WAKULLA COUNTY

HEALTH EQUITY PLAN

July 2022—June 2025

Updated 7/1/2022

Florida Department of Health in Wakulla County

Submitted by:

ASCENDANT HEALTHCARE PARTNERS

Transforming communities *for* healthier lives

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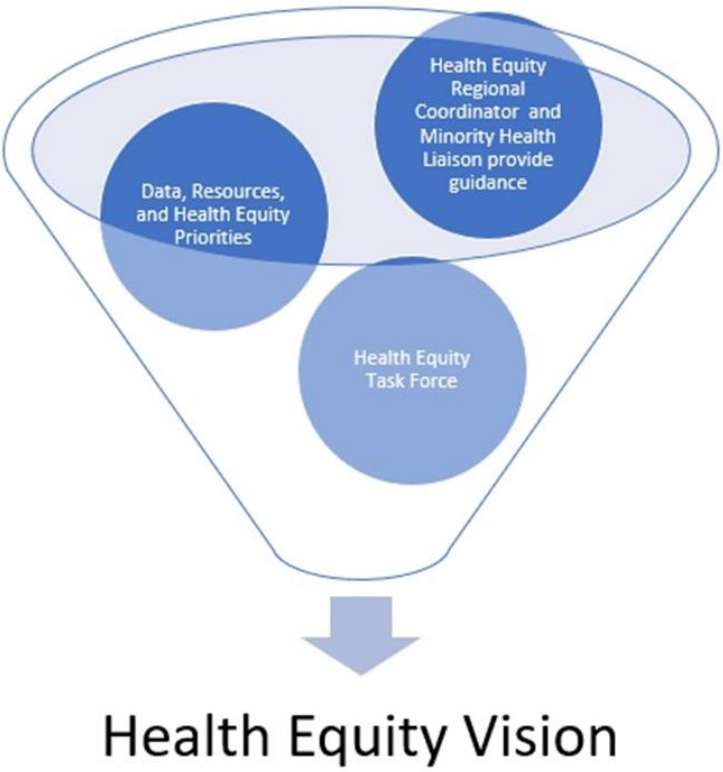
I. VISION

The vision statement provides focus, purpose, and direction to the health equity planning process. Visioning guides the community through a collaborative process that leads to a shared community aspiration. As a part of the Community Health Assessment (CHA) Wakulla County used the National Association of County and City Health Officials (NACCHO), Mobilizing for Action through Planning and Partnerships (MAPP) guidance. The Health Equity Vision was written by the Health Equity Taskforce under the guidance of the Health Equity Regional Coordinator and the Minority Health Liaison. Visioning was conducted at the beginning of the planning process to provide the framework throughout the stages of planning and unite around a shared vision.



The Regional Coordinator and Minority Health Liaison facilitated the shared vision. Ascendant Healthcare Partners facilitated the MAPP assessments as well as additional primary research. The Community Health Improvement Plan (CHIP) identified the Health Equity Taskforce as a subset of the Community Health Improvement Team.

II. PURPOSE OF THE HEALTH EQUITY PLAN

Health Equity is achieved when everyone can attain optimal health.

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

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

The purpose of the Health Equity Plan is to increase health equity within Wakulla. To develop this plan, Wakulla 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 Wakulla. This Health Equity Plan is not a county health department plan; it is a county-wide Health Equity Plan through which the Health Equity Taskforce, including a variety of government, non-profit, and other community organizations, align to address the SDOH's which 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 is when each individual or group of people is given the same resources or opportunities.

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

IV. PARTICIPATION

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

The Community Health staff can provide and support health and wellness education in communities stretching across the County. Program creates partnerships with community members through a wide variety of health and wellness programs and chronic disease management services. Community groups and organizations throughout the County to bring health education programs to all surrounding neighborhoods. As a result, many individuals, of all ages, genders and ethnicities now have the knowledge to make positive health and wellness choices. The Community Health Program provides health initiatives, education, and resources to benefit all of Wakulla County. These include health assessments, screenings and education classes, health coaching, community resources and referral. The image above was taken at the Spring into Good Health which brought together residents in Wakulla County to heighten awareness across all priority populations and organizations.

A. Minority Health Liaison

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

Minority Health Liaison: Tanasha Dollard
Minority Health Liaison Backup: Donna Clark

B. Health Equity Team

The Health Equity Team includes individuals that each represent a different program within the DOH-Wakulla. 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 Wakulla County to the Health Equity Taskforce. The Minority Health Liaison guides these discussions and the implementation of initiatives. The membership of the Health Equity Team is listed below.

Name	Title	Program
Grace Keith	Community Wellness Coordinator	Community Health, Health Equity
Tanasha Dollard	Minority Health Liaison	Health Disparities
Quincy Wimberly	Minority Health Regional Coordinator	Health Equity/Minority Health
Ava Vick	Health Aide	Medical Clinic
Angela Clark	School Health	School Clinics
Alisha Mason	HR Liaison	Administration
Phil Carter	Health Educator	Positive Youth Development, Healthiest Weight
Christie Mathison	Planner	Preparedness
Liz Jessup	Dental Assistant	Dental Clinic
Amber Rivers	Financial Assistant	Business
Michelle Henderson	Clerk	Business

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

Meeting Date	Topic/Purpose
2/7/2022	Health Equity and the Social Determinates of Health presentation - training
6/6/2022	Health Equity Checklist & Observations re: Internal and External Customers – team members discussed the checklist, what to look for and the topic of internal and external customers. Next steps were also presented. After the checklist is completed, the Team will present the identified gaps in service to the PMC. If approved, they will proceed to develop workplans and these will be submitted to the PMC for review and approval. It was decided that the workplans will lead to the creation of procedures to support health equity.

C. Health Equity Taskforce

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

Name	Title	Organization	Social Determinants of Health
Amy Bryan	Mental Health Coordinator	Wakulla County Schools	Education, Economic Stability
Amy Marcellja	Outreach Team	Authentic Life Church	Community Context
Brent Couch	Community Outreach/Plan Representative	Simply Healthcare	Healthcare
Cerissa Fondo	Center Manager	Tallahassee Community College - Wakulla	Education, Economic Stability
Chelsea Marshall-Hirvela	Family Nutrition Program Public Health Specialist	UF/IFAS- Northwest Region	Education
Christine Lepore	Community Member	Operation Wakulla	Community Context
Claudia Machado	Program Manager	MADD	Community Context
Donna Clark	Operations Manager	DOH Wakulla County	Healthcare
Elaine Gary	Real Estate Broker	Waypoint Properties	Neighborhoods, Community Context
Ellen MacMichael	Public Health Nutrition Consultant	DOH Leon	Healthcare
Emily Kohler	Tobacco Program Manager	Big Bend AHEC	Healthcare

Evelyn Savary	Community Member	Operation Wakulla	Community Context
Grace Keith	Liaison for (REDCH) Racial Ethnicity Disparities	DOH Wakulla County	Healthcare, Education
Herb Donaldson	Owner	Palaver Tree Theatre	Community Context
Janis Edwards	Big Bend AHEC Tobacco Cessation Educator	Big Bend AHEC - Tobacco Cessation	Healthcare
Jim Needham	Minister, Mental Health Counselor	Christ Church Anglican, Honey Lake Clinic	Community Context, Healthcare
Kara Walker	Community Engagement Coordinator	Big Bend Hospice	Healthcare
Kenny Manning	President	Be A Hero to Our Heroes	Community Context
Lisa McCloudy	General Manager	Sodexo	Healthcare
Lisa Rickert	Office Manager	Urgent Care of Wakulla	Healthcare
Liz Neighbors	Tobacco Cessation Specialist	DOH Wakulla	Healthcare
Marva Preston	Director of External Relations	FL Dept of Juvenile Justice	Neighborhoods, Community Context, Economic Stability
Clyde Preston	Minister	Grace Embraced Ministry	Community Context
Juanise Hoover	Community Member	Operation Wakulla	Community Context
Phillip Carter	Coordinator for Positive Youth Development/Health Educator	DOH Wakulla County	Education, Healthcare
Quincee Messersmith	Commissioner, District 4	Wakulla County Board of County Commissioners	Community Context, Economic Stability, Neighborhoods
Quincy Wimberly	Regional Minority Health/Health Equity Coordinator	FDOH - Wakulla	Healthcare
Ray Johnson	Major	Wakulla County Sheriff's Office	Neighborhoods, Community Context, Economic Stability
Samantha Kennedy	Director	UF/IFAS - Wakulla	Education, Community Context
Stephanie Weems	Veteran Care Coordinator	211 Big Bend	Healthcare, Community Context, Economic Stability
Tanasha Dollard	Minority Health Liaison	DOH Wakulla	Healthcare
Terence Watts	Community	FL - DCF	Community Context,

	Development Administrator		Healthcare
Tonya Hobby	Health Officer	DOH Wakulla County	Healthcare
Valerie Russell	APRN	Tallahassee Healthcare - Wakulla	Healthcare

The Health Equity Taskforce met on the dates below during the health equity planning process. Since the Health Equity Plan was completed, the Health Equity Taskforce has continued to meet at least quarterly to track progress.

Meeting	Topic/Purpose	Organizations
1/25/2022	Introduction of new state program, Health Equity and Minority Health-Health Disparities COVID-19, introduced Regional Coordinator, Quincy Wimberly	Health Equity Task Force
2/22/2022	Health Equity and The Social Determinates of Health – presentation/training	Health Equity Task Force
4/22/2022	Forces of Change Bring Partners Together on Common Ground to Collaboratively Address Changes	Health Equity Task Force (all members)
5/24/2022	Discussion regarding how to incorporate additional organizations as participants in the Health Equity Task Force and the Health Equity Coalition, discussion regarding health equity projects	Health Equity Task Force
6/28/2022	Review of Health Equity projects, plans, etc.	Health Equity Task Force

D. Coalition

The Coalition discussed strategies to improve the health of the community. The strategies focused on the following social determinants of health: education access and quality, health care access and quality, economic stability, social and community context, and neighborhood and built environment. Membership includes community leaders working to address each SDOH, as well as any relevant sub-SDOH. The Coalition assisted the Health Equity Taskforce by reviewing their Health Equity Plan for feasibility. Below is the list of Coalition members.

Name	Title	Organization
Dwight Burch	Chaplain	FL Department of Corrections – Wakulla Correctional Institute
Chelsea Marshall-Hirvella	Family Nutrition Program Public Health Specialist	UF/IFAS- Northwest Region
Grace Keith	Health Equity Liaison	FL DOH - Wakulla
Herb Donaldson	Owner	Palaver Tree Theatre

Kenny Manning	President	A Seat at the Table
J. Bernard Plummer	Minister	Spirit and Truth Ministries
Samuel Hayes	Minister	Mount Olive Primitive Baptist Church, #2
Robert Manning	Community Member	Wakulla Christian Coalition
Stephanie Weems	Community Member	Spirit and Truth Ministries
Tanansha Dollard	Minority Health Liaison	FL DOH - Wakulla
Tiffany Barnes	Insurance Broker	Independent
Winston Murphy	Veterans' Services	Wakulla County
Andrew Keith	Community Member	Crawfordville Lions Club
Dianne Woodard	Health Minister	Little Salem Primitive Baptist Church
Bossie Hawkins	Community Member	Wakulla Christian Coalition
Cheryl Randolph	Health Minister	Little Salem Primitive Baptist Church
Naquita Nelson	Instructor	FAMU School of Nursing
Karen Bartley	Physician	Tallahassee Memorial Health Care - Wakulla
Walesca Marrera	Community Member	FL DCF

The Health Equity Taskforce met on the below dates during the health equity planning process. Since the Health Equity Plan was completed, the Health Equity Taskforce has continued to meet at least quarterly to track progress.

Meeting Date	Organizations	Topic/Purpose
02/22/2022	Wakulla Health Equity Task Force	Presentation Health Equity and the Social Determinates of Health
04/16/2022	Palaver Tree Theatre Board of Directors	Presentation of Health Equity program
05/24/22	Wakulla Health Equity Task Force	Discussion regarding how to incorporate additional organizations in the Wakulla Wellness Task Force and the Wakulla Health Equity Task Force, also discussed health equity projects

05/26/22	Palaver Tree Theatre members, Be A Hero to Our Heroes, A Seat at the Table, Veterans' Services of Wakulla County, DOH Wakulla, Christ Church Anglican, New Hope Community Church, Crawfordville, Lions Club, community members	All-male discussion regarding Health Equity, topics regarding Social Determinates of Health and community issues affecting all residents as well as minority populations
06/02/2022	Palaver Tree Theatre members, Be A Hero to Our Heroes, A Seat at the Table, Veterans' Services of Wakulla County, Operation Wakulla, Little Salem Primitive Baptist Church, FL Department of Juvenile Justice, Grace Embraced Ministry, DOH Wakulla, Christ Church Anglican, New Hope Community Church, Crawfordville, Lions Club, community members	All-female discussion regarding Health Equity, topics regarding Social Determinates of Health and community issues affecting all residents as well as minority populations
06/09/2022	Palaver Tree Theatre, Teen Room Arcade youth, Wakulla DOH, community members	Youth discussion regarding effects of COVID on school, school safety and security, employment for youth, relationships with community members and families
07/21/2022	Palaver Tree Theatre, DOH Wakulla, Be A Hero to Our Heroes, A Seat at the Table, UF/IFAS – Wakulla, Veterans' Services of Wakulla County, Operation Wakulla, Crawfordville Lions Club, Teen Room Arcade, Wakulla Christian Coalition	Review of all Community Conversation meetings, discussion regarding Walkability projects, next steps for the Health Equity program.

E. Regional Health Equity Coordinators

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

Name	Region
Carrie Rickman	Emerald Coast
Quincy Wimberly	Capitol
Ida Wright	Northeast
Diane Padilla	North Central
Rafik Brooks	West
Lesli Ahonkhai	Central
Frank Diaz-Gines	Southwest
Natasha McCoy	Southeast

V. HEALTH EQUITY ASSESSMENT, TRAINING, AND PROMOTION

A. Health Equity Assessments

To improve health outcomes in Florida, it is critical to assess the knowledge, skills, organizational practices, and infrastructure necessary to address health inequities. Health equity assessments are needed to achieve the following:

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

Ascendant Healthcare Partners conducted health equity assessments to examine the capacity and knowledge of DOH-Wakulla staff and county partners to address social determinants of health. The DOH-Wakulla staff were surveyed to identify the baseline of understanding their role in health equity. Ascendant Healthcare Partners utilized MAPP assessments in combination with the Mobilizing and Organizing Partners to Achieve Health Equity Tool (April 2021). Below are the dates assessments were distributed and the partners who participated.

Date	Assessment Name	Organizations Assessed
2/22/2022	Local Public Health Assessment	Community Partners & Health Equity Taskforce
3/08/2022	Community Health Status Assessment	Primary data community
3/10/2022	Community Themes & Strengths Assessment	Community-wide
3/30/2022	Health Equity Survey: Baseline Understanding to Identify Future Training Needs	DOH-staff
4/22/2022	Forces of Change Assessment	Community Partners

Community Health Status Assessment

The Community Health Status Assessment (CHSA) identifies priority health and quality of life issues. Questions include: "How healthy are our residents?" and "What does the health status of our state look like?" The CHSA is a crucial component in the MAPP process, and it is during this stage that specific health issues (e.g., high cancer rates or low immunization rates) are identified. A broad range of data serves as the foundation for analyzing and identifying community health issues and determining where the community stands in relation to peer

communities, state data and national data. To better communicate findings, the County Health Rankings and Roadmaps model was used to group and frame information for the health status assessment. The County Health Rankings measure the health of nearly all counties in the nation and rank them within the state.[1] The Rankings are based on a model of population health that emphasizes the many factors that, if improved, can help make communities healthier places to live, learn, work and play.

Health Equity Lens

In addition to considering what the social determinants of health are, it is important to understand how they disproportionately affect underserved populations. Health equity is defined as all people having the opportunity to 'attain their full health potential and no one is disadvantaged from achieving this potential because of their social position or other socially determined circumstance.[2] A robust assessment of the larger social and economic factors affecting a community (e.g., housing, employment status, the built environment, etc.) should capture the disparities and inequities that exist for traditionally underserved groups. According to Healthy People 2030, a science-based platform that provides 10-year national objectives for improving the health of all Americans and achieving health equity requires focused efforts at the societal level to address avoidable inequalities, especially among those who have experienced socioeconomic disadvantage or historical injustices. A health equity lens guided the community health assessment process to ensure the data comprised a range of social and economic indicators and was presented for specific population groups. Within the CHSA strategies were used to identify patterns of health inequity within the community.

In Wakulla County, the leading causes of death identified were types of chronic disease: heart disease, cancer, and chronic lower respiratory disease. The analysis shows that 35% of Wakulla County adults have been told they had hypertension. The identified priority populations were African American, and elderly (65+).

Community Themes and Strengths Assessment

The County Themes and Strengths Assessment (CTSA) answers key questions, drawing from a cross-section of the public health system that includes local county health departments, state and community public health partners, and residents. This assessment results in a strong understanding of community issues and concerns, perceptions about quality of life and a listing of assets. The table below highlights the health disparities that were identified.

[1] Robert Wood Johnson Foundation. (2017). County Health Rankings and Roadmaps. Retrieved from http://www.countyhealthrankings.org/our-approach.
[2] Braveman, P.A., Monitoring equity in health and healthcare: a conceptual framework. Journal of Health, Population, and Nutrition, 2003. 21(3): p. 181

	White		Black		Hispanic/Latino		Asian-Pacific Islander		Native Indian/ Alaska Native	
	Male	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
Access to Care	22	60	3	9	0	1	0	2	0	1
Education (did not graduate High School)	1	1	0	0	0	0	0	0	0	0
Food Insecurities	8	58	1	5	0	1	0	0	0	0

Forces of Change

The partners of Wakulla County identified opportunities within access to care to be a new hospital opening, opportunities for further collaboration in partnerships and health education. The challenges identified were the funding to meet the specific needs of the community and the breakdown between services available and the priority populations in need.

Local Public Health Status Assessment (LPHSA)

Wakulla County used a combination of leadership and community stakeholders to engage in the survey. This assessment has been useful as a learning tool to assess Wakulla County's readiness to address agencies strengths and weaknesses as well as how they acknowledge and address health equity in the near future. The assessment emphasizes alignment with the essential public health services - those that experts agree will be most critical to protecting and promoting the health of the public in the future. The LPHSA showed partners in Wakulla County are aware of health equity and it illustrated the need to further improve partners knowledge in this area.

When the Wakulla County Health Department completed the Local Public Health System Assessment (LPHSA) using the National Public Health Performance Standards (NPHPS) Instrument, the questions about essential service delivery identified how well the local public health system acknowledges and addresses health inequities.

The diverse group of partners and public health professionals represented a wide spectrum of expertise which were surveyed to assess the performance and capacity of Wakulla's public health system. The survey provided the Essential Service description, activities, and model standard for each group of indicators. Utilizing the survey, participants then cast votes ranging from no activity to optimal activity. Voting results were presented virtually.

Responses for all ten Essential Public Health Services (EPHS) were entered into a standardized CDC-developed tool from which results were obtained.

Health Equity Employee Survey

On March 30, 2022, a Health Equity Employee survey was completed by all employees of the DOH-Wakulla. The 26-question survey instrument provided the opportunity to choose one of the following options: aware, functional, proficient, and expert.

Overall, the results showed that employees of DOH-Wakulla had a functional understanding of health equity, health inequities, and disparities. This survey provides the baseline for training opportunities that will increase their awareness of cultural competency training to improve staff skills in working with diverse populations.

All members of the DOH-Wakulla identified that it is very important for public health professionals to have the skills to identify health equity and social determinants of health expertise. The Health Equity Survey identified additional training requirements to provide optimum understanding of health equity, disparities, and engagement needs.

B. County Health Equity Training

Assessing the capacity and knowledge of health equity helped the Minority Health Liaison identified knowledge gaps and created cultural awareness training for the Health Equity Taskforce and the Coalition.

Date	Type of Education	Vulnerable Population Impacted
Ongoing	Special Needs Shelter Planning	Disabled, Elderly

C. County Health Department Health Equity Training

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

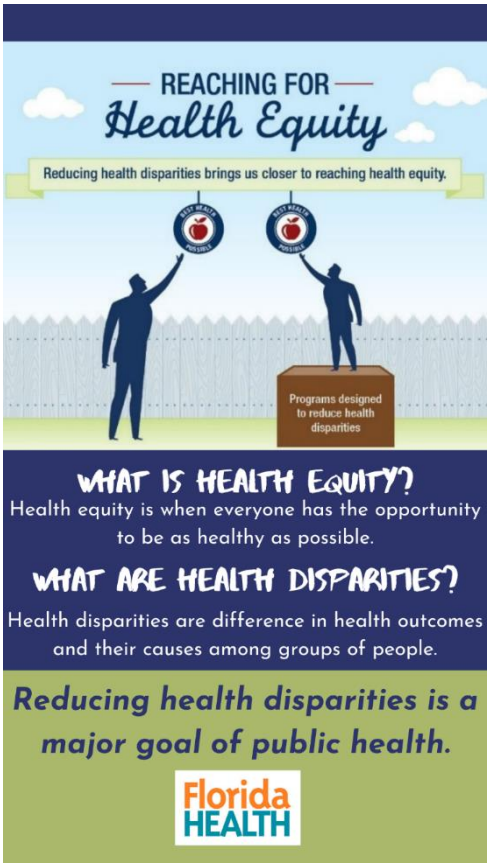
Date	Topics	Number of Staff in Attendance
2/7/2022	Cultural Awareness: Introduction to Cultural Competency and Addressing Health Equity: A Public Health Essential	40

DOH-Wakulla's Health Equity Team developed a shared understanding of health equity in Wakulla County through training and dissemination of resources.

D. Minority Health Liaison Training

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

Date	Topics
8/19/2021	FDOH Health Equity Efforts Overview
9/16/2021	Initiative Funding/Scope of Work
10/21/2021	Health Equity Project Management
11/18/2021	Health Equity Plan Template, Assessments, Partnerships
1/20/2022	Health Equity Plan Alignment, Handbook, Resource Library
2/17/2022	Social Determinates of Health
3/17/2022	Social Determinate of Health Project, Plan Standards, Letter of Support
4/22/2022	Budget Guidance



E. National Minority Health Month Promotion

Spring into Good Health - Our Minority Health Event

DOH-Wakulla participated in a Minority Health Month, by offering a Spring into Good Health health fair on April 23, 2022. Community leaders identified this as an opportunity to promote Minority Health Month and raise awareness and understanding of health equity. Prior to the event, DOH-Wakulla staff reached out to minority and vulnerable populations through traditional avenues such as the local paper, billboards, radio PSA and social media to invite them to this Minority Health Month event to heighten awareness of hypertension. At the event DOH-Wakulla staff, performed blood pressure checks and provided education on the importance of consistently monitoring blood pressure. Since behaviors impact health, this knowledge is a powerful tool for targeting and building health promotion activities. It also provides a way to see change in population health behaviors before morbidity or disease is apparent. Over 70 people visited the Minority Health/Health Equity DOH booth at this event.

VI. PRIORITIZING A HEALTH DISPARITY

The data about adults who have ever been told they had hypertension come from a state-based telephone surveillance system called the Behavioral Risk Fact Surveillance System (BRFSS). BRFSS is the nation's premier system of health-related telephone surveys that collect state data about U.S. residents regarding their health-related risk behaviors, chronic health conditions, and the use of preventive services. Florida utilizes BRFSS with financial and technical assistance from the Centers for Disease Control and Prevention (CDC). In Florida, the BRFSS is collected at the state level each year, and it is collected at the county level every three years.

Since behaviors impact health, this knowledge is a powerful tool for targeting and building health promotion activities. It also provides a way to see change in population health behaviors before morbidity or disease is apparent.

In 2019, in Wakulla County (34.5%) of adults who have been told they had hypertension is higher than the State (33.5%). In the last seven years Wakulla's hypertension rate has increased with the last two years surpassing the State.

Adults who have ever been told they had hypertension, Overall		
Year	Wakulla	Florida
2019	34.5% (26.2% - 42.8%)	33.5% (32.1% - 35%)
2013	33.3% (26.5% - 40%)	34.6% (33.5% - 35.7%)
2010	36.5% (29.8% - 43.2%)	34.3% (33.1% - 35.4%)
2007	31.9% (25.6% - 39%)	28.2% (27.2% - 29.2%)
2002	26.5% (21.9% - 31.1%)	27.7% (26.6% - 28.7%)

Wakulla County is in the first quartile for this measure. This means that relative to other counties in Florida, the situation occurs more often in three quarters in the counties. The map illustrates county data by quartile. It is shown when there are at least 51 counties with data for this measure.""[3]

The growth is concentrated in three of the priority populations, elderly (65+), Black/African American and People Living with Disabilities.

> **Elderly** is defined as a resident at least 65 years old. Elderly residents make up 15.9% pf Wakulla County's population. Fifty-two percent (2,791) of the elderly population in Wakulla County have been

[3] Florida Charts

told sometime in their life that they had hypertension. The median household income for the Wakulla County elderly is $42,087, which is about 10% below the State of Florida median household. Lack of public transportation and doctors who can treat diseases such as hypertension that affect the elderly are an issue to this population. The 21.6% of seniors with low access to healthy food in Wakulla County are at a disadvantage in defeating hypertension as eating healthy food is a tool in fighting hypertension.

Black/African Americans in Wakulla County make up 13.9% of the total population. During the period from 2014 to 2020 Wakulla County African American residents saw their age-adjusted death rate from hypertension fluctuate significantly and reach a peak in 2017. In 2007, last reporting of data, 33.6% of African Americans had been diagnosed with hypertension. Hospitalizations also fluctuated during in 2019 for African American residents. The median household income for Wakulla County African American residents is $46,989 which is above the State of Florida comparable data for African American residents but is almost 30% below the like number for Wakulla County white householders and is almost 40% below the median household income for Hispanic householders. Looking at African American students, they make up 10% of enrollment in Wakulla County schools, but only 1.3 % of talented students.

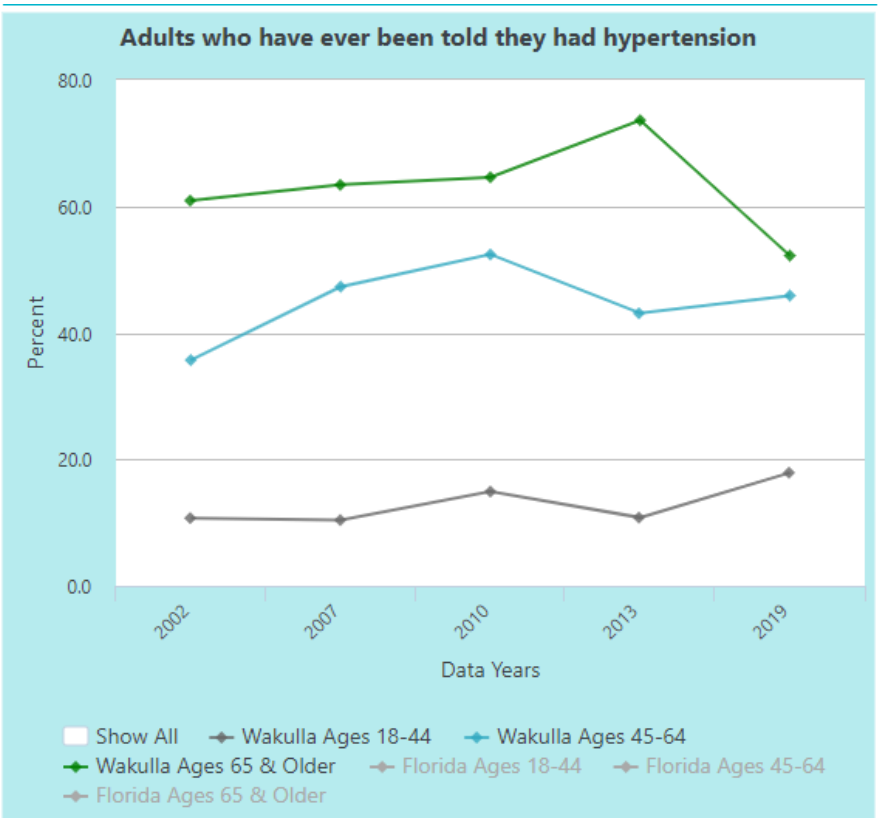
Residents who are living with disabilities who make up 13.4% of Wakulla County's population. The elderly represents the highest proportion within Wakulla County that have physical and emotional disabilities as well as hearing and mobility disabilities. African American/Black residents represent the highest population with vision disabilities. More than 30% of people with one or more disabilities suffer from hypertension.

The Social Determinants of Health (SDOH) are conditions in a community that affect a wide range of health issues.

Vulnerable Populations

Race/Ethnicity	Percentage of 2020 County Population (33,764)
White	82.4% (27,821)
Elderly 65 and over	15.9% (5,368)
Black/African American	13.9% (4,693)
People Living with a Disability	13.4% (4,524)
Veterans	11.7% (3,950)
Infants/Toddlers (0-5yrs)	5.2%
Hispanic/Latino	3.9%
Immigrants	2.5%
American Indian/Alaskan Native	0.7%
Asian	0.7%
Native Hawaiian/Other Pacific Islander	0.1%
LGBTQ+	No data currently available

The elderly in Wakulla County is the highest proportion (52%) of those who have been diagnosed with hypertension although is the only age group that is less than the State (58.7%) of being diagnosed. Within Wakulla the age groups 18-44 (17.9%) and 45-64 (45.9%) are higher that the State (12.4% and 39.3% respectively).



Adults in Wakulla County who are African American/Black (21.4%) and White (28.4%) surpass the State (more than 3% respectively) with physical/mental/emotional problems, vision, hearing, and mobility. Those over the age of 65 represent the highest proportion (34.5%) in Wakulla while the State represents 27.1%.

Adults who are limited in any way in any activities because of physical, mental, or emotional problems, Non-Hispanic Black		
Year	Wakulla	Florida
2016	21.4% (6.9% - 35.9%)	18.1% (15.2% - 21.1%)
2013		17.8% (15.1% - 20.5%)
2010		22% (18.3% - 25.7%)
2007	14.8% (6.7% - 29.7%)	16.8% (14.1% - 19.7%)

Adults who are limited in any way in any activities because of physical, mental, or emotional problems, Non-Hispanic White		
Year	Wakulla	Florida
2016	28.4% (23.2% - 33.7%)	25.4% (24.3% - 26.5%)
2013	21.2% (15.4% - 26.9%)	23.2% (22.2% - 24.2%)
2010	28.1% (21.8% - 34.4%)	26.2% (25.1% - 27.3%)
2007	27.7% (19.8% - 37.3%)	19.7% (18.8% - 20.6%)

Adults who are limited in any way in any activities because of physical, mental, or emotional problems, Ages 65 & Older		
Year	Wakulla	Florida
2016	34.5% (27.2% - 41.8%)	27.1% (25.4% - 28.9%)
2013	34.4% (24.2% - 44.7%)	28.6% (26.9% - 30.2%)
2010	36.9% (24.8% - 49%)	32.3% (30.8% - 33.9%)
2007	43.4% (27.5% - 60.8%)	27.6% (26% - 29.2%)

Within Wakulla County (5.1%) those with a vision disability exceed the State (4.5%) in those who are White. No data is available for African Americans/Black in 2019, however, in all preceding years that data was recorded Wakulla exceed the State by approximately 9%. The elderly with a vision disability is better than the State.

Adults who have a vision disability, Non-Hispanic White		
Year	Wakulla	Florida
2019	5.1% (1.5% - 8.8%)	4.5% (3.9% - 5.1%)
2016	5.9% (3.7% - 8.2%)	5.3% (4.8% - 5.9%)
2013	4.9% (1.2% - 8.5%)	4% (3.5% - 4.5%)

Adults who have a vision disability, Non-Hispanic Black		
Year	Wakulla	Florida
2019		8.1% (5.7% - 10.4%)
2016	16.6% (2.4% - 30.9%)	6.8% (5% - 8.7%)
2013	16.2% (0% - 32.6%)	7.5% (5.7% - 9.3%)

Adults who have a vision disability, Ages 65 & Older		
Year	Wakulla	Florida
2019	4.8% (1.5% - 8.1%)	7.5% (6.3% - 8.8%)
2016	11.3% (6.7% - 15.9%)	7.3% (6.2% - 8.3%)
2013	5.5% (0.9% - 10.1%)	5.6% (4.8% - 6.3%)

Wakulla County residents who have a hearing disability is highest with those who are elderly (16.7%) which exceeds the State (14.8%). No data was collected on African Americans during the collection period. White residents represented 4.9%, which is less than the State (8.4%).

Adults who have a hearing disability, Non-Hispanic White		
Year	Wakulla	Florida
2019	4.9% (1.8% - 8%)	8.4% (7.5% - 9.2%)
2016	9.7% (6.8% - 12.7%)	7.7% (7.1% - 8.3%)

Adults who have a hearing disability, Non-Hispanic Black		
Year	Wakulla	Florida
2019		4.1% (2.4% - 5.8%)
2016		3.8% (2.4% - 5.2%)

Adults who have a hearing disability, Ages 65 & Older		
Year	Wakulla	Florida
2019	16.7% (8.2% - 25.3%)	14.8% (13.2% - 16.3%)
2016	12.8% (8.2% - 17.4%)	13.6% (12.4% - 14.9%)

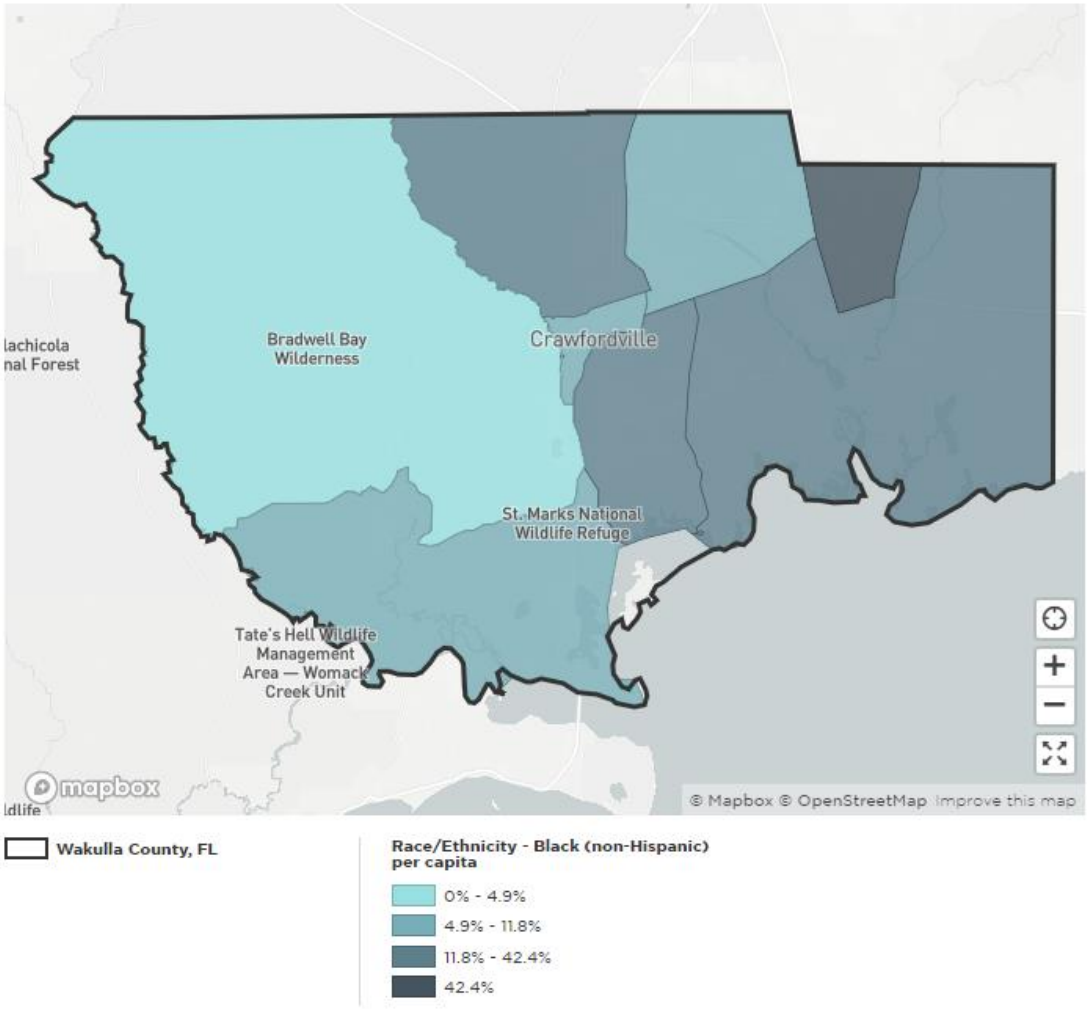
Wakulla County residents who are affected by a mobility issue is lower than the State. Those who are African American/Black has historically exceeded the State by at least 10%. No data was collected on African American in 2019; however, the trend would lean toward mobility continuing to be higher than the State.

Adults who have a mobility disability, Non-Hispanic White		
Year	**Wakulla**	**Florida**
2019	14.2% (7.2% - 21.1%)	17% (15.8% - 18.2%)
2016	17.8% (13.6% - 22.1%)	17.2% (16.3% - 18.1%)
2013	12.9% (9.2% - 16.6%)	16.1% (15.2% - 16.9%)

Adults who have a mobility disability, Non-Hispanic Black		
Year	**Wakulla**	**Florida**
2019		17.8% (14.2% - 21.4%)
2016	29.8% (12.4% - 47.2%)	16% (13.4% - 18.6%)
2013	36.7% (6.8% - 66.5%)	14.8% (12.4% - 17.1%)

Adults who have a mobility disability, Ages 65 & Older		
Year	**Wakulla**	**Florida**
2019	19.2% (11.8% - 26.7%)	29.1% (26.7% - 31.4%)
2016	31.6% (24.4% - 38.8%)	26.3% (24.5% - 28%)
2013	38.8% (28.4% - 49.1%)	26.5% (24.8% - 28.2%)

The map below shows where African American/Black residents reside within Wakulla County.



Sources: EPA Smart Location Database 2019; US Census Bureau ACS 5-year 2016-2020

Sources: US Census ACS 5-year

VII. SDOH DATA

The Social Determinants of Health (SDOH) are conditions in the places where people live, learn, work, and play that affect a wide range of health and quality-of life-risks and outcomes. The SDOH can be broken into the following categories: education access and quality, health care access and quality, neighborhood and built environment, social and community context, and economic stability. Some of the conditions which affect the five SDOH relative in Wakulla County are outlined below:

A. Education Access and Quality

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

How many residents have access to educational opportunities?

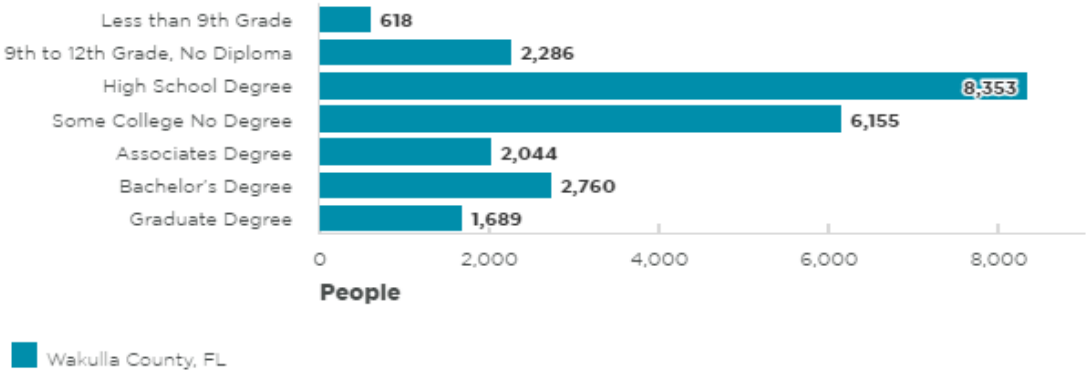
It is commonly known that good habits like eating well, maintaining a good weight, not smoking, and getting regular checkups can lead to better health. What is not as widely known is that access to quality education has been correlated to better health outcomes and possibly a longer life. In fact, individuals who graduate college live up to five years longer than those who did not graduate from high school. For this reason, the CDC considers education one of the top five social determinants of health (SDOH).[4]

Education improves nearly every factor impacting an individual's health. Literacy and the ability to understand health information is correlated with longer lifespans, greater educational attainment improves economic opportunity, and high school graduation is a critical predictor for whether an individual will be exposed to violent crime in their lifetime. Lifelong educational outcomes begin in preschool. Enrollment in a high-quality preschool often predicts lifelong educational and health outcomes.

A more educated community builds a stronger foundation for economic success, and directly impacts the overall well-being. Educational attainment shows the knowledge and skills of residents and identify areas where efforts to increase educational attainment would be most impactful.

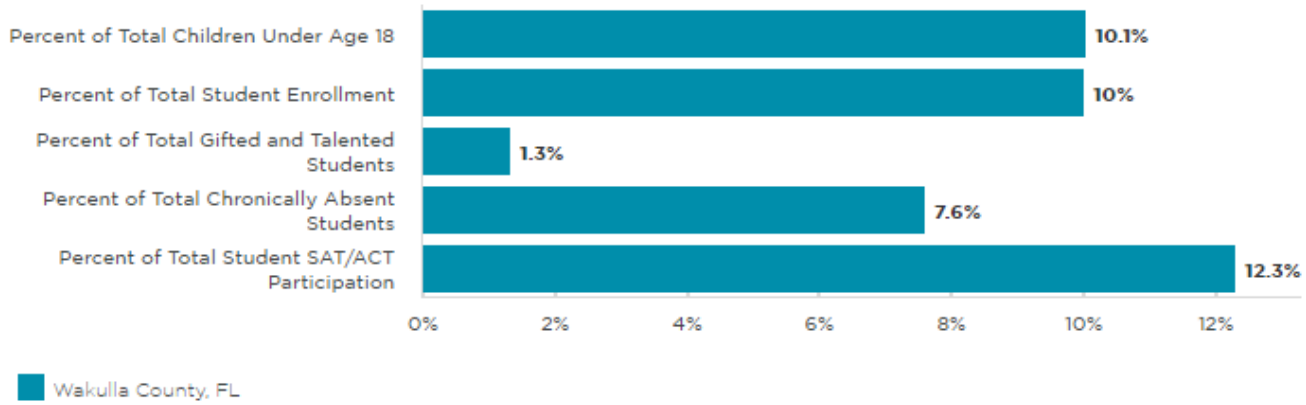
[4] Social Determinants of Health: Education Access and Quality - myNEXUS® (mynexuscare.com)

Educational Attainment



Sources: US Census Bureau ACS 5-year 2016-2020

Black Students At-A-Glance

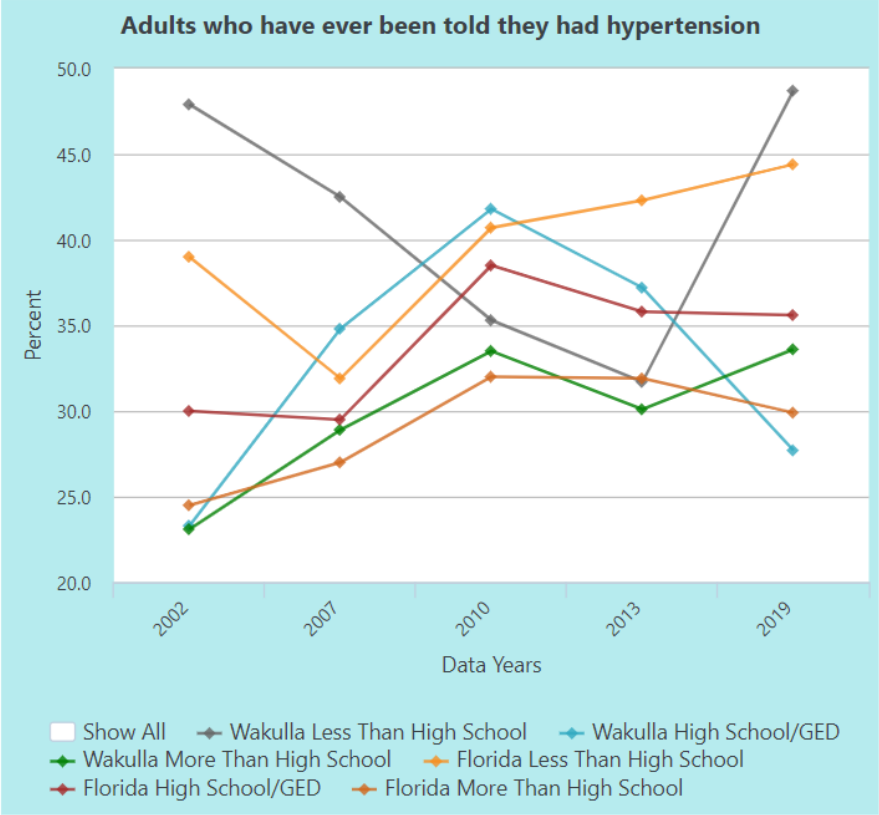


Sources: CRDC 2017-2018; US Census Bureau ACS 5-year 2016-2020

- **The impact of education access and quality on Hypertension**

Education Access and Quality: From 2013 to 2019, the percent of adults who have a high school diploma have been told they have hypertension has declined significantly to 28%, while those who didn't finish high school have seen their percentage jump to near 50%. Programs which help students finish high school should lower the residents being diagnosed with hypertension later in life.

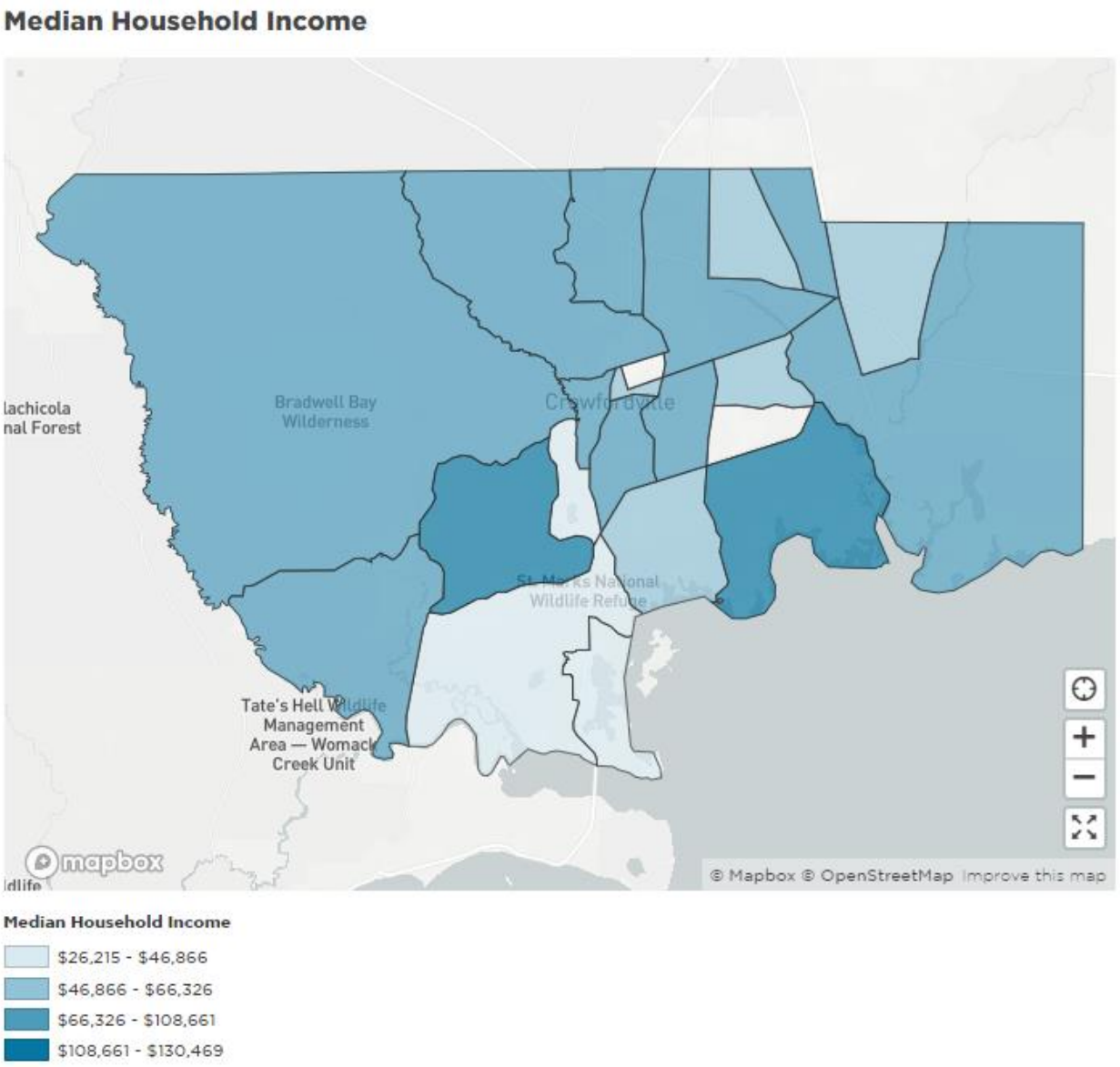
The chart below shows a higher propensity to have hypertension if less than a high school diploma. There is about a 20% decrease in people who graduated high school versus those that did not of adults who have ever been told they had hypertension in Wakulla County.



B. Economic Stability

- **Economic stability data for Wakulla County**

People with steady employment are less likely to live in poverty and more likely to be healthy, but many people have trouble finding and keeping a job. People with disabilities and injuries, may be especially limited in their ability to work. In addition, many people with steady work still don't earn enough to afford the things they need to stay healthy.



Sources: US Census Bureau ACS 5-year 2016-2020

Unemployment

Employment is the very foundation of economic opportunity. Unemployment makes it difficult, if not impossible, to meet life's basic needs and even a brief period of unemployment can negatively impact an individual's earnings for up to 20 years. Middle skill jobs often provide better wages than lower skill jobs, but also often require training or education beyond high school.

15,244
Labor Force Population
Wakulla County, FL

3.2%
Unemployment Rate
Wakulla County, FL

Sources: US Census Bureau ACS 5-year 2016-2020

5,389
Jobs by workplace location
Total Jobs
Wakulla County, FL

No data
Jobs
Jobs within 1/2 Mile of Transit Stop
Wakulla County, FL

3.2%
of total labor force
Unemployment Rate
Wakulla County, FL

$67,480
USD
Median Household Income
Wakulla County, FL

26.1%
of total jobs
Low Wage Jobs
Wakulla County, FL

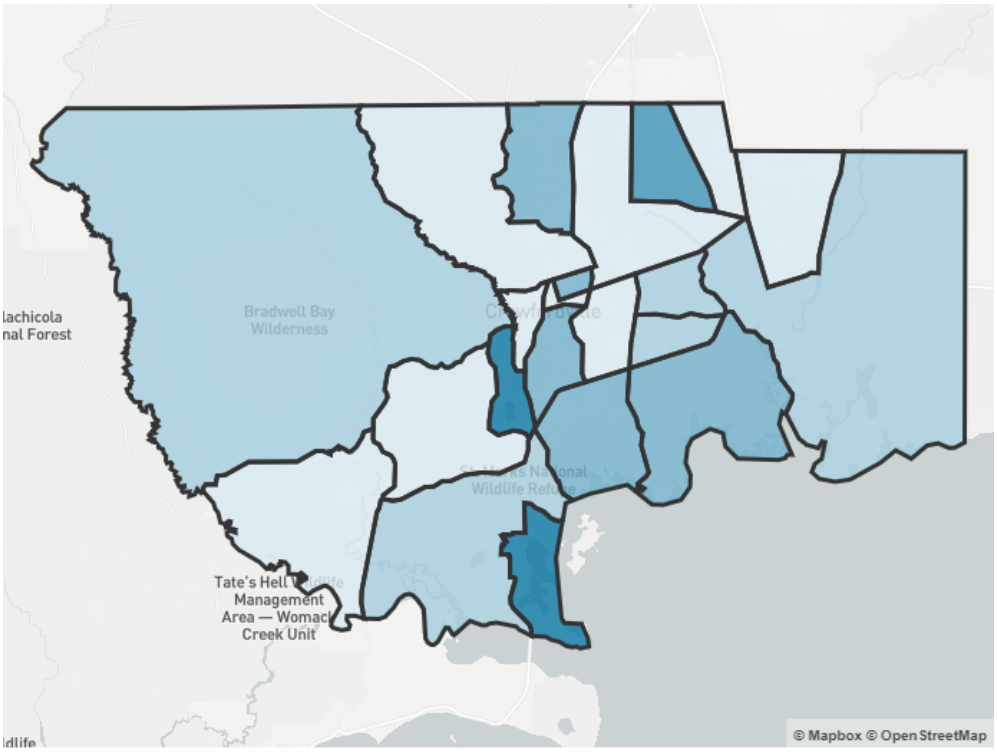
27%
of total population
Low Income Residents
Wakulla County, FL

Sources: EPA Smart Location Database 2019; US Census Bureau ACS 5-year 2016-2020

Note: Low wage jobs are as those where workers earn $1250/month or less. Low income residents is defined as the population that is living 200% or below poverty level.

Poverty Levels

The U.S. Census identifies individuals with a household income of up to 200% of the poverty level as low income. Low-income residents in communities with high income inequality face greater health risks. They are more likely to face barriers to healthy choices, such as longer distances to healthy food or affordable healthcare and are more likely to be exposed to environmental risks, such as low-quality housing.



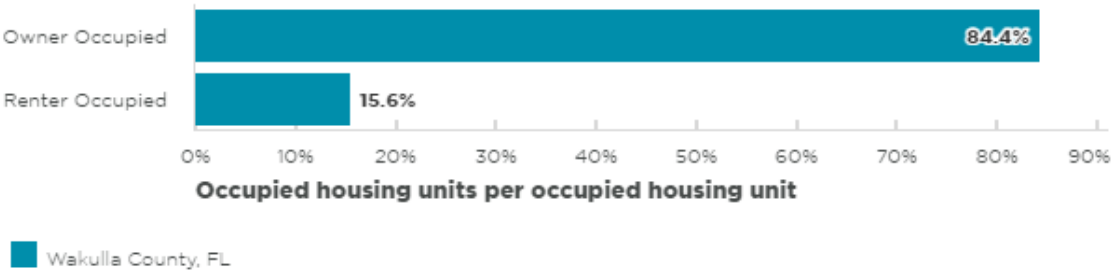
Sources: US Census Bureau ACS 5-year 2016-2020

27%
Ratio of Income to Poverty Level: 200% and Under - Low Income Population
Wakulla County, FL

7.5%
Percent of Population Below Poverty Level
Wakulla County, FL

Sources: US Census Bureau ACS 5-year 2016-2020

Occupied Owner vs Renter Occupied



Sources: US Census Bureau ACS 5-year 2016-2020

11,382
Occupied housing units
Occupied Housing Units
Wakulla County, FL

667
Vacant housing units
Vacant Housing Units
Wakulla County, FL

15.4%
Cost Burdened Homeowners
Wakulla County, FL

32.2%
Cost Burdened Renters
Wakulla County, FL

Sources: US Census Bureau ACS 5-year 2016-2020

Note: Vacant housing units includes those for reasons of foreclosure, personal/family reasons, held in legal proceedings, preparing to rent/sell, held for storage of household furniture, needs repairs, currently being repaired/renovated, specific use housing, extended absence, abandoned/possibly to be demolished/possibly condemned, and reason for vacant unknown

Income Spent on Housing and Transportation

59.8%
of income for median income families
Income Spent on Housing and Transportation (2012)
Wakulla County, FL

61.6%
of income for median income families
Income Spent on Housing and Transportation (Current)
Wakulla County, FL

Sources: US HUD & DOT LAI V2.0 2012; US HUD & DOT LAI V3.0 2016

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

High blood pressure is the most common chronic medical problem prompting visits to primary health care providers, yet it is estimated that only 34% of the 50 million American adults with hypertension have their blood pressure controlled to a level of <140/90 mm Hg. Thus, about two thirds of Americans with hypertension are at increased risk for cardiovascular events. The medical, economic, and human costs of untreated and inadequately controlled high blood pressure are enormous.[5]

Economic Stability: Wakulla County's African Americans and the elderly have low median incomes.

C. Neighborhood and Built Environment

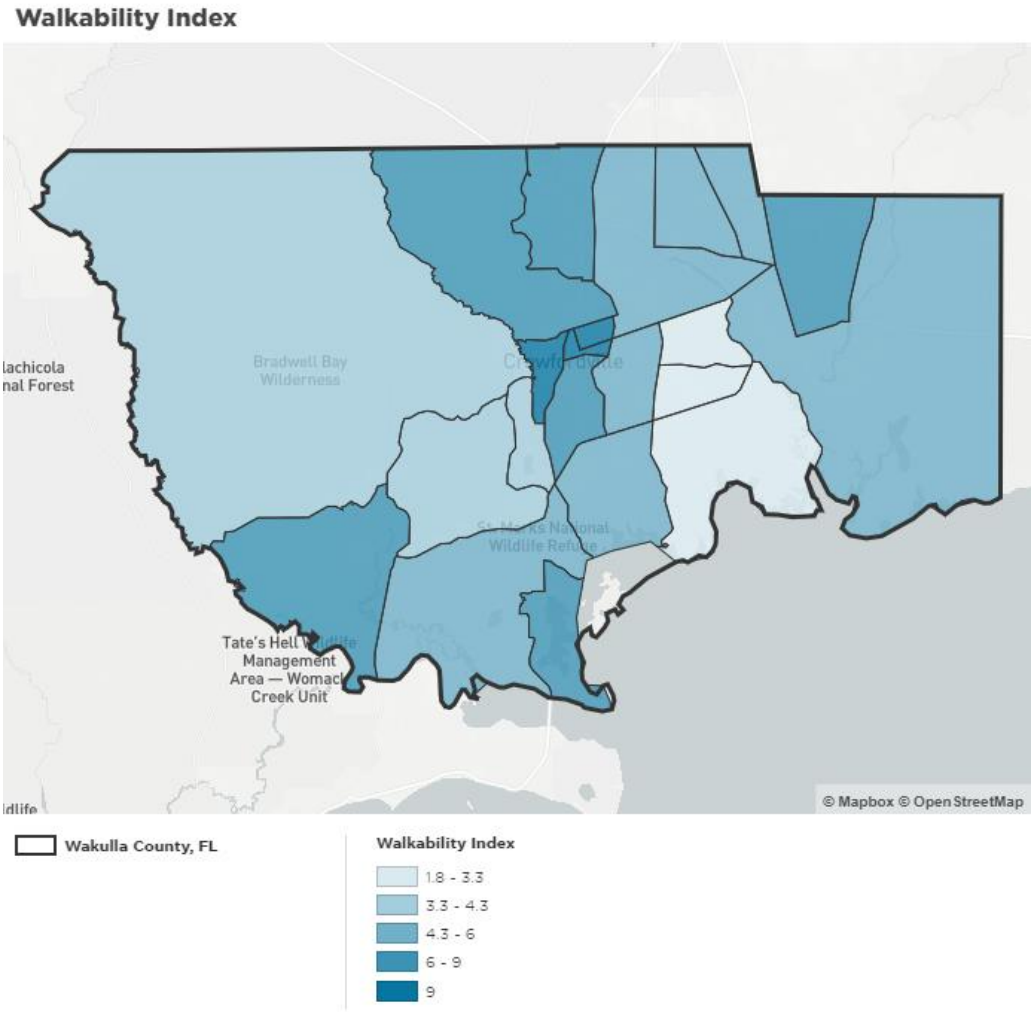
- **Neighborhood and built environment data for Wakulla County**

Walkability is a measure used to indicate the ease of pedestrian travel in an area. Scores start out at 1 and go up to 20, with scores closer to 1 indicating lower walkability and scores closer to 20 indicating higher walkability. Once you know which areas of your community are walkable and which are struggling, you can make more informed decisions about what kind of pedestrian improvements are needed and where. Wakulla County has a walkability index score of 5.4.

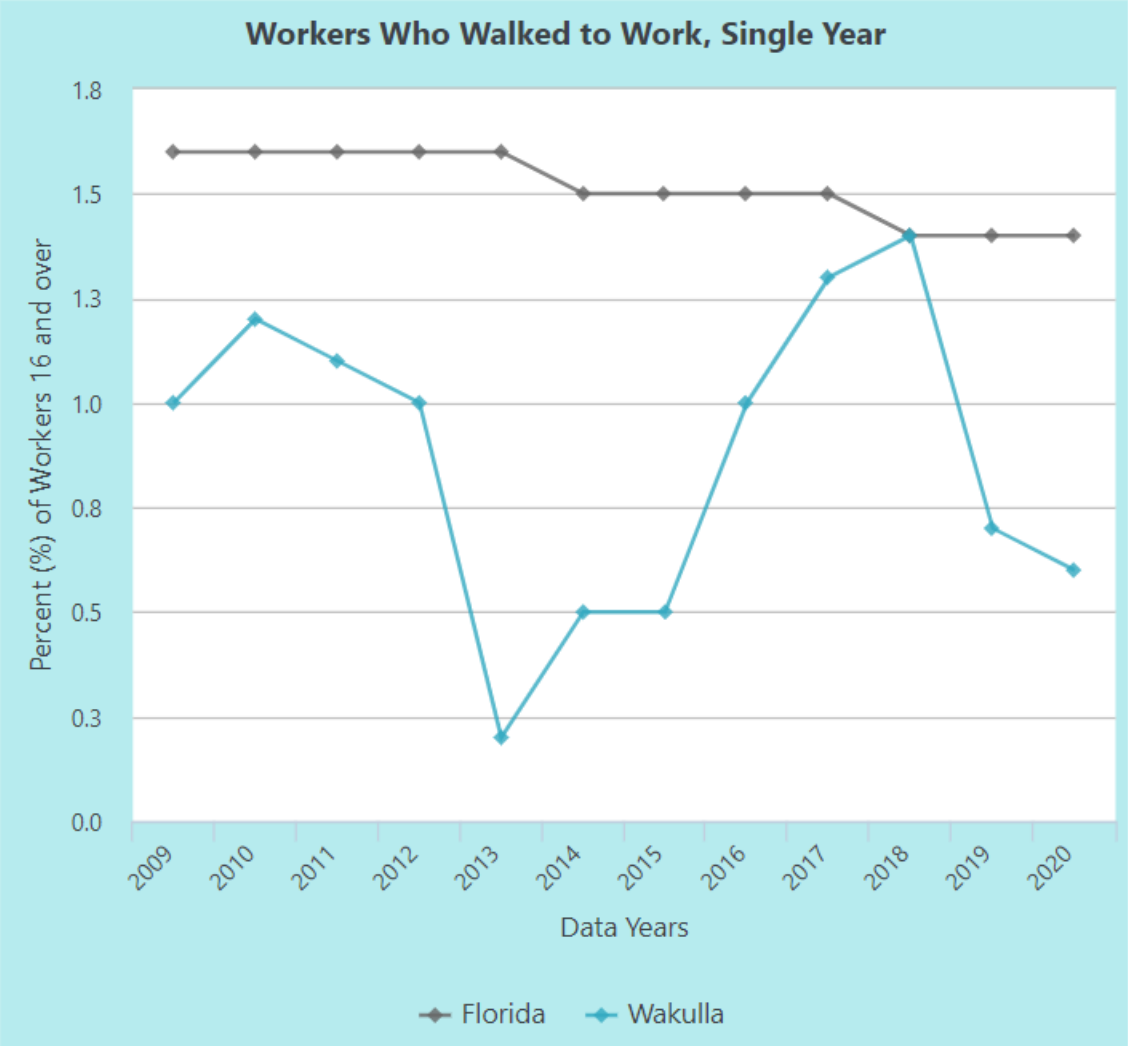
Walkability has a relationship with health benefits (by providing an active lifestyle), sustainable environment (by decreasing air pollution from less driving), and lead to efficiency in time and cost (residents of mixed-use walkable communities spend less time commuting to the shopping, dining, recreation, entertainment and even work destinations when they have the option of walking wherever they need to go).The factors that make a neighborhood walkable are:

[5] The economic impact of hypertension in the United States - PMC (nih.gov)

- **A center**: Walkable neighborhoods have a center, whether it's the main street or a public space.
- **People**: Enough people for businesses to flourish.
- **Mixed-income, mixed-use:** Affordable housing located near businesses.
- **Parks and public space**: Plenty of public places to gather and play.
- **Pedestrian design:** Buildings are close to the street and parking lots are relegated to the back.
- **Schools and workplaces:** Close enough that most residents can walk from their homes.
- **Complete streets:** Streets mostly designed for cyclists and pedestrians.



Under one percent of Wakulla County residents walk to work. The workers who are walking to work over the age of 16 accounts for under 1% of the population.



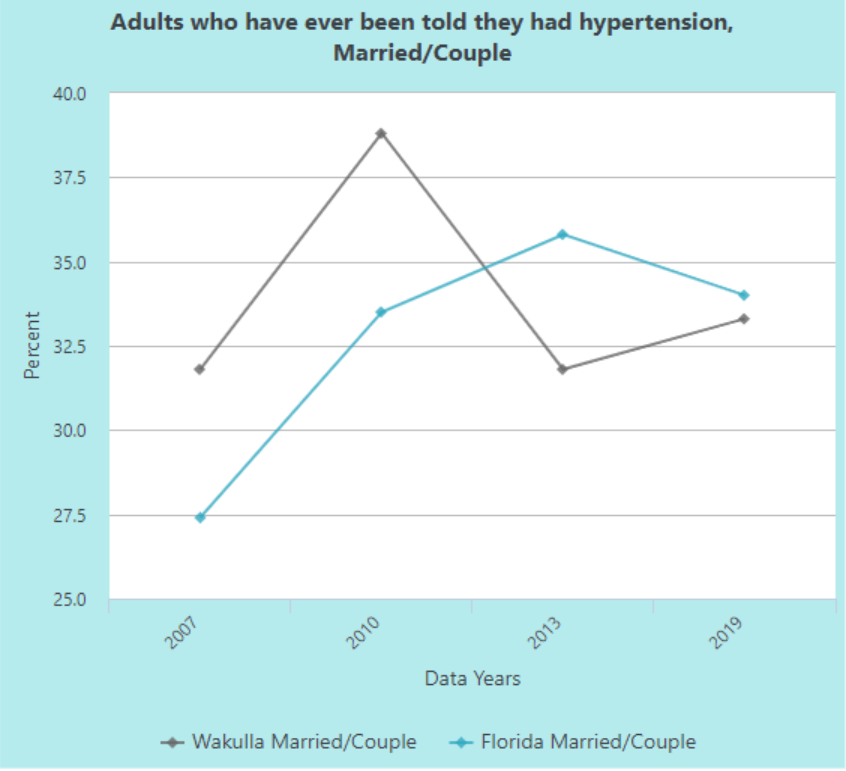
- **The impact of neighborhood and built environment on Hypertension**

Walkability is an important factor in livability because it promotes active forms of transport. Increasingly physically inactive and sedentary lifestyles contribute to around 3.2 million preventable deaths a year.

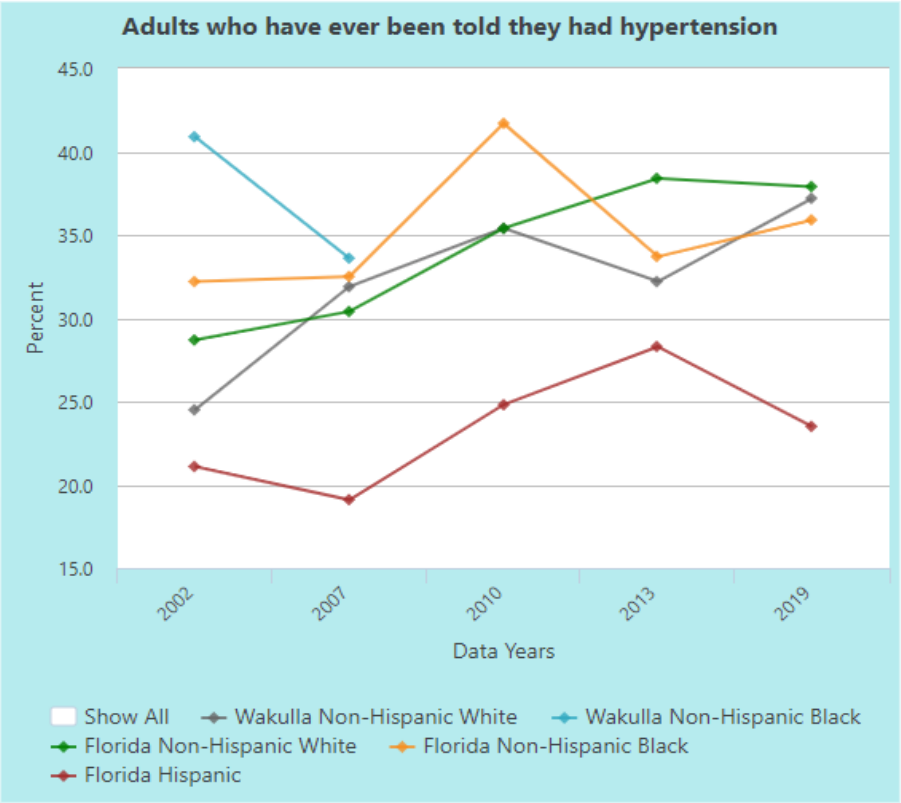
D. Social and Community Context

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

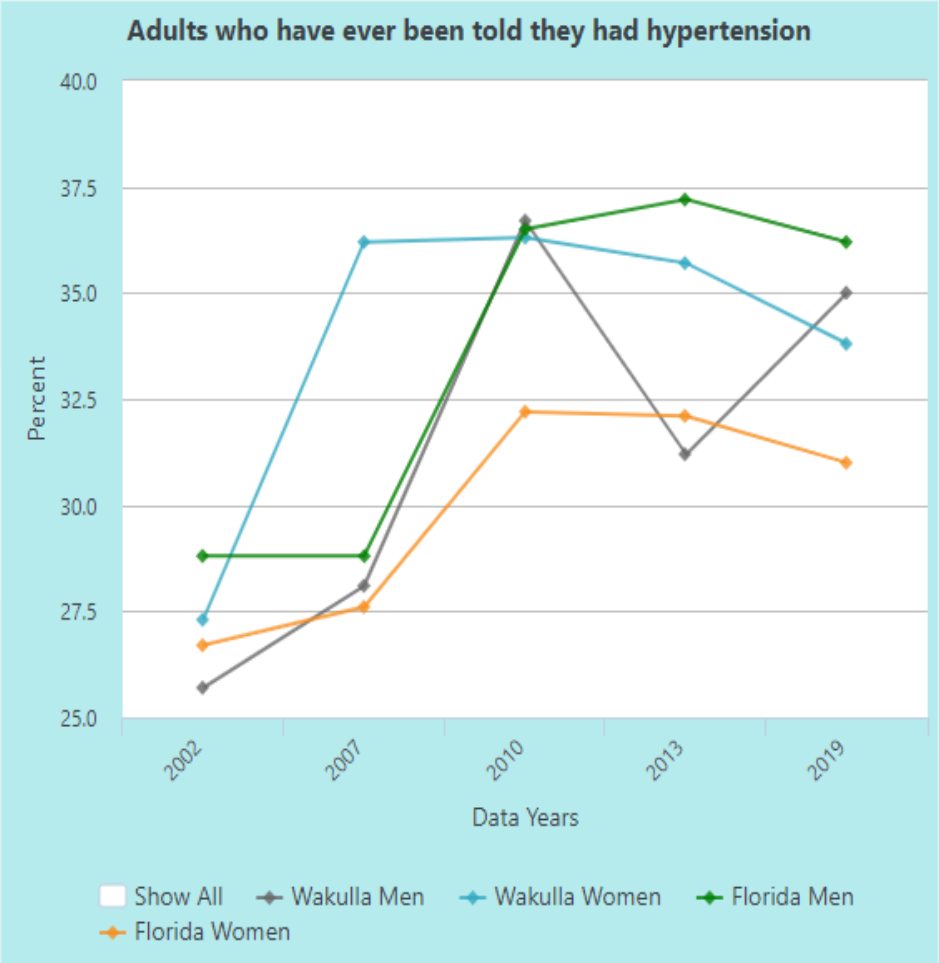
The social and community context in which people live includes the relationships formed between neighbors and their social and civic connections. Those who are married in Wakulla County who have been diagnosed with hypertension is lower than the State.



The figure below shows the proportion of adults who were told they had hypertension by race and ethnicity in Wakulla County and Florida from 2002 to 2019. What this graph emphasizes is the significant lack of data in hypertension in Wakulla County for the priority populations during this period.



The figure below shows the proportion of adults who were they had hypertension by sex Wakulla County and Florida from 2002 to 2019. While men are consistently higher in hypertension than women, in Wakulla County. The Wakulla County proportions for women are trending down and more aligned with the State. While the men in Wakulla County have a sharp increase from 2013 to 2019, although they are still lower than the State.

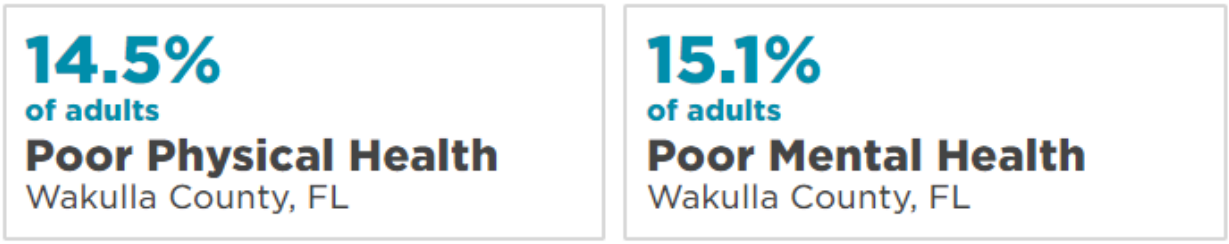


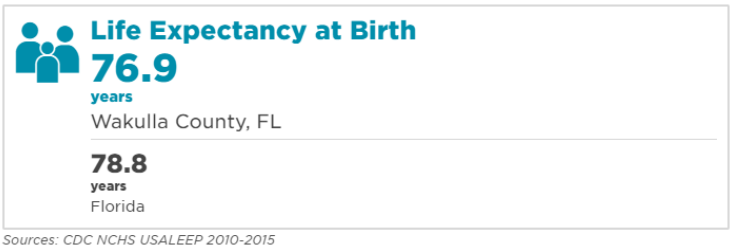
- **The impact of social and community context on Hypertension**

Social networks influence hypertension: Traditional risk factors for hypertension includes smoking, body mass index, and leisure-time physical activity. Factors such as social disadvantage, neighborhood conditions, low socioeconomic status, and disparities in healthcare resources are also associated with high instances of hypertension.[6]

E. Health Care Access and Quality

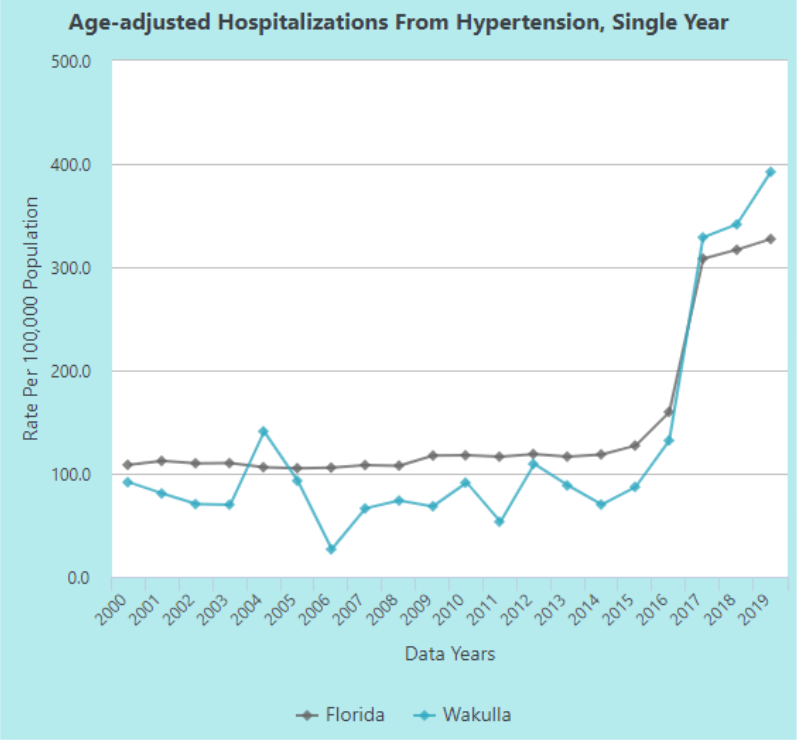
- **Health care access and quality data for Wakulla County**



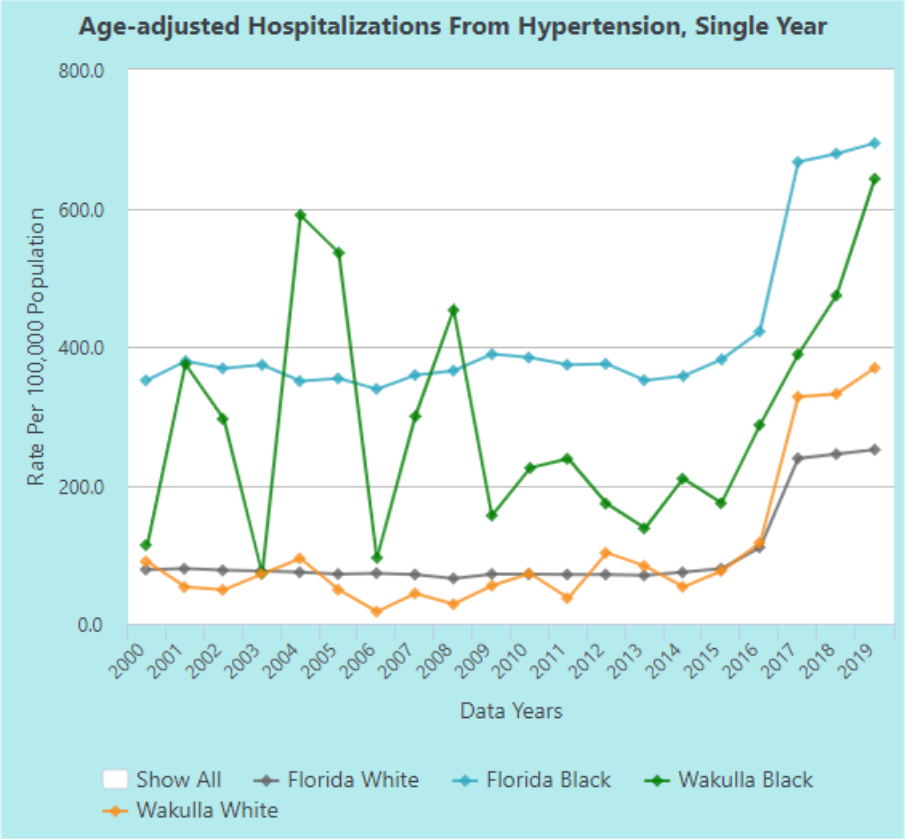


[6] Associations Between Social Determinants and Hypertension, Stage 2 Hypertension, and Controlled Blood Pressure Among Men and Women in the United States – nih.com

This graph reflects the significant increase in hospitalizations from hypertension from 2014 to 2019 in Wakulla County. Some patients with hypertension may feel fine, but when patients are diagnosed with hypertension, they are at higher risk for heart attacks, stroke, heart failure, poor circulation, and blood clots.

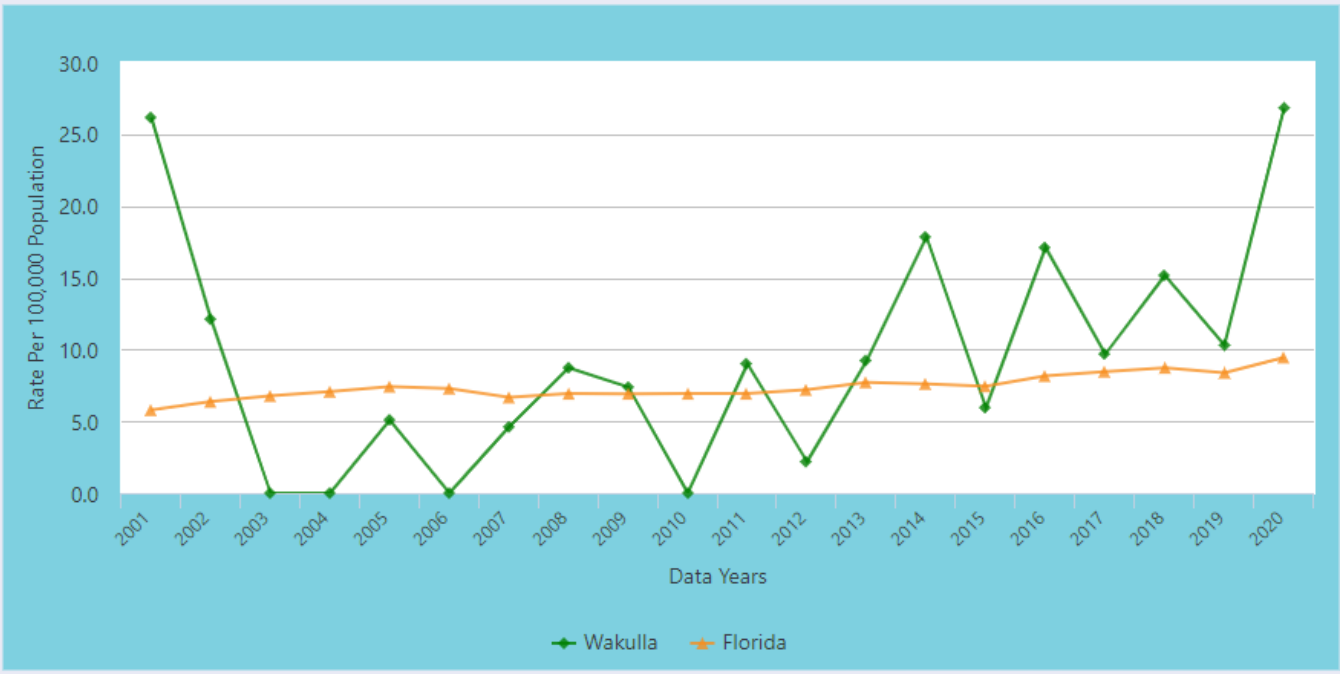


The African American priority population in Wakulla County has been on a sharp upward trend since 2015.

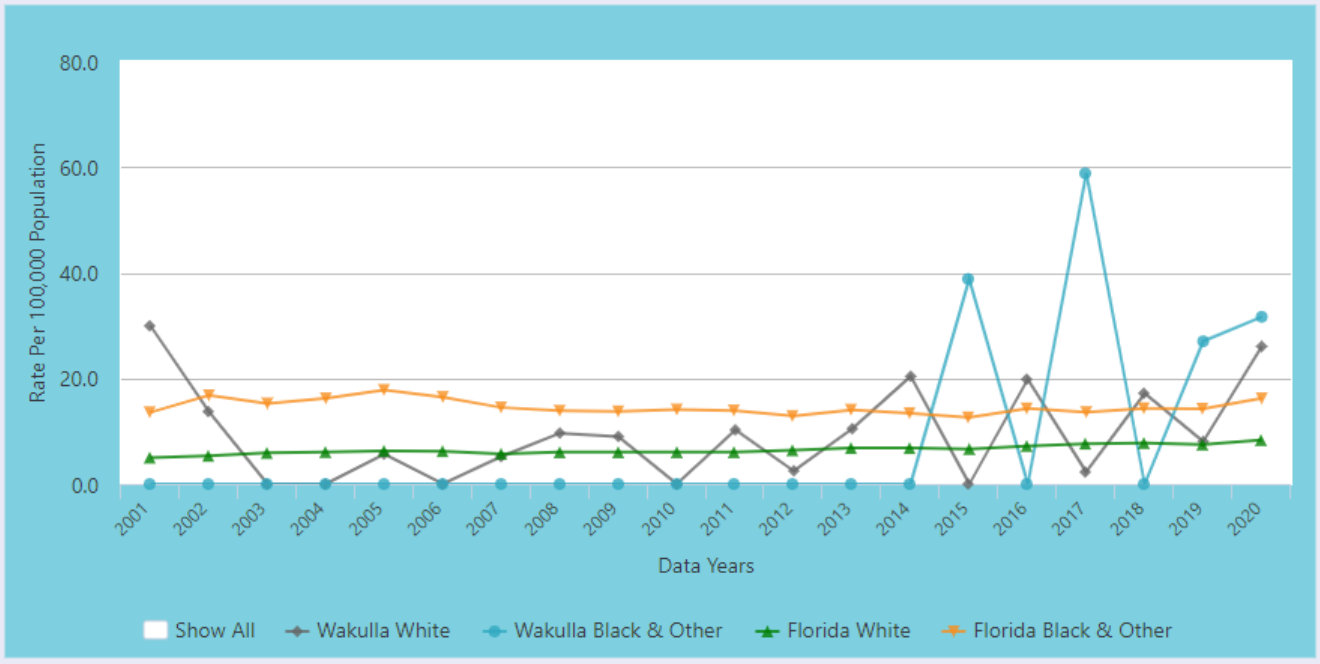


The following charts illustrate the number of deaths from hypertension. Hypertension can be caused by strokes, heart attacks, heart failure, kidney failure, consistently not taking blood pressure medications. As the number of hospitalizations increased in Wakulla County, so did the number of hypertension related deaths across all of the priority populations, especially the elderly.

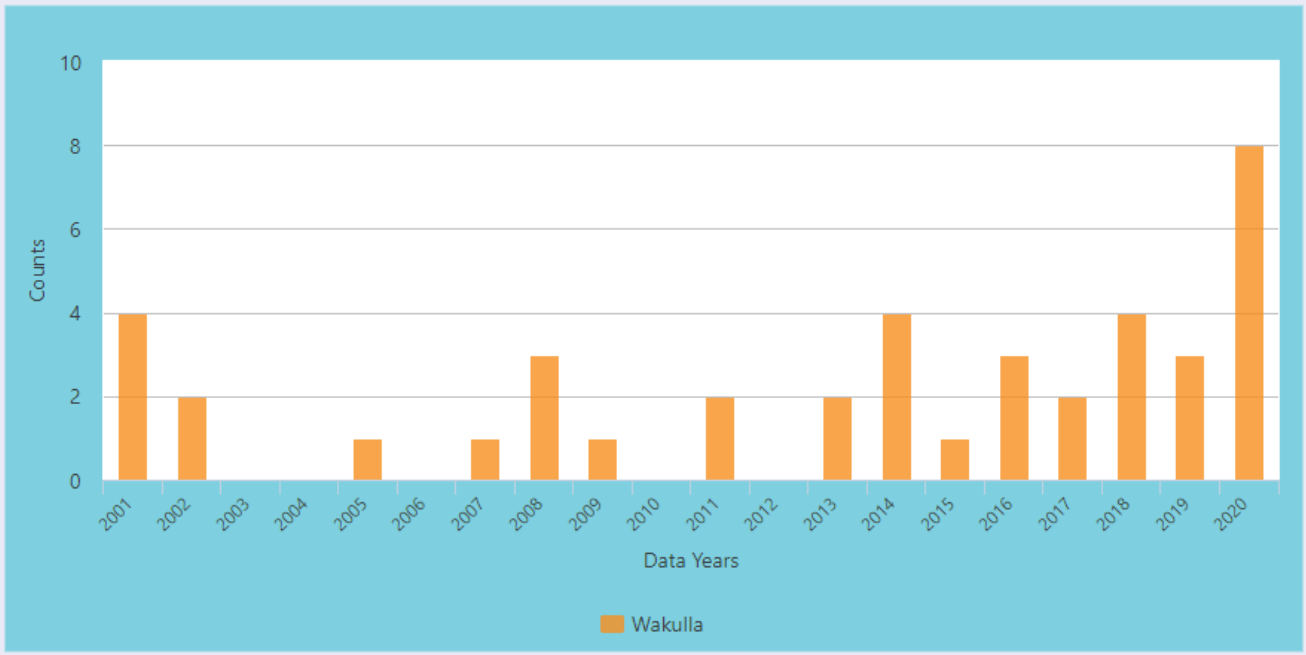
Age-adjusted Deaths From Hypertension, Single Year



Age-adjusted Deaths From Hypertension, Single Year



Deaths From Hypertension, Age 65-100, Single Year



** Click a legend category to hide or show that category.*

- **The impact of health care access and quality on Hypertension**

"Annualized healthcare expenditures in the United States were $2,000 higher for hypertension compared with non-hypertensive peers, 2.5 times the inpatient cost, almost double the outpatient cost, and nearly triple the prescription medication expenditure. The excess utilization of and expenditures associated with hypertension account for about $131 billion. This warrants intense effort toward hypertension prevention and management."[7]

Access to health services is an important step toward reducing health disparities.

- The number of physicians (11) grants the ability for residents to find a physician that meets their needs and health care goals.
- Residents identified dental and oral health as a top health concern and with only 5 dentists (increased by 1 in last 10 years), this can be alarming as poor dental health also affects overall health, employment, and well-being.
- Health care system walk in clinics are accessible for residents enabling timely access to care.

VIII. SDOH PROJECTS

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

A. Data Review

The Health Equity Taskforce reviewed data, including health disparities and SDOH provided by the Health Equity Team. The Health Equity Taskforce also researched evidence-based and promising approaches to improve the identified SDOH. The Health Equity Taskforce considered the policies, systems and environments that lead to inequities.

[7] Trends in Healthcare Expenditures Among US Adults With Hypertension – nih.com.

The 2022 Wakulla County's Community Health Assessment identified the leading causes of death that were identified were types of chronic disease: heart disease, cancer, and chronic lower respiratory disease. The identified priority populations were African American and elderly (65+).

B. Barrier Identification

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

C. Community Projects

The Health Equity Taskforce researched evidence-based strategies to overcome the identified barriers and improve the SDOH that impact the prioritized health disparity. The Health Equity Taskforce used this information to collaboratively design community projects to address the SDOH. During project design, the Health Equity Taskforce considered the policies, systems and environments that lead to inequities. Projects included short, medium, and long-term goals with measurable objectives. These projects were reviewed, edited, and approved by the Coalition to ensure feasibility.

Short Term: Offer Walkability Survey to civic organizations, task force(s) and health equity coalition members, local businesses, minority churches and the Wakulla Senior Citizens program participants and staff.		
Social Determinates of Health	**Barriers & Themes**	**Collaborative Strategies**
Neighborhood & Built Environment	U.S. mail (incorrect addresses, would have to include postage paid envelope for return, some residents only have P.O. Boxes and don't check mail on regular basis)	Utilize meetings and group members to help distribute to selected groups, provide printed surveys at the public library.
Education Access & Quality	Distribution methods –web-based (some may not feel comfortable with using web-based program, i.e., survey monkey, readability, more familiar with a language other than English)	Make available in Spanish Provide DOH HE/MH staff member is available to explain questions, assist with surveys
Economic Stability	Lack of internet connection to due to high cost	Provide QR code cards with link to survey at public library for patrons to use library computers
Health care access & quality	N/A	N/A
Social & Community Context	Distribution in person can be time-consuming and would require printed surveys or another way to provide access to a web-based survey.	Provide folder of printed surveys and cards with QR codes for survey to civic organizations' presidents, chair, etc. to distribute to members after a brief Health Equity presentation by Health Equity Team. Printed surveys will be distributed to churches, the library, and the senior center.
Short Term: Create a research project and follow-up report identifying the non-majority populations in Wakulla County.		
Social Determinates of Health	**Barriers & Themes**	**Collaborative Strategies**
Neighborhood & Built Environment	Web-based surveys are difficult to retrieve, many people have issues with connectivity, if they don't know the	Utilize meetings and group members to help distribute to selected groups, provide printed surveys at the public library.

	person(s) sending the emails, they will most likely not answer.	
Education Access & Quality	Readability will be important, especially for Hispanic residents and those with limited educational skills. Some residents do not know how to use a computer if the survey is sent via email.	Make available in Spanish Provide DOH HE/MH staff member is available to explain questions, assist with surveys
Economic Stability	Internet connectivity is an issue due to the high expense.	Provide links and QR codes at the library so that free public computers can be used.
Health care access & quality	N/A	N/A
Social & Community Context	Residents may feel uneasy when approached by someone new to fill out a survey.	Provide "familiar" faces from DOH to explain the purpose of the survey and distribute it. Select a "representative" from the organization to distribute and collect printed surveys.

Mid-Term: Offer monthly Wellness Walks

Social Determinates of Health	Barriers & Themes	Collaborative Strategies
Neighborhood & Built Environment	Lack of wide sidewalks on busy roads, pedestrians and cyclists having to share same space on roadside, multiuse paths not kept clear of brush, vines, etc., no lights for evening, early morning walking, wildlife	Involve Keep Wakulla County Beautiful and Sheriff's Office work crews to maintain paths and sidewalks, educate walking groups about local wildlife, include lights in walkability index, provide a "walking kit" for participants that include flashlight, water bottle, cooling cloth, reflective band, etc.
Education Access & Quality	When offering testing or print information, language may be an issue, familiarity with distances, i.e., quarter mile, half mile, etc.	Ensure readability is on par with acceptable grade level, add easy-to read graphics to information, have team member who can translate information into Spanish (most common language in the County other than English)
Economic Stability	Involving people who work	Offer incentives to employers who allow employees to take a walk break, create walking clubs for businesses, educate employers on the positive effects of walking, exercise for their workforce, create and maintain regular schedule of walks

Health care access & quality	N/A	N/A
Social & Community Context	Involving groups and individuals, lack of transportation to walking paths, multiuse paths, etc., differing locations within the county	Create walking clubs, community events around walking, offer to faith-based programs, create walking contests for groups/businesses, offer incentives for attending or walking certain distances, etc., involve school students and their families in school contests
Long Term: Increase walkability index		
Social Determinates of Health	**Barriers & Themes**	**Collaborative Strategies**
Neighborhood & Built Environment	Smooth, safe surfaces, clear from obstacles, located in all community areas where residents may not have access to physical activity and/or exercise	Inspection of existing pathways, ensure smooth surfaces when building new pathways so that those using ability aids will feel safe, build paths and sidewalks in outlying communities – St Marks, Woodville, Panacea and Sopchoppy
Education Access & Quality	Awareness of locations for walking paths/trails/multiuse path, map-reading	Have signage that provides maps of walking paths, distances, rules
Economic Stability	Funding sources may be reduced or eliminated	Ensure funding through FDOT and grants
Health care access & quality	N/A	N/A
Social & Community Context	Encouraging use by community groups and individuals, involvement of Board of County Commissioners, how to make further construction viewed as positive	Place information about times, locations, etc. on County websites, post in stores, restaurants, social media, show people enjoying paths and sidewalk to illustrate the positive effects of building them

Crawfordville Connectivity

Location

Crawfordville, FL

Narrative

PROPOSED PROJECT:

- Introduce well-connected, multimodal networks with bicycle and pedestrian infrastructure to increase the options for safe routes of travel.
- Design, permit and construct sidewalks throughout the *Crawfordville Town Plan* boundary to increase walkability, pedestrian access, and overall connectivity.
- Design, permit and construct a network of countywide, multi-use trails to improve safety, reduce motor vehicle-related injuries and fatalities, and provide links between neighborhoods, parks, business centers, transit stations and waterfront areas.

EXISTING CHARACTERISTICS:

- Multi-use trails within the Crawfordville Town Plan are currently limited to Azalea Park and the Shadeville Multi-Use Path.

PROJECTS: TRAILS, BLUEWAYS & TRAILHEADS

ADDITIONAL INFORMATION:

- As per Section 5-62 of the Land Development Code, all new developments are required to provide sidewalks along all public and private streets adjoining the development, with the exception of a single-family residence constructed on an existing lot of record.
- Refer to the *Crawfordville Town Plan*.
- See *Connector Trails*, page 118

Cost Estimate: TBD

Panacea Pedestrian Improvements

Location

Panacea, FL

Narrative

PROPOSED PROJECT:

- Increase pedestrian access and connectivity through the construction of sidewalks in the following areas:
  - Otter Lake Road – Panacea Community Center to St. Marks National Wildlife Refuge (approximately 0.5 miles)
  - Jer-Be-Lou Boulevard
  - Walker Street
  - Mound Street
  - Piney Street
  - Clark Avenue
  - Rock Landing Road
- Provide direct access to recreational facilities, businesses, and commercial areas
- Provides safe routes throughout residential neighborhoods.
- Add golf cart crossing over Coastal Highway.

EXISTING CHARACTERISTICS:

- Existing 5-foot-wide sidewalk along Coastal Highway (US 98) from Bud Crum Road to Mound Street with pedestrian crosswalks at Wakulla Welcome Center, Panacea Area Water System, Panacea Plaza. Additional pedestrian access from Coastal Highway down Otter Lake Road to the Panacea Community Center.

PROJECTS: SIDEWALKS

ADDITIONAL INFORMATION:

- Use a combination of sidewalks, crosswalks, and signage to provide added mobility for users. Recommendations were adapted from the Panacea Walkable Waterfronts Florida Community Group Pedestrian Project.
- See *Accomplishments and Updates 2016 – 2020*, pages 6-12

Estimated Cost: TBD

126

St. Marks Connectivity

Location

St. Marks, FL

Narrative

PROPOSED PROJECT:

- Increase pedestrian access and connectivity through the construction of sidewalks in the following areas:
  - Pirate's Cove Lane, Shell Island Road, Ward Street, Port Leon Drive, Whaley Street, Sylvania Avenue, Forbes Street, Crabapple Lane, City Park Avenue, Union Street, Mock Street and Riverside Drive

EXISTING CHARACTERISTICS:

- The City of St. Marks has limited pedestrian infrastructure with an existing sidewalk along portions of Port Leon Drive.

PROJECTS: TRAILS, BLUEWAYS & TRAILHEADS

ADDITIONAL INFORMATION:

- The Tallahassee-St. Marks Historical Railroad State Trail includes a 16-mile stretch of hard-surface, multi-use trail for bikers and hikers from Florida's Capital to the Gulf of Mexico. The City of St. Marks is located at the southern terminus of the trail, along with the San Marcos de Apalache Historic State Park. For more information on these recreational facilities, visit the Florida State Parks website at https://www.floridastateparks.org/.

Cost Estimate: TBD

122

Sopchoppy Connectivity

Location

Sopchoppy, FL

Narrative

PROPOSED PROJECT:

- Expand the multi-use trail connectivity currently serving the City of Sopchoppy, extending through downtown via Rose Street and connecting to the Apalachicola National Forest.
- Enhance walkability and increase pedestrian infrastructure through the construction of sidewalks along:
  - Yellow Jack Road from Mill Street to Gulf Street
  - Municipal Avenue, beginning at Argyle Street and extending to Gulf Street
  - Gulf Street from Municipal Avenue to Park Avenue
  - Connect the Myron B. Hodge City Park to downtown Sopchoppy via Park Avenue, beginning on at the Gulf Street intersection

EXISTING CHARACTERISTICS:

- Existing pedestrian infrastructure is limited to Rose Street, spanning from Winthrop Avenue to Yellow Jacket Road, and Municipal Avenue from Rose Street to Argyle Street.
- The Ochlocknee Bay Bike Trail (OBBT) currently begins in Sopchoppy but does not connect to the downtown area.

PROJECTS: TRAILS, BLUEWAYS & TRAILHEADS

ADDITIONAL INFORMATION:

- See *OBBT*, page 110

Cost Estimate: TBD

Wakulla County Senior Center to Community Center and Commercial Facilities

Location

33 Michael Drive, Crawfordville. FL

Narrative

PROPOSED PROJECT:

- Construct 5-foot-wide concrete sidewalk connecting the Wakulla Senior Citizens Center to local businesses and community services to increase walkability, pedestrian access, and connectivity.
- Provide direct access to recreational facilities, businesses, and commercial areas.
- Provide safe routes throughout residential neighborhoods

EXISTING CHARACTERISTICS:

- Existing pedestrian infrastructure includes a 5-foot-wide sidewalk beginning at the Wakulla County Senior Center on Michael Drive, moving south down Oak Street, with a pedestrian crossing over Wakulla Arran Road. The sidewalk continues down Wakulla Arran Road to Crawfordville Highway (US 319), with pedestrian crosswalks, signage, and signaling. There are currently gaps in the connectivity to the Wakulla County Community Center on Wakulla Arran Road and Trice Lane.

PROJECTS: SIDEWALKS

ADDITIONAL INFORMATION:

- See *Accomplishments and Updates 2016 – 2020*, pages 6-12
- Additional pedestrian infrastructure needs will be assessed and constructed as a component of the Crawfordville Highway (US 319) widening project.

Estimated Cost: TBD

IX. HEALTH EQUITY PLAN OBJECTIVES

A. Hypertension

The following chart presents our proposed Health Equity Projects.

	Lead Entity and Unit	Lead Point Person	Data Source	Baseline Value	Target Value	Plan Alignment
Short-Term SDOH Goal: Walkability Survey for civic organizations, Task Force(s) and Coalition members						
Objective: By December 31, 2022, selected groups will be offered a survey regarding the current "walkability" of the county, possible barriers, and solutions.	DOH Wakulla	Tan Dollard, Grace Keith	Heart Foundation Community Walkability Checklist, NHTSA Walkability Checklist	0%	75%	CHA CHIP
Objective: By March 2023, increase the participation in Walkability Surveys with the 3 priority populations identified, which include the elderly, African Americans, and disabled, in Wakulla from 0% to 15%.	Consultant – TBD	TBD	TBD	0%	15%	CHA CHIP
Medium-Term SDOH Goal: Wellness Walks						
Objective: By September 2024, to increase the walkability in Wakulla by hosting walking events in neighborhoods and communities that the elderly, African Americans, and Disabled individuals live in to increase walkability from 0 to 10%.	DOH Wakulla	Tan Dollard, Grace Keith, Community Health Staff	CDC "Step It Up" program, American Arthritis Foundation	0%	10%	CHA CHIP
Long-Term SDOH Goal: Improve Walkability Index in Wakulla County						
Objective: By June 31, 2026, decrease the percentage of elderly, African Americans and Disabled individuals who suffer from hypertension by 5%.	Wakulla Board of County Commissioners	Bill Gibson, Christie Mathison	Walkability Index	0%	5%	CHA CHIP

X. PERFORMANCE TRACKING AND REPORTING

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

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

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

XI. REVISIONS

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

Revision	Revised By	Revision Date	Rationale for Revision