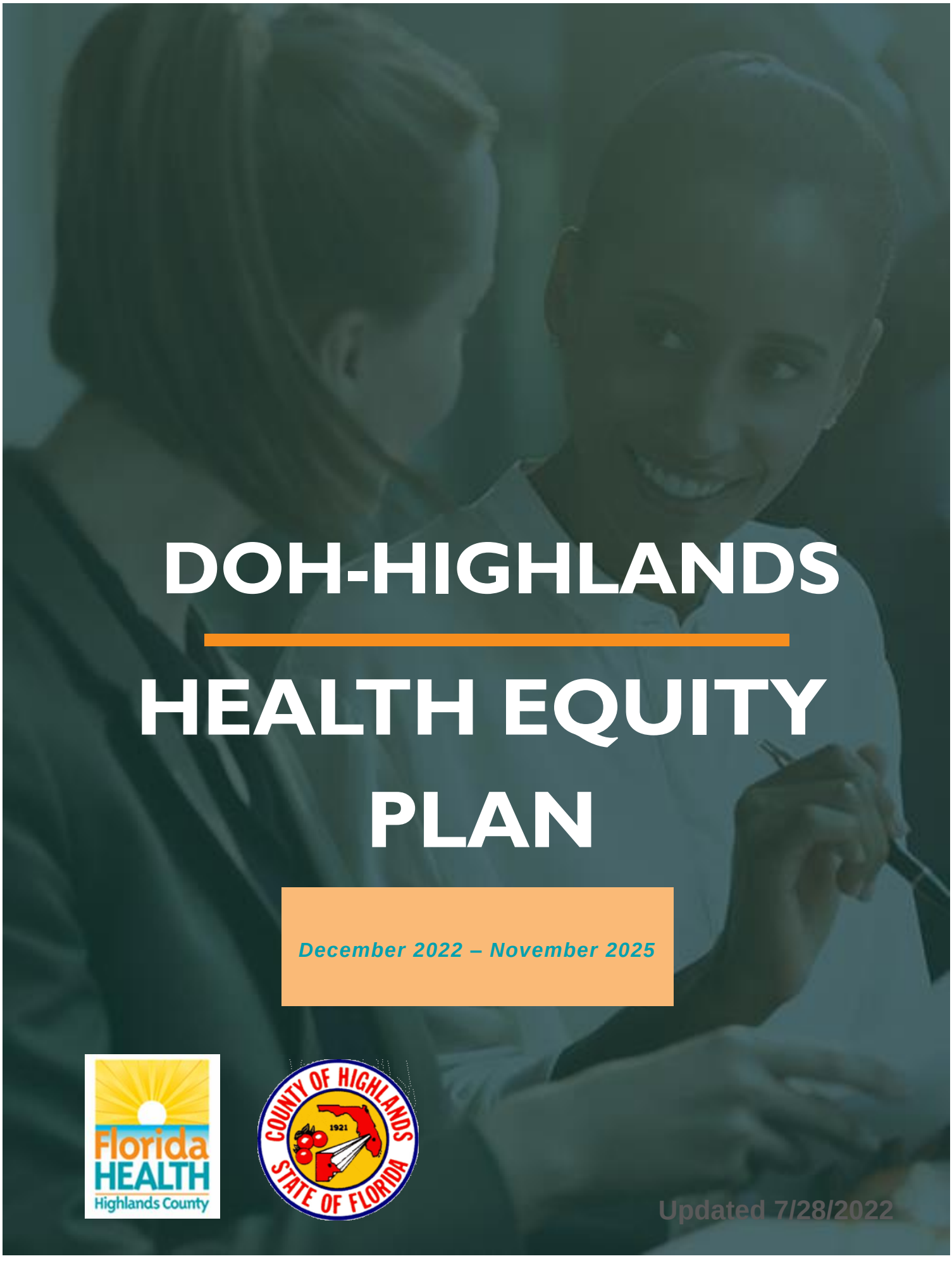


DOH-HIGHLANDS

HEALTH EQUITY PLAN

December 2022 – November 2025

Updated 7/28/2022

Table of Contents

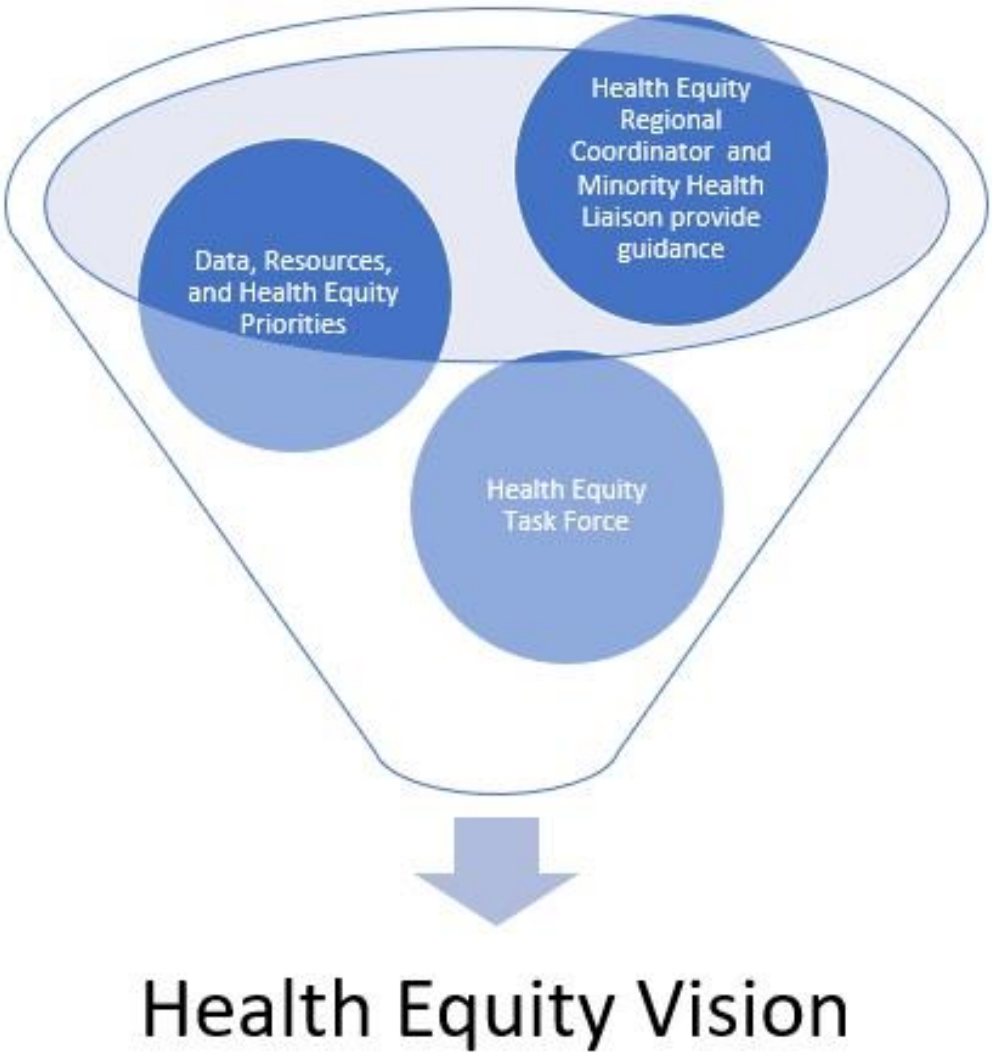
I. VISION

The Health Equity Team and the Health Equity Taskforce of Highlands County includes members representing various areas of the county health department, such as Community Programs, Epidemiology, Primary Care, School Health and Environmental Health, as well as partners from the community who we recognize are also members of the Tobacco Free Highlands/QuitDoc Foundation, Heartland Regional Transportation Planning Organization, Highlands County Board of County Commissioners, Health Families, and the United Way of Central Florida. These people played a fundamental and important role in establishing this Health Equity Plan and our Vision, bringing their knowledge about the needs of this community to the discussion and working collaboratively to develop this vision for Highlands County.

Due to the impacts of COVID-19 over the past two years, most agencies and organizations in Highlands County are just now beginning to resume normal operations. Unfortunately, this limits the ability of staff to commit time to additional meetings for a new project. Therefore, discussions regarding health equity in Highlands County and this plan were included in meetings already scheduled with or by stakeholders. It is our intention to build on these foundational discussions to increase the number of participants in this project and bring a deeper understanding of health equity and its true impact on the residents of Highlands County to future planning efforts.

Vision Statement:

“Highlands County will achieve reduced diagnoses of diabetes through innovative efforts to provide education on healthy lifestyles and increased access to health resources and healthy activities.”


Health Equity Regional Coordinator and Minority Health Liaison provide guidance
Data, Resources, and Health Equity Priorities
Health Equity Task Force
Health Equity Vision

II. PURPOSE OF THE HEALTH EQUITY PLAN

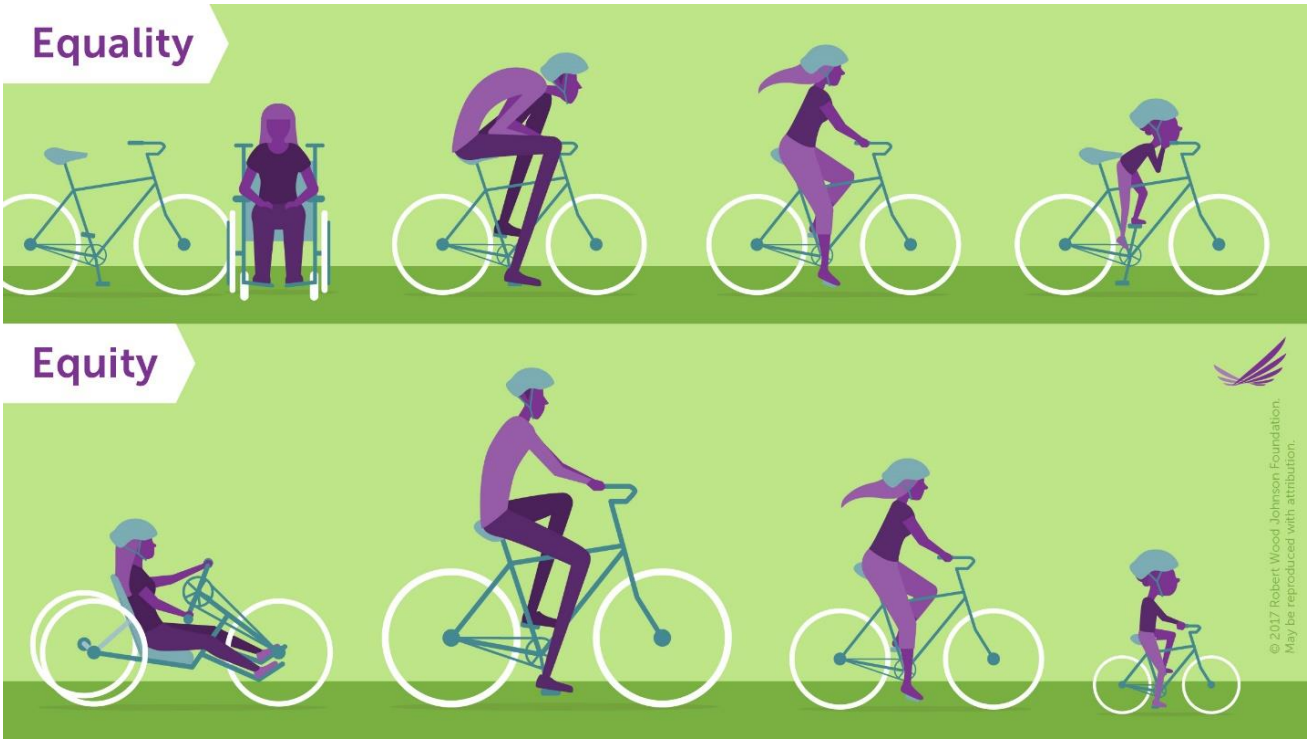
Health Equity is achieved when everyone can attain optimal health.

The Florida Department of Health's Office of Minority Health and Health Equity (OMHHE) works with governmental agencies and community organizations to address identified 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 2021-117 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 methods for reducing health disparities.

The purpose of the Health Equity Plan is to increase health equity within Highlands County. To develop this plan, the Florida Department of Health in Highlands County (DOH-Highlands) 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 Highlands 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 that impact health and well-being for everyone in the county.

III. DEFINITIONS



Health equity is achieved when everyone can attain optimal health.

Health inequities are systemic 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 means 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.

Highlands County organizations have just begun to move out of COVID-19 precautions to more normal operations, slowly resuming partner and stakeholder meetings and collaborations. Because of this fact, process has been slow in fully developing the health equity focus across agencies. However, the Minority Health Liaison from DOH-Highlands has integrated health equity discussion into all community partnerships and meetings that are being held, building the momentum for further development of a fully integrated Health Equity Task Force and Coalition as we move forward. For example, during meetings of the Tobacco Free Partnership, health equity topics were brought into discussions to remind

participants of the importance of considering these factors in strategic planning for Highlands County initiatives. Also, social determinants of health were discussed during the Heartland Regional Transportation Organization's meetings, to inform planning for transportation disadvantaged programs within the region.

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: Pamela A. Crain
Minority Health Liaison Backup: Angela Robles (interim)

Health Equity Team

The Health Equity Team includes individuals who represent various functional areas within the health department and are from varying backgrounds to more completely inform the efforts of this team. These people were chosen due to their areas of expertise and their ability to lend a more balanced perspective in cultural discussions. This team is charged with exploring opportunities to improve health equity efforts within all CHD programs. 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 Highlands 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 in the table below:

Name	Title	Program
Machele Albritton	Biological Scientist IV	Epidemiology
Rebecca Farias	Sr. Community Health Nurse	Clinic
Angie Robles	Operations and Management Consultant	Fiscal
Jackie Stimson	Sr. Clinic Nurse	School Health
Gladys Vazquez-Cisneros	Nurse Program Specialist	Epidemiology/Environmental Health
Jason Wolfe	Environmental Health Supervisor	Environmental Health
Pam Crain	Health Educator Consultant	Community Programs

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

Meeting Date	Topic/Purpose
February 23, 2022	Team intro and general discussion
March 23, 2022	General discussion and HE Month event planning
April 13, 2022	General discussion, finalize HE Month event
June 24, 2022	Limited discussion of Shining the Light project
June 29, 2022	General discussion: review final HE Plan; discuss HE Plan projects

B. Health Equity Taskforce

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

Name	Title	Organization	Social Determinant of Health
Pam Crain	Health Educator	DOH-Highlands	Healthcare Access and Quality
Amanda John	Program Director – Highlands County	Tobacco Free Highlands/Quit Doc Foundation	Education Access and Quality and Healthcare Access
Jessica Carlson	Community Health Advocate	QuitDoc Foundation	Health Education
Marybeth Soderstrom	Transportation Manager	Heartland Regional Transportation Planning Organization	Neighborhood and Built Environment
Ingra Gardner	Director of Community Programs	Highlands County Board of County Commissioners	Social and Community Context Economic Stability
Jessica Pease	Community Impact Assistant	United Way of Central Florida	Social and Community Context
Cynthia Acevedo	Healthy Families	Highlands County	Social and Community Context

Health Equity Taskforce members met on the below dates during the health equity planning process. As previously noted, health equity discussion has been inserted as a topic in meetings scheduled for other business so that stakeholders can begin to understand its meaning in the context of their endeavors to improve the lives of Highlands County residents. As this understanding grows, the Health Equity Taskforce may move forward with separate meetings that focus solely on health equity concerns for Highlands County. Since the Health Equity Plan was completed, the Health Equity Taskforce has continued to meet at least quarterly to track progress.

Meeting Date	Organizations	Topic/Purpose
03/02/2022	Tobacco Free Partnership QuitDoc Highlands County Sheriff Highlands County Schools Advent Health Sebring	Discussion of tobacco/vaping use in Highlands County youth; objectives and methods to reduce or deter same; aspects of health equity that should be considered or that already impact this choice

03/09/2022	Homelessness Taskforce Highlands County staff Samaritans Purse Advent Health Systems	Discussion of Taskforce efforts to mitigate homelessness in Highlands County; discussion of impact of identified SDOH on homeless populations in Highlands County; general topics and updates
04/05/2022	Highlands Community Action Group	Discussion of event in June and items to promote projects
04/13/2022	Homelessness Taskforce	Discussion of homelessness issues and SDOH that may impact homelessness
04/20/2022	HRTPO Local Coordinating Board	Discussion of transportation issues in the region, including those for transportation disadvantaged individuals and groups; discussion of impacts on SDOH
05/03/2022	Highlands Community Action Group	General discussion; event planning
05/18/2022	Children's Services Council	Discussion of funding for Highlands Homelessness help group; discussion of SDOH that impact homeless
06/01/2022	Tobacco Free Partnership	Discussion of tobacco and vape issues in Highlands; school-based issues; possible solutions or unexplored resources for prevention; legislative options; SDOH and inequities that impact decisions to start use of tobacco or vaping, especially in young people

C. Coalition

The Coalition discussed strategies to improve the health of the community during stakeholder meetings. Each group tends to focus on a specific issue, but this project allows all members to contribute their expertise in developing solutions for disparities that impact or are impacted by each of the others. We also referred to

previous health assessments and surveys, such as the Highlands County Community Health Assessment done in 2019, for insight into past efforts to improve health in the county in the interest of not repeating actions that proved unsuccessful before. 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 the table below for the current list of Coalition members, which will be updated as we move forward.

Name	Organization	Focus Area
Shane Lockwood	DOH-Highlands	Health
Randy Vosburg	Highlands County	County Government
Ingra Gardner	Highlands County	Community Programs
Laurie Hurner	Highlands County	County Government

D. Regional Health Equity Coordinators

There are eight Regional Health Equity Coordinators. These coordinators provide the Minority Health Liaison, Health Equity Team, and Health Equity Taskforce with technical assistance, training, and project coordination. The most current list of Regional Health Equity Coordinators is in the table below:

Name	Region	Expertise
Carrie Rickman	Emerald Coast	Technical assistance, training, and project coordination
Quincy Wimberly	Capitol	Technical assistance, training, and project coordination
Diane Padilla	North Central	Technical assistance, training, and project coordination
Ida Wright	Northeast	Technical assistance, training, and project coordination

Refik Brooks	West	Technical assistance, training, and project coordination
Lesli Ahonkhai	Central	Technical assistance, training, and project coordination, Faith-based engagement
Frank Diaz	Southwest	Technical assistance, training, and project coordination
Kimberly Watts	Southeast	Technical assistance, training, and project coordination

V. HEALTH EQUITY ASSESSMENT, TRAINING, AND PROMOTION

A. County Health Equity Training

Highlands County has not yet completed a health equity assessment; however, basic health equity training and skill development have been implemented to help ease the team into gaining knowledge and capabilities that will build over time to create a more focused and relevant Health Equity Plan.

The table below shows the dates, SDOH training topics, and organizations who attended training:

Date	Topics	Organization(s) receiving trainings
09/16/2021	Health Equity Liaison Meeting	DOH-Highlands Health Equity Liaison
09/28/2021	Health Equity overview with CTG team	DOH-Highlands Health Equity Liaison, Closing the Gap team
10/06/2021	Healthy People 2030 – Partnering on Social Determinants of Health	DOH-Highlands Health Equity Liaison

11/10/2021	Highlands County Visioning Session	DOH-Highlands Health Equity Liaison Highlands County Highlands County Schools South Florida State College
1/10/2022	Highlands County Committee	DOH-Highlands Health Equity Liaison
1/26/2022	Cultural Competency and Health Equity training	DOH-Highlands Health Equity Liaison
3/4/2022	MHL Diabetes SDOH Work Group	DOH-Highlands Health Equity Liaison
3/17/2022	ClearPoint training	DOH-Highlands Health Equity Liaison
5/10 – 6/14/2022	OMHHE HE Grant Writing Training	DOH-Highlands HEL

B. County Health Department Health Equity Training

The Florida Department of Health in Highlands County (DOH-Highlands) recognizes that ongoing training in health equity and cultural competency are critical for creating a sustainable health equity focus. At a minimum, all DOH-Highlands staff receive the *Cultural Awareness: Introduction to Cultural Competency* and *Addressing Health Equity: A Public Health Essential* training. In addition, the Health Equity Team will provide regular training to staff on health equity and cultural competency once they have been educated on these topics. The tentative training schedule is shown in the table below. Pre- and post-training assessments will be done to gauge staff knowledge before and after training sessions to determine what gaps may need to be addressed and scheduling additional sessions accordingly.

Date	Topics	Number of Staff in Attendance
July 2022	Cultural Awareness Annual Training	All staff
September 2022	Health Equity Overview with Regional Health Equity Liaison	Health Equity Team, supervisors, Senior Leaders
December 2022	Health Equity Overview	All staff
March 2023	Social Determinants of Health training	Health Equity Team, supervisors, Senior Leaders
April 2023	Social Determinants of Health training	All staff

C. 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 such topics as: the health equity planning process and goals, facilitation and prioritization techniques, reporting requirements, and taking a systems approach to address health disparities. Minority Health Liaison training is recorded below.

Date	Topics
10/06/2021	Healthy People 2030 – Partnering on Social Determinants of Health
01/26/2022	Cultural Competency and Health Equity training
03/17/2022	ClearPoint training

D. National Minority Health Month Promotion

On April 19th, 2022, members of the DOH-Highlands Health Equity Team joined with Avon Elementary staff to host an event highlighting health equity, healthy activities, healthy eating concepts, and literacy as a social determinant of health. The team, pictured above, worked in all PE classes for the day, interacting with all children during group activities, providing healthy eating items and literature, and helped Coach Bart Culpepper discuss healthy choices with each class. Additionally, the Health Equity Liaison discussed the Reading is Health project with media specialist Cindy Murphy, who worked with teachers on all grade levels to order reading books to give to each student as a way of encouraging them to read with a goal of increasing the reading level of students in Highlands County by 2025.

VI. PRIORITIZING A HEALTH DISPARITY

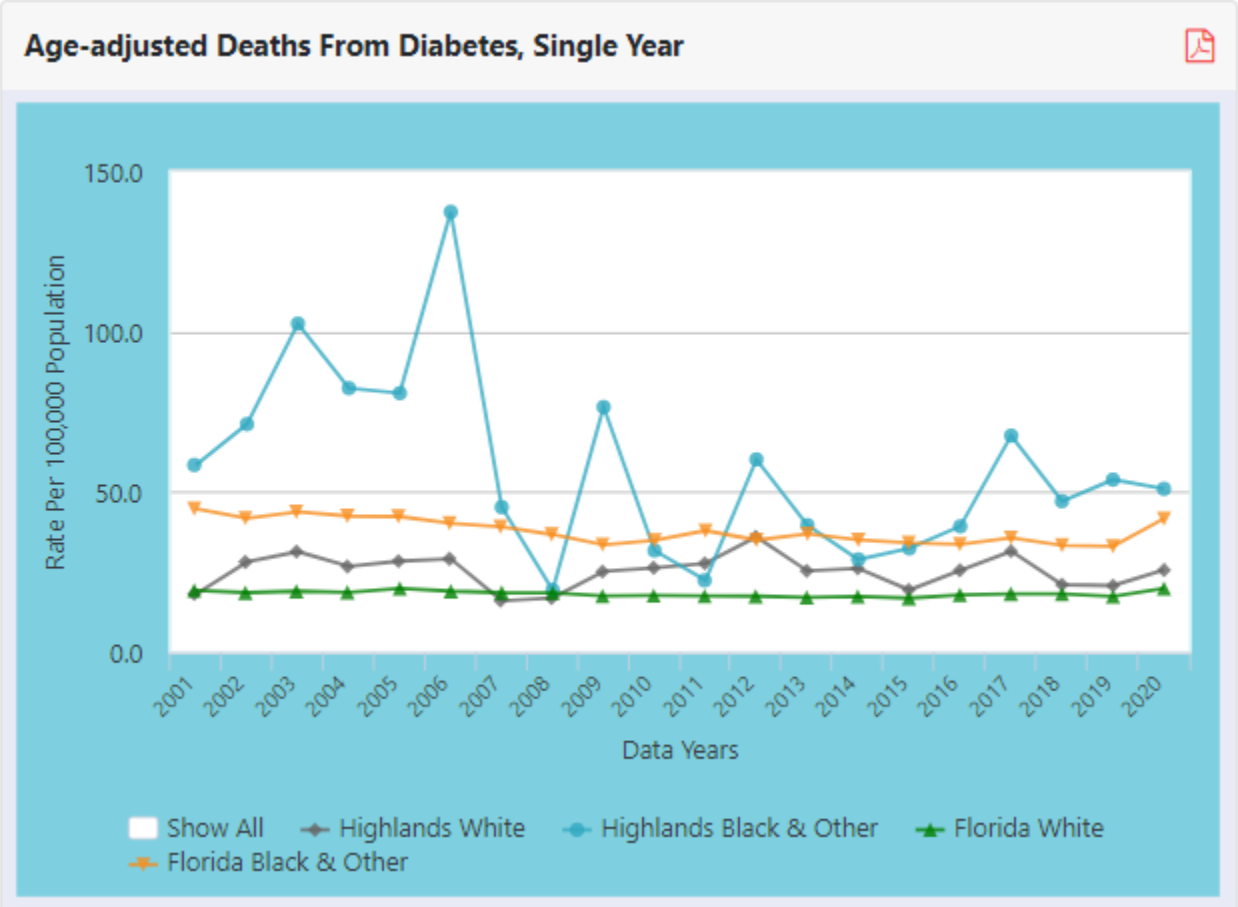
The Health Equity Team identified and reviewed health disparity data in Highlands County. Data was pulled from multiple sources, including FL Charts, HMS, US Census Bureau, HRSA, BestPlaces.net, and BRFSS. We also looked at programs already in place here and decided to work this year on how to improve each program through more focused research and data analysis.

The following health disparity of concern was identified in Highlands County: diabetes. Diabetes is a chronic disease marked by high levels of sugar in the blood. Having diabetes increases the risk of heart disease and stroke, and can lead to other serious complications, such as kidney failure, blindness, and amputation of lower extremity body parts. People with diabetes spend more on health care, have fewer productive years, and miss more workdays compared to those who don't have this disease.

Using the Priority Matrix and our current program priorities, the Health Equity Team decided to focus on diabetes in this Health Equity Plan. Data concerning diabetes as it relates to Highlands County is depicted in the sections of this plan. Of note are the data points below:

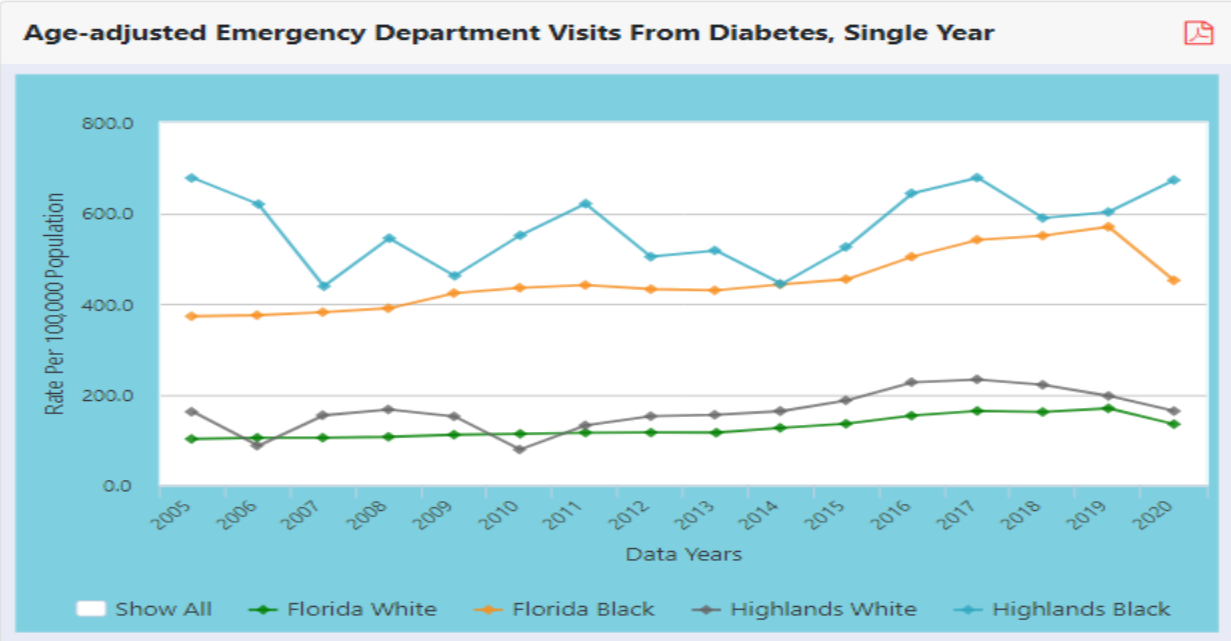
1. In Highlands County, the main ethnic groups are White(non-Hispanic) 66.1%, Black or African American (non-Hispanic) 10.5%, Asian 1.5%, and Hispanic or Latino 21.1%.
2. Hospitalization from diabetes impacts these ethnic groups as follows: White - 224, Black - 52, Black Other - 104, Hispanic - 51.
3. Deaths from diabetes during the most recent year available are: White – 62, Black – 6, Black Other – 10, and Hispanic – 9.
4. In 2019, 18% of adults in Highlands County overall have ever been told they have diabetes, compared to the state rate of 11.7%.
5. The age-adjusted rate per 100,000 population for deaths from diabetes overall in Highlands County was 27.8 compared to Florida at 23.2. This data shows that Black and Other populations in Highlands County are

dying from diabetes more than other group in our area. They also indicate that the Hispanic population is adversely impacted by diabetes, as well.



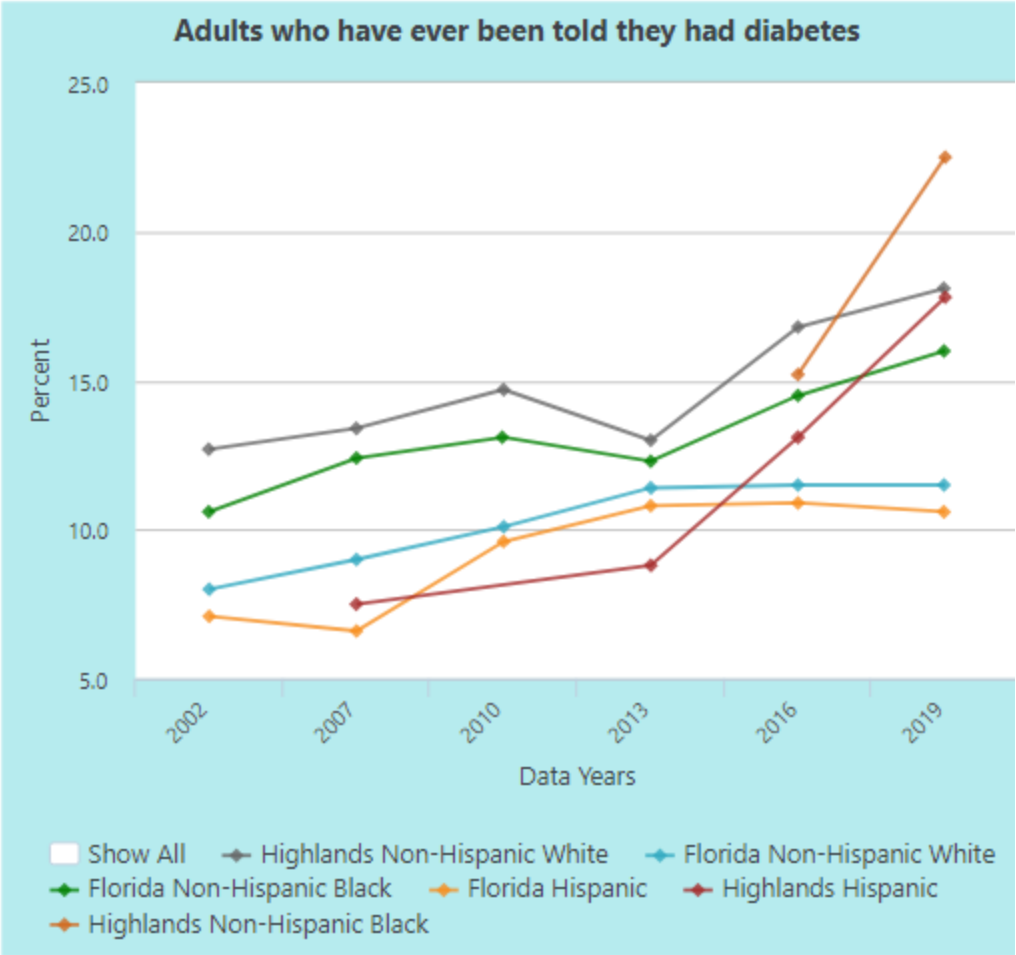
This graph shows that Black or African Americans have a higher death rate from diabetes when compared to the White population.

Data Source: Florida Charts



This graph shows that Black and African Americans have a higher Emergency Room Visits rate when compared to the White population.

Data Source: Florida Charts



Click on county name or "Florida" in the legend to hide or show the county or state.

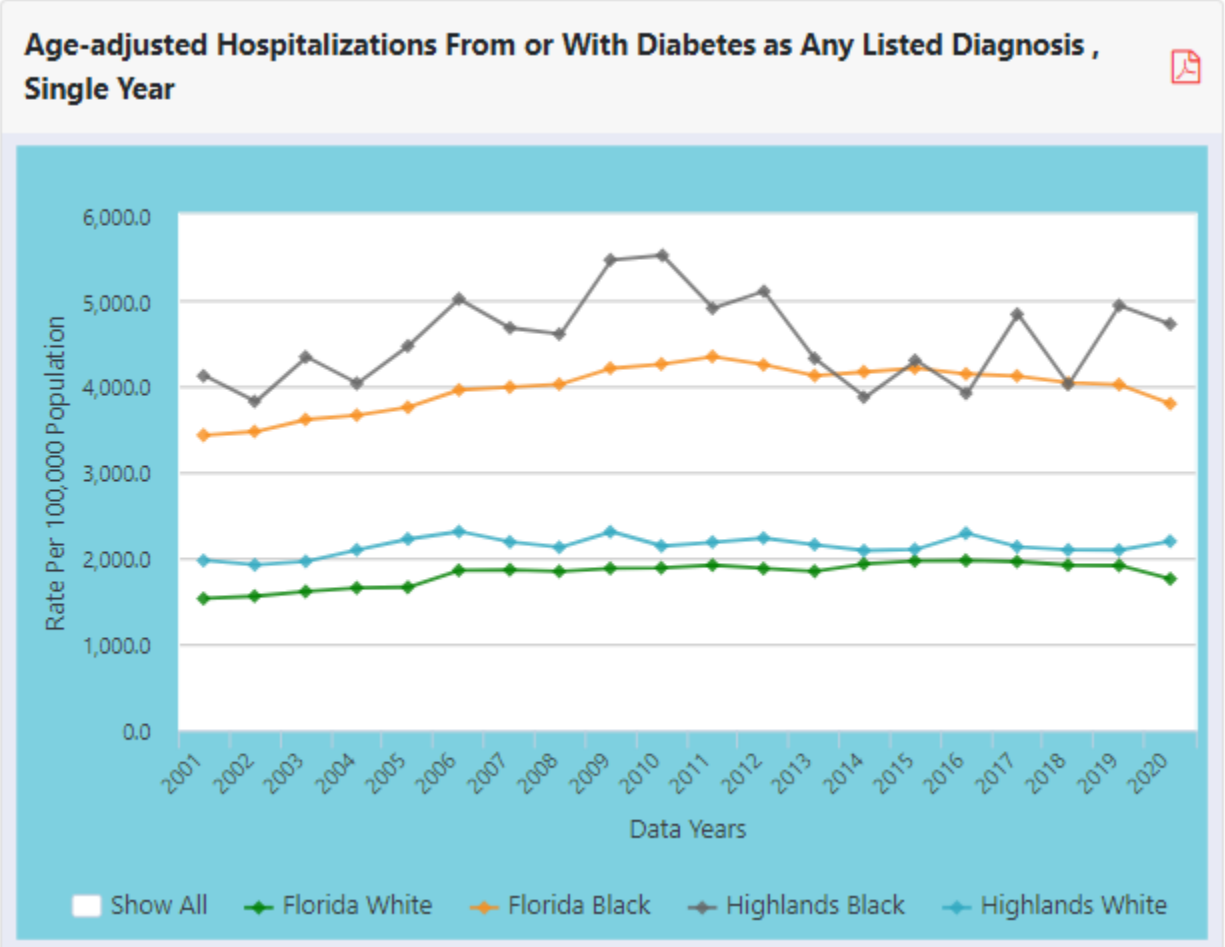
Print/PDF Export

Adults who have ever been told they had diabetes						
	Highlands			Florida		
Year	Non-Hispanic White	Non-Hispanic Black	Hispanic	Non-Hispanic White	Non-Hispanic Black	Hispanic
2019	18.1% (14.5% - 21.8%)	22.5% (10.1% - 34.9%)	17.8% (11% - 24.7%)	11.5% (10.5% - 12.4%)	16% (12.8% - 19.1%)	10.6% (8.2% - 13.1%)

The above graphics show a higher percentage of the Black and African Americans have ever been told they had diabetes when compare with the Hispanic and White population.

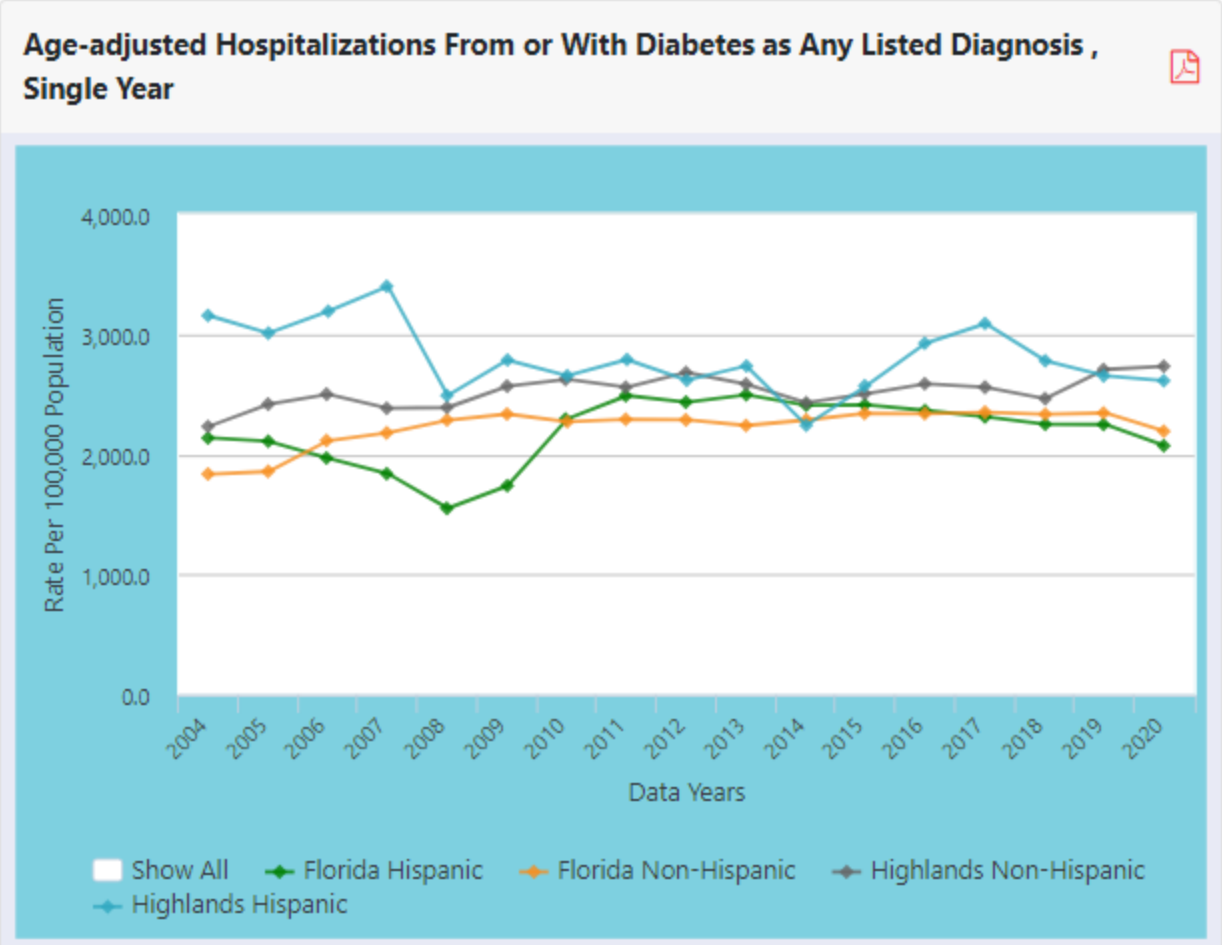
Data Source: Florida Charts

In 2020, the age-adjusted rate per 100,000 of Hospitalizations from or With Diabetes as Any Listed Diagnosis in Highlands County was 2713.3 compared to Florida at 2160.3. The line graph shows change over time when there are at least three years of data.



This graph shows a higher hospitalization rate from diabetes for the Black or African American populations when compared to the White population.

Data: Florida Charts



Veterans:

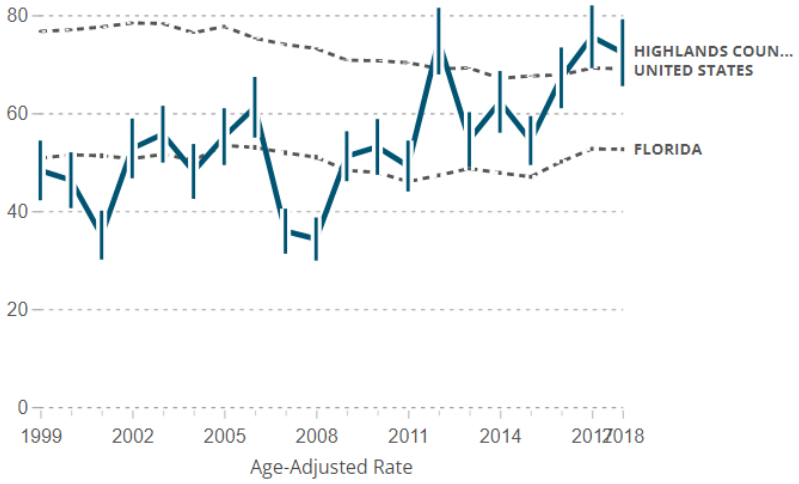
As per the U.S. Census Bureau, 2015-2019 American Community Survey 5-year Estimates, it was estimated that Highlands County has a total of 10,572 veterans. The race distribution is:

- White Alone: 9,895
- Black or African American: 404
- American Indian and Alaska Native: 20
- Native Hawaiian and Other Pacific Islander: 0
- Some other race alone: 150
- Two or more races: 90
- Hispanic or Latino: 729
- White Alone, not Hispanic or Latino: 9,343

Veterans Diabetes Mortality Trends in Highlands County, Florida, Data from the Live Stories webpage; www.livestories.com/statistics/florida/highlands-county-diabetes-deaths-mortality

Diabetes Mortality Trends in Highlands County, Florida

Diabetes Deaths per 100,000 Pop.



166
Deaths

Diabetes
2018
Highlands County, FL

Tracking mortality data for diabetes comes with caveats. The statistics shown here—"Diabetes as Contributing Cause of Death"—are based on the CDC's Multiple Cause of Death (MCD) data, where diabetes was present in the deceased but not necessarily listed as the underlying cause of death (UCD). Because diabetes increases the risk of other deadly maladies—for example, cardiovascular disease—using MCD statistics can help give a fuller picture of the disease's impact in Highlands County.

People Living with Disabilities

The report from Knwoli Data Science: Analysis of the Health Disparities Among People Living with Disability of June 8, 2022, shows the following:

- A higher rate of diabetes in people living with disabilities when compared to the rate of people with no disabilities
- Although the study reports this as “Not Significant”, people living with disabilities have a lower rate when asked if they ever had a class on diabetes education as compared with people with no disabilities.
- Other data provided in this report shows gaps in income, considered their neighborhood unsafe, were food insecure, and could not take their medications because of cost and transportation issues were the most important reason for delayed medical care.

LGBTQ+ Population

Significant information regarding the LGBTQ+ population was not available for our evaluation at the county level. We were able to access information from the research by the UCLA School of Law William Institute titled, “A Portrait of LGBT Adults in Southwest”. This research estimated the number of LGBTQ adults in Southwest Florida for five (5) counties by multiplying the percentage of 2012-2017 Gallup respondents identifying as LGBT. The Percentage is (3.4%; 95% CI [2.8%, 4.0%]) and rounding to the nearest 1,000.

The total population in Highlands as per the Census 2020 was 101,235 and, using the 3.4% and rounding formula of the research, we have an estimate of 4,000 residents in Highlands County who may identify as LGBTQ+.

- 5,134 in Charlotte
- 9,955 in Collier
- 375 in Glades
- 964 in Hendry
- 19,436 in Lee

Again, these are approximations based on the numbers provided in the research mentioned above. The county will look at other data, like the BRFSS reports, to expand the data collection efforts for this population. The study also highlights the following: LGBT adults in Southwest Florida, while somewhat younger, on average, than non-LGBT adults, are similar in many ways to their heterosexual, cisgender (non-transgender) peers. After taking age into consideration, LGBT and non-LGBT adults are similar on socioeconomic status, military service, health insurance coverage, self-rated health, and other indicators of health.

- The majority (66.1%) of LGBT adults are in the labor force.
- One in three (35.2%) LGBT adults is poor or near poor- earning less than about $32,000 per year for a family of two.
- Nearly one in five (19.7%) LGBT adults did not have enough money to buy food that they or their family needed in the prior year.
- Almost one in five (17.3%) LGBT adults lacks health insurance.
- 66.1% have achieved higher than high school level education.
- 97.3% have moved 2 times or fewer in the past 12 months.
- 57% report having a health weight BMI.

Differences between LGBT and non-LGBT adults include:

- Being less likely to be raising a child (16.5% versus 28.2%, respectively; parenting rates are similar for LGBT and non-LGBT women and Latino/as),
- More likely to be Latino/a (30.9% versus 19.2%, respectively),
- More likely to report a lifetime diagnosis of high cholesterol (33.1% versus 29.5%, respectively) and/or depression (24.9% versus 13.5%, respectively),
- More likely to be a current smoker (28.4% versus 16.6%, respectively; results were marginally significant after taking age into consideration).

The reports provide recommendations that the Health Equity Task Force found interesting for future action. Given the large proportion of LGBTQ+ adults that experience poverty and food insecurity, as well health risks and poor health (e.g., overweight and obesity, daily activity limitations, smoking, high cholesterol, lifetime depression), the following actions are recommended:

- Work to ensure that LGBTQ+ adults are accessing poverty reduction and food security programs.
- Investigate causes of high rates of depression as well as high rates of smoking.
- Work to ensure access to competent health care, including behavioral health services, for Southwest Florida's diverse LGBT community. Given the large number of people of a minority heritage in the area, competent care should also reflect adversity and opportunities to promote health along the lines of ethnicity and ensure access to linguistically appropriate services as needed.
- Support health promotion, including prevention and intervention efforts, that incorporate LGBT people, starting in adolescence. This includes mental health promotion and smoking prevention and cessation.
- Conduct research with youth and conduct further research with adults to explore topics not assessed in the Gallup Daily Tracking Survey (e.g., housing stability, discrimination experiences, acceptance, violence victimization, current mental health status, community priorities) in a larger sample that will support examination of results separately by sex and gender identity and sexual orientation, race-ethnicity, and age.
- Support non-discrimination protections for sexual orientation and gender identity in the city of Fort Myers and surrounding counties."

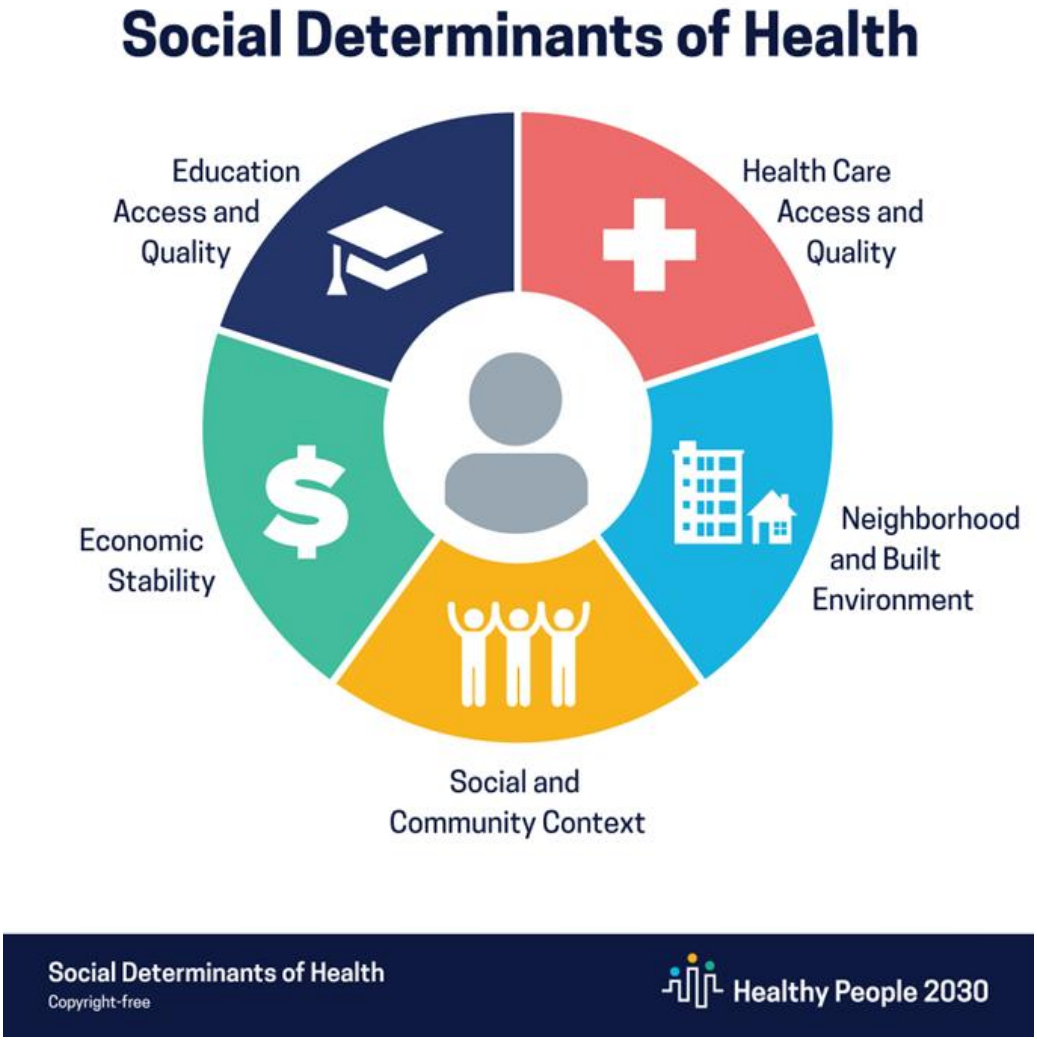
Data for other Priority Populations:

Additional data gathering is necessary in the county to collect health information for American Indian and Alaska Natives, Asian, Native Hawaiian and Other Pacific Islander.

Race and Hispanic Origin	
White alone, percent	⚠ 85.4%
Black or African American alone, percent (a)	⚠ 10.5%
American Indian and Alaska Native alone, percent (a)	⚠ 0.7%
Asian alone, percent (a)	⚠ 1.5%
Native Hawaiian and Other Pacific Islander alone, percent (a)	⚠ 0.1%
Two or More Races, percent	⚠ 1.8%
Hispanic or Latino, percent (b)	⚠ 21.1%
White alone, not Hispanic or Latino, percent	⚠ 66.1%

VII. SDOH DATA

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. The Health Equity Team identified multiple SDOH that impact diabetes. They are listed in the pages that follow.

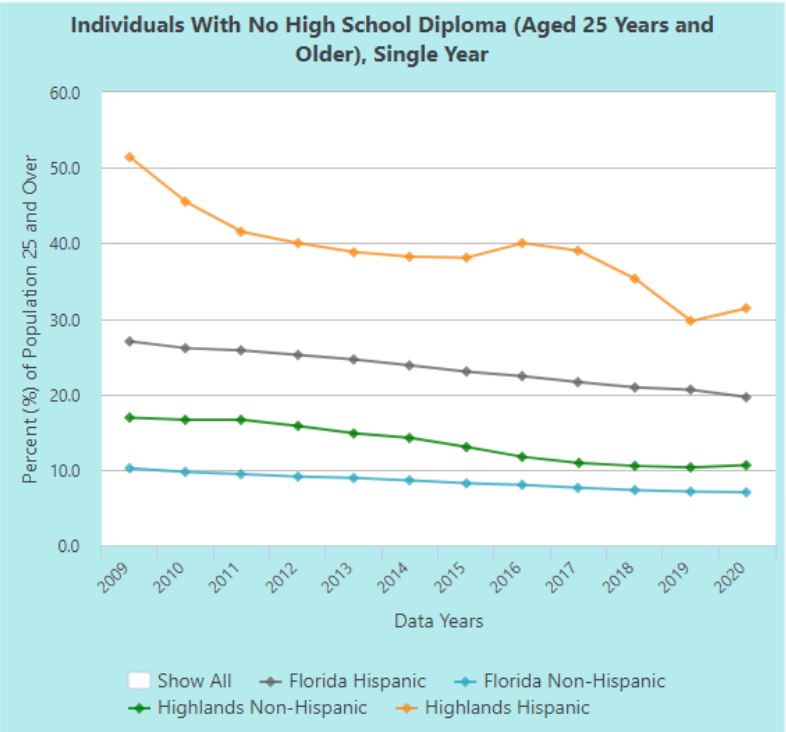


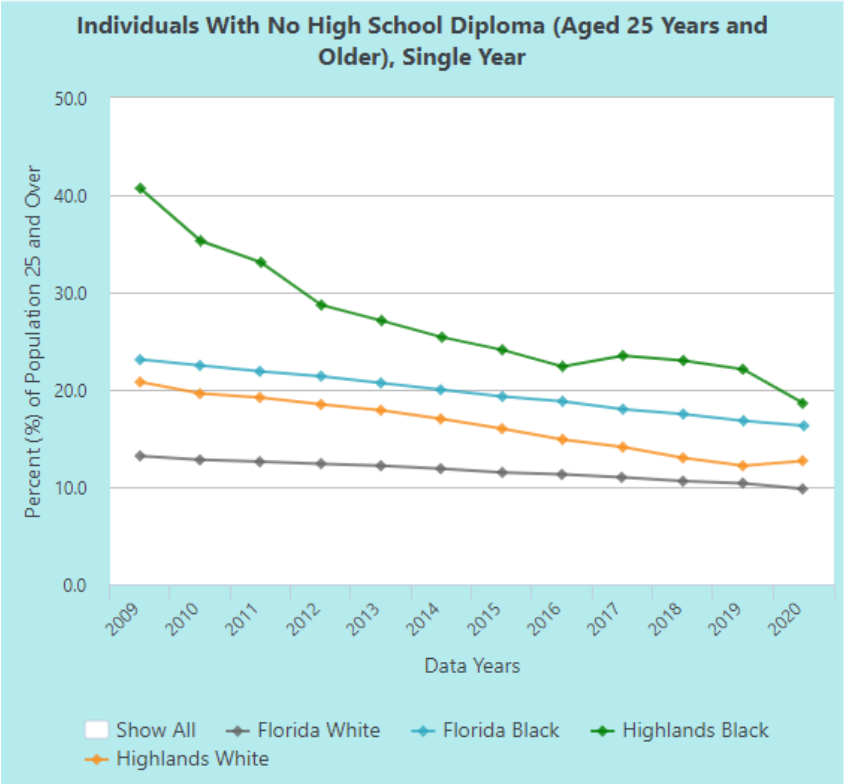
A. Education Access and Quality

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

Individuals 25 Years+ with No High School Diploma by Ethnicity

In 2020, the percentage of individuals 25 years and over with no high school diploma in Highlands County was 14.3% compared to the state rate of 11.8%. The percentage of Hispanic individuals 25 years and over in Highlands County with no high school diploma was 31.4% compared to non-Hispanic individuals at 10.6%. The line graphs below and on the following page show change over time. For Black or African Americans, data shows that 18.6% do not have a high school diploma in Highlands County as compared to 12.7% of Whites. Lack of a high school diploma impacts diabetes by leaving a gap in the ability to read and understand medical needs, forms, information, medication instructions, and other life skills. To improve diabetes, Highlands County is addressing ethnic disparities related to achieving a high school diploma, e.g., literacy in limited English-speaking households, through our Reading is Health project.





- **The impact of education access and quality on diabetes.**

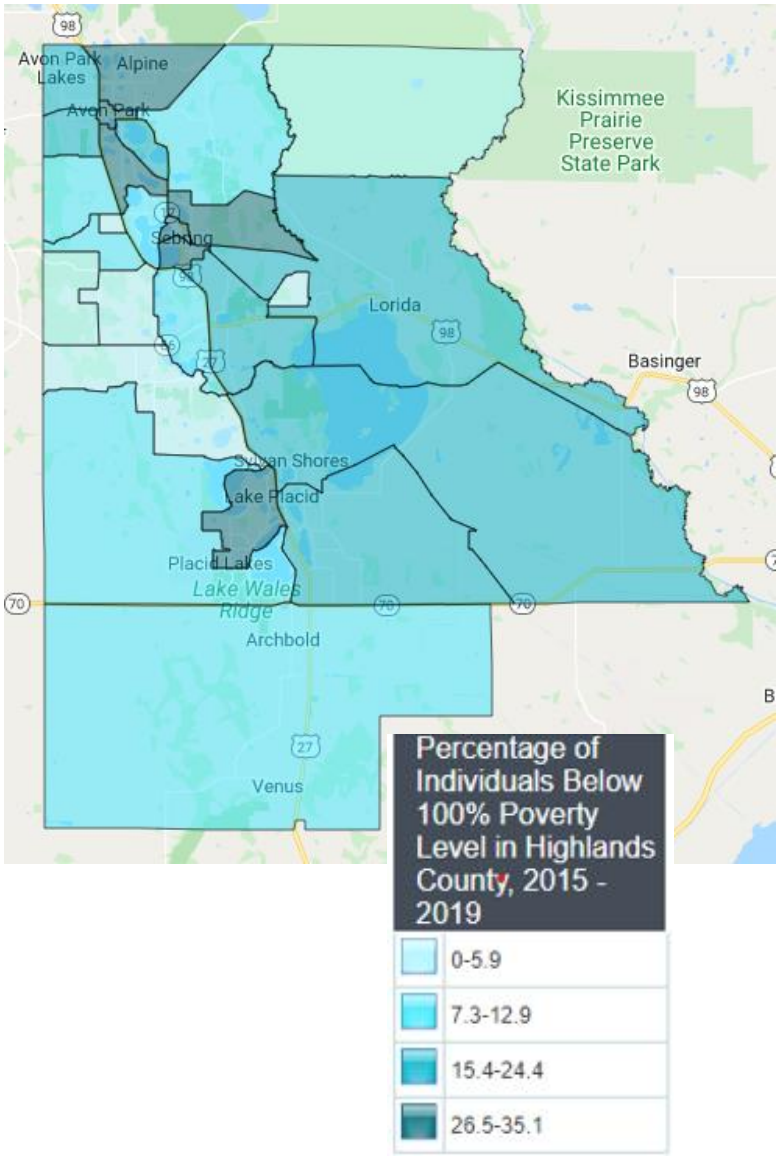
Education Access and Quality		
SDOH	**Vulnerable Populations Impacted**	**How the SDOH Impacts (Health Disparity)**
Literacy	Hispanics; Blacks or African Americans; Lower income populations; Limited English-speakers; those with learning disabilities or who cannot read; refugees; the visually impaired	Being able to read allows people to manage their own healthcare. This is especially true for those who do not speak English, such as many in the Hispanic population. Without this skill, they must rely on interpreters or others who can accompany them to appointments or fill out forms. These people are not able to advocate for their own health because they cannot read information, forms, or signs, or may have difficulty understanding what they are being told by healthcare providers.
Language	Hispanics; Haitians; Limited English-speakers; those with learning disabilities	Having information available to each person in a language or format they understand is crucial to health.

	or who cannot read; refugees; the visually impaired	
Early Childhood Development	Hispanics; Blacks or African Americans; Diabetic children and their caregivers	Literacy is key to health. If a child can understand what is being said about their condition from an early age, they can participate in their care and communicate their needs.
Vocational Training	Hispanics; Blacks or African Americans; Lower income populations; Limited English-speakers; those with learning disabilities or who cannot read; refugees, the visually impaired	All these populations experience limitations to their ability to learn, but perhaps less so in the vocational training environment where there may be assistance available to overcome those limitations. However, there is still the lack of ability to find a job that will pay enough to afford quality health care and resources needed, particularly for those with diabetes.
Higher Education	Hispanics; Blacks or African Americans; Lower income populations; Limited English-speakers; those with learning disabilities or who cannot read; refugees, the visually impaired	Those with these limitations are less likely to go on to earn an advanced degree, thereby reducing their chance of obtaining a higher-paying career that would allow them to afford quality health care, foods, and the services and medicines needed to maintain health when living with diabetes.

B. Economic Stability

- **Economic stability data for Highlands County**

As the Census data for 2019 below indicates, there are very few areas in Highlands County that are above poverty level or at the 3rd quartile. In fact, the average rate for Highlands County residents below 100% of the poverty level is 18.8% across all census tracts. This factor contributes to the lack of access to nutritious foods necessary to maintain a healthy diet and the ability to afford insurance that will cover health issues like diabetes, along with the supplies and medicines necessary to monitor and maintain health.

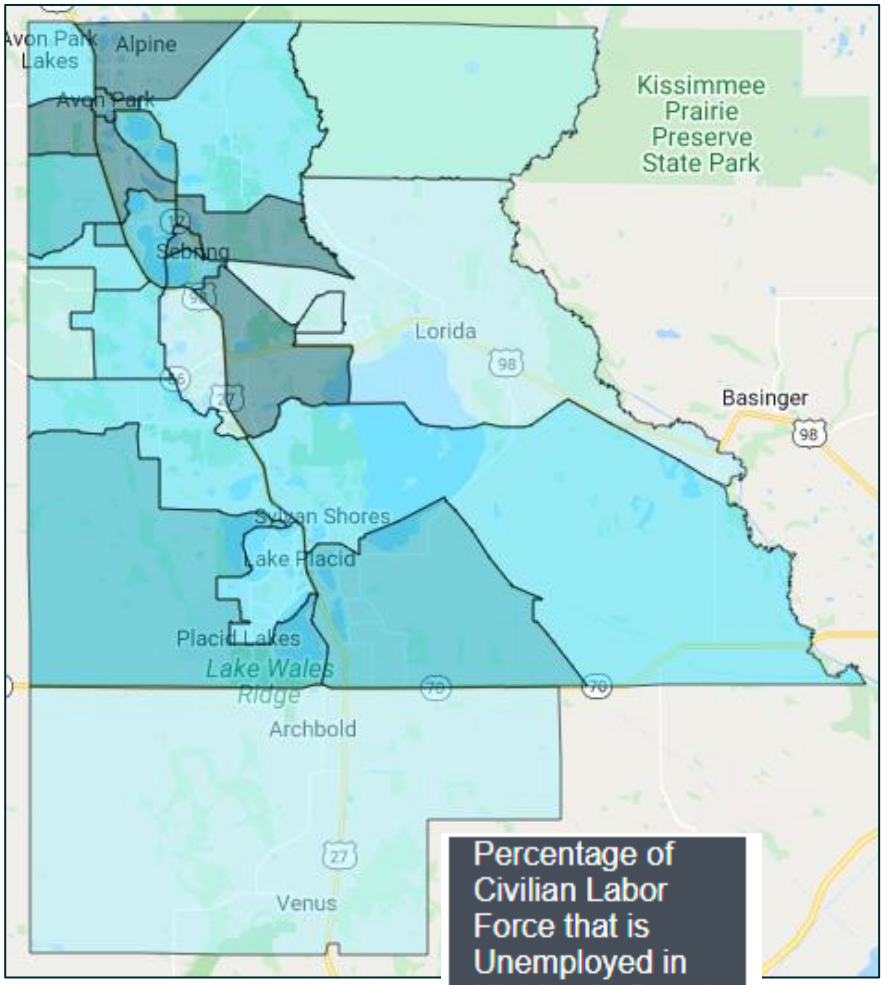


Percentage of Individuals Below 100% Poverty Level in Highlands County, 2015 - 2019

Census Tract	Rate	Quartile
9601.01	9.1	2
9601.02	22.9	3
9601.03	28.5	4
9602	26.5	4
9603	30.5	4
9604	24.4	3
9605.01	15.5	3
9605.02	11.8	2
9606.01	5.6	1
9606.02	11.8	2
9607	7.3	2
9608	30.2	4
9609	34.8	4
9610	17	3
9611	35.1	4
9612	15.4	3
9613.01	5.2	1
9613.02	12.9	2
9614	5.9	1
9615	22	3
9616.01	9.1	2
9616.02	12.5	2
9616.03	34.3	4
9617	21.9	3
9800	0	1
9801	0	1
9802	0	1

- **Economic stability data for Highlands County, cont'd.**

Highlands County has an average unemployment rate of 8.9%, as indicated by the Census data below. This may not be a good reflection of how unemployment impacts health, however. As shown, there are only two census tracts in the county with unemployment rates at or below the state average of 3.2%. There are 14 tracts in the mid-range of up to 10% and 7 tracts with rates above 10%. The highest unemployment rate is 24.4% in tract 9603. Some census tracts with high unemployment correlate to those with high poverty levels, but not all of them, so this relationship needs further analysis.



Percentage of Civilian Labor Force that is Unemployed in Highlands County, 2015 - 2019

Census Tract	Rate	Quartile
9601.01	7.3	2
9601.02	8.5	3
9601.03	15	4
9602	12.2	4
9603	24.4	4
9604	7.3	2
9605.01	14.8	4
9605.02	7.5	3
9606.01	8.8	3
9606.02	5.2	2
9607	7.7	3
9608	16.8	4
9609	23.6	4
9610	0.7	1
9611	11.7	3
9612	12.6	4
9613.01	5.8	2
9613.02	1.1	1
9614	5.9	2
9615	5	2
9616.01	1.7	1
9616.02	10.6	3
9616.03	6.7	2
9617	10.4	3
9800	0	1
9801	0	1
9802	0	1

- **Economic stability data for Highlands County, cont'd.**

Median household income is an indicator of the buying power of people in Highlands County. This income allows people to pay for basic requirements and gives them the latitude to decide how to spend the balance of that income on non-necessities or wants as opposed to needs. No census tract in Highlands County was at or above the state median household income of $59,227 for 2019.

In reviewing the data related to those specific populations in Highlands County that are more impacted by diabetes, we find that both the Black and Hispanic groups have higher rates of families living below the poverty level than any other group in the county.

Families Below Poverty Level, Percentage of Families, Single Year				
	Highlands		Florida	
	Hispanic	Non-Hispanic	Hispanic	Non-Hispanic
Data Year	Percent (%)	Percent (%)	Percent (%)	Percent (%)
2020	21.5	8.9	13.6	6.0
2019	24.4	8.7	15.0	6.2

Families Below Poverty Level, Percentage of Families, Single Year				
	Highlands		Florida	
	White	Black	White	Black
Data Year	Percent (%)	Percent (%)	Percent (%)	Percent (%)
2020	10.8	19.8	7.8	16.9
2019	10.6	28.3	8.3	18.1

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

Economic Stability		
SDOH	**Vulnerable Populations Impacted**	**How the SDOH Impacts Diabetes**
Employment	Black or African American; Hispanic; Lower socio-economic groups; Limited income diabetics; homeless diabetics	Some people may receive public assistance because of low income but would lose that if they worked more. Highlands County has seven census tracts where unemployment is high – 12-24% of the population.
Income	Black or African American; Hispanic; Lower socio-economic groups; Limited income diabetics; homeless diabetics	They may receive public assistance because of low income but would lose that if they had additional income, even in a small amount. Highlands County has a low median income of $21,750 and a high of $52,035. Some census tracts report no income figures, so this leaves the data incomplete for those areas.
Expenses	Limited income diabetics	Those with diabetes incur more expenses for healthcare, medicine and supplies than other diseases.
Debt	Limited income diabetics	Those with diabetes may incur greater debt for healthcare, medicines and supplies
Medical Bills	Limited income diabetics	Those with diabetes may incur larger or more frequent medical bills for healthcare related to diabetes, its medicines, supplies and complications
Support	Limited income diabetics	Those receiving support from public agencies may lose that should there be a change in their circumstances.
Hunger	Limited income diabetics	Diabetes causes dietary changes that those who have limited income may not be able to afford, resulting in hunger from eating incorrectly for the disease or from lack of money to purchase proper food.

C. Neighborhood and Built Environment

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

Highlands County, 2015-19		
Indicator	**State**	**County**
Different state (%)	2.8	3.0
Abroad (%)	1.1	1.2
TOTAL HOUSING UNITS[4]	**9448159**	**55791**
HOUSING OCCUPANCY[4]		
Occupied housing units	7736311	41740
Occupied housing units (%)	81.9	74.8
Owner-occupied (%)	65.4	75.3
Renter-occupied (%)	34.6	24.7
Household size owner-occupied unit (people)	2.63	2.29
Household size renter-occupied unit (people)	2.67	2.88
Vacant housing units (%)	18.1	25.2
Homeowner vacancy (%)	2.3	3.8
Rental vacancy (%)	8.4	8.7
Occupying Mobile home (%)	8.9	24.7
Occupying Boat, RV, van, etc. (%)	0.1	0.8
Median value of owner-occupied units (dollars)	215300	108100
OCCUPIED HOUSING UNIT CHARACTERISTICS[4]		
Lacking complete plumbing facilities (%)	0.3	0.1
Lacking kitchen facilities (%)	0.7	0.5
With utility gas as heating fuel (%)	4.6	1.0
With bottled, tank or LP gas as heating fuel (%)	0.9	1.4
With electricity as heating fuel (%)	92.2	96.3
With fuel oil, kerosene etc. as heating fuel (%)	0.1	0.0
With coal or coke as heating fuel (%)	0.0	0.0
With wood as heating fuel (%)	0.2	0.2
With solar energy as heating fuel (%)	0.1	0.0
With other fuel as heating fuel (%)	0.1	0.0
With no fuel used to heat (%)	1.9	1.0
With no vehicles available (%)	6.3	5.2
With 1 vehicle available (%)	39.7	50.7
With 2 vehicles available (%)	38.4	34.5
With 3 or more vehicles available (%)	15.6	9.5

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

Neighborhood and Built Environment		
SDOH	**Vulnerable Populations Impacted**	**How the SDOH Impacts (Health Disparity)**
Housing	Black or African American; Hispanic; Lower socio-economic groups; Homeless; elderly; limited income diabetics; disabled	Housing is a primary concern for disadvantaged populations, e.g., the homeless. This would be complicated by having diabetes, adding the complexity of needing refrigerated medicine and food to manage the disease. Housing may be seen as their top priority.
Transportation	Black or African American; Hispanic; Lower socio-economic groups; Homeless and limited mobility residents; elderly; blind; disabled	Transportation to medical care and pharmacies/grocery stores is critical to management of diabetes.
Safety	All diabetic residents	People with diabetes who live in unsafe areas are not able to access stores and healthcare easily.
Parks	All diabetic residents: children	Transportation to and from parks and recreation areas is sometimes a challenge for those with chronic diseases such as diabetes. Disease also limits the ability of those impacted to participate in activities that are offered at parks and recreation areas.
Playgrounds	Children	Children who have diabetes and live in areas without playgrounds and/or lighted sports fields lack exercise, which helps manage diabetes and weight.
Walkability	All diabetic residents	People with diabetes who do not have access to walkable areas are not able to easily get the exercise they need to manage the disease.
Geography	All diabetic residents living in the more outlying areas of the county	Transportation to and from accessible areas for activity can be challenging and limit the ability of those with chronic diseases to access same.
Access to nutritional food	Black or African American; Hispanic; Seniors; Lower socio-economic groups;	A healthy diet is crucial to disease management. Those with diabetes who lack access to nutritional foods, e.g., transportation to the store or a fresh

	Homeless; limited income diabetics; transportation disadvantaged diabetics; elderly	market, will choose unhealthy options due to convenience.

D. Social and Community Context

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

Highlands County, 2015-19		
Indicator	**State**	**County**
SOCIAL SUPPORT AND ENGAGEMENT[7]		
Households with one or more types of computing devices (%)	91.5	83.0
Households with access to broadband internet (%)	83.0	74.3

- **The impact of social and community context on diabetes**

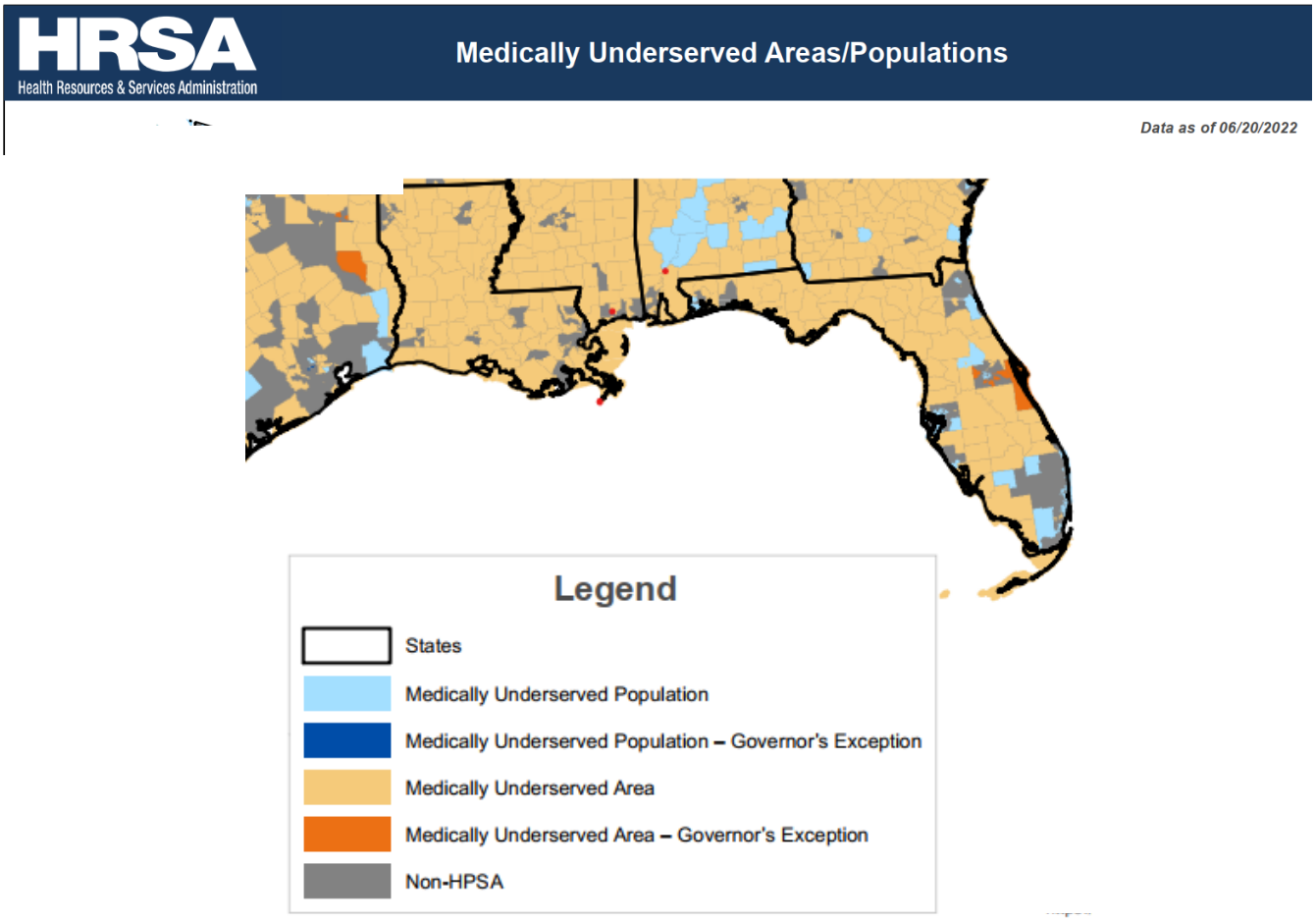
Social and Community Context		
SDOH	**Vulnerable Populations Impacted**	**How the SDOH Impacts (Health Disparity)**
Social Integration	All	Ability to interact with those around you and who make up your social community is key to health. Humans are social beings and need that contact with others to fully realize their potential and to fulfill needs.
Support Systems	All	Access to the internet is key to obtaining information regarding social interactions and health care needs.

		Many services, social and medical, are not easily accessed without the internet or a cell phone.
Community Engagement	All	Those who suffer from chronic disease may find it difficult to travel to activities outside the home. Most community engagement events happen in areas of the county that bring participants from the more rural edges, e.g., downtown areas, parks, convention centers.
Discrimination	Black or African American; Hispanic; Seniors; Lower socio-economic groups; Homeless; elderly; disabled; young children; religious groups; those who identify as other genders or homo/pan/bisexual	Experiencing or fear of experiencing discrimination may keep those with diabetes from seeking help and accessing resources, even if they do have the ability. Trauma from previous experiences may deter the person. Lack of interest or empathy from care resources may make the person less likely to seek help in their own area. Also, those who are well-known in the community may prefer to not seek help within their county for fear of reprisals, judgements, or publicity.
Stress	All	Stress of daily living when complicated by all the above can overwhelm even those without health issues. The added stigma of a chronic disease and the inherent complications adds levels of stress that need to be managed through competent healthcare professionals, along with the treatment for the disease. Often, however, this aspect of care is overlooked, not accepted by the patient, or needed services are unavailable in the area.

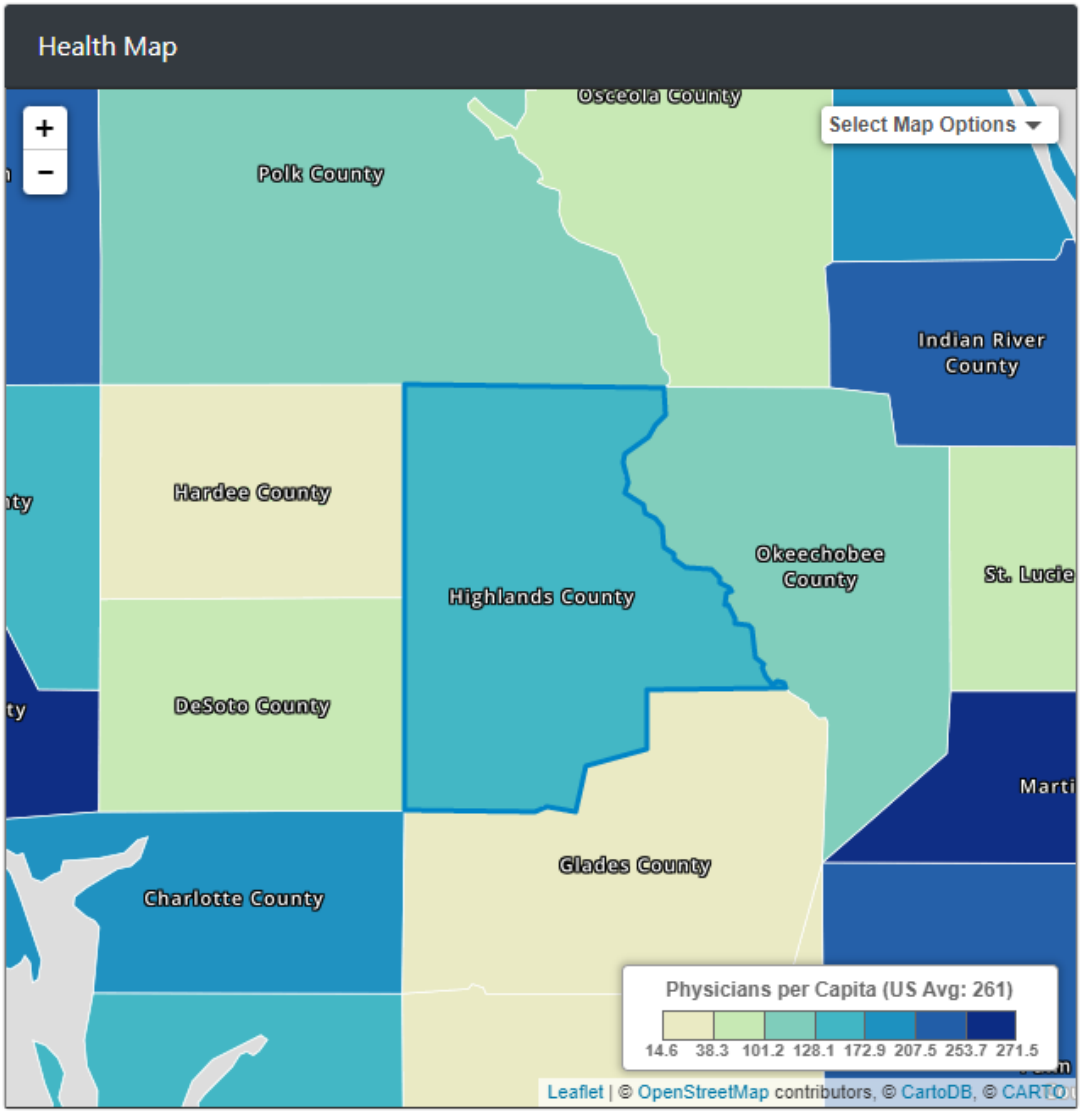
E. Health Care Access and Quality

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

Highlands County, 2015-19		
Indicator	**State**	**County**
HEALTH INSURANCE COVERAGE[2]		
Civilian noninstitutionalized population	20588432	102275
With health insurance coverage (%)	87.2	88.9
With private health insurance (%)	62.7	53.2
With public coverage (%)	37.0	58.4
No health insurance coverage (%)	12.8	11.1
Under 19 years	4424249	18700
No health insurance coverage (%)	7.2	4.7
Employed 19 to 64 years	8730014	29714
With health insurance coverage (%)	83.1	79.5
With private health insurance (%)	77.8	65.0
With public coverage (%)	7.7	16.6
No health insurance coverage (%)	16.9	20.5
Unemployed 19 to 64 years	495267	2805
With health insurance coverage (%)	59.4	64.1
With private health insurance (%)	39.0	27.9
With public coverage (%)	23.2	43.9
No health insurance coverage (%)	40.6	35.9
Not in labor force	2802161	15300
With health insurance coverage (%)	79.0	81.0
With private health insurance (%)	50.5	37.9
With public coverage (%)	35.3	49.7
No health insurance coverage (%)	21.0	19.0



As indicated in the map above, Highlands County is designated as a Medically Underserved Area by HRSA, the Health Resources & Services Administration. As such, DOH-Highlands is allowed to provide needed primary care and limited dental services to the people of Highlands County at a reduced cost, depending on qualifications.



According to BestPlaces.net, as shown in the map above, there are 166 physicians per 100,000 population in Highlands County, below the US average of 210 per 100,000. The Health Cost Index is 8.6% higher at 108.6 than the US average of 100.

As indicated in the table below, Highlands County students receive much less financial support than the US average. Combined expenditures per student is 24% less than the US average and the student-to-teacher ratio is 11% lower. Students per librarian is approximately 7% higher than the US average. All of these statistics increase the likelihood that students in Highlands County schools receive less focus on learning, which may result in a lower ability to read, depending on the focus of each school.

EDUCATION	Highlands, Florida	United States
Expend. per Student	$9,063	$12,383
Educ. Expend. per Student	$8,512	$10,574
Instr. Expend. per Student	$4,756	$6,428
Pupil/Teacher Ratio	15	16.8
Students per Librarian	577.5	538.1
Students per Counselor	497.3	403.2

Health Care Access and Quality		
SDOH	**Vulnerable Populations Impacted**	**How the SDOH Impacts (Health Disparity)**
Health Coverage	Hispanics; Seniors; Homeless; refugees; uninsured; underinsured; migrant workers;	Those with diabetes in these populations may not be able to pay for or get to healthcare. Those with limited English proficiency may not understand how to find healthcare; those who rely on others for transportation/housing may feel unable to ask for more help.
Provider Linguistic and Cultural Competency	Hispanics; refugees; foreign visitors; deaf/hard-of-hearing; followers of certain religions	Social mores from different cultures dictate how healthcare can be appropriately provided. People from these cultures who have diabetes may be reluctant to see a provider who is not appropriate or culturally aware. Communication via language or sign will be difficult if the provider is not aware of or concerned with language, cultural, or disability barriers. People may therefore choose to not seek care.
Provider Availability	All	Highlands County is a designated health care provider shortage area. This issue makes access to health care a concern, especially for those who are more vulnerable, e.g., diabetics. Finding a provider who can meet the needs of those who may have limited resources for payment, transportation, ability to pay for medications, etc. is challenging and may result in these people delaying care until it becomes emergent.
Quality of Care	All	Due to the lack of providers in Highlands County, quality of care may be compromised by less availability of specialists for those with diabetes.

II. 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 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, such as lack of equitable access to health resources and quality health care, transportation disadvantaged programs, and employer-sponsored health and pay policies, among others.

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.

Partners	SDOH	Partner Barriers	Theme	Collaborative Strategies
All	Health care access	Transportation		Heartland Rides program
Highlands County Schools; Highlands County Libraries; Big Brothers, Big Sisters; Boys and Girls Clubs; DOH-Highlands	Education	reading levels; high school graduation rates; access to books	Reading is Health	Reading is Health project
DOH-Highlands; Central Florida Healthcare; Highlands County	Access to affordable health care	Lack of insurance or money to self-pay; health literacy; lack of access to online information		Primary care clinic at DOH-Highlands and FQHC; screening and referrals; sliding-scale fees for self-pay
All	Easy access to safe places to exercise or be active	Lack of lighting in public ball fields make them unusable in darker months at the times needed to promote team sports; cost of access to parks; transportation to parks		Use MHHE grant funding to purchase lights for fields where teams play; provide passes to state parks; work with HRTPO to include parks in Heartland Rides program; provide vouchers for rides

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.

Project 1 is our *Tools for Health* project. Because Highlands County has such high rates of diabetes, we looked at what we could do within programs that already exist at Highlands CHD. Our Closing the Gap Diabetes Wellness Program already serves all residents with either pre-diabetes or diabetes, with most of those clients being of the Hispanic population. The current program provides classes on diabetes and nutrition, gives information for clients to take home, and some small items to help them eat better, such as a MyPlate dinner plate and a fruit-infusing water bottle. This didn't seem to be enough to make a permanent lifestyle change for most clients.

After discussing how to better serve these people, we have decided to increase our monitoring and follow-up time to 6 months, with monthly check-ins to see how each client is doing. We have also purchased blood glucose monitoring kits and ancillary supplies to give to those clients who need to test their blood sugar to maintain health. These extra tools should truly help clients who may not have otherwise been able to afford the monitors and supplies. We will help them keep track of their progress for the 6-month period and see if this effort has been effective. In addition to blood sugar monitors, we have also purchased some wrist blood pressure cuffs for those who have the comorbidity of high blood pressure, again with the aim of giving better tools for maintaining health.

Project 2 is our *Reading is Health* program for improving literacy in Highlands County. Currently, only 45% of all children in Highlands County elementary schools read at a third grade or higher level. Since being able to read is key to health literacy, we have partnered with several groups in the County and a local elementary school to begin improving this statistic. We have purchased over 5,000 books to give away for children of all ages and reading levels, with some books containing both English and Spanish text. These books have been distributed to our three local libraries for their reading programs, our Boys and

Girls Clubs, and Big Brothers and Big Sisters. In addition, we partnered with the media coordinator at Avon Elementary and were able to order books chosen by teachers from each grade to give away to their students. In the coming grant years, we plan to expand this project to include more teachers and schools. Many thanks to the Maternal Child Health and Healthy Babies Grant for funding this literacy as a social determinant of health project!

Project 3 was developed through community involvement activities by our Health Equity Team members. Some are parents whose children go to local athletic fields to play sports. During the winter months, when it gets dark early, there are no lighted sports fields for the teams to play on. Unfortunately, most parents who are involved don't get out of work early enough for the kids to play while it is still light enough. This project will work to find affordable lighting solutions for these fields and increase the amount of time year-round that children and adults from all groups can be physically active, although those from lower socio-economic groups will be most impacted by this being a successful project.

III. HEALTH EQUITY PLAN OBJECTIVES

A. DIABETES

- **Health Disparity Objective:** By December 30, 2025, reduce the rate of adults in Highlands County who have ever been told they have diabetes in the Black or African American population from 22.5% in 2019 to 21.4% and in the Hispanic populations in Highlands County from 17.8% in 2019 to 16.9%.

  Source: FL Charts

  As shown in the following charts, Hispanics and Blacks in Highlands County have a higher rate of ever being told they have diabetes than Whites. These populations are also more likely to live below 100% of the poverty level, have limited access to healthcare, and be less educated, all of which leaves them more vulnerable to chronic diseases, such as diabetes.

Adults who have ever been told they had diabetes						
	Highlands			Florida		
Year	Non-Hispanic White	Non-Hispanic Black	Hispanic	Non-Hispanic White	Non-Hispanic Black	Hispanic
2019	18.1% (14.5% - 21.8%)	22.5% (10.1% - 34.9%)	17.8% (11% - 24.7%)	11.5% (10.5% - 12.4%)	16% (12.8% - 19.1%)	10.6% (8.2% - 13.1%)
2016	16.8% (11.9% - 21.7%)	15.2% (2% - 28.4%)	13.1% (2.7% - 23.4%)	11.5% (10.8% - 12.2%)	14.5% (12.3% - 16.8%)	10.9% (9.3% - 12.6%)
2013	13% (9.1% - 16.9%)		8.8% (0.5% - 17.2%)	11.4% (10.7% - 12.2%)	12.3% (10% - 14.6%)	10.8% (8.7% - 12.8%)

- **Tools for Health Table**

	Lead Entity and Unit	Lead Point Person	Data Source	Baseline Value	Target Value	Plan Alignment
Long-Term SDOH Goal: Improve the Use of Healthcare Resources in our Diabetes vulnerable population						
Objective: By December 30, 2025, maintain a level of 50% of Closing the Gap clients who actively monitor their blood sugar for a period of 12 months after attending our class.	DOH-Highlands Closing the Gap program	Pam Crain	Client surveys and follow-up	0	50%	

Medium-Term SDOH Goal: Improve Knowledge of Healthcare Resources and Health Care Access and Quality						
Objective: By December 30, 2024, increase the number of provider referrals to our Closing the Gap Program.	DOH-Highlands Closing the Gap program	Andrea DeSantiago	Spreadsheet data	<10 per month	>10 per month	
Short-Term SDOH Goal: Improve Access to Health Care Access and Resources						
Objective: By June 30, 2023, design and initiate an enhanced monitoring program for all Closing the Gap clients that includes blood glucose monitoring for at least 12 months after referral	DOH-Highlands Closing the Gap program	Andrea DeSantiago	Client surveys and follow-up	no enhanced program	design and implementation of enhanced program	

- **Reading is Health Table**

	Lead Entity and Unit	Lead Point Person	Data Source	Baseline Value	Target Value	Plan Alignment
Long-Term SDOH Goal: Improve Literacy						

Objective: By December 30, 2025, increase the rate of Highlands County students reading at a 3rd grade level from 44% to 50%	DOH-Highlands, Community Programs	Pam Crain	Florida Scorecard (thefloridascorecard.org)	44%	50%	
Medium-Term SDOH Goal: Improve Reading Activity						
Objective: By September 30, 2024, order and deliver additional books to local partners for reading projects	DOH-Highlands Community Programs	Pam Crain	Internal spreadsheet: Book Orders.xlsx	2,500 books	7,500 books	
Short-Term SDOH Goal: Improve Access to Books						
Objective: By August 30, 2022, deliver already ordered books to local partners for reading projects	DOH-Highlands Community Programs	Pam Crain	Internal spreadsheet: Book Orders.xlsx	0 books	2,500 books	

- **Shining a Light on Health Table**

	Lead Entity and Unit	Lead Point Person	Data Source	Baseline Value	Target Value	Plan Alignment
Long-Term SDOH Goal: Neighborhood and Built Environment						
Objective: By December 30, 2025, purchase and install field lighting at 3 public sports venues where teams cannot	DOH-Highlands Health Equity Team	Jason Wolfe	Community survey	0 fields lighted	3 fields lighted	

play at night because there is no lighting						
Medium-Term SDOH Goal: Improve Collaboration in Neighborhood and Built Environment						
Objective: By December 30, 2024, work with county partners to identify need and order appropriate lighting for public sports fields; determine how to pay for power to run the lights.	DOH-Highlands Health Equity Team	Jason Wolfe	Community partner meeting notes	0 fields identified; power fees not covered	3 fields identified; payment for power fees settled	
Short-Term SDOH Goal: Improve Communication in Neighborhood and Built Environment						
Objective: By December 2023, meet with county partners to discuss purchase of lights to increase access to public fields for team activities	DOH-Highlands Health Equity Team	Jason Wolfe	Community partner meeting notes	0 community meetings held	3 community meetings held; consensus reached	

IV. 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 (email, project updates, Teams, and in-person meetings as they return to the norm, 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.

V. REVISIONS

Annually, the Health Equity Taskforce reviews the Health Equity Plan to identify strengths, opportunities for improvement, and lessons learned. Data will be gathered via surveys and shared in meetings and by email with appropriate groups. This information is then used to revise the plan as needed.

	Revised By	Revision Date	Rationale for Revision
