MARTIN COUNTY DEPARTMENT OF HEALTH

HEALTH EQUITY PLAN

July 2022 – June 2027

Florida HEALTH Martin County

Prepared by:
HCSEF Health Council of Southeast Florida
www.hcsef.org

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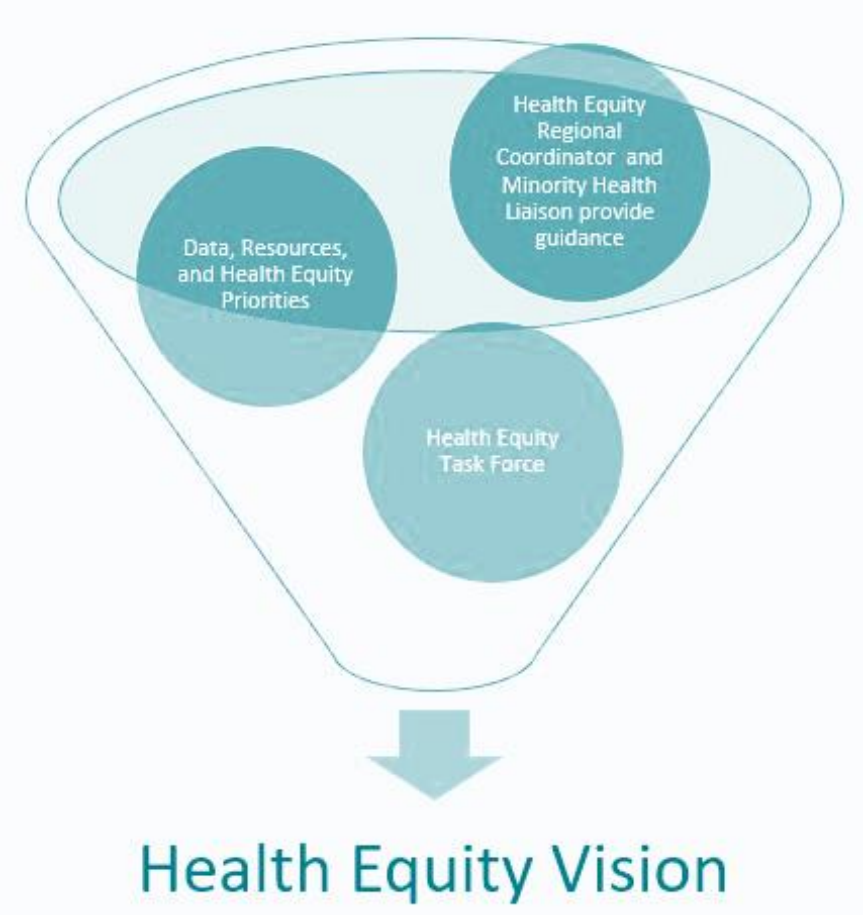
I. VISION



During a Martin County Health Equity Taskforce meeting on March 24, 2022, the Martin County Health Equity Taskforce participated in a visioning activity, during which members answered several questions from both the Mobilizing for Action through Planning and Partnerships (MAPP) visioning guidance and the Strengths, Opportunities, Aspirations, and Results (SOAR) Analysis model, including:

- **"What does a healthy Martin County mean to you?"**
    - Taskforce responses included: a healthier, happier community; a place where every child has access to a healthy life; environmental conditions of access to healthy food, healthy spaces/environment, clean water; a Martin County where there are no barriers to achieving optimal health; an equitable living environment where people have access to good food, adequate healthcare, and safe and clean living conditions with outdoor

access to play and exercise' greater access to quality health care, strong education, good jobs, nutritious food, and clean water.

- **"What are our greatest strengths?"**
  - Taskforce responses included: the unique way that Martin County has a wide range of environments (rural and suburban); wealth makes the county unique; participation of local nonprofits and foundations that support community work; people like to retire in Martin County; diversity, cost of living, and the weather; increased distance from I-95 to Martin County, which plays a role in reduced air pollution and traffic; preserves and other ecological spaces; amazing small businesses and beautiful water-front gems; the perfect environment for being active.

- **"What is our most compelling aspiration and how can we use our strengths to improve health equity and obesity and overweight status in Martin County?"**
  - Taskforce responses included: work with youth and agriculture in the county, envisioning a green space or system where residents can access food with a hyper focus on local food production; merging food production and access to healthy produce where individuals can have access and the opportunity to participate in growing; a community garden with local community ownership; accessible garden from House of Hope; a traveling garden that travels to children; to ensure people have access to healthy, fresh vegetables.

- **"What does success look like in three years? In 10 years? How will we know when we see it?"**
  - Taskforce responses included: exercise is correlated with good health outcomes, often more than good diets; success can look like an increase in fruit/vegetable consumption per week or increase in physical activity; working with the city and county to establish more parks and green spaces to encourage exercise in the community; the Hispanic and Black populations with lower obesity percentages; increased awareness in Martin County about what obesity and overweight status means and what health factors can be influenced; through the children, educating the parents on nutrition, on how and where to access medical help, etc.

Based on these fruitful discussions, during the Martin County Health Equity Taskforce meeting on April 19, 2022, the members voted on our vision statement. Proudly, our vision statement is as follows:

"A Martin County where there are no systemic barriers to individuals achieving their best health."

II. PURPOSE

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 residents face in achieving wellness which ultimately produce health inequities. 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 inequities in their communities.

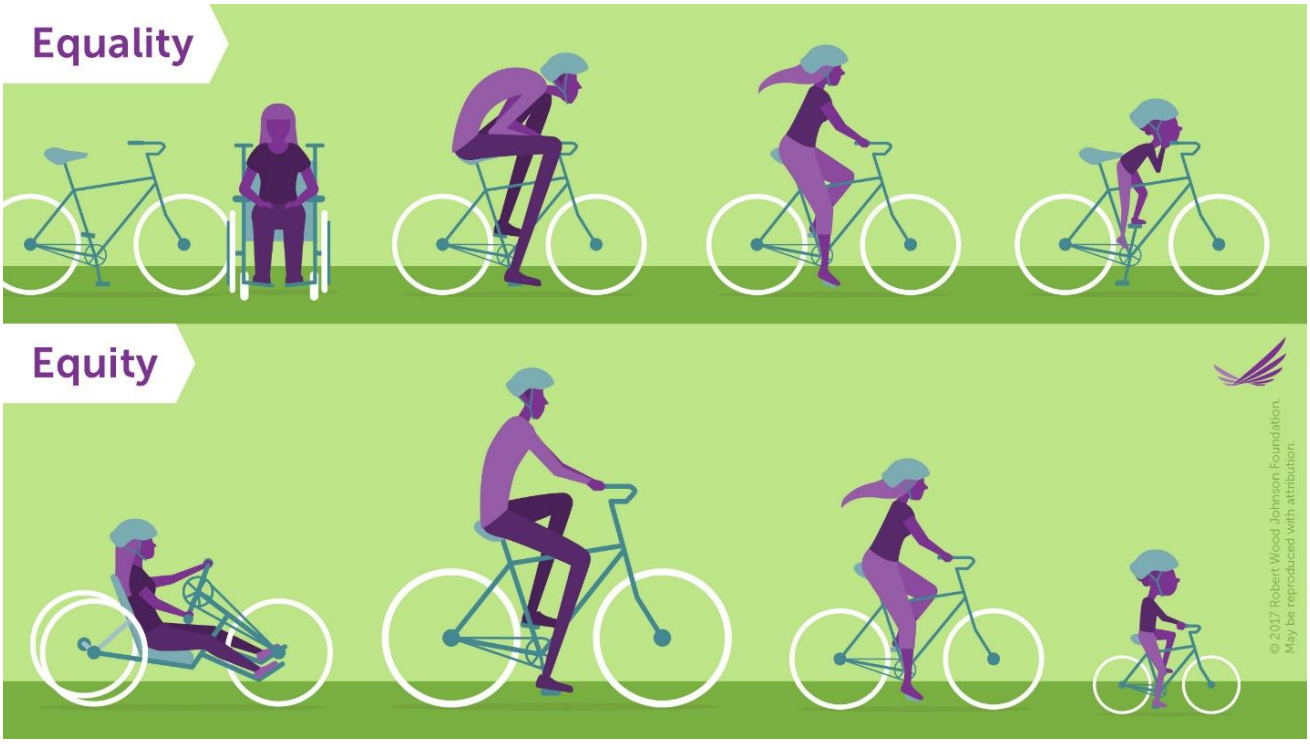
The Health Equity Plan should guide counties in their efforts to create and improve systems and opportunities to achieve optimal health for all residents, especially key priority populations. County organizations have a critical role in addressing the Social Determinants of Health (SDOH) by fostering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

The purpose of the Health Equity Plan is to increase health equity, improve health outcomes, and decrease disparities for populations experiencing significant health inequities within Martin County. To develop this plan, the Martin 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 factors impacting health inequities within Martin 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, have aligned strategies to address the SDOH factors that impact health and well-being in the county.

"Health Equity is achieved when everyone can attain optimal health."

- Robert Wood Johnson Foundation

III. DEFINITIONS



Health equity is achieved when everyone can attain optimal health.

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

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

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

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

IV. PARTICIPATION

Cross-sector collaborations and partnerships are essential components of improving health and well-being in a community. Cross-sector collaboration provides the opportunity for organizations to share expertise and resources to uncover 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, including the Minority Health Liaison, Martin County Health Equity Team, Martin County Health Equity Taskforce, and Martin County Health Equity Coalition, involved in this initiative provided the range of expertise necessary to develop the Health Equity Plan. The implementation of this plan will be pioneered by the Martin County Health Equity Taskforce, which includes a diverse group of community leaders, agencies, and community members.

In Fall 2021, the Department of Health in Martin County engaged the Health Council of Southeast Florida to facilitate the development of the Martin County Health Equity Plan. From December 2021 through January 2022, the Health Council of Southeast Florida, Minority Health Liaison, and Health Equity Team recruited members via flyer distribution at community events, word of mouth, existing partnerships, and through the Martin County Community Health Advisory Council. As a result of these efforts, a diverse group of community leaders and community members formed the Martin County Health Equity Taskforce and the Martin County Community Health Advisory Council agreed to serve as the Martin County Health Equity Coalition. This Plan includes additional details on the diverse group of dedicated individuals who have played an integral role in the development of Martin County's plan to advance health equity.

To further illustrate Martin County's cross-sector collaborations in action, as depicted in the top photo below, Florida Department of Health in Martin County (DOH-Martin) and the Health Equity Team participated in the Martin Luther King Junior event and distributed health education materials, health insurance information, and information about community resources to low-income residents. DOH-Martin and Health Equity Team staff engaged with representatives from different community organizations, including Martin County Public Transit (MARTY). Many residents experience barriers related to transportation when attempting to access health care in Martin County, so this newly established relationship will help identify and address transportation-related issues.

In the photos below, DOH-Martin and the Health Equity Team participated in the second Indiantown Health Community meeting for the Protocol for Assessing Community Excellence in Environmental Health (PACE-EH) initiative. As part of this initiative, DOH-Martin is working closely with The Village of Indiantown Leaders, and Mayor of Indiantown Jackie Clarke who is also an employee of the Florida Department of Health in Martin County, to plan and implement a community-driven PACE-EH Project.

A. Minority Health Liaison

The Minority Health Liaison supports the Office of Minority Health and Health Equity (OMHHE) in advancing health equity and improving health outcomes of key priority populations experiencing significant health inequities and negatively impacted by barriers related to the Social Determinants of Health (SDOH). The Minority Health Liaison's primary responsibilities include partnership engagement, health equity planning, and health equity project implementation. The Minority Health Liaison also facilitates health equity discussions and coordinates strategic collaborations with the goal of elevating the shared efforts of the county to improve health equity among our Martin County residents facing the most significant barriers related to health.

Minority Health Liaison: Angelica Castillo Da Silva

Minority Health Liaison Backup and DOH Administrator: Patsy Lindo-Wood

B. Health Equity Team

The Health Equity Team includes individuals from the DOH-Martin County that each represent a different program or department. The Health Equity Team was created in an effort to collectively explore 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 inequities and the SDOHs in Martin County to the Health Equity Taskforce and Coalition. The Minority Health Liaison guides these discussions and the implementation of initiatives. Members of the Health Equity Team are listed in the table below.

Name	Title	Program	Member Role
Angelica Castillo Da Silva	Health Equity Liaison	Health Equity	Lead the development of the Health Equity Plan; provide the group with consistent updates
Patsy Lindo-Wood	Administrator	Community Health/Health Equity	Oversee the development of the Health Equity Plan
Robert King	Government Operations Consultant	Purchasing	Participate in prioritization; review and provide input on the Plan
Edward Bradley	Emergency Preparedness Coordinator	Emergency Preparedness	Participate in prioritization; review and provide input on the Plan
Gabriela Chavez	Family Counselor	Healthy Start	Participate in prioritization; review and provide input on the Plan
Nyame Nti Nsibienakou-Fawohodie	CDC Epidemiologist Fellow	Epidemiology	Participate in prioritization; review and provide input on the Plan

Vilma Smith	Government Operations Consultant IV	Epidemiology	Participate in prioritization; review and provide input on the Plan
Daniza Robinson	Biological Scientist IV	Epidemiology	Participate in prioritization; review and provide input on the Plan
Guillermo Swai	Biological Scientist IV	Epidemiology	Participate in prioritization; review and provide input on the Plan
Myra White	School Health Nurse	School Health	Participate in prioritization; review and provide input on the Plan
Milagros Ruiz	Dental Hygienist	School Health	Participate in prioritization; review and provide input on the Plan
Rafaela Salgado	Case Manager	School Health	Participate in prioritization; review and provide input on the Plan
Carol Bennett	Care Coordinator Healthy Start	Healthy Start	Participate in prioritization; review and provide input on the Plan
Jackie Clarke	HIV/ STDS Counselor	HIV	Participate in prioritization; review and provide input on the Plan
Brenda Matheny	Maternal and Child Health/ Healthy Babies Program Coordinator	Healthy Babies	Participate in prioritization; review and provide input on the Plan

The Health Equity Team met on the dates listed below during the Health Equity Plan planning process. Following the completion of the Health Equity Plan, the Health Equity Team will meet at least quarterly to track progress.

Meeting Date	Topic
December 17, 2021	This was the first meeting. All members of the Health Equity Team were introduced. The Team discussed the Social Determinants of Health and how they impact Martin County residents. The Team reviewed data and looked at the CDC Social Vulnerability map. The Team decided on future meeting dates and times.
January 12, 2022	During this meeting, the Team reviewed some additional data in Martin County and discussed the definition of Health Equity. The Health Equity Plan template was introduced. The Team discussed the need for creating a Health Equity Coalition and who would be great participants for the Coalition and Taskforce.

	The Indiantown Health Community Committee was also discussed. Meetings for this committee will cover the needs of the community, specifically regarding childhood obesity and access to healthy food.
March 2, 2022	The Health Equity Team reviewed health disparities in Martin County. The Health Equity Liaison led a consensus workshop to collaboratively decide on one disparity seen in the data that is most pressing in Martin County. The Health Equity Team created a Prioritization Matrix, giving scores to four of the top priorities. Overweight and Obesity, Heart Disease/Stroke, and Diabetes had the highest scores.
March 7, 2022	During the March 7th Health Equity Team meeting, the group reviewed data more closely and applied the Prioritization Matrix again. During this meeting, the Team concluded that Overweight and Obesity has the greatest health disparities seen among populations in Martin County.
April 13, 2022	The Health Equity Team discussed events scheduled during Minority Health Month, including: • April 16th - Healthy Start Baby Shower for Black or African American pregnant women at the East Stuart Community Center. • April 23rd - Health Fair Event, including Zumba and nutrition classes, at the Cassidy Center in Golden Gate • April 30th - YMCA Healthy Kids Event in Indiantown where DOH-Martin distributed nutrition information During this meeting, the Health Equity Team also discussed the PACE-EH initiatives. The Health Equity Liaison gave a report on the meetings with the Indiantown Health Community Committee and shared the surveys developed in English and Spanish assessing healthy food availability in Indiantown.
June 1, 2022	The Health Equity Team discussed details of the Health Equity Plan and what had been accomplished to this point. The Health Equity Team also decided that the cover photo for the Plan will be of Martin County residents. Because the Health Equity Team is also part of the Health Equity Taskforce, the Team discussed some of the details of the PACE-EH project that will be implemented in Indiantown, including the surveys and survey participant recruitment strategies.

C. Health Equity Taskforce

The Health Equity Taskforce includes DOH-Martin County staff and representatives from a diverse range of organizations, including direct service organizations, that address the SDOHs in Martin County. During the months of December 2021 and January 2022, the Health Equity Team worked to recruit a diverse array of partners via different community events, flyer e-blasts, and direct one-on-one engagements. From February 2022 to May 2022, the Health Equity Taskforce met monthly to develop the Martin County Health Equity Plan. During each meeting, members engaged in thoughtful discussion, contributing their knowledge and deep understanding of community needs and the impact of the SDOHs in Martin County. These thoughtful insights directly informed the Martin County Health Equity Plan and, together, the Health Equity Taskforce and the Health Equity Team designed the Plan's projects to strategically focus on addressing upstream factors to advance health equity and reduce inequities among Martin County residents.

The Health Equity Taskforce members are listed in the table below.

Name	Organization	SDOH	Member Roles
Luci Delgado	Whole Child Connection Martin County	Access to Health Care	Gather information; research strategies; provide input
Dorothy Oppensheiser	Tykes and Teens	Access to Health Care	Gather information; research strategies; provide input
Samantha Suffich	Martin County Healthy Start Coalition	Access to Health Care/Economic Stability	Gather information; research strategies; provide input
Bruce Roeder	Helping People Succeed	Economic Stability	Gather information; research strategies; provide input
Yvette Goodiel	University of Florida	Built Environment/ Access to Education	Gather information; research strategies; provide input
Amanda Tejada-Blanco	Universal Health Services	Access to Health Care	Gather information; research strategies; provide input
Dr. Alethia DuPont	Tykes and Teens	Access to Health Care	Gather information; research strategies; provide input
Jennifer Buntin	UF/IFAS Extension Family Nutrition Program	Built Environment/Economic Stability	Gather information; research strategies; provide input
Karlette Peck	Community Member/Public Health Professional	Access to Health Care	Gather information; research strategies; provide input
Caitlynne Oaknueru	Boys and Girl Scouts	Built Environment/Access to Education	Gather information; research strategies; provide input

Christine Pelaez-Pena	Epilepsy Florida	Access to Health Care	Gather information; research strategies; provide input
Jenna Desranleau	Cleveland Clinic	Access to Health Care	Gather information; research strategies; provide input
Natalie Parkell	UF/IFAS Extension 4-H Program	Access to Health Care	Gather information; research strategies; provide input
Brittani Coore	American Heart Association	Access to Health Care	Gather information; research strategies; provide input
Denise Lasarte	Epilepsy Florida	Access to Health Care	Gather information; research strategies; provide input
Jacklyn Rivera	Martin County	Built Environment/ Economic Stability	Gather information; research strategies; provide input
Leslie Frederick	House of Hope	Economic Stability	Gather information; research strategies; provide input
Kaley Newby	211 Palm Beach/Treasure Coast	Economic Stability/Social & Community Context	Gather information; research strategies; provide input
Althea Jefferson	Village of Indiantown	Built Environment/Social and Community Context	Gather information; research strategies; provide input
Deborah Resos	Village of Indiantown	Built Environment/Social and Community Context	Gather information; research strategies; provide input
Jackie Clarke	Village of Indiantown	Built Environment/Social & Community Context	Gather information; research strategies; provide input
Tracy Bryant	Village of Indiantown	Built Environment/Social & Community Context	Gather information; research strategies; provide input
Patricia Brown	Boys and Girls Club	Access to Education/Economic Stability	Gather information; research strategies; provide input
Kristine Murphy	YMCA Indiantown	Social & Community Context	Gather information; research strategies; provide input
Juan Carlos Lasso	Holy Cross Church	Social & Community Context	Gather information; research strategies; provide input

The Health Equity Taskforce met during the health equity planning process on the dates listed in the table below.

Meeting Date	Organizations	Topic/Purpose
February 10, 2022	Whole Child Connection Martin County Tykes and Teens Healthy Start Helping People Succeed University of Florida Universal Health Services UF/IFAS Extension Community Member/ Boys and Girl Scouts Epilepsy Florida Cleveland Clinic American Heart Association DOH-Martin County House of Hope 211 Palm Beach County/Treasure Coast	Welcome to Martin County Health Equity Task Force. Present data and introduce the Health Equity Plan.
March 24, 2022	Whole Child Connection DOH-Martin County Tykes and Teens Healthy Start Helping People Succeed University of Florida Universal Health Services UF/IFAS Extension Community Member/ Boys and Girl Scouts Epilepsy Florida Cleveland Clinic American Heart Association House of Hope 211 Palm Beach County/Treasure Coast	Introduced Martin County disparity, and relationship with the Social Determinants of Health. Selected priority population. Started conversation about vision for our Health Equity Plan.
April 19, 2022	Whole Child Connection DOH-Martin County Tykes and Teens Healthy Start Helping People Succeed University of Florida Universal Health Services Tykes and Teens UF/IFAS Extension Community Member/	Voted on a vision for our Health Equity Plan. Selected an Evidence-based Framework. Discussed our strategic objective and introduced evidence-based strategies.

	Boys and Girl Scouts Epilepsy Florida Cleveland Clinic American Heart Association Epilepsy Florida Martin County House of Hope 211 Palm Beach County/Treasure Coast	
May 24, 2022	Village of Indiantown DOH-Martin County Epilepsy Florida Tykes and Teens UF/IFAS Extension Healthy Start 211 Palm Beach County/Treasure Coast House of Hope Treasure Coast Food Bank Whole Child Connection Coral Shores Behavioral Health	Reviewed Health Equity Plan progress and collaborated on Health Equity Plan projects to address the prioritized health disparity and populations.

D. Coalition

The Martin County Health Equity Coalition's goal is to oversee implementation of the Health Equity Plan, its projects, and all related activities. The Coalition will meet at least quarterly to track progress. Because of the Health Equity Plan's clear alignment with the Martin County Community Health Improvement Plan (CHIP) strategies and its strategic focus on eliminating barriers to the SDOHs to improve the health of residents, the Martin County Community Health Advisory Council will serve as the Martin County Health Equity Coalition. During the CHIP Advisory Council meeting on December 8, 2021, members agreed to serve in this capacity if activities can be integrated into current CHIP meetings.

On June 2, 2022, the Coalition assisted the Health Equity Taskforce by reviewing the Health Equity Plan for feasibility. Coalition members reviewed and agreed that the outlined community projects were feasible and made no suggestions for revisions. In fact, one Coalition member requested for their organization to be added as a key partner for the community projects.

Members of the Martin County Health Equity Coalition include cross-sector leaders working to address complex issues facing Martin County residents. Participation by diverse community representation and collaboration between these stakeholders is fundamental to the implementation and success of the Health Equity Plan. Members of the Coalition represent the following sectors: health care, education, social and support services, mental health, faith-based organizations, academia, fire rescue, law enforcement, transportation, youth services, elder services, nutrition and food services, and city and county officials. A full membership list can be found in Addendum A.

E. Regional Health Equity Coordinators

There are eight Regional Health Equity Coordinators at the Florida Department of Health. These coordinators provide the Minority Health Liaison, Health Equity Team, and Health Equity Taskforce in each County with technical assistance, training, and project coordination.

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

Regional Health Equity Coordinator contact information is listed below.

Consortium/Lead County	Name	Phone	Email
Emerald Coast- Jackson	Carrie Rickman	850-526-2412 x182	Carrie.Rickman@flhealth.gov
Capital- Wakulla	Quincy Wimberly	850-888-6076	Quincy.Wimberly@flhealth.gov
Northeast- Volusia	Ida Wright	386-956-7813	Ida.Wright@flhealth.gov

North Central- Alachua	Diane Padilla	352-225-4354	Diane.Padilla@flhealth.gov
West- Pinellas	Rafik Brooks	727-568-8091	Rafik.Brooks@flhealth.gov
Central- Seminole	Lesli Ahonkhai	407-665-3276	Lesli.Ahonkhai@flhealth.gov
Southeast- Broward	Natasha McCoy (Interim)	225-803-0709	Natasha.McCoy@flhealth.gov
Southwest- Lee	Frank Diaz-Gines	239-332-9519	Frank.Diaz@flhealth.gov

V. HEALTH EQUITY ASSESSMENT, TRAINING, AND PROMOTION

A. Health Equity Assessments

To improve health outcomes in Florida, it is critical to assess the knowledge, skills, organizational practices, and infrastructure necessary to 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

At this time, the Health Equity Assessment is currently pending approval from the Florida Department of Health. As soon as the Assessment is approved, DOH-Martin County will conduct a health equity assessment to examine the capacity and knowledge of DOH-Martin County staff and county partners to address the social determinants of health.

B. County Health Department Health Equity Training

DOH- Martin County recognizes that ongoing training in health equity and cultural competency is critical for sustaining a health equity focus throughout all county efforts. At a minimum, all DOH-Martin County 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 provided is recorded below.

Date	Topics
Available on demand	Addressing Health Equity: A Public Health Essential
Available on demand	Cultural Awareness: Introduction to Cultural Competency and Humility

C. Countywide Health Equity Trainings

The Health Equity Team shared information with the Health Equity Taskforce on the Florida Department of Health's Office of Minority Health and Health Equity (OMHHE) free, web-based Health Equity Grant Writing Training. The training was designed to help organizations gain skills writing grant proposals and developing impactful projects focusing on health equity.

Below are the dates and SDOH training topics.

Date	Topics
Tuesdays, May 10th through June 14th	Writing grants to improve economic stability, neighborhood and physical environment, education, access to healthier food, community, and collaborative partnerships to improve access to health care

D. Minority Health Liaison Training

The Office of Minority Health and Health Equity and the Health Equity Regional Coordinator provide training and technical support to the Minority Health Liaison on topics such as: the health equity planning process and goals, facilitation and prioritization techniques, reporting requirements, and taking a systems approach to address health disparities. The Minority Health Liaison trainings are listed in the table below.

Date	Topics
January 25, 2022	"Cultural Competency & Health Equity"; A virtual 1.5 hours training held by the Statewide Health Equity Training Administrator for Minority Health Liaisons (MHL)
February 22-24, 2022	"Elements of a Healthy, Equitable Community"; To strengthen facilitation skills using the Technology of Participation methods
April 13, 2022	"Implementing Upstream Strategies to Advance Health Equity in Public Health Practice"
May 29, 2022	2019 State of Health Equity at CDC Forum
May 26, 2022	Cultural Awareness: Introduction to Cultural Competency and Humility

E. National Minority Health Month

DOH-Martin County's Minority Health Month Event occurred on April 23, 2022 at Golden Gate Park in Stuart and was called Music and Movement (Música y Movimiento). DOH-Martin partnered with several media outlets, including The Hispano Newspaper, the Martin County Interagency Coalition, and the Martin County Connection Newsletter, to promote the event among key priority populations through ads and social media posts. DOH-Martin also ran press releases through partners and media outlets, promotional posts on Twitter, posted flyers in DOH-Martin clinics, used WhatsApp to community directly with community members, and conducted in-person outreach at establishments near the park's surrounding area and neighborhood. As a result, this was a very successful event where DOH-Martin promoted nutrition and healthy lifestyles in an area where a large proportion of Black or African American and Hispanic residents reside.

During the event, DOH-Martin, Martin County Parks and Recreation, University of Florida/Institute of Food and Agricultural Sciences (UF/IFAS) Extension Program, House of Hope, Career Source, and Women, Infants, and Children (WIC) of Martin County provided information on nutrition and healthy lifestyles, WIC services, breastfeeding resources, pool safety, exercise, career services, and insurance. The UF/IFAS Extension Program also provided water and healthy beverage samples, and DOH-Martin spoke to attendees about the Health Equity Plan priority to reduce obesity in Martin County among Black or African American and Hispanic or Latino youth.

Moreover, DOH-Martin invited a well-known Zumba instructor to conduct a Zumba class, in which many Black or African American and Hispanic residents participated and enjoyed! DOH-Martin shared information on free weekly Zumba classes offered by the House of Hope, so residents can continue to engage in physical activity opportunities. Many of Martin County's Latino and African American families attended the celebration.

During Minority Health Month, the Martin County Health Equity Team also conducted outreach and tabled at other events to share nutrition and healthy lifestyle resources, including Healthy Start's Black and African American Baby Shower, held on April 15, 2022, and the YMCA Healthy Kids Day Event in Indiantown, held on April 30, 2022.

As seen in the photo below, on May 11, 2022, the City of Stuart recognized DOH-Martin's Go Healthy Martin team for their mission to promote good health for all.

VI. PRIORITIZING A HEALTH DISPARITY

To prioritize a health disparity for the Martin County Health Equity Plan, the Health Equity Team gathered secondary data related to resident demographics, health outcomes, and the Social Determinants of Health (SDOHs) to evaluate and identify specific populations in Martin County experiencing significant health inequities and health outcome disparities. Data was pulled from multiple sources, such as the Florida Department of Health Division of Public Health Statistics and Performance Management, United States Census Bureau's American Community Survey, Florida Behavioral Risk Factor Surveillance System Survey, Florida Youth Tobacco Survey, National Survey on LGBTQ Youth Mental Health, Martin County School District, County Health Rankings and Roadmaps, Centers for Disease Control and Prevention (CDC), Transgender Discrimination Survey, internal Florida Department of Health databases, the Knowli Data Science and the FSU Claude Pepper Center Faculty, and other community organizations.

Every attempt was made to find data available on groups known through research to experience worse health outcomes, such as Black or African Americans, American Indian and Alaska Natives, Asians, Native Hawaiian and other Pacific Islanders, Hispanics and Latinos, elders aged 65 years and older, infants and toddlers aged 0 to 5 years, people living with disabilities, veterans, individuals identifying as lesbian, gay, bisexual, transgender, and/or queer (LGBTQ+), immigrants, and people living within specific ZIP codes or Census Tracts. The Health Equity Team included overall county-level data, data by Census Tract or ZIP code, and data for these high priority groups mentioned above in this report wherever possible. Unfortunately, data related to health outcomes and the SDOHs was unavailable for these groups or areas in several instances. The Health Equity Taskforce plans to address this in the Plan through the implementation of a data collection project. More information on this project can be found on page 247.

After gathering all available secondary data on Martin County residents, the Health Equity Team reviewed the data with the Health Equity Taskforce during meetings where members were invited to participate in discussion. After these discussions with the Health Equity Taskforce, the Health Equity Team held a consensus meeting, in which discussion and data were evaluated using the Prioritization Matrix, to determine a health outcome disparity to prioritize for the Health Equity Plan. The Prioritization Matrix assigns ratings to health outcomes against criteria, such as total impact, alignment, and actionable feasibility, weighs the criteria by level of importance, and calculates a priority score for each health outcome. As seen in the table below, the following health disparities were identified in Martin County: obesity, diabetes, and heart disease/stroke. Please see below for the Martin County Health Equity Team's completed Prioritization Matrix.

Proposed area for health equity improvement base on local Community Health Assessment, CHIP and Data from Florida CHARTS	Size of the Problem	Severity of the Problem	Availability of Current Interventions	Economic and Societal Impact	Total
Obesity	5	4	4	5	400
Diabetes	4	4	4	5	320
Heart Disease/Stroke	2	5	3	5	150

Through this data collection and evaluation process, the Health Equity Team identified and prioritized the following health disparity for the Martin County Health Equity Plan:

Overweight and Obesity Among Black or African American and Hispanic or Latino Youth

Through the development of this plan, it has become very clear that many communities in Martin County are facing significant health inequities related to the SDOHs, causing distinct disparities in health outcomes, specifically overweight and obesity. As explored in this report, Black or African American and Hispanic or Latino youth are at significant risk of becoming overweight or obese and experience the greatest disparities in overweight and obese status and SDOHs compared to their counterparts. This is not only apparent because of the prevalence of overweight and obesity among this population based on the most recent data available, but it is also critical to address because of the barriers they face related to the SDOHs, thus inhibiting their opportunity to achieve optimal health throughout their lifespan. Additionally, being overweight or obese leads to increased medical costs and

loss of productivity, further exacerbating the economic burden of the disease on individuals and society as a whole.[1]

Research shows that, in the United States, the prevalence of obesity among Hispanic or Latino children aged 2 to 5 years old is four times higher than their non-Hispanic White counterparts, and the prevalence among those aged 6 to 11 years old is twice as high when compared to their non-Hispanic White counterparts. Furthermore, from 2011 to 2014, the prevalence of obesity among non-Hispanic Black children aged 2 to 5 years old was 10.4% compared to 5.2% among their non-Hispanic White counterparts. For children aged 6 to 11 years old during this same time period, 21.4% of non-Hispanic Black children were obese versus 13.6% of their non-Hispanic White counterparts.[2] This data is especially alarming and is a complex issue facing our communities.

Additionally, overweight or obese children are more likely to remain obese into adulthood and to develop other health complications, such as diabetes and cardiovascular disease.[3] Health behavior, which directly impacts overweight and obesity risk, is influenced by the social and environmental factors, or the SDOHs, in which individuals live and experience life. Further, for youth in particular, the social and environmental factors in which they live are not their own choice and are influenced by their parents or caregivers. This is an important consideration when reviewing data, as adult health outcomes are also an indication of family behavior and barriers to the SDOHs, which will ultimately impact youth to a greater extent. For example, among food insecure Latino households in the United State, the prevalence of obesity increases among youth across generations.[4] Because of the clear disparities that these populations face, as demonstrated in this report through data and literature, the Health Equity Taskforce has chosen to focus on this priority population for future efforts.

It is important to note that, while attempts were made to disaggregate by other key populations, such as individuals who identify as lesbian, gay, bisexual, transgender, and/or queer (LGBTQ+), immigrants, and individuals who reside in specific ZIP codes and/or census tracts, currently, there is no available

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[1] LaVeist, T. A., Gaskin, D., & Richard, P. (2011). Estimating the Economic Burden of Racial Health Inequalities in the United States. International Journal of Health Services, 41(2), 231–238. https://doi.org/10.2190/HS.41.2.c
[2] Ogden, C. L., Carroll, M. D., Lawman, H. G., Fryar, C. D., Kruszon-Moran, D., Kit, B. K., & Flegal, K. M. (2016). Trends in Obesity Prevalence Among Children and Adolescents in the United States, 1988-1994 Through 2013-2014. JAMA, 315(21), 2292–2299. https://doi.org/10.1001/jama.2016.6361
[3] Sahoo, K., Sahoo, B., Choudhury, A. K., Sofi, N. Y., Kumar, R., & Bhadoria, A. S. (2015). Childhood obesity: causes and consequences. Journal of family medicine and primary care, 4(2), 187–192. https://doi.org/10.4103/2249-4863.154628
[4] Flórez, KR, Katic, BJ, López-Cevallos, DF, et al. The double burden of food insecurity and obesity among Latino youth: Understanding the role of generational status. Pediatric Obesity. 2019; 14:e12525. https://doi.org/10.1111/ijpo.12525

overweight or obesity data for these specific populations. The Martin County Health Equity Taskforce is implementing a SDOH Screening Tool Community Project to address these gaps in data. We also made sure to include national-level data wherever there were gaps, from sources such as the Trevor Project, the National Transgender Discrimination Survey, and the US Department of Veterans Affairs. Moreover, several efforts at the state and federal level are taking place to address these gaps, and the Martin County Health Equity Taskforce will look into how we can support these initiatives. For instance, to address the lack of sexual orientation and gender identity data, there is a Health People 2030 objective to "Increase the number of states, territories, and the District of Columbia that include questions on sexual orientation and gender identity in the Behavioral Risk Factor Surveillance System (BRFSS)."[5] Available data on overweight and obesity status and the SDOHs for Martin County residents that was compiled and evaluated during this process is listed on the following pages.

Finally, as a note, evidence shows that **immigrant populations** experience lower obesity rates and, thus, do not experience obesity-related disparities. A large national study found that non-immigrant populations experienced higher obesity rates than immigrant populations (22% and 14%, respectively).[6] Therefore, while we do include SDOH indicators disaggregated by nativity, this will not be a prioritized population for our efforts to reduce obesity in Martin County.

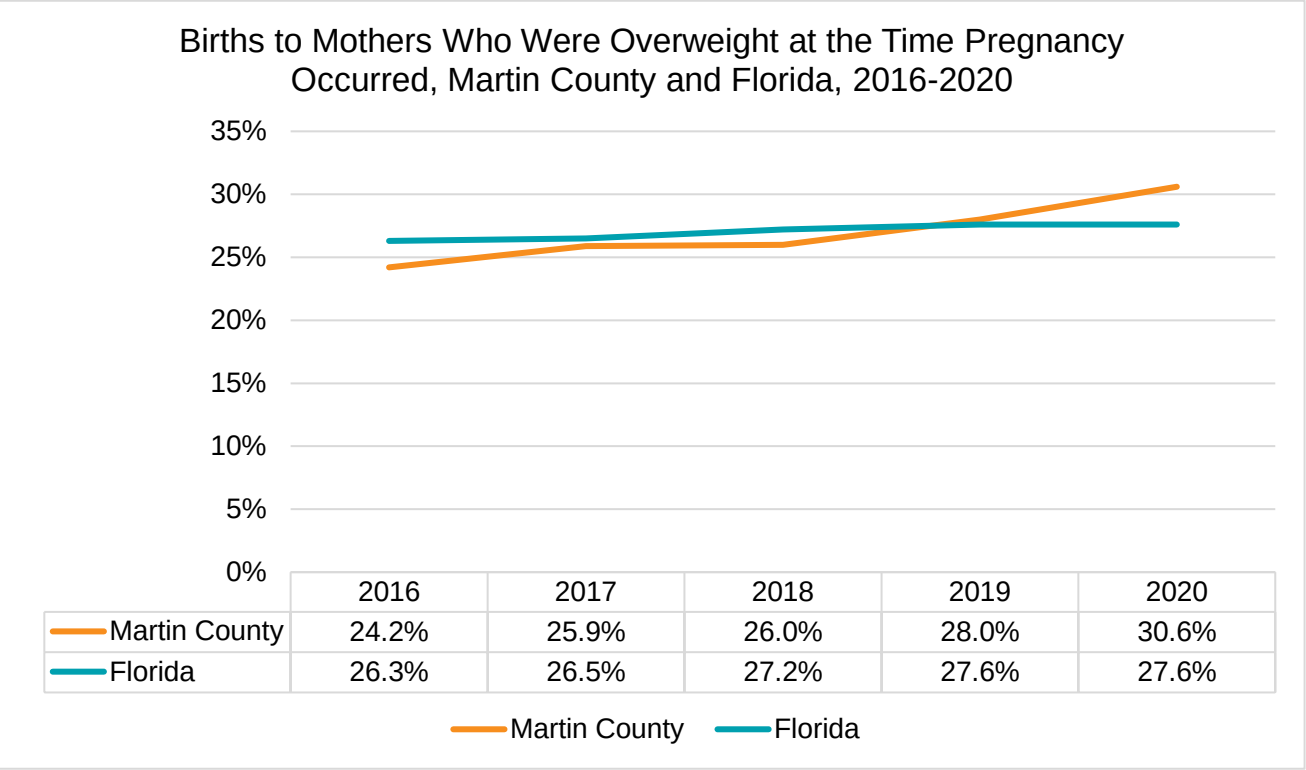
[5] Increase the number of states, territories, and DC that include sexual orientation and gender identity questions in the BRFSS — LGBT-03 (n.d.). In *Healthy People 2030*. Retrieved from https://health.gov/healthypeople/objectives-and-data/browse-objectives/lgbt/increase-number-states-territories-and-dc-include-sexual-orientation-and-gender-identity-questions-brfss-lgbt-03

[6] Goel, M.S., McCarthy, E.P., et al. (2004). Obesity among US immigrant subgroups by duration of residence. *JAMA.* 292(23): 2860-2867.

Births to Mothers Who Were Overweight at the Time Pregnancy Occurred

Women who are overweight or obese while pregnant are more likely to have premature births, babies with birth defects, or babies who are large for gestational age. These women are also more likely to have complications during labor and birth, and their babies are at a higher risk of developing heart disease, diabetes, and obesity later in life. [7] [8]

The figure below shows the proportion of births to mothers who were obese at the time that pregnancy occurred for both **Martin County** and **Florida** from 2016 to 2020. Overall, the proportion of births to obese mothers in Martin county steadily increased and exceeded that of the State's. Most recently, in 2020, 30.6% of births in Martin County were to obese mothers, compared to 27.6% of births in Florida.

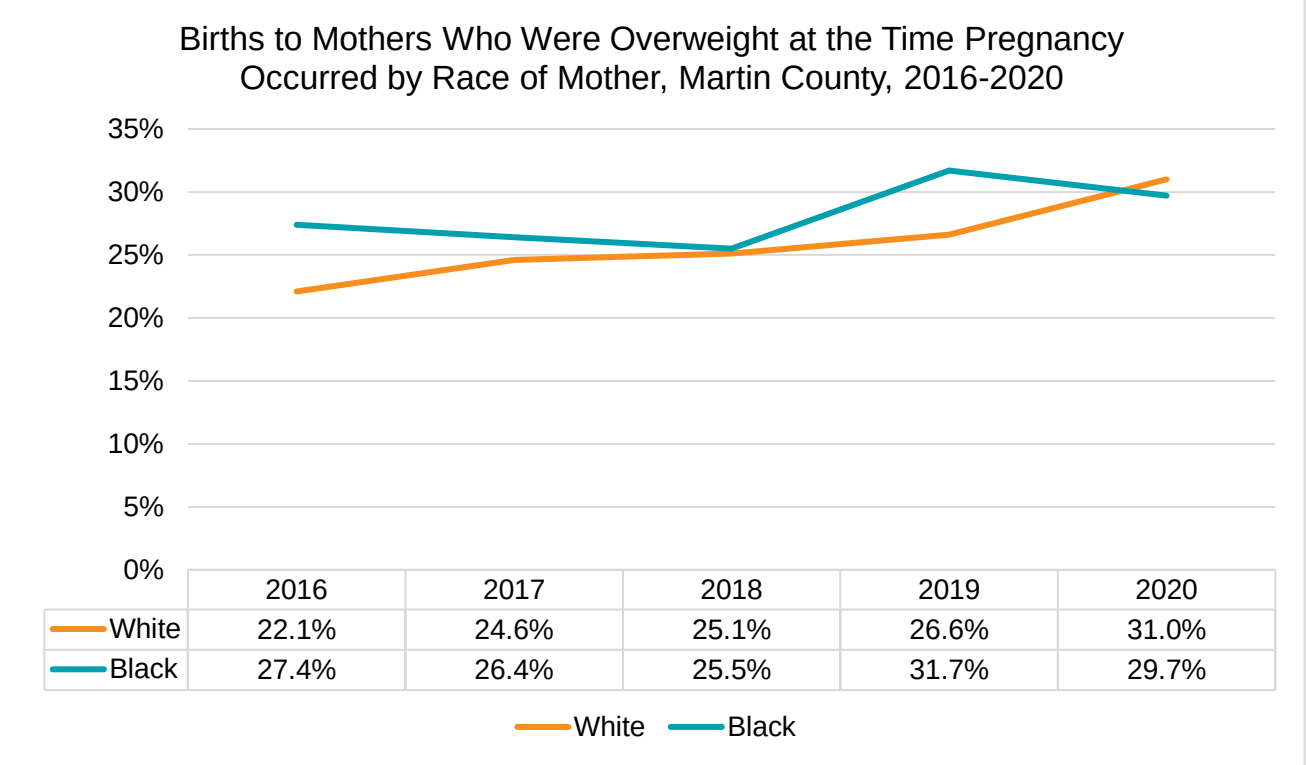


	2016	2017	2018	2019	2020
Martin County	24.2%	25.9%	26.0%	28.0%	30.6%
Florida	26.3%	26.5%	27.2%	27.6%	27.6%

Source: Florida Department of Health, Bureau of Vital Statistics

[7] Fitzsimons, K. J., Modder, J., & Greer, I. A. (2009). Obesity in pregnancy: risks and management. Obstetric medicine, 2(2), 52–62. https://doi.org/10.1258/om.2009.090009
[8] Leddy, M. A., Power, M. L., & Schulkin, J. (2008). The impact of maternal obesity on maternal and fetal health. Reviews in obstetrics & gynecology, 1(4), 170–178.

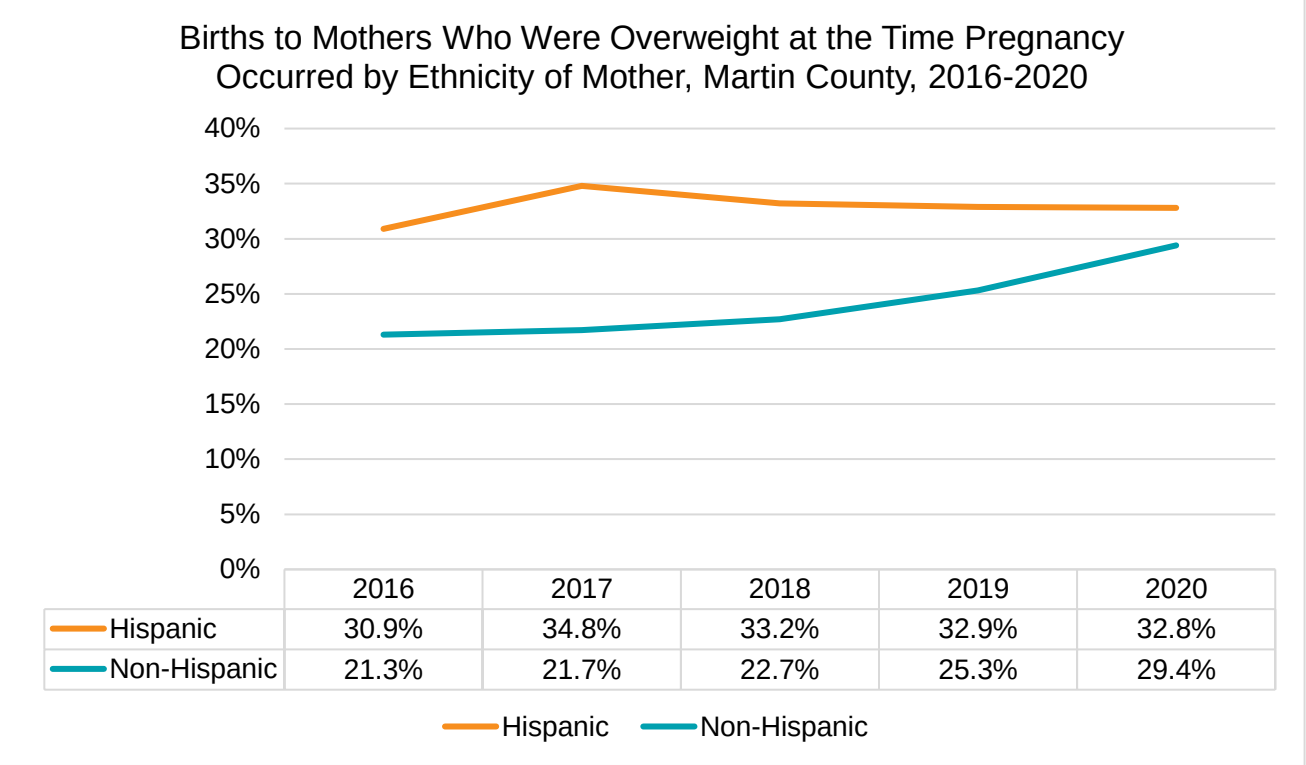
The figure below shows the proportion of births to mothers who were overweight at the time of pregnancy occurred by **race** of mother in Martin County from 2016 to 2020. There was fluctuation among births of Black mothers with a decrease from 27.4% in 2016 to 25.5% in 2018, an increase to 31.7% in 2019, and a decrease to 29.7% in 2020. Among births to White mothers, there was a steady increase from 22.1% who were overweight in 2016 to 31.0% in 2020. Most recently in 2020, 29.7% of Black births were to overweight mothers, compared to 31.0% of White births.



	2016	2017	2018	2019	2020
White	22.1%	24.6%	25.1%	26.6%	31.0%
Black	27.4%	26.4%	25.5%	31.7%	29.7%

Source: Florida Department of Health, Bureau of Vital Statistics

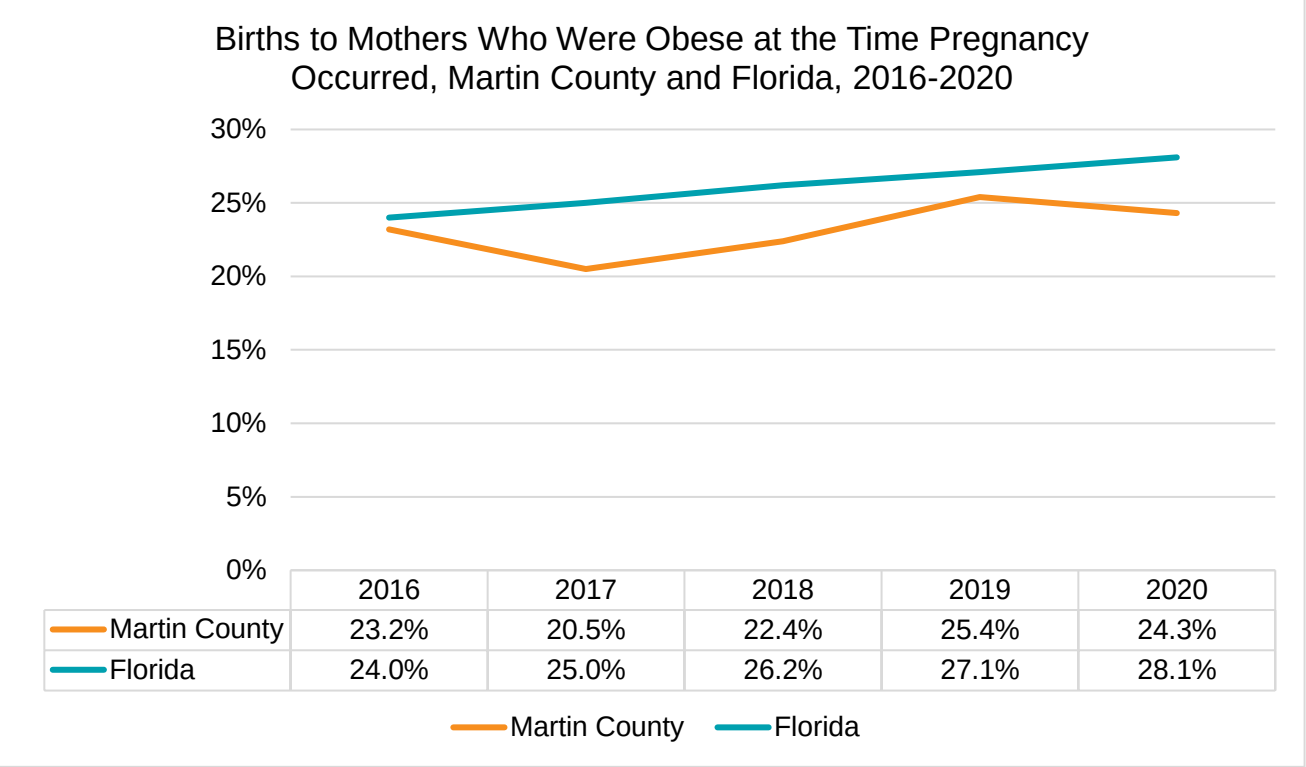
The figure below shows the proportion of births to mothers who were overweight at the time of pregnancy occurred by **ethnicity** in Martin County from 2016 to 2020. The proportion of births to overweight Hispanic mothers increased from 2016 (30.0%) to 2017 (34.8%), then decreased slightly each year to 2020 (32.6%). There was a steady increase in the proportion of births among Non-Hispanic overweight mothers from 2016 (21.3%) to 2020 (29.4%). The proportion of births to mothers who were overweight at the time of pregnancy among Hispanic mothers was higher than the proportion among non-Hispanic mothers each year during this timeframe. Most recently in 2020, 32.8% of Hispanic births were to overweight mothers, compared to 29.4% of non-Hispanic births.



Source: Florida Department of Health, Bureau of Vital Statistics

Births to Mothers Who Were Obese at The Time of Pregnancy

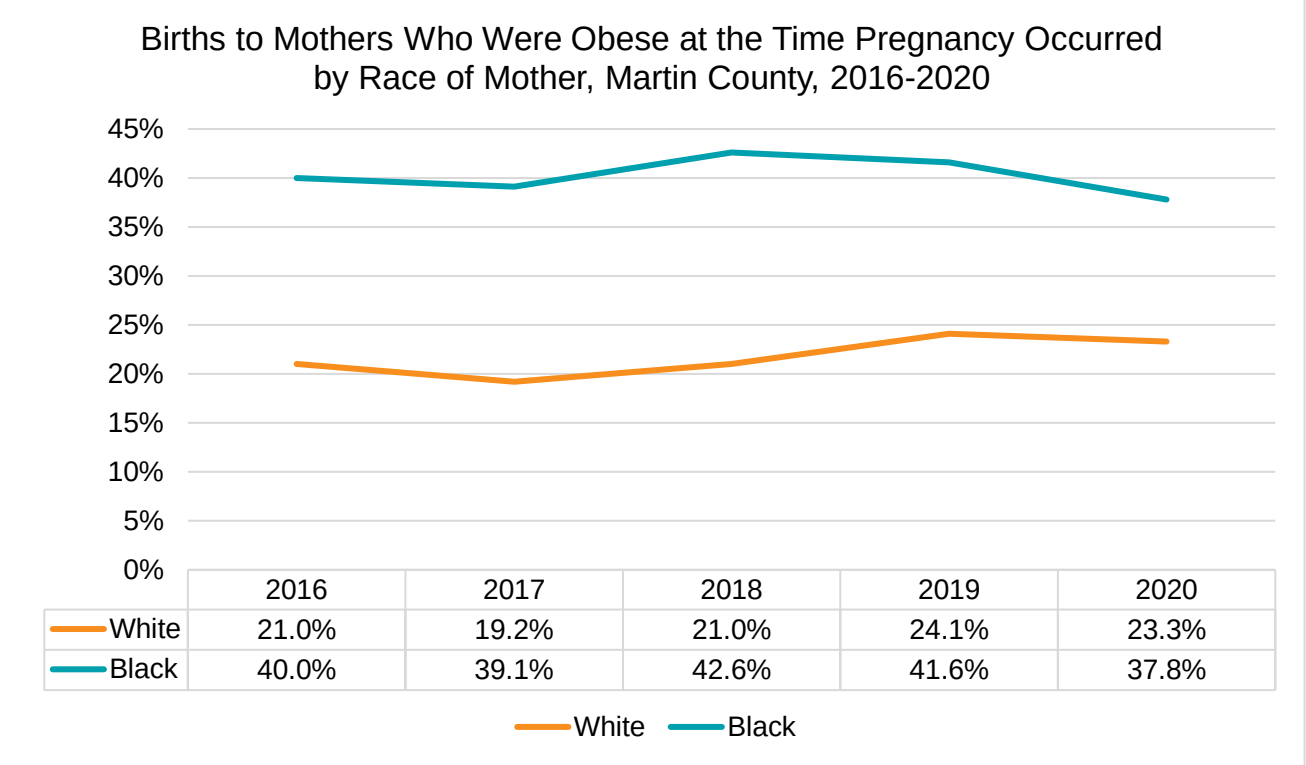
The figure below shows the proportion of births to mothers who were obese at the time of pregnancy occurred in **Martin County** and **Florida** from 2016 to 2020. Each year, the proportion of births to obese mothers at the time pregnancy occurred steadily increased in Florida and exceeded that of Martin County's. Although there was some fluctuation, the proportion increased from 23.2% in 2016 to 24.3% in 2020 in Martin County. Most recently in 2020, 24.3% of births were to mothers who were obese at the time of pregnancy in Martin County, compared to 28.1% in Florida.



	2016	2017	2018	2019	2020
Martin County	23.2%	20.5%	22.4%	25.4%	24.3%
Florida	24.0%	25.0%	26.2%	27.1%	28.1%

Source: Florida Department of Health, Bureau of Vital Statistics

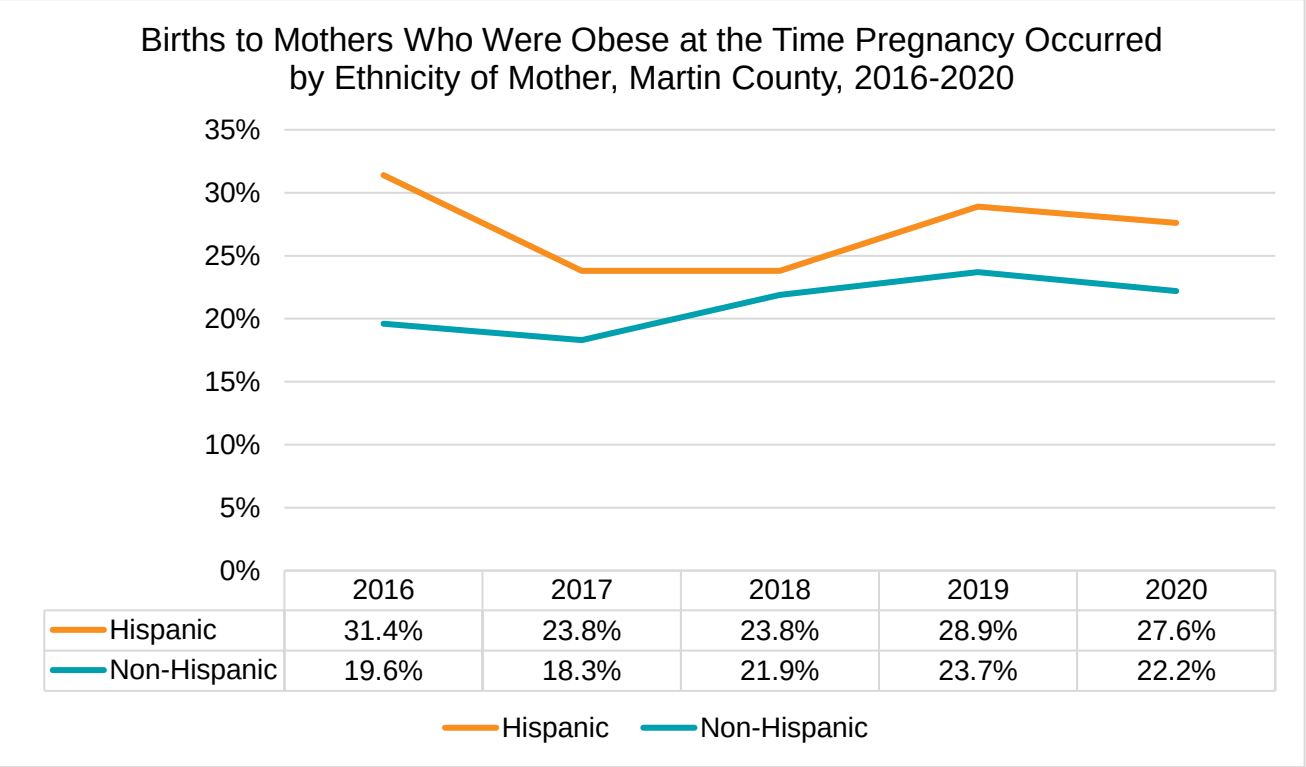
The figure below shows the proportion of births to mothers who were obese at the time pregnancy occurred by **race** of mother in Martin County from 2016 to 2020. There was an overall decrease in proportion of Black births to obese mothers from 40.0% in 2016 to 37.8% in 2020. Comparatively, the proportion of White births to obese mothers increased from 21.0% in 2016 to 23.3% in 2020. Most recently in 2020, 37.8% of Black births were to obese mothers, compared to 23.3% of White births to obese mothers. Unfortunately, data for other racial groups was unavailable for this indicator.



	2016	2017	2018	2019	2020
White	21.0%	19.2%	21.0%	24.1%	23.3%
Black	40.0%	39.1%	42.6%	41.6%	37.8%

Source: Florida Department of Health, Bureau of Vital Statistics

The figure below shows the proportion of births to mothers who were obese at the time pregnancy occurred by **ethnicity** in Martin County from 2016 to 2020. There proportion fluctuated among both births to obese Hispanic and non-Hispanic mothers. Among births to Hispanic mothers who were obese, there was an overall decrease from 31.4% in 2016 to 27.6% in 2020. Among births to non-Hispanic mothers who were obese, there was an overall increase from 19.6% in 2016 to 22.2% in 2020. Most recently in 2020, 27.6% of Hispanic births were to obese mothers, compared to 22.2% of non-Hispanic births.



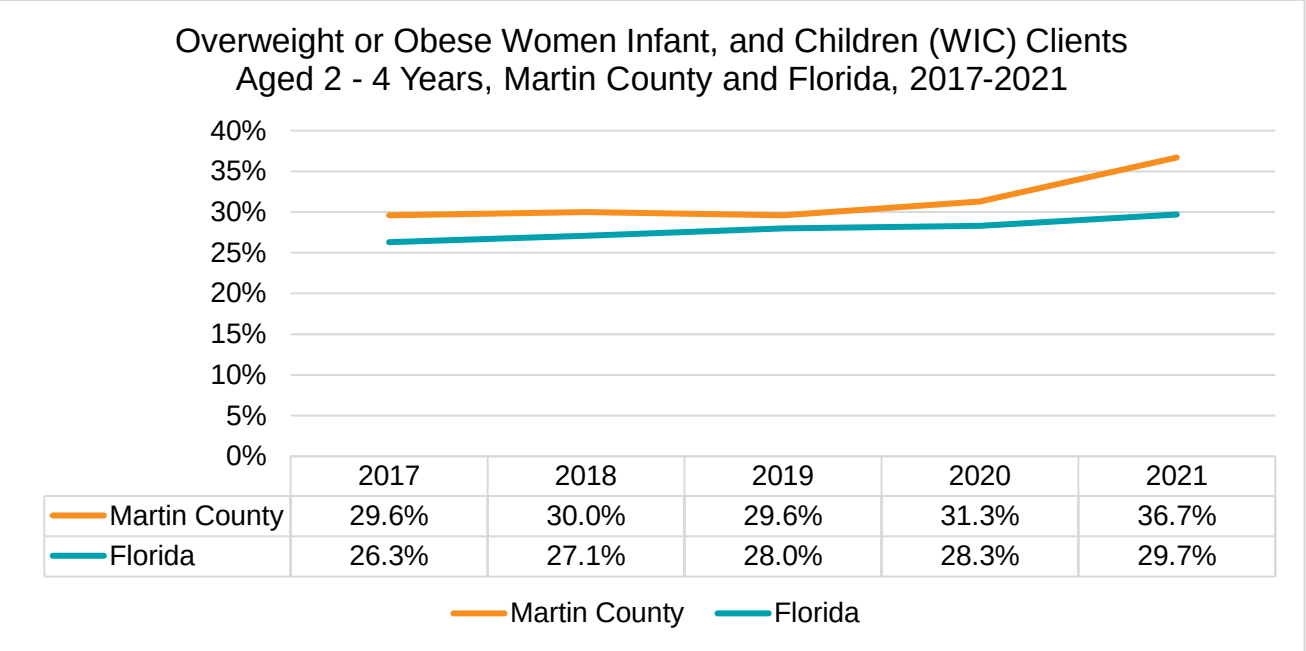
	2016	2017	2018	2019	2020
Hispanic	31.4%	23.8%	23.8%	28.9%	27.6%
Non-Hispanic	19.6%	18.3%	21.9%	23.7%	22.2%

Source: Florida Department of Health, Bureau of Vital Statistics

Overweight or Obese Women, Infant, and Children (WIC) Clients Aged 2-4

Being overweight or obese during childhood increases a child's chance of developing medical problems that can affect present and future health.[9] This includes serious conditions, like Type 2 diabetes, high blood pressure, and high cholesterol, which were all once considered adult diseases. Examining overweight and obesity status among young children helps inform progress toward the goal of promoting healthful diets and healthy weight.

The figure below shows the proportion of overweight or obese Women, Infant, and Children (WIC) clients ages 2 to 4 years old in both **Martin County** and **Florida** from 2017 to 2021. Overall, a higher proportion of WIC clients were overweight or obese in Martin County each year during this timeframe. Most recently, the proportion of overweight or obese WIC clients in Martin County increased from 31.3% in 2020 to 36.7% in 2021. Notably, this data was not available disaggregated by specific demographics; however, as of May 2022 and according to the Florida Department of Health in Martin County's WIC program database, 69% of WIC clients in Martin County are Hispanic or Latino, 12% are Black or African American, 59% reside in Stuart, and 33% reside in Indiantown.



	2017	2018	2019	2020	2021
Martin County	29.6%	30.0%	29.6%	31.3%	36.7%
Florida	26.3%	27.1%	28.0%	28.3%	29.7%

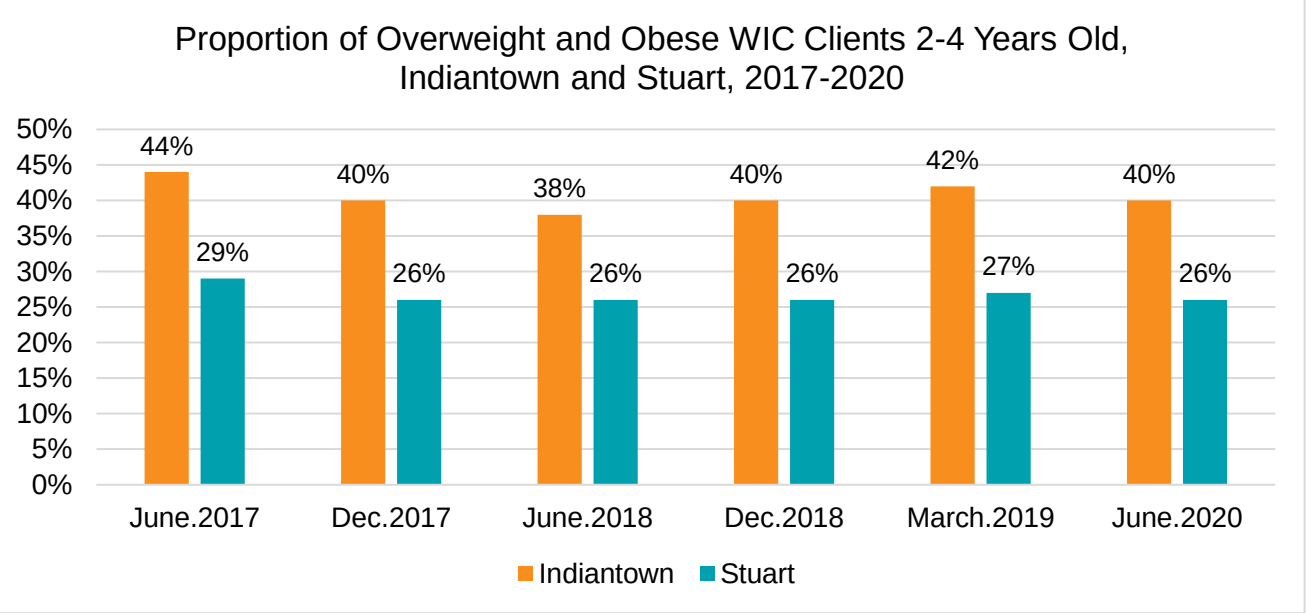
Source: Florida Department of Health, WIC & Nutrition Services, FLWiSE

[9] Daniels, S.R. (2006). The consequences of childhood overweight and obesity. *The Future of Children.* 16(1): 47-67.

Overweight or Obese Women, Infant, and Children (WIC) Clients Aged 2-4 in Indiantown and Stuart

As previously mentioned, being overweight or obese during childhood increases a child's chance of developing medical problems that can affect present and future health.[10] This includes serious conditions, like Type 2 diabetes, high blood pressure, and high cholesterol, which were all once considered adult diseases. Examining overweight and obesity status among young children helps inform progress toward the goal of promoting healthful diets and healthy weight.

The figure below shows the proportion of overweight or obese Women, Infant, and Children (WIC) clients ages 2 to 4 years old in both **Indiantown** and **Stuart** from 2017 to 2020. Overall, a much higher proportion of WIC clients were overweight or obese in Indiantown each year during this timeframe compared to in Stuart. Most recently, the proportion of overweight or obese WIC clients in Indiantown was 40% in Indiantown, compared to 26% in Stuart. Notably, this data was not available disaggregated by specific demographics; however, as of May 2022 and according to the Florida Department of Health in Martin County's WIC program database, 69% of WIC clients in Martin County are Hispanic or Latino and 12% are Black or African American. Moreover, 59% reside in Stuart and 33% reside in Indiantown.

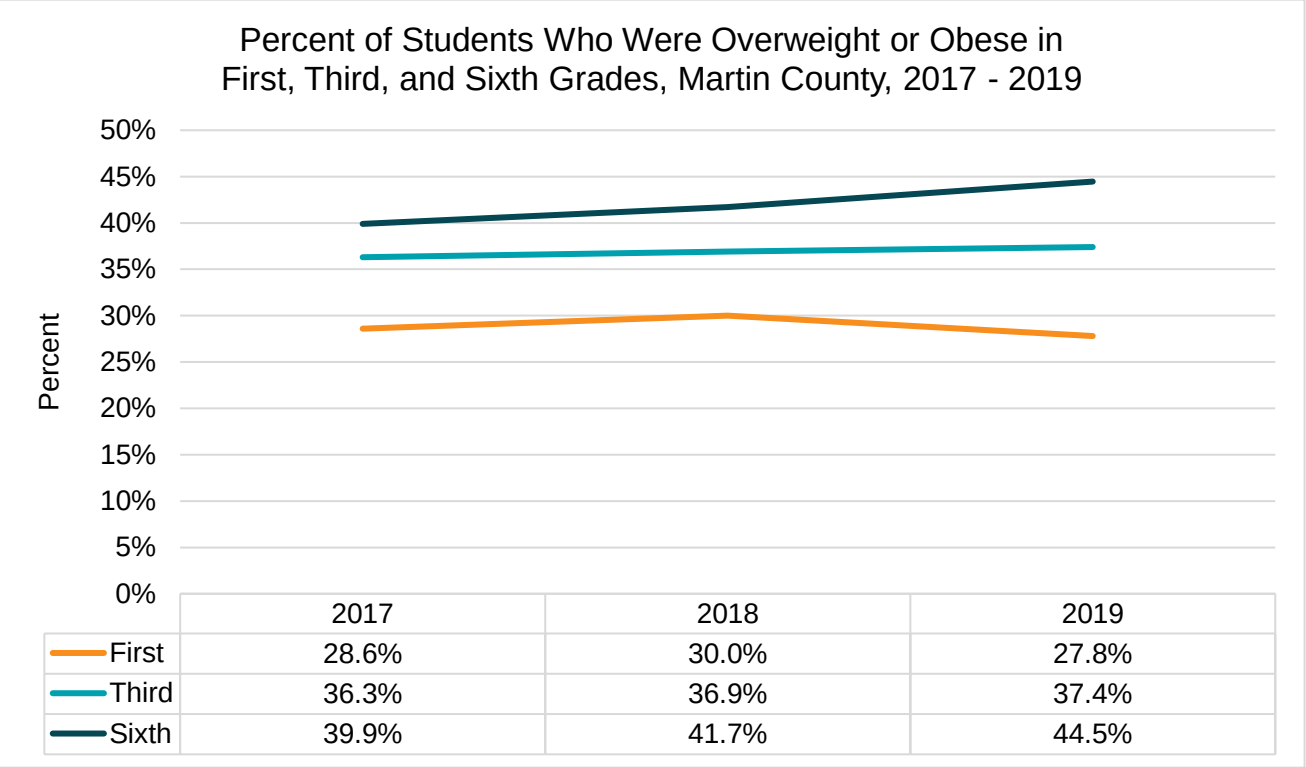


Source: Florida Department of Health, WIC & Nutrition Services

[10] Daniels, S.R. (2006). The consequences of childhood overweight and obesity. *The Future of Children.* 16(1): 47-67.

Students Who Are Overweight or Obese, First, Third, and Sixth Grade

The figure below shows the proportion of students who were overweight or obese in the **first, third**, and **sixth grades** in Martin County from 2017 to 2019. The proportion of students in first grade increased from 28.6% in 2017 to 30.0% in 2018, then decreased to 27.8% in 2019. Comparatively, the proportion of students in third grade increased incrementally from 36.3% in 2017 to 37.4% in 2019. The proportion of students in sixth grade also increased from 39.9% in 2017 to 44.5% in 2019. Most recently, in 2019, 44.5% of students were overweight or obese by the sixth grade, 37.4% by the third grade, and 27.8% by the first grade.



	2017	2018	2019
First	28.6%	30.0%	27.8%
Third	36.3%	36.9%	37.4%
Sixth	39.9%	41.7%	44.5%

Source: Florida Department of Health in Martin County, 2022

Overweight and Obesity School Health Screening Data

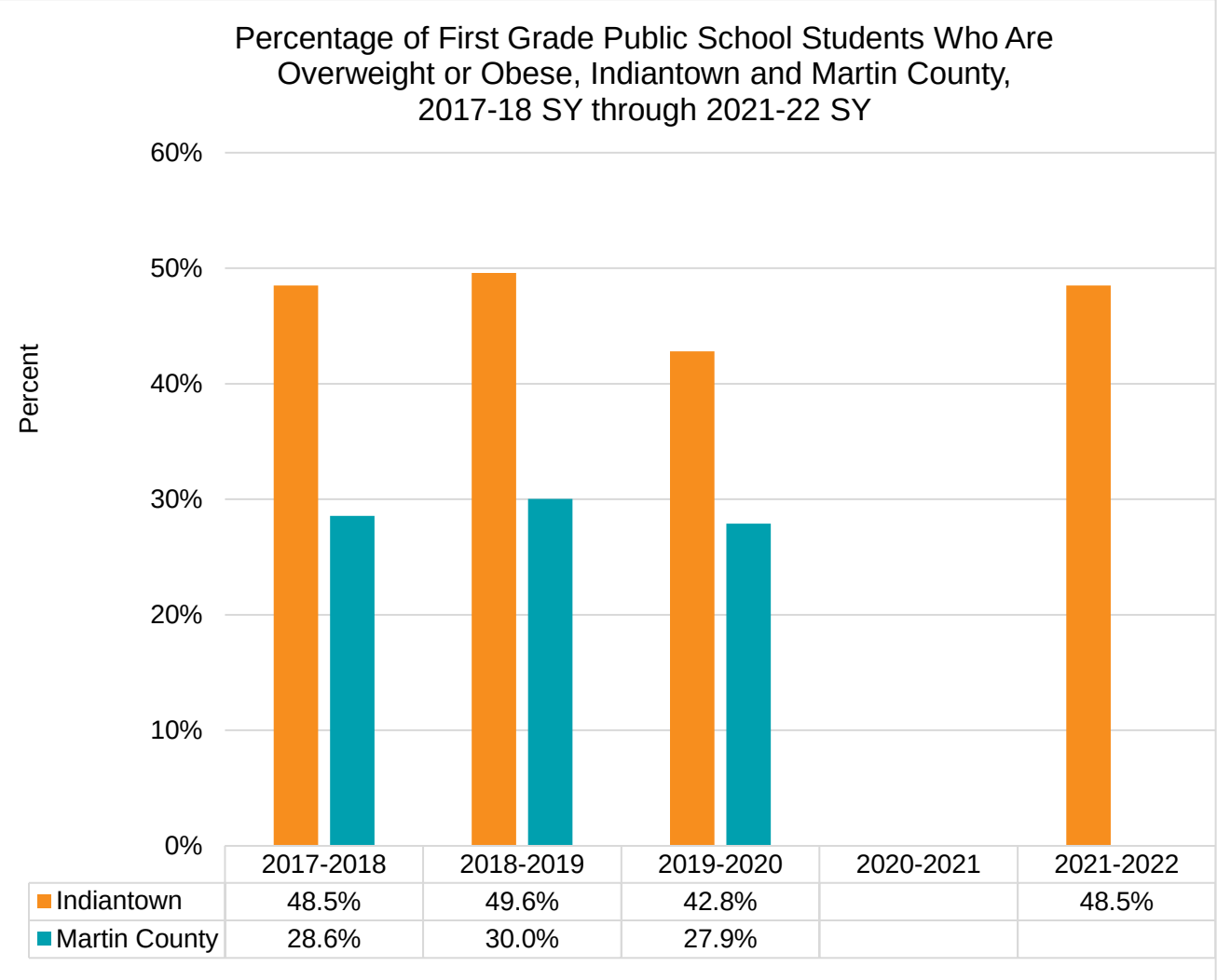
The table below shows the proportion of overweight and obese **first graders** in Martin County elementary schools during the 2019 to 2020 school year. Warfield Elementary, located in Indiantown, had the highest proportion of overweight and obese first graders (43%), followed by Port Salerno Elementary (36%) and Seawind Elementary (34%). The schools with the lowest proportion of overweight and obese first graders were Citrus Grove Elementary (16%), Palm City Elementary (18%), and Jensen Beach Elementary (18%). The Martin County Health Equity Taskforce is implementing a PACE-EH Community Project in Indiantown to improve the neighborhood and built environment, increase access to healthy, affordable foods, and reduce obesity among this population.

Overweight and Obese First Graders, Martin County Elementary Schools, 2019-2020

School	Neighborhood (Zip Code)	Overweight and Obese
Bessey Creek Elementary	Palm City (34490)	20.2%
Citrus Grove Elementary		15.7%
Palm City Elementary		18.0%
Hobe Sound Elementary	Hobe Sound (33455)	27.3%
Seawind Elementary		34.4%
Jensen Beach Elementary	Jensen Beach (34957)	18.0%
JD Parker Elementary	Stuart (34996)	26.9%
Port Salerno Elementary		36.3%
Pinewood Elementary		27.1%
Crystal Lake Elementary		26.9%
Felix A. Williams Elementary		26.7%
Warfield Elementary	Indiantown (34956)	**42.8%**

Source: Florida Department of Health in Martin County, 2022

This graph shows the percentage of **first grade** public school students who were overweight and obese in **Indiantown** and **Martin County** overall. Each year where full data was available, the proportion of first grade public school students who were overweight or obese was much higher in Indiantown compared to the county overall. To note, due to the pandemic and resulting school closures, there was data missing for the 2019 to 2020 school year. For the 2020 to 2021 school year, many schools still faced challenges and did not perform health screenings. As a result, data is unavailable for many schools across the county for the 2021 to 2022 school year.



	2017-2018	2018-2019	2019-2020	2020-2021	2021-2022
Indiantown	48.5%	49.6%	42.8%		48.5%
Martin County	28.6%	30.0%	27.9%		

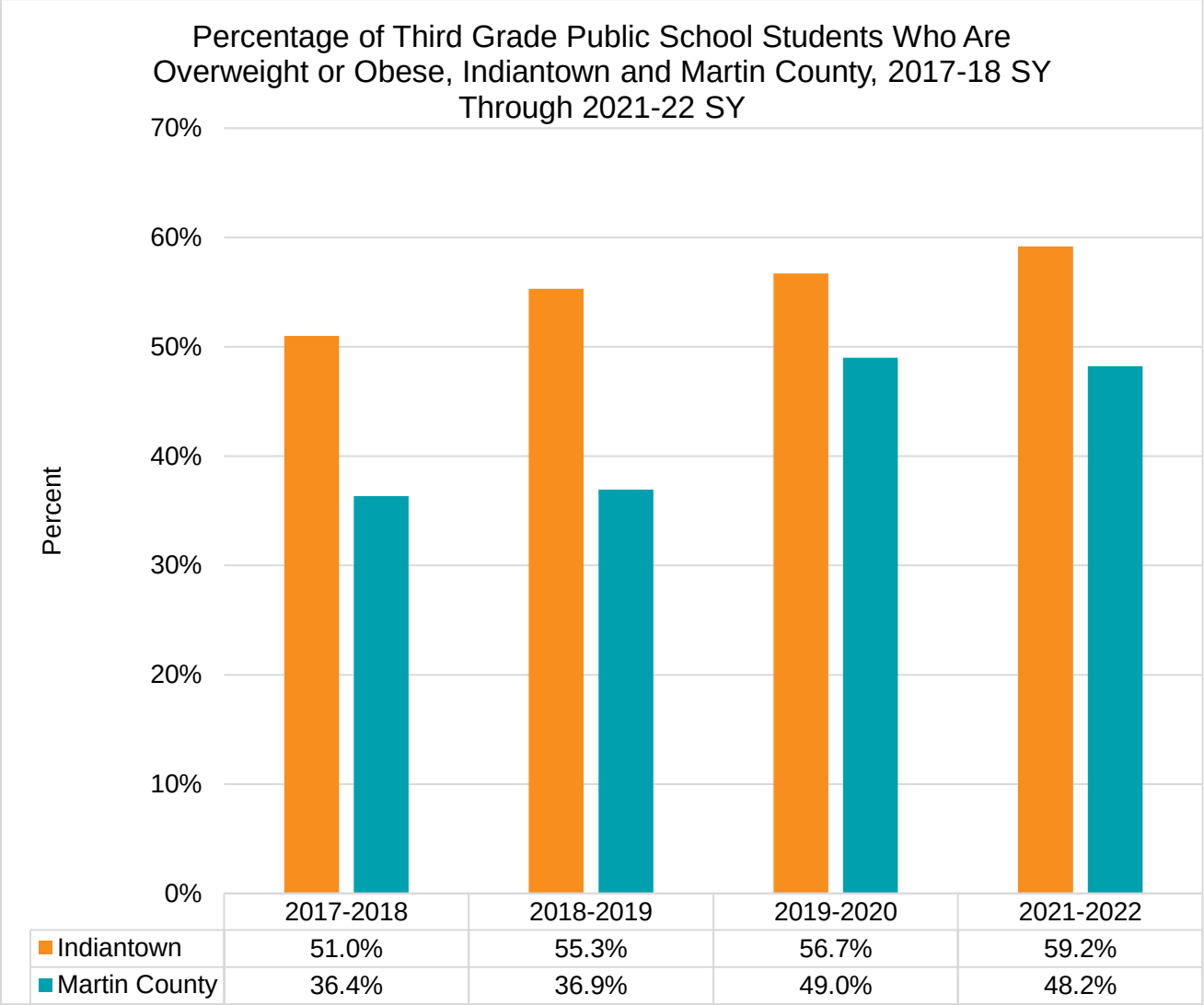
Source: Florida Department of Health in Martin County, 2022

This table shows the proportion of overweight and obese **third graders** in Martin County elementary schools during the 2019 to 2020 school year. Warfield Elementary, located in Indiantown, had the highest proportion of overweight and obese third graders (49%), followed by Pinewood Elementary (46%) and JD Parker Elementary (43%). The schools with the lowest proportion of overweight and obese third graders were Bessey Creek Elementary (21%) and Palm City Elementary (21%), both located in Palm City.

Overweight and Obese Third Graders, Martin County Elementary Schools, 2019-2020		
School	**Neighborhood (Zip Code)**	**Overweight and Obese**
Bessey Creek Elementary	Palm City (34490)	20.6%
Citrus Grove Elementary		31.3%
Palm City Elementary		20.7%
Hobe Sound Elementary	Hobe Sound (33455)	41.0%
Seawind Elementary		41.2%
Jensen Beach Elementary	Jensen Beach (34957)	32.4%
JD Parker Elementary	Stuart (34996)	43.3%
Port Salerno Elementary		39.5%
Pinewood Elementary		45.7%
Crystal Lake Elementary		36.1%
Felix A. Williams Elementary		27.7%
Warfield Elementary	Indiantown (34956)	**49.0%**

Source: Florida Department of Health in Martin County, 2022

This graph shows the percentage of **third grade** public school students who were overweight and obese in **Indiantown** and **Martin County** overall from the 2017 to 2018 school year to the 2021 to 2022 school year. Each year where full data was available, the proportion of first grade public school students who were overweight or obese was much higher in Indiantown compared to the county overall. The proportion has also steadily increased in Indiantown. To note, due to the pandemic and resulting school closures, there was data missing for the 2019 to 2020 school year. For the 2020 to 2021 school year, many schools still faced challenges and did not perform health screenings.



	2017-2018	2018-2019	2019-2020	2021-2022
Indiantown	51.0%	55.3%	56.7%	59.2%
Martin County	36.4%	36.9%	49.0%	48.2%

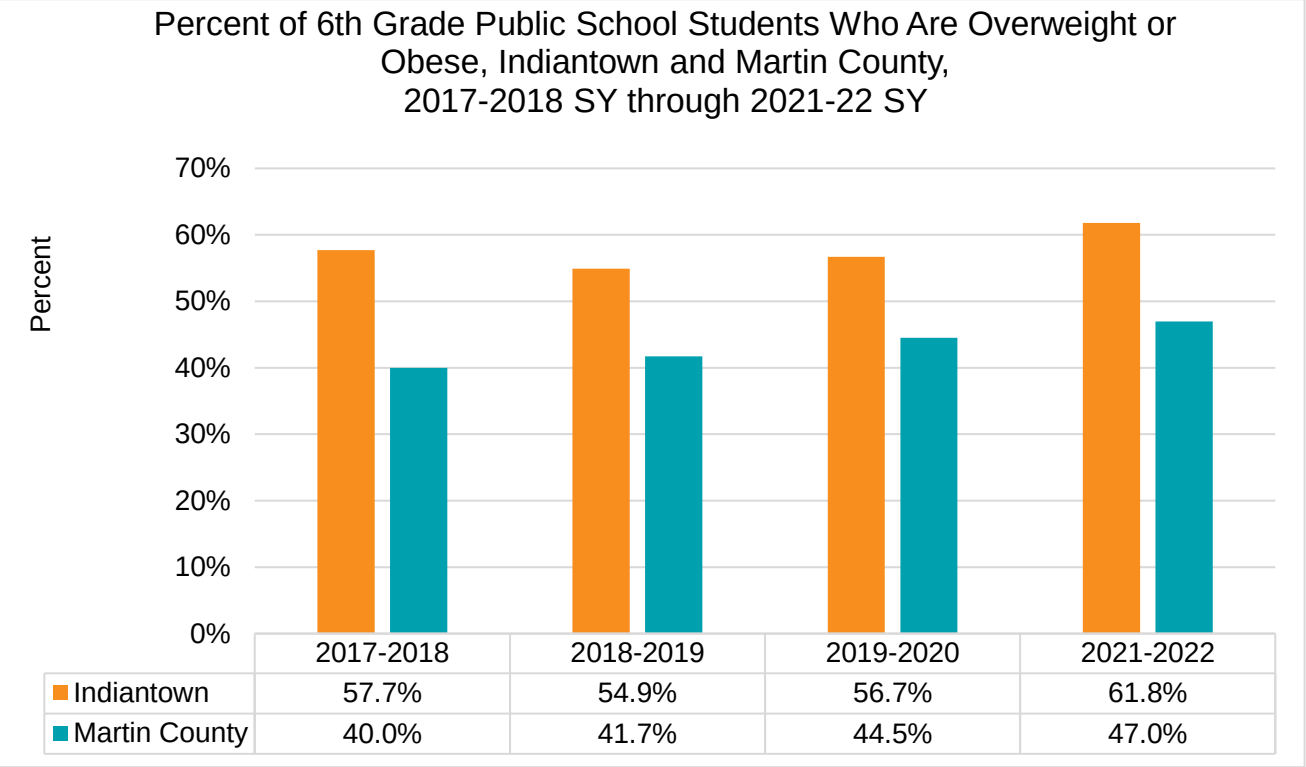
Source: Florida Department of Health in Martin County, 2022

The table below shows the proportion of overweight and obese **sixth graders** in Martin County middle schools during the 2019 to 2020 school year. Indiantown Middle School in Indiantown had the highest proportion of overweight and obese sixth graders (56.7%), followed by Dr. David Anderson Middle School in Stuart (50.3%). The school with the lowest proportion of overweight and obese sixth graders was Hidden Oaks Middle School, located in Palm City (32.2%).

Overweight and Obese Sixth Graders, Martin County Middle Schools, 2019-2020		
School	**Neighborhood (Zip Code)**	**Overweight and Obese**
Hidden Oaks Middle School	Palm City (34990)	32.2%
Indiantown Middle School	Indiantown (34956)	**56.7%**
Murray Middle School	Stuart (34997)	46.3%
Stuart Middle School		42.0%
Dr. David Anderson Middle School		50.3%

Source: Florida Department of Health in Martin County, 2022

The figure below shows the proportion of **sixth grade** public school students who are overweight or obese in **Indiantown** and **Martin County** from the 2017 to 2018 school year to the 2021 to 2022 school year. Each school year, the proportion of overweight or obese sixth grade students in Indiantown exceeded that of Martin County's. Most recently, in the 2021 to 2022 school year, 61.8% of sixth grade students in Indiantown were overweight or obese, compared to 47.0% of students in Martin County. There is a very clear disparity between overweight and obese health outcomes for students in Indiantown compared to students in Martin County overall.

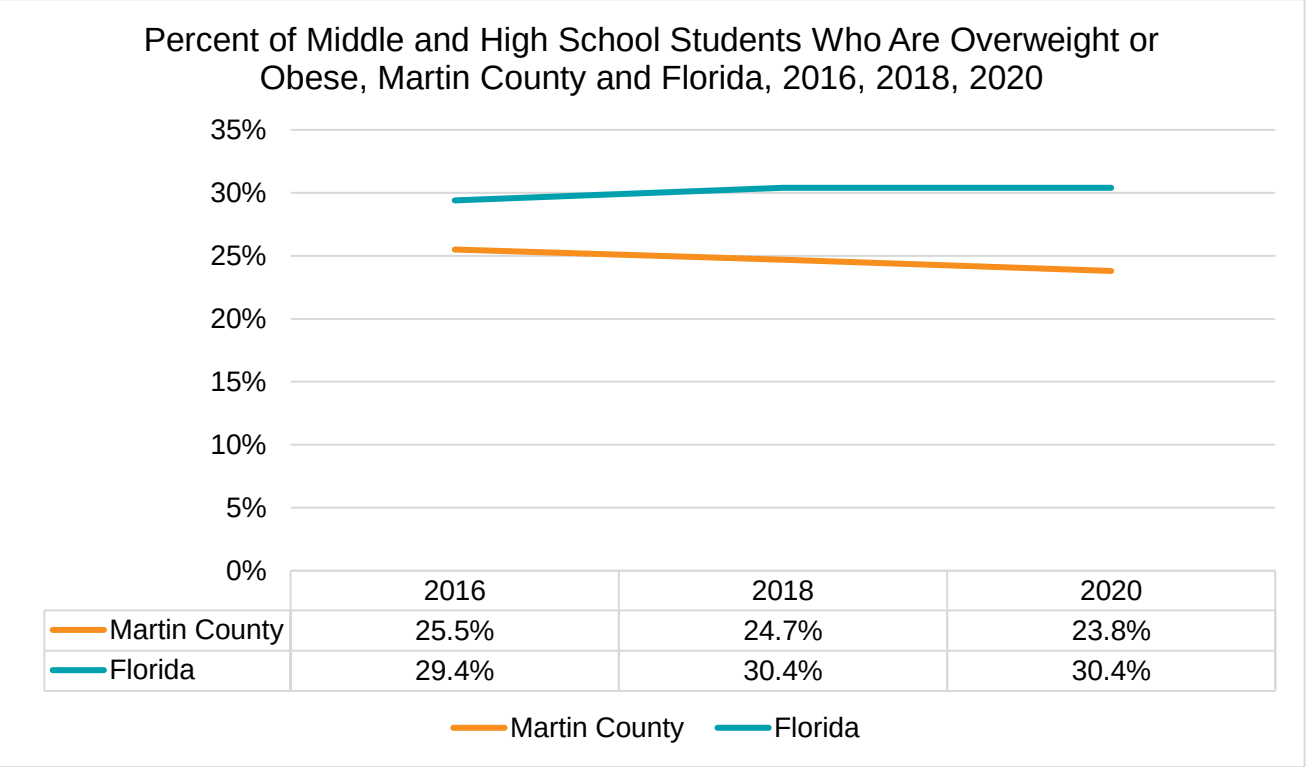


	2017-2018	2018-2019	2019-2020	2021-2022
Indiantown	57.7%	54.9%	56.7%	61.8%
Martin County	40.0%	41.7%	44.5%	47.0%

Source: Florida Department of Health in Martin County, 2022

Middle and High School Students Who Are Overweight or Obese

The figure below shows the proportion of middle and high school students who were obese in both **Martin County** and **Florida** from 2016 to 2020. Each year, the proportion of obese students in Martin County exceeded that of the State's. Most recently, in 2020, 23.8% of middle and high school students in Martin County were obese, compared to 30.4% of middle and high school students in Florida.

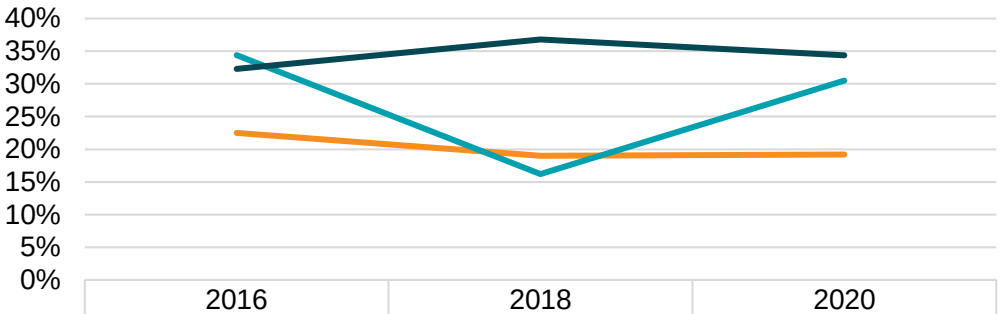


	2016	2018	2020
Martin County	25.5%	24.7%	23.8%
Florida	29.4%	30.4%	30.4%

Source: Florida Department of Health, Division of Community Health Promotion, Florida Youth Tobacco Survey (FYTS)

The figure below shows the proportion of middle and high school students who were overweight or obese by **race and ethnicity** in Martin County in 2016, 2018, and 2020. Most recently, in 2020, 34.4% of Hispanic students in Martin County were overweight or obese, compared to 30.5% of non-Hispanic Black students and 19.2% of non-Hispanic White students. There are significant disparities between overweight or obese Hispanic, non-Hispanic Black, and non-Hispanic White middle and high school students, as seen below. The Martin County Health Equity Taskforce plans to address this by focusing on Black or African American and Hispanic or Latino middle and high school students as a part of the Plan's health disparity objective.

Percent of Middle and High School Students Who Are Overweight or Obese by Race and Ethnicity, Martin County, 2016, 2018, 2020



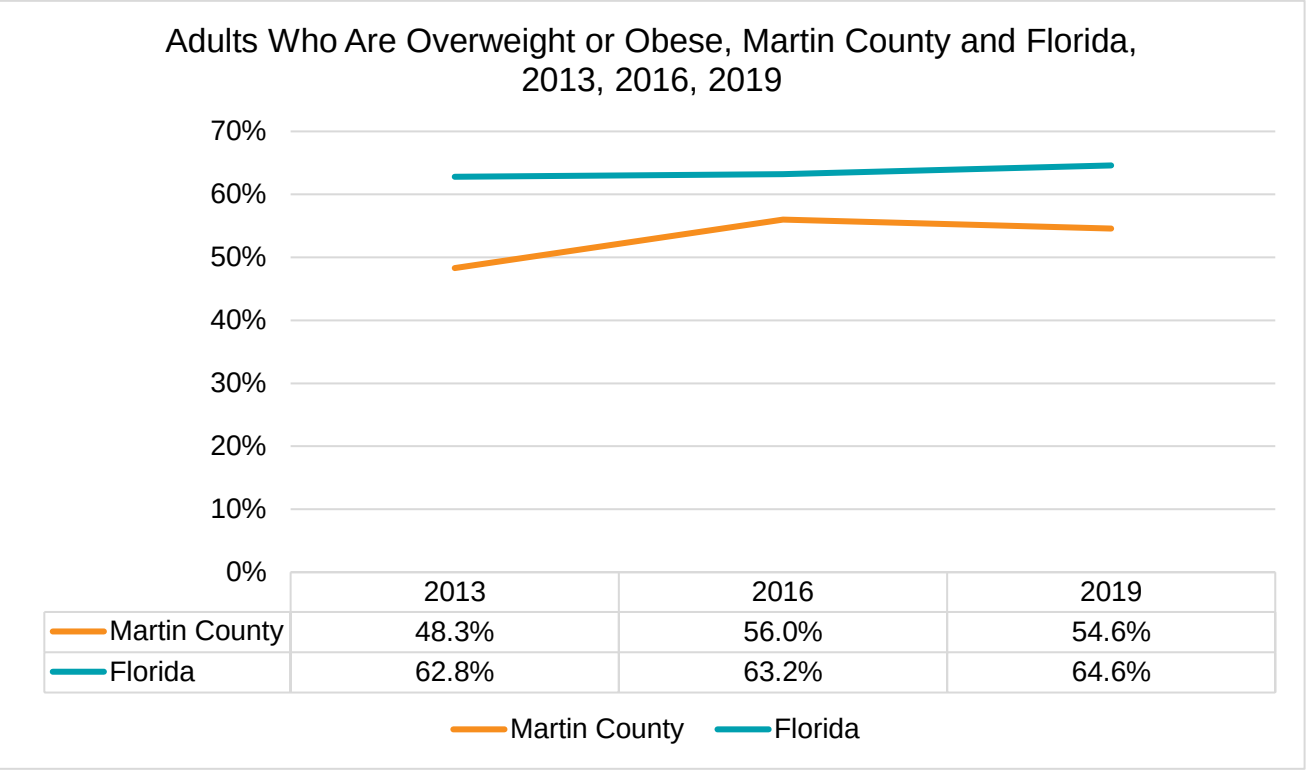
	2016	2018	2020
Non-Hispanic White	22.5%	19.0%	19.2%
Non-Hispanic Black	34.4%	16.2%	30.5%
Hispanic	32.3%	36.8%	34.4%

Non-Hispanic White Non-Hispanic Black Hispanic

Source: Florida Department of Health, Division of Community Health Promotion, Florida Youth Tobacco Survey (FYTS)

Adults Who Are Overweight or Obese

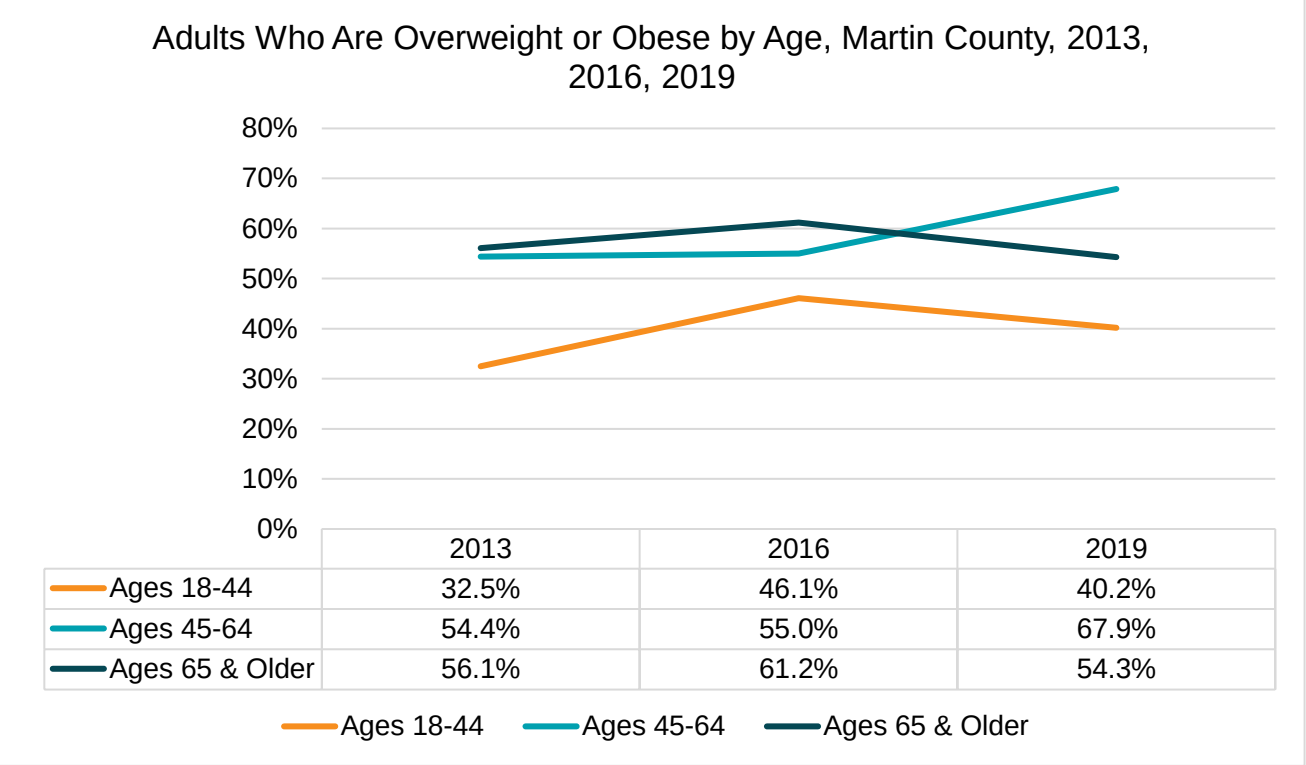
The figure below shows the proportion of adults who were overweight or obese in both **Martin County** and **Florida** in 2013, 2016, and 2019. The proportion of overweight or obese adults in Martin County increased from 2013 (48.3%) to 2016 (56.0%), then decreased slightly in 2019 (54.6%). Most recently, in 2019, 64.6% of adults in Florida were overweight or obese, compared to 54.6% of adults in Martin County.



	2013	2016	2019
Martin County	48.3%	56.0%	54.6%
Florida	62.8%	63.2%	64.6%

Source: Florida Behavioral Risk Factor Surveillance System telephone survey conducted by the Centers for Disease Control and Prevention (CDC) and Florida Department of Health Division of Community Health Promotion

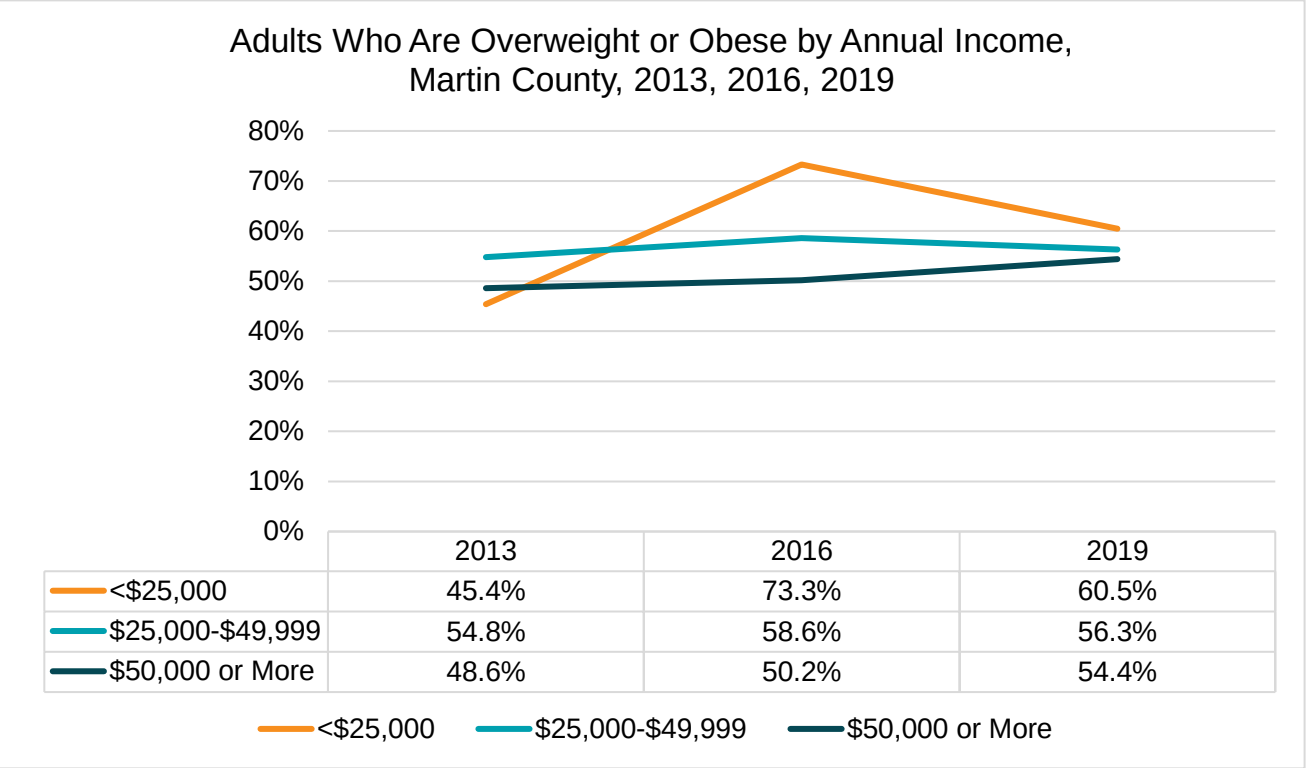
The figure below shows the proportion of adults who were overweight or obese by **age group** in Martin county in 2013, 2016, and 2019. There was fluctuation in the overweight or obese proportion among the age groups year-to-year. Additionally, the proportion of adults aged 45 to 64 increased slightly from 2013 (45.5%) to 2016 (55.0%), then further increased in 2019 (67.9%). Most recently in 2019, 67.9% of adults aged 45 to 64 years were overweight or obese, compared to 54.3% of adults aged 65 years and older and 40.2% of adults aged 18 to 44 years.



	2013	2016	2019
Ages 18-44	32.5%	46.1%	40.2%
Ages 45-64	54.4%	55.0%	67.9%
Ages 65 & Older	56.1%	61.2%	54.3%

Source: Florida Behavioral Risk Factor Surveillance System telephone survey conducted by the Centers for Disease Control and Prevention (CDC) and Florida Department of Health Division of Community Health Promotion

The figure below shows the proportion of o obese by **annual income** in Martin County in 2013, 2016, and 2019. There was fluctuation in the overweight or obese proportion among the income groups year-to-year. However, most recently in 2019, 60.5% of adults with an annual income less than $25,000 were overweight or obese, compared to 56.3% of adults with an annual income between $25,000 to $49,000 and 54.4% of adults with an annual income over $50,000.

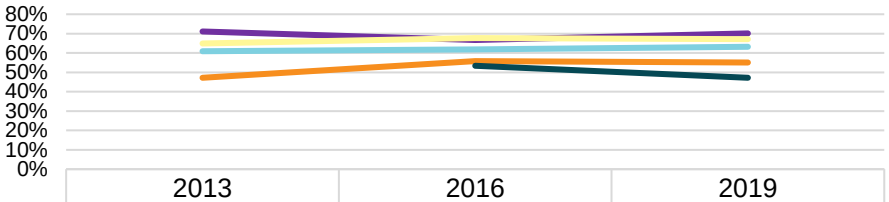


	2013	2016	2019
<$25,000	45.4%	73.3%	60.5%
$25,000-$49,999	54.8%	58.6%	56.3%
$50,000 or More	48.6%	50.2%	54.4%

Source: Florida Behavioral Risk Factor Surveillance System telephone survey conducted by the Centers for Disease Control and Prevention (CDC) and Florida Department of Health Division of Community Health Promotion

The figure below shows the proportion of adults who were overweight or obese by **race and ethnicity** in Martin County and Florida in 2013, 2016, and 2019. Unfortunately, there was no data available for Martin County non-Hispanic Back adults for any years reported and for Hispanic adults for 2013. In addition to county-level data, state level data is provided for reference. Most recently in 2019, 55.1% of non-Hispanic white adults in Martin County were overweight or obese, compared to 47.2% of Hispanic adults. At the state level, 70.1% of non-Hispanic Black adults were overweight or obese, compared to 67.2% of Hispanic adults and 63.2% of non-Hispanic White adults. The Martin County Health Equity Taskforce will address the missing data for Black non-Hispanic residents through the SDOH Screening Tool Community Project.

Adults Who Are Overweight or Obese by Race and Ethnicity, Martin County, 2013, 2016, 2019



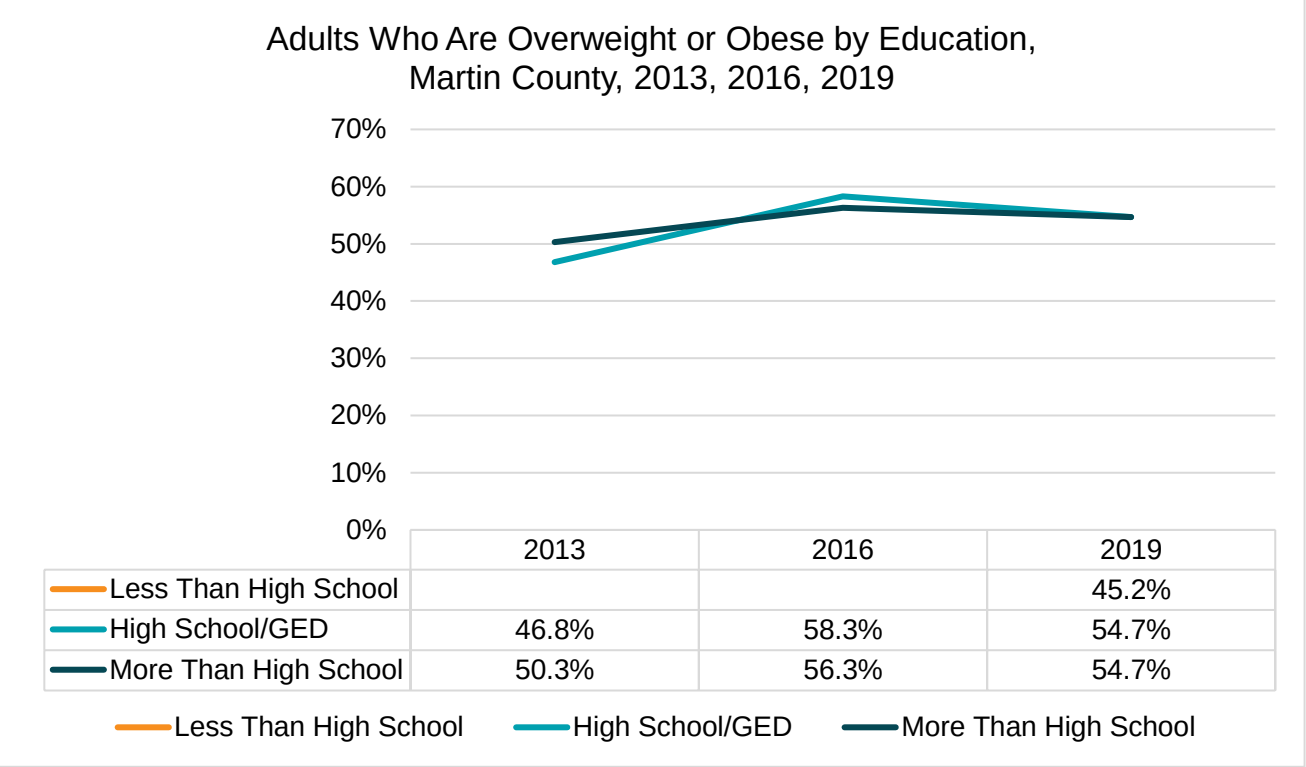
	2013	2016	2019
Martin County, Non-Hispanic White	47.2%	55.8%	55.1%
Martin County, Non-Hispanic Black			
Martin County, Hispanic		53.4%	47.2%
Florida, Non-Hispanic White	60.9%	61.9%	63.2%
Florida, Non-Hispanic Black	71.1%	66.7%	70.1%
Florida, Hispanic	64.9%	67.7%	67.2%

Source: Florida Behavioral Risk Factor Surveillance System telephone survey conducted by the Centers for Disease Control and Prevention (CDC) and Florida Department of Health Division of Community Health Promotion

Moreover, although no county-level data is currently available, nationally, 44.6% of **Native Hawaiian and Other Pacific Islander** residents were obese, compared to 28.2% of White residents. [11] Similarly, **American Indian and Alaska Native** residents experienced much higher proportions of adults who were obese (48.1%).[12] However, lower proportions of **Asian** residents were obese (11%).[13]

[11] Centers for Disease Control and Prevention. 2015. Health Conditions and Behaviors of Native Hawaiian and Pacific Islander Persons in the United States, 2014. https://www.cdc.gov/nchs/data/series/sr_03/sr03_040.pdf
[12] Centers for Disease Control and Prevention, 2020. Summary Health Statistics: National Health Interview Survey: 2018. https://www.cdc.gov/nchs/nhis/shs/tables.htm
[13] Centers for Disease Control and Prevention. 2015. Health Conditions and Behaviors of Native Hawaiian and Pacific Islander Persons in the United States, 2014. https://www.cdc.gov/nchs/data/series/sr_03/sr03_040.pdf

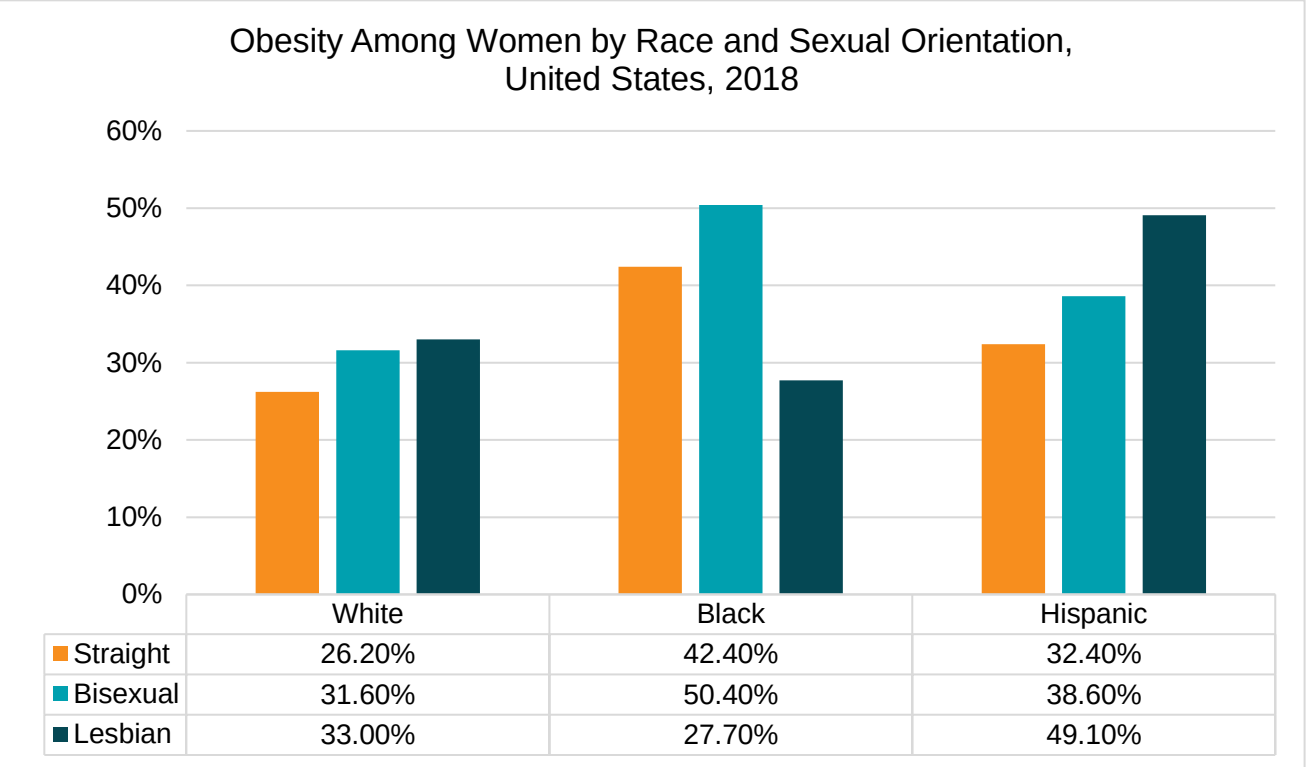
The figure below shows the proportion of adults who were overweight or obese by **education** in Martin County from 2013 to 2019. Unfortunately, there was no data available for adults with less than high school education for 2013 and 2016. The proportion of adults with a high school education/GED and adults with more than a high school education increased from the years 2013 to 2019. Most recently in 2019, 54.7% of adults with a high school education/GED and more than a high school education were overweight or obese, compared to 45.2% with less than a high school education. The Martin County Health Equity Taskforce will address missing data for those with less than high school education with the SDOH Screening Tool Community Project.



	2013	2016	2019
Less Than High School			45.2%
High School/GED	46.8%	58.3%	54.7%
More Than High School	50.3%	56.3%	54.7%

Data Source: Florida Behavioral Risk Factor Surveillance System telephone survey conducted by the Centers for Disease Control and Prevention (CDC) and Florida Department of Health Division of Community Health Promotion

At this time, as mentioned, there is no state or county level obesity data available for LGBTQ+ individuals; however, national research has found that compared to heterosexual women, **lesbian** and **bisexual women** are more likely to be overweight or obese, less likely to have annual routine physical exams, and more likely not being able to seek care due to cost. On the contrary, **gay men** in the United States are less likely to be overweight or obese compared to their heterosexual counterparts.[14] [15] Through the SDOH Screening Tool Community Project, the Martin County Health Equity Taskforce aims to capture county-level data to inform future efforts for serving these populations.

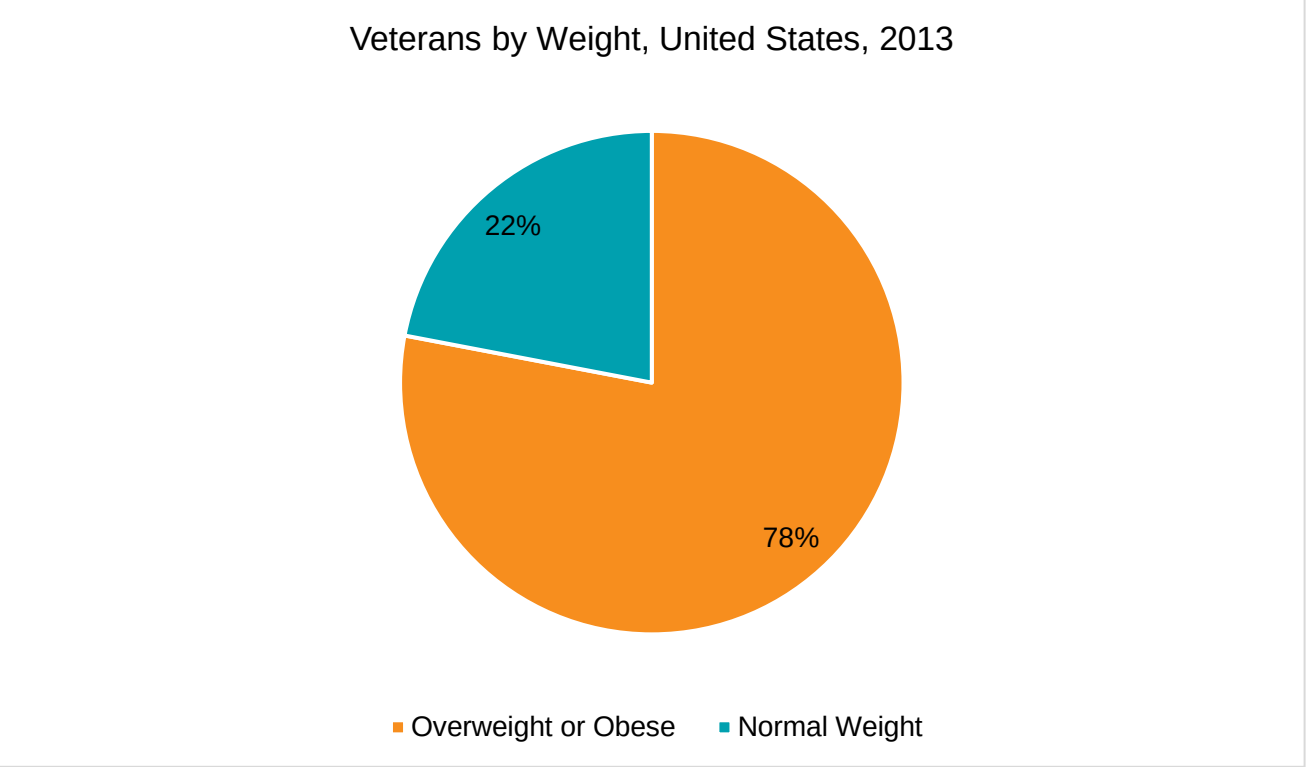


	White	Black	Hispanic
Straight	26.20%	42.40%	32.40%
Bisexual	31.60%	50.40%	38.60%
Lesbian	33.00%	27.70%	49.10%

Source: George Washington University. Obesity and LGBTQ Health.

[14] Struble CB, Lindley LL, Montgomery K, et al. (2010). Overweight and obesity in lesbian and bisexual college women. *J Am College Health*.59(1):51-6.
[15] Blosnich, J.R., Farmer, G.W., Lee, J.G.L. et al. (2010). Health inequalities among sexual minority adults: Evidence from Ten US States. *American Journal of Preventive Medicine.* 46(4): 337-349.

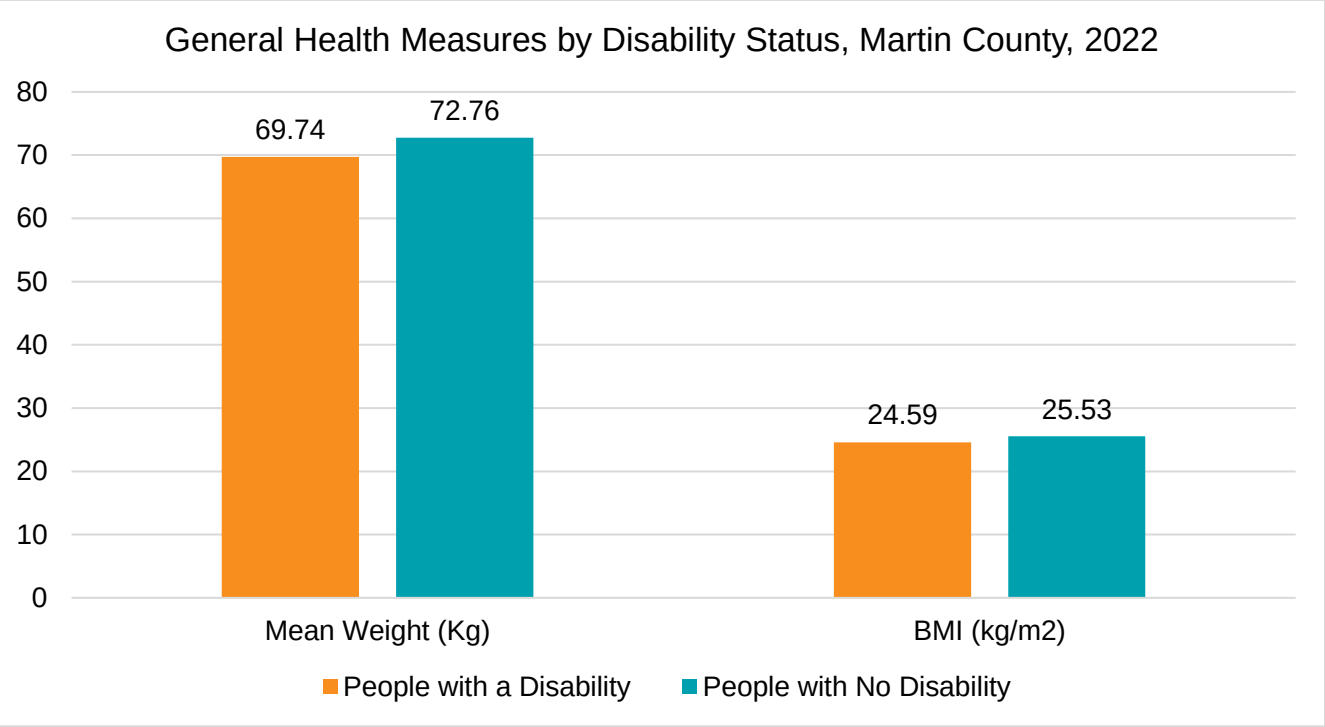
At this time, there is no current national, state, or county-level data available for obesity or overweight status among veterans. However, the US Department of Veterans Affairs (VA) estimated that, in 2013, 78% of **veterans** were either overweight or obese, and over 165,000 veterans who received their health care from the VA were experienced morbid obesity.[16] In Martin County, 10.5% or 14,025 of residents are veterans. If we extrapolate from this national study, approximately 10,940 veterans are overweight and obese in the county as well. The Martin County Health Equity Taskforce will be collecting county-level data for this specific population through the SDOH Screening Tool Community Project to consider future community projects aimed at reaching veterans in the county.



Source: US Department of Veterans Affairs, 2013

[16] US Department of Veterans Affairs. Office of Research and Development. Obesity. Retrieved from: https://www.research.va.gov/topics/obesity.cfm

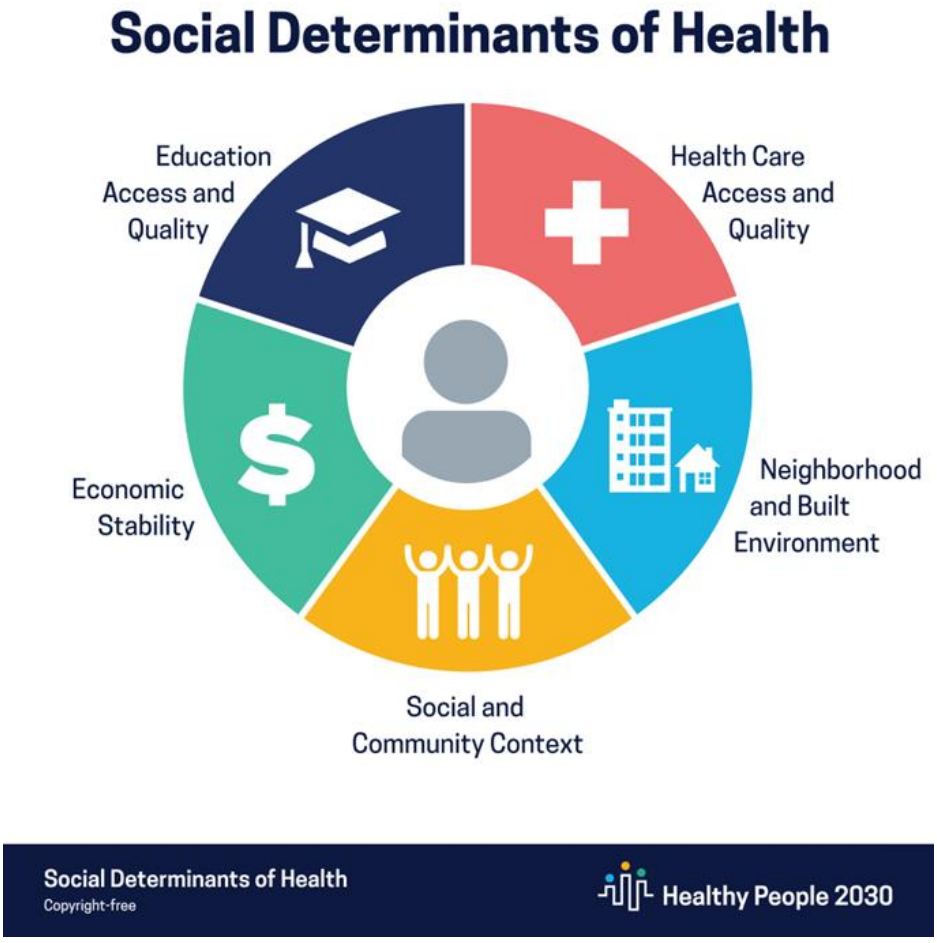
The State recently conducted a review on the health status of **people living with disabilities** across all 67 counties. The figure below shows obesity-related and general health metrics among both people with at least one disability and people with no disabilities in Martin County. The descriptive statistics show that people with a disability in Martin County have a significantly lower average weight (69.74 kg), compared to their counterparts with no disability (72.76 kg), and also have a significantly lower average BMI (24.59 kg/m^2 vs. 25.53 kg/m^2 among people with no disability). Thus, although we disaggregate by disability status with respect to the SDOH to highlight important disparities, people living with a disability in Martin County do not experience obesity-related disparities and will not be considered one of the prioritized populations.



Source: Knowli Data Science and the FSU Claude Pepper Center Faculty, 2022

VII. SOCIAL DETERMINANTS OF HEALTH

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, in collaboration with the Martin County Health Equity Taskforce, identified multiple SDOHs that impact obesity in Martin County and they are listed below.



A. Education Access & Quality

Education Access and Quality Data for Martin County

One of the foundational factors, or Social Determinants of Health (SDOH), that determine an individual's and community's health is the availability and opportunity to access quality education. Lower educational attainment is directly correlated with worse health outcomes; the inverse is also true.[17] Higher educational attainment can potentially lead to more employment opportunities, higher pay, employer subsidized health insurance, and the ability to purchase healthier food. It may even allow an individual to move to an area with less crime and safe spaces to recreate outside. Additionally, the availability of early childhood education opens up the opportunity for parents, and oftentimes women or single-parents, to seek employment. While the relationship between the SDOHs, including access to quality education, is complex, it is important to consider. The following data explores education access and quality in Martin County. To note, considerable efforts were made to find all of the following information related to education access and quality among priority populations, including Black or African Americans, American Indian and Alaska Natives, Asians, Native Hawaiians, Hispanic and Latinos, elders, infants and toddlers, people living with disabilities, veterans, people identifying as LGBTQ+, and immigrants. Research shows these populations experience health inequities at higher rates. However, data was unavailable for these populations in several instances.

[17]Braveman, P., & Gottlieb, L. (2014). The Social Determinants of Health: It's Time to Consider the Causes of the Causes. Public Health Reports, 129(1_suppl2), 19–31. https://doi.org/10.1177/00333549141291S206

Early Childhood Education

The following table shows the number of children served, including those in School Readiness and Voluntary Prekindergarten (VPK), by early childcare providers in Martin County during Fiscal Year 2020 – 2021. Early childhood education is for children aged 0 to 5 years old. School Readiness is a program designed to support low-income families and is funded primarily by the Child Care and Development Fund Block Grant and administered by the Division of Early Learning.[18] VPK is free prekindergarten for children aged 4 and 5 years who live in Florida and helps early learners build a strong educational foundation for school.[19]

The availability of childcare providers in the County is important to examine, because, not only does it provide the educational foundation for young children to succeed as they continue to learn, but it also offers parents the opportunity to seek employment and job training outside the home. This is particularly important for women, single-parents or caregivers, and lower-income families. In addition, Early Childcare and Education (ECE) settings are an important point of intervention for obesity prevention, as enrolled children typically receive several meals and snacks while in care, accounting for a large proportion of their daily caloric intake. Thus, this is one of the best opportunities for children to build a foundation for healthy nutrition and physical activity.[20] As such, the Martin County Health Equity Taskforce will be implementing a Go NAPSACC Community Project to increase access to healthy food and physical activity within ECE settings and to improve the quality of early education received.

In Martin County, there were 56 early childcare providers during Fiscal Year 2020-2021 that provided either School Readiness or VPK programs.

[18] (2021, March 15). In *Florida's School Readiness Program Fact Sheet for Families*. Retrieved from http://www.floridaearlylearning.com/school-readiness/school-readiness-for-families
[19] (n.d.). In *Division of Early Learning*. Retrieved from http://www.floridaearlylearning.com/vpk/floridas-vpk-program
[20] Centers for Disease Control and Prevention. (2022). Overweight & Obesity: Early Care and Education (ECE). Retrieved from: https://www.cdc.gov/obesity/strategies/childcareece.html

Children Served by Early Childhood Education Provider, Martin County, FY 2020-2021				
Provider Name	**City**	**Total Children Served**	**School Readiness Children Served**	**Voluntary Prekindergarten (VPK) Children Served**
All About ABC's Learning Center, Inc.	Stuart	59	59	0
All About ABC's Learning Center II	Stuart	27	27	0
Alphabet Farms Preschool, Inc.	Palm City	9	0	9
Apple Tree Academy II	Jensen Beach	138	119	36
Apple Tree Academy III	Palm City	62	40	27
Apple Tree Academy IV	Stuart	141	116	40
Apple Tree Academy V	Stuart	128	112	29
Bethel Lutheran Preschool	Hobe Sound	47	0	47
Boys & Girls Clubs of Martin County – Hobe Sound	Hobe Sound	11	11	0
Boys & Girls Clubs of Martin County – Indiantown	Indiantown	8	8	0
Boys & Girls Clubs of Martin County – Palm City	Palm City	6	6	0
Boys & Girls Clubs of Martin County – Port Salerno	Stuart	8	8	0
Bridges Montessori	Stuart	99	82	24
Dunbar Center, Inc.	Hobe Sound	84	87	20
First Baptist Christian Pre-School	Stuart	23	0	23
First United Methodist Preschool-Stuart	Stuart	46	0	46

Gertrude Walden Child Care Center, Inc.	Stuart	170	165	21
Global Learning of Stuart, Inc.	Stuart	74	69	10
High Hopes Preschool	Palm City	27	0	27
Hobe Sound Christian Academy	Hobe Sound	15	0	15
Hobe Sound Early Learning Center	Hobe Sound	76	44	38
Home Away from Home Jensen Beach Preschool, LLC	Jensen Beach	37	26	12
Hope Rural School	Indiantown	19	0	19
Immanuel Early Learning Center	Palm City	30	0	30
Jensen Beach Community Church Preschool	Jensen Beach	25	0	25
Kids First of Stuart	Stuart	23	15	11
Little Einsteins	Stuart	10	0	10
Little Feet Learning Center, Inc.	Jensen Beach	27	27	0
Louis Dreyfus Citrus Branch – YMCA of Indiantown	Indiantown	75	75	0
MCSD Bessey Creek Elementary	Palm City	66	15	51
MCSD Citrus Grove Elementary	Palm City	27	7	20
MCSD Crystal Lake Elementary	Stuart	27	7	20
MCSD Felix A. Williams Elementary	Stuart	71	56	15
MCSD Hobe Sound Elementary	Hobe Sound	43	25	18
MCSD J.D. Parker Elementary	Stuart	59	43	18
MCSD Jensen Beach Elementary	Jensen Beach	51	32	19

MCSD Palm City Elementary	Palm City	55	28	28
MCSD Perkins Childhood Center	Indiantown	64	0	64
MCSD Pinewood Elementary	Stuart	97	97	0
MCSD Port Salerno Elementary	Stuart	30	30	0
MCSD Salerno Learning Center	Stuart	55	0	55
MCSD Salerno School House	Stuart	23	0	23
MCSD Seawind Elementary	Hobe Sound	27	27	0
MCSD Stuart Learning Center	Stuart	19	0	19
MCSD Warfield Elementary	Indiantown	3	3	0
Parents' Choice Preschool LLC	Jensen Beach	58	50	8
Pebblestone Academy, Inc.	Stuart	64	63	9
Redeemer Lutheran Church and School	Stuart	24	0	24
Reed Child Care & Learning Center Corp	Stuart 145	145	140	13
Reed Child Care & Learning Center II	Stuart	80	76	13
Riverside Montessori	Stuart	29	6	23
St. Joseph Catholic School	Stuart	18	0	18
Temple Beit Hayam Early Childhood Learning Center	Stuart	30	12	21
The Grace Place Preschool	Stuart	23	0	23
The Learning Cove	Palm City	26	11	16
YMCA Child Development Center – Teddy Bear Academy	Stuart	165	157	11

Source: Division of Early Learning, Early Learning Coalition of Indian River, Martin, and Okeechobee Counties, Annual Report FY 2020-2021

School District Grades

This table shows the school grades by school for elementary, middle, and high schools in Martin County from 2016 to 2019. School grades provide a way to measure performance of a school and to understand how well the school is serving its students. Schools are given grades A, B, C, D, or F.[21] More information on school grades can be found here.

In 2019, eleven schools in Martin County received an A grade, seven received a B grade, and three received a C grade. During this same year, no schools received a D or F grade. Notably, Stuart Middle School, Palm City Elementary School, Hidden Oaks Elementary School, Bessey Creek Elementary School, Jensen Beach High School, Citrus Grove Elementary, and Clark Advanced Learning Center all received A grades each year from 2016 to 2019. Lower educational attainment and less access to quality education is correlated with lower socioeconomic status, which is correlated with poorer health outcomes, including higher rates of obesity and chronic diseases.[22] As such, the Martin County Health Equity Taskforce will consider future community projects to address educational disparities within the school district.

School Grades by School, 2016 - 2019				
School	**2016**	**2017**	**2018**	**2019**
Stuart Middle School	A	A	A	A
Sea Wind Elementary School	C	B	C	A
Martin County High School	C	B	B	A
J. D. Parker School of Technology	C	C	C	C
Palm City Elementary School	A	A	A	A
Murray Middle School	B	B	B	B
Port Salerno Elementary School	C	C	C	C

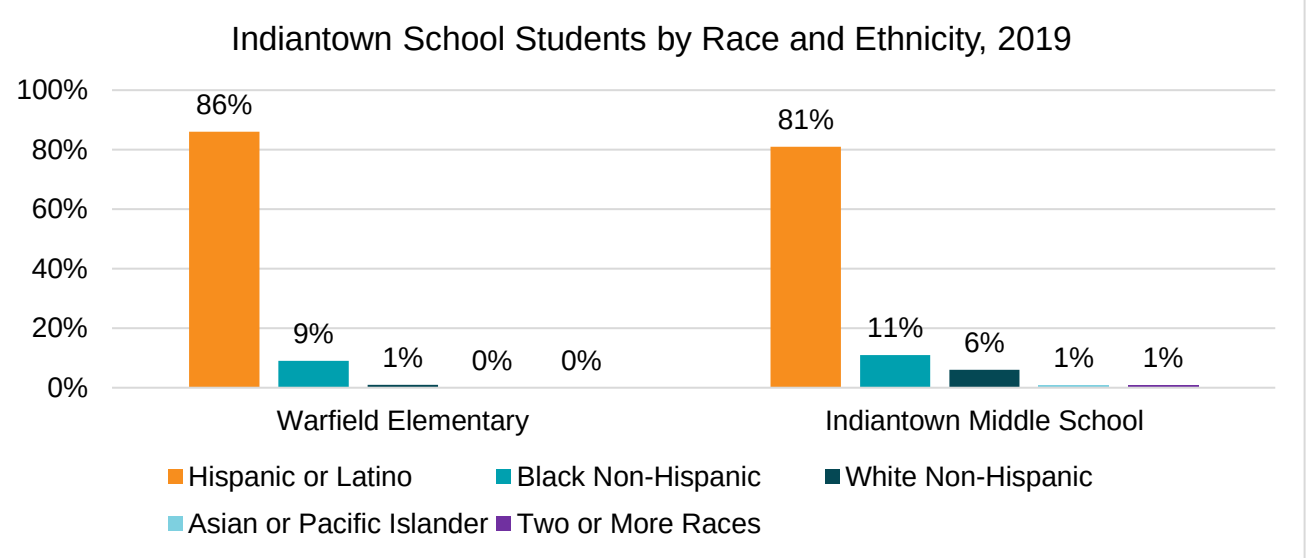
[21] 2021 School Grades Overview (n.d.). In *Florida Department of Education*. Retrieved from https://www.fldoe.org/core/fileparse.php/18534/urlt/SchoolGradesOverview21.pdf
[22] Tulane School of Public Health and Tropical Medicine (2021). Education as a Social Determinant of Health. Retrieved from: https://publichealth.tulane.edu/blog/social-determinant-of-health-education-is-crucial/

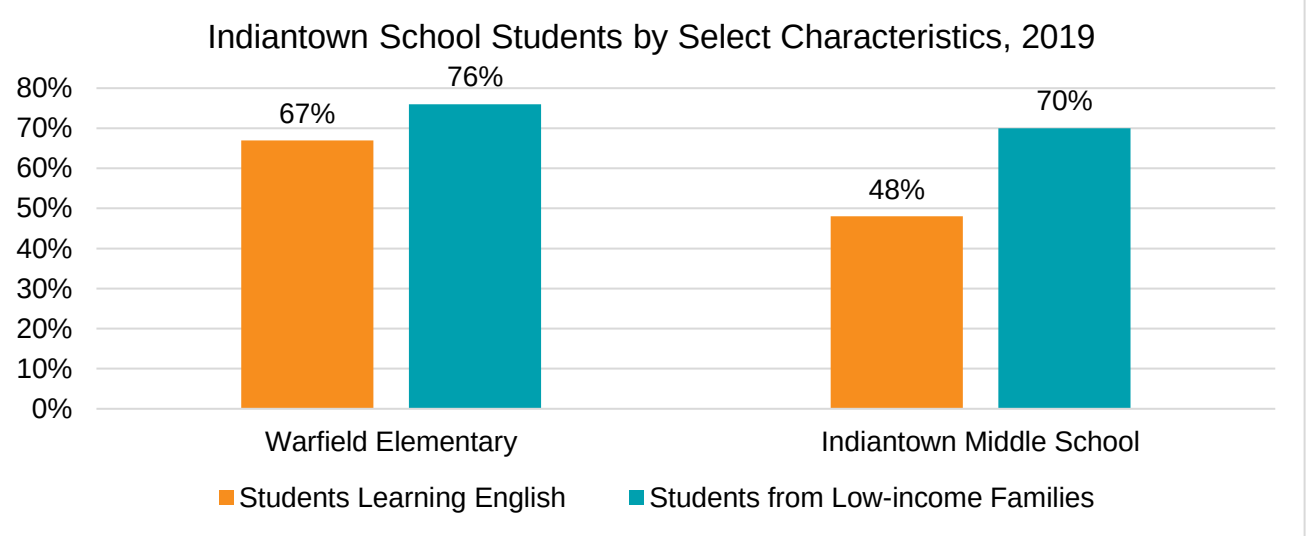
Hobe Sound Elementary School	C	B	C	C
Warfield Elementary School	C	B	C	A
Jensen Beach Elementary School	B	B	A	B
Indiantown Middle School	C	C	C	B
South Fork High School	C	B	B	B
Pinewood Elementary School	B	B	B	B
Crystal Lake Elementary School	C	A	B	A
Hidden Oaks Middle School	A	A	A	A
Bessey Creek Elementary School	A	A	A	A
Felix A Williams Elementary School	B	A	B	B
Jensen Beach High School	B	A	A	A
Dr. David L. Anderson Middle School	B	B	A	B
Citrus Grove Elementary	A	A	A	A
Clark Advanced Learning Center	A	A	A	A
Treasure Coast Classical Academy	-	-	-	-

Source: Florida Department of Education

Indiantown School Demographics

Given the clear overweight and obesity related disparities that first grade, third grade, and sixth grade students in Indiantown face, the Martin County Health Equity Taskforce is determined to prioritize this region, which includes a large proportion of our prioritized population, Hispanic or Latino and Black or African American youth. As can be seen in the chart below, the large majority of both Warfield Elementary students and Indiantown Middle School students are Hispanic or Latino (86% and 81%, respectively), followed by Black non-Hispanic students (9% and 11%, respectively). Moreover, as seen in the second chart below, a large proportion of both Warfield Elementary and Indiantown Middle School students were learning English (67% and 48%, respectively) and were from low-income families (76% and 70%, respectively). Moreover, in Indiantown overall, 26.4% of residents were children, 24.3% of residents live below the federal poverty level, and the median household income is $43,406.





Source: National Center for Education Statistics, 2019

LGBTQ+ Youth School Experiences

At this time, there is no county or state-level school data among **LGBTQ+ residents**. However, the Trevor Project analyzed data on LGBTQ+ youth nationwide who received crisis and counseling services. Their analysis found that in more recent years, academic performance concerns significantly increased among LGBTQ+ youth ages 13 to 24, as well as mental health concerns.[23] Additionally, the National Transgender Discrimination Survey found that, in Florida, K-12 students of **trans experience** reported staggering rates of harassment (78%), physical assault (41%), and sexual violence (10%), resulting in 14% leaving their school.[24] The Martin County Health Equity Taskforce will collect data on these populations through the SDOH Screening Tool Community Project to determine the best way to reduce these adverse school related experiences among LGBTQ youth.

LGBTQ+ youth academic concerns increased from the 2019-2020 school year to the 2020-2021 school year

- 1.8X more concerns related to keeping pace with classwork
- 1.4X more concerns related to grades
- 1.4x more concerns related to homework

Commonly, LGBTQ+ youth mentioned mental health issues in the context of shool

- LGBTQ youth mentioned depression, anxiety, fear, worry, loneliness, stress, upset, isolation, etc.
- Mental health issues have become more commonly reported during the pandemic

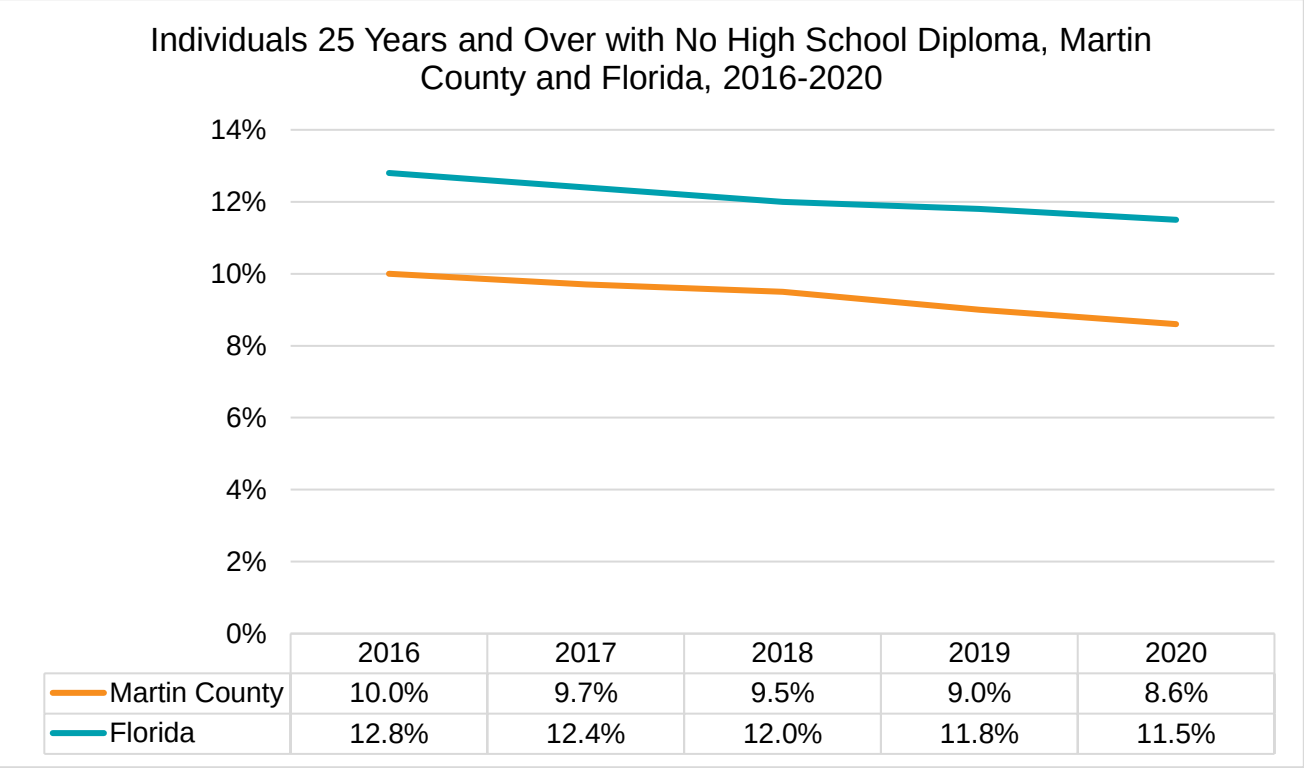
Source: The Trevor Project, 2021

[23] Trevor Project. 2021. School-related conversations across the Trevor Project's Crisis Services. Retrieved from: https://www.thetrevorproject.org/research-briefs/school-related-conversations-across-the-trevor-projects-crisis-services/
[24] National Center for Transgender Equality and the National Gay and Lesbian Task Force. 2012. Florida Results. Retrieved from: https://transequality.org/sites/default/files/docs/resources/ntds_state_fl.pdf

Educational Attainment

High school dropouts are more likely to be unemployed or employed in low-wage jobs, live below the poverty level, and have worse social and health outcomes compared to those who receive a high school diploma.[25] Moreover, educational attainment, mainly due to its association with other socioeconomic indicators, has been found to have some correlation with obesity; however, further research is needed to determine any causal relationship.[26]

This graph shows individuals 25 years and over with no high school diploma in **Martin County** and **Florida** from 2016 to 2020. During this time frame, the proportion of residents with no high school diploma in Martin County steadily decreased from 10.0% in 2016 to 8.6% in 2020. Each year, the proportion in Martin County was less than the proportion at the state level overall.



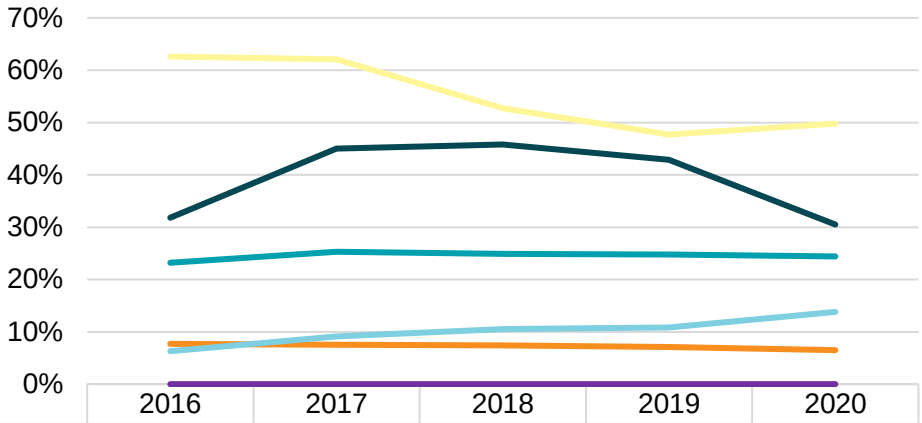
	2016	2017	2018	2019	2020
Martin County	10.0%	9.7%	9.5%	9.0%	8.6%
Florida	12.8%	12.4%	12.0%	11.8%	11.5%

Source: United States Bureau of the Census, American Community Survey, Table C15002A, C15002B. C15002C, C15002D, C15002E, C15002F, C15002G, C15002H, and C15002I

[25] Messacar, D., & Oreopoulos, P. (2012). Staying in school: A proposal to raise high school graduation rates. Hamilton Project, Brookings.
[26] Cohen, A. K., et al. (2013). Educational attainment and obesity: A systematic review. *Obes Rev.* 14(12): 989-1005.

The graph below shows individuals 25 years and over with no high school diploma by **race** in Martin County from 2016 to 2020. Each year, residents of some other race, American Indian or Alaska Native residents, and Black residents accounted for higher proportions of those with no high school diploma. The proportion of Black residents with no high school diploma was much greater than the proportion of White residents each year during this time frame. Most recently in 2020, 24.4%, almost a quarter, of Black residents 25 years and over did not have a high school diploma compared to 6.5% of White residents. As previously mentioned, educational attainment, mainly due to its association with other socioeconomic indicators, has been found to have some correlation with obesity, though further research is needed to determine any causal relationship.[27]

Individuals 25 Years and Over with No High School Diploma by Race, Martin County, 2016-2020

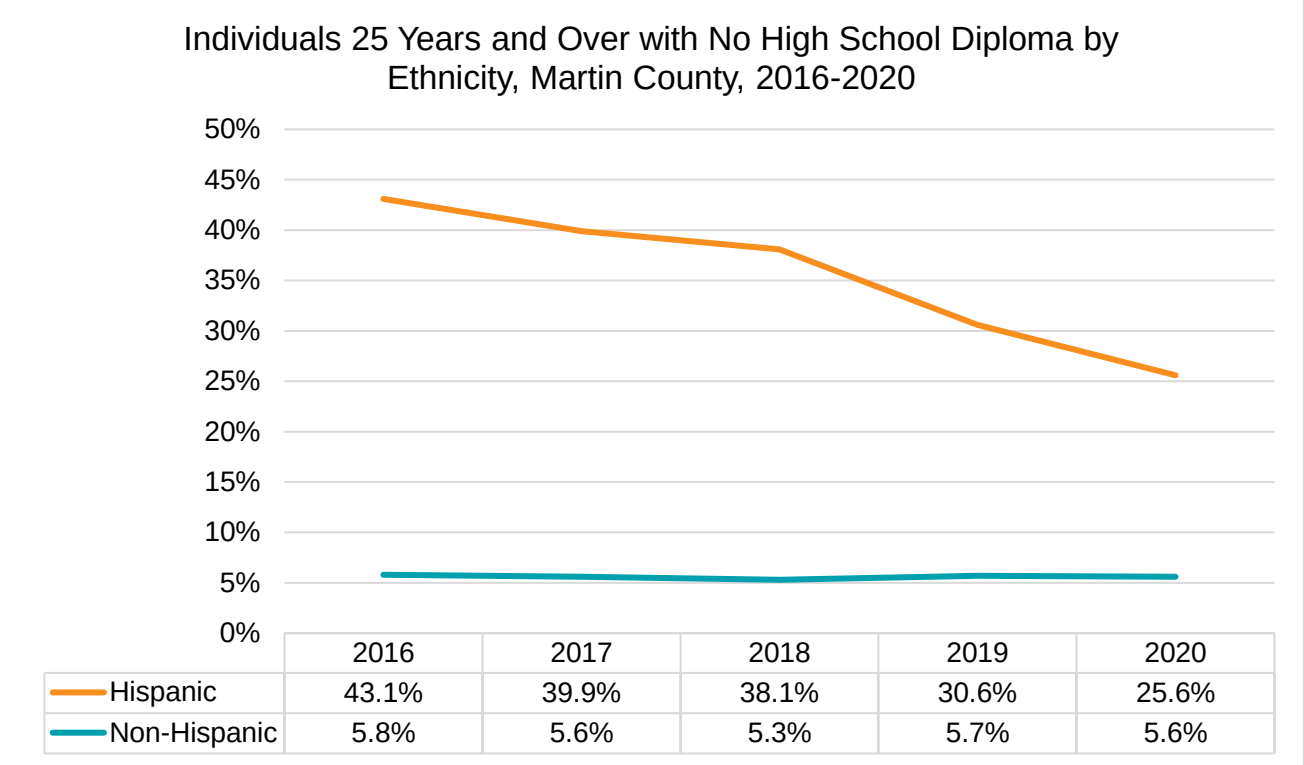


	2016	2017	2018	2019	2020
White	7.7%	7.5%	7.4%	7.1%	6.5%
Black	23.2%	25.3%	24.9%	24.8%	24.4%
American Indian or Alaska Native	31.8%	45.0%	45.8%	42.9%	30.5%
Asian	6.3%	9.1%	10.5%	10.8%	13.8%
Native Hawaiian or Pacific Islander	0.0%	0.0%	0.0%	0.0%	0.0%
Some Other Race	62.6%	62.1%	52.7%	47.7%	49.8%

Source: United States Bureau of the Census, American Community Survey, Table C15002A, C15002B. C15002C, C15002D, C15002E, C15002F, C15002G, C15002H, and C15002I

[27] Cohen, A. K., et al. (2013). Educational attainment and obesity: A systematic review. *Obes Rev.* 14(12): 989-1005.

This graph shows individuals 25 years and over with no high school diploma by **ethnicity** in Martin County from 2016 to 2020. While the proportion of residents with no high school diploma remained steady among non-Hispanic residents during this timeframe, the proportion steadily decreased among Hispanic residents. Most recently in 2020, 25.6% of Hispanic residents 25 years and over did not have a high school diploma compared to 5.6% of non-Hispanic residents. As previously mentioned, educational attainment, mainly due to its association with other socioeconomic indicators, has been found to have some correlation with obesity, though further research is needed to determine any causal relationship.[28]

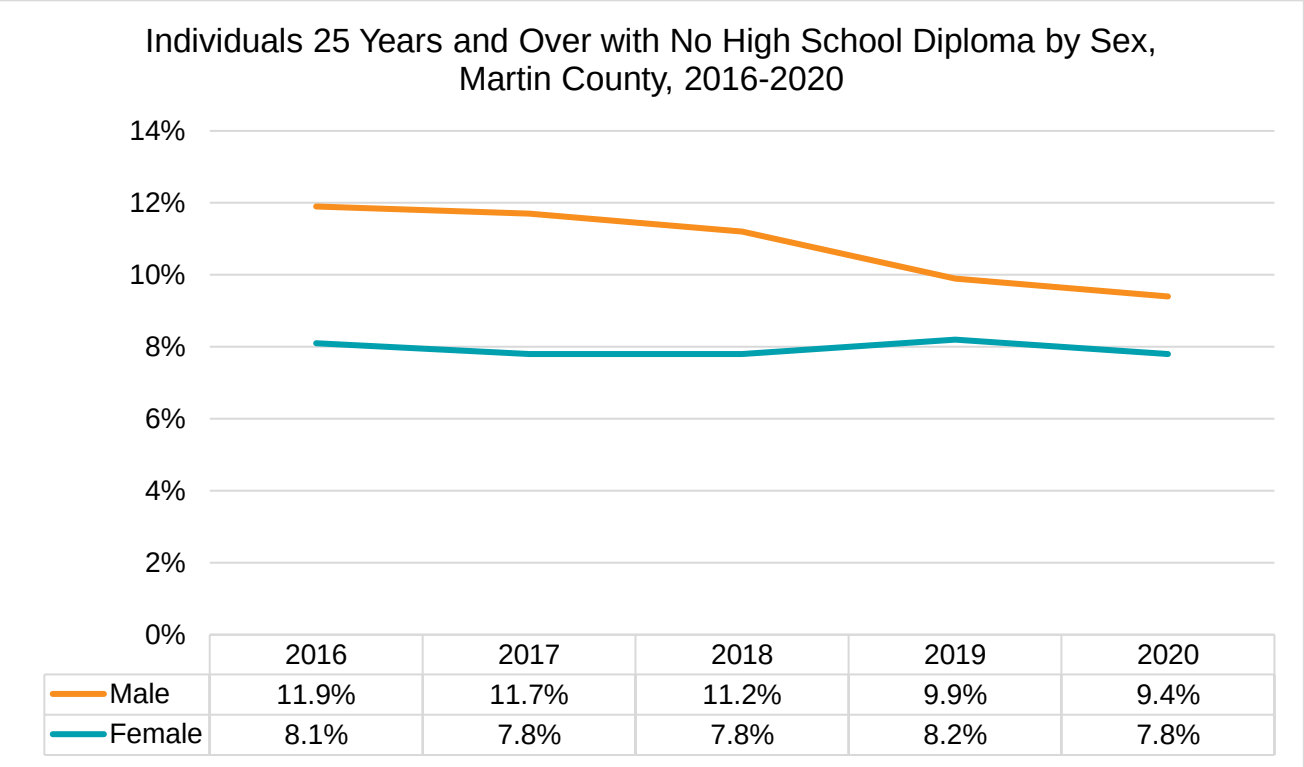


	2016	2017	2018	2019	2020
Hispanic	43.1%	39.9%	38.1%	30.6%	25.6%
Non-Hispanic	5.8%	5.6%	5.3%	5.7%	5.6%

Source: United States Bureau of the Census, American Community Survey, Table C15002A, C15002B. C15002C, C15002D, C15002E, C15002F, C15002G, C15002H, and C15002I

[28] Cohen, A. K., et al. (2013). Educational attainment and obesity: A systematic review. *Obes Rev.* 14(12): 989-1005.

This graph shows individuals 25 years and over with no high school diploma by **sex** in Martin County from 2016 to 2020. The proportion of females 25 years and over with no high school diploma remained relatively steady during this timeframe, while the proportion of males decreased from 11.9% in 2016 to 9.4% in 2020. Most recently in 2020, the proportion of males with no high school diploma was 9.4% compared to 7.8% of females. As previously mentioned, educational attainment, mainly due to its association with other socioeconomic indicators, has been found to have some correlation with obesity, though further research is needed to determine any causal relationship.[29]



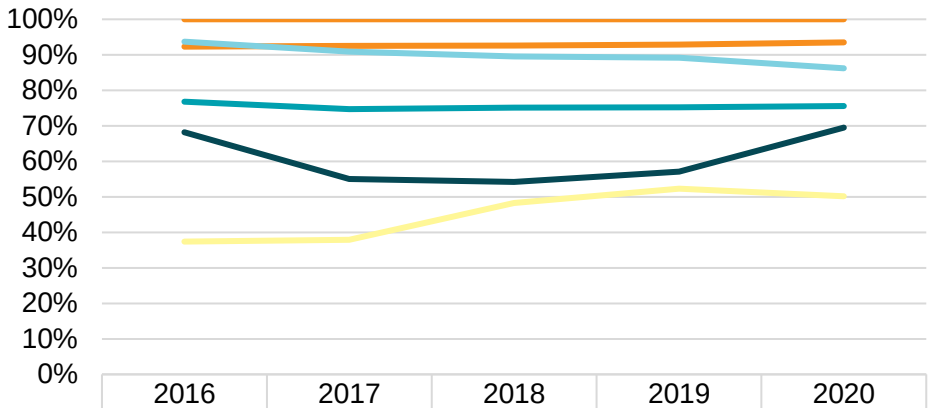
	2016	2017	2018	2019	2020
Male	11.9%	11.7%	11.2%	9.9%	9.4%
Female	8.1%	7.8%	7.8%	8.2%	7.8%

Source: United States Bureau of the Census, American Community Survey, Table C15002A, C15002B. C15002C, C15002D, C15002E, C15002F, C15002G, C15002H, and C15002I

[29] Cohen, A. K., et al. (2013). Educational attainment and obesity: A systematic review. *Obes Rev.* 14(12): 989-1005.

The graph below shows educational attainment, specifically high school graduate or higher, by **race** in Martin County from 2016 to 2020. Each year during this timeframe, Native Hawaiian and Other Pacific Islander residents had the highest proportion of individuals achieving high school graduate or higher, while residents identifying as some other race alone had the lowest proportion. Notably, the proportion of Asian residents who graduated high school or obtained higher education decreased from 93.7% in 2016 to 86.2% in 2020. All other groups remained fairly steady or increased. Most recently in 2020, 100% of Native Hawaiian and Other Pacific Islander residents were high school graduates or higher, followed by White residents (93.5%), Asian residents (86.2%), Black residents (75.6%), American Indian or Alaska Native residents (69.5%), and those identifying as some other race alone (50.2%). As previously mentioned, educational attainment, mainly due to its association with other socioeconomic indicators, has been found to have some correlation with obesity, though further research is needed to determine any causal relationship.[30]

Educational Attainment, High School Graduate or Higher by Race, Martin County, 2016 - 2020



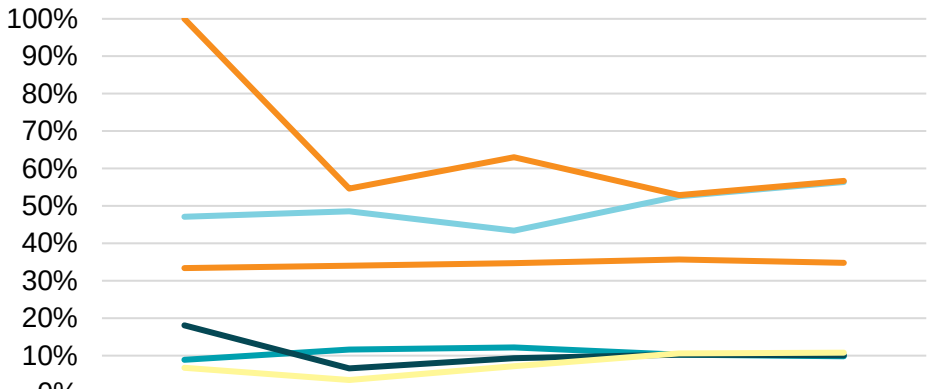
	2016	2017	2018	2019	2020
White	92.3%	92.5%	92.6%	92.9%	93.5%
Black	76.8%	74.7%	75.1%	75.2%	75.6%
American Indian or Alaska Native	68.2%	55.0%	54.2%	57.1%	69.5%
Asian	93.7%	90.9%	89.5%	89.2%	86.2%
Native Hawaiian and Other Pacific Islander	100.0%	100.0%	100.0%	100.0%	100.0%
Some Other Race Alone	37.4%	37.9%	48.3%	52.3%	50.2%

Source: United States Bureau of the Census, American Community Survey, Table S1501

[30] Cohen, A. K., et al. (2013). Educational attainment and obesity: A systematic review. *Obes Rev.* 14(12): 989-1005.

This graph shows educational attainment, specifically Bachelor's degree or higher, by **race** in Martin County from 2016 to 2020. Each year during this timeframe, Native Hawaiian and Other Pacific Islander residents had the highest proportion of individuals achieving a Bachelor's degree or higher. Notably, the proportion of American Indian or Alaska Native residents with a Bachelor's degree or higher decreased from 18.1% in 2016 to 10.1% in 2020. All other groups remained fairly steady or increased in recent years. In 2020, 56.7% of Native Hawaiian and Other Pacific Islander residents had a Bachelor's degree or higher, compared to 56.4% of Asian residents, 34.8% of White residents, 10.8% of residents identifying as some other race alone, 10.1% of American Indian or Alaska Native residents, and 9.8% of Black residents. As previously mentioned, educational attainment, mainly due to its association with other socioeconomic indicators, has been found to have some correlation with obesity, though further research is needed to determine any causal relationship.[31]

Educational Attainment, Bachelor's Degree or Higher by Race, Martin County, 2016 - 2020

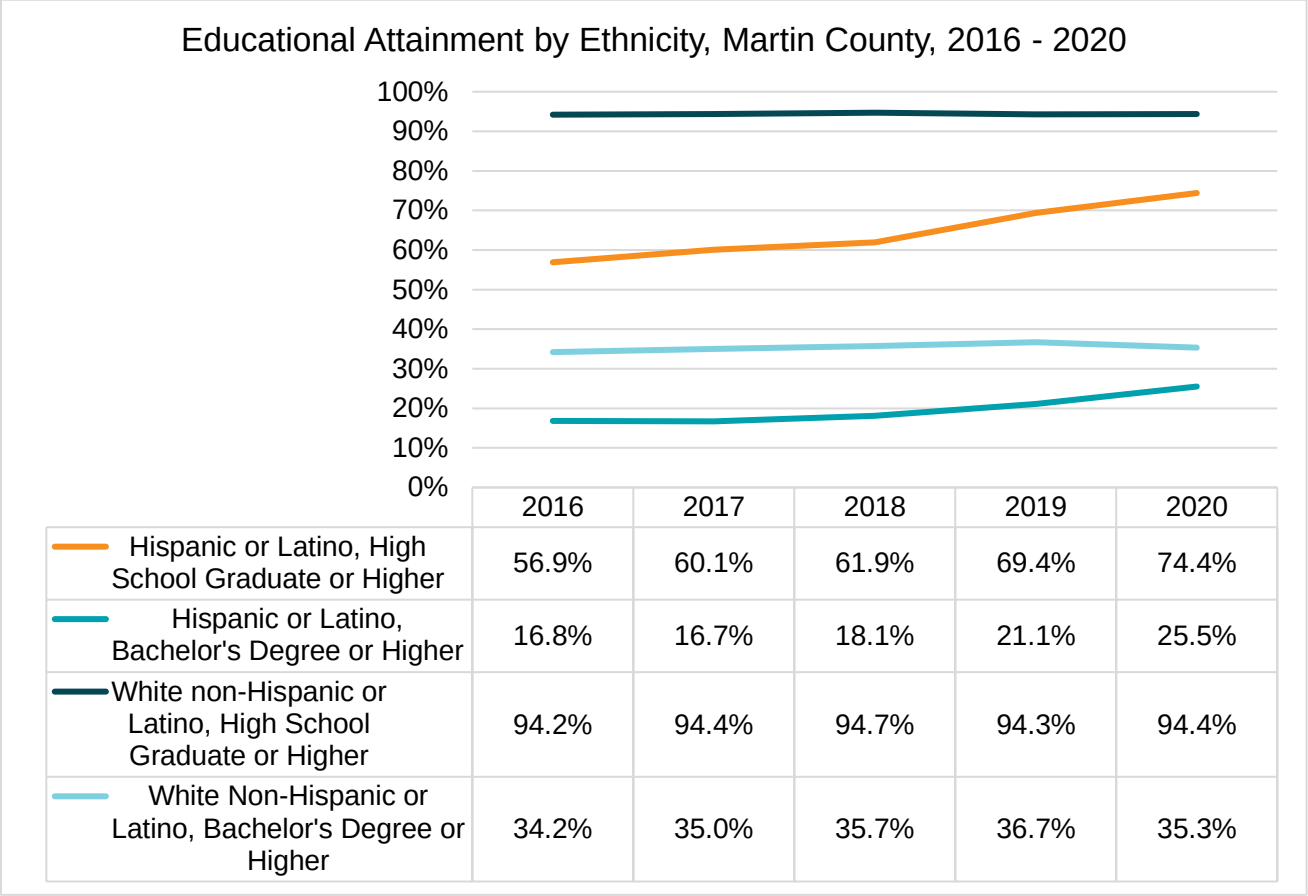


	2016	2017	2018	2019	2020
White	33.4%	34.0%	34.7%	35.7%	34.8%
Black	8.9%	11.6%	12.2%	10.3%	9.8%
American Indian or Alaska Native	18.1%	6.6%	9.3%	10.3%	10.1%
Asian	47.1%	48.6%	43.4%	52.6%	56.4%
Native Hawaiian and Other Pacific Islander	100.0%	54.6%	63.0%	52.9%	56.7%
Some Other Race Alone	6.8%	3.5%	7.2%	10.6%	10.8%

Source: United States Bureau of the Census, American Community Survey, Table S1501

[31] Cohen, A. K., et al. (2013). Educational attainment and obesity: A systematic review. *Obes Rev.* 14(12): 989-1005.

The figure below shows educational attainment by **ethnicity** in Martin County from 2016 to 2020. Each year, the proportion of residents who graduated high school or higher and those with a Bachelor's Degree or higher was highest among White non-Hispanic or Latino residents compared to Hispanic or Latino residents. These ethnic educational disparities are associated with other socioeconomic and health disparities. In 2020, 1.3 times more White non-Hispanic residents were high school graduates or higher (94.4%) compared to Hispanic residents (74.4%), and 1.4 times more White non-Hispanic residents had a Bachelor's Degree or higher (35.3%) compared to Hispanic residents (25.5%). As previously mentioned, educational attainment, mainly due to its association with other socioeconomic indicators, has been found to have some correlation with obesity, though further research is needed to determine any causal relationship.[32]



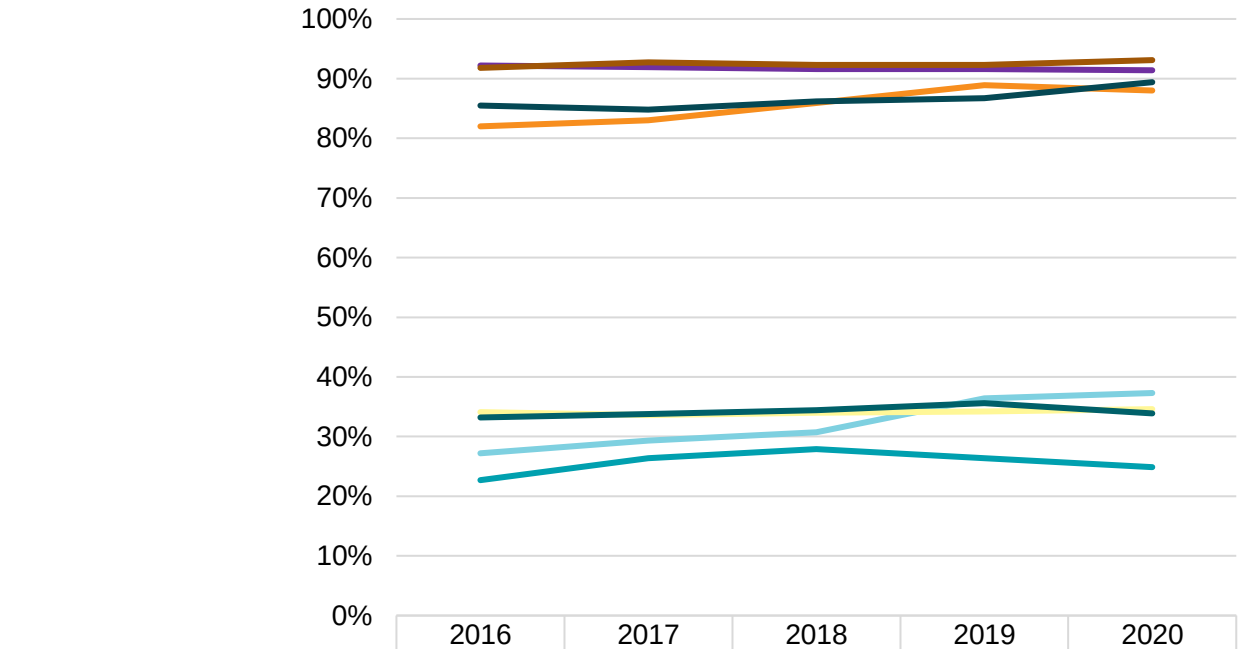
	2016	2017	2018	2019	2020
Hispanic or Latino, High School Graduate or Higher	56.9%	60.1%	61.9%	69.4%	74.4%
Hispanic or Latino, Bachelor's Degree or Higher	16.8%	16.7%	18.1%	21.1%	25.5%
White non-Hispanic or Latino, High School Graduate or Higher	94.2%	94.4%	94.7%	94.3%	94.4%
White Non-Hispanic or Latino, Bachelor's Degree or Higher	34.2%	35.0%	35.7%	36.7%	35.3%

Source: United States Bureau of the Census, American Community Survey, Table S1501

[32] Cohen, A. K., et al. (2013). Educational attainment and obesity: A systematic review. *Obes Rev.* 14(12): 989-1005.

The figure on the following page shows educational attainment by **age** in Martin County from 2016 to 2020. Each year, the highest proportion of high school graduates or higher was among residents aged 45 to 64 and residents aged 65 and over, followed by residents aged 25 to 24 years and residents aged 34 to 44 years. With respect to residents with Bachelor's Degrees or higher, the highest proportion was among residents aged 45 to 64 years, residents aged 65 and over, and residents aged 35 to 44 years, who exceeded all age groups in 2020. The lowest proportion of both residents with high school degrees or higher and Bachelor's Degrees or higher was among residents aged 25 to 34 years. Most recently in 2020, 93.1% of residents aged 65 and over had a high school degree or higher, which was 1.1 times higher than residents aged 25 to 24 years (88%). Additionally, 37.3% of residents aged 35 to 44 years had Bachelor's Degrees or higher, 1.5 times higher than residents aged 25 to 34 years (24.9%). As previously mentioned, educational attainment, mainly due to its association with other socioeconomic indicators, has been found to have some correlation with obesity, though further research is needed to determine any causal relationship.[33]

[33] Cohen, A. K., et al. (2013). Educational attainment and obesity: A systematic review. *Obes Rev.* 14(12): 989-1005.

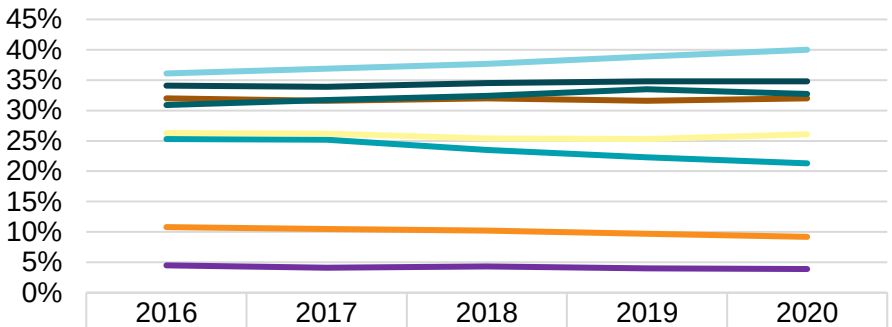


	2016	2017	2018	2019	2020
25-34 Years, High School Graduate or Higher	82.0%	83.0%	85.9%	88.9%	88.0%
25-34 Years, Bachelor's Degree or Higher	22.7%	26.4%	27.9%	26.4%	24.9%
35-44 Years, High School Graduate or Higher	85.5%	84.8%	86.2%	86.7%	89.4%
35-44 Years, Bachelor's Degree or Higher	27.2%	29.3%	30.7%	36.4%	37.3%
45-64 Years, High School Graduate or Higher	92.2%	91.9%	91.6%	91.6%	91.4%
45-64 Years, Bachelor's Degree or Higher	34.1%	33.6%	34.0%	34.2%	34.6%
65+ Years, High School Graduate or Higher	91.8%	92.7%	92.3%	92.3%	93.1%
65+ Years, Bachelor's Degree or Higher	33.2%	33.8%	34.4%	35.6%	33.9%

Source: United States Bureau of the Census, American Community Survey, Table S1501

The figure below shows educational attainment by veteran status in Martin County from 2016 to 2020. Consistently, a higher proportion of veterans attained higher educational levels than non-veterans and a lower proportion had less than a high school education. Most recently in 2020, 40% of veterans had a Bachelor's degree compared to 33% of non-veterans, 35% of veterans had some college or an Associate's degree compared to 32% of non-veterans, and 4% of veterans had less than a high school education compared to 9% of all non-veterans. As previously mentioned, educational attainment, mainly due to its association with other socioeconomic indicators, has been found to have some correlation with obesity, though further research is needed to determine any causal relationship.[34]

Educational Attainment by Veterans Status, Martin County, 2016 - 2020

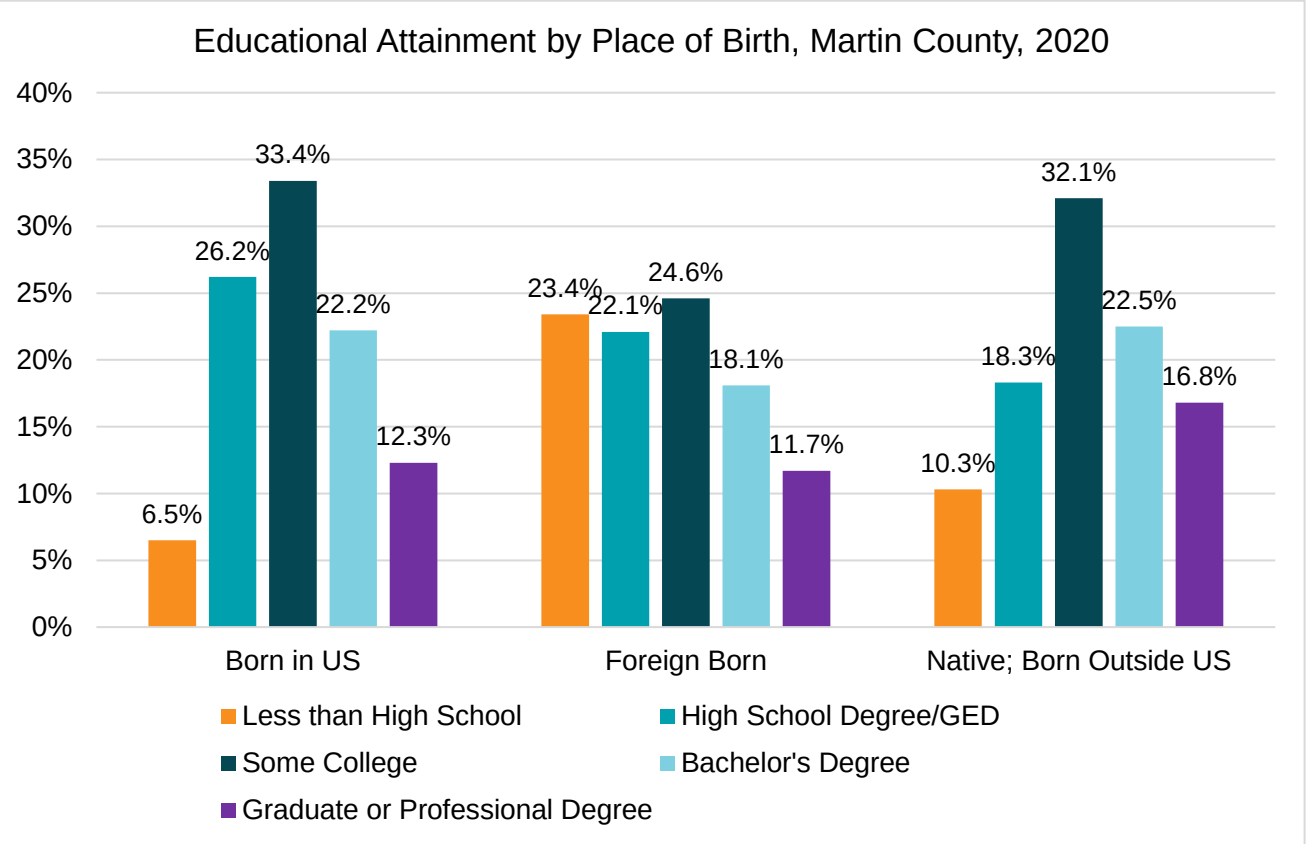


	2016	2017	2018	2019	2020
Veterans, Less than high school graduate	4.5%	4.1%	4.3%	4.0%	3.9%
Veterans, High school graduate	25.3%	25.2%	23.5%	22.3%	21.3%
Veterans, Some college or associate's degree	34.1%	33.9%	34.5%	34.8%	34.8%
Veterans, Bachelor's degree or higher	36.1%	36.9%	37.7%	38.9%	40.0%
Non-Veterans, Less than high school graduate	10.8%	10.5%	10.2%	9.7%	9.2%
Non-Veterans, High school graduate	26.3%	26.2%	25.4%	25.3%	26.1%
Non-Veterans, Some college or associate's degree	32.0%	31.6%	32.0%	31.6%	32.0%
Non-Veterans- Bachelor's degree or higher	30.9%	31.7%	32.4%	33.5%	32.7%

Source: United States Bureau of the Census, American Community Survey, Table S2101

[34] Cohen, A. K., et al. (2013). Educational attainment and obesity: A systematic review. *Obes Rev.* 14(12): 989-1005.

The figure below shows educational attainment by **place of birth** among the population over 25 in Martin County in 2020. A higher proportion of foreign-born residents had less than a high school degree (23.4%) compared to native residents who were born outside the United States (10.3%) and those born in the United States (6.5%). A higher proportion of residents born in the United States had a high school degree or GED (26.2%) compared to foreign-born residents (22.1%) and native residents born outside the United States (18.3%). When it came to those with some college and Bachelor's Degrees, a higher proportion of residents born in the United States (33.4%) attained those levels of education compared to native residents born outside the United States (32.1%) and foreign-born residents (24.6%). However, native residents born outside the United States had the highest proportion achieving graduate or professional degree compared to other groups. As previously mentioned, educational attainment, mainly due to its association with other socioeconomic indicators, has been found to have some correlation with obesity, though further research is needed to determine any causal relationship.[35]



Source: US Census Bureau, American Community Survey, 2020

[35] Cohen, A. K., et al. (2013). Educational attainment and obesity: A systematic review. *Obes Rev.* 14(12): 989-1005.

Literacy

Research shows that there is a correlation between lower literacy levels, lower educational attainment, and lower socioeconomic status, all of which directly contribute to worse health outcomes, including overweight and obesity.[36] [37] The National Center for Education Statistics National Assessment of Adult Literacy provides the percentage of residents in a county or state that lack basic prose literacy skills. However, the most recent data available at the state and county level was from 2003. As seen in the table below, 11% of residents in Martin County lacked base prose literacy skills in 2003, compared to 20% of Florida residents overall.

Adult Literacy Estimate, Martin County and Florida, 2003			
Location	**Percent Lacking Basic Prose Literacy Skills**	**95% Credible Interval Lower Bound**	**95% Credible Interval Upper Bound**
Martin County	11%	5.2%	18.6%
Florida	20%	17.0%	22.9%

Source: National Center for Education Statistics, National Assessment of Adult Literacy, 2003

[36] US Department of Health and Human Services (2022). Healthy People 2030: Language and Literacy. Retrieved from: https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/language-and-literacy

[37] Cohen, A. K., et al. (2013). Educational attainment and obesity: A systematic review. *Obes Rev.* 14(12): 989-1005.

Languages Spoken at Home

This table shows the population 5 years and over that speak English only or speak English "very well" and speak English less than "very well" in Martin County in 2020. In Martin County in 2020, 94.6% of residents aged 5 years and older either spoke English or spoke English "very well." Of those that speak a language other than English, 56.4% of Spanish speaking residents spoke English "very well," the lowest proportion of all groups. Where language barriers are present, miscommunication between providers and patients is also likely, impacting health literacy and the provision of culturally competent and linguistically appropriate care.[38] To address any language-related disparities, the Martin County Health Equity Taskforce is committed to language justice, ensuring information and services are accessible to all residents, regardless of what language they speak.

Specified Language Speakers, Population 5 Years and Over, Martin County, 2020		
Population/Language	**Speak English Only or Speak English "Very Well"**	**Speak English Less Than "Very Well"**
Population 5 Years and Over	94.6%	5.4%
Speak a language other than English	60.5%	39.5%
Spanish	56.4%	43.6%
Other Indo-European Languages	67.7%	32.3%
Asian and Pacific Island Languages	73.1%	26.9%
Other Languages	94.9%	5.1%

Source: US Census Bureau, American Community Survey, 2020

[38]Shamsi, H. A. et al. (2020). Implications of language barriers for healthcare: A systematic review. *Oman Med J.* 35(2): e122.

The Impact of Education Access and Quality on Overweight Status and Obesity in Martin County

The Martin County Health Equity Taskforce discussed how Education Access and Quality contributes to obesity and overweight status in Martin County. Discussion points are included in the table below.

Education Access and Quality		
SDOH	**Priority Populations Impacted**	**How the SDOH Impacts Obesity**
Early Childcare and Education	Hispanic residents; Black residents; Indiantown residents	Not only does early care and education provide the educational foundation for young children to succeed as they continue to learn, but it also offers parents the opportunity to seek employment and job training outside the home. Moreover, Early Childcare and Education (ECE) settings are an important point of intervention for obesity prevention, as enrolled children typically receive several meals and snacks while in care, accounting for a large proportion of their daily caloric intake. Thus, this is one of the best opportunities for children to build a foundation for healthy nutrition and physical activity.
Educational Attainment	Hispanic residents; Black residents; American Indian or Alaska Native residents; residents of some other race	Access to quality education and higher educational attainment increase access to information, higher levels of health literacy, and access to increased income and employment opportunities, which, in turn, leads to increased access to healthcare, improved lived environments, and access to healthy foods. As such, due to its association with other socioeconomic indicators, it has been found to have some correlation with obesity.
Language	Hispanic residents; Indiantown residents; residents who speak English less than very well	Where language barriers are present, miscommunication between providers and patients is also likely, impacting health literacy and the provision of culturally competent and linguistically appropriate care, leading to missed opportunities for receiving adequate nutrition counseling and obesity diagnoses and treatment.
Education Access	Black and Hispanic residents	Members stressed the importance of adequate education and its correlation to health with respect to nutritional knowledge and understanding what you eat and how to determine where to access healthy foods.
Education Quality	Black and Hispanic residents	Quality education plays a large part in receiving education that is culturally competent, celebrating cultural foods as nutritious as well.

B. Economic Stability

Economic Stability Data for Martin County

Economic stability is a major social determinant of health, as individuals who are living in poverty have limited ability to afford necessities, such as healthy and nutritious food, health care, and adequate, stable housing.[39] People who experience financial hardship are also less likely to be able to prioritize their health, given some other more immediate, pressing priorities. Evidence shows that individuals who are steadily employed are also more likely to be healthy and have a better quality of life, although during the pandemic, employment rates have declined.[26] As such, it is timely to consider how economic stability impacts health and what can be done to improve conditions. Moreover, there are clear racial and ethnic disparities in terms of poverty, employment, benefits income, and cost burden. Economic stability is also a clear social determinant of overweight status and obesity. Those who experience financial instability and poverty are also likely to experience food insecurity, but also more likely to purchase more affordable foods that tend to be low in nutritional value, such as food from fast food restaurants.[40] People with lower socioeconomic status are also less likely to live in neighborhoods with access to green spaces and parks that promote increased physical activity. The following section includes economic stability data for Martin County. To note, considerable efforts were made to find all of the following information related to economic stability among priority populations, including Black or African Americans, American Indian and Alaska Natives, Asians, Native Hawaiians, Hispanic and Latinos, elders, infants and toddlers, people living with disabilities, veterans, people identifying as LGBTQ+, and immigrants. Research shows these populations experience health inequities at higher rates. However, data was unavailable for these populations in several instances.

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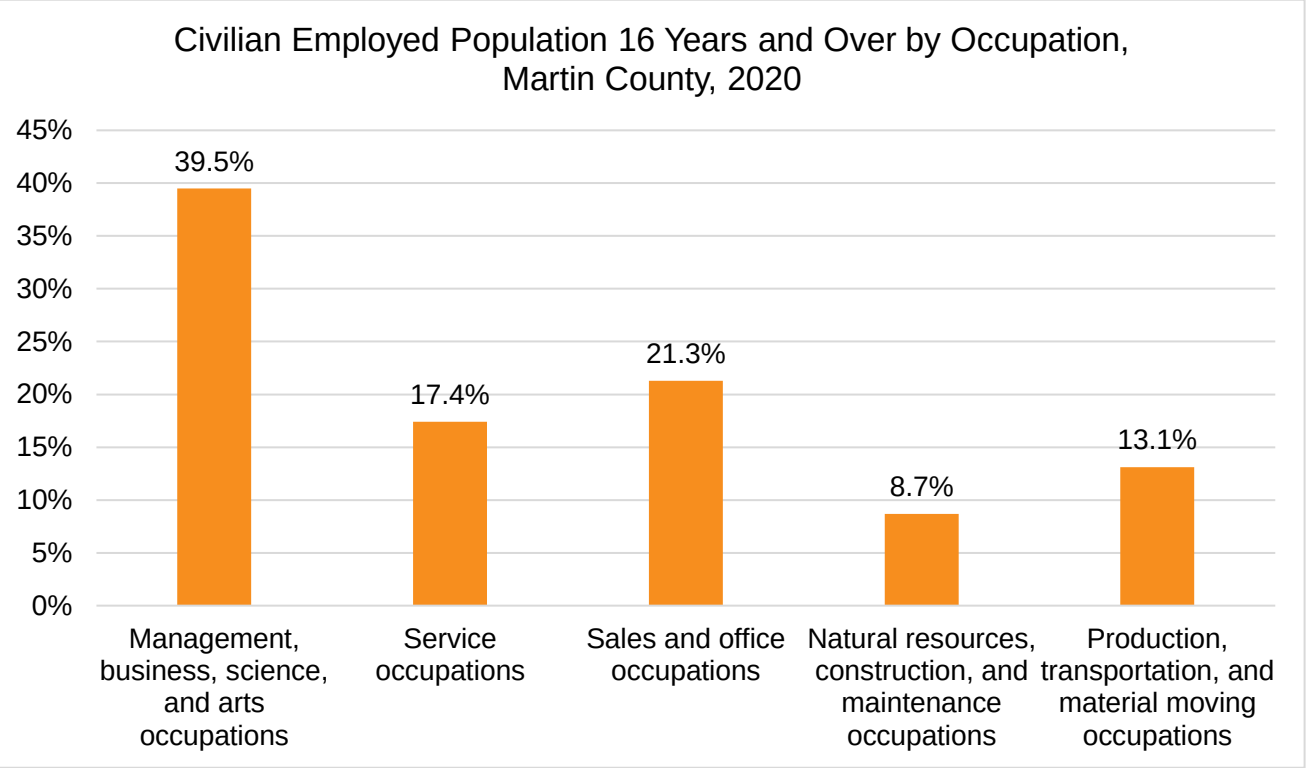
[39] US Department of Health and Human Services. Healthy People 2030: Economic Stability. Retrieved from: https://health.gov/healthypeople/objectives-and-data/browse-objectives/economic-stability
[40] Drenoswki, A. (2012). The economics of food choice behavior: Why poverty and obesity are linked. *Obesity Treatment and Prevention: New Directions. Nestle Nutr Inst Workshop Ser.* 73: 95-112.

Occupation

This figure shows the civilian employed population 16 years and over by **occupation** in Martin County in 2020. Work environments that are high-demand, where individuals work long hours, are shown to increase the risk for overweight and obesity. Overweight and obesity increase absenteeism and can result in the loss of employment and income, which is strongly associated with poor health outcomes.[41] In Martin County, among employed residents, management, business, science, and arts occupations accounted for the highest proportion of reported occupations (39.5%), followed by sales and office occupations (21.3%). Natural resources, construction, and maintenance occupations accounted for the lowest proportion (13.5%).

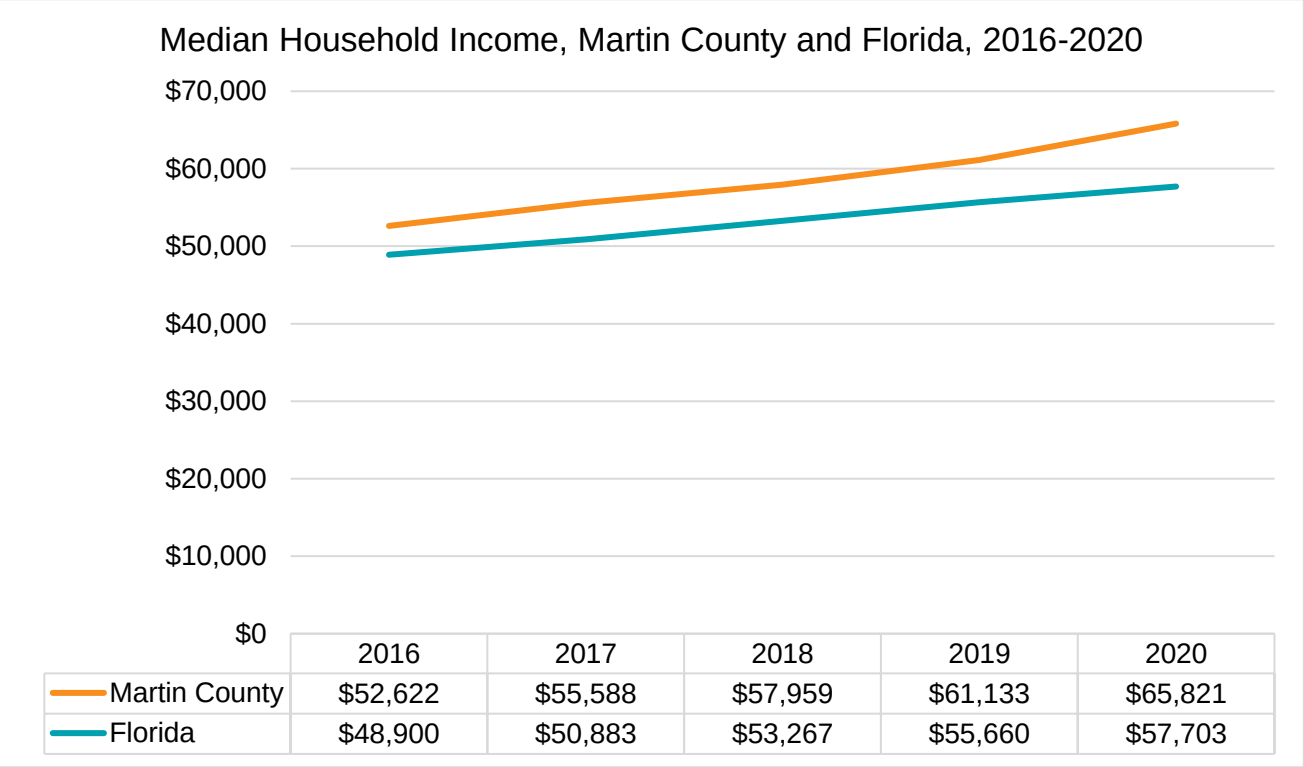


Source: United States Bureau of the Census, American Community Survey, Table S2405.

[41] Schulte, P.A. et al. (2007). Work, obesity, and occupational safety and health. *Am J Public Health.* 97(3): 428-436.

Median Household Income

This graph shows the median household income in **Martin County** and **Florida** from 2016 to 2020. During this timeframe, the median household income increased steadily in Martin County from $52,622 in 2016 to $65,821 in 2020. Each year, the median household income was greater in Martin County than at the state level. Most recently in 2020, the median household income was $65,821 in Martin County compared to $57,703 in Florida. Research shows that income impacts racial and ethnic groups and men and women differently, with it having a negative correlation with obesity for some groups and a positive correlation for others.[42]



	2016	2017	2018	2019	2020
Martin County	$52,622	$55,588	$57,959	$61,133	$65,821
Florida	$48,900	$50,883	$53,267	$55,660	$57,703

Source: United States Bureau of the Census, American Community Survey, Table B19013.

[42] Zare, H., Gilmore, D.R., et al. (2021). How income inequality and race/ethnicity drive obesity in US adults: 1999-2016. *Healthcare (Basel).* 9(11): 1442.

This table shows the median household income by **Census Tract** in Martin County in 2020.

In 2020, as we can see in the table below Census Tract shows that tract 16.02 had the highest median income of $176,250, followed by Census Tracts 5.02 ($125,750) and 6.10 ($124,596). During this same year, the Census Tracts with the lowest median household income were Census Tracts 12 ($30,871), 14.07 ($35,529), and 14.08 ($37,886). The wealth disparity between the Census Tracts with the lowest and highest median income in 2020 was $145,379. As previously mentioned, evidence demonstrates that income impacts racial and ethnic groups and genders differently, with it having a negative correlation with obesity for some groups and a positive correlation for others.[43]

Median Household Income by Census Tract, Martin County, 2020	
Census Tract	**Median Household Income**
1	$74,978
2	$74,621
3	$50,206
4	$65,135
5.01	$51,396
5.02	$125,750
6.03	$76,996
6.04	$120,673
6.06	$105,842
6.07	$68,113
6.10	$124,596
7.01	$83,015

[43] Zare, H., Gilmore, D.R., et al. (2021). How income inequality and race/ethnicity drive obesity in US adults: 1999-2016. *Healthcare (Basel).* 9(11): 1442.

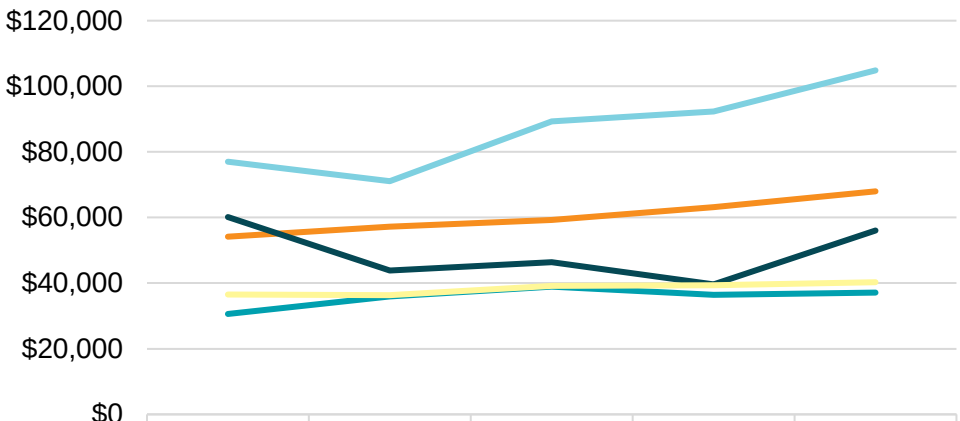
7.02	$40,718
8	$45,610
9.01	$42,250
9.02	$52,489
10	$49,286
11.03	$69,271
11.05	$59,500
11.06	$65,046
11.07	$63,025
11.08	$75,261
12	$30,871
13.01	$53,571
13.02	$73,858
14.04	$64,286
14.06	$96,000
14.07	$35,529
14.08	$37,886
14.09	$68,611
14.10	$58,313
15	$110,938
16.01	$97,980
16.02	$176,250
17.01	$96,118

17.02	$49,131
17.03	$95,928
18.03	$58,151
18.04	$43,270
18.05	$44,489
18.06	$80,096

Source: United States Bureau of the Census, American Community Survey, Table DP03.

This graph shows the median household income by **race** in Martin County from 2016 to 2020. Each year, Asian residents had the highest median income, followed by White residents, and Black residents had the lowest. The median household income among Black residents increased from 2016 ($30,606) to 2018 ($38,929), decreased in 2019 ($36,467), then increased slightly again in 2020 ($37,089). The median household income among White residents was higher than Black residents each year and increased steadily from $54,164 in 2016 to $67,979 in 2020. The median household income disparity between White and Black residents in 2020 was $30,890. As previously mentioned, research shows that income impacts racial and ethnic groups and genders differently, having a negative relationship with obesity for some groups and a positive relationship for others.[44] As an example, a study conducted in the US found a significant correlation between higher poverty-to-income ratios and obesity among non-Hispanic White men and non-Hispanic Black men, but this was not the case among their Hispanic or women counterparts.

Median Household Income by Race, Martin County, 2016-2020

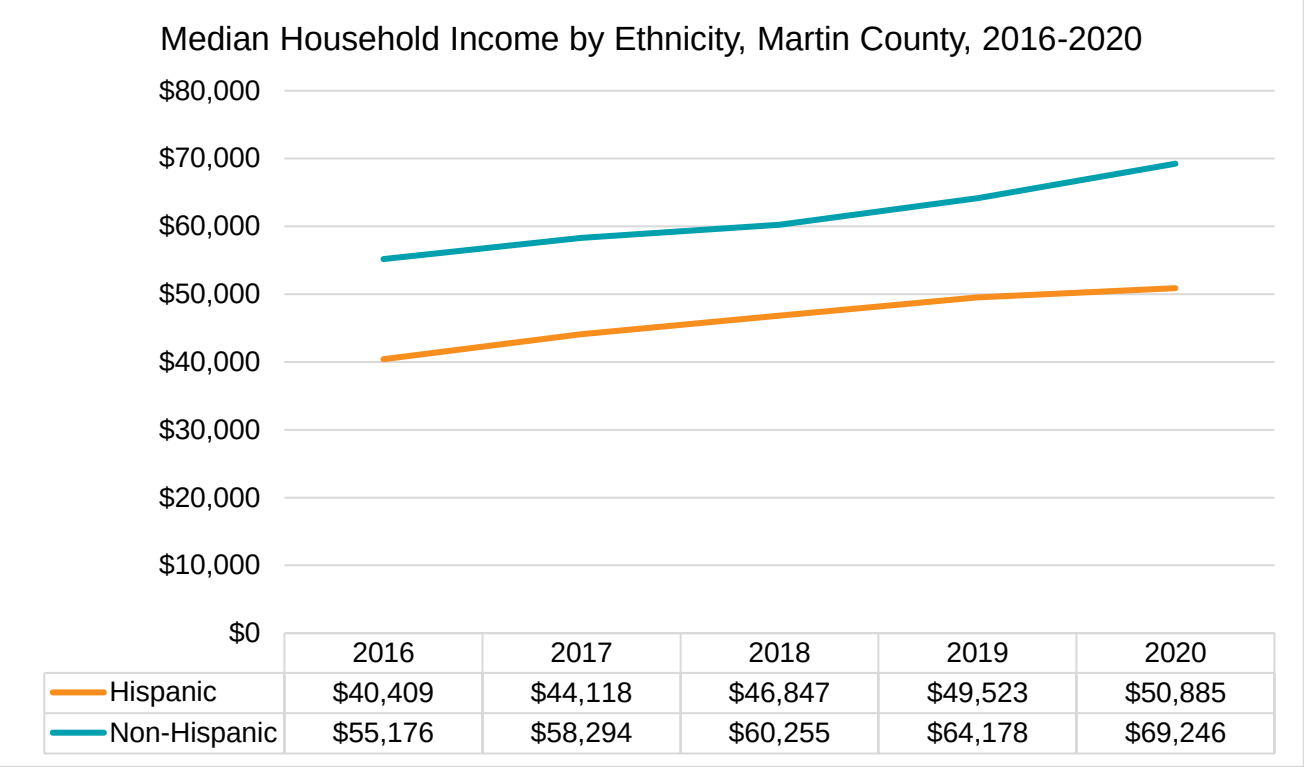


	2016	2017	2018	2019	2020
White	$54,164	$57,170	$59,286	$63,178	$67,979
Black	$30,606	$35,918	$38,929	$36,467	$37,089
American Indian and Alaska Native	$60,144	$43,889	$46,364	$39,625	$56,042
Asian	$77,031	$71,080	$89,346	$92,319	$104,850
Native Hawaiian and Other Pacific Islander					
Some Other Race	$36,546	$36,341	$39,129	$39,385	$40,283

Source: United States Bureau of the Census, American Community Survey, Table B19013.

[44] Zare, H., Gilmore, D.R., et al. (2021). How income inequality and race/ethnicity drive obesity in US adults: 1999-2016. *Healthcare (Basel).* 9(11): 1442.

The graph below shows the median household income by **ethnicity** in Martin County from 2016 to 2020. The median household income among both Hispanic and non-Hispanic residents increased during this time frame. Most recently in 2020, the median household income among non-Hispanic residents was $69,246 compared to $50,885 among Hispanic residents. The median household income disparity between these groups in 2020 was $18,361. As previously mentioned, national research shows that income impacts racial and ethnic groups and genders differently, having a negative relationship with obesity for some groups and a positive relationship for others.[45] A US study found no correlation between higher poverty-to-income ratio and obesity among Hispanic residents.

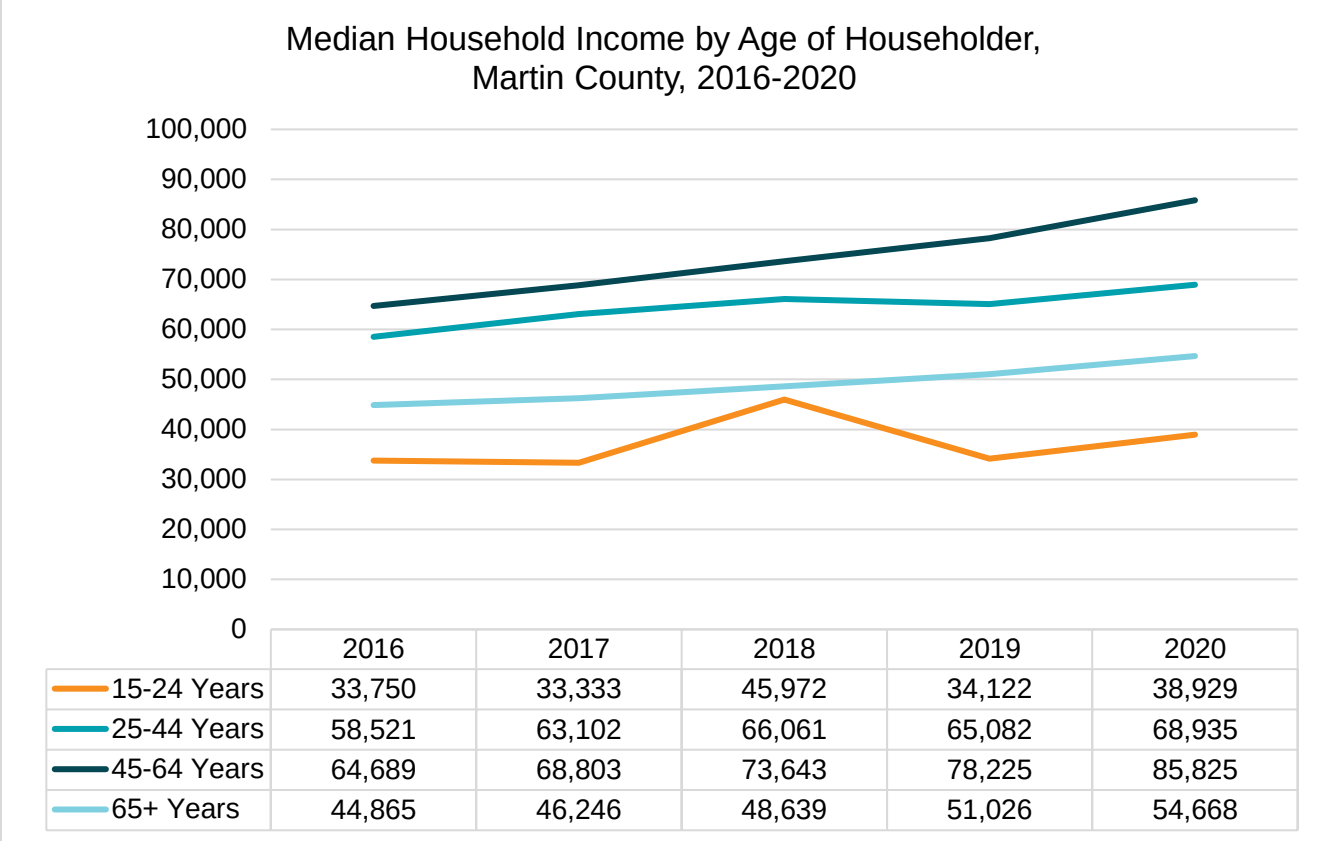


	2016	2017	2018	2019	2020
Hispanic	$40,409	$44,118	$46,847	$49,523	$50,885
Non-Hispanic	$55,176	$58,294	$60,255	$64,178	$69,246

Source: United States Bureau of the Census, American Community Survey, Table B19013.

[45] Zare, H., Gilmore, D.R., et al. (2021). How income inequality and race/ethnicity drive obesity in US adults: 1999-2016. *Healthcare (Basel).* 9(11): 1442.

The figure below shows median household income by **age** of the head of household in Martin County from 2016 to 2020. Each year, residents aged 45 to 64 years earned higher median incomes, followed by residents aged 25 to 44 years, while residents aged 15 to 24 years earned the lowest median income, followed by residents 65 years and older. Most recently in 2020, residents aged 45 to 64 made on average $85,825, compared to $38,929 among residents 15 to 24 years old and $54,668 among residents 65 years and older. As previously mentioned, evidence demonstrates that income impacts racial and ethnic groups and genders differently, having a negative correlation with obesity for some groups and a positive correlation for others.[46]



	2016	2017	2018	2019	2020
15-24 Years	33,750	33,333	45,972	34,122	38,929
25-44 Years	58,521	63,102	66,061	65,082	68,935
45-64 Years	64,689	68,803	73,643	78,225	85,825
65+ Years	44,865	46,246	48,639	51,026	54,668

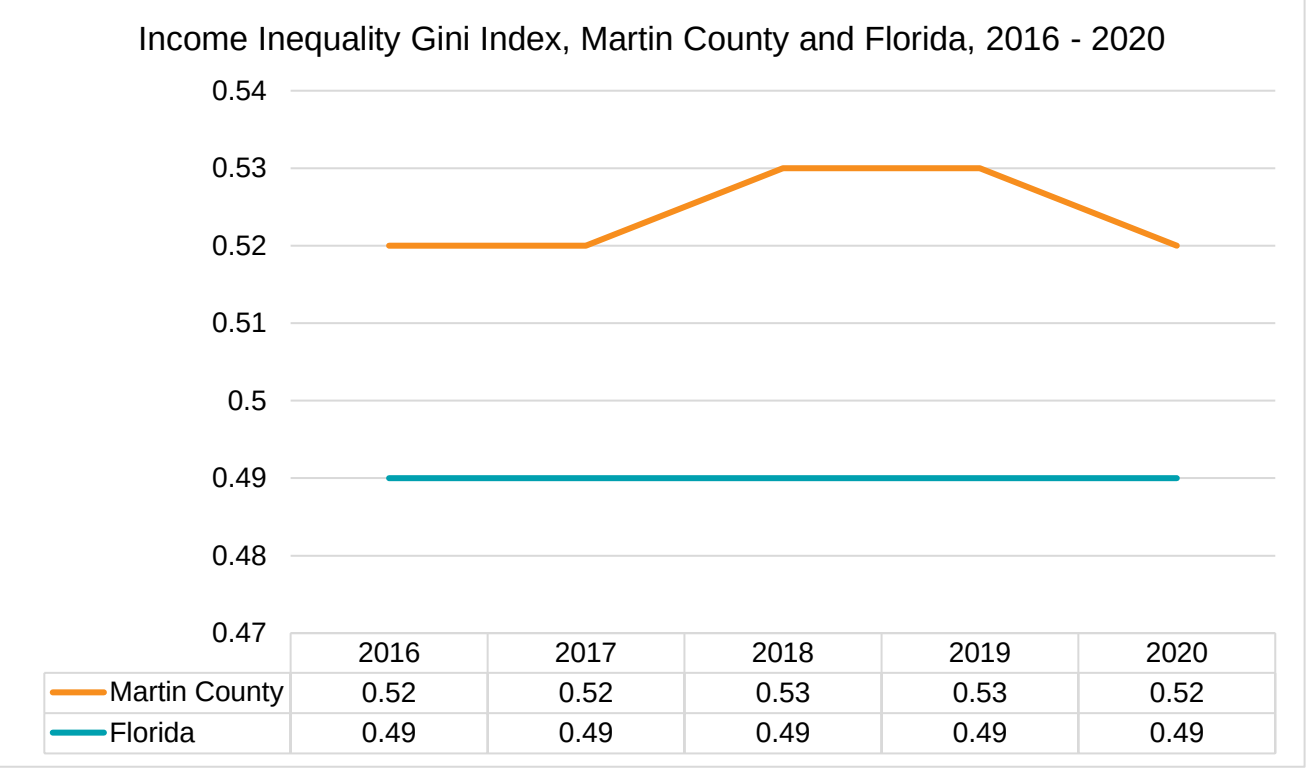
Source: United States Bureau of the Census, American Community Survey, Table B19013.

[46] Zare, H., Gilmore, D.R., et al. (2021). How income inequality and race/ethnicity drive obesity in US adults: 1999-2016. *Healthcare (Basel).* 9(11): 1442.

Income Inequality

The Gini index of income inequality, measures how much the household income distribution varies from a proportionate distribution. For example, if every value, or household income in this case, was equal in the distribution, then the distribution would be purely proportionate. The Gini index ranges from 0, or perfect equality, to one, perfect inequality.[47] Research shows that income inequality leads to increased nutritional problems and is directly association with obesity.[48]

The graph below shows the income inequality Gini index in Martin County and Florida from 2016 to 2020. Each year during this timeframe, income inequality was slightly higher and more unequal in Martin County compared to Florida.



	2016	2017	2018	2019	2020
Martin County	0.52	0.52	0.53	0.53	0.52
Florida	0.49	0.49	0.49	0.49	0.49

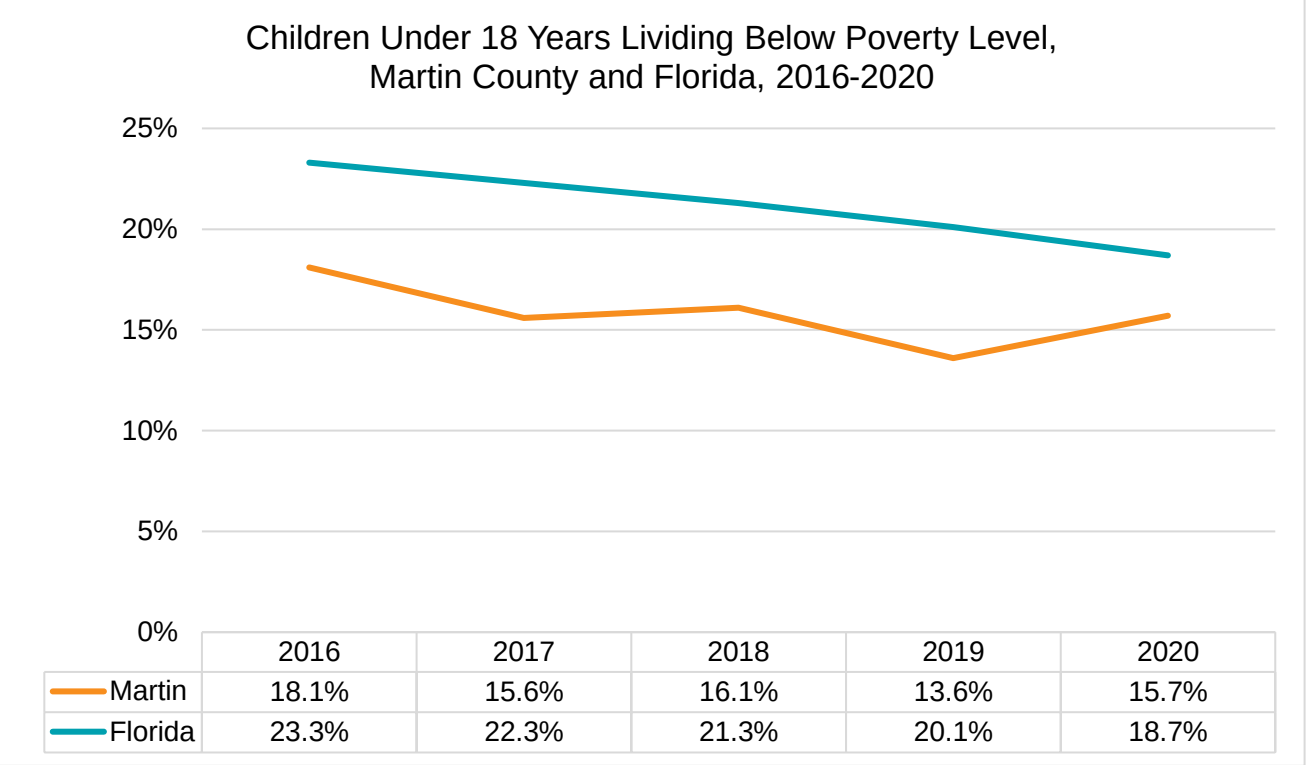
Source: United States Bureau of the Census, American Community Survey, Table B19083.

[47] American Community Survey and Puerto Rico Community Survey, 2020 Subject Definitions (n.d.). In *United States Census Bureau*. Retrieved from https://www2.census.gov/programs-surveys/acs/tech_docs/subject_definitions/2020_ACSSubjectDefinitions.pdf

[48] Pickett KE, Kelly S, Brunner E, et alWider income gaps, wider waistbands? An ecological study of obesity and income inequalityJournal of Epidemiology & Community Health 2005;59:670-674.

Poverty

The figure below shows the proportion of children under 18 years old living below the federal poverty level in Martin County and Florida from 2016 to 2020. Each year, Florida had a larger proportion of children living below the poverty level, though this proportion steadily decreased. In Martin County, the proportion decreased from 2018 to 2019 but increased in 2020 again. Most recently in 2020, 15.7% of children in Martin County were living below the poverty level compared to 18.7% in Florida. Research shows that children living in poverty are at higher risk for obesity by adolescence.[49] The Martin County Health Equity Taskforce is implementing a PACE-EH Community Project in Indiantown, where there is high poverty and a high proportion of obese children, to mitigate the negative impact that poverty has on health. Specifically, the project aims to increase access to affordable healthy food and walkable areas.

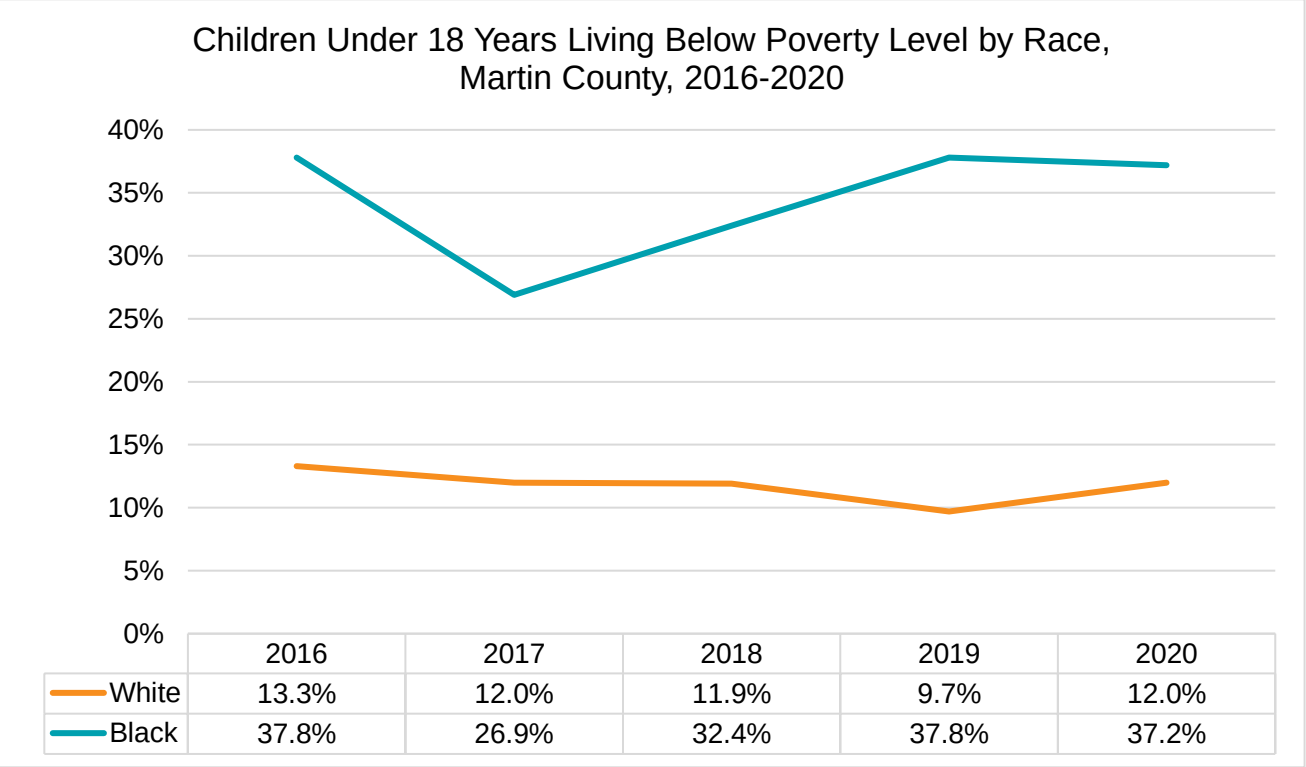


	2016	2017	2018	2019	2020
Martin	18.1%	15.6%	16.1%	13.6%	15.7%
Florida	23.3%	22.3%	21.3%	20.1%	18.7%

Source: United States Bureau of the Census, American Community Survey, Table S1701.

[49] Lee, H., Andrew, M., et al. (2013). Longitudinal associations between poverty and obesity from birth through adolescence. *American Journal of Public Health.* 104, e70-e76.

The figure below shows children living below the poverty level by **race** in Martin County from 2016 to 2020. Each year, a much higher proportion of Black children in Martin County were living below the poverty level. Most recently in 2020, 37.2% of Black children were living below the poverty level compared to 12% of White children. As mentioned, research shows that children living in poverty are at higher risk for obesity by adolescence.[50] Unfortunately, data for all other racial groups was unavailable. The Martin County Health Equity Taskforce is implementing a PACE-EH Community Project in Indiantown, where there is high poverty and a high proportion of obese children, to mitigate the negative impact that poverty has on health, specifically access to affordable healthy food and walkable areas, and reduce racial health disparities.

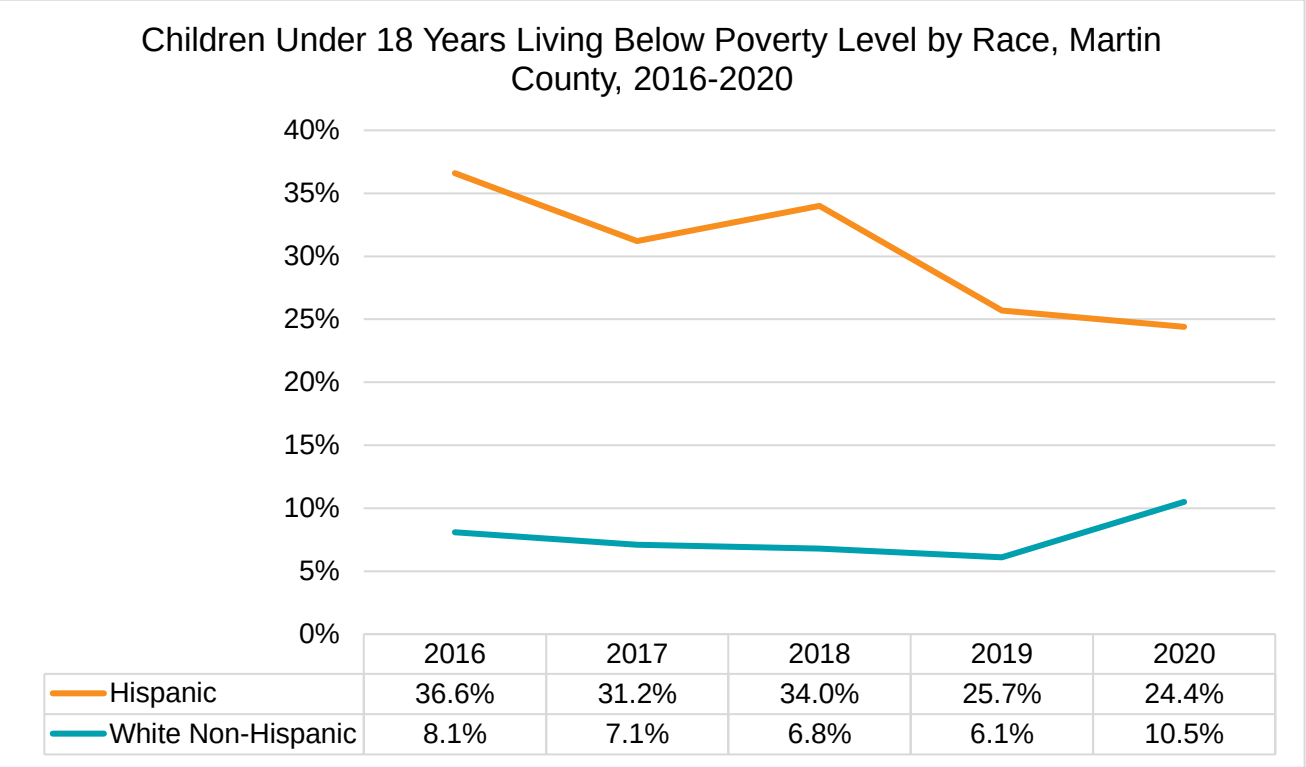


	2016	2017	2018	2019	2020
White	13.3%	12.0%	11.9%	9.7%	12.0%
Black	37.8%	26.9%	32.4%	37.8%	37.2%

Source: United States Bureau of the Census, American Community Survey, DP03.

[50] Lee, H., Andrew, M., et al. (2013). Longitudinal associations between poverty and obesity from birth through adolescence. *American Journal of Public Health.* 104, e70-e76.

The figure below shows children living below the poverty level by **ethnicity** in Martin County from 2016 to 2020. Each year, a much higher proportion of Hispanic children lived below the poverty level, though the proportion decreased over time from 36.6% in 2016 to 24.4% in 2020. The proportion of non-Hispanic White children living below the poverty level steadily decreased from 2016 (8.1%) to 2019 (6.1%), then increased from 6.1% to 10.5% in 2020. Most recently in 2020, 2.3 times more Hispanic children were living below the poverty level. As mentioned, research shows that children living in poverty are at higher risk for obesity by adolescence.[51] The Martin County Health Equity Taskforce is implementing a PACE-EH Community Project in Indiantown, where there is high poverty and a high proportion of obese children, to mitigate the negative impact that poverty has on health, specifically access to affordable healthy food and walkable areas, and reduce ethnic health disparities.

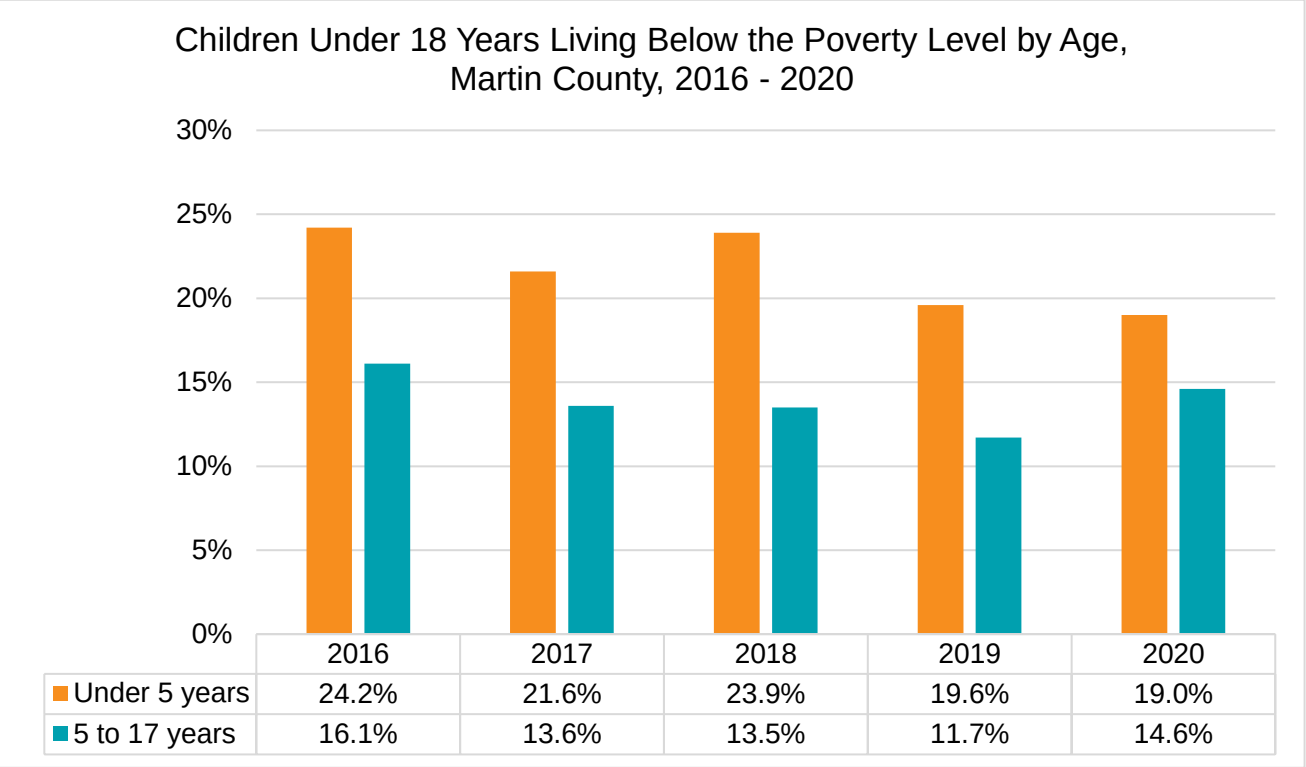


	2016	2017	2018	2019	2020
Hispanic	36.6%	31.2%	34.0%	25.7%	24.4%
White Non-Hispanic	8.1%	7.1%	6.8%	6.1%	10.5%

Source: United States Bureau of the Census, American Community Survey, Table DP03.

[51] Lee, H., Andrew, M., et al. (2013). Longitudinal associations between poverty and obesity from birth through adolescence. *American Journal of Public Health.* 104, e70-e76.

This graph shows the percent of **children** under 18 years living below the poverty level by **age** in Martin County from 2016 to 2020. The percentage of children under 5 years old living below the poverty level decreased from 2016 (24.2%) to 2017 (21.6%), increased in 2018 (23.9%), then decreased to 2020 (19.0%). While the percentage of children 5 to 17 years old living below the poverty level decreased from 2016 (16.1%) to 2019 (11.7%), the proportion increased most recently in 2020 (14.6%). As mentioned, research shows that children living in poverty are at higher risk for obesity by adolescence.[52] The Martin County Health Equity Taskforce is implementing a PACE-EH Community Project in Indiantown, where there is high poverty and a high proportion of obese children, to mitigate the negative impact that poverty has on health, specifically limited access to affordable healthy food and walkable areas.



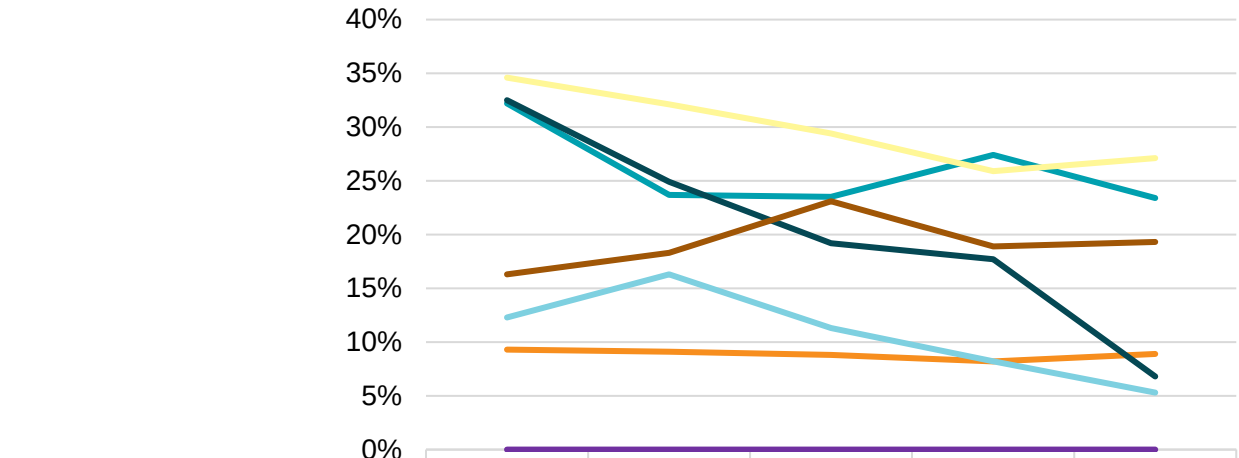
	2016	2017	2018	2019	2020
Under 5 years	24.2%	21.6%	23.9%	19.6%	19.0%
5 to 17 years	16.1%	13.6%	13.5%	11.7%	14.6%

Source: United States Bureau of the Census, American Community Survey, Table S1701.

[52] Lee, H., Andrew, M., et al. (2013). Longitudinal associations between poverty and obesity from birth through adolescence. *American Journal of Public Health.* 104, e70-e76.

The graph on the following page shows individuals living below the poverty level by **race** in Martin County from 2016 to 2020. The proportion of individuals living below the poverty level fluctuated among most groups during this timeframe. Most recently, the proportion of individuals living below the poverty level was 27.1% among individuals identifying as some other race, 23.4% among Black residents, 19.3% among individuals identifying as two or more races, 8.9% among White residents, 6.8% among American Indian and Alaska Native residents, 5.3% among Asian residents, and 0% among Native Hawaiian and Other Pacific Islander. As shown here, there is a clear disparity between racial groups among those living below the poverty level. In the United States, communities with higher poverty rates also experience higher obesity rates, due to the easy access to and affordability of highly processed foods with high calories and no nutritional value.[53] The Martin County Health Equity Taskforce acknowledges this as a serious cause for concern and is, thus, implementing a PACE-EH Community Project in Indiantown, a low-income and low food access area.

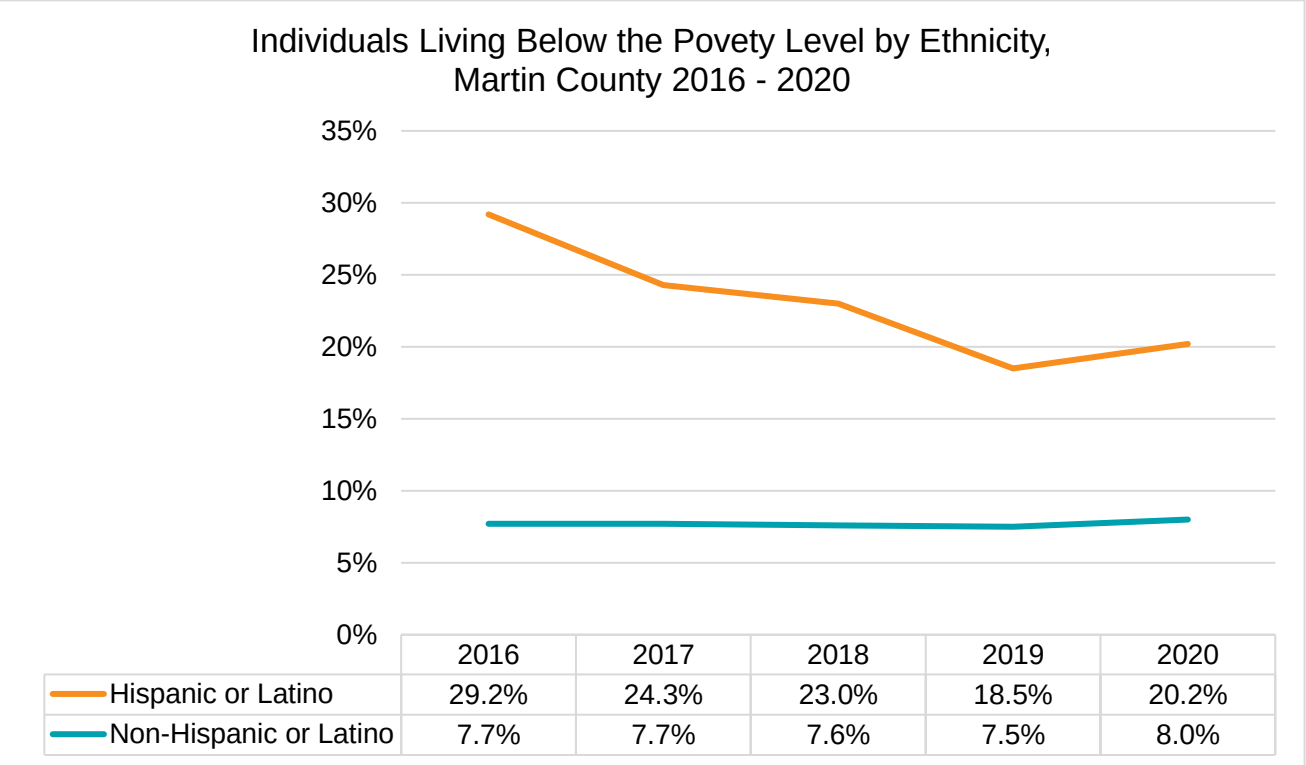
[53] Zukiewicz-Sobczak, W., Weoblewska, P, et al. (2014). Obesity and poverty paradox in developed countries. *Annals of Agricultural and Environmental Medicine.* 21(3): 590-594.



	2016	2017	2018	2019	2020
White	9.3%	9.1%	8.8%	8.2%	8.9%
Black or African American	32.2%	23.7%	23.5%	27.4%	23.4%
American Indian and Alaska Native	32.5%	24.9%	19.2%	17.7%	6.8%
Asian	12.3%	16.3%	11.3%	8.2%	5.3%
Native Hawaiian and Other Pacific Islander	0.0%	0.0%	0.0%	0.0%	0.0%
Some other race	34.6%	32.1%	29.4%	25.9%	27.1%
Two or more races	16.3%	18.3%	23.1%	18.9%	19.3%

Source: United States Bureau of the Census, American Community Survey, Table S1701.

This graph shows the proportion of individuals living below the poverty level by **ethnicity** in Martin County from 2016 to 2020. The proportion of Hispanic or Latino residents living below the poverty level fluctuated slightly but decreased overall from 29.2% in 2016 to 20.2% in 2020. The proportion of non-Hispanic or Latino residents remained fairly steady but increased slightly from 7.7% in 2016 to 8.0% in 2020. As previously mentioned, communities with higher poverty rates also experience higher obesity rates, due to the easy access to and affordability of highly processed foods with high calories and no nutritional value.[54] The Martin County Health Equity Taskforce acknowledges this as a serious cause for concern and is, thus, implementing a PACE-EH Community Project in Indiantown, where there a majority of residents are Hispanic or Latino and low-income and where there is low access to affordable, healthy foods.

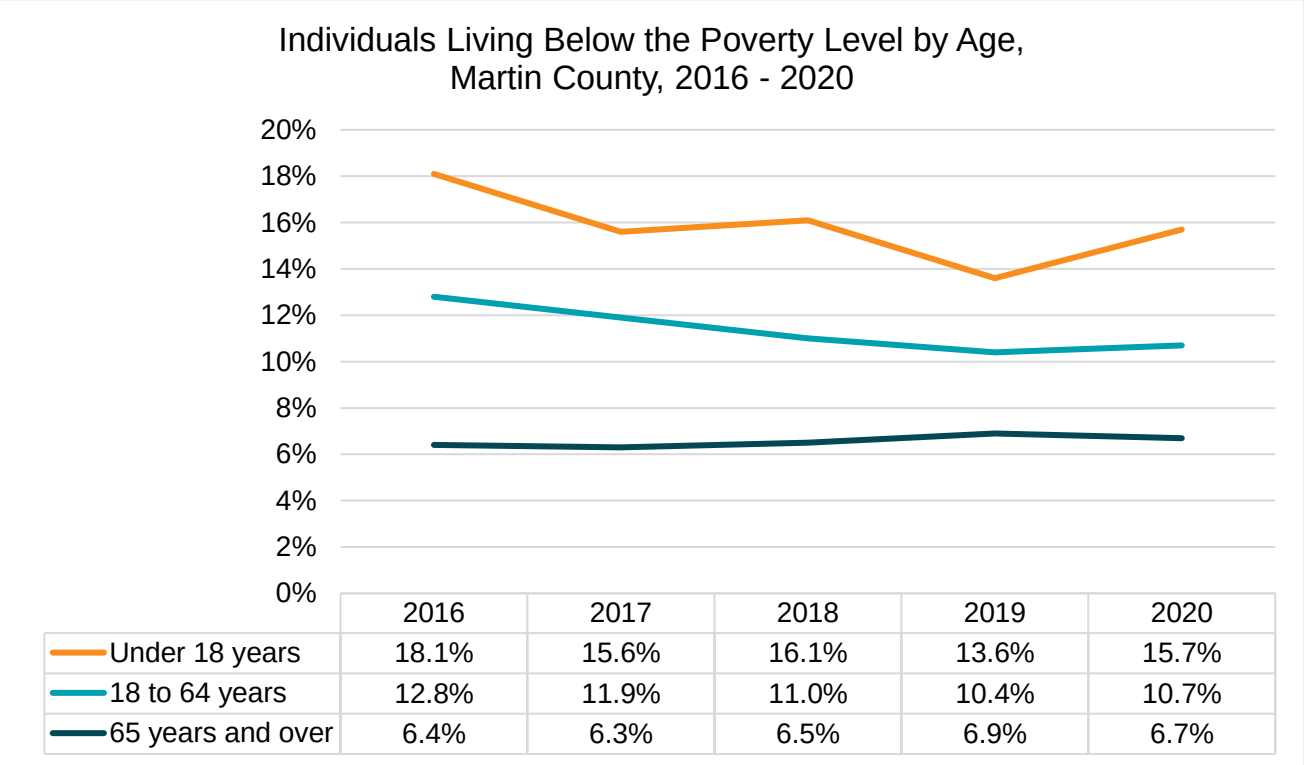


	2016	2017	2018	2019	2020
Hispanic or Latino	29.2%	24.3%	23.0%	18.5%	20.2%
Non-Hispanic or Latino	7.7%	7.7%	7.6%	7.5%	8.0%

Source: United States Bureau of the Census, American Community Survey, Table S1701.

[54] Zukiewicz-Sobczak, W., Weoblewska, P, et al. (2014). Obesity and poverty paradox in developed countries. *Annals of Agricultural and Environmental Medicine.* 21(3): 590-594.

The graph below shows individuals living below the poverty level by **age** in Martin County from 2016 to 2019. Each year during this timeframe, children under 18 years old had the highest proportion living under the poverty level, while those 65 years of age and older had the lowest proportion. Most recently in 2020, the proportion of children under 18 years old living below the poverty level was 15.7%, followed by 10.7% among those 18 to 64 years old and 6.7% among those 65 years of age and older. As previously mentioned, communities with higher poverty rates also experience higher obesity rates, due to the easy access to and affordability of highly processed foods with high calories and no nutritional value.[55] The Martin County Health Equity Taskforce acknowledges this as a serious cause for concern and is, thus, implementing a PACE-EH Community Project in Indiantown.



	2016	2017	2018	2019	2020
Under 18 years	18.1%	15.6%	16.1%	13.6%	15.7%
18 to 64 years	12.8%	11.9%	11.0%	10.4%	10.7%
65 years and over	6.4%	6.3%	6.5%	6.9%	6.7%

Source: United States Bureau of the Census, American Community Survey, Table S1701.

[55] Zukiewicz-Sobczak, W., Weoblewska, P, et al. (2014). Obesity and poverty paradox in developed countries. *Annals of Agricultural and Environmental Medicine.* 21(3): 590-594.

This table shows the proportion of individuals living below the poverty level by **age** and **Census Tract** in Martin County in 2020. In Census Tract 18.03, 54.2% children under 18 years old were living below the poverty level in 2020, the highest of all Census Tracts for that age group. In Census Tract 18.06, 49.3% of residents 18 to 64 years old were living below the poverty level, also the highest of all Census Tracts for that age group. The Census Tract with the highest proportion of individuals 65 years of age and older living below the poverty level was Census Tract 18.06. Census Tract 18.03 includes parts of Indiantown, an area Martin County has chosen to focus on as a part of this plan. As stated previously, communities with higher poverty rates also experience higher obesity rates, due to the easy access to and affordability of highly processed foods with high calories and no nutritional value.[56] The Martin County Health Equity Taskforce acknowledges this as a serious cause for concern and is, thus, implementing a PACE-EH Community Project in Indiantown, a low-income and low food access area.

Individuals Living Below the Poverty Level by Age and Census Tract, Martin County, 2020				
Census Tract	**Under 18 years (%)**	**18 years and over (%)**	**18 to 64 years (%)**	**65 years and over (%)**
1	0.0%	3.0%	3.2%	2.9%
2	32.4%	8.7%	9.6%	7.4%
3	16.0%	10.8%	13.3%	4.3%
4	26.6%	11.7%	13.9%	6.8%
5.01	14.9%	20.4%	24.2%	12.1%
5.02	0.0%	4.1%	3.4%	4.8%
6.03	3.6%	2.9%	2.6%	3.6%
6.04	3.2%	4.4%	4.7%	3.8%
6.06	10.4%	5.3%	3.8%	8.5%
6.07	0.0%	10.0%	2.7%	14.4%
6.10	21.5%	10.4%	16.2%	1.8%
7.01	0.0%	11.6%	16.0%	7.1%
7.02	0.0%	10.3%	4.1%	16.1%

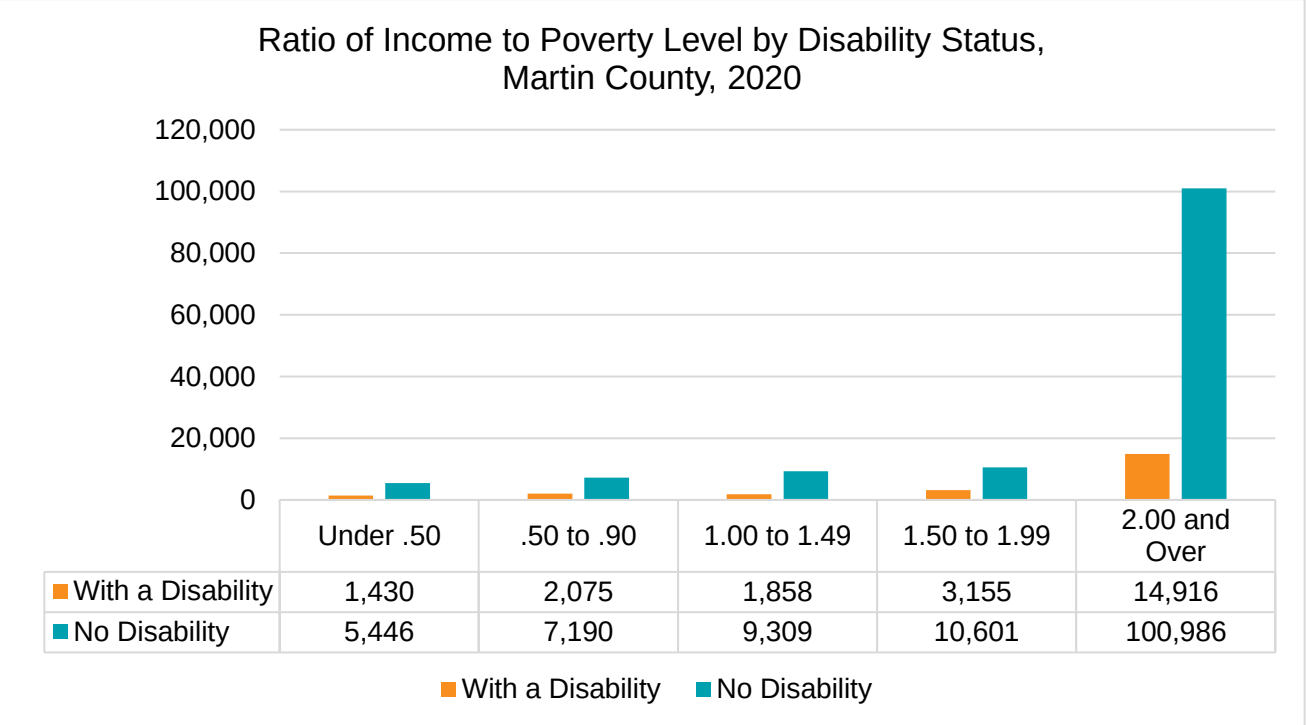
[56] Zukiewicz-Sobczak, W., Weoblewska, P, et al. (2014). Obesity and poverty paradox in developed countries. *Annals of Agricultural and Environmental Medicine.* 21(3): 590-594.

8	18.9%	15.4%	16.1%	12.3%
9.01	0.0%	9.1%	7.1%	9.8%
9.02	18.2%	6.2%	6.3%	6.1%
10	36.9%	14.3%	14.8%	12.8%
11.03	0.0%	6.1%	4.4%	7.8%
11.05	0.0%	4.8%	4.2%	6.0%
11.06	12.1%	12.5%	12.2%	13.7%
11.07	0.0%	5.7%	6.8%	3.1%
11.08	0.0%	6.1%	3.7%	7.8%
12	44.4%	19.0%	18.7%	20.8%
13.01	44.8%	14.6%	18.3%	5.4%
13.02	9.6%	7.0%	6.6%	7.4%
14.04	20.2%	14.3%	17.9%	7.9%
14.06	0.0%	1.7%	2.4%	0.0%
14.07	48.8%	18.5%	23.5%	15.5%
14.08	1.6%	8.6%	11.4%	3.9%
14.09	25.2%	8.0%	9.4%	6.9%
14.10	3.5%	8.0%	9.1%	6.6%
15	0.0%	10.1%	14.0%	4.5%
16.01	2.2%	4.4%	8.0%	0.7%
16.02	0.0%	3.5%	3.7%	2.9%
17.01	7.4%	2.8%	3.9%	0.0%
17.02	0.0%	4.8%	0.0%	11.0%
17.03	0.0%	2.3%	3.3%	0.0%
18.03	54.2%	27.3%	31.3%	0.8%
18.04	36.9%	13.3%	16.4%	6.3%
18.05	0.0%	9.7%	11.3%	0.0%
18.06	0.0%	43.9%	49.3%	21.8%

Source: United States Bureau of the Census, American Community Survey, Table S1701.

Ratio of Income to Poverty Level

The ratio of income-to-poverty level represents the ratio of income to the appropriate poverty threshold. Ratios under 1.0 signify that the income is below the official definition of poverty, whereas a ratio over 1.0 indicates an income over the poverty level. For instance, a ratio of 1.5 means that the income is 150 percent above the appropriate poverty level. This graph shows the ratio of income to poverty level by **disability status** in Martin County in 2020. The majority of Martin County residents with and without a disability had a ratio of income to poverty level of 2.00 and over in 2020. Of the residents with a disability, 14,916 had a ratio of income to poverty level of 2.00 or over. Similarly, 100,986 residents without a disability had a ratio of income to poverty level of 2.00 and over. Unfortunately, there is no county-level data related to obesity among disabled individuals, though research shows that individuals with disabilities have a higher prevalence of overweight compared to individuals who are not disabled.[57] The Martin County Health Equity Taskforce recognizes that adding a layer of poverty to that disparity is likely to exacerbate the issue. As such, an SDOH Screening Tool Community Project will be implemented to assess the extent of the issue among this prioritized population.



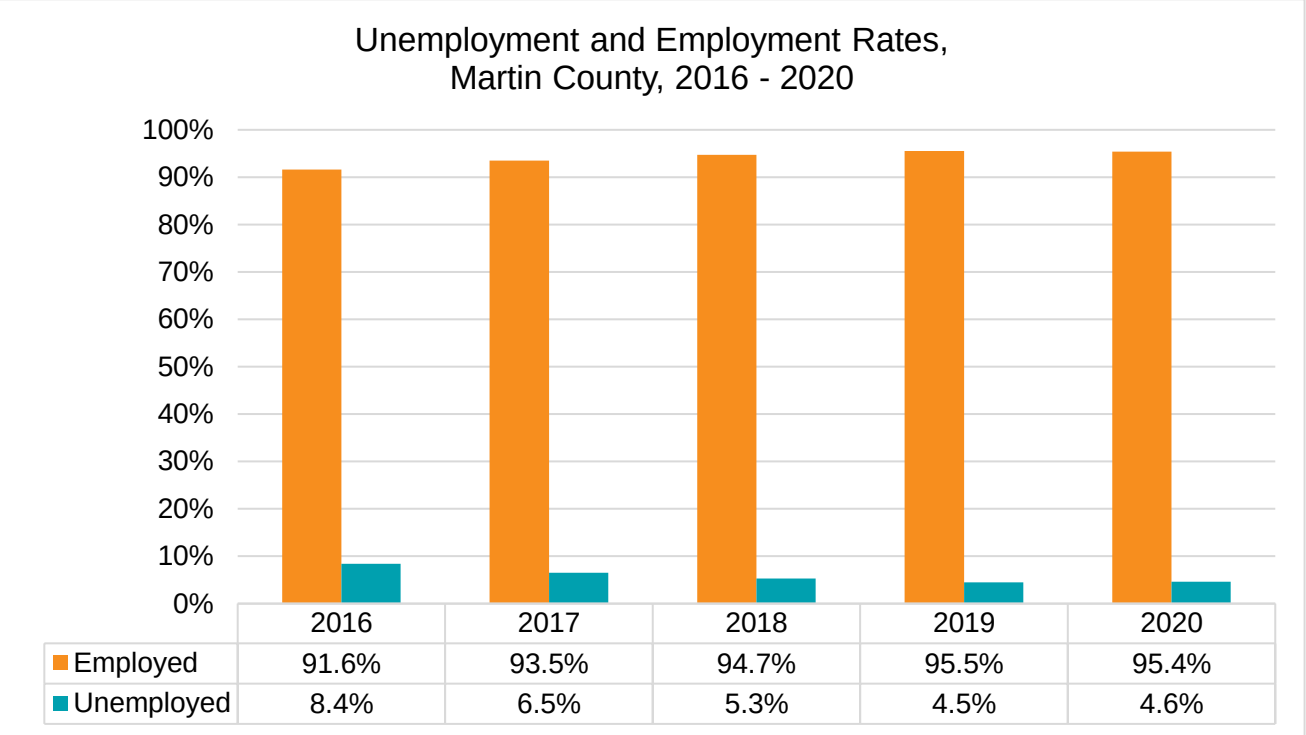
	Under .50	.50 to .90	1.00 to 1.49	1.50 to 1.99	2.00 and Over
With a Disability	1,430	2,075	1,858	3,155	14,916
No Disability	5,446	7,190	9,309	10,601	100,986

Source: United States Bureau of the Census, American Community Survey, Table C18131.

[57] Rimmer, J.H., Rowland, J.L., et al. (2007). Obesity and secondary conditions in adolescents with disabilities: Addressing the needs of an underserved population. *Journal of Adolescent Health.* 41(3): 224-229.

Employment Status

Stable employment increases economic opportunity and opportunity for upward social mobility, which have been shown to lead to better self-reported health and health behaviors.[58] This graph shows the unemployment and employment rates among **Martin County** residents from 2016 to 2020. The employment rate increased from 91.6% in 2016 to 95.5% in 2019, then decreased slightly to 95.4% in 2020. Following the opposite trend, the unemployment rate decreased from 8.4% in 2016 to 4.5% in 2019, then increased slightly to 4.6% in 2020. Unemployment, particularly long-term unemployment, has been found to be directly correlated with higher rates of obesity in the United States.[59] The Martin County Health Equity Taskforce recognizes this as an important social determinant of obesity, though the proportion of unemployed residents has decreased over time in the county.



	2016	2017	2018	2019	2020
Employed	91.6%	93.5%	94.7%	95.5%	95.4%
Unemployed	8.4%	6.5%	5.3%	4.5%	4.6%

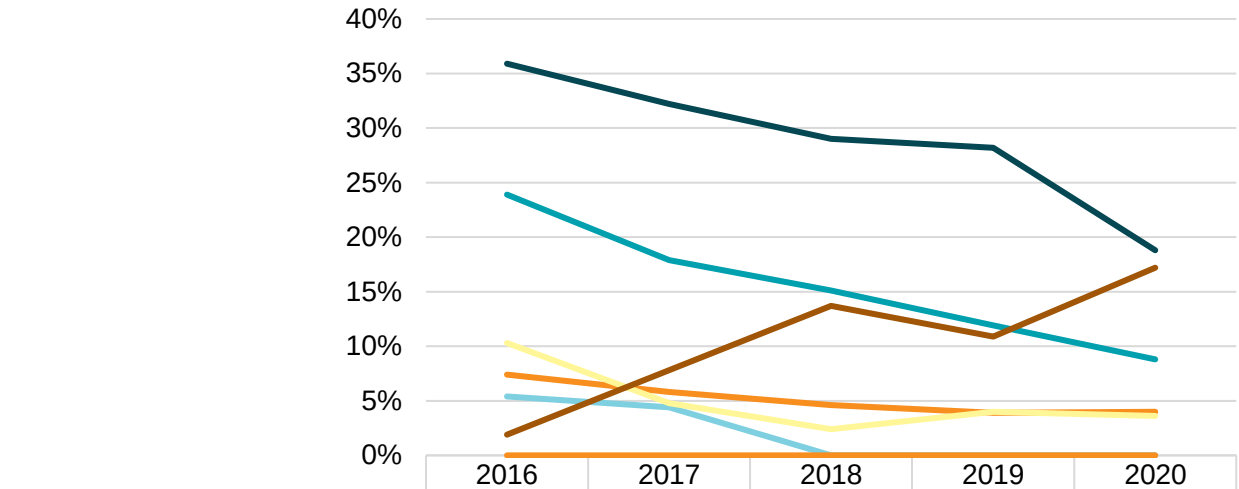
Source: United States Bureau of the Census, American Community Survey, Table S2301.

[58] Venkataramani, MD, A., Brigell, MPH, R., O'Brien, PhD, R., Chatterjee, MD, P., Kawachi, PhD, I., & Tsai, MD, A. (2016, October 3). Economic opportunity, health behaviours, and health outcomes in the USA: a population-based cross-sectional study. The Lancet Public Health, 1(1), 18-25. doi:https://doi.org/10.1016/S2468-2667(16)30005-6

[59] Crabtree, S. (2014). Obesity linked to long-term unemployment in US. Findings from Gallup. Retrieved from: https://news.gallup.com/poll/171683/obesity-linked-long-term-unemployment.aspx

The graph on the following page shows the unemployment rate by **race** among Martin County residents from 2016 to 2020. While American Indian and Alaska Native residents had the highest proportion of residents experiencing unemployment each year during this time frame, the proportion among this population decreased from 2016 (35.9%) to 2020 (18.8%). Most recently in 2020, the unemployment rate among American Indian and Alaska Native residents was 18.8%, followed by 17.2% among residents who identify as two or more races, 8.8% among Black or African American residents, 4.0% among White residents, 3.6% among residents who identify as some other race, 0% among Asian residents, and 0% among Native Hawaiian and other Pacific Islander residents. As stated previously, unemployment, particularly long-term unemployment (for a year or more), has been found to be directly correlated with higher rates of obesity in the United States.[60] The Martin County Health Equity Taskforce recognizes employment related disparities as important social determinants of health, though the proportion of unemployed residents has decreased over time among the majority of racial categories, aside from residents of two or more races.

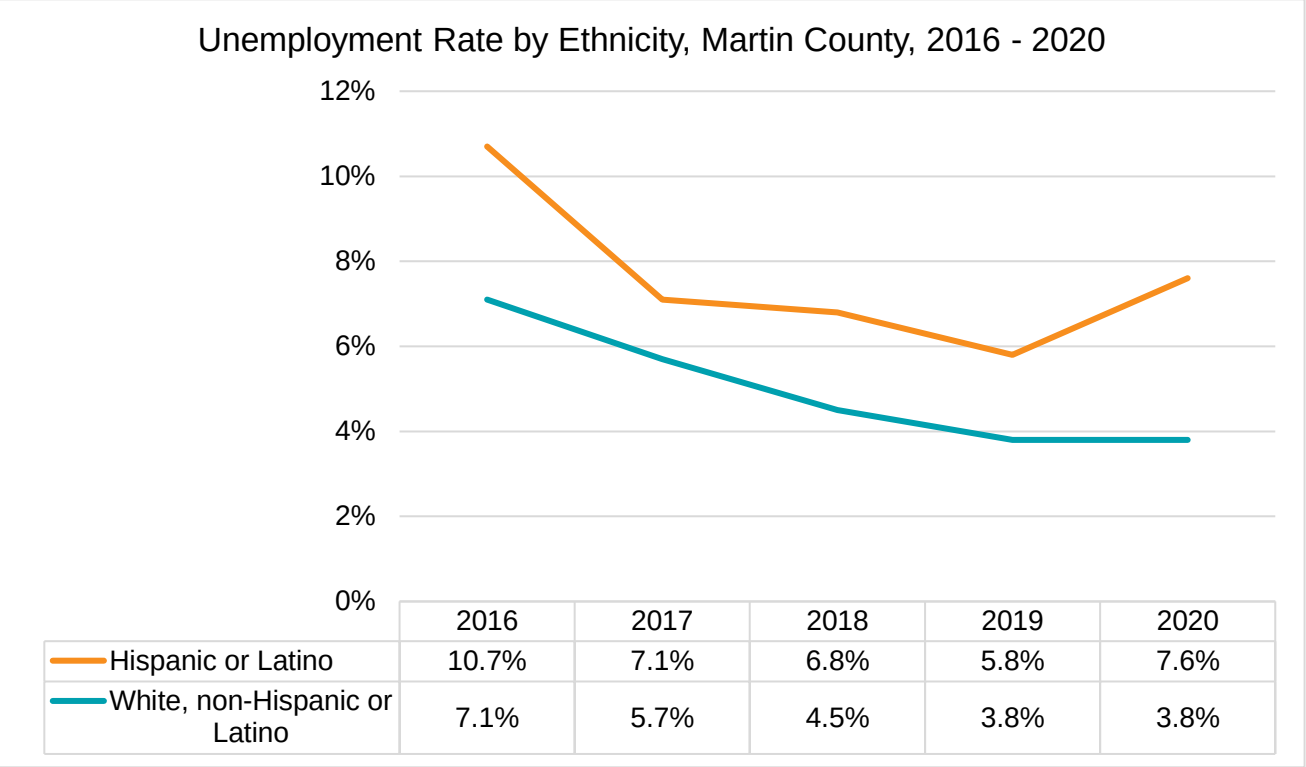
[60] Crabtree, S. (2014). Obesity linked to long-term unemployment in US. Findings from Gallup. Retrieved from: https://news.gallup.com/poll/171683/obesity-linked-long-term-unemployment.aspx



	2016	2017	2018	2019	2020
White alone	7.4%	5.8%	4.6%	3.9%	4.0%
Black or African American alone	23.9%	17.9%	15.1%	11.9%	8.8%
American Indian and Alaska Native alone	35.9%	32.2%	29.0%	28.2%	18.8%
Asian alone	5.4%	4.4%	0.0%	0.0%	0.0%
Native Hawaiian and Other Pacific Islander alone	0.0%	0.0%	0.0%	0.0%	0.0%
Some other race alone	10.3%	4.8%	2.4%	4.0%	3.6%
Two or more races	1.9%	7.8%	13.7%	10.9%	17.2%

Source: United States Bureau of the Census, American Community Survey, Table S2301.

This graph shows the unemployment rate by **ethnicity** among Martin County residents from 2016 to 2020. The rate among Hispanic or Latino residents decreased from 10.7% in 2016 to 5.8% in 2019, then increased to 7.6% in 2020. The unemployment rate among White, non-Hispanic or Latino residents decreased from 7.1% in 2016 to 3.8% in 2019, where it remained steady at 3.8% in 2020. As previously mentioned, unemployment has been found to be directly correlated with higher rates of obesity in the United States.[61] The Martin County Health Equity Taskforce recognizes employment related ethnic disparities as important social determinants of health and is, thus, working to mitigate the financial challenges associated with accessing healthy foods by implementing a PACE-EH Community Project in Indiantown, where a high proportion of residents are Hispanic or Latino and low-income.

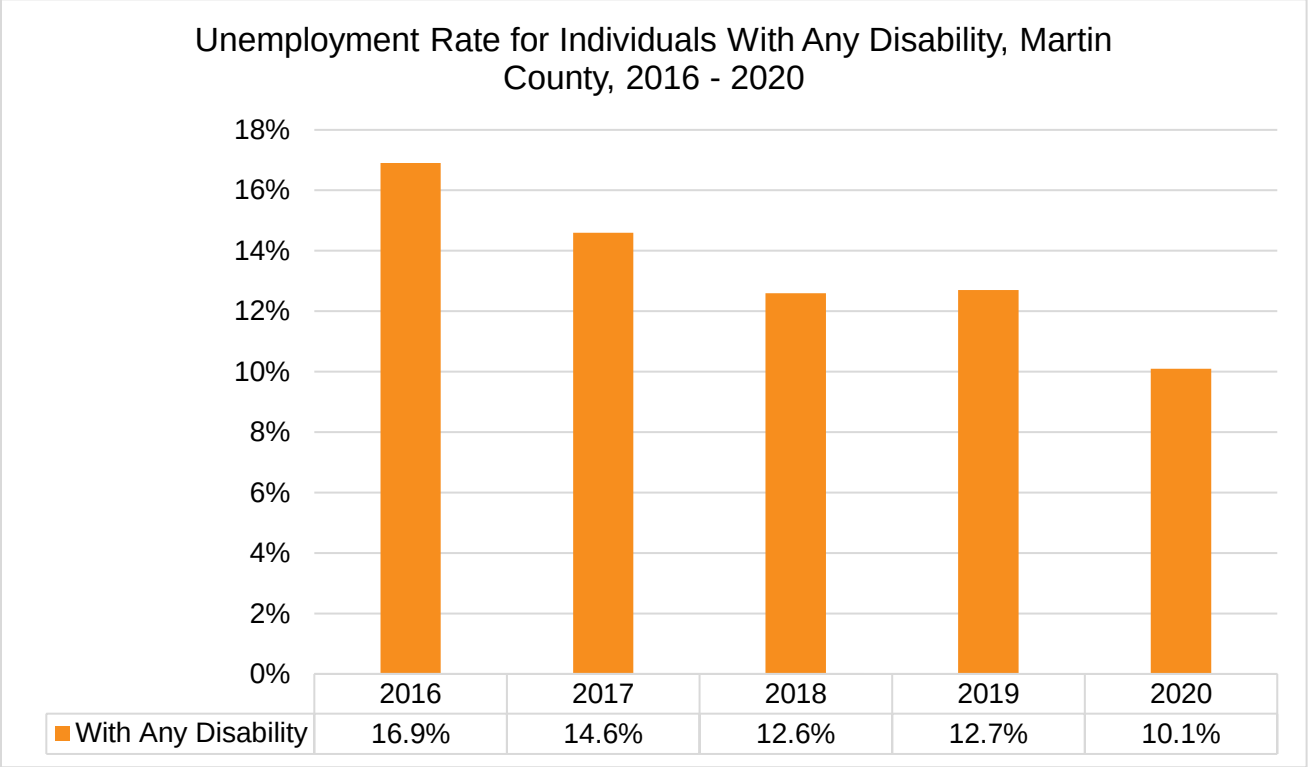


	2016	2017	2018	2019	2020
Hispanic or Latino	10.7%	7.1%	6.8%	5.8%	7.6%
White, non-Hispanic or Latino	7.1%	5.7%	4.5%	3.8%	3.8%

Source: United States Bureau of the Census, American Community Survey, Table S2301.

[61] Crabtree, S. (2014). Obesity linked to long-term unemployment in US. Findings from Gallup. Retrieved from: https://news.gallup.com/poll/171683/obesity-linked-long-term-unemployment.aspx

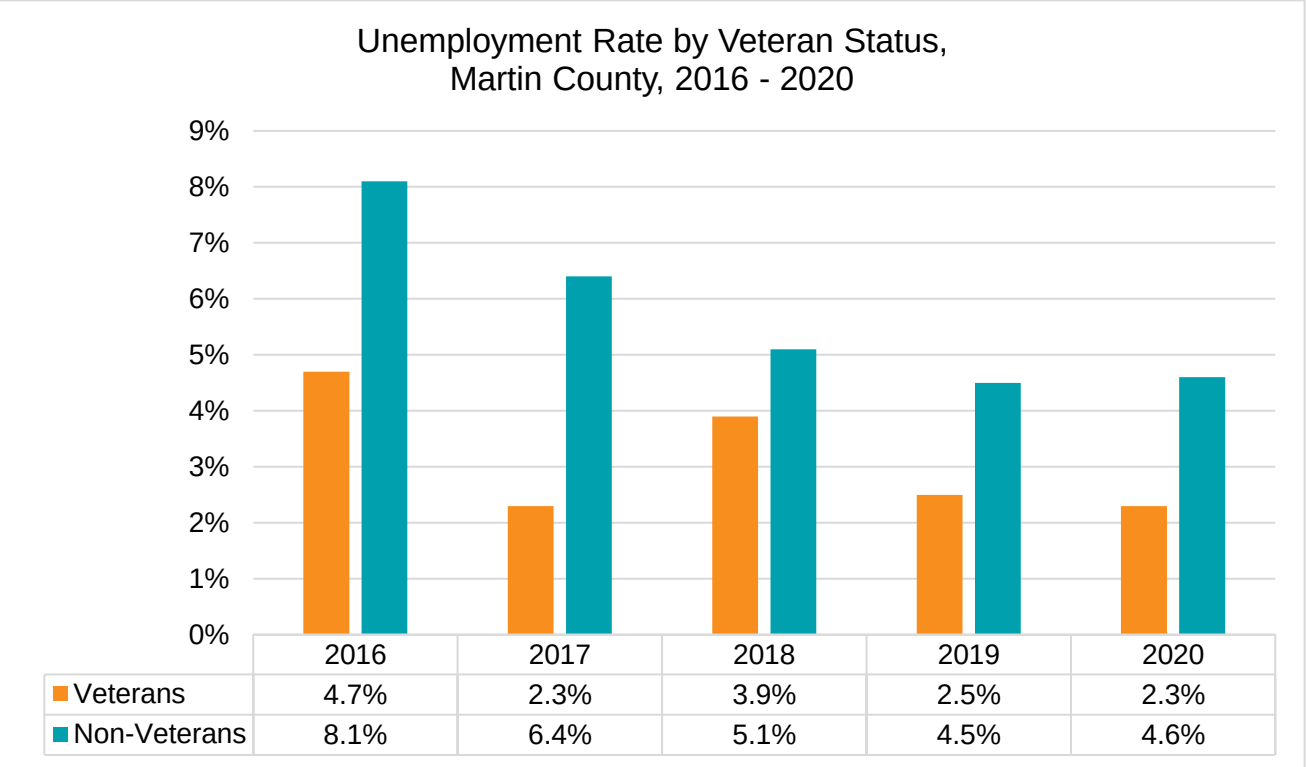
The graph below shows the unemployment rate for **individuals with any disability** in Martin County from 2016 to 2020. The rate decreased from 16.9% in 2016 to 10.1% in 2020. However, as seen in previous data, the unemployment rate among individuals with any disability was higher than the unemployment rate for individuals across the county each year during this timeframe. Most recently in 2020, the unemployment rate among individuals with any disability was 10.1% compared to the county-wide rate of 4.6%. As stated previously, in the United States, unemployment is associated with higher rates of obesity.[62] The Martin County Health Equity Taskforce recognizes employment as an important social determinant of obesity, though the proportion of unemployed residents has decreased over time among residents with a disability.



Source: United States Bureau of the Census, American Community Survey, Table S2301.

[62] Crabtree, S. (2014). Obesity linked to long-term unemployment in US. Findings from Gallup. Retrieved from: https://news.gallup.com/poll/171683/obesity-linked-long-term-unemployment.aspx

The graph below shows the unemployment rate by **veteran status** among Martin County residents from 2016 to 2020. The unemployment rate among veterans fluctuated during this timeframe, but decreased overall from 4.7% in 2016 to 2.3% in 2020. The rate among veterans remained lower than the rate among non-veterans each year. Unemployment is associated with higher rates of obesity.[63] As such, the Martin County Health Equity Taskforce recognizes employment as an important social determinant of obesity, though the unemployment rate has decreased over time among veterans in the county.

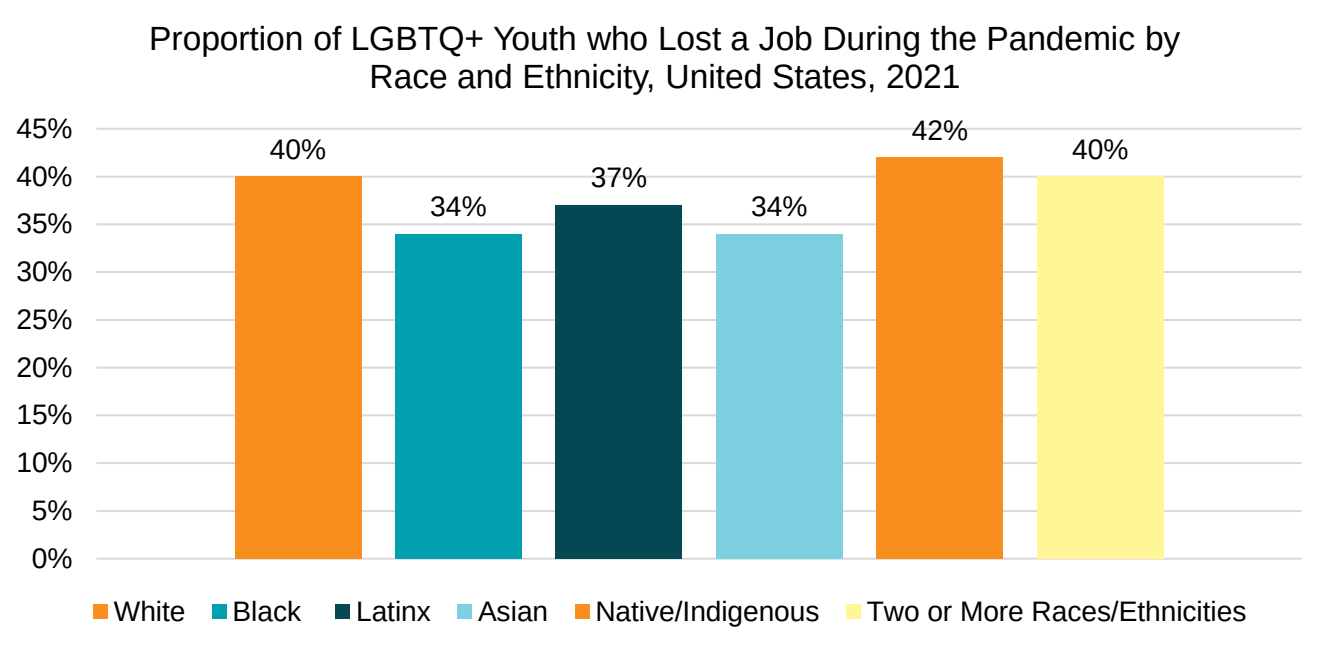


	2016	2017	2018	2019	2020
Veterans	4.7%	2.3%	3.9%	2.5%	2.3%
Non-Veterans	8.1%	6.4%	5.1%	4.5%	4.6%

Source: United States Bureau of the Census, American Community Survey, Table S2101.

[63] Crabtree, S. (2014). Obesity linked to long-term unemployment in US. Findings from Gallup. Retrieved from: https://news.gallup.com/poll/171683/obesity-linked-long-term-unemployment.aspx

Currently, there is no state or county level data on LGBTQ+ residents related to employment. However, the Trevor Project's National Survey on LGBTQ Youth Mental Health 2021 Survey assessed the COVID-19 pandemic's impact on employment and financial stability among **LGBTQ youth** aged 13 to 24. This survey showed that almost 40% of all LGBTQ youth stated that they lost their job during the pandemic. Furthermore, over 80% said that the pandemic made their living situation more stressful.[64] The highest proportion of job loss among this group was among Native/Indigenous LGBTQ youth (42%), followed by White LGBTQ youth (40%), LGBTQ youth of two or more races/ethnicities (40%), and Latinx LGBTQ youth (37%). Furthermore, the National Transgender Discrimination Survey found that, in Florida, 81% of residents of **trans experience** were harassed at work and 56% were either fired, not hired, or denied a promotion. Moreover, a staggering 9% were unemployed.[65] Research shows that job insecurity is linked to worse health outcomes.[66] With particularly high rates of job loss in this population, this is especially concerning. The Martin County Health Equity Taskforce is committed to addressing missing data for this population as a community project.



Source: Trevor Project National Survey on LGBTQ Mental Health, 2021

[64] Trevor Project. National Survey on LGBTQ Youth Mental Health 2021. Retrieved from: https://www.thetrevorproject.org/survey-2021/?section=Covid19
[65] National Center for Transgender Equality and the National Gay and Lesbian Task Force. 2012. Florida Results. Retrieved from: https://transequality.org/sites/default/files/docs/resources/ntds_state_fl.pdf
[66] Khubchandani, J., Price, J.H. Association of Job Insecurity with Health Risk Factors and Poorer Health in American Workers. J Community Health 42, 242–251 (2017). https://doi.org/10.1007/s10900-016-0249-8

Income Benefits

The table below shows the percentage of students with **free or reduced-price lunch status** by school in Martin County during the 2021 to 2022 school year. Free and reduced-price lunches are provided through the National School Lunch Program (NSLP), a federally funded program serving public, nonprofit private schools, and residential child care facilities. Student eligibility is determined by family income or status as a homeless, migrant, runaway, or foster child. Participating schools must serve meals that meet Federal requirements.[67] Income eligibility requirements for the 2021 to 2022 school year can be found here. When a school has a high percentage of student who qualifying for free or reduced-price lunch, this indicates that a large percentage of students are living in low-income situations, which is associated with increased risk for obesity.[68] As such, the Martin County Health Equity Taskforce will consider future projects aimed at reducing childhood poverty.

During the 2021 to 2022 school year, 100% of students in the following schools qualified for Free or Reduced-Price Lunch during this school year: Indiantown Middle School, J.D. Parker School of Technology, Pinewood Elementary, Port Salerno Elementary, Spectrum Academy, Warfield Elementary, and Willoughby Learning Center.

Free and Reduced-Price Lunch by School, Martin County, 2021-22 SY	
School	**Percent of Students with Free or Reduced-Price Lunch Status**
Bessey Creek Elementary School	23.8%
Citrus Grove Elementary	19.0%
Clark Advanced Learning Center	14.9%
Crystal Lake Elementary School	39.4%
Dr. David L. Anderson Middle School	51.1%
Ese Homebound	41.7%
Felix A Williams Elementary School	36.1%
Hidden Oaks Middle School	19.8%

[67] The National School Lunch Program (2017, November). In United States Department of Agriculture. Retrieved from https://fns-prod.azureedge.us/sites/default/files/resource-files/NSLPFactSheet.pdf

[68] May, L. A., Pan, L., et al. (2013). Vital signs: Obesity among low-income, preschool-aged children – United States, 2008-2011. *MMWR Morb Mortal Wkly Rep.* 62(31): 629-634.

Hobe Sound Elementary School	53.2%
Indiantown Middle School	100.0%
J. D. Parker School of Technology	100.0%
Jensen Beach Elementary School	38.5%
Jensen Beach High School	26.9%
Martin County High School	31.5%
Martin S.A.I.L.S	-
Murray Middle School	53.0%
Palm City Elementary School	16.6%
Pinewood Elementary School	100.0%
Pk Early Intervention	36.2%
Port Salerno Elementary School	100.0%
Port Salerno Learning Center	0.0%
Prekindergarten Programs	81.8%
Project Search	-
Riverbend Academy	0.0%
Sea Wind Elementary School	55.8%
South Fork High School	41.3%
Spectrum Academy	100.0%
Stuart Middle School	39.5%
The Hope Academy for Autism	0.0%
The Hope Charter Center for Autism	0.0%
Treasure Coast Classical Academy	0.2%
Warfield Elementary School	100.0%
Willoughby Learning Center	100.0%

Source: Florida Department of Education, 2022

This table shows the percentage of households with **income benefits** by **Census Tract** in Martin County in 2020. The Census Tracts with the highest percentage of residents with cash public assistance income were Census Tracts 18.03 (13.1%), 14.10 (6.1%), and 11.06 (5.2%). The Census Tracts with the highest percentage of residents with Food Stamp/SNAP benefits were Census Tracts 18.03 (44.7%), 8 (30.9%), and 18.04 (27.5%). To note, Census Tracts 18.03 and 18.04 include parts of Indiantown, an area of Martin County that has particularly high rates of overweight and obese children and adults. Communities with a high proportion of households receiving cash public assistance or food stamp/SNAP benefits may face significant barriers with other social determinants of health, but participation in SNAP has been found to significantly reduce Body Mass Index and the likelihood of obesity among youth.[69] As such, the Martin County Health Equity Taskforce will explore ways to increase SNAP awareness and participation.

Households with Income Benefits by Census Tract, Martin County, 2020						
Census Tract	With Earnings	With Social Security	With Retirement Income	With Supplemental Security Income	With Cash Public Assistance Income	With Food Stamp/SNAP Benefits
1	35.2%	76.9%	57.7%	2.2%	0%	0.5%
2	57.7%	51%	40.2%	2.5%	0.6%	3.7%
3	70.1%	37.4%	17.6%	9.1%	3.1%	14.4%
4	65.6%	47.3%	26.2%	4.6%	3.7%	9%
5.01	69.7%	40.1%	20.4%	1.6%	1%	9.3%
5.02	68.3%	59.4%	28.2%	1.8%	0%	0%
6.03	78.2%	35.2%	20.6%	1.5%	0.6%	3.7%
6.04	68.8%	47.4%	31.2%	4.1%	0%	2.7%
6.06	69.4%	41.5%	23.4%	0.2%	0.6%	0.2%

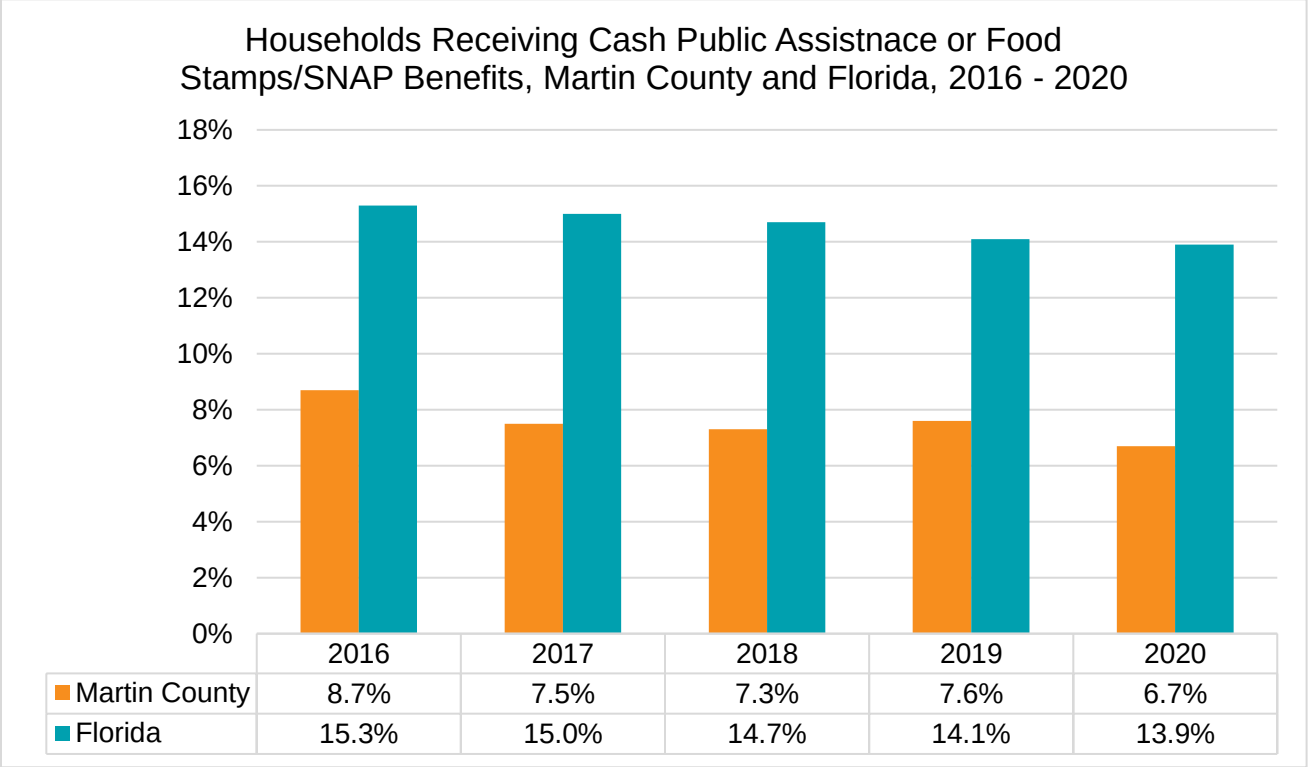
[69] Schmeiser, M.D. (2011). The impact of long-term participation in the supplemental nutrition assistance program on child obesity. *Health Economics.* 21(4): 386-404.

6.07	44.8%	71.1%	40.2%	3.3%	0.6%	1.1%
6.10	60.7%	51.2%	30.4%	3.7%	0.4%	0%
7.01	48.4%	48.1%	45.1%	0%	1.1%	0%
7.02	38.8%	72.3%	36.4%	1.6%	0%	7.3%
8	70.3%	36.5%	24.4%	5.3%	0.8%	30.9%
9.01	30.5%	84%	57.2%	1.9%	0%	1.4%
9.02	60%	58.2%	31%	2.1%	1.9%	3.2%
10	67.4%	33.2%	23.1%	7.2%	2.4%	10.3%
11.03	52.7%	55.4%	43.4%	0.5%	1.5%	1.5%
11.05	68.9%	38.5%	19.4%	4.1%	2.6%	3.5%
11.06	79.1%	35.7%	22%	0.9%	5.2%	13%
11.07	79.4%	45.1%	30%	12.5%	5%	5%
11.08	49.5%	72.7%	41.7%	5.7%	0.8%	1.2%
12	76%	24.7%	15.9%	4.4%	1.7%	22.7%
13.01	66.3%	46.4%	28.4%	6.5%	1.3%	12.1%
13.02	56.1%	59.3%	27.6%	3.2%	0%	0%
14.04	66.5%	46.9%	27.5%	1.3%	0.8%	6.6%
14.06	75.5%	39.6%	28.7%	4.4%	2.3%	0%
14.07	28.9%	63.3%	52.8%	10.7%	0%	3.6%
14.08	78.2%	46%	19.5%	1.6%	0%	6.3%
14.09	50.5%	59.9%	40%	3.2%	0.6%	2.4%
14.10	61.2%	53.6%	35.8%	2.2%	6.1%	11.3%
15	67%	47.1%	27%	3.1%	0.4%	0.7%

16.01	51.5%	63.3%	47.2%	1.5%	0.3%	0.8%
16.02	75.1%	48.8%	25.8%	2.5%	0%	0%
17.01	79.8%	40.1%	33.4%	0%	0%	2.2%
17.02	46.5%	59.7%	38.3%	11%	0%	8.8%
17.03	78%	52.1%	24.9%	0%	4.6%	1.2%
18.03	80.8%	25.5%	10.4%	0%	13.1%	44.7%
18.04	67.8%	53%	37.2%	3.1%	3.3%	27.5%
18.05	83.2%	25.7%	16.3%	3%	6.9%	19%
18.06	81%	48.2%	17.5%	0%	6.6%	19%

Source: United States Bureau of the Census, American Community Survey, Table DP03.

This graph shows the proportion of households receiving cash public assistance or food stamps/SNAP benefits in Martin County and Florida from 2016 to 2020. During this timeframe, the proportion of households receiving cash public assistance or food stamps/SNAP benefits decreased in Martin County from 8.7% in 2016 to 6.7% in 2020. In 2020, the proportion of households receiving cash public assistance or food stamps/SNAP benefits was 13.9% among Florida residents overall compared to 6.7% of Martin County residents. As previously mentioned, SNAP participation has been found to significantly reduce Body Mass Index and the likelihood of obesity among youth, due to increased access to healthy and nutritional foods.[70] As such, the Martin County Health Equity Taskforce will explore ways to increase SNAP awareness and participation.



	2016	2017	2018	2019	2020
Martin County	8.7%	7.5%	7.3%	7.6%	6.7%
Florida	15.3%	15.0%	14.7%	14.1%	13.9%

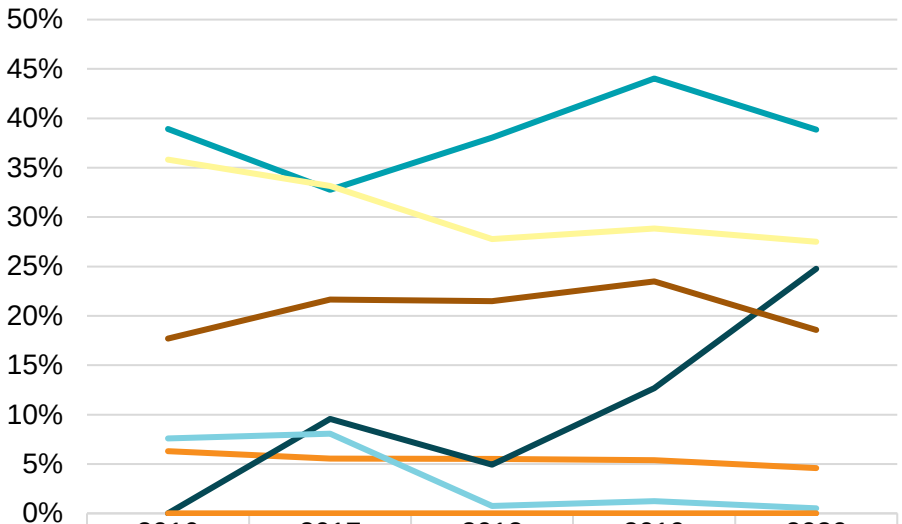
Source: United States Bureau of the Census, American Community Survey, Table B19058.

[70] Schmeiser, M.D. (2011). The impact of long-term participation in the supplemental nutrition assistance program on child obesity. *Health Economics.* 21(4): 386-404.

The figure on the following page shows the proportion of households receiving food stamps/SNAP benefits by **race** in Martin County from 2016 to 2020. The proportion of households receiving food stamps/SNAP benefits was highest among Black or African American households each year during this timeframe, followed by residents who identified as some other race alone, except in 2017 where the inverse was true. Most recently in 2020, the proportion of households receiving food stamps/SNAP benefits was 38.9% among Black or African American households, 27.5% among those identifying as some other race alone, 24.8% among American Indian and Alaska Native households, 18.6% among those identifying as two or more races, 4.6% among White households, 0.5% among Asian households, and 0.0% among Native Hawaiian and other Pacific Islander households. As previously stated, SNAP participation significantly reduces Body Mass Index and the likelihood of obesity among youth, due to increased access to healthy and nutritional foods.[71] As such, the Martin County Health Equity Taskforce will explore ways to increase SNAP awareness and participation among communities of color.

[71] Schmeiser, M.D. (2011). The impact of long-term participation in the supplemental nutrition assistance program on child obesity. *Health Economics.* 21(4): 386-404.

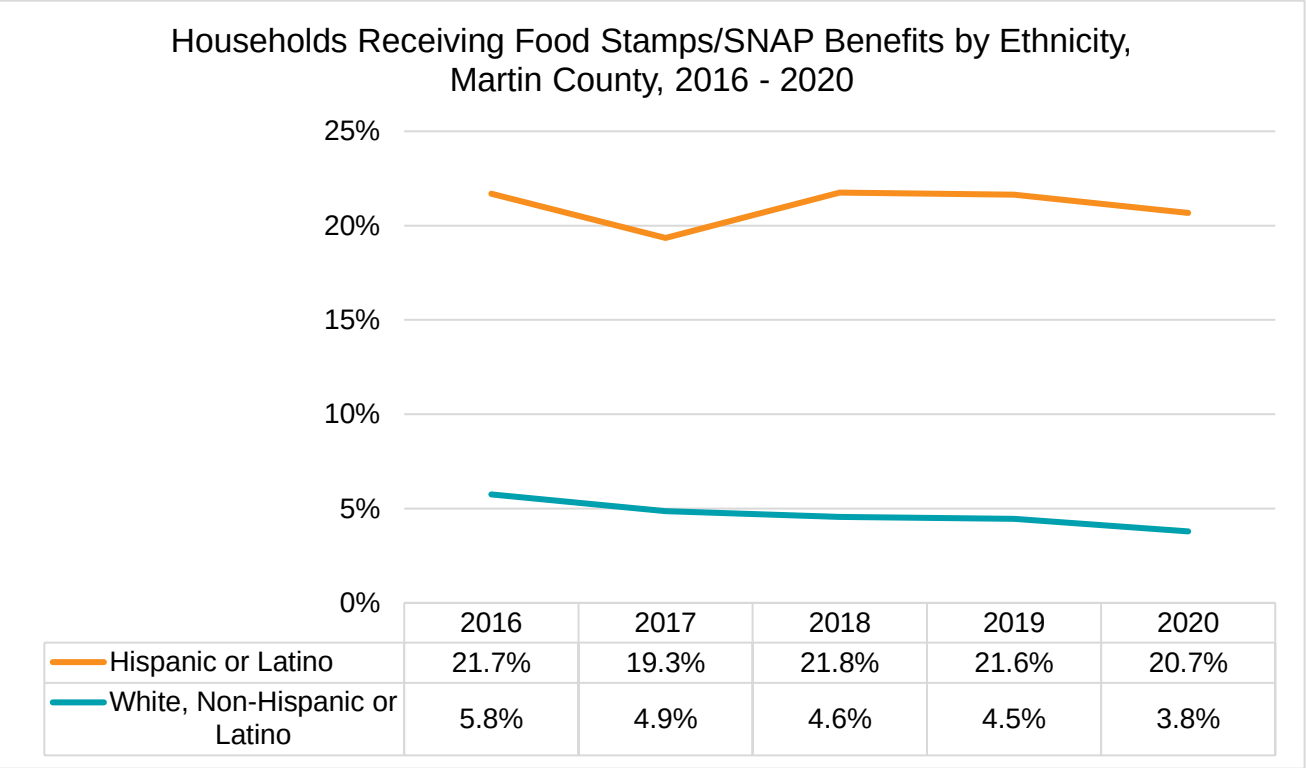
Households Receiving Food Stamps/SNAP Benefits by Race, Martin County, 2016 - 2020



	2016	2017	2018	2019	2020
White alone	6.3%	5.5%	5.5%	5.4%	4.6%
Black or African American alone	38.9%	32.8%	38.0%	44.0%	38.9%
American Indian and Alaska Native alone	0.0%	9.6%	4.9%	12.7%	24.8%
Asian alone	7.6%	8.1%	0.8%	1.2%	0.5%
Native Hawaiian and Other Pacific Islander alone	0.0%	0.0%	0.0%	0.0%	0.0%
Some other race alone	35.8%	33.1%	27.8%	28.9%	27.5%
Two or more races	17.7%	21.6%	21.5%	23.5%	18.6%

Source: United States Bureau of the Census, American Community Survey, Table S2201.

This graph shows the proportion of households receiving food stamps/SNAP benefits by **ethnicity** in Martin County from 2016 to 2020. During this timeframe the proportion of Hispanic or Latino households receiving food stamps/SNAP benefits was higher than the proportion among White, non-Hispanic or Latino households. The proportion among White, non-Hispanic or Latino decreased from 5.8% in 2016 to 3.8% in 2020, while the proportion among Hispanic or Latino households fluctuated slightly between 21.7% in 2016 and 20.7% in 2020. In 2020, the proportion of Hispanic or Latino households receiving food stamps/SNAP benefits was over five times as high as the proportion among White, non-Hispanic or Latino households. As previously stated, SNAP participation significantly reduces Body Mass Index and the likelihood of obesity among youth, due to increased access to healthy and nutritional foods.[72] As such, the Martin County Health Equity Taskforce will explore ways to increase SNAP awareness and participation among communities of color, including Hispanic and Latino communities.



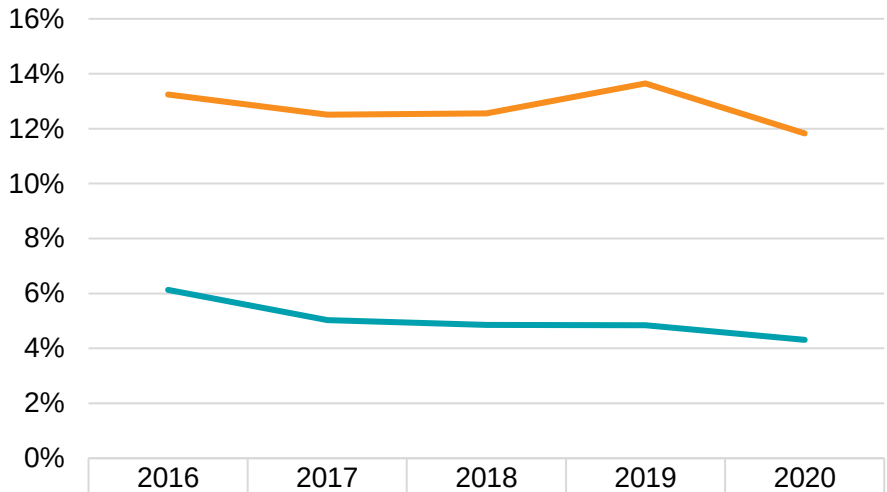
	2016	2017	2018	2019	2020
Hispanic or Latino	21.7%	19.3%	21.8%	21.6%	20.7%
White, Non-Hispanic or Latino	5.8%	4.9%	4.6%	4.5%	3.8%

Source: United States Bureau of the Census, American Community Survey, Table S2201.

[72] Schmeiser, M.D. (2011). The impact of long-term participation in the supplemental nutrition assistance program on child obesity. *Health Economics.* 21(4): 386-404.

This figure shows the proportion of households receiving food stamps/SNAP benefits by **disability status** in Martin County from 2016 to 2020. Of the households with one or more people with a disability, the proportion of those receiving food stamps/SNAP benefits decreased slightly from 13.2% in 2016 to 11.8% in 2020. However, households with one or more people with a disability were more than twice as likely to receive food stamps/SNAP benefits when compared to households with no persons with a disability during this same timeframe. Most recently in 2020, the proportion of households receiving food stamps/SNAP benefits among households with no persons with a disability was 4.3% compared to 11.8% of households with one or more people with a disability. As previously stated, SNAP participation significantly reduces Body Mass Index and the likelihood of obesity among youth, due to increased access to healthy and nutritional foods.[73] As such, the Martin County Health Equity Taskforce will explore ways to increase SNAP awareness and participation.

Households Receiving Food Stamps/SNAP Benefits by Disability Status, Martin County, 2016 - 2020



	2016	2017	2018	2019	2020
With one or more people with a disability	13.2%	12.5%	12.6%	13.6%	11.8%
With no persons with a disability	6.1%	5.0%	4.9%	4.8%	4.3%

Source: United States Bureau of the Census, American Community Survey, Table S2201.

[73] Schmeiser, M.D. (2011). The impact of long-term participation in the supplemental nutrition assistance program on child obesity. *Health Economics.* 21(4): 386-404.

Child Care Cost Burden

Not only does quality, affordable childcare positively impact child development, but having access to affordable childcare also increases the opportunity for parents or guardians to gain employment or seek educational opportunities outside the home. However, when the cost of childcare is too high or consumes a large percentage of household income, families make difficult tradeoffs for basic needs. Historically, the Department of Health and Human Services considered childcare affordable if the expense consumed less than 10% of household income. However, they more recently proposed an "affordability threshold" of 7% of household income.[74] High cost of childcare is also a reason many women in particular leave the work force, further contributing to the pay gap between men and women.

According to the 2022 County Health Rankings, and based on 2020 and 2021 data, childcare costs were 25% of household income for households with two children in **Martin County**. As previously mentioned, children enrolled in childcare typically receive several meals and snacks while in care, accounting for a large proportion of their daily caloric intake. Thus, this is one of the best opportunities for children to build a foundation for healthy nutrition and physical activity.[75] The Martin County Health Equity Taskforce realizes that not all children are enrolled in ECEs due to the high-cost burden; as such, future community projects will be prioritized to increase access to healthy meals and physical activity opportunities among unenrolled children.

Child Care Cost Burden, Martin County, 2022	
Child Care Costs as a Percent of Median Household Income (Two Children)	25%

Source: County Health Rankings & Roadmaps, Childcare Cost Burden, 2022

[74] Child Care and Development Fund (CCDF) Program, A Proposed Rule by the Health and Human Services Department on 12/24/2015. https://www.federalregister.gov/documents/2015/12/24/2015-31883/child-care-and-development-fund-ccdf-program
[75] Centers for Disease Control and Prevention. (2022). Overweight & Obesity: Early Care and Education (ECE). Retrieved from: https://www.cdc.gov/obesity/strategies/childcareece.html

The Impact of Economic Stability on Overweight Status and Obesity in Martin County

The Martin County Health Equity Taskforce discuss how Economic Stability contributes to overweight status and obesity in Martin County. Discussion points are included in the table below.

Economic Stability		
SDOH	**Priority Populations Impacted**	**How the SDOH Impacts Obesity**
Income	Black and Hispanic residents; Residents who live in census tracts 12, 14.07, and 14.08.	Partners emphasized the importance of income, as residents without economic stability are less likely to purchase healthy foods and turn to fast food options. Moreover, research shows that income impacts racial/ethnic groups and genders differently, having a negative relationship with obesity for some groups, and a positive relationship for others. As an example, a study conducted in the US found a significant correlation between higher poverty-to-income ratios and obesity among non-Hispanic White men and non-Hispanic Black men. However, research also shows that children living in poverty are at higher risk for obesity by adolescence.
Unemployment	Black and Hispanic residents; residents of two or more race; American Indian and Alaska Native Residents	Members mentioned that the increased unemployment rate and inflation during the COVID-19 pandemic has led to unprecedented levels of stress, which contributes to overeating and limited ability to purchase healthy foods. Partners also stressed that those who are unemployed are more likely to be uninsured and to have access to health care issues. Research has demonstrated a clear correlation: unemployment, particularly long-term unemployment, has been found to be directly correlated with higher rates of obesity.
Poverty	Black and Hispanic residents and children	Partners also discussed the density of fast food restaurants and convenience marts and the lack of fresh grocery stores and healthy food options in impoverished and low-income areas. In the United States, communities with higher poverty rates also experience higher obesity rates, due to the easy access to and affordability of highly processed foods with high calories and no nutritional value. Moreover, a national study found that children below the age of 2 who live in poverty are a high risk for obesity by age 15.
Benefits Income	Black and Hispanic residents and children	Communities with a high proportion of households receiving cash public assistance or food stamp/SNAP benefits may face significant barriers with other social determinants of health, but participation in SNAP has been found to significantly reduce Body Mass Index and the likelihood of obesity among youth.

C. Neighborhood & Built Environment

Neighborhood and Built Environment Data for Martin County

Where people live, work, play, and spend their time has a huge impact on both their health and quality of life. Communities of color and low-income families are more likely to live in neighborhoods with less access to affordable healthy food, green spaces and parks, quality water, and quality air. They are also more likely to live in areas with high congestion and higher rates of crime and violence.[76] One systemic review of various studies found a direct and strong correlation between the neighborhood and built environment and obesity, with some focusing on the impact that built environment has on dietary behaviors, and others focusing on the impact it has on physical activity levels.[77] The following data explores the neighborhood and built environment in Martin County. To note, considerable efforts were made to find all of the following information related to neighborhood and built environment among priority populations, including Black or African Americans, American Indian and Alaska Natives, Asians, Native Hawaiians, Hispanic and Latinos, elders, infants and toddlers, people living with disabilities, veterans, people identifying as LGBTQ+, and immigrants. Research shows these populations experience health inequities at higher rates. However, data was unavailable for these populations in several instances.

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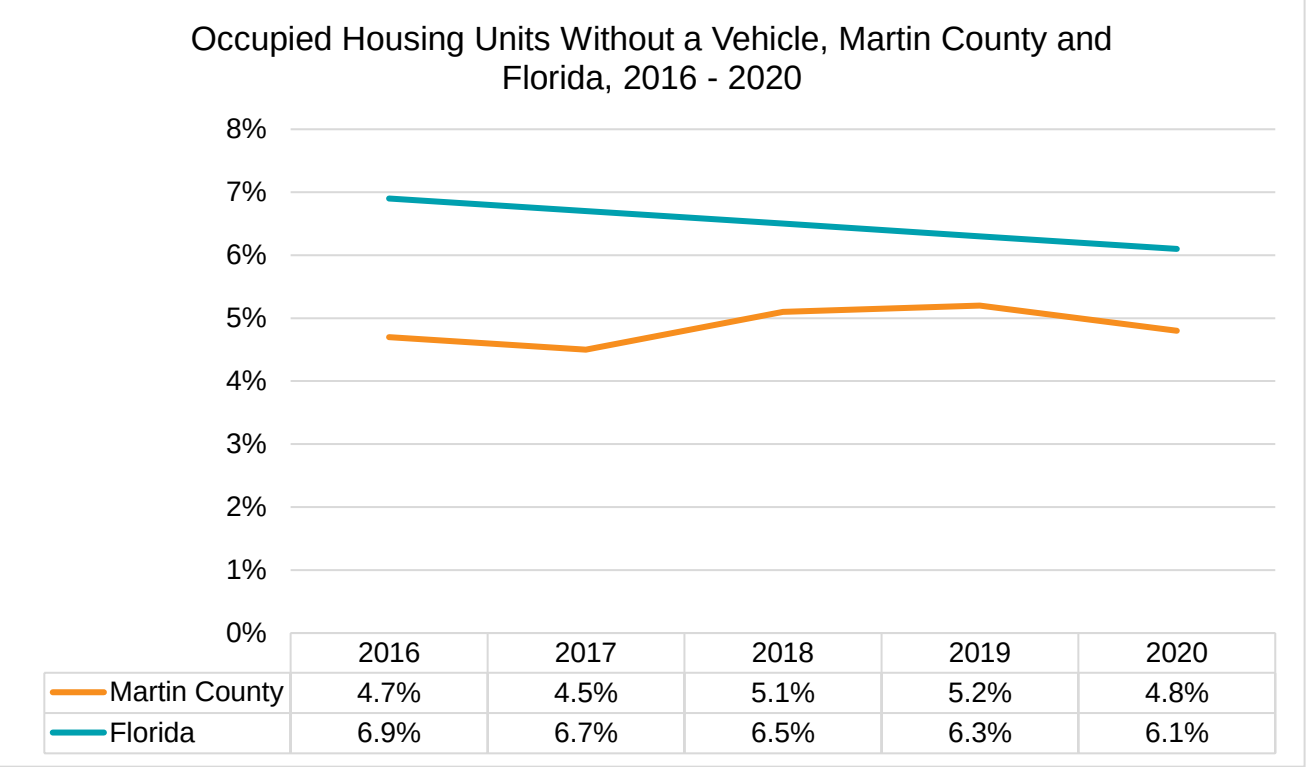
[76] US Department of Health and Human Services. Healthy People 2030: Neighborhood and Built Environment. Retrieved from: https://health.gov/healthypeople/objectives-and-data/browse-objectives/neighborhood-and-built-environment

[77] Papas, M.A., Alberg, A.J., et al. (2007). The built environment and obesity. *Epidemiologic Reviews.* 29(1): 129-143.

Transportation

Transportation is an important social determinant of health, as those without adequate means of transportation face barriers to accessing essential health care services, employment opportunities, and healthy foods, among other services and resources. This graph shows the percentage of occupied housing units without a vehicle in **Martin County** and **Florida** from 2016 to 2020. While the percentage of occupied housing units without a vehicle decreased during this timeframe in Florida, the percent in Martin County increased from 4.5% in 2017 to 5.2% in 2019, then decreased to 4.8% in 2020. Most recently in 2020, the percent of occupied housing units without a vehicle was 4.8% in Martin County compared to 6.1% in Florida overall. Research has shown that improvements in walkability and transit options, leading to the decrease in automobile use, improve health outcomes and reduce obesity.[78] The Martin County Health Equity Taskforce acknowledges this as an important determinant of obesity, thus, as part of the PACE-EH Community Project in Indiantown, a survey to assess walkability perception and needs among residents will be implemented.



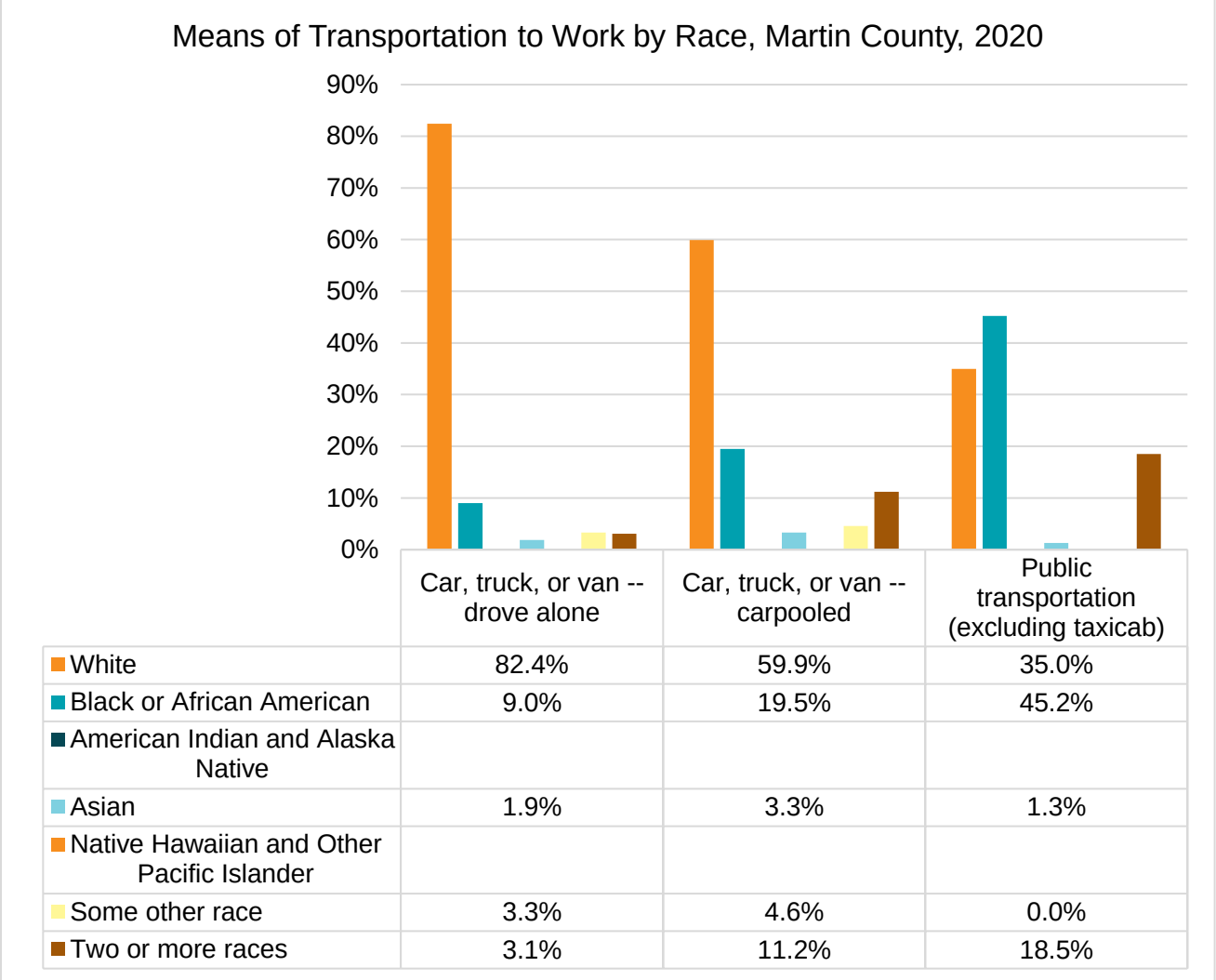
	2016	2017	2018	2019	2020
Martin County	4.7%	4.5%	5.1%	5.2%	4.8%
Florida	6.9%	6.7%	6.5%	6.3%	6.1%

Source: United States Bureau of the Census, American Community Survey, Table DP04.

[78] Samimi, A. et al. (2009). Effects of transportation and built environment on general health and obesity. *Transportation Research Part D: Transport and Environment.* 14(1): 67-71.

The graph on the following page shows means of transportation to work by **race** in Martin County in 2020. During this year, a higher proportion of White residents drove alone in a car, truck, or van to work, while a higher proportion of Black or African American residents and residents identifying as two or more races used public transportation, excluding taxicab. A higher proportion of Asian residents and those identifying as some other race carpooled to work by car, truck, or van. Additionally, White residents comprised the largest proportion of those who drove alone (82.4%) and those who carpooled (59.9%) by car, truck, or van, and Black or African American residents comprised the largest proportion of those who rode public transportation, excluding taxicab, (45.2%) to work. As previously mentioned, research has shown that improvements in walkability and transit options, leading to the decrease in automobile use, improve health outcomes and reduce obesity.[79] The Martin County Health Equity Taskforce acknowledges this as an important determinant of obesity, thus, as part of the PACE-EH Community Project in Indiantown, a survey to assess walkability perception and needs among residents will be implemented. In addition, to address the lack of available transportation data for American Indian and Alaska Native residents, the Taskforce is also implementing a SDOH Screening Tool which will address this gap.

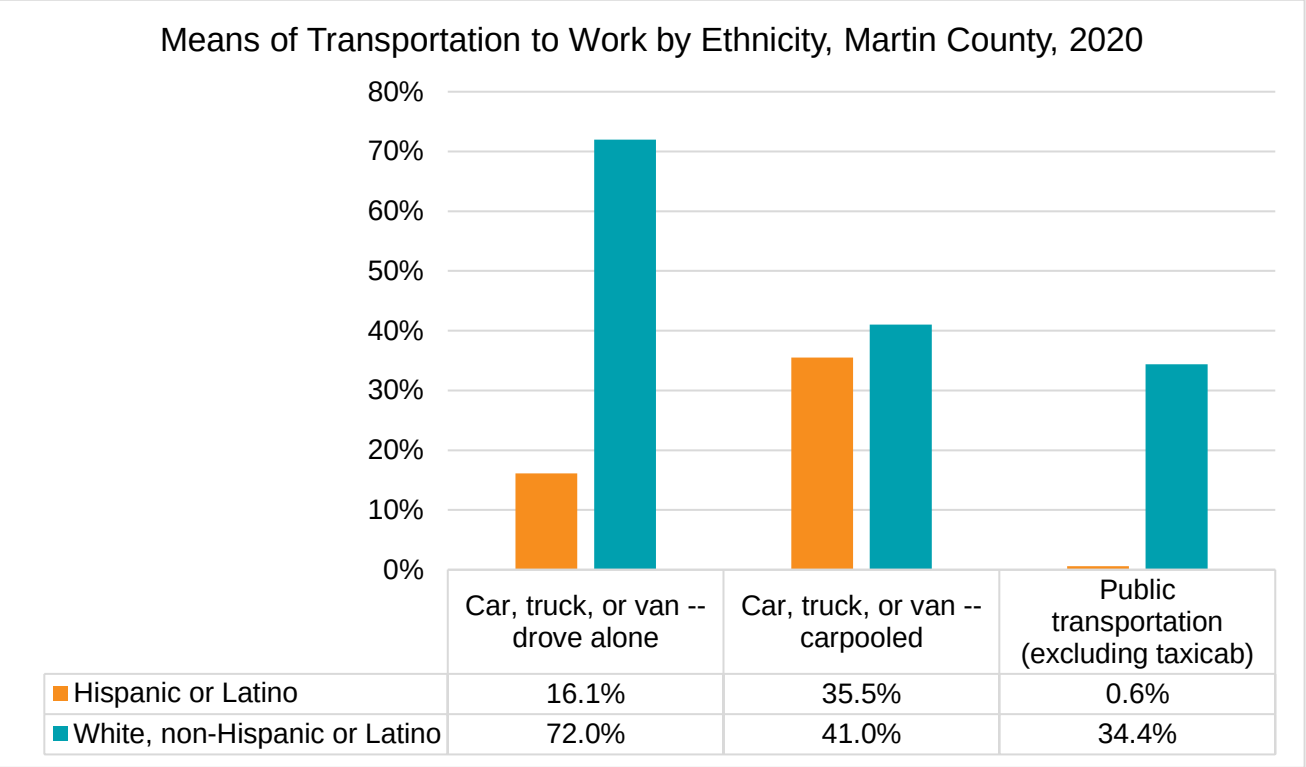
[79] Samimi, A. et al. (2009). Effects of transportation and built environment on general health and obesity. *Transportation Research Part D: Transport and Environment.* 14(1): 67-71.



	Car, truck, or van -- drove alone	Car, truck, or van -- carpooled	Public transportation (excluding taxicab)
White	82.4%	59.9%	35.0%
Black or African American	9.0%	19.5%	45.2%
American Indian and Alaska Native			
Asian	1.9%	3.3%	1.3%
Native Hawaiian and Other Pacific Islander			
Some other race	3.3%	4.6%	0.0%
Two or more races	3.1%	11.2%	18.5%

Source: United States Bureau of the Census, American Community Survey, Table S0804.

The graph below shows means of transportation to work by ethnicity among Martin County residents in 2020. White, non-Hispanic or Latino residents comprised the largest proportion of residents who drove alone (72.0%) or carpooled (41.0%) in a car, truck, or van and utilized public transportation, excluding taxicab (34.4%). The largest disparity exists between those who drove alone in a car, truck, or van, with 72.0% of White, non-Hispanic or Latino and 16.1% of Hispanic or Latino residents. As previously mentioned, research has shown that improvements in walkability and transit options, leading to the decrease in automobile use, improve health outcomes and reduce obesity.[80] The Martin County Health Equity Taskforce acknowledges this as an important determinant of obesity, thus, as part of the PACE-EH Community Project in Indiantown, a survey to assess walkability perception and needs among residents will be implemented.

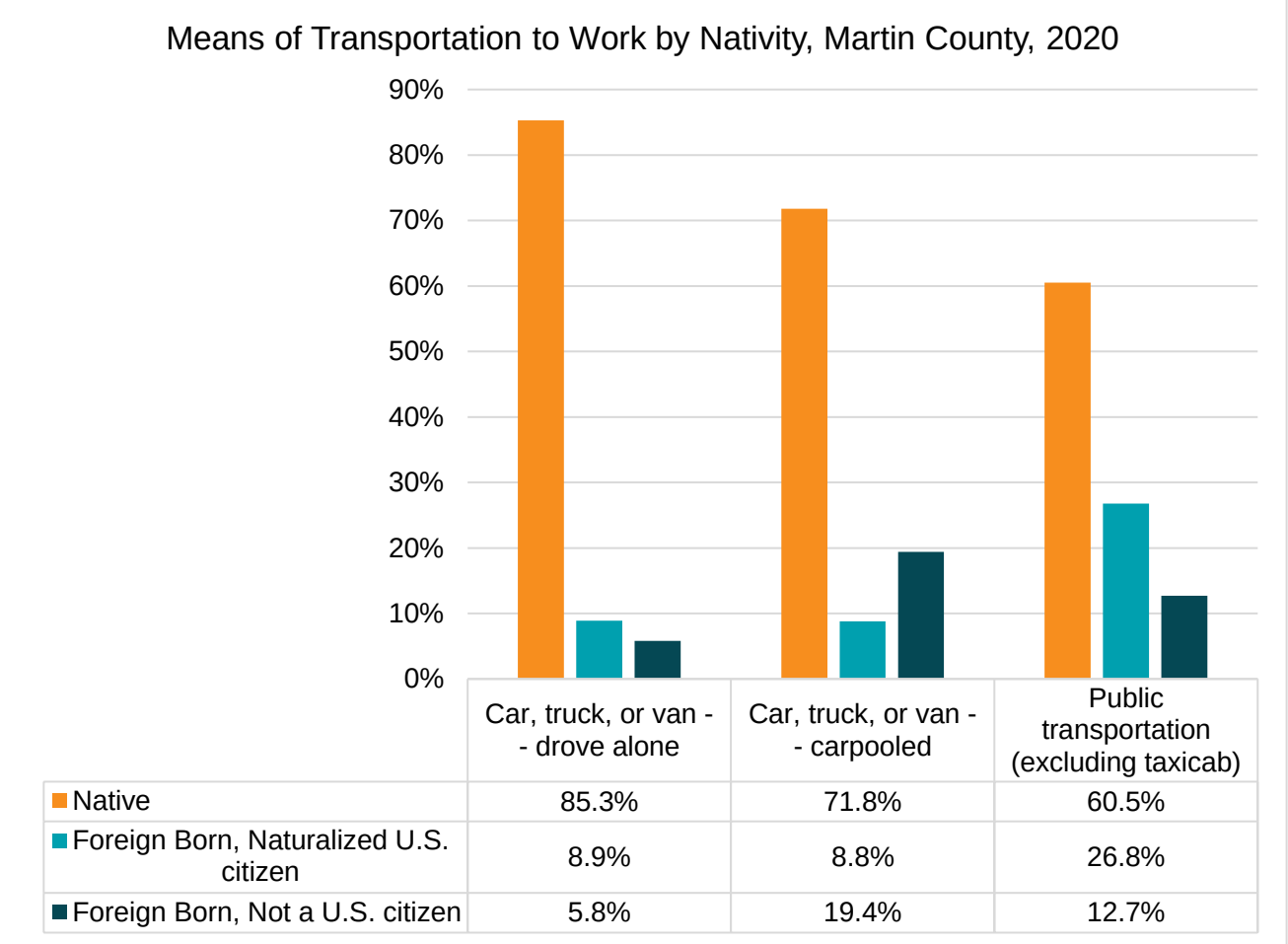


	Car, truck, or van -- drove alone	Car, truck, or van -- carpooled	Public transportation (excluding taxicab)
Hispanic or Latino	16.1%	35.5%	0.6%
White, non-Hispanic or Latino	72.0%	41.0%	34.4%

Source: United States Bureau of the Census, American Community Survey, Table S0804.

[80] Samimi, A. et al. (2009). Effects of transportation and built environment on general health and obesity. *Transportation Research Part D: Transport and Environment.* 14(1): 67-71.

This graph shows the means of transportation to work by **nativity** in Martin County in 2020. The largest disparity is seen between those who drove alone by car, truck, or van, with workers in this group being 85.3% native, 8.9% foreign born and a naturalized citizen, and 5.8% foreign born and not a U.S. citizen. As previously mentioned, research has shown that improvements in walkability and transit options, leading to the decrease in automobile use, improve health outcomes and reduce obesity.[81] The Martin County Health Equity Taskforce acknowledges this as an important determinant of obesity, thus, as part of the PACE-EH Community Project in Indiantown, a survey to assess walkability perception and needs among residents will be implemented.

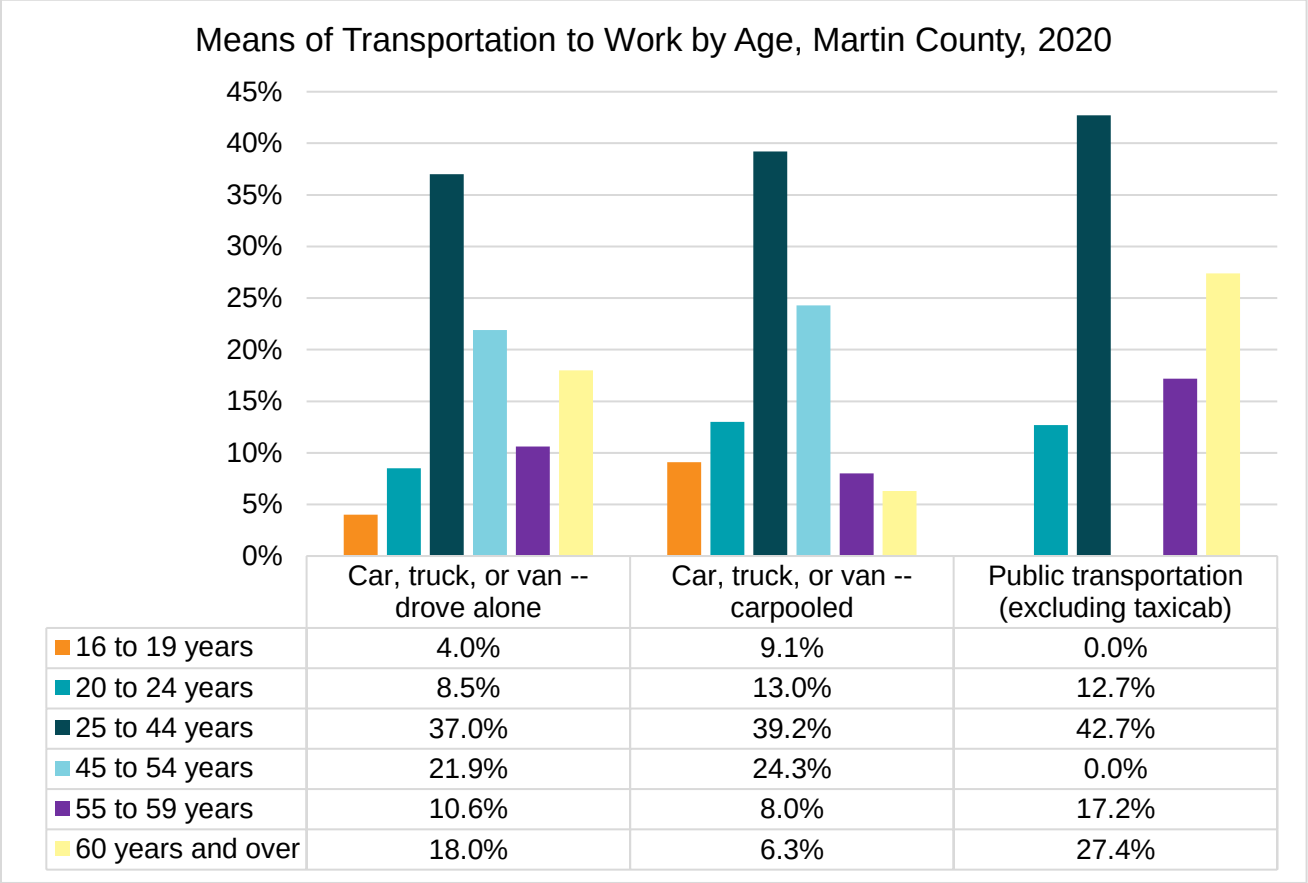


	Car, truck, or van - - drove alone	Car, truck, or van - - carpooled	Public transportation (excluding taxicab)
Native	85.3%	71.8%	60.5%
Foreign Born, Naturalized U.S. citizen	8.9%	8.8%	26.8%
Foreign Born, Not a U.S. citizen	5.8%	19.4%	12.7%

Source: United States Bureau of the Census, American Community Survey, Table S0804.

[81] Samimi, A. et al. (2009). Effects of transportation and built environment on general health and obesity. *Transportation Research Part D: Transport and Environment.* 14(1): 67-71.

This graph shows the means of transportation to work by **age** among Martin County residents in 2020. Those aged 25 to 44 years old comprised the largest proportion of those who drove alone (37%), those who carpooled (39%), and those who took public transportation (43%). Most 16 to 19-year-old, 20 to 24-year-old, and 25 to 44-year-old residents carpooled, while most 55 to 59-year-old residents and residents 60 and over took public transportation. Overall, the majority of all residents carpooled. As previously stated, evidence shows that improvements in walkability and transit options, leading to the decrease in automobile use, improve health outcomes and reduce obesity.[82] The Martin County Health Equity Taskforce acknowledges this as an important determinant of obesity, thus, as part of the PACE-EH Community Project in Indiantown, a survey to assess walkability perception and needs among residents will be implemented.



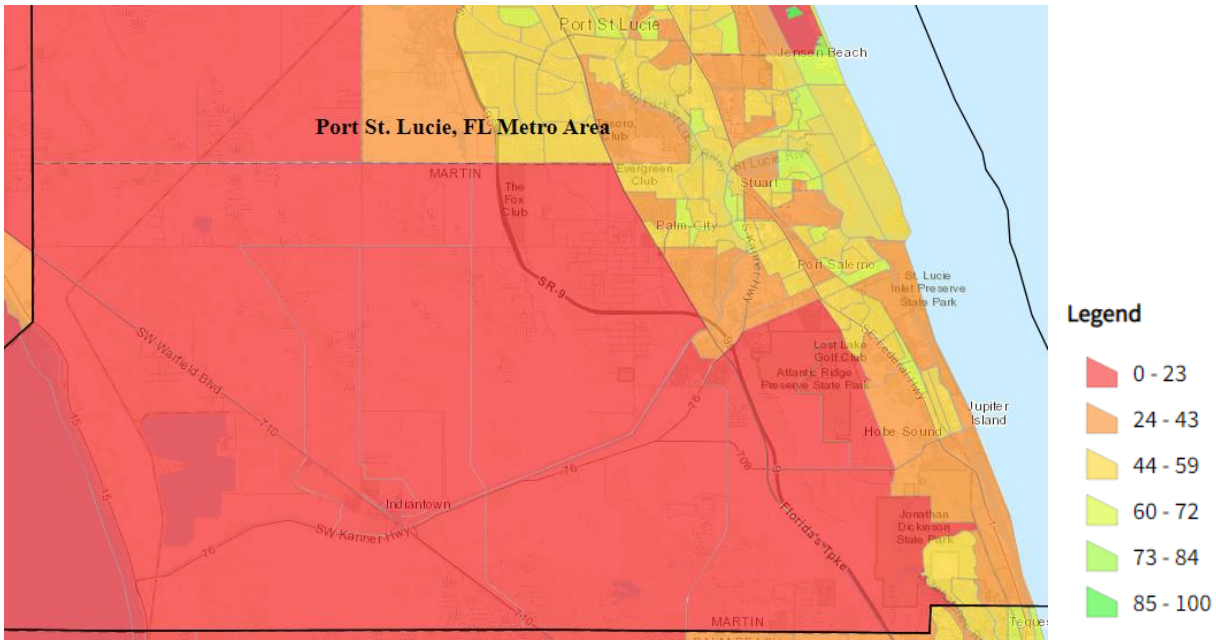
	Car, truck, or van -- drove alone	Car, truck, or van -- carpooled	Public transportation (excluding taxicab)
16 to 19 years	4.0%	9.1%	0.0%
20 to 24 years	8.5%	13.0%	12.7%
25 to 44 years	37.0%	39.2%	42.7%
45 to 54 years	21.9%	24.3%	0.0%
55 to 59 years	10.6%	8.0%	17.2%
60 years and over	18.0%	6.3%	27.4%

Source: United States Bureau of the Census, American Community Survey, Table S0804.

[82] Samimi, A. et al. (2009). Effects of transportation and built environment on general health and obesity. *Transportation Research Part D: Transport and Environment.* 14(1): 67-71.

Workplace Location Efficiency

Workplaces in areas with high walkability and public transit options make travel more convenient, so residents do not have to rely on personal vehicles. This also can reduce pollution levels, costs, infrastructure burden, and even promotes a better quality of life, as one study shows.[83] The Smart Location Calculator, created by the United States Environmental Protection Agency (EPA), is a tool used to understand how workplace location impacts worker commute travel. A location efficiency score from 0 to 100 is calculated for each area, where 0 indicates the least location-efficient area and 100 indicates the most location-efficient area. Indicators used to create this score include worker commute mode-share, vehicle miles traveled, and workplace accessibility via transit. As quoted by the EPA, "Location efficiency reduces resource demands while fostering a healthier, more sustainable built environment and providing equitable access to jobs and services."[84] As seen in the picture below, higher location-efficient areas are concentrated in parts of Jensen Beach, Stuart, Port Salerno, Palm City, and northern Hobe Sound, while the lowest location-efficient areas are located in western Hobe Sound and everything west of Florida's Turnpike.



Source: United States Environmental Protection Agency, Smart Location Calculator

[83] Jaśkiewicz, M., Besta, T. Is Easy Access Related to Better Life? Walkability and Overlapping of Personal and Communal Identity as Predictors of Quality of Life. *Applied Research Quality Life* **9,** 505–516 (2014). https://doi.org/10.1007/s11482-013-9246-6

[84] Smart Location Mapping (n.d.). In United States Environmental Protection Agency. Retrieved from https://www.epa.gov/smartgrowth/smart-location-mapping

Air Quality

The table below shows the proportion of residents and children who live within 500 feet of a busy roadway, an important indicator for measuring air quality. In Martin County, the proportion of the population living within 500 feet of a busy roadway increased from 6% to almost 9% from 2016 to 2019. Similarly, the proportion of schools and day care facilities within 500 feet of a busy roadway increased, but more drastically, from 7.8% to 17.7% from 2016 to 2017. Air pollution leads to overweight status and obesity due to metabolic dysfunction, the onset of chronic disease, and reduction of time outdoors and participating in physical activity.[85] The Martin County Health Equity Taskforce will continue to monitor this indicator to determine the need for community projects aimed at reducing air pollution; however, walkability will be assessed as part of the PACE-EH Community Project in Indiantown.

Residents and Children Living Within 500 Feet of a Busy Roadway, Martin County, 2016, 2019

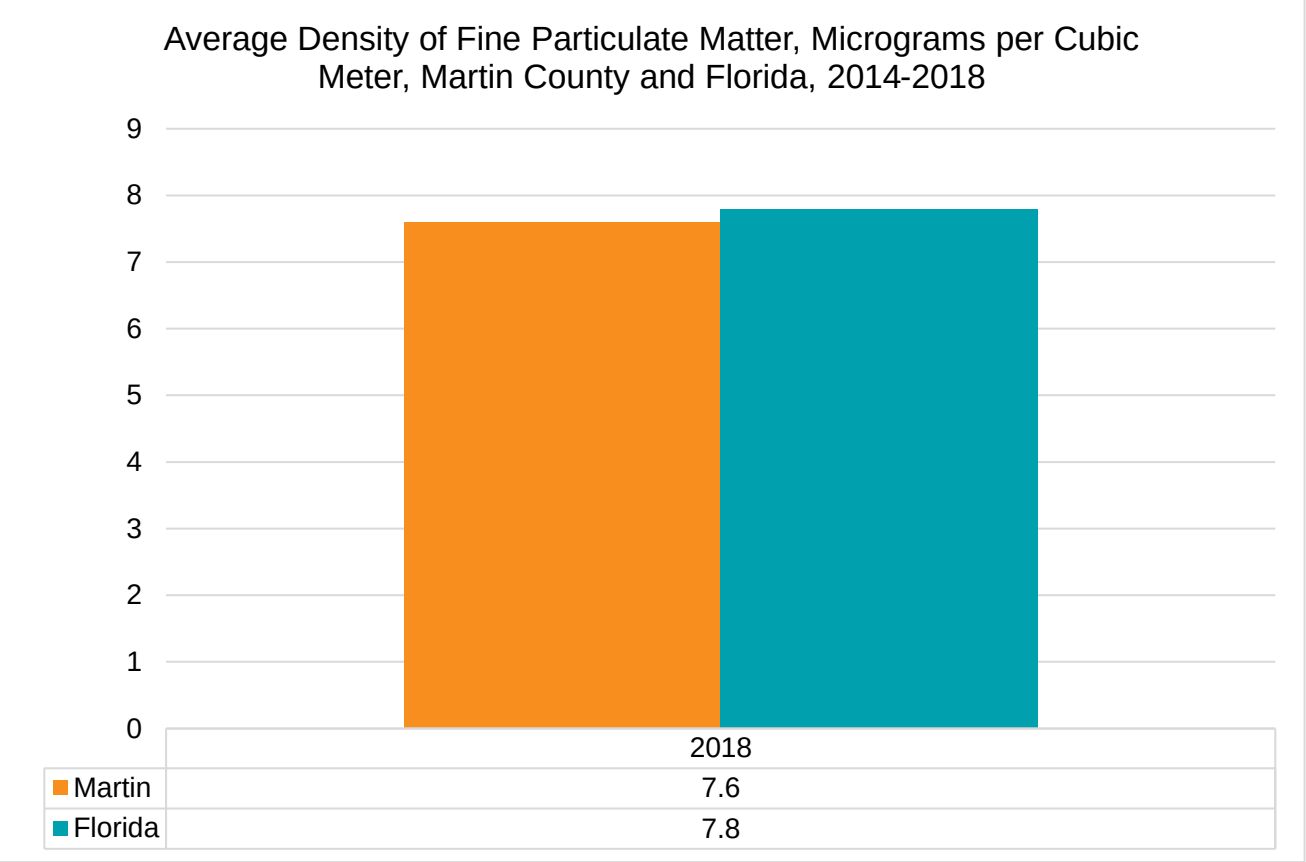
Indicator	2016	2019
Population Living Within 500 Feet of a Busy Roadway	6.0%	8.8%
Schools and Day Care Facilities Within 500 Feet of a Busy Roadway	7.8%	17.7%

Source: Florida Department of Health, Florida Environmental Public Health Tracking, 2019

[85] An, R., Ji, M, Yan, H. & Guan, C. (2018). Impact of ambient air pollution on obesity: A systematic review. *International Journal of Obesity.* 42: 1112-1126.

Air Pollution

The figure below shows average density of fine particulate matter in Martin County and Florida in 2018. Air pollution has negative impacts on human health and human development.[86] Florida reported a slightly higher average density of fine particulate matter compared to Martin County. In 2018, Martin County reported a level of 7.6 micrograms per cubic meter as compared to 7.8 micrograms per cubic meter for the state of Florida. Air pollution often leads to unhealthy weight due to metabolic dysfunction, lower levels of physical activity, and the increased risk for chronic disease.[87]



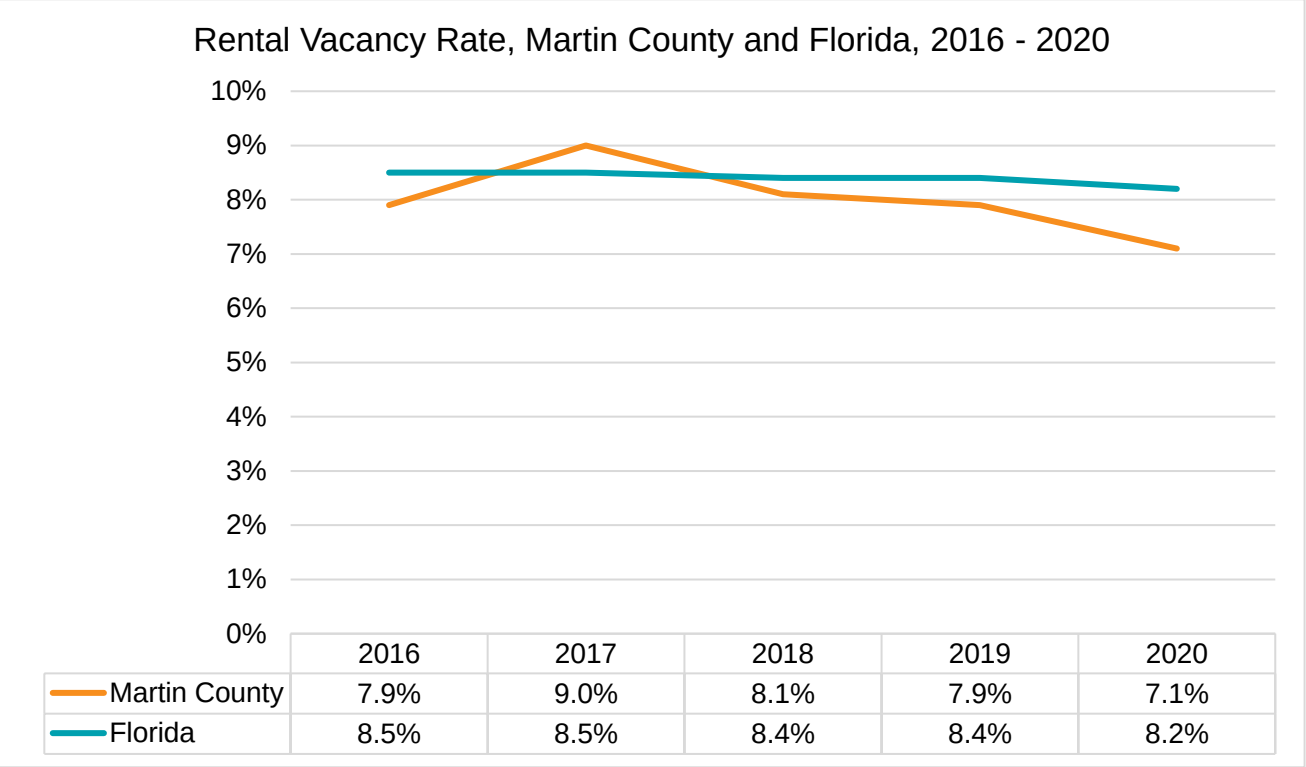
Source: Florida Department of Health, Florida Environmental Public Health Tracking, 2019

[86] Manisalidis, Ioannis, et al. "Environmental and health impacts of air pollution: a review." *Frontiers in public health* (2020): 14.

[87] An, R., Ji, M., Yan, H., & Guan, C. (2018). Impact of ambient air pollution on obesity: a systematic review. *International Journal of Obesity.* 42: 1112-1126.

Housing

This graph shows the rental vacancy rate in Martin County and Florida from 2016 to 2020. According to research, low availability of rental units may cause people with the lowest incomes to rent substandard housing units, potentially exposing them to health and safety risks, or forcing them to move in with others. All of these factors can have a negative impact on health and quality of life.[88] While the rental vacancy rate in Martin County increased from 7.9% in 2016 to 9.0% in 2017, the rate then decreased each year to 7.1% in 2020. Further, the rental vacancy rate was lower in Martin County compared to the state for each year, except 2017.



	2016	2017	2018	2019	2020
Martin County	7.9%	9.0%	8.1%	7.9%	7.1%
Florida	8.5%	8.5%	8.4%	8.4%	8.2%

Source: United States Bureau of the Census, American Community Survey, Table DP04.

[88] Housing Instability (n.d.). In *Healthy People 2030*. Retrieved from https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/housing-instability#cit6

The figure below shows important occupied housing unit characteristics by census tract in Martin County in 2020. Census tract 15 accounted for the highest proportion of housing units that lacked complete plumbing facilities (1.7%), followed by census tract 11.5 (1.2%) and census tract 14.08 (1.1%). Census tract 5.01 accounted for the highest proportion of housing units that lack kitchen facilities (4.1%), followed by census tract 17.03 (3.8%) and census tract 10 (3.3%). Census tract 18.03 accounted for the highest proportion of housing units using utility gas as heating fuel (19.0%), followed by census tract 5.02 (15.0%) and census tract 3 (10.3%). Census tract 18.05 accounted for the highest proportion of housing units using bottled, tank or LP gas as heating fuel (8.1%), followed by census tract 14.08 (6.5%) and census tract 15 (4.0%). All occupied housing units in census tracts 7.01, 17.01, 17.02, and 18.06 used electricity as heating fuel (100.0%), whereas the lowest proportion of housing units that did were found in census tracts 18.03 (80.4%) and census tract 5.02 (83.6%). Only two census tracts had housing units using fuel oil or kerosene as heating fuel: census tract 16.02 (1.6%) and census tract 1 (0.9%). Similarly, only two census tracts had any occupied housing units that use wood as heating fuel: census tract 11.06 (2.2%) and census tract 11.03 (1.9%). Finally, the census tracts that accounted for the highest proportion of housing units with no fuel were census tracts 18.05 (5.07%), 11.07 (4.1%), and 9.02 (3.9%). Indoor environment, specifically people's homes where they spend most of their time, has an extremely huge impact on one's health and the risk for obesity.[89] As such, the Martin County Health Equity Taskforce will consider future community projects to address housing-related disparities.

Occupied Housing Unit Characteristics by Census Tract, Martin County, 2020								
Census Tract	**Lacking complete plumbing facilities**	**Lacking kitchen facilities**	**Utility gas as heating fuel**	**Bottled, tank or LP gas as heating fuel**	**Electricity as heating fuel**	**Fuel oil, kerosene etc. as heating fuel**	**Wood as heating fuel**	**No fuel**
1	0.0%	0.0%	3.9%	2.8%	92.4%	**0.9%**	0.0%	0.0%
2	0.4%	1.3%	1.5%	0.7%	96.8%	0.0%	0.0%	1.0%
3	0.0%	0.0%	**10.3%**	0.0%	88.4%	0.0%	0.0%	1.3%
4	0.0%	1.0%	1.2%	0.6%	97.5%	0.0%	0.0%	0.3%
5.01	0.0%	**4.1%**	2.1%	1.2%	93.4%	0.0%	0.0%	3.2%
5.02	0.7%	0.7%	**15.0%**	0.8%	**83.6%**	0.0%	0.0%	0.7%

[89] Hood, E. (2005). Dwelling disparities: How poor housing leads to poor health. *Environ Health Prospect.* 113(5): A310-A317.

6.03	0.7%	0.7%	3.3%	0.0%	94.9%	0.0%	0.0%	1.8%
6.04	0.0%	0.0%	0.6%	0.0%	98.4%	0.0%	0.0%	1.0%
6.06	0.0%	0.0%	0.8%	2.1%	96.5%	0.0%	0.0%	0.6%
6.07	0.0%	0.0%	0.0%	0.8%	95.8%	0.0%	0.0%	3.3%
6.10	0.0%	0.0%	1.1%	0.6%	97.5%	0.0%	0.0%	0.9%
7.01	0.0%	0.0%	0.0%	0.0%	**100.0%**	0.0%	0.0%	0.0%
7.02	0.0%	0.0%	3.2%	0.9%	95.9%	0.0%	0.0%	0.0%
8	0.8%	0.8%	0.0%	0.8%	98.5%	0.0%	0.0%	0.8%
9.01	0.0%	1.6%	3.3%	0.0%	94.9%	0.0%	0.0%	1.0%
9.02	0.0%	1.2%	5.6%	1.1%	89.4%	0.0%	0.0%	**3.9%**
10	0.0%	**3.3%**	0.7%	0.0%	96.7%	0.0%	0.0%	2.6%
11.03	0.0%	0.0%	0.7%	0.0%	94.4%	0.0%	**1.9%**	1.4%
11.05	**1.2%**	0.0%	6.6%	0.0%	92.4%	0.0%	0.0%	0.0%
11.06	0.0%	2.2%	2.6%	0.9%	90.7%	0.0%	**2.2%**	3.6%
11.07	0.0%	0.0%	0.0%	2.3%	93.5%	0.0%	0.0%	**4.1%**
11.08	0.0%	0.0%	2.4%	0.0%	96.6%	0.0%	0.0%	0.9%
12	0.4%	0.0%	0.0%	0.7%	96.2%	0.0%	0.0%	3.1%
13.01	0.0%	0.0%	0.0%	0.0%	97.9%	0.0%	0.0%	2.1%
13.02	0.0%	0.0%	0.4%	0.0%	96.5%	0.0%	0.0%	3.0%
14.04	0.4%	0.4%	1.7%	1.7%	94.4%	0.0%	0.0%	2.2%
14.06	0.0%	0.0%	0.6%	0.0%	98.1%	0.0%	0.0%	0.6%
14.07	0.0%	0.0%	0.0%	0.8%	99.2%	0.0%	0.0%	0.0%
14.08	**1.1%**	1.1%	0.2%	**6.5%**	90.7%	0.0%	0.0%	2.7%
14.09	0.0%	0.0%	0.4%	0.7%	98.2%	0.0%	0.0%	0.7%
14.10	0.0%	0.0%	2.2%	1.0%	96.3%	0.0%	0.0%	0.5%
15	**1.7%**	0.3%	4.0%	**4.0%**	88.8%	0.0%	0.0%	3.1%
16.01	0.0%	0.0%	5.1%	1.0%	91.2%	0.0%	0.0%	2.7%
16.02	0.0%	0.0%	0.0%	3.8%	93.2%	**1.6%**	0.0%	1.4%
17.01	0.0%	0.0%	0.0%	0.0%	**100.0%**	0.0%	0.0%	0.0%

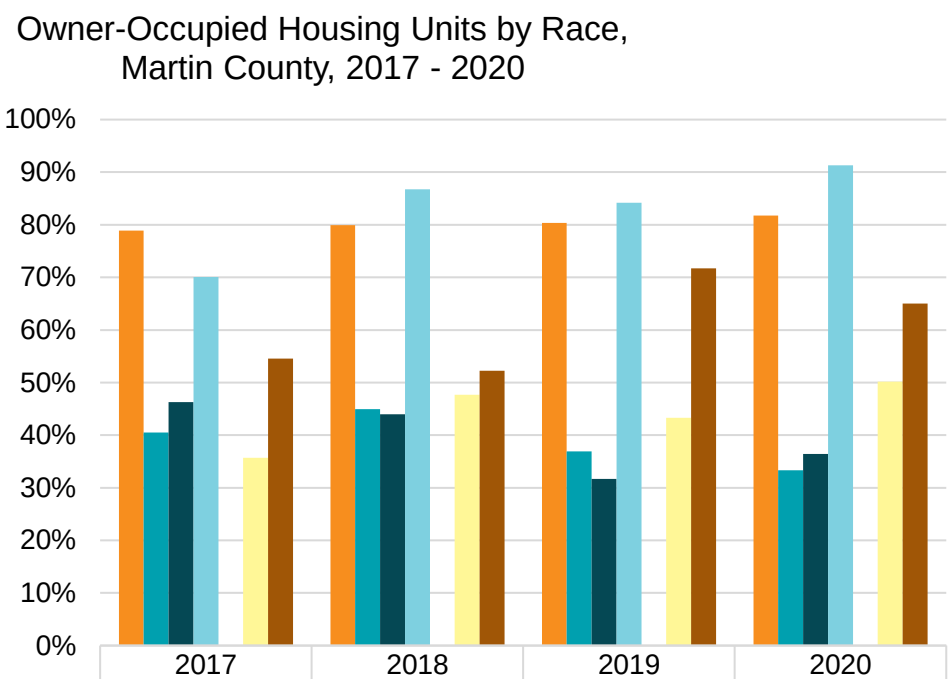
17.02	0.0%	0.0%	0.0%	0.0%	**100.0%**	0.0%	0.0%	0.0%
17.03	0.0%	**3.8%**	1.0%	1.3%	97.6%	0.0%	0.0%	0.0%
18.03	0.0%	0.0%	**19.0%**	0.6%	**80.4%**	0.0%	0.0%	0.0%
18.04	0.0%	0.0%	2.9%	0.7%	93.5%	0.0%	0.0%	3.0%
18.05	0.0%	0.0%	0.2%	**8.1%**	85.9%	0.0%	0.0%	**5.7%**
18.06	0.0%	0.0%	0.0%	0.0%	**100.0%**	0.0%	0.0%	0.0%

Source: United States Bureau of the Census, American Community Survey, Table DP04.

The figure on the following page shows owner-occupied housing units by **race** in Martin County from 2017 to 2020. Home ownership is an indication of financial health and stability, which can lead to less stress, access to health care through stable employment, and less risk of overweight and obesity.

From 2018 to 2020, among all occupied housing units in each racial group, Asian residents had the highest proportion of owner-occupied housing units compared to all other groups, with 86.7% in 2018, 84.2% in 2019, and 91.3% in 2020. Black or African American, along with those identifying as some other race, had a much lower proportion of residents in owner-occupied housing units. Additionally, the proportion of Black or African American in owner-occupied housing units declined overall during this period from 40.5% in 2017 to 33.4% in 2020. According to a systemic review, home ownership is found to be associated with lower risk of child overweight status and obesity.[90] As such, the Martin County Health Equity Taskforce will consider future community projects to address housing-related disparities.

[90] Kim, Y., Cubbin, C. Oh, S. (2019). A systematic review of neighborhood economic context on child obesity and obesity-related behaviors. *Obesity Reviews.* 20(3): 420-431.



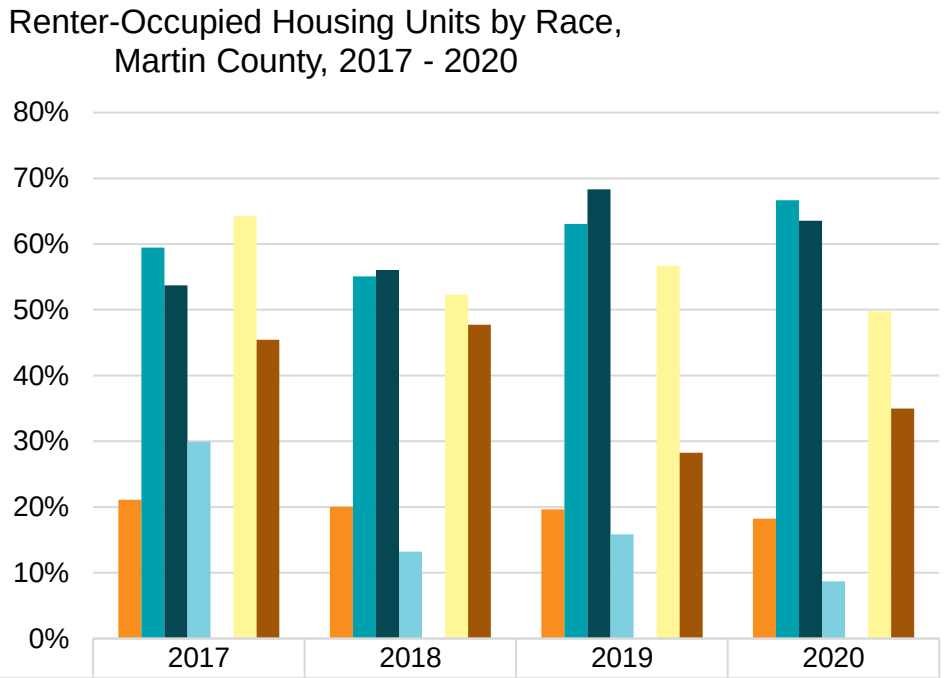
	2017	2018	2019	2020
White	78.9%	80.0%	80.4%	81.7%
Black or African American	40.5%	44.9%	36.9%	33.4%
American Indian and Alaska Native	46.3%	44.0%	31.7%	36.4%
Asian	70.1%	86.7%	84.2%	91.3%
Native Hawaiian and Other Pacific Islander	0.0%	0.0%	0.0%	0.0%
Some other race	35.7%	47.7%	43.3%	50.2%
Two or more races	54.6%	52.2%	71.7%	65.0%

Source: United States Bureau of the Census, American Community Survey, Table S2502.

The figure on the following page shows renter-occupied housing units by **race** in Martin County from 2017 to 2020. Individuals who rent may work lower-wage jobs, live pay-check to pay-check, or have to make stressful decisions in order to pay for basic needs. Stress has been shown to lead to higher blood pressure and less physical activity, directly affecting an individual's risk for overweight and obesity.[91] [92]

During this timeframe, Black or African American, American Indian and Alaska Native, and those identifying as some other race all had very high proportions of residents in renter-occupied housing units, while White and Asian residents had much lower proportions. Most recently in 2020, Black or African Americans had the highest proportion of residents living in renter-occupied housing units with 66.6% and Asian residents had the lowest with 8.7%. As previously mentioned, home ownership is associated with lower risk of child overweight status and obesity.[93] As such, the Martin County Health Equity Taskforce will consider future community projects to address housing-related disparities.

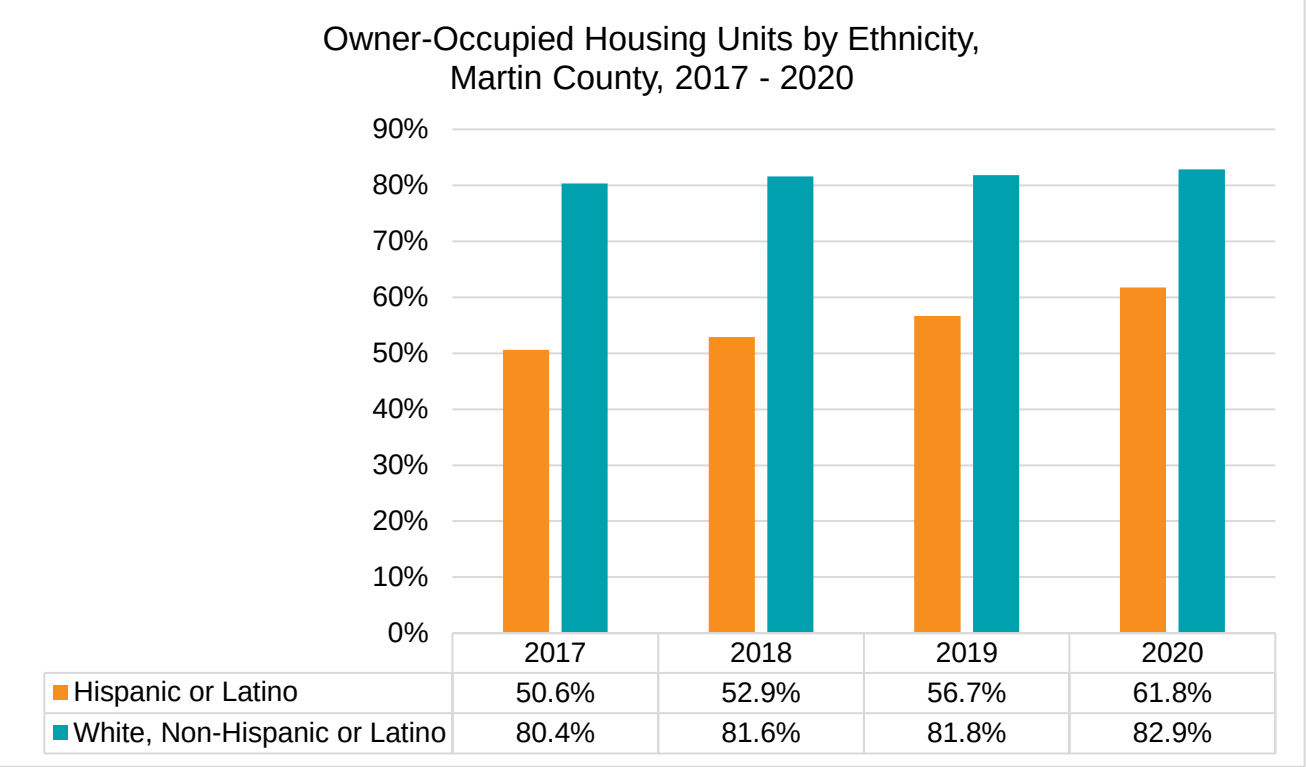
[91] Gasperin, D., Netuveli, G., Dias-da-Costa, J. S., & Pattussi, M. P. (2009). Effect of psychological stress on blood pressure increase: a meta-analysis of cohort studies. Cadernos de saude publica, 25(4), 715-726.
[92] Brockmann, A.N., Ross, K.M. Bidirectional association between stress and physical activity in adults with overweight and obesity. J Behav Med 43, 246–253 (2020). https://doi.org/10.1007/s10865-020-00145-2
[93] Kim, Y., Cubbin, C. Oh, S. (2019). A systematic review of neighborhood economic context on child obesity and obesity-related behaviors. *Obesity Reviews.* 20(3): 420-431.



	2017	2018	2019	2020
White	21.1%	20.0%	19.6%	18.3%
Black or African American	59.5%	55.1%	63.1%	66.6%
American Indian and Alaska Native	53.7%	56.0%	68.3%	63.6%
Asian	29.9%	13.3%	15.8%	8.7%
Native Hawaiian and Other Pacific Islander	0.0%	0.0%	0.0%	0.0%
Some other race	64.3%	52.3%	56.7%	49.8%
Two or more races	45.4%	47.8%	28.3%	35.0%

Source: United States Bureau of the Census, American Community Survey, Table S2502.

The figure below shows owner-occupied housing units by **ethnicity** in Martin County from 2017 to 2020. During this timeframe, White residents had a higher proportion of residents living in owner-occupied households compared to Hispanic or Latino residents, although the proportion among both groups increased from 2017 to 2020. Most recently in 2020, 82.9% of White occupied housing units were owner-occupied, while 61.8% of Hispanic or Latino occupied housing units were owner-occupied. As stated previously, home ownership is linked to lower risk of child overweight status and obesity.[94] As such, the Martin County Health Equity Taskforce will consider future community projects to address housing-related disparities.

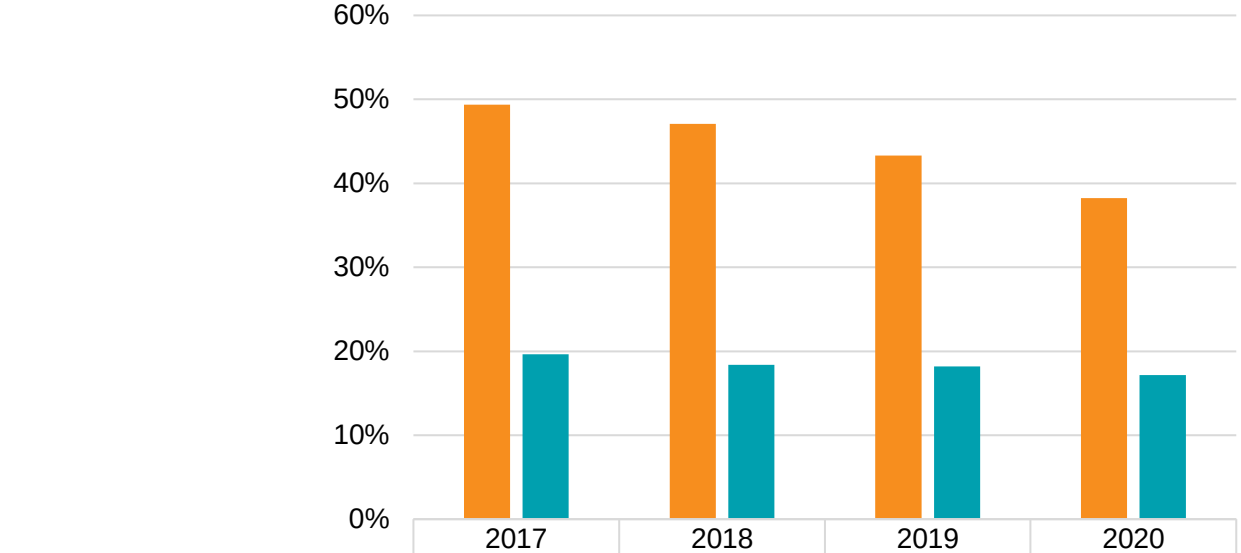


	2017	2018	2019	2020
Hispanic or Latino	50.6%	52.9%	56.7%	61.8%
White, Non-Hispanic or Latino	80.4%	81.6%	81.8%	82.9%

Source: United States Bureau of the Census, American Community Survey, Table S2502.

[94] Kim, Y., Cubbin, C. Oh, S. (2019). A systematic review of neighborhood economic context on child obesity and obesity-related behaviors. *Obesity Reviews.* 20(3): 420-431.

The figure below shows renter-occupied housing units by **ethnicity** in Martin County from 2017 to 2020. During this timeframe, Hispanic or Latino residents had a larger proportion of residents living in renter-occupied housing compared to their White, non-Hispanic or Latino counterparts. However, the proportion declined among both groups from 2017 to 2020. Most recently in 2020, 38.2% of Hispanic occupied housing units were renter-occupied, while 17.1% of White occupied housing units were renter-occupied. As mentioned, home ownership is linked to lower risk of child overweight status and obesity.[95] As such, the Martin County Health Equity Taskforce will consider future community projects to address housing-related disparities.

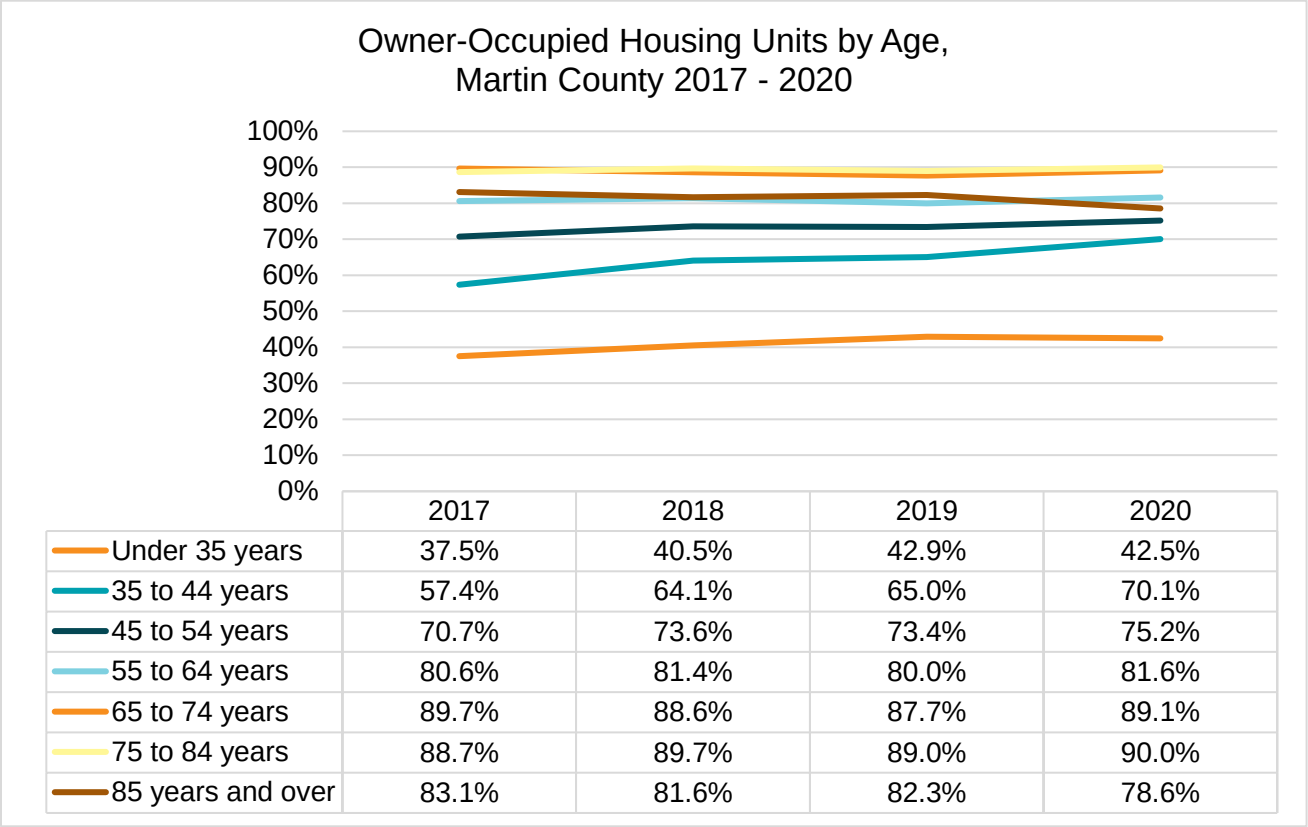


	2017	2018	2019	2020
Hispanic or Latino	49.4%	47.1%	43.3%	38.2%
White, Non-Hispanic or Latino	19.6%	18.4%	18.2%	17.1%

Source: United States Bureau of the Census, American Community Survey, Table S2502.

[95] Kim, Y., Cubbin, C. Oh, S. (2019). A systematic review of neighborhood economic context on child obesity and obesity-related behaviors. *Obesity Reviews.* 20(3): 420-431.

The figure below shows owner-occupied housing units by **age** in Martin County from 2017 to 2020. The residents with largest proportion living in owner-occupied housing units is among residents aged 75 to 84 years old, while the lowest proportion occurred among those under 35 years old. Most recently in 2020, 90.0% of occupied housing units among those aged 75 to 84 years old were owner-occupied, compared to 42.5% of occupied housing units among those under 35 years old. Based on the notion that individuals build wealth over time, allowing them to purchase a home as they grow older, this is a naturally occurring disparity. However, among residents aged 85 years and over in occupied housing units, 78.6% were owner-occupied, which was relatively lower than the 90.0% of residents aged 75 to 84 in owner-occupied housing units. This could be due to older individuals moving into assisted living or hospice style facilities. As stated previously, home ownership is linked to lower risk of child overweight status and obesity.[96] As such, the Martin County Health Equity Taskforce will consider future community projects to address housing-related disparities.

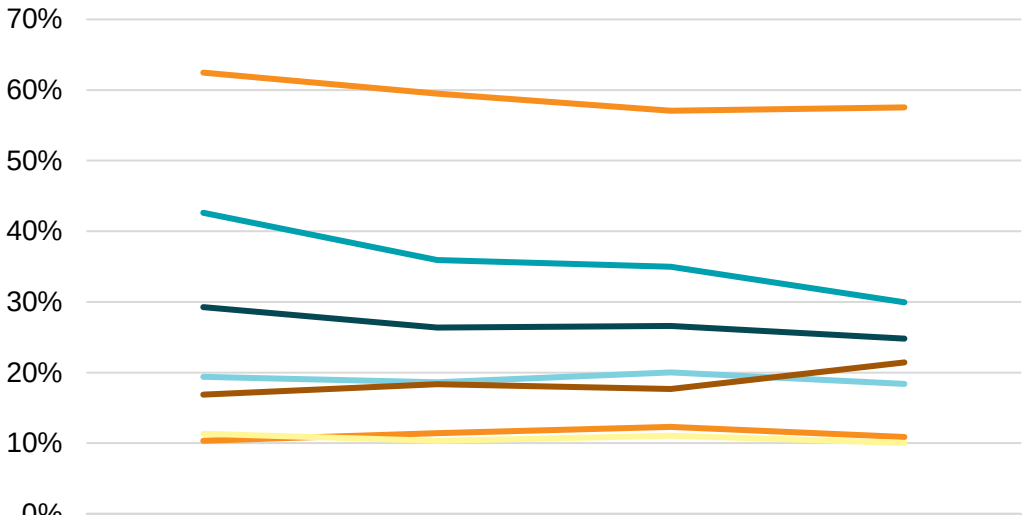


	2017	2018	2019	2020
Under 35 years	37.5%	40.5%	42.9%	42.5%
35 to 44 years	57.4%	64.1%	65.0%	70.1%
45 to 54 years	70.7%	73.6%	73.4%	75.2%
55 to 64 years	80.6%	81.4%	80.0%	81.6%
65 to 74 years	89.7%	88.6%	87.7%	89.1%
75 to 84 years	88.7%	89.7%	89.0%	90.0%
85 years and over	83.1%	81.6%	82.3%	78.6%

Source: United States Bureau of the Census, American Community Survey, Table S2502.

[96] Kim, Y., Cubbin, C. Oh, S. (2019). A systematic review of neighborhood economic context on child obesity and obesity-related behaviors. *Obesity Reviews.* 20(3): 420-431.

The figure below shows renter-occupied housing units by **age** in Martin County from 2017 to 2020. During this timeframe, the proportion of residents under 35 in renter-occupied housing units was the highest compared to all other age groups and decreased from 2017 (62.5%) to 2020 (57.5%). Those aged 75 to 84 years had the lowest proportion of residents in renter-occupied housing units each year except 2017.The only age group in which the proportion of renter-occupied housing groups increased was among those aged 85 years and over, from 16.9% in 2017 to 21.4% in 2020. As mentioned, home ownership is linked to lower risk of child overweight status and obesity.[97] As such, the Martin County Health Equity Taskforce will consider future community projects to address housing-related disparities.



	2017	2018	2019	2020
Under 35 years	62.5%	59.5%	57.1%	57.5%
35 to 44 years	42.6%	35.9%	35.0%	29.9%
45 to 54 years	29.3%	26.4%	26.6%	24.8%
55 to 64 years	19.4%	18.6%	20.0%	18.4%
65 to 74 years	10.3%	11.4%	12.3%	10.9%
75 to 84 years	11.3%	10.3%	11.0%	10.0%
85 years and over	16.9%	18.4%	17.7%	21.4%

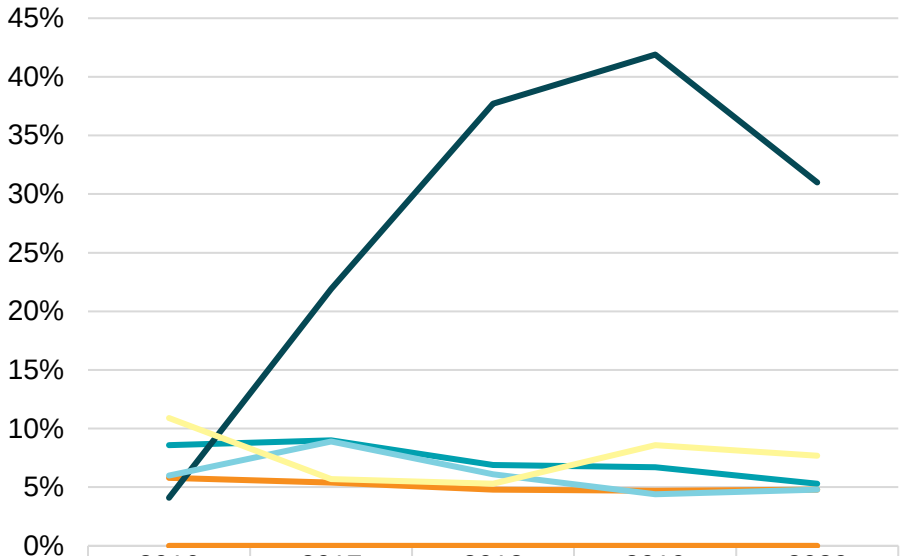
Source: United States Bureau of the Census, American Community Survey, Table S2502.

[97] Kim, Y., Cubbin, C. Oh, S. (2019). A systematic review of neighborhood economic context on child obesity and obesity-related behaviors. *Obesity Reviews.* 20(3): 420-431.

The figure on the following page shows individuals aged 1 year and older who lived in a different house within the same county one year earlier by **race** in Martin County from 2016 to 2020. An individual's ability to thrive can be greatly impacted by instability and the lack of familiar surroundings. Geographic mobility is also correlated with the lack of a specific health care site, placing individuals at risk for poorer health outcomes.[98] In Martin County, American Indian and Alaska Native residents, residents of some other race, and Black residents consistently accounted for higher proportions of residents who moved year-to-year. Most recently in 2020, 5.3% of Black residents lived in a different house one year earlier within the same county compared to 4.8% of White residents. Unstable housing and multiple moves are associated with adverse health outcomes and food insecurity in childhood, contributing to racial and ethnic health disparities.[99] As such, the Martin County Health Equity Taskforce will consider future community projects to address housing-related disparities.

[98] Huffman, L.C & Wise, P.H. (2009). Geographic mobility and residential instability. *Developmental-Behavioral Pediatrics.* 4.
[99] Sandel, M, Sheward, R., et al. (2018). Unstable Housing and Caregiver and Child Health in Renter Families. *Pediatrics*. 141 (2): e20172199.

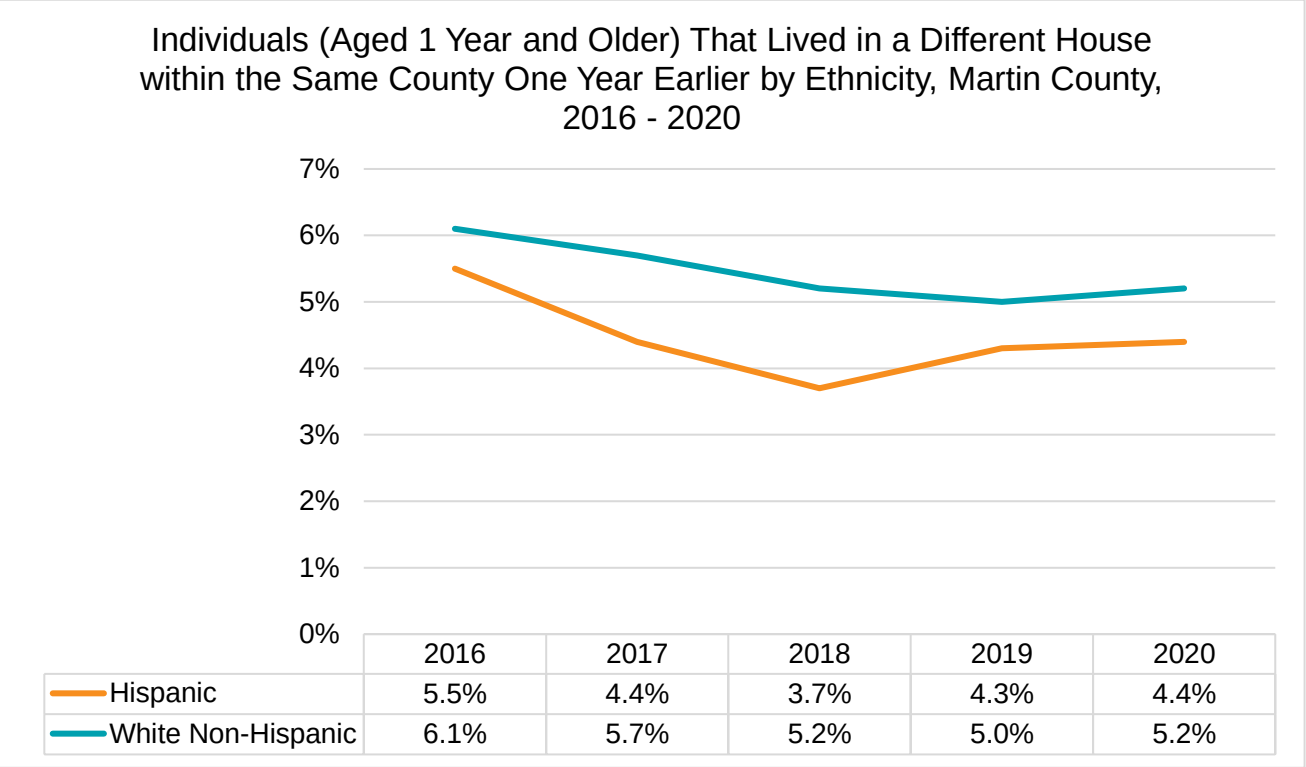
Individuals (Aged 1 Year and Older) That Lived in a Different House within the Same County One Year Earlier by Race, Martin County, 2016 - 2020



	2016	2017	2018	2019	2020
White	5.8%	5.4%	4.8%	4.7%	4.8%
Black	8.6%	9.0%	6.9%	6.7%	5.3%
American Indian and Alaska Native	4.10%	21.90%	37.70%	41.90%	31%
Asian	6.00%	8.90%	6.10%	4.40%	4.80%
Native Hawaiian and Other Pacific Islander	0%	0%	0%	0.00%	0%
Some Other Race	10.90%	5.70%	5.30%	8.60%	7.70%

Source: United States Bureau of the Census, American Community Survey, Table B07401.

The figure below shows individuals aged 1 year and older who lived in a different house within the same county one year earlier by **ethnicity** in Martin County from 2016 to 2020. As previously mentioned, geographic mobility is correlated with the lack of stable health care engagement, placing individuals at risk for poorer health outcomes.[100] In Martin County, non-Hispanic residents consistently accounted for higher proportions of residents who moved year-to-year. Most recently in 2020, 5.2% of non-Hispanic residents lived in a different house one year earlier compared to 4.4% of Hispanic residents. As mentioned, unstable housing and multiple moves are associated with adverse health outcomes and food insecurity in childhood, contributing to racial and ethnic health disparities.[101] As such, the Martin County Health Equity Taskforce will consider future community projects to address housing-related disparities.

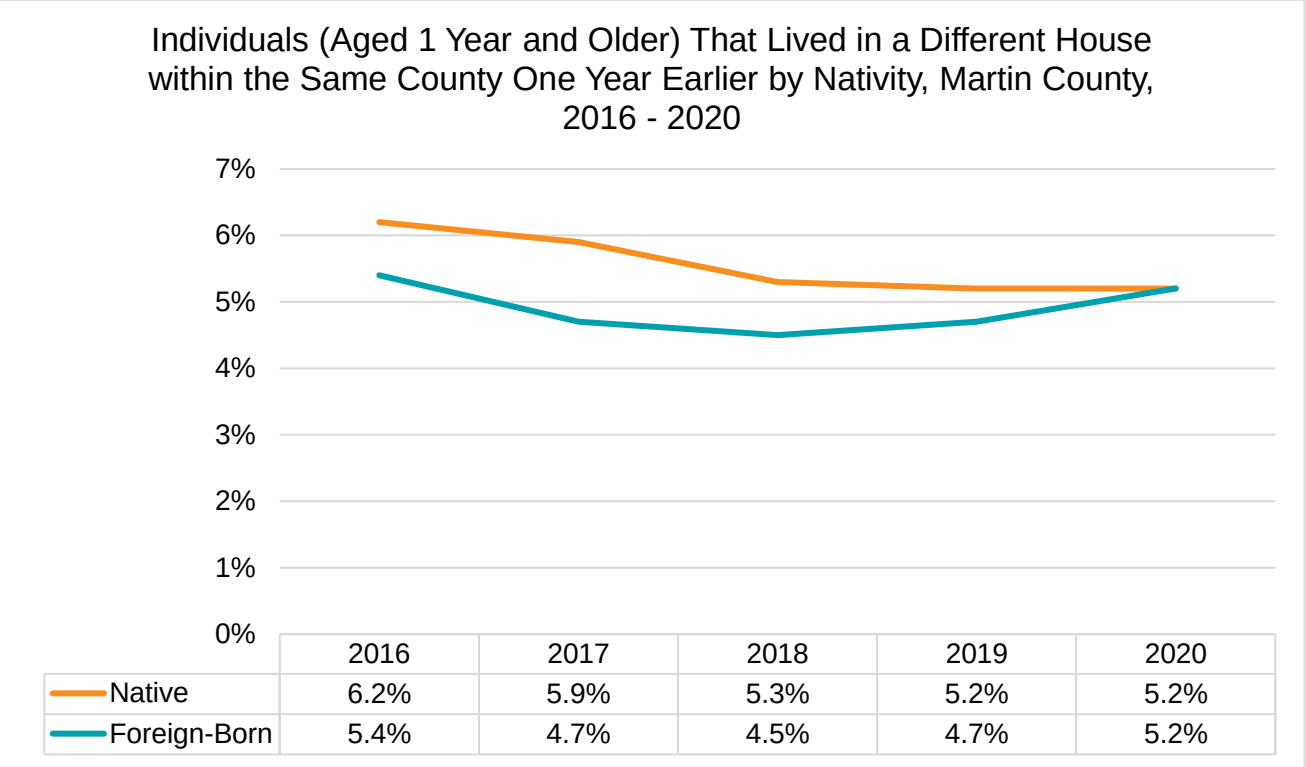


	2016	2017	2018	2019	2020
Hispanic	5.5%	4.4%	3.7%	4.3%	4.4%
White Non-Hispanic	6.1%	5.7%	5.2%	5.0%	5.2%

Source: United States Bureau of the Census, American Community Survey, Table B07401.

[100] Huffman, L.C & Wise, P.H. (2009). Geographic mobility and residential instability. *Developmental-Behavioral Pediatrics.* 4.
[101] Sandel, M, Sheward, R., et al. (2018). Unstable Housing and Caregiver and Child Health in Renter Families. *Pediatrics*. 141 (2): e20172199.

The figure below shows individuals aged 1 year and older who lived in a different house within the same county one year earlier by **nativity** in Martin County from 2016 to 2020. As previously mentioned, geographic mobility is correlated with the lack of stable health care engagement, placing individuals at risk for poorer health outcomes.[102] In Martin County, US native residents consistently accounted for higher proportions of residents who moved year-to-year, except for in 2020. Most recently in 2020, 5.2% of both US native residents and foreign-born residents moved within the same county in the past year. As mentioned, unstable housing and multiple moves are associated with adverse health outcomes and food insecurity in childhood, contributing to racial and ethnic health disparities.[103] As such, the Martin County Health Equity Taskforce will consider future community projects to address housing-related disparities.



	2016	2017	2018	2019	2020
Native	6.2%	5.9%	5.3%	5.2%	5.2%
Foreign-Born	5.4%	4.7%	4.5%	4.7%	5.2%

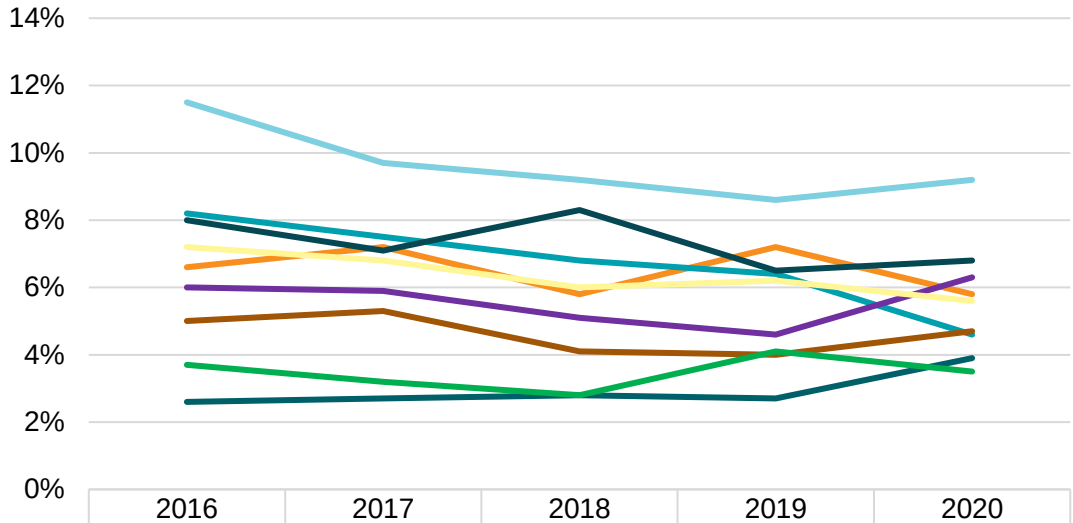
Source: United States Bureau of the Census, American Community Survey, Table B07401.

[102] Huffman, L.C & Wise, P.H. (2009). Geographic mobility and residential instability. *Developmental-Behavioral Pediatrics.* 4.
[103] Sandel, M, Sheward, R., et al. (2018). Unstable Housing and Caregiver and Child Health in Renter Families. *Pediatrics*. 141 (2): e20172199.

The figure on the following page shows individuals aged 1 year and older who lived in a different house within the same county one year earlier by **age** in Martin County from 2016 to 2020. As previously mentioned, geographic mobility is correlated with the lack of stable health care engagement, placing individuals at risk for poorer health outcomes.[104] In Martin County, a higher proportion of residents aged 25 to 34 years moved within the same county in the previous year, while residents 65 years and older accounted for the lowest proportions each year. As mentioned, unstable housing and multiple moves are associated with adverse health outcomes and food insecurity in childhood, contributing to racial and ethnic health disparities.[105] As such, the Martin County Health Equity Taskforce will consider future community projects to address housing-related disparities.

[104] Huffman, L.C & Wise, P.H. (2009). Geographic mobility and residential instability. *Developmental-Behavioral Pediatrics.* 4.
[105] Sandel, M, Sheward, R., et al. (2018). Unstable Housing and Caregiver and Child Health in Renter Families. *Pediatrics*. 141 (2): e20172199.

Individuals (Aged 1 Year and Older) That Lived in a Different House within the Same County One Year Earlier by Age, Martin County, 2016 - 2020



	2016	2017	2018	2019	2020
1 to 4 years	6.6%	7.2%	5.8%	7.2%	5.8%
5 to 17 years	8.2%	7.5%	6.8%	6.4%	4.6%
18 to 24 years	8.0%	7.1%	8.3%	6.5%	6.8%
25 to 34 years	11.5%	9.7%	9.2%	8.6%	9.2%
35 to 44 years	6.0%	5.9%	5.1%	4.6%	6.3%
45 to 54 years	7.2%	6.8%	6.0%	6.2%	5.6%
55 to 64 years	5.0%	5.3%	4.1%	4.0%	4.7%
65 to 74 years	2.6%	2.7%	2.8%	2.7%	3.9%
75+ years	3.7%	3.2%	2.8%	4.1%	3.5%

Source: United States Bureau of the Census, American Community Survey, Table B07401.

Homelessness

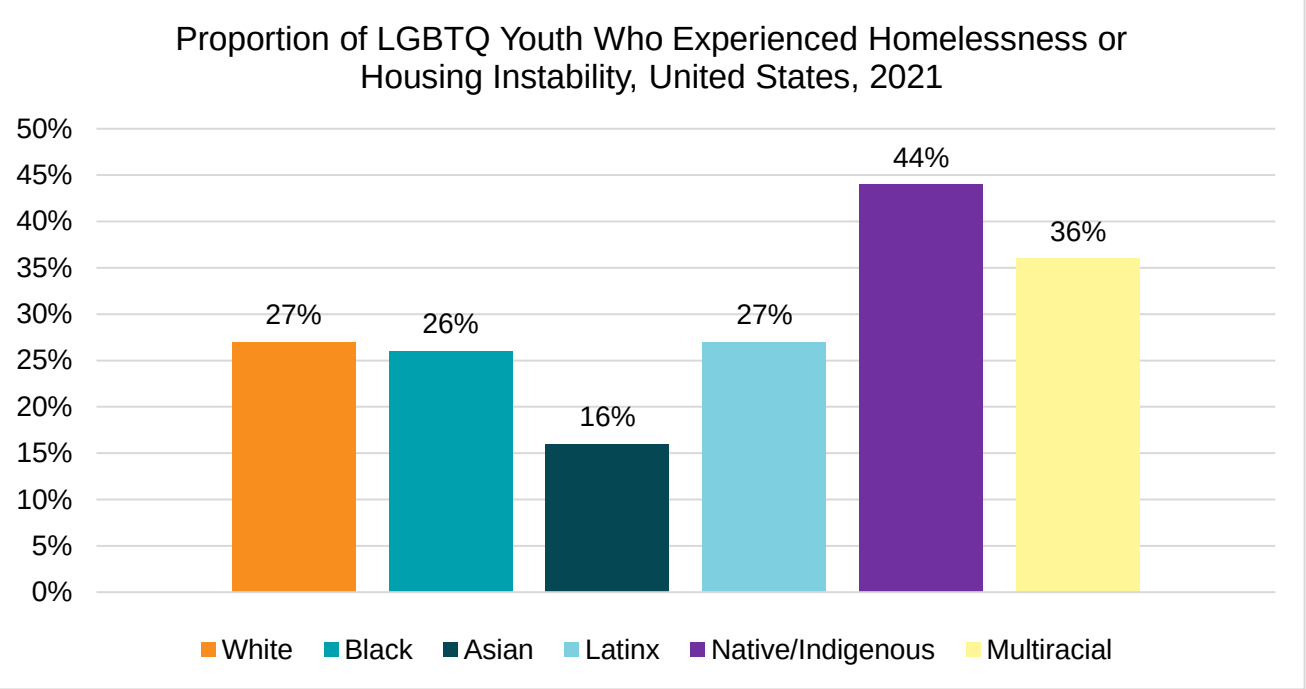
The table below shows homeless or unaccompanied youth in Martin County in 2020. Evidence demonstrates that a hunger-obesity paradox exists in the United States, with a high prevalence of obesity among homeless residents.[106] In 2020, there were a total of 669 homeless students (3.4% of all students) and a total of 39 unaccompanied youth (0.2% of all youth aged 18 and under). Research shows that unaccompanied homeless youth have unhealthy diets, poor nutritional status, and a higher rate of obesity.[107] As such, the Martin County Health Equity Taskforce will consider ways to address homelessness among youth.

Homeless or Unaccompanied Youth, Martin County, 2020		
Indicator	**Total**	**Percent**
Homeless Students (2020)	669	3.4%
Unaccompanied Youth (2020)	39	0.2%

Source: Florida Department of Education, 2020 / U.S. Department of Housing and Urban Development & Florida Department of Children and Families, Office of Homelessness, Council on Homelessness Annual Report, Point-in-Time Count of Homeless People, FLHealthCHARTS, 2020

[106] Koh, K.A., Hoy, J.S., O'Connell, J.J., & Montgomery, P. (2012). The hunger-obesity paradox: Obesity in the homeless. *J Urban Health.* 89(6): 952-964.
[107] Hatsu, I., Gunther, C., et al. (2019). Unaccompanied homeless youth have extremely poor diet quality and nutritional status. *International Journal of Adolescence and Youth.* 319-332.

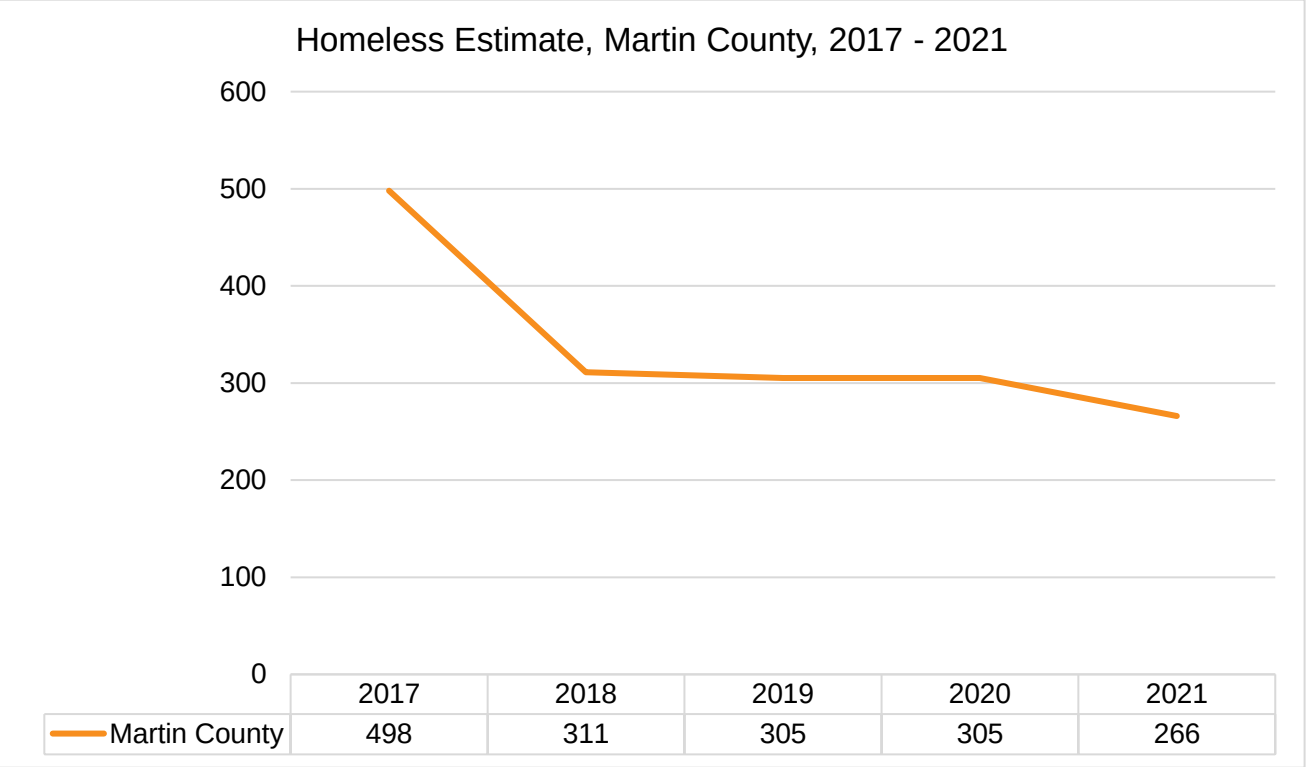
While there is no county data on housing among **LGBTQ+ youth**, the Trevor Project 2021 National Survey on LGBTQ Youth Mental Health examined housing instability and homelessness among LGBTQ youth aged 13 to 24 years old. In 2021, 44% of Native/Indigenous LGBTQ youth experienced homelessness or housing instability, followed by 36% of multiracial, 27% of Latinx, 27% of White, 26% of Black, and 16% of Asian LGBTQ youth.[108] Furthermore, the National Transgender Discrimination Survey found that, in Florida, residents of trans experience faced housing discrimination and housing instability, with 12% getting evicted, 14% being denied a home, 16% experiencing homelessness, and 23% needing to find temporary housing.[109] Furthermore, the 2019 BRFSS Florida State Survey found that 21% of the LGTBQ population were unable to pay mortgage in comparison to 10.2% for the heterosexual population. As mentioned, research shows that unaccompanied homeless youth have unhealthy diets, poor nutritional status, and a higher rate of obesity.[110] As such, the Martin County Health Equity Taskforce will consider ways to address homelessness among youth and plans to address missing county-level data among the LGBTQ+ population as a community project.



[108] Trevor Project. 2021. National Survey on LGBTQ Mental Health. Retrieved from: https://www.thetrevorproject.org/research-briefs/homelessness-and-housing-instability-among-lgbtq-youth-feb-2022/
[109] National Center for Transgender Equality and the National Gay and Lesbian Task Force. 2012. Florida Results. Retrieved from: https://transequality.org/sites/default/files/docs/resources/ntds_state_fl.pdf
[110] Hatsu, I., Gunther, C., et al. (2019). Unaccompanied homeless youth have extremely poor diet quality and nutritional status. *International Journal of Adolescence and Youth.* 319-332.

Source: Trevor Project, National Survey on LGBTQ Mental Health, 2021

The table below shows **homeless** estimate in Martin County from 2017 to 2021, based on a point-in-time count. As previously mentioned, evidence demonstrates that a hunger-obesity paradox exists in the United States, with a high prevalence of obesity among homeless residents.[111] From 2017 to 2021, the number of estimated homeless residents in Martin County decreased from 498 to 266. Homelessness is no longer associated with being underweight – recent evidence shows that a considerable proportion of homeless individuals are actually overweight, while a minority are underweight.[112] The Martin County Health Equity Taskforce will consider ways to address homelessness.



	2017	2018	2019	2020	2021
Martin County	498	311	305	305	266

Source: Florida Department of Children and Families, Office of Homelessness, Council on Homelessness Annual Report, Point-in-Time Count of Homeless People

[111] Koh, K.A., Hoy, J.S., O'Connell, J.J., & Montgomery, P. (2012). The hunger-obesity paradox: Obesity in the homeless. *J Urban Health.* 89(6): 952-964.
[112] Koh, K.A., Hoy, J.S., et al. (2012) The Hunger–Obesity Paradox: Obesity in the Homeless. *Journal of Urban Health.* 89: 953-964.

Access to Healthy Food Source and Recreation

The table below shows healthy food and recreation access in 2019 in Martin County and Florida. Martin County had lower proportions of residents within ½ mile of a healthy food source (16%), residents within ½ mile of fast food restaurant (18%), and residents within ½ mile of park (38.6%), compared to the state (28%, 29.3%, and 40.1%, respectively). However, Martin County had a higher proportion of residents within a 10-minute walk of an off-street trail system (32%) compared to Florida (18%). Convenient access to healthy, affordable foods is associated with improved health outcomes and reduced obesity, while the inverse is true where there is increased exposure to fast-food outlets and unhealthy foods.[113] Additionally, children with access to parks and recreational resources are less likely to be overweight or obese.[114] Oftentimes, there is less access to healthy foods and walkable green spaces in communities of color, which is the case in Indiantown, Martin County. As such, the Martin County Health Equity Taskforce is implementing a PACE-EH Community Project in Indiantown to improve access to affordable and healthy food sources and assess walkability and transit needs.

Healthy Food and Recreation Access, Martin County and Florida, 2019		
Indicator	**Martin County**	**Florida**
Population Within ½ Mile of Healthy Food Source (2019)	16.0%	27.7%
Population Within ½ Mile of Fast Food Restaurant (2019)	18.0%	29.3%
Population Within ½ Mile of a Park (2019)	38.6%	40.1%
Population Within Ten Minute Walk (½ Mile) of an Off-Street Trail System (2019)	31.9%	18.2%

Source: Florida Department of Health, Florida Environmental Public Health Tracking, 2019

[113] Hilmers, A., Hilmers, D.C. & Dave, J. (2012). Neighborhood disparities in access to healthy foods and their effect on environmental justice. *American Journal of Public Health.* 102: 1644-1654.
[114] Wolch, J., Jerrett, M., et al. (2011). Childhood obesity and proximity to urban parks and recreational resources: A longitudinal cohort study. *Health & Place.* 17(1): 207-214.

The table on the following page shows healthy food and recreation access by **census tract** in Martin County in 2019. Convenient access to healthy, affordable foods is associated with improved health outcomes and reduced obesity.[115] The census tracts with the highest proportion of residents within ½ mile of a healthy food source were census tracts 12 (84.8%), 3 (50.3%), and 9.02 (41.5%); on the contrary, the census tracts with the lowest proportions were census tracts 5.02, 6.07, 6.1, 14.07, 16.01, and 16.02, each with 0%.

Increased exposure to fast-food outlets and unhealthy foods is associated with adverse health outcomes and obesity.[116] The census tracts with the highest proportion of residents within ½ mile of a fast food restaurant were census tracts 10 (73.9%), 9.02 (56.8%), and 3 (54.2%), whereas, the census tracts with the lowest proportion were census tract 5.02, 6.1, 13.02, 14.07, 16.01 and 16.02, each with 0%.

Children and families with convenient access to parks and recreational resources are less likely to be overweight or obese.[117] The census tracts with the highest proportion of residents within ½ mile of a park were census tracts 8 (100%), 1 (84.4%), and 14.07 (77.6%); inversely, the census tracts with the lowest proportions were census tracts 18.02 (0%), 14.09 (0.1%), 17 (0.7%), and 18.01 (2.1%).

Walking to use public transportation and transit substantially reduces obesity.[118] The census tracts with the highest proportion of residents within a 10-minute walk of an off-street trail system were census tracts 14.06 (100%), 13.02 (96.1%), and 14.08 (84.7%); however, the census tracts with the lowest proportion were census tracts 5.02, 6.07, 8, 9.01, and 9.02, each with 0%.

As previously mentioned, oftentimes, there is less access to healthy foods and walkable green spaces in communities of color, which is the case in Indiantown, Martin County. As such, the Martin County Health Equity Taskforce is implementing a PACE-EH Community Project in Indiantown to improve access to affordable and healthy food sources and to assess walkability and transit needs.

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[115] Hilmers, A., Hilmers, D.C. & Dave, J. (2012). Neighborhood disparities in access to healthy foods and their effect on environmental justice. *American Journal of Public Health.* 102: 1644-1654.
[116] Hilmers, A., Hilmers, D.C. & Dave, J. (2012). Neighborhood disparities in access to healthy foods and their effect on environmental justice. *American Journal of Public Health.* 102: 1644-1654.
[117] Wolch, J., Jerrett, M., et al. (2011). Childhood obesity and proximity to urban parks and recreational resources: A longitudinal cohort study. *Health & Place.* 17(1): 207-214.
[118] Edwards, R.D. (2008). Public transit, obesity, and medical costs: Assessing the magnitudes. *Preventive Medicine.* 46(1): 14-21.

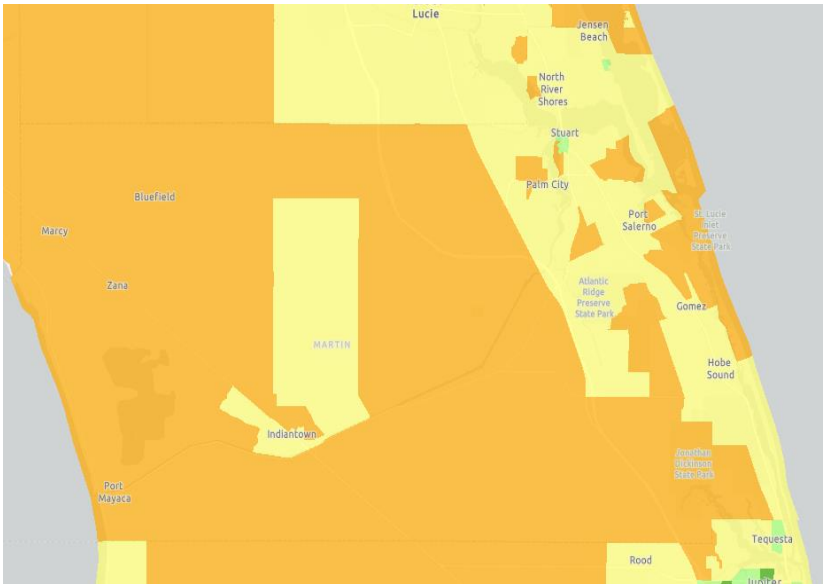
Healthy Food and Recreation Access by Census Tract, Martin County, 2019				
Census Tract	Population Within ½ Mile of Healthy Food Source (2019)	Population Within ½ Mile of Fast Food Restaurant (2019)	Population Within ½ Mile of a Park (2019)	Population Within Ten Minute Walk (½ Mile) of an Off-Street Trail System (2019)
1	24.2%	32.6%	**84.4%**	2.4%
2	34.2%	31.7%	24.2%	56.9%
3	**50.3%**	**54.2%**	35.4%	0.3%
4	29.8%	28.4%	75.2%	46.5%
5.01	7.2%	8.7%	68.4%	8.6%
5.02	0%	0%	60.9%	0%
6.03	38.8%	28.8%	33.2%	1.5%
6.04	9.7%	4.7%	19.0%	2.7%
6.06	6.9%	9.4%	20.0%	11.7%
6.07	0%	19.9%	45.3%	0%
6.1	0%	0%	27.5%	1.4%
7	-	-	51.0%	23.7%
8	19.2%	26.3%	**100%**	0%
9.01	12.4%	22.7%	39.1%	0%
9.02	**41.5%**	**56.8%**	74.5%	0%
10	22.6%	**73.9%**	48.9%	54.6%
11.02	-	-	4.6%	63.2%
11.03	14.3%	27.3%	60.6%	32.4%
11.04	-	-	19.7%	55.8%
12	**84.8%**	47.1%	66.5%	30.8%
13.01	31.2%	5.5%	68.3%	0.3%
13.02	5.8%	0%	76.7%	**96.1%**
14.04	3.3%	3.4%	23.4%	36.7%

14.06	7.3%	8.0%	43.6%	**100%**
14.07	0%	0%	**77.6%**	36.1%
14.08	20.3%	21.7%	76.1%	**84.7%**
14.09	8.9%	10.8%	0.1%	14.3%
14.1	8.1%	9.4%	52.9%	62.3%
15	2.5%	3.0%	62.6%	73.9%
16.01	0%	0%	40.9%	39.4%
16.02	0%	0%	10.4%	39.9%
17	-	-	0.7%	14.3%
18.01	-	-	2.1%	16.1%
18.02	-	-	0%	18.2%

Source: Florida Department of Health, Florida Environmental Public Health Tracking, 2019

Walkability

Walkability is a measurement used to assess how complete, sustainable, and healthy a geographic area is, with more walkable areas promoting safety, social cohesion, and physical health through increased opportunities for physical activity and recreational walking, which ultimately improves health outcomes, including reduced obesity rates.[119] The map below includes a visual portrayal of the EPA's National Walkability Index in Martin County. The vast majority of the county is shaded orange, indicating a low walkability score or a less walkable area, while a minority is shaded yellow, indicating a below average walkability score. The Martin County Health Equity Taskforce is implementing a PACE-EH Community Project in Indiantown to improve access to affordable and healthy food sources and to assess walkability and transit needs.



Walkability Index

- 1 - 5.75 (Least Walkable)
- 5.76 - 10.50 (Below Average Walkable)
- 10.51 - 15.25 (Above Average Walkable)
- 15.26 - 20 (Most Walkable)

Source: United States Environmental Protection Agency, National Walkability Index

[119] Lee, E. & Dean, J. (2018). Perceptions of walkability and determinants of walking behavior among urban seniors in Toronto, Canada. *Journal of Transport & Health*. 9: 309-320.

Internet Connectivity

The figure below shows internet connectivity and access by census tract in Martin County in 2020. The majority of all census tracts had high proportions of households with one or more types of computing devices (range: 80.6% - 100%) and households with access to broadband internet (range: 70.4% - 95.5%). The census tract with the highest proportion of households with one or more types of computing devices was 18.06 (100%), accounting for proportion 1.2 times higher than census tract 18.03 (80.6%). The census tract with the highest proportion of households with access to broadband internet was 6.06 (95.5%), accounting for a proportion 1.4 times higher than census tract 18.04 (70.4%). Recent research shows that, although broadband access increases access to information, resources and telehealth services, that increased internet access and use can have positive and negative effects on health behaviors, such as engaging in physical activity, drinking, and smoking.[120]

Internet Connectivity by Census Tract, Martin County, 2020		
Census Tract	**Households with One or More Types of Computing Devices**	**Households with Access to Broadband Internet**
1	98.6%	91.3%
2	88.0%	87.7%
3	96.8%	87.7%
4	95.6%	89.8%
5.01	92.9%	86.6%
5.02	98.4%	94.8%
6.03	93.0%	91.5%
6.04	97.4%	93.6%
6.06	96.3%	95.5%

[120] DiNardi, M., Guldi, M., & Simon, D. (2018). Body weight and Internet access: evidence from the rollout of broadband providers. *Journal of Population Economics.* 32: 877-913.

6.07	93.7%	88.6%
6.10	95.8%	91.3%
7.01	93.7%	86.7%
7.02	86.7%	83.3%
8	92.4%	76.9%
9.01	83.1%	76.2%
9.02	92.0%	87.1%
10	88.7%	76.6%
11.03	95.6%	88.9%
11.05	95.1%	89.6%
11.06	92.6%	84.0%
11.07	97.7%	88.7%
11.08	95.1%	91.6%
12	91.4%	74.7%
13.01	96.6%	84.4%
13.02	96.8%	93.4%
14.04	94.9%	88.4%
14.06	99.4%	94.1%
14.07	83.6%	75.1%
14.08	93.0%	85.1%
14.09	96.1%	93.4%
14.10	93.8%	90.3%
15	94.5%	91.6%

16.01	83.6%	77.2%
16.02	97.0%	93.4%
17.01	98.5%	83.2%
17.02	94.9%	88.4%
17.03	95.0%	90.8%
18.03	80.6%	72.4%
18.04	86.2%	70.4%
18.05	91.6%	76.8%
18.06	100.0%	85.4%

Source: United States Bureau of the Census, American Community Survey, Table S2801.

The Impact of Neighborhood and Built Environment on Obesity in Martin County

The Martin County Health Equity Taskforce discussed how Neighborhood and Built Environment contribute to overweight status and obesity in Martin County. Discussion points are included in the table below.

Neighborhood and Built Environment		
SDOH	**Priority Populations Impacted**	**How the SDOH Impacts Obesity**
Transportation	Rural communities; Black and Hispanic residents	Members discussed low-income and low food access with transportation overlays, stating that access and transportation can play a role in food choices, even if education and cost components are present. Moreover, research has shown that improvements in walkability and transit options, leading to the decrease in automobile use, improve health outcomes and reduce obesity.
Housing Characteristics	Census tracks with higher proportions of households that lack plumbing, kitchens, utilities, and fuel.	Indoor environment, specifically people's homes where they spend most of their time, has an extremely huge impact on one's health and the risk for obesity. Partners stressed Kitchen availability and its role in healthy eating, with an emphasis on homeless populations who do not have anywhere to store groceries or cook healthy meals.
Housing	Black residents; Hispanic residents; American Indian and Alaska Native residents	Home ownership is found to be associated with lower risk of child overweight status and obesity, as there is likely increased financial stability and ability to afford healthy foods and to access green spaces and physical activity resources. Moreover, research shows that unaccompanied homeless youth have unhealthy diets, poor nutritional status, and a higher rate of obesity. And recent evidence shows that a considerable proportion of homeless individuals are actually overweight, while a minority are underweight.
Geographic Mobility	Black residents; American Indian and Alaska Native residents	Unstable housing and multiple moves are associated with adverse health outcomes and food insecurity in childhood, contributing to racial and ethnic health disparities.
Workplace Location Efficiency	Communities who live in Hobe Sound and west of the Florida's Turnpike	Workplaces in areas with high walkability and public transit options make travel more convenient, so residents do not have to rely on personal vehicles. This also can reduce pollution levels, costs, infrastructure burden, and even promotes better health outcomes and a better quality of life.
Air Quality and Pollution	Populations within 500 feet of a busy roadway; more urban communities within the county	Air pollution leads to overweight status and obesity due to metabolic dysfunction, the onset of chronic disease, and reduction of time outdoors and participation in physical activity.

Access to green spaces/sport facilities	Black and Hispanic residents	Partners mentioned the importance of the proximity to parks, green spaces, and sport facilities to facilitate and encourage active and healthy lifestyles and exercise. Children with access to parks and recreational resources are less likely to be overweight or obese.
Access to healthy foods	Rural communities; Black and Hispanic residents	Convenient access to healthy, affordable foods is associated with improved health outcomes and reduced obesity, while the inverse is true where there is increased exposure to fast-food outlets and unhealthy foods.
Broadband access	Rural communities; Black and Hispanic residents	Members mentioned the digital divide, with lower broadband access in more rural areas, where residents need increased ability to research healthy foods and recipes.

D. Social & Community Context

Social and Community Context Data for Martin County

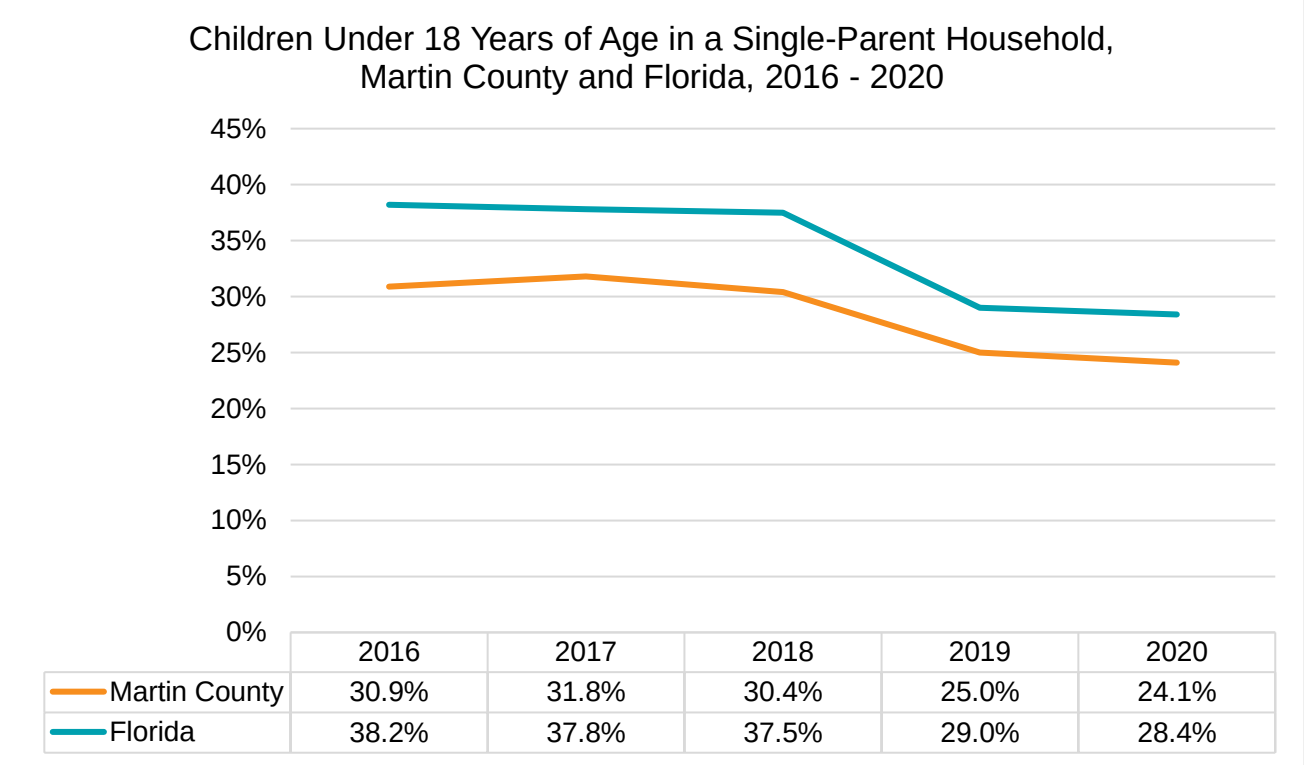
Social and community context play is an important social determinant of health to consider, as it impacts both health outcomes and quality of life. Social support can act as a protective or mitigating factor when individuals face conditions beyond their control, such as financial instability or unsafe living conditions, while the opposite is true when individuals experience social isolation or have no social support.[121] Moreover, a recent study conducted among women in the United States found that individuals who experienced food insecurity reported lower levels of social support and were more likely to experience overweight status and obesity.[122] The following data explores the social and community context in Martin County. To note, considerable efforts were made to find all of the following information related to social and community context among priority populations, including Black or African Americans, American Indian and Alaska Natives, Asians, Native Hawaiians, Hispanic and Latinos, elders, infants and toddlers, people living with disabilities, veterans, people identifying as LGBTQ+, and immigrants. Research shows these populations experience health inequities at higher rates. However, data was unavailable for these populations in several instances.

[121] US Department of Health and Human Services. Healthy People 2030: Social and Community Context. Retrieved from: https://health.gov/healthypeople/objectives-and-data/browse-objectives/social-and-community-context

[122] Ashe, K.M. & Lapane, K.L. (2018). Food insecurity and obesity: Exploring the role of social support. *Journal of Women's Health.* 27(5).

Household Context

The figure below shows children under 18 years of age in a single-parent household in Martin County and Florida from 2016 to 2020. Martin County consistently accounted for lower proportions of children in single-parent households each year, compared to the state, though the proportion has decreased for both over time. Most recently in 2020, 24.1% of children in Martin County lived in single-parent households, compared to 28.4% in Florida. Children of single-parent households are at higher risk for obesity due to reduced homemade meals, less family meal time, and less physical activity.[123] The Martin County Health Equity Taskforce is implementing the Go NAPSACC Community Program to increase healthy eating and physical activity best practices in childcare settings, which also includes a family education and engagement component. The Taskforce will also be prioritizing the future implementation of community projects that reach children who are not enrolled in ECEs.



	2016	2017	2018	2019	2020
Martin County	30.9%	31.8%	30.4%	25.0%	24.1%
Florida	38.2%	37.8%	37.5%	29.0%	28.4%

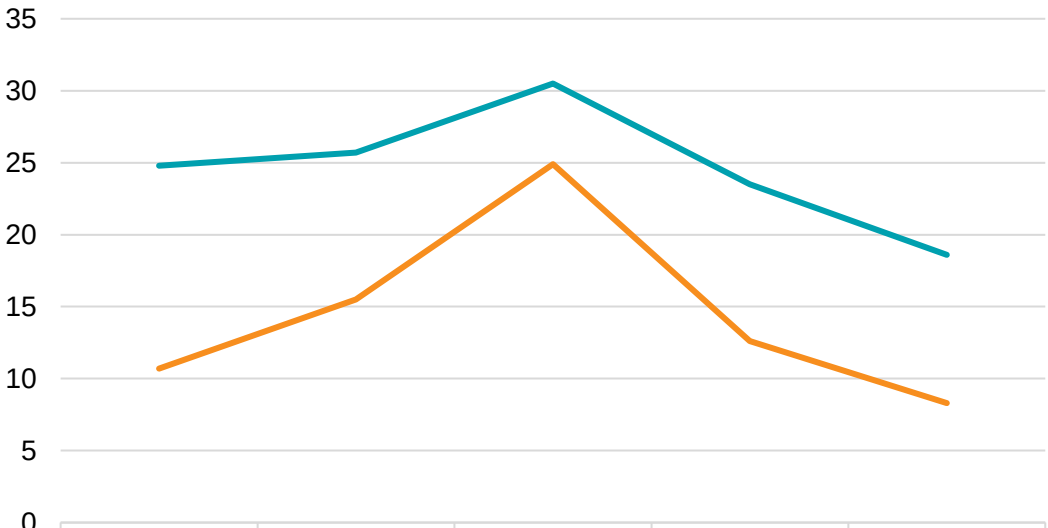
Source: United States Bureau of the Census, American Community Survey, Table B09005.

[123] Duriancik, D.M. & Goff, C.R. (2019). Children of single-parent households are at a higher risk of obesity: A systematic review. *Journal of Child Health Care.* https://doi.org/10.1177/1367493519852463

Safety

The figure below shows the school environment safety incident rate per 1,000 K-12 students in Martin County and Florida from 2017 to 2021. Martin County has consistently had lower rates of school safety incidents than the state, though the rate increased for both the county and the state in 2019 and then sharply declined through 2021. Importantly, during the COVID-19 pandemic, virtual schooling was implemented, which may have contributed to the decrease in 2020 and 2021. Most recently in 2021, Florida had a school safety incident rate (18.6 per 1,000) 2.2 times higher than Martin County (8.3 per 1,000). Evidence shows that exposure to violence and less safe neighborhoods in early childhood is associated with increased risk for obesity.[124] The Martin County Health Equity Taskforce will consider future community projects aimed at improving neighborhood and school environments, fostering a strong sense of community, and increasing safety. Additionally, as part of the PACE-EH Community Project in Indiantown, walkability and safety needs will be assessed.

School Environment Safety Incidents Rate, Per 1,000 K-12 Students, Martin County and Florida, 2017 - 2021

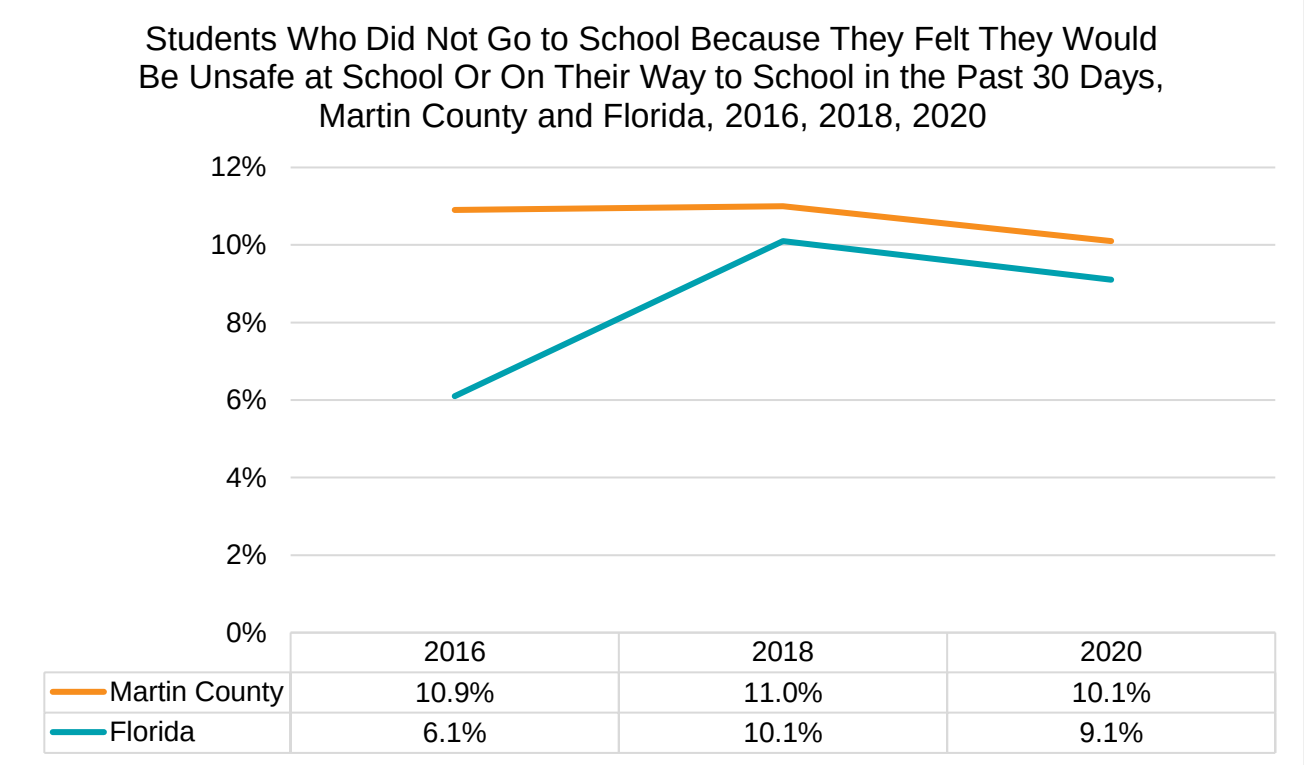


	2017	2018	2019	2020	2021
Martin County	10.7	15.5	24.9	12.6	8.3
Florida	24.8	25.7	30.5	23.5	18.6

Source: FLHealthCHARTS, Florida Department of Education, 2021

[124] Boynton-Jarrett, R., Fargnoli, J, et al. (2010). Association Between Maternal Intimate Partner Violence and Incident Obesity in Preschool-Aged Children. *Arch Pediatr Adolesc Med.* 2010;164(6):540-546. doi:10.1001/archpediatrics.2010.94

The figure below shows the proportion of students who did not go to school because they felt they would be unsafe at school or on their way to school in the past 30 days in Martin County and Florida from 2016 to 2020. Martin County consistently had higher proportions of students who did not go to school due to safety concerns compared to the state, which experienced an increase from 2016 to 2018. Most recently in 2020, 10.1% of Martin County students did not go to school because they felt they would be unsafe at or on their way to school, compared to 9.1% of students in Florida. As previously mentioned, research has found that exposure to violence and less safe neighborhoods in early childhood is associated with increased risk for obesity.[125] The Martin County Health Equity Taskforce will consider future community projects aimed at improving neighborhood and school environments, fostering a strong sense of community, and increasing safety. Additionally, as part of the PACE-EH Community Project in Indiantown, walkability and safety needs will be assessed.



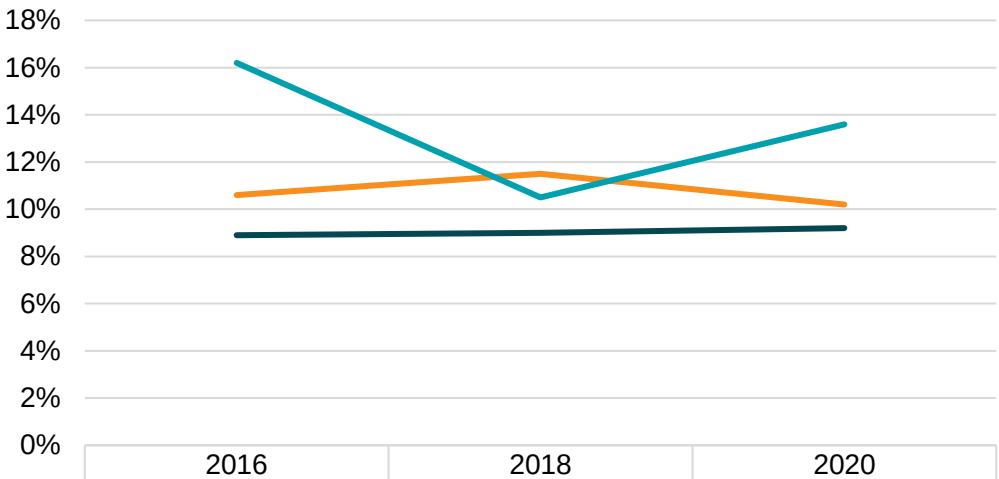
	2016	2018	2020
Martin County	10.9%	11.0%	10.1%
Florida	6.1%	10.1%	9.1%

Source: Florida Department of Health, Division of Community Health Promotion, Florida Youth Tobacco Survey (FYTS).

[125] Boynton-Jarrett, R., Fargnoli, J, et al. (2010). Association Between Maternal Intimate Partner Violence and Incident Obesity in Preschool-Aged Children. *Arch Pediatr Adolesc Med.* 2010;164(6):540-546. doi:10.1001/archpediatrics.2010.94

The figure below shows the proportion of students who did not go to school because they felt they would be unsafe at school or on their way to school in the past 30 days by **race and ethnicity** in Martin County from 2016 to 2020. Each year, Hispanic students accounted for the lowest proportion of students who did not go to school due to safety concerns, whereas non-Hispanic Black students accounted for the highest proportions in 2016 and 2020, and White non-Hispanic students accounting for a slightly higher proportion in 2018. Most recently in 2020, 13.6% of non-Hispanic Black students did not go to school due to safety concerns in the past 30 days, followed by 10.2% of non-Hispanic White students and 9.2% of Hispanic students. As previously mentioned, research shows that exposure to violence and less safe neighborhoods in early childhood is associated with increased risk for obesity.[126] The Martin County Health Equity Taskforce will consider future community projects aimed at improving neighborhood and school environments, fostering a strong sense of community, and increasing safety. Additionally, as part of the PACE-EH Community Project in Indiantown, walkability and safety needs will be assessed.

Students Who Did Not Go to School Because They Felt They Would Be Unsafe at School Or On Their Way to School in the Past 30 Days by Race and Ethnicity, Martin County, 2016, 2018, 2020

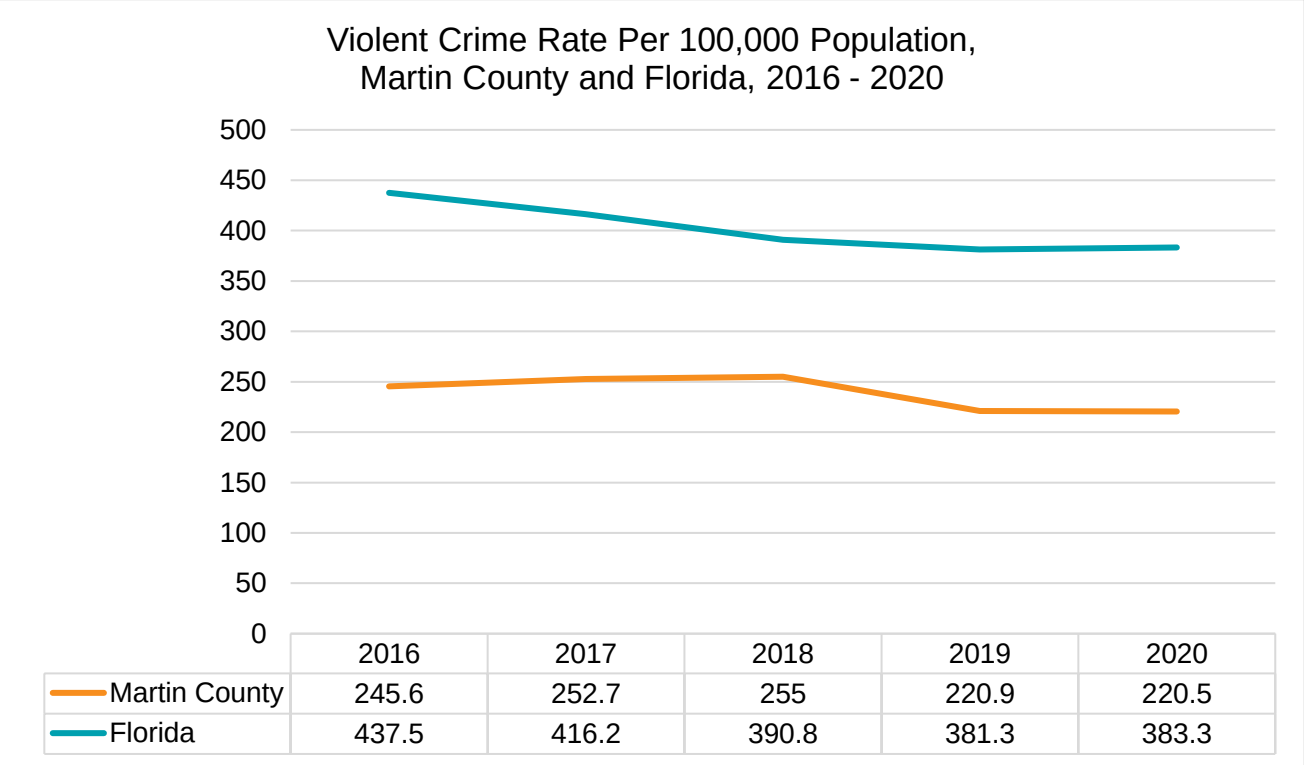


	2016	2018	2020
Non-Hispanic White	10.6%	11.5%	10.2%
Non-Hispanic Black	16.2%	10.5%	13.6%
Hispanic	8.9%	9.0%	9.2%

Source: Florida Department of Health, Division of Community Health Promotion, Florida Youth Tobacco Survey (FYTS).

[126] Boynton-Jarrett, R., Fargnoli, J, et al. (2010). Association Between Maternal Intimate Partner Violence and Incident Obesity in Preschool-Aged Children. *Arch Pediatr Adolesc Med.* 2010;164(6):540-546. doi:10.1001/archpediatrics.2010.94

The figure below shows the violent crime rate per 100,000 population in Martin County and Florida from 2016 to 2020. Violent crimes include murder, rape, robbery, and aggravated assault. Martin County has had a consistently lower violent crime rate than the state. Most recently in 2020, Martin County had a violent crime rate (220.5 per 100,000 population) 1.7 times lower than Florida (383.3 per 100,000 population). As previously mentioned, research has found that exposure to violence and less safe neighborhoods in early childhood is associated with increased risk for obesity.[127] The Martin County Health Equity Taskforce will consider future community projects aimed at improving neighborhood and school environments, fostering a strong sense of community, and increasing safety. Additionally, as part of the PACE-EH Community Project in Indiantown, walkability and safety needs will be assessed.



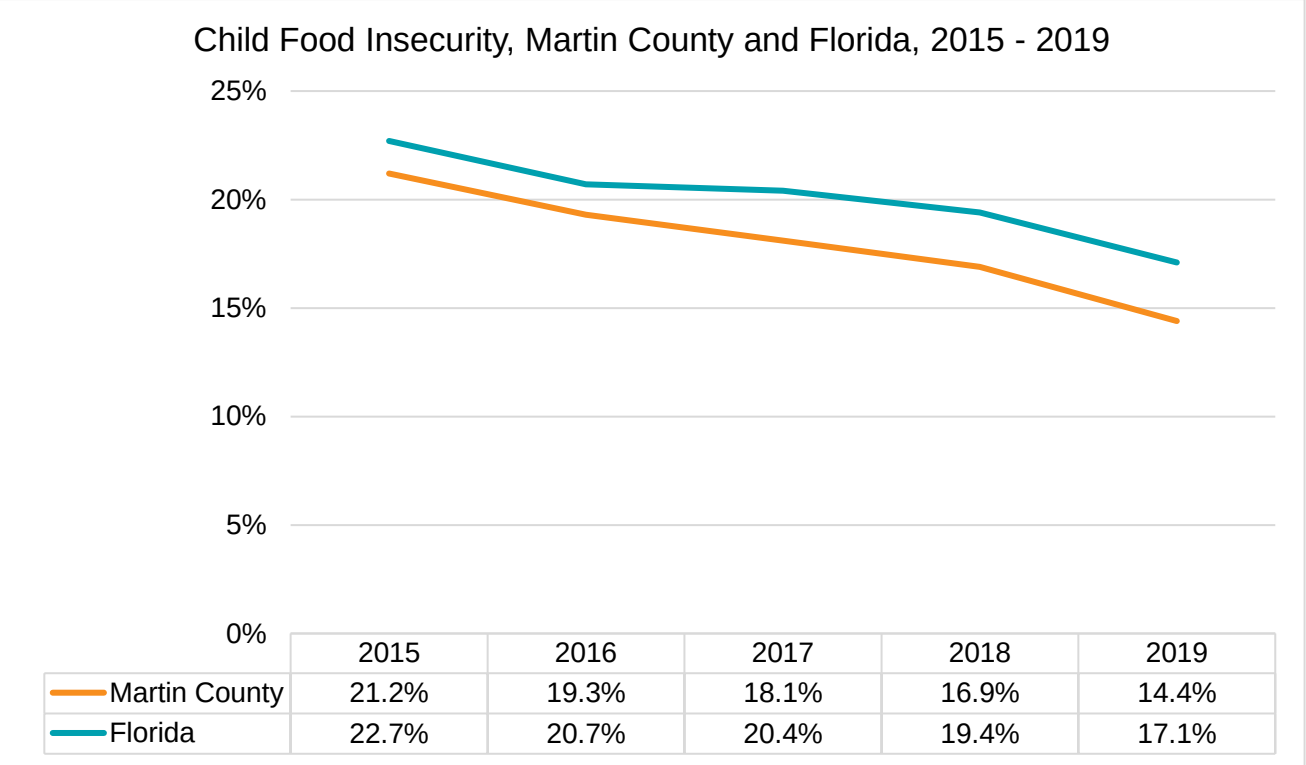
	2016	2017	2018	2019	2020
Martin County	245.6	252.7	255	220.9	220.5
Florida	437.5	416.2	390.8	381.3	383.3

Source: FLHealthCHARTS, Florida Department of Law Enforcement, 2020

[127] Boynton-Jarrett, R., Fargnoli, J, et al. (2010). Association Between Maternal Intimate Partner Violence and Incident Obesity in Preschool-Aged Children. *Arch Pediatr Adolesc Med.* 2010;164(6):540-546. doi:10.1001/archpediatrics.2010.94

Food Insecurity

The figure below shows the proportion of children with food insecurity in Martin County and Florida from 2015 to 2019. Martin County consistently had lower proportions of children facing food insecurity than the state, though the proportion decreased for both over time. Most recently in 2019, 14.4% of children in Martin County experienced food insecurity, compared to 17.1% in Florida. Children who experience food insecurity without hunger are much more likely to be obese compared to their food secure peers.[128] The Martin County Health Equity Taskforce are implementing a Go NAPSACC Community Project to address food insecurity and increase healthy eating and physical activity among young children.

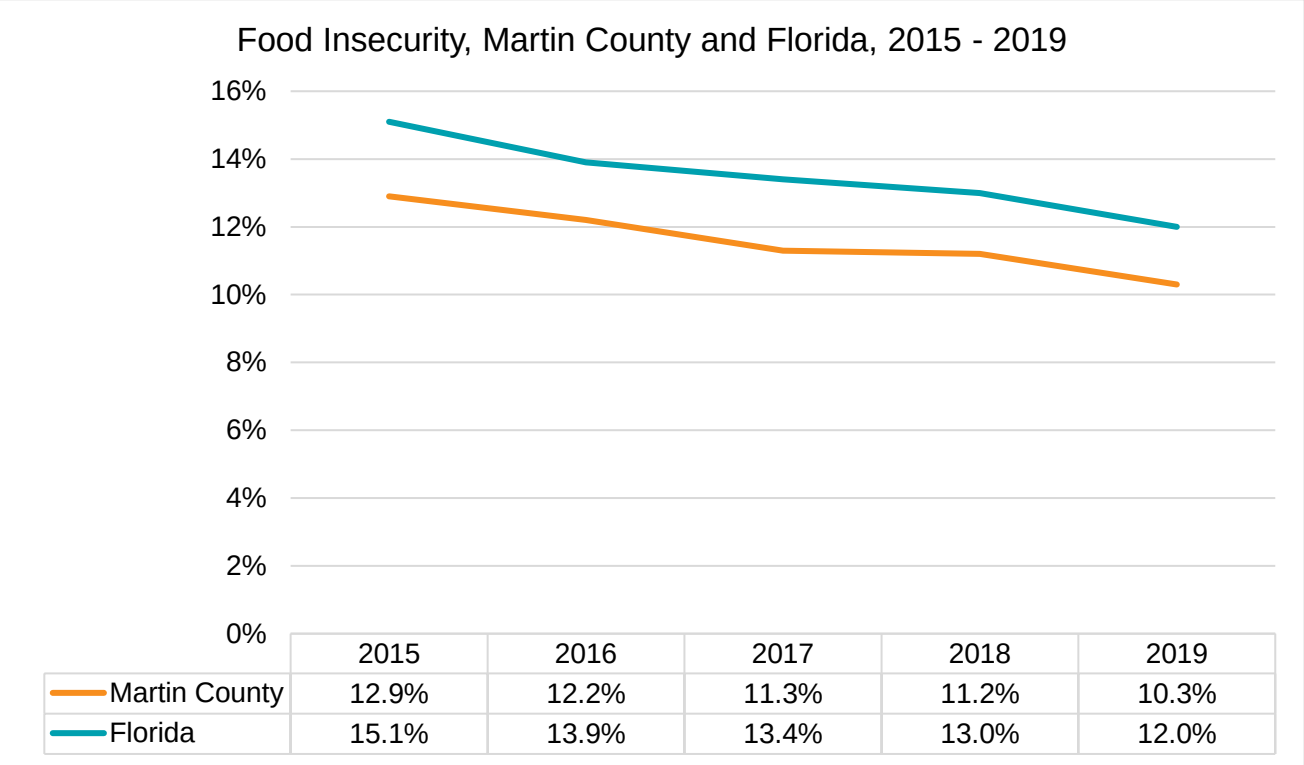


	2015	2016	2017	2018	2019
Martin County	21.2%	19.3%	18.1%	16.9%	14.4%
Florida	22.7%	20.7%	20.4%	19.4%	17.1%

Source: Feeding America, Map the Meal Gap, 2020

[128] Metallinos-Kastaras, E., Must, A., Gorman, K. (2012). A longitudinal study of food insecurity on obesity in preschool children. *Journal of the Academy of Nutrition and Dietetics.* 112(12): 1949-1958.

The figure below shows the proportion of residents with food insecurity in Martin County and Florida from 2015 to 2019. Martin County consistently had lower proportions of residents facing food insecurity than the state, though the proportion decreased for both over time. Most recently in 2019, 10.3% of residents in Martin County experienced food insecurity, compared to 12.0% in Florida. Food insecurity is associated with adverse health outcomes among both children and adults due to social disruption, poor dietary intake, and less physical activity.[129] The Martin County Health Equity Taskforce is addressing food insecurity in childhood through the Go NAPSACC Community Project, as well as in Indiantown through the PACE-EH Community Project, aimed at increasing access to healthy and affordable foods.

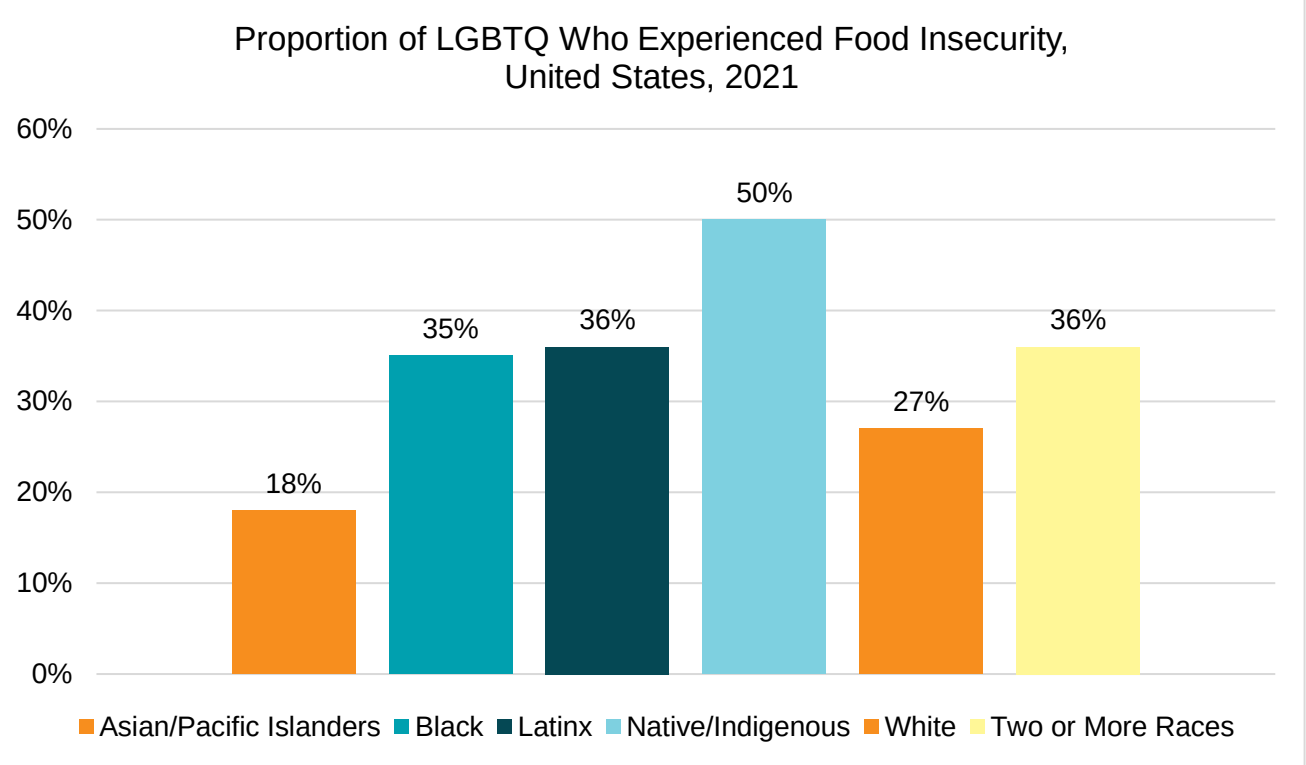


	2015	2016	2017	2018	2019
Martin County	12.9%	12.2%	11.3%	11.2%	10.3%
Florida	15.1%	13.9%	13.4%	13.0%	12.0%

Source: Feeding America, Map the Meal Gap, 2020

[129] Frongillo, E.A. & Bernal, J. (2014). Understanding the coexistence of food insecurity and obesity. *Current Pediatrics Report.* 2: 284-290.

Currently, there is no county or state-level food insecurity data among LGBTQ+ residents. However, the Trevor Project 2021 National Survey on LGBTQ Youth Mental Health assessed mental health and associated factors, including food insecurity, among **LGBTQ youth** in the United States. The survey found that 30% of LGBTQ youth experienced food insecurity in the past month, including 50% of all Native/Indigenous LGBTQ youth. Moreover, 27% of LGBTQ youth reported worrying that food at home would run out in the past month before they or their family had the ability to purchase more, and 19% said that, in the last month, they were hungry but couldn't eat because there wasn't enough food.[130]



Source: Trevor Project. National Survey on LGBTQ Youth Mental Health, 2021

[130] Trevor Project. 2021 National Survey on LGBTQ Youth Mental Health. Retrieved from: https://www.thetrevorproject.org/survey-2021/?section=FoodInsecurity

Child Opportunity Index

The Child Opportunity Index 2.0 (COI 2.0) measures neighborhood resources and conditions that impact child development and is based on indicators in education, health and environment, and social and economic domains.[131] Between 2010 and 2015, census tracts in Martin County ranged from Very Low to Very High. Most recently in 2015, the census tracts with a COI 2.0 score of Very Low were census tracts 5.01, 8, 10, and 12. Alternatively, the census tracts with a COI 2.0 score of Very High included census tracts 2, 5.02, 6.03, 6.04, 6.07, 6.10, 11.03, 14.06, 15, 16.01, and 16.02. The Martin County Health Equity Taskforce is committed to improving neighborhood resources and conditions for children through the PACE-EH community project in Indiantown.

Child Opportunity Index 2.0, Martin County, 2010, 2015		
Census Tract	**2010**	**2015**
1	80 (high)	63 (High)
2	67 (High)	84 (Very High)
3	49 (Moderate)	67 (High)
4	72 (High)	68 (High)
5.01	47 (Moderate)	17 (Very Low)
5.02	90 (Very High)	91 (Very High)
6.03	84 (Very High)	91 (Very High)
6.04	93 (Very High)	95 (Very High)
6.06	82 (Very High)	80 (High)
6.07	74 (High)	87 (Very High)
6.10	84 (Very High)	85 (Very High)

[131] diversitydatakids.org. 2022. “Child Opportunity Index 2.0 database”, retrieved from https://data.diversitydatakids.org/dataset/coi20-child-opportunity-index-2-0-database?_external=True on Jun 07 2022.

7.01	-	-
7.02	-	-
8	14 (Very Low)	20 (Very Low)
9.01	47 (Moderate)	77 (High)
9.02	44 (Moderate)	51 (Moderate)
10	9 (Very Low)	19 (Very Low)
11.03	71 (High)	87 (Very High)
11.05	-	-
11.06	-	-
11.07	-	-
11.08	-	-
12	20 (Very Low)	16 (Very Low)
13.01	49 (Moderate)	35 (Low)
13.02	80 (High)	62 (High)
14.04	49 (Moderate)	76 (High)
14.06	86 (Very High)	85 (Very High)
14.07	25 (Low)	65 (High)
14.08	22 (Low)	30 (Low)
14.09	51 (Moderate)	72 (High)
14.10	74 (High)	42 (Moderate)
15	91 (Very High)	90 (Very High)
16.01	76 (High)	96 (Very High)
16.02	90 (Very High)	88 (Very High)

17.01	-	-
17.02	-	-
17.03	-	-
18.03	-	-
18.04	-	-
18.05	-	-
18.06	-	-

Source: Diversity Data Kids, Child Opportunity Index 2.0 Index Data, 2022

Social Associations

The table below shows the rate of social associations in both Martin County and Florida in 2019. Social support and networks greatly improve both health outcomes and quality of life, whereas social isolation and the lack of community involvement are both associated with increased morbidity and early mortality.[132] In addition, social support is a predictor of health behaviors, with those who are socially connected being more likely to engage in active and healthy lifestyles, compared to those with minimal social support. Evidence also demonstrates that individuals who are engaged in voluntary groups or organizations experience higher levels of social trust, as they are more likely to trust others within the same group or organization, thereby engaging in similar health behaviors. In 2019, Martin County had a social association rate (9.8 per 10,000 population) 1.4 times higher than Florida (7.0 per 10,000 population).

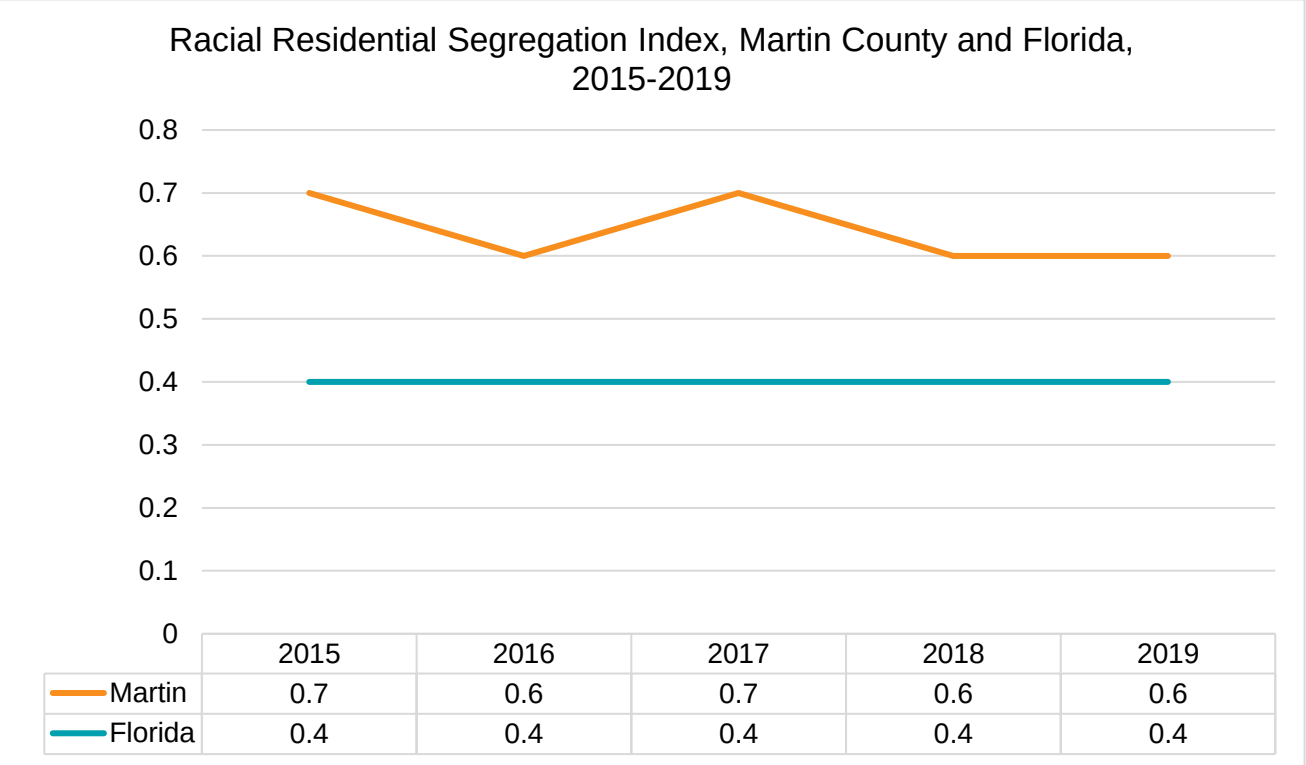
Social Associations, Rate Per 10,000 Population, Martin County and Florida, 2019		
Indicator	**Martin County**	**Florida**
Rate of Social Associations	9.8	7.0

Source: County Healthy Rankings, County Business Patterns, 2019

[132] Robert Wood Johnson Foundation. (2022). County Health Rankings: Social Associations. Retrieved from: https://www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model/health-factors/social-and-economic-factors/family-social-support/social-associations

Racial Residential Segregation

The figure below shows racial residential segregation index in Martin County. The racial residential segregation index ranges from 0.0 to 1.0, with 1.0 indicating maximum segregation.[133] Segregation is also correlated with higher mortality. Between 2015 and 2019, Martin County had a higher racial residential segregation index, ranging from 0.6 to 0.7, while the state of Florida remained constant at 0.4. Evidence shows that Black and Hispanic residents in areas with high dissimilarity, segregation, concentration, and isolation levels are more likely to be obese.[134] As such, the Martin County Health Equity Taskforce will consider future community projects aimed to directly increase racial integration.



	2015	2016	2017	2018	2019
Martin	0.7	0.6	0.7	0.6	0.6
Florida	0.4	0.4	0.4	0.4	0.4

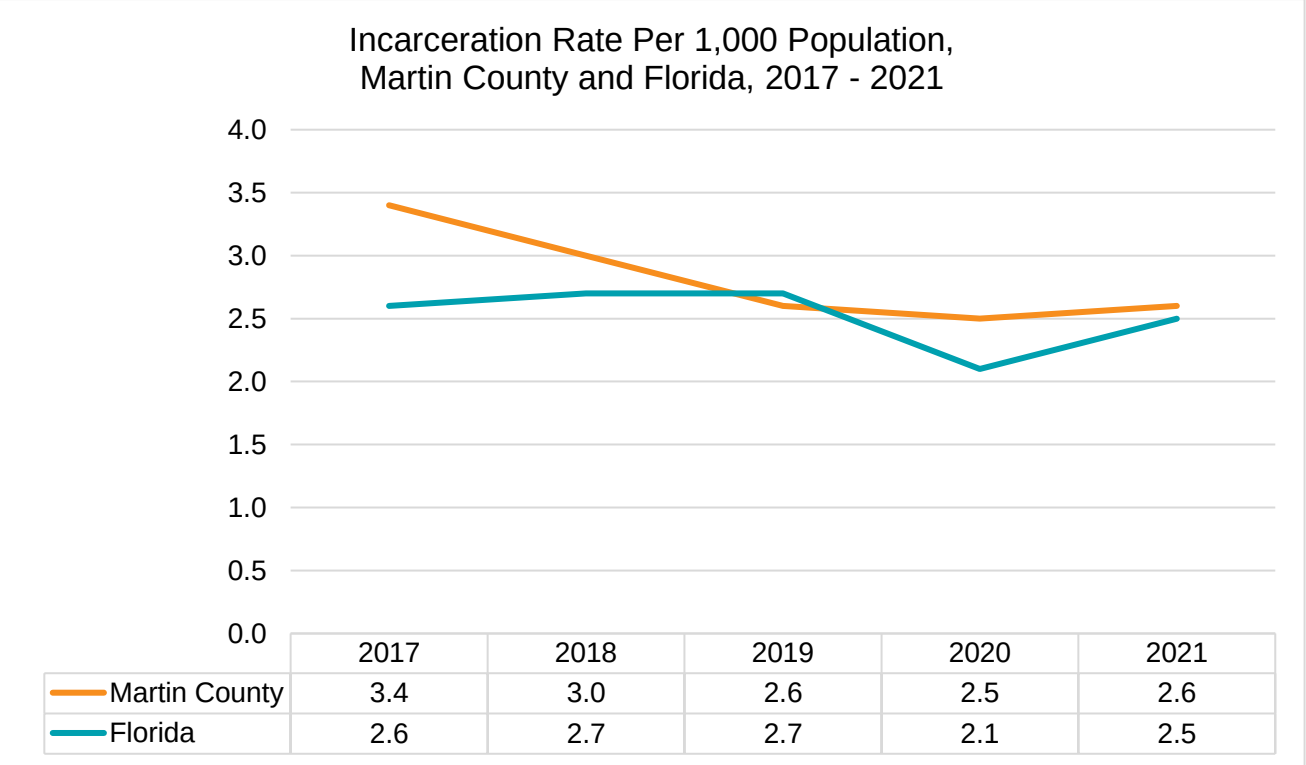
Source: US Census Bureau, American Community Survey, Table B02001

[133] United States Census. Housing Patterns: Appendix B: Measures of Residential Segregation Measures of Residential Segregation. https://www.census.gov/topics/housing/housing-patterns/guidance/appendix-b.html

[134] Yu, C., Woo, A., et al. (2017). The impacts of residential segregation on obesity. *Journal of Physical Activity and Health.* 15(11): 834-839.

Incarceration

The figure below shows the incarceration rate per 1,000 population in Martin County and Florida from 2017 to 2021. Martin County had a higher incarceration rate than the state for most years, with the exception of 2019. In the county, the rate decreased from 2017 to 2020, and then increased slightly in 2021; however, Florida experienced more fluctuation, with a slight increase from 2017 to 2019, followed by a decrease in 2020, to an increase again in 2021. Most recently in 2021, Martin County's incarceration rate was 2.6 per 1,000 population, compared to the state's rate of 2.5 per 1,000 population. One study conducted in the east south-central region in the United States found that prison populations gained weight during their incarceration.[135]



	2017	2018	2019	2020	2021
Martin County	3.4	3.0	2.6	2.5	2.6
Florida	2.6	2.7	2.7	2.1	2.5

Source: Florida Department of Corrections, 2021

[135] Gates, M.L. & Bradford, R.K. (2015). The Impact of Incarceration on Obesity: Are Prisoners with Chronic Diseases Becoming Overweight and Obese during Their Confinement? *Journal of Obesity.* 2015.

LGBTQ+ Social Experiences

Currently, there is no county or state-level data on LGBTQ+ residents available, but the Trevor Project 2021 National Survey assessed LGBTQ Youth Mental Health among youth 13 to 24 years old. Nationally, 75% of LGBTQ youth aged 13 to 24 years ever experienced discrimination based on their sexual orientation or gender identity, 88% reported social media negatively impacted their well-being, only 33% lived in an LGBTQ-affirming home, and 48% stated that they wanted mental health care but couldn't get it. However, 96% also stated that social media has positively impacted their well-being.[136]

National Survey on LGBTQ Youth Mental Health, United Stated, 2021	
Experiences	**Proportion of LGBTQ Youth with Experience**
Discrimination Based on Sexual Orientation or Gender Identity	75%
Live in an LGBTQ-Affirming Home	33%
Social Media has Positively Impacted Well-Being	96%
Social Media has Negatively Impacted Well-Begin	88%
Wanted Mental Health Care but Could Not Get It	48%

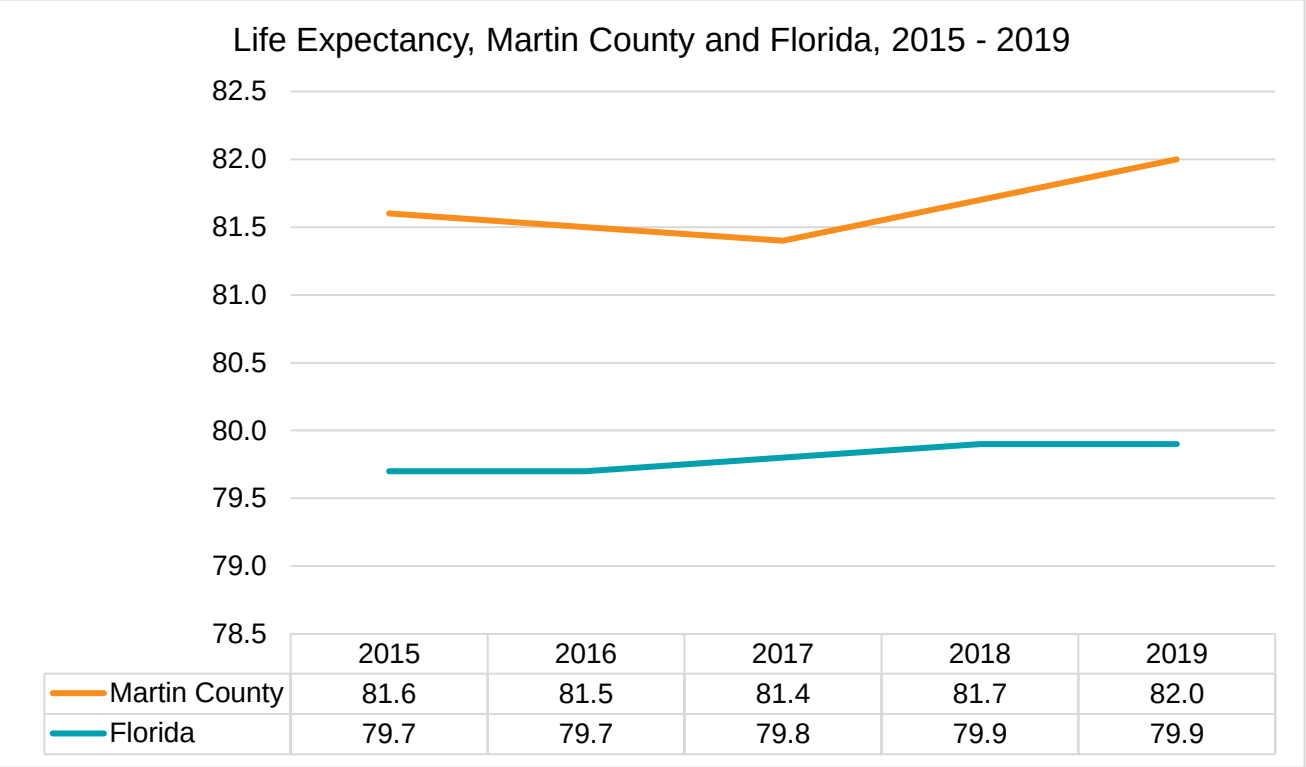
Source: Trevor Project. National Survey on LGBTQ Youth Mental Health, 2021

Also, the 2019 BRFSS Survey in Florida found that 30.1% of the LGBTQ population experience stress (tense, restless, nervous, anxious, or unable to sleep) in comparison to 11.7% of the Straight population.

[136] Trevor Project. 2021 National Survey on LGBTQ Youth Mental Health. Retrieved from: https://www.thetrevorproject.org/survey-2021/?section=FindingSupport

Life Expectancy

The figure below shows life expectancy in years for Martin County and Florida from 2015 to 2019. Life expectancy is a theoretical estimate of the average number of years that a person is expected to live from birth, based on current death rates by age group. Importantly, the estimate may change based on the number of residents who migrate to and from a geographical location, aging, and death rate changes. From 2015 to 2019, Martin County had consistently higher life expectancy than the state. Most recently in 2019, the life expectancy in Martin County was 82 years, compared to the life expectancy of 79.9 years in Florida. Evidence shows that obesity substantially reduces life expectancy, which further explains the Martin County Health Equity Taskforce priority to reduce obesity in Martin County.[137]



	2015	2016	2017	2018	2019
Martin County	81.6	81.5	81.4	81.7	82.0
Florida	79.7	79.7	79.8	79.9	79.9

Source: Death data are from Florida Bureau of Vital Statistics. Population data are from the UMass Donahue Institute and the Florida Legislature Office of Economic and Demographic Research.

[137] National Institute of Health (2020). Extreme obesity shaves years of life expectancy. Retrieved from: https://irp.nih.gov/blog/post/2020/01/extreme-obesity-shaves-years-off-life-expectancy

The Impact of Social and Community Context on Obesity in Martin County

The Martin County Health Equity Taskforce discussed how Social and Community Context impact overweight status and obesity in Martin County. Discussion points are included below.

Social and Community Context		
SDOH	**Priority Populations Impacted**	**How the SDOH Impacts Obesity**
Safety	Black and Hispanic residents; low-income residents	Evidence shows that exposure to violence and less safe neighborhoods in early childhood is associated with increased risk for obesity
Food Insecurity	Black and Hispanic residents; low-income residents	Children who experience food insecurity without hunger are much more likely to be obese compared to their food secure peers. Food insecurity is associated with adverse health outcomes among both children and adults due to social disruption, poor dietary intake, and less physical activity.
Social Support and Networks	Low-income residents with less access to social associations	Social support and networks greatly improve both health outcomes and quality of life, whereas social isolation and the lack of community involvement are both associated with increased morbidity and early mortality. In addition, social support is a predictor of health behaviors, with those who are socially connected being more likely to engage in active and healthy lifestyles, compared to those with minimal social support. Evidence also demonstrates that individuals who are engaged in voluntary groups or organizations experience higher levels of social trust, as they are more likely to trust others within the same group or organization, thereby engaging in similar health behaviors.
Racial Segregation	Black and Hispanic residents	Members discussed racial segregation, urban planning issues, and intentional redlining and zoning, which contributes to health disparities due to differences in access to important resources.
Household Context	Hispanic and Black children and families	Children of single-parent households are at higher risk for obesity due to reduced homemade meals, less family meal time, and less physical activity.
Life Expectancy	Black and Hispanic residents	Members mentioned that some neighborhoods do not have the same resources and access to health care services, leading to poorer health outcomes, decreased life expectancy, and an increase in obesity.
Incarceration	Black and Hispanic residents; communities of color	Members highlighted the knowledge on the stark disparities on incarceration rates with much higher rates among Black and Hispanic residents compared to their White and Non-Hispanic counterparts. These disparities contribute to differences in opportunity, wealth, freedom, access and poorer health outcomes. Moreover, one study found that prison populations gained weight during their incarceration

E. Health Care Access & Quality

Health Care Access and Quality Data for Martin County

Health care access and quality plays a direct role in health outcomes and quality of life, as high quality and timely screenings and care can make all the difference. Those who do not have health insurance are less likely to attend regular primary care visits, receive preventive care and timely diagnoses, have the ability to pay for health care services, and afford necessary treatment.[138] Moreover, those in more rural communities may have a harder time accessing services due to proximity and transportation barriers related to access in-person care and limited broadband access for accessing telehealth services. Additionally, with respect to obesity prevention and treatment, medical providers may experience challenges due to limited training in obesity management and weight loss strategies, adding an additional barrier to people receiving effective interventions.[139] The following data explores health care access and quality in Martin County. To note, considerable efforts were made to find all of the following information related to health care access and quality among priority populations, including Black or African Americans, American Indian and Alaska Natives, Asians, Native Hawaiians, Hispanic and Latinos, elders, infants and toddlers, people living with disabilities, veterans, people identifying as LGBTQ+, and immigrants. Research shows these populations experience health inequities at higher rates. However, data was unavailable for these populations in several instances.

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[138] US Department of Health and Human Services. Healthy People 2030: Health Care Access and Quality. Retrieved from: https://health.gov/healthypeople/objectives-and-data/browse-objectives/health-care-access-and-quality

[139] Frood, S., Johnston, L.M, et al. (2013). Obesity, complexity, and the role of the health system. *Current Obesity Reports.* 2: 320-326.

Health Insurance Coverage

The table below shows health insurance coverage status by census tract in Martin County in 2020. Across the county, most census tracts had a high proportion of residents with health insurance coverage, although there were several where the proportion of residents with no health insurance coverage exceeded 20%. The census tracts with the highest proportion of residents with no health insurance coverage were 18.06 (37.4%), 5.01 (25.9%), 18.05 (22.3%), and 18.04 (21.4%). Lack of health insurance coverage has broad consequences on children and families in America, including unmet needs, delayed care, and lack of preventative screenings.[140] This may lead to children and families not knowing about their overweight and obese status and not receiving important mitigation options, nutritional counseling and self-management techniques. The Martin County Health Equity Taskforce acknowledges this as important point of intervention and will consider future community projects aimed at addressing the lack of coverage in certain communities.

Health Insurance Coverage Status by Census Tract, Martin County, 2020		
Census Tract	**With Health Insurance Coverage**	**No Health Insurance Coverage**
1	98.6%	1.4%
2	88.4%	11.6%
3	93.4%	6.6%
4	92.2%	7.8%
5.01	74.1%	25.9%
5.02	98.3%	1.7%
6.03	94.5%	5.5%
6.04	94.7%	5.3%
6.06	95.5%	4.5%
6.07	95.2%	4.8%
6.10	98.5%	1.5%
7.01	94.3%	5.7%
7.02	95.9%	4.1%
8	89.2%	10.8%
9.01	96.8%	3.2%

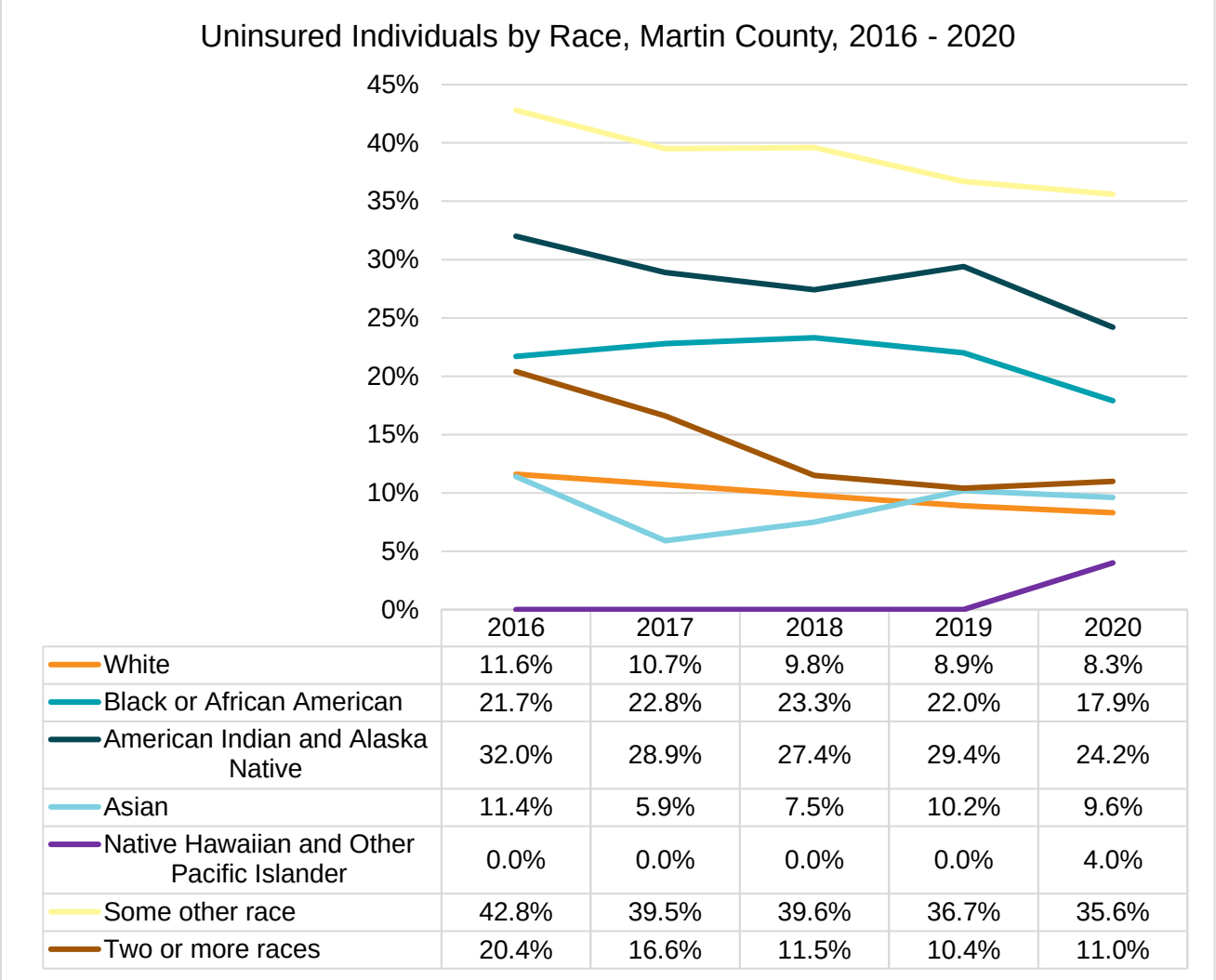
[140] Lave, J.R., Keane, C.R., et al. (1998). The impact of lack of health insurance on children. *Journal of Health and Social Policy.* 10(2): 57-73.

9.02	92.2%	7.8%
10	90.7%	9.3%
11.03	97.8%	2.2%
11.05	89.9%	10.1%
11.06	85.8%	14.2%
11.07	89.1%	10.9%
11.08	94.8%	5.2%
12	72.5%	27.5%
13.01	81.5%	18.5%
13.02	91.4%	8.6%
14.04	90.9%	9.1%
14.06	93%	7%
14.07	94.8%	5.2%
14.08	82.4%	17.6%
14.09	96.6%	3.4%
14.10	89.7%	10.3%
15	94.7%	5.3%
16.01	95.4%	4.6%
16.02	94.8%	5.2%
17.01	88.2%	11.8%
17.02	88.7%	11.3%
17.03	90.3%	9.7%
18.03	76%	24%
18.04	78.7%	21.3%
18.05	77.7%	22.3%
18.06	62.6%	37.4%

Source: United States Bureau of the Census, American Community Survey, Table DP03.

The figure on the following page shows the proportion of uninsured individuals by **race** in Martin County from 2016 to 2020. Each year, residents who identified as some other race accounted for the highest proportions of uninsured residents, followed by American Indian and Alaska Native residents and Black or African American residents. On the contrary, Native Hawaiian and Other Pacific Islander residents, White residents, and Asian residents accounted for the lowest proportion of uninsured residents. Most recently in 2020, 35.6% of residents of some other race were uninsured, followed by 24.2% of American Indian and Alaska Native residents and 17.9% of Black or African American residents, compared to 4% of Native Hawaiian and Other Pacific Islander residents, 8.3% of White residents, 9.6% of Asian residents, and 11% of residents who identify as two or more races. As previously mentioned, the lack of health insurance coverage has broad consequences on children and families in America, including unmet needs, delayed care, and lack of preventative screenings.[141] This may lead to children and families not knowing about their overweight and obese status and not receiving important mitigation options, nutritional counseling and self-management techniques. The Martin County Health Equity Taskforce acknowledges this as important point of intervention and will consider future community projects aimed at addressing the lack of coverage in certain communities.

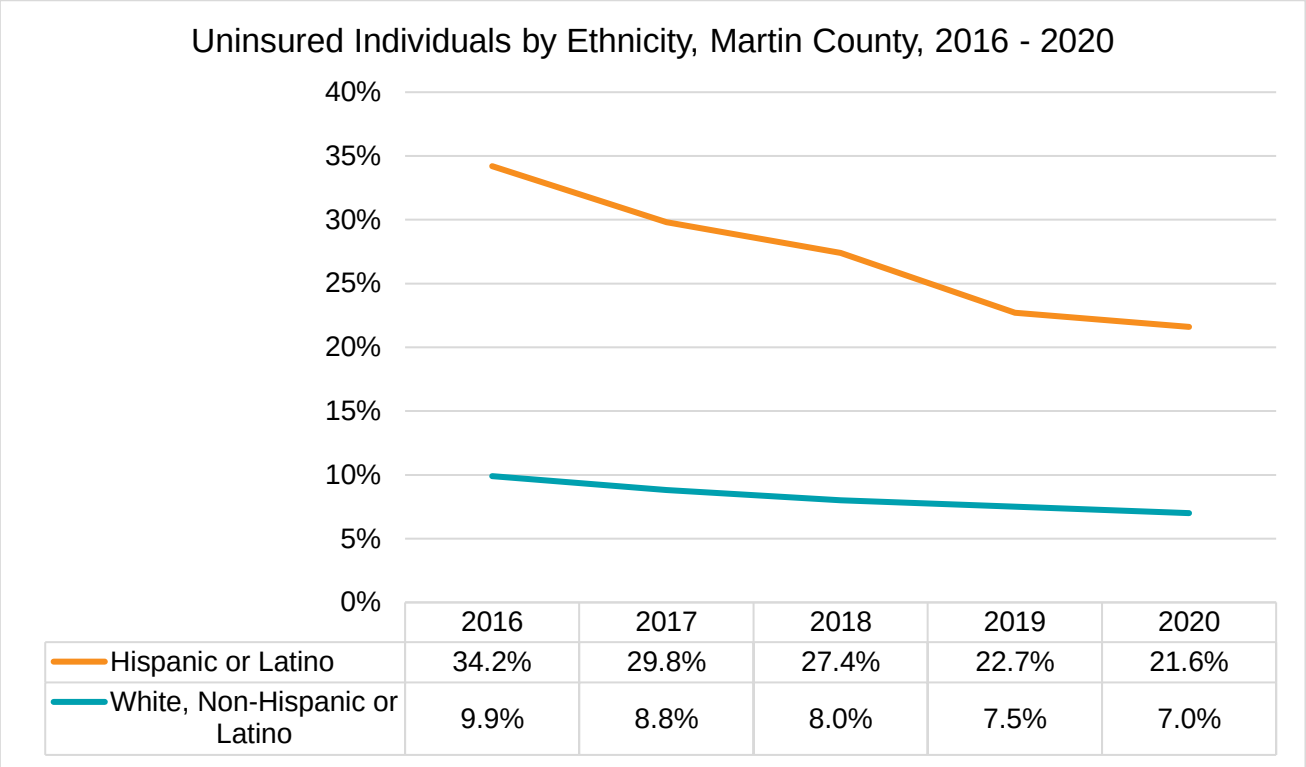
[141] Lave, J.R., Keane, C.R., et al. (1998). The impact of lack of health insurance on children. *Journal of Health and Social Policy.* 10(2): 57-73.



	2016	2017	2018	2019	2020
White	11.6%	10.7%	9.8%	8.9%	8.3%
Black or African American	21.7%	22.8%	23.3%	22.0%	17.9%
American Indian and Alaska Native	32.0%	28.9%	27.4%	29.4%	24.2%
Asian	11.4%	5.9%	7.5%	10.2%	9.6%
Native Hawaiian and Other Pacific Islander	0.0%	0.0%	0.0%	0.0%	4.0%
Some other race	42.8%	39.5%	39.6%	36.7%	35.6%
Two or more races	20.4%	16.6%	11.5%	10.4%	11.0%

Source: United States Bureau of the Census, American Community Survey, Table S2701.

The figure below shows the proportion of uninsured individuals by **ethnicity** in Martin County from 2016 to 2020. Each year, a higher proportion of Hispanic residents were uninsured compared to White non-Hispanic residents, though the proportion decreased over time. Most recently in 2020, the proportion of Hispanic residents who were uninsured (21.6%) was just over three times higher than the proportion of uninsured White non-Hispanic residents (7%). As previously mentioned, the lack of health insurance coverage has broad consequences on children and families, including unmet needs, delayed care, and lack of preventative screenings.[142] This may lead to children and families not knowing about their overweight and obese status and not receiving important mitigation options, such as nutritional counseling and self-management techniques. The Martin County Health Equity Taskforce acknowledges this as important point of intervention and will consider future community projects aimed at addressing the lack of coverage in certain communities.



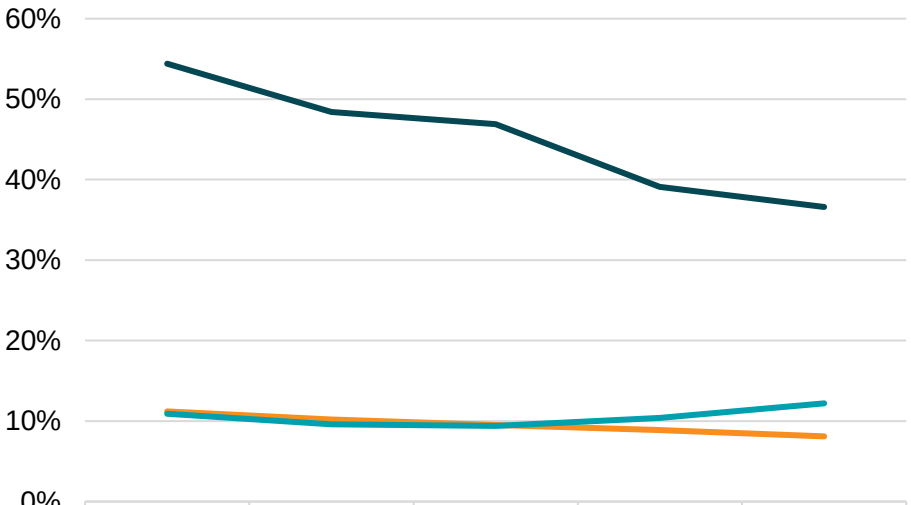
	2016	2017	2018	2019	2020
Hispanic or Latino	34.2%	29.8%	27.4%	22.7%	21.6%
White, Non-Hispanic or Latino	9.9%	8.8%	8.0%	7.5%	7.0%

Source: United States Bureau of the Census, American Community Survey, Table S2701.

[142] Lave, J.R., Keane, C.R., et al. (1998). The impact of lack of health insurance on children. *Journal of Health and Social Policy.* 10(2): 57-73.

The figure below shows the proportion of uninsured individuals by **nativity** in Martin County from 2016 to 2020. There was a consistently and substantially higher proportion of uninsured foreign-born residents who were not citizens that were uninsured during this timeframe, though the proportion decreased over time. Native-born and foreign-born naturalized residents had similar lower proportions from 2016 to 2018, but the proportion increased in 2019 and 2020 among foreign-born naturalized residents. Most recently in 2020, the proportion of uninsured foreign-born residents who were not citizens (36.6%) was three times higher than the proportion of uninsured foreign-born naturalized residents (12.2%) and 4.5 times higher than native-born residents (8.1%). As previously mentioned, the lack of health insurance coverage has broad consequences on children and families in America, including unmet needs, delayed care, and lack of preventative screenings.[143] This may lead to children and families not knowing about their overweight and obese status and not receiving important mitigation options, such as nutritional counseling and self-management techniques. The Martin County Health Equity Taskforce acknowledges this as important point of intervention and will consider future community projects aimed at addressing the lack of coverage in certain communities.

Uninsured Individuals by Nativity, Martin County, 2016 - 2020



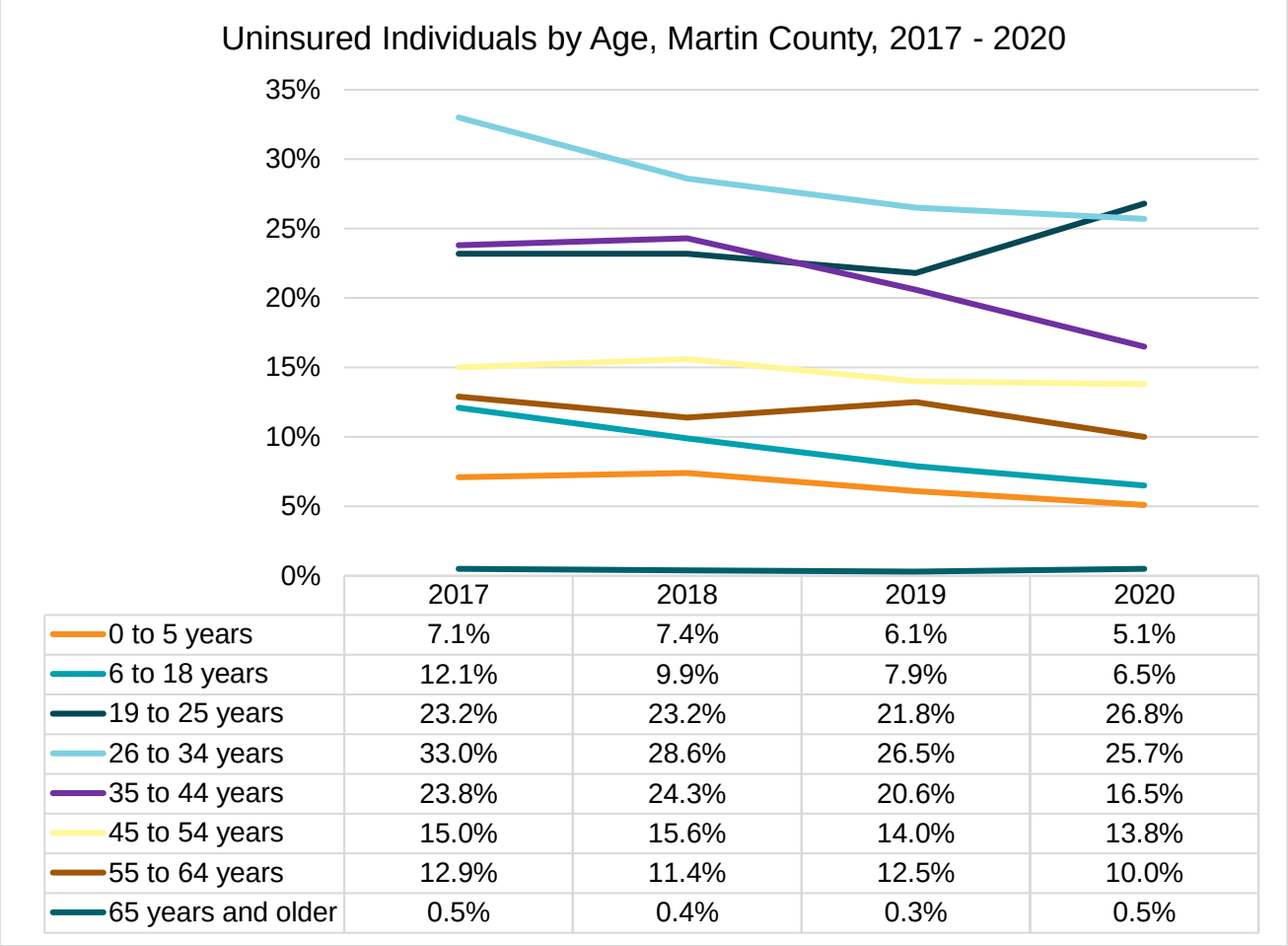
	2016	2017	2018	2019	2020
Native Born	11.2%	10.2%	9.5%	8.9%	8.1%
Foreign Born, Naturalized	10.9%	9.6%	9.4%	10.4%	12.2%
Foreign Born, Not a Citizen	54.4%	48.4%	46.9%	39.1%	36.6%

Source: United States Bureau of the Census, American Community Survey, Table S2701.

[143] Lave, J.R., Keane, C.R., et al. (1998). The impact of lack of health insurance on children. *Journal of Health and Social Policy.* 10(2): 57-73.

The figure on the following page shows the proportion of uninsured individuals by **age** in Martin County from 2016 to 2020. Individuals aged 26 to 34 years old accounted for higher proportions of uninsured residents from 2017 to 2019 but, in 2020, individuals aged 19 to 25 years old accounted for the highest proportion. Residents aged 65 years and older consistently account for the lowest proportions, followed by those aged 0 to 5 years old. Most recently in 2020, 26.8% of residents aged 19 to 25 years old were uninsured, followed by 25.7% of 26 to 34-year-old residents, 16.5% of 35 to 44-year-old residents, 13.8% of 45 to 54-year-old residents, 10% of 55 to 64-year-old residents, 6.5% of 6 to 18-year-old residents, 5.1% of 0 to 5-year-old residents, and, finally, 0.5% of residents aged 65 and over. As previously mentioned, the lack of health insurance coverage has broad consequences on children and families, including unmet needs, delayed care, and lack of preventative screenings.[144] This may lead to children and families not knowing about their overweight and obese status and not receiving important mitigation options, such as nutritional counseling and self-management techniques. The Martin County Health Equity Taskforce acknowledges this as important point of intervention and will consider future community projects aimed at addressing the lack of coverage in certain communities.

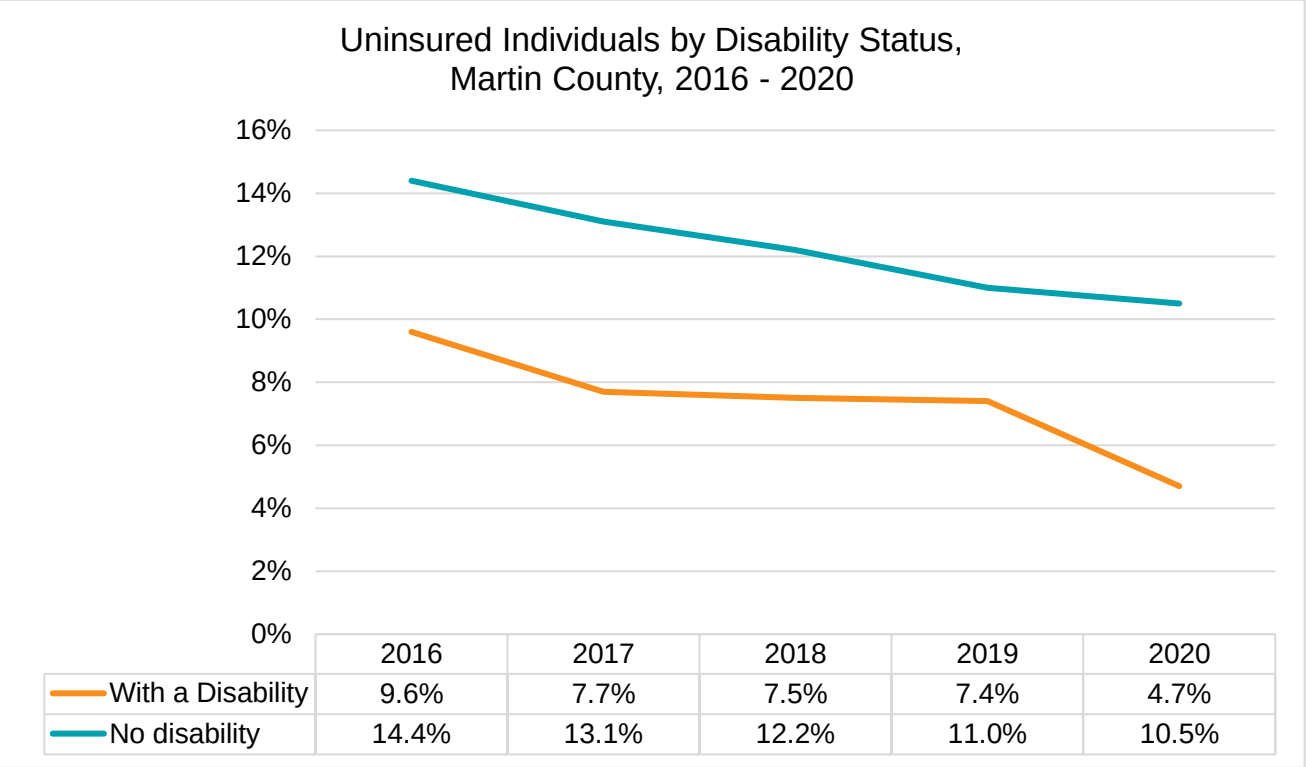
[144] Lave, J.R., Keane, C.R., et al. (1998). The impact of lack of health insurance on children. *Journal of Health and Social Policy.* 10(2): 57-73.



	2017	2018	2019	2020
0 to 5 years	7.1%	7.4%	6.1%	5.1%
6 to 18 years	12.1%	9.9%	7.9%	6.5%
19 to 25 years	23.2%	23.2%	21.8%	26.8%
26 to 34 years	33.0%	28.6%	26.5%	25.7%
35 to 44 years	23.8%	24.3%	20.6%	16.5%
45 to 54 years	15.0%	15.6%	14.0%	13.8%
55 to 64 years	12.9%	11.4%	12.5%	10.0%
65 years and older	0.5%	0.4%	0.3%	0.5%

Source: United States Bureau of the Census, American Community Survey, Table S2701.

The figure below shows the proportion of uninsured individuals by **disability status** in Martin County from 2016 to 2020. Individuals with no disability accounted for consistently higher proportions of uninsured individuals compared to individuals with a disability, though the proportion declined among both groups over time. Most recently in 2020, 10.5% of residents with no disability were uninsured, compared to 4.7% of individuals with a disability. As previously mentioned, the lack of health insurance coverage has broad consequences, including unmet needs, delayed care, and lack of preventative screenings.[145] This may lead to residents not knowing about their overweight and obese status and not receiving important mitigation options, nutritional counseling and self-management techniques. The Martin County Health Equity Taskforce acknowledges this as important point of intervention and will consider future community projects aimed at addressing the lack of coverage in certain communities.



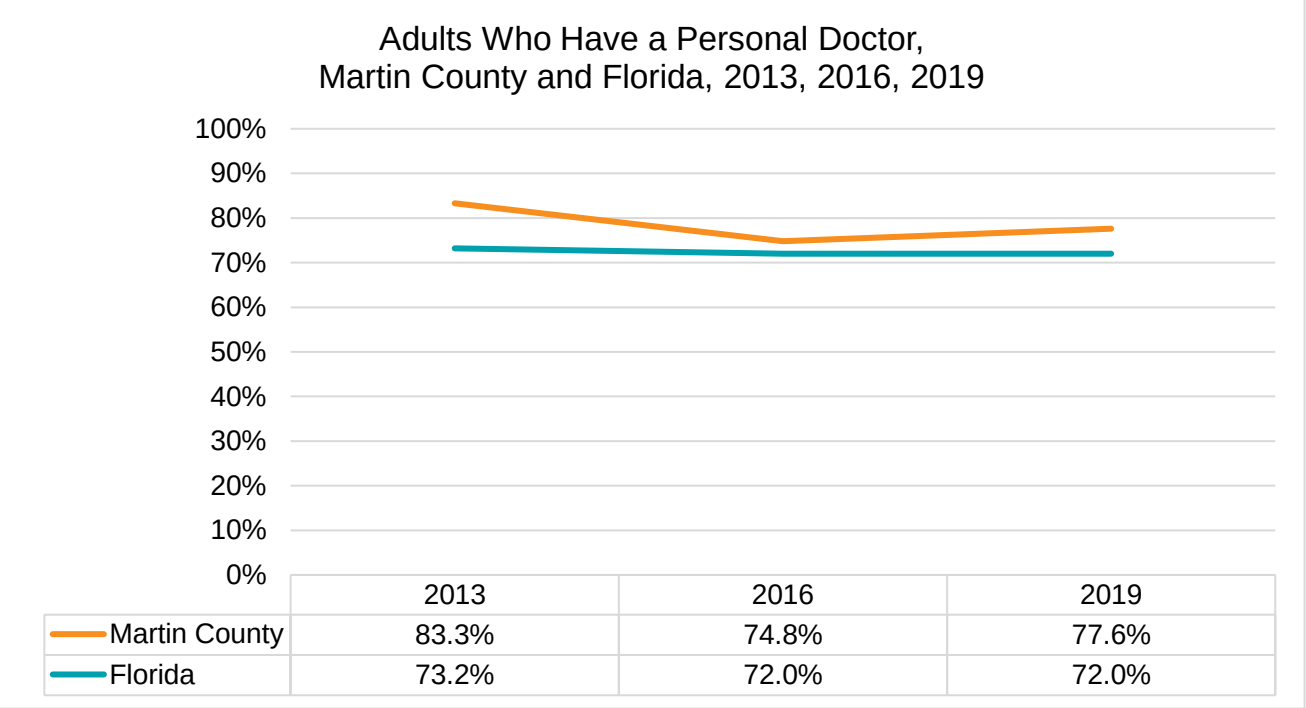
	2016	2017	2018	2019	2020
With a Disability	9.6%	7.7%	7.5%	7.4%	4.7%
No disability	14.4%	13.1%	12.2%	11.0%	10.5%

Source: United States Bureau of the Census, American Community Survey, Table S2701.

[145] Lave, J.R., Keane, C.R., et al. (1998). The impact of lack of health insurance on children. *Journal of Health and Social Policy.* 10(2): 57-73.

Health Care Engagement

This figure shows the proportion of adults who have a personal doctor in **Martin County** and **Florida** in 2013, 2016, and 2019. One study showed that adults who receive regular care from a personal or family physician are more likely to receive preventative services, such as BMI and blood pressure checks.[146] These services could catch signs of overweight or obesity early, allowing physicians and patients the opportunity to work together to prevent either from progressing further or from comorbidities arising. The proportion of adults in Martin County who had a personal doctor was higher each year than the proportion of adults who had a personal doctor statewide. Most recently in 2019, 77.6% of adults in Martin County had a personal doctor, whereas 72.0% of adults in Florida had a personal doctor. Primary care visits are an important point of care for obesity diagnoses and obesity care and management plan development.[147] As such, the Martin County Health Equity Taskforce will consider future community projects aimed at improving access to primary care.

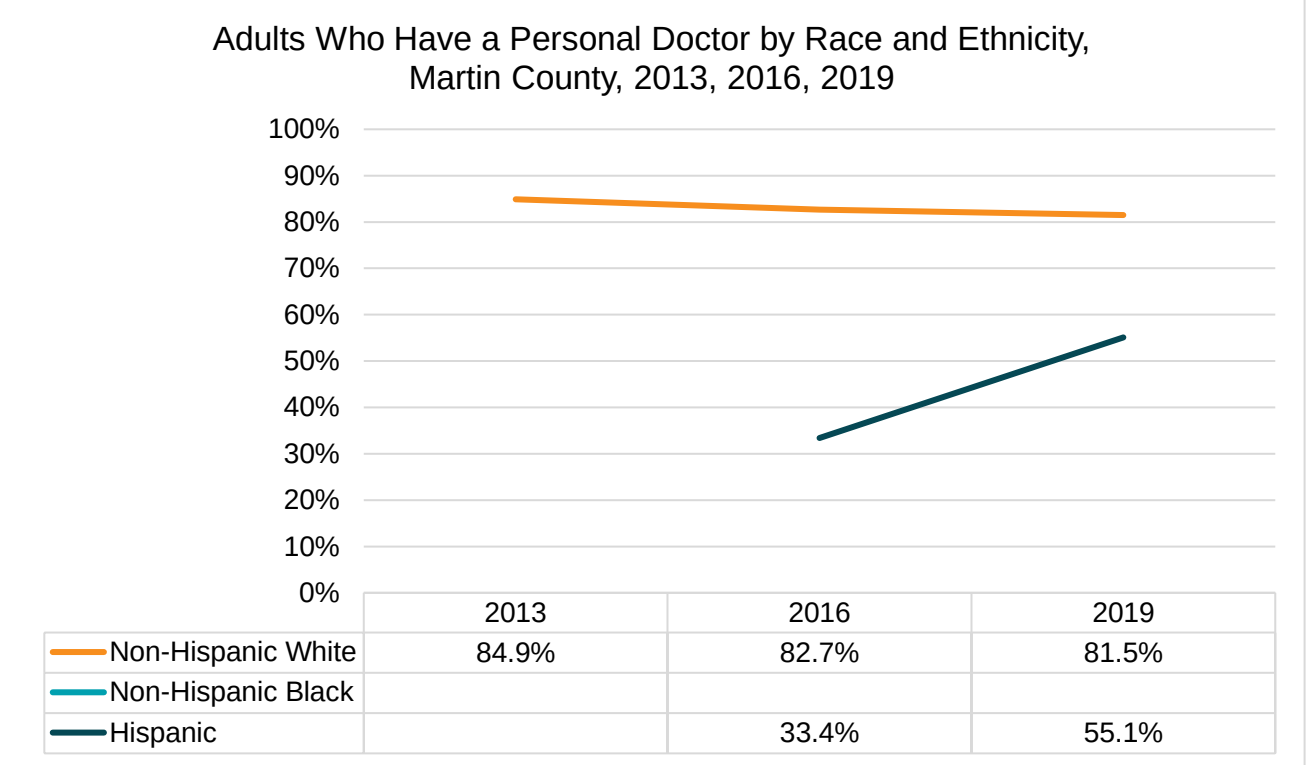


	2013	2016	2019
Martin County	83.3%	74.8%	77.6%
Florida	73.2%	72.0%	72.0%

Source: Florida Behavioral Risk Factor Surveillance System telephone survey conducted by the Centers for Disease Control and Prevention (CDC) and Florida Department of Health Division of Community Health Promotion.

[146] McIsaac, W., Fuller-Thomson, E., & Talbot, Y. (2001, January 1). Does having regular care by a family physician improve preventive care? Canadian Family Physician, 47(1), 70-76.
[147] Bardia, A., Holtan, S.G., et al. (2007). Diagnosis of obesity by primary care physicians and impact on obesity management. *Mayo Clinic Proceedings*. 82(8): 927-932.

The figure below shows adults who had a personal doctor in Martin County by **race** and **ethnicity** in 2013, 2016, and 2019. Unfortunately, data for non-Hispanic Black residents for all years included here and for Hispanic residents for 2013 was unavailable. Among non-Hispanic White residents, the proportion who had a personal doctor declined from 84.9% in 2013 to 81.5% in 2019. However, the proportion of Hispanic residents who had a personal doctor increased from 2016 (33.4%) to 2019 (55.1%). This could be due to the high proportion of Hispanic residents who are uninsured in Martin County, which limits access to affordable, routine medical care, delays needed care, and further exacerbates health issues, including overweight and obesity. As mentioned, primary care visits are an important point of care for obesity diagnoses and obesity care and management plan development.[148] As such, the Martin County Health Equity Taskforce will consider future community projects aimed at improving access to primary care among communities of color. In addition, the missing data among Black non-Hispanic residents will be addressed through the SDOH Screening Tool Community Project.

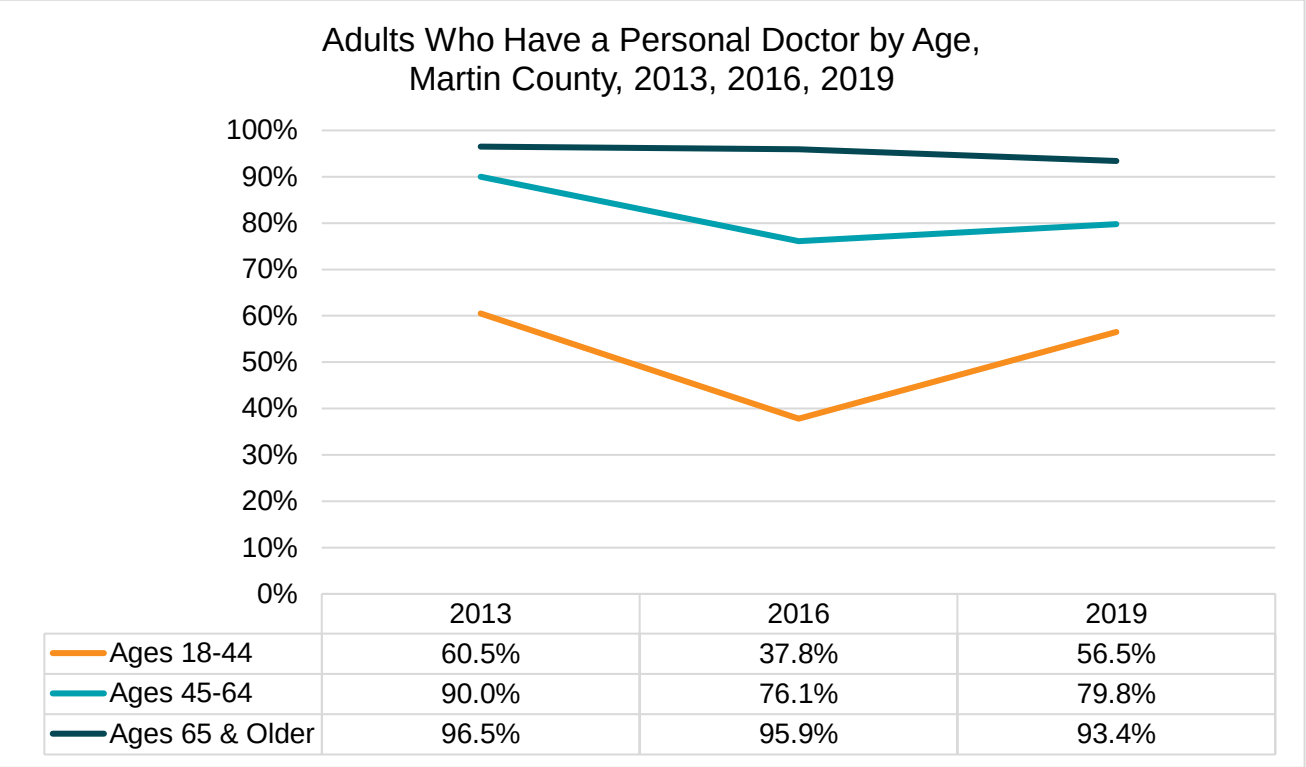


	2013	2016	2019
Non-Hispanic White	84.9%	82.7%	81.5%
Non-Hispanic Black			
Hispanic		33.4%	55.1%

Source: Florida Behavioral Risk Factor Surveillance System telephone survey conducted by the Centers for Disease Control and Prevention (CDC) and Florida Department of Health Division of Community Health Promotion.

[148] Bardia, A., Holtan, S.G., et al. (2007). Diagnosis of obesity by primary care physicians and impact on obesity management. *Mayo Clinic Proceedings*. 82(8): 927-932.

This figure shows the proportion of adults who have a personal doctor by **age** in Martin County in 2013, 2016, and 2019. During each of these years, the proportion of adults who had a personal doctor was the lowest among adults ages 18 to 44 compared to other age groups, with 60.5% in 2013, 37.8% in 2016 and 56.5% in 2019. Alternatively, the proportion was highest among adults ages 65 and older. However, this proportion gradually declined each year from 96.5% in 2013 to 93.4% in 2019. As mentioned, primary care visits are an important point of care for obesity diagnoses and obesity care and management plan development.[149] As such, the Martin County Health Equity Taskforce will consider future community projects aimed at improving access to primary care among younger adults.



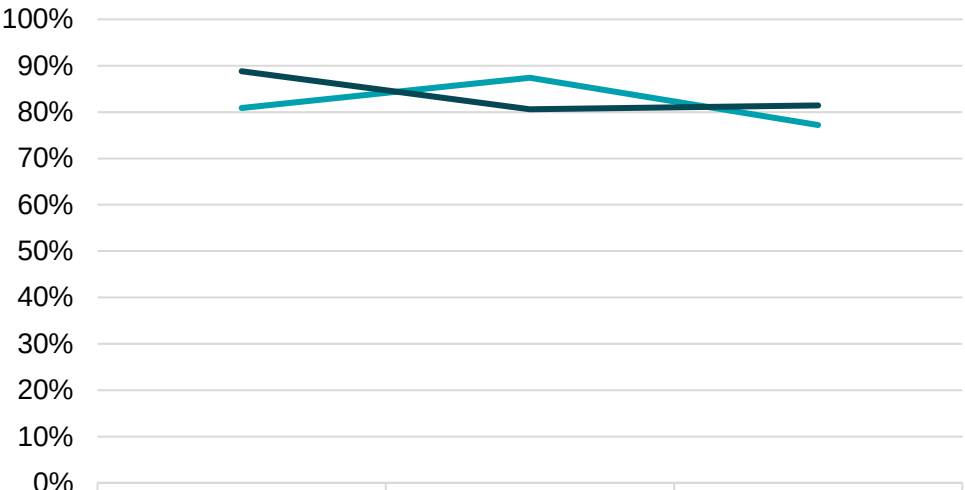
	2013	2016	2019
Ages 18-44	60.5%	37.8%	56.5%
Ages 45-64	90.0%	76.1%	79.8%
Ages 65 & Older	96.5%	95.9%	93.4%

Source: Florida Behavioral Risk Factor Surveillance System telephone survey conducted by the Centers for Disease Control and Prevention (CDC) and Florida Department of Health Division of Community Health Promotion.

[149] Bardia, A., Holtan, S.G., et al. (2007). Diagnosis of obesity by primary care physicians and impact on obesity management. *Mayo Clinic Proceedings*. 82(8): 927-932.

The figure below shows the proportion of adults how have a personal doctor by **education level** in Martin County in 2013, 2016, and 2019. Unfortunately, for both 2014 to 2016, there was no data for those with a less than high school education. For other groups, the proportion fluctuated over time. Most recently in 2019, 81.4% of those with more than a high school education had a personal doctor, compared to 77.2% of those with a high school degree or GED and 56% of those with less than high school education. As mentioned, primary care visits are an important point of care for obesity diagnoses and obesity care and management plan development.[150] As such, the Martin County Health Equity Taskforce will consider future community projects aimed at improving access to primary care. In addition, the missing data among those with less than high school education will be addressed through the SDOH Screening Tool Community Project.

Adults Who Have a Personal Doctor by Education Level, Martin County, 2013, 2016, 2019

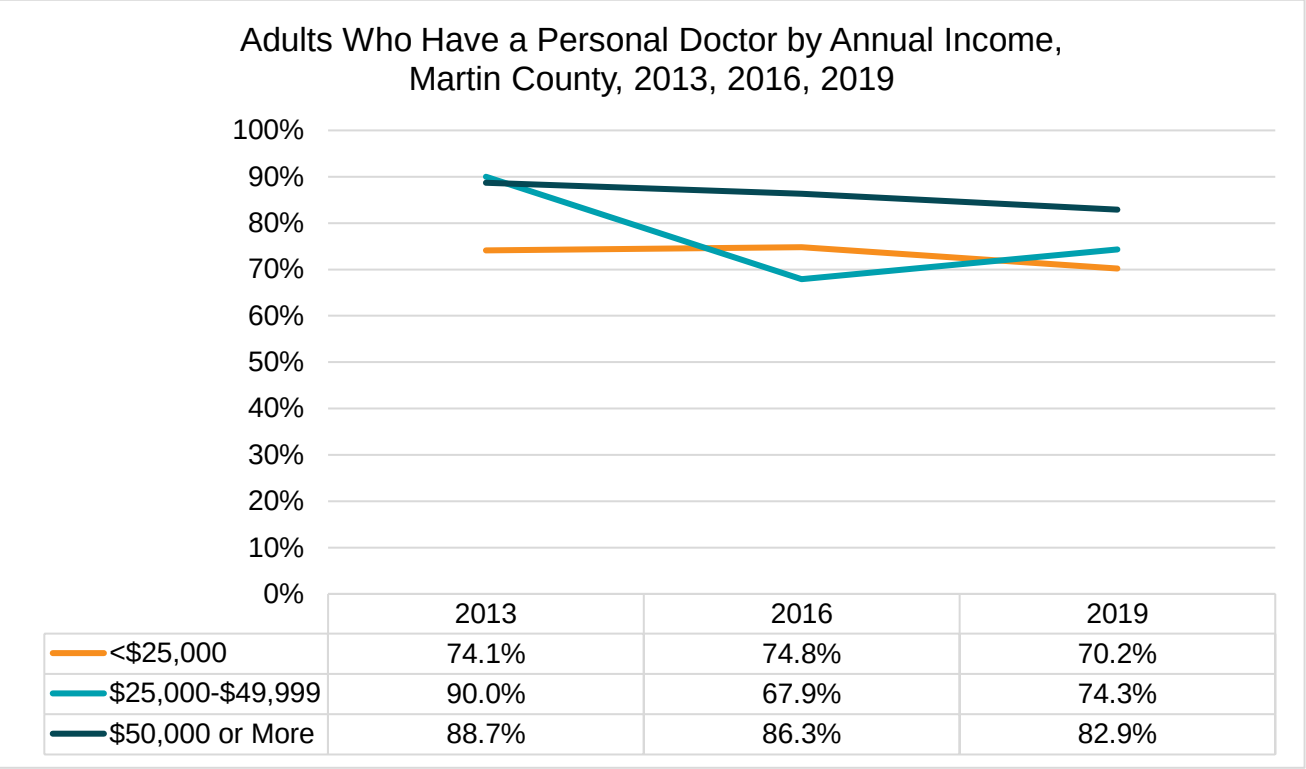


	2013	2016	2019
Less Than High School			56.0%
High School/GED	80.9%	87.4%	77.2%
More Than High School	88.8%	80.6%	81.4%

Source: Florida Behavioral Risk Factor Surveillance System telephone survey conducted by the Centers for Disease Control and Prevention (CDC) and Florida Department of Health Division of Community Health Promotion.

[150] Bardia, A., Holtan, S.G., et al. (2007). Diagnosis of obesity by primary care physicians and impact on obesity management. *Mayo Clinic Proceedings*. 82(8): 927-932.

The figure below shows the proportion of adults who have a personal doctor by **annual income** in Martin County in 2013, 2016, and 2019. Those with higher income accounted for higher proportions of those with a personal doctor, though there was fluctuation over time. Most recently in 2019, 82.9% of adults who made $50,000 or more had a personal doctor, compared to 74.3% of those who made $25,000 to $49,999 and 70.2% of those who made less than $25,000 in annual income. As mentioned, primary care visits are an important point of care for obesity diagnoses and obesity care and management plan development.[151] As such, the Martin County Health Equity Taskforce will consider future community projects aimed at improving access to primary care.



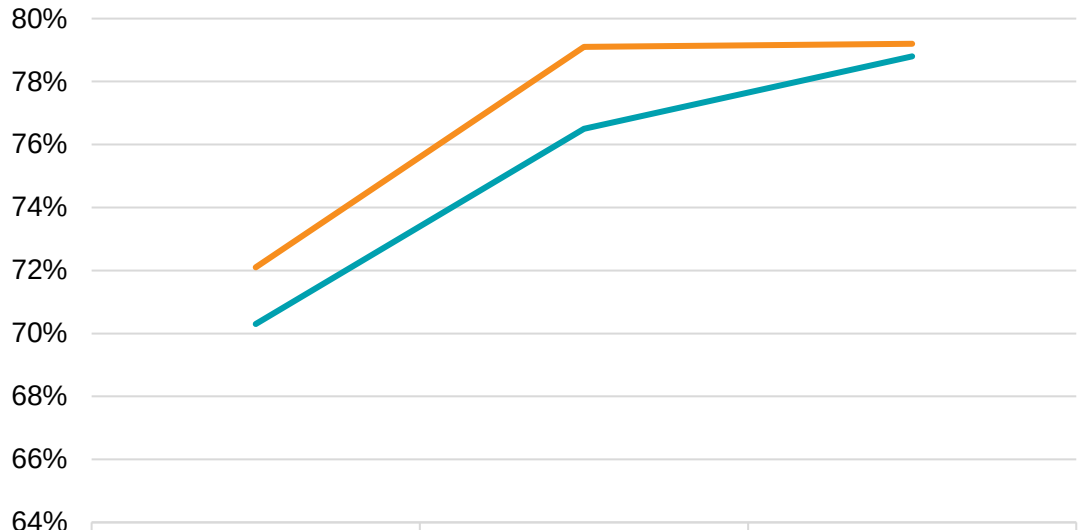
	2013	2016	2019
<$25,000	74.1%	74.8%	70.2%
$25,000-$49,999	90.0%	67.9%	74.3%
$50,000 or More	88.7%	86.3%	82.9%

Source: Florida Behavioral Risk Factor Surveillance System telephone survey conducted by the Centers for Disease Control and Prevention (CDC) and Florida Department of Health Division of Community Health Promotion.

[151] Bardia, A., Holtan, S.G., et al. (2007). Diagnosis of obesity by primary care physicians and impact on obesity management. *Mayo Clinic Proceedings*. 82(8): 927-932.

The figure below shows the proportion of adults who had a medical checkup in the past year in Martin County and Florida in 2013, 2016, and 2019. Consistently, a higher proportion of Martin County residents had a checkup in the past year than residents in the state overall, though the proportion increased for both over time. Most recently in 2019, 79.2% of Martin County residents had a medical checkup in the past year compared to 78.8% of Florida residents. Screening and diagnosis of obesity is essential to improving health status, with a study demonstrating those with overweight status or obesity who received a diagnosis being over two times more likely to attempt to lose weight.[152] Given that annual primary care visits are an essential point of care, the Martin County Health Equity Taskforce will consider future community projects aimed at facilitating access, though the proportion has increased over time in the county.

Adults Who Had a Medical Checkup in the Past Year, Martin County and Florida, 2013, 2016, 2019

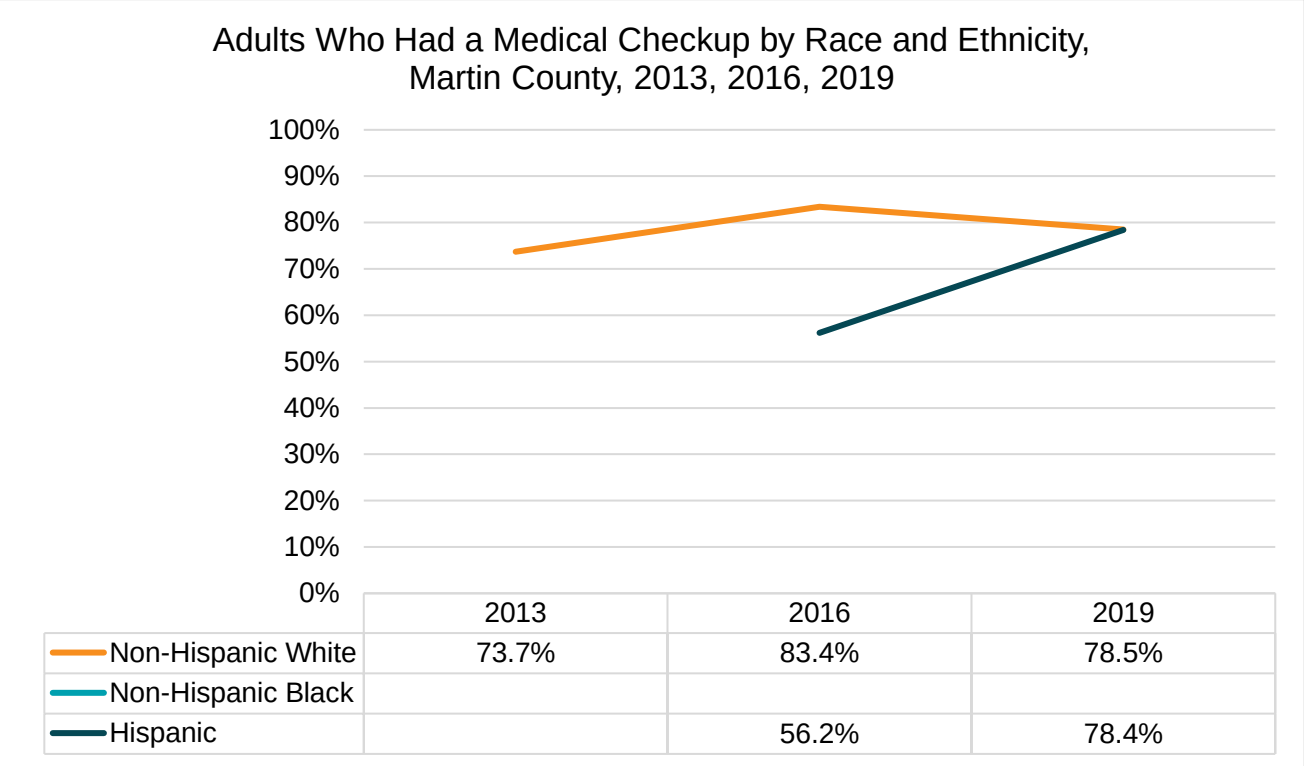


	2013	2016	2019
Martin County	72.1%	79.1%	79.2%
Florida	70.3%	76.5%	78.8%

Source: Florida Behavioral Risk Factor Surveillance System telephone survey conducted by the Centers for Disease Control and Prevention (CDC) and Florida Department of Health Division of Community Health Promotion.

[152] Kahan, S.I (2018). Practical strategies for engaging individuals with obesity in primary care. *Mayo Clinic Proceedings.* 93(3): 351-359.

The figure below shows the proportion of adults who had a medical checkup by **race and ethnicity** in Martin County in 2013, 2016, and 2019. Unfortunately, for all reportable years, there was no data available for non-Hispanic Black residents, and for Hispanic residents, data is only available for 2016 and 2019. In 2016, non-Hispanic residents had a much higher proportion of adults who had a medical checkup, though in 2019, the gap closed. As mentioned, screening and diagnosis of obesity is essential to improving health status, with a study demonstrating those with overweight status or obesity who received a diagnosis being over two times more likely to attempt to lose weight.[153] Given that annual primary care visits are an essential point of care, the Martin County Health Equity Taskforce will consider future community projects aimed at facilitating access among communities of color. In addition, the lack of data among Black non-Hispanic residents will be addressing through the SDOH Screening Tool Community Project.



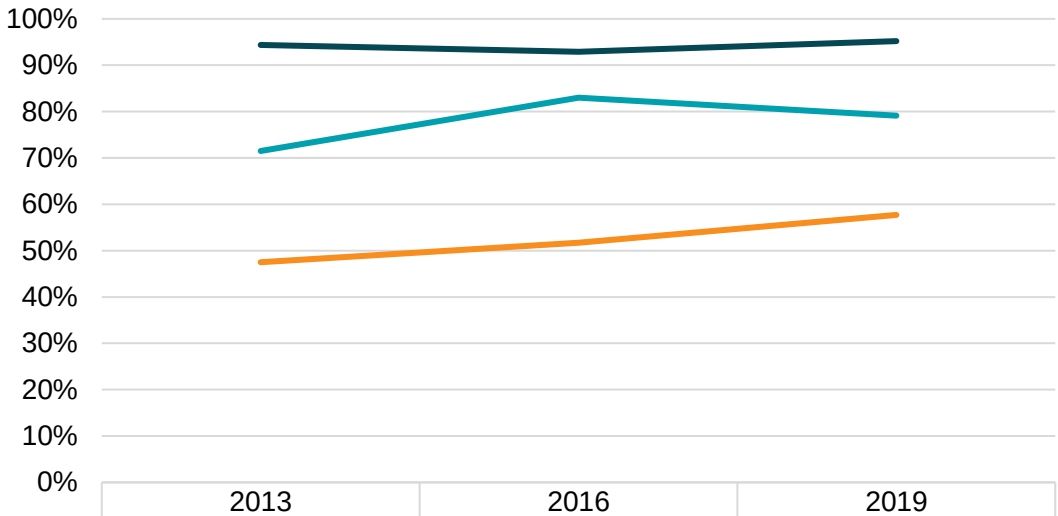
	2013	2016	2019
Non-Hispanic White	73.7%	83.4%	78.5%
Non-Hispanic Black			
Hispanic		56.2%	78.4%

Source: Florida Behavioral Risk Factor Surveillance System telephone survey conducted by the Centers for Disease Control and Prevention (CDC) and Florida Department of Health Division of Community Health Promotion.

[153] Kahan, S.I (2018). Practical strategies for engaging individuals with obesity in primary care. *Mayo Clinic Proceedings.* 93(3): 351-359.

The figure below shows the proportion of adults who had a medical checkup by **age** in Martin County in 2013, 2016, and 2019. Perhaps unsurprisingly, a higher proportion of older adults had a medical checkup in the past year. Most recently in 2019, 95% of adults aged 65 and older had a medical checkup in the past year, compared to 79% of adults aged 45 to 64 and 58% of adults aged 18 to 44. As mentioned, screening and diagnosis of obesity is essential to improving health status. One study demonstrated that those with overweight status or obesity who received a diagnosis were two times more likely to attempt to lose weight.[154] Given that annual primary care visits are an essential point of care, the Martin County Health Equity Taskforce will consider future community projects aimed at facilitating access among younger adults.

Adults Who Had a Medical Checkup in the Past Year by Age, Martin County, 2013, 2016, 2019



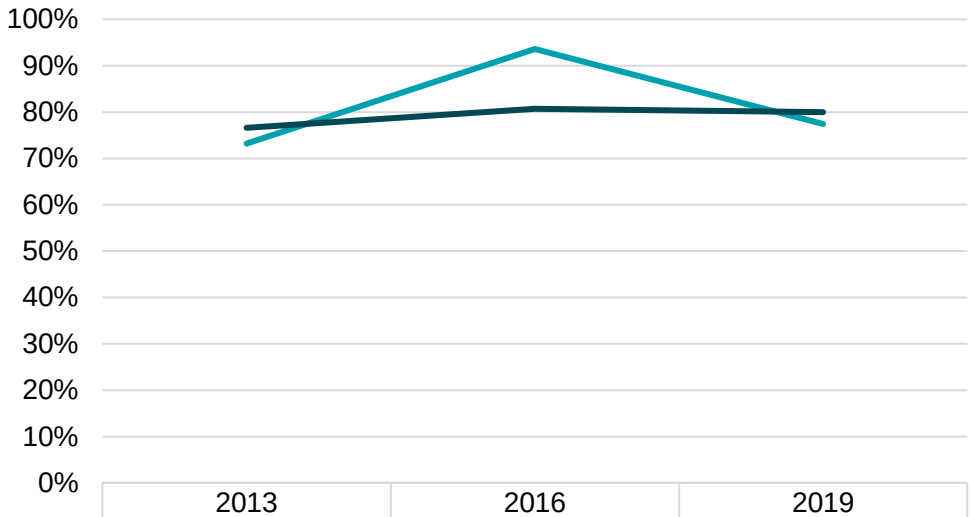
	2013	2016	2019
Ages 18-44	47.5%	51.7%	57.7%
Ages 45-64	71.5%	83.0%	79.1%
Ages 65 & Older	94.4%	92.9%	95.2%

Source: Florida Behavioral Risk Factor Surveillance System telephone survey conducted by the Centers for Disease Control and Prevention (CDC) and Florida Department of Health Division of Community Health Promotion.

[154] Kahan, S.I (2018). Practical strategies for engaging individuals with obesity in primary care. *Mayo Clinic Proceedings.* 93(3): 351-359.

The figure below shows the proportion of adults who had a medical checkup by **education level** in Martin County in 2013, 2016, and 2019. Unfortunately, there was no data for adults with less than high school education until 2019. For the other groups, there was some fluctuation over time. Most recently in 2019, 80% of adults with more than high school education had a medical checkup in the past year, compared to 77% of those with a high school education and 78% of those with less than a high school education. As mentioned, screening and diagnosis of obesity is essential to improving health status, with a study demonstrating those with overweight status or obesity who received a diagnosis being over two times more likely to attempt to lose weight.[155] Given that annual primary care visits are an essential point of care, the Martin County Health Equity Taskforce will consider future community projects aimed at facilitating access.

Adults Who Had a Medical Checkup in the Past Year by Education Level, Martin County, 2013, 2016, 2019

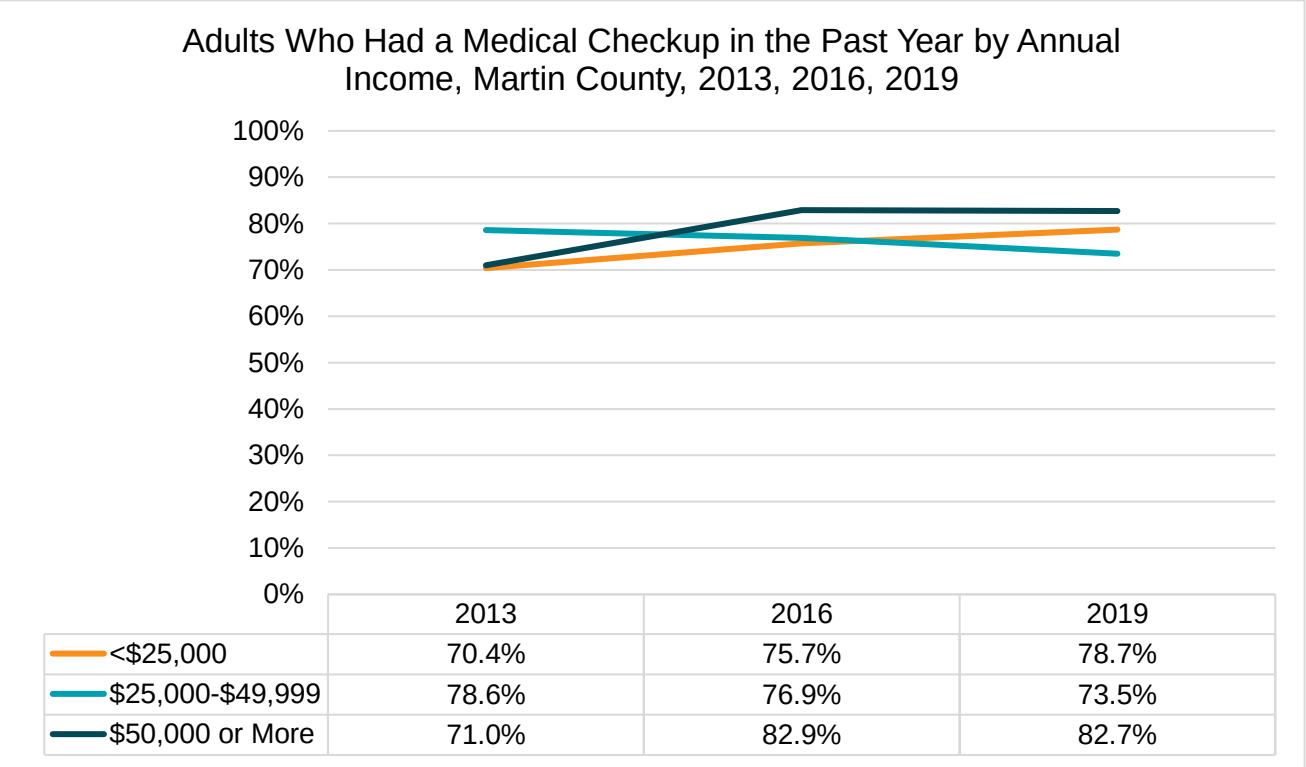


	2013	2016	2019
Less Than High School			77.8%
High School/GED	73.2%	93.6%	77.4%
More Than High School	76.6%	80.7%	80.0%

Source: Florida Behavioral Risk Factor Surveillance System telephone survey conducted by the Centers for Disease Control and Prevention (CDC) and Florida Department of Health Division of Community Health Promotion.

[155] Kahan, S.I (2018). Practical strategies for engaging individuals with obesity in primary care. *Mayo Clinic Proceedings.* 93(3): 351-359.

The figure below shows the proportion of adults who had a medical checkup by **annual income** in Martin County in 2013, 2016, and 2019. Over time, there was fluctuation in the proportion among the different income groups. Most recently in 2019, 83% of those who made $50,000 or more in annual income had a medical checkup in the past year, compared to 79% of those who made less than $25,000 and 74% of those who made $25,000 to $49,999. As mentioned, screening and diagnosis of obesity is essential to improving health status, with a study demonstrating those with overweight status or obesity who received a diagnosis being over two times more likely to attempt to lose weight.[156] Given that annual primary care visits are an essential point of care, the Martin County Health Equity Taskforce will consider future community projects aimed at facilitating access.

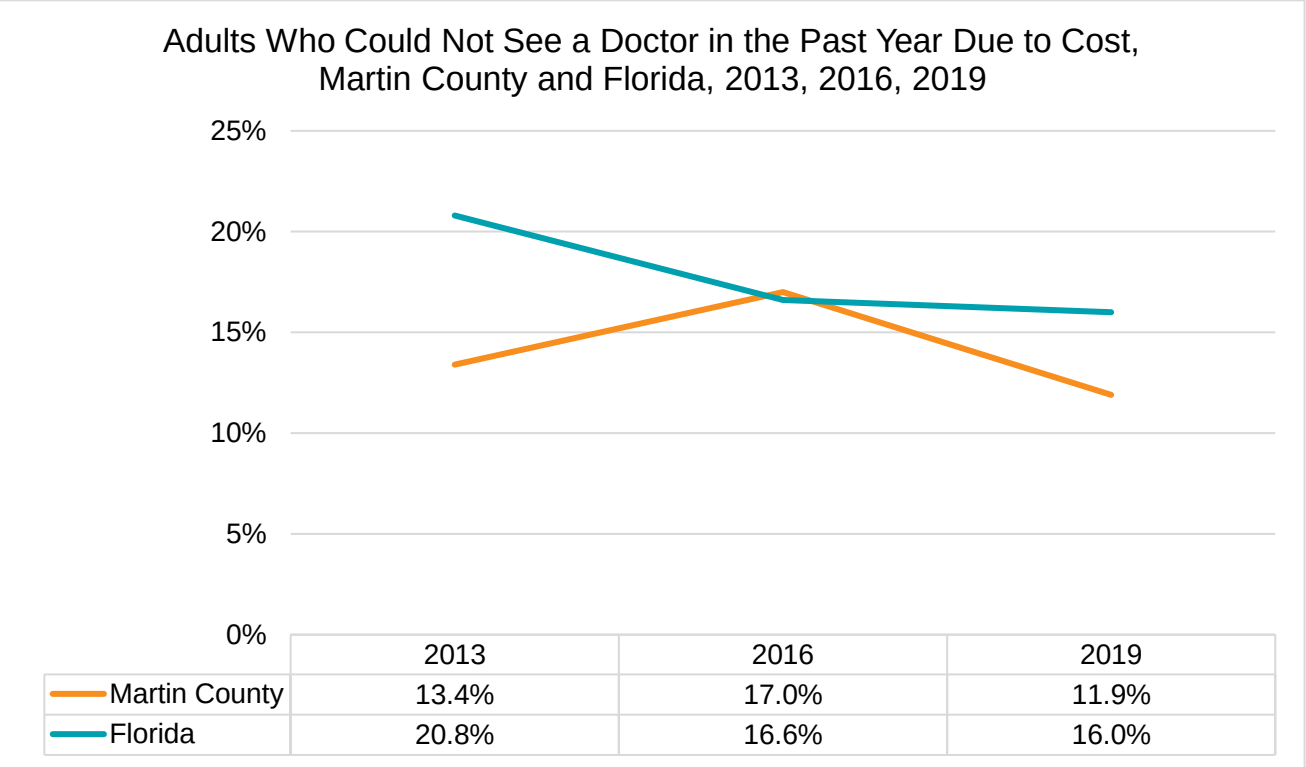


	2013	2016	2019
<$25,000	70.4%	75.7%	78.7%
$25,000-$49,999	78.6%	76.9%	73.5%
$50,000 or More	71.0%	82.9%	82.7%

Source: Florida Behavioral Risk Factor Surveillance System telephone survey conducted by the Centers for Disease Control and Prevention (CDC) and Florida Department of Health Division of Community Health Promotion.

[156] Kahan, S.I (2018). Practical strategies for engaging individuals with obesity in primary care. *Mayo Clinic Proceedings.* 93(3): 351-359.

The figure below shows the proportion of adults who could not see a doctor in the past year due to cost in Martin County and Florida in 2013, 2016, and 2019. Although there was some fluctuation, a higher proportion of residents could not see a doctor in the past year due to cost for two of the three years reported. Most recently in 2019, 16% of adults in Florida could not see a doctor in the past year due to cost compared to 12% of adults in Martin County. Obesity has a huge impact on overall health and is also correlated with high medical costs.[157] Compounding obesity with the inability to pay for medical visits only exacerbates the issue, so the Martin County Health Equity Taskforce will consider ways to mitigate any cost-related barriers to care in the future, though the proportion of residents who could not see a doctor in the past year due to cost has decreased from 2016 to 2019.



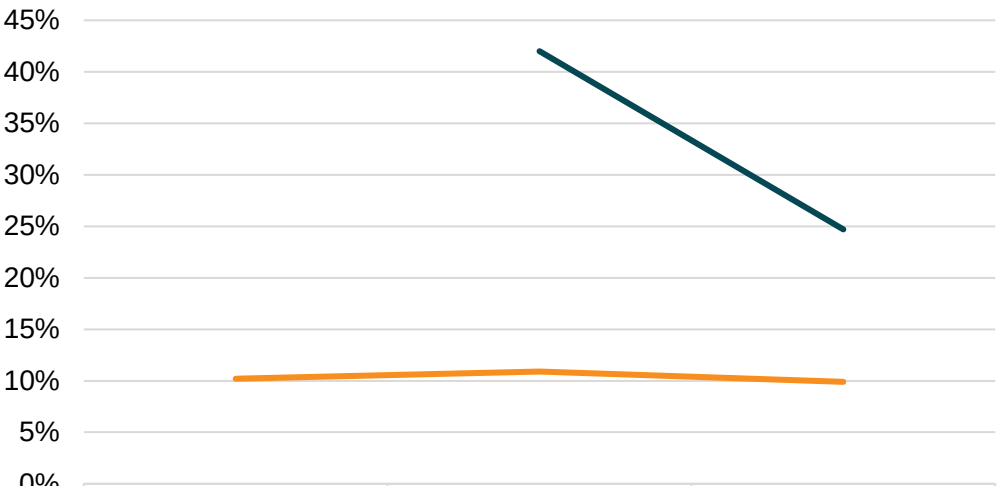
	2013	2016	2019
Martin County	13.4%	17.0%	11.9%
Florida	20.8%	16.6%	16.0%

Source: Florida Behavioral Risk Factor Surveillance System telephone survey conducted by the Centers for Disease Control and Prevention (CDC) and Florida Department of Health Division of Community Health Promotion.

[157] Van Baal, P. Polder, J.J., et al. (2008). Lifetime medical costs of obesity: Prevention no cure for increasing health expenditure. *PLoS Medicine.* https://doi.org/10.1371/journal.pmed.0050029

The figure below shows the proportion of adults who could not see a doctor in the past year due to cost by **race and ethnicity** in Martin County in 2013, 2016, and 2019. Unfortunately, for all reportable years, there was no data available for Black non-Hispanic residents, and for Hispanic residents, there was no data available for 2013. From 2016 to 2019, a much higher proportion of residents could not see a doctor due to cost in the past year compared to White non-Hispanic residents. Most recently, the proportion among Hispanic residents was 2.5 times higher (24.7%) than among White non-Hispanic residents (9.9%). As mentioned, obesity has a huge impact on overall health and is also correlated with high medical costs.[158] Compounding obesity with the inability to pay for medical visits only exacerbates the issue, so the Martin County Health Equity Taskforce will consider ways to mitigate any cost-related barriers to care in the future, though the proportion of residents who could not see a doctor in the past year due to cost has decreased from 2016 to 2019. Additionally, the lack of data for Black non-Hispanic residents will be addressed through the SDOH Screening Tool Community Project.

Adults Who Could Not See a Doctor in the Past Year Due to Cost by Race and Ethnicity, Martin County, 2013, 2016, 2019

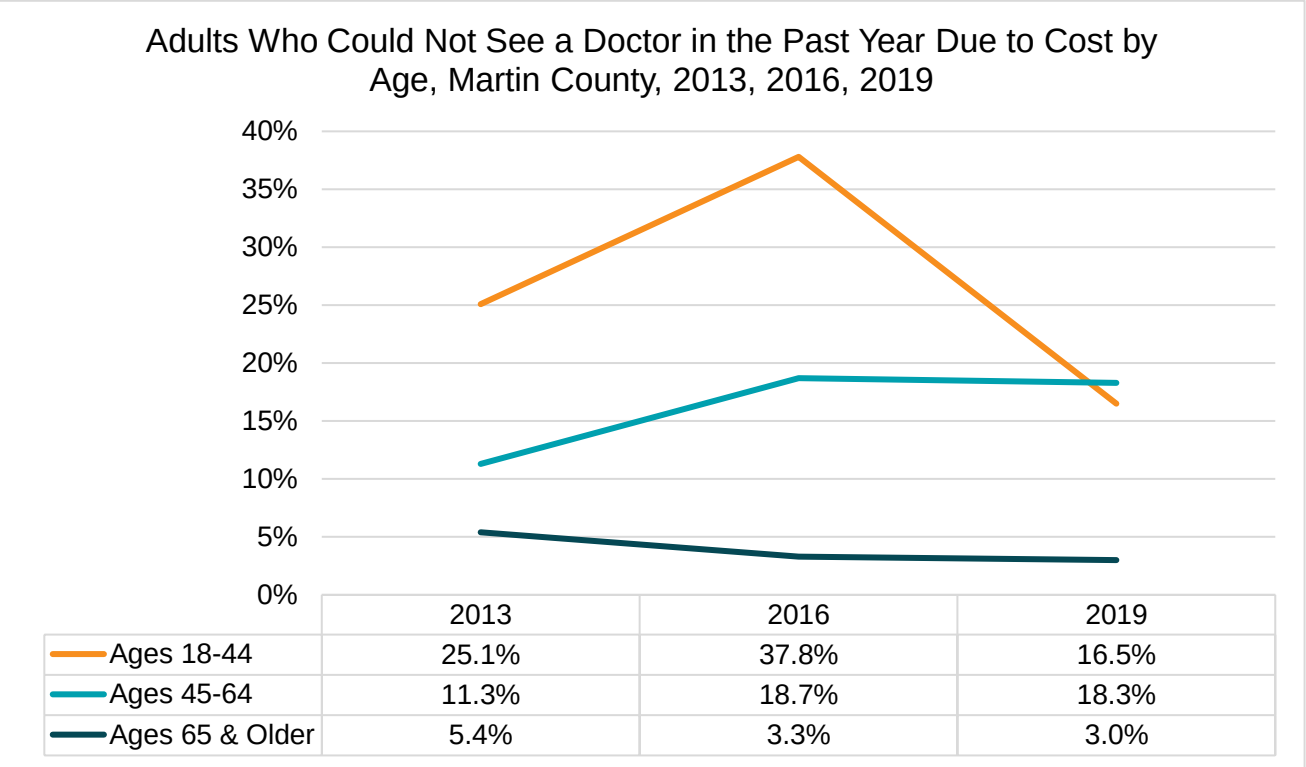


	2013	2016	2019
Non-Hispanic White	10.2%	10.9%	9.9%
Non-Hispanic Black			
Hispanic		42.0%	24.7%

Source: Florida Behavioral Risk Factor Surveillance System telephone survey conducted by the Centers for Disease Control and Prevention (CDC) and Florida Department of Health Division of Community Health Promotion.

[158] Van Baal, P. Polder, J.J., et al. (2008). Lifetime medical costs of obesity: Prevention no cure for increasing health expenditure. *PLoS Medicine.* https://doi.org/10.1371/journal.pmed.0050029

The figure below shows the proportion of adults who could not see a doctor in the past year due to cost by **age** in Martin County in 2013, 2016, and 2019. Generally, a lower proportion of older adults could not see a doctor in the past year due to cost, though there was a decrease in the proportion of younger adults from 2016 to 2019. Most recently in 2019, 3.0% of adults aged 65 years and older could not see a doctor in the past year due to cost, compared to 18.3% of adults aged 45 to 64 years and 16.5% of adults aged 18 to 44 years. As mentioned, obesity has a huge impact on overall health and is also correlated with high medical costs.[159] Compounding obesity with the inability to pay for medical visits only exacerbates the issue, so the Martin County Health Equity Taskforce will consider ways to mitigate any cost-related barriers to care in the future, though the proportion of residents who could not see a doctor in the past year due to cost has decreased overall from 2016 to 2019.

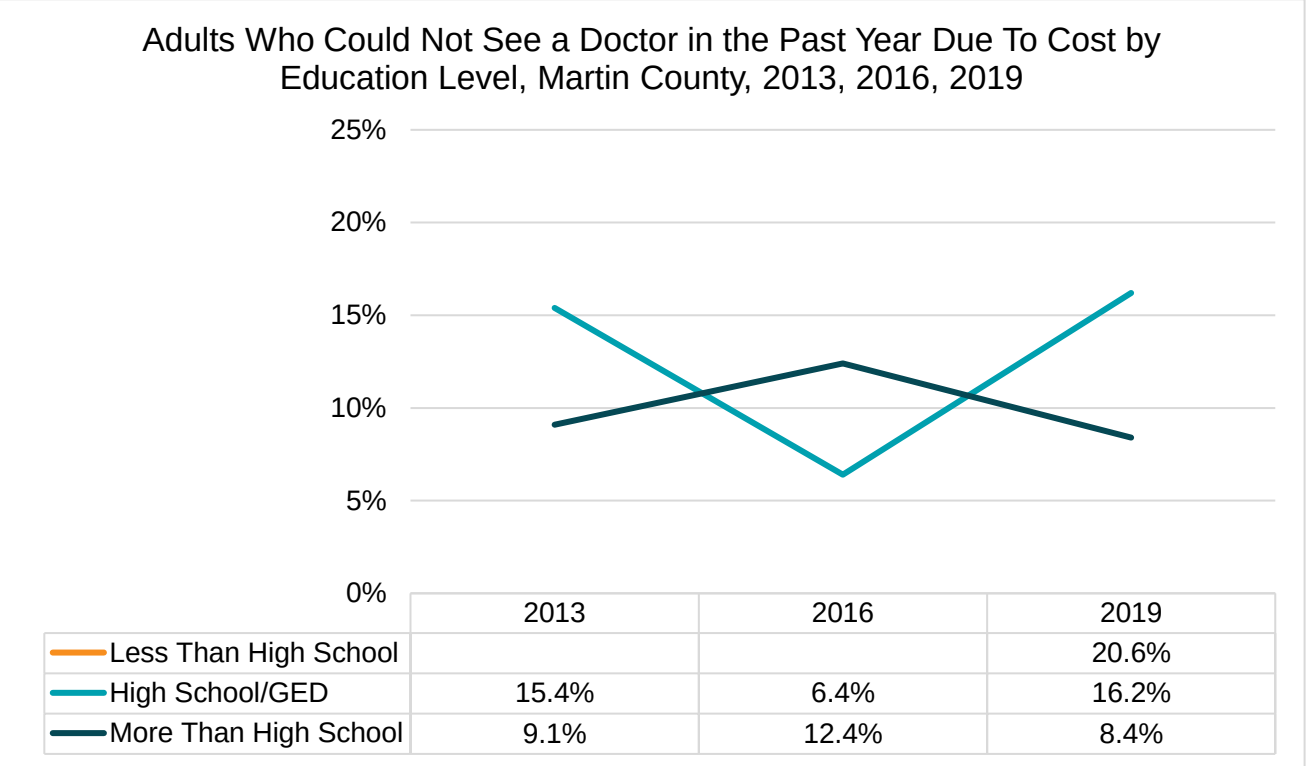


	2013	2016	2019
Ages 18-44	25.1%	37.8%	16.5%
Ages 45-64	11.3%	18.7%	18.3%
Ages 65 & Older	5.4%	3.3%	3.0%

Source: Florida Behavioral Risk Factor Surveillance System telephone survey conducted by the Centers for Disease Control and Prevention (CDC) and Florida Department of Health Division of Community Health Promotion.

[159] Van Baal, P. Polder, J.J., et al. (2008). Lifetime medical costs of obesity: Prevention no cure for increasing health expenditure. *PLoS Medicine.* https://doi.org/10.1371/journal.pmed.0050029

The figure below shows the proportion of adults who could not see a doctor in the past year due to cost by **education level** in Martin County in 2013, 2016, and 2019. Unfortunately, data was not available for those with less than high school education until 2019. Over time, there was fluctuation in the proportion among the different educational levels. Most recently in 2019, however, 20.6% of adults with less than high school education could not see a doctor in the past year due to cost, compared to 16.2% of adults with a high school education or GED and 8.4% of adults with more than a high school education. As mentioned, obesity has a huge impact on overall health and is also correlated with high medical costs.[160] Compounding obesity with the inability to pay for medical visits only exacerbates the issue, so the Martin County Health Equity Taskforce will consider ways to mitigate any cost-related barriers to care in the future. Additionally, the lack of data for residents with less than high school education will be addressed through the SDOH Screening Tool Community Project.



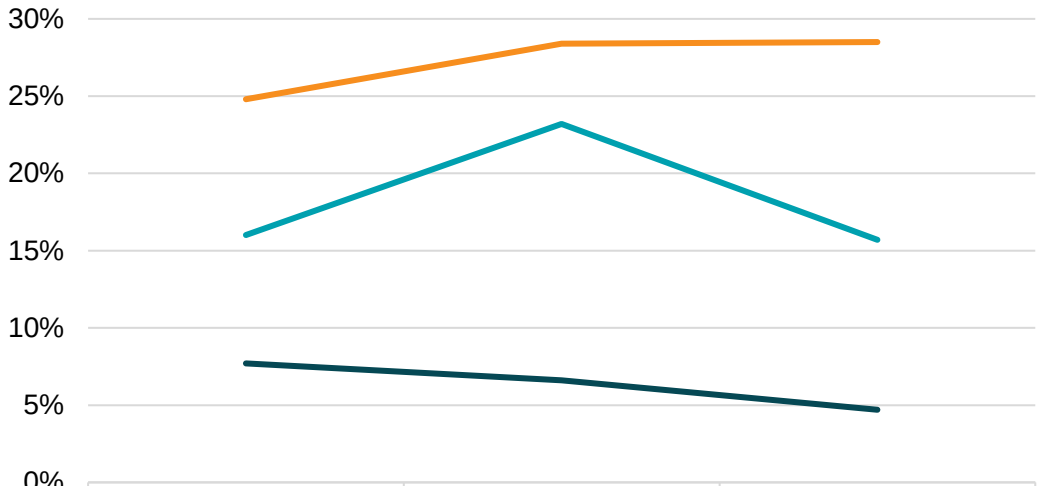
	2013	2016	2019
Less Than High School			20.6%
High School/GED	15.4%	6.4%	16.2%
More Than High School	9.1%	12.4%	8.4%

Source: Florida Behavioral Risk Factor Surveillance System telephone survey conducted by the Centers for Disease Control and Prevention (CDC) and Florida Department of Health Division of Community Health Promotion.

[160] Van Baal, P. Polder, J.J., et al. (2008). Lifetime medical costs of obesity: Prevention no cure for increasing health expenditure. *PLoS Medicine.* https://doi.org/10.1371/journal.pmed.0050029

The figure below shows the proportion of adults who could not see a doctor in the past year due to cost by **annual income** in Martin County from 2013 to 2019. Generally, and perhaps unsurprisingly, a lower proportion of those with higher annual incomes could not see a doctor in the past year due to cost. In 2019, 29% of those who made less than $25,000 in annual income could not see a doctor in the past year due to cost, compared to 16% of those who made $25,000 to $49,999 and 5% of those who made $50,000 or more. As mentioned, obesity has a huge impact on overall health and is also correlated with high medical costs.[161] Compounding obesity with the inability to pay for medical visits only exacerbates the issue, so the Martin County Health Equity Taskforce will consider ways to mitigate any cost-related barriers to care in the future among lower income residents.

Adults Who Could Not See a Doctor in the Past Year Due to Cost by Annual Income, Martin County, 2013, 2016, 2019



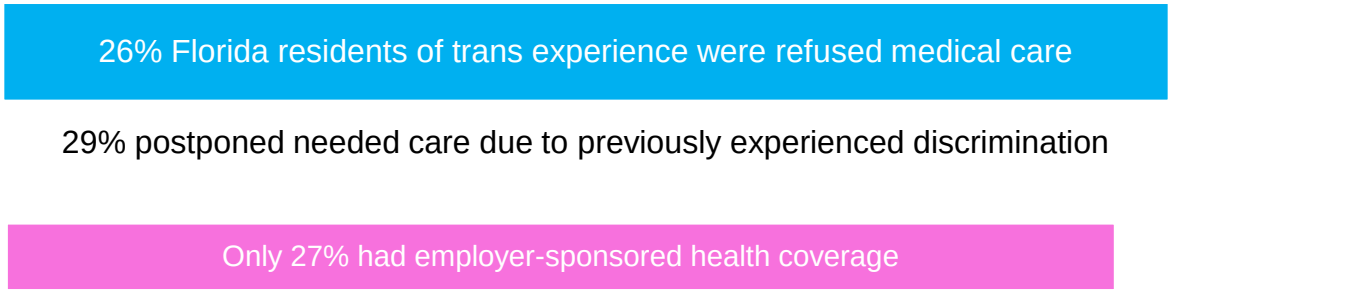
	2013	2016	2019
<$25,000	24.8%	28.4%	28.5%
$25,000-$49,999	16.0%	23.2%	15.7%
$50,000 or More	7.7%	6.6%	4.7%

Source: Florida Behavioral Risk Factor Surveillance System telephone survey conducted by the Centers for Disease Control and Prevention (CDC) and Florida Department of Health Division of Community Health Promotion.

[161] Van Baal, P. Polder, J.J., et al. (2008). Lifetime medical costs of obesity: Prevention no cure for increasing health expenditure. *PLoS Medicine.* https://doi.org/10.1371/journal.pmed.0050029

Health Care Discrimination Among Residents of Trans Experience

Importantly, many residents of trans experience face discrimination when seeking health care services. In 2012, the National Transgender Discrimination Survey found that, in Florida, 26% of trans residents were refused medical care, 29% postposed medical care when they needed it due to previous experiences of discrimination, and only 27% had employer-sponsored health coverage, compared to 59% of the state's general population.[162] The Martin County Health Equity Taskforce is committed to collecting county-level data to determine the best course for improving access to quality and affirming health care services among trans residents and other LGBQ residents. Also, the 2019 BRFSS Florida State Survey found that 72% of LGTBTQ population had a medical check up in the past year, in comparison to 80.8% of the straight population,

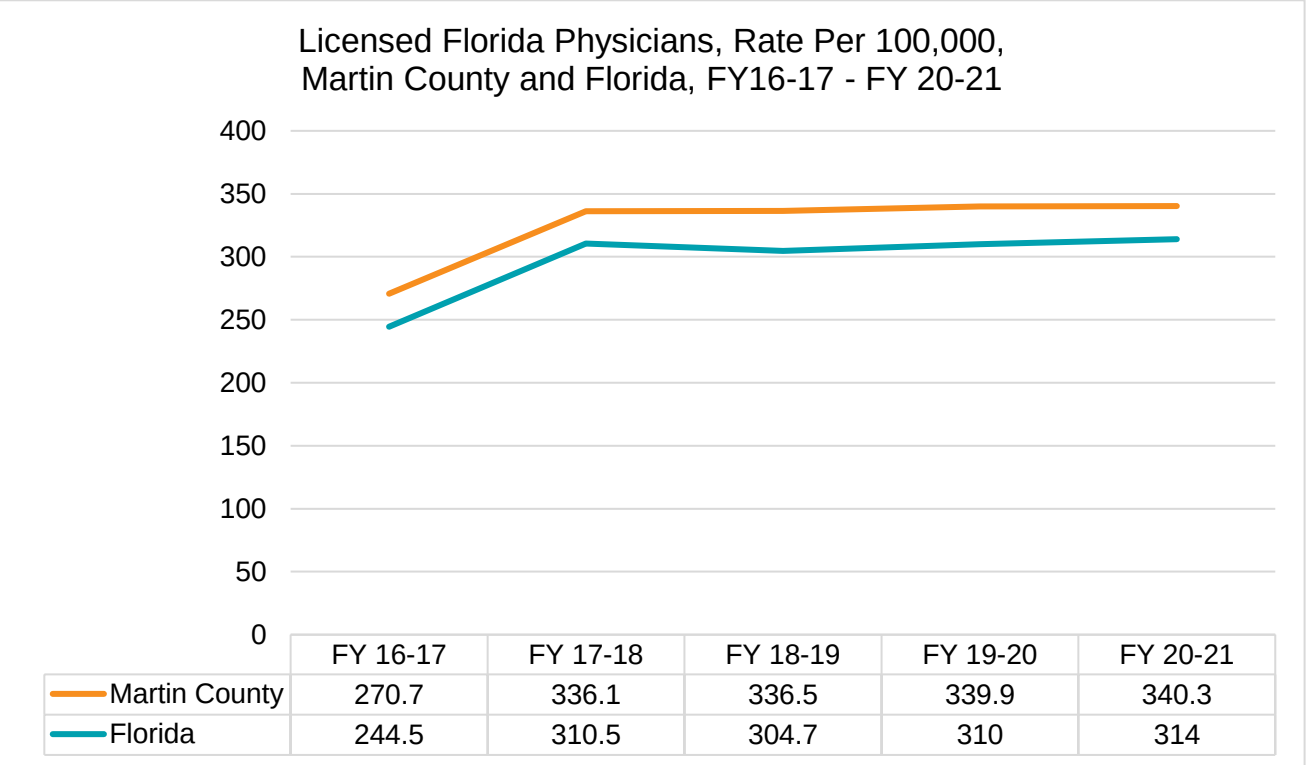


Source: National Center for Transgender Equality and the National Gay and Lesbian Task Force, National Transgender Discrimination Survey, 2012

[162] National Center for Transgender Equality and the National Gay and Lesbian Task Force. 2012. Florida Results. Retrieved from: https://transequality.org/sites/default/files/docs/resources/ntds_state_fl.pdf

Health Care Provider Supply

The figure below shows the rate of Licensed Florida Physicians per 100,000 population in Martin County and Florida from FY 16-17 to FY 20-21. For both the county and the state, there was an overall increase over time, though the county consistently had a higher rate. In FY 20-21, Martin County had 340 Licensed Florida Physicians per 100,000 population, compared to 314 per 100,000 population across the state. Geographic access and availability of medical providers, particularly providers who receive specialized training on obesity management, is integral for improving obesity-related health outcomes.[163]

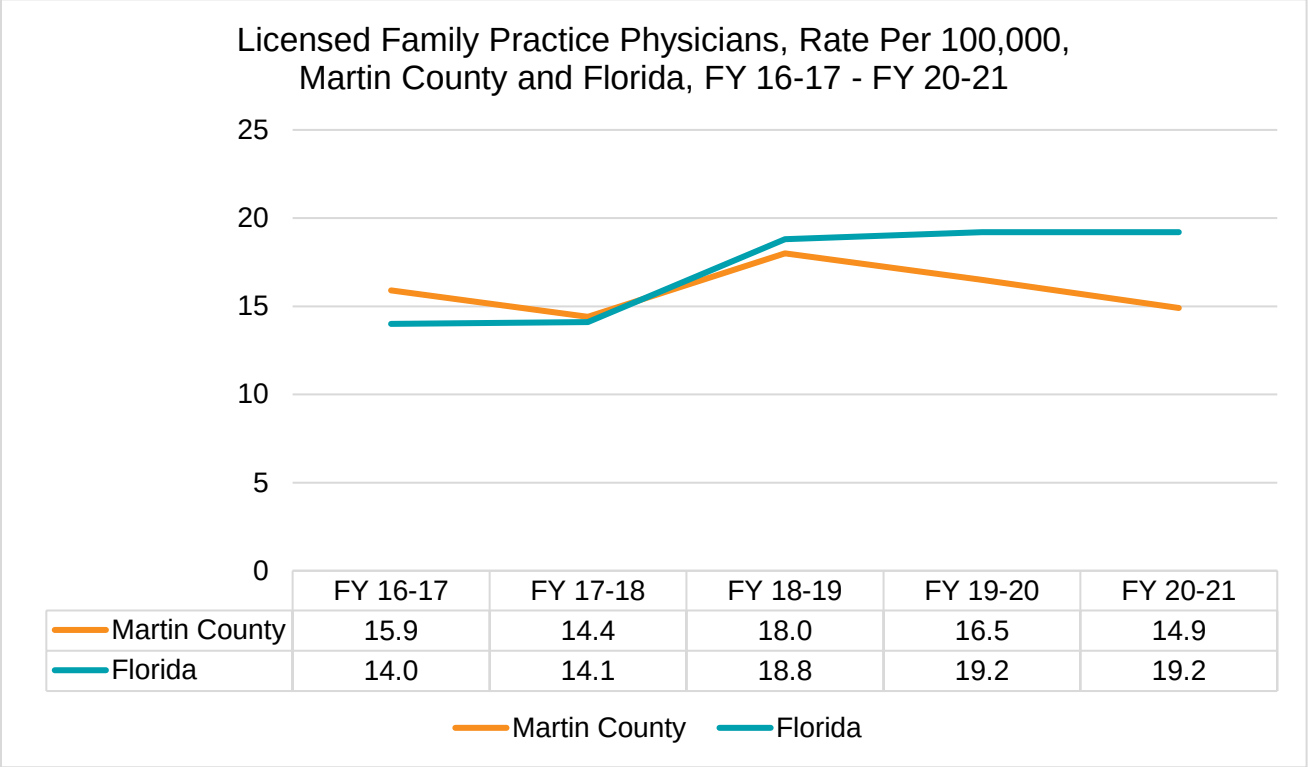


	FY 16-17	FY 17-18	FY 18-19	FY 19-20	FY 20-21
Martin County	270.7	336.1	336.5	339.9	340.3
Florida	244.5	310.5	304.7	310	314

Source: Florida Department of Health, Division of Medical Quality Assurance

[163] Pollack, C.C., Onega, T. et al. (2022). A national evaluation of geographic accessibility and provider availability of obesity medicine diplomates in the United States between 2011 and 2019. *International Journal of Obesity.* 46: 669-675.

The figure below shows the rate of Licensed Family Practice Physicians per 100,000 population in Martin County and Florida from FY16-17 to FY 20-21. There has been some fluctuation over the years, but Florida surpassed the county's rate in more recent years. In FY 20-21, Florida had 19.2 Licensed Family Practice Physicians per 100,000 population, compared to 14.9 per 100,000 population in Martin County. As mentioned, geographic access and availability of medical providers, particularly providers who receive specialized training on obesity management, is integral for improving obesity-related health outcomes.[164]

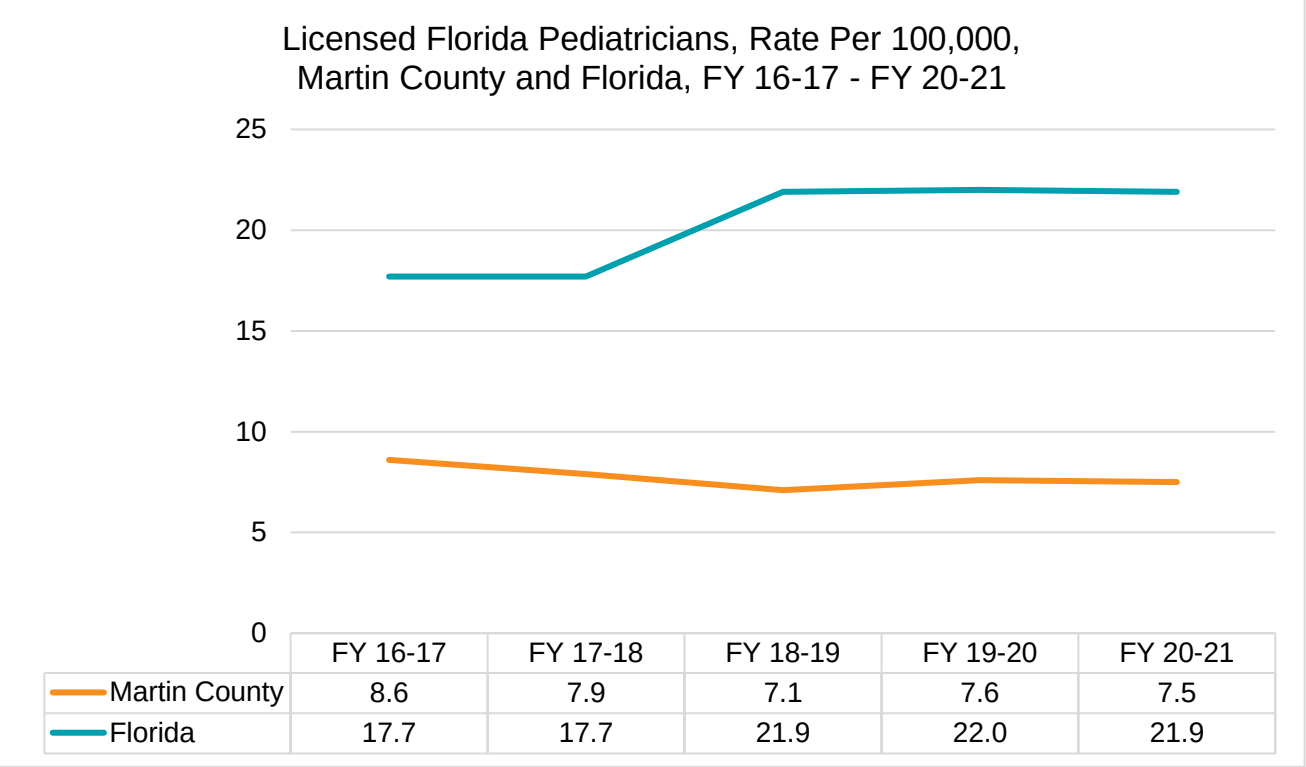


	FY 16-17	FY 17-18	FY 18-19	FY 19-20	FY 20-21
Martin County	15.9	14.4	18.0	16.5	14.9
Florida	14.0	14.1	18.8	19.2	19.2

Source: Florida Department of Health, Division of Medical Quality Assurance

[164] Pollack, C.C., Onega, T. et al. (2022). A national evaluation of geographic accessibility and provider availability of obesity medicine diplomates in the United States between 2011 and 2019. *International Journal of Obesity.* 46: 669-675.

The figure below shows the rate of Licensed Florida Pediatricians per 100,000 population in Martin County and Florida from FY 16-17 to FY 20-21. Each year, Florida's rate surpassed the county. In FY 20-21, Florida had 21.9 Licensed Florida Pediatricians per 100,000 population, compared to 7.5 per 100,000 population in Martin County. As mentioned, geographic access and availability of medical providers, particularly providers who receive specialized training on obesity management, is integral for improving obesity-related health outcomes.[165]

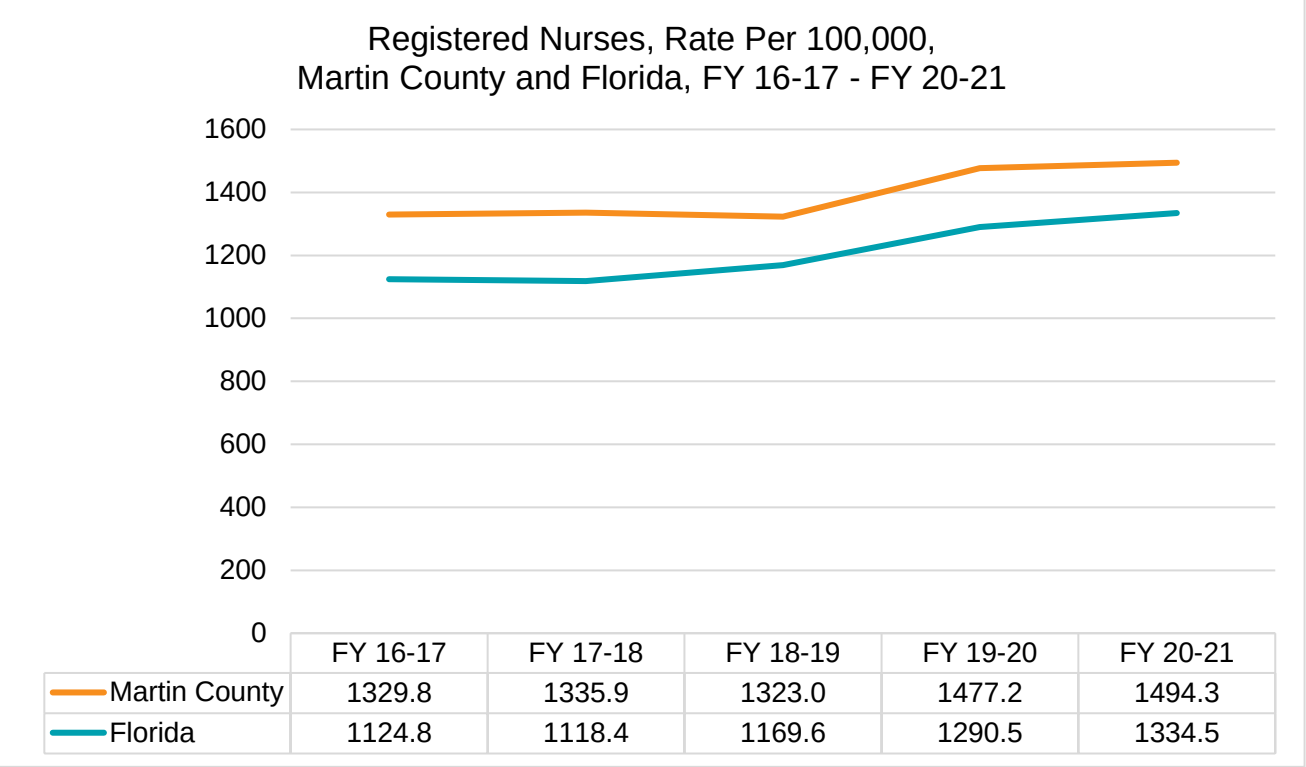


	FY 16-17	FY 17-18	FY 18-19	FY 19-20	FY 20-21
Martin County	8.6	7.9	7.1	7.6	7.5
Florida	17.7	17.7	21.9	22.0	21.9

Source: Florida Department of Health, Division of Medical Quality Assurance

[165] Pollack, C.C., Onega, T. et al. (2022). A national evaluation of geographic accessibility and provider availability of obesity medicine diplomates in the United States between 2011 and 2019. *International Journal of Obesity.* 46: 669-675.

The figure below shows the rate of Registered Nurses per 100,000 population in Martin County and Florida from FY 16-17 to FY 20-21. Each year, Martin County had a higher rate than the state. In FY 20-21, Martin County had 1,494.3 Registered Nurses per 100,000 population, compared to 1,334.5 per 100,000 population in Florida. As mentioned, geographic access and availability of medical providers, particularly providers who receive specialized training on obesity management, is integral for improving obesity-related health outcomes.[166]

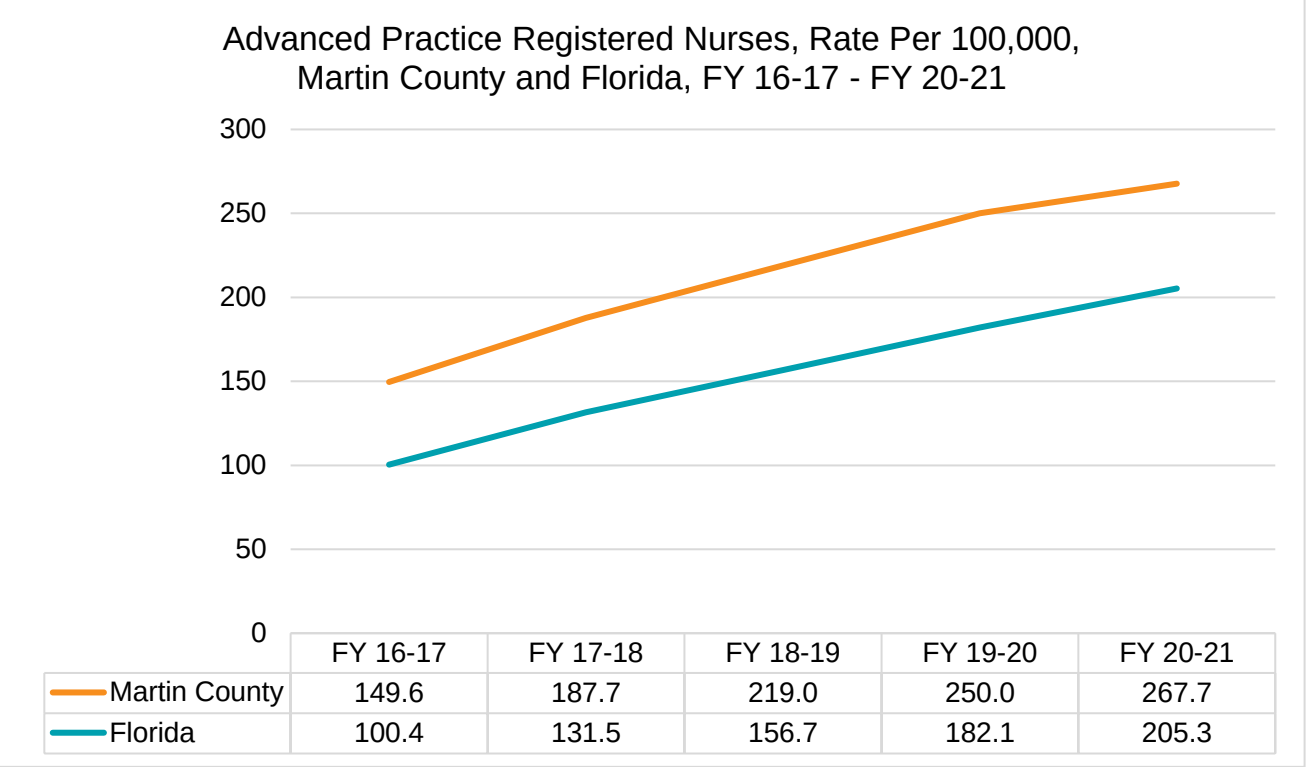


	FY 16-17	FY 17-18	FY 18-19	FY 19-20	FY 20-21
Martin County	1329.8	1335.9	1323.0	1477.2	1494.3
Florida	1124.8	1118.4	1169.6	1290.5	1334.5

Source: Florida Department of Health, Division of Medical Quality Assurance

[166] Pollack, C.C., Onega, T. et al. (2022). A national evaluation of geographic accessibility and provider availability of obesity medicine diplomates in the United States between 2011 and 2019. *International Journal of Obesity.* 46: 669-675.

The figure below shows the rate of Advanced Practice Registered Nurses (APRN) per 100,000 population in Martin County and Florida from FY 16-17 to FY 20-21. Each year, Martin County had a higher rate than the state, though the rate increased for both. In FY 20-21, Martin County had 267.7 APRN per 100,000 population, compared to 205.3 per 100,000 population in Florida. As mentioned, geographic access and availability of medical providers, particularly providers who receive specialized training on obesity management, is integral for improving obesity-related health outcomes.[167]

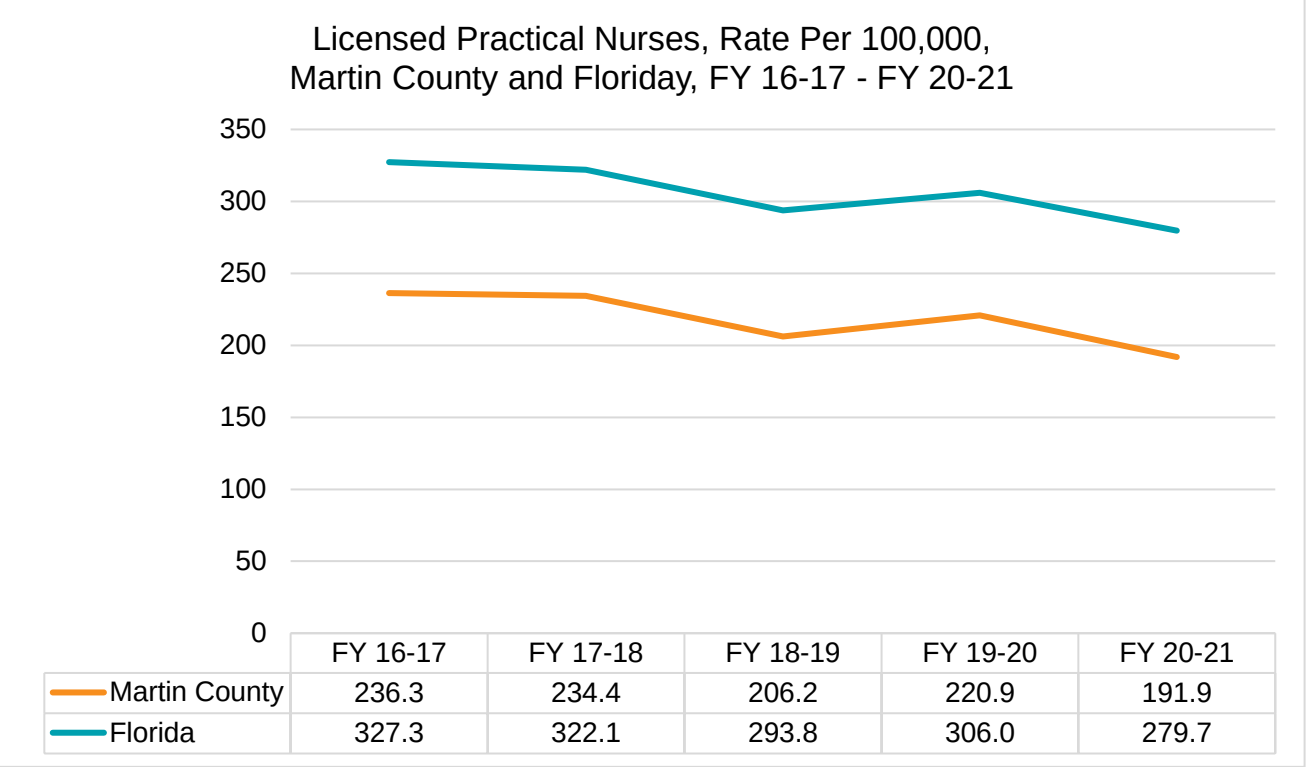


	FY 16-17	FY 17-18	FY 18-19	FY 19-20	FY 20-21
Martin County	149.6	187.7	219.0	250.0	267.7
Florida	100.4	131.5	156.7	182.1	205.3

Source: Florida Department of Health, Division of Medical Quality Assurance

[167] Pollack, C.C., Onega, T. et al. (2022). A national evaluation of geographic accessibility and provider availability of obesity medicine diplomates in the United States between 2011 and 2019. *International Journal of Obesity.* 46: 669-675.

The figure below shows the rate of Licensed Practical Nurses (LPN) per 100,000 population in Martin County and Florida from FY 16-17 to FY 20-21. Each year, Florida had a higher rate than Martin County, though the rate decreased for both. In FY 20-21, Florida had 279.7 LPN per 100,000 population, compared to 191.9 per 100,000 population in Martin County. As mentioned, geographic access and availability of medical providers, particularly providers who receive specialized training on obesity management, is integral for improving obesity-related health outcomes.[168]

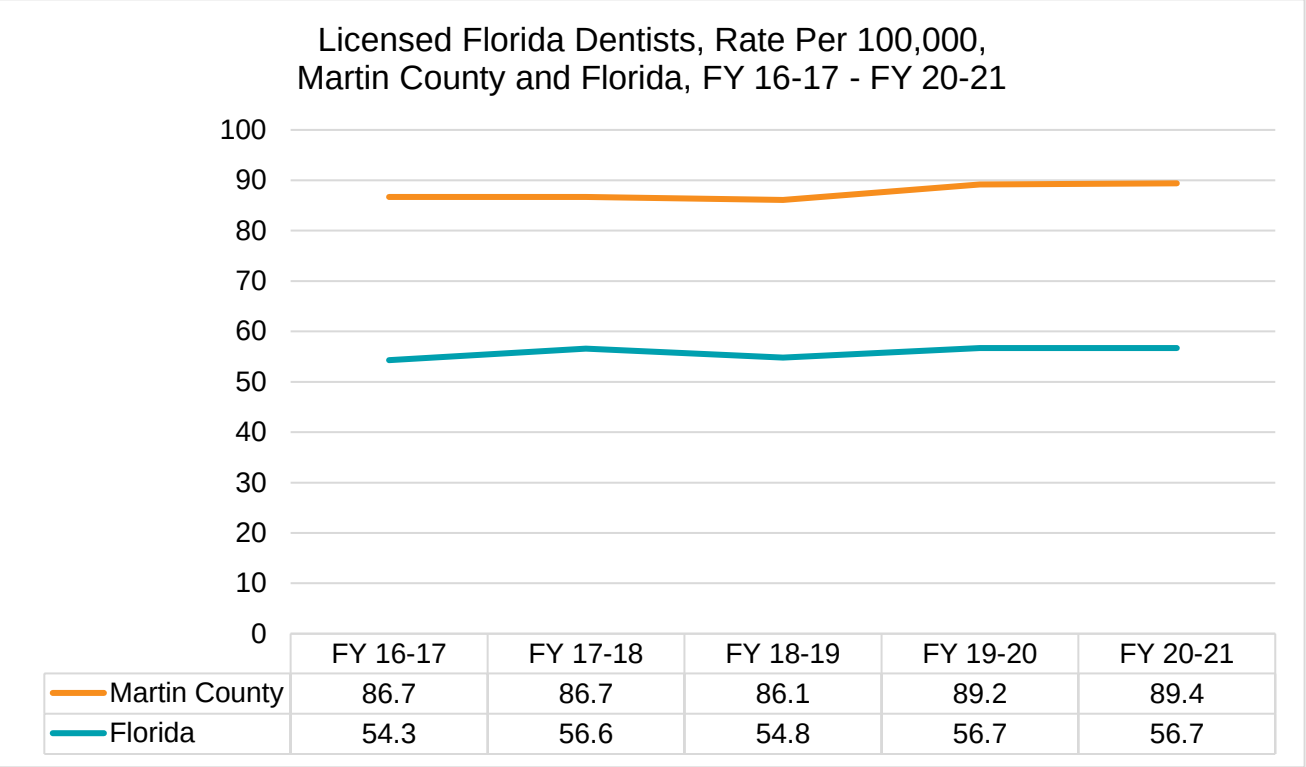


	FY 16-17	FY 17-18	FY 18-19	FY 19-20	FY 20-21
Martin County	236.3	234.4	206.2	220.9	191.9
Florida	327.3	322.1	293.8	306.0	279.7

Source: Florida Department of Health, Division of Medical Quality Assurance

[168] Pollack, C.C., Onega, T. et al. (2022). A national evaluation of geographic accessibility and provider availability of obesity medicine diplomates in the United States between 2011 and 2019. *International Journal of Obesity.* 46: 669-675.

The figure below shows the rate of Licensed Florida Dentists per 100,000 population in Martin County and Florida from FY 16-17 to FY 20-21. Each year, Martin County had a higher rate than the state. In FY 20-21, the rate of Licensed Florida Dentists was 89.4 per 100,000 population in Martin County, compared to 56.7 per 100,000 population in Florida. Evidence shows that people with obesity are also likely to experience oral health issues, such as periodontal disease, dental caries, and tooth erosion.[169] As such, the availability of dentists is important to improve the health outcomes of Martin County residents who are overweight or obese.

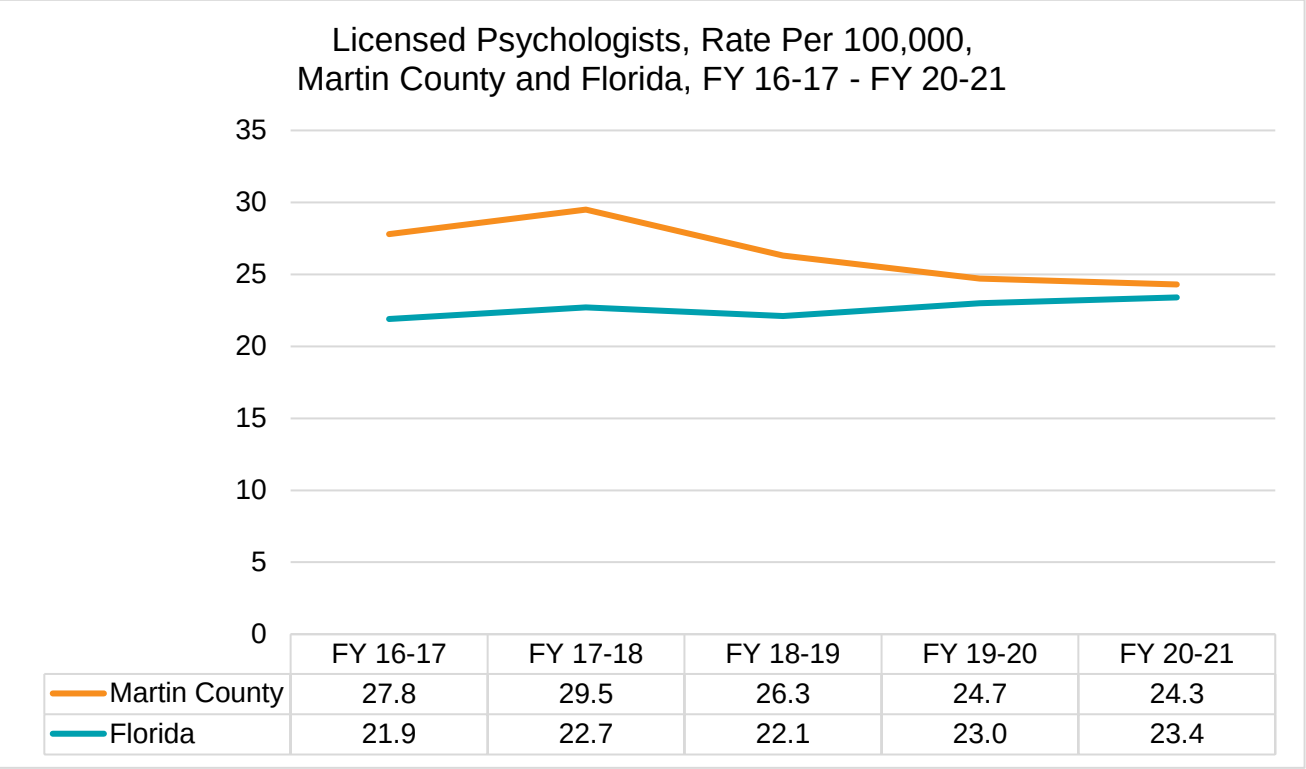


	FY 16-17	FY 17-18	FY 18-19	FY 19-20	FY 20-21
Martin County	86.7	86.7	86.1	89.2	89.4
Florida	54.3	56.6	54.8	56.7	56.7

Source: Florida Department of Health, Division of Medical Quality Assurance

[169] Suvan, J. & D'Aiuto, F. (2013). Assessment and management of oral health in obesity. *Current Obesity Reports.* 2: 142-149.

The figure below shows the rate of psychologists per 100,000 population in Martin County and Florida from FY 16-17 to FY 20-21. Each year, Martin County had a higher rate than the state, though it experienced a decrease and the state experienced an increase. In FY 20-21, Martin County had 24.3 psychologists per 100,000 population, compared to 23.4 per 100,000 in Florida. Obesity is higher among individuals with certain mental health conditions, such as depression. As such, the availability of licensed mental health providers is essential for mitigation.[170]

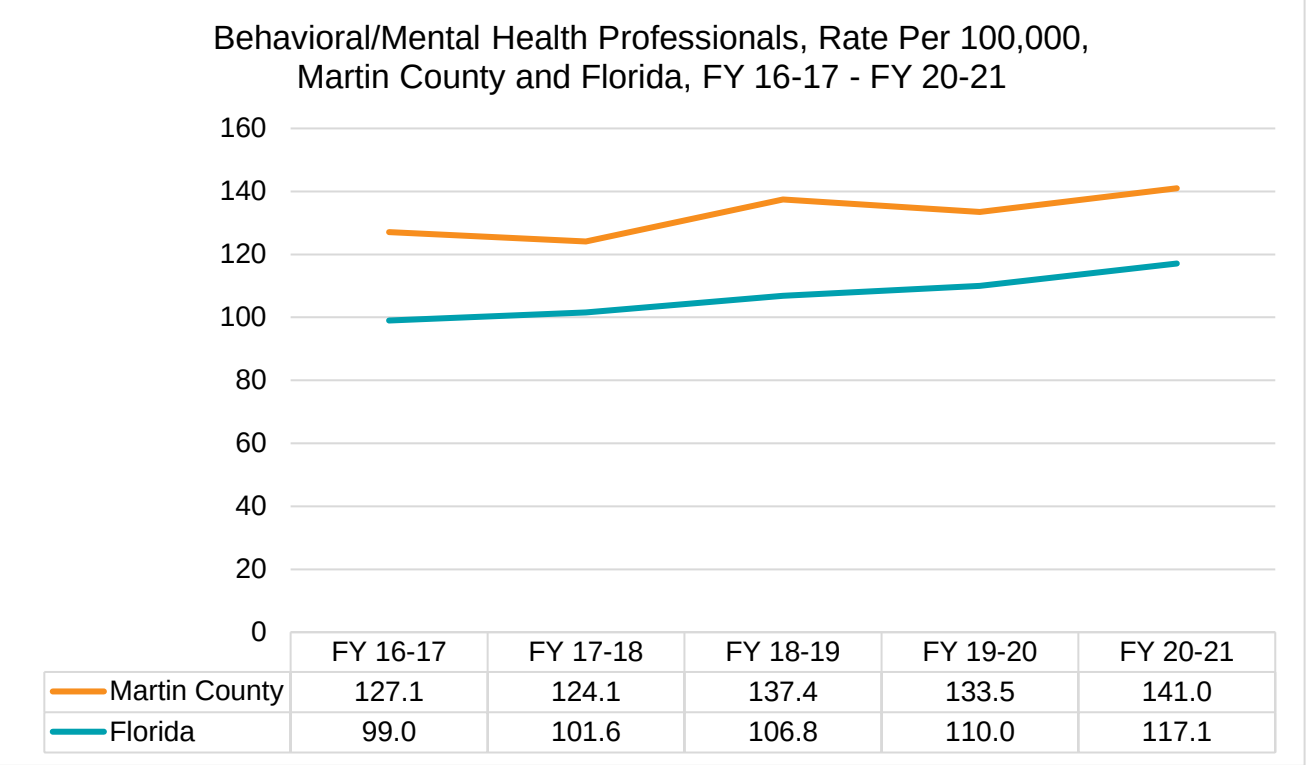


	FY 16-17	FY 17-18	FY 18-19	FY 19-20	FY 20-21
Martin County	27.8	29.5	26.3	24.7	24.3
Florida	21.9	22.7	22.1	23.0	23.4

Source: Florida Department of Health, Division of Medical Quality Assurance

[170] Allison, D.B., Newcomer, J.W. et al (2009). Obesity among those with mental disorders: A National Institute of Mental Wellbeing meeting report. *American Journal of Preventive Medicine.* 36(4): 341-350.

The figure below shows the rate of Behavioral/Mental Health Professionals (BHMP) per 100,000 population in Martin County and Florida from 2016 to 2021. Each year, Martin County had a higher rate than the state, though the rate increased for both over time. In FY 20-21, Martin County had 141 BHMP per 100,000 population, compared to 117.1 per 100,000 population in Florida. As mentioned, obesity is higher among individuals with certain mental health conditions, such as depression. As such, the availability of licensed mental health providers is essential for mitigation.[171]

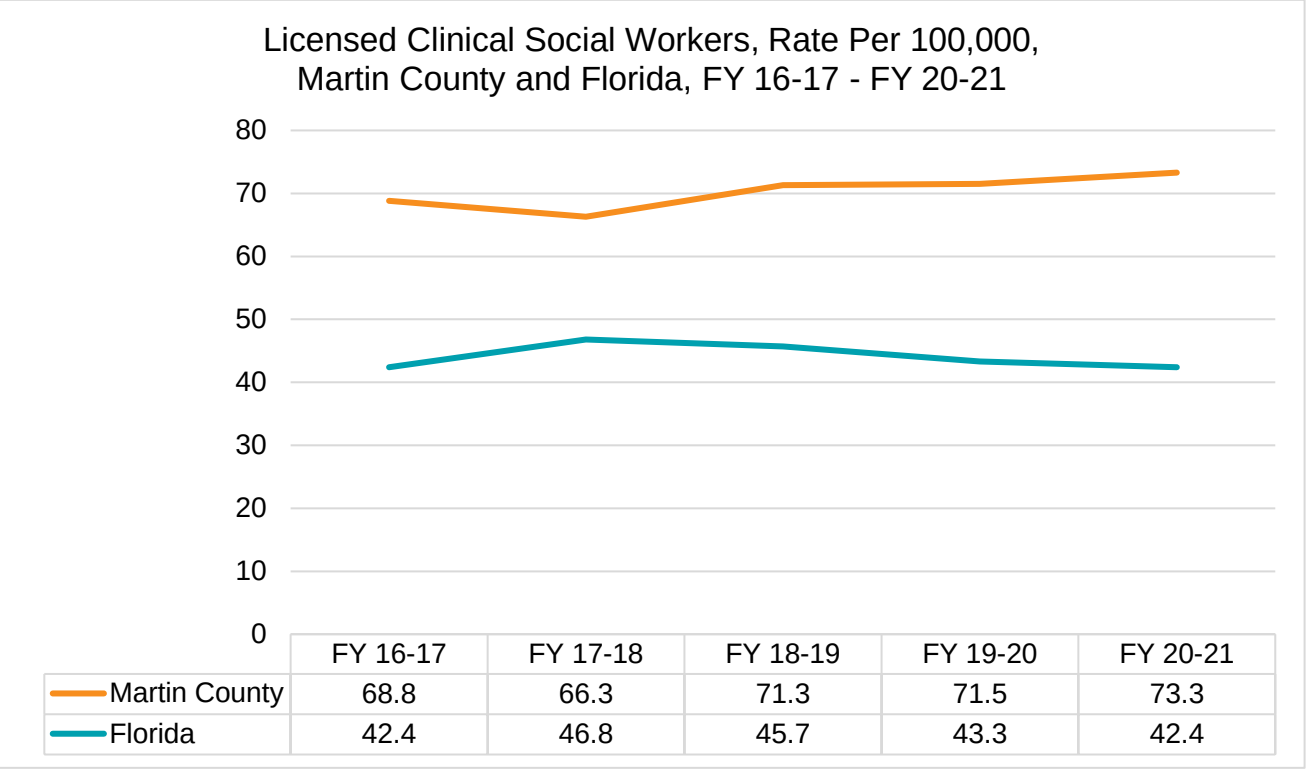


	FY 16-17	FY 17-18	FY 18-19	FY 19-20	FY 20-21
Martin County	127.1	124.1	137.4	133.5	141.0
Florida	99.0	101.6	106.8	110.0	117.1

Source: Florida Department of Health, Division of Medical Quality Assurance

[171] Allison, D.B., Newcomer, J.W. et al (2009). Obesity among those with mental disorders: A National Institute of Mental Wellbeing meeting report. *American Journal of Preventive Medicine.* 36(4): 341-350.

The figure below shows the rate of Licensed Clinical Social Workers (LCSW) per 100,000 population in Martin County and Florida from 2016 to 2021. Each year, Martin County had a higher rate than the state. In FY 20-21, Martin County had 73.3 LCSW per 100,000 population, compared to 42.4 per 100,000 population in Florida. As stated, obesity is higher among individuals with certain mental health conditions, such as depression. As such, the availability of licensed mental health providers is essential for mitigation.[172]

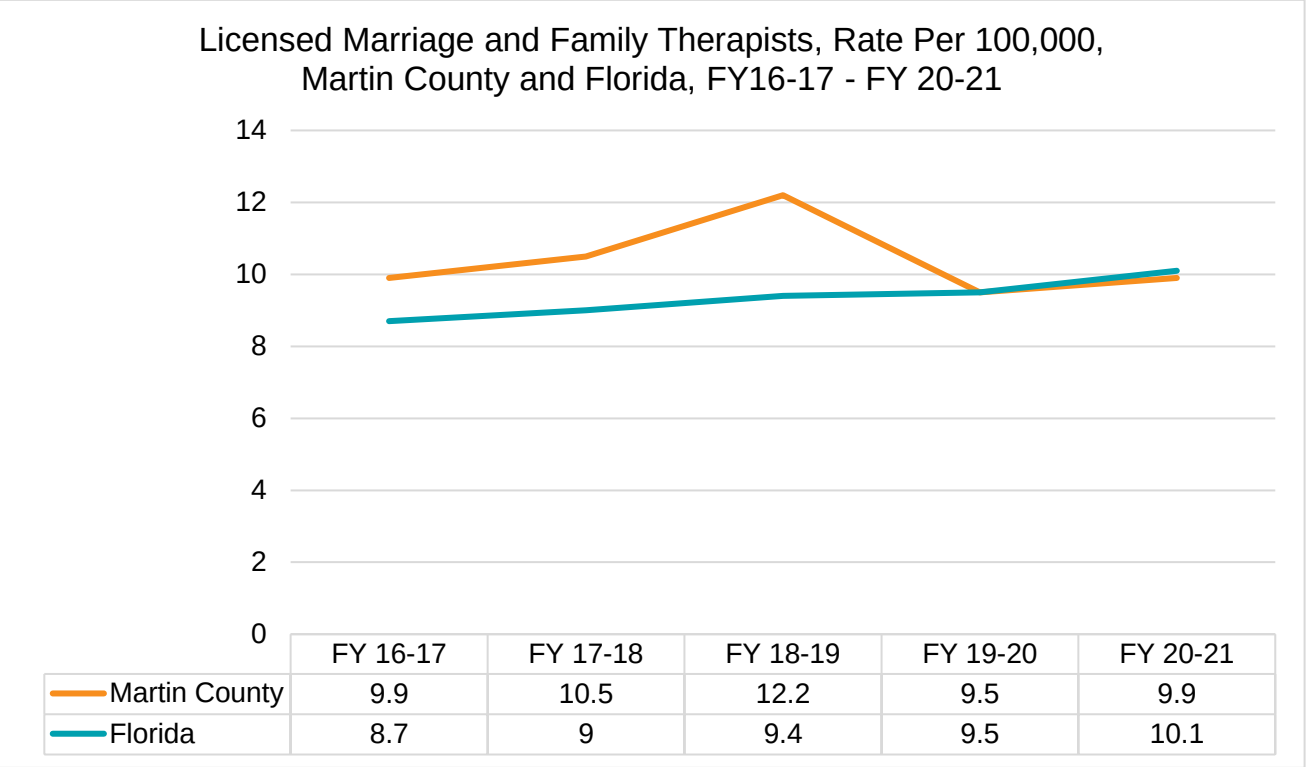


	FY 16-17	FY 17-18	FY 18-19	FY 19-20	FY 20-21
Martin County	68.8	66.3	71.3	71.5	73.3
Florida	42.4	46.8	45.7	43.3	42.4

Source: Florida Department of Health, Division of Medical Quality Assurance

[172] Allison, D.B., Newcomer, J.W. et al (2009). Obesity among those with mental disorders: A National Institute of Mental Wellbeing meeting report. *American Journal of Preventive Medicine.* 36(4): 341-350.

The figure below shows the rate of Licensed Marriage and Family Therapists (LMFT) per 100,000 population in Martin County and Florida from FY 16-17 to FY 20-21. Up until FY 19-20, Martin County had a higher rate than the state. In FY 20-21, Florida had 10.1 LMFT per 100,000 population, compared to 9.9 per 100,000 population in Martin County. As mentioned, obesity is higher among individuals with certain mental health conditions, such as depression. As such, the availability of licensed mental health providers is essential for mitigation.[173]

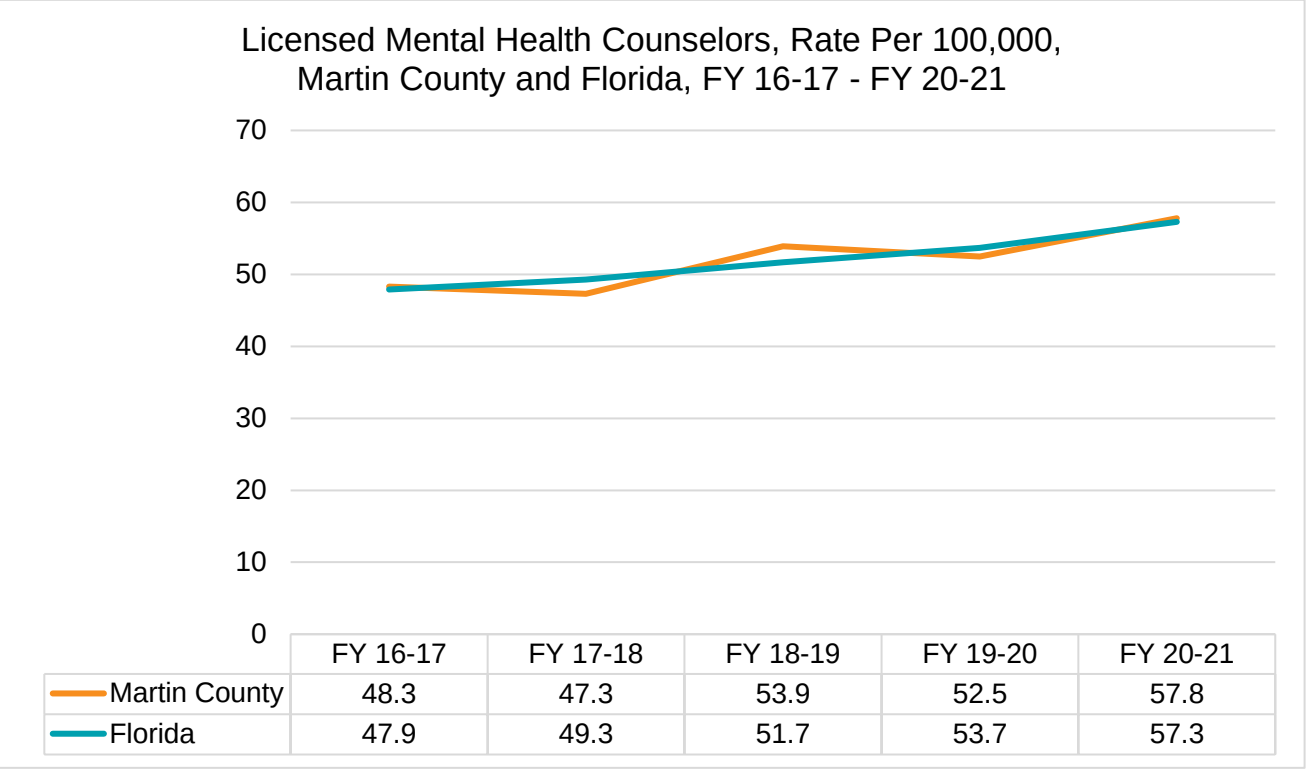


	FY 16-17	FY 17-18	FY 18-19	FY 19-20	FY 20-21
Martin County	9.9	10.5	12.2	9.5	9.9
Florida	8.7	9	9.4	9.5	10.1

Source: Florida Department of Health, Division of Medical Quality Assurance

[173] Allison, D.B., Newcomer, J.W. et al (2009). Obesity among those with mental disorders: A National Institute of Mental Wellbeing meeting report. *American Journal of Preventive Medicine.* 36(4): 341-350.

The figure below shows the rate of Licensed Mental Health Counselors (LMHC) per 100,000 population in Martin County and Florida from FY 16-17 to FY 20-21. Each year, the rate was very similar for both the county and the state and increased for both over time. In FY 20-21, Martin County had 57.8 LMHC per 100,000 population and Florida had 57.3 per 100,000 population. As mentioned, obesity is higher among individuals with certain mental health conditions, such as depression. As such, the availability of licensed mental health providers is essential for mitigation.[174]



	FY 16-17	FY 17-18	FY 18-19	FY 19-20	FY 20-21
Martin County	48.3	47.3	53.9	52.5	57.8
Florida	47.9	49.3	51.7	53.7	57.3

Source: Florida Department of Health, Division of Medical Quality Assurance

[174] Allison, D.B., Newcomer, J.W. et al (2009). Obesity among those with mental disorders: A National Institute of Mental Wellbeing meeting report. *American Journal of Preventive Medicine.* 36(4): 341-350.

Medically Underserved Areas (MUAs)

Medically Underserved Areas (MUAs) and Medically Underserved Populations (MUPs) identify geographic areas and populations with a lack of access to primary care services. MUAs have a shortage of primary care health services for residents within a geographic area, while MUPs are specific sub-groups of people living in a defined geographic area with a shortage of primary care health services. Designations are based on the Index of Medical Underservice (IMU). The IMU is calculated based on four criteria: the population to provider ratio; the percent of the population below the federal poverty level; the percent of the population over age 65; and the infant mortality rate. IMU can range from 0 to 100, where zero represents the completely underserved. Areas or populations with IMUs of 62.0 or less qualify for designation as an MUA/P. In Martin County, the Indiantown Service Area, is also a Primary Care and Mental Health Shortage Area. Given the direct impact adequate diagnosis, treatment, and management has on the prevalence of obesity, the Martin County Health Equity Taskforce is implementing a PACE-EH Community Project in Indiantown to further assess their environmental needs.

Martin County	MUA/P Score
Indiantown Service Area	60.8

Source: Health Resources and Service Administration, 2020

Health Professional Shortage Areas (HPSAs)

A Health Professional Shortage Area (HPSA) is a geographic area designated by the Health Resources Services Administration (HRSA) as having a shortage of primary, dental, or mental health professionals. THE HPSA FTE Short score is the number of full time equivalent (FTE) practitioners needed to achieve the population to practitioner target ratio determined by the discipline. The HPSA Score determines the priority for assigning clinicians and ranges from 0 to 26, with the higher score the greater the priority.[175] As of May 2022, Martin County had two primary care, one dental health, and two mental health HPSAs. Of the primary care HPSAs, one was the Indiantown Service area, with a HPSA score of 10, and one was the Martin Correctional Institution, with a HPSA score of 6. The dental health HPSA was the Martin Correctional Institution with a HPSA score of 3. Of the mental Health HPSAs, one was the Indiantown Service Area, with a HSPA score of 14, and the other was the Martin Correctional Institution with a HPSA score of 21. All designated HPSAs in Martin County were non-rural. Given the direct impact adequate diagnosis, treatment, and management has on the prevalence of obesity, the association between oral health and obesity, and the association between mental health and obesity, the Martin County Health Equity Taskforce is implementing a PACE-EH Community Project in Indiantown to further assess their environmental needs.

Health Professional Shortage Areas (HPSAs), Martin County, As of May 2022

Discipline	HPSA ID	HPSA Name	Designation Type	Primary State Name	HPSA FTE Short	HPSA Score	Rural Status
Primary Care	11284 98353	Indiantown Service Area	Geographic HPSA	Florida	3.70	10	Non-Rural
Primary Care	11238 66885	Martin Correctional Institution	Correctional Facility	Florida	1.44	6	Non-Rural
Dental Health	61272 66410	Martin Correctional Institution	Correctional Facility	Florida	1.33	3	Non-Rural
Mental Health	71281 17565	Indiantown Service Area	Geographic HPSA	Florida	1.00	14	Non-Rural
Mental Health	71299 18924	Martin Correctional Institution	Correctional Facility	Florida	2.13	21	Non-Rural

Source: Health Resources and Services Administration, data.HRSA.gov

[175] HRSA Find (n.d.). In data.HRSA.gov. Retrieved from https://data.hrsa.gov/tools/shortage-area/hpsa-find

Health Resource Availability

The table below shows lists the licensed hospitals in Martin County and the ZIP codes that they are located in in 2020. In 2020, there were four licensed hospitals, with Cleveland Clinic Martin North Hospital located in 34994 and Cleveland Clinic Martin South Hospital, Coral Shores Behavioral Health, and Encompass Health Rehab Hospital an Affiliate of Martin Health all located in 34997.

Licensed Hospitals, Martin County, 2020	
Hospital	**Zip Code**
Cleveland Clinic Martin North Hospital	34994
Cleveland Clinic Martin South Hospital	34997
Coral Shores Behavioral Health	34997
Encompass Health Rehab Hospital an Affiliate of Martin Health	34997

Source: Health Resources and Service Administration, 2020

The table below lists the licensed nursing homes in Martin County and the cities that they are located in as of May 2022. In 2022, there were 833 available licensed beds across seven nursing homes: four in Stuart, two in Palm City, and one in Hobe Sound.

Licensed Nursing Homes, Martin County, As of May 2022				
Name	**City**	**Phone**	**Licensed Beds**	**Profit Status**
Martin Nursing and Rehabilitation	Stuart	(772) 223-8777	120	For-Profit
Orchid Cove at Stuart	Stuart	(772) 286-9440	120	For-Profit
Palm City Nursing and Rehab Center	Palm City	(772) 288-0060	120	For-Profit
Solaris Healthcare Parkway	Stuart	(772) 287-9912	177	Not-For-Profit
Stuart Rehabilitation and Healthcare	Stuart	(772) 283-5887	120	For-Profit
The Terrace at Hobe Sound	Hobe Sound	(772) 546-5800	120	For-Profit
Water's Edge Health and Rehabilitation	Palm City	(772) 223-5863	56	For-Profit

Source: FloridaHealthFinder.gov

The table below lists the licensed home health agencies in Martin County and the city that they are located in as of May 2022. In 2022, there were 14 home health agencies: 10 in Stuart, three in Hobe Sound, and one in Palm City.

Licensed Home Health Agencies, Martin County, As of May 2022				
Name	**City**	**Phone**	**Licensed Beds**	**Profit Status**
Activa Home Health	Hobe Sound	(561) 819-0460	0	For-Profit
Always Best Care Senior Services	Hobe Sound	(772) 205-3888	0	For-Profit
Anchor Home Health Services, LLC	Stuart	(772) 463-6016	0	For-Profit
Aveanna Home Health	Stuart	(883) 283-6286	0	For-Profit
Champion Home Health Care	Stuart	(772) 287-5432	0	For-Profit
Evergreen Private Care of Florida LLC	Stuart	(772) 291-2990	0	For-Profit
First Home Care Solutions LLC	Stuart	(561) 567-7432	0	For-Profit
Health at Home	Palm City	(772) 288-7386	0	For-Profit
Homereach LLC	Stuart	(772) 878-3534	0	For-Profit
Nightingale Private Care, Inc.	Hobe Sound	(772) 245-8390	0	For-Profit
Perfect Care Home Health Agency	Stuart	(772) 419-8892	0	For-Profit
Senior Helpers of The Treasure Coast	Stuart	(772) 463-1112	0	For-Profit
Superior Care Home Health Agency LLC	Stuart	(772) 678-6994	0	For-Profit
Visiting Nurse Association of Florida Inc	Stuart	(772) 286-1844	0	Not-For-Profit

Source: FloridaHealthFinder.gov

The table below lists the Federally Qualified Health Centers (FQHC) in Martin County and the ZIP codes that they are located in. In 2020, there were two FQHC: 1) Indiantown Center Satellite Site in 34956 and 2) Stuart Center Satellite Site located inside the Florida Department of Health in Martin County building. FQHCs offer a number of essential services, including preventive health services that are essential for both the prevention, diagnosis, and management of obesity and prevention of other associated chronic diseases.

Federally Qualified Health Centers (FQHC), Martin County, 2020	
Federally Qualified Health Center	**Zip Code**
Indiantown Center (Satellite Site)	34956
Stuart Center (Satellite Site - Located Inside Martin County Health Dept. Bldg.)	34994

Source: Florida Community Health Centers, Inc., 2020

The Impact of Health Care Access and Quality on Obesity in Martin County

The Martin County Health Equity Taskforce discussed how Health Care Access and Quality impacts overweight status and obesity in Martin County.

Health Care Access and Quality		
SDOH	**Priority Populations Impacted**	**How the SDOH Impacts Obesity**
Health Coverage	Black and Hispanic residents; American Indian and Alaska Native residents; undocumented residents; migrants; foreign-born residents	Members discussed that health insurance coverage is associated with increased access to needed prescription drugs, preventative primary care visits, important health screenings, and specialty health care services. Those without coverage may delay care which exacerbates health issues. With respect to obesity, many without coverage may not know they have a weight issue and may not receive proper treatment and counseling on how to implement healthier habits.
Provider Linguistic and Cultural Competency	Black and Hispanic residents; undocumented residents; migrants	Members discussed the need for linguistically and culturally competent services, especially for Hispanic/Latino residents, Haitian residents, migrant farmworkers, and residents without documentation. Black and Hispanic communities experience higher rates of overweight status and obesity, so ensuring culturally and linguistically appropriate service provision is essential.
Primary Care Access (Personal Doctor, Medical Checkup, Inability to Pay for Care)	Hispanic residents; Black residents; young adults; low-income residents	Adults who receive regular care from a personal or family physician are more likely to receive preventative services, such as BMI and blood pressure checks. Thus, primary care visits are an important point of care for obesity diagnoses and obesity care and management plan development. Screening and diagnosis of obesity is essential to improving health status, with a study demonstrating those with overweight status or obesity who received a diagnosis being over two times more likely to attempt to lose weight. Obesity has a huge impact on overall health and is also correlated with high medical costs. Compounding obesity with the inability to pay for medical visits only exacerbates the issue.
Provider Availability	Black and Hispanic residents; undocumented residents; migrants; rural communities	Members discussed that although many residents do have health coverage, they may not have access to the provider or care that they need, due to a limited number of specialty care providers located in some pockets of the county, such as Indiantown. This is particularly worrisome with respect to comorbidities that those who are obese experience; for instance, many who are obese experience coronary heart disease and have limited ability to seek care from a cardiologist. Moreover, geographic access and availability of medical providers, particularly providers who receive specialized training on obesity management, is integral for improving obesity-related health outcomes

VIII. SDOH PROJECTS

The Minority Health Liaison recruited and engaged members across the county, including government agencies, nonprofits, private businesses, and community organizations, to join the Health Equity Taskforce. The Minority Health Liaison took into consideration the prioritized health disparity and the impactful SDOHs identified by the Health Equity Team during recruitment. The flyers below were disseminated by the Health Equity Team to recruit members. Flyer distribution occurred at different community events, at local strip malls and parks, through the local WIC office, throughout Indiantown, and through community partners to their clients and staff.

A. Data Review

The Health Equity Taskforce reviewed data, including health disparities and SDOHs provided by the Health Equity Team. The Health Equity Taskforce also researched evidence-based interventions and strategies and promising approaches to improve the identified SDOHs, these included **Go NAPSACC**, an evidence-based tool for implementing policies and improving childcare setting environments to reduce obesity; **Protocol for Assessing Community Excellence in Environmental Health (PACE-EH)**, an evidence-based framework for improving environmental health for the community by the community; and different evidence-based SDOH Screening Tools, such as **PRAPARE**, to adequately screen for barriers and needs. More details can be found in the community project descriptions below.

Further, the Health Equity Taskforce considered the policies, systems, and environments that lead to inequities and health outcome disparities. For instance, the Taskforce considered the limited public transportation infrastructure that exists in the county and limits the ability for residents to access healthy food sources and necessary care and services, the lack of adequate kitchen facilities and safe food storage in some pockets of the community, and the lack of adequate representation in the health care system with respect to communities of color and residents whose first language is not English.

Upon further review of the obesity and SDOH disparity data and an in-depth literature review on how each SDOH impacts obesity, the Taskforce noted that the neighborhood and built environment and education access and quality are the most pressing SDOH to address with the first iteration of this plan. However, the Taskforce also notes that other SDOH, such as economic stability, health care access and quality, and social and community context, also play a critical role in the prevalence of obesity-related disparities; as such, the Health Equity Taskforce will consider future community projects aimed at improving these conditions. The Health Equity Taskforce meeting minutes, in which the data review process and evidence-based strategy discussions are documented in detail, are included in Addendum B.

Throughout the implementation phase, the Martin County Health Equity Taskforce and Martin County Health Equity Team will meet at least quarterly to monitor community project progress. The Minority Health Liaison will work to collect and track process measure data (i.e., PACE-EH survey analysis, PACE-EH action plan; completed Go NAPSACC assessments, etc.), in addition to collecting and reporting back on the secondary objective data (i.e., proportion of students who are obese; proportion of WIC clients who are obese, etc.). The Minority Health Liaison will also report on progress to the Health Equity Regional Coordinators and the Office of Minority Health and Health Equity on a consistent basis as needed, but at least quarterly.

B. Barrier Identification

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

Partners	SDOH	Partner Barriers	Theme	Collaborative Strategies
Epilepsy Florida with Taskforce Members in agreement	Neighborhood and Lived Environment	Transportation Access	Limited transportation access impacts access to care, healthy foods, and resources	Partner with MARTY, the Martin County Public Transportation Agency and other ride share agencies; identify mobile health strategies for those in remote locations (i.e., traveling garden, telehealth, etc.)
Dr. Poitier-Anderson with Taskforce Members in agreement	Economic Stability	Economic disparities lead to unhealthy behaviors and lack of access among lower-income residents	Residents tend to choose whatever is cheapest so they can quickly fill their stomachs. School-age children rely on the choices provided at school and rely on parents for quick and easy dinner options at home.	Identify cost-effective options for healthy choices; revisit school curriculums to include a component for students to learn about preparing healthy menus; start evidence-based nutrition education in early care and childcare settings; look into the wide implementation of Go NAPSACC and Florida's Healthy Environments for Reducing Obesity (FL HEROs) Recognition Program; programs should be implemented at times when working heads of families can participate and have access to free childcare services; partner with afterschool programs in Indiantown, such as the

				Boys and Girls Club YMCA, etc. to provide health and fitness.
Tykes and Teens with Taskforce Members in agreement	Access to healthcare	Transportation, lack of available staff, and stigma are barriers for mental health	Increasing access to mental health services will also reduce obesity, as mental health issues contribute to weight issues, the lack of exercise, and unhealthy choices	Increase awareness of available transportation options, improve awareness of mental health issues, normalize seeking care, and partner with the Managing Entity to increase access to mental health services
American Heart Association with Taskforce Members in agreement	Neighborhood and lived environment, access to healthy foods	Lack of access to fresh fruits and vegetables	Access to fresh foods and vegetables is key to improving obesity and overweight status in Martin County	Secure funding to implement changes that can help increase access in communities through sustainable environmental changes
American Heart Association with Taskforce Members in agreement	Neighborhood and lived environment	Lack of adequate shelving and cold-food storage at food pantries	Lack of appropriate built environments for food storage limits the ability to serve fresh and healthy foods	Establish a pop-up farmers market or urban garden; address startup cost barriers, find space, and get permits; identify long-term funding sources to ensure sustainability
211/Health Insurance with Taskforce Members in agreement	Access to health care	Language barriers; disinformation when it comes to health insurance coverage	There is a lack of staff who speak and resources in all needed languages, such as Spanish, Haitian Creole,	Ensure resources are translated into multiple languages; ensure that bilingual staff are hired or that translation services are available; have allied healthcare professionals speak with their clients

			and Aztec. There is also disinformation regarding “Obamacare” and thinking it no longer exists	about health insurance options; build trust with community members because people need to feel comfortable with disclosing personal information

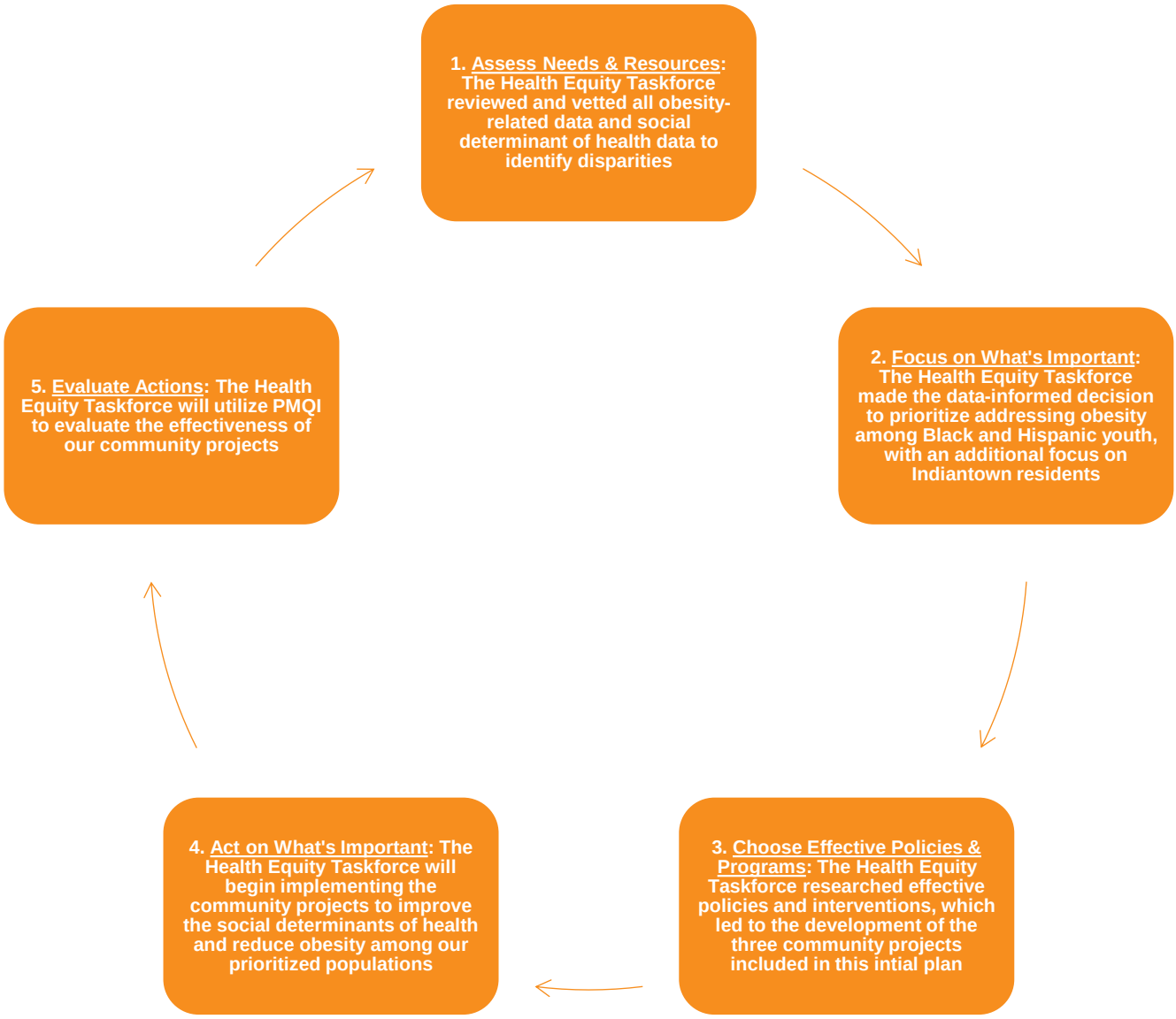
C. Community Projects

The Health Equity Taskforce chose the **County Health Rankings and Roadmaps' Steps to Move Your Community Forward** framework, an evidence-based, established methodology to design the community projects. This framework is depicted in the figure on the next page and includes five steps: (1) assess needs and resources, (2) focus on what's important, (3) choose effective policies and programs, (4) act on what's important, and (5) evaluate actions.[176] The Health Equity Taskforce also chose to integrate the **Performance Management and Quality Improvement (PQMI)** framework for evaluation to improve effectiveness and quality of the Plan's projects.

Using the Steps to Move Your Community Forward framework, the Health Equity Team and Taskforce assessed all health outcome and SDOH data on Martin County residents, as seen in this report. Along with using the County Health Rankings and Roadmaps' Steps to Move Your Community Forward, the Health Equity Taskforce also researched evidence-based strategies to overcome the identified barriers and improve the SDOH that impact the prioritized health disparity, overweight and obesity.

Through multiple meetings and discussions, the Health Equity Team found, in collaboration with the Taskforce and based on all available data, that overweight and obesity is affecting Black or African American and Hispanic children at extremely high rates compared to all other groups and is causing significant and undeniable health disparities between groups. Through this process, the Health Equity Plan's projects were created to address specific SDOHs impacting the disparity found in overweight and obesity status among Black or African and Hispanic children in Martin County. These projects include the Protocol for Assessing Community Excellence in Environmental Health (PACE-EH) project in Indiantown, a county-wide effort focusing on young children in early care and education settings through Go NAPSACC, and a data collection project with the goal of collecting missing data for key priority populations where data is currently unavailable in Martin County. During project design, the Health Equity Taskforce considered the policies, systems, and environments that lead to inequities. Projects include short, medium, and long-term goals with measurable objectives. These projects were reviewed, edited, and approved by the Health Equity Coalition during a meeting on June 2, 2022 to ensure feasibility. Projects are explained in detail in the following section.

[176] Action Center (2022). In County Health Rankings & Roadmaps. Retrieved from https://www.countyhealthrankings.org/take-action-to-improve-health/action-center


1. Assess Needs & Resources: The Health Equity Taskforce reviewed and vetted all obesity-related data and social determinant of health data to identify disparities
2. Focus on What's Important: The Health Equity Taskforce made the data-informed decision to prioritize addressing obesity among Black and Hispanic youth, with an additional focus on Indiantown residents
3. Choose Effective Policies & Programs: The Health Equity Taskforce researched effective policies and interventions, which led to the development of the three community projects included in this intial plan
4. Act on What's Important: The Health Equity Taskforce will begin implementing the community projects to improve the social determinants of health and reduce obesity among our prioritized populations
5. Evaluate Actions: The Health Equity Taskforce will utilize PMQI to evaluate the effectiveness of our community projects

IX. HEALTH EQUITY PLAN OBJECTIVES

A. Overweight and Obesity in Martin County

Determining a Health Disparity Objective

After compiling and evaluating all available data for priority populations in Martin County and determining a health disparity focus area and priority population, the Health Equity Taskforce and the Health Equity Team developed the Plan's health disparity objective to evaluate the success of the Plan and its projects. The Health Equity Taskforce used a trend analysis tool developed by the Health Promotion and Statistics Branch at the National Center for Health Statistics (NCHS), which was utilized in the development of the Healthy People 2030 objective targets. The purpose of the trend analysis is to calculate targets using a projection based on linear trend analysis of historical trend data.[177]

When examining overweight and obesity disparities between youth populations, the Martin County Health Equity Taskforce found that in Martin County in 2020 the percentage of overweight or obese Black or African American middle and high school students was 30.5% and the percentage of overweight or obese Hispanic middle and high school students was 34.4%. However, the percentage of overweight or obese non-Hispanic white middle and high school students during this same year was 19.2%, which demonstrates a disparity of over 10 percentage points between White students and their Black or African American and Hispanic counterparts.[178] Using the trend analysis tool, the Health Equity Taskforce found that, without any intervention, the percentage of White overweight or obese middle and high school students is projected to be 18.2% in 2027, compared to 20.6% among Black or African American students and 29.9% of Hispanic students. While the percentage of overweight or obese students in each population decreases at least slightly, disparities between these populations continue to persist.

Looking at the percentage of WIC clients aged 0 to 2 years old, 36.7% were overweight or obese in Martin County in 2021. The trend analysis tool shows that this percentage will rise to 38.6% in 2027. While this data is not disaggregated by sub-group for comparison, such as race or ethnicity, infants and toddlers aged 0 to 5 are recognized as a priority population in and of itself. Because of this, the alarming proportion of overweight or obese children in this group, and the critical importance of

[177] Hubbard, M.S., K., Klein, M.P.H., R., Huang, M.P.H., C.P.H., D., & Talih, Ph.D., M. (2020, September). Target-Setting Methods in Healthy People 2030. In Healthy People 2030, Healthy People Statistical Notes. Retrieved from https://www.cdc.gov/nchs/data/statnt/statnt28-508.pdf
[178] Florida Department of Health, Division of Community Health Promotion, Florida Youth Tobacco Survey (FYTS)

establishing positive healthy behaviors at a young age, the Health Equity Taskforce chose to incorporate this population into the health disparity objective, as well.

The Health Equity Taskforce used the projected benchmarks produced by the trend analysis tool to determine target numbers for each priority population. To note, it was determined after reviewing the data and the trend analysis tool that choosing the target below the projection without any intervention for Black or African American students (11.9%) seemed to be an unreasonable and unrealistic goal. Based on this observation, target numbers were modified using the tool. Trend analysis graphs for the health disparity objective populations can be found starting in Addendum C. The health disparity objective chosen by the Martin County Health Equity Taskforce is as follows:

By 2027, reduce overweight and obesity in Martin County among:

- ***Black or African American middle and high school students from 30.5% (2020) to 29.2%***
- ***Hispanic middle and high school students from 34.4% (2020) to 24.6%***
- ***and WIC clients (2-4 years old) from 36.7% (2021) to 35.9%***

PACE-EH, Indiantown Project Table

Through discussions with the Health Equity Taskforce, they explained significant barriers to health facing Martin County residents related to the built environment, specifically regarding access to healthy and affordable food. Specific points mentioned during Taskforce meetings include how cost influences healthy food buying behavior, there is a high density of fast-food restaurants and convenience marts in low-income areas leaving residents with the unhealthiest options to choose from, and low-income neighborhoods, regardless of cost of food, still experience transportation barriers getting to healthy food sources. The Taskforce also expressed the desire to not duplicate efforts, but to build upon work already being done. For these reasons, it was determined that the Martin County Health Equity Plan will focus on implementing a PACE-EH initiative already in motion in Indiantown. PACE-EH, also known as the **Protocol for Assessing Community Excellence in Environmental Health**, is a methodology consisting of tasks to engage the public's involvement, collect necessary and relevant information pertaining to community environmental health status, rank issues, and set local priorities for action.[179]

This project, outlined in detail below, will focus on full implementation of the PACE-EH protocol. Through this protocol, surveys will be distributed to Indiantown residents to assess barriers to accessing healthy foods, proximity to healthy food sources, and related needs, along with needs among residents related to walkability, access to green spaces and parks, time spent outdoors, and spaces needed for physical activity. Informed by these assessments, future PACE-EH projects will be developed to address any barriers facing residents with the goal of improving overweight and obesity outcomes for first, third, and sixth grade children in Indiantown. Future community projects can potentially include, but are not limited to, community gardens, efforts to increased access to SNAP or Fresh Access Bucks, providing incentives to increase the width of sidewalks or bike lanes, or adding fitness equipment to parks, all of which were mentioned by the Health Equity Taskforce as potential ideas.

Moreover, the Martin County Health Equity Taskforce and Martin County Health Equity Team will meet at least quarterly to monitor progress with respect to the process measures and objectives. The Minority Health Liaison will work to collect and track process measure data (i.e., PACE-EH survey analysis, PACE-EH action plan, etc.), in addition to collecting and reporting back on the secondary objective data (i.e., proportion of students who are obese). The Minority Health Liaison will also report on progress to the Health Equity Regional Coordinators and the Office of Minority Health and Health Equity on a consistent basis as needed, but at least quarterly.

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[179] Protocol for Assessing Community Excellence in Environmental Health (2000, May). In Centers for Disease Control and Prevention. Retrieved from https://www.cdc.gov/nceh/ehs/docs/pace-eh-guidebook.pdf

Using a trend analysis tool developed by the Health Promotion Statistics Branch at the National Center for Health Statistics and used to develop the Healthy People 2030 targets, historical data on overweight and obese first, third, and sixth graders in Indiantown was used to determine future outcome projections without intervention. Without intervention, by the 2026-27 SY, the percentage of **first grade** children in **Indiantown** who are overweight or obese is projected to be 45.5%. Without intervention, by the 2026-27 SY, the percentage of **third grade** children in **Indiantown** who are overweight or obese is projected to be 67.1%. Without intervention, by the 2026-27 SY, the percentage of **sixth grade** children in **Indiantown** who are overweight or obese is projected to be 67.0%. Project targets for each age group were chosen based on these projections with the intention that this project, or intervention, will either further decrease the projection or reverse the upward trend. Detailed trend analysis data for the PACE-EH project can be found in Addendum D.

The following table outlines the specific details of the PACE-EH initiative in Indiantown.

	Lead Entity and Unit	Lead Point Person	Data Source	Baseline Value	Target Value	Plan Alignment
Long-Term SDOH Goals: • Improve neighborhood and lived environment and access to affordable healthy food, by fully implementing PACE-EH-based project as a Martin County Health Equity Plan Community Project. • Improve neighborhood and lived environment by assessing access to parks and green space, walkability, and needed support for enhancing physical activity opportunities, and implementing a walkability Martin County Health Equity Plan Community Project.						
Objective: By 2027, improve access to healthy and affordable food to decrease the proportion of children in Indiantown who are overweight or obese from 48.5% to 40.3% among 1st graders, from 59.3% to 55.0% among 3rd graders, and from 61.8% to 54.7% among 6th graders.	Florida Department of Health in Martin County	Angelica Castillo da Silva, Minority Health Liaison	Martin County School District	48.5% obese or overweight 1st graders 59.3% obese or overweight 3rd graders 61.8% obese or overweight 6th graders	40.3% obese or overweight 1st graders 55.0% obese or overweight 3rd graders 54.7% obese or overweight 6th graders	Healthiest Weight Plan

Note: From 2019-2020 to 2021-2022, the proportion of both 1st graders, 3rd graders, and 6th graders who were overweight or obese in Indiantown increased considerably (i.e., 42.8% to 48.5% among 1st graders; 48.9% to 59.3% among 3rd graders; and 56.7% to 61.8% 6th graders). Through this project, we aim to reverse this upward trend, decreasing the proportion over time.						
Key Activities			Key Partners		Process Measures	
• Develop a PACE-EH community project to improve access to healthy food in Indiantown, as lower rates of obesity are found in areas with increased access to healthy foods. • Complete walkability survey analysis. • Develop a community project to improve walkability and outdoor spaces based on walkability survey analysis.			DOH-Martin Indiantown Mayor Village of Indiantown 21st Century Director – Boys and Girls Club in Indiantown YMCA Indiantown Holy Cross Church House of Hope Faith-Based Organizations		Development and integration of a PACE-EH-informed community project. Development and integration of a walkability project. Action-plan implementation. Development and integration of Healthy Food Accessibility project.	
Medium-Term SDOH Goals: • Improve neighborhood and lived environment and access to affordable healthy food, by determining key recommendations for PACE-EH activities based on survey findings.						

• Improve neighborhood and lived environment by developing and disseminating a survey to assess access to parks and green space, walkability, and needed support for enhancing physical activity opportunities.						
Objective: By 2025, improve access to healthy and affordable food to decrease the proportion of children in Indiantown who are overweight or obese from 48.5% to 42.0% among 1st graders, from 59.3% to 58.0% among 3rd graders, and from 61.8% to 57.6% among 6th graders. Note: From 2019-2020 to 2021-2022, the proportion of both 1st graders, 3rd graders, and 6th graders who were overweight or obese in Indiantown increased considerably (i.e., 42.8% to 48.5% among 1st graders; 48.9% to 59.3% among 3rd graders; and 56.7% to 61.8% 6th graders). Through this project, we aim to reverse this upward trend, decreasing the proportion over time.	Florida Department of Health in Martin County	Angelica Castillo da Silva	Martin County School District	48.5% obese or overweight 1st graders 59.3% obese or overweight 3rd graders 61.8% obese or overweight 6th graders	42.0% obese or overweight 1st graders 58.0% obese or overweight 3rd graders 57.6% obese or overweight 6th graders	Healthiest Weight Plan

Key Activities	Key Partners	Process Measures
• Determine recommendations based on PACE-EH survey analysis, which includes an assessment of barriers to accessing healthy foods, proximity to healthy food sources, and related needs. • Establish PACE-EH activities for project development and implementation in Health Equity Plan. • Develop and distribute a new survey to assess needs among Indiantown residents related to walkability, access to green spaces and parks, time spent outdoors, and spaces needed for physical activity.	DOH-Martin Indiantown Mayor Village of Indiantown 21st Century Director – Boys and Girls Club in Indiantown YMCA Indiantown Holy Cross Church House of Hope Faith-Based Organizations	Written recommendations. Written project activities. Developed action plan.

Short-Term SDOH Goal: Improve neighborhood and lived environment and access to affordable healthy food, by analyzing a community survey to assess access to healthy food in Indiantown.

Objective: By 2024, improve access to healthy and affordable food to decrease the proportion of children in Indiantown who are overweight or obese from 48.5% to 42.8% among 1st graders, from 59.3% to 58.0% among 3rd graders, and from 61.8% to 57.6% among 6th graders. Note: From 2019-2020 to 2021-2022, the proportion of both 1st graders, 3rd graders, and 6th graders who were	Florida Department of Health in Martin County	Angelica Castillo da Silva	Martin County School District	48.5% obese or overweight 1st graders 59.3% obese or overweight 3rd graders 61.8% obese or overweight 6th graders	42.8% obese or overweight 1st graders 58.6% obese or overweight 3rd graders 59.0% obese or overweight 6th graders	Healthiest Weight Plan

overweight or obese in Indiantown increased considerably (i.e., 42.8% to 48.5% among 1st graders; 48.9% to 59.3% among 3rd graders; and 56.7% to 61.8% 6th graders). Through this project, we aim to reverse this upward trend, decreasing the proportion over time.						
Key Activities			Key Partners		Process Measures	
Complete PACE-EH a survey analysis, which includes an assessment of barriers to accessing healthy foods, proximity to healthy food sources, and related needs.			DOH-Martin Indiantown Mayor Village of Indiantown 21st Century Director – Boys and Girls Club in Indiantown YMCA Indiantown Holy Cross Church House of Hope Faith-Based Organizations		Completed survey analysis.	

Go NAPSACC Project Table

Research confirms that preventing overweight and obesity in early childhood is extremely important, because obesity is difficult to reverse and can persist into adult life, increasing risk of cardiovascular disease, type 2 diabetes, cancer, and other complex comorbidities.[180] [181] [182] [183] Not only do these health conditions negatively impact quality of life, but overweight and obesity also increase the financial burden of health care on the individual, employers providing health insurance, and the health care industry as a whole. Additionally, the underlying causes and risk factors for overweight and obesity, such as nutrition behavior and physical activity, are largely modifiable and impacted greatly by the SDOHs.

Children aged 0 to 5 enrolled in early care and education (ECE) settings spend the majority of their daytime at a child care facility, which emphasizes the importance and opportunity of focusing interventions in this area. However, not all children of this age are enrolled in a formal child care setting and are taken care of by a parent, guardian, or full-time caregiver. Future projects as a part of the Health Equity Plan will be considered to focus on this group, as well.

Go NAPSACC is an evidence-based tool designed to support providers of early childhood education self-assess, set goals, and implement best practices, policies, and environments that support the healthy growth and development of young children. Access to Go NAPSACC and personalized technical assistance support is available at no cost to child care providers across the state through the Healthy Kids, Healthy Futures Technical Assistance Program (HKHF TAP) initiative and funding from the Florida Department of Health.

During the Health Equity Taskforce meeting in May, the Taskforce reviewed this evidence-based tool and determined it would be an effective way to improve built environments to reduce obesity among Black and Hispanic children in Martin County. Importantly, the Taskforce also discussed the need to reach children who are not currently enrolled in ECE programs. As such, in the near future, the Taskforce will determine appropriate interventions to reach all children in Martin County, but agree that Go NAPSACC is a tool that we should leverage now.

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[180] Lanigan, J. (2018). Prevention of overweight and obesity in early life. Proceedings of the Nutrition Society, 77(3), 247-256. doi:10.1017/S0029665118000411
[181] Simmonds, M., Llewellyn, A., Owen, C. G., & Woolacott, N. (2016). Predicting adult obesity from childhood obesity: a systematic review and meta-analysis. Obesity reviews, 17(2), 95-107.
[182] Lakshman, R., Elks, K., & Ong, K. (2012, October). Childhood Obesity. Circulation, 126(14), 1770-1779. doi:https://doi.org/10.1161/CIRCULATIONAHA.111.047738
[183] The NS, Suchindran C, North KE, Popkin BM, Gordon-Larsen P. Association of Adolescent Obesity With Risk of Severe Obesity in Adulthood. JAMA. 2010;304(18):2042–2047. doi:10.1001/jama.2010.1635

As depicted in the graphic on this page, Go NAPSACC's five-step improvement process is: (1) **Assess** current practices based on the most up-to-date research, (2) **Plan** for change, (3) **Take Action** to complete goals, (4) Participate in professional development trainings to **Learn More**, and (5) **Keep it Up** to continue improving on what still needs work. The Go NAPSACC platform includes a library of evidence-based resources, professional development training videos, and step by step instructions for creating strategic action plans and goals based on self-assessments. While child care providers can choose to complete activities in seven different focus areas, including: 1) Child Nutrition; 2) Infant & Child Physical Activity; 3) Outdoor Play & Learning; 4) Oral Health; 5) Screen Time; 6) Farm to ECE; and 7) Breastfeeding & Infant Feeding, this Project and Go NAPSACC technical assistance support in Martin County will focus on making improvements in Child Nutrition and Infant & Child Physical Activity focus areas by focusing on staff training and provider self-assessment post-assessment scores.[184]

Source: Go NAPSACC, https://www.gonapsacc.org

With this project, efforts in Martin County have the potential to reach all children enrolled in early care settings, whether it be a formal facility or family child care home. Through utilizing Go NAPSACC and implementing healthy eating and physical activity best practices, child care providers also have the opportunity to apply for the **Florida's Healthy Environments for Reducing Obesity (FL HEROs)** statewide recognition and award program. This program celebrates licensed child care providers for meeting healthy eating and physical activity best practices that align with the Go NAPSACC benchmarks. The hope that more child care providers are encouraged to make healthy eating and physical activity a priority in their child care settings to ultimately reduce childhood overweight and obesity in Martin County.

Moreover, the Martin County Health Equity Taskforce and Martin County Health Equity Team will meet at least quarterly to monitor progress with respect to the process measures and objectives. The Minority Health Liaison will work to collect and track process measure data (i.e., Go NAPSACC registrations; completed Go NAPSACC assessments, etc.), in addition to collecting and reporting back

[184] Our Focus Areas (2018). In Go NAPSACC. Retrieved from https://gonapsacc.org/

on the secondary objective data (i.e., proportion of WIC clients who are obese, etc.). The Minority Health Liaison will also report on progress to the Health Equity Regional Coordinators and the Office of Minority Health and Health Equity on a consistent basis as needed, but at least quarterly.

A trend analysis tool, developed by the Health Promotion Statistics Branch at the National Center for Health Statistics and used develop the Healthy People 2030 targets, and historical data on overweight and obese **WIC clients aged 2 to 4** was used to determine future outcome projections without intervention for this project. Without intervention, by 2027, the percentage of WIC clients aged 2 to 4 that are projected to be overweight or obese will be 38.6%. Project targets were chosen based on this projection with the intention that this project, or intervention, will either further decrease the projection or reverse the upward trend. Detailed trend analysis data for the Go NAPSACC project can be found in Addendum E.

The following table outlines the specific details of the GO NAPSACC initiative in Martin County.

	Lead Entity and Unit	Lead Point Person	Data Source	Baseline Value	Target Value	Plan Alignment
Long-Term SDOH Goal: Improve the neighborhood and built environment and education access and quality in Early Care and Education (ECE) settings by implementing policies, systems, and environmental changes that meet healthy eating and physical activity best practices and promote healthy habits.						
Objective: By 2027, improve the built environment in ECEs to further decrease the proportion of WIC clients aged 2-4 years old who are overweight or obese from 36.7% to 35.9%. Note: Through our Go NAPSACC work, we will have a direct positive impact on our infants and toddlers. Without any intervention, by 2027, the proportion of WIC clients aged	Florida Department of Health, Martin County – Healthiest Weight Florida	Wanda Frazier	Florida Department of Health, WIC and Nutrition Services, FLWiSE	36.7%	35.9%	Healthiest Weight Plan

2-4 years old who are overweight or obese is projected to be 38.6%. We hope to reverse this upward trend.						
Objective: By 2027, improve the built environment in ECEs to decrease the proportion of first grade students who are overweight or obese from 41.3% to 35.3%. Note: Through our Go NAPSACC work, children who receive this early intervention and engage in healthy eating and physical activity best practices early in life are likely to continue these practices throughout their lifespans. Without any intervention, by 2027, the proportion of first grade students who are overweight or obese is projected to be 46.4%. We hope to reverse this upward trend.	Florida Department of Health, Martin County – Healthiest Weight Florida	Patsy Lindo-Wood	Martin County School District	41.3% students overall	35.3% students overall	Healthiest Weight Plan
Key Activities			Key Partners		Process Measures	

Provide technical assistance to ECE providers to increase implementation of healthy eating and physical activity policy, systems, and environmental best practices and family engagement (healthy eating and physical activity education provided to the families of children). Provide technical assistance to ECE providers to increase access to professional development training for staff to improve quality of education for children and families. Provide technical assistance to ECE providers to prepare them for applying for the Florida's Healthy Environments for Reducing Obesity (HEROs) Recognition Program.			DOH-Martin Healthiest Weight Florida Health Council of Southeast Florida Healthy Kids Healthy Futures Program UF/IFAS Extension Program		Go NAPSACC pre- and post-self-assessment scores in Child Nutrition and Infant and Child Physical Activity focus areas Completed Go NAPSACC Child Nutrition and Infant and Child Physical Activity Trainings Florida's HEROs applications received Florida's HEROs awards	
Medium-Term SDOH Goal: Improve the neighborhood and built environment and education access and quality in Early Care and Education (ECE) settings by providing direct technical assistance to ECE providers that supports healthy eating and physical activity best practice goal setting and implementation.						
Objective: By 2025, improve the built environment in ECEs to decrease the proportion of WIC clients aged 2-4 years old who are overweight or obese from 36.7% to 36.2%. Note: Through our Go NAPSACC work, we will have a direct positive impact on our infants and toddlers. Without any intervention, by 2027, the proportion of WIC clients aged 2-4 years old who are overweight or	Florida Department of Health, Martin County – Healthiest Weight Florida	Wanda Frazier	Florida Department of Health, WIC and Nutrition Services, FLWiSE	36.7%	36.2%	Healthiest Weight Plan

obese is projected to be 38.6%. We hope to reverse this upward trend.						
Objective: By 2025, improve the built environment in ECEs to decrease the proportion of first grade students who are overweight or obese from 41.3% to 37.3%. Note: Through our Go NAPSACC work, children who receive this early intervention and engage in healthy eating and physical activity best practices early in life are likely to continue these practices throughout their lifespans. Without any intervention, by 2027, the proportion of first grade students who are overweight or obese is projected to be 46.4%. We hope to reverse this upward trend.	Florida Department of Health, Martin County – Healthiest Weight Florida	Wanda Frazier	Martin County School District	41.3% students overall	37.3% students overall	Healthiest Weight Plan
Key Activities			Key Partners		Process Measures	

Provide technical assistance to ECE providers and assist them with developing and completing goals related to Child Nutrition in Go NAPSACC. Provide technical assistance to ECE providers and assist them with developing and completing goals related to Infant and Child Physical Activity in Go NAPSACC.			DOH-Martin Healthiest Weight Florida Health Council of Southeast Florida Healthy Kids Healthy Futures Program UF/IFAS Extension Program		Open and/or completed Child Nutrition goals in Go NAPSACC Open and/or completed Physical Activity goals in Go NAPSACC	
Short-Term SDOH Goal: Improve the neighborhood and built environment and education access and quality in Early Care and Education (ECE) settings by recruiting and enrolling providers to participate in Go NAPSACC technical assistance and ensuring all programs are connected to a local Go NAPSACC technical assistance consultant.						
Objective: By 2023, improve the built environment in ECEs to decrease the proportion of WIC clients aged 2-4 years old who are overweight or obese from 36.7% to 36.5%. Note: Through our Go NAPSACC work, we will have a direct positive impact on our infants and toddlers. Without any intervention, by 2027, the proportion of WIC clients aged 2-4 years old who are overweight or obese is projected to be 38.6%. We hope to reverse this upward trend.	Florida Department of Health, Martin County – Healthiest Weight Florida	Wanda Frazier	Florida Department of Health, WIC and Nutrition Services, FLWiSE	36.7%	36.5%	Healthiest Weight Plan

Objective: By 2023, improve the built environment in ECEs to decrease the proportion of first grade students who are overweight or obese from 41.3% to 39.3%. Note: Through our Go NAPSACC work, children who receive this early intervention and engage in healthy eating and physical activity best practices early in life are likely to continue these practices throughout their lifespans. Without any intervention, by 2027, the proportion of first grade students who are overweight or obese is projected to be 46.4%. We hope to reverse this upward trend.	Florida Department of Health, Martin County – Healthiest Weight Florida	Patsy Lindo-Wood	Martin County School District	41.3% students overall	39.3% students overall	Healthiest Weight Plan
Key Activities			Key Partners		Process Measures	
Increase the number for ECE providers recruited and enrolled on Go NAPSACC. Connect ECE providers to Technical Assistance Consultants.			DOH-Martin Healthiest Weight Florida Health Council of Southeast Florida Healthy Kids Healthy Futures Program		Go NAPSACC Childcare Program Registrations	

	UF/IFAS Extension Program	

SDOH Screening Tool Project Table

The Social Determinants of Health (SDOH) Screening Tool will be developed to aid in data collection and the identification of unique health needs of key priority populations, including but not limited to, for example, those who are Hispanic or Latino, Black or African American, those who identify as lesbian, gay, bi-sexual, transgender, or queer (LGBTQ+), disabled, elderly, or infant and toddlers aged 0 to 5, who may be experiencing health inequities at high rates. Currently, health outcome data, as well as indicators related to the SDOH, for specific populations previously mentioned, is not available at the county-level, by ZIP code, or by Census Tract in Martin County. Lack of available data on these populations further contributes to inequities, as community organizations may choose not to focus on changing policy, system, and environmental changes without data justification or baseline data to track progress. For this reason, it is important to examine health outcome and SDOH data for all populations, and specifically for those mentioned above, to determine which groups are experiencing health inequities at the highest rates to strategically inform decision making and health equity project planning.

Moreover, the Martin County Health Equity Taskforce is determined to apply an intersectional lens to this Health Equity Plan. Intersectionality is a framework or theory that posits that through our fluid and multiple identities, our experiences and levels of power and privilege may differ.[185] For instance, you may find racial health disparities, but when you also add gender, ethnicity, sexual orientation, and disability status, you may find additional health disparities are experienced by multiple, compounded identities. Through this community project, the Martin County Health Equity Taskforce aims to collect data among all prioritized populations to explore additional health disparities that should be addressed in future iterations of this plan with future community projects. This additional insight will enable the Taskforce to assess the complex way that multiple forms of discrimination, such as racism, sexism, homophobia, and classism, intersect to shape obesity and other health outcomes and quality of life among historically marginalized communities.

For this project, the SDOH Screening Tool that will be developed and implemented will combine components of other existing SDOH screening tools, including but not limited to the National Association of Community Health Centers' Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences tool (PRAPARE), the American Academy of Family Physicians' Social Needs Screening Tool, and the Center for Medicaid and Medicaid Services' Accountable Health Communities Health-Related Social Needs Screening Tool. The Martin County Health Equity Taskforce will determine which components of these tools are appropriate to incorporate for Martin County.

[185] Cho, S., Crenshaw, K.W., & McCall, L. (2013). Toward a field of intersectionality studies: Theory, applications, and praxis. *Journal of Women in Culture and Society.* 38(4).

As this project is implemented, the Martin County Health Equity Taskforce and Martin County Health Equity Team will meet at least quarterly to monitor progress. The Minority Health Liaison will work to collect and track process measure data (i.e., screening tool development, dissemination, analysis, etc.), in addition to collecting and reporting back on the secondary objective data (i.e., current understanding of needs, obesity status, etc.). The Minority Health Liaison will also report on progress to the Health Equity Regional Coordinators and the Office of Minority Health and Health Equity on a consistent basis as needed, but at least quarterly.

	Lead Entity and Unit	Lead Point Person	Data Source	Baseline Value	Target Value	Plan Alignment
Long-Term SDOH Goal: Improve all Social Determinants of Health and obesity among priority populations by assessing county-level and ZIP-code level neighborhood and lived environment, health care access and quality, income, employment, benefits/financial support, educational attainment, social support and integration, and obesity and overweight status among Hispanic or Latino residents, Black or African American residents, LGBTQ+ residents, elders over 65 years old, infant and toddlers 0 to 5 years old (enrolled and not enrolled in early education settings), veterans, people living with disabilities, and foreign-born residents to inform additional community-based health equity projects.						
Objective: By 2027, reduce obesity and overweight status among Hispanic or Latino residents and Black or African American residents from baseline value determined by the Survey/Screening Tool responses. **Objective:** By 2027, reduce obesity and overweight status among Black and Hispanic LGBTQ+ residents, elders, infants and toddlers aged 0-5, veterans, people living with disabilities, and foreign-born	Florida Department of Health, Martin County – Community Health Planning and Statistics	Angelica Castillo da Silva	SDOH Survey/Screening Tool	To be determined based on collected data	To be determined based on collected data	Florida SHIP (2017-2021): HE1, HE3

residents from the baseline values determined by the Survey/Screening tool responses. **Objective:** By 2027, improve specific social determinants of health among Black and Hispanic LGBTQ+ residents, elders, infants and toddlers aged 0-5, veterans, people living with disabilities, and foreign-born residents from baseline values determined by the Survey/Screening tool responses. Note: While our priority population remains Black and Hispanic children and families, the Martin County Health Equity Taskforce understands that an intersectional lens is important to apply to our health equity work to recognize that health is shaped by a multi-dimensional overlapping of factors, experiences, and						

identities, such as race, class, income, education, age, ability, sexual orientation, gender identity, immigration status, ethnicity, indigeneity, and geography.						
Key Activities			Key Partners		Process Measures	
Complete SDOH Survey/Screening Tool Analysis Develop recommendations for community projects to integrate into the Martin County Health Equity Plan to address obesity and overweight status and improve social determinants of health among Black or African American adults, LGBTQ+ residents, elders, veterans, people living with disabilities, and foreign-born residents.			Florida Department of Health in Martin County Martin County Health Equity Taskforce		Completed SDOH Survey/Screening Tool Analysis Written recommendations for Health Equity Plan community projects	
Medium-Term SDOH Goal: Improve all Social Determinants of Health and obesity among priority populations by implementing a mechanism to assess county-level and ZIP-code level neighborhood and lived environment, health care access and quality, income, employment, benefits/financial support, educational attainment, social support and integration, and obesity and overweight status among Hispanic or Latino residents, Black or African American residents, LGBTQ+ residents, elders over 65 years old, infant and toddlers 0 to 5 years old (enrolled and not enrolled in early education settings), veterans, people living with disabilities, and foreign-born residents.						
Objective: By 2024, improve the current understanding on the obesity and overweight status among Hispanic or Latino and Black or African American	Florida Department of Health, Martin County – Community Health Planning	Angelica Castillo da Silva	SDOH Survey/Screening Tool	No data available on Black or African American adults in Martin County who are	Complete point-in-time data on the proportion of Black or African American adults in Martin	Florida SHIP (2017-2021): HE1, HE3

Martin County residents. **Objective:** By 2024, improve the current understanding on the obesity and overweight status among LGBTQ+ residents, elders, infants and toddlers aged 0-5, veterans, people living with disabilities, and foreign-born residents. **Objective:** By 2024, improve the current understanding on social determinant of health needs (income, employment, housing, educational attainment, health coverage, etc.) among LGBTQ+ residents, elders, infants and toddlers aged 0-5, veterans, people living with disabilities, and foreign-born residents. Note: While our priority population remains Black and Hispanic children and families, the Martin County Health Equity Taskforce	and Statistics			obese or overweight. No available data on obesity and overweight status among LGBTQ+ residents, elders, veterans, people living disabilities, and foreign-born residents. No available data on social determinant of health needs among LGBTQ+ residents, elders, veterans, people living with disabilities, and foreign-born residents.	County who are obese or overweight. Complete point-in-time data on the proportion of LGBTQ+ residents, elders, veterans, people living with disabilities, and foreign-born residents in Martin County who are obese or overweight. Complete point-in-time data on social determinants of health (i.e., income, employment, housing, educational attainment, health coverage, etc.)	

understands that an intersectional lens is important to apply to our health equity work to recognize that health is shaped by a multi-dimensional overlapping of factors, experiences, and identities, such as race, class, income, education, age, ability, sexual orientation, gender identity, immigration status, ethnicity, indigeneity, and geography.					among LGBTQ+ residents, elders, veterans, people living with disabilities, and foreign-born residents in Martin County.	
Key Activities			Key Partners		Process Measures	
Develop a Survey/Screening Tool Implementation and Distribution Plan Develop a tracking system to monitor response rates (e.g., Survey Monkey, intra-agency tracking) Distribute Survey/Screening Tool			Florida Department of Health in Martin County Martin County Health Equity Taskforce		Survey/Screening Tool Implementation and Distribution Plan Number of SDOH Survey/Screenings Completed (Response Rate)	
Short-Term SDOH Goal: Improve data collection efforts related to all Social Determinants of Health and overweight and obesity among prioritized populations by developing a mechanism to assess county-level and ZIP-code level neighborhood and lived environment, health care access and quality, income, employment, benefits/financial support, educational attainment, social support and integration, and obesity and overweight status among Hispanic or Latino residents, Black or African American residents, LGBTQ+ residents, elders over 65 years old, infant and toddlers 0 to 5 years old (enrolled and not enrolled in early education settings), veterans, people living with disabilities, and foreign-born residents.						

Objective: By 2023, improve obesity and overweight status data collection methods for Hispanic or Latino and Black or African American Martin County residents. **Objective:** By 2023, improve obesity and overweight status data collection methods for LGBTQ+ residents, elders, infants and toddlers aged 0-5, veterans, people living disabilities, and foreign-born residents. **Objective:** By 2023, improve social determinant of health (income, employment, housing, health coverage, educational attainment, etc.) data collection methods for LGBTQ+ residents, elders, infants and toddlers aged 0-5, veterans, people living disabilities, and foreign-born residents.	Florida Department of Health, Martin County – Community Health Planning and Statistics	Angelica Castillo da Silva	Systemic review of available data sources	No data collection mechanism in place	Data collection mechanism in place	Florida SHIP (2017-2021): HE1, HE3

Note: While our priority population remains Black and Hispanic children and families, the Martin County Health Equity Taskforce understands that an intersectional lens is important to apply to our health equity work to recognize that health is shaped by a multi-dimensional overlapping of factors, experiences, and identities, such as race, class, income, education, age, ability, sexual orientation, gender identity, immigration status, ethnicity, indigeneity, and geography.						
Key Activities			Key Partners		Process Measures	
Conduct research on different tools available to assess social determinants of health and health status/outcomes. Design a survey/screening tool to assess social determinants of health and health status/outcomes.			Florida Department of Health in Martin County Martin County Health Equity Taskforce		Finalized survey/screening tool	

X. PERFORMANCE TRACKING AND REPORTING

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

The Minority Health Liaison serves as the point of contact in their county for sharing progress updates, implementation barriers, and practices associated with the Health Equity Plan. The Minority Health Liaison is responsible for gathering data and monitoring and reporting progress achieved on the goals and objectives of the Health Equity Plan. At least quarterly, the Minority Health Liaison meets with the Health Equity Taskforce to discuss progress and barriers. The Minority Health Liaison tracks and submits indicator values to the OMHHE within 15 days of the quarter end.

Annually, the Minority Health Liaison submits a Health Equity Plan Annual Report assessing progress toward reaching goals, objectives, achievements, obstacles, and revisions to the Regional Health Equity Coordinator and Coalition. The Regional Health Equity Coordinator and Coalition leaders provide feedback to the Minority Health Liaison and the Health Equity Taskforce from these annual reports. The Minority Health Liaison then submits the completed report to OMHHE by July 15th annually.

XI. REVISIONS

Annually, the Health Equity Taskforce reviews the Health Equity Plan to identify strengths, opportunities for improvement, and lessons learned. This information is then used to revise the plan as needed.

Revision	Revised By	Revision Date	Rationale for Revision

XII. ADDENDUM

Addendum A

Martin County Community Health Improvement Plan (CHIP) Advisory Council Members

First Name	Last Name	Agency
Agnieszka	Marshall	Tykes & Teens, Inc
Anastasia	Anderson	Florida Department of Health in Martin County
Angela	Aulisio	Cleveland Clinic Martin Health
Angelica	Castillo DaSilva	DOH-Martin Health Equity Liaison
Annette	Lopez	Kane Center/Council on Aging of Martin County
Anthony	Dowling	Village of Indiantown
Audrey	Burzynski	Hobe Sound Resident
Blaine	Albright	Christ Fellowship Church
Bob	Zaccheo	Project Lift
Bonnie	Russo	Helping People Succeed
Caitlynne	Palmieri	Boys & Girls Club of Martin County
Carol	Wegener-Vitani	Florida Department of Health Martin County
Cayuna	Williams	Martin County School District
Cecilia	Escobar	Florida Community Health Center
Chris	Stephenson	Director of Transportation
Chris	Kammel	Martin County Fire Rescue
Chris	Jackson	Project LIFT
Christine	Palaez Pena	Epilepsy Florida
Craig	Perry	Treasure Coast Hospice
Darryl	Houston	Community Foundation of Palm Beach & Martin Counties
David	Dyess	City of Stuart
Deirda	Kinnaman	House of Hope/Golden Gate Center
Denise	Waniger	Communities Connected for Kids

Diana	Gomez	AmBetter
Donna	Gardner	Mary's Home
Doug	Smith	Martin County Board of County Commissioners
Gabriela	Chavez-Munden	Florida Department of Health in Martin County
Holly	Forde	Martin County Community Action Coalition
Jackie	Clark	Mayor, City of Indiantown
Janet	Cooper	Helping People Succeed
Janice	Greller	NAMI Martin County
Jeff	Marquis	The Salvation Army
Jennifer	Doak, PhD	Indian River State College
Jennifer	Buntin	UF/IFAS Family Nutrition Program
Jerry	Gore	Pentecostal Church of God in Stuart/Hands of Hope
Jessica	Tharp	City of Stuart
Jimmy	Smith	Martin NAACP
Joe	Flanagan	Community Leader
John	Perez	Martin County Sheriff's Department
Kameliya	Sapundzhieva	Coral Shores Behavioral Health
Karen	Ripper	The Council on Aging of Martin County
Karlette	Peck	The Healing Center of Martin County
Kevin	Herndon	Martin County Fire Rescue
Kim	Ouellette	Volunteers in Medicine
Lori	Sang	Light of the World Charities
Lynn	Frank	Health Council of Southeast Florida
Margaret (Peggy)	Brassard	Martin County Public Transit
Maryann	Diaz	Florida Rural Legal Services
Marybeth	Pena	Florida Department of Health in Martin County
Micah	Robbins	Palm Beach County Behavioral Health Coalition
Michelle	Miller	Martin County Health and Human Services
Natalie	Parkell	UF/IFAS Extension Family Nutrition Program

Natasha	Serra	IMOVEU
Nicole	King	Children's Services Council of Martin County
Pat	Houston	IRMO Early Learning Coalition
Patsy	Lindo-Wood	Florida Department of Health in Martin County
Rachel	Terlizzi	United Way of Martin County
Randee	Gabriel	211 Palm Beach County/Treasure Coast
Renay	Rouse	Florida Department of Health Martin County
Richard	Reilly	Martin County Library System
Robert	King	Florida Department of Health in Martin County
Robert	Ranieri	House of Hope/Golden Gate Center
Ruby	Aguirre	Treasure Coast Food Bank - Whole Child Connection
Samantha	Suffich	Healthy Start of Martin County
Sara	Aviles	United Way of Martin County
Shauna	Young	Florida Department of Health in Martin County
Sheila	Moore	Martin County Pre-K Programs/Head Start
Sherry	Siegfried	Treasure Coast Food Bank and Florida KidCare Coalition
Valerie	Graham	Quit Doc/Tobacco Free Partner
Yvette	Gregory	Love and Hope in Action (LAHIA)
Chad	Adcock	211 Palm Beach County/Treasure Coast
Jill	Taylor	Martin County Healthy Start Coalition
Nancy	Yarnell	Area Agency on Aging
Caroline	Valencia	March of Dimes

Addendum B

Martin County Health Equity Taskforce Meeting Minutes

Martin County Health Equity Taskforce - February 10, 2022	
Agenda Item	**Meeting Minutes**
Welcome and Introductions	C. Alcala welcomed the group and thanked everyone for their attendance. The agenda for the meeting was reviewed with participants. C. Wegener-Vitani thanked the group for their participation and expressed her gratitude for those on the call. Participants shared their name, organization or community, and one word that comes to mind when they think of health equity in Martin County.

Overview:
Health Equity Taskforce & Health Equity Plan
 	
Lesli Ahonkhai, MA
Regional Health Equity Coordinator
Florida Department of Health
	L. Ahonkhai gave an overview of the Health Equity Taskforce and Plan. L. Ahonkhai shared that the state office is follow Florida statute to create and implement Health Equity Plans that will allow communities to come together under a shared vision to address disparities in unique ways. Martin County is soliciting this group's help in creating a health equity taskforce. This team will be responsible for looking at the social determinants of Health that exist within martin county. These will guide the group in addressing the identified disparities. The taskforce should be inclusive of partners who influence issues impacting health in Martin County. The group will also work to implement evidence-based strategies to address the identified disparities.
	
	L. Ahonkhai also provided clarity on relevant terms. Equality is often looked at as a way of providing everyone with the same opportunities. However, if everyone was given the same size bike, some would still be left out and some will still have difficulties. Equity, on the other hand, looks at factors that are not necessarily the fault of the individual, such as systematic barriers that prevent individuals from achieving goals. In an equitable approach, a bicycle that fits the person's size would be provided so they can succeed.
	
	• Several definitions were provided to the group for understanding:
	  • Heath 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 are the conditions in which people are born, grow, learn, work, live, worship, and age that influence the health of people and communities.
Presentation: Current Health Landscape in Martin County	E. Rego shared data related to Martin County demographics, including age, race (20% of Martin County residents are Black), and ethnicity (14% identify as Hispanic). E. Rego shared data related to the Social Determinants of Health: • Education access: The percent of adults over the age of 25 years without a high school diploma was 24.8% for Black residents, compared to 7.1% for White residents. These percentages were higher among Hispanic populations (30.6%) compared to their non-Hispanic counterparts (5.7%). • Economic stability: Both Black and Hispanic populations reported lower median household incomes compared to their white, non-Hispanic counterparts. These groups also reported higher percentages of the population living under the poverty line and higher unemployment rates. • Environment – housing: The percentages of owner-occupied housing units was lower for Black and Hispanic populations compared to their White, non-Hispanic counterparts. These populations also experienced higher percentages of renter-occupied housing units and occupied housing with more than one occupant per room. • Healthcare access: The percent of residents with health insurance was lower among Black and Hispanic populations compared to their White, non-Hispanic counterparts. The group asked for future data points that disaggregate by country of origin when looking at indicators by race. The impact of identified mental health issues among the adult and adolescent population will also be vital to consider in the future. HCSEF can present trend over time data related to education in the future to show when education drops off. Additionally, HCSEF can present indicators related to mental health in the future. Health status indicators were also presented to the group, including: • In 2020, 30.5% of non-Hispanic Black middle and high school students were overweight or obese, 19.2% of non-Hispanic White middle and high school students were overweight or obese, and 34.4% of Hispanic middle and high school students were overweight or obese. • Obesity in adulthood has increased overall from 2016-2019 in Martin County.

	• When looking at obesity among mothers, Black and Hispanic mothers experience obesity at much higher percentages compared to their White, non-Hispanic counterparts. In looking at overweight/obesity data, it would be important to consider food deserts. HCSEF will determine the sample size for the childhood obesity data. It was noted that the school health nurses collect this data by grade. Future data by grade level, and compared by school location, can be shared in the future. It was noted by participants that there is a disparity in obesity between Western Martin County and Coastal Martin County. A suggestion was given to present School Health obesity data in the future. Obesity among mothers, broken down by age group, would be helpful to see if a lack of education (young mothers without a high school diploma) is related to obesity. The Kotelchuck index could be used, as well as breakdowns of obesity among mothers by age. Health outcome data was also presented to the group, including: • Leading causes of death in 2020: Black Martin County residents were much more likely to die of heart disease than any other group with a death rate of 191.0 per 100,000 population. For cancer, the death rate among non-Hispanic residents was the highest at 137.2 per 100,000 population with White and Black residents not far off. For unintentional injury, White and non-Hispanics had the highest rates with 72.9 per 100,00 and 72.5 per 100,000, which were significantly higher than the rate among Black residents at 9 per 100,000. For COVID-19, the rates among Hispanic and Black residents were much higher than all other groups with a rate of 147.2 per 100,000 population for the Hispanic residents and 123.1 per 100,000 for Black residents. The rate among Black residents was highest for stroke with a rate of 64.4 per 100,000. For diabetes, the rate among Hispanic residents was highest with 44.1 per 100,000 population. COVID-19 may influence these indicators going forward. • Heart disease age-adjusted death rates: The rate among Black Martin County residents was higher than the rate among White residents each year aside from a dip in 2018. Most recently in 2020, the rate among Black residents was 191.0 per 100,000 population. The rate among Non-Hispanics was higher than the rate among Hispanic residents each year except for 2020, where the rates for these two groups are about the same. The rate among Hispanics in 2020 was 119.6 and among non-Hispanics was 115.6. • Cancer age adjusted death rates: Black residents did have a much higher rate than White residents from 2016 to 2019 but then decreased to about the same rate in 2020, with the death rate among White residents at 132.4 per 100,000 and among

	Black residents at 129.4 per 100,000. Comparing Hispanic and non-Hispanic residents, we see that the cancer death rate among non-Hispanic residents was higher than Hispanic residents each year. In 2020, the cancer death rate among non-Hispanic residents was 137.2 per 100,000 while the rate among Hispanic residents was 78.3 per 100,000 population. • Unintentional injury age-adjusted death rates: While the rates fluctuated, the rate among White residents was higher than Black residents each year aside from 2017. In 2020, the unintentional injury death rate among White residents was 72.9 per 100,000 population, while the rate among Black residents was 9.0 per 100,000 population. • Age-adjusted death rates from COVID-19 in 2020: there is a very large disparity in the rate among Black vs White residents, with the rate among Black residents reaching 123.1 per 100,000 and the rate among White residents reaching 41.9 per 100,000. A very large disparity exists when looking at the death rate among Hispanic and non-Hispanic residents. The rate among Hispanic residents was 147.2 per 100,000 and the rate among non-Hispanics was 35.3 per 100,000. It was noted that 2021 data is not yet available, but we expect to see disparities persist between these racial and ethnic groups. • Age adjusted death rates from stroke: starting in 2017, Black residents had a much higher rate compared to White residents each year. While the rate among Black residents did decline from 2017 to 2019, there was a recent increase from 2019 to 2020. In 2020, the rate among Black residents was 64.4 per 100,000 and the rate among White residents was 50.3 per 100,000. When looking at Hispanic and non-Hispanic residents, the rates follow a similar path and remain about the same during this time frame. No major disparity exists between these two groups. • Diabetes age-adjusted death rates: In 2020, Black (16.2 per 100,000 population) and Hispanic (44.1 per 100,000 population) residents reported higher age-adjusted death rates from diabetes compared to their White (13.4 per 100,000 population) and non-Hispanic (13.3 per 100,000 population) counterparts. • The group noted that some of the indicators reported stark increases or decreases. In future meetings, HCSEF can present counts as well as rates to provide additional insight with this data. Targeted programs during these time periods may have also influenced the increases/decreases seen. It would be helpful to research programming over the time periods to provide context in these situations. Additionally, overall population fluctuations (population change over time) would be helpful in the future to provide context to some of the increases/decreases seen in the data.

Overview: Health Equity Taskforce Roles & Expectations Angelica Castillo Da Silva, MPH Health Equity Liaison Florida Department of Health, Martin County	A. Castillo Da Silva shared information regarding the Health Equity Taskforce roles and expectations. Taskforce members will participate in monthly meetings; research evidence-based strategies to address the identified health disparities; provide a diverse perspective on the health equity plan; and be the voice of the community.
Poll: Are you interested in joining the taskforce?	A poll question was posed to all participants through a Zoom poll: Based on the roles and expectations for the Health Equity Taskforce, are you interested in becoming a Martin County Health Equity Taskforce member? Yes: 78% (18/23) Maybe, but need more information: 13% (3/23) No: 4% (1/23) No, but I will refer someone else who would be: 4% (1/23) L. Ahonkhai shared that after the planning phase of this work, the taskforce will research an evidence-based strategy that will be effective in addressing the disparity identified. Goals, strategies, and action steps will be defined to make the plan actionable. This will be presented to leaders and stakeholders in the community who have leverage in policies and resources to implement the evidence-based strategies.

Next Steps	• Monthly Health Equity Taskforce Meetings
	• Development of the Health Equity Plan
	  ○ Health Priority
	  ○ Strategic Objectives
	  ○ Evidence-based Strategies
	• Martin County Health Equity Taskforce Presentation
	• Health Equity Plan Implementation

Wrap-Up and Adjourn	• C. Alcala thanked the group for their input and discussion in the meeting. Additional information for the next meeting will be sent shortly.

Martin County Health Equity Taskforce – March 24, 2022	
Agenda Item	**Meeting Minutes**
Welcome and Introductions	C. Alcala welcomed the group and thanked everyone for their attendance. The agenda for the meeting was reviewed with participants. C. Alcala introduced the Health Council of Southeast Florida. A. Castillo Da Silva welcomed the group on behalf of the Health Equity team at the Florida Department of Health in Martin County. Daniza Robinson of the Epidemiology Department and Lesli Ahonkhai of the regional Health Equity team welcomed the group, as well. Participants shared their name, organization or community, and how they stay healthy in Martin County in the chat.
Health Equity Taskforce & Health Equity Plan	C. Alcala provided a brief overview of the Health Equity Taskforce and Health Equity Plan. The goal of the group is to identify a priority area and address health equity in that area. The group will participate in health equity coalition meetings, research health disparities in the health area, and provide a diverse perspective in the health equity plan and provide a voice for the community. FDOH-Martin chose obesity and overweight status as the strategic health strategy to address in this plan. The group will review the Social Determinant of Health components related to this area and their effect on overweight and obesity. The group will also work on vision development, long-term and short-term goals, and evidence-based interventions and programs to address the issue in the community.
Priority Area Selection Process Angelica Castillo Da Silva, MPH Health Equity Liaison FDOH-Martin County	Angelica Castillo Da Silva shared the selection process for the prioritization area. Obesity, Diabetes, and heart disease had the biggest disparities in Martin County based on the findings. A matrix was used to score these proposed areas based on size of the problem, severity of the problem, availability of current interventions, and economic and social impact. A scoring key was used to score each topic in the matrix. Addressing overweight and obesity will have a positive effect on the other health indicators that were evaluated, such as Diabetes and heart disease/stroke.
Presentation: Overweight and Obesity in Martin County	K. Chamberlain presented data on overweight and obesity in Martin County. Being overweight or obese during childhood increases chances of developing medical problems that can affect present and future health. This includes serious conditions like Type 2 diabetes, high blood pressure and high cholesterol – all once considered adult diseases. This measure helps inform progress toward the goal of promoting healthful diets and healthy weight. In Martin County there was an increase in the percentage of overweight or obese WIC children

	starting in 2019. Most recently in 2021, 36.7% of children receiving WIC were overweight or obese compared to 29.7% of children receiving WIC in the state overall. Data related to the percentage of middle and high school students who are overweight or obese in Martin County shows that the percentage Hispanic middle and high school students who are overweight or obese is much greater than all other groups, with 34.4% overweight or obese in 2020. In 2020, 30.5% of non-Hispanic Black middle and high school students and 19.2% of non-Hispanic middle and high school students were also overweight or obese. Comparing males and females, 26.8% of middle and high school males versus 20.7% of middle and high school females were overweight or obese in 2020. Males saw a slight decrease during this timeframe, whereas females saw a slight increase. When looking at the percentage of students who are overweight or obese by grade level, the percentage of sixth graders who were overweight or obese increased between 2017 and 2019. The percentage of sixth graders who were overweight or obese increased during this time frame had the highest percentage each year with 44.5% being overweight or obese in 2019 compared to 37.4% of third graders and 27.8% of first graders. To note, that is almost half of sixth graders, over a third of third graders, and over a quarter of first graders in Martin County who were overweight or obese in 2019. Childhood obesity by school and neighborhood data was discussed. Over 15% of 1st graders were overweight at Seawind Elementary in Hobe Sound; JD Parker Elementary, Port Salerno Elementary, and Felix A. Williams Elementary in Stuart; and Warfield Elementary in Indiantown. Over 15% of 1st graders were obese in Hobe Sound Elementary and Seawind Elementary in Hobe Sound; Port Salerno Elementary and Pinewood Elementary in Stuart; and Warfield Elementary in Indiantown. Over 20% of 3rd graders were overweight in Citrus Grove Elementary in Palm City; Hobe Sound Elementary and Seawind Elementary in Hobe Sound; Jensen Beach Elementary in Jensen Beach; and Crystal Lake Elementary in Stuart. Over 20% of 3rd graders were obese in Hobe Sound Elementary in Hobe Sound; JD Parker Elementary, Port Salerno Elementary, and Pinewood Elementary in Stuart; and Warfield Elementary in Indiantown. Over 15% of 6th graders were overweight in all middle schools mentioned – Hidden Oaks Middle School in Palm City; Indiantown Middle School in Indiantown; and Murray Middle, Stuart Middle, and Dr. David Anderson Middle School in Stuart. Over 20% of 6th graders were obese in Indiantown Middle School in Indiantown and Murray Middle School, Stuart Middle School, and Dr. David Anderson Middle School in Stuart. The percentage of first grade public school students who were overweight and obese overall in Martin County and in Indiantown, which we know struggles particularly, was depicted. The percentage in Indiantown was much higher than the county overall. Because of the pandemic and due to school closures, there was data missing from the

	2019-2020 school year. For the 2020 to 2021 school year, there were similar issues due to the pandemic, so there was a focus on screening schools that needed the most services. Aggregate data was not available for Martin County as a whole because of this. When looking at the percentage of sixth grade public school students who were overweight or obese in Martin County compared to Indiantown specifically, the same trend was seen. Women who are overweight or obese while pregnant are more likely to have premature births, babies with birth defects like neural tube defects, or babies who are large for gestational age. These women are more likely to have complications during labor and birth, and their babies are at a higher risk of developing heart disease, diabetes, and obesity later in life. The presentation depicted the percentage of births to mothers who were overweight at the time of pregnancy in Martin County overall, as well as by race, ethnicity, and by sex of the child. While the percentage of Hispanic mothers who were overweight at the time of pregnancy slightly decreased in recent years, this group still has the highest percentage of overweight mothers as of 2020 with 32.8% overweight compared to 29.4% of non-Hispanic mothers. 31.0% of White mothers compared 29.7% of Black mothers were overweight as well. Of the births to overweight mothers, 31.7% were male and 29.4% were female. The percentage of births to mothers who were obese at the time of pregnancy in Martin County was depicted overall, as well as by race, ethnicity, and by sex of the child. All racial and ethnic groups saw a decline in births to obese mothers from 2019 to 2020. In 2020, 37.8% of Black mothers were obese at the time of pregnancy, a 14 percentage point disparity between White mothers at 23.3%. When comparing Hispanic versus non-Hispanic mothers, 27.6% of Hispanic mothers and 22.2% of non-Hispanic mothers were obese at the time of pregnancy. Looking at the percentage of adults who were overweight or obese in Martin County in 2013, 2016, and 2019 by race, ethnicity, and sex, we see that all groups saw a decline most recently from 2016 to 2019, except women who saw a 6.1% increase in obesity. In 2019, 55.1% of non-Hispanic white residents were overweight or obese versus 47.2% of Hispanic residents. There was a huge disparity between men and women in 2019 as well with 60.4% of men reporting being overweight or obese versus 48.7% of women residents. When looking at the percentage of adults who are overweight or obese by age group, the percentage of those age 45 to 64 who were overweight or obese rose significantly from 2016 at 55% to 2019 at 67.9%. The other age groups, 18 to 44 and 65 and older, decreased during this same timeframe.

	C. Alcala opened the floor to attendees to discussion questions or thoughts related to the overweight or obesity data that was presented. E. Rego reviewed Social Determinants of Health (SDOH) factors and how they may contribute to obesity and overweight status in Martin County, including education access, economic stability, health care access, neighborhood and built environment, and social and community context. E. Rego indicated that the participants would be asked how each SDOH may contribute to obesity and overweight status in Martin County. With regards to Education Access and Quality, Black (24.4%), American Indian and Native American (30.5%), and Hispanics (25.6%) reported wide disparities with regards to the percent of adults over the age of 25 without high school diploma as compared to White (6.5%), Asian (13.8%) and Non-Hispanic (5.6%). Males were also more likely (17.5%) than females to report not having a high school diploma past the age of 25 (12.9%) J. Buntin mentioned the impact of nutritional knowledge. N. Nti Nsibienakou-Fawohodie also mentioned understanding what you eat and how to determine where to get healthy foods. K. Peck mentioned access to care. D. Robinson mentioned the way education provides better access to information. K. Chamberlain expanded on health literacy comments, sharing that education level can lead to increased income and employment opportunities, which can in turn lead to more access. G. Wright shared that quality plays a large part receiving education that is culturally relevant and celebrates cultural foods being nutritious as well. K. Peck mentioned that males may have to go to work before graduating from high school - especially those that are undocumented. D. Lasarte emphasized that most obese children have obese adults in their households and the issues trickle down. D. Lasarte questioned if it was a lack of medical advice or if it is physiological. She also emphasized the role of cost in buying healthy foods compared to fast foods. E. Rego introduced economic stability as an additional social determinant of health. In particular, the percentage of Black (23.4%) and Hispanic (20.2%) residents living under the poverty line in 2020 was much higher than White (8.9%), and Non-Hispanic (8.0%) residents. D. Robinson shared that “income has a greater impact. If you don't have enough money to buy better quality food unfortunately you have to go to the $1 menu as Denise mentioned.” Dr. A. DuPont pointed to the density of fast-food restaurants and convenience marts in low-income areas. These areas do not have as many fresh grocery stores or healthy food options, leaving those residents to use the unhealthy options more often. N. Parkell shared, “The economic instability definitely leads to stress - "pandemic" eating anyone? And now that inflation is rising, we can expect these numbers to increase more perhaps...”. E. Rego also shared information about the social and community context social determinant of health. E. Rego described how research has linked segregation with higher rates of mortality. Racial residential

	segregation is associated with unequal access to health care resources, including health care settings and quality of treatment. Racial residential segregation contributes to poor health in minority populations, not just through SES differences but also through neighborhood effects. Racial residential segregation as measured through the Dissimilarity Index, the differential distribution of individuals by race or other social or income factors. When the Racial Residential Segregation Index is less than 0.3 the county's population is "well integrated". Values between 0.3 and 0.6 indicate the county's population is "moderately segregated". Values above 0.6 indicate the county's population is "very segregated." Martin County's was at 0.55 as of 2019. C. Alcala asked the group how they see these indicators affecting obesity and overweight status. K. Chamberlain spoke to issues of segregation of neighborhoods and access to safe places to live and play outside (for example, neighborhoods close to polluted areas or areas without parks, trails, or other elements of healthy infrastructure). E. Rego spoke to racial residential segregation and urban planning issues, such as redlining. B. Coore spoke to intentional redlining and zoning, which gives certain neighborhoods differences in resources. A. Castillo Da Silva echoed these points, stating that some neighborhoods do not have the same resources and access, leading to decreased health and increased overweight and obesity status in Martin County. K. Peck highlighted the difference in high school graduation rates between Black, White, and Hispanic residents. E. Rego introduced neighborhood and built environment as a social determinant of health. E. Rego shared a map of Martin County from the U.S. Department of Agriculture's Food Access Research Atlas indicating areas in Martin County where a significant portion of residents are far (1/2 mile for urban residents and 10 miles for rural residents). D. Lasarte shared "If we are going to mention schools, then all kids should be on an even playing field, because there are PE classes that need to be more effective, younger grades, Recess should be a must.". B. Coore touched on low-income and low food access with transportation overlays, stating that access and transportation can play a role in food choices, even if education and cost components are present. J. Buntin emphasized the location of parks, sport facilities, and good food accessibility. K. Chamberlain also highlighted the availability of a kitchen and its role in healthy eating, emphasizing homeless populations who do not have anywhere to store groceries or make meals. B. Coore agreed with this, adding thoughts on property maintenance on homes and lived environment. D. Lasarte mentioned the importance of internet access for residents to research healthy foods and recipes. C. Alcala will look into broadband access data that may shed light on this topic. E. Rego introduced health care access and quality as a social determinant of health. The percent of Black residents (82.1%), with any health insurance coverage was lower than the percentage among White residents (91.7%). Hispanic residents (78.4%) also reported a percentage of health insurance coverage that was lower than the

	percentage reported among Non-Hispanic residents (93.0%). C. Alcala asked the group for thoughts on how health care access and quality may affect obesity and overweight status in Martin County, such as the lack of insurance or the lack of access to primary care. L. Frederick mentioned that there are community healthcare options available for Martin County residents. E. Rego stated that health insurance coverage is associated with increased prescription drugs, increased preventative visits, and increased access to care. K. Chamberlain emphasized the lack of insurance and the role this plays in delayed care, which can exacerbate issues. A. Castillo Da Silva emphasized the role that access to providers can make a huge difference in understanding health. D. Robinson stated, “If you are sick without insurance you won't be able to see a Doctor leading to more problems or even death.”. N. Parkell stated, “I wonder if there is even a societal awareness of the definition of overweight and obese. If everyone around you, in your family, in your school looks the same - how do we communicate "healthy" weight?”. L. Frederick mentioned that sometimes people do have health insurance, but the provider they are trying to access is not located in the county, such as specialty care providers.
Priority Area Population Focus	A poll was launched to ask attendees to vote on the sub-population that they would like the Martin County Health Equity Plan to focus on. Responses were as follows: Elementary School Children: 2/15 (13%) Children Under 18: 5/15 (33%) Adults: 2/15 (13%) Black Residents: 4/15 (27%) Hispanic Residents: 1/15 (7%) Specific Neighborhood: 1/15 (7%) D. Robinson stated that a focus should be given to the young population “because they are our future.” B. Coore stated, “The data really shows a clear disparity for Black residents. They were disproportionately impacted across the board for health.” J. Buntin stated, “I voted for the elementary students, because we can start the education foundation in say kindergarten and built each year.” N. Nti Nsibienkou-Fawodie pointed to the data for her vote. N. Parkell stated “I selected children under 18 because the health factor seems to be set on a trajectory before grade 6.” A. Castillo Da Silva stated that a focus on children under the age of 18 years in specific neighborhoods of the county where disparities exist. C. Alcala suggested a focus on children under the age of 18 years, with a focus on black residents and specific neighborhoods J. Buntin suggested Title 1 children. D. Robinson suggested children under the age of 18 in segregated neighborhoods. B. Coore agreed and suggested looking at a broader group of families with children under the age of 18 years. J. Buntin agreed, stating that the head of household makes the shopping decisions. C. Pelaez-Pena stated “it is the adults deciding what the

	kids eat or don't eat" and N. Nti Nsibienkou-Fawodie agreed. A. Castillo Da Silva agreed with this suggestion and emphasized the need to choose an actionable and realistic priority. HCSEF and FDOH-Martin County will review all suggestions and finalize the priority area for the next meeting.
Our Vision	C. Alcala led the group in discussion about the group's shared vision for the work to be done. This vision will serve as the compass for all work and meetings going forward. The group was asked, "What does a healthy Martin County mean to you?" Angelica Castillo Da Silva mentioned the importance of access to health care. D. Robinson shared, "healthier, happier community." K. Peck stated, "a place where every child has access to a healthy life." N. Parkelll stated "Environmental conditions of access to healthy food, healthy space/environment, clean water." B. Coore stated, "a Martin County where there are no barriers to achieving optimal health." K. Chamberlain emphasized the importance of the lived environment and having access to safe outdoor areas. Nyame Nti Nsibienakou-Fawohodie stated, "a healthy Martin County in my opinion looks like an equitable living environment where people have access to good food, adequate healthcare, and safe, clean living conditions with outdoor access to play and exercise." Lesley Frederick shared, "greater access to quality health care, strong education, good jobs, nutritious food, and clean water." A. Castillo Da Silva emphasized the importance of good access to comfortable housing." K. Chamberlain asked the group about the strengths of the county, asking what makes the county unique and what is world class about the county. N. Nti Nsibienakou-Fawohodie empathized the unique way that Martin County has a wide range of environments (rural and suburban) and the high cost of housing. K. Peck stated that wealth makes the county unique with great income disparities. B. Coore emphasized the participation of local nonprofits and foundations that support community work. D. Robinson stated "many people will like to retire in Martin County." Diversity, cost of living, and weather were also highlighted. A. Castillo Da Silva mentioned the increased distance from I-95 to Martin County, which may play a role in reduced pollution and traffic or business in the community. K. Chamberlain mentioned the preserves and other ecological spaces that are available in Martin County. B. Coore stated "I'm proud to serve Martin and play there because it has amazing small businesses and beautiful water front gems. And its perfect environment for being active." E. Rego asked the group about the aspirations of the group and how we can use out strengths to improve health equity and overweight and obesity status in the county. N. Parkelll spoke to her work with youth and agriculture in Martin County. N. Parkelll suggested envisioning a greenspace or system where residents can access food with a hyper focus on local food production. This would merge food production and

	access to healthy produce where individuals can have access and the opportunity to participate into growing. A community garden with local community ownership would highlight the strengths of Martin County that the group discussed. K. Peck shared that there is an accessible garden from House of Hope. There is also a traveling garden that will travel to children. The mission of this work from House of Hope is to ensure people have access to healthy, fresh vegetables which would fall in line with the suggestions thus far. A. Castillo shared that the Boys and Girls Club has a garden in Indiantown. The group was also accessed what success means to them, answering questions such as "what does success look like in 3 years? 10 years?" and "how will we know when we see it?" K. Peck stated, "Exercise is correlated to good health outcomes, often more than good diets." N. Parkell stated, "Success can look like an increase in fruit/vegetable consumption per week or increase in physical activity (minutes per week)." A. Castillo Da Silva suggested working with the cities and county to establish more parks and green spaces to encourage exercise in the community." Daniza Robinson stated, "I'll like to see the Hispanic-black population with a lower obesity percentages." C. Alcala also spoke to increased awareness in Martin County to educate residents on what obesity and overweight status mean and what health factors can be influenced. Christine Pelaez-Pena stated, "Through the children, educating the parents on nutrition, on how/where to access medical help, etc.".
Next Steps	The Health Equity Task Force will research evidence-based strategies to overcome the identified barriers and improve the SDOH that impact the prioritized health disparity. The Health Equity Task Force will vote on a framework at next meeting and will use this information in the Plan to collaboratively design community projects to address the Social Determinants of health. Projects will include short, medium, and long-term goals with measurable objectives. These projects will be reviewed, edited, and approved by the Coalition to ensure feasibility. HCSEF will send a list of examples for participants to research. Attendees were asked to research these strategies and be prepared to vote on a strategy at the next meeting. Additional guidance will be sent following the meeting. At the April meeting, the group will vote on a vision for the group incorporating the points from today's discussion. HCSEF and FDOH-PBC will work to finalize the priority area based on the group's discussion prior to the next meeting.
Wrap-Up and Adjourn	C. Alcala thanked the group for their input and discussion in the meeting, emphasizing the importance of the group's participation in informing the work being done with this group. A. Castillo Da Silva thanked the group for their participation and expressed her excitement for the work going forward.

Martin County Health Equity Taskforce – April 19, 2022	
Agenda Item	**Meeting Minutes**
Welcome and Introductions	Carolina Alcala welcomed the group and thanked everyone for their attendance. The agenda for the meeting was reviewed with participants. Carolina Alcala introduced the Health Council of Southeast Florida. Angelica Castillo Da Silva welcomed the group on behalf of the Health Equity Team at the Florida Department of Health in Martin County and thanked partners for their participation. Participants shared their name, organization or community, and what they love most about Martin County in the chat.
Priority Population Selection	Carolina Alcala reviewed the priority population, which are Black and Hispanic children and families. This Priority Population was selected using the feedback from last meeting and in collaboration with Martin DOH. This Priority Population will be the group's main focus throughout the activities and discussions with this group and the future project.
Our Vision	Edward Rego reviewed visioning, stating that "visioning guides the community through a collaborative process that leads to a shared community aspiration. Vision statements provide focus, purpose, and direction to the health equity planning process." The responses from questions posed last meeting were used to draft a vision statement, including ensuring: • "a healthier, happier community." • "a place where every child has access to a healthy life." • "Environmental conditions that provide access to healthy food, healthy space/environment, clean water." • "adequate healthcare, and safe and clean living conditions with outdoor access to play and exercise." • "greater access to a strong education, good jobs, nutritious food." • "good access to affordable and comfortable housing." Edward Rego posed the vision, "*"A Martin County where there are no barriers to achieving optimal health"* to the group for consideration. E. Rego asked the group what their thoughts were on this version of the vision statement. Dr. Xenobia Poitier-Anderson expressed approval of the vision statement. Nyame Nti Nsibienakou-Fawohodie mentioned that "optimal health" may be broad and lead to misunderstandings in the general community.

	Lesli Ahonkhai shared that she approves of the vision statement. She shared that “optimal health” may mean different things to different people. However, when barriers are removed such as in health equity efforts, it is the hope that residents can achieve their own version of optimal health. She noted the importance of using this as an educational opportunity for the community regarding health equity. Kaley Newby stated, “Optimal Health in my opinion is heath equity for all ages, cultures, races.” Xenobia Poitier-Anderson stated, “When we determine the mission statement, it may clarify any lack of clarity "optimal" may present to the community.” Karlette Peck asked, “What about adding ‘systemic’ barriers?” Daniza Robinson noted, “Optimal Health for me is the well-being of any individual.” Brittani Coore stated, “I agree with adding systemic.” The group reviewed an edited version of the statement reading, “A Martin County where there are no systemic barriers to achieving optimal health.” Jill Taylor stated, “Optimal health is subjective. Maybe ‘a Martin County where your best health is achieved.” Nyame Nti Nsibienakou-Fawohodie, Katie Newby, and Lesli Ahonkhai agreed. Jill Taylor stated, “Everyone’s perception of their ‘best health’ is different and they definitely have a right to that.” Edward Rego revised the draft vision statement to read, “A Martin County where there are no systemic barriers to an individual achieving their best health” A poll was launched, asking “Do you approve of the vision statement for the Martin County Health Equity Taskforce: A Martin County where there are no systemic barriers to individuals achieving their best health?” Yes 14/17 (82%) No 1/17 (6%) Not Sure 2/17 (12%) Kaley Newby suggested that the vision should read “minimal” instead of “no systemic barriers” to be realistic. Gloria Wright stated, “I think "no" barriers seems unrealistic.” With that feedback, Carolina Alcala updated the vision statement and launched a new poll: “Do you approve of the vision statement for the Martin County Health Equity Taskforce: A Martin County where there are minimal systemic barriers to individuals achieving their best health.”

	Yes 8/16 (50%) No 4/16 (25%) Not Sure 4/16 (25%) Lesli Ahonkhai stated that she voted no in this poll because the vision should be far reaching and "stretch" goals. Lesli suggested a compromise could be "eliminate or reduce". Based on that feedback, the vision statement was updated to read: A Martin County where systemic barriers to individuals achieving their best health are eliminated *or* A Martin County where there are no systemic barriers to individuals achieving their best health. Angelica Castillo Da Silva suggested using the first vision statement that was presented during the meeting, as it was broader. Dr. Xenobia Poitier-Anderson agreed, stating that a higher-reaching vision would allow the group to continue to keep working and striving for the best outcome. Lesli Ahonkhai agreed. The revised version now reads: **A Martin County where there are no systemic barriers to individuals achieving their best health.** Carolina Alcala reassured the group that this process is iterative, so if there are future thoughts throughout the process or in between meetings, the group can revisit this vision at future meetings or in between meetings.
Barriers to Addressing Social Determinants of Health	Edward Rego shared data related to childhood obesity and overweight status. When looking at the percentage of middle and high school students who are overweight or obese in martin county overall, as well as by race, ethnicity, and sex in 2016, 2018 and 2020, the data shows that the percentage of Hispanic middle and high school students who are overweight or obese is much greater than all other groups with 34.4% overweight or obese in 2020. In 2020, 30.5% of non-Hispanic black middle and high school students and 19.2% of non-Hispanic middle and high school students were also overweight or obese. Data related to the percentage of 6th grade children in Martin County Middle Schools that were overweight or obese was presented. Data for the following middle schools was presented: • Indiantown Middle School 6th graders reported over 50% Overweight or Obese Status for three school years from 2017 to 2020 (data was unavailable for the 2020-2021 school year). • Dr. David Anderson Middle School showed an increasing trend from 41% in 2017-2018 to 50% in 2019-2020 and 2020-2021.

	• Hidden Oaks Middle School began just under 30% (29.2%) but increased to 32.5% in 2018-2019 and stayed stable at 32.2% in 2019-2020 (data was unavailable for the 2020-2021 school year). • Murray Middle School reported over 40% overweight and obese status for the first three years, and then reported over 50% (53%) in 2020, showing an increase. • Stuart Middle School fluctuated from 38.0% in 2017-2018, went over 40% in 2018-2019 (40.2%) and in 2019-2020 (42.0%) and fell to 36.4% in 2020-2021 Data related to the demographic breakdown of ZIP Codes with Schools that Report a High Percentage (above 15%) of Obesity/Overweight Status was presented. The schools included on the demographic breakdown were selected based on school health data from Martin DOH that indicated percentages of Obesity or Overweight Status in these schools that exceeded 15% in 2020. Overall, while all zip codes showed some level of Black and Hispanic residency, Indiantown zip codes had much higher percentages of Black and Hispanic residents. Edward Rego noted that a limitation of this analysis is that the overall demographics of a particular zip code may differ from the demographics of the student population attending those schools. Data was presented related to overweight or obese adults in Martin County in 2013, 2016, and 2019 by race, ethnicity, and sex. It was noted that there was unfortunately missing data for non-Hispanic black residents for all years and for Hispanic residents for 2013. All groups saw a decline most recently from 2016 to 2019, except women who saw a 6.1% increase in obesity. In 2019, 55.1% of non-Hispanic White residents were overweight or obese versus 47.2% of Hispanic residents. There was a significant disparity between men and women in 2019 with 60.4% of men reporting being overweight or obese versus 48.7% of women residents. The percentage of adults who are sedentary in Martin County was also presented. This data showed a slight decrease (1.1%) between 2013-2016 and nearly 4% increase between 2016-2019. Non-Hispanic White residents showed an increasing trend from 22.1% to 25.3% between 2013 and 2019. No data was available for Non-Hispanic Black residents for this indicator. Hispanic residents reported a sharp increase between 2016 (23.4%) and 2019 (44.2%). Kaitlin Chamberlain presented information and indicators related to the Social Determinants of Health specific to the priority population. Kaitlin Chamberlain noted that the social determinants of health encompass the structures, systems, and environments in place and include Education Access & Quality, Health Care Access & Quality, Economic Stability, Social & Community Context, and Neighborhood & Build Environment. These factors influence where people live, learn, work, and play and have a significant impact on behavior, ultimately

	impacting health outcomes. Unequal distribution of the social determinants of health lead to health inequities. Data was presented on the Social Determinants of Health. Taking a look at health inequities for Education Access & Quality, Health Care Access & Quality and Economic Stability, between Black and White residents and Hispanic and non-Hispanic residents, significant inequities existed in our Black and Hispanic populations in Martin County. Kaitlin emphasized that these factors can influence health in interconnected ways. Without a high school diploma, you're less likely to gain stable employment and receive enough wages to live let alone support a family. If someone does support a family in this situation, they may be buying processed food from a corner store. They may already be experiencing health issues like high blood pressure from stress but do not have health insurance coverage so do not seek care further exacerbating issues. Families living below the poverty line is also a data indicator related to the Social Determinant of Health Economic Stability. Data related to the Families Living Below the Poverty Line from 2018 to 2020 in Martin County was shown. Based on the data, non-Hispanic Black and Hispanic populations experience the highest percentages of families living below the poverty line. While both slightly decreased from 2019 to 2020, there are still significant inequities. It was emphasized that having adequate financial resources limits the ability to access health services increases physical stress, and individuals in this circumstance likely don't live in an area where it's safe to walk or play outside. Which brings me to my next slide. Racial residential segregation data was also presented. Racial residential segregation is measured through the Dissimilarity Index and is the differential distribution of individuals by race or other social or income factors. When the Racial Residential Segregation Index value is between 0.3 and 0.6, this indicates the county's population is "moderately segregated." Martin County falls into this category based on the data (63.1% of Black residents live in a racial residential segregated area compared to 19.6% of White residents; 43.3% of Hispanic residents live in a racial residential segregated area compared to 18.2% of non-Hispanic). Kaitlin noted that research has linked segregation with higher rates of mortality. Racial residential segregation is associated with inequities related to the distribution of health care resources. It is also an indication of racially segregated health care settings and lower quality of care. Racial residential segregation contributes to health inequities between racial groups, not just through socioeconomic status differences but also through neighborhood and lived environment effects. Maps were used to depict neighborhood and lived environment health outcome impacts. Kaitlin noted that the neighborhood and lived environment can also have a significant impact on health outcomes. A

	map by the US Department of Agriculture was presented that shows census tracts with a significant amount of low-income populations as well as a significant amount of residents having low access to a health food source, meaning that they live more than 1 mile away in an urban area and more than 10 miles in a rural area. Kaitlin emphasized that having limited access to a healthy and affordable food, like a supermarket or grocery store, makes it more difficult to eat a healthy diet. This resource also shows where there is a significant number of residents without vehicle access, which I will note for certain areas. Data related to Census Tracts 8 and 10 in Stuart were presented. Of all families with a householder who is White, 19.8% live below the poverty level while of all families with a householder who is Black or African American 32.3% live below the poverty level in these areas. Of all families with a householder who is Hispanic or Latino in these areas, 35.8% live below the poverty level. Of all families with a householder who is non-Hispanic or Latino in these areas, 14.8% live below the poverty level. In Census Tract 10, there is a higher percentage of families with a householder who is white or non-Hispanic living below the poverty level, with 16.6% of families with a householder who is white living below the poverty level versus 13.7% of families with a householder who is Black; and 18.1% of families with a householder who is non-Hispanic or Latino living below the poverty level versus 10.1% of families with a householder who is Hispanic. Kaitlin asked the group if anyone had an understanding as to why this might be in Census Tract 10. Additionally, Census Tract 8 (20.5%) and Census Tract 10 (10.1%) both have a relatively high number of households without vehicles that are more than one-half mile from a supermarket. Kaitlin noted that this indicates an impact on their ability to access a healthy food source. Looking at the total population in this Census Tract 14.08, 7.6% of all residents are living under the poverty level which is relatively low compared to some other areas in Martin County. There are a total of only 1,000 families living in this area, with only 65 identifying as black and 85 identifying as Hispanic. Of all families, 0.8% are living below the poverty level, which could be contributing to the low percentages of families in each racial and ethnic group shown here living below the poverty level. Data related to Census Tracts 18.03, 18.04, 18.05, and 18.06 were shown on the map and 18.03 – 18.05 in a table format. Census Tract 18.06 is not included in the table due to having less than 0% for all indicators. This area reported a total of 2,125 residents 92.5% were male in 2020, which could have contributed to the extremely low percentages for indicators related to families. In CT 18.03, the highest percentage of families living below the poverty level are Hispanic or Latino with 37.9% living below the poverty level. In Census Tract 18.04, the highest percentage is among Black or African American families when compared to White families, with 34.1% living below the poverty level. In this Census Tract, Hispanic or Latino families also have a higher percentage compared to Non-Hispanic or Latino families

	with 18.8% living below the poverty level. In Census Tract 18.05, when comparing Hispanic or Latino families and non-Hispanic or Latino families, 24.2% of Hispanic or Latino families are living below the poverty level compared to 0% of non-Hispanic or Latino families. CT 18.03, 18.04, and 18.05 includes areas of Indiantown. In Census Tracts 18.03 and 18.04 combined, a total of 6% of households do not have vehicles and are also more than one-half mile from a supermarket. Kaitlin asked the group: what barriers does your organization face when trying to address the social determinants of health? Christine Pelaez-Pena stated, “Transportation is definitely an issue for people living with Epilepsy.” Dr. Xenobia Poitier-Anderson shared that economic issues are the major barrier that she sees in her line of work, sharing that cost-effective options are needed for healthy choices in order to improve this. Residents tend to choose whatever is cheapest so they can quickly fill their stomachs. School age children rely on the choices provided at school and they rely on parents for easy, quick dinner options at home. Economics is a major issue. Family history, such as choices the children are brought up on, are all related directly to the population they are working with. Dorothy Oppenheiser stated, “Transportation, lack of available staff and the Stigma of seeking help for mental health needs are the barriers for mental health. The struggle with mental health issues may then contribute to weight issues.” Brittani Coore stated, “AHA helps to increase access to fresh fruits and vegetables. Having the funding to implement changes that can help increase access in communities through environmental changes is key and ensuring the changes are sustainable by being embedded in long-term funding streams.” Kaitlin asked the group, “How do you think we can work collaboratively as a taskforce and coalition to overcome these barriers?” Jennifer Buntin stated, “I am going to take this data to the schools in Indiantown Middle and Warfield and stress how much they need nutrition education” Dr. Xenobia Poitier-Anderson shared that Home Economics used to be part of the school curriculum. In those courses, students were taught how to prepare menus. These programs are no longer a part of the school curriculums, presenting a gap or shift in education of these topics. There is a shift back to the vocational focus, so this would be a good time to put some of these things back into place. Dorothy Oppenheiser stated, “Nutrition Education in the schools needs to start in kindergarten. We need Health Curriculum starting early in

	this and many other areas...” Nyame Nti Nsibienakou-Fawohodie agreed. Dorothy Oppenheiser stated, “Need an evidenced based curriculum... not one-shot lessons or events.” Carolina shared that there is a lot of great work happening in Martin County that can be built upon to help educate youth early. Carolina also mentioned that in previous meetings, health insurance and health care access was also defined as an issue that can impact obesity and overweight status. Karlette Peck stated, “Exercise is also needed.” Daniza Robinson stated, “Limited English.” Karlette Peck stated, “trust and cultural barriers.” Brittani Coore shared that she has heard of barriers such as pantries not having adequate shelving or cold-food storage, which limits their ability to serve fresh and healthy foods. She has also heard of instances where there is no local grocery store within a half mile. Brittani suggested that we could work to help establish a pop-up farmers market or urban garden. Brittani emphasized that addressing the startup cost barriers, finding space, and getting permits would help address environmental change barriers. Long-term funding sources for the partners who would help maintain these projects is needed for sustainability. Xenobia Poitier-Anderson stated, “It is important that programs are identified and implemented at times when working heads of families can participate and have access to free childcare services.” Brittani Coore stated, “Another barrier is having resources in all needed languages, Spanish, creole and Aztec. And staff that speak the languages.” Christine Pelaez-Pena stated, “There's been a lot of disinformation over the past few years regarding 'Obamacare'. there are a lot of people who believe it no longer exists. Over the last few years, I received many calls of people asking me how 'Trumpcare' works. People in authority (perhaps medical personnel?) are going to have to step out of their normal role to counter all the disinformation.” Jennifer Buntin stated, “we need to partner with the after school programs Indiantown -- Boys Girls Club YMCA and promote health and wellness fitness.” Christine Pelaez-Pena stated, “We do provide material in Spanish and Kreyol....” Carolina Alcala shared brief summary notes in the chat for the group to review as follows: • economic - more options for healthy choices (lettuce, tomatoes, juices - cost prohibitive) - most of people just worry about filling themselves up.

	• limited time and resources • family history and culture • curriculum change - home economics. • providing resources to establishing or implement environmental changes (community setting) Daniza Robinson stated, “Trust is very important because people will be able to disclose personal information.”
Evidence-Based Strategies and Frameworks Vote	Kaitlin shared that evidence-based strategies will guide our process for collaboratively design community projects in the next meeting to address the social determinants of health and barriers Black or African American and Hispanic children and families are facing in Martin County. These tools can be used to identify evidence-based interventions to target specific populations. Several evidence-based strategies and corresponding links were shared with the group prior to the meeting to inform decision-making. A poll was launched: Are you ready to vote on an evidence-based strategy? • Yes 6/16 (38%) • No, I need a brief overview 7/16 (44%) • No, I need more time to do my own research 3/16 (19%) Kaitlin provided an overview of each evidence-based strategy to assist those who requested additional information. • Mobilizing for Action through Planning and Partnerships (MAPP) - “Mobilizing for Action through Planning and Partnerships (MAPP) is a community-driven strategic planning process for improving community health. Facilitated by public health leaders, this framework helps communities apply strategic thinking to prioritize public health issues and identify resources to address them. MAPP is not an agency-focused assessment process; rather, it is an interactive process that can improve the efficiency, effectiveness, and ultimately the performance of local public health systems.” – National Association of County and City Health Officials • Health in All Policies | AD for Policy and Strategy | CDC - “Health in All Policies (HiAP) is a collaborative approach that integrates and articulates health considerations into policymaking across sectors to improve the health of all communities and people. HiAP recognizes that health is created by a multitude of factors beyond healthcare and, in many cases, beyond the scope of traditional public health activities. The HiAP approach provides one way to achieve the National Prevention Strategy and Healthy People 2020 goals and enhance the potential for state, territorial, and local health departments to improve health outcomes. The HiAP approach

	may also be effective in identifying gaps in evidence and achieving health equity." – Centers for Disease Control and Prevention • Protocol for Assessing Community Excellence in Environmental Health (PACE EH) (cdc.gov) - "The Protocol for Assessing Community Excellence in Environmental Health (PACE EH) guides local public health officials and communities through a process to explore the broad physical and social environments that impact health and safety. The assessment process engages communities in a series of tasks to investigate the relationships among what they value, how their local environment impacts their health, and what actions are necessary to live safer and healthier lives." - National Association of County and City Health Officials • Performance Management and Quality Improvement (phf.org) - "Performance Management (PM) is a systematic process aimed at helping achieve an organization's mission and strategic goals by improving effectiveness, empowering employees, and streamlining the decision-making process. Quality Improvement (QI) focuses on the process to help bring services to the next level with the aim to improve the overall health of a community. The Public Health Foundation (PHF) has been helping organizations improve the quality and performance of their services for years. Visit the performance management and quality improvement focus areas to learn more." – The Public Health Foundation • Steps to Move Your Community Forward | County Health Rankings & Roadmaps - "While there's no single path to making positive change in your community, we've compiled some of our favorite resources from across the Action Center to help you get started and feel confident that you've taken the foundational steps to make lasting changes that impact those around you – 1. Assess Needs and Resources; 2. Focus on What's Important; 3. Choose Effective Policies & Programs; 4. Act on What's Important; 5. Evaluate Actions; Work Together; Communicate" County Health Rankings & Roadmaps • The Community Guide – The Guide to Community Preventive Services (The Community Guide) is a collection of evidence-based findings of the Community Preventive Services Task Force (CPSTF). It is a resource to help you select interventions to improve health and prevent disease in your state, community, community organization, business, healthcare organization, or school. The Community Guide uses a science-based approach to determine whether an intervention approach

	works and is cost-effective, helps you identify and select intervention approaches for behavior change, disease prevention, and environmental change across more than 22 health topics, identifies where there is insufficient evidence and more research is needed, and complements decision support tools, such as Healthy People 2020 External Web Site Icon, and the Guide to Clinical Preventive Services Carolina shared that the Martin County CHA and CHIP uses MAPP to bring diverse partners to the table and uses assessments and data to make informed choices with diverse perspectives. With this approach, the group would develop goals, objectives, strategies, and action plans to make change over time. Angelica Castillo Da Silva shared that Martin County currently has a PACE-EH program in Indiantown with a Community Health Committee. This group is creating a survey to understand what the community thinks of access to healthy food in Indiantown. The community is guiding the direction they will go to solve the problem in this project. This project is about mid-way through. Lesli Ahonkhai stated that the group does not want to duplicate efforts that the community has already embarked upon. If the data and information gleaned from previous projects is still relevant, the group can build upon that and use it to develop a direct project to target. Carolina shared that through this taskforce, the group has assessed community needs and resources, focusing on what is important, and the next step is to choose effective policies and programs, falling in line with the evidence-based strategy of Steps to Move your Community Forward. Karlette Peck stated, “PACE. 5-2-1-0 was done before in Martin County also, not sure if it is still being used in any organizations at this point.” Angelica Castillo Da Silva stated, “Karlette – Yes, we still use 5-2-1-0 program for nutrition in Martin County.” Angelica Castillo Da Silva shared that the group has already done a lot of analysis, data pulling, and partner development, so the group would be ready to move forward and the County Health Rankings and Roadmaps approach, making it a good fit. More surveys may be needed. Nyame Nti Nsibienakou-Fawohodie stated, “MAPP and Steps to Move Your Community Forward, County Health rankings and Roadmaps”. She stated that those evidence-based strategies seemed to be a good fit based on the work and the steps we have already taken. That would allow the group to not re-invent the wheel, but improve and build upon it. Lesli Ahonkhai stated, “PACE-EH Implementation.”

	To determine the group's choice for the evidence-based strategy to be used, a second poll was launched: Which evidence-based strategy would you like to use as a guide for developing the Martin County Health Equity Plan? The results are as follows: • MAPP 3/14 (21%) • Health in all Policies 0/14 (0%) • PACE-EH 2/14 (14%) • PMQI 1/14 (7%) • **Steps to Move your Community Forward, County Health Rankings and Roadmaps 6/14 (43%)** • Community Guide 2/14 (14%)
Health Disparity Objective Development	Kaitlin noted that to begin the development of the overarching health disparity objective for the plan and based on our target population of Black or African American and Hispanic children and families, as well as the group's discussion, the proposed Health Disparity objective was as follows: By *[target date],* reduce overweight and obesity in: - Black or African American middle and high school students from ***30.5%*** *(2020)* to [*target value*] - Hispanic adults from ***47.2%*** *(2019)* to [*target value*] - Hispanic middle and high school students from ***34.4%*** *(2020)* to [*target value*] The group would like to include Black or African American adults in the objective, but baseline values are not available for this population at this time. BRFSS does come out with new data every 3 years, new data may be published this year. Kaitlin reassured the group that as soon as data is available for these residents, they will be included as a part of this objective. The group was asked to discuss the target date and target values for this objective. Lesli Ahonkhai stated, "5-years since it is a five-year plan." Dr. Xenobia Poitier-Anderson stated, "October 2023. There should be an annual update." Lesli Ahonkhai, Jennifer Buntin, Lesley Frederick and Angelica Castillo Da Silva agreed with an annual update. After additional discussion and clarification, Carolina confirmed that the group would like to **set the objective target date as 2027 and provide annual updates. As the annual updates are made, the group can revisit the overarching objectives and data.** Carolina confirmed that data will be constantly measured and evaluated between now and 2027. Each area will have specific long-term, medium-term, and short-term goals and objectives. As more data becomes available, these objectives can be updated.

	Brittani Coore suggested using short-term goals for each year to capture progress. Lesli Ahonkhai suggested using short and middle range goals, as well. Nyame Nti Nsibienakou-Fawohodie agreed. Carolina posed the revised objective as follow: By ***2027,*** reduce overweight and obesity in: - Black or African American middle and high school students from ***30.5%*** *(2020)* to [*target value*] - Hispanic adults from ***47.2%*** *(2019)* to [*target value*] - Hispanic middle and high school students from ***34.4%*** *(2020)* to [*target value*] The group revisited the slides to look at the trends to inform decision making in target value decisions. Nyame Nti Nsibienakou-Fawohodie asked, "what medical measures are going to be utilized to help gauge where the youth should be?" Angelica Castillo Da Silva shared that school health does have the data by school, but not by race and ethnicity. That is a barrier we have based on the available data. Nyame Nti Nsibienakou-Fawohodie asked whether information on youth medical history is available (such as diabetes, asthma, or other medical conditions that may tie into overweight and obesity). Angelica Castillo Da Silva noted that she would look into this. Carolina Alcala reviewed Healthy People 2030 goals that were similar to help inform decisions on the decrease we want to see. The following link was shared in the chat for participants: https://health.gov/healthypeople/objectives-and-data/browse-objectives/overweight-and-obesity/reduce-proportion-children-and-adolescents-obesity-nws-04 Dr. Xenobia Poitier-Anderson stated, "We want to keep in mind that unless we target and track this specific group whose data we're presenting, our outcomes will not be a true reflection of success." Carolina asked the group if they would need more time to make an informed decision. Angelica Castillo Da Silva and Brittani Coore agreed that more time would be useful. Angelica Castillo Da Silva suggested a poll next week. Dr. Xenobia Poitier-Anderson and Daniza Robinson agreed. **A survey will be sent out via email to vote on the measures, and results will be shared at the next meeting.**
Next Steps	Kaitlin reviewed the timeline for the Health Equity Plan, as follows: • April – Choose vision, voted/chose evidence-based strategies, and discussed health disparity objective. HCSEF w**ill send a poll between this meeting and the next meeting to vote on the objective measures for each indicator, with a timeline of 2027.**

	• May – Design evidence-based projects with short-, medium-, and long-term goals • June – Martin County Health Equity Plan Review • July – Implementation begins Kraig McHardy shared, "We should also have an awareness campaign to go along with the healthy living curriculum at the developmental ages K-5. Healthy living fundraisers in the schools to offset all the candy fundraisers. Change the culture to emphasize healthy living. We also can have a play on obesity prevention that can be shown in your health education classes. Also an internship program where students cover high school sports events with a healthy living blog. Awareness will be instrumental in the success of the mission." Many members of the group supported these ideas. Kaitlin reviewed the group's next steps, as follows: • Prior to next meeting: (a) Use the evidence-based strategy we voted on today to explore evidence-based interventions (b) You'll receive a reminder with a call-to-action **(c) HCSEF will send poll for objective measures** • Next meeting: (a) Working meeting with two breakout rooms (b) Design two evidence-based projects focused on improving the Social Determinants of Health for our priority population (c) Create short-, medium-, and long-term goals and objectives for each project (d) Identify lead organization, lead point person, data source, baseline value, and target value for each goal and objective
Adjourn	Kaitlin and Carolina thanked the group for their input and rich discussion in the meeting. Angelica Castillo Da Silva shared that a health fair is taking place at the Golden Gate neighborhood. There will be a Zumba class and car seat education opportunities. There will also be UF/IFAS nutrition education information. Angelica thanked the group for attending. Renay Rouse shared a flyer for the April 23, 2022 event. The meeting was adjourned at 4:00 PM. The post-meeting survey can be found here: https://www.surveymonkey.com/r/TJ7GQTW

Martin County Health Equity Taskforce – May 24, 2022	
Agenda Item	**Meeting Minutes**
Welcome & Introductions	C. Alcala welcomed the group and thanked everyone for their attendance. The agenda for the meeting was reviewed with participants. C. Alcala introduced the Health Council of Southeast Florida. A. Castillo da Silva and C. Vitani welcomed the group on behalf of the Health Equity team at the Florida Department of Health in Martin County. Participants shared their name, organization or community, and their favorite locations for a healthy meal in Martin County.
Martin County Health Equity Plan	C. Alcala provided a brief overview of the Health Equity Taskforce and Health Equity Plan. Through previous discussions and meetings on Health Equity in Martin County, the Martin County Health Equity Taskforce decided on this vision for the Martin County Health Equity Plan: "A Martin County where there are no systemic barriers to individuals achieving their best health." The final prioritized health disparity objective is "By 2027, reduce overweight and obesity in Martin County among: Black or African American middle and high school students from 30.5% (2020) to 29.2%, Hispanic middle and high school students from 34.4% (2020) to 24.6%, and WIC clients (2-4 years old) from 36.7% (2021) to 35.9%"." The trend analysis tool was introduced to discuss how targets were determined, with input from the survey in mind. One change that was discussed was the sole focus on children, as there is incomplete data in Martin County on Black or African American and Hispanic adults.
Martin County Health Equity Plan Projects	K. Chamberlain shared the selection process for the Martin County HEP projects: based on previous discussions regarding health equity, the Social Determinants of Health, and health outcomes in Martin County, as well as researching evidence-based interventions and initiatives already happening in the community with community partners. Past input provided by the Martin County Equity Task Force was highlighted to build upon the work already being done. The first project is PACE-EH, or the Protocol for Assessing Community Excellence in Environmental Health, in Indiantown, which assesses neighborhood and lived environmental factors and prioritizes children and families of Indiantown, of which a large percentage are Hispanic. The second is Go NAPSACC, also focusing on neighborhood and lived environmental factors, but for children age 0-5 enrolled in early

	care and education settings. And the third mentioned is the Social Determinant of Health Screening Tool. Input provided in past meetings were included in consideration of the projects discussed. C. Alcala introduced the short, medium- and long-term objectives for PACE-EH, Indiantown. The short-term SDOH goal is improving neighborhood and lived environment, specifically access to affordable healthy food, by analyzing a community survey to assess access to healthy food in Indiantown. The medium-term SDOH goal is to improve neighborhood and lived environment, specifically access to affordable healthy food, by determining key recommendations for PACE-EH activities based on survey findings. Improve neighborhood and lived environment, specifically built environment, by assessing access to parks and green space, walkability, and needed support for enhancing physical activity opportunities. The long-term SDOH goal is improve neighborhood and lived environment, specifically access to affordable healthy food, by fully implementing PACE-EH-based project as a Martin County Health Equity Plan Community Project. A. Castillo da Silva is the lead point of person from the Florida Department of Health in Martin County as the lead entity. Key partners include DOH-Martin, Indiantown Mayor, Village of Indiantown, 21st Century Director – Boys and Girls Club in Indiantown, YMCA Indiantown, Holy Cross Church and House of Hope. C. Alcala transitioned the group into a discussion, welcoming questions or thoughts related to the PACE-EH, Indiantown community project. A. Castillo da Silva discussed sidewalks and walkability and how it can be incorporated inside the neighborhoods to increase activity. A. Jefferson pointed out that LDR's illustrate incentives to residential projects and could be potentially explored. D. Resos mentioned master planning parks to add fitness equipment. J. Taylor mentioned Healthy Fresh Start, to implement breast feeding to decrease childhood obesity. A. Jefferson had an additional comment regarding periodically checking in on residential projects that are being implemented. Each time there's a residential development, the school board recalculates school zone projects for modifications. A. Castillo da Silva mentioned a community garden depending on survey analysis. N. Parkell posed a question as to whether there would be a place in this portion of the plan to add increased access to SNAP and Fresh Access Bucks programs within the food system in Indiantown. C. Alcala introduced the short, medium- and long-term objectives for the Go NAPSACC project. The short-term SDOH goal is to improve the built environment in Early Care and Education (ECE) settings by recruiting and enrolling providers to participate in Go NAPSACC technical assistance and ensuring all programs are connected to a local Go NAPSACC technical assistance consultant. The medium-term

	SDOH goal is to improve the built environment in Early Care and Education (ECE) settings by providing direct technical assistance to ECE providers that supports healthy eating and physical activity best practice goal setting and implementation. The long-term SDOH goal is to improve the built environment and education access and quality in Early Care and Education (ECE) settings by implementing policies, systems, and environmental changes that meet healthy eating and physical activity best practices and promote healthy habits. The lead entity of Go NAPSACC is the Florida Department of Health, Martin County – Healthiest Weight Florida. The lead point person is Patsy-Lindo Wood. C. Alcala transitioned the group into a discussion, welcoming questions or thoughts related to the Go NAPSACC community project. J. Taylor asked for clarification on Go NAPSACC and the Healthy Heroes incentive. K. Chamberlain provided the link to the group and a brief overview of Go NAPSACC (https://gonapsacc.org/) . E. Carmichael provided a short video to watch (https://youtu.be/qUiSK5K7Qrs). G. Wright posed a question about whether there is anything in place for children who are not currently enrolled in ECE's. ECE's were defined by C. Alcala. J. Taylor mentioned integrating a Healthy Start for nutritional counseling. A. Castillo da Silva mentioned the WIC program as a main point of focus to support breast feeding. J. Taylor discussed Helping People Succeed as a resource to utilize through the Home Instruction for Parents of Preschool Youngsters (HIPPY) Program. The link was provided by G. Wright (https://www.hpsfl.org/programs/successful-families/baby-steps/home-instruction-for-parents-of-preschool-youngsters). C. Alcala introduced the short, medium- and long-term objectives Social Determinant of Health Screening Survey. The SDOH screening tool will develop to aid in data collection and the identification of unique health needs of key populations who maybe experiencing health inequities at high rates. The short-term SDOH goal is to improve data collection efforts related to all Social Determinants of Health and overweight and obesity among prioritized populations by developing a mechanism to assess county-level and ZIP-code level neighborhood and lived environment, health care access and quality, income, employment, benefits/financial support, educational attainment, social support and integration, and obesity and overweight status among Black or African American residents, LGBTQ+ residents, elders over 65 years old, veterans, people living with disabilities, and foreign-born residents. The medium-term SDOH goal is to improve all Social Determinants of Health and obesity among priority populations by implementing a mechanism to assess county-level and ZIP-code level neighborhood and lived environment, health care access and quality, income, employment,

	benefits/financial support, educational attainment, social support and integration, and obesity and overweight status among Black or African American residents, LGBTQ+ residents, elders over 65 years old, veterans, people living with disabilities, and foreign-born residents. The long-term SDOH goal is to improve all Social Determinants of Health and obesity among priority populations by assessing county-level and ZIP-code level neighborhood and lived environment, health care access and quality, income, employment, benefits/financial support, educational attainment, social support and integration, and obesity and overweight status among Black or African American residents, LGBTQ+ residents, elders over 65 years old, veterans, people living with disabilities, and foreign-born residents to inform additional community-based health equity projects. The Florida DoH, Martin County Community Health Planning and Statistics department is the lead entity of the project with A. Castillo da Silva as the lead point person. C. Alcala discussed that through the development of the Health Equity Plan, missing data for key populations, such as LGBTQ+, Disabled, Black or African American, or Elderly was found. Existing evidence and research have demonstrated that these populations experience health outcome disparities and health inequities. Without county-level data, there is no certainty to the extent of health inequities in Martin County C. Alcala transitioned the group into a discussion, welcoming questions or thoughts related to the SDOH Screening Tool community project. A. Castillo da Silva discussed the importance of quantitative data and survey collection. K. Chamberlain discussed the opportunity to incorporate children 0-5 either enrolled or not enrolled for community assessment to coincide with community data. D. Resos mentioned the Kane Center in Stuart to assist, provide input, and point in the right direction regarding elders and people living with disabilities. A. Castillo da Silva thanked D. Resos for mentioning a potential partner. C. Alcala thanked the group for their input and discussion in the meeting, emphasizing the importance of the group's participation in informing the work being done with this group. D. Resos commented on the Martin County Parks and Rec department invitation and their involvement with the AS/OS program. D. Resos also provided a contact with the Martin County Parks and Recreation department: Katya Lysak, Recreation Administrator (klysak@martin.fll.us). C. Alcala opened the floor for discussion on collaboration as organizations through current efforts. T. Allen-Camizzi mentioned Community Shores and could share potential trends relating to nutrition and physical activity. L. Frederick

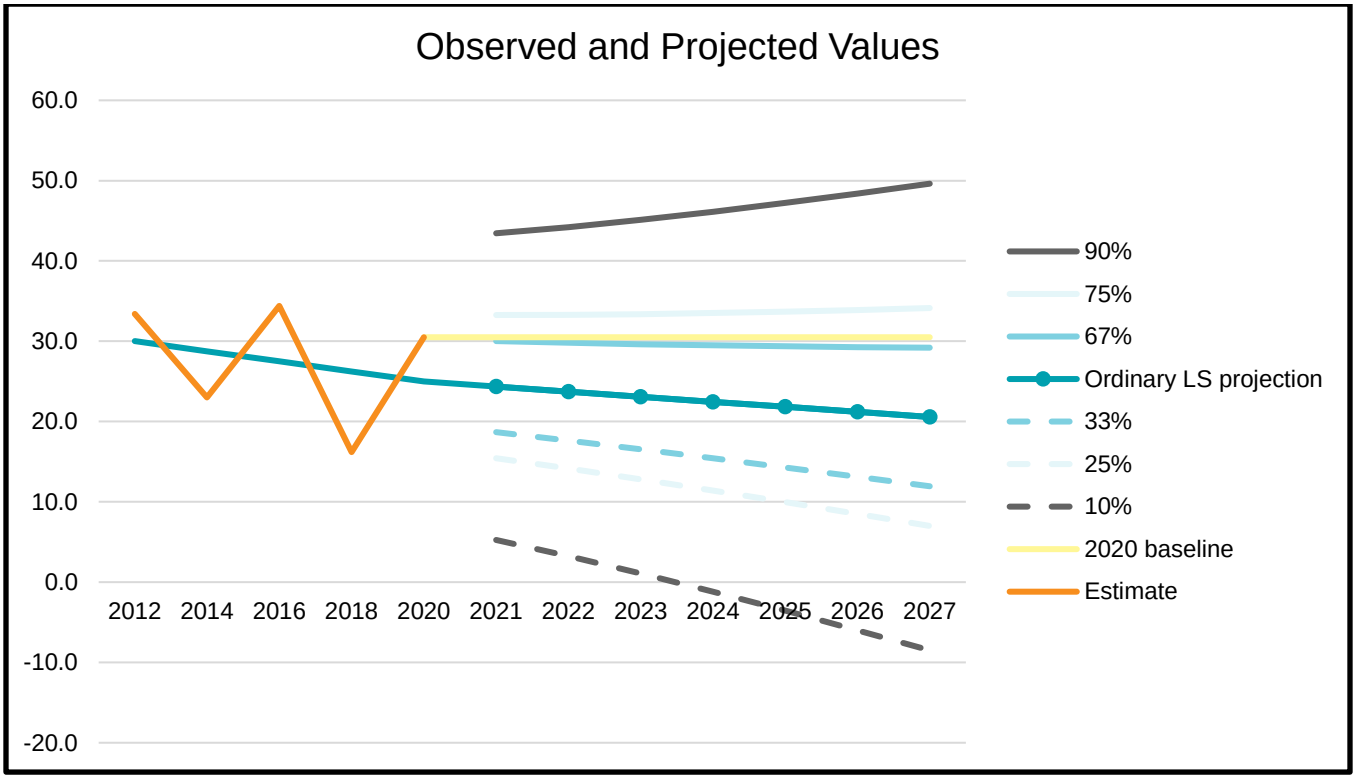
	mentioned the House of Hope traveling garden. J. Taylor and D. Resos commented the House of Hope and traveling garden as well. G. Wright posed a question regarding a reference guide for Martin County. J. Taylor mentioned the 211-community resource guide as an available source and provides the link (https://211pbtc.myresourcedirectory.com/). D. Resos mentioned the Martin County Chamber. C. Pena mentioned the Martin County Interagency Coalition. D. Resos provided a link (https://www.tykesandteens.org/shine-a-light/). C. Pena provided accompanying flyers.
Community Collaboration	C. Alcala thanked the group for their input and discussion in the meeting, emphasizing the importance of the group's participation in informing the work being done with this group. A feedback survey was provided to the group after the presentation. A. Castillo da Silva thanked the group for their participation and expressed her excitement for the work going forward.
Next Steps & Adjourn	The Health Equity Task Force will finalize the Martin County Health Equity Plan in June. The Health Equity Task Force will begin the implementation phase starting in July.

Addendum C

Trend Analysis: Health Disparity Objective

Black or African American Middle and High School Students

Data Source: https://www.FLHealthCHARTS.gov

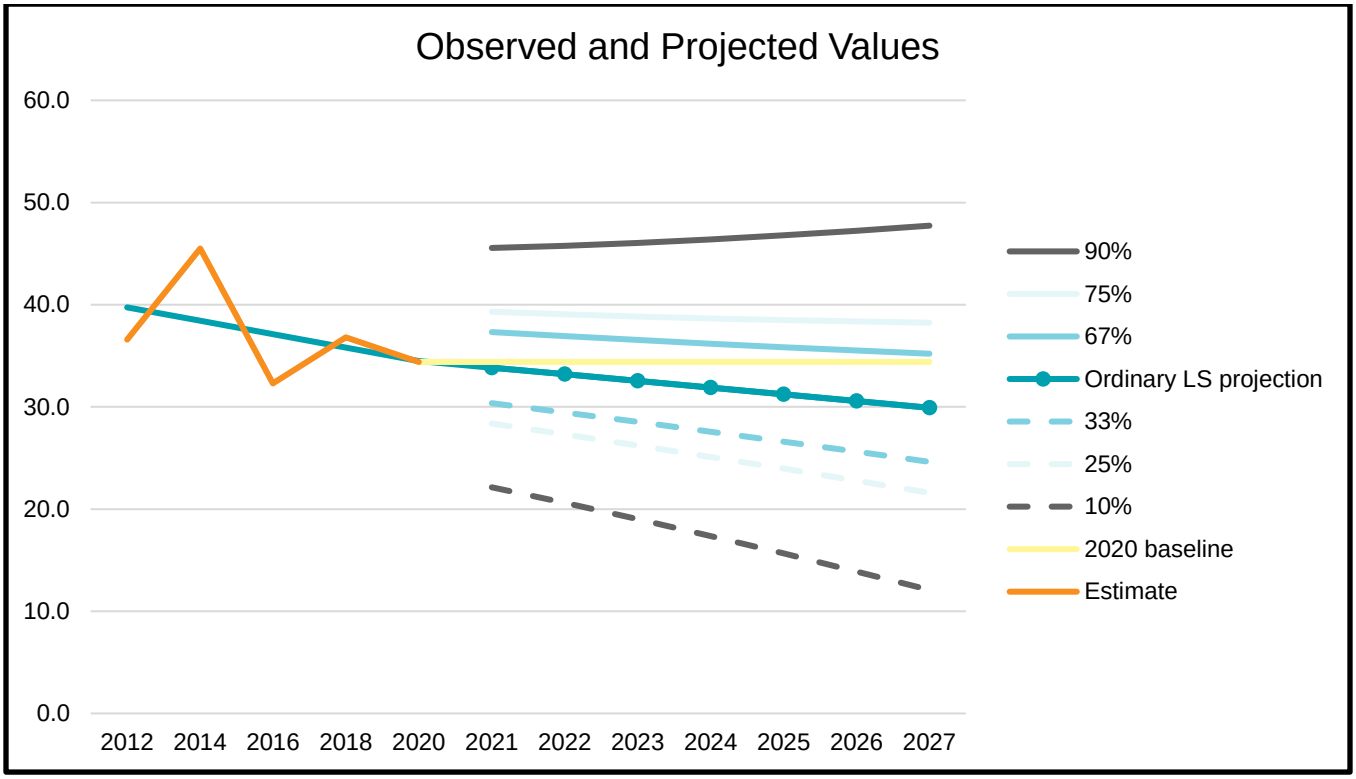


Based on the linear trend from the Ordinary LS projection, and using the model assumptions and data provided…

...there is a 90% chance that 2027 value will meet or exceed:	**49.6**
...there is a 75% chance that 2027 value will meet or exceed:	**34.1**
…there is a 67% chance that 2027 value will meet or exceed:	**29.2**
…there is a 50% chance that 2027 value will meet or exceed:	**20.6**
…there is a 33% chance that 2027 value will meet or exceed:	**11.9**
…there is a 25% chance that 2027 value will meet or exceed:	**7.0**
…there is a 10% chance that 2027 value will meet or exceed:	**-8.5**
The 2020 baseline is:	**30.5**

Hispanic Middle and High School Students

Data Source: https://www.FLHealthCHARTS.gov

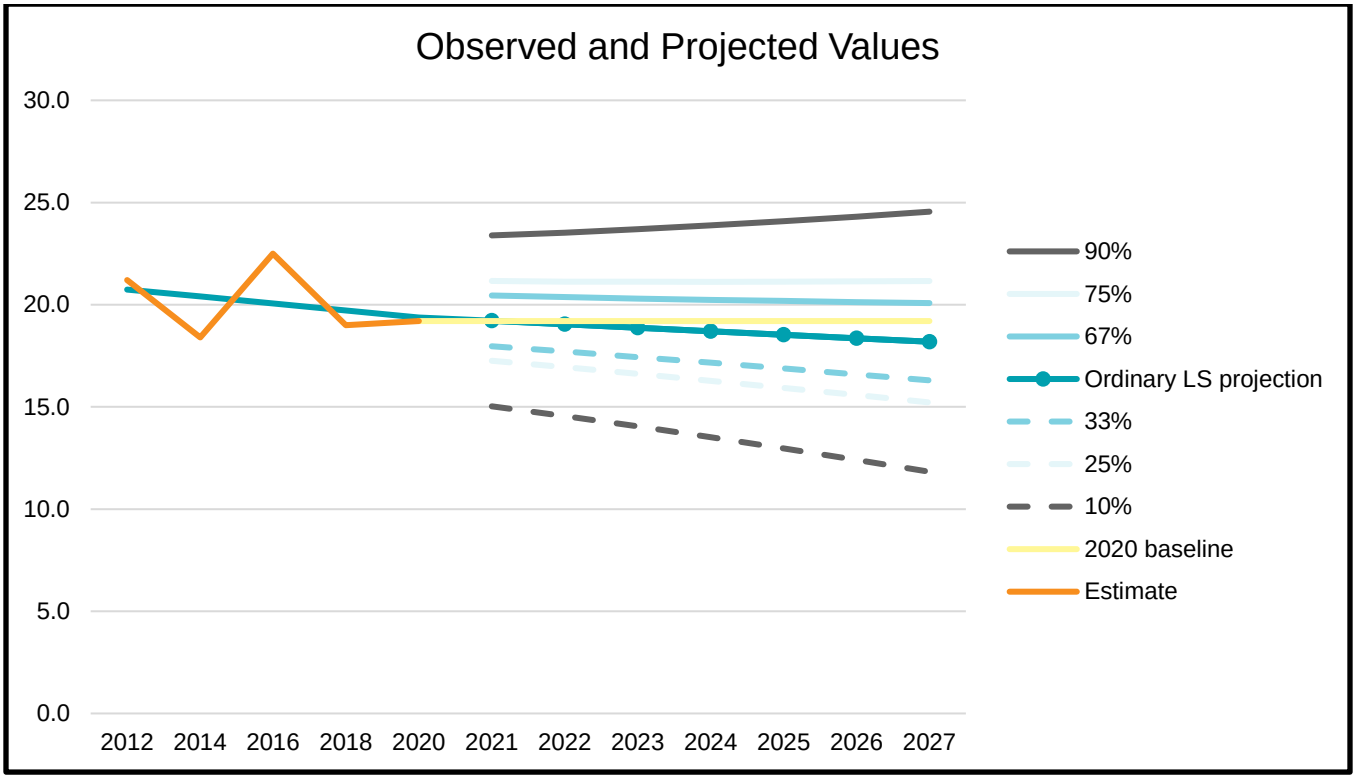


Based on the linear trend from the Ordinary LS projection, and using the model assumptions and data provided…

...there is a 90% chance that 2027 value will meet or exceed:	**47.7**
...there is a 75% chance that 2027 value will meet or exceed:	**38.2**
…there is a 67% chance that 2027 value will meet or exceed:	**35.2**
…there is a 50% chance that 2027 value will meet or exceed:	**29.9**
…there is a 33% chance that 2027 value will meet or exceed:	**24.6**
…there is a 25% chance that 2027 value will meet or exceed:	**21.6**
…there is a 10% chance that 2027 value will meet or exceed:	**12.1**
The 2020 baseline is:	**34.4**

White Middle and High School Students

Data Source: https://www.FLHealthCHARTS.gov

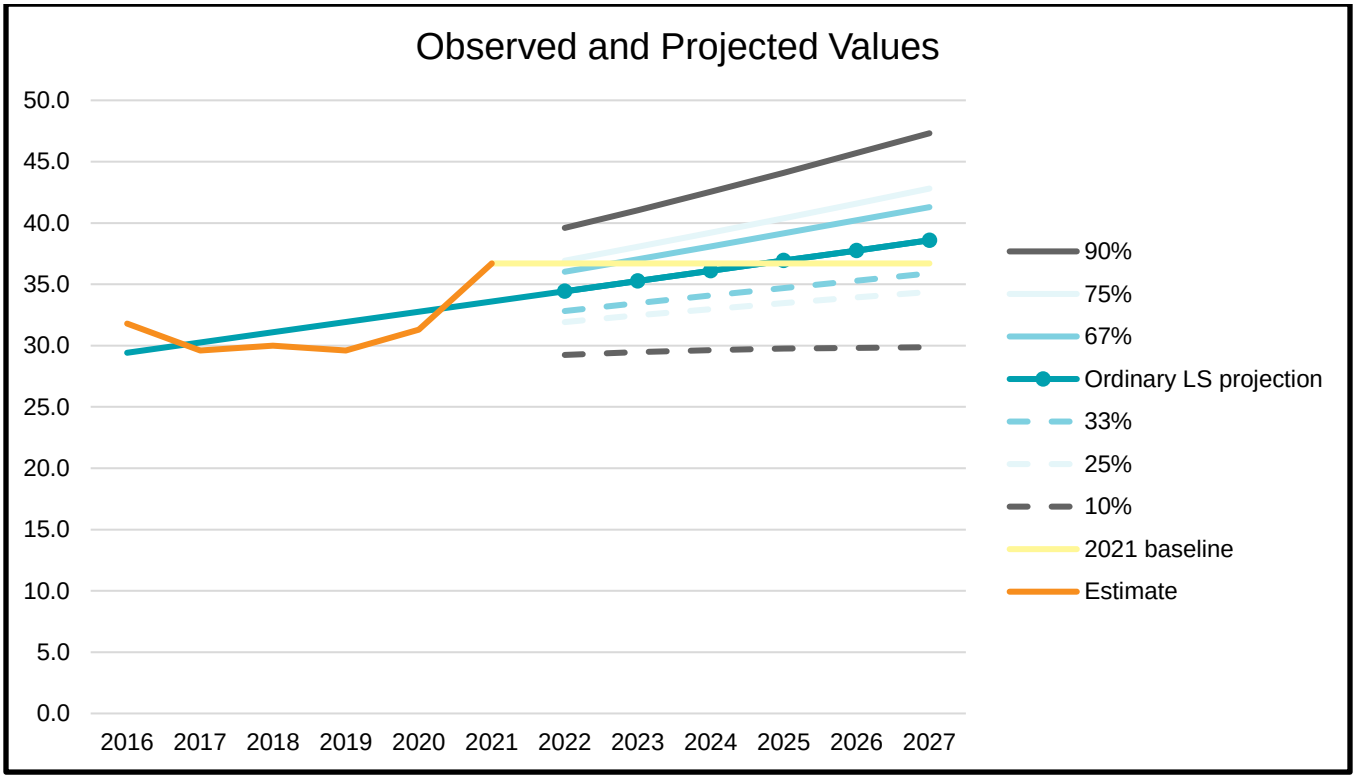


Based on the linear trend from the Ordinary LS projection, and using the model assumptions and data provided…

...there is a 90% chance that 2027 value will meet or exceed:	**24.6**
...there is a 75% chance that 2027 value will meet or exceed:	**21.2**
…there is a 67% chance that 2027 value will meet or exceed:	**20.1**
…there is a 50% chance that 2027 value will meet or exceed:	**18.2**
…there is a 33% chance that 2027 value will meet or exceed:	**16.3**
…there is a 25% chance that 2027 value will meet or exceed:	**15.2**
…there is a 10% chance that 2027 value will meet or exceed:	**11.8**
The 2020 baseline is:	**19.2**

WIC Clients Who Are Overweight or Obese (Aged 2 – 4 Years)

Data Source: https://www.FLHealthCHARTS.gov



Based on the linear trend from the Ordinary LS projection, and using the model assumptions and data provided…

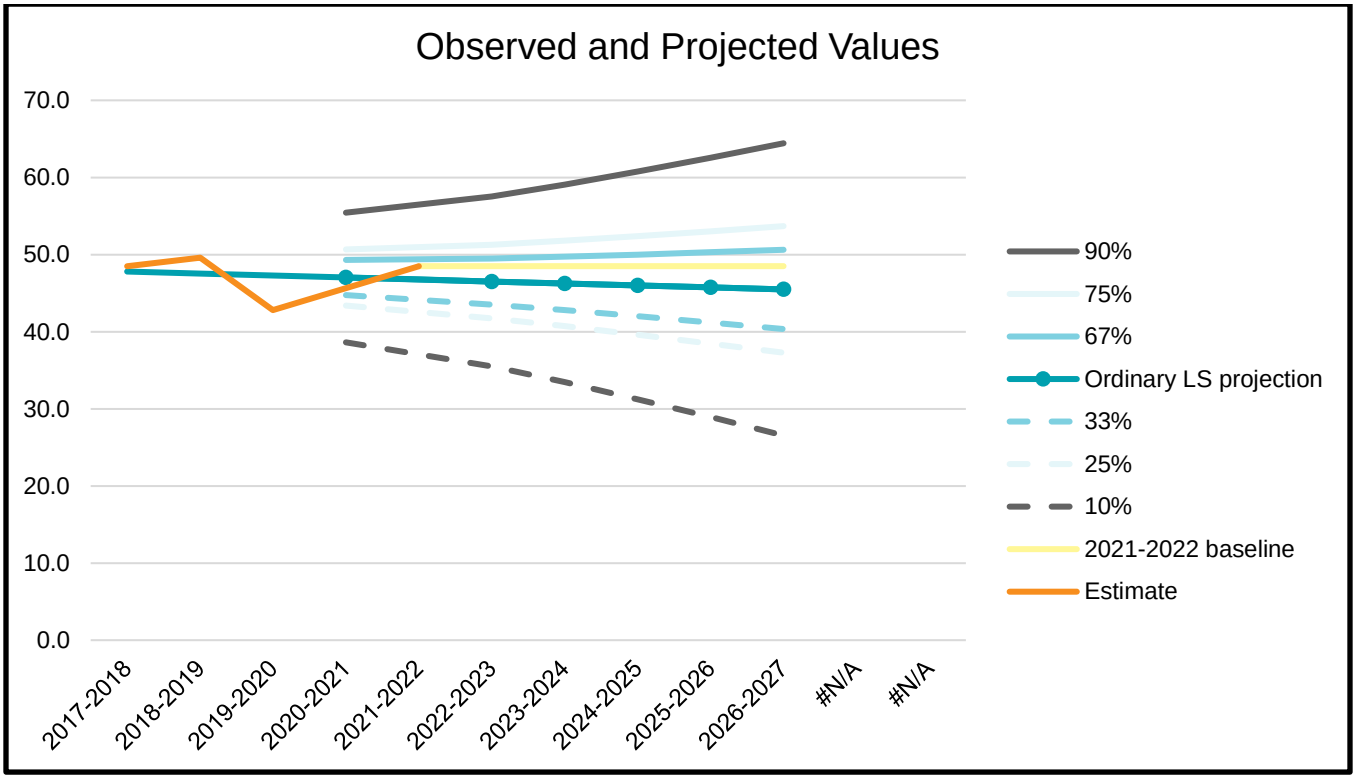
...there is a 90% chance that 2027 value will meet or exceed:	**47.3**
...there is a 75% chance that 2027 value will meet or exceed:	**42.8**
…there is a 67% chance that 2027 value will meet or exceed:	**41.3**
…there is a 50% chance that 2027 value will meet or exceed:	**38.6**
…there is a 33% chance that 2027 value will meet or exceed:	**35.9**
…there is a 25% chance that 2027 value will meet or exceed:	**34.4**
…there is a 10% chance that 2027 value will meet or exceed:	**29.9**
The 2021 baseline is:	**36.7**

Addendum D

Trend Analysis: PACE-EH, Indiantown Project

First Grade Students, Indiantown

Data Source: Martin County School District

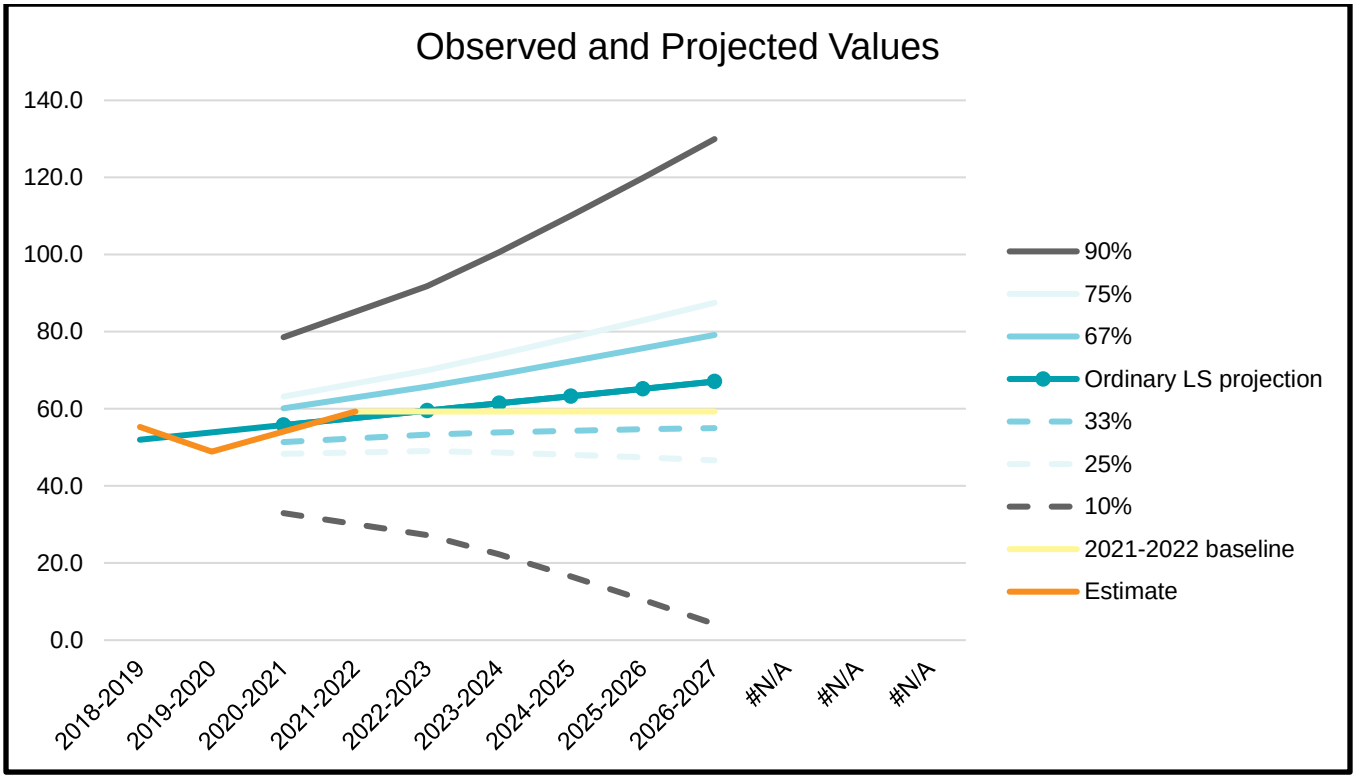


Based on the linear trend from the Ordinary LS projection, and using the model assumptions and data provided…

…there is a 90% chance that 2026-2027 value will meet or exceed:	64.4
…there is a 75% chance that 2026-2027 value will meet or exceed:	53.7
…there is a 67% chance that 2026-2027 value will meet or exceed:	50.6
…there is a 50% chance that 2026-2027 value will meet or exceed:	45.5
…there is a 33% chance that 2026-2027 value will meet or exceed:	40.3
…there is a 25% chance that 2026-2027 value will meet or exceed:	37.3
…there is a 10% chance that 2026-2027 value will meet or exceed:	26.5
The 2021-2022 baseline is:	48.5

Third Grade Students, Indiantown

Data Source: Martin County School District

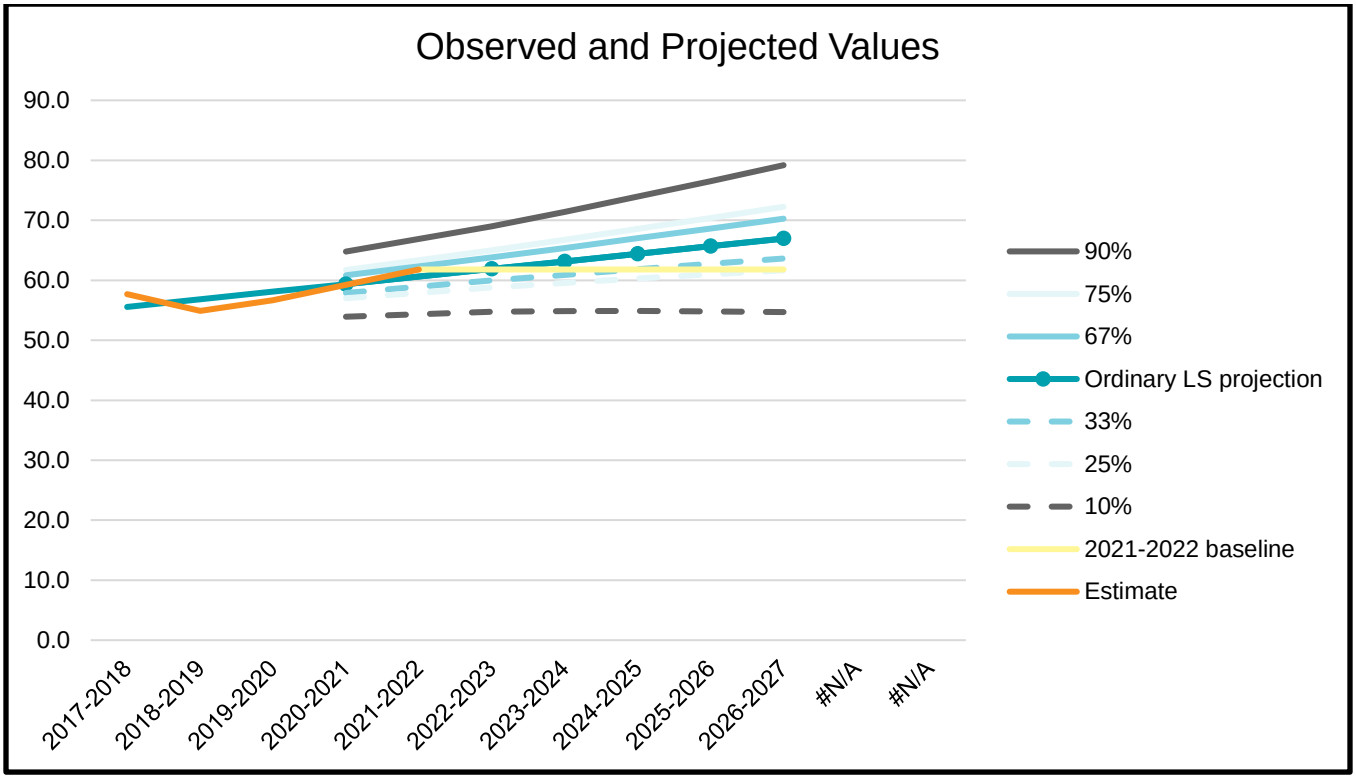


Based on the linear trend from the Ordinary LS projection, and using the model assumptions and data provided…

...there is a 90% chance that 2026-2027 value will meet or exceed:	**130.0**
...there is a 75% chance that 2026-2027 value will meet or exceed:	**87.5**
…there is a 67% chance that 2026-2027 value will meet or exceed:	**79.2**
…there is a 50% chance that 2026-2027 value will meet or exceed:	**67.1**
…there is a 33% chance that 2026-2027 value will meet or exceed:	**55.0**
…there is a 25% chance that 2026-2027 value will meet or exceed:	**46.6**
…there is a 10% chance that 2026-2027 value will meet or exceed:	**4.2**
The 2021-2022 baseline is:	**59.3**

Sixth Grade Students, Indiantown

Data Source: Martin County School District



Based on the linear trend from the Ordinary LS projection, and using the model assumptions and data provided…

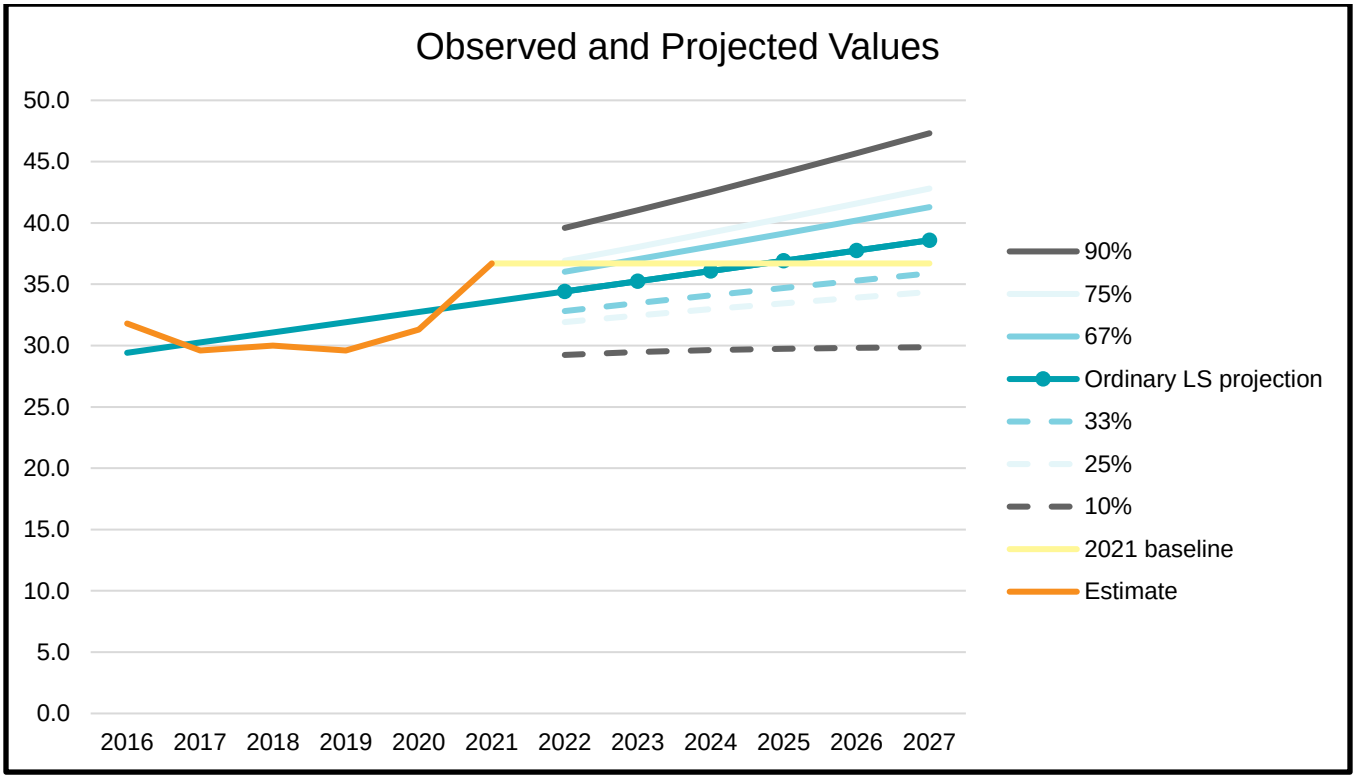
...there is a 90% chance that 2026-2027 value will meet or exceed:	79.2
...there is a 75% chance that 2026-2027 value will meet or exceed:	72.3
…there is a 67% chance that 2026-2027 value will meet or exceed:	70.3
…there is a 50% chance that 2026-2027 value will meet or exceed:	67.0
…there is a 33% chance that 2026-2027 value will meet or exceed:	63.6
…there is a 25% chance that 2026-2027 value will meet or exceed:	61.7
…there is a 10% chance that 2026-2027 value will meet or exceed:	54.7
The 2021-2022 baseline is:	61.8

Addendum E

Trend Analysis: Go NAPSACC Project

WIC Clients Who Are Overweight or Obese (Aged 2 – 4 Years)

Data Source: https://www.FLHealthCHARTS.gov



Based on the linear trend from the Ordinary LS projection, and using the model assumptions and data provided…

...there is a 90% chance that 2027 value will meet or exceed:	47.3
...there is a 75% chance that 2027 value will meet or exceed:	42.8
…there is a 67% chance that 2027 value will meet or exceed:	41.3
…there is a 50% chance that 2027 value will meet or exceed:	38.6
…there is a 33% chance that 2027 value will meet or exceed:	35.9
…there is a 25% chance that 2027 value will meet or exceed:	34.4
…there is a 10% chance that 2027 value will meet or exceed:	29.9
The 2021 baseline is:	36.7