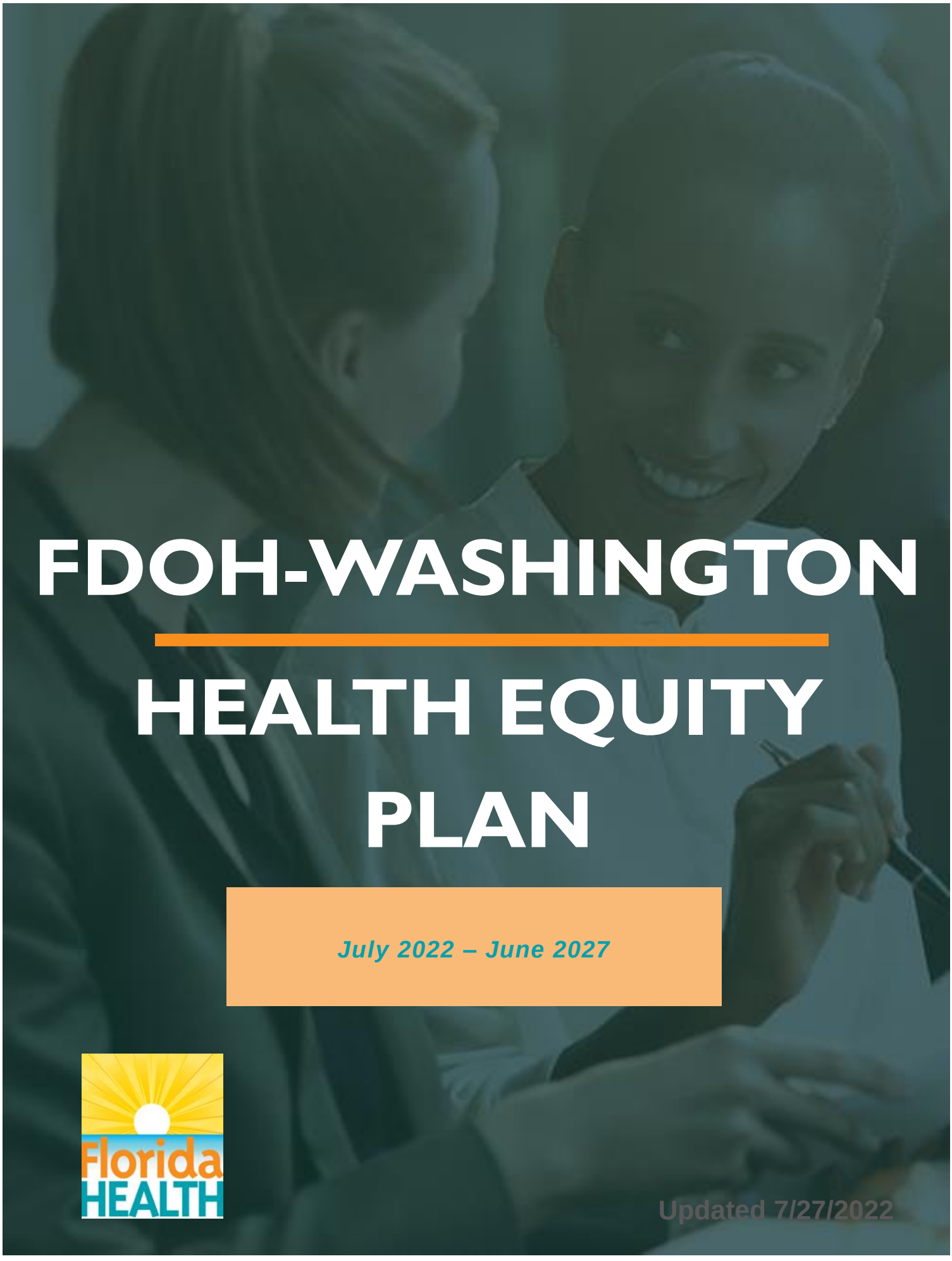


FDOH-WASHINGTON

HEALTH EQUITY PLAN

July 2022 – June 2027

Florida HEALTH

Updated 7/27/2022

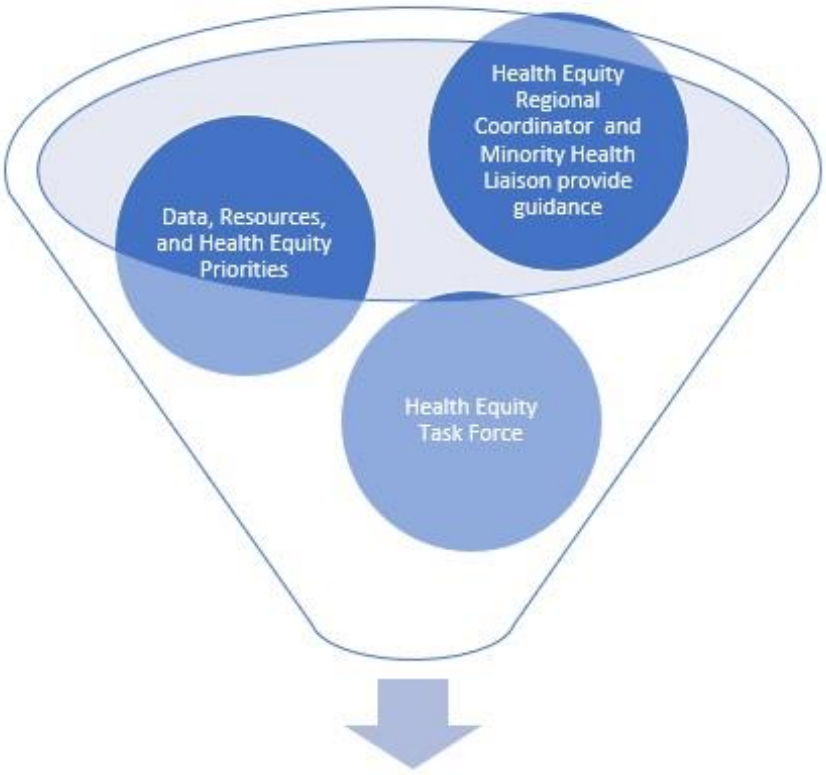
Table of Contents

I. VISION AND MISSION

Vision: The attainment of the highest level of health for all Washington County residents.

Mission: To educate and empower Washington County residents to achieve their full health potential through the improvement of influencing factors and social determinants of health.

The Florida Department of Health in Washington County (FDOH-Washington) collaborated with members of the Health Equity Task Force to initially develop a vision and mission statement during a meeting on April 19, 2022. The vision and mission are representative of the ongoing work the FDOH-Washington aims to do within the county.



Health Equity Vision

II. PURPOSE OF THE HEALTH EQUITY PLAN

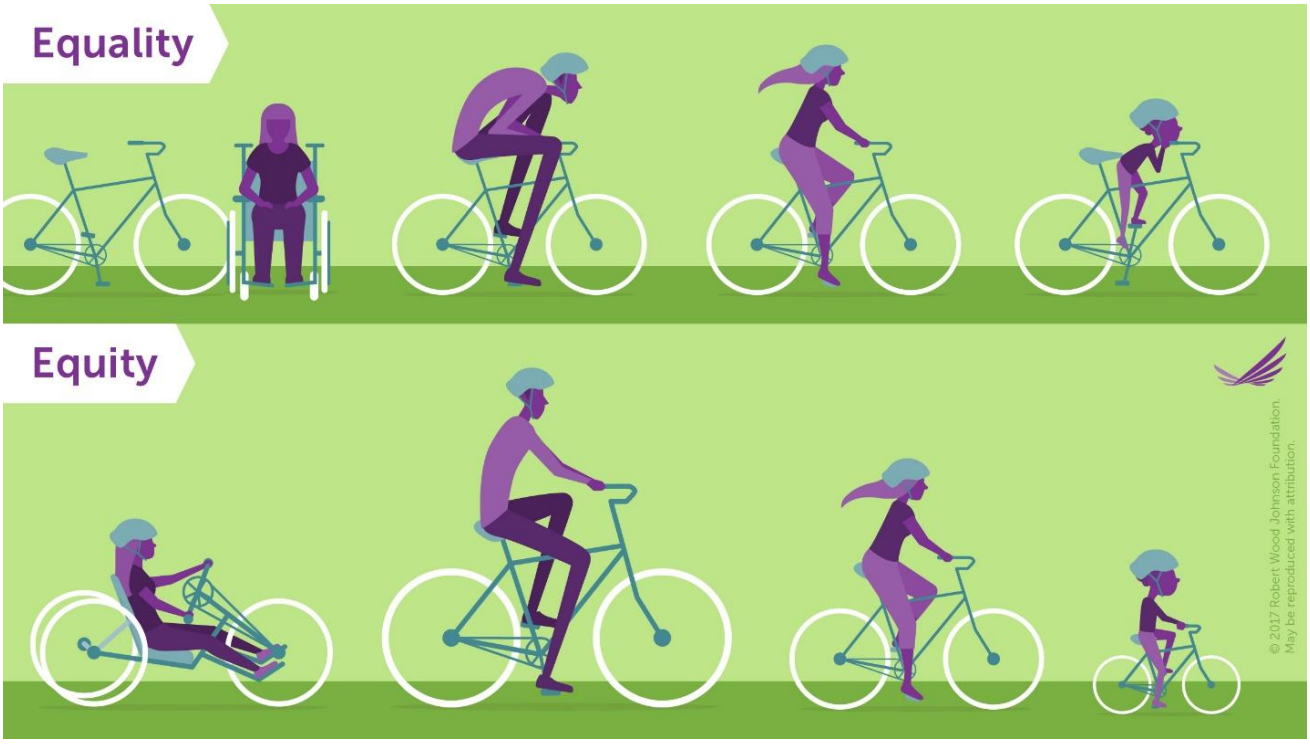
Health Equity is achieved when everyone can attain optimal health.

The Florida Department of Health's Office of Minority Health and Health Equity (OMHHE) works with government agencies and community organizations to address the barriers that inhibit 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 will guide county 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, 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 improve health equity within Washington County. To develop this plan, the FDOH-Washington 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 Washington County. The Health Equity Plan will not be solely utilized by the county health department. The Health Equity Taskforce, comprised of a variety of local entities including government, non-profits, and other organizations, will also employ the Health Equity Plan to collectively address the SDOH that impact county-wide health and well-being.

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 disparities 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 accomplished 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 collaborations reveal the impact of education, health care access and quality, economic stability, social and community context, 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.

January

On January 24th, 2022, select members of the health equity team met to conduct an environmental scan of community leaders and determine prospective members for the health equity task force in Washington County. The team considered community leaders from a variety of sectors including private industry, local government, education, faith-based, and other community organizations. While an extensive list was generated during this meeting, notable prospective members included: Mayor Tracey Andrews, Mayor of Chipley; Dr. Peterson, Vice-principle at Vernon High School; Pastor Priscilla Brown; and Jiranda White.

Special consideration was also given to ensure that the different geographic areas of the county were represented. As a follow up to the meeting, Minority Health Liaison FaNeician Russ made person calls to the prospective members to ask for their participation in the task force. Members that accepted are included in the list of task force members.

February

SDOH scans were conducted by the FDOH-Washington staff to ascertain needs of the communities in Washington County. A special point of interest in this scan included a free clinic administered by Dr. Sheffield based in the TJ Rouhlac Enrichment Center. As an outcome of this scan, FDOH-Washington was able to provide this clinic with two exam tables to help increase the volume of clients served and quality of care provided at the clinic. In partnership with the OMHE,

the FDOH-Washington staff hope to partner with this clinic as an outreach location for a blood pressure self-monitoring program in FY 22-23. Additionally, select members of the health equity team reviewed charts data to identify potential health disparities. The findings were presented during a team meeting on February 28th.

March

The health equity team focused on preparation for the upcoming minority health fair "April Fest." Task force members promoted the event through engagement other in community activities including the weekly "Stepping into Spring" community walk throughout March and April sponsored by Northwest Florida Community Hospital.

Messaging and themes for the minority health fair were established. The theme was Empowered: Yourself and Your Health. The developed is featured below.

April

Task force members were highly engaged with promotion of the upcoming minority health event. A focus group was held with task force members and community leaders pertaining to the health equity plan. During this focus group, the main areas of concern were access to care and food access. "April Fest" was held on April 30th.

May

The task force met to review social disparity data and give feedback on priority areas. While data for Washington County was limited, there were pronounced health disparities in all data measures concerning diabetes. This health disparity aligns with community concerns of access to care and food access and was settled on as the focus disparity.

The task force, along with community leaders and stakeholders, participated in consensus workshops concerning access to care and food access on May 26th. The results of the consensus workshop informed short-, medium-, and long-term goals for the health equity plan.

The FDOH-Washington appreciates all cross-sector collaborations and highly regard all partnerships within the community.

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: FaNeician Russ
Minority Health Liaison Backup: James P. Lewis

B. Health Equity Team

The Health Equity Team includes individuals that each represent a different program within the CHD. The Health Equity Team explores opportunities to improve health equity efforts within the county health department. Members of the Health Equity Team assess the current understanding of health equity within their program and strategize ways to improve it. The Health Equity Team also relays information and data concerning key health disparities and SDOH in Washington 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
James Lewis	Program Manager	Community Projects
Milton Brown	Training Specialist II	Health Equity
Valery Lawton	Program Manager	Healthy Start
Brittany Johnson	Director of Nursing	FDOH – Washington Clinic
Haylee Sapp	OPS Clerk	Tobacco Prevention
Lisa Moon	Training Specialist II	Tobacco Prevention
Brittney Sanders	Public Information Officer	FDOH – Washington
Olivia Brock	Senior Health Educator	Healthiest Weight
Amber Whitford	Planner I	Disaster Preparedness
Brenda Blitch	Planning Consultant	Disaster Preparedness
Traci Corbin	Health Officer	FDOH – Washington

The Health Equity Team met on the dates below 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
January 24, 2022	Environmental scan for potential task force members
Feb. 15,2022	Planned Activities/Upcoming Activities/Activities Performed
February 28, 2022	Present and review health disparity data
March 15, 2022	Planned Activities/Upcoming Activities/Activities Performed

C. Health Equity Taskforce

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

Name	Title	Organization
Tracy Andrews	Mayor	City of Chipley
Tracey Long	Director	Council on Aging
Dr. Charles Peterson	Vice Principal	Vernon High
Dr. Valdee Sheffield	Medical Doctor	TJ Roulhac Enrichment Center
Bridget Peterson	Community Leader	South Washington Back to School
Donna Taylor	Teacher	Vernon Middle School
Priscilla Brown	Pastor	Community Leader
Naomi Guy	Nurse	Shepard's Gate Church/Food bank
Jiranda White	Grants Director	Washington County School District
James Lewis	Program Manager	Community Projects
Milton Brown	Training Specialist II	Health Equity
Valery Lawton	Program Manager	Healthy Start
Brittany Johnson	Director of Nursing	FDOH – Washington Clinic
Haylee Sapp	OPS Clerk	Tobacco Prevention
Lisa Moon	Training Specialist II	Tobacco Prevention
Brittney Sanders	Public Information Officer	FDOH – Washington
Olivia Brock	Senior Health Educator	Healthiest Weight

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
April 19, 2022	Community leaders	Task force members engaged community leaders in a focus group to ascertain community's health needs and health challenges. As a result of this focus group and resulting discussions the task force learned that access to services and essential needs. Social Determinants that came to the forefront were access to care and

		neighborhood and built environment specifically food desserts/access to fresh fruits and vegetables.
May 5, 2022	Health Equity Task Force	Discussed next steps after focus group session. The next meeting will include task force members with stakeholders that can impact access to care and food access. This will be hosted as back-to-back consensus workshops for these two identified areas.
May 26, 2022	Health Equity Taskforce, Healthy Equity Team, Health Care Representatives, Public Transportation Representatives.	Consensus workshop topics on access to care and food access. How can getting care to people and people to care be facilitated? Throughout this conversation we agreed that mobile care is needed, better and reliable transportation is needed, direct communication, expansion of services, and rural community events would help with the access to care.

D. Coalition

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

Name	Title	Organization
Tracy Andrews	Mayor	City of Chipley
Tayler Amerson	Director	Council on Aging
Dr. Charles Peterson	Vice Principal	Vernon High
Dr. Sheffield	Medical Doctor	TJ Roulhac Enrichment Center
Bridget Peterson	Community Leader	South Washington Back to School
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Lisa Moon	Training Specialist II	FDOH-Washington
Brittney Sanders	Public Information Officer	FDOH – Washington
Olivia Brock	Senior Health Educator	FDOH-Washington
Jennifer Eldridge	School Health Coordinator	FDOH- Washington
Heather Shelby	Director of Care	Kindred at Home
Janai Groomes	Program Director	Chipola Healthy Start
Judy Corbus	Family and Consumer Science Agent	UF-IFAS Extension
Cecilia Spears		Early Learning Coalition of Northwest Florida

Tiffany Cohen		Help Me Grow – Early Learning Coalition
Lauren Anzaldo	Suicide Prevention Coordinator	Gulf Coast Veterans Affairs

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
Kimberly Watts	Southeast

V. HEALTH EQUITY ASSESSMENT, TRAINING, AND PROMOTION

A. County Health Equity Training

The Minority Health Liaison assessed the prevalence and awareness of health equity through several measures, including the Community Health Assessment. The process of this assessment helped the Minority Health Liaison identify knowledge gaps and create training plans for the Health Equity Taskforce, the Coalition, and other county partners.

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

Date	Topics	Organization(s) receiving trainings
January 25, 2022	Cultural Competency and Health Equity Training	Health Equity
The 3rd Thursday of each month	SDOH, HE plans, and budgets	Minority Health Liaisons
April 12-13, 2022	SDOH and HE plans	Minority Health Liaisons
April 28, 2022	Walton County Health Summit	County/ MHL

B. County Health Department Health Equity Training

The FDOH-Washington recognizes that ongoing training in health equity and cultural competency are critical for creating a sustainable health equity focus. At a minimum, all FDOH-Washington staff have 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. All FDOH-Washington staff received both trainings. The trainings are also mandatory for all new staff as part of the orientation plan. Previous training sessions for new hires are recorded below.

Date	Topics	Number of Staff in Attendance
June 1, 2021-April 1, 2022	Cultural Awareness: Introduction to Cultural Competency	6
June 1, 2021-April 1, 2022	Addressing Health Equity: A Public Health Essential training	6

C. Minority Health Liaison Training

The Office of Minority Health and Health Equity and the Health Equity Regional Coordinator have provided 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 dates and topics are recorded below.

Date	Topics
January 25, 2022	Cultural Competency and Health Equity
February 7, 2022	Integrating Racial Equity and Mental Wellbeing in Tobacco Cessation

February 8, 2022	Addressing Food Insecurity throughout COVID-19
March 23, 2022	ClearPoint Training
March 24, 2022	Threats of Commercial Tobacco use and Reducing Disparities in Underserved Hispanic Populations
April 27-29, 2022	Technology of Participation (ToP) facilitation
May 10 – June 6, 2022	Grant Writing Trainings

D. National Minority Health Month Promotion

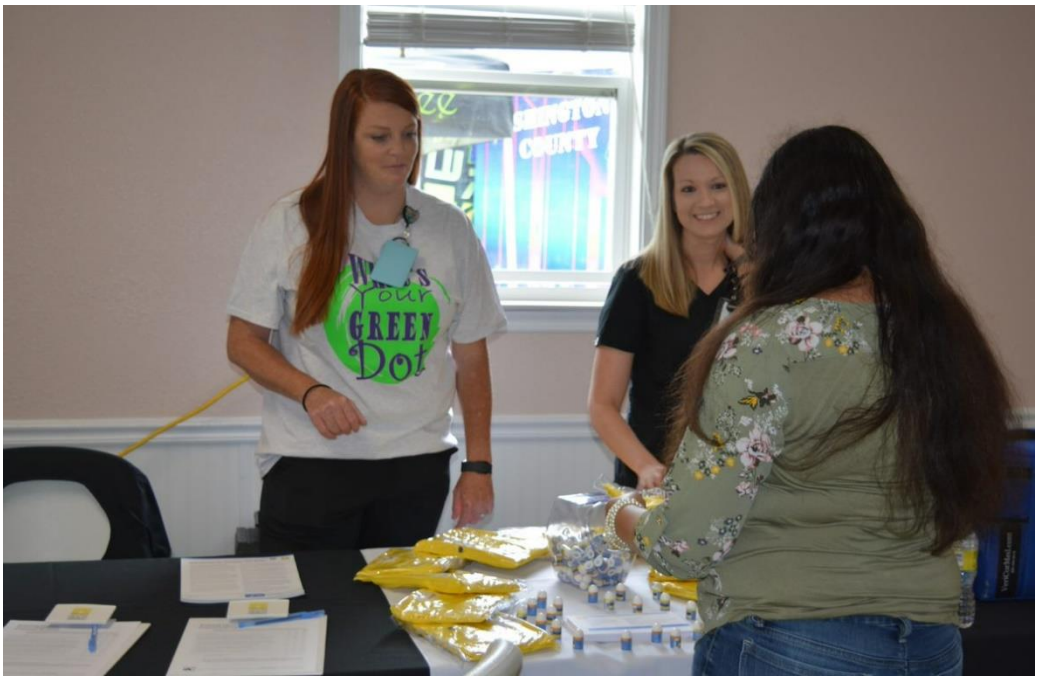
Various partners of the health equity team, task force, and coalition engaged in promotion of national minority health month. Events and promotion occurred throughout the month culminating in a minority health fair called “April Fest” as mentioned above.

There were numerous promotional activities during the months of March and April, including “Step into Spring.” Minority Health Liaison FaNeician Russ also attended several church services to promote minority health month and the upcoming health fair.

The Minority Health Liaison at Rock the Falls music festival. FDOH-Washington set up a booth set up to promote tracking steps, healthy eating, exercising, and seeking preventative care. Due to not having a MHL in Holmes County, this was held in Washington County, where many Holmes County residents did come and were invited to join us.

Students from the local track team joined the FDOH-Washington's weekly 30-minute "Stepping into Spring" walks. This was combined with both CHD staff.

A community resident receives blood glucose check from Northwest Florida Community Hospital staff at April Minority Health Event, "April Fest." This was held in Washington County, due to not having a MHL in Holmes County, we combined it with both CHD staff.



A community resident interacts with Holmes/Washington clinic staff at April Minority Health Event, "April Fest." This was held in Washington County, but due to not having a MHL in Holmes County, we combined it with both CHD staff.

A community resident interacts with Holmes/Washington FDOH Healthy Start program staff at April Minority Health Event, "April Fest." This was held in Washington County, but due to not having a MHL in Holmes County, we combined it with both CHD staff.

A community resident interacts with FDOH cancer prevention table at April Minority Health Event, "April Fest." This was held in Washington County, but due to not having a MHL in Holmes County, we combined it with both CHD staff.

The Minority Health Liaison, FaNeician Russ, and Health Equity Coalition member, Milton Brown, attended the 2022 Chamber of Commerce Banquet to network with potential community partners and recruit vendors for the Health Fair for National Minority Health Month. The Minority Health Liaison also informed many partners of current events such as the Stepping into Spring weekly walks.

VI. PRIORITIZING A HEALTH DISPARITY

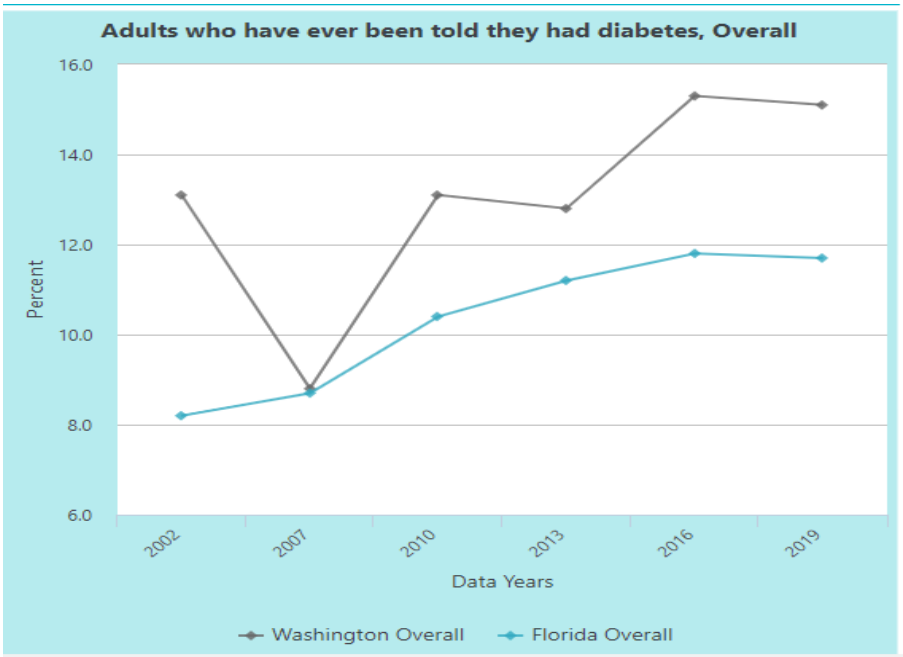
The Health Equity Team identified and reviewed health disparities data in Washington County. Data was pulled from several sources including Florida Health CHARTS, Centers for Disease Control and Prevention, and County Health Rankings.

Data pertaining to diabetes and food deserts were identified as having significant disparities in Washington County. Using CHARTS data, the Health Equity Team agreed to focus on diabetes in the Health Equity Plan, because improvement in this health outcome and related disparities were quantifiable.

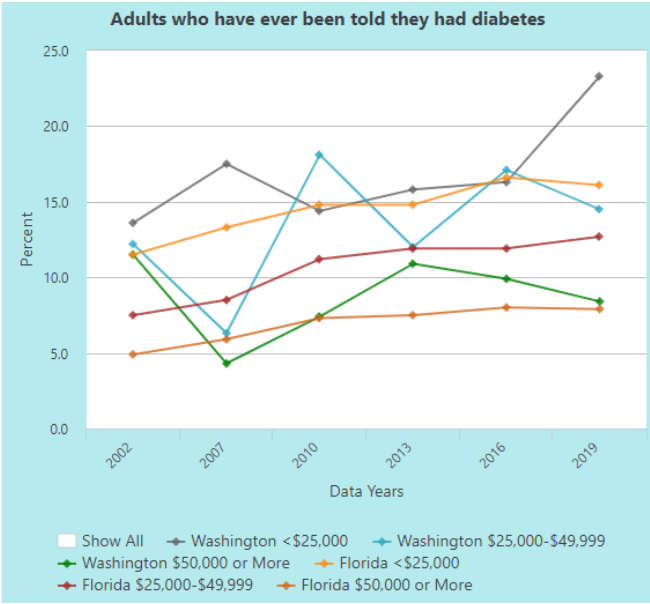
According to 2022 data from the “Analysis of the Health Disparities Among People Living with Disabilities,” prevalence of diabetes is significantly higher ($p < 0.001$) in individuals with at least one disability compared to individuals with no disability in Washington County.

The 2020 American Community Survey (ACS) concluded that approximately 10.5% of the Washington County population are veterans. There is no data specifically quantifying the prevalence of diabetes among the veteran population in Washington County. However, research suggests that veterans living in rural areas, such as Washington County, are more likely to suffer from diabetes than their urban counterparts (Conzad, Capra, & Maher, 2016).

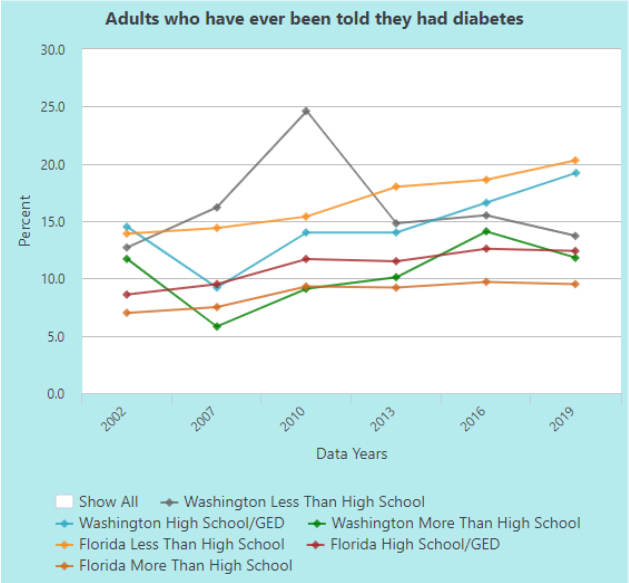
Approximately 3.3% of the Washington County population identified as immigrants on the 2020 ACS. There is no data measuring the prevalence of diabetes among the immigrant population. Studies have shown that US immigrants have a higher risk if risk of diabetes compared to US-born individuals (Dias et al, 2020).



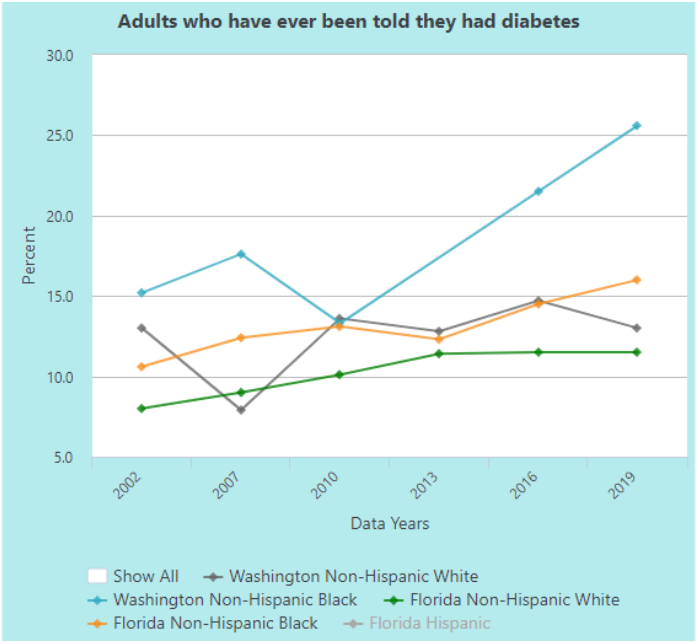
Graph 1.0. According to FL CHARTS 2019 data, 15.0% of adults in Washington County had ever been told they had diabetes. The rate had increased significantly since 2007 and was higher than the state average.



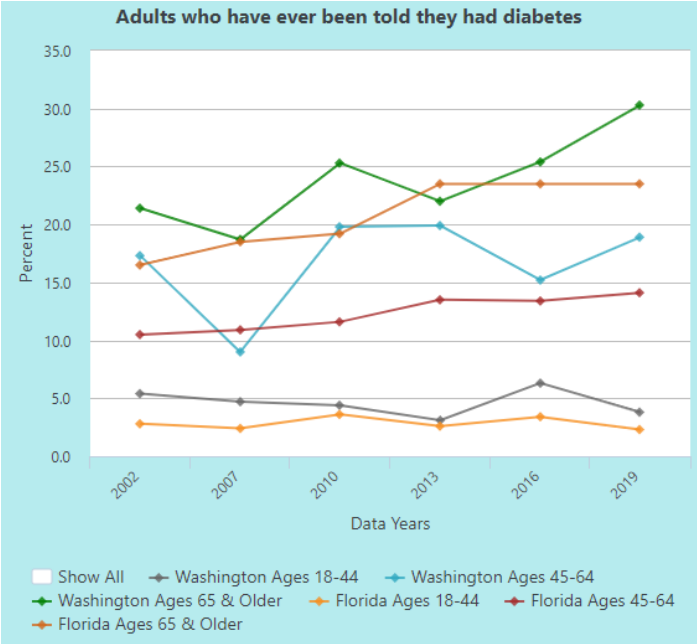
Graph 1.1. Washington County residents with an annual household income of less than $25,000 were more likely to have ever been told that they had diabetes, compared to those with a household income of $25,000 to $49,999 or more than $50,000, per 2019 FL CHARTS data.



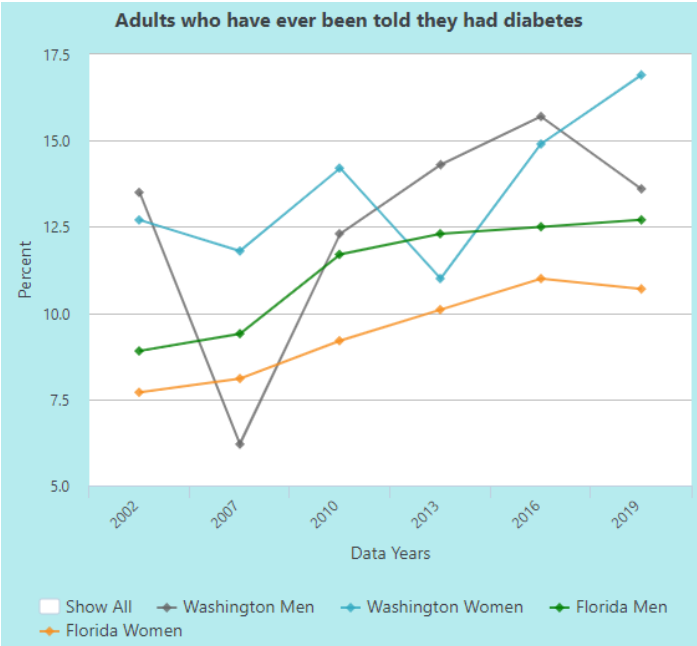
Graph 1.2. According to FL CHARTS, 19.2% of Holmes County adults with a high school education had been told they had diabetes in 2019. That same year, the rate was 13.7% for those with less than high school education and 11.8% for those with more than a high school education.



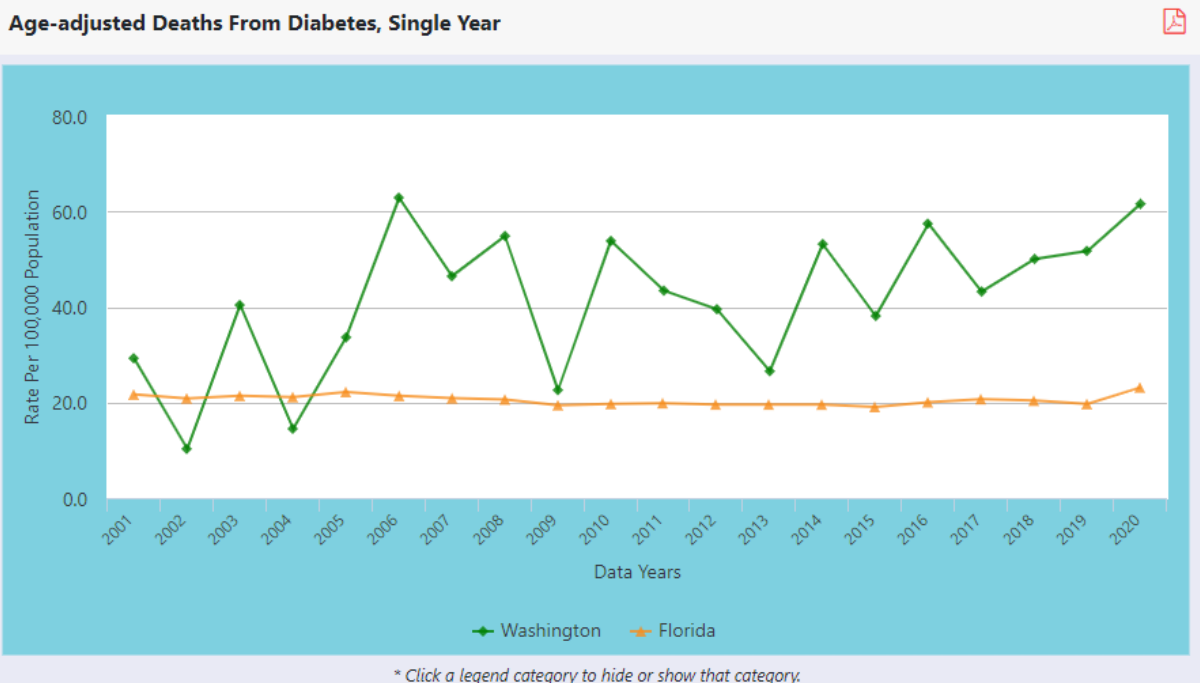
Graph 1.3. FL CHARTS data from 2019 showed that Black Washington County adults had a significantly higher risk of having ever been told they had diabetes compared to White adults.



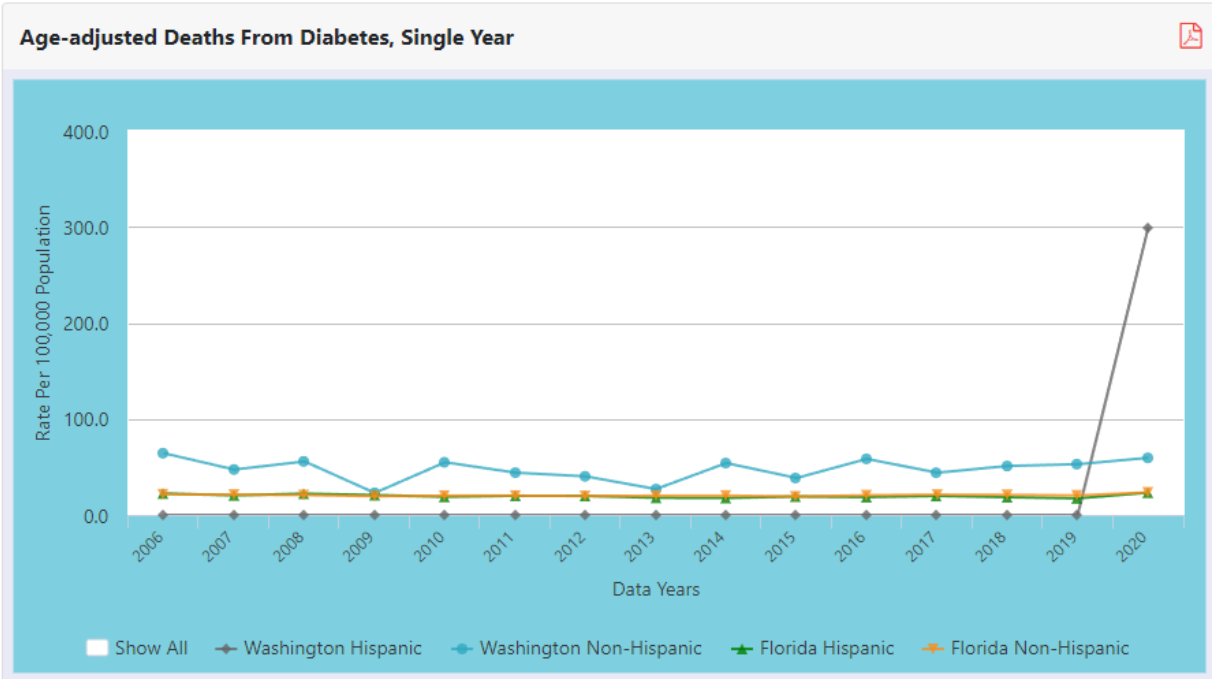
Graph 1.4. In 2019, Washington County residents ages 65 and older were more likely to have ever been told they had diabetes than those ages 45 to 64 or 18 to 44.



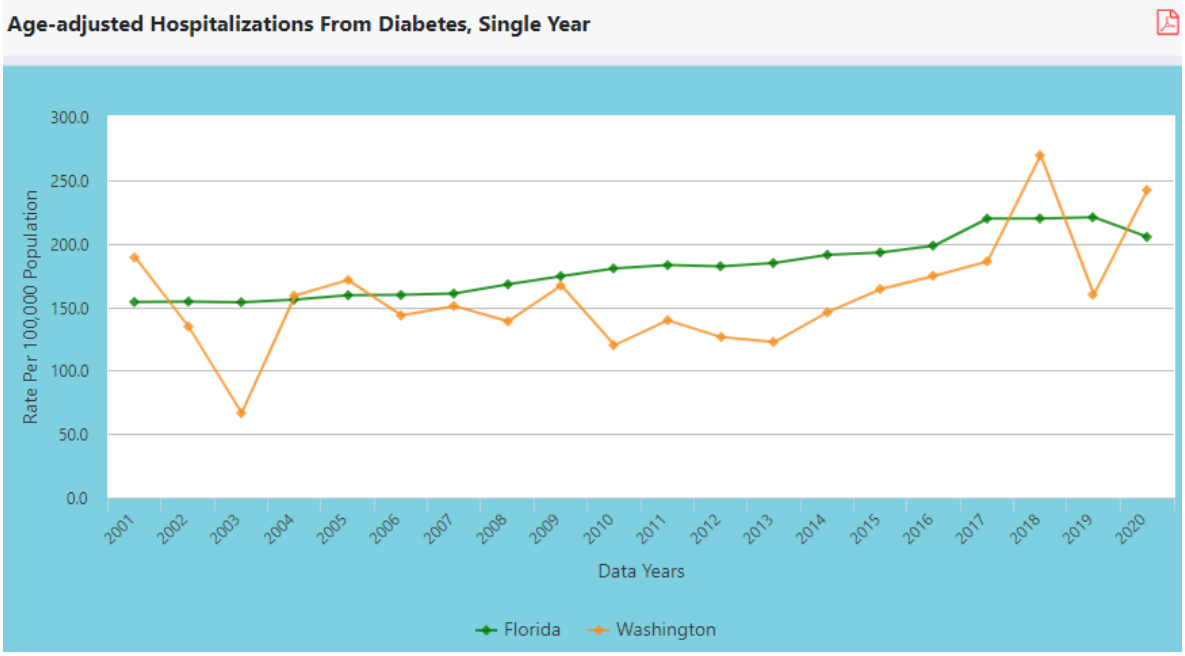
Graph 1.5. FL CHARTS data from 2019 suggests that women in Washington County were more likely to have ever been told they had diabetes than men. However, in Florida overall men were more likely to have ever been told they had diabetes than women.



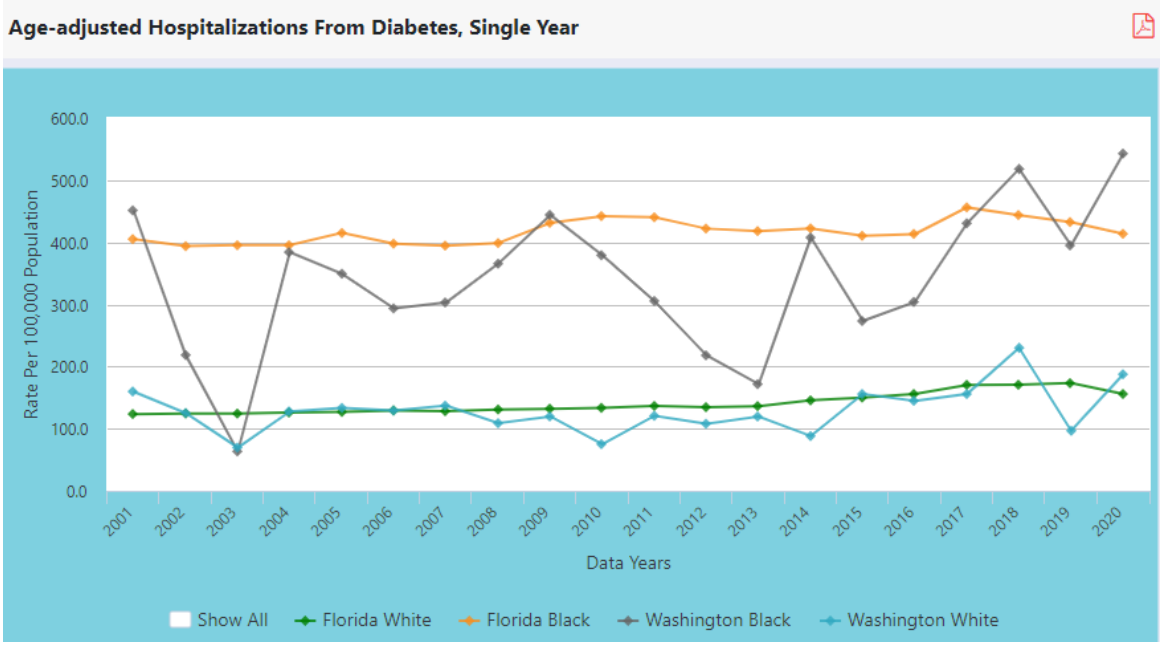
Graph 1.6. This graph from FL CHARTS states the age-adjusted deaths from diabetes in a single year from 2001 through 2020.



Graph 1.7. This graph from FL CHARTS shows age-adjusted deaths from diabetes in Washington County, differentiated by race. From 2019-2020, there was a drastic change in the Hispanic deaths.



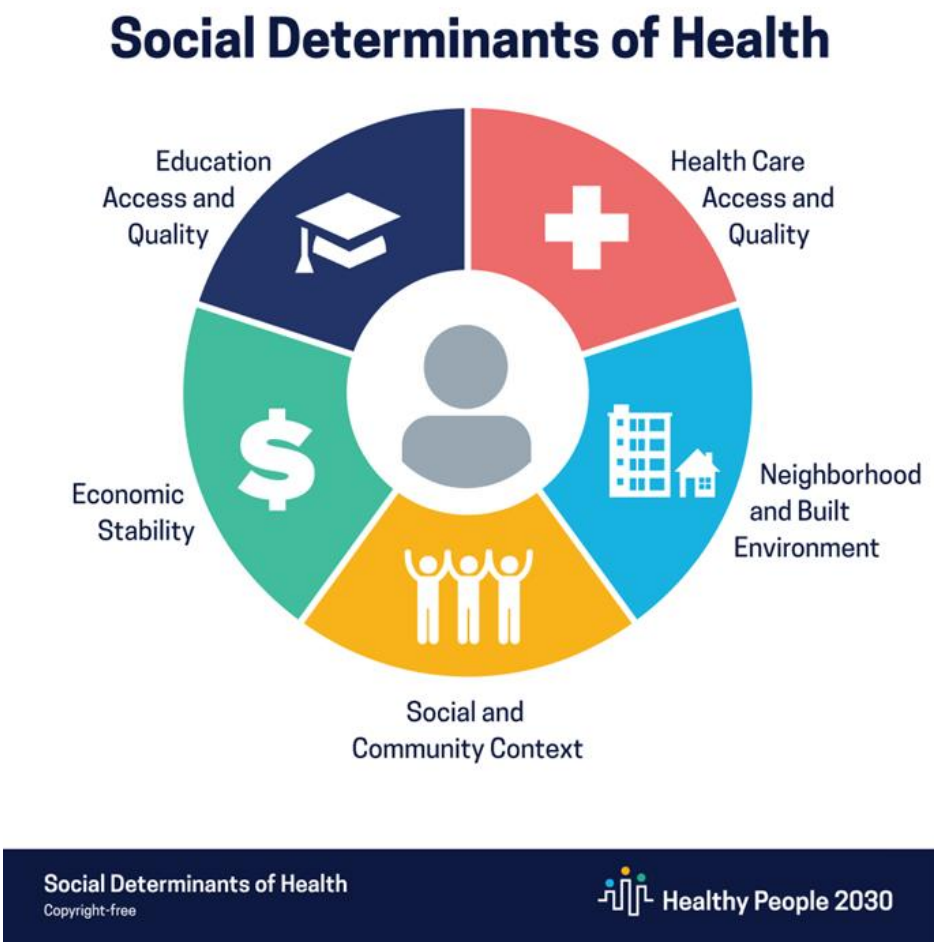
Graph 1.8. This graph from FL CHARTS states the age-adjusted hospitalizations from diabetes in a single year from 2001 through 2020.



Graph 1.9. This graph from FL CHARTS shows age-adjusted hospitalizations from diabetes in Washington County, differentiated by race. There were many more hospitalizations from diabetes among Black residents compared to White residents.

VII. SOCIAL DETERMINANTS OF HEALTH DATA

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



A. Education Access and Quality

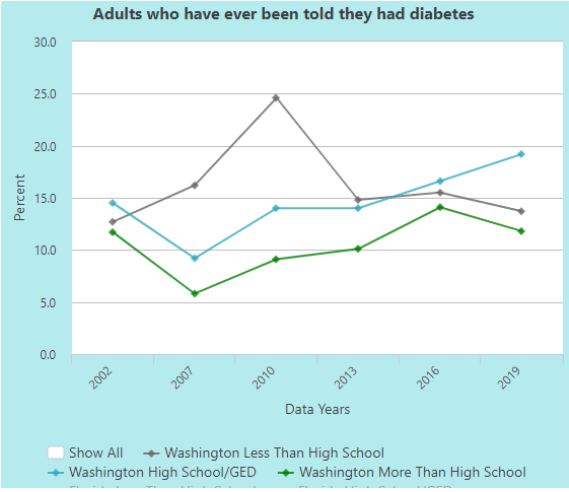
Health literacy is defined as “the degree to which individuals can obtain, process, and understand and communicate about health-related information needed to make informed health decisions” (Cavanaugh, 2011). Literacy also includes skills related to printed information, oral communication, and numeracy. These skills contribute to the self-management of diabetes.

Health literacy influences health outcomes of diabetes through acquisition of disease specific knowledge, self-efficacy improvement, and adherence with self-care behaviors (Cavanaugh, 2011). Low health literacy rates have been associated with worse diabetes knowledge in a variety of settings (Cavanaugh, 2011). There is no data in FL CHARTS regarding the literacy level of Washington County residents.

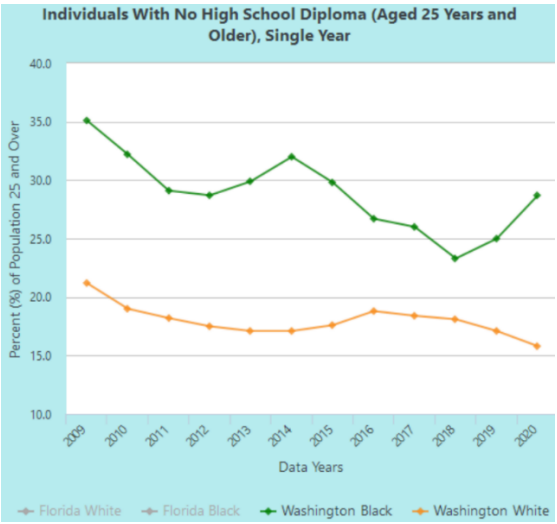
Some of the greatest health literacy disparities occur among racial and ethnic minority groups and those who do not speak English as a first language. People with low health literacy in addition to limited English proficiency are twice as likely to report poor health status compared to individuals without these barriers (Healthy People 2020).

Education level is an indicator of socioeconomic status, which correlates with personal health. Research shows that those who have attained higher levels of education are less likely to develop diabetes (Borrell et al., 2006). In a study by Borrell et al., individuals with less than a high school education were 1.6 times more likely to have diabetes than those with a bachelor’s degree or higher (2006). This suggests that higher education attainment provides the knowledge and skills needed to adopt health behaviors that lower the risk of chronic disease such as diabetes.

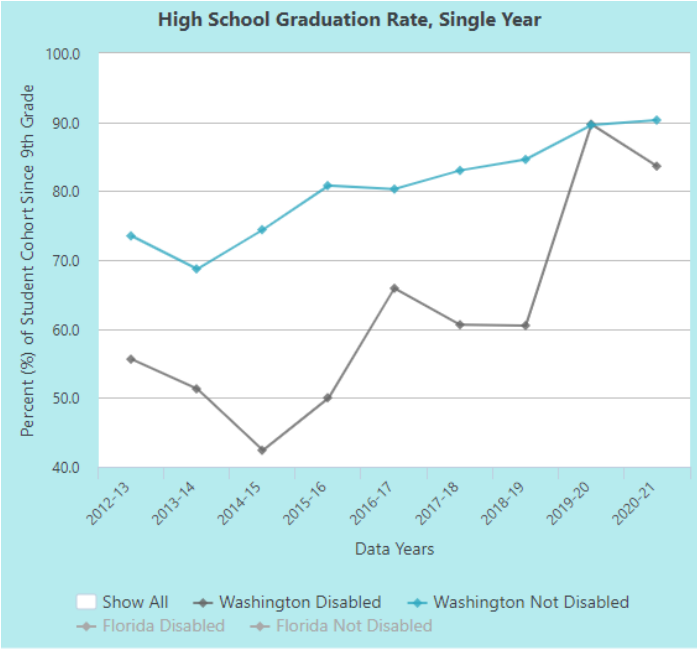
According to 2022 data from the “Analysis of the Health Disparities Among People Living with Disabilities,” a higher proportion of Washington County residents without a disability had received a high school diploma/GED and higher education compared to residents with at least one disability.



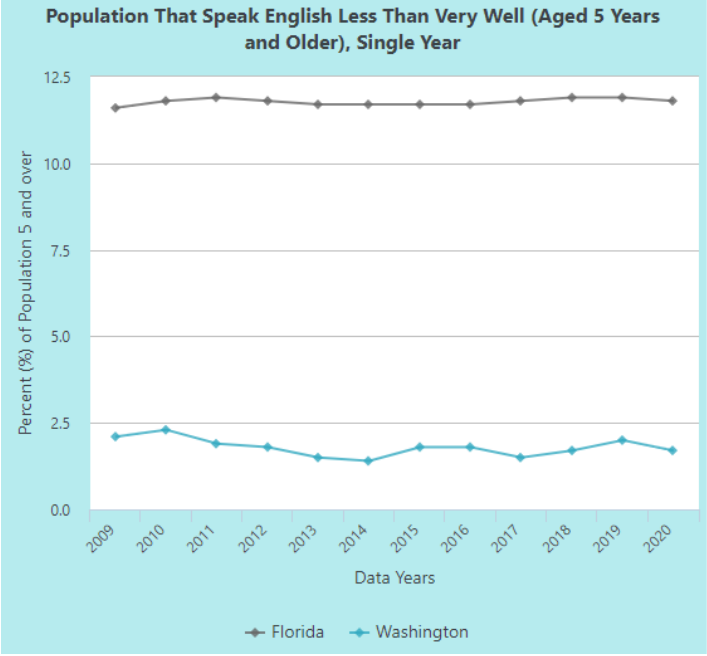
Graph 2.0. According to FL CHARTS, 19.2% of Washington County adults with a high school education had been told they had diabetes in 2019. That same year, the rate was 13.7% for those with less than a high school education and 11.8% for those with more than a high school education.



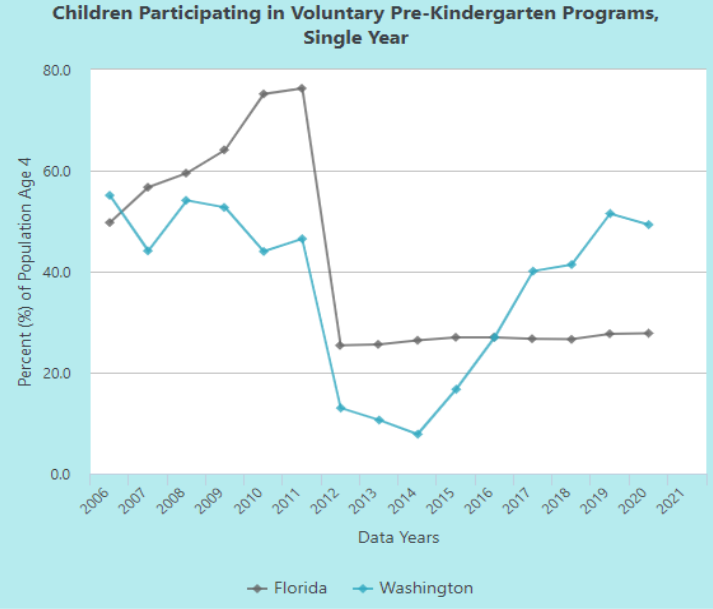
Graph 2.1. Per FL CHARTS data, Black individuals over the age of 25 in Washington County were less likely to have a high school education, compared to White individuals in 2020.



Graph 2.2. FL CHARTS data reveals that the high school graduation rate for non-disabled individuals was higher than the rate for disabled individuals in the 2020-2021 school year.



Graph 2.3. Only 1.7% of Washington County residents reported speaking English less than very well in 2020, per FL CHARTS. This is much lower than the Florida average.



Graph 2.4. Data indicated that 49.3% of eligible Washington County children participated in voluntary pre-kindergarten programs in 2020, which is higher than the Florida average. There is no data in FL CHARTS stratifying Washington County participation in a voluntary pre-kindergarten program by sociodemographic factors.

Education Access and Quality		
SDOH	**Vulnerable Populations Impacted**	**SDOH Impact on Diabetes Disparity**
Language	Rural, racial and ethnic minority groups	Language barriers can contribute to low health literacy, which is associated with to poor diabetes outcomes.
Early Childhood Development	Low income and rural areas	Educational support in early childhood improves health behaviors and outcomes later in life.
Literacy	Low income	Low literacy can impact health literacy levels. Limited health literacy is associated with poor chronic disease outcomes, including diabetes.
Higher Education	Rural, low income	Residents in low income and rural areas have less access and resources to seek higher education. Higher levels of education are commonly associated with better life-long health outcomes.

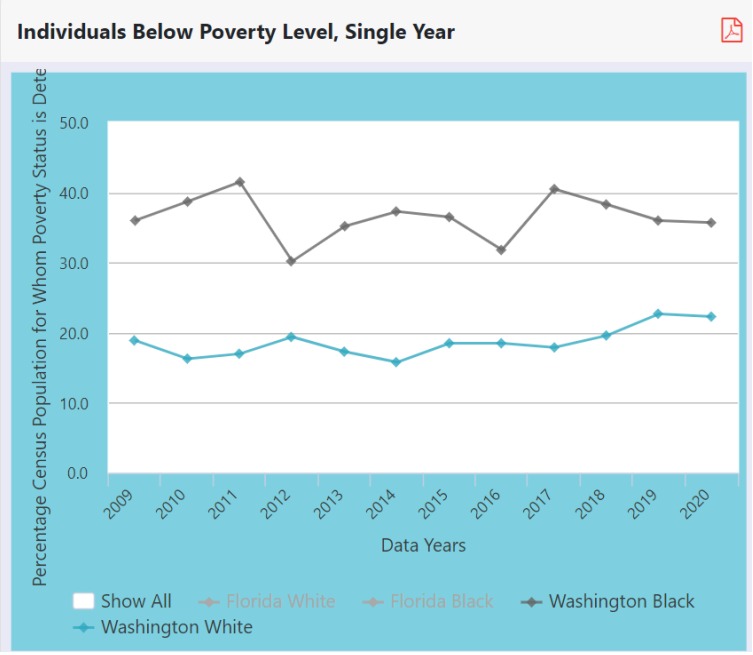
B. Economic Stability

Socioeconomic status (SES) is a construct that includes educational, economic, and occupational status (Hill-Briggs et al., 2020). SES is known to be a predictor of disease onset and progression levels for diabetes, as well as many other chronic diseases. Economic status is often determined by income (Hill-Briggs, 2020). In a data analysis of the National Health Interview Survey (NHIS) by Beckles and Chou (2016), there was an increase in diabetes prevalence in those with lower levels of income.

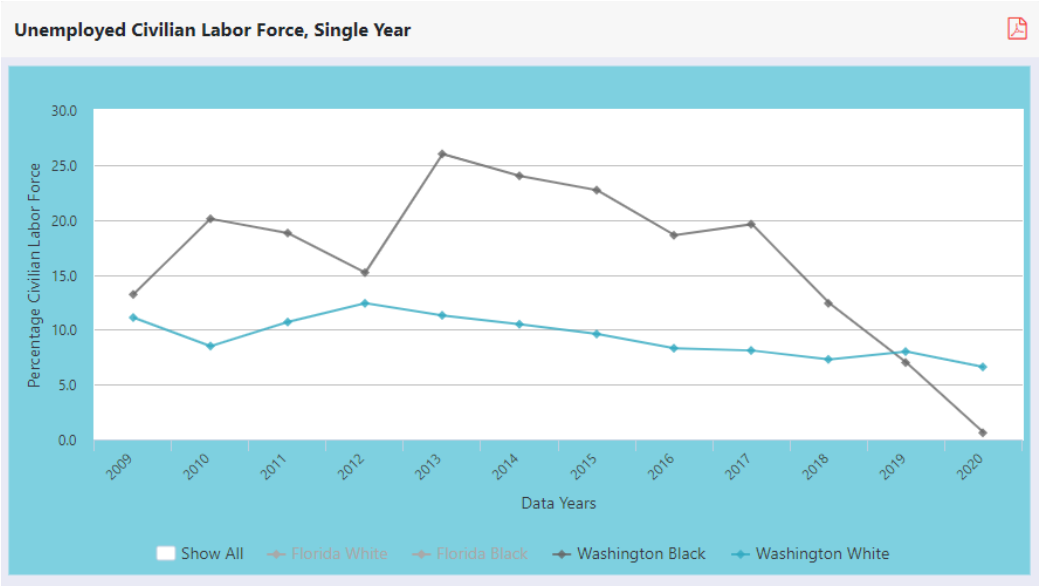
When looking at household income, adults with type-two diabetes with a household income below the federal poverty line have a twofold higher risk of diabetes-related mortality compared to those with the highest household income levels (Saydah, 2010).

In 2020, the median household income for Washington County was $44,700, which was lower than the Florida average of $61,700. Washington County was categorized as a high poverty area (US Census, 2020).

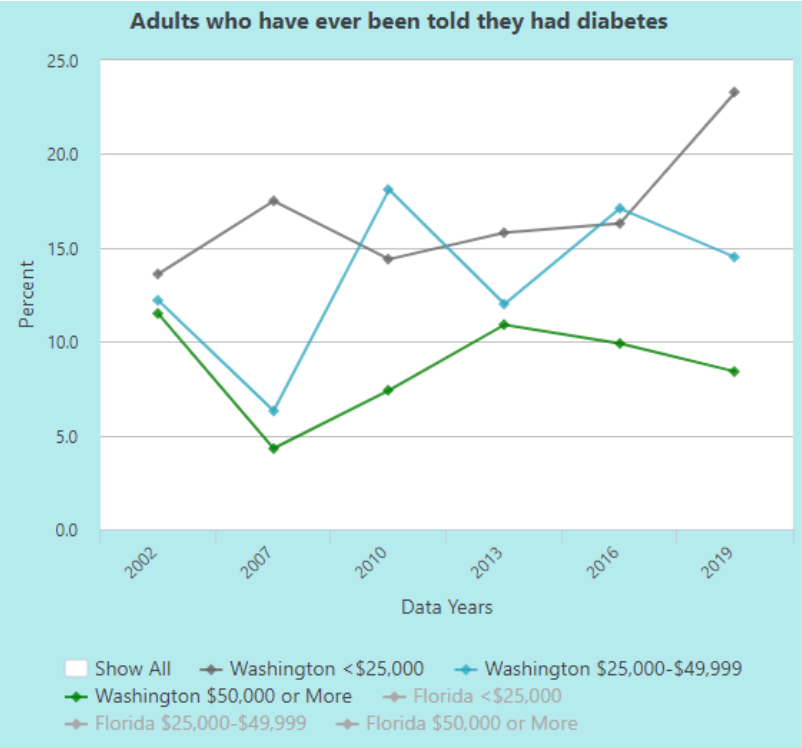
According to 2022 data from the “Analysis of the Health Disparities Among People Living with Disabilities,” Washington County residents with at least one disability had a lower household income than residents without a disability. In addition, individuals with at least one disability were significantly ($p < 0.001$) more likely to be food insecure (not enough money for food or not enough money for balanced meals) compared to individuals without a disability. There was not a significant difference in Washington County residents who reported that they could not take their medication due to cost between those with at least one disability and those without disability.



Graph 3.0. Per FL CHARTS data, there was a significant disparity in the percentage of Washington County residents below the poverty line based on race over the past 10 years, with drastically more Black individuals below the poverty line than White individuals.



Graph 3.1. Until recent years, the civilian unemployment rate for the Black population was higher than that of the White population in Washington County. However, FL CHARTS data reveals that the civilian unemployment rate for the Black population was lower than that of the White population in 2019 and 2020



Graph 3.2. In 2019, Washington County residents with a lower annual household income were more likely to have ever been told that they had diabetes than residents with a higher annual household income.

Economic Stability		
SDOH	**Vulnerable Populations Impacted**	**SDOH Impact on Diabetes Disparity**
Employment	Minimum wage workers, Disabled, Racial and ethnic minorities	Employment provides funds needed to afford necessities. Often it is a person's source of health insurance. Those without health insurance are at greater risk of poor health outcomes and less likely to seek out preventative care such as screenings and checkups.
Income	Disabled, Low SES	Lower income leaves less resources to devote to preventative medical care and health food procurement, which aid in diabetes prevention.
Expenses	Low income, Disabled, Racial and ethnic minorities	High cost of living relative to income is a major barrier, leaving a small budget for dietary needs and life-saving medication such as insulin.

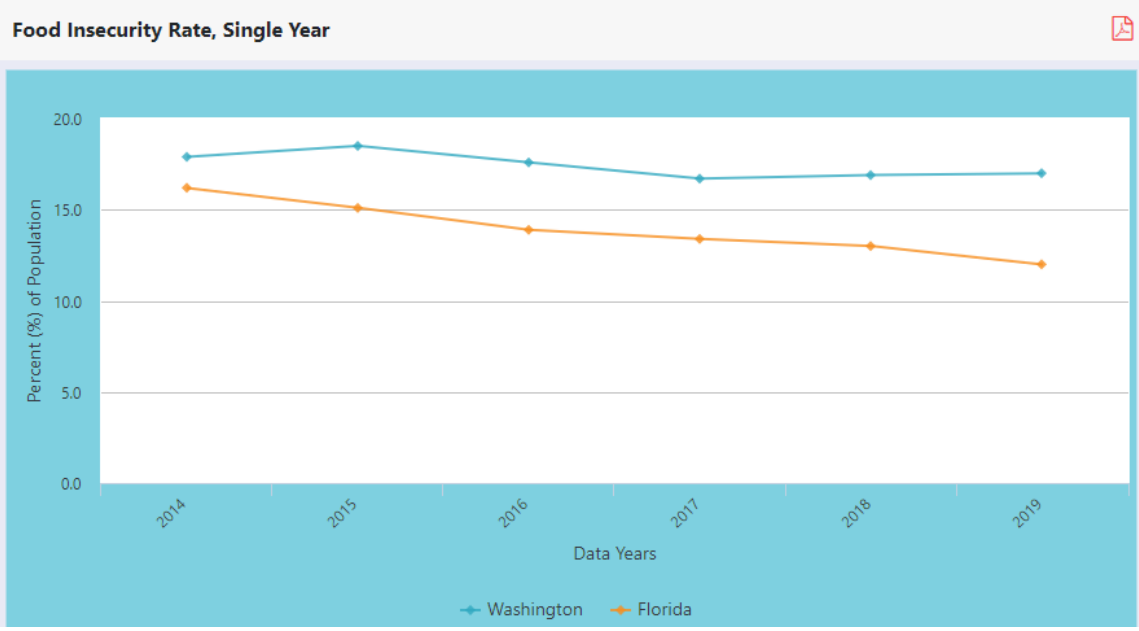
C. Neighborhood and Built Environment

Food access is a challenge for many Washington County residents. With much of the county being rural and a high poverty area, there is inconsistent access to the amount of food needed to live a healthy lifestyle. According to research, food insecurity is associated with high hemoglobin A1c test results, which lead to poor health outcomes (Berkowitz et al, 2018).

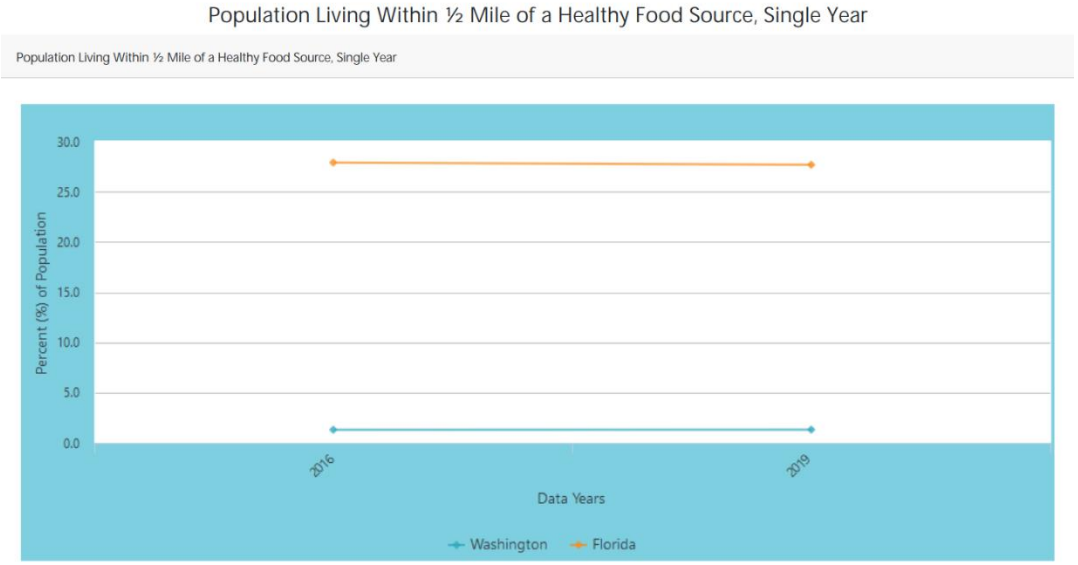
Access to recreational areas is important to support healthy physical activity and a healthy lifestyle. Lack of physical activity is a risk factor for chronic diseases, including diabetes and heart disease. Access to parks and facilities where leisure-time physical activity can be done has been associated with lower rates of diabetes and better health outcomes (Smith et al, 2016). Many Washington County residents do not have access to parks near their homes.

Lack of public transportation increases the economic burden of vehicle maintenance, contributing to less income available for regular doctor's visits and nutritional foods which are known to decrease the risk of diabetes. Longer commutes leave less time for physical activity during the day. As stated above, increased physical activity is also associated with lower incidence of diabetes.

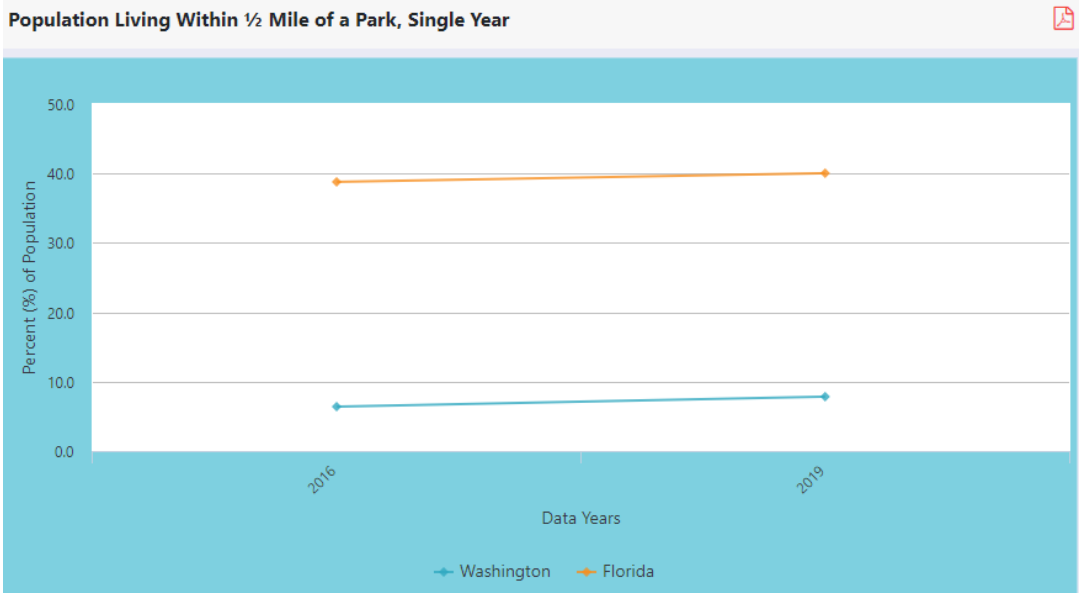
According to 2022 data from the "Analysis of the Health Disparities Among People Living with Disabilities," Washington County residents with at least one disability were significantly ($p < 0.001$) more likely to be delayed in receiving medical care due to transportation issues than residents without a disability.



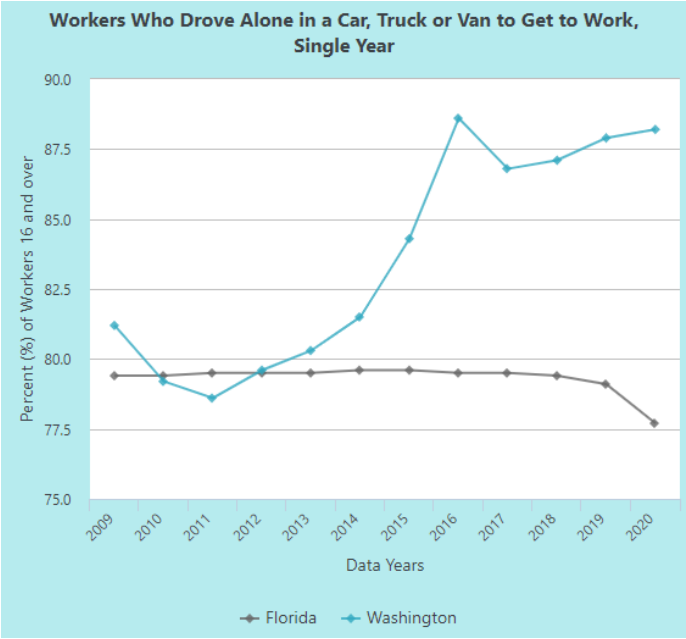
Graph 4.0. There was no data in FL CHARTS differentiating Washington County food insecurity rate by sociodemographic factors. However, the rate of food insecurity in Washington County was higher than the Florida average in 2019.



Graph 4.1. Only 1.3% of the Washington County population lived within ½ mile of a healthy food source, while the statistic was 27.7% for the Florida population in 2019. There was no data in FL CHARTS stratifying the percentage of the Washington County population that lived within ½ mile of a healthy food source by sociodemographic factors.



Graph 4.2. There are many public boat launches and recreational areas in Washington County. However, only 7.8% of the Washington County population lived within ½ mile of a park, compared to the Florida rate at 40.1% in 2019.



Graph 4.3. Washington County does not have a public transportation system. Due in part to the lack of public transportation, 82% of residents drove alone to work and many had a long commute according to FL CHARTS. This is higher than the Florida average.

Neighborhood and Built Environment		
SDOH	**Vulnerable Populations Impacted**	**SDOH Impact on Diabetes Disparity**
Transportation	Low income, rural areas, Disabled	Washington County does not have a public transportation system. Lack of transportation can prevent residents from accessing healthcare resources, which is especially important for chronic illnesses such as diabetes.
Parks	Rural	Parks provide recreational activities and opportunities to be active, which lowers the risk of diabetes. Only 7.8% of residents live within ½ mile of a park.
Average Commute Time	Rural, low income	Per FL CHARTS, 54% of residents have a daily commute of 30 minutes or more. Longer commutes leave less time for physical activity, which lowers the risk of chronic disease.
Access to nutritional food	Low income, rural areas	Washington County residents in more rural areas have food insecurities, meaning they do not have consistent access to enough food for a healthy and active life which causes diabetes and other health problems.

D. Social and Community Context

Research suggests that rate of diabetes is twice as high in those with mental health illnesses, such as depression and anxiety (Anderson et al, 2001). Mental health illnesses have also been associated with poorer outcomes in those with diabetes (Vinogradova et al, 2010).

Given the higher-than-average rate of mental illness in Washington County, residents have an increased risks of developing diabetes in association with mental health comorbidities. In addition, they are more susceptible to poor health outcomes stemming from the negative interaction between mental health illness and diabetes.

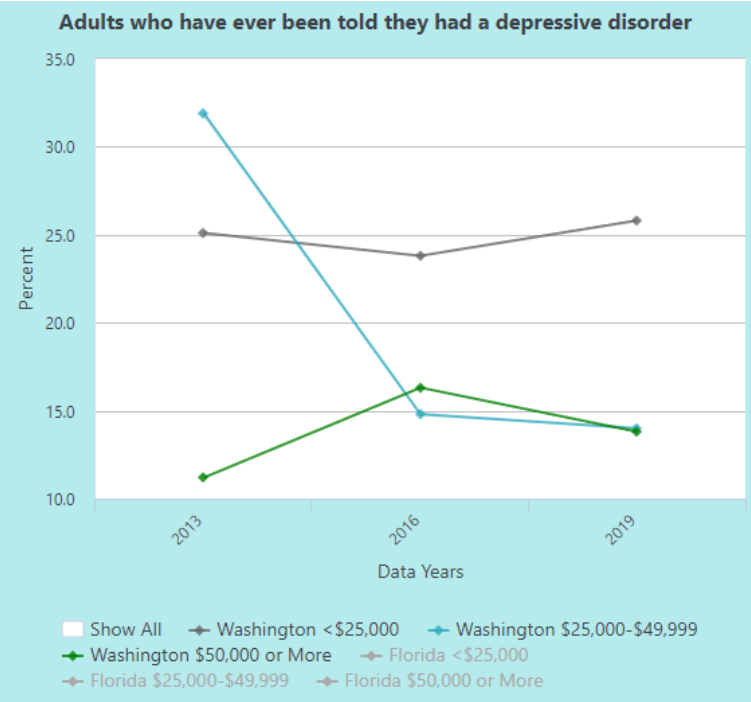
According to 2022 data from the “Analysis of the Health Disparities Among People Living with Disabilities,” Washington County residents with at least one disability were significantly ($p < 0.001$) more likely to have ever been diagnosed with a depressive disorder than residents without a disability. In addition, individuals with at least one disability were significantly ($p < 0.01$) more likely to report experiencing stress most or all of the time compared to individuals without a disability.

Another indicator that negatively impacts social, mental, and physical health is substance abuse (CDC, 2022). Many forms of substance abuse are known to adversely impact diabetic outcomes. Examples of substance abuse include smoking, binge, drinking and illicit drug use. Research shows that smoking increases the risk of diabetes complications (Walter et al, 2017). According to

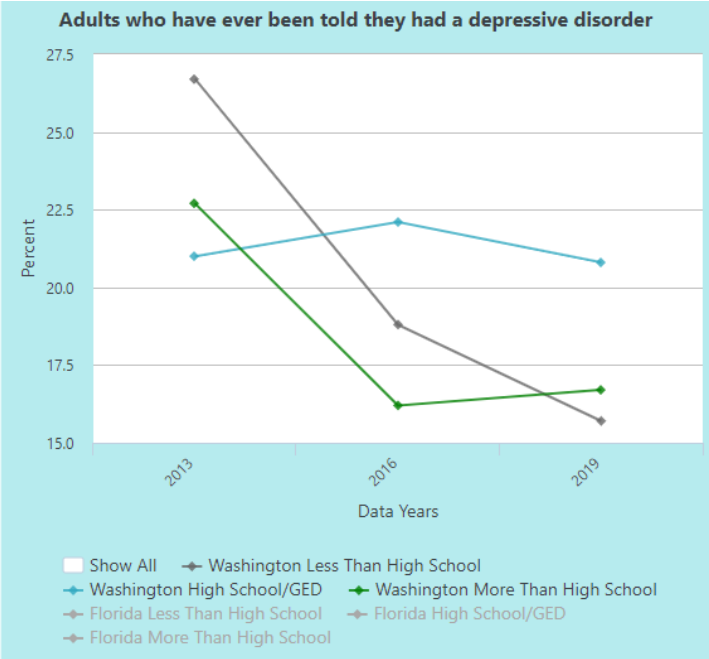
2022 data from the “Analysis of the Health Disparities Among People Living with Disabilities,” there is not a significant difference in the prevalence of smoking between those with at least one disability and those without disability.

Binge drinking (5 or more drinks for males and 4 or more drinks for females during a single occasion) has also been linked to an increased risk of developing several chronic diseases, including diabetes (Polsky & Akturk, 2017). Binge drinking is associated with poor diabetic health outcomes, due to decreased self-care adherence (Engler, Ramsey & Smith, 2013). Additionally, illicit opioid drug use negatively impacts diabetic outcomes through interaction with metabolic pathways (Malinovská, 2020).

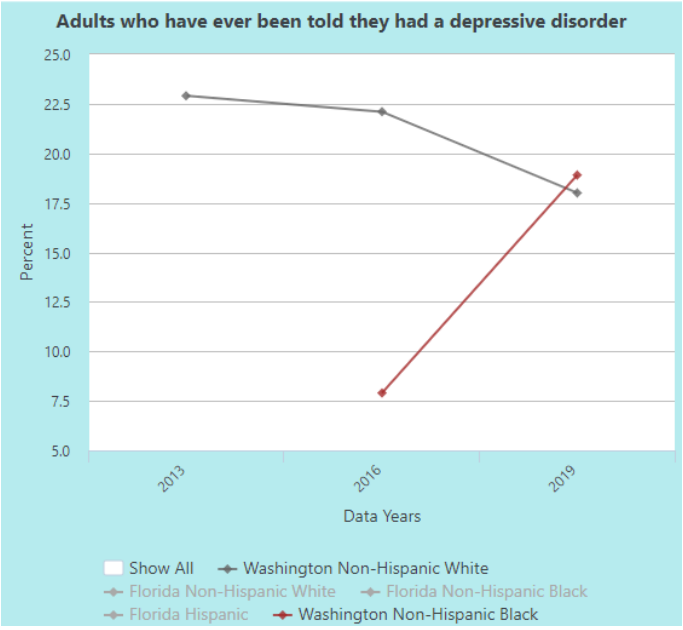
Due to the rates of substance abuse among Washington County residents and the known adverse associations between substance abuse and diabetes, Washington County residents are at a higher risk of poor diabetic outcomes.



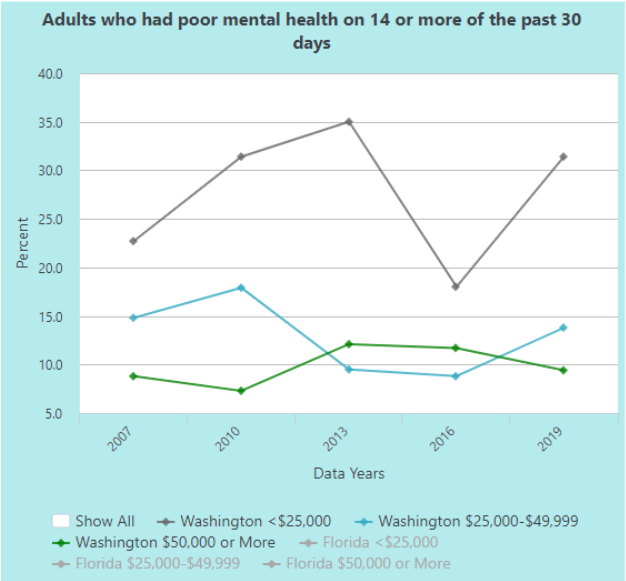
Graph 5.0. According to FL CHARTS data, Washington County residents with an annual household income of less than $25,000 were more likely to have ever been told they had a depressive disorder than those with an income of $25,000 to $49,999 or more than $50,000.



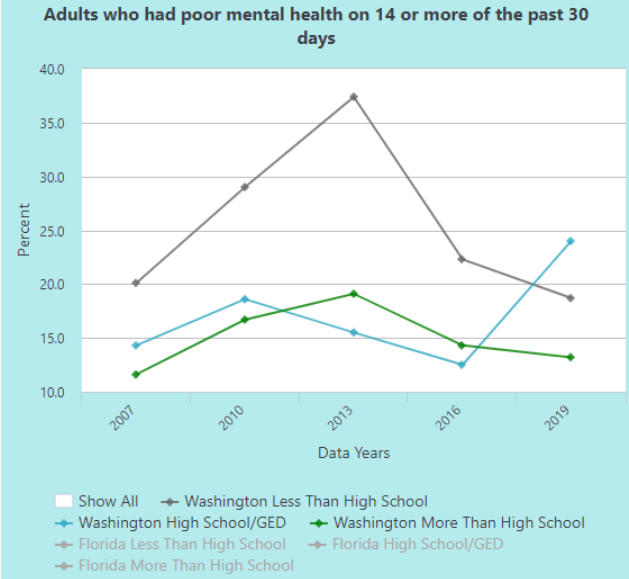
Graph 5.1. Per FL CHARTS data, adults in Washington County that had a high school education were more likely to have ever been told they had a depressive disorder than those with less than a high school education or a higher education.



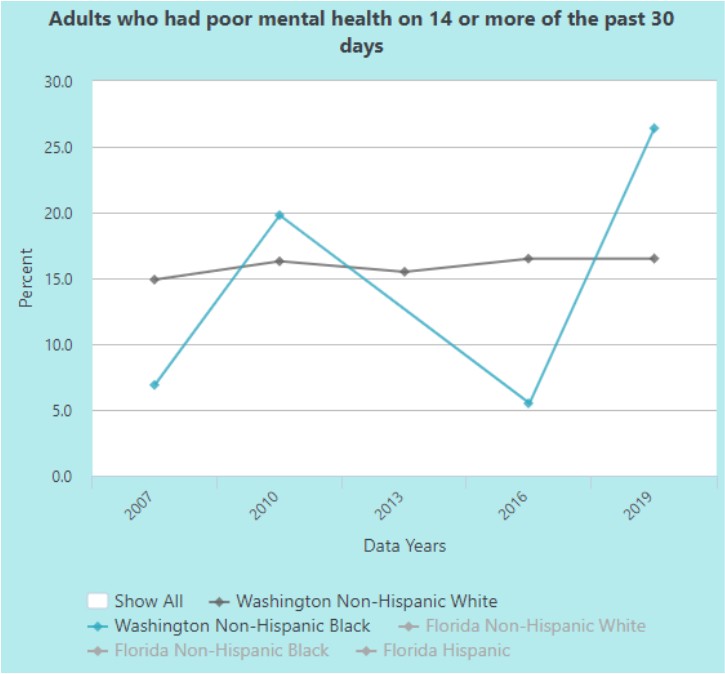
Graph 5.2. In 2019, FL CHARTS data indicated that the percentage of adults who had ever been told they had a depressive disorder was slightly higher for non-Hispanic Black adults than non-Hispanic White adults.



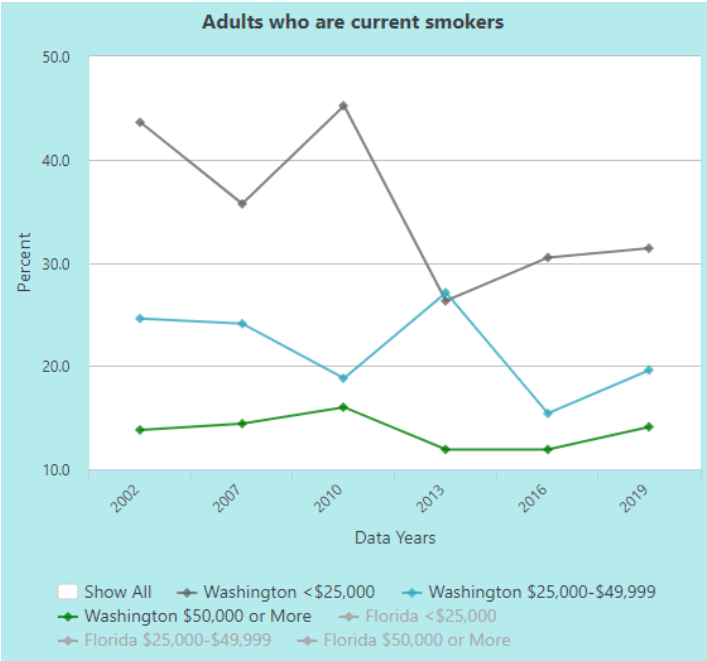
Graph 5.3. Washington County adults with a lower annual household income were more likely to have experienced poor mental health days on 14 or more of the past 30 days than those with a higher annual household income, per FL CHARTS.



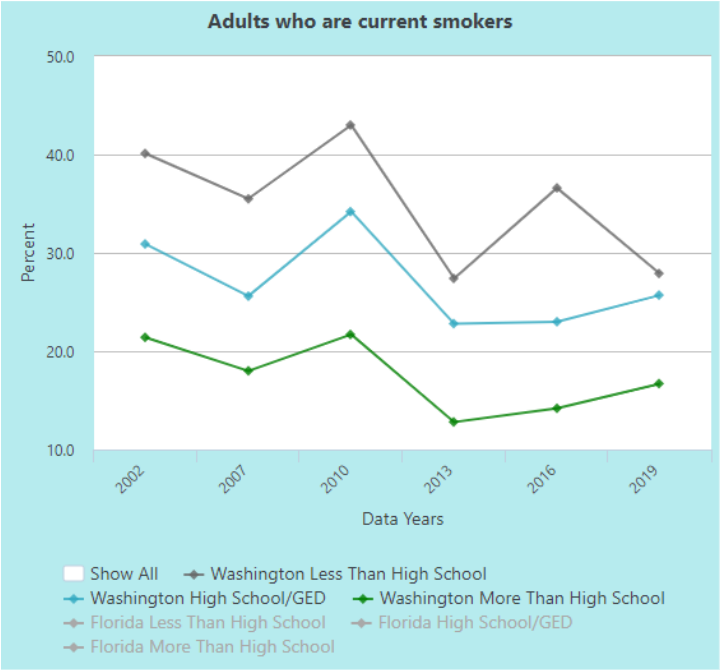
Graph 5.4. Per FL CHARTS 2019 data, adults in Washington County that had a high school education were more likely to have experienced poor mental health days on 14 or more of the past 30 days than those with less than a high school education or a higher education.



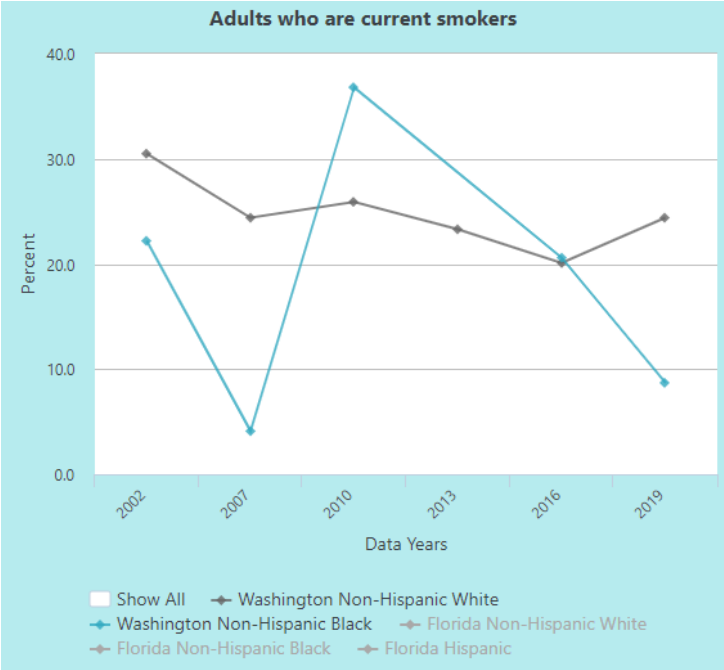
Graph 5.5. In 2019, FL CHARTS data indicated that the percentage of adults who had experienced poor mental health days on 14 or more of the past 30 days was higher for non-Hispanic Black adults than non-Hispanic White adults.



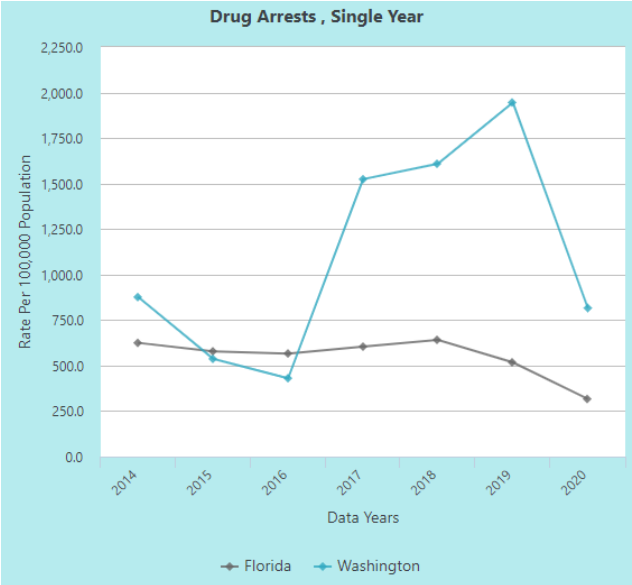
Graph 5.6. Data from FL CHARTS showed that Washington County adults with lower household income were more likely to be current smokers.



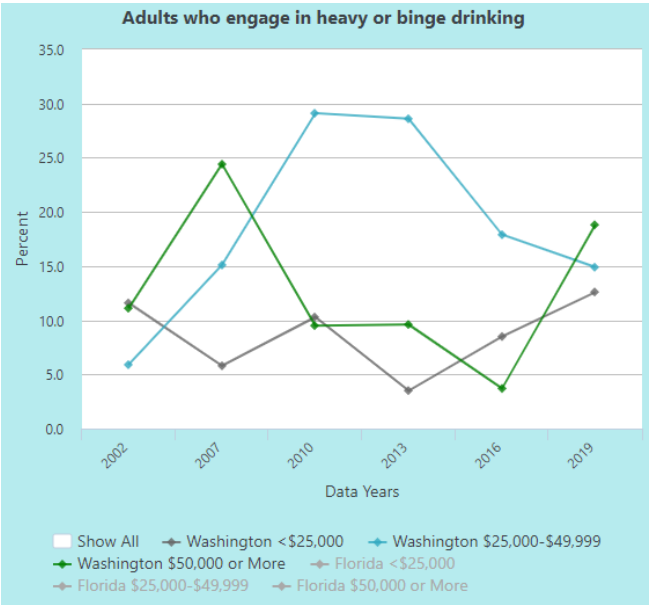
Graph 5.7. Washington County adults with a lower formal education level were also more likely to be current smokers, per FL CHARTS 2019 data.



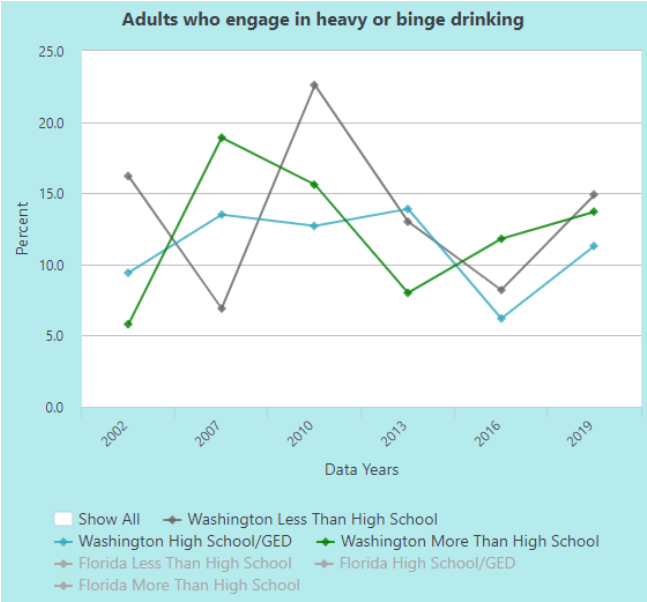
Graph 5.8. Per 2019 FL CHARTS data, non-Hispanic White adults in Washington County were more likely to be current smokers than non-Hispanic Black adults.



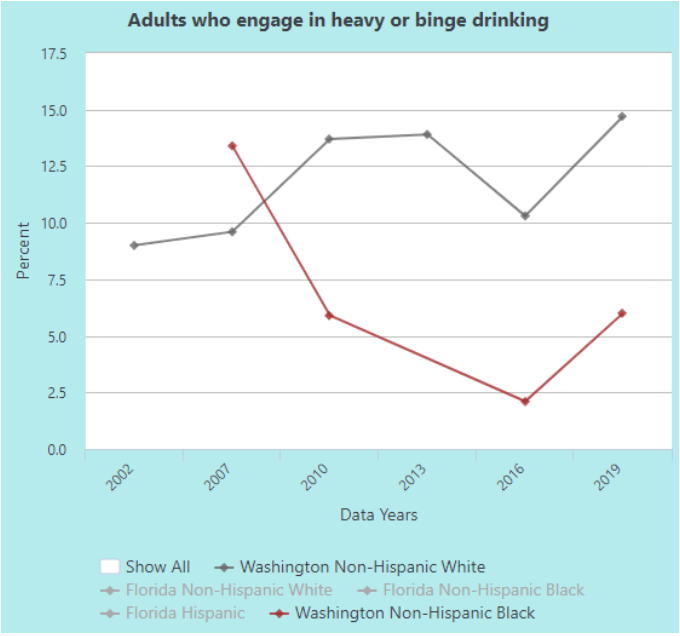
Graph 5.9. While there was no specific data regarding illicit drug use, the rate of adult drug arrests in Washington County was much higher than the Florida average. There was no data in FL CHARTS stratifying Washington County adult drug arrests by sociodemographic factors.



Graph 5.10. According to 2019 FL CHARTS data, adults in Washington County with an average household income of $50,000 or more were more likely to engage in binge drinking than those whose household income of $25,000-$49,999 or less than $25,000 a year.



Graph 5.11. Washington County adults that have graduated high school or obtained a GED were at higher risk for engaging in binge drinking than those who did not graduate high school or attended higher education, per FL CHARTS data.



Graph 5.12. According to 2019 FL CHARTS data, non-Hispanic White adults in Washington County were more likely to engage in binge drinking than non-Hispanic Black adults.

Social and Community Context		
SDOH	**Vulnerable Populations Impacted**	**SDOH Impact on Diabetes Disparity**
Mental Health Illness	Rural, Low SES, Racial and Ethnic Minorities, Disabled	Those with mental health illnesses have a higher risk of developing diabetes and experiencing poorer health outcomes.
Substance Abuse	Rural, Low SES, Racial and Ethnic Minorities	Substance abuse has been linked to adverse outcomes and increased incidence of diabetes.

E. Health Care Access and Quality

Easy access to primary healthcare providers has been shown to decrease hospitalization and medical emergencies, as well as improve health outcomes (Shi, 2012). Lack of transportation, cost, inadequate health insurance, and provider availability are often cited as known barriers to access to care in rural, low-income areas such as Washington County (Syed, Gerber & Sharp, 2013).

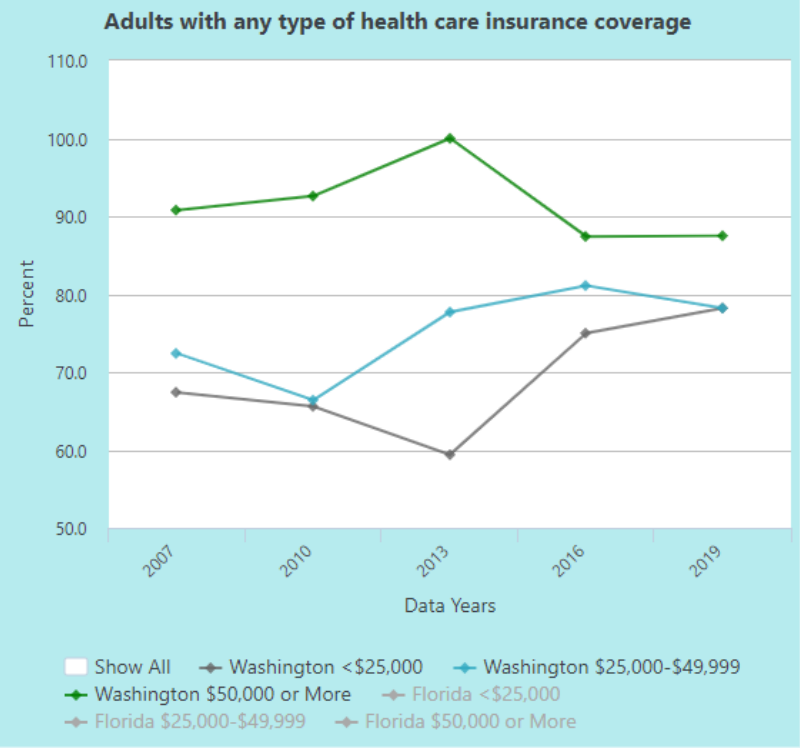
Washington County has one hospital, Northwest Florida Community Hospital, located in the county seat of Chipley. The facility has 59 beds in addition to a 34-bed Long Term Care Facility and 25-bed Critical Access hospital. It also includes Health Clinics, a Home Health Agency, and a clinic located in Vernon. There are numerous primary care providers within the city limits of Chipley and two within the city limits of Vernon. However, there are no other primary care providers outside of these areas. Residents from more rural communities in the county must travel a significant distance to reach healthcare providers.

According to 2022 data from the “Analysis of the Health Disparities Among People Living with Disabilities,” Washington County residents with at least one disability were significantly ($p < 0.001$) more likely to be delayed in receiving medical care due to transportation issues than residents without a disability.

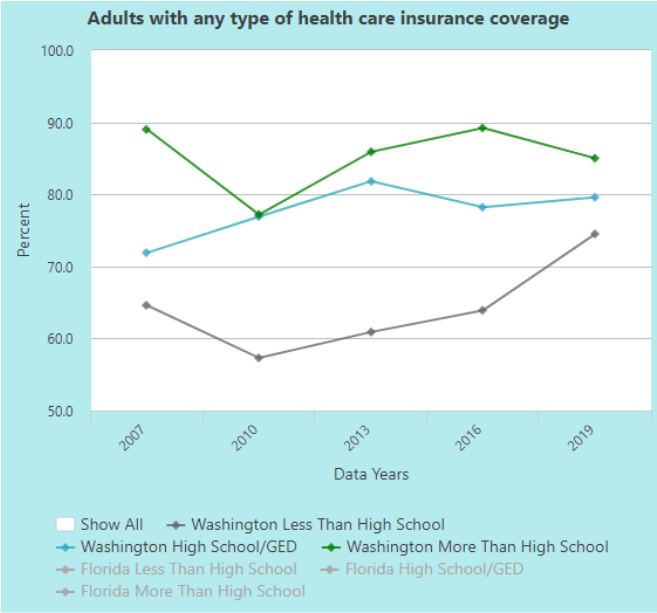
Research suggests that insurance stability improves clinical care regarding diabetes management. In a study by Brown et al. (2021), it was found that insurance stability was associated with better glycemic control.

According to the American Community Survey, 55.8% of Washington County residents had private health insurance in 2020 (ACS, 2021). An estimated 42.7% of residents had public coverage, and 15.9% were uninsured (ACS, 2021). The FDOH-Washington, the Federal Qualified Health Center, and Pancare, offer medical and dental care to residents that are uninsured. However, the self-pay prices of local private providers may serve as a barrier to healthcare access.

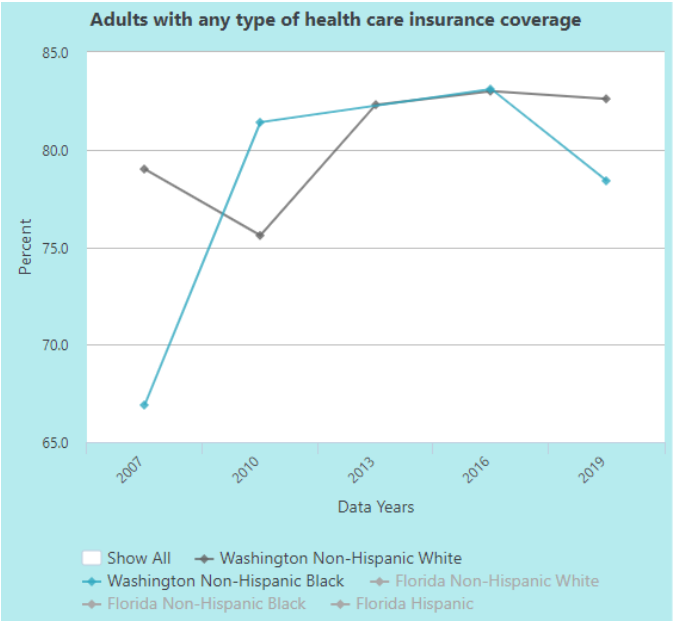
Data from the 2022 “Analysis of the Health Disparities Among People Living with Disabilities” shows that there is not a significant difference in health care insurance coverage between individuals with at least one disability and individuals without disability.



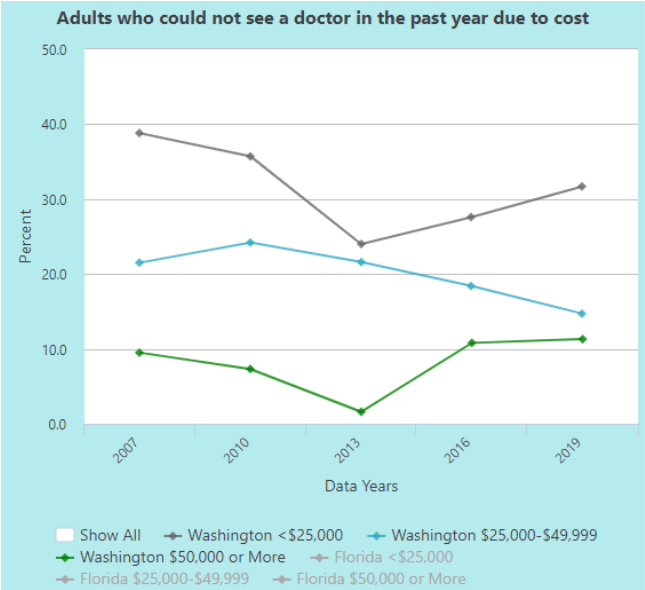
Graph 6.0. According to FL CHARTS data, residents of Washington County with a household income of less than $25,000 were less likely to have any type of healthcare insurance coverage than those with a household income of $25,000 to $49,000 or more than $50,000.



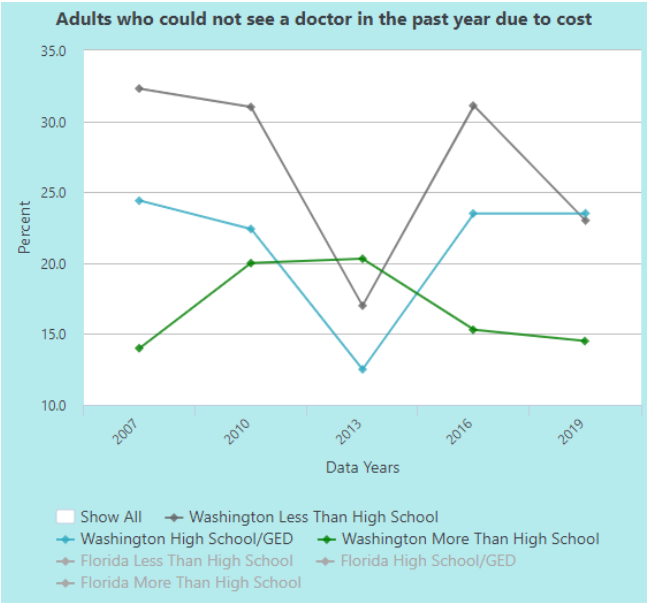
Graph 6.1. Washington County adults with less than a high school education were less likely to have any type of healthcare insurance coverage, compared to those with a high school education or those with a higher education, per FL CHARTS.



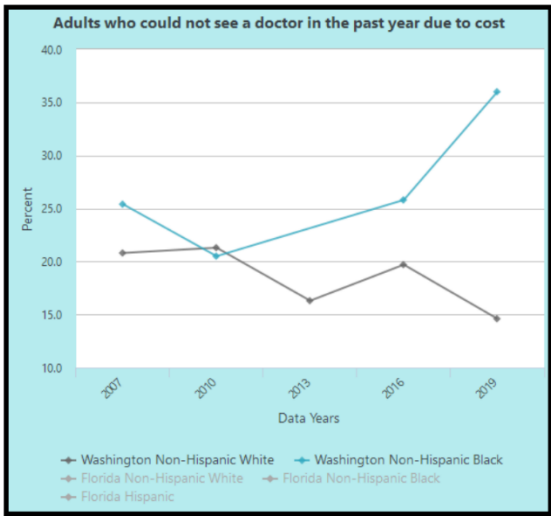
Graph 6.2. Data in FL CHARTS indicated that in 2019 Black adults in Washington County were less likely to have any type of health care insurance coverage than White adults.



Graph 6.3. FL CHARTS showed that Washington County adults with a household income of less than $25,000 were more likely to be unable to see a doctor in the past year due to cost than those with a household income of $25,000 to $49,999 or more than $50,000.



Graph 6.4. Washington County Residents with less than a high school education and those with a high school education were more likely to be unable to see a doctor in the past years due to cost than those with a higher education, per FL CHARTS data.



Graph 6.5. According to FL CHARTS data, there is a growing disparity regarding access to healthcare. In 2019, 36% of Non-Hispanic Black adults could not see a doctor in the past year due to cost. The rate for Non-Hispanic White adults was 14.6%.

Health Care Access and Quality		
SDOH	**Vulnerable Populations Impacted**	**SDOH Impact on Diabetes Disparity**
Health Coverage	Uninsured, Unemployed, Low SES	Health insurance coverage is linked to access to screening services and preventative care and better management of chronic disease, such as diabetes.
Price	Low SES, Disability, Racial and Ethnic Minorities	High cost is a significant limiting factor for those seeking healthcare services for management of chronic diseases, such as diabetes.
Provider Availability	Rural residents, Low SES	A shortage of providers in rural areas make it difficult to be seen for medical 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 SDOHs identified by the Health Equity Team during recruitment.

During Task Force meetings access to health care, transportation needs, and food deserts were discussed. Identified barriers predominately affect rural areas, because they are miles away from providers, clinics, and fresh fruit and vegetable markets. Rural areas have less access to communication methods and find it hard to get transportation to and from the doctor.

A. Data Review

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

Data review revealed that the proportion of adults who had ever been told they had diabetes was much higher in Washington County than the state average (Graph 1.0). In addition, data shows that adults who had ever been told they had diabetes were more likely to be Black (Graph 1.3), female (Graph 1.5), ages 65 and older (Graph 1.4), less educated (Graph 1.2), low income (Graph 1.1), or disabled.

Regarding the SDOH of Education Quality and Access, individuals over the age of 25 without a high school diploma were more likely to be Black than White (Graph 2.1). Also, the graduation rate was higher for non-disabled individuals than for disabled individuals (Graph 2.2). There were no other statistics differentiating graduation rate by income, gender, or other sociodemographic factors.

In the SDOH category of Economic Stability, the percentage of Washington County residents under the poverty level was much higher in the Black population compared to the White population (Graph 3.0). However, the unemployment rate was lower for Black individuals than White individuals in 2019 and 2020 (Graph 3.1).

Regarding the SDOH of Built Environment and Neighborhood, data review revealed that an extremely small percentage of the Washington County population lived near a public park or a healthy food source (Graphs 4.1, Graph 4.2). Data review also showed that the rate of food insecurity was much higher in Washington County compared to the state average (Graph 4.0). Several factors contributed to the high rate of food insecurity, including lack of a public transportation system in the county. There were no other statistics differentiating food insecurity by race, income, gender, or other sociodemographic factors.

In the SDOH category of Social and Community Context, increased incidence of diabetes has been associated with mental health illness and substance abuse. A review of Washington County data revealed that individuals who have ever been told they had a depressive disorder or had poor mental health on 14 of the last 30 days were more likely to be Black (Graph 5.2, Graph 5.5), low income (Graph 5.0, Graph 5.3), or less than college educated (Graph 5.1, Graph 5.4). Substance abuse in Washington County can be assessed by reviewing rates of smoking, binge drinking, and drug-related arrests. The rates of adults who were current smokers and annual drug arrests were higher in Washington County than the state average (Graph 5.6 – Graph 5.9). Current smokers in Washington County were more likely to be White (Graph 5.8), less educated (Graph 5.7), or lower income (Graph 5.6). There were no statistics differentiating drug arrests by race, income, gender, education, or other sociodemographic factors.

Regarding the SDOH of Healthcare Access and Quality, Washington County residents were less likely to have any type of health care insurance than the Florida average. Individuals without insurance were more likely to be Black (Graph 6.2), less educated (Graph 6.1), and lower income (Graph 6.2). Washington County residents who could not see a doctor in the past year due to cost were more likely to be Black (Graph 6.5), less educated (Graph 6.4), or lower income (Graph 6.3).

B. Barrier Identification

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

Partners	SDOH	Partner Barriers	Collaborative Strategies
Northwest Florida Community Hospital	Access to Healthcare	Getting patients to their medical appointments, communication	Direct communication
Tri-County Transportation	Transportation	Not enough drivers, communication	Better strategic marketing
FDOH-Jackson	Access to Healthcare	Communication, Transportation	Direct communication, available transportation
Washington County Council on Aging	Access to Healthcare, Food Deserts	Transportation, restrictions	Speaking with markets that accept fruit and vegetable vouchers from seniors.
Faith-Based Organizations	Access to Healthcare, Transportation, and Food Deserts	Method of communication, access to healthcare, and transportation	Direct communication, available resources, more community outreach
Shepherd's Gate Food Bank	Food Deserts	Available resources, communication	More community outreach and expand available resources
FDOH Disaster and Preparedness	Transportation, Food Deserts	Communication	Direct communication

C. Community Projects

The FDOH-Washington chose Mobilizing for Action through Planning and Partnership (MAPP) for the Task Force. Local health leaders facilitate meetings to better the community. A Task Force of community leaders, faith-based organizations, businesses, and food banks has been organized to visualize and brainstorm community improvement projects. Strategic meetings and brainstorming sessions to improve community SDOH have been conducted. The short-, medium-, and long-term goals have actions in place to carry out the vision and mission.

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 SDOHs. 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.

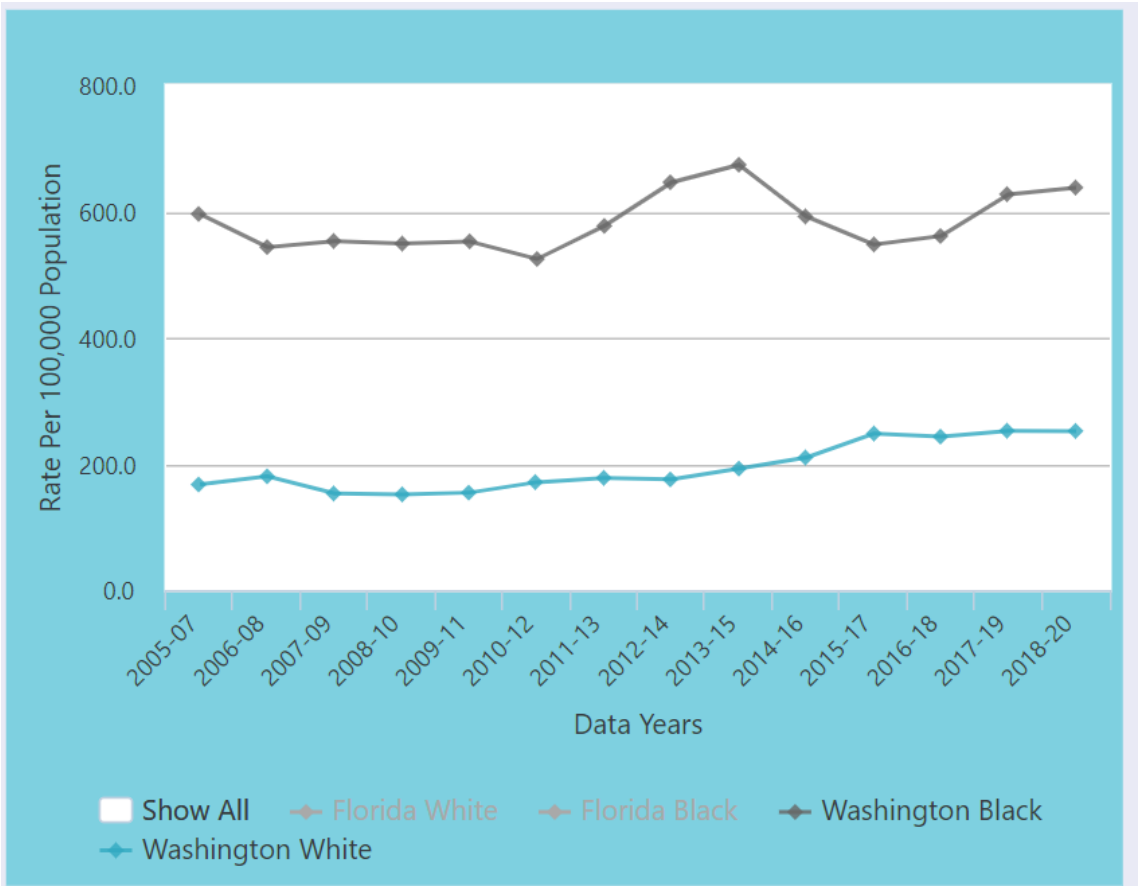
Since having the Task Force meetings there has been a change in the Washington County Summer Lunch Program, where Campbell Park (one of the rural areas) has been included in the summer program. Washington County School District will now deliver breakfast and lunch meals at Campbell Park in Ebro. Additionally, direct communication and partnerships have been formed from the Task Force meetings.

IX. HEALTH EQUITY PLAN OBJECTIVES

A. Diabetes

Objective: By June 2027, decrease age-adjust the 3-year rolling rate of emergency department visits from diabetes among Washington County African-American residents by 10%, from 638 per 100,000 to 574 per 100,000.

The objective of a 10% decrease in the age-adjusted, 3-year rolling rate of emergency department visits from diabetes among Washington County African-American residents is feasible, because a similar change was seen over the trends from the past 5 years.



Graph 7.0. The 3-year rolling rate of emergency department visits from diabetes among Black residents has been higher than White residents in Washington County throughout previous years.

Access to Care Project Storyboard

Access to Care Project

HEALTH EQUITY PROJECT EXECUTIVE SUMMARY

Florida Department of Health in Washington County
Contact Information: FaNeician Russ | 850-703-5624 | faneician.russ@flhealth.gov

PROBLEM
Diabetes and Pre-diabetes disproportionately affect minority populations in Washington County. Being a rural and medically underserved area, it is difficult for residents to manage their diabetes due to limited access to care.

EMPOWERED

"YOURSELF AND YOUR HEALTH"

SOCIAL DETERMINANTS OF HEALTH ADDRESSED
Health Care Access and Quality, Social and Community Context

PRIORITY POPULATIONS
African American Washington County residents.

PARTNERS
Northwest Florida Community Hospital, Tri-County Transportation, Faith-Based Organizations.

PROJECT GOAL
Increase access to healthcare for rural and minority populations in Washington County.

FUNDING & FEASIBILITY
Funding for this project is supported by the Florida Department of Health in Washington County through the CDC Covid Disparities grant. These projects were deemed feasible due to the already existing relationships with community partners.

CLAS STANDARD OPERATIONALIZED
Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.

PROJECT OBJECTIVE
By June 2027, decrease the percentage of adults who could not see a doctor due to cost by 20%.

SUMMARY OF ACTIONS
1. Review data on healthcare access and diabetes prevalence in Washington County.
2. Coordinate with community partners to develop plans for increasing access to care.
3. Identify grants that could be improve access to care initiatives.
4. Task force members will apply for grants to fund access to care initiatives.
5. Monitor and evaluate improvements and identify successes.

RESULTS
Please not that this area will be completed once the project has ended.

NEXT STEPS
Please note that this area will be completed once the project has ended.

Food Desert Project Storyboard

Food Desert Project

HEALTH EQUITY PROJECT EXECUTIVE SUMMARY

Florida Department of Health in Washington County
Contact Information: FaNeician Russ | 850-703-5624 | faneician.russ@flhealth.gov

PROBLEM
Diabetes and Pre-diabetes disproportionately affect minority populations in Washington County. Being a rural and medically underserved area, it is difficult for residents to manage their diabetes due to limited access to nutritious foods.

EMPOWERED

"YOURSELF AND YOUR HEALTH"

SOCIAL DETERMINANTS OF HEALTH ADDRESSED
Neighborhood and Built Environment, Social and Community Context

PRIORITY POPULATIONS
African American and Rural Washington County residents.

PARTNERS
Washington County Council on Aging, Faith-Based Organizations, Shepherd's Gate Food Bank, Government agencies.

PROJECT GOAL
Decrease prevalence of food deserts in Washington County.

FUNDING & FEASIBILITY
Funding for this project is supported by the Florida Department of Health in Washington County through the CDC Covid Disparities grant. These projects were deemed feasible due to the already existing relationships with community partners.

CLAS STANDARD OPERATIONALIZED
Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.

PROJECT OBJECTIVE
By August 2024, increase the number of locations offering fresh fruits and vegetables in rural locations by 10%.

SUMMARY OF ACTIONS
1. Review data on food deserts and diabetes prevalence in Washington County.
2. Coordinate with community partners to develop plans for increasing access to nutritious food.
3. Implement project initiatives to increase availability of WIC qualifiable markets.
4. Monitor and evaluate improvements and identify successes.

RESULTS
Please not that this area will be completed once the project has ended.

NEXT STEPS
Please note that this area will be completed once the project has ended.

Access to Care Project Goals

	Lead Entity and Unit	Lead Point Person	Evaluation Measure	Baseline Value	Target Value	Plan Alignment
Short-Term SDOH Goal: To increase the capacity to provide reliable transportation and healthcare access for Washington County residents.						
Objective: By June 2021, increase the number of Health Equity Task Force meetings from 0 to 1.	FDOH-Washington	FaNeician Russ	Washington Health Equity Task Force Meeting Minutes	2020-0	2021-1	Completed
Medium-Term SDOH Goal: To increase transportation resources accessible for Washington County residents.						
Objective: By July 2023, increase the number of grants applied for by Health Equity Task Force members 0 to 1.	FDOH-Washington	FaNeician Russ	Washington Health Equity Task Force Meeting Minutes	2021-0	2023-1	
Long-Term SDOH Goal: To improve access to healthcare in Washington County.						
Objective: By June 2027, decrease the percentage of adults who could not see a	FDOH-Washington	FaNeician Russ	FL CHARTS	2019 – 36%	29%	

doctor due to cost by 20%.						

	Lead Entity and Unit	Lead Point Person	Evaluation Measure	Baseline Value	Target Value	Plan Alignment
Short-Term SDOH Goal: To improve access to meals for children during summer break.						
Objective: By June 2022, increase the number of school lunch program distribution center to more rural areas in the county, from 4 to 5.	Washington County School District	Jiranda White Director of Federal Programs.	Summer Lunch Program records	2021-4	2022-5	Completed
Medium-Term SDOH Goal: To improve access to healthy food available in Washington County.						
Objective: By June 2022, increase WIC and agricultural program information distribution points at markets from 3 to 4.	Washington County Council on Aging	Tracey Long	WIC	2021-3	2022-4	
Long-Term SDOH Goal: To reduce the amount of food deserts in Washington County.						
Objective: By August 2024, increase the number of locations offering fresh fruits and vegetables in rural locations by 10%.	FDOH-Washington	FaNeician Russ	Retailer evaluation	TBD	TBD	

Food Deserts Project Goals

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. Regional Health Equity Coordinators facilitate systematic communication within their region. Systematic information-sharing enables successful practices to be replicated in other counties and programs.

The Minority Health Liaison serves as the point of contact in their county for sharing progress updates, implementation barriers, and best practices associated with the Health Equity Plan. The Minority Health Liaison is responsible for gathering data, monitoring progression, and reporting results of Health Equity Plan implementation.

At least quarterly, the Minority Health Liaison meets with the Health Equity Taskforce to discuss progress and barriers. The Minority Health Liaison tracks and submits indicator values to the OMHHE within 15 days of the quarter end.

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

XI. REVISIONS

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

Revision	Revised By	Revision Date	Rationale for Revision

XII. CITATIONS

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