DOH-LEON

HEALTH EQUITY PLAN

January 2022 – January 2026

Updated 7/21/2022

Table of Contents

I. Vision 4
II. Purpose of the Health Equity Plan 6
III. Definitions 7
IV. Participation 8
A. Minority Health Liaison 10
B. Health Equity Team 11
C. Health Equity Taskforce 12
D. Health Equity Coalition 15
E. Regional Health Equity Coordinators 20
A. Health Equity Assessments 21
B. County Health Equity Training 25
C. County Health Department Health Equity Training 27
D. Minority Health Liaison Training 27
E. National Minority Health Month Promotion 29
V. Prioritizing a Health Disparity 31
VII. SDOH Data 37
A. Education Access and Quality 38
B. Economic Stability 44
C. Neighborhood and Built Environment 47
D. Social and Community Context 54
E. Health Care Access and Quality 59
viii. SDOH Projects 61
A. Data Review 61
B. Barrier Identification 62
C. Community Projects 64
IX. Health Equity Plan Objectives 70
Infant Mortality 70

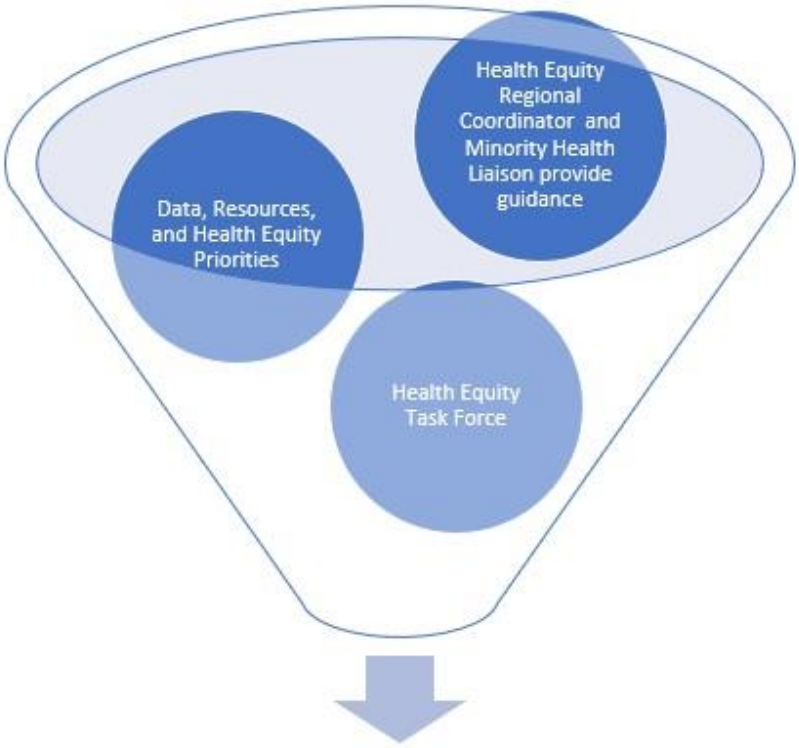
X. Performance Tracking and Reporting 76
XI. Revisions 77
XII. References 78

I. VISION

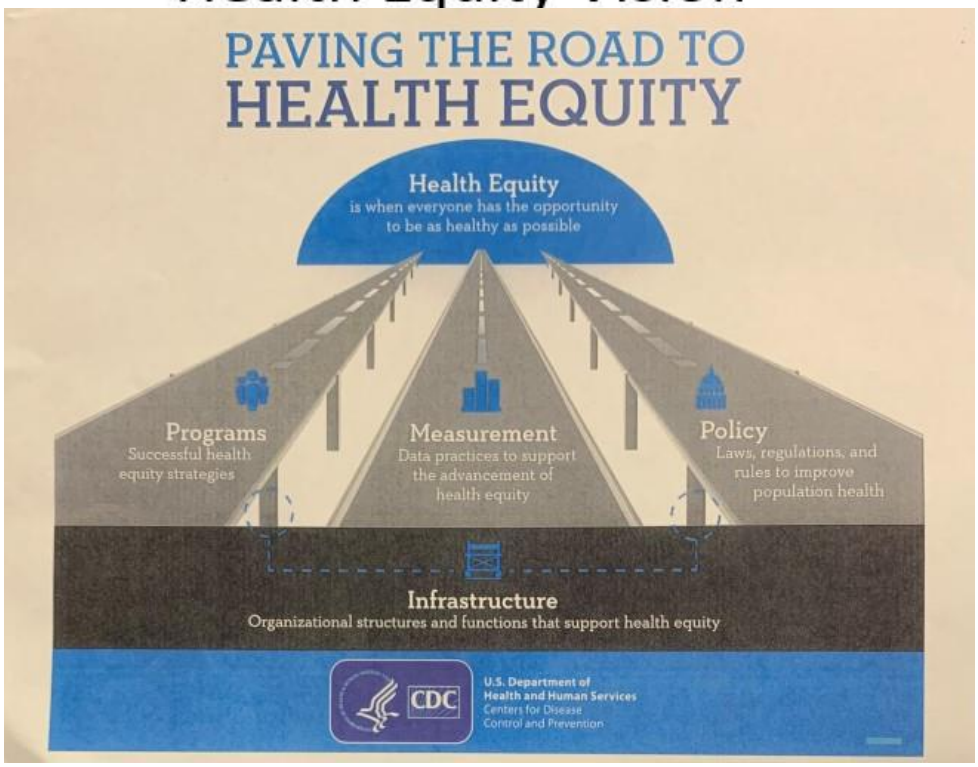
Visioning guides the community through a collaborative process that leads to a shared vision. These Vision statements will provide focus, purpose, and direction to the health equity planning process. The Health Equity Vision will be written by the Health Equity Taskforce under the guidance of the Health Equity Regional Coordinator and the Minority Health Liaison in Leon County.

Visioning is ideally conducted at the beginning of the planning process to provide a framework throughout the stages of planning. Effective facilitation by the Regional Health Equity Coordinator and Minority Health Liaison is essential to ensure that the Health Equity Taskforce members coalesce around a shared vision. As an example, the National Association of County and City Health Officials (NACCHO) has provided great instructions for facilitating visioning in their Mobilizing for Action through Planning and Partnerships (MAPP) guidance.

The Regional Coordinator and Minority Health Liaison can use the TOP facilitation method to guide the training or use the Community Health Improvement Team already established community vision/mission. These joint discussions will lead to shared understanding moving forward towards the stated vision of the Florida Department of Health: Vision: To be the Healthiest State in the Nation.



Health Equity Vision



II. PURPOSE OF THE HEALTH EQUITY PLAN

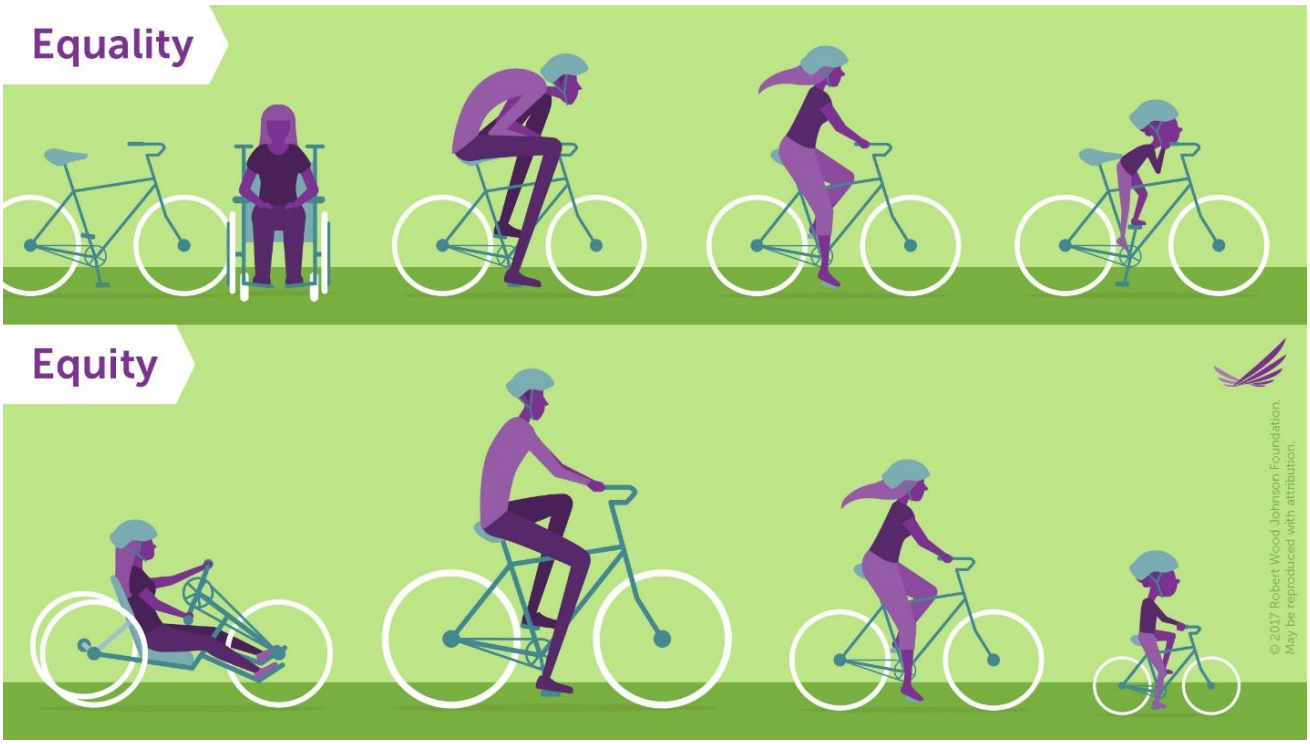
Health Equity is achieved when everyone can attain optimal health.

The Florida Department of Health's Office of Minority Health and Health Equity (OMHHE) works with government agencies and community organizations to address the barriers inhibiting populations from reaching optimal health. A focus on health equity means recognizing and eliminating the systemic barriers that have produced disparities in achieving wellness. In response to Chapter 2021-1700 of the Florida Statute, effective July 1, 2021, each county health department (CHD) has been provided resources to create a Health Equity Plan to address health disparities in their communities.

The Health Equity Plan should guide counties in their efforts to create and improve systems and opportunities to achieve optimal health for all residents, especially vulnerable populations. County organizations have a critical role in addressing the social determinants of health (SDOHs) by fostering multi-sector and multi-level partnerships, conducting surveillance, and integrating data from multiple sources, and leading approaches to develop upstream policies and solutions. This plan acknowledges that collaborative initiatives to address the SDOHs are the most effective at reducing health disparities.

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

III. DEFINITIONS



Health equity is achieved when everyone can attain optimal health.

Health inequities are systematic differences in the opportunities that 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 (SDoH) are the conditions in which people are born, grow, learn, work, live, worship, and age that influence the health of people and communities.

(Reference materials from the Office of Minority Health and Health Equity Onboarding Training session for Minority Health Liaisons: May 2022).

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.

Intergenerational Women's Group

Finding Solutions for Striving Families

Tallahassee, lies within Leon County Florida, was founded in 1824 and serves as the capital of the state of Florida. According to the 2020 US Census' American Community 5-Year Estimates, Leon County encompasses 702 square miles, with a population of roughly 291,863 residents with diverse backgrounds. The demographics of Leon County are White 60.2%, Black 31.2%, Asian 3.6%, 5% other races, and Hispanic/Latino (all races) 6.6%. In addition, most residents 25 years and older are high school graduates (93.4%), and more than one- third have a bachelor's degree or higher (46.6%), allowing a stable median household annual income of $54,675 between the years of 2016-2020. (Reference: Office of Minority Health and Health Equity CDC Accelerator Plan)

However, approximately 19.6% residents are live below the poverty level and approximately 7.8% do not have health insurance. According to the University of Wisconsin Population Health Institute, County Health Rankings, Leon County is ranked number 16 in overall health outcomes in the state of Florida in

2020. Despite its overall good health status, Leon County still has disparate communities with significant numbers representing health inequities related to the social determinants of health.

Data from 2018-2020 published by the Florida Department of Health as Health Equity Profile 2020 in FL Health CHARTS outlines racial and ethnic disparities in all 67 counties. This report shows the difference in various health outcomes among non-Hispanic White and Black residents. Based on data in this report, Black residents experienced poorer health outcomes related to chronic diseases including obesity, cardiovascular disease as well as infant mortality, STDs, HIV, and tobacco use. One neighborhood will be highlighted here to draw attention to the collaborative impact partnerships with shared vision and goals, leveraging resources can change the landscape of a striving community to one of sustainable and resilient outcomes. Office of Minority Health and Health Equity CDC Accelerator Plan

Griffin Heights, commonly known as Springfield, is located northwest of downtown Tallahassee and was built in the early 1900s. Since the1970's, the residents have witnessed the quality of the neighborhood housing decline and a scarcity of resources.

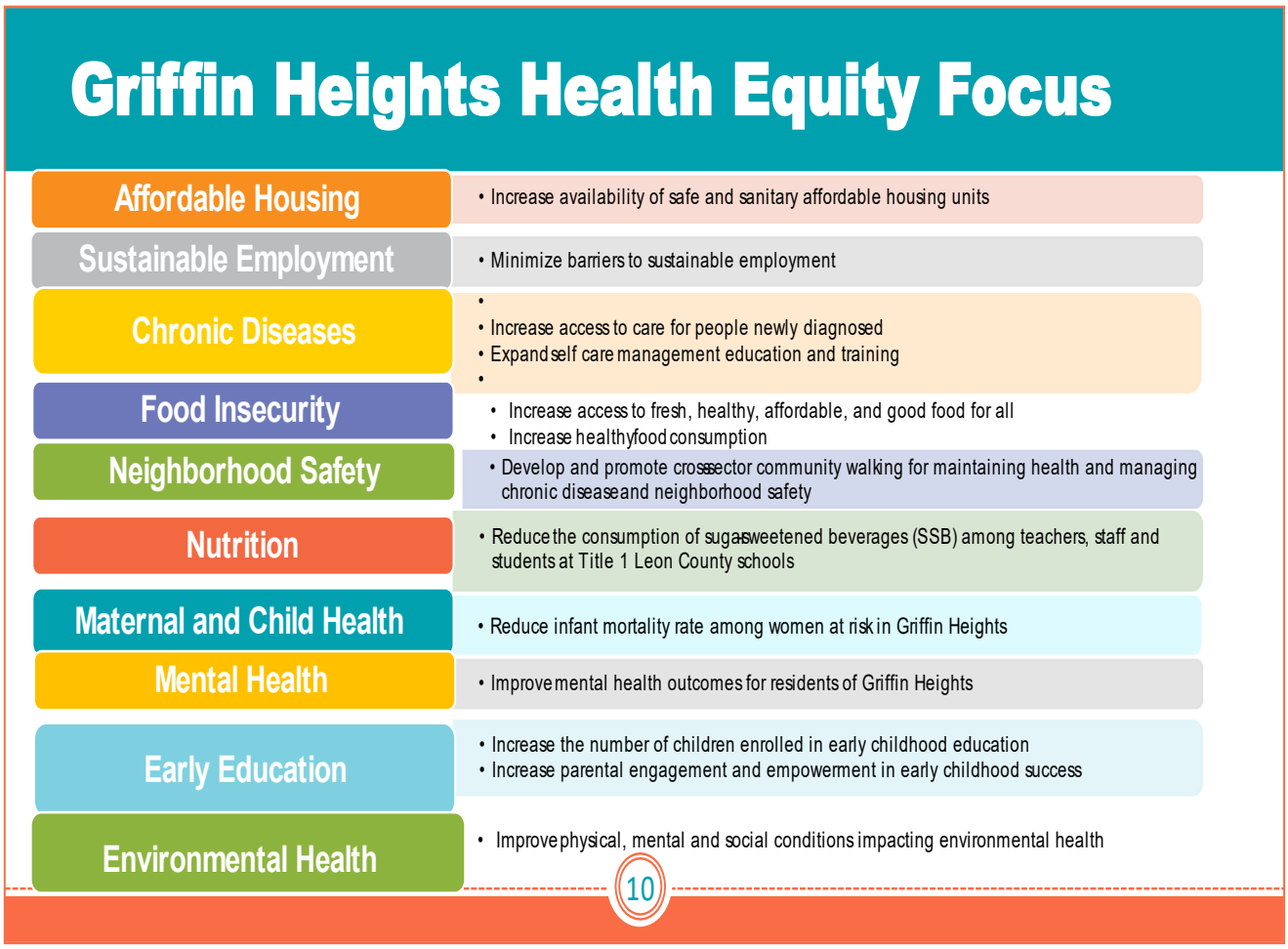
The community of Griffin Heights neighborhood has about 5,478, of which 68.2 percent are African American located in the zip code of 32304. This community was chosen according to the Florida of Commerce report Florida because it has the highest rates of poverty in. The Florida State University Urban and Regional Planning conducted a survey within the community to address the issues and concerns of the neighbors.

According to the individuals living within this area, Griffin Heights faces high crime volumes, poor infrastructure, lack of access to healthy food and resources, and economic advances. Concerns with children in the area include safety and health-related issues regarding speech, hearing, vision, or movement. Many of the residents have transportation challenges and walk to reach various services.

For example, there are no grocery stores near Griffin Heights, and the closest grocery store is over two miles. In addition, to access to healthy foods, Griffin Heights residents have limited access to health care and wellness activities. Approximately 9.8% of residents in Griffin Heights have no health insurance and are below the average community.

Providing easy access to healthcare services and wellness activities to residents in the community would be a valuable resource. Like most communities, they too strive for educational opportunities and academic success for their children, economic advancement, and health equity. To address these inequities our work begins with the Minority Health Liaisons' focus on the Social Determinants of Health (SDoH) through the application of their Health Equity lens.

(Office of Minority Health and Health Equity CDC Accelerator Plan)



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: Ms. Mary Miaisha Mitchell
Minority Health Liaison Backup: Mr. Marcus West
Minority Health Liaison Backup: Dr. Jacquelynn M. Hairston

B. Health Equity Team

The Health Equity Team includes individuals that each represent a different program within the CHD. The Health Equity Team explores opportunities to improve health equity efforts within the county health department. Members of the Health Equity Team assess the current understanding of health equity within their program and strategize ways to improve it.

The Health Equity Team also relays information and data concerning key health disparities and SDOH in Leon County to the Health Equity Taskforce. The Minority Health Liaison provides technical support to enhance discussions for implementation of initiatives. Four County Health Department Programs make up the Health Equity Team inclusive of: Tobacco, Healthiest Weight, Breast and Cervical Cancer and Community Health and Planning as described in the Health Equity Plan Template. The membership of the Health Equity Team is listed below:

Name	Title	Program
Mr. Marcus West	Division Director	DOH-Leon Community Health and Planning Division
Dr. Jacquelynn M. Hairston	Human Services Analyst	DOH-Leon Community Health and Planning Division
Ms. Arianna Waddell	Operations Analyst II	DOH-Leon Community Health and Planning Division
Ms. Mary Miaisha Mitchell	Minority Health Liaison	DOH-Leon Community Health and Planning Division
Trishay Burton	OPS Human Services Program Specialist	DOH- Leon Community Health and Planning/OMH-Health Equity
Ms. Shelia Morris	OPS Community Engagement Specialist Liaison	DOH-Leon Community Health and Planning Division
Ms. Nicole Everett	OPS Community Engagement Specialist - Behavioral Health Navigator	DOH-Leon Community Health and Planning Division
Ms. Maja Troupe	OPS Community Engagement Specialist	DOH-Leon Community Health and Planning Division,
Ms. Talethia Edwards	OPS Community Engagement Specialist,	DOH-Leon Community Health and Planning Division
Ms. Lauren Wade	Health Educator Consultant SES	DOH-Leon Health Education Division
Ms. Natasha “Monique” Coleman	Human Services Program Specialist	DOH-Leon Health Education Division
Ms. Leigh Miles	Health Educator, Healthiest Weight	DOH-Leon Health Education Division
Mr. Darrell Feagin	Health Educator, Tobacco Free Florida	DOH-Leon Health Education Division
Ariel Ward	OPS Human Services Program Specialist	DOH-Leon Health Education Division
Sylvia Hooker	Community Health Support Aide	DOH-Leon Health Education Division

The Health Equity Team met on the below dates during the health equity orientation, training, and early planning process. Since the Health Equity Plan is not completed, selected members of the Health Equity Team, stakeholders and community members have met at least monthly to track progress.

Meeting Date	Topic/Purpose
June 2021-June 2022 Ongoing	Neighborhood First Plans & Community Conversations
6/23/21	Office of Minority Health & Health Equity and Leon County Health Department Overview Meeting
11/23/21	CDC CTG FDOH meeting
12/22/21	SDOH Accelerated Grant meeting
January 15th, 2022	CDC Quarterly Report Meeting revolving SDOH Accelerated Plans
2/23/22 Monthly-June	Quarterly Staff Meeting on Health Equity
4/12/22	6 Month Review SDOH Meeting
4/21/22	SDOH Agenda Meeting
5/3/22	SDOH Health Equity Management Meeting
6/16/22	Monthly Minority Health Equity Liaison meetings
January-June 2022	Monthly Minority Health Equity Liaison meetings
Ongoing July2022-June 2023	Weekly Divisional internal meetings reporting Health Equity

C. Health Equity Taskforce

The Health Equity Taskforce includes CHD staff, CHIP members, neighborhood and representatives from various organizations shared their knowledge about community needs and the social determinants of health that might impact health outcomes. DOH's Collaboration within this group addresses upstream factors to achieve health equity. Input from the Health Equity Taskforce contributes to the final Leon County Health Equity Plan guides the Minority Health Liaison in the design and implementation of projects. Health Equity Taskforce members are listed below:

Name	Title	Organization	Social Determinant of Health
Mr. Marcus West	Division Director	DOH-Leon Community Health and Planning Division	Health Care Systems, Access and Quality, Built Environment, Housing, Education, Food, Economic Stability, Social and Community Context
Dr. Jacquelynn M. Hairston	Human Services Analyst	DOH-Leon Community Health and Planning Division	Health Care Access and Quality, Neighborhood safety, crime and violence against women and girls, Education
Ms. Mary Miaisha Mitchell	Minority Health Liaison – Human Services Program Specialist	DOH-Leon Community Health and Planning Division	Built Environment, Cultural and Linguistic Competency, Community Engagement, food insecurity, maternal and child health, clinical linkages
Trishay Burton	Human Services Program Specialist	DOH-Leon Health Education Division	Maternal child health, health and nutrition, physical activity
Dr. Michelle Gayle	Assistant Superintendent	Leon County Schools	Education, Access, and Quality
Mr. Rodney Landers	Community Action Team Co-Leader	Griffin Heights Neighborhood First Plan	Built Environment, Economic Development, Food Insecurity
TBA		Florida Department of Transportation	Transportation, Built Environment
Ashley Edwards	Director	City of Tallahassee Parks and Recreation	Built Environment and Economic Development
John Baker	Manager	City of Tallahassee Neighborhood Affairs	Built Environment and Economic Development Neighborhood Safety
Karen Woodall	Executive Director	Florida People's Advocacy Center	Social Support Networks
Marcellas Durham, Jr.	Family Services Case Manager	Capital Area Community Action Agency	Resident Empowerment
Brenda Williams	Executive Director	Tallahassee Housing Authority, Florida	Affordable housing, built environment, economic stability
Joedrecka Brown Speights M.D.	Professor and Chair, Department of Family Medicine, and Rural Health	Florida State University College of Medicine	Quality of care, Community based participatory research, health inequities, Clinical Linkages,
Alison Wiman	Executive Director	Big Bend AHEC	Health care access: Tobacco Cessation and Education
Courtney Atkins	Executive Director	Whole Child Leon	Early Childhood Education
Jim Murdaugh	President	Tallahassee Community College Workforce Department	Education Access and Quality, Economic Development in 32304 Prosperity for All Champion

Name	Title	Organization	Social Determinant of Health
Dr. Larry Robinson	President	Florida Agricultural and Mechanical University Dept. Of Psychology	Education Access and Quality, 32304 Prosperity for All Champion
Dr. Richard D. McCullough	President	Florida State University	Education, Access, and Quality, Prosperity for All Champion

Meeting Date	Organizations	Meeting Date
Monthly Meetings June 2021-2022	Florida State University College of Medicine, University of Florida Extension Services, Citizens, Scientists, Community Health Workers	Monthly Meetings June 2021-2022
Second Wednesday Monthly & Quarterly Reporting Jan-June 2022	Florida Department of Health Tobacco Partnership	Second Wednesday Monthly & Quarterly Reporting Jan-June 2022
Quarterly CHIP Meetings Monthly Coalition Meetings as scheduled	Apalachee Mental Health Mental Health Coalition Big Bend	Quarterly CHIP Meetings Monthly Coalition Meetings as scheduled
*Transitional Issues Staffing Turnover Yet to identify lead agency	Career Source Tallahassee Community College Workforce Development	*Transitional Issues Staffing Turnover • Yet to identify lead agency
Quarterly Developmentary Screening Equity Task Force Meetings (Monthly)	Whole Child Leon Early Childhood Education CHIP	Quarterly Developmentary Screening Equity Task Force Meetings (Monthly)
Weekly Meetings Jan-June 2022	Capital Area Healthy Start Coalition • 5-year service plan • Healthy Babies Work Plan • Community Health Improvement Plan	Weekly Meetings Jan-June 2022

Ongoing weekly workshops, education, outreach, and training sessions. Jan-June 2022	• Department of Health • HIV/STD • Chronic Disease • WIC • Environmental Health • Community Health & Planning	Ongoing weekly workshops, education, outreach, and training sessions. Jan-June 2022

The Minority Health Liaison connects at least monthly with representatives of the Health Equity Taskforce during the health equity for orientation, training, and planning process. Since the Health Equity Plan is not completed, the Health Equity Taskforce has continued to meet at least quarterly to track progress. These ongoing meetings and conversations are preparing members to focus on equity terminology incorporation of the health equity lens within their perspective organization.

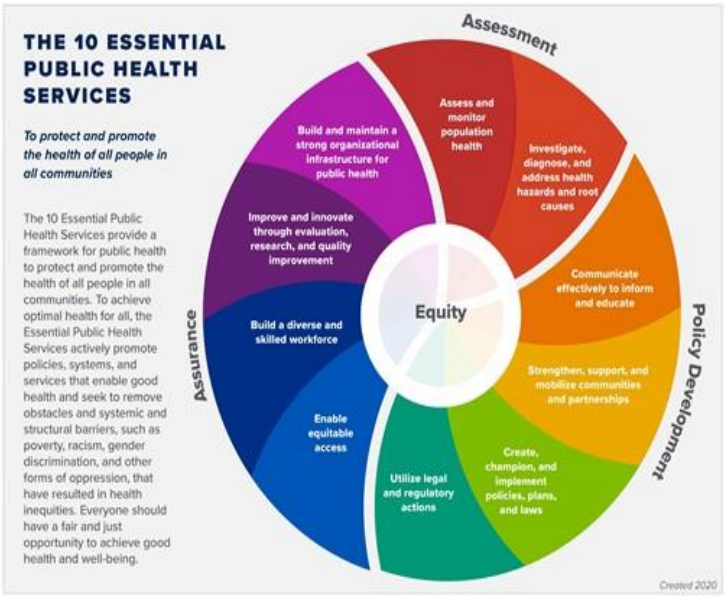
D. Health Equity Coalition

The Leon County Health Department has ongoing discussions on strategies to improve the health of the community by embodying the **LCHD Mission "To protect, promote & improve the health of all people in Florida through integrated state, county, & community efforts**. Building strong coalitions with residents to address things that matter to them are strategies that not only encompass health and well-being but also community engagement aspects of mutual respect, shared vision, and collaborative partnerships.

Using Evidence Based Practices (EBP) focused on a System of Care that is family oriented, youth-focused, community driven in adherence to cultural-linguistic competency (CLC) are additional strategies focused on the social determinants of health: education access and quality, health care access and quality, economic stability, food insecurity, maternal child health, social and community issues, and neighborhood and built environment. Membership includes community leaders working to address each SDOH, as well as any clinical linkages related to the SDOHs. Bi-Monthly Community Conversations provide space for community and providers to discuss topics impacting the quality of life of the residents in Tallahassee/Leon County.

These forums will assist the Health Equity Taskforce and Coalition in reviewing their Health Equity Plan for feasibility. Such engaging sessions are also designed to acquaint members with the Health Equity Framework for suggested program strategies, measurements, data practices, and policy recommendations that leads towards advancing total equity. Regular interactions, technical support, training, coordination and other resource support from our Regional Health Equity Coordinator, Mr. Quincy Wimberly, further strengthens our health equity work.

USING OUR HEALTH EQUITY LENS



SYSTEMS
PARTNERS
STAKEHOLDERS
RESIDENTS
YOUTH
COMMUNITY
CULTURE
FAMILY
WELL- BEING

Look at the prospective Coalition Members listed below:

Sector/Focus Area	Name/Organization/Title	Contact information
United Way of the Big Bend (UWBB)	Bernice Cox Executive Director	Work: (850)414-0855 Email: berneice@uwbb.org
Neighborhood First Plans Representatives *(32304 zip code and HWY 20 neighborhood in particular, neighborhood facing adversities, food insecurity, food access, community safety (xenophobia/racism))* *www.Talgov.com*	Rodney Landers Griffin Heights Neighborhood Mutaqee Akbar Frenchtown Neighborhood Talethia Edwards Bond Neighborhood Walter McDonald Providence Neighborhood	Cell:850-212-8143 Corhan674@gmail.com Cell: 850-228-1419 m.akbar@akbarlawfirm.com Cell: 850-933-9235 Toedwarda1069@yahoo.com Cell: 561-929-3901 walterwmcdonald@gmail.com
Big Bend Habitat for Humanity (Housing)	Antoine Wright Executive Director	Work: (850)-574-2288 Email: awright@bigbendhabitat.org
The Leon County Sheriff's Office *(neighborhood safety, diversion/mediation programs, juvenile incarceration, impacts of incarceration of parent/guardian, community re-entry program/services)*	Sheriff Walter McNeil, _____ _____ Shonda Knight, Executive Director of Community and Media Relations, The Leon County Sheriff's Office	Work: (850) 606-3345 Email: mcneilw@leoncountyfl.gov Work: (850) 606-3270 Email: knights@leoncountyfl.gov
FSU Center for Criminology and Public Policy Research- (Primary Investigator)	Thomas G. Blomberg, Ph.D., Executive Director	Work: (850)-644-7365 Email: tblomberg@fsu.edu
Education *(ACEs, educational attainment, youth unemployment, discipline, trauma-informed interventions, MBHS)*	Ann Meisenzahal Leon County Schools	Work: (850) 322-6884 Email: annabelle58@embargmail.com

Tallahassee Housing Authority Housing	Brenda Williams Executive Director	Work: (850) 385-3126 • Brendawilliams@Tallha.org
City of Tallahassee Neighborhood Affairs	John Baker, Manager	Work: (850) 891-8773 Cell: (850) 294-5069 John.Baker@talgov.com
Office of Human Service and Community Partnerships	Shington Lamy	Work: (850)606-1900 Cell: (305) 989-7831 LamyS@leoncountyfl.gov
Council on Neighborhood Associations CONA	Christic Henry	Cell: (850)509-5559 christic@southcityfoundation.org
Parks and Recreation (*green space, infrastructure, safety, zoning, relationships with law enforcement*)	Ashley Edwards City of Tallahassee	Work: (850) 891-3863 Ashley.edwards@talgov.com
Leon County Detention Center *(neighborhood safety, diversion/mediation programs, impacts of incarceration of parent/guardian, workforce development programs, recidivism, trauma-informed services, re-entry program/services)*	Asst. Sheriff Steve Harrelson, The Leon County Sheriff's Office	Cell: (850)606-3362 harrelsons@leoncountyfl.gov
Equity Tallahassee Leon Group *(legacy of slavery in communities, history of mistrust within communities of color, community supports that help build resilience, HBCU presence and moving towards equity)*	Courtney Atkins Whole Child Leon	Work: (850) 692-3134 Email: courtneyatkinswcl@gmail.com courtney@wholechildleon.org
United Partners for Human Services	Amber Tynan, Executive Director, United Partners for Human Services (UPHS)	Work: (850)-296-8330 Cell: (850)-590-3439 Email: amber@uphsfl.org

(food insecurity, affordable housing, access to MHBH services)		
City of Tallahassee – StarMetro Transportation (public transportation or physical mobility in general—are the roads safe? Does public transportation provide adequate access to communities with high % of transit-dependent populations? In my mind these are linked with food insecurity and human services)	Kwentin Eastberg, Staff to the Local Transportation Disadvantaged Coordinating Board _____ William E. "Bill" Herndon, Special Transportation Manager	Work: (850)-488-6211 ext. 105 Email: keastberg@arpc.org _____ Work: (850)-891-5200 Email: William.Hearndon@TalGov.com
Economic/small business development and/or chamber of commerce (*economic impact of universities*, *workforce, and industry growth)*	Cristina Paredes, CEO, Director Tallahassee-*Leon County Office of Economic Vitality*	Work: (850) 219-1080 Email: cparedes@oevforbusiness.org
Food banks/assistance	Second Harvest of the Big Bend Monique Van Pelt	Work: (850) 562-3033 x222 monique@fightinghunger.org
Capital Area Justice Ministry	Lead Organizer: Leah Wiley	Work: (727) 403-5434 capitalareajustice@gmail.com www.capitalareajustice.org
Adverse Childhood Experiences (ACES)Abuse, Neglect and Household Dysfunction	Mimi Graham Director of Florida State University Center for Prevention and Early Intervention Policy	Work: (850)922-1302 Cell: (850)510-7770 mgraham@fsu.edu
Children's Services Council	Cecka Rose Green, CEO	Cell:850-688-2140 cgreen@cscleon.org
Children's Services Council and Homeless	Liza McFadden	lizamcfadden@lizapartners.com

Leon County Office of Sustainability	Tessa Schreiner	Work: (850) 606-5021 schreinert@leoncountyfl.gov
Tallahassee Chamber of Commerce	Sue Dick President/CEO	Work: (850) 521-3100 Cell: (850)509-0794 sdick@talchamber.com
CareerSource Capital Region	Jim McShane CEO	Work: (850) 617-4601 Cell: (850) 559-3860 Jim.mcshane@careersourcecapitalregion.com
Tallahassee Lenders' Consortium, Inc. d/b/a TLC	Karen Miller Executive Director	Work: (850)222-6609 x 100 Pam Greene – Assistant Director pgreene@tallahasseelenders.org
Tallahassee Food Network, Inc. (TFN) iGROW WhateverYou Like	Dr. Qasimah P Boston Chairman of the Board	Cell: (912)220-5663 abarakaq@aol.com
Capital Area Community Action Agency	Marcellas Durham, Jr., Family Services Case Manager for Leon County & The Getting Ahead Program	O: (850) 347-0898 x 201 Work Mobile: (850) 688-6033 Marcellas.durham@cacaainc.org Mobile: (321) 400-4413 durhammarcellas@gmail.com

E. Regional Health Equity Coordinators

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

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

Health Equity Assessment, Training, and Promotion

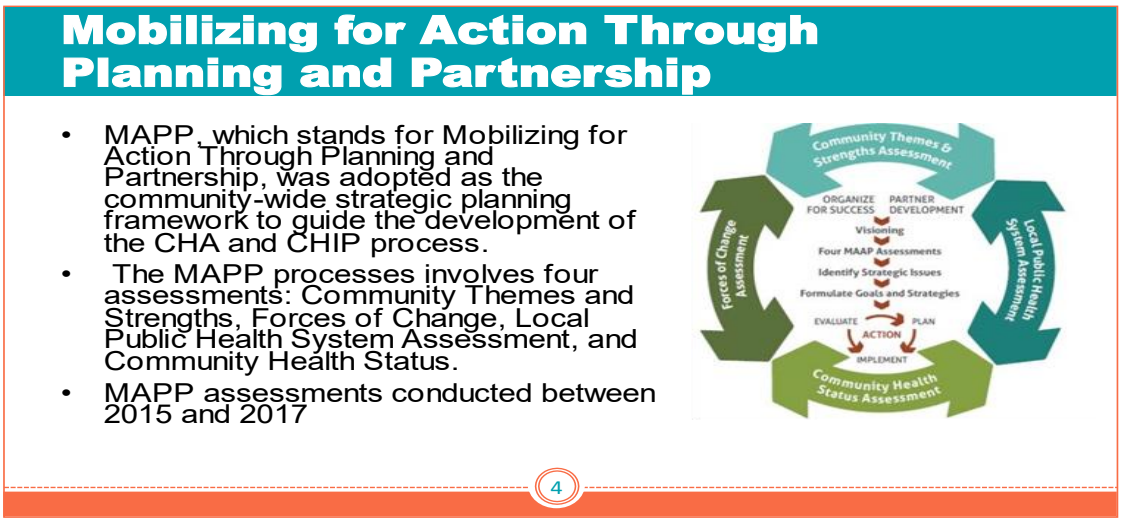
A. Health Equity Assessments

Leon County will choose to use assessments related to Culturally and Linguistically Appropriate Services CLAS Standards, cultural competency, Health Equity Assessments, or others to improve health outcomes in Florida. It is critical to assess the knowledge, skills, organizational practices, and infrastructure necessary to address health inequities. Health equity assessments are needed to achieve the following:

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

Leon County is participating in the **Resilience Catalyst** work group with seven other cities to speak to the Root Causes of why people are poor. The previous Health Officer applied for the opportunity to be considered for this prestigious appointment as one of the counties in the United States. LCHD teamed up with George Washington University, American Public Health Association (APHA), National Association of City and County Health Officials (NACCHO) and the Center for Disease Control.

This Resilience Catalyst group of local teams of key informants, leadership and Chief Health Strategist will address housing, public education, criminal justice, and law enforcement to drive initiatives that address ACEs, injury prevention, opioid misuse, suicide, food insecurity and the impact of structural racism on community characteristics, such as homelessness, juvenile incarceration rates and educational attainment. And now Pandemic: often framed as a social determinants of health.



Leon County recruited stakeholders, CHIP leaders, partner/community voices and internal staff feedback health equity assessment(s) to examine the capacity and knowledge of Leon County CHD staff and county partners to address social determinants of health. Review and instrument markups were instructional in choosing to make adequate revisions to the tool. (Beginning February 8, 2022.)

This survey instrument was administered to 100+ internal staff members; has since been reduced from 90 questions and stakeholders initial review and feedback on the instrument further refined it by 50%. Stakeholders, staff, and Health Equity Team comments will assure that we are assessing the gaps in primary data and are avoiding duplicative secondary data sources from other instruments or datasets.

The intent with an interactive instrument is not only to capture study questions that people are not currently looking at but are applicable to our changing environment which requires incorporating our overarching Health Equity Lens. A few comments are captured below which will enhance our ability to employ our Health Equity Lens more effectively. The community health assessment should be reviewed and organized by three questions:

- should questions be added to the existing survey?
- are there missing questions that should be included?
- should questions be deleted from the initial survey?

Below are the dates assessments were distributed and the partners who participated.

Date	Assessment Name	Organizations Assessed
February 15, 2022	• Clinical Linkages all with Equity Lens • not combining "*No Opinion/Don't Know*" as one response • need to include a measure on health literacy. • food security/insecurity • environmental health. • women's health issues • pertinent pandemic issues • Intimate partner violence has increased during the pandemic. • Add several preconception health questions • questions about racism and discrimination • issues including taking folic acid, • health before pregnancy, • experiences of stress • stress management • involvement of father of the child • new terminology related to pregnancy is pregnant persons. • overall perception of 1) what are the barriers to your best health, 2) what are the barriers to your best healthcare? • ask the everyday racism questions: https://scholar.harvard.edu/davidrwilliams/node/32397 • ask about community resilience and strengths- which areas help provide strength that could be bolstered or focused on for better health- faith, community, other?	Stakeholders from academia sought to view the CHA with eye on Pandemic, forces of change for new metrics
May 2022 - June 2022	CHIP Leadership all with Equity Lens	Members of the CHIP Leadership reviewed the 102 CHA questions to reduce the number of questions by half

Date	Assessment Name	Organizations Assessed
		and seeking to sought by similarities and distinctions
February 14, 2022	Community and Partner Engagement	Prior community members and volunteers reviewed the questions using an equity lens and attention to cultural and linguistic competency
January 2022 February 21, 2022	Internal staff • Are we trying to capture the same information from the previous CHA? For example, the CHA asked, "Have you ever had a mammogram?" While the available secondary data measures "having had a mammogram within the previous two years." • Is there available secondary data that drills down to all the focus areas (Bond, Chaires, Fairbanks, Greater Frenchtown, Highway 20, Macon, South City, Woodville)? For example, the Macon Community's boundaries fall within a block group. The secondary data for the behavioral risk factor measures only drill down to the census tract level.	Focused on duplicity and stories from the field that might hinder willingness to participate, scope, access, and reach.

Over the next year, the Florida Department of Health in Leon County will be working with residents and community partners to complete the 2022 - 2027 Leon County Community Health Assessment (CHA). The Community Health Assessment identifies health issues of primary concern and, more importantly, provides critical information to those in a position to impact the health of our region, such as local government, elected officials, social and human services agencies, businesses, and health care providers and consumers.

One primary goal of the CHA is to help increase understanding of our community's current health, both through specific health indicators and community input regarding issues and areas of concern. In turn, this information aids in the development of the Community Health Improvement Plan (CHIP). The CHIP

presents a long-standing, organized effort to address health issues in a community based on results from the CHA.

The health department is required to complete the CHA/CHIP process every three to five years, in which the last CHA was completed in 2016. The previous assessment included six focus areas.

• Highway 20/Aenon Church Road	• Bond/Southside Area
• Griffin Heights/ Frenchtown Area	• Fairbanks Ferry Road
• South City	• Macon Community

Unlike the previous CHA, the upcoming process will be conducted using a Health Equity Lens to address the social determinants of health and the gaps, challenges, and barriers as well as a glance into the focus on changes that occurred during the pandemic that could prevent attainment of optimal health and well-being. The target areas were selected based on high poverty rates, low median household income, low homeownership, and health indicators such as: household food insecurity, mortality rates, health status and unhealthy air quality.

B. County Health Equity Training

The Minority Health Liaison will identify knowledge gaps and create training plans for the Health Equity Taskforce, the Coalition, and other county partners to assess their capacity and knowledge of Health Equity. The Minority Health Liaison and Regional Coordinator, using specific activities conducted by the Health Equity Team will develop a shared understanding of health equity in Leon County through training and dissemination of resources.

The Health Equity Team will use the model from DOH Leadership Team in the onboarding training for the Taskforce and the Coalition including *Cultural Awareness: Introduction to Cultural Competency* and *Addressing Health Equity: A Public Health Essential* training. In addition to the perspectives and recommendations from the Regional Health Equity Coordinator, Health Equity Taskforce and Coalition, our expert partners, and stakeholders can offer training in other areas of need such as: Motivational Interviewing, Community Engagement and Community Based Participatory Research. See one example below:

Community Engagement

- **WHAT IS CBPR? Community Based Participatory Research**
- **CBPR is a partnership approach to research involving collaboration**
- **between community members and researchers in all aspects of the**
- **research process. From problem identification to research design, to**
- **analysis and policy recommendations, community members are**
- **partners in every step. CBPR partnerships require equitable sharing of**
- **power, resources, knowledge, and credit**

Below are the dates, SDOH training and orientation discussion topics used by the Health Equity Team to educate community partners and organizations who attended training about the intent of the Health Equity Workplan. Primary discussions were directed towards how to incorporate a Health Equity Lens into the work currently being done in their perspective organizations.

Date	Topics	Organization(s) receiving trainings
February - November 2021	– FROM WORDS TO ACTION A Practical Guide and Toolkit for Operationalizing Diversity, Equity & Inclusionary Guidebook, Assessment, Training, and Implementation UPHS Guidebook - https://uphsfl.org/wp-content/uploads/2021/09/UPHS-DEI-Guidebook-and-Toolkit.pdf	United Partner for Human Services Agencies, City of Tallahassee representatives, County Community Human Service leadership and non-profit organizations
February 16th, 2022	Community Conversations- Health Equity Lens & SDOH	FSU, Healthy Start Coalition, Gadsden Health advisory group, multiple stakeholders/ organizations
March 7, 2022	Diversity, Equity, Inclusion (DEI) and Advocacy Resource Guide from UPHS introduced to community representatives	FSU Community Conversations, Human Service Providers Community Residents
March 2022	CHSP incorporates mandatory DEI training for human service providers seeking City/County funding	200=+ human service providers
2nd Quarter 2022	CHIP Leadership shared Stakeholder perspectives on incorporating Health Equity Lens into the review and update to CHA and CHIP in alliance with SHIP.	Mental Health Council of the Big Bend, Tallahassee Memorial Hospital, Apalachee Mental Health, Whole Child Leon, Capital Area Healthy Start- Leon County STD and HIV

Monthly, 2022	Intergenerational Women's Group	Florida's Peoples Advocacy Center

C. County Health Department Health Equity Training

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

Date	Topics	Number of Staff in Attendance
January 25, 2022	Cultural Competency and Health Equity in Public Health Planning	Get attendance from Mrs. White
March 18, 2022	Health Equity and Social Determinants of Health	Six Health Equity Taskforce members
April 7, 2022	Maternal Child Health Week Proclamation, City Commission Meeting	2 members of Health Equity Team were in attendance

D. Minority Health Liaison Training

The Office of Minority Health and Health Equity and the Health Equity Regional Coordinator provide training and technical support to the Minority Health Liaison on topics such as: the health equity planning process and goals, facilitation, and prioritization techniques, reporting requirements, and taking a systems approach to address health disparities. Key members of the Health Equity Taskforce are highly skilled experts who can assist with post training, health equity assessments. measurements and evaluation. Several Minority Health Liaison trainings are recorded below.

Date	Topics
January 25, 2022	Cultural Competence & Health Equity Training
January 27, 2022	Health Equity Team Planning Meeting

February 18, 2022	Regional Health Equity Coordinator with Minority Health
March 3, 2022	Health Equity & SDOH Orientation Training
March 9, 2022	Minority Health Liaison Check in with MH Regional Coordinator
March 22, 2022	Health Equity Template Review Meeting
April 13, 2022	Minority Health Liaisons Onboarding Training
April – June 16, 2022	Health Equity Plan Meetings with the Regional Minority Health Liaisons

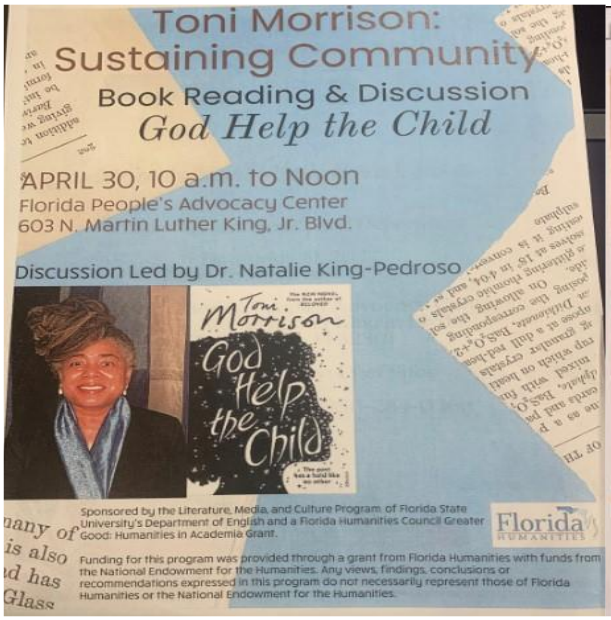
E. National Minority Health Month Promotion

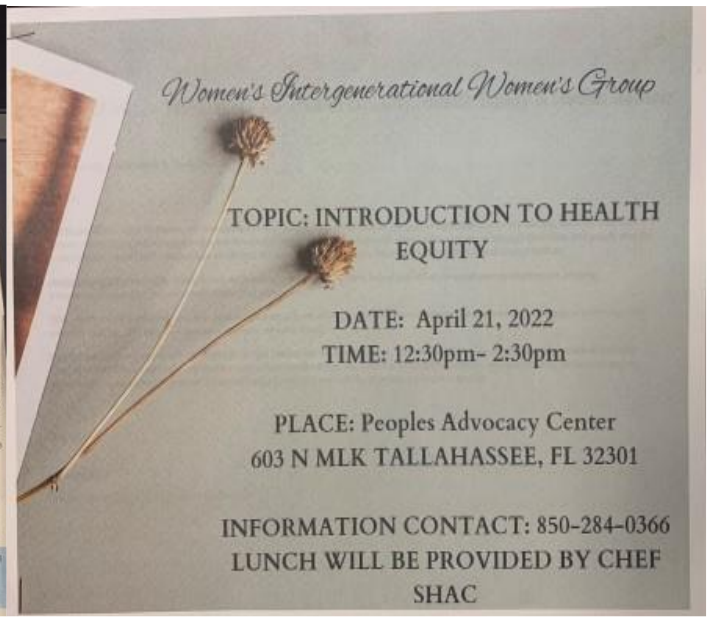
April is Minority Health Month Theme: Give Your Community A Boost

Date	Event	Time	Location	Organizer	Disparity	SOHD
April 2, 2022	Collards and Cornbread	10-12 pm	Tallahassee Food Network, iGROW Community Garden 611 Dent St Tallahassee, FL.32304	Mary Miaisha Mitchell	Infant and Maternal Mortality	PACE -EH Built Environment Place Matters Zip Code 32304
April 7, 2022 -	SNAP Education	5:00pm - 7pm	Lawrence Gregory Community Center Dade Street 32304	Shelia Morris	Obesity	Physical Activity Nutrition Food Insecurity Transportation
April 11, 2022 -	Maternal Child Health Seminar	11:30 -1pm	Virtual	Talethia Edwards	Maternal Mortality	Structural Racism Pre- conception Health
April 14, 2022 -	Community Minority Health Activity	7pm Virtual	Zoom ID - 925 5399 9317 Pass Code: 364939	By Omega PSI Phi Fraternity Inc Health Seminar	Diabetes, Cancer	Health and Neighborhood Safety
April 18, 2022	Black Women & Sexual Awareness	2 pm	FACEBOOK Live & YouTube	Nicole Everett	Mental Health Cancer HIV	Affordable Care
April 18, 2022	Black Women & Sexual Awareness	2 pm	FACEBOOK Live & YouTube	Nicole Everett	Mental Health Cancer HIV	Affordable Care
April 20, 2022	CORE Resource Fair	6pm -8pm	Walker Ford Community Center Bond Community 32310	CHD Team Wil Provide Health Educational Display Table	Chronic diseases Diabetes, CVD	Access/Insurance Health Literacy
April 21, 2022	Women's Intergenerational Women's Group	12:30 -2:30pm	Florida People's Advocacy Center 603 N. MLK, Jr. Blvd 32301	Mary Miaisha Mitchell and Chasedi Peoples	Introduction to Health Equity	Social Determinants of Health
April 23, 2022	Minority Health Fair	8am-3pm	Bethel Missionary Baptist Church 32303	Leon CHD will Provide Health Educational Display Table	Mental Health	Postpartum Depression ACE 's
April 25-30 2022	Healthy Heart	1pm -2pm	Peacock Center 528 West Brevard Street 32304	Maja Troupe	Cardiovascular Disease	Economic Stability Income

During the National Minority Health Month Promotion more than 15 events were held in communities with partners, residents, and colleagues. Below is a snapshot of events and several pictures to capture the energy and boost to the community. Attention to the health disparities ranged from Infant and maternal mortality, food insecurity, obesity/diabetes, environmental health, men's health, educational displays, mental health, cancer, and other chronic diseases. Families engaged in lots of fun activities, met new neighbors, shared good food, and the events reached over 250+ participants.

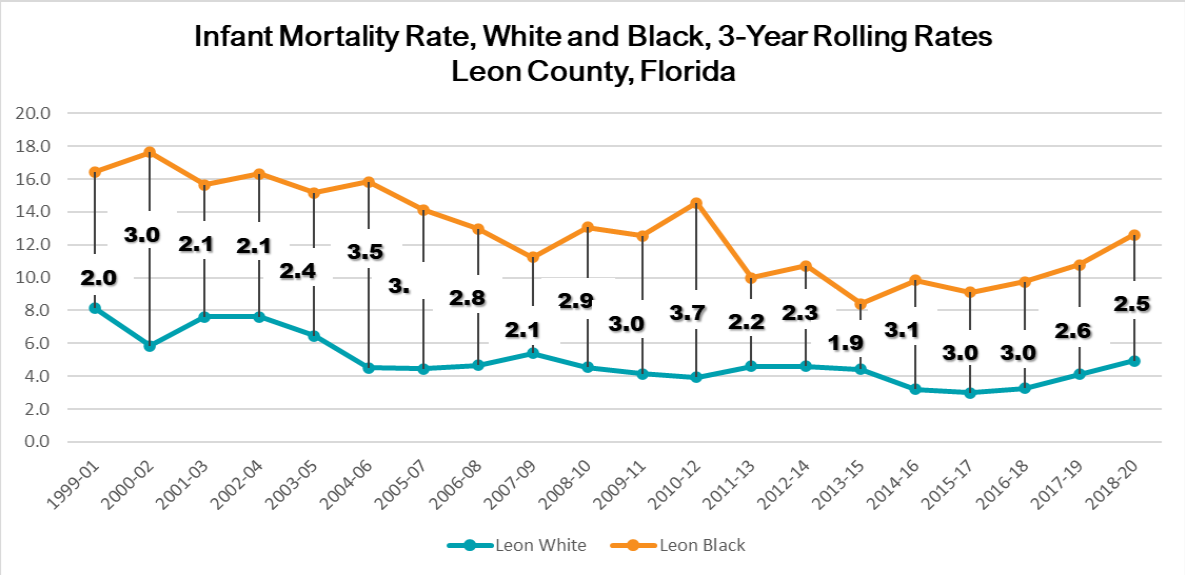
National Minority Health Month in April included a special event with Melanin Mothers Meet, a community partner. The City of Tallahassee, Mayor John Dailey, Commissioners: Dianne Williams-Cox, Jack Porter, Jeremy Matlow, and Curtis Richardson recognized community stakeholders with a Proclamation for Black Maternal Health Week. The event is online at the City of Tallahassee Commission Meeting website, talgov.com, and was featured on minority media outlets with talking points about Health Equity. Several other Minority Health Month activites are highlighted below:





V. PRIORITIZING A HEALTH DISPARITY

In Leon County, black infants are **2.5 times** more likely to die before their first birthday than white infants. In 32304, there were 1,743 live births and 15 infant deaths. These deaths correspond to a rate of 8.6. Black infants accounted for 72.0% (1,255 births) of the total live births in the ZIP Code. Additionally, they represented about 93.3% or fourteen of the fifteen infant deaths in the 32304 area according to the Florida Department of Health, Bureau of Vital Statistics.



The Health Equity Team reviewed and identified health disparities data in Leon County. Data was pulled from multiple sources including Florida Charts, Feeding America, Healthy People 2030 and the Florida Department of Health, Bureau of Vital Statistics to focus on vulnerable and marginalized populations. Priority Population include racial minorities, ethnic minorities, LGBTQ+ populations, the elderly, children, communities with low socio-economic status, people with disabilities, veterans. pregnant women and other groups at risk for health disparities.

The following health disparities were identified in Leon County:

- Infant Mortality
- Maternal Mortality and
- SDOH.

Using **FL Charts** data source and the ***Protocols for Assessing Community Excellence in Environmental Health*** (PACE-EH) method, the Health Equity Team decided to work on Infant Mortality in the Health Equity Plan. Infant and maternal mortality have long been topics of discussion in minority communities. **Black women are over 3 times more likely to die from a pregnancy-related cause**

than white women in Leon County. This focus will allow greater attention and the action necessary to address health inequity with broad based collaborators.

PACE-EH strongly encourages formation of partnerships with various groups in the community to provide services across all sectors that highlight health and wellness in the Built Environment. The ***Protocols for Assessing Community Excellence in Environmental Health*** 13 elements fully describe the tasks to be implemented for a healthier community.

Educating residents regarding issues of food insecurity, health and wellness are of top priority for residents. Supplemental Nutrition (SNAP), Invest Health national support to Food Insecurity, healthy weight, air and water quality, pollution, EJ Screen, affordable housing, City Clean Energy Plan, as well as environmental justice with local, regional, and national partners are a part of PACE-EH.

PACE-EH and another partner; NACCHO provides a variety of prioritization matrices to review with the Health Equity Taskforce, the Coalition and the health Equity Team. This will start an education and training model to begin this process. We will propose the use of Community Engagement, CBPR and Clinical Translation Science Initiatives (CTSI) as evidence-based methods to address this health disparity, using our Health Equity Lens.

The National Renewable Energy Lab grant will increase resident knowledge on solar and renewable energy with several job opportunities. Funding to educate residents on air monitoring was awarded from national partner in the Moving Forward Network and will allow families who are energy burden to get some relief from the stressors and anxieties reported during pandemic. Many are still facing environmental conditions and associated challenges.

These SDOH are applicable to the goals, objectives, and strategies used in the COPE (Childhood Obesity Prevention Education's model and vision for *healthy babies, healthy families, and healthy communities. Our collaborators at FSU.*

Why Maternal and Child Health Equity?

- ***Strong history of community organizing among Black residents in Leon and Gadsden counties***
- ***Recent Infant Mortality data sparked interest in exploring determinants of poor birth outcomes***
- ***Promoting health equity=key component of FSU College of Medicine Mission***
- ***Community -based participatory research approach***
- ***Emphasis on translating research findings into strategic action for change***

Florida State University College of Medicine Health Equity Partners

Maternal & Child Health, 2018-2020		
Indicators	**Leon**	**Florida**
Infant Deaths (< 365 Days) per 1,000 Births	All: 9.1 White: 5.0 Black: 12.6	All: 6.0 White: 4.3 Black: 11.0
Black-White Ratio:	**2.52**	**2.56**
% Live Births Under 2500 Grams	All: 10.4% White: 6.6% Black:15.2%	All: 8.7% White: 7.1% Black: 14.0%
Black-White Ratio:	**1.46**	**1.97**
% Live Births Less than 37 Weeks Gestation	All: 11.2% White: 8.5% Black: 14.7%	All: 10.4% White: 9.3% Black: 14.4%
Black-White Ratio:	**1.73**	**1.55**
% Births with Prenatal Care 3rd Trimester or No Prenatal Care	All: 6.3% White: 4.8% Black: 8.3%	All: 7.2% White: 6.5% Black: 9.3%
Black-White Ratio:	**1.73**	**1.43**
% Mothers who Initiate Breastfeeding	All: 81.6% White: 89.5% Black: 71.6%	All: 85.9% White: 87.9% Black: 78.3%
White-Black Ratio:	**1.25**	**1.12**
Maternal Deaths, Rate Per 100,000	All: 45.4 White: 22.5 Black: 77.1	All: 20.1 White: 15.2 Black: 36.5
Black-White Ratio:	**3.43**	**2.40**
Source: Florida Department of Health, Bureau of Vital Statistics		

The table above shows that black infants have a higher burden of adverse health outcomes than white infants. Additionally, they are more likely to die before their first birthday than white babies. Black mothers are also more likely to receive late or no prenatal care than white mothers.

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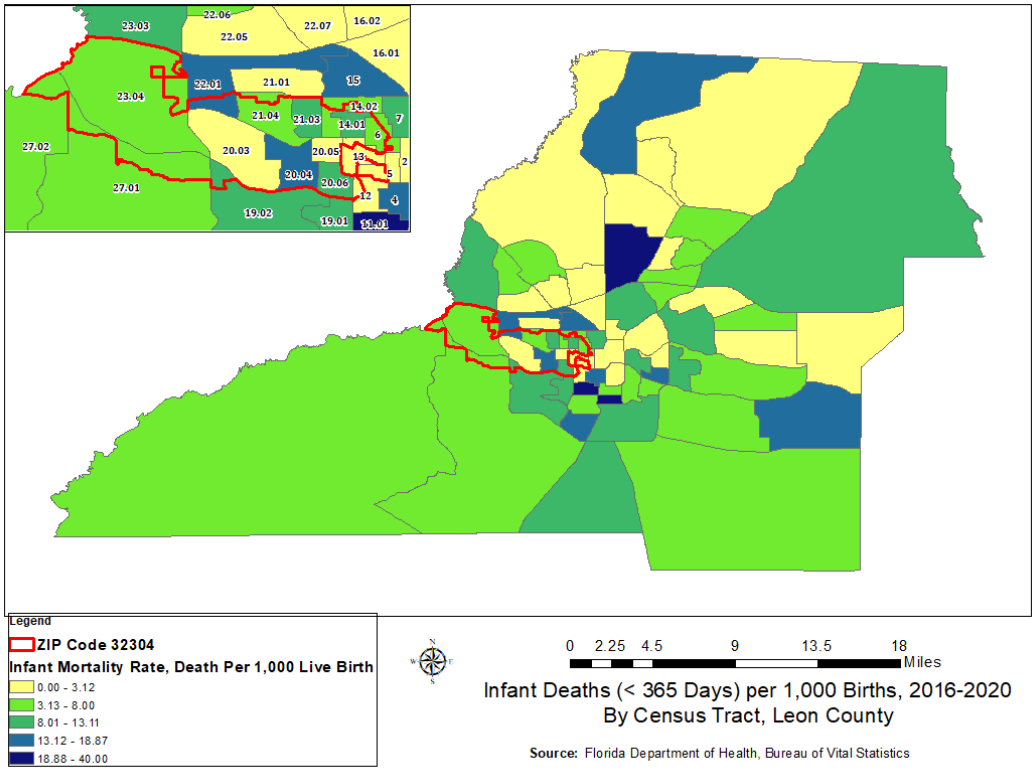
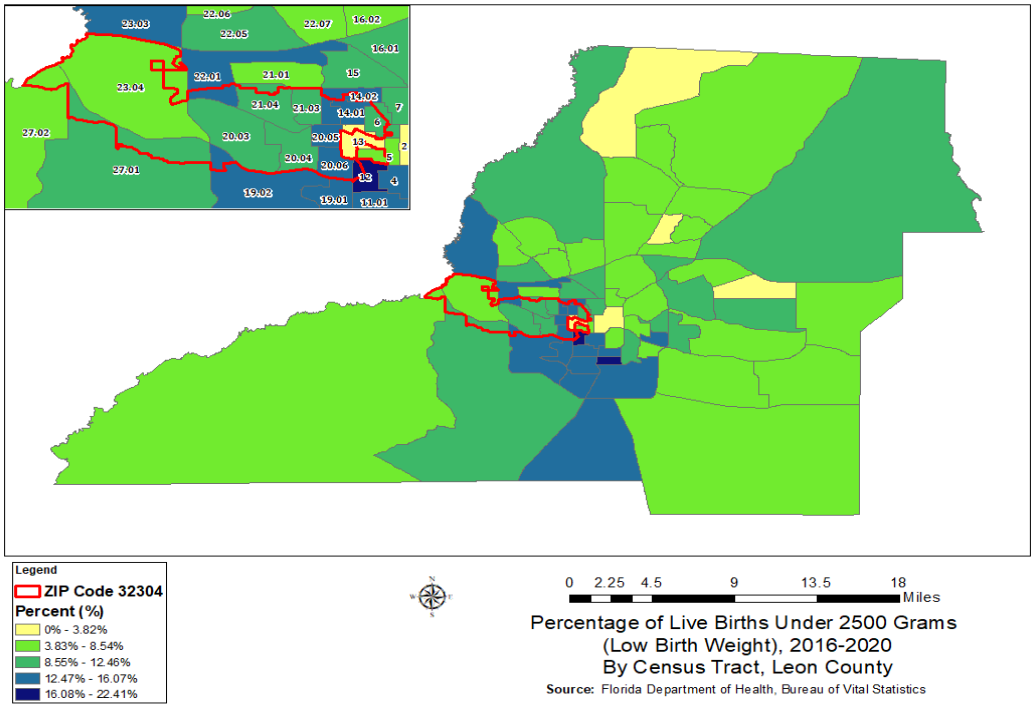
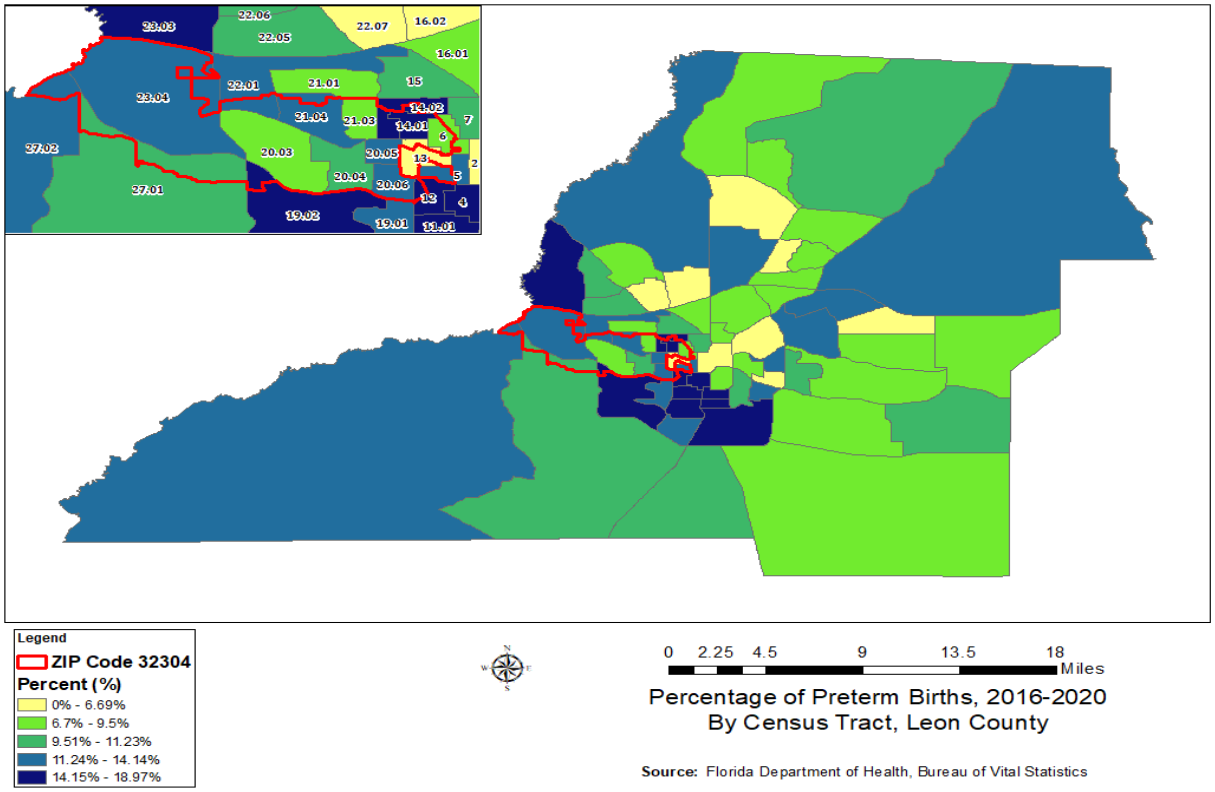
Unintentional suffocation and strangulation in bed was the leading cause of infant death in Leon County, from 2018-2020		
Causes of Infant Deaths in Leon County, 2018-2020	**Number of Deaths**	**Infant Death Rate**
Unint Inj: Suffocation & Strangulation In Bed (W75)	10	1.1
Extreme Low Birth Weight or Extreme Immaturity (P07.0, P07.2)	6	.7
Premature Rupture of Membranes (P01.1)	6	.7
Incompetent Cervix (P01.0)	5	.6
Other Ill-Defined and Unspecified Causes of Mortality (R99)	4	.5
Sudden Infant Death Syndrome (R95)	4	.5
Maternal Complications of Pregnancy (P01.2-P01.4, P01.6-P01.9)	3	.3
Other Congenital Anomalies (Q10-Q18, Q86-Q89)	3	.3
Other Perinatal Conditions (P29, P70.3-P70.9, P71-P76, P78-P81, P83.0-P83.1, P83.3-P83.9, P90-P96)	3	.3
Blood, Blood-Forming, Hemorrhagic Diseases (D65-D76)	2	.2
Cardiomyopathy (I42)	2	.2
Chorioamnionitis (P02.7)	2	.2
Congenital Anomalies of Musculoskeletal Sys (Q65-Q85)	2	.2
Congenital Anomalies of Respiratory Sys (Q30-Q34)	2	.2
Edward's Syndrome (Q91.0-Q91.3)	2	.2
Hydrops Fetalis Not Due to Hemolytic Dis (P83.2)	2	.2
Multiple Pregnancy (P01.5)	2	.2
Necrotizing Enterocolitis (P77)	2	.2
Placenta Complications (P02.0-P02.3)	2	.2
Respiratory Distress (P22)	2	.2
Slow Fetal Growth & Fetal Malnutrition (P05)	2	.2
Acute Bronchitis & Acute Bronchiolitis (J20-J21)	1	.1
All Other Diseases (F01-F9, H00-H57, L00-M99, O00-O99)	1	.1
Anoxic Brain Damage (G93.1)	1	.1
Cerebrovascular Diseases (I60-I69)	1	.1
Congenital Anomalies of Genitourinary Sys (Q50-Q64)	1	.1
Congenital Anomalies of Heart (Q20-Q24)	1	.1
Congenital Pneumonia (P23)	1	.1
In Situ/Benign/Malignant Neoplasms Uncert/Unk Behavior (D00-D48)	1	.1
Other & Unspec Genitourinary System Dis (N00-N15, N20-N23, N26, N28-N98)	1	.1
Other Chromosomal Anomalies (Q92-Q99)	1	.1
Other Cong. Anomalies Central Nervous System (Q01-Q02, Q04, Q06-Q07)	1	.1
Patau's Syndrome (Q91.4-Q91.7)	1	.1
Source: Florida Department of Health, Bureau of Vital Statistics		

In Leon County, black infants are <u>2.5 times</u> more likely to die before their first birthday than white infants.



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ZIP Code 32304
Percent (%)
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6.7% - 9.5%
9.51% - 11.23%
11.24% - 14.14%
14.15% - 18.97%
0 2.25 4.5 9 13.5 18
Miles
Percentage of Preterm Births, 2016-2020
By Census Tract, Leon County
Source: Florida Department of Health, Bureau of Vital Statistics


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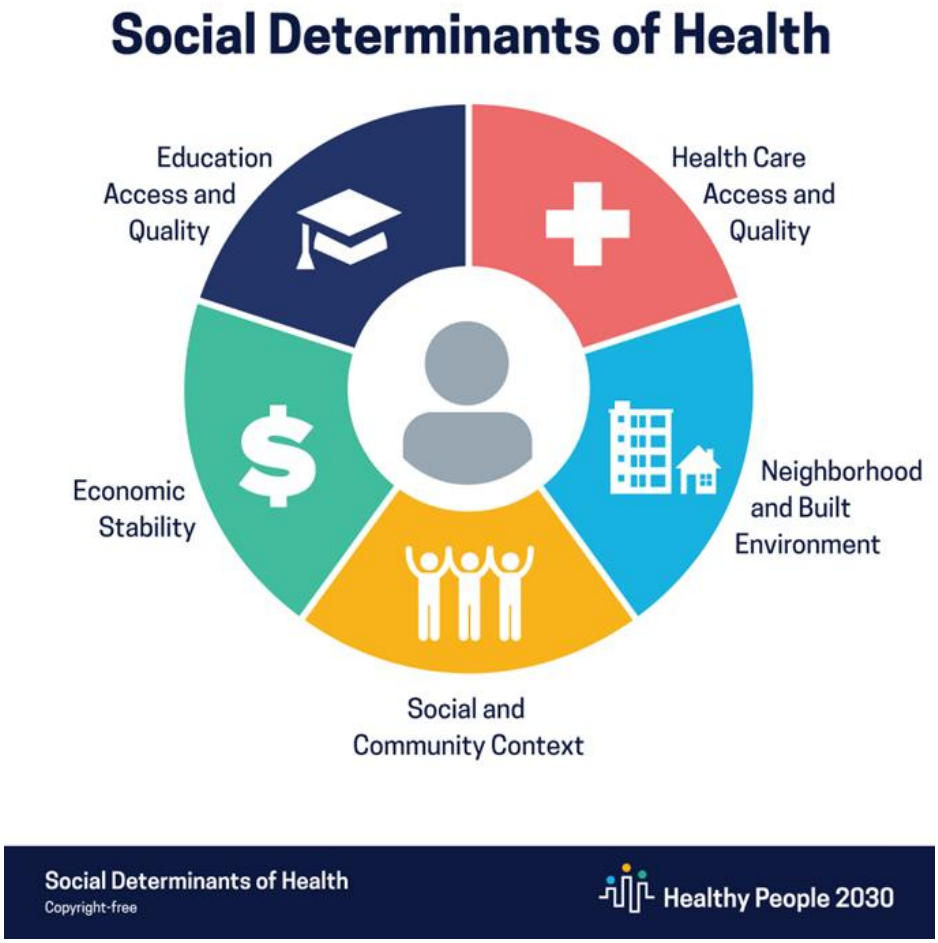
VII. SDOH DATA

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



A. Education Access and Quality

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

Increase the proportion of 8th-graders with reading skills at or above the proficient level — AH-R04

Fifty-one percent of 8th graders in the Leon County School District passed the English Language Arts portion of the Florida Standards Assessments (FSA).

Leon County School District, English Language Arts, Spring 2022 Results

						Percentage in Each Achievement Level				
District Number	District Name	Grade	Number of Students	Mean Scale Score	Percentage in Level 3 or Above	1	2	3	4	5
00	STATE TOTALS	08	212,986	334	49	30	21	23	16	10
37	LEON	08	2,301	335	51	30	19	22	17	12

Source: Florida Department of Education

Increase the proportion of 8th-graders with math skills at or above the proficient level — AH-R05

Only 34% of Leon County 8th graders passed the mathematics section of the FSA. This percentage is lower than the state's average of 42 percent.

The test results for 17 of the Leon County Schools are available. The results showed that 13 out of the 17 schools had less than 50 percent of the 8th graders passing the mathematics assessment.

Leon County School District, Mathematics Florida Standards Assessment, Spring 2022 Results

District Number	District Name	Grade	Number of Students	Mean Scale Score	Percentage in Level 3 or Above	Percentage in Each Achievement Level				
						1	2	3	4	5
00	STATE TOTALS	08	150,381	329	42	36	23	23	10	8
37	LEON	08	1,548	325	34	44	22	23	7	5

Source: Florida Department of Education

Increase the proportion of 4th-graders with reading skills at or above the proficient level — AH-05

About 54% of 4th graders in the Leon County School District passed the English and language arts portion of the FSA. The lowest passing rates were among Title I Schools, Success Academy (0%), Griffin (22%), Woodville (30%), Ft. Braden (30%), and Nims (31%).

Leon County School District, English Language Arts, Spring 2022 Results

District Number	District Name	Grade	Number of Students	Mean Scale Score	Percentage in Level 3 or Above	Percentage in Each Achievement Level				
						1	2	3	4	5
00	STATE TOTALS	04	198,473	312	57	23	20	25	21	10
37	LEON	04	2,376	311	54	24	21	23	21	11

Source: Florida Department of Education

Increase the proportion of 4th-graders with math skills at or above the proficient level — AH-06

Fifty-eight percent of Leon County 4th graders passed the mathematics portion of the FSA.

Leon County School District, Mathematics Florida Standards Assessment, Spring 2022 Results

District Number	District Name	Grade	Number of Students	Mean Scale Score	Percentage in Level 3 or Above	Percentage in Each Achievement Level				
						1	2	3	4	5
00	STATE TOTALS	04	194,936	314	61	24	15	26	22	14
37	LEON	04	2,377	313	58	28	15	23	20	14

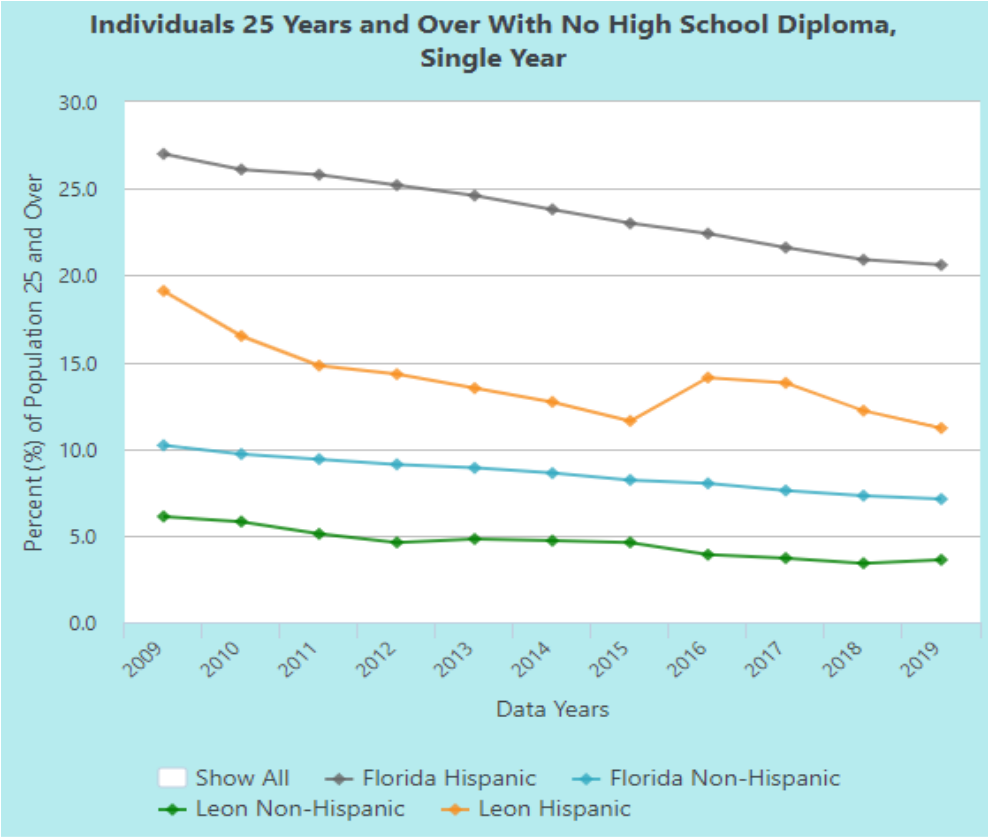
Source: Florida Department of Education

Increase the proportion of high school graduates in college the October after graduating — SDOH-06

Leon School District, 2018-19, Florida Graduates Who Enrolled in Any Florida Higher Education	
Category	**Percentage**
Total Students	64.3%
Economically Disadvantaged	54.7%
English Language Learners	35.7%
Students with Disabilities	48.7%
American Indian/Alaskan Native	*
Asian	62.6%
Black/African American	56.2%
Hispanic	65.6%
Multiracial	70.2%
Native Hawaiian/Other Pacific Islander	*
White	70.3%
Female	68.5%
Male	59.6%
*Data are suppressed when the total number of students within a subgroup (across all categories) is less than 10 and is noted by an asterisk (*).	
Source: Florida Department of Education	

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

In 2019, the percentage of individuals 25 years and over with no high school diploma in Leon County was 7.4% compared to Florida at 11.8%. The percentage of Hispanic individuals 25 years and over in Leon County, with no high school diploma, was 11.1% compared to non-Hispanic individuals at 5.2%. The line graph shows change over time. Lack of a high school diploma impacts (prioritized health disparity) by (process and impact). To improve (prioritized health disparity), Leon County is addressing ethnic disparities related to achieving a high school diploma. Partners with the Griffin Heights Children and Families Resource Center have included educational attainment in their logic model during the next 5 years of the Neighborhood First Plan. Griffin Heights has the second highest ranking of residents with less than a high school diploma (14.01) among the 27 census tracts in zip code 32304.



Mothers without a high school education were more likely to give birth to an infant with low birth weight or born prematurely than mothers with at least a high school diploma.

Birthweight by Mother's Educational Level, 2018 to 2020, Leon County							
Educational Level	**< 2500 grams (LBW)**		**2500+ grams**		**Unknown Birthweight**		**Total**
	#	**%**	**#**	**%**	**#**	**%**	
No High School Diploma	107	14.2%	646	85.8%		-	753
High School Graduate or Higher	798	10.0%	7,204	90.0%		-	8,002
Unknown Educational Level	12	19.0%	50	79.4%	1	1.6%	63
Total	**917**	**10.4%**	**7,900**	**89.6%**	**1**	**-**	**8,818**
Source: Florida Department of Health, Bureau of Vital Statistics							

Preterm Births by Mother's Educational Level, 2018 to 2020, Leon County							
Educational Level	**<37**		**37+**		**Unknown Weeks**		**Total**
	#	**%**	**#**	**%**	**#**	**%**	
Less than High School Diploma	109	14.5%	643	85.4%	1	0.1%	**753**
High School Graduate or Higher	862	10.8%	7,134	89.2%	6	0.1%	**8,002**
Unknown Educational Level	13	20.6%	47	74.6%	3	4.8%	**63**
Total	**984**	**11.2%**	**7,824**	**88.7%**	**10**	**0.1%**	**8,818**
Source: Florida Department of Health, Bureau of Vital Statistics							

- **The impact of education access and quality on Infant Mortality**

Education Access and Quality		
SDOH	**Vulnerable Populations Impacted**	**How the SDOH Impacts (Infant Mortality)**
Education	All racial ethnic minorities LGBTQ Economically Disadvantaged and People with disabilities	Poor reading levels and vocabulary, low graduation rates, storytelling, parent, and children reading hour to improve Health Literacy and Language, Early Childhood Development. Educate family, father, friends, and others in village on maternal care.

Education	All racial ethnic minorities LGBTQ Economically Disadvantaged and People with disabilities	1000-word challenge to support pregnant moms, readiness for kindergarten and 3rd grade retention
Vocational Training	All racial ethnic minorities LGBTQ	Focus on partnerships with trades schools, community colleges and community apprenticeships
Higher Education	Single parent households Minority Men and Boys	High school dropouts., speaking to the pipeline and crime, 14.01 CT has highest % of single-family households
Health Care System	Elderly, Teens	Community reach on HIV education and sexual activity and spread of diseases among women and vulnerable populations, Limited Linguistics and Cultural competency training Making sure moms in the house have support for their desired result (healthy baby). Surround mom with supportive thinking from family, father, and friends. Making sure the air quality in the home is good for baby and mom.

Teen Births

Births to teen mothers can indicate many risk factors, including low income, low maternal education, lack of access to or ineffective contraception or family planning practices, and the initiation of sexual activity at a young age. ZIP Code 32304 had a higher percentage of teen births (7.3%) compared to the rest of Leon County (4.8%) and Florida (4.6%).

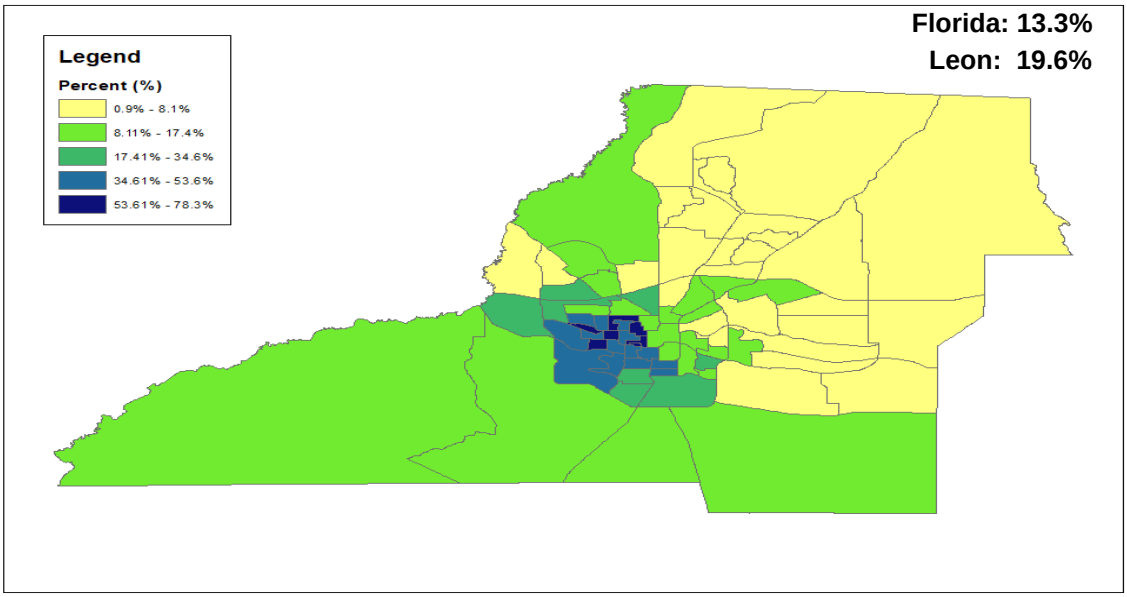
Race/Ethnic Group	Number	Percentage
White	19	4.6%
Black	102	8.1%
Other	6	8.2%
Unknown	0	0.0%
Hispanic	4	3.2%
Non-Hispanic	123	7.6%
Unknown	0	0.0%
Total	**127**	**7.3%**
Source: Florida Department of Health, Bureau of Vital Statistics, 2016-2020		

B. Economic Stability

- **Economic stability data for Leon County**

Reduce the proportion of people living in poverty — SDOH-01

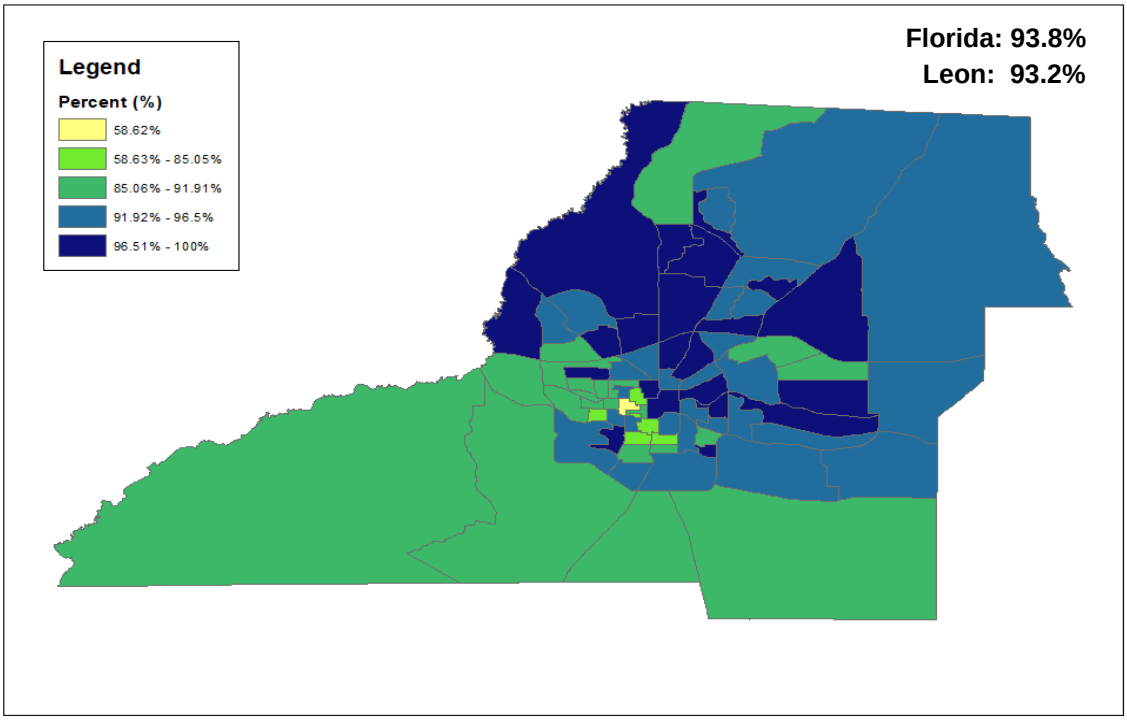
Percent of Persons were living Below the Poverty Threshold in Leon County By Census Tract



Source: 2020: ACS 5-Year Estimates

Increase employment in working-age people — SDOH-02

Percent of the Working-age Population aged 16 to 64 years were Employed in Leon County By Census Tract



Source: 2020: ACS 5-Year Estimates

- **The impact of economic stability on Infant Mortality.**

Economic Stability		
SDOH	**Vulnerable Populations Impacted**	**How the SDOH Impacts (Infant Mortality)**
Job insecurity	Low/Moderate, folk in the service industry	Pandemic caused loss of jobs across all sectors engagement in solar, renewable energy, environmental mediation, and job training Employment impact family well being Social integration; lack of networking; poverty, moms gaining access to more education on finding jobs, building healthy families, diet and motivated to make a living.
Financial Stability	Low to moderate	Undue burdens and stressors, depression, suicide Associated with limited income
Expenses	Those in poverty,	Making choices on use of limited household goods and services. Elderly and those on fixed incomes are challenged
Debt / Medical Bills	Heads of household, elderly, and persons with disabilities	food and medicine vs housing and utilities substandard housing
Infrastructure	Families and children, persons with disabilities and elderly	Sidewalks, parks, lightening, and pathways increased neighborhood safety concerns, limited seating at bus stops and lack of covering to shield from inclement weather
Transportation	All populations Racial and ethnic minorities, LGBTQ, persons with disabilities and elderly	Limited mobility and access to resources, cost of travel. Walking half a mile to catch a bus in extreme weather conditions, and
Food and Hunger	LMI. ALICE, all populations	COVID-19 impact food insecurity Healthy conversations around diet during pregnancy, labor, and delivery. Building confidence in speaking up for self.
Health Literacy	All populations	Ongoing education/understanding of COVID-19

C. Neighborhood and Built Environment

Community-Clinical Linkages

Aim 1: Identify communal and environmental factors that promote or hinder health-seeking behaviors among residents in the Griffin Heights neighborhood.

Responses to stressful social and economic conditions may take many forms, such as active efforts (overexertion) and unhealthy behaviors (smoking, alcohol abuse, opioid use) to respond to, and cope with those adverse conditions.

Residents in the neighborhood have stated there is limited access to educational, vocational, and employment resources/opportunities for youth and adults.

Aim 2: Better access to facilities, services and programming that support emotional, physical, and social health.

Limited access to health, mental health, and recreational resources for youth and adults.

Neighborhood residents must travel outside the community to access health and mental health services.

Residents also voiced that the following are the best ways to increase access to better health resources: (1) provide neighborhood health workshops, (2) provide safe spaces and counseling in the neighborhood, and (3) host mobile health units.

3

Project title: “Don’t Move. Improve!”:

Building Community Resilience at the
Griffin Heights Children & Families Resource Center

Why is this project Important?

The Griffin Heights Children & Family Resource Center (the Center) will serve as a community hub providing residents with resources, referrals, education, and training to address key human service needs related to health (including maternal/child health and mental health), nutrition, food access, child development, senior services, education, and employment. The Center will be in a public housing community within the Griffin Heights neighborhood in Tallahassee, FL. A building, owned by a local health center but not currently in use, has been leased and serves as the Center location.

A network of partners will work collaboratively to integrate service delivery with wraparound services and a more customized approach to quality care for children and families. Special attention will be paid to the cultural competencies and social determinants of health and related issues that matter to residents.

The Griffin Heights residents for that past three years have developed an action plan to bring about positive neighborhood change that focuses both on people and places. The Center has been identified by the neighborhood as one of the top projects and is key to neighborhood revitalization. The Center will serve as a catalyst for change, reduce barriers and provide a bridge for residents to access needed services. Addressing health and safety disparities is a primary goal. Support is needed in the form of building retrofits, technology, broadband networking, staffing and volunteer coordination, PPE's, marketing, and security infrastructure.

What makes this hometown so special?

Griffin Heights, an historically African American neighborhood located in the City of Tallahassee, FL, has many assets including its many passionate lifelong residents, active neighborhood association and rich neighborhood history. However, it also faces challenges including weakening social connections, a declining homeownership rate, encroachment from development and limited access to food and human services.

Griffin Heights residents are prepared to meet these challenges and have a long history of improving their community and creating opportunities for neighbors. The spirit of activism and hope to create a vibrant and thriving community can be seen through different initiatives over the years and as evidenced through the neighborhood motto, "Don't Move. Improve!"

In 2019 the Griffin Heights neighborhood began its Neighborhood First community planning effort, managed, and supported by the City's Neighborhood Affairs Division. Resident-led action teams identified four top priorities: Economic Development & Resident Empowerment, Neighborhood Safety & Crime Prevention, Community Beautification, and Neighborhood Infrastructure & Land Use.

Residents worked with partners to develop the "Griffin Heights Neighborhood First Plan" which was adopted by the Griffin Heights Neighborhood Association in the fall of 2020. Citizens continue to work hard and volunteer countless hours to enhance the quality of life in Griffin Heights. The commitment, creativity and tenacity of the residents is the driving force behind the Neighborhood First planning process and will generate assets as the plan is implemented. The neighborhood has a long history of important contributions to Tallahassee and the time for reinvestment is now.

Approximately how many people in this community will benefit from this project?

The Griffin Heights Children & Family Resource Center is open to all but will target residents of Griffin Heights and surrounding neighborhoods. As with many of Tallahassee's early neighborhoods, Griffin Heights has seen significant changes over the years. In 2018, the estimated population was 5,478 (2,221 households) representing an increase of over 13% since 2000. Outreach to 200 families at the Springfield Apartments public housing where the Approximately 190 units that house 607 residents, including 365 children is of central focus.

There is a demonstrated need for the Center. Residents of Griffin Heights have been historically underserved and have experienced the trauma of multiple instances of community violence. The neighborhood is also located within the poorest zip codes (32304) in the state, and one that has been most disproportionately affected by COVID-19 in Leon County.

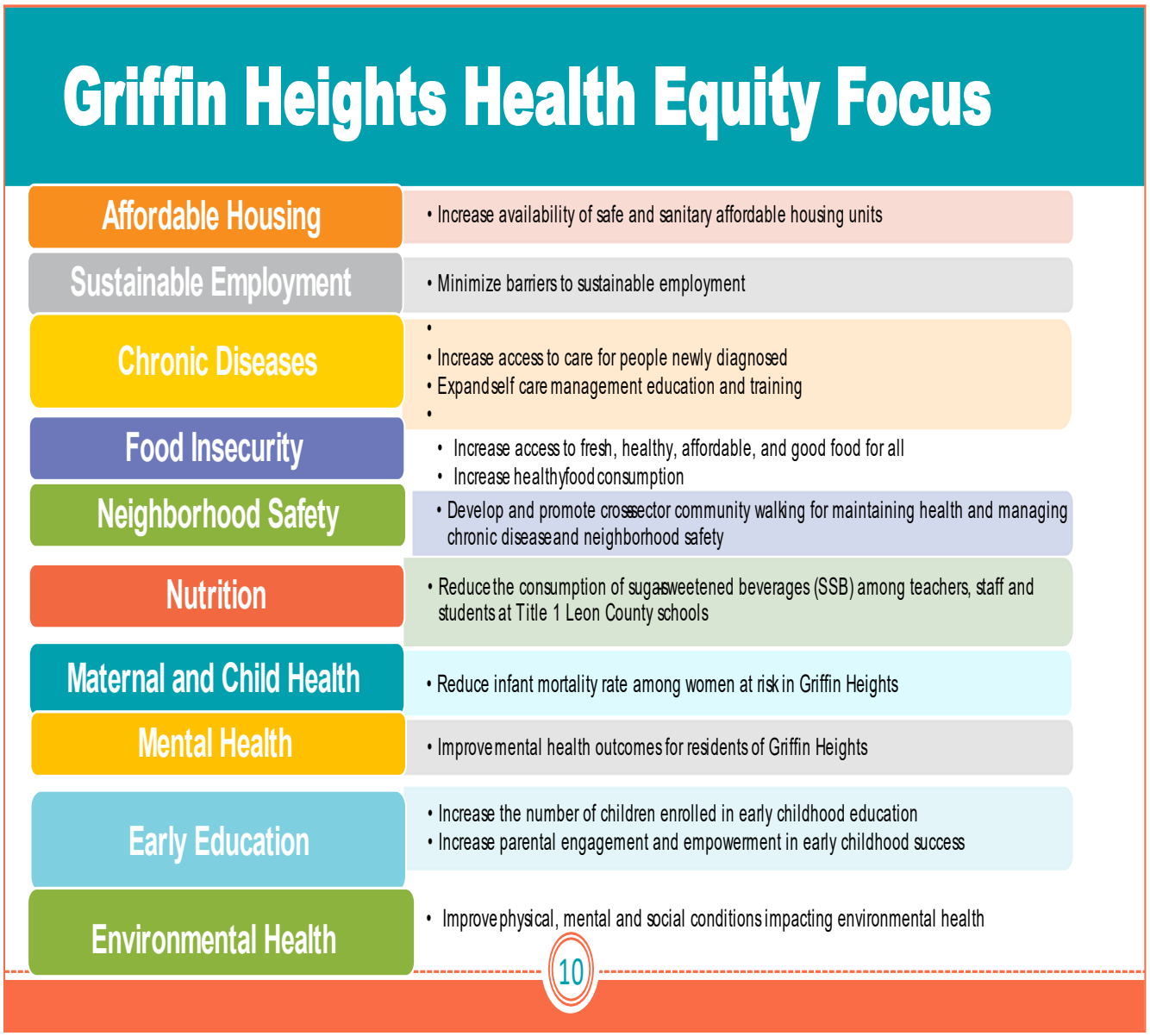
The average household size is 2.24 people, and the median household income is $24,959. Educational attainment in the community is diverse, as 22.4% of the population have a bachelor's degree or higher while 20.6% have not obtained a high school diploma or equivalent. Median age is 23.8 years old.

There are services out there to help families thrive, but they can often be difficult to navigate. The Center will act as a trusted "hub" to connect families to resources, support, and training. It will create opportunities for intergenerational connections and build capacity for residents to develop their own solutions to community issues and offer a safe space for community gathering.

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

Reduce the rate of minors and young adults committing violent crimes — AH-10

Number of Arrest, Leon County, 2019		
	Adult	Juvenile
Murder	23	3
Manslaughter	4	1
Forcible Rape	13	6
Robbery	40	11
Aggravated Assault	295	27
Source: Florida Department of Law Enforcement		


Griffin Heights Health Equity Focus
Affordable Housing
• Increase availability of safe and sanitary affordable housing units
Sustainable Employment
• Minimize barriers to sustainable employment
Chronic Diseases
•
• Increase access to care for people newly diagnosed
• Expand self care management education and training
•
Food Insecurity
• Increase access to fresh, healthy, affordable, and good food for all
• Increase healthy food consumption
Neighborhood Safety
• Develop and promote cross-sector community walking for maintaining health and managing chronic disease and neighborhood safety
Nutrition
• Reduce the consumption of sugar-sweetened beverages (SSB) among teachers, staff and students at Title 1 Leon County schools
Maternal and Child Health
• Reduce infant mortality rate among women at risk in Griffin Heights
Mental Health
• Improve mental health outcomes for residents of Griffin Heights
Early Education
• Increase the number of children enrolled in early childhood education
• Increase parental engagement and empowerment in early childhood success
Environmental Health
• Improve physical, mental and social conditions impacting environmental health
10

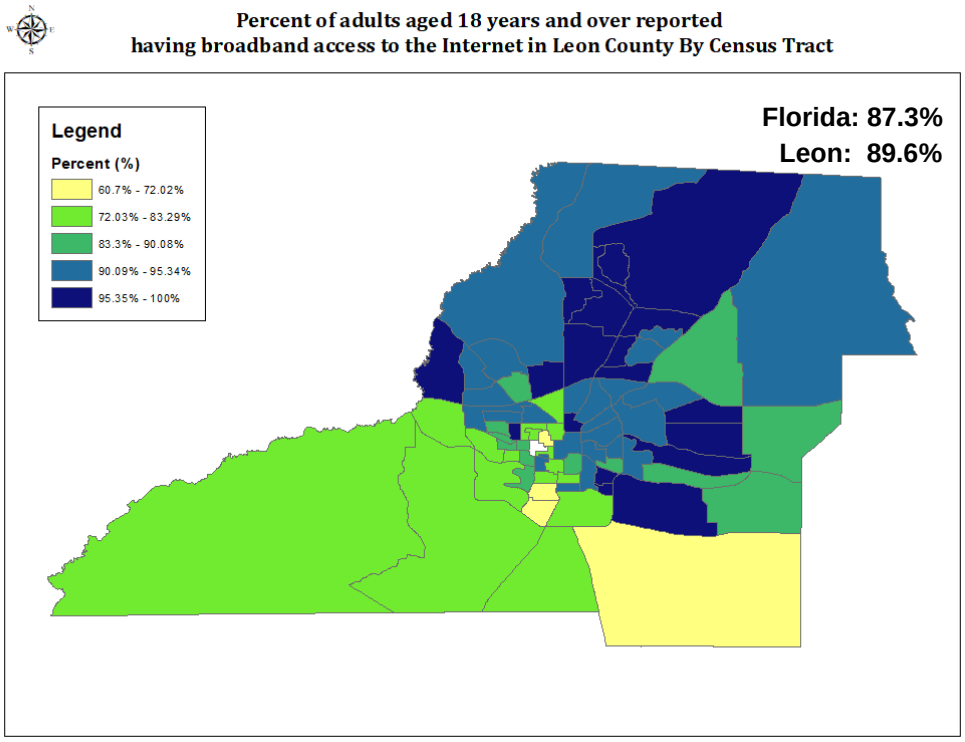
School Environmental Safety Incident Reporting, 2020-21

Type of Incident	Total Incidents
Alcohol	3
Arson	1
Aggravated Battery	1
Burglary	0
Bullying	22
Disruption On Campus - Major	6
Drug Sale/Distribute No Alcohol	1
Drug Use/Possess, Except Alcohol	54
Fighting	78
Harassment	10
Hazing	0
Homicide	0
Kidnapping	0
Physical Attack	17
Robbery	0
Larceny/Theft	6
Sexual Assault	1
Sexual Battery	0
Sexual Harassment	9
Sex Offense (Other)	8
Tobacco	80
Threat/Intimidation	44
Trespassing	2
Vandalism	0
Weapons Possession	13
Other Major Offenses	3
DISTRICT TOTAL:	359
Source: Florida Department of Education	

Reduce bullying of transgender students — LGBT-D01

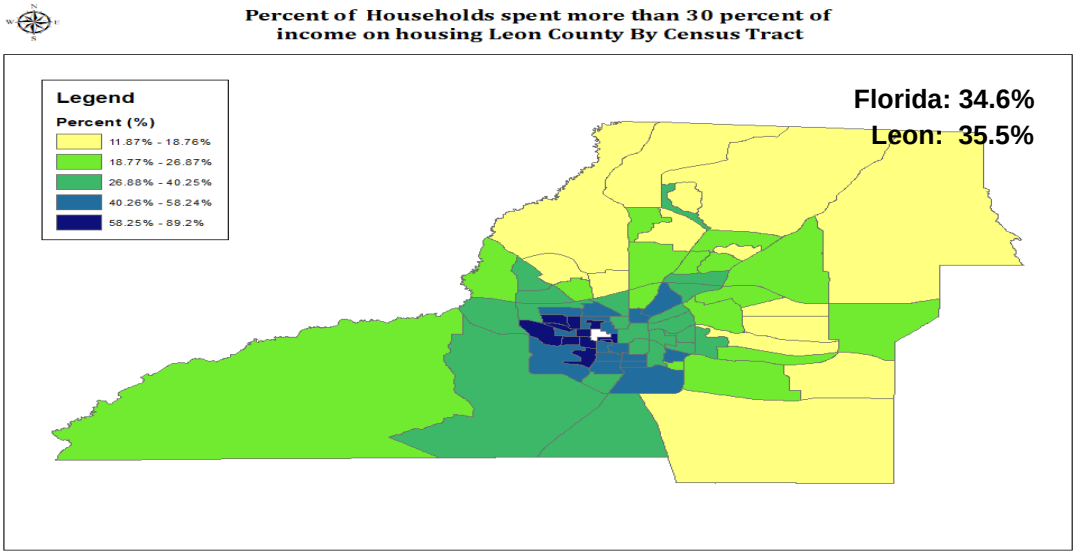
Leon County School District, 2020-21 Allegations of Harassment or Bullying	
Category	**Allegations of Harassment or Bullying**
On the basis of disability	9
On the basis of race, color, or national origin	12
On the basis of religion	4
On the basis of sex	15
On the basis of sexual orientation	26
Source: Florida Department of Education	

Increase the proportion of adults with broadband internet — HC/HIT-05



Source: 2020: ACS 5-Year Estimates

Reduce the proportion of families that spend more than 30 percent of income on housing — SDOH-04



Source: 2020: ACS 5-Year Estimates

- **The impact of neighborhood and built environment on renewable energy**

Neighborhood and Built Environment		
SDOH	**Vulnerable Populations Impacted**	**How the SDOH Impacts (Health Disparity)**
Housing	All populations Racial and ethnic minorities, LGBTQ	High rent and mortgage payments, fear of eviction and homelessness, poor housing stock increase energy burdens Social isolation: pregnant women and mothers without access to resources needed to care for their children, family unaware on how to help.
Transportation	All populations Racial and ethnic minorities, LGBTQ	Gas prices increasing, high car maintenance and insurance costs
Neighborhood Safety	All Racial and ethnic minorities, LGBTQ populations	Neighborhood watch, fear, and trust issues with law enforcement
Parks	All populations	Attention to Under resourced communities
Playgrounds	Children, people with disabilities	Combining gardens and playgrounds for educational purposes, soil testing
Walkability	All populations, low socio-economic status, people with disabilities	Neighborhood safety and security concerns in Promise Zone communities and air pollution
Geography and Crime	Racial and ethnic minorities, LGBTQ+ populations, the elderly, children,	Substandard housing, monitoring rent control, poverty, pollution, homicides
Access to nutritious food	communities with low socio-economic status, people with disabilities	Partnerships with farmers and growers, Community gardens Feeding America and Farm Share
Economics	Racial and ethnic minorities, All populations	Economic empowerment in renewable energy jobs industry and farmer support
Health Literacy	All populations including health and human service providers	New skill sets and workforce terminology on food deserts, renewable energy Mothers are unaware of their resources, tools, and access Finding creative ways to build confidence in mothers
Environmental Health	All populations	New data, National Renewal Energy Lab (NREL) see attached Model

D. Social and Community Context

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

Overall Food Insecurity

The United States Department of Agriculture (USDA) defines food security as the condition in which "all people at all times to have enough food for an active, healthy life." While food insecurity refers to a "household-level economic and social condition of limited or uncertain access to adequate food."2

Food insecurity is associated with adverse health outcomes for both adults and children. For example, research shows that food insecurity is associated with chronic conditions like diabetes and hypertension linked to diet and nutrition.3
Also, food insecurity has a significant association with obesity in women.4

Feeding America has an annual 'Map the Meal Gap' report that examines food insecurity in every county and congressional district. Feeding America estimates that in 2020, about 34,920 people, or 12.0% of the population, were food insecure. That means nearly 1 in 9 individuals did not have reliable access to enough food to stay active and have a healthy life. Additionally, 66%of the food insecure population in Leon County qualified based on income for SNAP (food stamps) and other federal nutrition programs, while 27% did not qualify. The county's rate exceeded the state average of 10.6% and the national rate of 11.8%. Griffin Heights Neighborhood Is starkly different from national and state data:

- 51.9% of the population in this neighborhood is food insecure and
- 2,732 food insecure people live in this neighborhood.
  Feeding America Data 2021

With the growing population of Florida, the food gap will widen across all vulnerable and marginalized groups, including the ALICE populations (the working poor). Leon County continues to assess food insecurity in surrounding communities. During May and June 2022 partners from Leon County, Second Harvest Feeding America, the Children’s Service Council, and the City of Tallahassee hosted

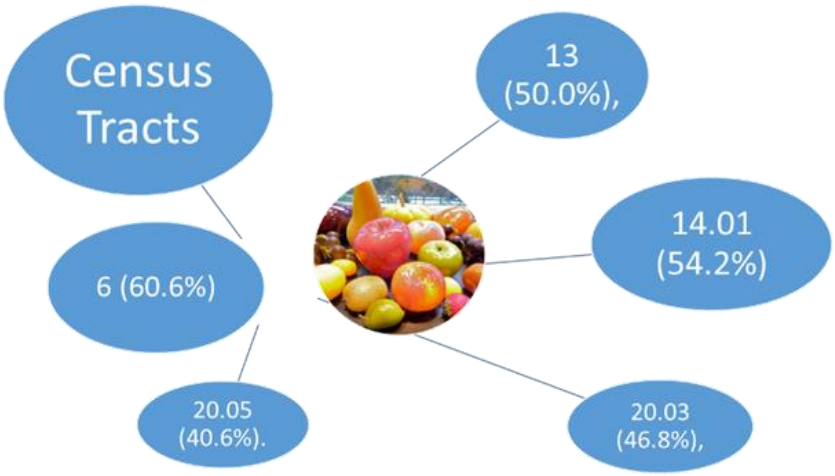
Community Dinners with residents from 10 communities to hear their voices, concerns, barriers, and recommendations to be presented to the Leon County Commissioners. The findings and recommendation will become a part of the Health Equity Taskforce and Coalition workplan as we apply our Health Equity lens to this SDOH.

The population of **Leon County, Florida** in **2020** was **295,460, 7.1% up** from the **275,981** who lived there in **2010**. For comparison, the US population grew **6.5%** and Florida's population grew **15.3%** during that period. *USA Facts*

2 United States Department of Agriculture, Economic Research Service. (2016, September 7). *Food Security in the U.S.: Overview*. Retrieved from USDA Web site: http://ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-us.asp

3 Seligman, Hilary K; Laraia, Barbara A; Kushel, Margot B. (2009). Food Insecurity Is Associated with Chronic Disease among Low-Income NHANES Participants. *Journal of Nutrition, 140*, 304-310. Retrieved from: http://jn.nutrition.org/content/140/2/304.full

4 Franklin, B., Jones, A., & Love, D. et. al (2012). Exploring Mediators of Food Insecurity and Obesity: A Review of Recent Literature. *Journal of Community Health, 37*, 253–264. Retrieved from: http: //link.springer.com/article/10.1007/s10900-011-9420-4



Frenchtown=6
Griffin Heights=14.01

Breaking Bread Together: Neighborhood Dinner & Conversation on Tackling Food Insecurity

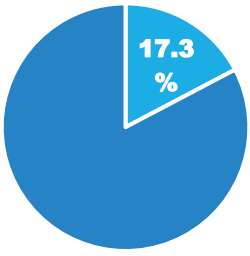
Recommendations to move us toward developing a local food system in Tallahassee/Leon County:

- Cooking demonstrations and teaching children to grow food with farmers
- Provide vouchers to workers to pickup food from restaurants daily that they plan to throw away
- Allow walk up food distribution for nondrivers
- Better messaging & communication of resources available
- Finding resources inside the community, instead of outside
- Pop up markets weekly, with fresh foods and veggies for community
- Appoint neighborhood leaders to hold other residents accountable for attending neighborhood meetings regarding food scarcity
- Create more culturally driven gatherings with activities for children, music, vendors and community leaders to share awareness with residents how to stay connected to resources, gain access and learn how they can help their own community
- Create food banks in each neighborhood
- Create workshops that assist residents in building emotionally intelligent relationships with their neighbors and the community leaders

Eliminate very low food security in children — NWS-02

About 17.7% of children in Leon County are food insecure, exceeding the state's average of 15.7%.

FOOD INSECURE CHILDREN: 9,390
Leon: 17.3% Children Food Insecurity



ESTIMATED PROGRAM ELIGIBILITY AMONG FOOD INSECURE CHILDREN

39%	Likely ineligible for federal nutrition programs (incomes above 185% of poverty)
61%	Income eligible for federal nutrition programs (incomes at or below 185% of poverty)

Source: Feeding America

- **The impact of social and community context on Infant Mortality**

Social and Community Context		
SDOH	**Vulnerable Populations Impacted**	**How the SDOH Impacts Infant Mortality**
Social and Community Context	Racial and ethnic minorities, LGBTQ+ populations, the elderly, children, communities with low socio-economic status, people with disabilities, veterans, infants, and toddlers	Disparities Inequities  Social Integration, civic engagement, Stress, trauma, and anxieties associated with Discrimination are common occurrences. Building excitement and confidence in moms and families about pregnancy, labor, and delivery. Conversations around skills, tools, and access to coping with adversity, character building and personality traits.
Neighborhood and Built Environment	All populations People with disabilities pregnant women elderly. Racial and ethnic minorities Veterans LGBTQ+	Social connectivity, resources, referrals, wraparound services, internet access, social media, are barriers for single moms/fathers and absent fathers/mothers, assault and battery, intimate partner violence and substance abuse, shame, and stigma, pre and postpartum depression are environmental stressors. Substandard housing conditions
Health Care Access and Quality Systems	All vulnerable populations Racial and ethnic minorities, LGBTQ+	Chronic health conditions, dietary and sleep practices, harboring anger, financial distress and "worration" and loss of income when seeking resources, health services and access to daily essentials lead to poor mental/physical health outcomes; accessing appointments are challenging when seeing 3-5 providers at different locations without transportation
Education	BIPOC, Children, People with disabilities pregnant women elderly	Recognition of variables and supportive counseling programs that screen for early intervention of ACES are needed; providers'

	elderly. Racial and ethnic minorities	terminology not understood by patients' clients and community members Health Literacy and provider biases
Food and Hunger	pregnant women, all People with disabilities elderly. Racial and ethnic minorities Veterans LGBTQ+	• pregnant women and mothers experiencing food insecurity often have the limited resources or support systems needed to care for and feed their children and families, air, and water quality and • gathering food from community resources or social networks can impact physical, mental, and emotional health, weathering, and depression

The table below shows that compared to whites, blacks were less likely to see a doctor due to cost, were less likely to have a personal doctor, were less likely to report that their overall health was good and were less likely to get a medical checkup visit a dentist.

Access to Care in Leon County and Florida, 2019		
	Leon	**Florida**
Adults who could not see a doctor at least once in the past year due to cost	All: 11.9%a White: 8.4% Black: 16.9%	All: 16.0% White: 13.5% Black: 16.8%
Adults who have a personal doctor	All: 82.3% White: 88.2% Black: 75.5%	All: 72.0% White: 76.8% Black: 72.1%
Adults who said their overall health was good to excellent	All: 91.4% White: 92.2% Black: 89.7%	All: 80.3% White: 81.9% Black: 80.5%
Adults who had a medical checkup in the past year	All: 73.5% White: 72.1% Black: 81.7%	All: 78.8% White: 80.6% Black: 82.7%
Adults who visited a dentist or a dental clinic in the past year*	All: 70.8% White: 77.2% Black: 57.9%	All: 63.0% White: 65.9% Black: 57.5%

***2016 BRFSS Results

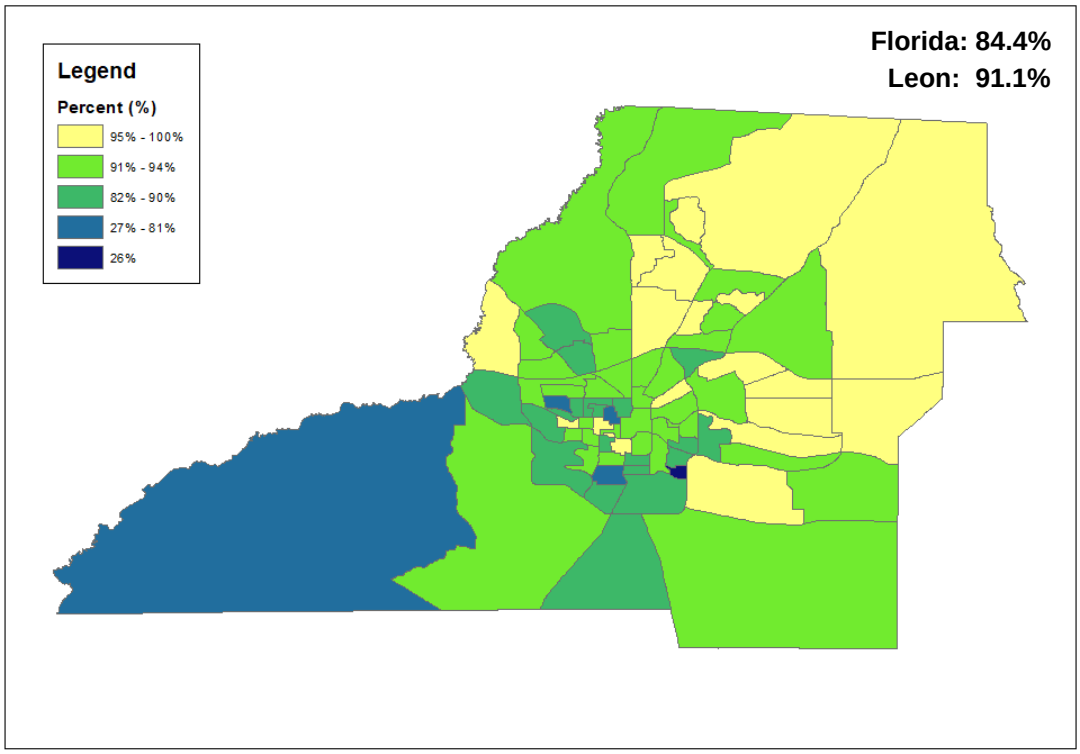
Source: Florida Behavioral Risk Factor Surveillance System

E. Health Care Access and Quality

Health Care Access and Quality Data in Leon County

Increase the proportion of people with health insurance — AHS-01

Percent of Persons under 65 years had Medical Insurance in Leon County By Census Tract



Source: 2020: ACS 5-Year Estimates

Health Care Access and Quality		
SDOH	**Vulnerable Populations Impacted**	**How the SDOH Impacts Infant Mortality**
Health Access and Quality Care	All populations Racial and ethnic minorities, women and children, LGBTQ, transgender	Insurance gaps or no insurance coverage, limited health education, knowledge of services, benefits, and resources. More research on systems of care for these populations.
Social Context	All populations Racial and ethnic minorities, LGBTQ	Communication and language barriers, fears associated with seeking clarification or asking questions and/or understanding professional jargon Provider Linguistic and Cultural Competency
Health Access and Quality of Care	Racial and ethnic minorities, children, and families	Pregnant moms reported no access to doctors during COVID-19, WIC and breastfeeding limitations, office closures and providers not accepting those on Medicaid. Provider Availability impacts maternal and child health
Quality of Care	Minorities, women, and all populations	Issues with bedside manners, pain treatment, stereotypes and biases, and lack of conversations with the people or providers who care Discrimination- Some black mothers are not taken seriously when pain is mentioned to health care providers.
Economic Stability	All populations	High annual deductibles, copays, prescription drugs, frequency of visits to specialists and screening High cost of transportation and travel time impacts Income. breastfeeding benefits to moms/babies Going into motherhood not knowing enough about how to care for baby
Education	Racial and ethnic minorities	Local resources and CARE in relating historical facts and connections to air quality and chronic diseases, asthma, and respiratory illnesses,
Health Literacy	All populations	food insecurity, diabetes, obesity, neighborhood safety and high blood pressure, family history, drug, and substance use

VIII. SDOH PROJECTS

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

Regional Health Equity Coordinators and Minority Health Liaisons will work together to design and facilitate the Health Equity Taskforce workshops. The workshops will be engaging, interactive, and equitable. In the workshops, Health Equity Taskforce members should: 1) write a shared vision for the Health Equity Plan, 2) review data on the prioritized health disparity and the SDOH that contribute to the disparity. The Health Equity Team will design presentations to present to the Taskforce from the), 3) identify barriers to addressing the SDOH, 4) design evidence-based projects to address the SDOH that impact the prioritized health disparity, 5) write objectives with measurable indicators.

A. Data Review

The Health Equity Taskforce will continue to review data, including health disparities and SDOHs provided by the Health Equity Team. The Health Equity Taskforce will also research evidence-based and promising practices and approaches to improve the identified SDOHs. The Health Equity Taskforce considered the policies, systems and environments that lead to the maternal child health disparities and inequities. The DOH-Leon's Health Equity Team identified the following types of evidence-based practices and frameworks tailored to improve SDOH for the selected population(s) in Leon County:

1. Mobilizing for Action through Planning and Partners (MAPP)
2. Health in All Policies (HIAP)
3. Protocol for Assessing Community Excellence in Environmental Health (PACE-EH)
4. SDOH Accelerator Plans
5. Performance Management and Quality Improvement (PMQI)
6. Steps to Move Your Community Forward
7. Community Based Participatory Research
8. Public Health Administration Board (PHAB) Standards and Measures

Community Engagement and Community Based Participatory Research are approaches that will be introduced to the Health Equity Taskforce to bring greater knowledge, understanding and capacity for clinical linkages and the built environment. The Health Equity Team will review a variety of data collection methods that would be useful to explore with the Taskforce. We will use a participatory evaluation process to gage the progress of the work; collect numbers and stories;and share updates with Coalition. To track progress some tools include: attendance records, digital stories from partner

conversations, feedback from local, regional, national and global collaborations. Attention will be given to number of activities, actions taken and the integration of Health Equity Lens into the ongoing work. Below are proposed methods for consideration:

Data Collection Methods

- Three focus groups
  - Younger women
  - Older women
  - Mixed age women
- Group sessions about 90 minutes each
- Topic prompts re: nutrition, stress, racism, grief, etc.
- Emphasis on dialogue and social support
- Session's audio recorded in full
- Medical and Bridge students transcribed sessions

B. Barrier Identification

Members of the Health Equity Taskforce are working in silos and collaboratively to identify their organizations' barriers to fully addressing the SDOHs relevant to their organization's mission. Common themes are being explored as well as collaborative strategies to overcome barriers. One barrier recently identified as a disparate area in Leon County and is closely related to Infant and Maternal mortality is: HIV/STI. Taskforce representatives suggest greater focus on minorities and women and other vulnerable populations as we develop the Health Equity 2023 Workplan. CHIP representatives upon review of the current CHA offered several questions to be added to the revised CHA to broaden our Health Equity Lens:

The following questions relate to ease of access to HIV and STI screening in both clinical and non-clinical settings:

Doctors in Florida are required to offer routine, opt-out HIV testing at annual visits. If you have a primary care doctor, does your doctor discuss the importance of sexual health, and offer you routine HIV and STI screenings at your annual visit? Y/N

Are you aware that there are approved medications known as Pre-Exposure Prophylaxis (PrEP) that can prevent an HIV infection if people are exposed through sex or through sharing injection equipment? Y/N

Are you aware that PrEP medication and services available at the Leon County Health Department and are free to those without insurance who or those who cannot afford the cost?

Are you familiar with a local organization or business that offers access to free condoms and other risk reduction items in Leon County?

This discussion with Team members about common barriers and possible strategies, recommendations any ways to collaborate begins a fruitful interaction for relationship building. CHIP members have started these discussion as they work to apply Health Equity Lens in all they do.

The Health Equity Team of Human Service Specialists housed in the Community Health and Planning Division are also in discussion about the **LCHD Mission "To protect, promote & improve the health of all people in Florida through integrated state, county, & community efforts**. The Community Engagement work requires ongoing interaction with residents in addressing things that matter to them. These are qualities that not only encompass health and well-being but also community engagement aspect of mutual respect, collaborative partnerships, using Evidence Based Practices focused on a System of Care that is family oriented, youth-focused, community based in adherence to cultural-linguistic competency. They are embedding Health Equity into their daily activities.

Partners	SDOH	Partner Barriers	Theme	Collaborative Strategies
Community Engagement Team	Social and Community Networks	Many service providers are working in silos	Shared Vision	Using data to identify disparities through Equity Lens
UPHS And Partners	Neighborhood and Built Environment	Identifying gaps in human service provisions and challenges in implementing DEI principles.	Collaboration	Work with human service to operationalize DEI Principles into their vision and mission and statement.
Leon County STD/STI	Access to Health and quality care	Competitive relationships with providers offering similar services	Coordination and Collaboration	Ease of access to HIV and STI screening in both clinical and non-clinical settings.
Sister Friends Tallahassee Birthing Project	Social and Community Context	Engaging fathers in activities along with friends who will be in the life of the child	Networking in communities	Participate in the trainings and educational programming that the Little Sisters are involved
Neighborhood First Plan Team members	Economic Stability	Leveraging resources	Cohesion	Strategically adopt the plan and tasks the community members have selected as target needs and high priority areas

Griffin Heights Children and Families Resource Center	Education Access and Quality	Mothers to begin reading frequently to baby	Consensus	Introduce to technique whereby Mothers and Fathers/Significant others are able use their voice to stimulate baby at first conception and throughout the pregnancy

Additionally, all Taskforce Members will have an historical overview of the proposed plan, people, places, and projects as we journey together in developing the Health Equity Work Plan and the SDOH Community Projects.

32304 Prosperity for All Summits Goals and Activities

To City and County-wide calls for attendance, partners, residents, collaborators, and sponsors led to four successful ***32304 Prosperity for All Summits***. The voices of 400+ participants identified 10 areas of need required to move forward in the 32304 neighborhoods to address poverty. The goals, strategies, and actions were developed in small groups at the Summits, and ideas from online participants who reviewed the Summit documents. The current or potential implementing organizations, and online participants were encouraged to review the goals they were interested in and identified which roles their organization would contribute for actionable change. Since COVID 19 the Teams have not met as a collective, however work groups have begun to implement the findings from the Summit into actionable programs and services. The next Summit Update is planned for August 2022 to continue poverty in 32304 and surrounding communities.

C. Community Projects

Griffin Heights Neighborhood First Plan

Integrate Griffin Heights Neighborhood First Plan (GHNFP) led by the members of the Community Action Team into LCHD overall goals to bring the residents vision into all components speaking with “A Clear Voice” for true engagement in the Community Health Assessments (CHA), and Community Health Improvement Plan (CHIP) to express in their own voices via the Neighborhood First Plan. The GHNFP funded by the City of Tallahassee (COT) from 2021-2026 and is supported by the Department of Parks and Recreation Neighborhood Affairs Division, The Plan can be found on COT website: talgov.com.

The Health Equity Team did limited research on evidence-based strategies to overcome the identified barriers and improve the SDOH that impact the infant and maternal mortality. The Health Equity Taskforce will use this information to collaboratively design community projects to address the SDOHs. During project design, the Health Equity Taskforce will consider the policies, systems and environments that lead to inequities. Projects included short, medium, and long-term goals with measurable objectives. These projects will be reviewed, edited, and approved by the Coalition to ensure feasibility. Each of the recommended evidenced based strategies will be researched and the Taskforce will jointly

decide which are more suitable for the work ahead. Voices and comments from the community are part of the deliberation and included in ongoing training (highlighted in yellow). As noted earlier, there are several models already up for review to develop Leon County SDOH Framework.

Recommended SDOH Community Projects to be considered by the Health Equity Taskforce:

- 32304 SDOH Improvement Project: Goals and Objectives
- 32304 Black Infant Mortality Reduction Project: Goals and Objectives
- 32304Maternal Reduction Project: Goals and Objectives

Community feedback- **create new ways for mothers to have a better quality of life**

Community and Social Impact	Health Access	Education	Physical Environment	Economic Stability
Building excitement and confidence in moms and families about pregnancy, labor, and delivery, character building and personality traits. Family unaware on how to assist mom so she spends less time in isolation	Moms need assistance on knowing the foods to eat for baby and mom health. Understanding food is connected to thought and mind. Teach families how to cook healthy and what to eat	Educate family, father, friends, and others in the village Mental Health- finding creative ways to build confidence in mothers	Making sure the moms in the house have support for their desired result (healthy baby) Surround mom with supportive attitudes from family, fathers, and friends	Breastfeeding lowers medical cost, reduce risks of disease High cost of transportation to access healthy food
Support Systems- family members, fathers, the mother's village ACES- Childhood trauma effecting mom's birth outcome	Social Isolation- pregnant women and mothers need resources to care for their children	Social Integration- poverty, moms gaining access to education on diet healthy families and motivated to making a living.	Community Engagement- healthy conversations: diet, pregnancy, labor, and delivery.	Stress- Going into motherhood not knowing enough about how to care for baby and self.

Discrimination- Some black mothers are not taken seriously when pain is mentioned to heath care providers	Conversations around skills, tools, and access to coping with adversity	Building confidence in the mothers to assure their success in delivery	Making sure the air quality in the home is good for baby and mom.	Health Literacy- Mothers are unaware of access to resources, tools, and other support services.

Please see the storyboards below of the three proposed projects:

The 32304 SDOH Improvement Project

Problem: There are working individuals and families unable to afford the necessities of housing, childcare, food, transportation, and health care.

Project: What will you do to reduce the percentage of Asset Limited, Income Constrained, Employed (ALICE) residents living in ZIP Code 32304?

Background: About 29% of households in ZIP Code 32304 are ALICE — Asset Limited, Income Constrained, Employed. ALICE households earn more than the Federal Poverty Level, but less than the basic cost of living for the county (the ALICE Threshold). Therefore, ALICE households are forced to make tough choices, such as deciding between quality childcare or paying the rent, which have long-term consequences not only for ALICE, but for all.

Scope: Residents living in 32304 could benefit from increased wages that keep pace with the cost of household essentials (housing, childcare, food, transportation, health care, and a basic smartphone plan).

SDOH Addressed: Economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context

Priority Population: 32304 residents

Long-term, DOH-Leon is working to improve services concerning environmental and social factors, (such as education, employment and economic opportunities, literacy, social support) and provide for the availability of those resources to meet the daily needs that influence infant, adolescent, and maternal health behaviors along with health status in the 32304 zip code/census tracts. Medium-term, DOH-Leon is working to Improve prevention/education addressing behavioral health issues and conditions impacting women, children, families, and communities (ACEs, Trauma Informed). This includes COVID-19 education and training.

Team Members: Team Members: DOH-Leon Community Health & Planning, DOH-Leon Health Equity Team, CAHSC, The Sister Friends Tallahassee Birthing Project, and Melanin Moms, Griffin Heights Children and Families Resource Center, Tallahassee, Food Network, Inc. Greater Frenchtown Revitalization Council

Results: Please note that this area will be completed once the project ended

Project Goals and Objectives: December 31, 2026, Reducing the population of Leon County residents designated ALICE from 49% (2007-2018) to 39% in 5 years concentrating in the 32304 ZIP code/census tracts

Root Causes and Barriers: Root causes of income inequity include educational attainment disparities, access to resources like broadband internet, job availability, and literacy. Rent cost-burden has become an increasing issue nationwide.

Next Steps: Please note that this area will be completed once the project ended

The 32304 Black Infant Mortality Reduction Project

Problem: Black infant deaths in 32304	**Project:** What will you do to reduce the black infant mortality rate in ZIP Code 32304?
Background: From 2018 to 2020, there were 12 infants that died before their first birthday in ZIP Code 32304. Black infants accounted for 11 or 91.7% of these deaths in 32304. The black infant mortality rate for this period was 1.5 death per 1,000 live births. African Americans have the highest infant mortality rate of any racial or ethnic group in the United States. **Scope:** Black infants born to mother who are ZIP Code 32304 residents **SDOH Addressed:** Economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context **Priority Population:** 32304 residents; mothers and infants, fathers	DOH-Leon is working to reduce the number of pre-term and low birth weight (LBW) babies born to Black women and the rate of maternal mortality among Black women by: • Increasing the number of Black women who enter care in their first trimester. • Educating Black women of childbearing age on the impact of risk factors (including, but not limited to: smoking, substance use, obesity) on future pregnancies and infant health. • Educating men on the importance of their health on pregnancy and birth outcomes.
Team Members: Team Members: DOH-Leon Community Health & Planning, DOH-Leon Health Equity Team, CAHSC, The Sister Friends Tallahassee Birthing Project, and Melanin Moms, Griffin Heights Children and Families Resource Center, Tallahassee, Food Network, Inc. Greater Frenchtown Revitalization Council	**Results:** Results: Please note that this area will be completed once the project ended
Project Goals and Objectives: By 2026, reduce the annual black infant mortality rate from 10.8 (2017-2019) to 9 per 1,000 live births. (Infant Mortality [0-364 days from birth, 3-Year Rolling). (This objective used the Florida Department of Health, Bureau of Vital Statistics as the data source). **Root Causes and Barriers:** Root causes of black infant mortality include social inequalities that determine socioeconomic status: income, maternal education, maternal age, marital status, parity, smoking, alcohol and substance use, and health insurance coverage. There is also structural racism in health care and social service delivery, in which black women receive poorer quality care than white women.	**Next Steps:** Please note that this area will be completed once the project ended

The 32304 Maternal Mortality Reduction Project

Problem: Maternal deaths in 32304	**Project:** What will you do to reduce the black maternal mortality rate in ZIP Code 32304?
Background: In 2020, there was one maternal death in ZIP Code 32304, which was a black woman. **Scope:** Black mothers who are ZIP Code 32304 residents **SDOH Addressed:** Economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context **Priority Population:** 32304 residents; mothers	Long-term, DOH-Leon is working to reduce the black maternal rate by conducting activities to prevent the death of a woman during pregnancy, at delivery, or up until one year after delivery. Additionally, it is working to create a maternal support program to decrease social isolation.
Team Members: DOH-Leon Community Health & Planning, DOH-Leon Health Equity Team, CAHSC, The Sister Friends Tallahassee Birthing Project, and Melanin Moms, Griffin Heights Children and Families Resource Center, Tallahassee, Food Network, Inc. Greater Frenchtown Revitalization Council	**Results:** Results: Please note that this area will be completed once the project ended
Project Goals and Objectives: By 2026, reduce the annual black maternal mortality rate by conducting activities to prevent the death of a woman during pregnancy, at delivery, or up until one year after delivery. **Root Causes and Barriers:** Structural racism leads to disparities in income, housing, safety, education, and other circumstances that are associated with poorer health and increased rates of chronic disease. These, in turn, place Black women at greater risk than white women of pregnancy-related deaths from cardiomyopathy and hypertension, among other causes. Racism in the health care sector compounds the issue, with Black women less likely to have access to treatment and receive good-quality care.	**Next Steps:** Please note that this area will be completed once the project ended

IX. HEALTH EQUITY PLAN OBJECTIVES

A. (Prioritized Health Disparity)
Infant Mortality

Health Disparity Objective: By 2026, reduce the population of Leon County residents designated ALICE from 49% (2007-2018) to 39% in 5 years.

This objective used ALICE Threshold, 2007-2018; American Community Survey, 2007-2018 as the data source).

The 32304 SDoH Improvement Project

The 32304 SDoH Improvement Project Goals and Objectives						
	Lead Entity and Unit	**Lead Point Person**	**Data Source**	**Baseline Value**	**Target Value**	**Plan Alignment**
Long-Term SDOH Goal: Improve services concerning environmental and social factors, (such as education, employment and economic opportunities, literacy, social support) and provide for the availability of those resources to meet the daily needs that influence infant, adolescent, and maternal health behaviors along with health status in the 32304 zip code/census tracts.						
Objective: By December 31, 2026, Reducing the population of 32304 residents designated ALICE from 29% to 20% in 5 years concentrating in the 32304 zip code/census tracts.	DOH-Leon Community Health & Planning, DOH-Leon PACE-EH	Mary Miaisha Mitchell	ALICE Threshold, 2007-2018; American Community Survey, 2007-2018	29%	20%	DOH-Leon Community Health Improvement Plan
Medium-Term SDOH Goal: Improve prevention/education addressing behavioral health issues and conditions impacting women, children, families, and communities (ACEs, Trauma Informed). This includes COVID-19 education and training.						

The 32304 SDoH Improvement Project Goals and Objectives						
	Lead Entity and Unit	**Lead Point Person**	**Data Source**	**Baseline Value**	**Target Value**	**Plan Alignment**
Objective: By December 31, 2024, improve prevention/education by addressing behavioral health issues and conditions by reducing ACES from 19.7% to 18% in Title 1 among high school students.	DOH-Leon Community Health & Planning, DOH-Leon PACE-EH	Mary Miaisha Mitchell	ALICE Threshold, 2007-2018; American Community Survey, 2007-2018, Leon County ACEs DCF Fact Sheet	19.7%	18%	DOH-Leon Community Health Improvement Plan
Short-Term SDOH Goal: Improve education/training addressing air quality issues for outdoor workers, as well as for people who are at risk (Children at play, farmers, athletes, landscapers/construction workers). Policies are needed to address affordable housing, poverty, and inequities in 32304. Education/Training will be provided to community members, partners, and stakeholders.						
Objective: By December 31, 2023, improve air quality issues for people who are at risk in 32304 from 10% to 9%.	DOH-Leon Community Health & Planning, DOH-Leon PACE-EH	Mary Miaisha Mitchell	ALICE Threshold, 2007-2018; American Community Survey, 2007-2018,	10%	9%	DOH-Leon Community Health Improvement Plan

Health Disparity Objective: By 2026, reduce the annual black infant mortality rate from 10.8 (2017-2019) to 9 per 1,000 live births. (Infant Mortality [0-364 days from birth, 3-Year Rolling).

(This objective used the Florida Department of Health, Bureau of Vital Statistics as the data source).

The 32304 Black Infant Mortality Reduction Project

The 32304 Black Infant Mortality Reduction Project Goals and Objectives						
	Lead Entity and Unit	**Lead Point Person**	**Data Source**	**Baseline Value**	**Target Value**	**Plan Alignment**
Long-Term SDOH Goal: Improve the quality of care for reducing the annual black infant mortality rate addressing the racial disparities in healthcare for the 32304 census tracts though four priority areas under three broader categories: 1) Access to Care; 2) Racial Disparities in Health Outcomes; 3) Maternal Mental Health and Substance Exposed Newborns.						
Objective: By December 31, 2026, reduce the gap found between the infant mortality rate of Black women which is 10.8 per 1,000 live births compared to 4.1 per 1,000 live births for white women.	DOH-Leon Community Health & Planning, DOH-Leon PACE-EH, CAHSC, The Sister Friends Tallahassee Birthing Project, Melanin Mothers Meet	Mary Miaisha Mitchell	Florida Department of Health, Bureau of Vital Statistics, CAHSC Service Delivery Plan 2021-2026	10.8%	8%	DOH-Leon Community Health Improvement Plan, CAHSC Service Delivery Plan 2021-2026
Medium-Term SDOH Goal: Improve the advanced safe sleep behaviors among families and infant caregivers, promote breastfeeding, increase the percentage of infants who are ever breastfed, and infants breastfed exclusively through 6 months.						
Objective: By December 31, 2024, integrate awareness around education, attitude, and emotional intelligence through social context and issues concerning	DOH-Leon Community Health & Planning, DOH-Leon PACE-EH, CAHSC, The Sister Friends	Mary Miaisha Mitchell	Florida Department of Health, Bureau of Vital Statistics, 32304 Prosperity Summit Data Book, 8-10-22	0% reporting	10% reporting	DOH-Leon Community Health Improvement Plan,

The 32304 Black Infant Mortality Reduction Project Goals and Objectives						
	Lead Entity and Unit	**Lead Point Person**	**Data Source**	**Baseline Value**	**Target Value**	**Plan Alignment**
reducing infant mortality.	Tallahassee Birthing Project, Melanin Mothers Meet		Healthy People 2030			Griffin Heights Neighborhood First Plan
Short-Term SDOH Goal: Improve conducting activities to prevent the death of an infant before his or her first birthday. Activities may include education, awareness, and linkage to social support programs, as well as safe sleep, and breastfeeding.						
Objective: By December 31, 2023, create a social support program(s) in 32304 to decrease social isolation to reduce annual black infant mortality among black mothers presenting for quality health care from 78% to 75%.	DOH-Leon Community Health & Planning, DOH-Leon PACE-EH, CAHSC, The Sister Friends Tallahassee Birthing Project, Melanin Mothers Meet	Mary Miaisha Mitchell	Florida Department of Health, Bureau of Vital Statistics 32304 Prosperity Summit Data Book, 8-10-22 Healthy People 2030	78%	75%	DOH-Leon Community Health Improvement Plan Griffin Heights Neighborhood First Plan

Health Disparity Objective: By 2026, reduce the annual black maternal mortality rate by conducting activities to prevent the death of a woman during pregnancy, at delivery, or up until one year after delivery.

(This objective used the Florida Department of Health, Bureau of Vital Statistics as the data source).

The 32304 Maternal Mortality Reduction Project

The 32304 Maternal Mortality Reduction Project						
	Lead Entity and Unit	**Lead Point Person**	**Data Source**	**Baseline Value**	**Target Value**	**Plan Alignment**
Long-Term SDOH Goal: Reduce the annual Black mother's mortality rate by conducting activities to prevent the death of a woman during pregnancy, at delivery, or up until one year after delivery.						
Objective: By December 31, 2026, reduce the annual black maternal mortality rate from 77.0 (2017-2019) to 76 per 1,000 live births.	DOH-Leon Community Health & Planning, DOH-Leon, CAHSC	Mary Miaisha Mitchell	Florida Department of Health, Bureau of Vital Statistics	77.0%	76%	DOH-Leon Community Health Improvement Plan
Medium-Term SDOH Goal: Improve Reduce the number of pre-term and low birth weight (LBW) babies born to Black women and the rate of maternal mortality among Black women by: • Increasing the number of Black women who enter care in their first trimester. • Educating Black women of childbearing age on the impact of risk factors (including, but not limited to: smoking, substance use, obesity) on future pregnancies and infant health. • Educating men on the importance of their health on pregnancy and birth outcomes. • Increasing the number of referrals into services for Black women with identified risk factors for adverse pregnancy and birth outcomes.						
Objective: By December 31, 2024, reduce the annual black infant mortality rate in 32304 from 8.6% (2016-2020) to 7% per 1,000 live births.	DOH-Leon Community Health & Planning, DOH-Leon PACE-EH, CAHSC, The Sister Friends Tallahassee Birthing Project, Melanin Mothers Meet	Mary Miaisha Mitchell	Florida Department of Health, Bureau of Vital Statistics, 32304 Report 3-30-22	8.6%	7%	DOH-Leon Community Health Improvement Plan Griffin Heights Neighborhood First Plan

The 32304 Maternal Mortality Reduction Project						
	Lead Entity and Unit	**Lead Point Person**	**Data Source**	**Baseline Value**	**Target Value**	**Plan Alignment**
Short-Term SDOH Goal: Improve the reduction of maternal mortality among black mothers presenting for quality health care by 10% by creating a maternal support program(s) to decrease social isolation.						
Objective: By December 31, 2023, create a maternal support program to decrease social isolation to reduce maternal mortality among black mothers by using the three types of support: (1). Partner (2). Family (3). Doula.	DOH-Leon Community Health & Planning, DOH-Leon, CAHSC The Sister Friends Tallahassee Birthing Project, Melanin Mothers Meet	Mary Miaisha Mitchell	Florida Department of Health, Bureau of Vital Statistics	0% reporting	10% reporting	DOH-Leon Community Health Improvement Plan

(This objective used the Florida Department of Health, Bureau of Vital Statistics as the data source).

X. PERFORMANCE TRACKING AND REPORTING

Ongoing communication is critical to the achievement of health equity goals and the institutionalization of a health equity focus. The successes of Health Equity Plan projects are shared with OMHHE, partners, other CHDs, CHD staff, and the Central Office through systematic information-sharing, networking, collecting, and reporting on knowledge gained, so that lessons learned can be replicated in other counties and programs. Regional Health Equity Coordinators facilitate systematic communication within their region.

The Minority Health Liaison serves as the point of contact in their county for sharing progress updates, implementation barriers, and practices associated with the Health Equity Plan. The Minority Health Liaison is responsible for gathering data, 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 will track and submit indicator values and report monthly attendance to the OMHHE within 15 days of the quarter end.

Members will report any finding, progress, activities, accomplishments, and challenges incorporating Diversity, Equity, and Inclusion principles into their organizational structure. Each will be expected to share a “Story from the Field” to highlight application of their Equity Lens in real practice. The Marshall Ganz model will be shared in a template to guide the process.

Speakers invited to the quarterly meetings will educate, advise, or train on a highlighted area sited in the Community Feedback portion of the meeting. All minutes and stories will be compiled for documentation, ongoing training, and Community Conversations. Each organization will have an opportunity to facilitate a meeting, record minutes, set the agenda as part of the capacity building and growing the members basic skill sets for professional and leadership development. Capturing the historical data is a key component for measuring programs effectiveness. Pre and post tests will be rendered for any training or speaking engagements.

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. A Recognition Ceremony will be held for an Equity Lens Year end View.

XI. REVISIONS

Annually, the Health Equity Taskforce reviews the Health Equity Plan to identify strengths, opportunities for improvement, barriers/challenges and lessons learned. This information is then used to revise the plan as needed with projections for the next annual report, implementation and strengthening the Health Equity Plan moving forward.

Revision	Revised By	Revision Date	Rationale for Revision
#1	Mitchell/Hairston	6.22.22	Recommendation per Regional Minority Health Coordinator

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