DOH-MONROE

HEALTH EQUITY PLAN

July 2022 – July 2025

Florida HEALTH

A POSITIVE STEP OF MONROE COUNTY

CHI Community Health of South Florida, Inc.

S.O.S. Foundation

United Way of Collier and the Keys

MONROE COUNTY FLORIDA

Rural Health Network

CHARTING THE COURSE

HEALTH + HOUSING

WestCare Guidance/ Care Center, Inc.

HOUSING AUTHORITY OF THE CITY OF KEY WEST, FLORIDA

MONROE COUNTY COALITION ★ COM SAFE AND DRUG FREE PARTNERSHIPS OF MONROE

Billy Davis & Associates, Inc.

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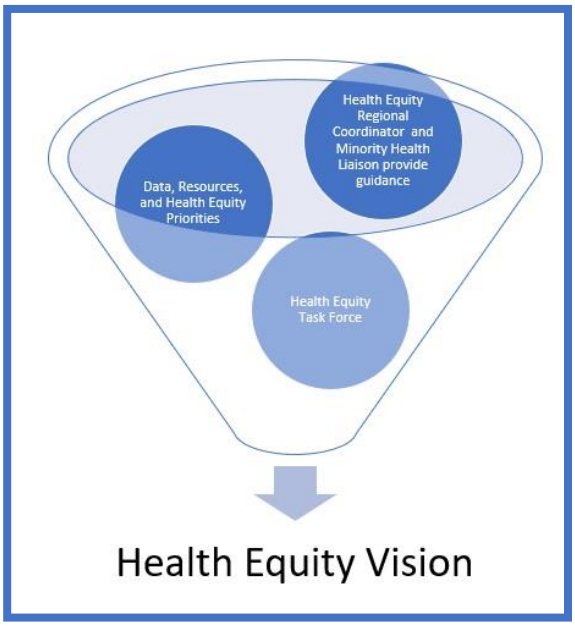
I. VISION

The below health equity vision resulted from a joint method of collaborative techniques. First, principals of MAPP guidance were applied, and Task Force members participated in open form response to two visioning questions: “What are important characteristics of a healthy community for all who live, work, and play here?” and “How do you envision the Monroe County public health system in the next five or ten years?” After initial brainstorming, key themes were identified. Four placeholder statements were presented for construction of the statement. Members identified a working statement and alterations were made to reflect important themes and aspects unique to Monroe County. The following vision statement resulted:



We envision a Monroe County in which every resident, regardless of race, ethnicity, age, gender, sexual orientation, religion, geographic location, socioeconomic status, or other physical or social characteristic, has every opportunity to maximize their health and thrive.

II. PURPOSE OF THE HEALTH EQUITY PLAN

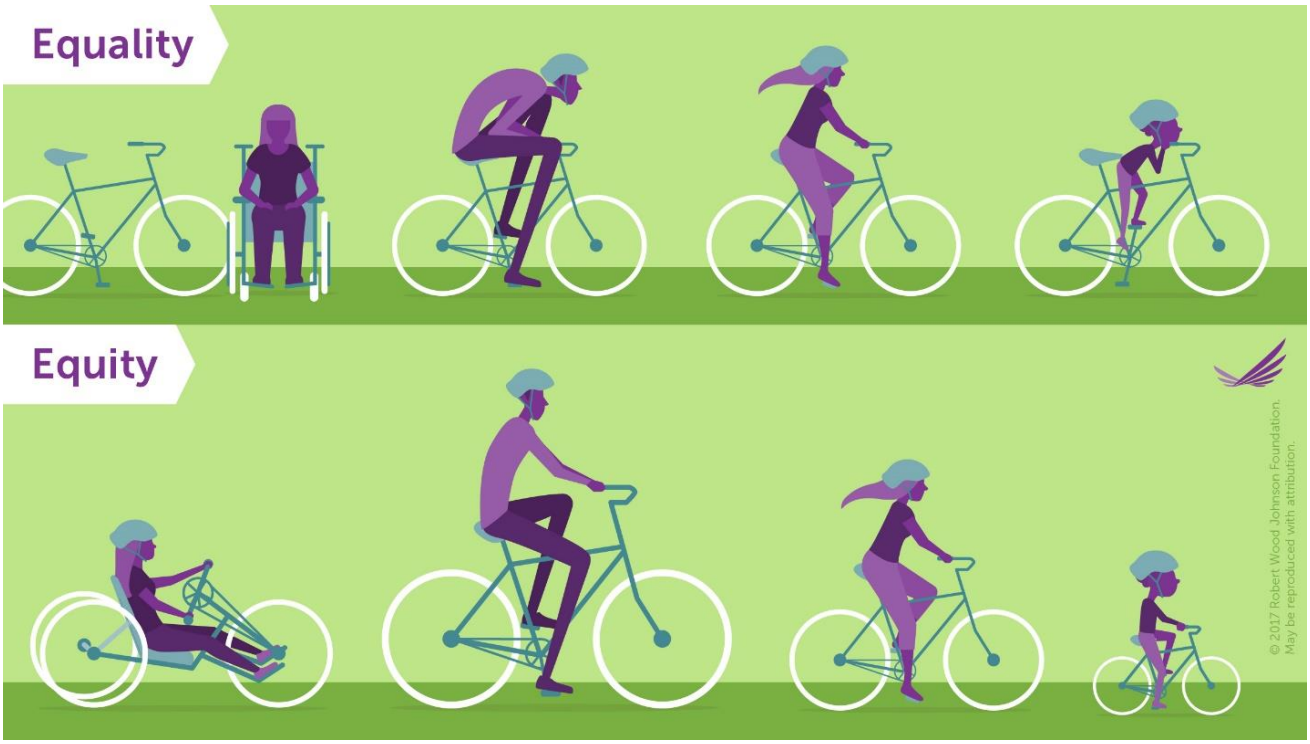
Health Equity is achieved when everyone can attain optimal health.

The Florida Department of Health's Office of Minority Health and Health Equity (OMHHE) works with government agencies and community organizations to address the barriers inhibiting populations from reaching optimal health. A focus on health equity means recognizing and eliminating the systemic barriers that have produced disparities in achieving wellness. In response to Chapter 2021-117 of the Florida Statute, effective July 1, 2021, each county health department (CHD) has been provided resources to create a Health Equity Plan to address health disparities in their communities.

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

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

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.

Social vulnerability refers to the potential negative effects on communities caused by external stresses on human health.[i]

Mental (or psychological) distress: a set of painful mental and physical symptoms that are associated with normal fluctuations of mood in most people. In some cases, however, psychological distress may indicate the beginning of major depressive disorder, anxiety disorder, schizophrenia, somatization disorder, or a variety of other clinical conditions.[ii]

IV. PARTICIPATION

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

Figure 1: Community Health of South Florida, Inc. (CHI) staff members share information about their health center services with clients at the SOS Foundation's food pantry on Stock Island.

Figure 2: SOS Foundation staff members tour CHI's new health center to become more informed and better serve food pantry clients in need of health and dental services.

Members of the Health Equity Task Force and additional community stakeholders have partnered to increase recruitment, coordination, engagement, and collaboration in cross-sector initiatives.

Beginning in Fall of 2021, bimonthly Minority Health Events provided a venue for cross-sector engagement and information sharing. Participating organizations and stakeholders provided service information to minority communities and networked with social service providers from various SDOH sectors. Each of the 20 events engaged approximately five providers and 22 community members (445 total). The Minority Health Liaison worked directly with SOS Foundation who provided Publix gift cards and healthy meals. Billy Davis & Associates, a minority vendor, and Monroe County Coalition provided Amazon gift cards for raffles.

The Health Equity Task Force meetings provided opportunities for key community stakeholders to engage in cross-sector communication about shared barriers and collaborative strategies. Several cross-sector initiatives have already resulted from these engagement opportunities. For example, Task Force members representing the Florida Department of Health in Monroe County, Community Health of South Florida, Inc. (CHI), and the SOS Foundation (SOS) implemented collaborative strategies to address shared barriers to reaching populations in need of services. These strategies have included an in-person informational booth of CHI services at SOS's highest volume food pantry and a tour of CHI by SOS's Community Outreach Coordinator and DOH's Minority Health Liaison. Similar additional cross-sector collaborations between Health Equity Task Force stakeholders have occurred.

A. Minority Health Liaison

The Minority Health Liaison supports the Office of Minority Health and Health Equity in advancing health equity and improving health outcomes of minorities through partnership engagement, health equity planning, and implementation of health equity projects to improve social determinants of health. The Minority Health Liaison facilitates health equity discussions, initiatives, and collaborations related to elevating the shared efforts of the county.

Minority Health Liaison: Paige Volpenhein
Minority Health Liaison Backup: Alison Kerr

B. Health Equity Team

The Health Equity Team includes individuals that each represent a different program within the DOH. The Health Equity Team explores opportunities to improve health equity efforts within the county health department. Members of the Health Equity Team assess the current understanding of health equity within their program and strategize ways to improve it. The Health Equity Team also relays information and data concerning key health disparities and SDOH in Monroe to the Health Equity Task Force. The Minority Health Liaison guides these discussions and the implementation of initiatives. The membership of the Health Equity Team is listed below:

Name	Title	Program
Paige Volpenhein	Health Equity Consultant	Minority Health

Donna Stayton (Q1 & Q2)	Director of Community Health Improvement & Planning	Strategic Planning
Alison Kerr	Planning Manager & Public Information Officer	Community Health
Talley Anne Reeb	Interim Director of Nursing	Nursing, Family Planning, Immunizations
Hannah Hamilton	Public Health Nutritionist Supervisor	WIC
Jessica Lariz	Senior Human Service Program Manager	Healthy Start
Cyna Wright	Public Health Services Manager	HIV/AIDS
Dana Portillo	FDOH-Monroe School Health Coordinator	School Health
Jennifer Lefelar (Q3)	Community Health Planner	Minority Health

The Health Equity Team met on the below dates during the health equity planning process. Since the Health Equity Plan was completed, the Health Equity Team has met at least quarterly to track progress. Agendas and meeting minutes are available for all meetings.

Meeting Date	Topic/Purpose
February 3, 2022	To introduce the goals of the HE Team and HE Plan, to outline the roles of the Coalition and Task Force, and to present initial data on health disparities in Monroe County
February 17, 2022	To present additional data to fill gaps in health disparities and to begin presenting data on social determinants of health in Monroe County. Also, to identify potential members of the HE Task Force
April 1, 2022	To share progress on HE Task Force progress and to identify additional members; to begin discussing DOH Monroe needs
May 20, 2022	To share updates on the work of the HE Task Force and to discuss health equity trainings for DOH staff

C. Health Equity Task Force

The Health Equity Task Force includes representatives from various organizations that provide services to address SDOHs. Members of this Task Force brought their knowledge about community needs and SDOH. Recruitment efforts included (1) working with Health Equity Team to identify a list of over 20 potential task force members, (2) balancing task force member requests so that the group would evenly reflect the five SDOH themes, (3) reaching out via email, phone, or in-person contact to share about the Health Equity Plan and invite identified persons to participate, (4) calling or meeting with some prospective members to share about expectations and goals of the Task Force, and (5) surveying persons who agreed to participate on best meeting times.

Task Force members were highly engaged during meetings, reviewing data, identifying barriers, and identifying potential projects, and discussing final details of the two projects. Task Force members reviewed drafts of the Health Equity Plan, identifying opportunities for improvement. Between meetings, several task force members collaborated in Minority Health Events, which are the basis of one of the two projects.

Name	Title	Organization	Social Determinant of Health
Paige Volpenhein	Health Equity Consultant	Florida DOH in Monroe County	Minority Health Liaison
Selena Quintanilla	Community Outreach Coordinator; Volunteer	SOS Foundation; Monroe County Immigration Coalition	Economic Stability; Neighborhood and Built Environment; Social and Community Context
Billy Davis	Executive Director; Owner	A Positive Step Monroe; Billy Davis and Associates	Social and Community Context; Economic Stability
Peter Batty	Community Relations Director	Housing Authority of the City of Key West	Neighborhood and Built Environment
Anna Haskins	Senior Coordinator of Special Projects	Monroe County Social Services	Neighborhood and Built Environment
Lisa Marciniak	Marathon Site Director	Guidance Care Center	Health Care Access and Quality
Leslie Holmes	Coordinator of Adult Education	Monroe County School District	Education Access and Quality
Michelle Norwood	Director of Client Services	AH of Monroe	Health Care Access and Quality

Michelle Coldiron	Monroe County Commissioner	Monroe County Commissioners	Education Access and Quality; Economic Stability; Social and Community Context; Neighborhood and Built Environment; Health Care Access and Quality
Rochelle Pearson	Director	Rural Health Network	Health Care Access and Quality
Marianne Finizio	Vice President of Community Relations & Business Development	Community Health of South Florida, Inc. (CHI)	Health Care Access and Quality
Alison Kerr	Planning Manager, Public Information Officer	Monroe DOH	Health Care Access and Quality
Leah Stockton	FL Keys Area President	United Way of Collier and the Keys	Education Access and Quality; Economic Stability; Social and Community Context; Neighborhood and Built Environment; Health Care Access and Quality
Susan Moore	Executive Director	Monroe County Coalition	Education Access and Quality; Economic Stability; Social and Community Context; Neighborhood and Built Environment; Health Care Access and Quality
Cali Roberts	Executive Director	Womankind	Health Care and Access and Quality

The Health Equity Task Force met on the below dates during the health equity planning process. Since the Health Equity Plan was completed, the Health Equity Task Force has continued to meet at least quarterly to track progress. Agendas and meeting minutes are available for all meetings.

Meeting Date	Organizations	Topic/Purpose
April 21, 2022	Monroe County Department of Health;	To introduce members; to provide an overview of the Health Equity

	SOS Foundation; A Positive Step of Monroe/Billy Davis and Associates; Rural Health Network; CHI; Monroe County Board of Commissioners	Plan in general and the roles of the Task Force specifically; To show brief data regarding health disparity on Team's chosen health outcome for priority population; To discuss participating organizations' barriers to fully addressing social determinants of health
May 5, 2022	Monroe County Department of Health; SOS Foundation; Monroe County School District-Adult Education; CHI	To review and discuss SDOH barriers; To review new data relevant to previously discussed barriers; To discuss projects for HE Plan
May 26, 2022	Monroe County Department of Health; SOS Foundation; A Positive Step of Monroe/Billy Davis and Associates; CHI; Monroe County Board of Commissioners; Monroe County School District-Adult Education	To create vision for health equity in Monroe County; To review drafted Project I and make changes; To discuss Project II; To begin discussing objectives for projects; To set timeline for submission of Health Equity Plan
June 10, 2022	Monroe County Department of Health; SOS Foundation; A Positive Step of Monroe/Billy Davis and Associates; CHI; Rural Health Network; United Way of Collier and the Keys	To review project language of Project I and Project II; To set objectives for Project I and Project II

D. Coalition

The Coalition utilized the pre-organized network of partners that make up the Substance Abuse and Mental Health Planning Committee. Prior to the Health Equity Planning process, partners had been regularly meeting to discuss strategies to improve mental health in the

community. The strategies included a focus on the SDOHs affecting mental health and substance abuse. Membership includes community leaders working to address SDOHs within each theme. The Coalition assisted the Health Equity Task Force by reviewing their Health Equity Plan for feasibility. See Addendum A for a list of Coalition members.

E. Regional Health Equity Coordinators

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

Name	Region	Expertise
Carrie Rickman	Emerald Coast	Nursing
Quincy Wimberly	Capitol	Inclusive Strategies in Public Health and Technical Assistance
Diane Padilla	North Central	Non-Profit Engagement
Ida Wright	Northeast	Community Engagement, Project Management
Rafik Brooks	West	Health Care Leadership
Lesli Ahonkhai	Central	Faith-Based Engagement
Frank Diaz-Gines	Southwest	Health Insurance
Kimberly Watts	Southeast	Minority Health

V. HEALTH EQUITY PROMOTION

A. National Minority Health Month Promotion

Figure 3: April Minority Health Event at the Church of God of Prophecy

Figure 4: April Minority Health Event at the Jack T Murray Senior Citizen Complex in Bahama Village

National Minority Health Month events were kicked off on March 28th at the Jack T. Murray Senior Housing Facility, followed by three events in April at the First Congregational Church /Church of GOD of Prophecy (April 4th), Key Largo Christian Center (April 23rd), and Stock Island Bernstein Park (April 26th).

Monroe County Minority Health Events were a collaboration with Billy Davis & Associates, Monroe County Coalition, Guidance/Care Center, Rural Health Network, SOS Foundation, Area Health Education Center, Douglas Gym Community Center, Domestic Abuse Shelter, Key West Housing Authority (KWHA), CHI, Grand Lodge Free Masons, Saint Paul AME Church, Monroe County and Key West governments, First Congregational Church /Church of GOD of Prophecy, Key Largo Christian Center, Monroe County Schools Adult Education program, Wayne R. Dapser (immigration attorney), and Keys AHEC. Spanish and Creole translation services were provided.

During these events, the Minority Health Liaison introduced the chosen health disparity, discussed data surrounding the SDOHs in Monroe County, and described the process of creating the plan, highlighting the actionable project implementation phase. This series of April events reached 98 mostly low-income and minority Monroe County residents and indirectly impacted many more.

VI. PRIORITIZING A HEALTH DISPARITY

The Health Equity Team identified and reviewed health disparity and SDOH data in Monroe County. Data was pulled from multiple sources, including the Behavioral Risk Factor Surveillance System (BFSS), Monroe County CASPER report (2019), SOS Foundation's Food Insecurity Survey (2021), CDC/ASDTR Social Vulnerability Index (2018), CDC PLACES, and the American Community Survey (ACS). Additional studies and reports from government and other organizations were included. References are included for all data sources. Census regions of 9800 (population: 17), 9801 (population: 0), and 9900 (population:0) were excluded from census-level data discussion due to having populations of less than 20 individuals.

The following health disparities were identified in Monroe County: **cardiovascular disease, mental health, substance abuse, and HIV/AIDS**. Using a two-round multi-voting technique with prior consideration and discussion of a feasibility and need strategy grid, the Health Equity Team identified **mental health** as the priority health disparity for the Health Equity Plan. During both rounds of blind voting, Health Equity Team members unanimously selected mental health. For the purposes of this plan, mental health and substance abuse were highlighted as separate health disparities. However, data indicates that there is significant overlap in these health issues. This is further discussed in the SDOH Data section under the Social and Community Context SDOH theme.

Mental Health in Monroe County:

County geographic distribution of frequent mental distress, as defined by having "not good" mental health on 14 or more of the past 30 days among adults 18 years and older, is presented in Figure 5. This map highlights census tract regions in the Lower, Middle, and Upper Keys as having the highest prevalence of frequent mental health distress. Specific geographic locations for these regions are further described in Table 1. The census tract with the highest frequent mental health prevalence includes part of the "New Town" region of Key West and the "true north" half of Stock Island. Special attention should be paid to these priority regions. This plan will highlight significant overlap in geographic areas of highest need within SDOH themes.

Frequent mental health distress crude prevalence projection (%)

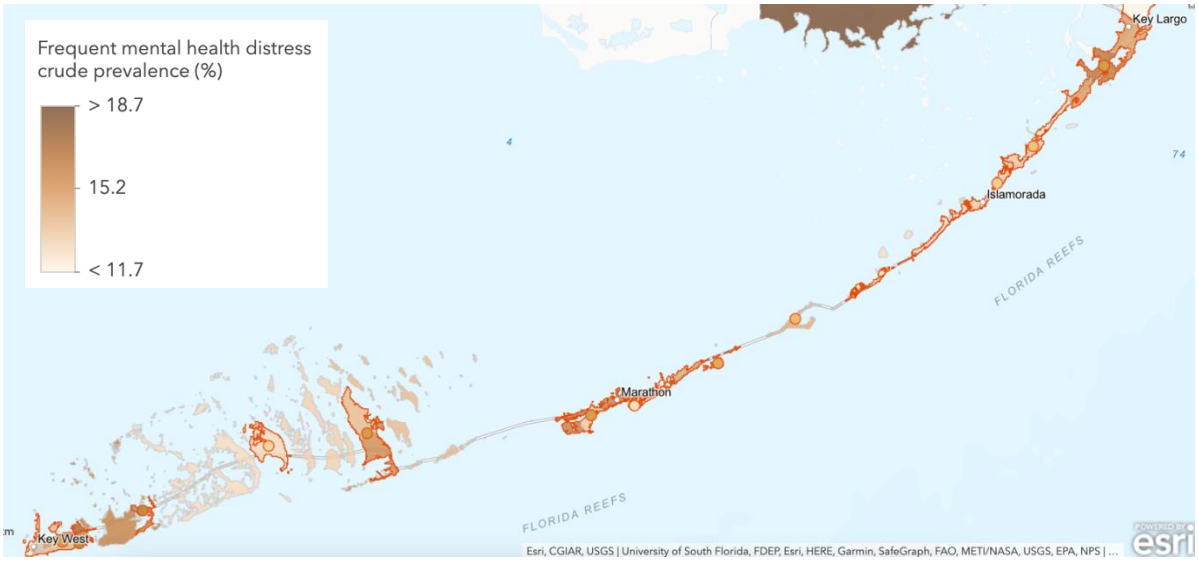


Figure 5: Freq. mental health distress by census tract [Source: CDC PLACES, 2021 (Modeling based on BRFSS 2019)]

Frequent mental health distress by census tract – priority regions		
Census Tract	**Freq mental health distress crude prevalence (%), 2019**	**General Location**
9719	17.2	New Town, KW/Stock Island (Lower Keys)
9704	16.4	Key Largo (Upper Keys)
9718	16.1	Stock Island (Lower Keys)
9717	16.0	Boca Chica, Big Coppitt, and surrounding Keys (Lower Keys)
9713	16.0	South Marathon/ Boot, Knight and surrounding Keys (Middle Keys)

Table 1: Freq mental health distress by census tract [Source: CDC PLACES, 2021 (Modeling based on BRFSS, 2019)]

Mental Health Disparities:

The Health Equity Team considered various priority population groups, including racial minorities, ethnic minorities, children (<18 years), seniors (65+), populations with low socioeconomic status, LGBTQ+ populations, populations with disabilities, and veterans. Mental health data was stratified by available demographics. Available mental health data existed for racial minorities, ethnic minorities, children, seniors, populations with low socioeconomic status, and populations with disabilities. Limited county-level data was identified for LGBTQ+ populations, and the Minority Health Liaison will work to find addition sources of data for this population. The Minority Health Liaison will also work to identify data sources for veteran data in Monroe County.

Racial minorities, ethnic minorities, children, and seniors are not priority populations considered in this plan, as Monroe County data does not show disparities in mental health statuses and outcomes by these demographics. National data suggests disparities by veteran status, and this populations will be considered as additions to this plan as county-level data is analyzed. There are significant disparities in mental health outcomes and statuses by socioeconomic status, disability status, and LGBTQ+ status. These disparities are discussed and SDOH factors mediating outcomes are outlined.

Mental Health by Race and Ethnicity:

Mental health by ethnicity was considered via two indicators: hospitalizations for mental disorders and frequent mental distress (poor mental health on >= 14 of last 30 days). Racial and ethnic minorities had lower hospitalizations for mental disorders (Table 2)[iii] and reported poor mental health on >=14 days less frequently (Table 3)[iv] than white and non-Hispanic populations. Data is not available for non-Hispanic Black populations reporting poor mental health on 14 or more of the past 30 days. Because there is a lack of racial and ethnic mental health disparity for these indicators, racial and ethnic minority populations are not a priority population of this plan to address mental health disparities.

Indicator	Measure	Year(s)	Total	White	Black	Other Race	Hispanic	Non-Hispanic
Hospitalizations for mental disorders	Per 100,000 population	2020	803.6	821.7	629.7	471.1	803.6	904

Table 2: Hospitalizations for mental disorders by race and ethnicity [Source: Florida Agency for Health Care Administration (AHCA), 2020 (via FLHealthCHARTS)]

Adults who had poor mental health on 14 or more of the past 30 days						
	Monroe			Florida		
Year	Non-Hispanic White	Non-Hispanic Black	Hispanic	Non-Hispanic White	Non-Hispanic Black	Hispanic
2019	15.5% (8.9% - 22.1%)		13.3% (5.2% - 21.4%)	15% (13.7% - 16.3%)	12.3% (8.9% - 15.7%)	12.5% (9.4% - 15.5%)
2016	7.7% (3.9% - 11.6%)		16.5% (6.5% - 26.6%)	12.2% (11.4% - 13%)	10.8% (8.6% - 13%)	9.9% (8.4% - 11.4%)

Table 3: Freq mental health distress by race and ethnicity [Source: BRFSS, 2015-2019 (via FLHealthCHARTS)]

Mental Health by Age (Senior 65+):

Priority for senior populations (aged 65+) was considered via frequent mental distress, as defined by having poor mental health on 14 or more of the last 30 days. As seen in Table 4, ages 65 and older reported frequent mental distress at lower rates than age brackets of adults 18-44 and 45-64.[v] Therefore, seniors are not a priority population of this plan to address mental health disparities.

Adults who had poor mental health on 14 or more of the past 30 days						
	Monroe			Florida		
Year	Ages 18-44	Ages 45-64	Ages 65 & Older	Ages 18-44	Ages 45-64	Ages 65 & Older
2019	15.4% (5.8% - 25%)	16.8% (8.2% - 25.5%)	9% (3.6% - 14.3%)	15.6% (13.6% - 17.7%)	15% (12.9% - 17.1%)	9.7% (8.1% - 11.4%)
2016	12.5% (4.5% - 20.5%)	10.8% (5.2% - 16.5%)	7.1% (1.4% - 12.9%)	12.5% (11.3% - 13.8%)	13% (11.8% - 14.2%)	7.3% (6.4% - 8.3%)

Table 4: Freq mental distress by age group [Source:BRFSS, 2016-2019 (via FLHealthCHARTS)]

Mental Health by Age (Children <18 years):

Table 5 highlights children aged 1-5 receiving mental health treatment in Monroe County per 1,000 population. According to the Department of Children and Families, in 2020, 4.1 per 1,000 population, or 0.41% of Monroe County children aged 1-5 years, accessed mental health treatments.[vi] This indicator is not available for adults, but compared to adult mental health data outcomes for frequent mental distress (Table 4), a lesser proportion of children are affected by

mental health. Therefore, children are not considered a priority population of this plan to address mental health disparities.

Children Receiving Mental Health Treatment Services (Aged 1-5 Years), Rate Per 1,000 Population 1-5, Single Year								
	Monroe				Florida			
Data Year	Count	Denom	Rate	MOV	Count	Denom	Rate	MOV
2020	14	3,380	4.1	2.2	4,126	1,180,033	3.5	0.1
2019	0	3,332	0.0		2,751	1,157,190	2.4	0.1
2018	35	3,471	10.1*	3.3	3,279	1,151,424	2.8	0.1

Table 5: Children receiving mental health treatment [Source: Florida Department of Children and Families, 2018-2020]

Mental Health by Veteran Status:

Mental health data for veterans was not available at the county level. However, national data shows associations between veteran status and mental health conditions and outcomes, like depression, PTSD, and suicides. The US Department of Veteran Affairs finds that PTSD diagnoses vary by service era. For example, 15% of Vietnam veterans were diagnosed with PTSD at the time of the most recent study in the 19080s whereas between 11% and 20% of Operations Iraqi Freedom/Enduring Freedom veterans have PTSD in a given year.[vii]

According to the 2021 National Veteran Suicide Prevention Annual Report, veteran suicides represented 13.7% of total suicides in 2019. The suicide rate among veterans in 2019 was 52.3% higher than for non-veterans.[viii] The Minority Health Liaison will work with the Office of Minority Health to identify Monroe County-specific data sources for inclusion in the Health Equity Plan. In the meantime, veteran data is included in the plan's priority region tables, which are included in each SDOH theme. Overlap between census tracts with a high proportion of veteran residents and SDOHs are highlighted within each SDOH theme.

Mental Health by LGBTQ+ Status:

Monroe County's LGBTQ+-related data from the 2017-2019 BRFSS does not meet the sample size requirement for analysis, and there is no other census-level data available for inclusion in this plan. National data clearly shows links between LBGTQ+ status and mental health. According to the National Alliance on Mental Illness, lesbian, gay, and bisexual adult populations are 2 times as likely to experience a mental health condition, compared to heterosexual adults. Furthermore, transgender individuals are 4 times as likely to experience a metal health condition and 8 times more likely to attempt suicide when compared to cisgender adults.[ix]

The 2018 Community Themes and Strengths Assessment prioritized inclusion of LGBTQ+ respondents by surveying at (1) A.H. of Monroe, an organization specializing in providing medical care for individuals living with HIV and (2) the KW Business Guild, a nonprofit devoted to promoting Key West travel to LGBTQ+ populations. The mission of the Key West Business Guild is to "promote LGBT travel to Key West through marketing and the promotion of special events; to support gay-owned, gay-managed, and gay-friendly businesses; to strengthen the Gay community's position within the local community by supporting relevant LGBTQ+ issues."[x] 29 surveys were collected at AH of Monroe and 18 surveys were collected at the KW Business Guild. 59% of the 46 respondents who selected at least one health concern selected mental health and/or suicide as one of the top five health concerns in Monroe County. LGBTQ+ populations are a priority population of this plan.[xi]

Mental Health by Disability Status:

According to the CDC, nationally, 1 in 4 persons have a disability, and adults living with disabilities report experiencing frequent mental distress approximately 5 times as often as adults not living with disabilities.[xii] According to the American Community Survey 2016-2020 five-year estimate, 6.1% of Monroe County residents under 65 live with a disability.[xiii] Among all non-institutionalized persons, 10.2% of Monroe County residents are living with a disability, compared to 13.6% of Floridians.[xiv] Census-level data for non-institutionalized individuals with a disability in Monroe County is shown in Figure 7. The census tracts with the highest proportion of residents with a disability are 9720, 9706, 9704, 9724, and 9703, respectively. These census tracts will be compared to SDOH census data to note overlap within each SDOH theme.

Figure 7: Percentage of noninstitutionalized individuals with a disability in Monroe County [Source: ACS, 2015-2020 (via FLHealthCHARTS)

Frequency of reporting poor mental health outcomes is desperate by disability status. The proportion of Monroe County residents aged 18-65 diagnosed with a depressive disorder is higher for individuals living with a disability than those who are not. 21% of people living with at least one disability reported having been diagnosed with a depressive disorder, compared to 9% of those with no reported disabilities (Table 6).[xv] Adults younger than 65 living with disabilities reported an average of 3.48 poor physical and mental health days per month, while Monroe County residents with no disabilities reported 0.64 days on average per month (Table 6).[xvi]

Disability Status and Mental Health (Monroe County)		
	People with no disabilities (ages 18-65)	People with at least one disability (ages 1-65)
Have been diagnosed with a depressive disorder (%)	9%	21%
Average number of poor physical and mental health days (#)	0.64	3.48

Table 6: Disability status by mental health outcomes [Source: FDOH, OMHHE (unpublished)]

Some mechanisms by which mental health disparities by disability status result are outlined in the SDOH data. Due to these disparities in mental health outcomes by disability status, individuals living with disabilities are a priority population of this plan. This plan aims to reduce poor mental health outcomes for populations living with disabilities though addressing SDOHs that affect mental health for this population group.

Mental Health by Socioeconomic Status:

Socioeconomic status is an economic and social standing measure of a person in relation to others, and it is often measured through combined indicators such as salary, education, occupation, employment, and/or wealth. Education Access and Quality and Economic Stability are two SDOH themes. Socioeconomic status is also recognized as a population health disparity group by Healthy People 2030.

The CDC's Social Vulnerability Index (SVI) utilizes 15 US census indicators to identify regions that need assistance before, during, and after any kind of disaster. The indicators determine a community's social vulnerability, which "refers to the potential negative effects on communities caused by external stressors on human health".[xvii] The 15 indicators are grouped into four themes, including a theme of socioeconomic status.

The CDC's SVI groups four indicators to measure overall socioeconomic status in Monroe County and highlights the communities that have the least favorable socioeconomic indicator averages. The indicators for this measure include (1) below poverty, (2) unemployed, (3) income, and (4) no high school diploma. On average, Monroe County's socioeconomic data in this indicator is better off than 90% of counties in the United States (Figure 6).

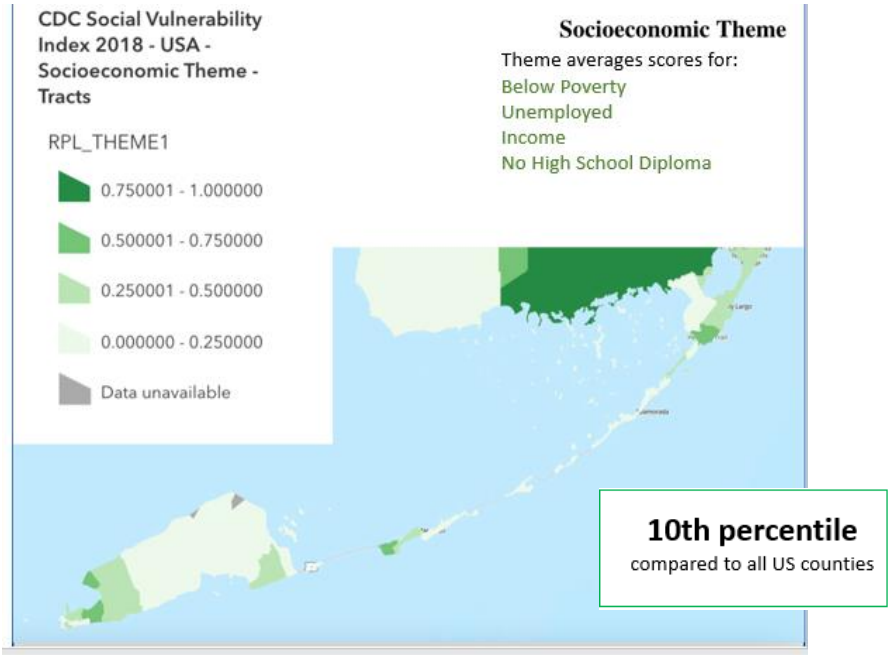


Figure 6: Socioeconomic Vulnerability by Census Tract [Source: SVI Index, Center for Disease Control, 2018]

Although, as indicated by the CDC SVI, Monroe County has better socioeconomic outcomes than most US counties, Monroe County has an income inequality index of 0.5, with 0

representing perfect income equality and 1 representing perfect income inequality. Monroe County is in the least favorable quartile for income inequality, with inequality worse off than 75% of Florida counties. [xviii] Therefore, the lowest socioeconomic groups must be considered in policies and programs to promote health equity.

Mental health outcomes were considered across socioeconomic groups. Mental health is considered via two indicators: (1) Adults who had poor mental health on 14 or more of the past 30 days and (2) adults who had ever been told they had a depressive disorder. Socioeconomic status is considered via two indicators of socioeconomic status: (1) income and (2) educational attainment.

A higher proportion of adults reported poor mental health on 14 or more of the past 30 days among those who made less than $25,000 in income than those who made $25,000-$49,000 and $50,000+ (Table 7/Figure 8).[xix] Similarly, individuals with less than a high school diploma/GED reported poor mental health on 14 or more of the past 30 days more frequently than those with a high school diploma and education greater than high school (Table 8/Figure 9).[xx] This mental health indicator shows disparity by socioeconomic status.

Adults who had poor mental health on 14 or more of the past 30 days						
	Monroe			Florida		
Year	<$25,000	$25,000-$49,999	$50,000 or More	<$25,000	$25,000-$49,999	$50,000 or More
2019	28% (12.9% - 43.2%)	9.3% (0% - 19.8%)	13.8% (6.2% - 21.4%)	20.9% (17.9% - 23.8%)	13.4% (11.2% - 15.7%)	9.3% (7.8% - 10.8%)
2016	21.4% (10.1% - 32.7%)	12.4% (4% - 20.8%)	3.7% (0.5% - 6.9%)	17.8% (16.2% - 19.4%)	11.9% (10.3% - 13.4%)	7.6% (6.6% - 8.7%)
2013	22.8% (11.2% - 34.3%)	8.8% (0.9% - 16.7%)	3.8% (1% - 6.6%)	20.1% (18.2% - 22%)	13% (11% - 14.9%)	6.7% (5.7% - 7.6%)

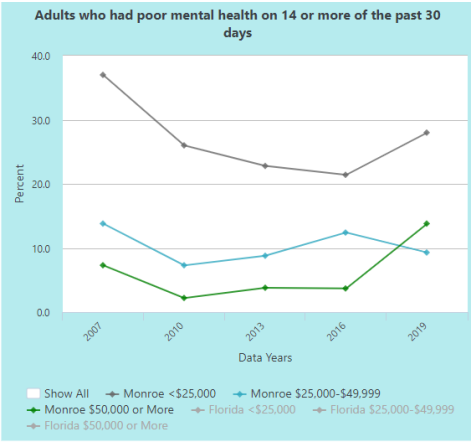


Table 7 & Figure 8: Mental health by socioeconomic status (income) [Source: BRFSS, Florida DOH Division of Community Health, 2007-2019 (via FLHealthCHARTS)]

Adults who had poor mental health on 14 or more of the past 30 days						
	Monroe			Florida		
Year	Less Than High School	High School/GED	More Than High School	Less Than High School	High School/GED	More Than High School
2019		18.1% (6.2% - 30.1%)	10% (5.4% - 14.6%)	19.5% (15.5% - 23.6%)	14.2% (11.9% - 16.5%)	12.5% (11.1% - 13.8%)
2016	18.4% (3.6% - 33.2%)	15.2% (6.5% - 23.8%)	6.6% (2.8% - 10.3%)	15.3% (12.8% - 17.8%)	12.1% (10.8% - 13.4%)	10.1% (9.3% - 11%)
2013		4.9% (0% - 10.1%)	9.3% (5.2% - 13.4%)	19.7% (16.1% - 23.3%)	13.5% (12% - 15.1%)	10.4% (9.5% - 11.3%)

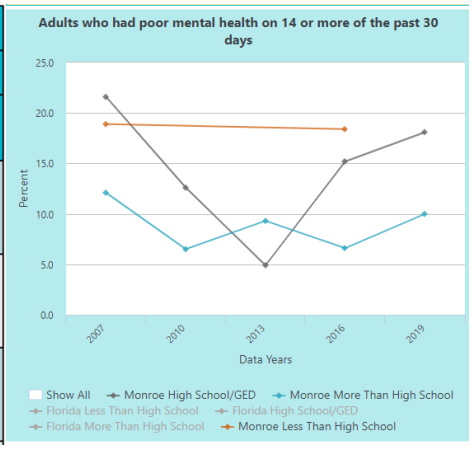


Table 8 & Figure 9: Mental health by socioeconomic status (education) [Source: BFRSS, 2007-2019 (via FLHealthCHARTS)]

A greater proportion of adults reported that they had been told they have a depressive disorder among those who made less than $25,000 in income than those who made $25,000-$49,000 and $50,000+ (Table 9/Figure 10).[xxi] Reporting poor mental health via this indicator was more common among individuals with less than a high school diploma/GED than those with a high school diploma or education beyond high school (Table 10/Figure 11).[xxii] This mental health indicator shows disparity by socioeconomic status.

Adults who have ever been told they had a depressive disorder						
	Monroe			Florida		
Year	<$25,000	$25,000-$49,999	$50,000 or More	<$25,000	$25,000-$49,999	$50,000 or More
2019	31% (17.6% - 44.5%)	13.3% (4% - 22.5%)	10.4% (4% - 16.8%)	25.5% (22.5% - 28.4%)	19.2% (16.4% - 22%)	12.9% (11.2% - 14.5%)
2016	18.5% (8% - 29%)	3.7% (0% - 7.5%)	7.4% (2.4% - 12.4%)	20.6% (18.9% - 22.2%)	14.9% (13.2% - 16.7%)	9.9% (8.8% - 11%)
2013	20.7% (9.7% - 31.7%)	24.4% (7.4% - 41.5%)	9.6% (2.5% - 16.6%)	23.8% (21.9% - 25.6%)	16.5% (14.8% - 18.2%)	11.3% (10.2% - 12.4%)

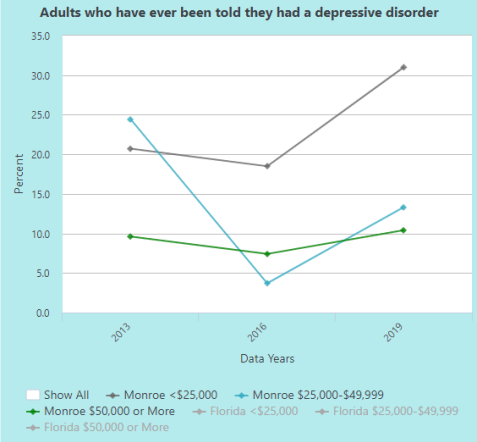


Table 9 & Figure 10: Mental health by socioeconomic status (income) [Source: BFRSS, 2013-2019 (via FLHealthCHARTS)]

Adults who have ever been told they had a depressive disorder						
	Monroe			Florida		
Year	Less Than High School	High School/GED	More Than High School	Less Than High School	High School/GED	More Than High School
2019		13% (4.6% - 21.4%)	13.7% (8.6% - 18.8%)	22.9% (18.7% - 27.1%)	16.1% (14% - 18.3%)	17.1% (15.6% - 18.6%)
2016	25% (8.6% - 41.5%)	8.7% (2.4% - 15%)	9.5% (5.1% - 13.9%)	19.3% (16.4% - 22.1%)	14.7% (13.3% - 16.1%)	12.9% (12% - 13.8%)
2013	25.1% (5.9% - 44.2%)	18.5% (5.6% - 31.4%)	13% (6.8% - 19.2%)	20.9% (17.9% - 24%)	15.8% (14.3% - 17.3%)	16.3% (15.3% - 17.3%)

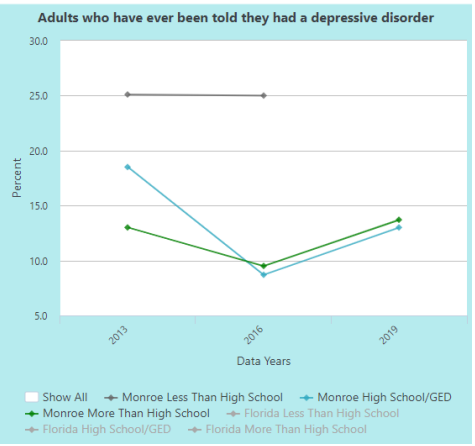


Table 10 & Figure 11: Mental health by socioeconomic status (income) [Source: BFRSS, 2013-2019 (via FLHealthCHARTS)]

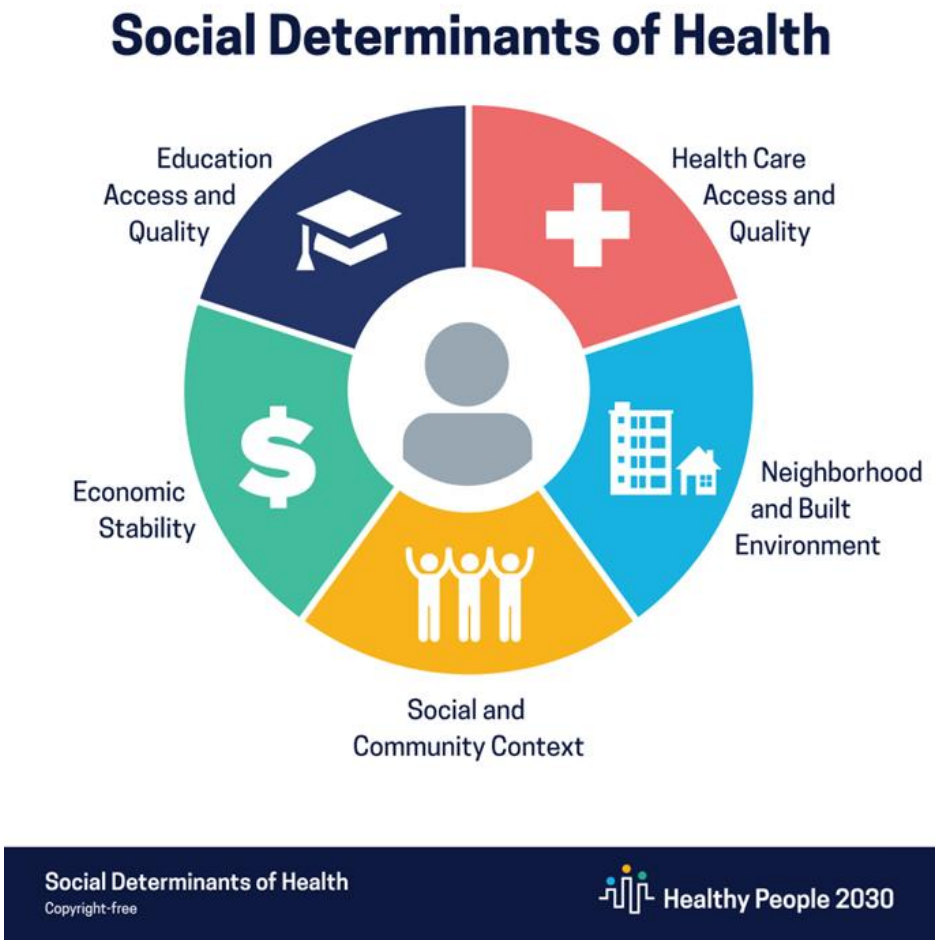
According to income and education indicators, mental health disparities exist between socioeconomic groups. Populations with lower socioeconomic status are at a higher risk of poor mental health status and outcomes because of the SDOHs affecting low-SES groups. Populations with low socioeconomic have limited resources to meet their basic needs—like housing, transportation, nutritious food, health care, child care, etc. These burdens create stressors that can impact mental health distress, as further detailed in Section VII: SDOH Data.

Due to disparities in mental health status and outcome data, low socioeconomic status is a priority population for this plan. This plan aims to reduce poor mental health outcomes for populations of low socioeconomic status though addressing SDOHs that affect mental health for this population group.

Priority populations of this plan include LGBTQ+ populations, populations living with disabilities, and populations with low socioeconomic status.

VII. SDOH DATA

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



A. Education Access and Quality in Monroe County

High School Education/GED: In 2020, the percentage of individuals 25 years and over with no high school diploma or equivalent in Monroe County was 8.1%, compared to Florida at 11.5% (Table 11).[xxiii]

Education Access and Quality: County to State Comparison				
	Monroe		Florida	
	2020	2019	2020	2019
Individuals with no high school diploma (or equivalent) (aged 25 years and older) (%)	8.1	8.6	11.5	11.8
High school graduation rate (%)	91.5	92.0	90.0	90.0
Births to mothers with less than a high school education (%)	12.5	12.8	10.7	11.0

Table 11: Education & Quality SDOHs [Sources: United States Bureau of the Census, American Community Survey; Florida Department of Education, EIAS; Florida Department of Health, Bureau of Vital Statistics, 2018-2020 (via FLHealthCHARTS)]

Educational attainment is a component of socioeconomic status, one of the priority populations of this plan. However, data supports that other socioeconomic status indicators, like income and wealth, are associated with education. According to Healthy People 2020, individuals in the US aged 16-24 are 4.1 times less likely to obtain a high school diploma or be enrolled in high school if they are low-income.[xxiv] Healthy People 2020 also reports that lifetime wealth increases by 15% for each year of high school completed.[xxv]

Disability status is also linked to educational attainment. In Monroe County, among residents with at least one disability, 16% reported not having attained a high school degree or equivalent—higher than the 6% of respondents without a disability who reported not attaining a high school degree.[xxvi]

Evidence supports that educational attainment is linked to mental health outcomes. For example, having a high school degree or GED is a determinant of future salary, which has been shown to impact mental health outcomes. Table 7/Figure 8 and Table 9/Figure 10 show the direct relationship between high school education/GED and mental health in Monroe County using two mental health indicators. Although data is missing for some categorical groups for some years, in all available instances, individuals with a high school diploma or GED were less likely to report that they had “poor mental health on 14 or more of the past 30

days" [xxvii] and that they had "ever been told that they had a depressive disorder.", [xxviii] These trends were consistent for both Monroe County and State of Florida data.

To improve disparities in mental health, Monroe County is addressing high school education/GED and vocational training. Vocational training, like academic education, can provide education that directly relates to career advancement, which can be especially beneficial for populations without college degrees and those who may face vocational challenges due to disability.

Education-related indicators vary by geography in Monroe County. To assess geographical regions of highest need for education access and quality SDOH projects, the below census maps for educational attainment were considered. Five census tracts in Monroe County showed >6% of population with less than a 9th grade education (Table 12). These census tracts include regions of South Old Town/Bahama Village in Key West, Stock Island, Lower Marathon, and Mid-Key Largo. Five census regions showed >6% of population with some high school education but no diploma (Table 13). These regions include midtown Key West, Stock Island, Boca Chica/Big Coppitt, Lower Marathon, and Tavernier. Education census data is compared to demographic data of priority populations. The most vulnerable census tracts, as defined as being among the 5 highest ranking census tracts in disability status and veteran status, are marked with an asterisk. If there is overlap between census tracts with worst off education rankings and the five tracts with highest reported frequent mental distress, those census tracts are marked with an asterisk.

Figure 12: Educational attainment by census tract (less than 9th grade education) [Source: Florida Department of Health Bureau of Vital Statistics and the 2015 American Community Survey, 2015-2019 (via FLHealthCHARTS)]

Educational attainment by census tract (less than 9th grade education) – priority regions					
Census Tract	**Population >=25 yrs with less than 9th grade**	**Freq Mental Health Distress**	**Civilian non-institutional population with a**	**Civilian population 18 years and over**	**Location**

	education (%), 2015-2019 (5 worst off census tracts)	Crude Prevalence (%), 2019	disability (%), 2015-2019	who are veterans (%), 2016-2020	
9704	13.6	16.4*	14.7*	10.6	Key Largo (Upper Keys)
9713	8.1	16.0*	12.1	6.5	South Marathon/ Boot, Knight and surrounding Keys (Middle Keys)
9718	9.6	16.1*	12.5	6.6	Stock Island (Lower Keys)
9719	6.3	17.2*	6.4	5.9	New Town KW/Stock Island (Lower Keys)
9726	10.5	14.2	9.2	9.1	South Old Town/Bahama Village, KW (Lower Keys)

Table 12: Educational attainment by census tract (less than 9th grade education)- priority regions [Sources: Florida Department of Health Bureau of Vital Statistics and American Community Survey's 2015-2019 & 2016-2020 five-year estimates (via FLHealthCHARTS); CDC PLACES, 2021 (Modeling based on BRFSS, 2019)]

Figure 13: Educational attainment by census tract (high school education, no diploma) [Source: Florida Department of Health Bureau of Vital Statistics and the 2015 American Community Survey, 2015-2019 (via FLHealthCHARTS)]

Educational attainment by census tract (high school education, no diploma) – priority regions

Census Tract	Population >=25 yrs with less than 9th grade education (%), 2015-2019 (5 worst off census tracts)	Freq Mental Health Distress Crude Prevalence (%), 2019	Civilian non-institutional population with a disability (%), 2015-2019	Civilian population 18 years and over who are veterans (%), 2016-2020	Location
9707	6.9	13.3	8.4	10.5	Tavernier (Upper Keys)
9713	13.8	16.0*	12.1	6.5	South Marathon/ Boot, Knight and surrounding Keys (Middle Keys)
9717	8.4	16.0*	7.5	17.4*	Boca Chica, Big Coppitt, and surrounding Keys (Lower Keys)
9718	10.7	16.1*	12.5	6.6	Stock Island (Lower Keys)
9722	8.4	15.2	5	9.5	Mid-town, Key West (Lower Keys)

Table 13: Educational attainment by census tract (HS education, no diploma)- priority regions [Sources: Florida Department of Health Bureau of Vital Statistics and American Community Survey's 2015-2019 & 2016-2020 five-year estimates (via FLHealthCHARTS); CDC PLACES, 2021 (Modeling based on BRFSS, 2019)]

English Language Proficiency: According to the 2020 American Community Survey, 10.4% of Monroe County's population over 5 speak English less than well, compared to 11.8% state-wide.[xxix] Research shows that English language proficiency mediates socioeconomic factors, social interactions, and discrimination. These factors, the study found, negatively impact mental health.[xxx] English language proficiency provides a pathway for social mobility through increased education and economic opportunities. As previously detailed, data shows that education and salary are linked to poor mental health outcomes.

Furthermore, while individuals without English language proficiency may have strong social and community relationships with groups sharing the same ethnic cultures and language, those without strong relationships with people who speak the same language are likely to struggle to create social ties, which have been shown to be protective against mental health conditions.[xxxi] Individuals without English language skills are disadvantaged in accessing resources when services aren't culturally and linguistically competent, which offers another pathway by which language skills can impact mental health.

A literature review of 41 studies on language and mental health found that the large majority of the studies found significant associations between lower language proficiency and higher prevalence/severity of mental health conditions.[xxxii] To improve disparities in mental health, Monroe County is addressing English language proficiency.

B. Economic Stability in Monroe County

Income & Poverty: According to the ACS, the median household income in Monroe County is $72,012 compared to Florida at $57,703, and the unemployment rate is 7.9% compared to the Florida average of 7.7%.[xxxiii] 10.6% of Monroe County individuals live below the poverty line compared to 13.3% of Floridians.[xxxiv] Notably, Monroe County is ranked in the highest quartile for economic inequality, with a score of 0.5 (Table 14).[xxxv]

Economic Stability: County to State Comparison				
	Monroe		Florida	
	2020	2019	2020	2019
Median household income	$72,012	$70,033	$57,703	$55,660
Income inequality index	0.5	0.5	0.5	0.5
Unemployment rate (% of labor force)	7.9	2.1	7.7	3.3
Poverty rate (%)	10.6	10.9	13.3	14.0
Individuals below 200% of Poverty Level (%)	25.2	27.3	32.9	34.2
Occupied households with monthly housing costs of 30% or more of household income (%)	42.1	42.2	34.7	34.7
Renter-occupied housing units with gross rent costing 30% or more of household income (%)	59.8	59.1	56.4	56.3

Table 14: Economic stability SDOHs [Sources: United States Bureau of the Census, American Community Survey; United States Department of Labor, Bureau of Labor Statistics; Feeding America, Map the Meal Gap, 2018-2020 (via FLHealthCHARTS)

According to the ACS, 59.8% of Monroe County renters spend 30% or more of their income on housing costs.[xxxvi] Due to Monroe County's high housing costs, residents have less money to spend on other needs and wants. The US poverty rate, as shown in Table 14, is based on a national standard, which does not account for Monroe County's high cost of living. Therefore, we assume that the proportion of families in Monroe unable to meet their basic needs is higher than this statistic indicates. Poverty presents challenges in accessing the education and vocational training necessary to increase income, especially for parents who may also require childcare.

Individuals living with a disability experience economic disparities due to physical or mental limitations, discrimination, lack of access to opportunities and services, the potential extra costs associated with specialized health care, and other factors. In Monroe County, 57% of individuals with a disability reported earning less than $25,000 annually, compared to only 28% of people without a disability.[xxxvii]

Having a low income and living below the poverty line increases life stressors, preventing individuals from meeting their basic needs and thriving. The relationships between income and mental health in Monroe County according to two mental health indicators are shown in Table 7/Figure 8 & Table 9/Figure 10. In all instances, individuals with the lowest bracket of income (<$25,000) reported having poor mental health on 14 of the past 30 days[xxxviii] and having been diagnosed with a depressive disorder[xxxix] at higher rates.

Geographic maps highlighting regions of low median income and high poverty can be used to identify priority regions for projects to address economic stability in Monroe County. Where census tracts for low income/high poverty overlap with high rates of frequent mental health

distress, a high rate of persons with disabilities, and/or a high percentage of veteran residents, the overlap is denoted by an asterisk (Table 15).

Figure 14: Income by census tract [Source: Florida Department of Health Bureau of Vital Statistics and the 2015 American Community Survey 5-year estimates, 2018-2020 (via FLHealthCHARTS)]

Household income by census tract– priority regions					
Census Tract	**Median household income ($), 2015-2019 (5 worst off census tracts)**	**Freq mental health distress crude prevalence (%), 2019**	**Civilian non-institutional population with a disability (%), 2015-2019**	**Civilian population 18 years and over who are veterans (%), 2016-2020**	**Location**
9704	49,625	16.4*	14.7*	10.6	Key Largo (Upper Keys)
9713	41,793	16.0*	12.1	6.5	South Marathon/ Boot, Knight and surrounding Keys (Middle Keys)
9714.01	55,043	15.5	11.2	5.1	Big Pine (Lower-Middle Keys)

9719	55,452	17.2*	6.4	5.9	New Town KW/Stock Island (Lower Keys)
9724	50,566	15.3	14.6	7.8	Bahama Village, Old Town, Key West (Lower Keys)

Table 15: Household income by census tract- priority regions [Sources: Florida Department of Health Bureau of Vital Statistics and American Community Survey's 2015-2019 & 2016-2020 five-year estimates (via FLHealthCHARTS); CDC PLACES, 2021 (Modeling based on BRFSS, 2019)]

Figure 15: Poverty by census tract [Source: Florida Department of Health Bureau of Vital Statistics and the 2015 American Community Survey 5-year estimates, 2018-2020 (via FLHealthCHARTS)]

Poverty by census tract- priority regions					
Census Tract	**Individuals below 100% poverty level (%), 2015-2019 (5 worst off census tracts)**	**Freq mental health distress crude prevalence (%), 2019**	**Civilian non-institutional population with a disability (%), 2015-2019**	**Civilian population 18 years and over who are veterans (%), 2016-2020**	**Location**
9704	20.3	16.4*	14.7	10.6	Key Largo (Upper Keys)
9705	18.8	14.9	9.1	11.7	South Key Largo (Upper Keys)

9713	15.2	16.0*	12.1	6.5	South Marathon/ Boot, Knight and surrounding Keys (Middle Keys)
9719	19.3	17.2*	6.4	5.9	New Town KW/Stock Island (Lower Keys)
9724	16.6	15.3	14.6*	7.8	Bahama Village, Old Town, Key West (Lower Keys)

Table 16: Poverty by census tract- priority regions [Sources: Florida Department of Health Bureau of Vital Statistics and the American Community Survey's 2015-2019 & 2016-2020 five-year estimates (via FLHealthCHARTS); CDC PLACES, 2021 (Modeling based on BRFSS, 2019)]

Food Insecurity: The food insecurity rate in Monroe County is 10.7%, compared to 12.0% Florida-wide.[xl] In February of 2021, Health Equity Task Force partner, SOS Foundation, in conjunction with Johns Hopkins School of Public Health, distributed 1,565 surveys to food pantry clients at SOS Stock Island and Key Largo food pantries. Analysis of the 2021 Food Insecurity Survey showed that 39% of clients reported skipping a meal in the past 30 days due to finances and 85% of clients reported worrying about running out of food before receiving money to buy more. The survey, collected one year post onset of Covid-19, showed that 83% of clients self-reported having been unable to make necessary payments since March 2020, an indication that these individuals were having to choose between basic needs, like rent, utilities, and food. 39% of the respondents reported mental or physical health struggles due to Covid-19.[xli] The results of this survey project indicate a need for wrap-around services for food insecure populations.

Individuals living with disabilities are more likely to be food insecure. As previously detailed, individuals with disabilities have lower income than individuals who do not live with disabilities, meaning that they have less funds to purchase healthy, nutritionally valuable foods. In Monroe County, 39% of individuals living with a disability do not have enough money for food, compared to 10% among populations without disabilities.[xlii] In addition, transportation or physical barriers can also cause persons living with a disability to be food insecure.

Unsurprisingly, consuming nutritionally valuable foods is associated with income, an indicator of seriocomic status. As seen in Table 17 and Figure 16, populations with the lowest income report consuming two or more servings of vegetables per day least frequently. In Monroe County and Florida-wide, frequency of reporting consumption of two servings of vegetables increases with each income bracket.[xliii]

Adults who consumed two or more servings of vegetables per day						
	Monroe			Florida		
Year	<$25,000	$25,000-$49,999	$50,000 or More	<$25,000	$25,000-$49,999	$50,000 or More
2019	20.6% (4.5% - 36.6%)	37% (17.9% - 56.2%)	57.5% (45.9% - 69.2%)	33.2% (29.8% - 36.7%)	34.8% (31.3% - 38.3%)	41.8% (39% - 44.6%)
2013	39.2% (21.3% - 57.1%)	49% (32.1% - 65.9%)	54.3% (42.8% - 65.9%)	35.5% (33.1% - 37.9%)	39.6% (37.1% - 42.1%)	46% (44% - 48%)

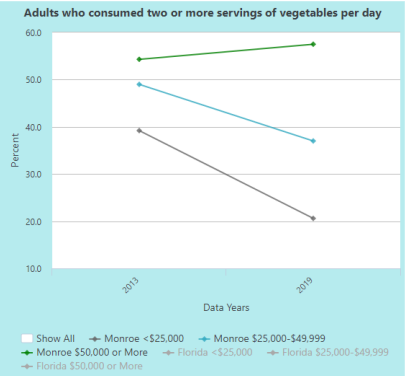


Table 17 & Figure 16: Food security by income [Source: BRFSS, CDC and Florida DOH Division of Community Health, 2013-2019 (via FLHealthCHARTS)]

Food insecure populations are unable to meet their basic nutritional needs, which is a life stressor that can negatively impact mental health. Previous research shows that food insecurity is significantly linked to poor mental health outcomes, even after adjusting for various sociodemographic factors.[xliv] To improve disparities in mental health, Monroe County is addressing food insecurity for individuals in Monroe County with low socioeconomic status and/or disabilities.

C. Neighborhood and Built Environment in Monroe County

According to the CDC's Social Vulnerability Index (SVI), Monroe County ranks in the worst off 2% of US counties in the housing and transportation index theme.[xlv] This index theme combines five indicators: multi-unit structures, mobile homes, crowding, no vehicle, and group quarters.

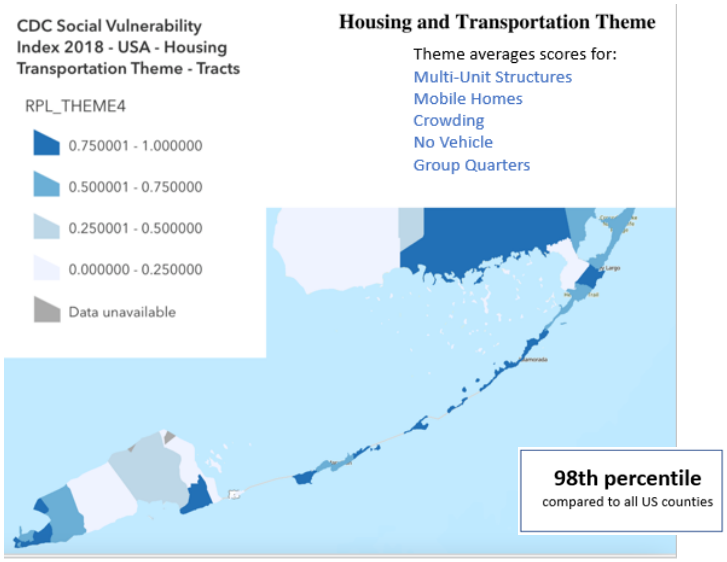


Figure 17: Housing and transportation vulnerability by census tract [Source: SVI Index, Center for Disease Control, 2018]

Housing in Monroe County is expensive, with the median cost of owner-occupied housing in Monroe County costing $558,100 compared to an average of $232,000 in Florida (Table 18).[xlvi] 40.9% of housing in Monroe County is renter-occupied, higher than the Florida average of 33.8%,[xlvii] and a higher proportion of Monroe County residents (42.1%) pay 30% or more of their income on housing costs than the average Florida resident (34.7%).[xlviii] Notably, the proportion of Monroe County individuals spending more than 30% of income on housing costs increases for renters. 59.8% of renters in Monroe County spend 30% or more of their income on rent.[xlix] High housing costs require that a high proportion of income is spent on housing, leaving less for other basic needs, like food, health care, etc. In Monroe County, the SOS Foundation's Food Insecurity Survey project found that 45% of food pantry respondents self-reported struggling to make rent payments.[l]

Built Environment (Housing): County to State Comparison				
	Monroe		Florida	
	2020	2019	2020	2019
Median owner-occupied housing unit value	$558,100	$494,100	$232,000	$215,300
Occupied households with monthly housing costs of 30% or more of household income (%)	42.1	42.2	34.7	34.7
Renter-occupied housing units with gross rent costing 30% or more of household income (%)	59.8	59.1	56.4	56.3

Table 18: Built environment (housing) County to State comparison [Source: United States Bureau of the Census, American Community Survey, 2018-2020 (via FLHealthCHARTS)]

High housing costs force populations of low-socioeconomic status into more crowded and poorer quality housing, as well as into less desirable neighborhoods. 6% of Monroe County residents who reported having at least one disability considered their neighborhood to be unsafe, compared to 3% among residents without a disability.[li]

Having poor quality housing and/or high cost of housing can lead to life stressors that can impact mental health. According to a literature review published by the National Institute of Health, environmental and housing characteristics, such as housing quality, housing affordability, overcrowding, residential instability (higher for renters), and post-disaster- and gentrification-related housing displacement, are associated with poorer mental health outcomes.[lii] To identify and implement projects for this plan, geographic regions of highest need were determined by considering maps of renter-occupied housing units and percentage of occupied mobile homes.

Overlap between regions with highest renter-occupied housing and regions with highest frequent mental health distress were identified. Notably, four of the five respective census tract regions for frequent mental distress and mobile homes overlapped, indicating that residents in geographic areas with a high volume of mobile housing report frequent mental distress at higher rates. Census tracts high populations of individuals with low-SES, individuals living with disabilities, and veterans were tracked with SDOH indicators and frequent mental distress. Asterisks were used to denote overlap in top five worst off census tracts in each category.

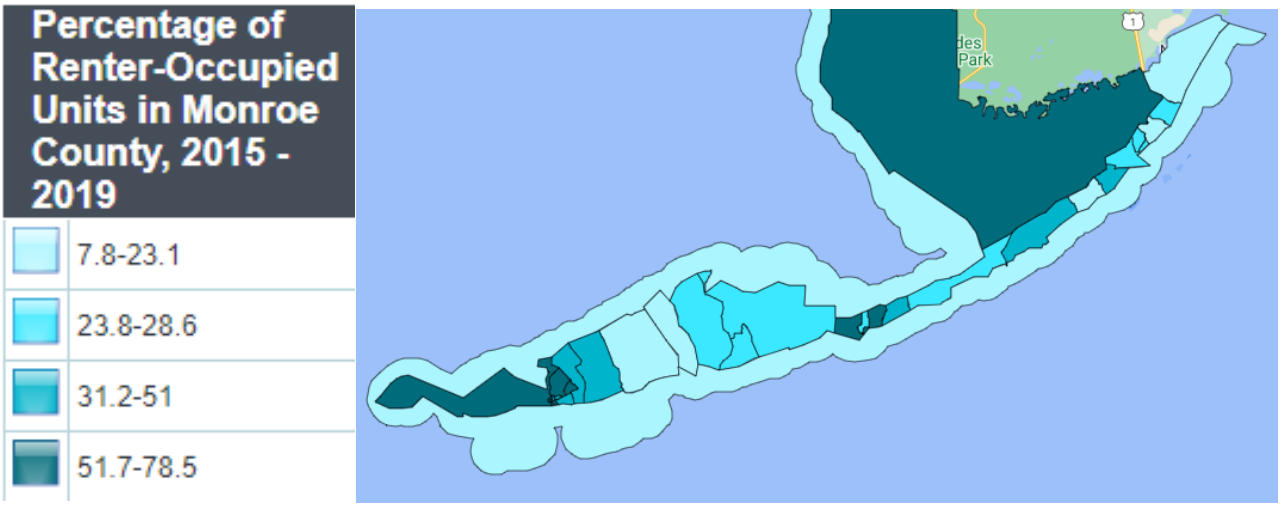


Figure 18: Renter-occupied units by census tract [[Source: Florida Department of Health Bureau of Vital Statistics and the 2015 American Community Survey 5-year estimates; 2015-2019 (via FLHealthCHARTS)

Renter-occupied units by census tract- priority regions						
Census Tract	**Renter-occupied housing units in Monroe County (%), 2015-2019**	**Freq mental health distress crude prevalence (%), 2019**	**Individuals below 100% poverty level (%), 2015-2019**	**Civilian non-institutional population with a disability (%), 2015-2019**	**Civilian population 18 years and over who are veterans (%), 2016-2020**	**Location**

	(5 worst off census tracts)					
9713	67.1	16.0*	15.2*	12.1	6.5	South Marathon/ Boot, Knight and surrounding Keys (Middle Keys)
9719	64.1	17.2*	19.3*	6.4	5.9	New Town Key West/Stock Island (Lower Keys)
9721	78.5	14.0	5.3	8.0	11.8	New Town, Key West
9724	63.9	15.3	16.6*	14.6*	7.8	Bahama Village, Old Town, Key West (Lower Keys)
9726	56.4	14.2	15.1	9.2	9.1	South Old Town/Bahama Village, Key West (Lower Keys)

Table 19: Renter-occupied housing units by census tract- priority regions [Sources: Florida Department of Health Bureau of Vital Statistics and the American Community Survey's 2015-2019 & 2016-2020 five-year estimates (via FLHealthCHARTS); CDC PLACES, 2021 (Modeling based on BRFSS, 2019)]

Figure: 19: Occupied mobile homes by census tract [Source: Florida Department of Health Bureau of Vital Statistics and the 2015 American Community Survey 5-year estimates; 2015-2019 (via FLHealthCHARTS)]

Occupied mobile homes by census tract- priority regions

Census Tract	Occupied mobile homes in Monroe County, 2015-2019 (%) (5 worst off census tracts)	Freq mental health distress crude prevalence (%), 2019	Individuals below 100% poverty level (%), 2015-2019	Civilian non-institutional population with a disability (%), 2015-2019	Civilian population 18 years and over who are veterans (%), 2016-2020	Location
9703	26.4	14.7	10.4	13.4*	11.7	Key Largo (Upper Keys)
9704	38.9	16.4*	20.3*	14.7*	10.6	Key Largo (Upper Keys)
9713	42.0	16.0*	15.2*	12.1	6.5	South Marathon/ Boot, Knight and surrounding Keys (Middle Keys)
9717	32.9	16.0*	8.8	7.5	17.4*	Boca Chica, Big Coppitt, and surrounding Keys (Lower Keys)

9718	24.9	16.1*	12.7	12.5	6.6	Stock Island (Lower Keys)

Table 20: Occupied mobile homes by census tract- priority regions [Sources: Florida Department of Health Bureau of Vital Statistics and the American Community Survey's 2015-2019 & 2016-2020 five-year estimates (via FLHealthCHARTS); CDC PLACES, 2021 (Modeling based on BRFSS, 2019)]

Transportation: High housing costs can lead to gentrification, pushing populations with lower incomes out of neighborhoods and to Keys further from work and social networks. For all individuals, but especially for those without access to adequate transportation, this can lead to poor mental health outcomes. According to the ACS, in Monroe County, 7.4% of occupied housing units are without a vehicle[liii] and 0.8% use public transportation to get to work.[liv] In a 2022 study published in the Journal of Transportation and Health, authors found that among 1,944 low-income adults, reporting mental health conditions were positively associated with requests for other social services. Among these associations, unmet needs for transportation were most prevalent, and this association remained statistically significant after adjustments were made for cofounders.[lv]

Built Environment (transportation): County to State Comparison				
	Monroe		Florida	
	2020	2019	2020	2019
Occupied housing units without a vehicle (%)	7.4	7.9	6.1	6.3
Workers who used public transportation to get to work (%)	0.8	1.0	1.6	1.8

Table 21: Built environment (transportation) County to State comparison [Source: United States Bureau of the Census, American Community Survey, 2018-2020 (via FLHealthCHARTS)]

Access to adequate transportation is important for accessing nutritionally valuable foods. As discussed in the Economic Stability section, previous research has shown strong links between food security and mental health. In addition to affordability, transportation is a key component of access, In Monroe County, only 24% of individuals live within a ½ mile of a health food source,[lvi] meaning that those without transportation may be too far to walk or bike to purchase nutritionally acceptable foods. This can be more challenging for some persons with severe physical disabilities.

Built Environment: County to State Comparison				
	Monroe		Florida	
	2019	2016	2019	2016
Population living within 1/2 mile of a health food source (%)	24.0	27.8	27.7	27.9

Table 22: Built environment SDOHs (food insecurity) [Source: Florida Environmental Public Health Tracking, 2016-2019 (via FLHealthCHARTS)]

To improve mental health disparities, Monroe County is addressing transportation and food access SDOHs for low-SES populations, individuals living with disabilities, and LGBTQ+ populations. The below census map highlights regions of vulnerability for the SDOH of transportation, and for other transportation-related SDOHs, including food access. Table 23 lists the five census tracts with the highest percentage of houses with no vehicles, along with the tracts' associated rates of frequent

mental distress, poverty, disability, and veteran status. Overlap in worst off census tracts by these indicators are highlighted with an asterisk.

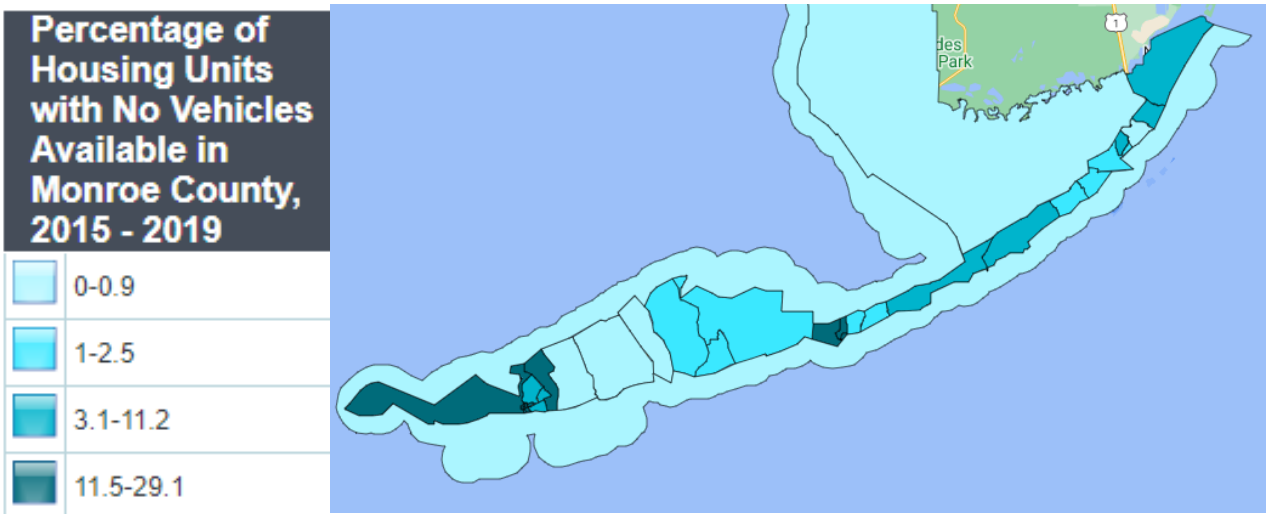


Figure 20: Vehicle access by census tract [Source: Florida Department of Health Bureau of Vital Statistics and the 2015 American Community Survey 5-year estimates; 2015-2019 (via FLHealthCHARTS)]

Housing units with no vehicles by census tract- priority regions						
Census Tract	**Housing units with no vehicles available, 2015-2019 (%) (5 worst off census tracts)**	**Freq mental health distress crude prevalence (%), 2019**	**Individuals below 100% poverty level (%), 2015-2019**	**Civilian non-institutional population with a disability (%), 2015-2019**	**Civilian population 18 years and over who are veterans (%), 2016-2020**	**Location**
9713	19.1	16.0*	15.2*	12.1	6.5	South Marathon/ Boot, Knight and surrounding Keys (Middle Keys)
9718	14.5	16.1*	12.7	12.5	6.6	Stock Island (Lower Keys)
9723	17.8	13.7	6.2	8.3	7.8	New Town, Key West (Lower Keys)

9724	29.1	15.3	16.6*	14.6*	7.8	Bahama Village, New Town, Key West (Lower Keys)
9725	15.5	12.1	1.7	8.3	11.5	NE New Town, Key West (Lower Keys)

Table 23: Occupied mobile homes by census tract- priority regions [Sources: Florida Department of Health Bureau of Vital Statistics and the American Community Survey's 2015-2019 & 2016-2020 five-year estimates (via FLHealthCHARTS); CDC PLACES, 2021 (Modeling based on BRFSS, 2019)]

D. Social and Community Context in Monroe County

Parenting/Caregiver Support: According to the 2020 American Community Survey, 23.3% of Monroe County children live in single-parent households[lvii] and 0.5% of Monroe County grandparents are responsible for their grandchildren. These are indicators of potential stressful childhood experiences, such as parental divorce/separation, death, incarceration, etc.

Social and community context SDOHs (parenting/caregiver support): County to State Comparison				
	Monroe		Florida	
	2020	2019	2020	2019
Children in single-parent households (aged 0-17 years) (%)	23.3	24.2	28.4	29.0
Grandparents responsible for own minor grandchildren (aged 0-17 years) among all grandparents (%)	0.5	0.5	1.1	1.1
Births to mothers born in other countries (%)	42.1	42.6	32.6	33.5

Table 24: Social and community context SDOHs (parenting/caregiver support) [Sources: United States Bureau of the Census, American Community Survey; Florida Department of Health, Bureau of Vital Statistics, 2018-2020 (via FLHealthCHARTS)]

According to the CDC, adverse childhood experiences (ACEs) are potentially traumatic experiences that happen in childhood.[lviii] These experiences can impact opportunities later in life. 2020 data shows a link between Florida adults who experience four or more ACEs and educational attainment, with lower rates of having experienced >=4 ACEs among those with education greater than high school/GED, indicators of socioeconomic status.[lix]

Social and Community Context Outcomes by Socioeconomic Status (2020)						
	Socioeconomic Status					
	Income			Education		
	<$25,000	$25,000-$49,000	>$50,000	<HS/GED	HS/GED	>HS/GED
Adults who experienced four or more adverse childhood experiences (ACEs) (%)	18.6	21.5	18.5	20.7	19.6	17.7
Adults who reported living with anyone who served time or was sentenced to serve time in prison, jail, or other correction facility (%)	12.5	12.8	9.0	15.5	11.5	7.9

Table 25: Social and community context SDOHs [Source: BRFSS CDC and Florida DOH Division of Community Health, 2020 (via FLHealthCHARTS)]

Individual and family risk factors (e.g., families with young caregivers/single parents and adults with low levels of education) as well as community risk factors (e.g., communities with high rates of violence and easy access to drugs/alcohol) are risk factors for ACEs. Protective factors, such as stable employment opportunities for caregivers and communities with access to quality childcare, can be considered in addressing social and community context SDOHs that impact mental health. To improve socioeconomic disparities in mental health, Monroe County is addressing parenting and caregiver support for individuals in Monroe County with low socioeconomic status.

Community and Social Support: Stability of geographical location is an important characteristic of building networks of support, as individuals with inconsistent living arrangements have less opportunity to build strong community with peers and social networks. In Monroe County, 17.8% of individuals ages 1 and over lived in a different house one year earlier, compared to 13.6% State-wide.[lx] In Monroe County, 11% of individuals with at least one disability reported having moved more than 2 times in the last 12 months, compared to 4% among persons without disabilities. Online social networks provide another avenue for individuals to build community and peer social support. In Monroe County, 85.7% of individuals have access to broadband internet.[lxi]

Social and Community Context: County to State Comparison				
	Monroe		Florida	
	2020	2019	2020	2019
Individuals (aged 1 year and older) that lived in a different house one year earlier (%)	17.8	17.0	13.6	14.0
Households with one or more types of computing devices (%)	94.2	92.7	93.1	91.5
Households with access to broadband internet (%)	85.7	83.6	85.4	83.0

Table 26: Social and community context SDOHs [Sources: United States Bureau of the Census, American Community Survey; Florida Department of Health, Bureau of Vital Statistics, 2018-2020 (via FLHealthCHARTS)]

To improve socioeconomic and disability disparities in mental health, Monroe County is addressing parenting and caregiver support and community and peer social support for individuals in Monroe County with low socioeconomic status and those living with disabilities. Areas with housing instability, as defined by living in a different house one year prior, is presented in the table below. The table shows that regions of South Marathon and Stock Island overlap in having high proportions of residents living in a different house the year before and frequent mental health distress. Priority population data for socioeconomic status, disability status, and veteran status are presented below.

Different house one year prior by census tract- priority regions						
Census Tract	Different House (%) (100-Same House (%)), 2015-2019 (5 worst off census tracts)	Freq mental health distress crude prevalence (%), 2019	Individuals below 100% poverty level (%), 2015-2019	Civilian non-institutional population with a disability (%), 2015-2019	Civilian population 18 years and over who are veterans (%), 2016-2020	Location

9711	23.7	15.8	13.0	7.5	7.4	Marathon (Middle Keys)
9713	23.4	16.0*	15.2*	12.1	6.5	South Marathon/ Boot, Knight and surrounding Keys (Middle Keys)
9715.02	27.1	13.0	6.6	9.6	14.4*	Summerland Key, Middle Torch, Big Torch Keys (Lower-Middle Keys)
9719	30.0	17.2*	19.3*	6.4	5.9	New Town KW/Stock Island (Lower Keys)
9721	28.8	14.0	5.3	8.0	11.8	New Town, Key West (Lower Keys)

Table 27: Different house one year prior by census tract- priority regions [Sources: Florida Department of Health Bureau of Vital Statistics and the American Community Survey's 2015-2019 & 2016-2020 five-year estimates (via FLHealthCHARTS); CDC PLACES, 2021 (Modeling based on BRFSS, 2019)]

Substance Abuse: Substance abuse can be considered as both a health disparity and a determinant of health for other health disparities. For the purposes of this plan, substance abuse was first considered as a health disparity by the Health Equity Team. The disparity data for substance abuse and mental health were considered as separate options for the priority health disparity of this plan. The Health Equity Team selected mental health as the priority disparity, but the relationship between mental health and substance abuse as comorbid health disparities and as determinants of one another must be considered.

According to the National Institute on Drug Abuse, approximately half of people who experience mental illness during their lifetime also experience a substance use disorder.[lxii] Among adults with serious mental illness, as defined by having been diagnosed with "major depression, schizophrenia, bipolar disorder, and other mental disorders that cause serious impairment," 25% also have a substance use disorder.[lxiii] Studies have indicated that using drugs at an early age is a risk factor for eventual mental illness diagnoses. There are several potential confounders for this relationship, such as genetics, environment, and psychosocial experiences, so causality cannot be assumed.[lxiv]

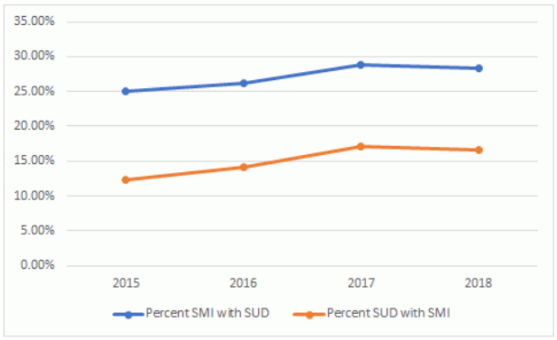


Figure 21: Substance abuse and mental health [Source: SAMHSA, Center for behavioral health statistics and quality, national survey on drug use and health, mental health, detailed tables, 2015-2018]

The National Institute on Drug Abuse highlights three possible mechanisms leading to comorbidity between mental illness and substance abuse. First, shared risk factors can commonly lead to the development of both mental illnesses and substance use disorders. Second, mental illness can contribute to substance abuse. Third, substance abuse can contribute to mental illness.[lxv] The projects in this plan will focus on the third pathway by which substance abuse can impact mental illness.

In 2020, there were 101 non-fatal overdose emergency department visits in Monroe County and 26.4 drug overdose deaths.[lxvi] In 2019, 26.4% of adults engaged in heavy or binge drinking, and this was highest for populations of higher socioeconomic status (education more than high school and income $50,000 or more).[lxvii]

While national studies have shown that the relationship between socioeconomic status and substance use/substance abuse can differ by substance, SES indicator, and personal vs familial use of substances,[lxviii, lxix] with some indicators showing worse substance use/abuse outcomes among populations of higher SES, generally rates of severe drug problems are worse off among the poor. For this reason, some socioeconomic indicators (such as poverty) are risk factors for drug use and addition.[lxx,lxxi]

Drug addiction is a disability in the United States.[lxxii] Among people living with disabilities other than drug addiction, disability increases risk for substance abuse, although the strength of this effect is dependent on both disability and substance type.[lxxiii, lxxiv]

According to the CDC, gay and bisexual men, lesbians, and transgender individuals are more likely to use alcohol and drugs and have higher rates of substance abuse.[lxxv] 25% of transgender and gay people abuse alcohol, which is substantially higher than the 10% of the general population. Furthermore, men who have sex with men are 9.5 times more likely to use heroin than men who do not have sex with men.[lxxvi] Factors including discrimination and prejudice can lead to substance abuse among LGBTQ+ individuals. Social prejudice can lead

to isolation, and housing, employment, health care, and other forms of discrimination can impact other SDOHs that affect substance abuse outcomes.

To improve socioeconomic, disability, and LGBTQ+ disparities in mental health outcomes, Monroe County will address substance abuse as a part of this plan.

E. Health Care Access and Quality in Monroe County

In Monroe County, 17.1% of residents are uninsured, compared to 12.7% of Floridians.[lxxvii] According to the 2019 BRFSS, only 67.6% of respondents have a personal doctor, compared to 72.0% of Floridians.[lxxviii] These indicators suggest that accessing care in Monroe County is a challenge, especially for low-income populations. According to the BRFSS, populations with higher incomes typically report having a personal doctor at higher rates. In 2019, Monroe County populations earning <$25,000 and $25,000-49,999 reported having a personal doctor at similar frequencies (63.9% and 61.5%, respectively).

Health Care Access and Quality: County to State Comparison				
	Monroe		Florida	
	2019	2016	2019	2016
Adults who have a personal doctor (%)	67.6	65.2	72.0	72.0
Adults who could not see a doctor in the past year due to cost (%)	14.2	15.3	28.1	17.1
Adults who had a medical checkup in the past year (%)	72.5	67.7	78.8	76.5
Adults who visited a dentist or dental clinic in the past year (%)	x	66.7	x	63.0

Table 28: Health care access and quality SDOHs [Source: BRFSS, CDC and Florida DOH Division of Community Health, 2016-2019 (via FLHealthCHARTS)]

However, 75.5% of respondents earning $50,000 reported having a personal doctor,[lxxix] indicating a possible sweet spot for intervention.

Adults who have a personal doctor						
	Monroe			Florida		
Year	<$25,000	$25,000-$49,999	$50,000 or More	<$25,000	$25,000-$49,999	$50,000 or More
2019	63.9% (48.1% - 79.8%)	61.5% (46.6% - 76.5%)	75.5% (66.6% - 84.4%)	69.2% (66% - 72.3%)	68.9% (65.5% - 72.4%)	77.4% (75.1% - 79.7%)
2016	46.9% (33.4% - 60.5%)	57.6% (44.7% - 70.4%)	78.7% (70.2% - 87.2%)	64.9% (62.8% - 67%)	72.4% (70.2% - 74.5%)	79.7% (78.1% - 81.2%)
2013	58.5% (40.6% - 76.4%)	75.4% (59% - 91.8%)	80% (69% - 91%)	61.7% (59.3% - 64%)	73.2% (70.7% - 75.7%)	85.1% (83.7% - 86.5%)

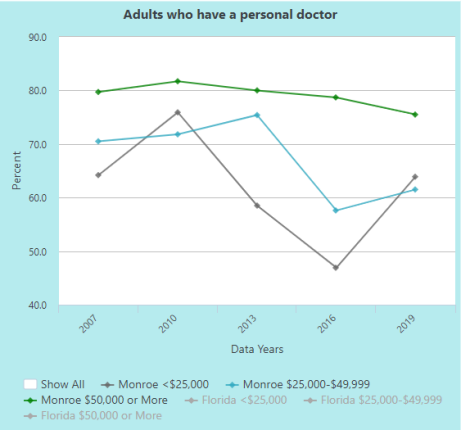


Table 29 & Figure 22: [Source: BRFSS, CDC and Florida DOH Division of Community Health, 2007-2019 (via FLHealthCHARTS)]

Unsurprisingly, reasons people do not access care commonly include cost of health care. The 2019 BRFSS showed that low income was positively correlated with reporting not seeing a doctor in the past year due to cost. In Monroe County, 28.3% of adults earning <$25,000 reported not seeing a doctor in the past year due to cost, compared to 14.1% among those in the $25,000-$49,999 income bracket and 10.4% among people earning more than $50,000.[lxxx]

Adults who could not see a doctor in the past year due to cost						
	Monroe			Florida		
Year	<$25,000	$25,000-$49,999	$50,000 or More	<$25,000	$25,000-$49,999	$50,000 or More
2019	28.3% (15.4% - 41.2%)	14.1% (2.8% - 25.4%)	10.4% (3.6% - 17.2%)	25.7% (22.8% - 28.6%)	19.6% (16.4% - 22.8%)	9.2% (7.4% - 11%)
2016	26.7% (14.6% - 38.7%)	15.4% (6.6% - 24.3%)	4.7% (0.6% - 8.8%)	27.7% (25.8% - 29.7%)	16.8% (15.1% - 18.5%)	8.4% (7.3% - 9.6%)

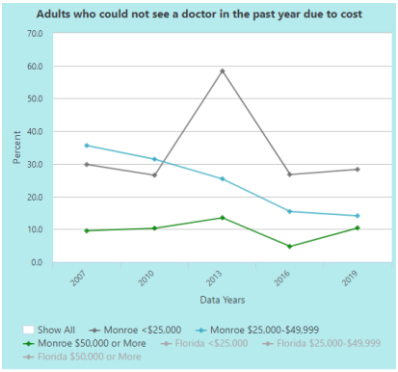


Table 30 & Figure 23: Cost-prohibitive medical care by income [Source: BRFSS, CDC and Florida DOH Division of Community Health, 2007-2019 (via FLHealthCHARTS)]

Monroe County residents living with disabilities have health care coverage at higher rates than those without disabilities. This is likely because they require more frequent and/or severe medical care. However, cost is particularly prohibitive for populations with disabilities. In Monroe County, 13% of individuals with disabilities reported not receiving care because of cost, compared to only 6% among populations without disabilities.

There are several mechanisms by which having access to quality health care can impact mental health. First, having regular check-ups helps prevent chronic diseases that are associated with mental health conditions. For example, a person who is insured and has a

personal doctor can access primary care easier and can be monitored for early signs of diabetes. According to the CDC, individuals with diabetes are 2 to 3 times more likely to have depression than people without diabetes.[lxxxi] Furthermore, individuals with health insurance and a usual doctor can be screened for symptoms of mental health conditions, potentially preventing onset of severe mental illness. According to the NHIS, individuals in the US with anxiety/depression who did not have health insurance received less mental health care than individuals who had insurance (Figure 24).[lxxxii] Similarly, respondents with anxiety/depression who had a usual source of health care reported more treatment of mental health conditions (Figure 25).[lxxxiii]

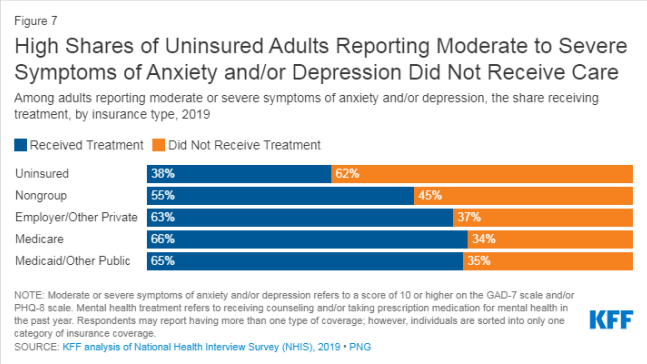


Figure 24: Mental health treatment by health insurance status [Source: KFT analysis, National Health Interview Survey (NHIS), 2019]

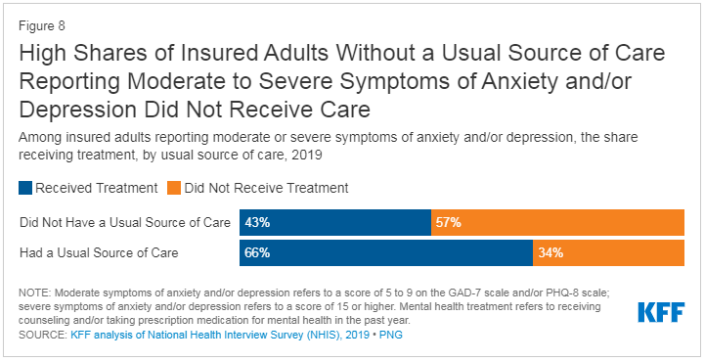


Figure 25: Mental health treatment by health insurance status [Source: KFT analysis, National Health Interview Survey (NHIS), 2019]

To reduce disparities in mental health, Monroe County is addressing SDOHs in the health care access and quality theme, including health insurance and access to primary care. Regions of high need are identified by census tracts with the highest percentage of no health insurance. For example, Stock Island and southern Marathon show low rates of health insurance and high rates of frequent mental distress. Priority population-related data is included in the table for comparison, and overlap in highest poverty, disability, and veteran status data is highlighted.

Figure 26: Health insurance coverage by census tract [Source: BRFSS, CDC and Florida DOH Division of Community Health, 2015-2019 (via FLHealthCHARTS)]

Health insurance coverage by census tract- priority regions						
Census Tract	**Individuals with no health insurance coverage in Monroe County (%), 2015-2019 (5 worst off census tracts)**	**Freq mental health distress crude prevalence (%), 2019**	**Individuals below 100% poverty level (%), 2015-2019**	**Civilian non-institutional population with a disability (%), 2015-2019**	**Civilian population 18 years and over who are veterans (%), 2016-2020**	**Location**
9713	44.5	16.0*	15.2*	12.1	6.5	South Marathon/ Boot, Knight and surrounding Keys (Middle Keys)
9719	29.9	17.2*	19.3*	6.4	5.9	New Town KW/Stock Island (Lower Keys)
9722	24.8	15.2	14.4	5.0	9.5	Mid-town, Key West (Lower Keys)

9723	24.7	13.7	6.2	8.3	7.8	New Town, Key West (Lower Keys)
9726	26.5	14.2	15.1	9.2	9.1	South Old Town/Bahama Village, KW (Lower Keys)

Table 31: Health insurance coverage by census tract- priority regions [Sources: Florida Department of Health Bureau of Vital Statistics the American Community Survey's 2015-2019 & 2016-2020 five-year estimates (via FLHealthCHARTS); CDC PLACES, 2021 (Modeling based on BRFSS, 2019)]

VIII. SDOH PROJECTS

The Minority Health Liaison recruited and engaged members across the county, including government agencies, nonprofits, private businesses, and community organizations, to join the Health Equity Task Force. Surveys from priority population of individuals of low socioeconomic status were used during the design of both projects. The Minority Health Liaison took into consideration the prioritized health disparity and the impactful SDOHs identified by the Health Equity Team during recruitment. See IV: Participation Section C for more details regarding recruitment and participation of the Health Equity Task Force.

A. Data Review

The Health Equity Task Force reviewed data, including health disparities and SDOHs, provided by the Health Equity Team. The Health Equity Task Force also researched evidence-based and promising approaches to improve the identified SDOHs.

B. Barrier Identification

Members of the Health Equity Task Force worked collaboratively to identify barriers to fully addressing the SDOHs relevant to their organization's mission. Common themes were explored as well as collaborative strategies to overcome barriers. The primary common theme was found to be related to priority populations knowledge of and access to available services.

Partner	SDOH(s)	Partner Barriers	Theme(s)	Collaborative Strategies
SOS Foundation	Food Access; Transportation	Complicated geography for food pantry model	Neighborhood & Built Environment	Distribution partnerships with churches and schools on underserved, rural Keys

SOS Foundation	Hunger; Expenses; Stress	Pantry model offers acute hunger relief without addressing root causes	Economic Stability	Formal enhanced referral program in partnership with nonprofit & gov't organizations to address economic and social root causes of hunger
A Positive Step of Monroe	Employment; stress	Lack of regular employment for fathers	Social and Community Context; Economic Stability	Career training
A Positive Step of Monroe	Fathering	Lack of role models; generational lack of involved fathers	Social and Community Context	If fathers received higher wages, some might have more time to be home with children
A Positive Step of Monroe	Incarceration; stress	Many fathers end up at Monroe County Detention Center and are unable to identify childcare services	Social and Community Context; Economic Stability	Rehabilitation services; career training;
Monroe County Board of Commissioners	Immigration	People who are undocumented have a more difficult time accessing resources–even when resources are available to those who are not documented & legal status is not questioned	Social and Community Context	Clear communication to clients about what information is collected and where the information is reported; in-person referrals from organizations/people who are undocumented trust
CHI	transportation	Transportation to health services is difficult for people without access to vehicles	Health care access and quality; Neighborhood & Built Environment	Policy changes; bus route additions
SOS Foundation	transportation	Transportation to food pantries and other social services is difficult for people without access to vehicles	Neighborhood & Built Environment	Policy changes; bus route additions
Monroe DOH	language; literacy	Language and literacy (reading and computer) barriers prevent community members from accessing information about resources.	Social and Community Context	In-person providers can link to care and services (Suggested by DOH & County Commissioner/echoed by A Positive Step Monroe, SOS Foundation, and others)
Rural Health Network	housing	Cost of housing in the Keys (especially lower keys) is unreasonable for those with low income.	Neighborhood & Built Environment	Policy change
Rural Health Network	housing	Reaching homeless populations can be challenging for service providers	Neighborhood & Built Environment	Referrals that do not require use of phone or internet. Innovative methods of contact

Rural Health Network	Health care access; transportation	Weak continuum of care– specialized care requires insurance/funding and/or accessing mainland services (echoed by Marianne)	Health care access and quality	Policy solutions for transportation; collaborative methods for improving health insurance sign-ups
CHI	Knowledge of services; access to services	Lack of logistical infrastructure to simplify access to services	All categories	One-stop shopping to help with referral, transportation, and other resources to facilitate access to care & other services
SOS Foundation	Income; employment	Pantry clients are mostly working, but they're not paid a living wage	Economic Stability; Education Access and Quality	Career development; adult education; English classes;
CHI	Knowledge of services; access to services	People knowing that resources are out there (communication, getting the word out)	All categories	Referrals and word-of-mouth information sharing

C. Community Projects

The Health Equity Task Force researched evidence-based strategies to overcome the identified barriers and improve the SDOHs that impact the prioritized health disparity. The Health Equity Task Force used this information to collaboratively design community projects to address the SDOHs. Projects included short, medium, and long-term goals with measurable objectives. These projects were reviewed and approved by the Coalition to ensure feasibility.

Project 1: Client-Facing Referral System in Monroe County

Background

Monroe County benefits from a significant quantity of social service organizations. However, reaching clients in need of services remains a challenge. Monroe County is comprised of a 130-mile chain of islands, making it rural and difficult to serve. While the geographic scopes of many social service organizations are county-wide, those living far from organizations' physical venues may not be aware of or able to access services available to them. This is a difficult problem to overcome, as many solutions for improving information access require computer literacy skills, language abilities, and access to technology for uptake. These barriers may result in exclusion of populations most likely to benefit from services.

Project Overview

A project to provide social service information to populations of low socioeconomic status could improve mental health and reduce socioeconomic disparities in mental health outcomes through addressing the associated SDOHs. Many barriers identified by Task Force members highlighted service information and access in Monroe County. This project can improve accessibility of SDOH services in the following categories:

(1) **Education Access and Quality**, including referrals to organizations offering services for free/low-cost (1) GED services, (2) language classes, (3) vocational trainings, and (4) computer literacy classes
(2) **Economic Stability**, including referrals to free/low-cost (1) vocational trainings, (2) housing, (3) food pantries, (4) sign up assistance for government programs (SNAP/EBT, disability, etc.)
(3) **Neighborhood and Built Environment**, including referrals to free/low-cost (1) transportation, (2) housing, and (3) food pantries
(4) **Social and Community Context**, including referrals to free/low-cost (1) parenting classes and (2) church programs
(5) **Health Care Access and Quality**, including referrals to free/low-cost (1) primary health care, (2) specialized health care, (3) nutrition education classes, (4) STD/STI services, (5) smoking cessation services, and (6) dental health services

Currently, no data is available on how many client-facing social service organizations utilize formal referral systems or how many clients in Monroe County undergo formal referral processes. Establishing baselines for these metrics are short-term goals of this project. Measurement tables and data graphs included in Section VII SDOH Data highlight the opportunity for social service organizations to improve SDOH outcomes through formal referral systems. This project addresses the unique geographic barriers in Monroe County by meeting clients at sites they already visit.

A survey project in Monroe County by the SOS Foundation found that more than 30% of food pantry clients desired more information on referrals.[lxxxiv] In 2021, SOS directly served over 11,000 unduplicated clients, representing a total of more than 24,000 individuals including all members of households (children, partner, etc.). These figures alone indicate that thousands of pantry clients could benefit from a referral program at the one organization alone. This project intends to extend to several client-facing community organizations in Monroe County.

Project Description and Creation Methodology

To maximize efficiency and prevent duplication of services, this project will work to strengthen current systems of service information sharing, such as United Way's Community Resource Guide and keyshelp.org online page, as well as the Minority Health Events. Previous evidence-based guides and studies were considered, including *Community Resource Referral Platforms:*

A Guide for Health Care Organizations[lxxxv] and *Assessing the Capacity of Local Social Service Agencies to Respond to Referrals from Health Care Providers*.[lxxxvi] As a result of research and discussion with stakeholders in Monroe County, this project highlights a flexible system of referrals, which will vary between providers. A flexible system is more feasible, as it does not necessarily require program budget and can more seamlessly fit within differing client intake systems. Furthermore, social service organizations have varying levels of client interfacing. Therefore, there is not a budget-friendly one-fits-all solution, so participating social service organizations will have the opportunity to participate in ways they deem most effective for the clients they serve.

CLAS standards will be foundational to the systems of referrals. Participating organizations counting toward project objectives must provide referral information in English, Spanish, and Creole. The Health Equity Task Force will be responsible for collecting outcome indicators from participating client-facing social service organizations and updating information to a shared reporting system.

Priority population feedback was considered in the design of this project. Prior to project design, 316 surveys were administered in English (45%), Spanish (29%), and Creole (26%) to determine what proportion of individuals accessing two food pantries in Lower and Upper Keys would be interested in receiving referrals to other services. 31% of the 86 Upper Keys respondents indicated interest in referrals from pantry staff in at least one of the social service categories. 32% of the 230 Lower Keys respondents wanted referral services provided.

After the project and objectives were drafted, the project was presented to 27 Monroe County residents attending a Minority Health Event, which included people with low-SES and people living with disabilities. Feedback was positive, and respondents recommended offer referral services that are less common and potentially more difficult to locate (eye care, specialized health care, life insurance, etc.).

Although systems may vary from organization to organization, the SOS Foundation's proposed system is provided below as an example:

> The SOS Foundation's food pantries see approximately eight hundred clients per week, most of which could benefit from many social services. SOS does not currently have a formal system for referrals. SOS will begin a policy for screening new clients for referral needs on first pantry visit. This will be electronically added to the current intake system for all clients. After screening, referrals will be provided by intake staff in verbal and written form, in English, Spanish, or Creole. After first visit and for all existing clients, each client will be screened for referral needs two times per year at minimum. If a client is unable

to contact the referred service for any reason, SOS staff will serve as an intermediary between the service provider and make a one-on-one plan with the service provider. Outcomes for number of referrals provided will be tracked in SOS Foundation's pantry intake software.

An altered version of the "Steps to Move Your Community Forward" methodology was used in development of this project. In April 2022, Health Equity Task Force members identified barriers to their organization fully addressing relevant SDOHs to assess needs and resources, highlighting overlap to determine shared barriers. A feasibility strategy grid was considered to identify priorities to address with projects (April & May 2022). Research was considered, and a flexible referral project was deemed feasible for implementation over three years. During each Health Equity Task Force meeting, members revisited the project to collaborate on continuous development (May 2022). The Minority Health Liaison utilized detailed meeting notes and information from a shared Task Force document to create the initial draft (May 2022). Members reviewed and edited the projects as a group (May & June 2022). The project was shared with the Health Equity Coalition (June 2022) for feedback on feasibility, and suggestions were returned via email or call.

Project Steps

Project steps of the Task Force include (1) surveying organizations to establish a baseline for number of client-facing social service organizations with organizational policies for client referrals and estimated number of clients receiving referrals from client-facing social service organizations; (2) identifying social service organizations interested in participating in the project; (3) meeting between Task Force member and stakeholder from participating social service organization (if not represented on Task Force) to share best practices and/or identify referral methods; (4) distributing shared referral information (Community Resource Guide, keyshelp.org, Upper Keys Resource Map, Conch Republic App & Monroe County Coalition Resource Directory) to participating organizations; (5) collecting outcome information from participating social service organizations providing referrals and entering the data into a reporting system; (6) providing annual progress reports to CHD, Health Equity Regional Coordinators, and the Office of Minority Health and Health Equity (July 2023, July 2024, & July 2025).

The Minority Health Liaison will be primarily responsible for project steps, with assistance from members of the Health Equity Task Force.

Project 2: Minority Health Information Events in Monroe County

Background

Monroe County residents of low socioeconomic status could benefit from relationship-based connection to social services. Due in part to the rural island geography of Monroe County, many residents face unique barriers in acquiring knowledge of and access to social services. Many social service programs are centered in the populous region of Key West, resulting in underserved geographic regions of residents without adequate knowledge of or access to resources.

Previous research shows that community-based word-of-mouth information sharing is an effective way to promote social service programs in underserved communities. The Age-Friendly Cleveland Assessment found that 58.9% of respondents said they use word-of-mouth to identify and access services, the second most common response.[lxxxvii] Additional US-based studies showed that word-of-mouth was the second and third most frequently cited response when asked how clients identified sexual assault and HIV/AIDS services.[lxxxviii] The Center for Community Solutions found that word-of-mouth information sharing through trusted intermediaries is an effective strategy that should be utilized by social service providers. Personal interactions, they found, are vital to effective promotion of services in communities in need.[lxxxix]

The Monroe County Coalition conducted a needs assessment in Monroe County prior to implementation of this project. In Fall of 2021, the Monroe County Coalition surveyed 258 respondents aged 19-82 years old to determine which types of services and presenters would be most beneficial. Participants reported food banks and meals (52%), medical services (42%), glasses and vision services (16%), dental services (16%), children/family counseling services (14%), HIV testing services (14%), meal planning and healthy eating education (11%), and domestic abuse information (2%). Open-ended responses included housing assistance, legal services, childcare, jobs/employment, teen mental health, teen sex education, teen drug education, medical services, homelessness, senior services, veteran services, mental health services, substance abuse services, financial assistance, ID cards, and jobs for felons.

Project Overview

In Fall of 2021, The Monroe County Coalition began hosting bimonthly Minority Health Events throughout Monroe County's Lower, Middle, and Upper Keys. Each event is led by Health Equity Task Force member, Billy Davis of Billy Davis & Associates, a minority vendor of the Monroe County Coalition. These events spurred cross-sector collaborations between more than thirteen social service organizations and attracted an average of 22 individuals per event. To date, 445 individuals have attended the Monroe County Coalition's Minority Health Events. Spanish and Creole translators are available to translate information provided by speakers.

This project helps reduce the barriers identified by Task Force members during the barrier identification process, including access to services and promoting information about services. This project also reduces transportation barriers for attendees wanting to learn about services, as the events will take place in various locations throughout the Keys. The Minority Health Events follow an evidence-based two-generation approach by providing information on resources for both children and adults. This approach, recommended by Healthy People 2030, highlights the need for wrap-around services for children and adults in families without economic security. Expansion of this existing program can further reduce the identified barriers to acquiring information about and accessing services, which will improve SDOHs in Monroe County and work to reduce socioeconomic disparities in mental health.

For events taking place between October 2022 and October 2023, current program activities will continue, and additional new activities will promote further success of the effort. All efforts will aim to provide information about SDOH services/opportunities in the following areas, at minimum:

(1) **Education Access and Quality,** including information about (1) GED services, (2) language classes, and (3) vocational trainings
(2) **Economic Stability**, including information about cost (1) vocational trainings, (2) housing, (3) food pantries, (4) sign up assistance for government food programs
(3) **Neighborhood and Built Environment**, including information about (1) transportation, (2) housing, and (3) food pantries
(4) **Social and Community Context**, including information about (1) parenting classes, (2) church programs, (3) local grass-roots organization services for community improvement and (4) opportunities to attend open City Council, Board of County Commissioner, and other local government meetings
(5) **Health Care Access and Quality**, including information about (1) primary health care, (2) specialized health care, (3) nutrition education classes, (4) STD/STI services, (5) smoking cessation services, and (6) dental health services

Project Description and Creation Methodology

This project proposes 20 Minority Health Events throughout Monroe County, which will take place between October 2022 and October 2023. Each event will at minimum include four organization representatives from varying SDOH themes. In total, at least 20 organizations serving Monroe County will participate in at least one event, and each event will aim to attract an audience of at least 30 Monroe County residents. Through these events, 600 residents will be reached directly and many more will be reached indirectly.

New activities for this project include scale-up in promotion and data tracking of the events. New objectives of this project include (1) increasing the number of total participating social service organizations from 13 to 20, (2) increasing the average attendance per event from 22 to 30, (3) tracking the number of cross-collaborative efforts/partnerships resulting from

participating in Minority Health Events, and (4) tracking the predicted number individuals reached through post-event word-of-mouth information sharing through a survey question addition.

New promotional activities will include flyers, social media campaigns, direct texting campaigns, and word-of-mouth promotion at client-facing social services. All physical and virtual promotional activities will follow CLAS standards and will be promoted in English, Spanish, and Creole. Evidence based strategies will be utilized to ensure promotional materials abide by health literacy guidelines, as stated as a goal in Healthy People 2030.

The Task Force will be responsible for helping to recruit new providers to present at events, disseminating physical and event promotional materials to client audiences, participating in implementation of events, and tracking outcomes related to number of providers participating and people reached.

A version of the “Steps to Move Your Community Forward” methodology was used in development of this project. In April 2022, Health Equity Task Force members identified barriers to their organization fully addressing relevant SDOHs to assess needs and resources, highlighting overlap to determine shared barriers. A feasibility strategy grid was considered to identify priorities to address with projects (April & May 2022). Research was considered, and a continuation and scale up of minority health events was deemed feasible for implementation. During each Health Equity Task Force meeting, members revisited the project to collaborate on continuous development of details (May 2022). The Minority Health Liaison utilized detailed meeting notes and information from a shared Task Force document to create the initial draft (May 2022). Members reviewed and edited the project as a group (June 2022). The projects were presented to priority populations and feedback was collected (June 2022). The project was shared with the Health Equity Coalition for feedback on feasibility, and suggestions were returned via email or call (June 2022).

Project Steps

Project steps of the Task Force include (1) identifying community leaders to partner with and locations to host events; (2) promoting future Minority Health Events via social media, texting campaigns, and printed materials in English, Spanish, and Creole; (3) recruiting new participation from social service organizations though email, phone, and in-person communication; (4) tracking the total number of Monroe County residents reached (direct and indirect) though scanned paper sign-in sheets (direct) and paper surveys (indirect); (5) tracking the number of new cross-collaborative partnerships resulting between organizations as a result of the events via annual presenter survey to all participating organizations; (6) uploading data from Steps 4 & 5 to shared excel form; (7) providing an annual progress report to CHD, Health Equity Regional Coordinators, and the Office of Minority Health and Health Equity (July 2023 & July 2024).

The Minority Health Liaison and Billy Davis of Billy Davis & Associates, a minority vendor, will be primarily responsible for project steps, with assistance and oversight from Health Equity Task Force.

IX. HEALTH EQUITY PLAN OBJECTIVES

A. Mental Health

Health Disparity Objective: By July 2025, decrease mental health indicator of "Adults who reported poor mental health on 14 of the past 30 days" from 15.0% (2019) to 11.7%.

Project 1: Client-Facing Referral Systems in Monroe County

	Objectives	Lead Entity, Unit, Point Person	Data Source	Baseline Value	Target Value
Long-term Goals	**Long-Term SDOH Goal: Improve outcomes in education access and quality**				
	Objective: By 2030, reduce individuals with no high school diploma (Aged 25 Years and Older) from 8.1% to 5.0%.	Monroe County School District Adult Education, Adult Education Coordinator, Leslie Holmes	United States Bureau of the Census, American Community Survey, 2020	8.1%	5.0%
	Long-term SDOH Goal: Improve outcomes in economic stability				
	Objective: By 2030, maintain individuals below poverty level at 10.6%	SOS Foundation, Pantry Outreach Coordinator, Selena Quintanilla	United States Bureau of the Census, American Community Survey, 2020	10.6%	10.6%
	Long-term SDOH Goal: Improve outcomes in built environment				
	Objective: By 2030, reduce renter-occupied housing units with gross rent costing 30% or more of household income from 59.8% to 49.7%	FL DOH, Minority Health Liaison, Paige Volpenhein	United States Bureau of the Census, American Community Survey, 2020	59.8%	49.7%
	Long-term SDOH Goal: Improve outcomes in social and community context				

	Objective: By 2030, maintain individuals (aged 1 year and older) that lived in a different house one year earlier at 17.8%	FL DOH, Minority Health Liaison, Paige Volpenhein	United States Bureau of the Census, American Community Survey, 2020	17.8%	17.8%
	Long-term SDOH Goal: Improve outcomes in health care access and quality				
	Objective: By 2030, decrease the proportion of Monroe County residents who do not have health insurance from 17.1% to the state average of 12.7%.	CHI, Vice President of Community Relations & Business Development, Marianne Finizio; Rural Health Network, Director, Rochelle Pearson, FL DOH, PIO & Planning Mgr., Alison Kerr	United States Bureau of the Census, American Community Survey; 2020 5-year estimate	17.1%	12.7%
Medium-term Goals	**Medium-Term SDOH Goal: Improve knowledge of and access to services addressing (1) education access and quality, (2) economic stability, (3) neighborhood and built environment, (4) social and community context, and (5) health care access and quality**				
	Objective By July 2025, increase organizations with formal systems for multi-lingual referrals for SDOH services from baseline (see short-term objective) to 7 client-facing social service organizations providing regular referrals to:				
	(1) Education access and quality	FL DOH, Minority Health Liaison, Paige Volpenhein	Baseline Survey	Established during baseline survey	7
	(2) Economic stability	FL DOH, Minority Health Liaison, Paige Volpenhein	Baseline Survey	Established during baseline survey	7
	(3) Neighborhood and built environment	FL DOH, Minority Health Liaison, Paige Volpenhein	Baseline Survey	Established during baseline survey	7
	(4) Social and community context	FL DOH, Minority Health Liaison, Paige Volpenhein	Baseline Survey	Established during baseline survey	7
	(5) Health care access and quality	FL DOH, Minority Health Liaison, Paige Volpenhein	Baseline Survey	Established during baseline survey	7

	Objective: By July 2025, increase number of individuals who are screened for referrals at a minimum of one high-volume social service organization from baseline (short-term objective) to 4,500	SOS Foundation, Pantry Coordinator, Selena Quintanilla	Reporting System	0	4,500
Short-term Goals	**Short-Term SDOH Goal: Obtain an understanding of current referral efforts in Monroe County by client-facing social service organizations, as they relate to providing regular information about (1) education access and quality, (2) economic stability, (3) neighborhood and built environment, (4) social and community context, and (5) health care access and quality**				
	Objective: By October 2022 survey 30 social service organizations to establish baseline for number of organizations providing referral for social services in (1) education access and quality, (2) economic stability, (3) neighborhood and built environment, (4) social and community context, and/or (5) health care access and quality:	FL DOH, Minority Health Liaison, Paige Volpenhein & United Way of Collier & the Keys, FL Keys Area President, Leah Stockton	Baseline Survey	0	30
	Objective: By October 2022 survey 30 social service organizations to establish baseline for estimated number of clients receiving referrals per month	Minority Health Liaison, Paige Volpenhein & United Way of Collier & the Keys, FL Keys Area President, Leah Stockton	Baseline Survey	0	30

Project 2: Minority Health Information Events in Monroe County

	Objectives	Lead Entity, Unit, Point Person	Data Source	Baseline Value	Target Value
Long-term Goals	**Long-Term SDOH Goal: Improve outcomes in education access and quality**				
	Objective: By 2030, reduce individuals with no high school diploma (Aged 25 Years and Older) from 8.1% to 5.0%.	Monroe County School District Adult Education, Adult Education Coordinator, Leslie Holmes	United States Bureau of the Census, American Community Survey, 2020	8.1%	5.0%
	Long-term SDOH Goal: Improve outcomes in economic stability				

	Objective: By 2030, maintain individuals below poverty level at 10.6%	SOS Foundation, Pantry Outreach Coordinator, Selena Quintanilla	United States Bureau of the Census, American Community Survey, 2020	10.6%	10.6%
	Long-term SDOH Goal: Improve outcomes in built environment				
	Objective: By 2030, reduce renter-occupied housing units with gross rent costing 30% or more of household income from 59.8% to 49.7%	FL DOH, Minority Health Liaison, Paige Volpenhein	United States Bureau of the Census, American Community Survey, 2020	59.8%	49.7%
	Long-term SDOH Goal: Improve outcomes in social and community context				
	Objective: By 2030, maintain individuals (aged 1 year and older) that lived in a different house one year earlier at 17.8%	FL DOH, Minority Health Liaison, Paige Volpenhein	United States Bureau of the Census, American Community Survey, 2020	17.8%	17.8%
	Long-term SDOH Goal: Improve outcomes in health care access and quality				
	Objective: By 2030, decrease the proportion of Monroe County residents who do not have health insurance from 17.1% to the state average of 12.7%.	CHI, Vice President of Community Relations & Business Development, Marianne Finizio; Rural Health Network, Director, Rochelle Pearson, FL DOH, PIO & Planning Mgr., Alison Kerr	United States Bureau of the Census, American Community Survey; 2020 5-year estimate	17.1%	12.7%
Medium-term Goals	**Medium-Term SDOH Goal: Improve knowledge of and access to services addressing (1) education access and quality, (2) economic stability, (3) neighborhood and built environment, (4) social and community context, and (5) health care access and quality**				
	Objective: By October 2023, increase the number of events where information is presented by organizations providing services in the below SDOH themes from respective baseline numbers to target values				

(1) Education access and quality	Billy Davis and Associates, Billy Davis & FL DOH, Minority Health Liaison, Paige Volpenhein	Minority Health Provider Sign-in Forms	3	13
(2) Economic stability	Billy Davis and Associates, Billy Davis & FL DOH, Minority Health Liaison, Paige Volpenhein	Minority Health Provider Sign-in Forms	20	40
(3) Neighborhood and built environment	Billy Davis and Associates, Billy Davis & FL DOH, Minority Health Liaison, Paige Volpenhein	Minority Health Provider Sign-in Forms	20	40
(4) Social and community context	Billy Davis and Associates, Billy Davis & FL DOH, Minority Health Liaison, Paige Volpenhein	Minority Health Provider Sign-in Forms	20	40
(5) Health care access and quality	Billy Davis and Associates, Billy Davis & FL DOH, Minority Health Liaison, Paige Volpenhein	Minority Health Provider Sign-in Forms	20	40
Objective: By October 2023, increase the total number of social service presenters at Minority Health Events from 13 to 20	Billy Davis and Associates, Billy Davis & FL DOH, Minority Health Liaison, Paige Volpenhein	Minority Health Provider Sign-in Forms	13	20
Objective: By October 2023, increase the total number of attendees at Minority Health Events from 455 to 1,060	Billy Davis and Associates, Billy Davis & FL DOH, Minority Health Liaison, Paige Volpenhein	Minority Health Attendee Sign-in Forms	445	1,060

Short-term Goals	**Short-Term SDOH Goal: Obtain an understanding of current referral efforts in Monroe County by client-facing social service organizations, as they relate to providing regular information about (1) education access and quality, (2) economic stability, (3) neighborhood and built environment, (4) social and community context, and (5) health care access and quality**				
	Objective: By January 2023 survey 100 event attendees to establish a baseline estimate for number of individuals who indirectly received information on services in (1) education access and quality, (2) economic stability, (3) neighborhood and built environment, (4) social and community context, and/or (5) health care access and quality:	Billy Davis and Associates, Billy Davis & FL DOH, Minority Health Liaison, Paige Volpenhein	Baseline Survey	0	100

Projects I & II: Alignment:

	2017-2021 Florida State Health Improvement Plan (SHIP)	Healthy People 2030	DOH-Monroe Strategic Plan	DOH-Monroe Community Health Improvement Plan (CHIP)
Project 1: Client-Facing Referral Systems in Monroe County	Strengthen the capacity of state and local agencies and other organizations to work collaboratively with communities and each other to support the specific needs of Florida's most vulnerable population—Goal HE3 Promote policy, systems, and environmental changes to increase access to and equitable consumption of healthy foods statewide for Floridians of all ages—Strategy HW1.1 Enhance community health systems to address social determinants of health through Asset-Based Community Development and partnerships— Goal CD2	Goal: Help people earn steady incomes that allow them to meet their health needs Goal: Increase educational opportunities and help children and adolescents do well in school Goal: Increase access to comprehensive, high-quality health care services Goal: Create neighborhoods and environments that promote health and safety Goal: Increase social and community support Goal: Promote health and safety in community settings Goal: Improve health care Goal: Increase health insurance coverage Goal: Promote safe and active transportation	Develop strategies to reduce Alcohol and Drug Abuse in Monroe County—Goal 1.B Increase access to care—Goal 2.A	To increase access to community wide comprehensive primary care services for uninsured, Medicaid and underinsured populations—Access to Care Goal 1 To increase access to community wide comprehensive primary care services for uninsured, Medicaid and underinsured populations—Mental Health & Substance Abuse Goal 1

Project 2: Minority Health Information Events in Monroe County	Strengthen the capacity of state and local agencies and other organizations to work collaboratively with communities and each other to support the specific needs of Florida's most vulnerable population—Goal HE3 Promote policy, systems, and environmental changes to increase access to and equitable consumption of healthy foods statewide for Floridians of all ages—Strategy HW1.1 Enhance community health systems to address social determinants of health through Asset-Based Community Development and partnerships— Goal CD2	Goal: Help people earn steady incomes that allow them to meet their health needs Goal: Increase educational opportunities and help children and adolescents do well in school Goal: Increase access to comprehensive, high-quality health care services Goal: Create neighborhoods and environments that promote health and safety Goal: Increase social and community support Goal: Promote health and safety in community settings Goal: Improve health care Goal: Increase health insurance coverage Goal: Promote safe and active transportation	Develop strategies to reduce Alcohol and Drug Abuse in Monroe County—Goal 1.B Increase access to care—Goal 2.A	To increase access to community wide comprehensive primary care services for uninsured, Medicaid and underinsured populations—Access to Care Goal 1 To increase access to community wide comprehensive primary care services for uninsured, Medicaid and underinsured populations—Mental Health & Substance Abuse Goal 1

II. 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 Task Force to discuss progress and barriers. The Minority Health Liaison tracks and submits indicator values to the OMHHE within 15 days of the quarter end.

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

III. REVISIONS

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

Revision	Revised By	Revision Date	Rationale for Revision

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Appendix A: Health Equity Coalition Members

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Susan Moore, Monroe County Coalition
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Joe Tripp, Key West Police Department
Alison Katz, Monroe 16th Circuit Drug Court
Erin Donald, Healthy Start
Jeannette McLernon, Florida Keys Outreach Coalition
Larry Coplin, Florida Treatment Services
Danielle Walden, Grieving Families
Phyllis Jackson, Grieving Families
Tom Goetz, Anchor's Away
Rochelle Pearson McEntrye, Rural Heath Network
Fany Flores, Thriving Mind South Florida
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