DOH-INDIAN RIVER

HEALTH EQUITY PLAN

June 2022 – April 2025

Florida HEALTH

F.A.C.T.

The Farmworker Association of Florida, Inc.

NAACP

Treasure Coast Community Health

TCCH

Healthcare for All People

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I. VISION

The World Health Organization defines health as a state of complete wellbeing and not merely the absence of disease or infirmity. Health Equity is the attainment of the highest level of health for all people. Persisting legacies of social problems such as structural racism are hampering the attainment of health equity, causing economic loss and most overwhelmingly the loss of human lives and potential. Harmful inequities and other failures of the nation's health system have been underscored by the COVID-19 pandemic, which has also highlighted "the urgency for strategic, equitable investments in our public health infrastructure" and the need for a "bold reimagining" of the medical tradition's policies and practices.[1]

The Health Equity Coalition is a subset of the Indian River County Community Health Improvement Plan (CHIP) and is rooted in three priorities housing, health, and economic opportunity and employment. The CHIP was developed with a health equity component in each of its priorities and aligns with the goals of the American Medical Association to push health equity forward by advancing policies on racism as a public health threat, health equity in medical education, health care delivery and research and practice.[2] The Health Equity Task Force and Coalition further these efforts to improve the accessibility, quality, and safety of health care; reduce costs while using resources efficiently; and improve the health and quality of life of the residents of Indian River County.

To appropriately align goals and objectives with the health equity priorities of the county, the Health Equity task force determined to identify the root causes of each priority.

The Florida Department of Health in Indian River engaged community partners and stakeholders in assessing the health needs of underserved communities, prioritizing health needs and devising an action plan through strategic planning. Coalition members include representatives from the fields of healthcare, social services, education, community development, philanthropy, city and county government, hospitality, and business.

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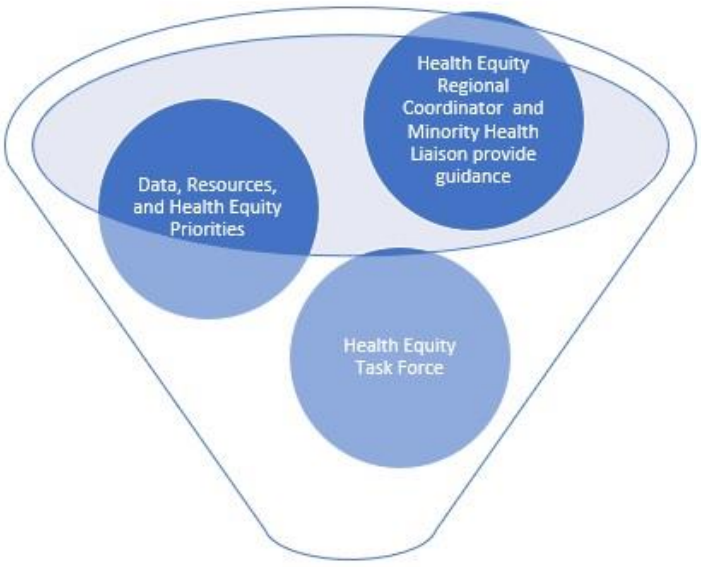
[1] "Race, Racism, and the Policy of 21st Century Medicine", Mia Keeys, Joaquin Baca and Aletha Maybank, Yale Journal of Myology and Medicine, (2021)

[2] American Medical Association, House of Delegates November 2020 AMA Special Meeting

The coalition held a series of meetings chaired by the Community Health Improvement Manager, from DOH-Indian River and including the Health Equity and Minority Health Liaison. Coalition members contributed their knowledge and viewpoints. The identified health inequities outlined in this plan are based on the review of quantitative data and qualitative data from various key stakeholders and community members including the Indian River County Health Needs Assessment, Healthy People 2030, ALICE reporting, Florida Health Charts, The Centers for Disease Control and Prevention among others.

Discussions about health disparities and gaps in education and services to under-resourced communities of color resulted in a consensus that all efforts to attain health as defined by the World Health Organization must include addressing equity to be successful at attaining a state of complete wellbeing for our community. A series of draft vision statements were discussed, but ultimately, “Achieve Health Equity for Indian River County” was chosen because it is targeted, brief and powerful.

The participation and dedication of the individuals that comprise the coalition, as advocates for their agencies and the populations they serve, brought tremendous value to this visioning process.



Health Equity Vision

Achieve Health Equity for Indian River County

II. PURPOSE OF THE HEALTH EQUITY PLAN

Health Equity is achieved when everyone can attain optimal health.

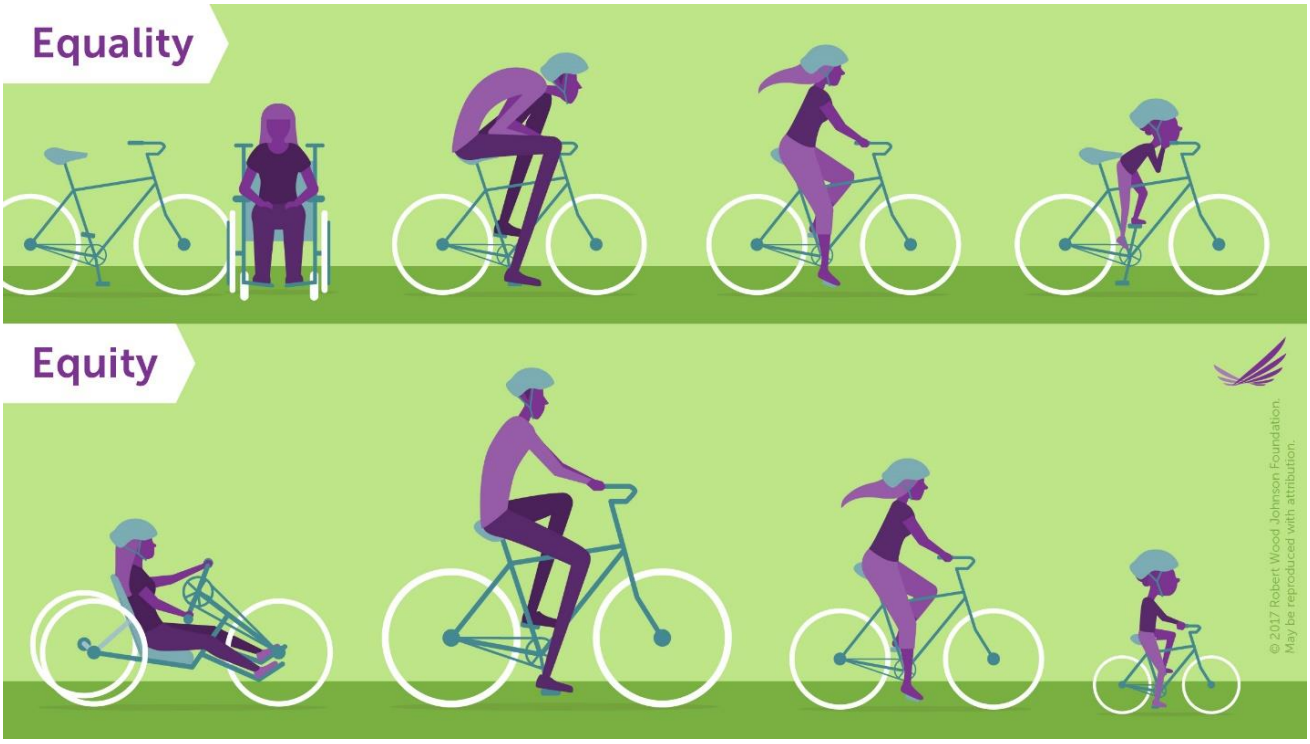
The Florida Department of Health's Office of Minority Health and Health Equity (OMHHE) works with government agencies and community organizations to address the barriers inhibiting populations from reaching optimal health. A focus on health equity means recognizing and eliminating the systemic barriers 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 marginalized 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 Indian River County. To develop this plan, the Department of Health in Indian River (DOH-Indian River) 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 Indian River 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 Task Force, including a variety of government, non-profit, and other community organizations, align to address the SDOH impact health and well-being in the county.

The Health Equity Task Force created the HE plan through examination of data and contributed quantitative and qualitative experience and expertise to the content of the plan and the selection of projects. HE coalition members were included in the process and were given the opportunity to review and comment. All comments received were positive.

III. DEFINITIONS



- **Health equity** is achieved when everyone can attain optimal health
- **Health inequities** are systematic differences in the opportunity 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.

A cross-sector partnership was formed between Florida State University (FSU), the Dasie Hope Center (DHC), Treasure Coast Food Bank and DOH-Indian River with a goal of education and awareness of healthy behaviors and good nutrition among children in underserved areas within Indian River County.

FSU sends medical students to DOH-Indian River for a public health training rotation, much like a brief internship. While at DOH-Indian River, these medical students review health data and determine effective measures to reduce health disparities. DOH-Indian River provides data sources, information about public health services and programs in the area as well as information about the history of the underserved communities in Indian River County. DHC, and other centers in underserved areas of the county, welcome the medical students and provides students and facilities and coordinate with Treasure Coast Food Bank for healthy food deliveries for students and their families. DHC is a childcare facility that serves the Wabasso community, one of Indian River County's underserved areas. Their programs are designed to allow children

of differing ages from the same family to work together on shared goals as well as providing a safe space for afterschool activities.

The results of this collaboration are beneficial for all partners. The FSU medical students receive an education on public health services, but more importantly, they are exposed to living conditions that will have lasting effects on the health of the students they interact with. Each medical student learns the value of considering the social determinants of health as well as medical diagnosis when dealing with their patients. They are also made aware of doctor shortages and the need for accessible health care in underserved communities.

The Dasie Hope Center, and other community centers, gain fresh perspectives and new programming from the classes and demonstrations presented by the medical students. These perspectives are passed from the centers to the parents both through the children and by literature and practice.

Through these collaborations, DOH-Indian River strengthens its collaboration with community organizations and extends its reach and impact in underserved communities.
DOH- Indian River is committed to providing place-based services and has established a satellite site at the Dasie Hope Center to serve as a community resource center and work in partnership with Dasie Hope staff to provide serves and support to the Wabasso community. DOH- Indian River services such as WIC, health screenings, HIV/AIDS testing and counseling, wellness activities and food distribution will all be available at the satellite site starting in early June 2022.

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 marginalized 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: Naomi Sainval
Minority Health Liaison Backup: Margaret Kearney

B. Health Equity Team

The Health Equity Team includes individuals that each represent different programs within the CHD. Team members were chosen by the Minority Health Liaison and invited to become a part of the team because of their dedication to our community and involvement with the effects of the SDOH in their areas of expertise. Representation from races and ethnicities living in the county was also a consideration and part of the recruitment process. The diverse backgrounds and experiences of the team members ensure inclusivity.

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 Indian River County to the Health Equity Task Force. 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
Naomi Sainval	Minority Health Liaison	Minority Health / Health Equity
Julianne Price	Environmental Administrator	Environmental Health
Alissia Cypress	Health Equity Liaison	Minority Health / Health Equity
Cheryl Martinez	Nurse Program Specialist	Nurse Family Partnership
John May	HSP Analyst	HIV/AIDS Community Outreach
Tony Brown	Environmental Consultant	PACE- EH, Community Outreach
Alma Miller	Community Human Services Specialist	PACE- EH, Community Outreach
Molly Steinwald	Community Health Improvement Manager	CHIP, Accreditation Lead
Margaret Kearney	Performance Improvement Manager / Backup Minority Health Liaison	Strategic Plan, WFD, PMQI

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
October 6, 2021	Progress reporting for Health Equity activities and community updates, including Nurse Family Partnership (NFP) activities, Direct on Scene Education (DOSE), HIV/AIDS community outreach, and DOH communications with a HE lens.
November 4, 2021	Progress reporting for Health Equity activities and community updates including NFP, DOSE, HIV/AIDS, DOH Mobile unit use, activating partner organizations for warm handoffs between agencies
January 6, 2022	Progress reporting for Health Equity activities and community updates including introduction of Coordinated Intake and Referral (CI&R) by Healthy Start, PEPW streamlining, partnering with Substance Awareness Center and Fellsmere Action Committee Team (FACT) for outreach events.
February 10, 2022	Progress reporting and planning for Health Equity events, community updates including Doula training in Wabasso, Fellsmere health and wellness event in March, Hispanic Resource and Job Fair in April and

	Unnatural Causes screenings on April 25th and 28th with NAACP and DOH moderated discussion following
March 2, 2022	Progress reporting for Health Equity activities, event planning, community updates, including NFP, doula program to provide prenatal and postnatal education and support, mental health first aid classes, AA meetings for Wabasso
April 20, 2022	Progress reporting for Health Equity activities, event planning and community updates including WIC and PEPW appointment coordination, Men & Boys Health Summit, Women & Girls Health Summit, PRIDE Health Summit planning for June and July. Countywide PACE survey distribution- addressing food access, housing issues, mental/ physical health states and access to social services
July 12, 2022	Progress report on NFP program with WIC and PEPW, update on DOSE Program and training, Update on the expansion of WIC, Mental Health First AID to school district and teachers progress report

C. Health Equity Task Force

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

Name	Title	Organization	Social Determinant of Health
Naomi Sainval	Minority Health Liaison	DOH- Indian River	Social & Community Context
Julianne Price	Environmental Administrator	DOH- Indian River	Social & Community Context, Neighborhood & Built Environment
Vicki Soule	Chief Executive Officer	Treasure Coast Community Health (TCCH)	Health Care Access and Quality
Annie May Brown	President	Fellsmere Action Community Team	Economic Stability
Freddie Woolfork	Director of Public Relations & Facilities Operations	Gifford Youth Achievement Center	Education Access & Quality

Maria Martinez	President	Farm Workers Association	Economic Stability
Alissia Cypress	Health Equity Liaison	DOH- Indian River	Social & Community Context
Cheryl Martinez	Nurse Program Specialist	DOH- Indian River	Health Care Access & Quality
John May	HSP Analyst	DOH- Indian River	Health Care Access & Quality
Tony Brown	Environmental Consultant	NAACP / DOH-Indian River	Social & Community Context, Neighborhood & Built Environment
Alma Miller	Community Human Services Specialist	NAACP / DOH-Indian River	Social & Community Context, Neighborhood & Built Environment
Molly Steinwald	Community Health Improvement Manager	DOH- Indian River	Social & Community Context, Neighborhood & Built Environment
Margaret Kearney	Performance Improvement Manager / Backup Minority Health Liaison	DOH- Indian River	Social & Community Context, Neighborhood & Built Environment

The Health Equity Task Force met on the below dates during the health equity planning process. Since the Health Equity Plan was completed, the Health Equity Task Force has continued to meet as needed to address issues and share advancement, but no less than quarterly to track progress.

Meeting Date	***Organizations***	**Topic/Purpose**
January 6, 2022	TCCH, DOH-Indian River, NAACP	Explanation of task force purpose. Discussion of issues, establish Vision statement
March 2, 2022	TCCH, GYAC, NAACP, DOH-Indian River	Discussion of issues in IRC, Selection of Priority Health Disparity, Cross sector communication efforts
April 20, 2022	TCCH. GYAC, NAACP, DOH Indian River	Development of project plan goals, objectives, and action steps-identification of barriers to care, sources for data, community partners, delegation of duties and next steps.

May 6, 2022	TCCH. GYAC, NAACP, DOH Indian River	Finalization of Health Equity Plan for presentation to HE Coalition.
June 6, 2022	DOH Indian River	Review of 5/6 recommended changes to HE Plan, HE Plan approval and submittal to HE Coalition

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 Task Force by reviewing their Health Equity Plan for feasibility. See Addendum A for a list of Coalition members.

DOH-Indian River and the Health Equity Coalition work with partner organizations throughout the county to increase the reach of programs and potential solutions. Communication between providers and between providers and clients is essential when working to address SDOH. Each Health Equity Team member shares information within DOH-Indian River as well as with coalition members and community partners.

As an example, The Nurse Family Partnership program operates jointly with Head Start and DOH-Indian River to provide expecting and new mothers the best chance of a healthy life. They partner with CareNet for physical checkups, Early Learning Coalition for childcare, Career Source Research Coast for job training and employment, Safe Space for intimate partner violence, Kids Closet for clothing, baby seats and other essentials and assist their clients with mental health evaluations in partnership with the Mental Health Collaborative. These partners contributed to the plan by providing insights on the barriers to service and SDOH, common health problem statistics, usage rates for services and communication blocks between agencies.

Another example of Health Equity Coalition member collaboration: Indian River County's mental health professionals, Mental Health Collaborative and the Mental Health Association provided speakers and materials for distribution to the Senior Resource Association and Senior Collaborative to combat isolation and depression. The Mental Health Collaborative is also providing train the trainer classes in Mental Health First Aid to members of the community.

DOH-Indian River is extending its reach by establishing a community resource center and the Dasie Hope Center, a community childcare center in Wabasso, FL. The partnership will expand the childcare services DHC provides to include senior services such as congregate meals, computer classes through a collaboration with Senior Resource Association. A partnership with the Gifford Youth Achievement Center will provide summer employment training and the Visiting Nurses Association (VNA) will assist with on-site screenings. Transportation and nutrition

issues will also be addressed by relocating county services for easy access to healthy foods and bus routes.

Each of these collaborations interconnect to form the whole cloth from which the Health Equity Plan was formed and play an integral part in creating a community effort to eliminate health disparities and promote equity in all SDOH. The Health Equity Plan was written by the Health Equity Task Force using the experience and knowledge of our Health Equity Coalition members. The coalition members provided community prospective and feasibility input.

Community engagement and research were the foundation of the Health Equity Plan. Health Equity Task Force members used the knowledge of current conditions in the community and available data to develop realistic goals and objectives to overcome barriers to care, reduce the effects of SCD on patients and caregivers and allow both to maintain normalcy.

Task Force members presented additional information, challenges, and opportunities for improvement at each meeting. The final Health Equity Plan was approved by the Task Force of June 6, 2022, and sent to the Coalition for adoption and approval on June 7, 2022.

See Addendum A for a list of Health Equity Coalition members.

E. Regional Health Equity Coordinators

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

Name	Region	Expertise
Carrie Rickman	Emerald Coast	Nursing
Quincy Wimberly	Capitol	Inclusive Strategies in Public Health & Technical Assistance
Diane Padilla	North Central	Non-Profit Engagement
Ida Wright	Northeast	Community Engagement & Project Management
Rafik Brooks	West	Health Care Leadership
Lesli Ahonkhai	Central	Faith-Based Engagement, PH Leadership, & PH Workforce Capacity Building & Mentoring
Natasha McCoy (interim)	Southwest	PH Practice, Grant Writing & Partnerships
Frank Diaz-Gines	Southeast	Health Insurance

V. HEALTH EQUITY TRAINING AND PROMOTION

A. County Health Equity Training

Health Equity Coalition members receive invitations to brief training sessions, articles on aspects of Health Equity and infographics and posters that can be displayed in their places of work. All goals and objectives contained in the Indian River County Community Health Improvement Plan (CHIP) are under review to ensure equitable delivery of services and care. All activities are viewed through a health equity lens.

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

Date	Topics	Organization(s) receiving trainings
April 28,2022	Screening of "Unnatural Causes" episode and discussion	Together for Health
April 20, 2022	Screening of "Unnatural Causes" episode and discussion	All staff invitation to the screening and discussion following
April 28, 2022	PACE-EH Survey Distribution	Health Equity Coalition
May 2, 2022	Infographic: Florida Health Approved Terms to Further Public Health Discussion	Health Equity Coalition and DOH staff
June 7, 2022	*Pain in the Nation: The Epidemics of Alcohol, Drug, and Suicide Deaths*	Health Equity Coalition

B. County Health Department Health Equity Training

The Florida Department of Health in Indian River (DOH-Indian River) recognizes that ongoing training in health equity and cultural competency are critical for creating a sustainable health equity focus. At a minimum, all DOH-(Indian River) staff receive the *Cultural Awareness: Introduction to Cultural Competency* and *Addressing Health Equity: A Public Health Essential* training.

Infographics and posters with Health Equity Information are posted on bulletin boards throughout the DOH-Indian River building as reminders to consider health equity in everything we do.

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
October 2021	"From Concepts to Practice: Health Equity, Health Inequities, Health Disparities and Social Determinants of Health" TRAIN Florida https://www.train.org/florida/course/1061047/	All DOH- Indian River staff
April 13, 2022	Implementing Upstream Strategies to Advance Health Equity in Public Health	HEAT members
May, 2022	Addressing Unconscious Bias in our Language TRAIN Florida https://www.train.org/florida/course/1077244/	All DOH- Indian River 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 topics such as: the health equity planning process and goals, facilitation and prioritization techniques, reporting requirements, and taking a systems approach to address health disparities. The Minority Health Liaison training is recorded below.

Date	Topics
10/22/21	FDOH health equity efforts, technical assistance, support, and resources for Health Equity Project Management Tool
11/18/21	Technical assistance, support, and resources for Health Equity Project Management Tool
2/16/22	Central Regional HE Monthly meeting- OMHHE updates, HE Plan Timeline, presentations by two counties. Sharing progress, ideas
3/16/22	Central Regional HE Monthly meeting- OMHHE updates, HE Plan Timeline, presentations by two counties. Sharing progress, ideas
3/17/22	Minority Health Liaison Meeting: Technical assistance, support, and resources for HE Plan, handbook review
4/12-13/22	Cultural Competency & Health Equity in Public Health Planning, Florida's Health Equity Capacity, Roles, and Responsibilities
4/20/22	Central Regional HE Monthly meeting- OMHHE updates, HE Plan Timeline, presentation- Klan we Talk by Daryl Davis. Sharing progress, ideas
4/21/22	Minority Health Liaison Meeting- discussion of budgets
5/19/22	Minority Health Liaison Meeting- overview of FL Charts, data discussion

7/25/2022	Minority Health Liaison onboarding training

D. National Minority Health Month Promotion

DOH- Indian River hosted a series of on-line presentations of a portion of Unnatural Causes. We chose two episodes " Not Just a Paycheck" which chronicles the closure of a large manufacturing plant in Michigan and the resultant health effects on the local population. The episode also contrasts this series of events with other countries that provide benefits that counteract these types of economic stressors for their populations. The other episode chosen was "Place Matters" which chronicles the harmful effects on health due to segregation and lack of access to jobs, nutritious foods, and safe, affordable housing. These effects have been harmful to the health of long-time African American residents, and new neighborhood residents.

The screenings were followed by a discussion led by Anthony J. Brown, President of the Indian River County Chapter NAACP, and Julianne Price, Co-Founder of Coalition for Attainable Homes, and the Environmental Administrator for DOH-Indian River. Discussion focused on the impact of Social Determinants of Health and the need to ensure health equity to succeed as a society.

Two screenings were scheduled. The first was April 25th as a Lunchtime of Learning. Invitations have been sent to all DOH-Indian River employees to meet in the DOH-Indian River library or join virtually.

The second screening was April 28th from 9:15am to 10:30am. The episode was presented to a group called Together for Health. This group includes members of the DOH-Indian River Health Equity Coalition, non-profit agencies throughout the county as well as city and county

representatives. The presentation was part of a well-attended regular meeting. An introduction was be made by Julianne Price, our Environmental Administrator, who explained our focus on Health Equity in all programs and services, the development of the Health Equity Plan with our Coalition Partners and an explanation of how community members can be involved.

DOH-Indian River also participated in the Hispanic Community Resource and Job Fair which was held on April 2nd from 3-6pm. This family friendly event featured 27 vendors from education, social services, non-profit organizations, local employers. DOH-Indian River provided information on our services and programming. DOH-Indian River used the event to distribute our community survey which contributes to our health disparity work plan. Leaders from the Hispanic Community organized the event to give community members the opportunity to learn about resources available to them. Legal staff from the Mexican Consulate were also in attendance to assist community members with citizenship and immigration questions.

Promotional materials for the Minority Health Month Events are in Appendix B.

VI. PRIORITIZING A HEALTH DISPARITY

The DOH-Indian River HEAT (Health Equity Action Team) is comprised of staff from multiple disciplines who are involved in our communities on a regular basis. The Health Equity Task Force includes community leaders in healthcare and social service organizations. The Health Equity Team and Health Equity Task Force met jointly and during these meetings open discussion of health issues within Indian River County. This led to a list of health disparities affecting minority and marginalized populations including racial minorities and communities with low socio-economic status. The issues discussed included HIV/AIDS, Mental Health for adults, focusing on new mothers, sickle cell disease, drug addiction, chronic illness, housing, lack of services for disabled individuals and access to care.

The HEAT identified and reviewed health disparities data in Indian River County. Data was pulled from multiple sources including Healthy People 2030, Centers for Disease Control and Prevention (CDC), ALICE reporting for Indian River County, DOH- Indian River community survey data, Florida Agency for Health Care Administration (AHCA), FL Youth Tobacco Survey (FYTS), U.S. Census Bureau, Shimberg Center for Housing Studies US Dept of Housing Development Comprehensive Housing Affordability Strategy (CHAS), FL DOH Vital Statistics.

Data gathered during the production of the Community Health Assessment (CHA) identified the following health disparities in Indian River County: poverty, lack of education, unemployment, diabetes, heart failure, HIV, Infant mortality, obesity, mental health, sickle cell disease, asthma, and unintentional falls.

Working in parallel to the HEAT to address these health disparities, members of the Health Equity Coalition (HEC) formed teams to maximize and apply knowledge and talent gained from their fields of expertise to reduce or eliminate the identified disparities by addressing the contributing social determinants of health. The three workgroups are focused on healthy weight/mental health, economic opportunity/ employment, and housing.

When asked to choose a focus for Health Equity efforts, the HEC and HEAT agreed that access to care was at the root of all health disparities and should be addressed with every health disparity that the Health Equity Task Force will develop a work plan to address.

When choosing the first, specific health disparity to address, the Health Equity Task Force evaluated data specific to the county and using a multi-voting technique, decided to focus on sickle cell disease (SCD) as the first disparity addressed in the Health Equity Plan. There were several reasons for this decision including: no access to specialized care within the county and a lack of knowledge about the disease within the public and healthcare providers. A clear indication of disparity is illustrated by the funding for research and cure for SCD. Although SCD is the most common genetic blood disorder in the United States[3] and three times more prevalent than other rare inherited disorders, funding for Cystic Fibrosis is 11 times greater than that for SCD[4]. SCD disproportionally affects Black and African Americans and often starts in infancy and toddler stages of life. These priority populations are negatively impacted by SDOH. This further influenced the Health Equity Task Force's selection of SCD as the first disparity to address and to increase the quality of life for SCD patients and their caregivers

Data concerning SCD is not prevalent. The Centers for Disease Control and Prevention states that the exact number of people living with SCD in the U.S. is unknown. It is estimated that SCD affects approximately 100,000 Americans. SCD occurs among about 1 out of every 365 Black or African American births. It occurs among about 1 out of every 16,300 Hispanic-American births. About 1 in 13 Black or African American babies is born with sickle cell trait (SCT).[5] The state of Florida has the highest prevalence of SCD in the nation.[6]

[3] Centers for Disease Control and Prevention. Data and Statistics: Sickle Cell Disease. https://www.cdc.gov/ncbddd/sicklecell/data.html. Accessed March 11, 2019

[4] Strouse JJ, Lobner K, Lanzkron S, Haywood C. NIH and National Foundation expenditures for sickle cell disease and cystic fi brosis are associated with PubMed publications and FDA approvals. *Blood*. 2013;122:1739

[5] https://www.cdc.gov/ncbddd/sicklecell/data.html

[6] NORD (National Organization for Rare Disorders). Huntington's Disease. https://rarediseases. org/rare-diseases/huntingtons-disease/. Accessed March 11, 2019

State[a]	Prevalence
Florida	8803
New York	8661
Texas	7132
Georgia	5797
Maryland	4860
California	4707
New Jersey	4256
North Carolina	3973
Louisiana	3936
Pennsylvania	3743
Total	**55,868**

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In 2010, the U.S. incidence estimate for sickle cell trait (based on information provided by 13 states) was 73.1 cases per 1,000 Black newborns, 3.0 cases per 1,000 white newborns, and 2.2 cases per 1,000 Asian or Pacific Islander newborns. The incidence estimate for Hispanic ethnicity (within 13 states) was 6.9 cases per 1,000.[8]

The table below shows the progression of the disease in the United States, specifically Indian River County.

Emergency Department Visit Counts and Crude Rates per 100,000 Due to Sickle Cell Disease as Primary Diagnosis, Florida, and Indian River County, 2020

	Florida		Indian River County	
	Count	**Crude rate/100,000**	**Count**	**Crude rate/100,000**
Overall	14,445	66.7	50	31.6
Age group, years				
0-17	1,428	33.3	7	28.2

[7] Lanzkron S, Carrol CP, Haywood C. Mortality rates and age at death from sickle cell disease: US, 1979-2005. Public Health Rep. 2013;128(2):110-116
[8] Agency for Health Care Administration (AHCA), 2020.

18-44	12,163	169.1	42	110.3
45-64	813	14.4	*	*
65 or older	41	0.9	*	*
Race/ethnicity				
Non-Hispanic White	168	1.5	*	*
Non-Hispanic Black	13,589	403.4	50	345.8
Non-Hispanic Other	52	5.0	*	*
Hispanic	569	9.9	*	*

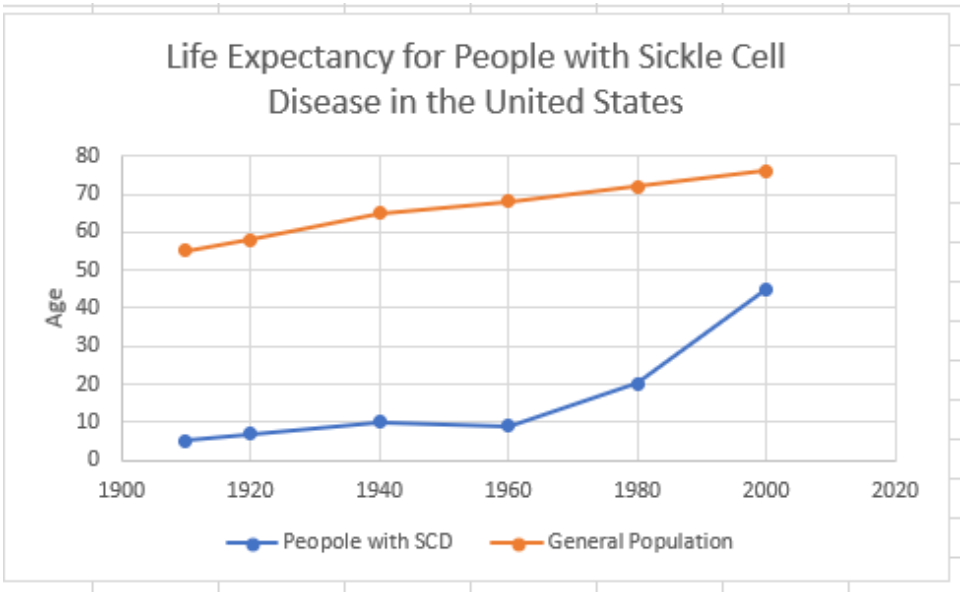
*Count lower than 5

Based on the National Institutes of Health, Sickle Cell Disease Association of America, Inc. Cystic Fibrosis Foundation© and Cystic Fibrosis Foundation Therapeutics Inc. in 2010 affected individual, funding for research and treatment of cystic fibrosis is 11 times greater than for SCD even though SCD is more than 3 times more prevalent than other rare inherited disorders.

Despite its higher prevalence, SCD awareness and funding are lower than that of other genetic disorders. People with SCD have less access to comprehensive team care than people with genetic disorders such as hemophilia and cystic fibrosis.[9]

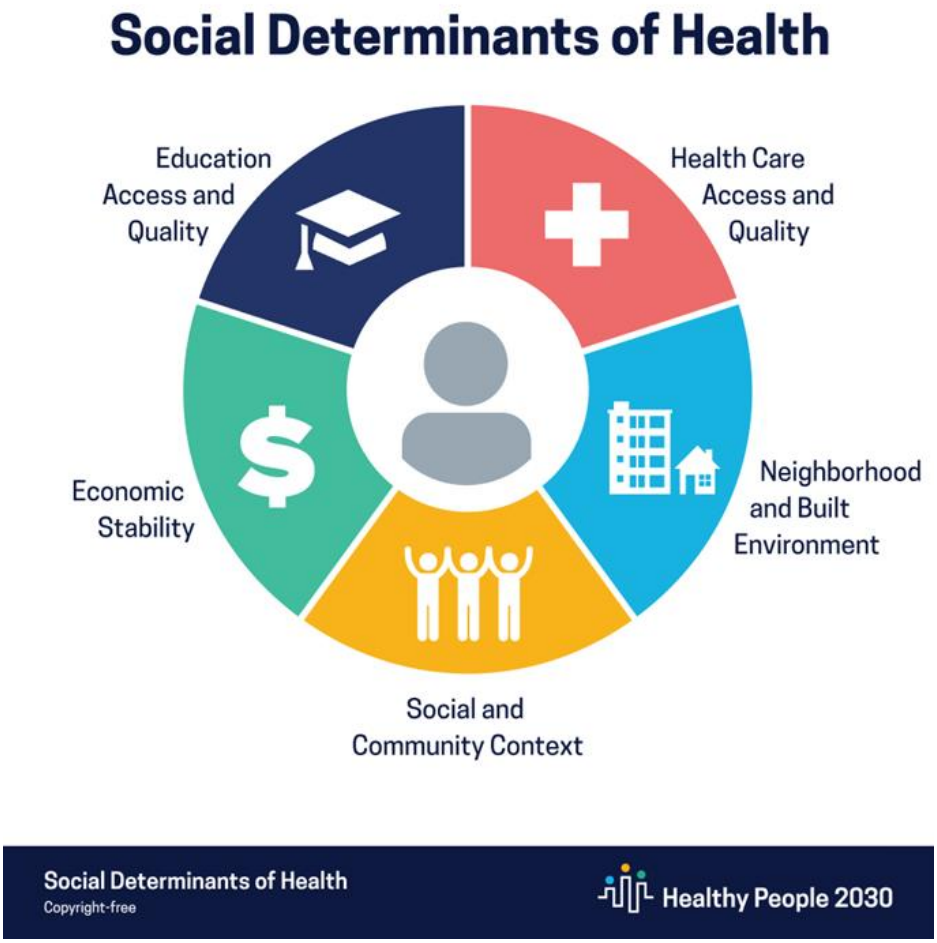
Major advances in SCD screening and interventions over the past four decades have increased life expectancy; however, life expectancy is still more than 30 years lower than that of the general population.[10,11]

[9] Adams-Graves P, Bronte-Jordan L. Recent treatment guidelines for managing adult patients with sickle cell disease: challenges in access to care, social issues, and adherence. Expert Rev Hematol. 2016;9(6):541-542.
[10] Lanzkron S, Carrol CP, Haywood C. Mortality rates and age at death from sickle cell disease: US, 1979-2005. Public Health Rep. 2013;128(2):110-116.
[11] Thein MS, Igbineweka NE, Thein SL. Sickle cell disease in the older adult. Pathology. 2017;49(1):1-9.


Life Expectancy for People with Sickle Cell Disease in the United States
Age
80
70
60
50
40
30
20
10
0
1900
1920
1940
1960
1980
2000
2020
Peopole with SCD
General Population

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 Sickle Cell Disease.



A. Education Access and Quality

- **Education Access and Quality data for Indian River County**

According to the US Census Bureau, American Community Survey, in 2019, the percentage of individuals with less than a 9th grade education in Indian River County was 3.5% which compares to Florida at 4.8%. However, the city of Fellsmere and surrounding areas, which have a large Hispanic population have much higher rates of low educational attainment. The city of Fellsmere has 8.3% of the population with less than a 9th grade education and 11.5% without a high school diploma. Education levels in majority Black and African American communities show similar results. The Gifford community has 9.7% of its population with less than a 9th grade education and 12.7% without a high school diploma.

Low educational achievement impacts SCD by reducing the ability of these populations to access information and treatment.

Disability is one of the highest risk factors for low education attainment. In 2020 According to Charts, 25,554 civilians, 16.5% of the population in Indian River County had a disability. The probability of an individual living with disability to attain a high school diploma is 25%.

To improve SCD, DOH-Indian River County is addressing ethnic and disability disparities related to achieving a high school diploma by working with our partners to conduct accessible GED classes in underserved communities.

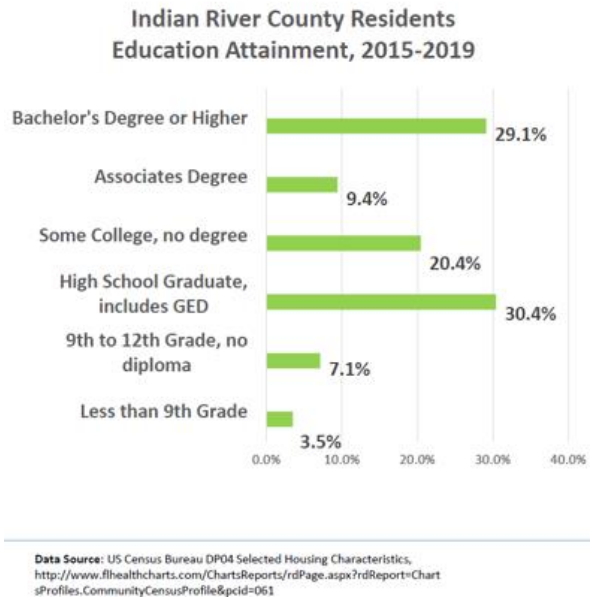
The table below shows the prevalence of SCD among different race and ethnic groups in Florida and Indian River County. In 2020, there was about 19 patients who were hospitalized due to SCD.

Hospitalization Counts and Crude Rates per 100,000 Due to Sickle Cell Disease as Primary Diagnosis, Florida, and Indian River County, 2020

Race/ethnicity	Florida		Indian River County	
	Count	Crude rate/100,000	Count	Crude Rate/100,000
Non-Hispanic White	87	0.8	*	*
Non-Hispanic Black	8,402	249.4	19	131.4
Non-Hispanic Other	61	5.8	*	*
Hispanic	499	8.6	*	*

Data source: Agency for Health Care Administration (AHCA)

The chart below shows the education level of the residents in Indian River County between 2015 and 2019.



The impact of education access and quality on Sickle Cell Disease

Education Access and Quality		
SDOH	**Vulnerable Populations Impacted**	**How the SDOH Impacts Sickle Cell Disease**
Literacy	African Americans, Blacks, Hispanics, Infants & Children	Lack of understanding and access to information regarding the Sickle Cell Trait (SCT), testing and SCD
Access to information	African Americans, Blacks, Hispanics, SCD Caregivers	Printed material sources such as libraries or medical clinic hours limited for individuals working multiple jobs
Early Childhood Development	African Americans, Blacks, Hispanics, Infants & Children	Neo-natal testing and disease management limited by lack of education regarding testing and treatment options

B. Economic Stability

- **Economic stability data for Indian River County**

In Indian River County 18.3% of children five and below and 6.5% of adults 65 and above are living below the poverty level (2019) and that number increases year over year. 40.6% of residents in Indian River County are 60 years or older and the median age is 53.5.

In 2013, 32.4% of residents who identified as Black or African American lived below the poverty line, higher than any other racial or ethnic group by at least 10%, which represents a racial disparity.

The disparity between those without a disability and those with at least one disability is an issue in Indian River County. In 2020 21% of individuals living with a disability made less than $35,000 yearly with inflation with about 43% not being able to pay bills in the last 12 months.

The Indian River County Community Needs Assessment 2019 stated that 33% of residents or roughly 20,000 households in Indian River County pay more than 30% of their monthly income for rents or mortgages, which is considered “housing cost-burdened”.

Indian River County contains communities that lack adequate income to afford necessities. Low-income families are affected by multiple, overlapping issues like lack of affordable housing, social isolation, chronic or acute health problems, high medical costs, low wages, and food insecurity.

This chart is a point in time county from Treasure Coast Homeless Services Council that show the number of homeless individuals in the county at a point in time. The report does not include an additional 175 households that were sharing housing or "couch surfing".

Total Homeless Individuals

	January 26, 2021	January 31, 2022	Difference
Adults	227	225	(2)
Children	34	65	+31
Total	**261**	290	**+29**

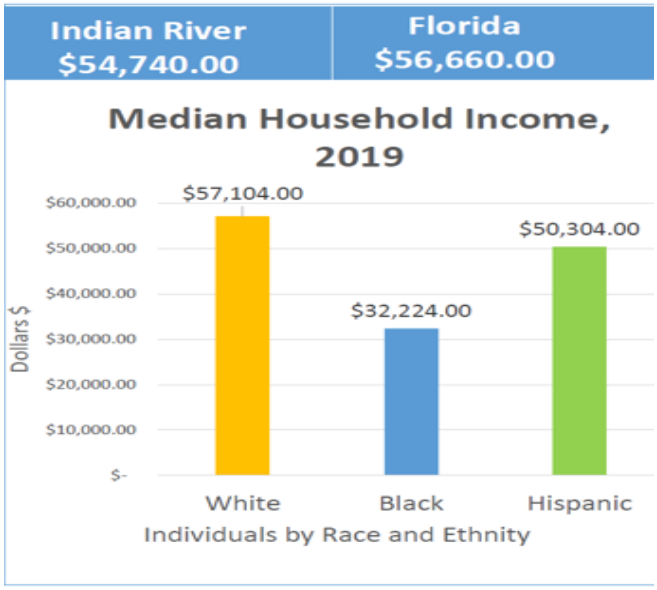
Veteran Status
(self-reported & not verified during the PIT count)

Veterans	**23**	**21**	**(2)**

2022 Sheltered & Unsheltered

	Sheltered	Unsheltered	Total
Adults	48	177	225
Children	38	27	65
Total	**86**	**204**	**290**

Median household incomes vary by race and ethnicity as the chart below illustrates.



Data Source: US Bureau of the Census, American Community Survey, Table B19013, http://www.flhealthcharts.com/ChartsReports/rdPage.aspx?rdReport=NonVitalIndGrp.Dataviewer

The chart below shows the unequal dispersion of wealth as measured by the GINI inequity index. Indian River County received an index value of 0.53, which is higher than both the State of Florida (0.49) and the United States (0.48)

Table 43. 2014-2018 Indian River Census Tract GINI Inequality.[83]

City	Tract	n	GINI Inequality
Fellsmere	509.03*	2,397	0.44
	509.04	1,904	0.37
Sebastian	508.02	3,474	0.36
	508.05*	1,580	0.4
	508.06	1,924	0.5
	508.07	1,919	0.36
	508.08	1,932	0.40
Vero Beach	501	2,539	0.55
	502	1,549	0.47
	504.02	1,217	0.62
Highlands	506.06	3,309	0.35
Indian River Shores	505.01	2,477	0.57
	505.05	1,711	0.53
West Vero Corridor	507.04	1,137	0.39
	507.05	2,700	0.44
	509.03*	2,397	0.44
Gifford	503.02	2,191	0.51
Vero Beach South	507.02	2,071	0.46
	507.03	3,291	0.41
	506.01	1,245	0.55
Wabasso	508.04	2,134	0.43
	508.05*	1,580	0.40

Note. "n" represents total households in the census tract. * denotes census tract overlap

Data Source: CARES Engagement Network (2020) Community Health Needs Assessment Health Indicators Report. Retrieved from CHNA Report.

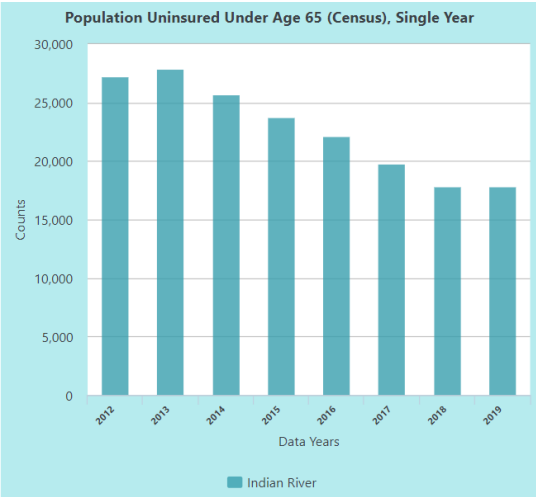
- **The impact of economic stability on Sickle Cell Disease**

Economic Stability		
SDOH	**Vulnerable Populations Impacted**	**How the SDOH Impacts Sickle Cell Disease**
Employment	African Americans, Blacks, Hispanics, Infants & Children	Individuals with Sickle Cell Disease require flexible work schedules to cope with absences due to SCD symptoms. Low-income earners may need multiple jobs to afford basic living expenses and would not have this flexibility.
Affordable Housing	African Americans, Blacks, Hispanics, SCD patients & caregivers	Medication and treatment add to household budgets. High housing costs limit the funds available for disease treatment.
Insurance	African Americans, Blacks, Hispanics, SCD patients & caregivers	In 2019, there were 17,811 uninsured individuals in the county, accounting for 27.8% of the workforce population, which was higher than the state (24.8%). Lack of insurance to cover the cost of medical care not covered by Medicaid or Medicare makes in county care too expensive for marginalized populations.
Food Insecurity	African Americans, Blacks, Hispanics, Infants & Children, SCD patients	In 2019 23.3% of the children in Indian River County experienced a food shortage due to inadequate finances. Good nutrition is important for health maintenance and can reduce SCD symptom severity.

C. Neighborhood and Built Environment

- **Neighborhood and built environment data for Indian River County**

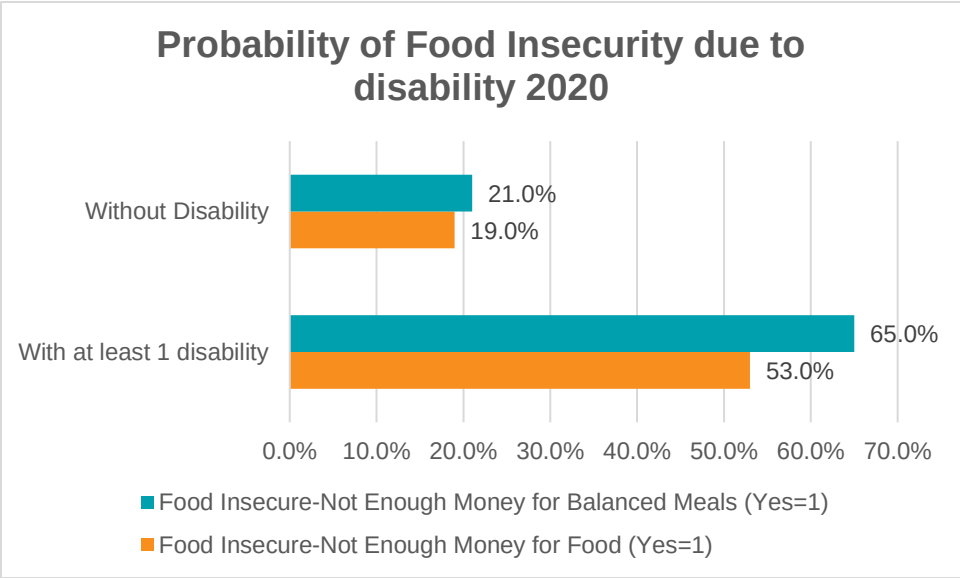
There are 7 nursing homes in Indian River County with a total of 674 licensed nursing home beds (2019). 21 assisted living facilities with a total of 965 beds serve the population plus 19 home health agencies and 1adult day care center. The population over age 55 is approximately 76,219 according to the U.S. Census bureau. Access to care facilities is constrained. Individuals who live at or below the poverty level and cannot afford insurance have fewer options for care. The chart below illustrates these issues.



Data Source; Florida Health Charts

These issues are compounded by a lack of access due to transportation issues, limited or no computer capabilities, little access to healthy foods, unsafe housing and neighborhoods and often unsanitary living conditions.

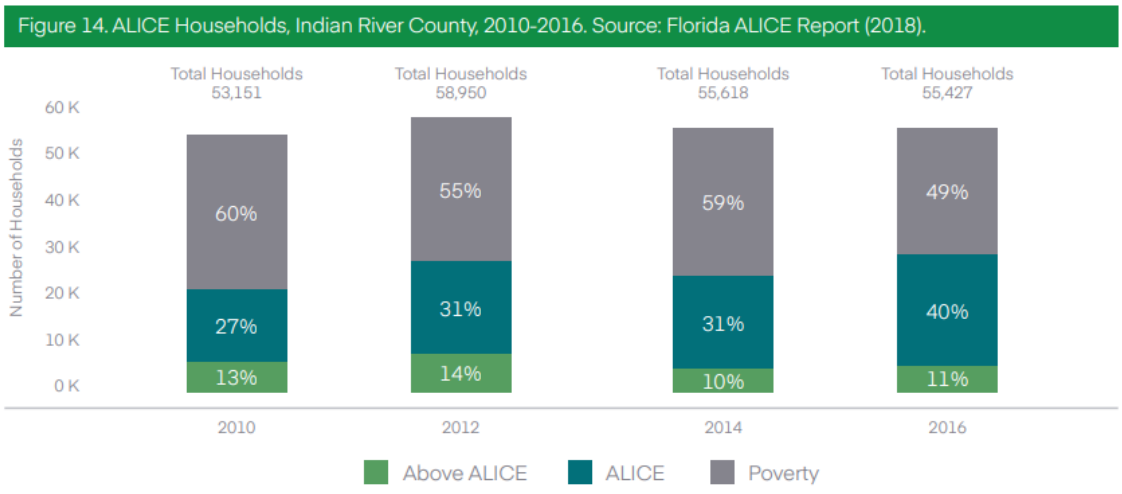
The table below shows that civilians living with a disability also face severe lack of access to food. The probability of a person living with a disability to face food and balanced meals insecurity is 53% due to cost.



Data source: FLDOH-Knowli Data Science

The charts below highlights the communities with limited access to transportation by car. Although free services are available, public transportation routes and schedules are limited.

Data Source: CARES Engagement Network (2020) Community Health Needs Assessment Health



Indicators Report. Retrieved from CHNA Report.

Table 46. 2010- 2015 Percent of Indian River Households with Low Food Access by Census Tract.[90]

City	Tract	n	% Low Food Access
Fellsmere	509.03*	7,150	94.62
	509.04	7,218	0.88
Sebastian	508.02	8,580	49.24
	508.05*	3,750	32.67
	508.06	4,660	63.29
	508.07	4,657	4.20
	508.08	3,888	0.00
Vero Beach	501	6,114	64.90
	502	2,329	55.12
	504.02	2,281	0.00
Highlands	506.06	10,817	59.26
Indian River Shores	505.01	5,291	100.00
	505.05	3,197	0.00
West Vero Corridor	507.04	2,186	0.00
	507.05	4,860	79.51
	509.03*	7,150	94.62
Gifford	503.02	5,354	86.87
Vero Beach South	507.02	5,149	38.19
	507.03	8,751	6.57
	506.01	2,354	24.25
Wabasso	508.04	4,956	88.39
	508.05*	3,750	32.67

Note. "n" represents total households in the census tract. * denotes census tract overlap

Data Source: CARES Engagement Network (2020) Community Health Needs Assessment Health Indicators Report. Retrieved from CHNA Report.

A lack of grocery stores, farmers markets or food pantries is another built environment challenge to Indian River County's minority, disabled, and low-income populations.

- **The impact of neighborhood and built environment on Sickle Cell Disease (SCD)**

Neighborhood and Built Environment		
SDOH	**Vulnerable Populations Impacted**	**How the SDOH Impacts Sickle Cell Disease**
Housing	African Americans, Blacks, Hispanics, SCD patients & caregivers, civilians living with a disability	Both home design and structure significantly influence housing quality and may affect mental and physical health. Steps, balconies, and windows are features of home design that may

		present a threat to safety, especially for individuals with physical disabilities [12], [13]
Transportation	African Americans, Blacks, Hispanics, SCD patients & caregivers, civilians living with a disability	The absence of SCD specialists in Indian River County requires patients to travel to neighboring counties for care. Bus service would require extended travel time with same day returns difficult
Safety	African Americans, Blacks, Hispanics, Children, SCD patients, civilians living with a disability	The quality of a home's neighborhood is shaped in part by how well individual homes are maintained, and widespread residential deterioration in a neighborhood can negatively affect mental health, which affects overall health[10]
Access to nutritional food	African Americans, Blacks, Hispanics, SCD patients & caregivers, civilians living with a disability	Just 12.06% of county residents live within ½ mile of a healthy food source.[14] With transportation constraints and physical activity limited due to SCD, access is very limited. Good nutrition is a core requirement for better health outcomes.

[12] Kruger DJ, Reischl TM, Gee GC. Neighborhood social conditions mediate the association between physical deterioration and mental health. Am J Community Psychol. 2007;40(3-4):261-71.

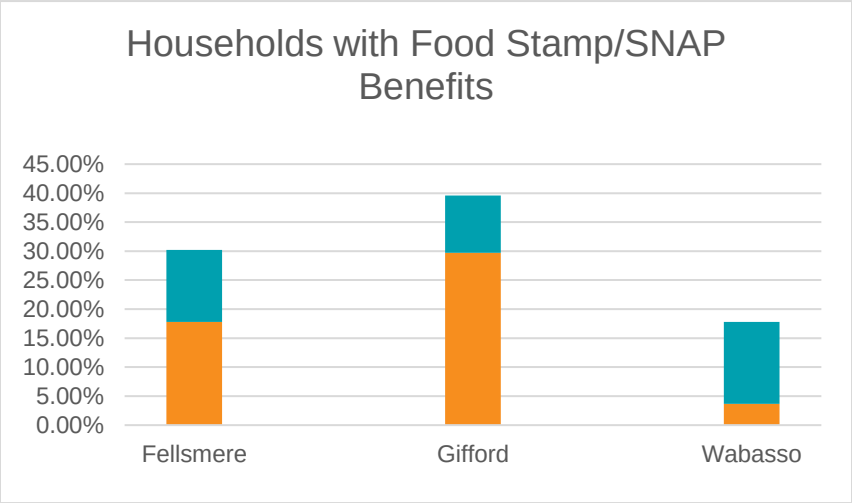
[13] Bonnefoy X. Inadequate housing and health: an overview. Int J Environ Pollut. 2007;30(3):411-429. 2. Krieger J, Higgins DL. Housing and health: time again for public health action. Am J Public Health. 2002;92(5):758-68.

[14] https://www.floridatracking.com/healthtracking/mapview.htm?i=8250&g=3&t=2019&ta=0&it=1

D. Social and Community Context

- **Social and community context data for Indian River County**

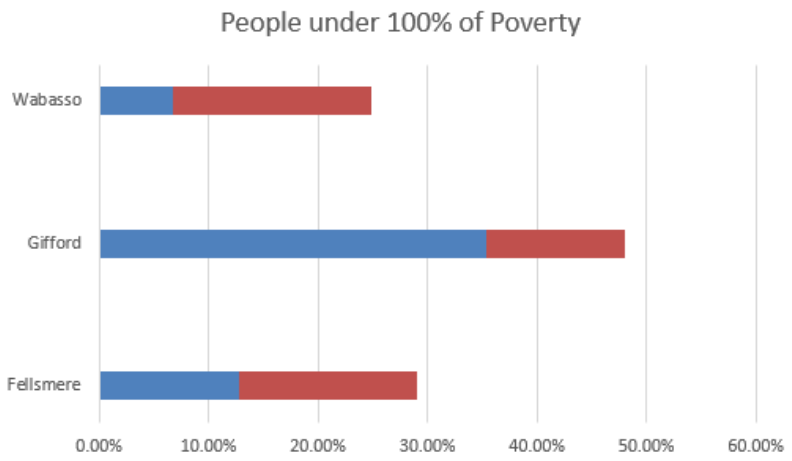
Indian River County has a wide income disparity between our barrier island communities and our western and central communities. Many of the residents of these western and central communities lack adequate income to afford necessities. Low-income families are affected by multiple, overlapping issues like lack of affordable housing, social isolation, chronic or acute health problems, high medical costs, low wages, and food insecurity. The data that follows illustrates the social and community context for the communities of Gifford, Wabasso and Fellsmere.



Fellsmere census tract codes 509.03 and 509.04,Gifford census tract codes 503.02 and 507.02, Wabasso census tract codes 508.04 and 508.5

Data Source Florida Health Charts Community Social & Economic Factors- 2015-19, US Census Bureau, American Community Survey 5-year estimates

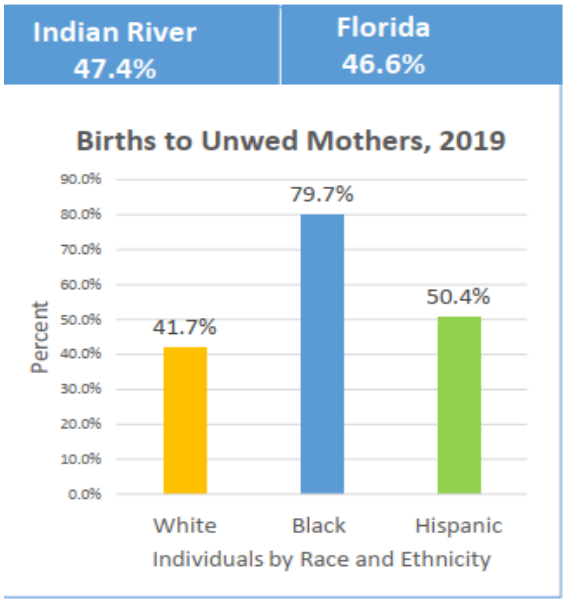
Indian River County has 6.3% families live under 100% of poverty which compares to 10% statewide. The chart below shows three communities living in poverty in much larger percentages.



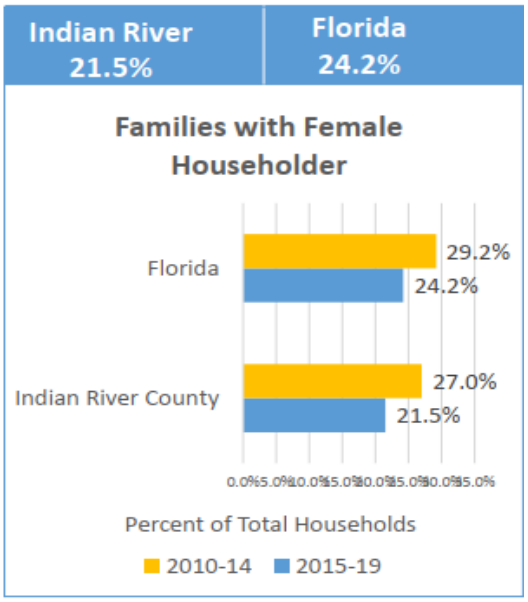
Fellsmere census tract codes 509.03 and 509.04, Gifford census tract codes 503.02 and 507.02, Wabasso census tract codes 508.04 and 508.05

Data Source Florida Health Charts Community Social & Economic Factors- 2015-19, US Census Bureau, American Community Survey 5-year estimates

The breakdown of the traditional family unit adds economic and social pressure in marginalized communities.



Data Source: Florida Department of Health, Bureau of Vital Statistics , http://www.flhealthcharts.com/ChartsReports/rdPage.aspx?rdReport=Birth.DataViewer&cid=0030



Data Source: US Census Bureau DP04 Selected Housing Characteristics, http://www.flhealthcharts.com/ChartsReports/rdPage.aspx?rdReport=ChartsProfiles.CommunityCensusProfile&pcid=061

- **The impact of social and community context on sickle cell disease**

Social and Community Context		
SDOH	**Vulnerable Populations Impacted**	**How the SDOH Impacts Sickle Cell Disease (SCD)**
Support Systems	African Americans, Blacks, Hispanics, SCD patients & caregivers, civilians living with a disability	Lack of family/ community support for emotional and logistic support can result in worse health outcomes
Community Engagement	African Americans, Blacks, Hispanics, SCD patients & caregivers, civilians living with a disability	Episodic diseases such as SCD reduce the ability of the person suffering from the disease to engage. Communities fighting poverty and social issues do not have the leisure time to extend help

Discrimination	African Americans, Blacks, Hispanics, SCD patients & caregivers, civilians living with a disability	SCD effects African Americans / Blacks at a higher rate than other races. The disease is sometimes viewed as a defect or failure rather than an illness
Stress	African Americans, Blacks, Hispanics, SCD patients & caregivers, civilians living with a disability	Stress caused by living conditions and community issues has a direct impact on SCD episode severity and frequency

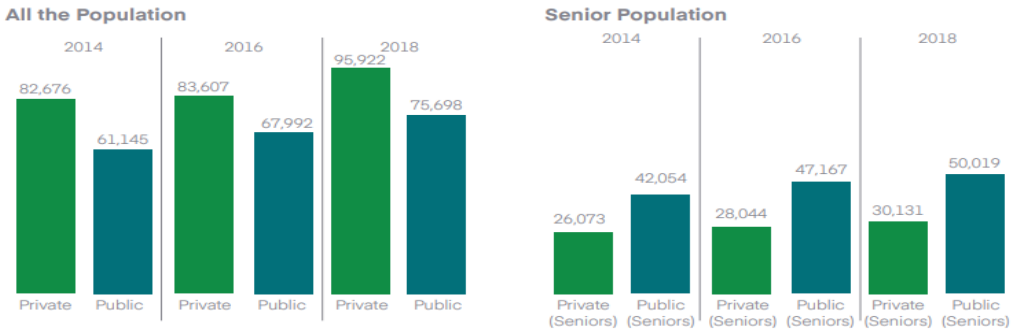
E. Health Care Access and Quality

- **Health care access and quality data for Indian River County**

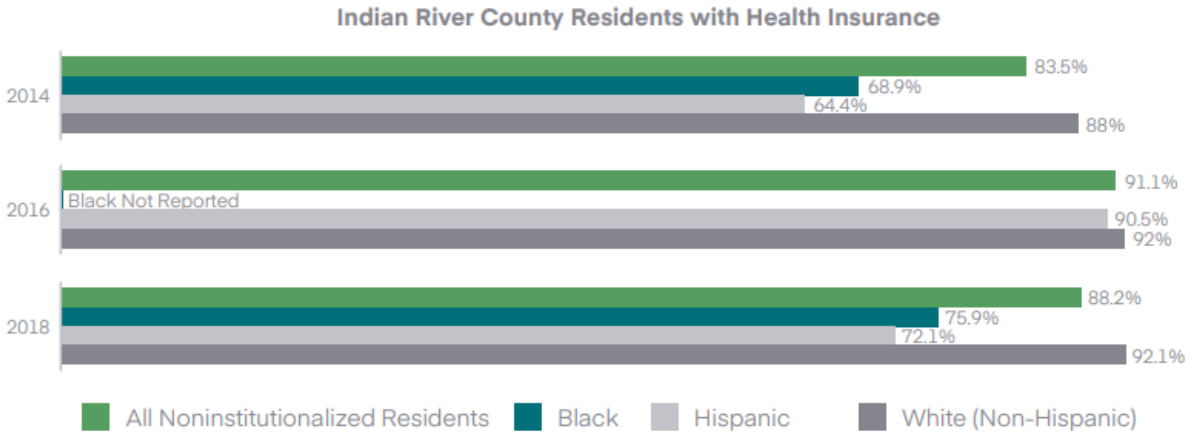
There are three licensed hospitals in Indian River County, two in Vero Beach and one in Sebastian, with a total of 590 licensed beds (2020). One of the two hospitals in Vero Beach is within two miles of Gifford, but the Wabasso and Fellsmere communities do not have close access to a hospital.
There are 8 Federally Qualified Health Centers and one administrative site in Indian River County, all part of Treasure Coast Community Health, Inc. These Health Centers have a significant impact on healthcare in areas that do not have close access to a hospital. The health centers also use a sliding scale for fees based on ability to pay.

One of the biggest barriers to receiving adequate clinical care is lack of insurance coverage, the percentage of insured residents of Indian River County was examined between the years 2014 and 2018. Since 2014, the percentage of residents with insurance coverage has increased steadily in 2019, there were 17,811 uninsured individuals in the county, accounting for 27.8% of the workforce population, which was higher than the state (24.8%).
In 2019, 0.8% of people in Florida lived with SCD. Individuals in the LGBTQ community are at a deficit when it comes to access to care. They are most likely to face discrimination and mistreatment when seeking care.

Figure 22. Insurance Status of Indian River County Residents, 2014-2018. Source: United States Census Bureau.[80]



The lack of insurance coverage in Indian River County paired with other challenges in healthcare access, behavioral, and environmental health may have a negative impact on the quality of life of its residents.



Regarding the availability of clinical services, the County Health Rankings provide information on ratios of providers to residents. The table below provides information on the ratios by provider type. The ratio of primary care physician (PCP) providers and mental health providers to residents is worse in Indian River County than in Florida, while the ratios of dentists to patients is better in Indian River than in Florida. In every case, the provider-patient ratios are worse in the county and state than they are nationally[15]

2018 County and\d State Level Provider to Patient Ratio

	Indian River	Florida
Access to Mental Health Provider	1:840	1:700
Access to Primary Care Physician	1:1,440	1:1,380
Access to Dentists	1:1,530	1:1,730

[15] https://www.countyhealthrankings.org/app/florida/2018/rankings/indian-river/county/outcomes/overall/snapshot 82 CARES Engagement Network (2020).

The percentage of Indian River adults whose poor physical or mental health kept them from doing usual activities on 14 or more of the past 30 days is detailed in the chart below.

2016 Florida BRFSS Data Report — **Indian River**

Health-Related Quality of Life

Percentage of adults whose poor physical or mental health kept them from doing usual activities on 14 or more of the past 30 days

		2016 County Measure	2016 County 95% CI		2016 State Measure	2016 State 95% CI		2013 County Measure
ALL	Overall	20.4	11.4	29.5	18.6	17.4	19.9	22.0
SEX	Men	29.7	12.1	47.4	18.6	16.7	20.5	18.1
	Women	15.0	5.6	24.4	18.7	17.1	20.3	24.6
RACE/ETHNICITY	Non-Hisp. White	22.1	11.4	32.8	19.1	17.8	20.5	24.7
	Non-Hisp. Black				18.9	14.7	23.0	
	Hispanic				17.3	14.2	20.3	
SEX BY RACE/ETHNICITY	Non-Hisp. White Men	29.8	10.5	49.0	18.7	16.7	20.7	24.7
	Non-Hisp. White Women	17.2	5.2	29.3	19.5	17.8	21.3	24.6
	Non-Hisp. Black Men				19.0	12.9	25.2	
	Non-Hisp. Black Women				18.7	13.2	24.3	
	Hispanic Men				17.4	12.9	21.9	
	Hispanic Women				17.2	12.9	21.4	
AGE GROUP	18-44				12.0	10.4	13.6	17.2
	45-64	21.4	6.2	36.6	26.3	23.9	28.7	27.1
	65 & Older	28.1	11.8	44.3	20.2	18.0	22.4	21.0
EDUCATION LEVEL	<High School				29.7	25.0	34.5	
	H.S. / GED	20.2	0.0	40.9	19.7	17.5	21.9	27.8
	>High School	14.6	5.3	23.9	15.1	13.8	16.4	20.2
ANNUAL INCOME	<$25,000	36.5	16.8	56.1	29.8	27.1	32.5	28.3
	$25,000-$49,999	9.6	1.6	17.7	17.4	14.7	20.0	18.3
	$50,000 or More	1.4 *	0.0	3.3	9.6	8.1	11.1	16.7
MARITAL STATUS	Married/Couple	5.4 *	1.2	9.6	17.7	15.9	19.4	15.9
	Not Married/Couple	32.8	18.0	47.6	19.6	17.9	21.3	30.5

- **The impact of health care access and quality on Sickle Cell Disease**

Health Care Access and Quality		
SDOH	**Vulnerable Populations Impacted**	**How the SDOH Impacts Sickle Cell Disease**
Health Coverage	African Americans, Blacks, Hispanics, SCD patients & caregivers, civilians living with a disability	The high cost of coverage for SCD is unaffordable to marginalized populations
Provider Availability	African Americans, Blacks, Hispanics, SCD patients & caregivers, civilians living with a disability	High demand for primary care providers disadvantages people relying on public health insurance. Physicians can accept or reject patients using public health options. There is no access to specialized care that is covered by Medicaid / Medicare in Indian River County. SCD patients travel to neighboring counties to receive care.
Quality of Care	African Americans, Blacks, Hispanics, Infants and Children,	Neo-natal testing and disease management are limited in Indian River County.

	civilians living with a disability	

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 Task Force. 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 Task Force reviewed data, including health disparities and SDOHs, provided by HEAT. The Health Equity Task Force also researched evidence-based and promising approaches to improve the identified SDOHs. All agreed and supported the vision of achieving health equity for Indian River County and had broad discussions on what that would mean and how we could achieve it. Data was pulled from multiple sources including Healthy People 2030, Centers for Disease Control and Prevention (CDC), ALICE reporting for Indian River County, DOH- Indian River community survey data, Florida Agency for Health Care Administration (AHCA), FL Youth Tobacco Survey (FYTS), U.S. Census Bureau, Shimberg Center for Housing Studies US Dept of Housing Development Comprehensive Housing Affordability Strategy (CHAS), FL DOH Vital Statistics, Agency for Health Care Administration (AHCA).

B. Barrier Identification

On a statewide project, DOH- Indian River received funding from Environmental Public Health Tracking (EPHT) to create a SDOH data dashboard to track health disparities in partnership with NAACP. NAACP surveyed chapters across the state of Florida to identify significant SDOH in their communities. Questions addressing barriers in education, economic stability, neighborhood and built environment, health and social and community context were included. Survey results identified barriers to care. EPHT, DOH-Indian River and NAACP are collect data and present it in a user-friendly format. The project will yield data and information that can be used for education and promotion of better health outcomes. The results of this project will demonstrate not only the barriers in addressing SDOH but will yield community specific data to support future efforts.

In Indian River County members of the Health Equity Coalition worked collaboratively to identify barriers to fully addressing the SDOHs relevant to their organization’s mission. Common themes were explored as well as collaborative strategies to overcome barriers. The chart below highlights the barriers that were most frequently discussed.

Organizations	Area of Operation/ Interest	SDOH	Barriers	Theme	Collaborative Strategies
Treasure Coast Community Health, Mental Health Collaborative, Cleveland Clinic-Indian River Hospital	Health services	Healthcare Access and quality	Doctor availability Patient/ doctor trust Interruptions in treatment regiments Lack of transportation, insurance, financial resources	Lack of access and confidence in social services/systems	Expand mental health services in IRC Train healthcare providers in trauma informed care Provide place-based services and education
Gifford Youth Achievement Center, United Way, Homeless Children's Foundation, Hope for Families	Children and Adolescent development, education, family care	Social and Community Context, Education	Educational skills below grade level Limited knowledge of healthy eating habits Limited food budgets and healthy food sources	Generational poverty and institutional racism	Provide volunteer tutors. Increase communication with parents to support learning Implement SNAP-Ed programing, food deliveries and improve coordination between agencies to increase access to nutritious, affordable food
Habitat for Humanity, Farmworkers Association, ARC of IR, Hope for Families, United Against Poverty	Housing, employment, and family support	Economic Stability	Transient population/ English as a second language Lack of transportation Cost of housing	Access to services	Coordinate ESL class schedules and locations with data showing areas of greatest need. Coordinate delivery of services with community partners Increase land availability and number of workforce housing units
Nurse/Family Partnership, Hope for Families	Maternal and infant health	Health Care Access and quality	Lack of coordination of care	Lack of communication and coordination between agencies	Increase communication to coordinate consecutive appointments, in home care and education
Fellsmere Action Community Team (F.A.C.T.), Economic Opportunities Council, Habitat for Humanity, IRC Chamber of Commerce, United Against Poverty	Economic Improvement	Economic Stability	Low wages create a cycle of poverty	Need for place-based services	Expand scope, marketing, impact, and candidate retention of paid apprenticeship programs Establish a community resource center in low-income community Conduct financial literacy classes

C. Community Projects

See Attachment A for a storyboard which describes the PACE-EH project to reduce health disparities in the care of people with Sickle Cell Disease in Indian River County.

The Health Equity Task Force and Health Equity Coalition have begun a Protocol for Accessing Community Excellence in Environmental Health (PACE-EH) project to define disparities and barriers to care in Indian River County. This project includes meetings with local community leaders, developing and delivering a community survey to collect information and data collection. Our PACE-EH to evaluate the needs of under resourced and medically underserved communities.

We used community feedback received as part of the PACE-EH project, monitor data, and use both to identify health disparities and launch initiatives to address the SDOH that affect identified disparities. For DOH-Indian River's first initiative, the Health Equity Task Force researched and chose evidence-based strategies to overcome the identified barriers and improve the SDOH that impact Sickle Cell Disease (SCD) based on findings from our PACE-EH project.

The Health Equity Task Force used PACE-EH to collaboratively design community projects to address the SDOHs that have an impact on SCD. The initial and future projects include short, medium, and long-term goals with measurable objectives. The initial and future projects were/ will be reviewed, edited, and approved by the Coalition to ensure feasibility.

To address the SDOH pertaining to sickle Cell Trait and disease, the HE Task Force and Coalition utilize their spheres of influence to improve and develop policies at the agency, municipality, and county levels. The many members of the HE Task Force includes the DOH, Nurse Family Partnership, Treasure Coast Community Health, Gifford Youth Achievement Center, Farm Worker Association, and Fellsmere Action Committee Team.

The Minority Health Liaison helps facilitate the conversation between local organization for the goal of influencing policies that eliminate the health disparities for underserved populations living with SCD. DOH collaborates with local partners to raise awareness of SCD and advocate for better access and accessible SDC care information from healthcare providers in Indian River County.

Nurse Family Partnership's priority population is underserved new mothers up to 2 years postpartum. They Educate mothers about SCD and refers them to care when applicable.

Treasure Coast Community Health also serves the underserved population of Indian River County. They provide SCD care and education that includes making sure patients

are properly diagnosed, referring them to a hematologist for continuance of care and following up with patients on care management.

The immigrant population particularly undocumented immigrants have been negatively affected by many social determinants of health due to fear of immigration laws, a language barrier and/or more. FWA works by bridging the gap between the immigrant communities and care by providing SDC education and referring members to trusted care sources.

Gifford is among the most impoverished communities of Indian River County. Gifford Youth Achievement Center focuses of school-aged youth. They work alongside the DOH to bring SCD awareness to the community through community events and communications with parents/legal guardians.

The Fellsmere Action Committee Team uses their influence and partnership with the Department of Health to improve the health of the communities they serve. FACT advocates for better SCD care and transparency from healthcare providers.

II. HEALTH EQUITY PLAN OBJECTIVES

A. Prioritized Health Disparity-Sickle Cell Disease

- **Health Disparity Objective:** By June 30, 2025, increase the number of agencies/organizations providing medical care for sickle cell disease in Indian River County from zero in 2022 to one [state registrations of businesses and not for profit organizations]

- Increase Access to Care for individuals living with Sickle Cell Disease
- By June 30, 2025, increase the number of events that promote screenings, blood and bone marrow drives, financial support, and awareness of SCD in Indian River County from 0 in 2021 to 25

	Lead Entity and Unit	Lead Point Person	Data Source	Baseline Value	Target Value	Plan Alignment
Long-Term SDOH Goal: Improve access to care by increasing education, community services, support, and research for SCD treatment and cure						
Objective: By June 30, 2025, increase the number of events that promote screenings, blood and bone marrow drives, financial support, and awareness of SCD in Indian River County from 0 in 2021 to 25	DOH-Indian River Health Equity Task Force in partnership with Phi Beta Sigma & SCDAA	Alma Miller, Alissia Cypress, DaJuane Harris	DOH- Indian River and Phi Beta Sigma records	0	25	CHIP Obj. 1.B.2
Objective: By June 30, 2025, decrease Emergency Department Visit Rate for Sickle Cell Disorders with Vaso-Occlusive Crises as Primary Diagnosis by 10% from 22.1 per 100,000 in 2020	DOH-HEAT with community partners and health equity coalition members	Naomi Sainval, Alma Miller, Tony Brown	Agency for Health Care Administration (AHCA)	22.1	19.9	CHIP Obj. 1.B.2 SP Obj. 3.1.2 & 3.1.5
Medium-Term SDOH Goal: Improve social and community context by identifying and increasing available resources						
Objective: By July 30, 2024, provide place-based services and information, increasing the number residents who receive SDOH assistance on an annual basis at FLDOH resource center at the Dasie Hope Center from 0 in February ,2022 to 240	DOH-Indian River Health Equity Task Force in partnership with Dasie Hope Center	Julianne Price, Alissia Cypress, Margaret Kearney, Naomi Sainval	DOH-Indian River records	0	240	CHIP Obj. 3.B.2 Strategic Plan: Priority 5-Goal 1
Objective: By December 30, 2024, increase the number of agencies in Indian River County that provide assistance to SCD patients and caregivers from 0 in 2022 to 1	DOH-Indian River Health Equity Task Force in partnership with Treasure Coast Community Health	Julianne Price, Alma Miller, Vicki Soule, Naomi Sainval	State of Florida Division of Corporations	0	1	Strategic Plan Priority 2-Goal 1 & Priority3,-Goal 1
Objective: By December 30, 2024, identify and reduce the effects of five SDOH that are barriers to care for SCD patients and their care givers, starting from a baseline of 0 known barriers in Feb. 2022	DOH-HEAT with community partners and health equity coalition members	Tony Brown, Alma Miller, Margaret Kearney, Alissia Cypress, Naomi Sainval	PACE EH Survey and DOH records	0	5	Strategic Plan Obj. 3.1.5
Short-Term SDOH Goal: Improve education access and quality by increasing individual and community education and awareness						

Objective: By June 30, 2023, increase community awareness of SCD. By providing access to SCD workshops and education from 0 in February 2022 to 10	DOH Indian River in partnership with NAACP	Tony Brown, Alma Miller, Alissia Cypress, Naomi Sainval	DOH records	0	10	Strategic Plan Priority3,-Goal 1 WFD Goal 5
Objective: By June 30, 2023, increase SCD awareness for health care professionals in Indian River County by increasing training sessions from 0 in February of 2022 to 5	DOH Indian River in partnership with TCCH and Indian River- Cleveland Clinic Hospital	Vicki Soule, Tony Brown, Naomi Sainval, James Rosencrance	DOH records	0	5	Strategic Plan Priority3,-Goal 1 WFD Goal 5

(Florida Behavioral Risk Factor Surveillance System (BRFSS), n.d.)

III. PERFORMANCE TRACKING AND REPORTING

Ongoing communication is critical to the achievement of health equity goals and the institutionalization of a health equity focus. The successes of Health Equity Plan projects are shared with OMHHE, partners, other CHDs, CHD staff, and the Central Office through systematic information-sharing, networking, collecting, and reporting on knowledge gained, so that lessons learned can be replicated in other counties and programs. Regional Health Equity Coordinators facilitate systematic communication within their region. Reporting generated from ClearPoint is shared by the Minority Health Liaison with DOH-Indian River staff, Central Office, and other CHD staff. Regional Health Equity meetings facilitate further sharing of best practices, barriers to progress and successes.

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 Task Force 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 Task Force from these annual reports. The Minority Health Liaison then submits the completed report to OMHHE by July 15th annually.

Annually, the Health Equity Task Force 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

Addendum A
Indian River County
Health Equity Coaltion

Member Organization	Name	Email	Phone Number
211 Palm Beach/ Treasure Coast	Colleen Walts	colleen.walts@211pbtc.org	561-383-1112
Arc of Indian River County	Heather Dales	heatherd@arcir.org	772-52-6854
CareerSource, Research Coast	Dale Shepperson	dshepperson@careersourcerc.com	866-482-4473
City of Fellsmere	Mark Mathes	citymanager@cityoffellsmere.org	772-646-6303
DOH-Indian River, Communicable Diseases	John May	john.may@flhealth.gov	772-794-7477
DOH-Indian River, Community Health Improvement Manager	Molly Steinwald	mary.steinwald@flhealth.gov	772-794-7410
DOH-Indian River, Environmental Administrator	Julianne Price	julianne.price@flhealth.gov	772-794-7445
DOH-Indian River, Health Equity Liaison	Patricia Gil	patricia.gil@flhealth.gov	772-794-7495
DOH-Indian River, Nurse Family Partnership	Cheryl Martinez	cheryl.martinez@flhealth.gov	772-794-7466
DOH-Indian River, Performance Improvement Manager	Margaret Kearney	margaret.kearney@flhealth.gov	772-794-7400 ext. 2110
DOH-Indian River, Health Equity Liaison	Carrie Williams	carrie.williams@flhealth.gov	772-794-7400 ext. 2160
Economic Opportunties Council	Jennifer Kozaczek	jkozaczek@eocofirc.net	772-589-8008 ext. 2119
Economic Opportunties Council	Wanda Hinton	whintoneocofirc.net	772-589-8008
Farmworkers Association	Maria Martenez	mariaMtx@floridafarmworkers.org	772-571-0081
Fellsmere Community Prayer and Worship	Annie Mae Brown	queenbrown571@yahoo.com	772-571-6659
Gifford Youth Achievement Center	Freddie Woolfork	fwoolfork@gyac.net	772-633-3941
Grandparents Raising Grandchildren	Connie Kirschbaum	conniek104@gmail.com	772-205-0132
Habitat for Humanity Restore	Jeff Francisco	jfrancisco@irchabitat.org	772-562-9860
Healthy Start, Cleveland Clinc Indian River	Dr. Sharon Packard	drsharonpackard@gmail.com	772-567-4311
Homeless Children's Fondation	Hannah Hite	hannah@hcfirc.com	772-532-1139
Homeless Children's Fondation	Rob Stein	robcstein@gmail.com	772-532-1505
Hope for Families Center	Marty Mercado	mmercado@hopeforfamiliescenter.org	772-567-5537
Indian River Community Foundation	Jeff Pickering	jeff.pickering@ircommunityfoundation.org	772-492-1407
Indian River County Chamber of Commerce	Helene Caseltine	helenec@indianrivered.com	772-567-3491
Indian River County Community Development	John Stoll	jstoll@ircgov.com	772-226-1237
Indian River County Human Services	Leigh Ann Uribe	Leigh.uribe@flhealth.gov	772-794-7400
Indian River County Sheriff's Office	Eric Flowers	eflowers@ircsheriff.org	772-569-6700
Indian River County, Metropolitan Planning Organization, IRC	Jim Mann	jmann@ircgov.com	772-226-1672
Indian River Hospital District	Jennifer Frederick	jennifer@irchd.com	,;;6-8;;414-79
IRC Healthy Start Coalition	Andrea Berry	Andrea@irchealthystart.org	772-563-9118 ext. 175
IRC Parks and Recreation	Kevin Kirwin	kkirwin@ircgov.com	772-226-1780
John's Island Community Service League	Ellen Kendall	ellenkendall@gmail.com	772-234-8810
John's Island Community Service League	Michelle Julian	mjulian1015@gmail.com	772-234-8810
John's Island Community Service League	Bob Solari	daidalos1184@gmail.com	772-231-0412
Marsh Landing Restaurant	Susan Adams	restmarshlanding@aol.com	772-571-8622
Mending Pieces	Carrie Williams	carrie.williams@flhealth.gov	772-584-5650
Mental Health Association	Jeanne Shepherd	jeanne@mhairc.org	772-569-9788
Mental Health Collaborative	Brett Hall	brett.hall@mhcollaborative.net	772-217-3663
NAACP- Indian River County	Anthony Brown	bustason01@yahoo.com	404-771-3575
NAACP- Indian River County	Alma Miller	glennandalmma@gmail.com	772-633-4724
School District of Indian River County	Christi Shields	Christi.Shields@indianriverschools.org	772-564-3000
Senior Collaborative	Abby Walters	awaltersfl@comcast.net	772-469-2270
Senior Collaborative	Randy Riley	rriley@ircsc.org	772-469-2270
Senior Resource Association	Emily Wilcox	ewilcox@sramail.org	772-569-0760
Substance Awareness Center	Carrie Maynard Lester	cmaynard@sacirc.org	772-770-4811
Technology Partners	Eric Price	eric@techpart.net	772-299-5178
Treasure Coast Community Health	Vicki Soule	VSoule@TCCHINC.ORG	772-257-8224
Treasure Coast Homeless Services Council and Coalition for Attainable Homes	Louise Hubbard	irhsclh@aol.com	772-567-7790
United Against Poverty	Matt Tanner	mtanner@unitedagainstpoverty.org	772-562-5429
United Against Poverty	Arminta Caldwell	minta@unitedagainstpoverty.org	772-772-2665
United Against Poverty	Jane McNulty Snead	jane@unitedagainstpoverty.org	772-770-2665
United Way of Indian River County	Nate Bruckner	nate.bruckner@unnitedwayirc.org	772-567-8900
VNA of the Treasure Coast	Pat Knipper	pknipper@vnatc.com	772-567-5551

Attachment A: Access to Care: Sickle Cell Disease

Problem:

Background: DOH Indian River has initiatied a PACE-EH Project that focuses on SDOH in under resourced and medically underserviced communities. Through community interactions and research, Access to care for Sickle Cell Disease was selected as the first initiative under our PACE-EH project. Sickle Cell Disease (SCD) is the most commone genetic blood disorder in the U.S. It is three times more prevelant than cystic fibrosis, muscular dystrophy and hemophilia, yet funding for Cystic Fibrosis is 11 times greater than that for SCD. The majority of people with SCD are adults and of African ancestry. Vaso-Occlusive Crises (VOCs), the clincal hallmark of SCD, cause frequent hospitalizations, increased healthcare costs and can affect social relationships, employment and education. In Indian River county, access to medical specialists for SCD is not available, 79% of VOCs are treated at home wtih many patients not seeking the medical attention they need. SCD decreases quality of life and increases the risk of organ damage, multi organ failure and death.

Scope: The first outcome from the PACE-EH project focuses on education, screening for Sickle Cell Trait and addressing access to care which will benefit the primarily people of African ancestry, but also people of Hispanic, South Asian, South European and Middle Eastern descent living in Indian River County.

Social Determinant(s) of Health addressed: Social and Community Context, Access to Quality Health Care, Neighborhood and Built Environment, Education

Priority Populations: The African American / Black community and children within the community are most impacted by Sickle Cell Disease and SickleCell Trait. This community is represented throught the development and implementation of the project by members of the Health Equity Action Te am (HEAT), The HE Coalition and the HE Equity Task Force.

Long-term Goal: Improve access to care by increasing education, community services, support, and research for SCD treatment and cure

Medium-term Goal: Improve social and community context by identifying and increasing available resources

Short-Term Goal: Improve education access and quality by increasing individual and community education and awareness

Team Members: HEALTH EQUITY TASK FORCE:
DOH INDIAN RIVER- *Julianne Price, Margaret Kearney, Cheryl Martinez, John May, Molly Steinwald & Alissia Cypress*
DOH/NAACP INDIAN RIVER - *Alma Miller & Tony Brown*
TREASURE COAST COMMUNITY HEALTH - *Vicki Soule*
GIFFORD YOUTH ACHIEVEMENT CENTER - *Freddie Woolfork*

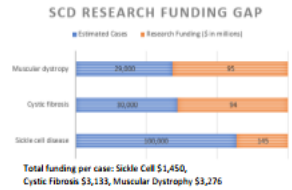
Long -Term Objectives:
* *Objective: By June 30, 2025, increase the number of events that promote screenings, blood and bone marrow drives, financial support and awareness of SCD in Indian River County from 0 in 2021 to 25.*
* *Objective; By June 30, 2025, decrease Emergency Department Visit Rate for Sickle Cell Disorders with Vaso-Occlusive Crises as Primary Diagnosis by 10% from 22.1 per 100,000 in 2020.*

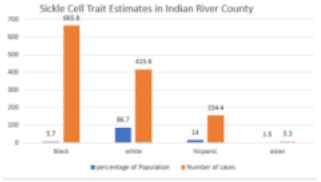
Medium-Term Objectives:
**Objective: By July 30, 2024, provide place-based services and information, increasing the number residents who receive SDOH assistance on an annual basis at FLDOH resource center at the Dasie Hope Center from 0 in February ,2022 to 240*
**Objective: By December 30, 2024, increase the number of agencies in Indian River County that provide assistance to SCD patients and caregivers from 0 in 2022 to 1.*
**Objective: By December 30, 2024, identify and reduce the effects of five SDOH that are barriers to care for SCD patients and their care givers from 0 known barriers in Feb. 2022*

Short-Term Objectives:
**Objective: By June 30, 2023, increase education access and quality of SCD workshops and education from 0 in February, 2022 to 10*
**Objective: By June 30, 2023 increase SCD awareness training sessions for health care professionals in Indian River County from 0 in February of 2022 to 5*

Data Sources for Objectives: National Organization for Rare Disorders (NORD); Center for Disease Control & Prevention (CDC), National Center for Health Statistics (NCHS), National Institute of Health. Research Portfolio Online Reporting Tools, State of Florida Division of Corporations, Cleveland Clinic Indian RIver Hospital, Healthy

Current performance:





Root Causes and Barriers:

Access to care is limited by a lack of physicians who have the skills to treat Sickle Cell Disease (SCD) and who accept Medicaid. Nemours Hospital, Orlando FL is the closest treatment center for SCD crises. Research is limited by a lack of funding and treatments are expensive and not guaranteed.

SCD is a disease that affects primarily people of African descent. In Indian River County, the percentage of African American/ Black residents is approximately 8.3% of the total population. Although the incidence of SCD African American/ Black communities is significant, and the number of individuals with SCT is high, but because it is largely confined to communities that do not hold power, the disease, it's affects on the lives of the patients and their families are, for the most part, overlooked.

People living with SCD and their caregivers face challenges in most aspects of life including medical care, insurance coverage, education, employment, transporation and nutrition.

Project:

Following the Protocol for Adressing Community Excellence in Environmental Health (PACE-EH), a survey has been deployed to adults in Indian River County to assess our county's service gaps and identify SDOH factors that contribute to chronic disease states. This data informs our choice of projects and highlights areas of need. The Health Equity Task Force (HETF) will hold a series of meetings with local SCD patients and their care givers to gain appreciation of the daily challenges of living with SCD. To determine areas of need and gaps in services provided within the county HETF reviewed services provided by local hospitals, clinics and physicians.

Educational efforts will include workshops and presentations as well as distribution of materials to and by coalition members. The HETF will review all materials to ensure they are culturally and linguistically appropriate and provide them to workshop attendees and visitors to Community Resource Centers

In addition, we will work with NAACP to support Congressional Initiative-U.S. H.R. 6216 - Sickle Cell Disease Comprehensive Care Act- by increasing awareness and providing information. This bill establishes and provides funds for a demonstration project for state Medicaid programs to improve outpatient care for individuals with sickle cell disease.

The long term goal of the project is to improve access to care for SCD. To achieve this goal, the HETF, health equity coaltion and community partners will examine gaps in services, SDOH effecting SCD patients and caregivers to determine immediate areas for improvement. We will partner with the Sickle Cell Disease Association of America and Phi Beta Sigma Fraternity, Inc. to support the sickle cell community through raising funds, mobilizing blood and bone marrow drives and collaborating to educate the community about sickle cell disease and sickle cell trait. Together we, as community-based organizations, will advocate for people affected by sickle cell conditions to maximize quality of life and raise public consciousness while advancing the search for a universal cure. We will support Phi Beta Sigma Fraternity Inc. Chapters and local American Red Cross chapters to host blood drives and the Be the Match Registry to host bone marrow drives. Phi Beta Sigma Chapters and DOH-Indian River will conduct screenings to help adolescents and adults detect sickle cell and organize fundraisers for sickle cell research, education and children's services.

Results:

Next Steps: