Equity Regional Coordinator provides 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	TOPIC
11/4/21	Seeking Health Equity: Understanding & Taking Actions on the root causes of Health Disparities
11/18/2021	Internal Monthly MHL Meeting
11/30/2021	Regional MHL Meeting
12/16/2021	Internal Monthly MHL Meeting
1/20/2022	Internal Monthly MHL Meeting
1/25/2022	Cultural Competency & Health Equity Trainings
2/17/2022	Monthly MHL Meeting
3/17/2022	Monthly MHL Meeting
4/12-4/13/2022	Onboarding Meeting MHL
4/21/2022	Monthly MHL Meeting
5/10/2022	Grant Writing Workshop OMHHE
5/19/2022	Monthly MHL Meeting

B. County Health Equity Training

Assessing the capacity and knowledge of health equity, through the (assessment name), helped the Minority Health Liaison identify knowledge gaps and create training plans for the Health Equity Taskforce, the Coalition, and other county partners.

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

Date	Topics	Organization(s) receiving trainings
4/26/2022	Training on various SDOHs and Health Equity Definitions	Internal and external coalitions

C. County Health Department Health Equity Training

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

Date	Topics	Number of Staff in Attendance

D.National Minority Health Month Promotion

In the month of April, the Health Equity Team participated in the “Parents as Teachers” community event: “Hop to It”. Culture was defined as the customary beliefs and patterns of and for behavior, both explicit and implicit, that are passed on to future generations by the society they live in and/or by a social, religious, or ethnic group within it. During the event the Health Equity Team promoted Healthy Lifestyles by distributing 5210 promotional items to encourage healthy eating and family involvement. A total of 20 families attended this event. Due to time constraints, the Health Equity logo was not included on the flyer.

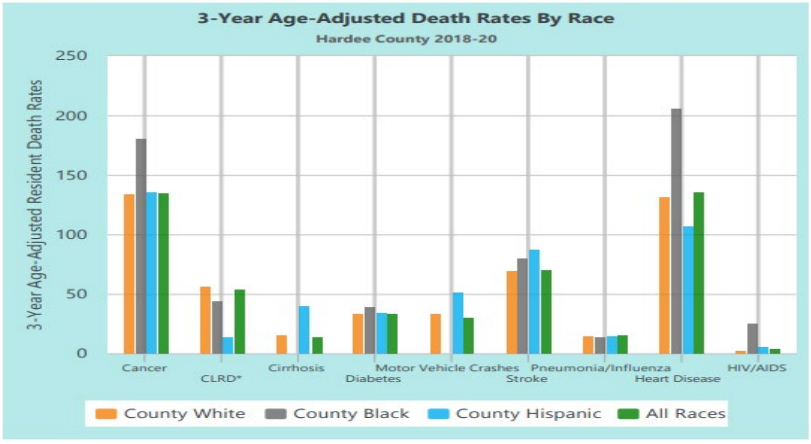
During the month of February, the Health Equity Team participated in a Black History Weekend presented by the Parks and Recreation Committee. During this event Black History was recognized through festivities, music, and history. Our Health Equity Team distributed flyers and educated our community on the importance of diabetes and minorities.

VI. PRIORITIZING A HEALTH DISPARITY

Commented [A1]: Look to add the info from the CHIP & CHA.

Diabetes is one of the top 5 leading causes of death in Hardee. Diabetes is a chronic disease that affects how your body turns food into energy and results in too much sugar in the blood. The National Institute of Diabetes and Digestive and Kidney Diseases reports that 34.2 million Americans had diabetes in 2020, and 7.3 million of them were undiagnosed. People with diabetes are more likely to have heart disease or a stroke. Diabetes is also the leading cause of kidney failure, lower-limb amputations, and adult-onset blindness.

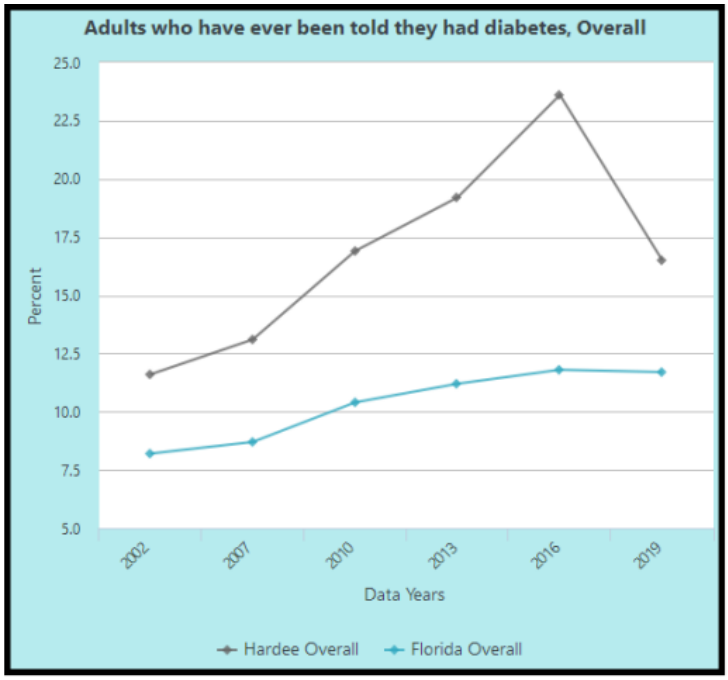
The Health Equity team reviewed limited health disparities data in Hardee County. After reviewing the data from various sources, including FLCHARTS, County Health Rankings, and Healthy People 2030. Using Technology of Participation, the Hardee County Health Equity Team identified diabetes as the health disparity. The Health Equity Team agreed to focus on this disparity in the Health Equity Plan.



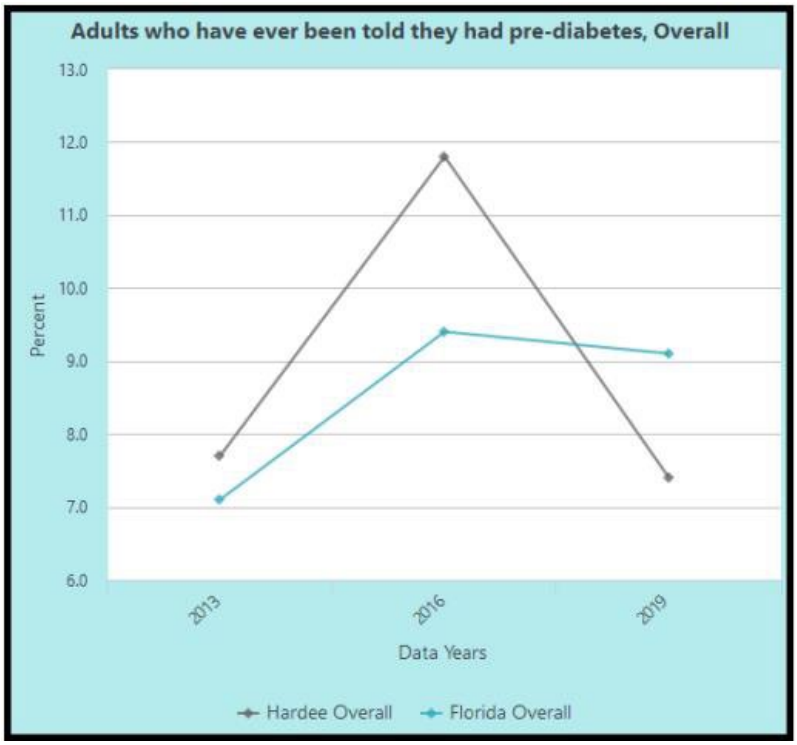
- In 2018, non-Hispanic blacks were twice as likely as non-Hispanic whites to die from diabetes.

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

SOURCE: https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=18



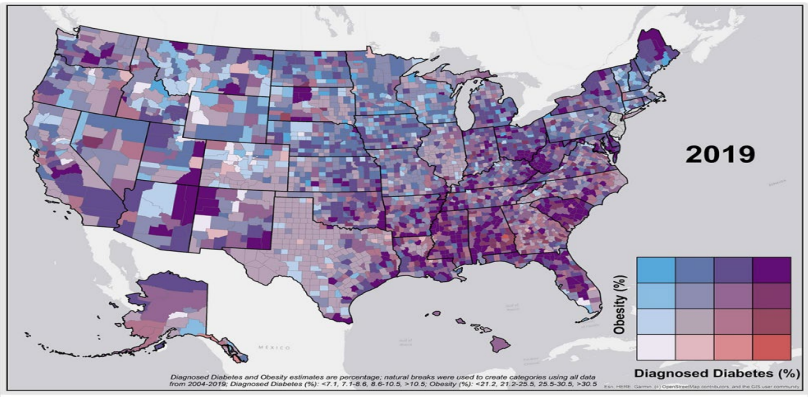
SOURCE: FLHealthCHARTS


Adults who have ever been told they had pre-diabetes, Overall
13.0
12.0
11.0
10.0
9.0
8.0
7.0
6.0
Percent
2013
2016
2019
Data Years
Hardee Overall
Florida Overall

SOURCE: FLHealthCHARTS

Hardee County has a high rate of diabetes and Obesity as shown by the map from the CDC below. The dark purple color indicates areas where there is a high rate of both.

Diabetes and Obesity Maps



SOURCE: CDC

Black Hardee County residents are more likely to be obese than White Hardee County residents. Black and Hispanic residents are more likely to be sedentary and are less likely to meet aerobic and muscle strengthening recommendations.

Indicator	Measure	Year(s)	Total	White	Black	Other Race
Adults who are obese	Percent	2019	29.8	27.9	48.6	
Adults who are overweight	Percent	2019	27.5	28.5	21.1	
Adults who are sedentary	Percent	2019	21.8	18.4	30.6	
Adults who are inactive or insufficiently active	Percent	2016	51.7	46.3	69.6	
Adults who meet aerobic recommendations	Percent	2016	50.6	55.9	33.9	
Adults who meet muscle strengthening recommendations	Percent	2019	39.2	41.4	34.8	

Hispanic	Non-Hispanic	Black/White	Other Race/White	Hispanic/Non-Hispanic	Non-Hispanic/Hispanic	Black/White	Other Race/White	Hispanic/Non-Hispanic	Non-Hispanic/Hispanic
27.1		1.7:1				1.4:1			
23.2		0.7:1				0.9:1			
26.8		1.7:1				1.2:1			
64.1		1.5:1				1.2:1			
38.9		0.6:1				0.8:1			
30		0.8:1				1.1:1			

SOURCE: FLHealthCHARTS

Hardee County residents age adjusted hospitalization rate for amputation of a lower extremity due to diabetes is more than 2x the state rate.

Diabetes			
Deaths: Age-adjusted death rate per 100,000 total population	Per 100,000 Total Population	2018-20	36
Hospitalizations: Age-adjusted hospitalization rate per 100,000 total population	Per 100,000 Total Population	2018-20	3,410
Hospitalizations: Age-adjusted hospitalization rate for amputation of a lower extremity due to diabetes	Per 100,000 Total Population	2018-20	68
Adults who have ever been told they had diabetes	Percent	2019	

33.5	4	21.1	
3,606.9	4	2,259.9	
75.9	4	37.1	4.3
16.5%	4	11.7%	

SOURCE: FLHealthCHARTS

Hispanic Hardee County residents are more likely to have ever been told that they have diabetes. Black, Other Race, and Hispanic Hardee County residents are more likely to visit an emergency room due to diabetes.

Black and Other Race Hardee County residents have a higher age adjusted death rate than their White counter parts.

SOURCE: FLHealthCHARTS

Indicator	Measure	Year(s)	Total	White	Black	Other Race
Diabetes						
Adults who have ever been told they had diabetes	Percent	2019	11.2	10.8	10.2	
Emergency room visits due to diabetes	Per 100,000 population	2020	151.7	88.8	378.7	129.2
Ambulatory Care Sensitive Hospitalizations From Diabetes (Aged 0-64 Years)	Per 100,000 population	2020	116.5			
Hospitalizations from or with diabetes	Per 100,000 population	2020	2662.8	1900	5756.5	2720
Diabetes age-adjusted death rate	Per 100,000 population	2020	19.9	16.2	34	28.6

Hispanic	Non-Hispanic	Black/White	Other Race/White	Hispanic/Non-Hispanic	Non-Hispanic/Hispanic	Black/White	Other Race/White	Hispanic/Non-Hispanic	Non-Hispanic/Hispanic
18.7		0.9:1				1.4:1			
113.5	155.9	4.3:1	1.5:1	0.7:1	1.4:1	3.4:1	2.6:1	0.8:1	1.2:1
2022.5	2671.1	3:1	1.4:1	0.8:1	1.3:1	2.2:1	2.6:1	0.9:1	1.1:1
5.9	21	2.1:1	1.8:1	0.3:1	3.6:1	2.4:1	1.2:1	1:1	1:1

SOURCE: FLHealthCHARTS

Diabetes Among People with Disabilities

DIABETES HEALTH MEASURES

Overall, people living with disabilities report worse diabetes health outcomes than people not living with disabilities, including higher rates of diabetes and pre-diabetes prevalence, and higher rates of receiving a diabetes test within the last 3 years. People living with two or more disabilities report equivalent or worse cardiovascular health outcomes across all these metrics. However, neither the age at time of diabetes diagnosis nor having a class on diabetes education varied with statistical significance across disability status.

Source: Knowli Data Science

"Overall, people living with disabilities report worse general health outcomes than people not living with disabilities, including lower self-ratings of overall health, more days of poor physical health in the last 30, more days of poor physical and mental health in the last 30 days, higher rates of depressive diagnosis disorder, BMI, higher rates of smoking at least 100 cigarettes in their lives, and lower rates of exercise."

Source: Knowli Data Science

VII. SDOH DATA

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

A. Education Access and Quality

Community Determinants							
Life expectancy	Years	2018-20	79.1 (77.8-80.4)				
Racial residential segregation	Index	2020	0.4044				
Individuals 25 years and over with no high school diploma	Percent	2016-20	23.8	20.2	43.2	53.4	40
High school graduation rate	Percent	2020	91.4	88.1	92.3		92.6
Population living within ½ mile of a park	Percent	2019	3.6				
Population living within ½ mile of a fast food restaurant	Percent	2019	0.5				
Workers who walked to work	Percent	2016-20	1.5				

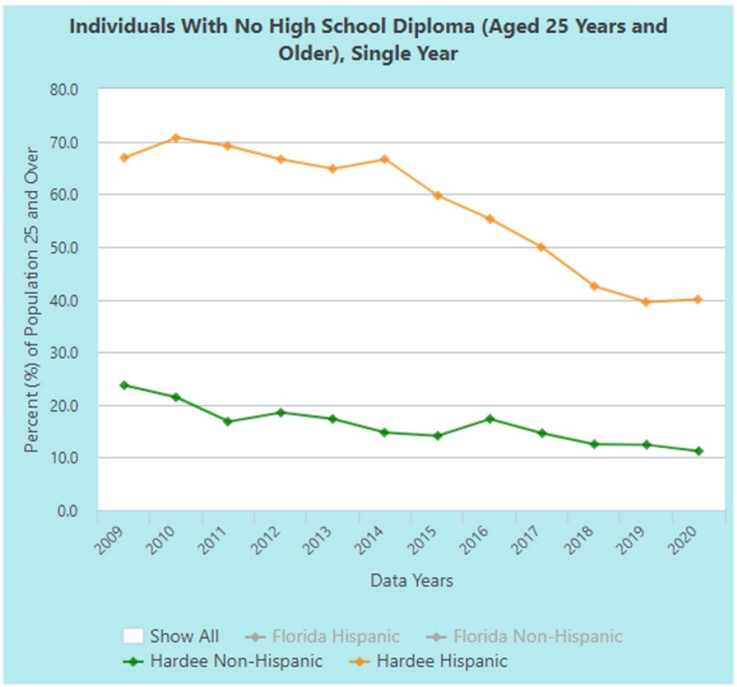
11.2	2.1:1	2.6:1	3.6:1	0.3:1	1.7:1	2.5:1	2.8:1	0.4:1
	1:1				0.9:1			

SOURCE: FLHealthCHARTS

Black and Hispanic Hardee County residents are more likely to be 25 years and over with no high school diploma. Black Hardee County residents have a slightly lower graduation rate than White Hardee County residents. Hardee County have a significantly lower high school completion percentage and lower percentage of residents who have completed some college compared to top US performers, according to County Health Rankings.

Social & Economic Factors				
High school completion	76%	73-79%	94%	89%
Some college	26%	21-32%	74%	64%

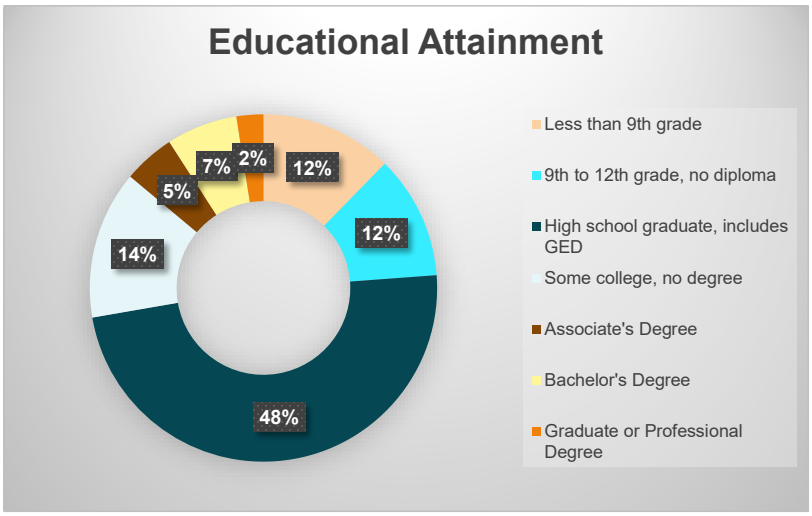
SOURCE: County Health Rankings and Road Maps



SOURCE: FLHealthCHARTS

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

In 2019, the percentage of Hispanic individuals 25 years and over with no high school diploma in Hardee County was 40% compared to non-Hispanic at 11.2%. The line graph shows change over time. Lack of a high school diploma impacts Diabetes by preventing the impacted population from seeking proper professional care. This is a direct result of literacy and language barriers.



SOURCE: FLHealthCHARTS

The highest educational attainment achieved by the majority of Hardee County residents is a high school diploma or GED or less. Approximately 28% of Hardee County residents have attended some College or received a college degree.

Education Access Among People with Disabilities

“People living with at least one disability report lower education attainment than people with no disabilities. People living with at least 2 disabilities report lower education attainment than people with no disabilities.”

TABLE 7: REPORTED EDUCATIONAL ATTAINMENT – ONE DISABILITY

Education	No Disabilities: Mean	No Disabilities: N	People Living With At Least 1 Disability: Mean	People Living With At Least 1 Disability: N
Never attended school/only kindergarten	0.01	9,501	0.01	4,399
Grades 1 - 8	0.03	9,501	0.06	4,399
Grades 9 - 11	0.06	9,501	0.16	4,399
Grades 12 or GED	0.29	9,501	0.31	4,399
College 1 – 3 Years	0.33	9,501	0.31	4,399
College 4 years or more	0.29	9,501	0.15	4,399

TABLE 8: REPORTED EDUCATIONAL ATTAINMENT – AT LEAST TWO DISABILITIES

Education	No Disabilities: Mean	No Disabilities: N	People Living With At Least 2 Disabilities: Mean	People Living With At Least 2 Disabilities: N
Never attended school/only kindergarten	0.01	9,501	0.01	2,309
Grades 1 - 8	0.03	9,501	0.08	2,309
Grades 9 - 11	0.06	9,501	0.18	2,309
Grades 12 or GED	0.29	9,501	0.31	2,309
College 1 – 3 Years	0.33	9,501	0.30	2,309
College 4 years or more	0.29	9,501	0.12	2,309

Source: Knowli Data Science

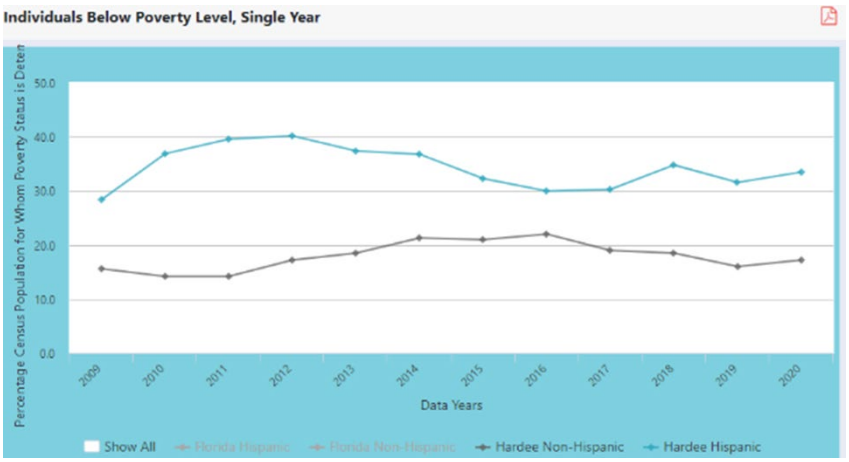
- **The impact of education access and quality on Diabetes**

Education Access and Quality		
SDOH	**Vulnerable Populations Impacted**	**How the SDOH Impacts (Health Disparity)**
Literacy	Hispanic	The impact of health literacy on skills needed to make health-related decisions may affect a patient's adherence

		to a treatment regimen (e.g., medication), which may decrease its benefits. Patients with low health literacy also tend to use the emergency department more often and are more likely to return to the emergency department after 2 weeks. One systematic review found low literacy (used as a proxy for health literacy) may impact parent/caregiver behavior (e.g., medication dosing)
Language	Hispanic	Lack of high school education can result in language barrier from patient to provider. This can lead to patients not seeking proper treatment to avoid discomfort, confusion, and beliefs.

B. Economic Stability

- **Economic stability data for Hardee County**



SOURCE: FLHealthCHARTS

Income and Employment							
Income Inequality	Index	2016-20	0.5185				
Median household income	Dollars	2016-20	$40,165	$37,137	-$666,666,666	$45,913	$35,877
Households with 1 worker	Percent	2016-20	31.6				
Individuals below poverty level	Percent	2016-20	24.7	24.7	21.2	25.6	33.5
Children under 18 below poverty level	Percent	2016-20	38.4	37.9	41.7	57.9	50.4
Unemployed civilian labor force	Percent	2016-20	8.1	7.3	35.8	6	8.7
Civilian labor force employed in management, business, science, or arts	Percent	2016-20	23.9				

$42,146	-17951.5:1	1.2:1	0.9:1	1.2:1	0.7:1	0.8:1		
17.2	0.9:1	1:1	1.9:1	0.5:1	1.8:1	1.3:1	1.7:1	0.6:1
18.3	1.1:1	1.5:1	2.8:1	0.4:1	2:1	1.7:1	1.9:1	0.5:1
5.7	4.9:1	0.8:1	1.5:1	0.7:1	1.8:1	1.2:1	1.1:1	0.9:1

SOURCE: FLHealthCHARTS

In 2019, the percentage of Hispanics below poverty level In Hardee County, was 33.5% compared to non-Hispanic individuals at 17.2%. The following graph shows change over time. Living below the poverty level impacts Diabetes by limiting economic stability, limiting access to resources, and limiting access to health care.

Economic Stability Among People with Disabilities

"Overall, people living with disabilities report worse economic stability than people with no disabilities, including lower incomes, higher rates of food insecurity, higher rates of not having enough money for balanced meals, and higher rates of financial insecurity."

TABLE 5: REPORTED INCOME – ONE DISABILITY

Income	No Disabilities: Mean	No Disabilities: N	People Living With At Least 1 Disability: Mean	People Living With At Least 1 Disability: N
Less than $10,000	0.04	8,207	0.11	3,757
$10,000 to less than $15,000	0.02	8,207	0.11	3,757
$15,000 to less than $20,000	0.08	8,207	0.15	3,757
$20,000 to less than $25,000	0.12	8,207	0.15	3,757
$25,000 to less than $35,000	0.12	8,207	0.13	3,757
$35,000 to less than $50,000	0.15	8,207	0.12	3,757
$50,000 to less than $75,000	0.14	8,207	0.12	3,757
More than $75,000	0.32	8,207	0.12	3,757

TABLE 6: REPORTED INCOME – AT LEAST TWO DISABILITIES

Income	No Disabilities: Mean	No Disabilities: N	People Living With At Least 2 Disabilities: Mean	People Living With At Least 2 Disabilities: N
Less than $10,000	0.04	8,207	0.15	1,969
$10,000 to less than $15,000	0.02	8,207	0.17	1,969
$15,000 to less than $20,000	0.08	8,207	0.17	1,969
$20,000 to less than $25,000	0.12	8,207	0.15	1,969
$25,000 to less than $35,000	0.12	8,207	0.13	1,969
$35,000 to less than $50,000	0.15	8,207	0.09	1,969
$50,000 to less than $75,000	0.14	8,207	0.08	1,969
More than $75,000	0.32	8,207	0.07	1,969

S

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

Economic Stability		
SDOH	**Vulnerable Populations Impacted**	**How the SDOH Impacts (Health Disparity)**
Employment	Hispanic	Having diabetes can lead to health-related disabilities causing limited employment options/ inability to work.
Income	Hispanic	Without employment due to internal/ physical disabilities can lead to little to no income to sustain a home and lifestyle.
Expenses	Hispanic	Other expenses are either paid late or unable to be paid for due to the importance of keeping up with proper care/ bills for diabetes services.
Medical Bills	Hispanic	Medical bills can affect the income of the person affected by diabetes by reducing income to pay other household bills in order to keep up with medical bills.
Hunger	Hispanic	Lack of education on proper diet and economic stability can lead to population to accept poor diets such as cheaper unhealthy meals.

C. Neighborhood and Built Environment

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

SOURCE: FLHealthCHARTS

In 2019, the percentage of population living within ½ mile of a park In Hardee County, was 3.6% compared to Florida at 40%. The following graph shows change over time. Access to

healthy food sources and recreational areas are necessary to support healthy diets and physical activity.

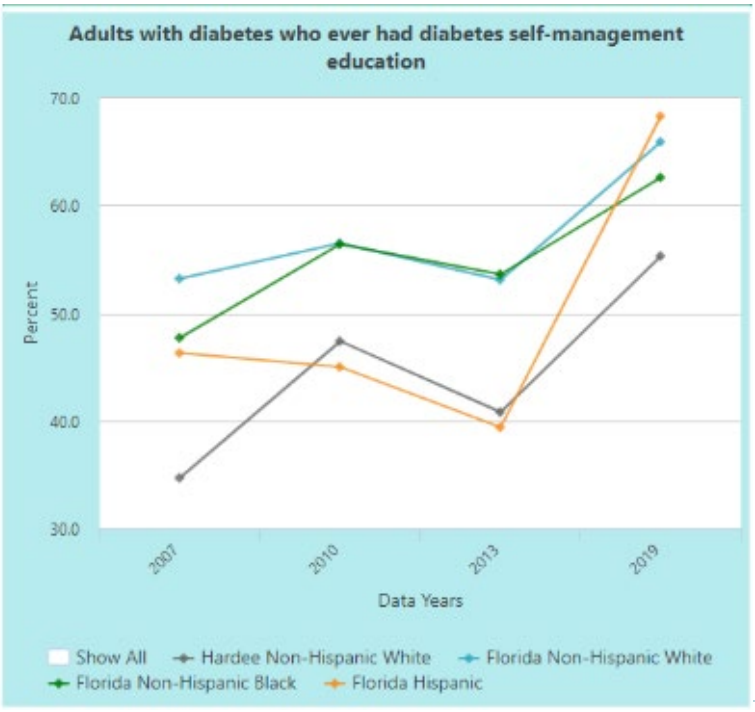
- **The impact of neighborhood and built environment on Diabetes**

Neighborhood and Built Environment		
SDOH	**Vulnerable Populations Impacted**	**How the SDOH Impacts Diabetes**
Transportation	Hardee County residents	Some residents are unable to commute to parks or trails because of the lack of community transportation. Not being able to get a 10–15-minute form of physical activity can lead to poor health and poor eating.
Parks/ playgrounds	Hardee County residents	Lack of physical activity and unhealthy eating are major risk factors for chronic diseases, the leading causes of death and disability in the United States. Chronic diseases include heart disease, diabetes, and cancer. Half of all adults in the U.S. have a chronic disease. A community approach to healthy living, like providing access to healthy foods and more places for physical activity, can have broader effects than the efforts of people working on their own to make healthy changes

D. Social and Community Context

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

  In 2019, in Hardee County, 41.8% of adults with diabetes who ever had diabetes self-management education (Overall) can be compared to 66.3% statewide. The line graph shows change over time when there are at least three years of data



SOURCE: FLHealthCHARTS

Social and Community Context Among People with Disabilities

"Overall, people living with disabilities report worse social and community context outcomes than people with no disabilities, including higher rates of moving more than twice in the last 12 months, higher rates of considering their neighborhoods unsafe, and higher rates of experiencing stress most or all of the time."

Source: Knowli Data Science

- **The impact of social and community context on Diabetes.**

Social and Community Context		
SDOH	**Vulnerable Populations Impacted**	**How the SDOH Impacts (Health Disparity)**
Support Systems	Hardee County Residents	Inconsistent support of program & language barrier when teaching class can lead to improper diabetes care.

Community Engagement	Hardee County Residents	Lack of proper media distribution/ rural county can affect the way members in the community receive invitations to participate in these classes.
Discrimination	Hardee County Residents	Classes are regularly in between 8-4pm resulting in most of our working community missing out in the scheduled class. Some of these classes require fees or qualifications to enroll in free or little to no charge resulting in residents not wanting to seek education/help.

E. Health Care Access and Quality

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

In 2019, The percentage of Hispanic adults who were overweight in Hardee County was 42.15 compared to White individuals at 34.8%. The following graph shows change over time.

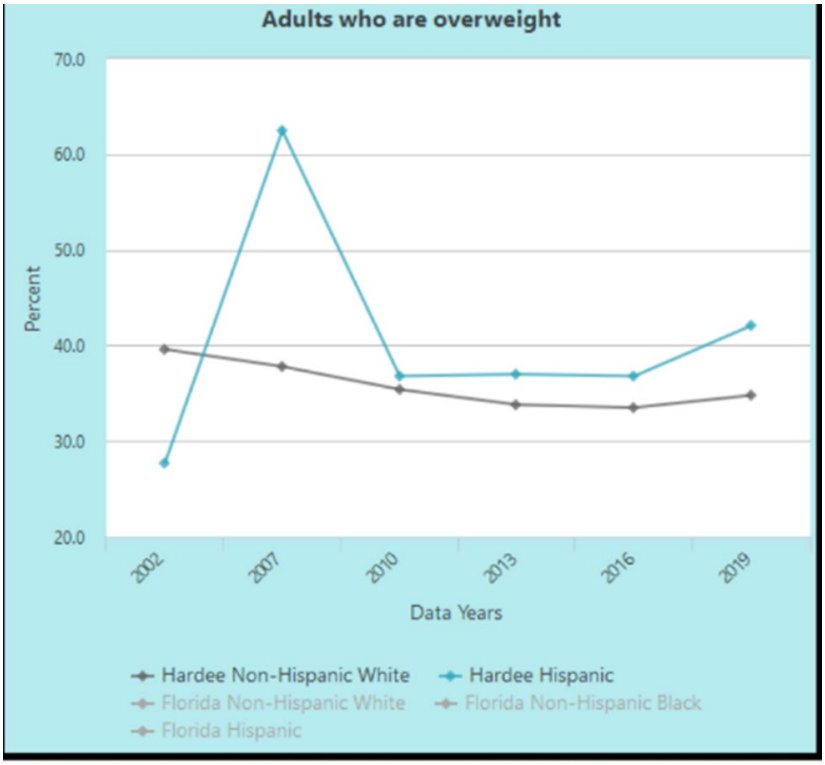
Indicator	Measure	Year(s)	Total	White	Black	Other Race
Behaviors and Exposures						
Adults who are current smokers	Percent	2019	20.7	24.5		
Adults who engage in heavy or binge drinking	Percent	2019	12.8	13.6		
Adults who are obese	Percent	2019	35.2	35.9		
Adults who are overweight	Percent	2019	36.5	34.8		
Adults who are sedentary	Percent	2019	42.7	46.9		
Adults who are inactive or insufficiently active	Percent	2016	66.1	63.4		
Adults who meet aerobic recommendations	Percent	2016	35.8	38		
Adults who meet muscle strengthening recommendations	Percent	2019	21.2	22.5		
Out-of-school suspensions grades K-12	Per 100,000 population	2020	3446.2			
Inmate Admissions	Count	2020	57			
Incarceration rate	Per 1,000 population	2020	3.4			

Hispanic	Non-Hispanic	Black/White	Other Race/White	Hispanic/Non-Hispanic	Non-Hispanic/Hispanic	Black/White	Other Race/White	Hispanic/Non-Hispanic	Non-Hispanic/Hispanic
15.1						0.8:1			
12						0.7:1			
33.5						1.4:1			
42.1						0.9:1			
37.8						1.2:1			
72.3						1.2:1			
29.9						0.8:1			
21.4						1.1:1			

SOURCE: FLHealthCHARTS

SOURCE: FLHealthCHARTS

The Health Resources and Services Administration (HRSA) has designated Hardee County as a Health Professional Shortage Area (HPSAs) and a Medically Underserved Area (MUA). HPSAs are designated by HRSA as having shortages of primary care, dental care, or mental health providers and may be geographic (a county or service area), population (e.g., low income or Medicaid eligible) or facilities (e.g., federally qualified health centers, or state or federal prisons). Hardee County has a received a designation for the county in primary care providers along with the Hardee Correctional Institute. Low Income/Migrant Farmworker and the Hardee Correctional Institute have received this status in dental health providers. The county and Hardee Correctional Institute also received this status for Mental Health providers.



SOURCE: FLHealthCHARTS

Adults who could not see a doctor in the past year due to cost, Overall	
Year	**Florida**
2019 18.6% (12.8% - 24.3%)	16% (14.8% - 17.3%)
2016 15.8% (12.3% - 19.4%)	16.6% (15.8% - 17.4%)
2013 24.6% (16.2% - 33%)	20.8% (19.7% - 21.8%)
2010 19.2% (14% - 24.3%)	17.3% (16.2% - 18.3%)
2007 38.3% (21.4% - 58.5%)	15.1% (14.2% - 16%)

FLHealthCharts.gov is provided by the Florida Department of Health, Division of Public Health Statistics and Performance Management.
Data Source: Florida Behavioral Risk Factor Surveillance System telephone survey conducted by the Centers for Disease Control and Prevention (CDC) and Florida Department of Health Division of Community Health Promotion.
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In all of the previous years with the exception of 2016, the percentage of adults who could not see a doctor in the past year due to cost was higher than the state percentage.

Health Care Access and Quality Among People with Disabilities

“People living with disabilities report worse healthcare access outcomes than people with no disabilities, including higher rates of not seeing a doctor because of cost, not having health

care coverage, and higher rates of reporting that the most important reason for delayed medical care is transportation access."

Source: Knowli Data Science

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

Health Care Access and Quality		
SDOH	**Vulnerable Populations Impacted**	**How the SDOH Impacts Diabetes**
Health Coverage	Hispanics	Having little to no health care can impact how Hispanics approach the proper care for any chronic disease. Check-ups or appointments can result costly.
Provider Linguistic and Cultural Competency	Hispanics	Providers are able to educate and provide proper resources for treatment, but language barrier and linguistics can result in patient not further treating their chronic disease such as Diabetes. Cultural

		sensitivity, acknowledgement, and understanding can help practitioners, such as diabetes care and education specialists, understand the influence of culture on health. Taking into consideration all that encompasses a person's health, such as their cultural beliefs, can help break barriers and improve quality of life for those people living with diabetes.
Quality of Care	Hispanics	The quality of diabetes care can vary widely across communities and population groups. Gaps in care can lead to complications or death and can increase costs. The prevalence has been increasing. Obesity increases the risk for diabetes. Over the past 20 years, obesity has dramatically increased in the U.S. There are wide racial and ethnic disparities in diabetes diagnosis, treatment, and outcomes

VIII. SDOH PROJECTS

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

A. Data Review

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

B. Barrier Identification

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

Partners	SDOH	Partner Barriers	Theme	Collaborative Strategies
Drug Free Hardee	Economic Stability and Education Access and Quality	Lack of Funding Lack of infrastructure	Education and Income Disparities	Sharing grant writing resources, collaboration to attain resources

Food Banks, Hardee Help Center	Neighborhood and Built Environment	Lack of access to healthy foods. Funding limitations	Food access	Consider Community Fridge partnerships at the Hardee Help Center office and other local businesses.
Advent Health/ Central Florida Health Care	Access to Healthcare	Attendance of classes. Referral Process to obtain clients. Length and time classes are offered.	Health care access	Implement referral system. Assist in finding additional clients. Offer different class times.

C. Community Projects

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

The Student Hub

The Student Hub is a project created by Drug Free Hardee to assist local high school students with finding and completing necessary resources to move to the next level after high school. The Student Hub assists students with applications related to college, technical schools, certificate programs, and GED programs. The Hub provides students with assistance applying for grants and financial aid to obtain their goals. This program connects students to resources and other available programs that improve education attainment goals as well as economic stability efforts. The Student Hub will assist students with job applications, resume building, and other training needed for job placement.

IX. HEALTH EQUITY PLAN OBJECTIVES

A. Diabetes

- **Health Disparity Objective: By June 30, 2023, decrease the percentage of Black (10.2%) and Hispanic (18.7%) Hardee County residents who have ever been told they had diabetes by 1% each to 9.2% (Black) and 17.7% (Hispanic).**

- **The Student Hub Table**

	Lead Entity and Unit	Lead Point Person	Data Source	Baseline Value	Target Value	Plan Alignment
Long-Term SDOH Goal: Improve education access and quality and economic stability among Hardee County residents through collaborations with community stakeholders and partners.						
Objective: By June 30,2027, increase the number of Hardee County residents obtaining a Bachelor's	Drug Free Hardee	Maria Pearson	Community Social and Economic factors US Census Bureau	9.1%	14.1%	Hardee County CHIP Drug Free Hardee Logic Models

degree or higher by 5%						
Medium-Term SDOH Goal: Improve education access and quality and economic stability among Hardee County residents through collaborations with community stakeholders and partners.						
Objective: By June 30,2025, decrease the percentage of Hardee County residents who have no high school diploma from 11.5% to 10%	South Florida State College and Drug Free Hardee	Katrina Blandin and Maria Pearson	Community Social and Economic factors US Census Bureau	11.5%	10%	Hardee County CHIP Drug Free Hardee Logic Models
Short-Term SDOH Goal: Improve education access and quality and economic stability among Hardee County residents through collaborations with community stakeholders and partners.						
Objective: By June 30, 2023, increase the number of students who use the Student Hub for applications, resources, and trainings from 0 to 25	Hardee Senior High School/ Drug Free Hardee	Mrs. Tammy Pohl (Principal) and Maria Pearson	Student Hub Sign-In sheets	0	25	Hardee County CHIP Drug Free Hardee Logic Models

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. The Minority Health Liaison hosts monthly meetings with internal and external partners to update, review, and collectively share input regarding the plan. 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 through the ClearPoint System.

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

REFERENCES:

FLHealthCharts:

https://www.flhealthcharts.gov/ChartsReports/rdPage.aspx?rdReport=ChartsProfiles.HealthEquityMergeMHProfile

Healthy People 2030:

https://health.gov/healthypeople/objectives-and-data/leading-health-indicators

County Health Rankings & Roadmaps:

https://www.countyhealthrankings.org/app/florida/2022/rankings/hardee/county/outcomes/overall/snapshot

Health Professional Shortage Area:

https://data.hrsa.gov/tools/shortage-area/hpsa-find

American Diabetes Association:

https://www.diabetes.org/

National Institute of Diabetes and Digestive and Kidney Disease:

https://www.niddk.nih.gov/health-information/health-statistics/diabetes-statistics

Center for Disease Control:

https://www.cdc.gov/diabetes/data/center/slides.html