DOH-SARASOTA

HEALTH EQUITY PLAN

July 2022 – June 2027

Approved July 26, 2022

Rev. Nov. 22, 2022

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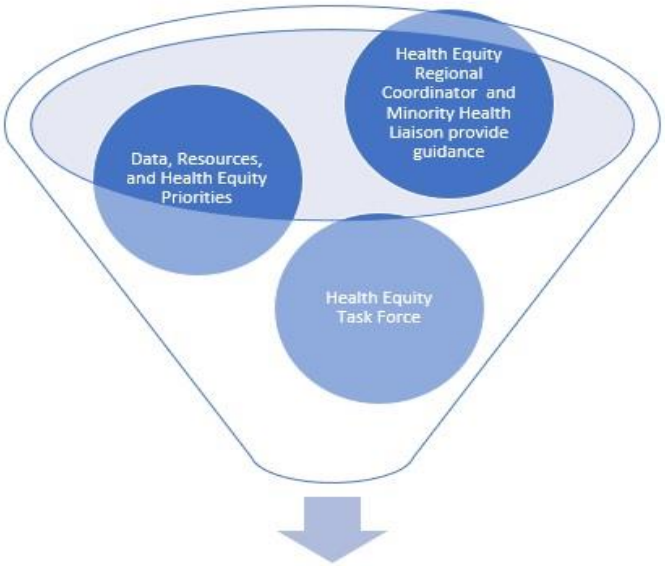
I. VISION

The vision for the Community Health Improvement Plan guided the DOH-Sarasota Health Equity Team. Based on discussion about what health equity would look like in an ideal community, key phrases and words were used to develop vision and mission statements. At the next meeting of the Health Equity Taskforce, the group considered the same question about what health equity would look like for our community. Again, key phrases and words were gathered to development a vision and mission statement. The statements from both groups were almost identical and presented to the full Health Equity Coalition where a final vision and mission statement were agreed upon.



Vision: A Sarasota County where equity is experienced by all members of the community for generations to come.

Mission: To educate and empower Sarasota County residents and stakeholders to address social determinants of health through education, policy, and practice leading to improved health and well-being for all residents through increased equity.

II. PURPOSE OF THE HEALTH EQUITY PLAN

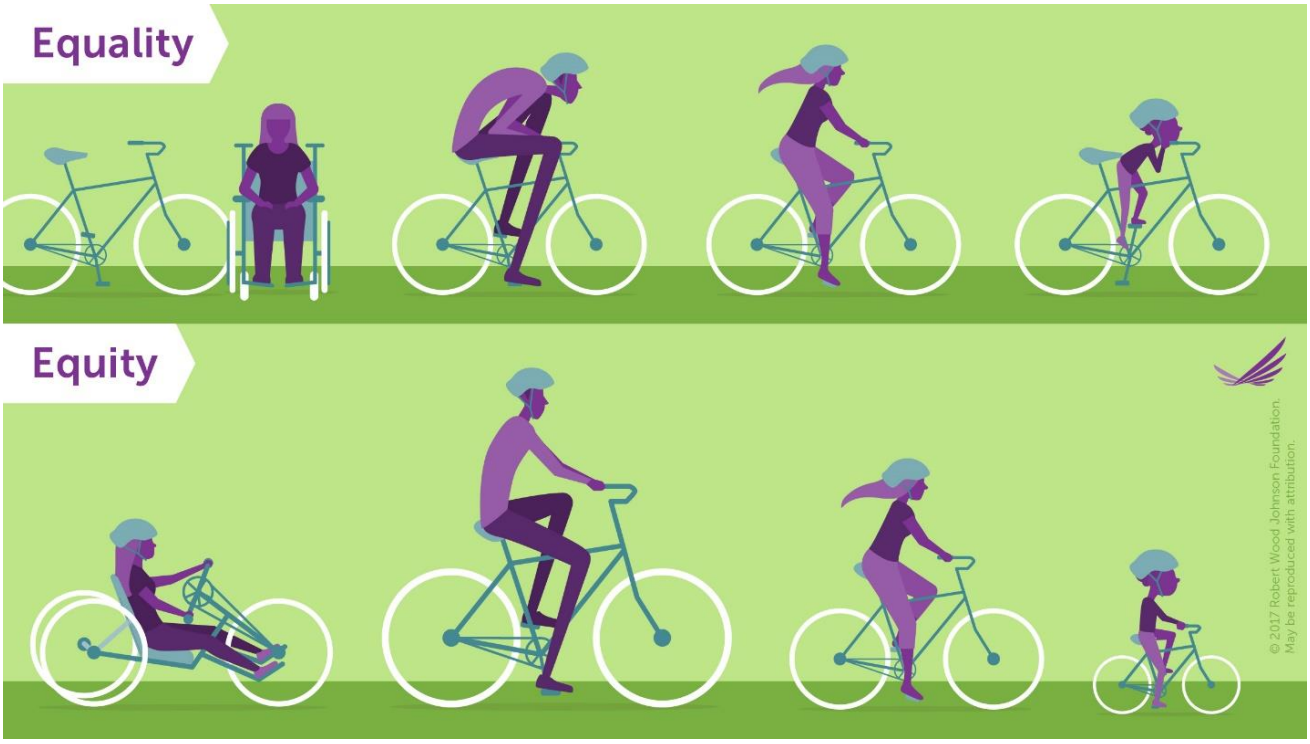
Health Equity is achieved when everyone can attain optimal health.

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

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

The purpose of the Health Equity Plan is to increase health equity within Sarasota County. To develop this plan, Sarasota 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 Sarasota County. This Health Equity Plan is not a county health department plan; it is a county-wide Health Equity Plan through which the Health Equity Taskforce, including a variety of government, non-profit, and other community organizations, align to address the SDOH impact health and well-being in the county.

III. DEFINITIONS



Health equity is achieved when everyone can attain optimal health

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

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

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

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

IV. PARTICIPATION

Cross-sector collaborations and partnerships are essential components of improving health and well-being. 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.

In Sarasota County, the Community Health Improvement Plan Leadership Council was the basis for the Health Equity Coalition. From there, additional key partners were added based on group discussion and brainstorming. Communication took place regularly to engage partners and foster collaboration.

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: Stephanie Seiffert
Minority Health Liaison Backup: Beth Kregenow

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 Sarasota to the Health Equity Taskforce. The Minority Health Liaison guides these discussions and the implementation of initiatives. Currently, the Health Equity Team meets monthly. The membership of the Health Equity Team is below.

Name	Title	Program
Lynette Herbert	Assistant Director/MHL Backup	Sarasota DOH
Stephanie Seiffert	Minority Health & Health Equity Liaison	Health Promotion, Education & Planning, Sarasota DOH
Audrey Shockley-Cummings	APRN	Specialty Services Clinic
Catherine Jones	Clerk	Health In Motion Team
William Freitas	Quality Control Administrator	Employee Development
Aleksandra Fitzgibbons	Immunization Program Director	Immunization Programs

Gary Ervin	Health Services Representative	Disease Intervention Services
Jerald Berry	Community Planner	Environmental Health
William Higginbotham	Director	Environmental Health
Ann Pollard	ARNP	Specialty Clinic
Candy Leckey	Asst. Community Health Nursing Director	Clinic Administration
Latalya Williams	Lab Manager	Lab
Marilee Ehresman	RN	Health in Motion/MMU

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
12/21/2021	Establish Health Equity Team, Disparities Data
1/18/2022	Health Equity Team Charter; Health Disparity & SDoH Data and Discussion, Vision Statement
2/15/2022	Internal Needs for Staff, Diabetes Data,
3/8/2022	Training Opportunities & Needs for Staff; SDoH Data
4/19/2022	Education Opportunities for Staff and Partners, Current SDoH and Diabetes Data
7/19/22	Health Equity Monthly Team Meeting
8/16/22	Health Equity Monthly Team Meeting
9/20/22	Health Equity Monthly Team Meeting
10/18/22	Health Equity Monthly Team Meeting. Intro to new Sarasota DOH MHL and SWFL Regional Coordinator, Frank Diaz, gave presentation on health equity and the SDoH. Discussed/shared Health Equity Plan Executive Summary, planned November National Diabetes Awareness Month Activities

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 Sarasota Health Equity Plan and oversaw the design and implementation of projects. Health Equity Taskforce members are listed below.

Name	Title	Organization	Social Determinant of Health
Maria Jose (MJ) Horen	Chief Program Officer	All Faiths Food Bank	Economic Stability
Chelsea Arnold	Initiative Manager	First 1000 Days Suncoast	Neighborhood & Built Environment and Social & Community Context
Matthew Elmer Sauer	Collaboration and Impact Officer	Charles & Margery Barancik Foundation	All SDoH
Mari Barnes	Vice President and Co-Founder	Lab Services	Health Care Access & Quality and Economic Development
Lisa Merritt MD	Executive Director	Multicultural Health Institute	Health Care Access & Quality
Lynette Herbert	Assistant Director	Sarasota DOH	Back Up Minority Health Liaison
Peter Casamento	Executive Director	Laurel Civic Agency	Social & Community Context
Pam Beitlich	Executive Director, Women & Children Services	Sarasota Memorial Healthcare System	Health Care Access & Quality
Stephanie Seiffert	CHIP Coordinator, Minority Health & Health Equity Liaison	Sarasota DOH	All SDoH
Dr. Vida Farhangi	Clinical Director	SMH Newtown Clinic	Healthcare Access & Quality

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

1/20/2022	DOH-Sarasota, Charles & Margery Barancik Foundation, First 1000 Days Suncoast, Sarasota Memorial Health Care, Multicultural Health Institute, Laurel Civic Agency, All Faiths Food Bank	Charter; Assessment; Current SDoH & Disparities Data
1/27/2022	DOH-Sarasota, Charles & Margery Barancik Foundation, First 1000 Days Suncoast, Sarasota Memorial Health Care, Multicultural Health Institute, Laurel Civic Agency, All Faiths Food Bank	Assessment; Health Disparity Data Shared by HE Team for HIV and Diabetes; Vision Statement Proposed
2/24/2022	DOH-Sarasota, Charles & Margery Barancik Foundation, First 1000 Days Suncoast, Sarasota Memorial Health Care, Multicultural Health Institute, Laurel Civic Agency, All Faiths Food Bank	SDoH Data and Diabetes Outcomes
3/31/2022	DOH-Sarasota, Charles & Margery Barancik Foundation, First 1000 Days Suncoast, Sarasota Memorial Health Care, Multicultural Health Institute, Laurel Civic Agency, All Faiths Food Bank	Goals & Objectives; Projects
4/28/2022	DOH-Sarasota, Charles & Margery Barancik Foundation, First 1000 Days Suncoast, Sarasota Memorial Health Care, Multicultural Health Institute, Laurel Civic Agency, All Faiths Food Bank, Lab Services	SDoH Data Section; SDoH Projects
7/26/22	Health Equity Task Force Meeting	Approved Sarasota County Health Equity Plan
8/3/22	Health Equity Coalition Meeting	Notified of Health Equity Plan publication on 7/29/22 and about interviews for new MHL during August 2022
10/3/22	DOH - Sarasota, Charles & Margery Barancik Foundation, Sarasota Memorial Health Care, Laurel Civic Agency, Gulf Coast Community Foundation, Centerplace Health, Glasser-	First Combined meeting of the CHIP Leadership Council and Health Equity Coalition;

	Schoenbaum (Community Alliance), Sarasota County HHS, Safe Children Coalition, Drug Free Sarasota, First 1000 Days, UF IFAS Extension, Englewood Community Coalition/CDC Drug Free Communities, Safe Guard Home Health Care/The Class Foundation, FSU College of Medicine, Alzheimer's Association, Multicultural Health Institute (MHI), Community Members from Newtown, LOVN CHATS, Labs Services	reviewed several CHIP objectives/edits, voted on incorporating the Health Equity Plan objectives into the CHIP plan Introduced to new MHL start date 9/3022

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-SDoH. The Coalition assisted the Health Equity Taskforce by reviewing their Health Equity Plan for feasibility. See Addendum A for a list of Coalition members.

E. Regional Health Equity Coordinators

There are eight Regional Health Equity Coordinators. These coordinators provide the Minority Health Liaison, Health Equity Team, and Health Equity 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
Vacant	Southeast

V. HEALTH EQUITY ASSESSMENT, TRAINING, AND PROMOTION

A. Health Equity Assessment

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

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

Sarasota County conducted a health equity assessment to examine the capacity and knowledge of Sarasota CHD staff and county partners to address social determinants of health. This took place during the first two meetings of the Taskforce on January 20 and 27, 2022. It included information about health equity and discussion about social determinants of health.

B. County Health Equity Training

Assessing the capacity and knowledge of health equity, through the assessment, helped the Minority Health Liaison identify knowledge gaps and create training plans for the Health Equity Team, Taskforce, Coalition, and other county partners.

The Florida Department of Health in Sarasota County recognizes that ongoing training in health equity and cultural competency are critical for creating a sustainable health equity focus. At a minimum, all DOH-Sarasota staff receive the *Cultural Awareness: Introduction to Cultural Competency* and *Addressing Health Equity: A Public Health Essential* training. In addition, the Health Equity Team provided training to staff on health equity and cultural competency during April. Further, community training was offered to community partners, Taskforce, and Coalition members. The training is listed below.

Date	Topics	Number of Staff in Attendance/ Organizations that Attended
April 4, 2022 April 5, 2022 April 6, 2022 April 7, 2022 April 8, 2022	National Public Health Week Emails – Each day included links to SDOH, Equity, and video	Sent to all Staff
April 1 – 30, 2022	National Minority Health Month Stall Talk	Shared with all Staff
May 18, 2022	Newtown Alive Trolley Tour – SDOH impacts on community	Multiple Community Partners and Staff
May 25, 2022	Venice History Tour – SDOH impacts on community	Multiple Community Partners and Staff

C. 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
August 2021 – May 2022 - Monthly	MHHE MHL Meeting
September 9, 2021	Racism and the Economy: Focus on Health
September 29, 2021	Best Practices in Public Health Communication to Promote Equity and Inclusion
October 5, 2021	Healthy People 2030 - Partnering on the Social Determinants of Health
November 18, 2021	MHHE MHL Meeting
December 2, 2021	Regional MHL Meeting
December 10, 2021	HDG21 Work Plan Development
January 26, 2022	Cultural Competency and Health Equity Training
February 21, 2022	Regional MHL Meeting
April 8, 2022 - Biweekly	Regional MHL Meetings
May 4-5, 2022	Florida Blue Foundation Conference - Big Issues in Health: A Focus on Health Equity

July 25, 2022	MHL Onboarding Orientation
July 28, 2022	SW Regional MHL/HE Meeting
August 18, 2022	State Monthly Minority Health Liaison Meeting
September 15, 2022	State Monthly Minority Health Liaison Meeting
Oct. 20.2022	Monthly MHL Meeting
Oct. 24, 2022	Launch Day - Health Equity: Health Providers Training Program
Oct. 26, 20222	Florida Health Literacy Virtual Summit
Oct. 27, 2022	Health Equity and HDG21 Q1 Report Meeting for Southwest Region
Oct. 31, 2022	OMHHE MHL Virtual Onboarding Orientation
Oct. 24- 31, 2022	Completed 6 Assigned, self-paced health equity training program modules for MHL cohort

D. National Minority Health Month Promotion

On Saturday, April 9, 2022, DOH-Sarasota and twenty community partners from the Health Equity Coalition partnered with the Newtown Nation Farmers Market to hold an event in honor of National Minority Health Month. This event was used to promote discussion around the Health Equity Plan that is being formed for Sarasota County with a focus on diabetes outcomes as the health disparity in our county. It was promoted through newspaper ads, mini-banners, and flyers. A regional press release was sent as well. With the theme of “Give Your Community A Boost,” community partners shared resources that exist in the community to impact social determinants of health. Resources addressed health issues and community needs throughout the lifespan. Games for youth, free food, music, and various health screenings were available. Additionally, COVID-19 vaccines were administered to residents during the event. We are happy to say that with the positive feedback, plans are in place for this to be a recurring event.

VI. PRIORITIZING A HEALTH DISPARITY

The Health Equity Team identified and reviewed health disparities data for Sarasota County. Data was pulled from multiple sources including:

- Charles & Margery Barancik Foundation and Gulf Coast Community Foundation Health Disparity Data Compilation
- Newtown Data Story
- Health Equity Profile on Florida Health Charts
- CDC Disability and Health Data System
- First 1,000 Days – Unite Us
- CARES Map Room
- Florida Department of Health – Florida Health Charts
- United States Census
- Kaiser Family Foundation Research Report
- JAMA
- US Department of Veterans Affairs

The following health disparity topics were identified in Sarasota County: HIV, diabetes, and asthma. Using a multi-voting technique, the Health Equity Team narrowed the scope based on a variety of factors including data, community capacity, and existing projects in the community. HIV and diabetes were presented as the top two priorities to the Health Equity Taskforce.

The Health Equity Taskforce made the final decision to work on diabetes in the Health Equity Plan since it impacts specific vulnerable populations in Sarasota County and requires attention to systems and policy change related to the SDOH. Data concerning diabetes in Sarasota County is following a general description of diabetes.

Diabetes is a life-long disease affecting how the body handles glucose (sugar). The body changes most of the food eaten into glucose, which the body uses for energy. Blood takes the glucose to the cells throughout the body and always has some glucose in it; however, too much glucose in the blood is not good for health. Diabetes means that blood glucose is too high.

Glucose needs insulin, a hormone made in the pancreas, to get into the body's cells. The pancreas releases insulin into the blood to assist with this process. If a body does not make enough insulin or the insulin does not assist the process correctly, glucose cannot get into the body's cells and stays in the blood. This makes blood glucose level high - causing diabetes.

Four types of diabetes are described below. For the purposes of the DOH-Sarasota Health Equity Plan, prediabetes and type 2 will be the focus.

- Type 1 diabetes is commonly diagnosed in children and young adults, and it is a lifelong condition. With this type, the body does not make insulin, so it must be injected daily. No prevention exists.
- Pre-diabetes is when blood glucose levels are elevated but are not high enough for a diagnosis of diabetes. Prediabetes raises your risk for type 2 diabetes, heart attack and stroke. Roughly 96 million American adults have prediabetes, but more than 80% do not know it.
- About 90 to 95% of people with diabetes have type 2. It develops over many years and is usually diagnosed in adults (but more and more in children, teens, and young adults). Type 2 diabetes occurs when the body makes insulin, but the insulin cannot do its job well, so glucose does not get into the cells. Type 2 diabetes can be prevented or delayed with healthy lifestyle changes, such as weight loss, making healthy food choices, and being physically active.
- Gestational diabetes develops in pregnant women who have never had diabetes. This type of diabetes is caused by a change in the way a woman's body responds to the hormone insulin during her pregnancy, resulting in elevated levels of blood glucose. Gestational diabetes usually goes away after birth, but it increases a woman's risk for type 2 diabetes later in life.

Data concerning diabetes in Sarasota County follows the general demographics below.

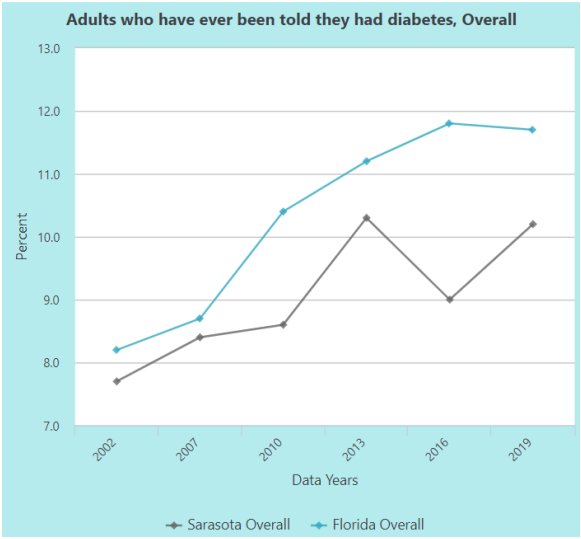
Per the 2020 U.S. Census, Sarasota County has a population of 434,006 with a median age of 56.6 and median household income of $64,644. The main ethnic group is non-Hispanic White at 82.8% of the population, and the largest age group belongs to the 65 years and over group at 37.3%. Percentages for various sectors of the population are below.

Age and Sex	
Persons under 5 years, percent	3.5%
Persons under 18 years, percent	14.0%
Persons 65 years and over, percent	37.3%
Female persons, percent	52.4%
Race and Hispanic Origin	
White alone, percent	91.5%
Black or African American alone, percent (a)	4.7%
American Indian and Alaska Native alone, percent (a)	0.3%
Asian alone, percent (a)	1.8%
Native Hawaiian and Other Pacific Islander alone, percent (a)	0.1%
Two or More Races, percent	1.6%
Hispanic or Latino, percent (b)	9.6%
White alone, not Hispanic or Latino, percent	82.8%
Population Characteristics	
Veterans, 2016-2020	41,215
Foreign born persons, percent, 2016-2020	12.2%

(Data Source: U.S. Census QuickFacts)

Data regarding diabetes diagnosis, pre-diabetes, hospitalizations, deaths, amputations, and emergency department visits will be presented on the following pages.

In 2019, only 10.2% of Sarasota County adults indicated they had ever been told they had diabetes. Although lower than the State (11.7%), the percentage has increased over time.



These rates are higher for population of those ages 65 and over (16.8%), non-Hispanic Blacks (13.9%) and Hispanics (12.0%).

	Sarasota		
Year	Ages 18-44	Ages 45-64	Ages 65 & Older
2019	0.5% (0% - 1.4%)	9.5% (5.7% - 13.3%)	16.8% (11.2% - 22.4%)
2016	3.4% (0% - 7.7%)	9.7% (3.8% - 15.7%)	11.5% (7% - 16%)

	Sarasota		
Year	Non-Hispanic White	Non-Hispanic Black	Hispanic
2019	10.2% (7.1% - 13.3%)	13.9% (0% - 32%)	12% (1% - 22.9%)
2016	7.4% (4.7% - 10.1%)		16.7% (0.1% - 33.4%)

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

When examined by education and income, additional disparities can be observed. 14.2% of residents making less than $25,000 annually and 13.8% of residents making $25,000 to $49,999 annually have been told they have diabetes. Significantly higher, 30.8% of those with less than a high school education have been told they have diabetes.

	Sarasota		
Year	<$25,000	$25,000-$49,999	$50,000 or More
2019	14.2% (7.2% - 21.2%)	13.8% (5.5% - 22%)	6.2% (3.2% - 9.2%)
2016	15.7% (6.5% - 24.8%)	10.8% (3.8% - 17.9%)	4.7% (2.3% - 7.2%)

	Sarasota		
Year	Less Than High School	High School/GED	More Than High School
2019	30.8% (14.3% - 47.3%)	10.3% (4.1% - 16.5%)	7.6% (5.3% - 9.9%)
2016		7.3% (2% - 12.6%)	8.5% (5.2% - 11.8%)

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

Other priority populations, including people with disabilities, Asians, veterans, and LGBTQ populations, can be examined to identify disparities related to diabetes diagnosis.

Health disparities are clear for adults with disabilities in Florida, including rate of diabetes. This is demonstrated in the table below.

	Persons with Disabilities	Persons without Disabilities
Has a personal physician	54.3%	63.7%
Reported poor health	40.5%	9.1%
Has diabetes	16.1%	6.6%

Data source: CDC Disability and Health Data System, 2020, BRFSS

Although Asians are estimated to be only 1.8% of the population in Sarasota County, diabetes could be found at a higher rate than the overall rate of 10.2%. According to the CDC, 1 in 3 Asian Americans who have diabetes may not know they have it. This may be due to higher amounts of fat around body organs, visceral fat, and less muscle which impacts Body Mass Index (BMI). As a result, Asian Americans are recommended to test for high blood sugar if their BMI is 23 or greater. The CDC estimates that Non-Hispanic Asians have rates of diabetes outlined below.

South Asians	23%
Southeast Asians	22%
East Asians	14%

Data source: YJ Cheng et al, JAMA December 24, 2019, online edition. CDC.

Veterans are a valued and special population in Sarasota County. The US Department of Veterans Affairs estimates that nearly 25% of VA's patient population has diabetes and reports that diabetes is the leading cause of blindness, end-stage renal disease, and amputation for VA patients. Veterans exposed to herbicides while serving in Vietnam are included in this estimate. It could be more than 10,000 veterans in Sarasota County.

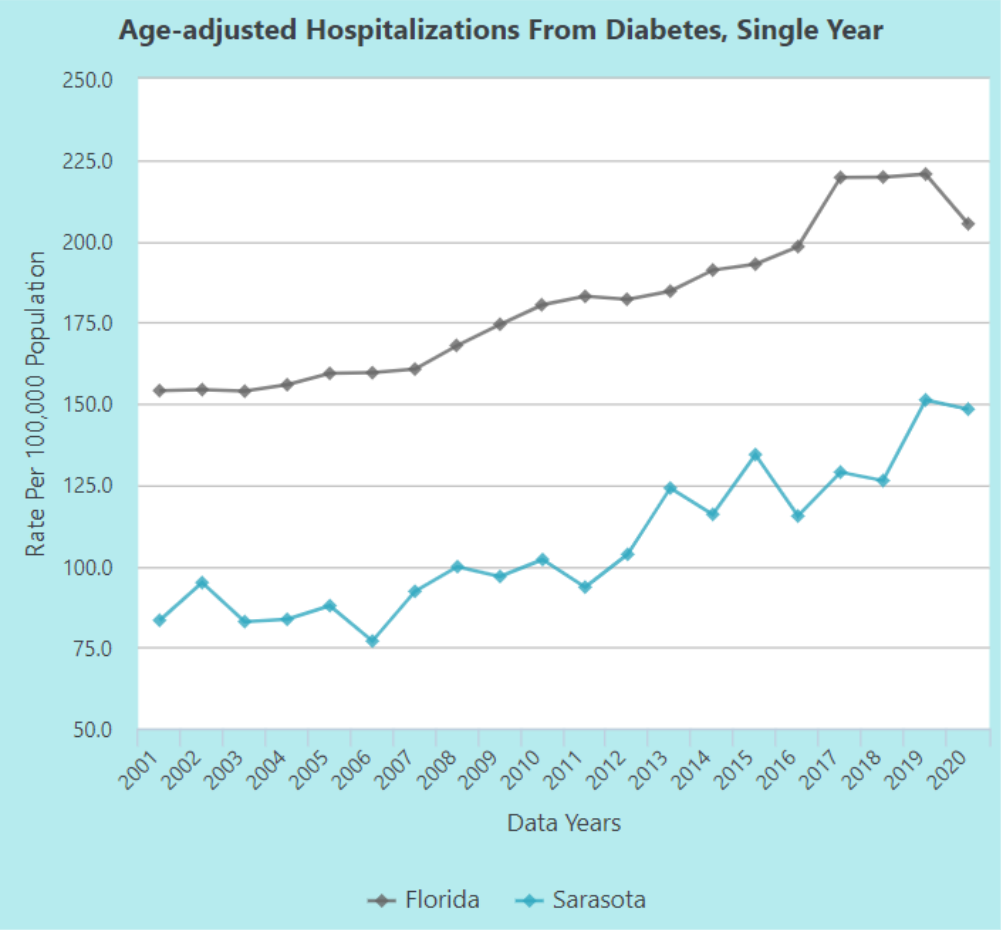
Data source: VA.gov/topics/diabetes and fedprac.com

People who are lesbian, gay, bisexual, transgender, or queer (LGBTQ) represent a diverse group including various races, ethnicities, ages, and socioeconomic statuses. In 2017, the National Health Interview Survey (NHIS) estimated 2.8% of adults identify as gay, lesbian or bisexual, and a Gallup poll from the same year estimated 4.1% identified as LGBT. Although very difficult to specify diabetes data for the LGBTQ community in Sarasota County, a few key organizations, such as CAN Community Health, may be able to provide insight into the rate of diabetes among their patient population. This can be an expanded focus of the new Community Health Assessment as well. Until specific local data is obtained, national studies show higher rates of chronic illnesses in the LGB community. This would likely include diabetes. Additionally, studies show the people in the LGBTQ community often face more complications related to diabetes.

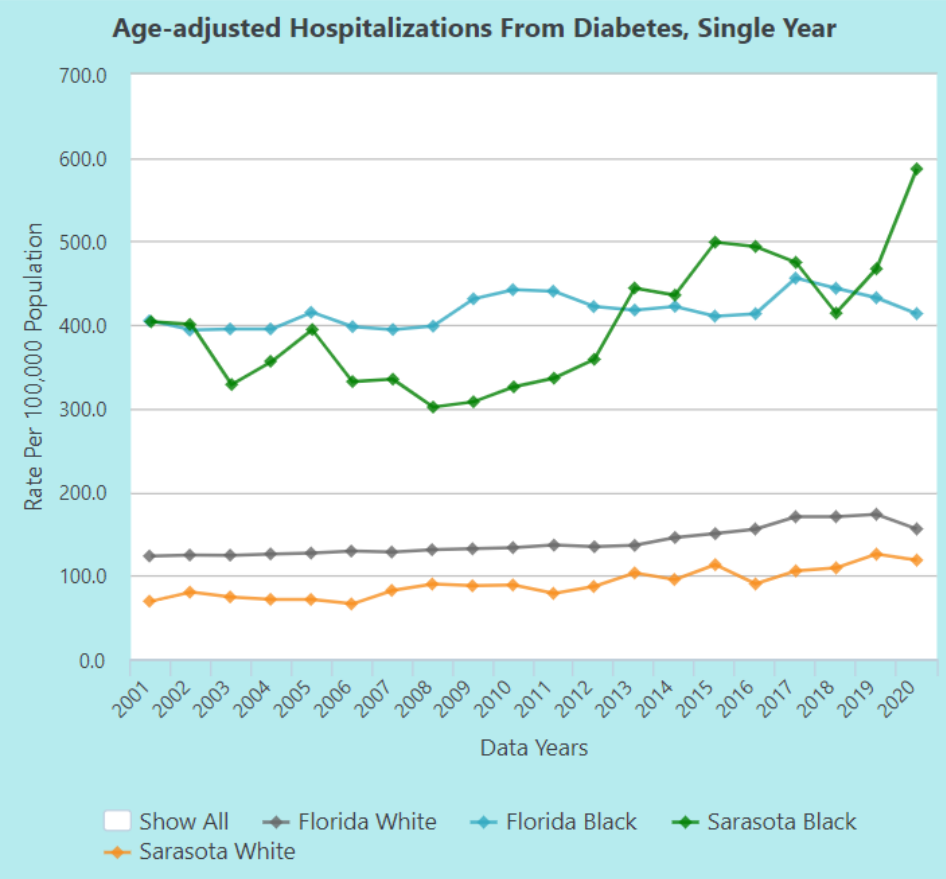
Data source: Kaiser Family Foundation Research Report, Health and Access to Care and Coverage for Lesbian, Gay, Bisexual, and Transgender (LGBT) Individuals in the U.S., May 2018.

When diabetes develops in any person, key outcomes such as hospitalizations, deaths and amputations can expose health disparities.

In 2020, the age-adjusted rate per 100,000 of hospitalizations from diabetes in Sarasota County was 148.3 compared to Florida at 205.3. Although lower than the State, the rate has increased steadily over time as shown in the graph below.



Disparities are apparent when examined by race. In 2020, the rate of diabetes hospitalizations for Black residents was 586.8, and the rate for Hispanic residents was 120.2. Although the rate of hospitalizations for Hispanic residents is lower than Sarasota County as a whole, it has increased over time.

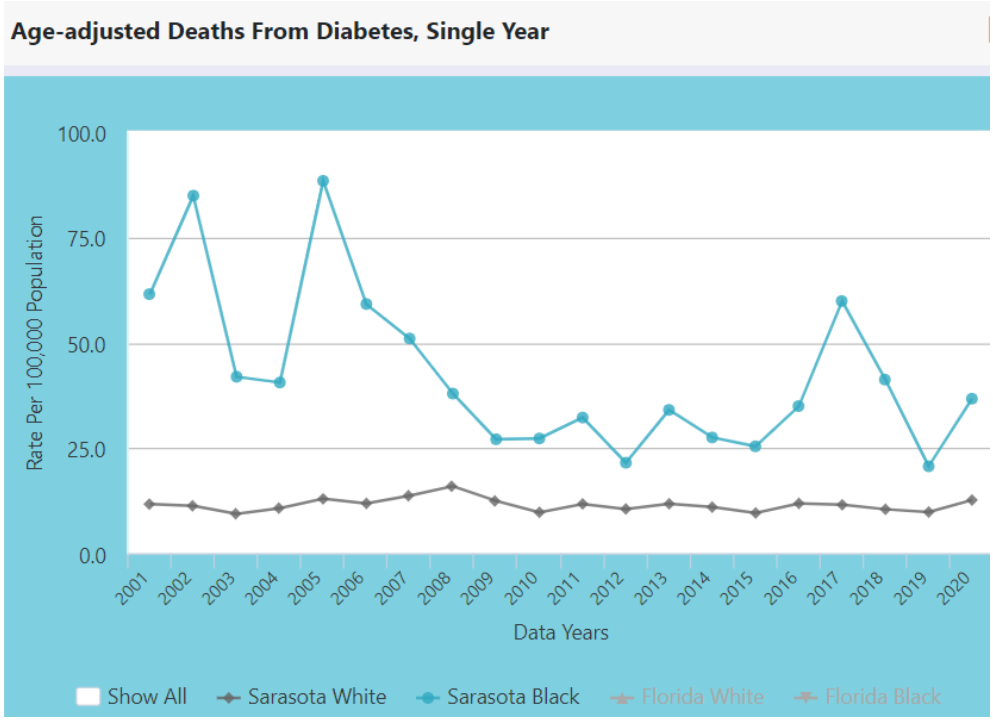


	Sarasota			
	White		Black	
Data Year	Count	Rate	Count	Rate
2020	627	118.4	123	586.8
2019	633	125.7	99	467.3
2018	518	109.2	88	414.2

	Sarasota			
	Hispanic		Non-Hispanic	
Data Year	Count	Rate	Count	Rate
2020	50	120.2	745	153.2
2019	57	143.6	741	155.5
2018	27	76.6	610	132.0

(Data Source: Florida Agency for Health Care Administration; Retrieved from FLHealthCharts.gov)

In 2020, the age-adjusted rate per 100,000 population of deaths from diabetes in Sarasota County was 13.4 compared to Florida at 23.2. When examined by race, the rate of deaths for Black residents was 36.7 and is shown in the graph below.

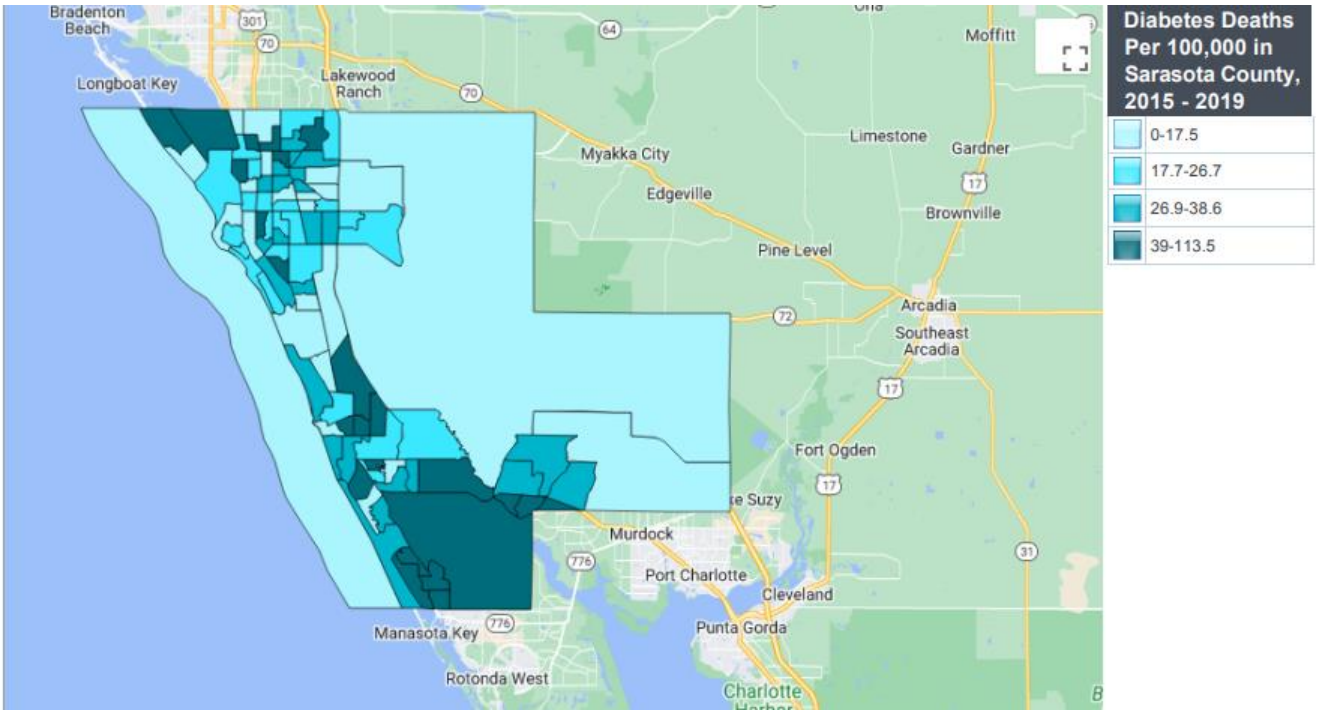


The rate for Hispanic residents has risen to 13.7, demonstrating the disparity.

When examined by sex, men in Sarasota County are dying from diabetes at a higher rate than women. The table below shows the rate for men reached 18.1 in 2020.

	Sarasota	
	Male	Female
Data Year	Rate	Rate
2020	18.1	9.5
2019	13.6	7.4
2018	16.2	7.0

Looking at the census tracts with the highest rate of deaths due to diabetes helps demonstrate diabetes disparity. Census tract 23.05 has the highest rate at 113.5 with census tract 27.24 and 3 following with 100.6 and 90.4 respectively. Although census tracts 23.05 and 27.24 are primarily White residents (99.1%) with 0.9% Asian, census tract 3 is primarily Black residents (83.7%).

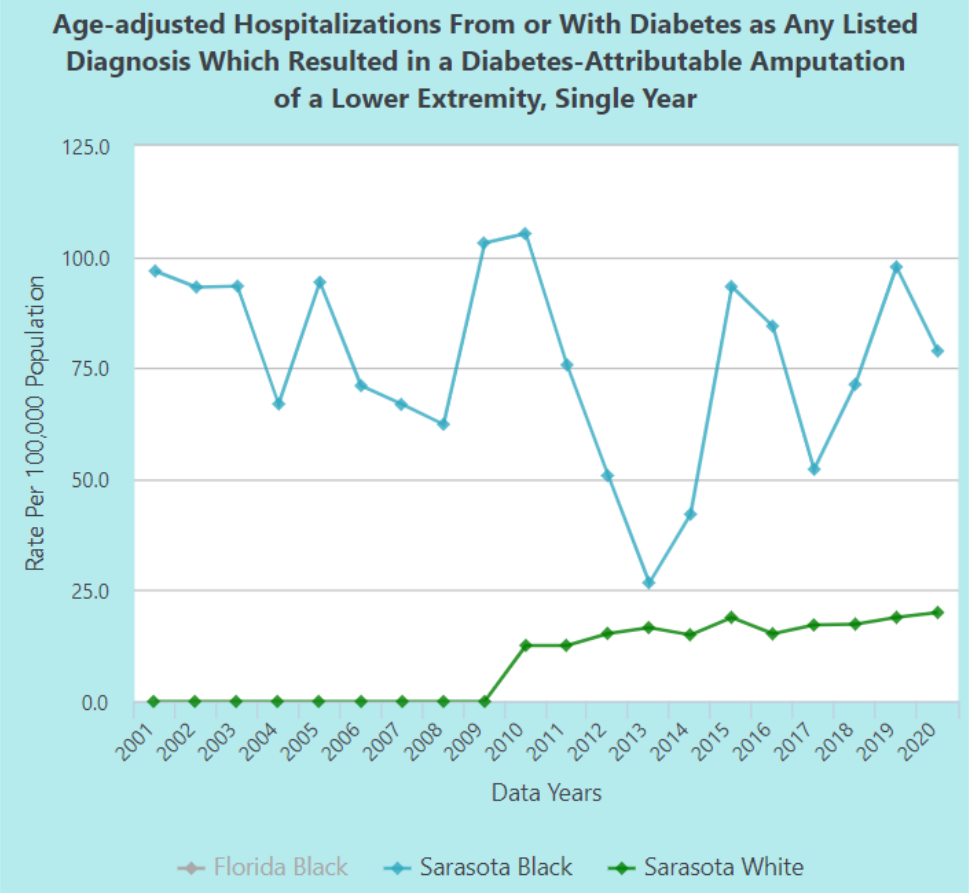


Diabetes Deaths Per 100,000 in Sarasota County, 2015 - 2019

Census Tract	Rate	Quartile
23.05	113.5	4
27.24	100.6	4
3	90.4	4

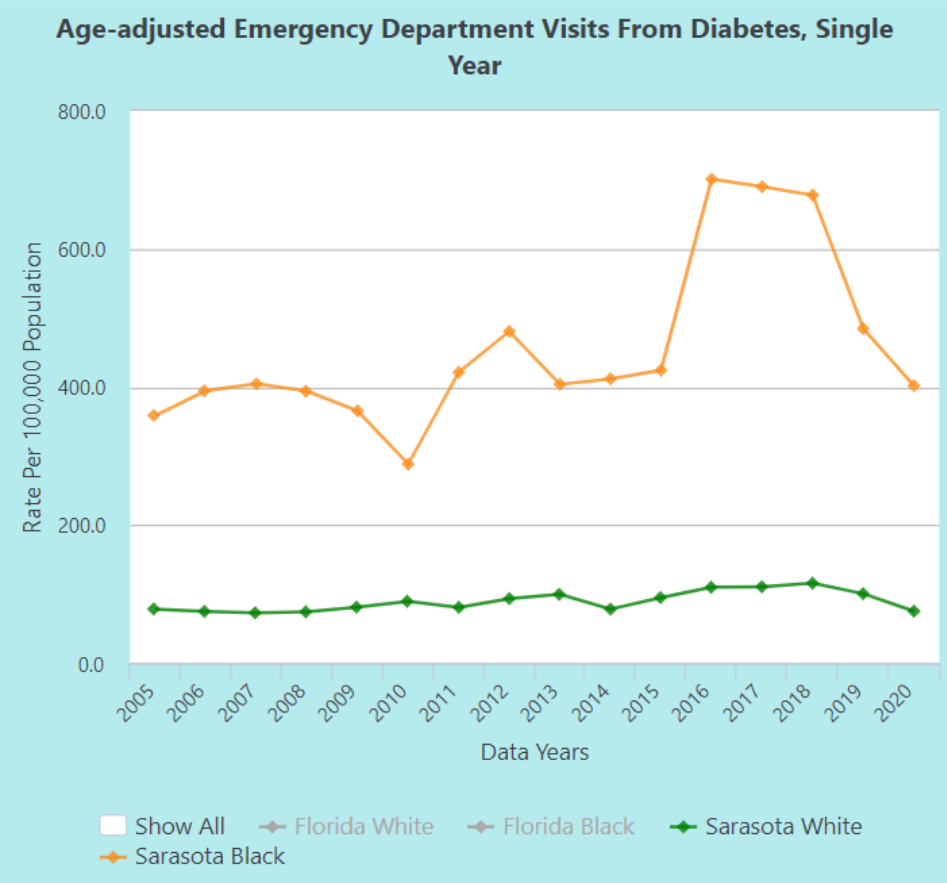
(Data Source: FLHealthCHARTS Community Map data is provided by the Florida Department of Health Bureau of Vital Statistics and the 2015 American Community Survey 5-year estimates (tables B02001, B03002, S0101, S1501, S1701, S1903, S2301, S2506, S2701)

Diabetes can bring additional problems if treatment is not maintained. The American Diabetes Association recommends routine screenings for at-risk individuals including foot assessments, eye exams, and blood pressure screenings. These routine screenings can help prevent adverse outcomes such as amputations in diabetic patients. In 2020, the rate of diabetes-attributable amputation of a lower extremity for Sarasota County was 22.4 per 100,000. As shown in the graphs below, when looking at different race and ethnicity groups, the rate for the same outcome in Black residents is 78.8 and in Hispanic residents is 31.3.



(Data Source: Florida Agency for Health Care Administration (AHCA); Retrieved from FLHealthCharts.gov)

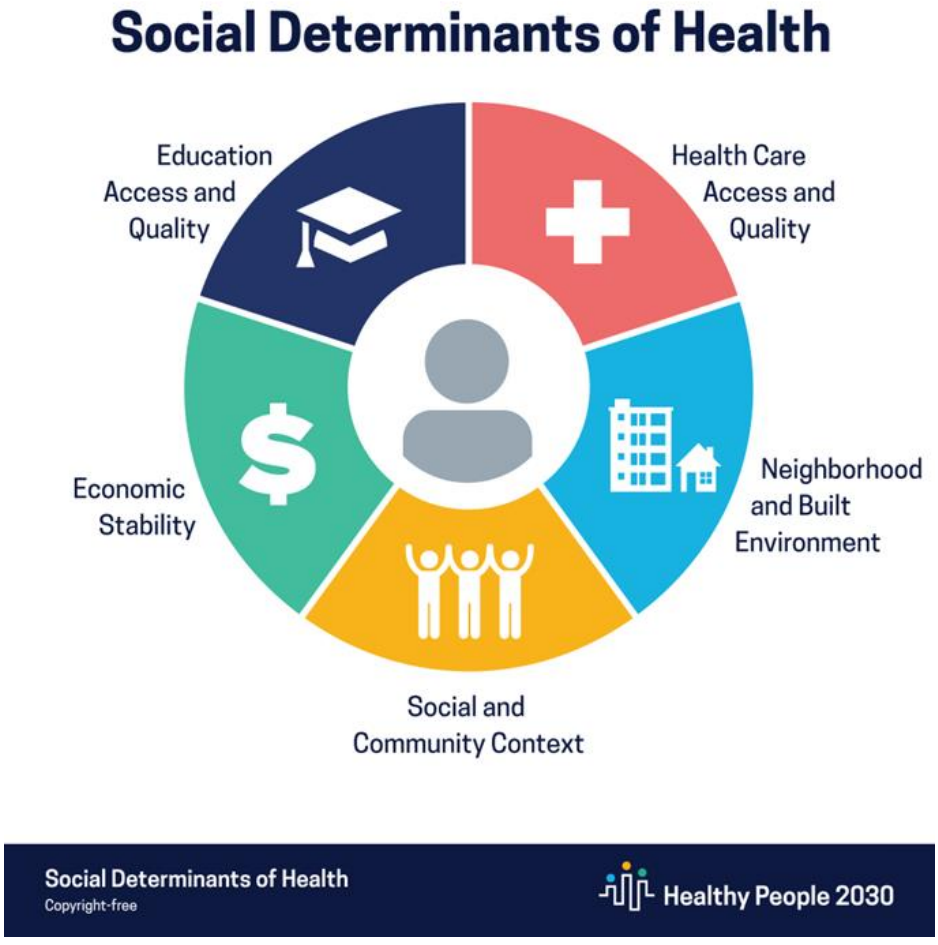
In 2020, the age-adjusted rate per 100,000 of emergency department visits from diabetes in Sarasota County was 100.7 compared to Florida at 195.6. In 2020, the rate of emergency department visits from diabetes for Black residents was 401.8, and the rate for Hispanic residents was 109.2, demonstrating the disparity.



(Data Source: Florida Agency for Health Care Administration (AHCA); Retrieved from FLHealthCharts.gov)

VII. SDOH DATA

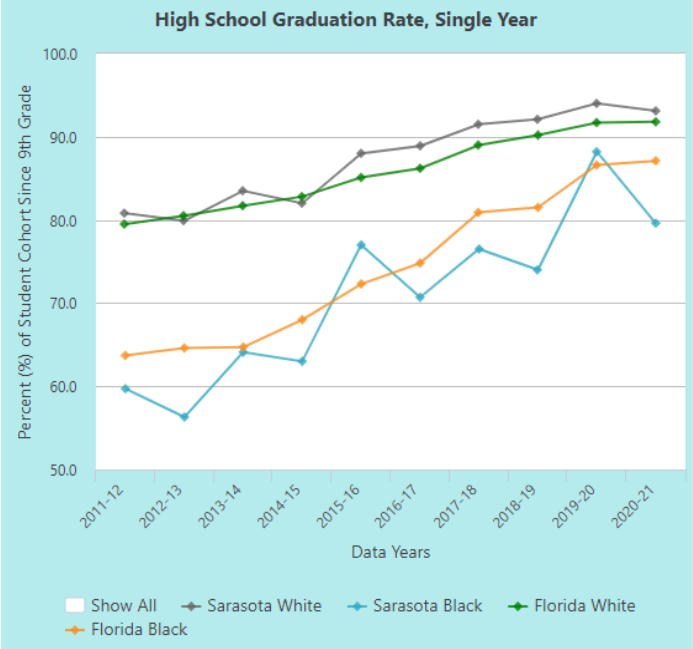
Social Determinants of Health (SDoH) are conditions in the places where people live, learn, work, and play that affect a wide range of health and quality-of life-risks and outcomes. The SDoH can be broken into the following categories: education access and quality, health care access and quality, neighborhood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

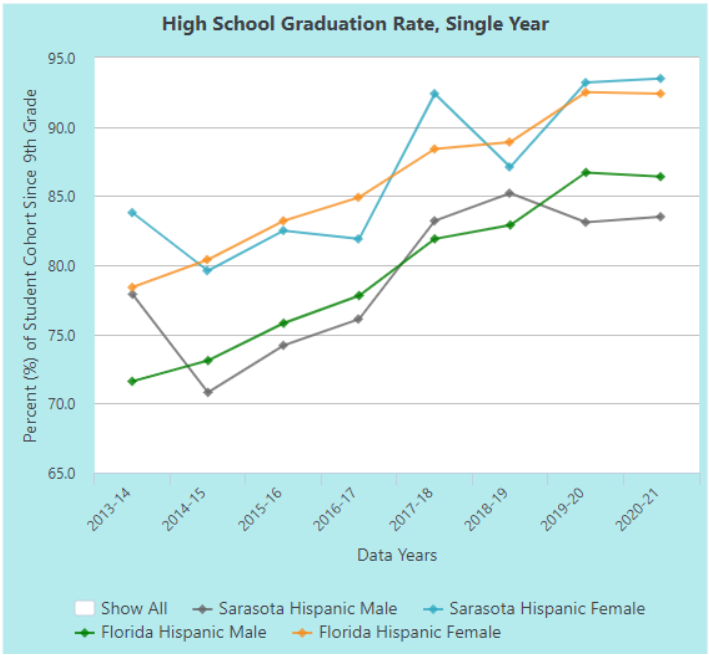


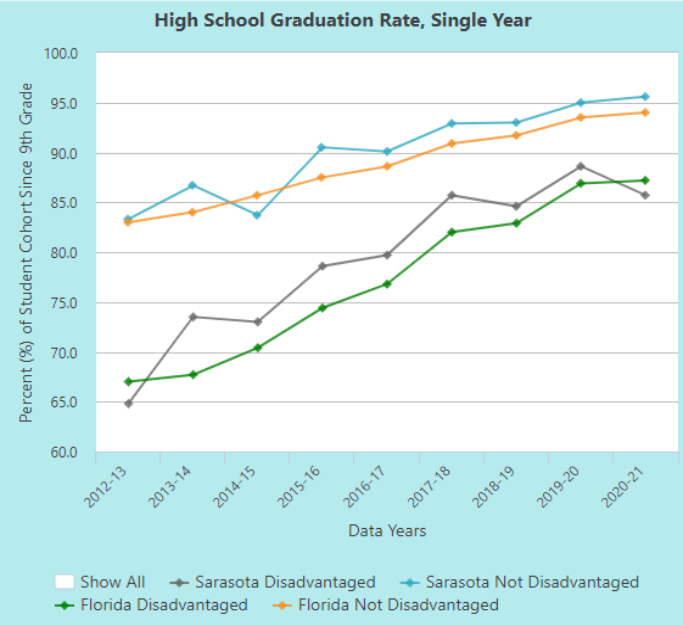
A. Education Access and Quality

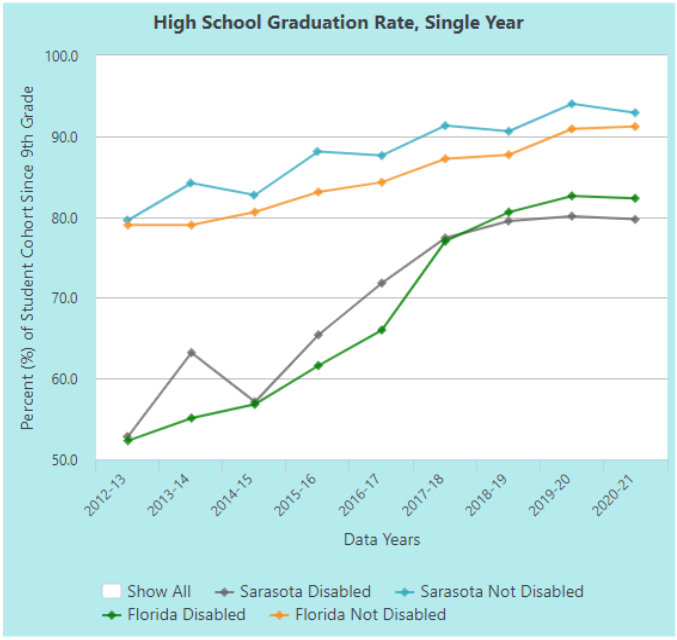
Data for Sarasota County

Receipt of a high school diploma enables individuals to pursue a higher education, including vocational school, trade programs or college. The high school graduation rate for the 2020-2021 school year in Sarasota County was 91%, compared to Florida at 90%. However, disparities exist when looking at various populations. In Sarasota County Hispanic male students, Black students, disadvantaged students (students eligible for free and reduced pride meals), and students with a disability all do worse than their counterparts in the county and at the state level. No specific data could be identified for Asian or LGBTQ students.







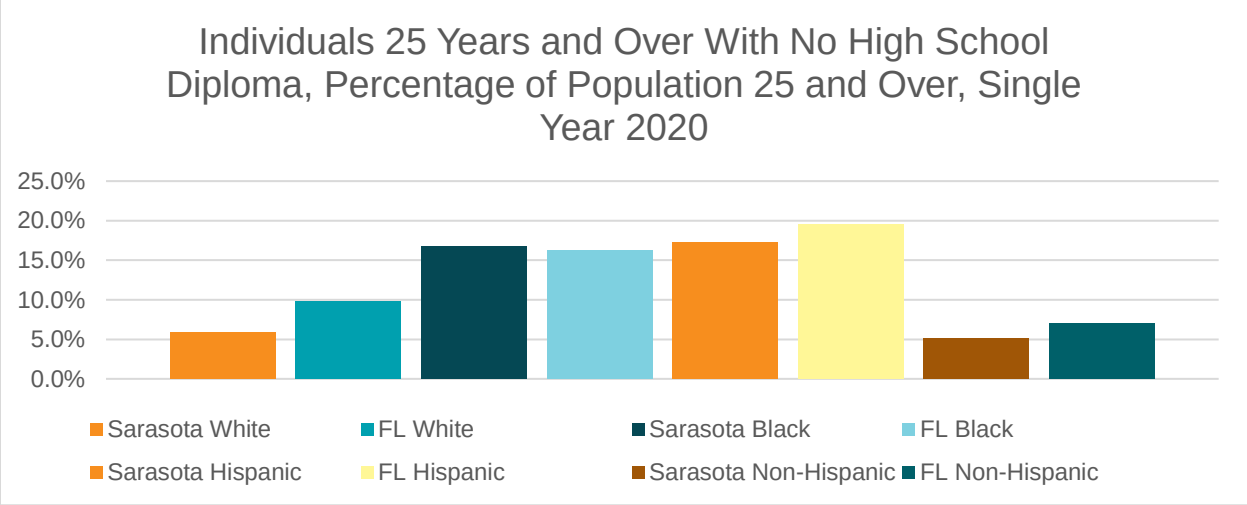


(Data Source: Florida Department of Education, Education Information and Accountability Services (EIAS), Retrieved from FLHealthCharts.gov)

When looking at individuals 25 years and over with no high school diploma, Sarasota County was at 6.8% in 2020. The percentage increases at 16.7% for Black residents and 17.3% for Hispanic.

(Data Source: United States Bureau of the Census, American Community Survey, Table C15002A, C15002B. C15002C, C15002D, C15002E, C15002F, C15002G, C15002H, and C15002, Retrieved from FLHealthCharts.gov)

As noted previously, education is a key disparity related to diabetes. In 2019, 30.8% of those with less than a high school education in Sarasota County have been told they have diabetes compared with 10.2% overall.



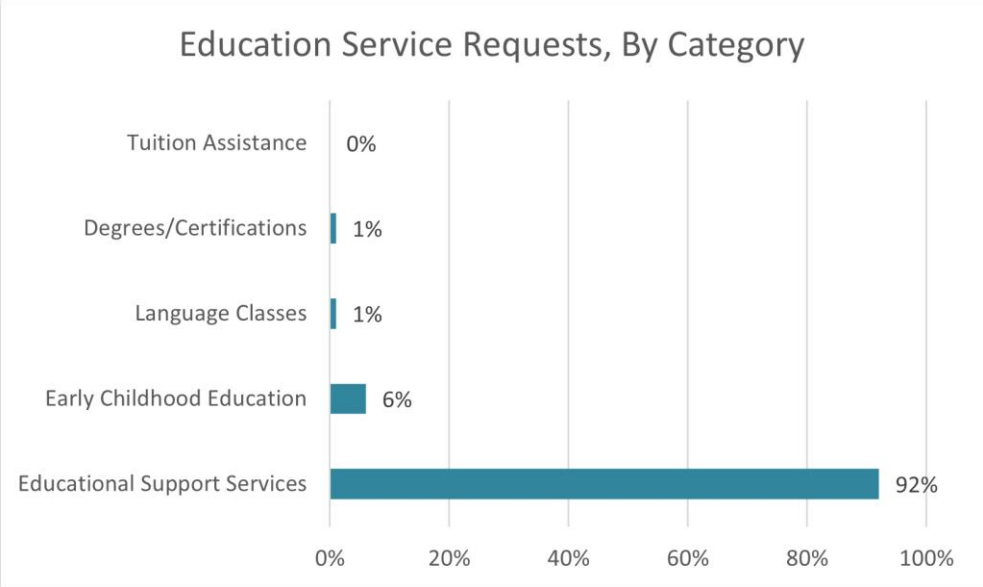
When looking at how students are entering school, for 2020 in Sarasota County the percentage of school readiness at kindergarten entry was 55.2% compared to Florida at 56.9%. In combination with this, the population aged 5+ that speak English less than very well in Sarasota County was 5% in 2020.

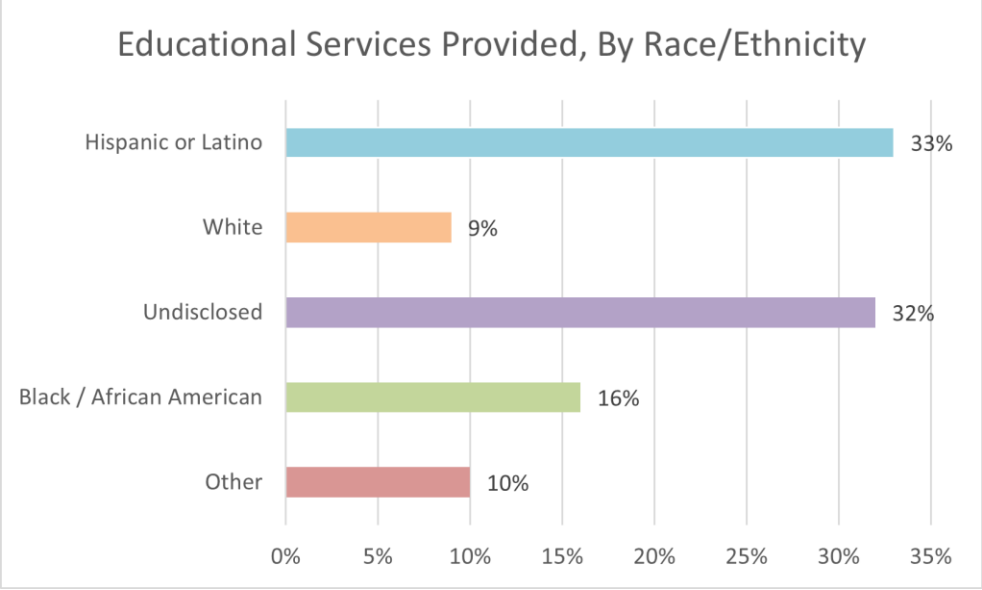
(Data Source: United States Bureau of the Census, American Community Survey, Table B06007, Retrieved from FLHealthCharts.gov).

Limited English Proficiency (LEP) can affect daily life. Persons who cannot speak English at least 'Very Well' or who do not live in a household where an adult speaks English 'Very Well' are determined to be linguistically isolated populations. Several census tracts have an estimated 0% population with LEP, while census tract 4.06 has the highest population with LEP at 30.4%.

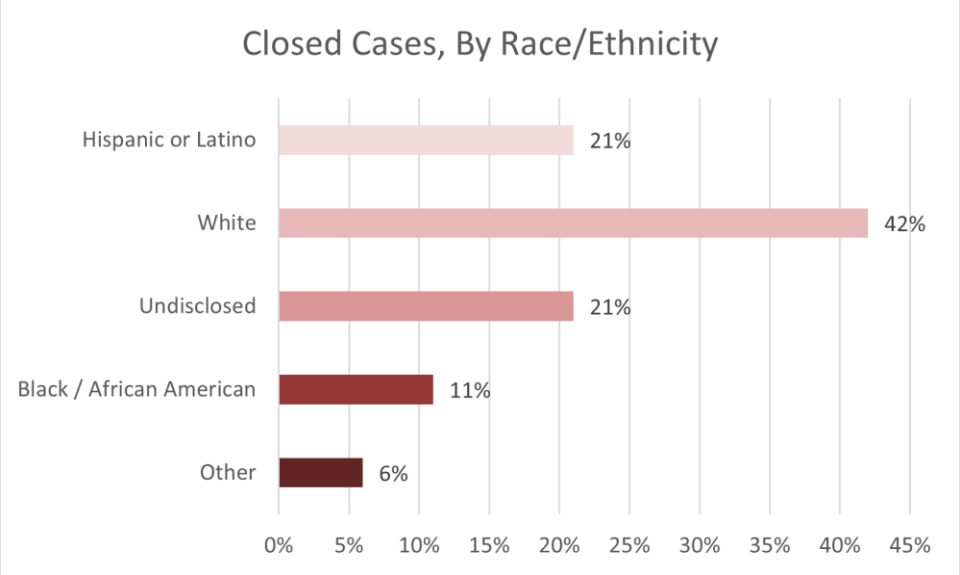
(Data Source: US Census Bureau, American Community Survey: 2015-19; Retrieved from: CARESHQ).

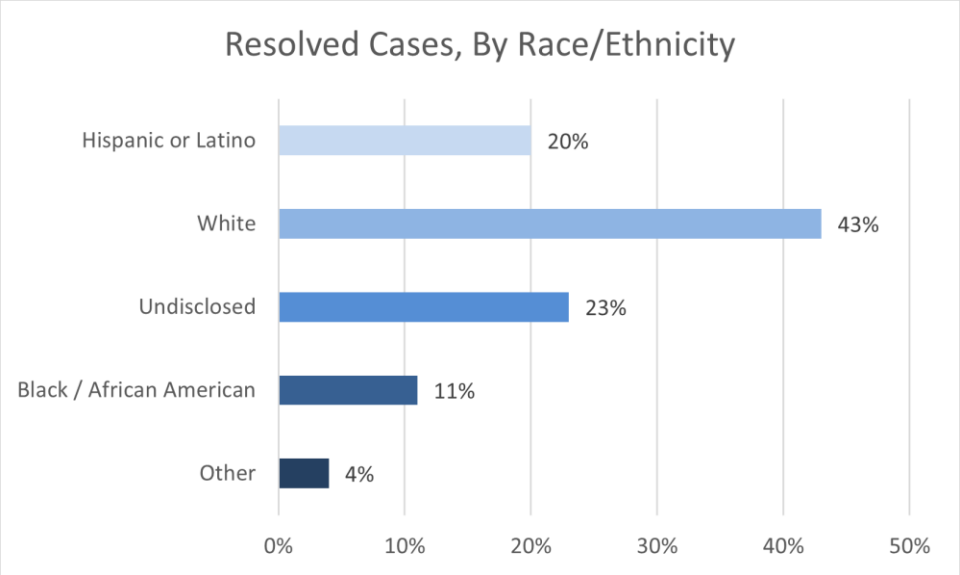
Sarasota County has access to local needs by utilizing the Unite Us Dashboard. From August of 2020 through April of 2022, 307 cases were created to address education needs. The most needed service under education was support services. Of education services requested, data can be looked at by race and ethnicity.





We can also view the percent of resolved, those clients that received requested educational services, and closed cases, cases that are responded to and are both resolved and unresolved, by race and ethnicity.





Based on the client race/ethnicities for closed and resolved cases, Hispanic residents were less likely to have closed or resolved cases. This can be attributed to trust, past experiences, language, and other factors related to education access and quality.

The Impact of Education Access and Quality on Diabetes

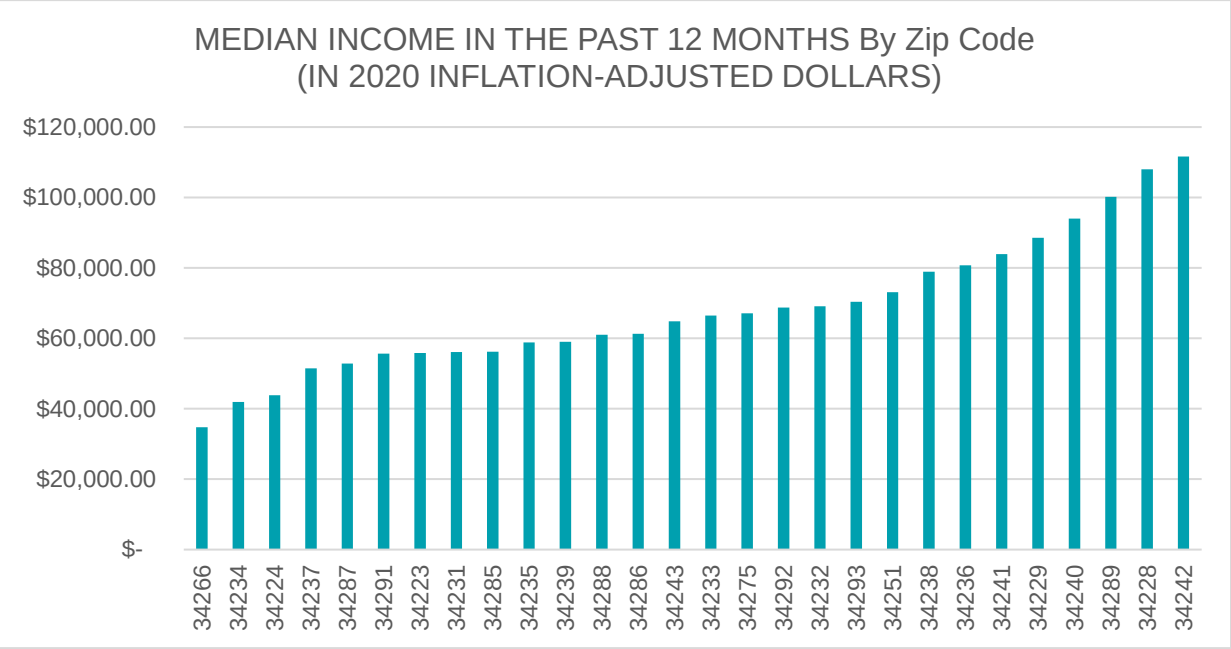
Education Access and Quality		
SDoH	**Vulnerable Populations Impacted**	**How the SDOH Impacts Diabetes**
High School Diploma	Hispanic, Black	30.8% of those with less than a high school education have been told they have diabetes.
Language	Hispanic	Populations with limited English proficiency (LEP) tend to have lower educational attainment and more likely to live in poverty, both associated with increased prevalence of diabetes, compared to English-proficient population. Having a LEP can be a barrier to accessing health care services and understanding information given.
Vocational Training	People Living with Disabilities, Black, Hispanic	Educational attainment is an indicator of economic prosperity. Only 6.2% of those making more than $50,000 annually have been told they have diabetes.
Higher Salary		

B. Economic Stability

Data for Sarasota County

The household income has increased over the last five years. In 2020, the median household income for Sarasota County $64,644, compared to Florida at $57,703. There are 122 census tracts in Sarasota County, with tract 3 having the lowest median household income at $25,594. This tract is comprised of the majority of Black residents in Sarasota County. 83.7% are Black, 12.5% are White, and 3.8% are two or more races. 8.2% are Hispanic. The median age is only 35.8. 47.3% of families are under 100% of poverty. Census tract 8.01, with the highest median household income at $136,810, is just a few miles away. That tract is comprised of 93.7% White residents, 3.3% residents of two or more races, and 1.5% Asian residents. 4.2% of the resident in that tract are Hispanic, and the median age is 72 years old. Only 1.1% of families are under 100% of poverty. The 2022 federal poverty level for a family/household of four is $27,750. This, along with the provided disparity diabetes data, demonstrates the need to focus efforts on census tract 3.

(Data Source: United States Bureau of the Census, American Community Survey, Table S1903 and (ACS) 5-year estimates.

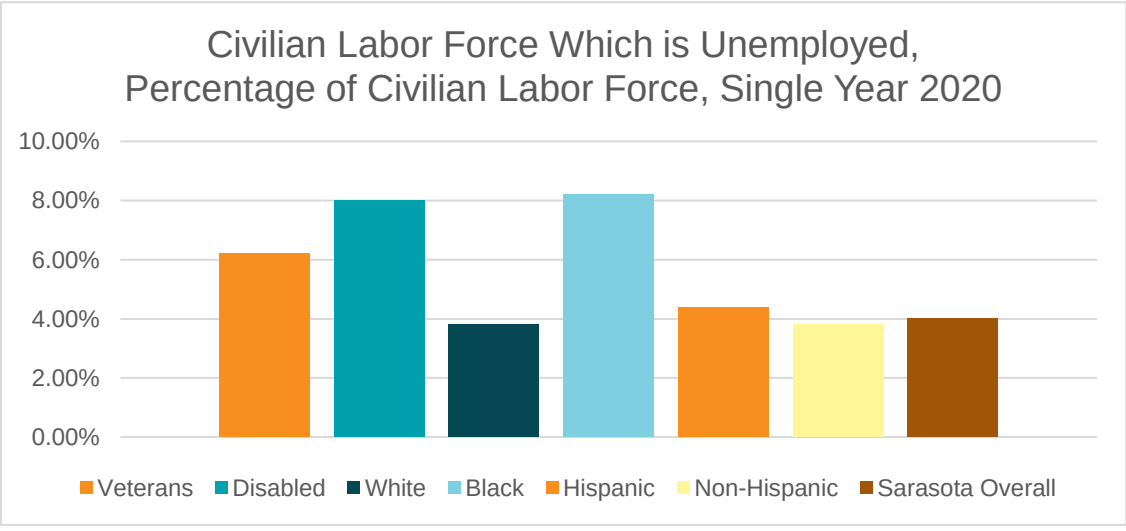


The median income not only differs based on location, but also race, ethnicity, age, and education level.

HOUSEHOLD INCOME BY RACE AND HISPANIC OR LATINO ORIGIN OF HOUSEHOLDER	
Households	$ 64,644.00
One race--	
White	$ 65,569.00
Black or African American	$ 44,060.00
American Indian and Alaska Native	$ 77,292.00
Asian	$ 61,053.00
Native Hawaiian and Other Pacific Islander	-
Some other race	$ 55,250.00
Two or more races	$ 60,461.00
Hispanic or Latino origin (of any race)	$ 58,866.00
White alone, not Hispanic or Latino	$ 66,077.00
HOUSEHOLD INCOME BY AGE OF HOUSEHOLDER	
15 to 24 years	$ 42,788.00
25 to 44 years	$ 73,763.00
45 to 64 years	$ 73,776.00
65 years and over	$ 58,311.00

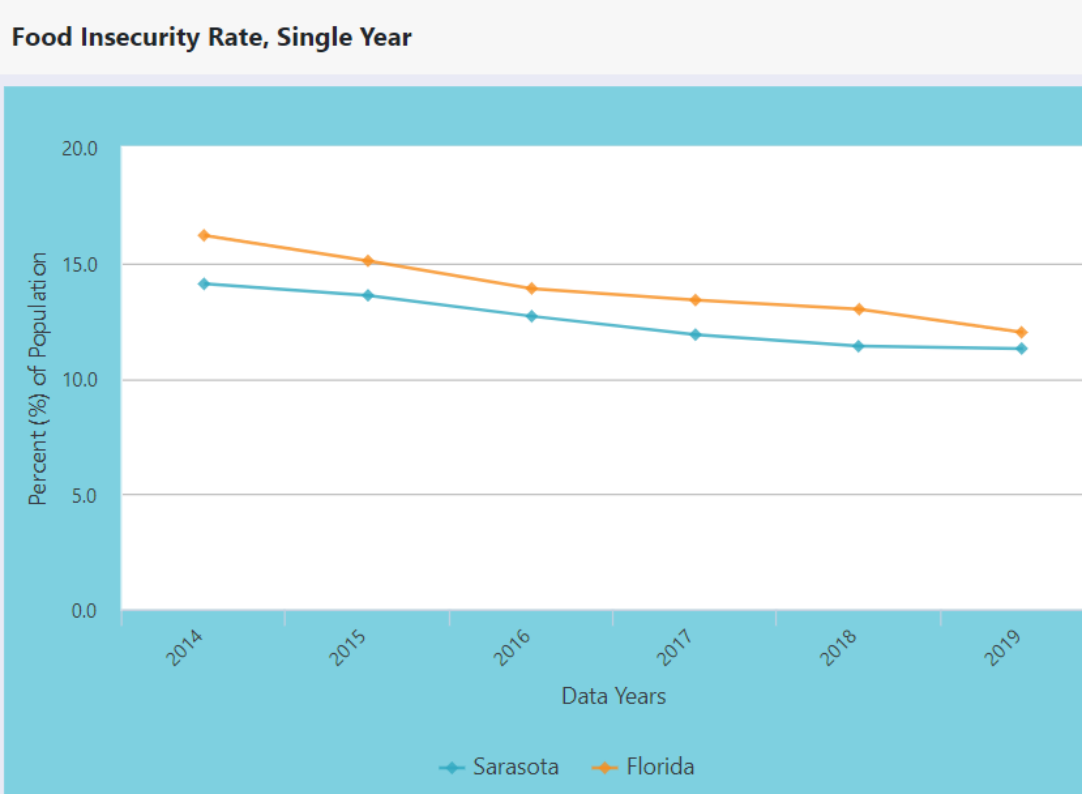
(Data Source: American Community Survey, 2020. Table S1903)

In Sarasota County, 4% of the civilian labor force is unemployed compared to 5.4% for Florida. These percentages change for specific population groups including persons with disabilities, veterans, Hispanic residents, and Black residents as shown in the table below.



(Data Source: United States Bureau of the Census, American Community Survey, Tables S2301 and S2101)

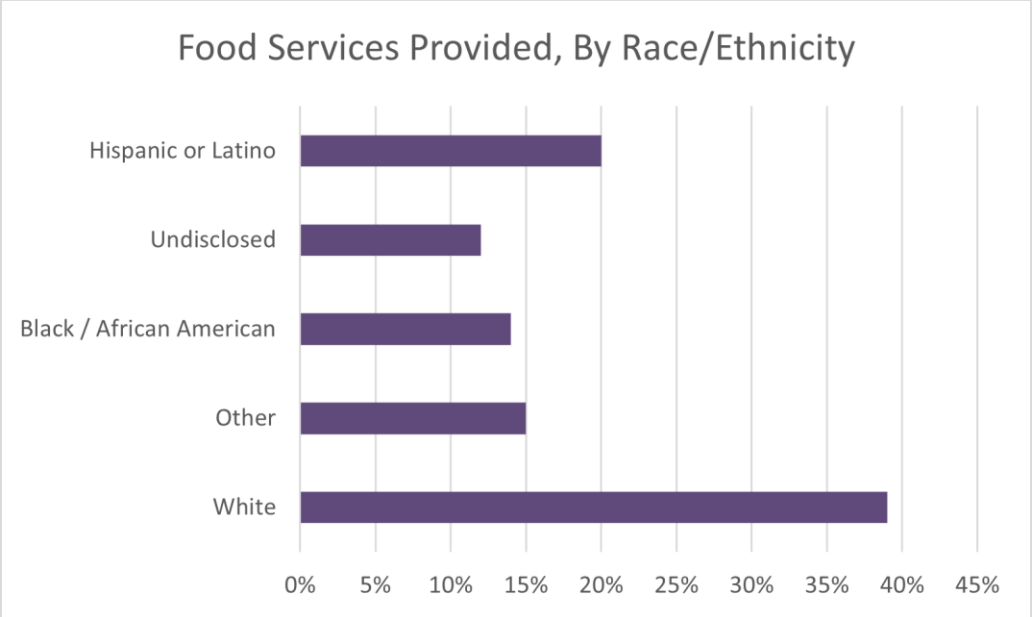
In 2019, the food insecurity rate in Sarasota County was 11.3% compared to Florida at 12.0%. Both rates were higher when looking at the child food insecurity rate. Sarasota County was at 14.8%, and Florida was 17.1%. Food insecurity rates have decreased over the past years, but due to the COVID19 pandemic the projected rates for 2021 show an increase with Sarasota County at 12.7%. Without being able to break down the data to priority populations, it can be assumed that residents in lower income area will be more food insecure.



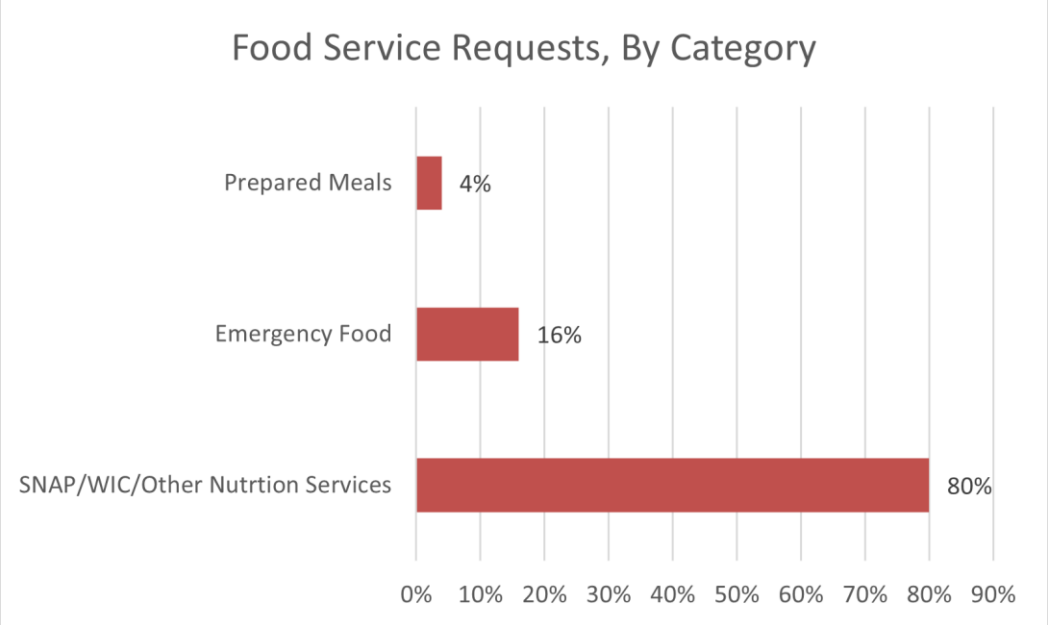
(Data Source: Feeding America, Map the Meal Gap.)

Sarasota County has access to local needs by utilizing the Unite Us Dashboard. From August of 2020 through April of 2022, 554 cases were created to address economic needs, including food insecurity, employment, and income assistance.

The most needed service was federal and other assistance programs (SNAP/WIC/Other) for food instability, job search and placement for employment, and emergency and one-time financial assistance for income. Of economic stability services requested, data can be looked at by race and ethnicity.



Data Source: Unite Us



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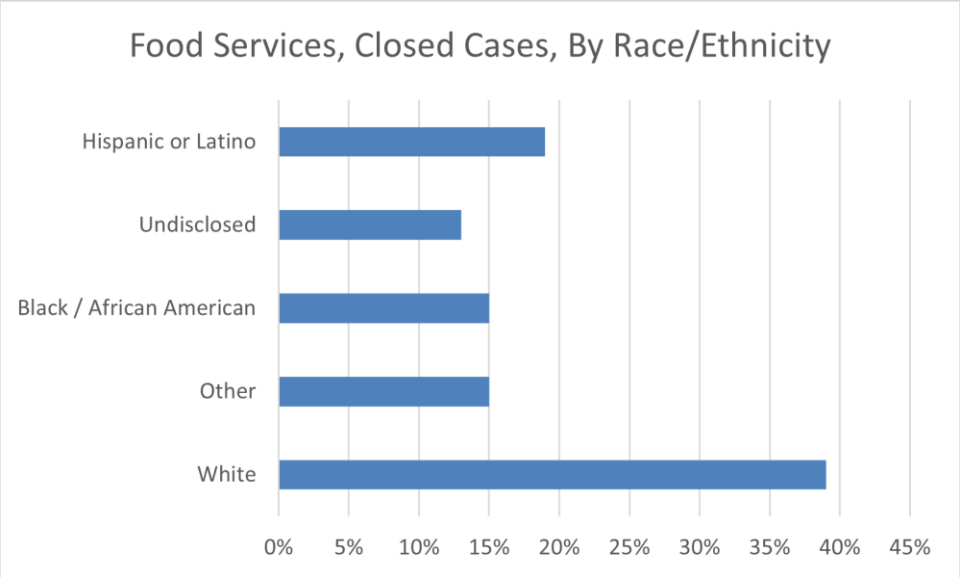

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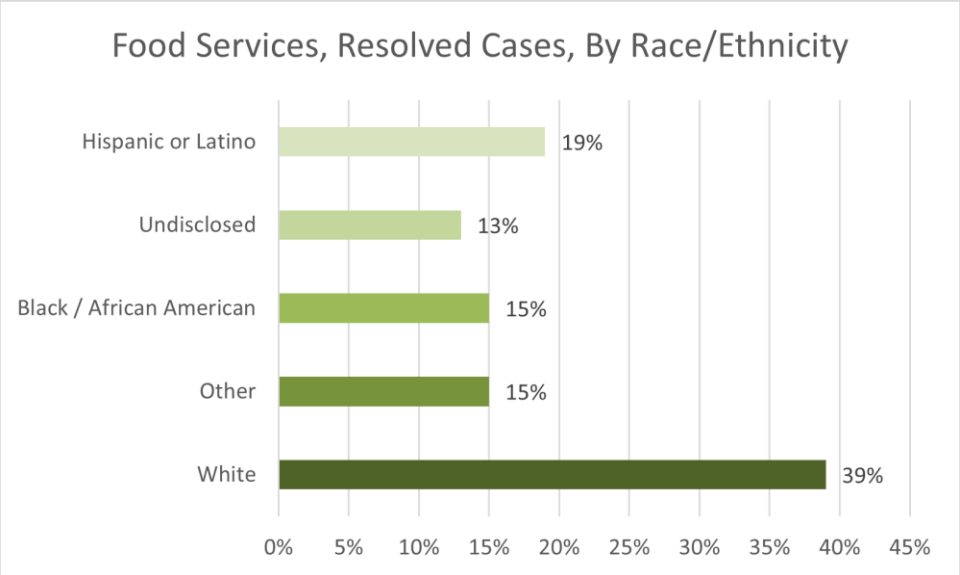
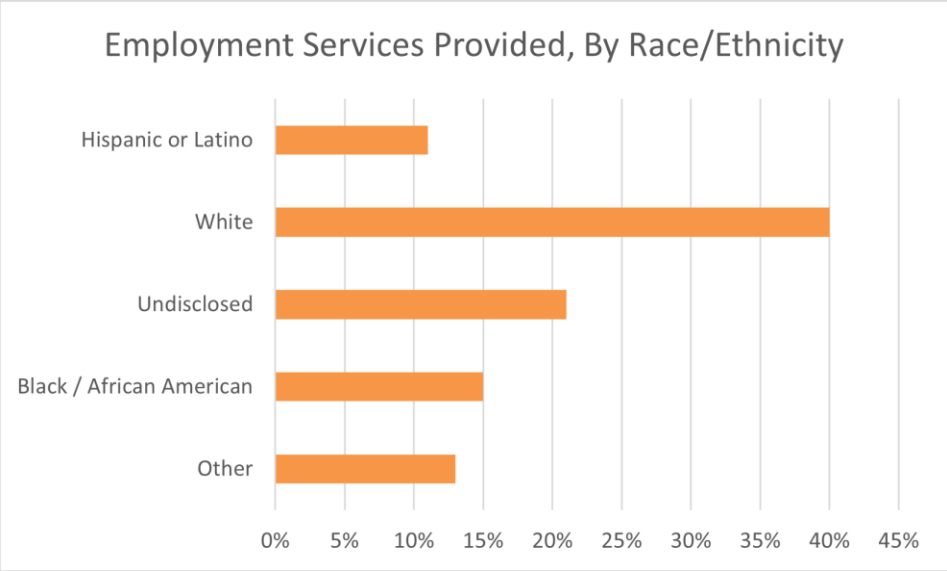


Data Source: Unite Us

The data for closed and resolved cases show clients were successful overall around food. Regardless of race or ethnicity, cases seemed to be closed or resolved. This could indicate a well-run system, process and/or policy in place.



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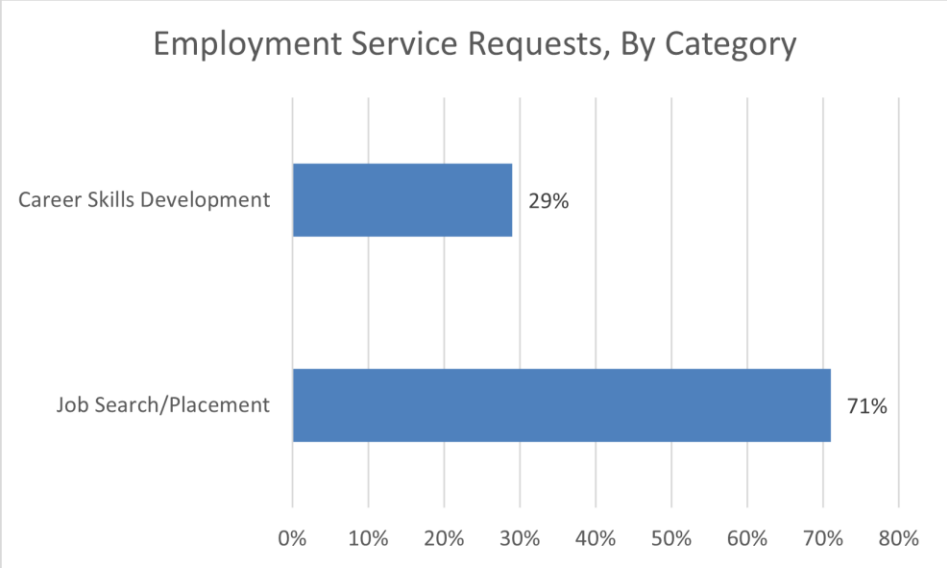

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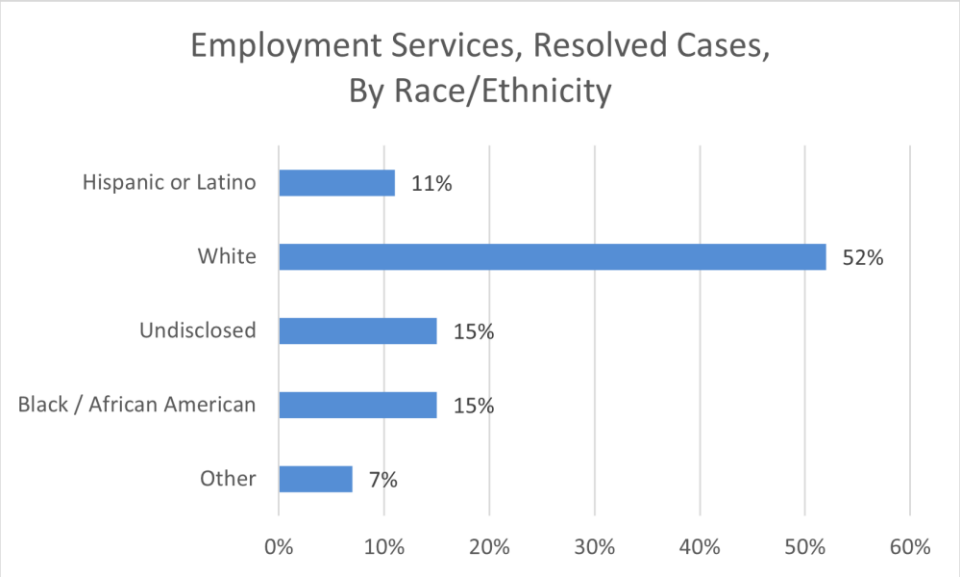

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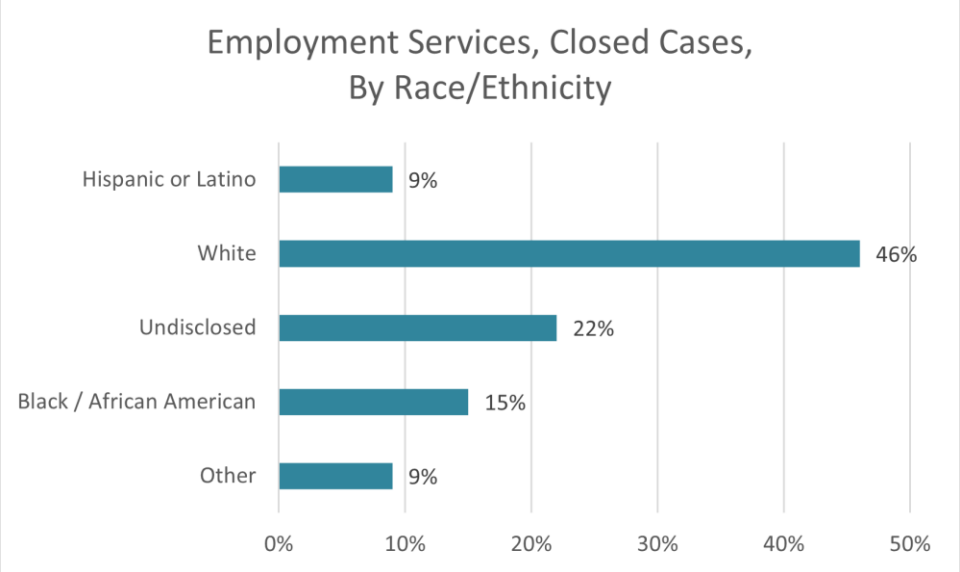
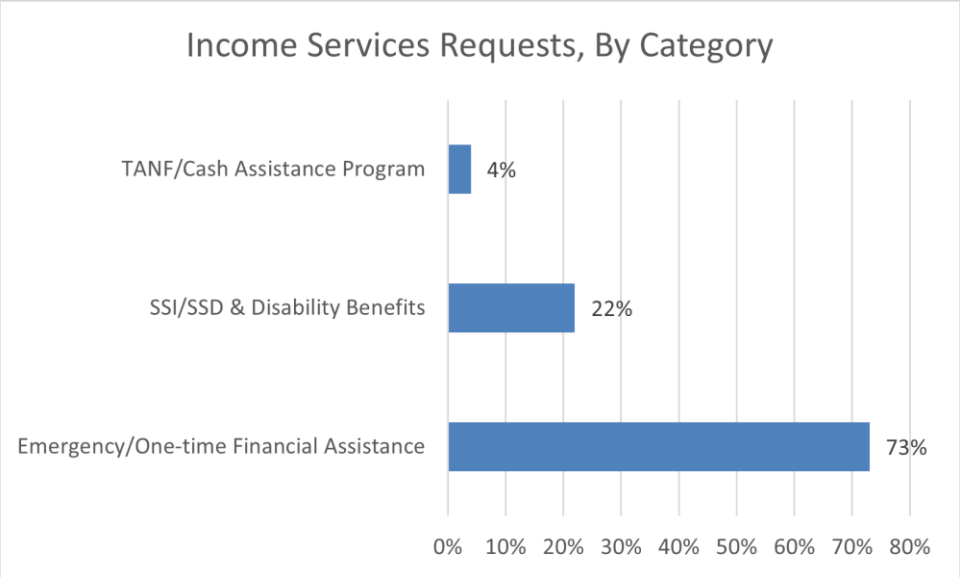


Data Source: Unite Us

Based on the closed and resolved cases for employment services, White and Black clients had the greatest chance of accessing and receiving employment assistance services compared to Hispanic clients. This may be due to trust, past experience, language, and other issues of SDoH. This provides further guidance on needs for the health disparity project – to connect with residents' lived experience.



Data Source: Unite Us

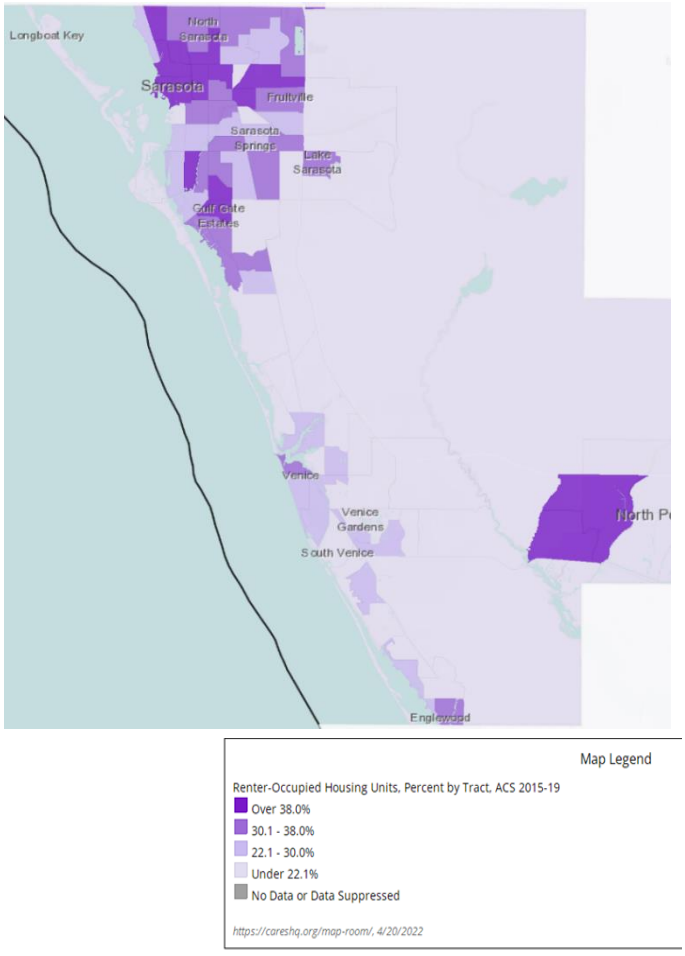
The Impact of Economic Stability on Diabetes

Economic Stability		
SDoH	**Vulnerable Populations Impacted**	**How the SDoH Impacts Diabetes**
Employment	People living with disabilities, Black residents, Veterans	Employment certainly impacts income which ties with diabetes data previously shown.
Income	Older residents, People living with disabilities, Black, Hispanic	Individuals and families that are lower in the socioeconomic status are more likely to develop diabetes than those with a higher socioeconomic status.
Food Insecurity	Children, Older residents	Food insecurity is a risk factor for poor diabetes management and diabetes outcomes.

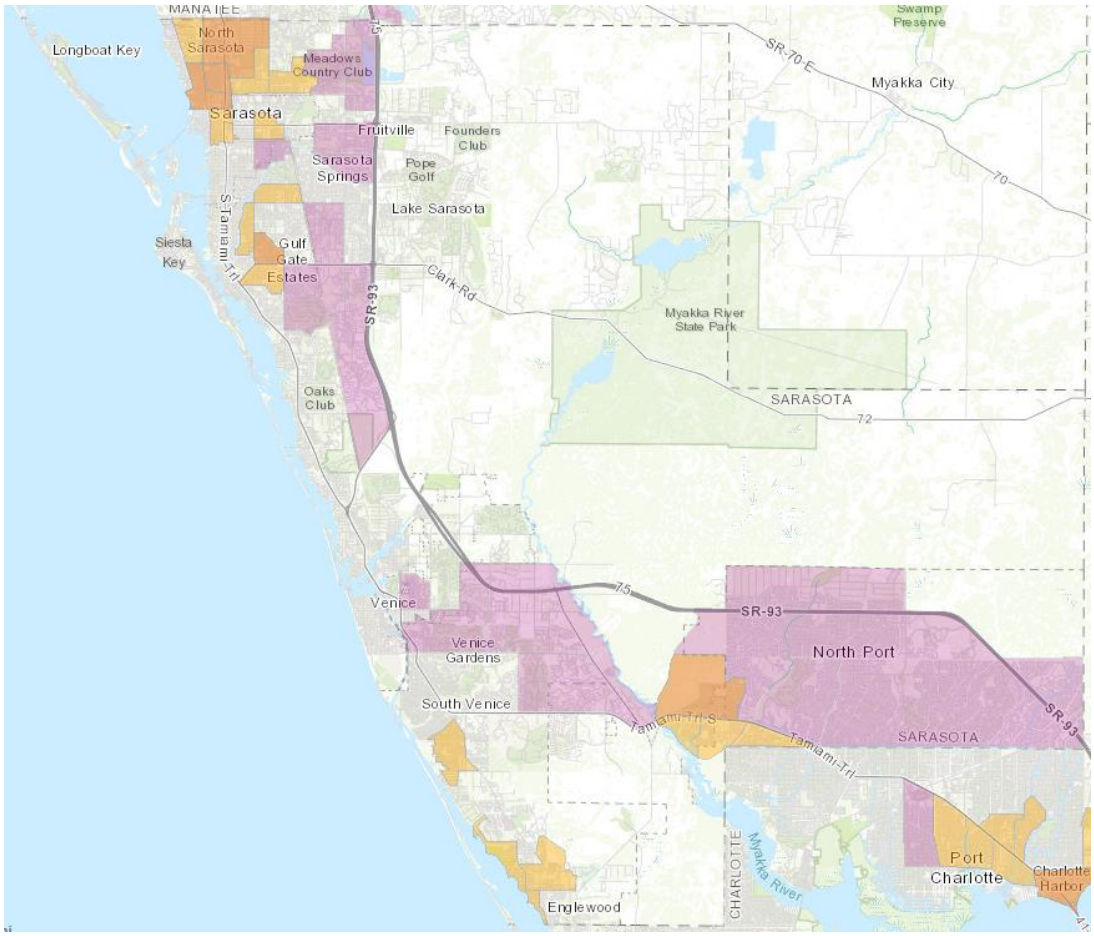
C. Neighborhood and Built Environment

Data for Sarasota County

In Sarasota County, 54.1% of renter-occupied housing units had a gross rent costing 30% or more of the household income, and 25.1% of housing units are renter occupied. This means residents are spending a significant amount of their income on housing – often to assure safe and adequate shelter. With higher rates of rentals, property values are lower, and neighborhoods are often views as less stable. Further, when looking across the county, census tract 8.01 has the highest median household income and a lower percent of renter occupied units at 2.7%. The census tract with the lowest median household income, tract 3, has 66.8% renter occupied units. 83.7% of residents in census tract 3 are Black, which further demonstrate the need to focus diabetes disparity efforts in that part of Sarasota County.



When we look at food access, many of these same neighborhoods with a high number of renters are considered low-income and have low vehicle access. On the map below, the purple areas indicate census tracts in which more than 100 households have no access to a vehicle and are more than ½ mile from the nearest supermarket and the light orange areas indicate census tracts that are considered low-income where a significant number or share of residents in more than ½ mile from the nearest supermarket. The highest of the overlapping areas has 24.5% of households without vehicles that are more than½ mile from a supermarket. This often represents areas with more Black residents.

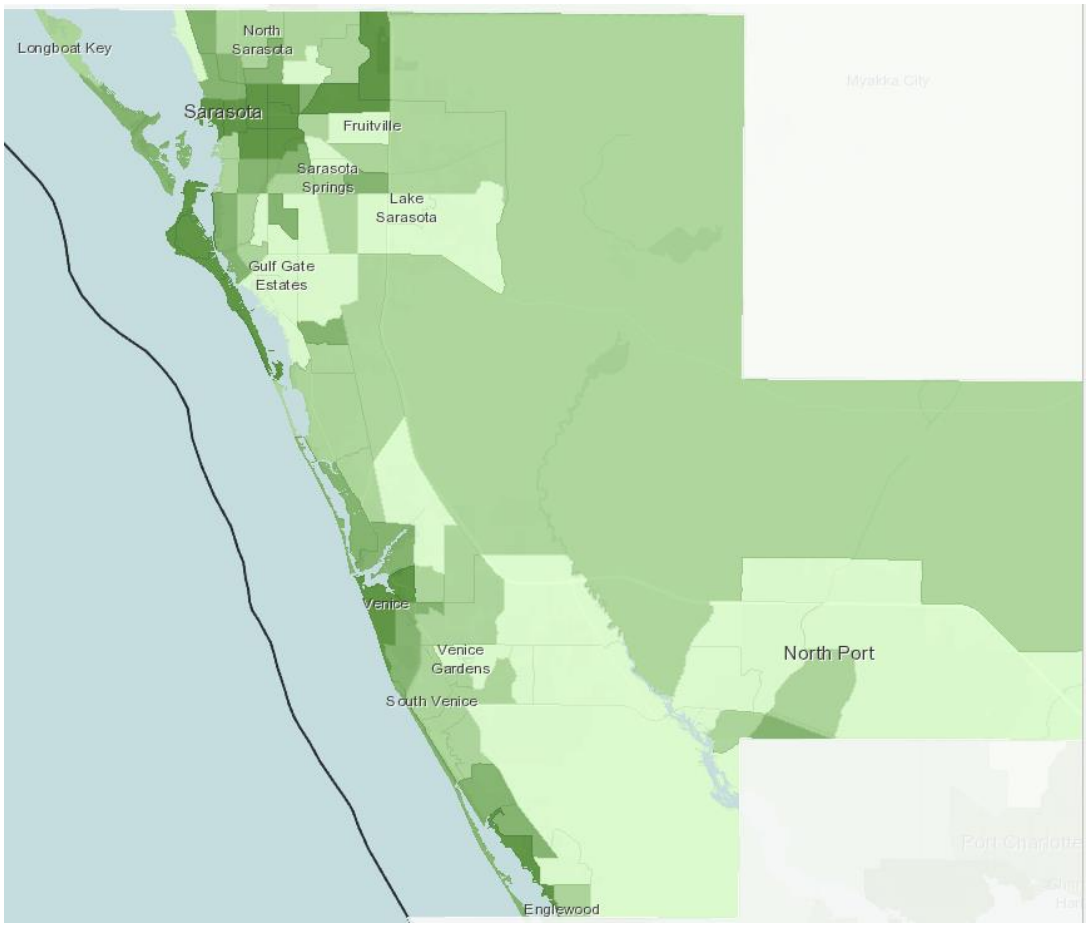


(US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas: 2019)

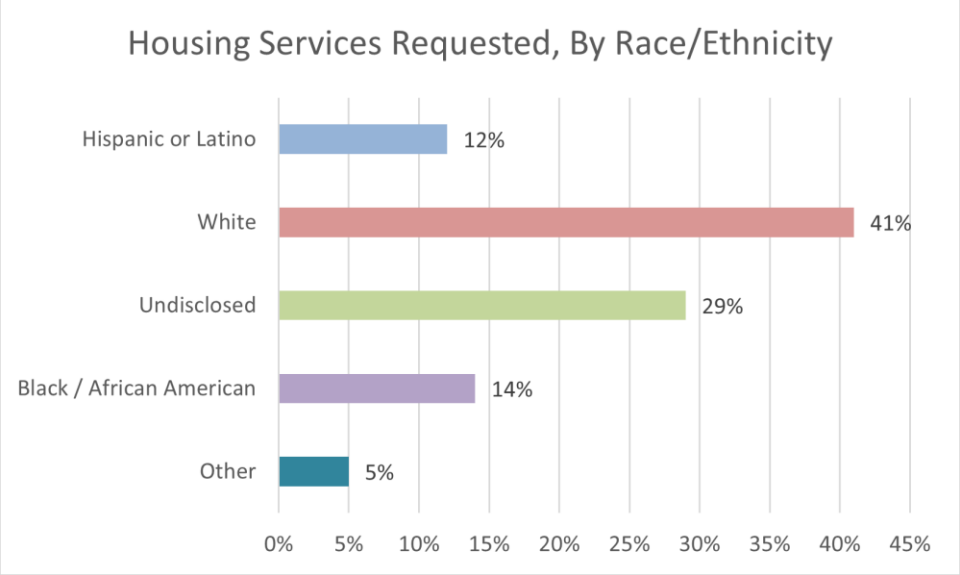
As of 2015, 34% of Sarasota's population lived within half a mile of a park. This rate ranged from 0% of the population to 100% of the population depending on the census tract. Living near a park allows for social connection, physical activity, and other healthy options. In this case residents should be accessible for diabetes interventions.

Population With Park Access (Within 1/2 Mile) by Tract, CDC EPHTN 2015

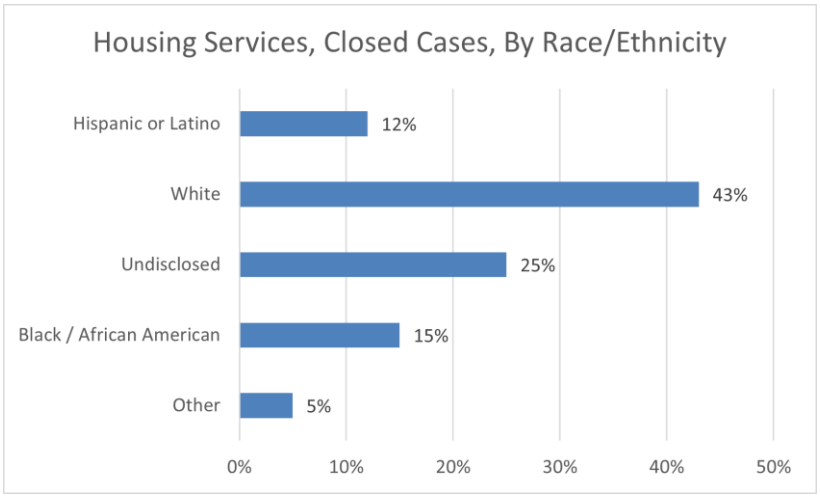
- Under 82%
- 53 - 82%
- 22 - 52%
- Under 21%



Sarasota County has access to local needs by utilizing the Unite Us Dashboard. From August of 2020 through April of 2022, 156 cases were created to address needs in the neighborhood and built environment, including stable housing and access to transportation. The top two most needed assistance services for housing were permanent housing and rent/mortgage payment. Transportation services were almost equally needed, though ride coordination services were the most requested. Of those services requested, data can be looked at by race and ethnicity. As with other SDoH, the success rate or completion rate is good indicating needs are being met. The lower percentage is most likely a reflection of the population as a whole.



Data Source: Unite Us



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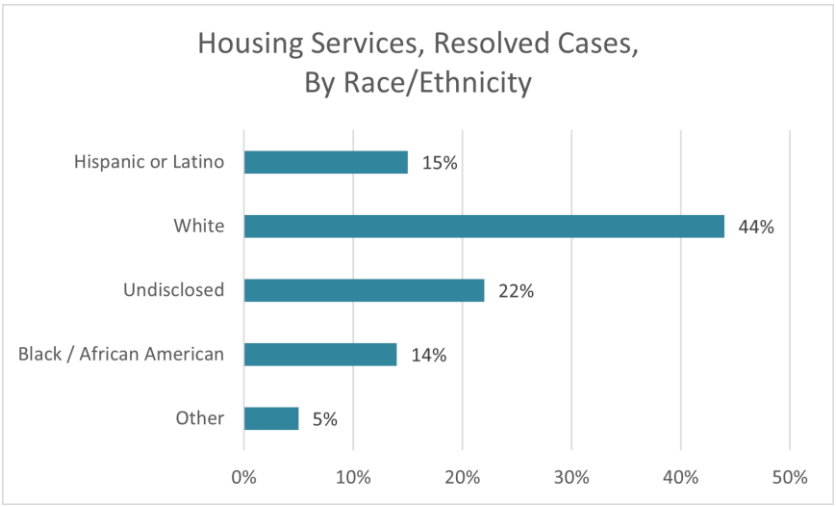

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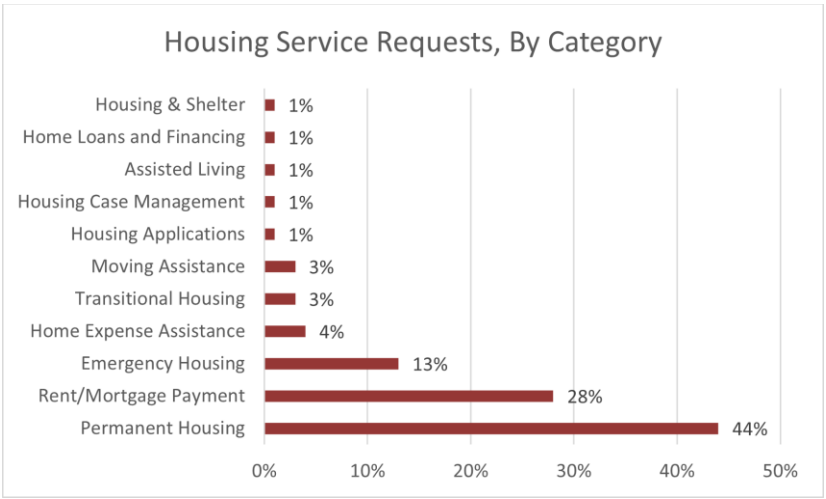
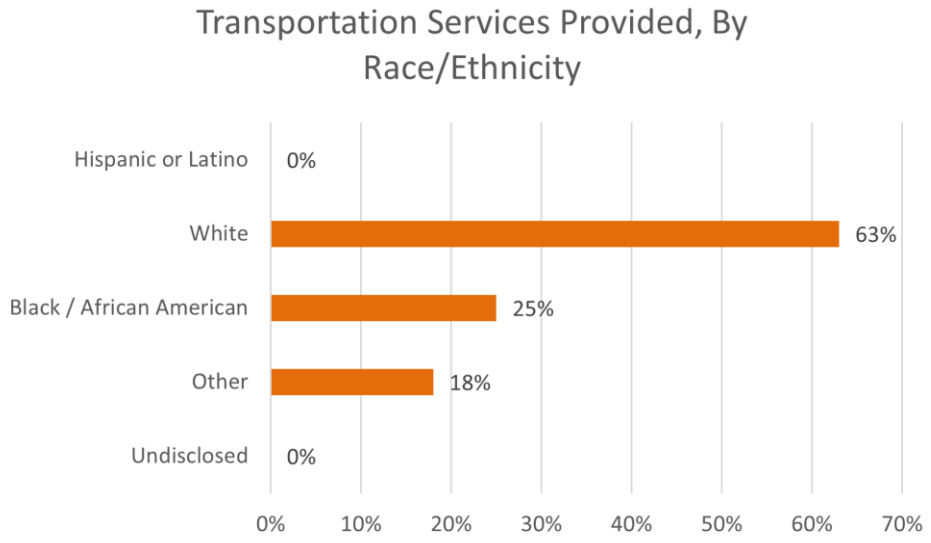


Data Source: Unite Us

Of the race/ethnicity of clients requesting housing services, White clients were the most likely to access and receive services. From the service requests, 14% of them were from Black/African American clients and 12% from Hispanic or Latino clients. When looking at the resolved cases, Hispanic or Latino clients were more likely to receive housing services than Black/African American clients.



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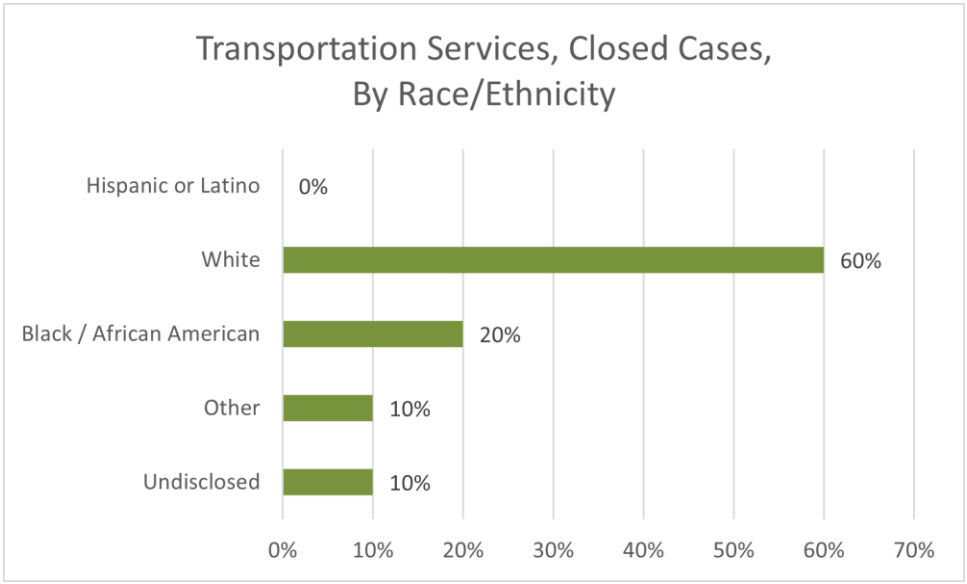

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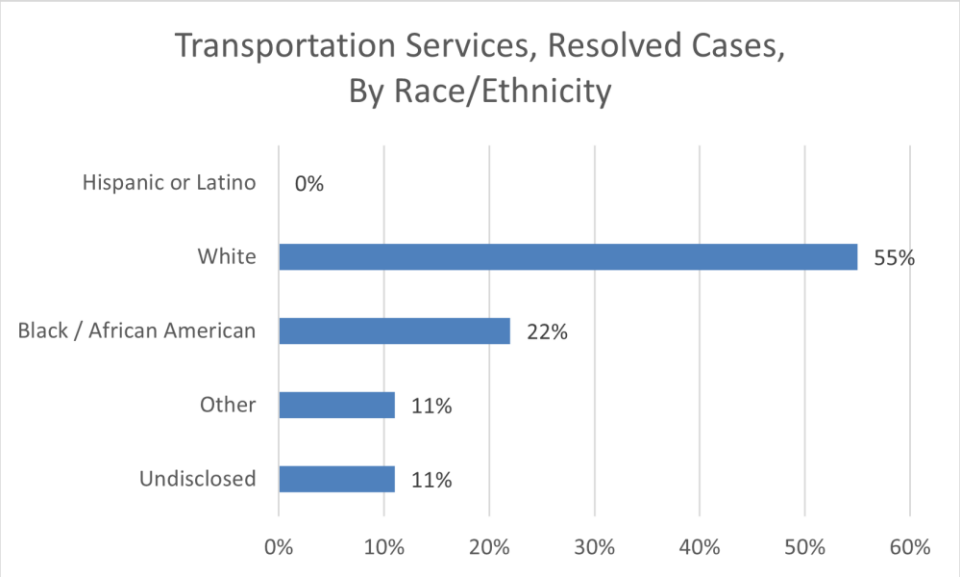
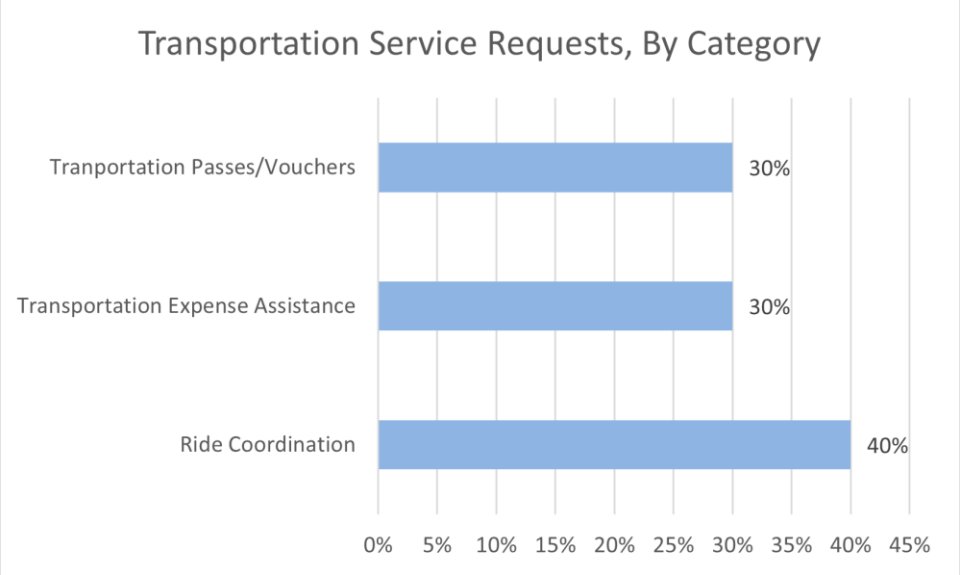


Data Source: Unite Us



Data Source: Unite Us

When looking at the closed and resolved cases, the race/ethnicity of clients are representative of those who requested transportation services.

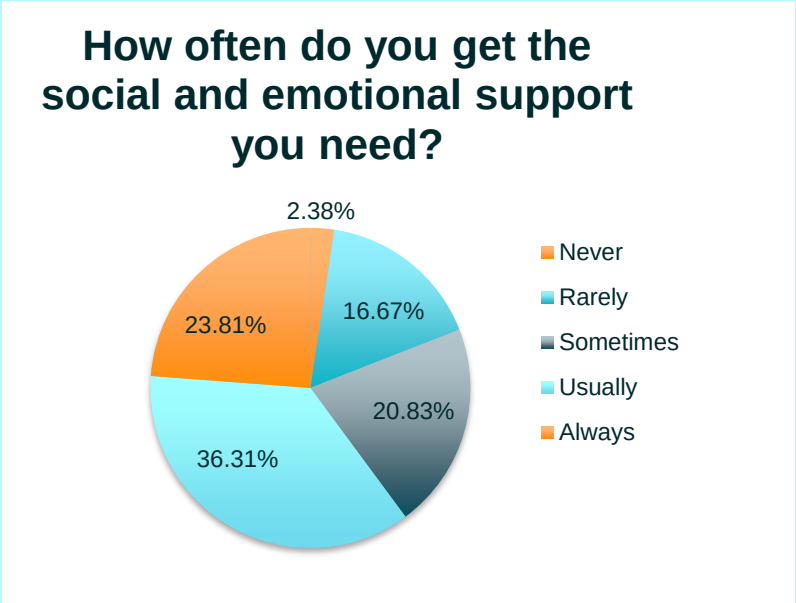
The Impact of Neighborhood and Built Environment on Diabetes

Neighborhood and Built Environment		
SDoH	**Vulnerable Populations Impacted**	**How the SDOH Impacts Diabetes**
Housing Instability	Older residents, People living with disabilities, Black, Hispanic	Housing instability may be linked to poor health outcomes and reduced health care access. This would relate to the disparity data for diabetes.
Parks	Older residents, People living with disabilities, Black, Hispanic, Children	Access to parks and playgrounds promotes healthy behaviors that impact diabetes outcomes. These areas should be accessible to residents and encourage activity.
Playgrounds		
Access to nutritional food	Older residents, People living with disabilities, Black, Hispanic, Children	Nutritional food is a component of prevention of and managing type 2 diabetes. Areas with transportation and low access may be more dependent on convenience stores to meet needs.

D. Social and Community Context

Data for Sarasota County

According to respondents to the CASPER Survey, more than 60% of residents feel they usually or always get the social and emotional support needed (Sarasota County CHA, 2019).



From the Unite Us data, 769 individuals sought out individual and family support, which includes services for support groups, peer support, life skills training and support, mentoring, spiritual enrichment, and respite care. These services provide support, opportunities of self-enrichment, and social engagement for members of the community. Services were requested in proportion to the population of the county.

According to the 2019 BRFSS, 85.6% of Sarasota County adults said their overall health was “good” to “excellent.” As outlined below residents with more education and higher salary report better health. Residents who are part of a couple also report better health, demonstrating the benefit of social interaction and connection. This can be incorporated into the diabetes plan.

2017-2019 Florida BRFSS Data Report — **Sarasota**

Health Status & Quality of Life

Percentage of adults who said their overall health was "good" to "excellent"

		2017-2019 County			2019 State			2016 County
		Measure	95% CI		Measure	95% CI		Measure
ALL	Overall	85.6	82.2	88.9	80.3*	79.0	81.5	85.4
SEX	Men	84.9	79.6	90.3	81.2	79.5	83.0	87.7
	Women	86.2	82.0	90.3	79.3*	77.6	81.1	83.4
RACE/ETHNICITY	Non-Hisp. White	85.6	81.9	89.3	81.9	80.7	83.1	86.7
	Non-Hisp. Black	95.8	90.4	100.0	80.5*	76.9	84.1	
	Hispanic	83.9	72.0	95.8	75.9	72.4	79.5	70.8
SEX BY RACE/ETHNICITY	Non-Hisp. White Men	84.4	78.2	90.5	82.6	80.9	84.3	87.8
	Non-Hisp. White Women	86.7	82.4	91.0	81.3	79.6	82.9	85.8
	Non-Hisp. Black Men				80.4	74.7	86.1	
	Non-Hisp. Black Women				80.6	76.1	85.1	
	Hispanic Men				78.1	73.1	83.0	
	Hispanic Women	90.0	79.1	100.0	74.0	68.9	79.1	
AGE GROUP	18-44	91.5	86.5	96.5	87.2	85.4	89.0	88.4
	45-64	80.8	73.2	88.4	77.0	74.6	79.4	81.2
	65 & Older	85.1	80.6	89.6	72.6*	70.2	74.9	86.9
EDUCATION LEVEL	<High School	67.9	51.4	84.3	57.6	52.6	62.5	
	H.S. / GED	80.0	72.3	87.6	78.5	76.2	80.9	84.6
	>High School	90.7	87.8	93.5	86.0*	84.7	87.3	86.5
ANNUAL INCOME	<$25,000	75.9	67.3	84.6	63.9*	60.5	67.2	65.9
	$25,000-$49,999	87.6	81.9	93.3	82.2	79.8	84.5	89.7
	$50,000 or More	89.3	84.6	94.1	91.1	89.8	92.4	93.0
MARITAL STATUS	Married/Couple	87.8	83.7	91.9	83.7	82.2	85.2	89.9
	Not Married/Couple	82.6	77.0	88.2	76.4	74.4	78.4	80.0

The Impact of Social and Community Context on Diabetes

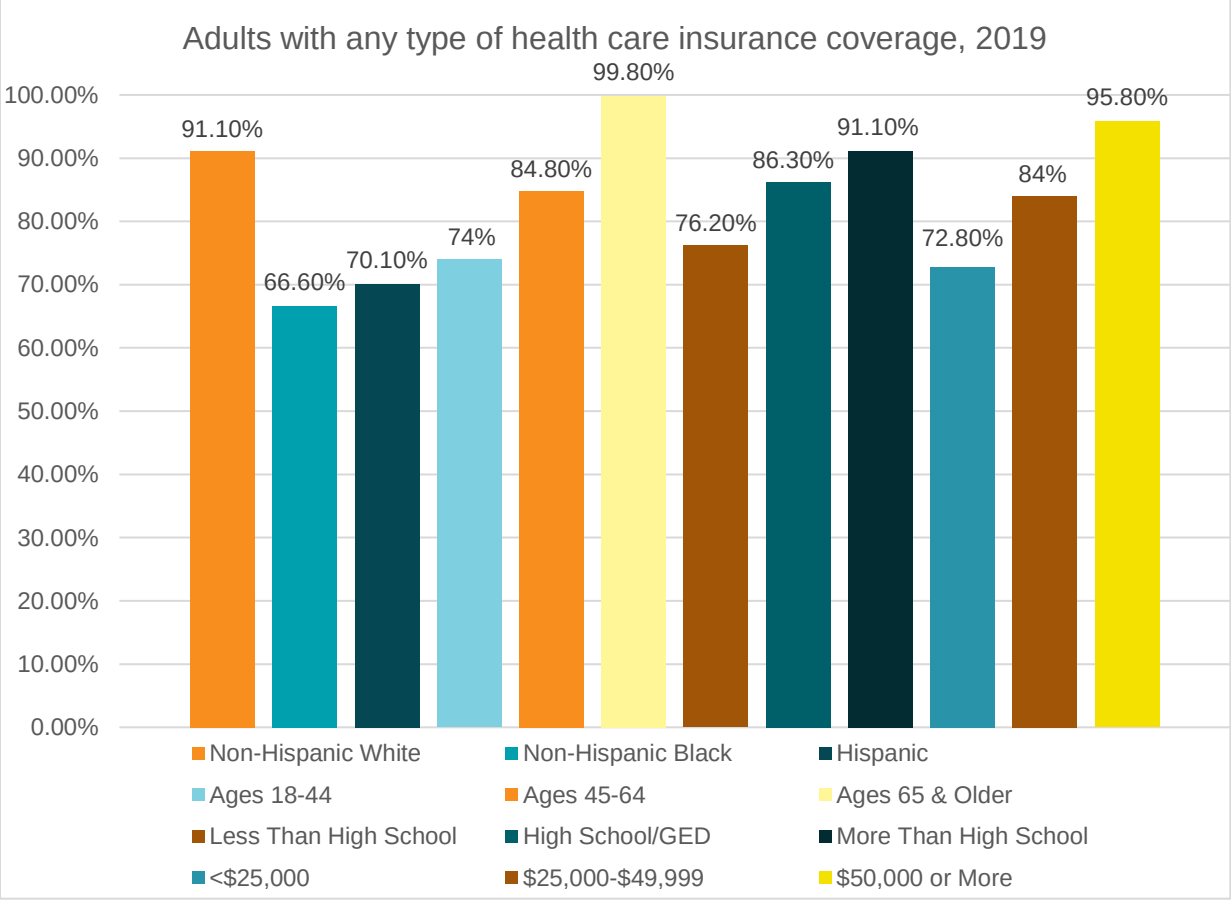
Social and Community Context		
SDoH	**Vulnerable Populations Impacted**	**How the SDOH Impacts Diabetes**
Support Systems	Older residents, People living with disabilities, Veterans	The American Diabetes Association recommends evidence-based programs with a social component or social interaction.
Community Engagement	Older residents, People living with disabilities	Community programs and volunteer opportunities can build and strengthen social supports for behavior change. Again, evidence-based programs utilize a social model for success.

E. Health Care Access and Quality

Data for Sarasota County

In 2019, 88.5% of adults in Sarasota County had any type of health insurance coverage compared to 84.2% for Florida. The below chart shows how this percentage can be lower or higher for various groups including individuals of different ages, incomes, and education levels as well as race and ethnicity. The average age in the county contributes to the higher percentage.

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



It is important that health information is presented in a way that all people can understand. In Sarasota County, 7.28% of adults aged 18-64 had limited English

proficiency. Depending on the census tract you live in, this ranges from 0% to 31.4%. Health literacy impacts health behaviors and will be considered when addressing diabetes disparities.

(US Census Bureau, American Community Survey: 2015-19; Retrieved from CARES HQ).

As stated above many adults have prediabetes and simply don't know. This could be assessed by regular monitoring of glucose and seeing your doctor regularly. Per the 2019 BRFSS data 59.7% of Sarasota adults have had a test for high blood sugar within the past 3 years. This percentage is lower when looking at various populations; only 37.9% of Black adults, 43.1% of 18- to 44-year-old adults, 40% of adults with less than high school education, 47.7% of adults making less than $25,000 a year, and 48.5% of adults not married/couple.

2017-2019 Florida BRFSS Data Report — **Sarasota**

Diabetes

Percentage of adults that have had a test for high blood sugar or diabetes with in the past 3 years

		2017-2019 County			2019 State			2016 County
		Measure	95% CI		Measure	95% CI		Measure
ALL	Overall	59.7	54.7	64.7	58.0	56.1	59.9	58.1
SEX	Men	55.7	47.8	63.5	55.8	53.0	58.6	55.6
	Women	63.1	56.8	69.5	59.8	57.2	62.4	60.4
RACE/ETHNICITY	Non-Hisp. White	61.3	55.9	66.7	61.2	59.3	63.1	59.6
	Non-Hisp. Black	37.9	12.8	63.0	52.7	47.0	58.5	
	Hispanic	57.4	37.0	77.8	56.2	51.3	61.2	
SEX BY RACE/ETHNICITY	Non-Hisp. White Men	58.2	49.5	67.0	59.9	57.0	62.8	57.4
	Non-Hisp. White Women	63.8	57.0	70.5	62.3	59.8	64.9	61.5
	Non-Hisp. Black Men				47.5	39.0	55.9	
	Non-Hisp. Black Women				57.2	49.4	64.9	
	Hispanic Men				53.3	46.2	60.4	
	Hispanic Women				58.7	51.9	65.6	
AGE GROUP	18-44	43.1	33.1	53.1	43.6	40.5	46.7	41.4
	45-64	64.2	54.9	73.5	67.2	64.0	70.4	58.1
	65 & Older	70.0	62.8	77.2	71.9	69.2	74.7	70.2
EDUCATION LEVEL	<High School	40.0	19.8	60.3	51.8	46.0	57.7	
	H.S. / GED	54.5	44.7	64.2	54.7	51.0	58.3	56.8
	>High School	65.3	59.8	70.7	61.2	58.9	63.6	58.3
ANNUAL INCOME	<$25,000	47.7	35.7	59.7	52.6	48.4	56.7	64.2
	$25,000-$49,999	56.8	46.9	66.7	54.3	50.2	58.4	58.8
	$50,000 or More	69.2	62.4	76.0	64.2	61.2	67.2	61.6
MARITAL STATUS	Married/Couple	69.4	63.3	75.5	64.8	62.4	67.3	56.3
	Not Married/Couple	48.5	41.2	55.9	50.7	47.8	53.6	60.2

These population groups can also be affected by not seeing a doctor or getting a regular check-up which could help diagnose prediabetes. In Sarasota County, 78.1% of adults had a medical check-up in the past year in 2019, but this rate varied by race, age, education level, and income as seen below.

Adults who had a medical checkup in the past year

	Sarasota		
Year	Non-Hispanic White	Non-Hispanic Black	Hispanic
2019	79.70% (75.7% - 83.7%)	71.60% (45.6% - 97.5%)	63.30% (46.3% - 80.2%)

Adults who had a medical checkup in the past year

	Sarasota		
Year	Ages 18-44	Ages 45-64	Ages 65 & Older
2019	58.80% (49.8% - 67.8%)	73.30% (65.6% - 80.9%)	93.20% (89.8% - 96.6%)

Adults who had a medical checkup in the past year

	Sarasota		
Year	Less Than High School	High School/GED	More Than High School
2019	65.50% (48.4% - 82.6%)	74.50% (66.4% - 82.6%)	81.70% (77.9% - 85.6%)

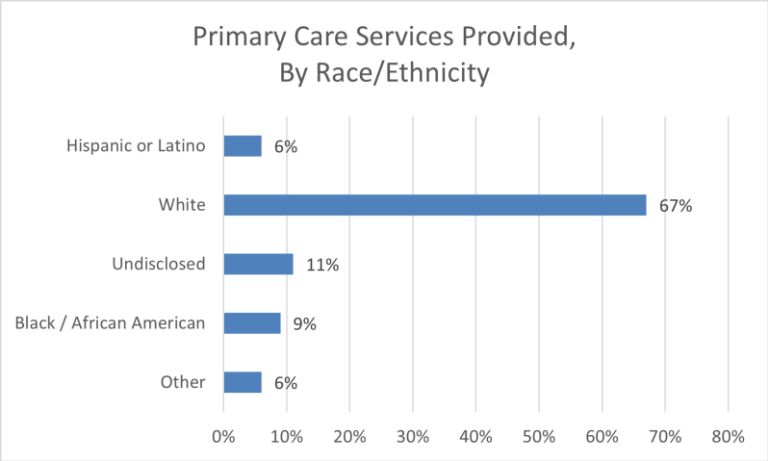
Adults who had a medical checkup in the past year

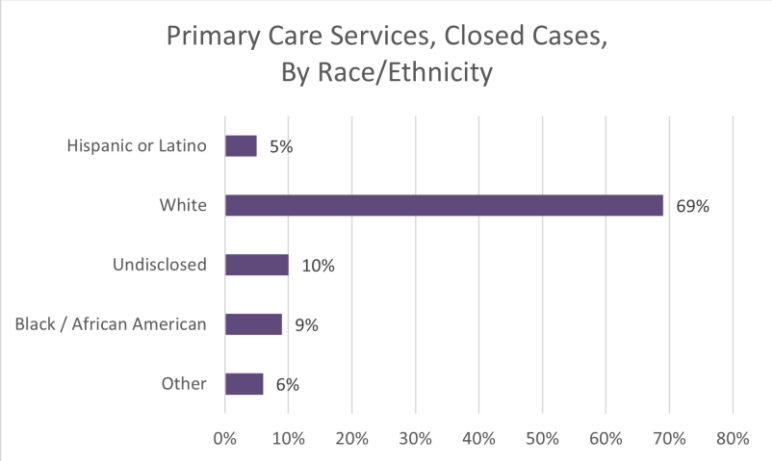
	Sarasota		
Year	<$25,000	$25,000-$49,999	$50,000 or More
2019	68.70% (59% - 78.4%)	74.60% (66.3% - 82.9%)	83.90% (79.2% - 88.6%)

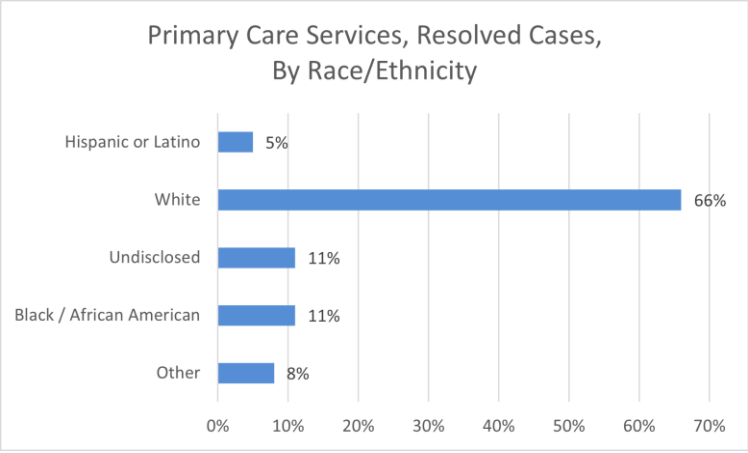
(Data Source: Florida Behavioral Risk Factor Surveillance System telephone survey conducted by the Centers for Disease Control and Prevention (CDC) and Florida Department of Health Division of Community Health Promotion)

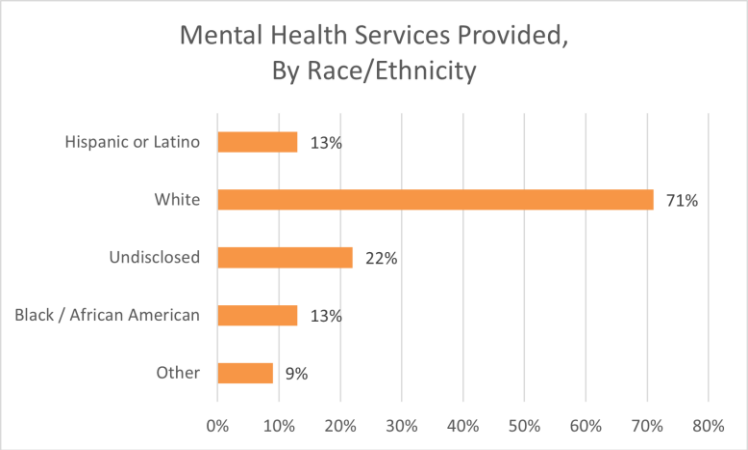
Coverage, seeing a provider, and understanding your health impacts the ability to prevent and treat diseases.

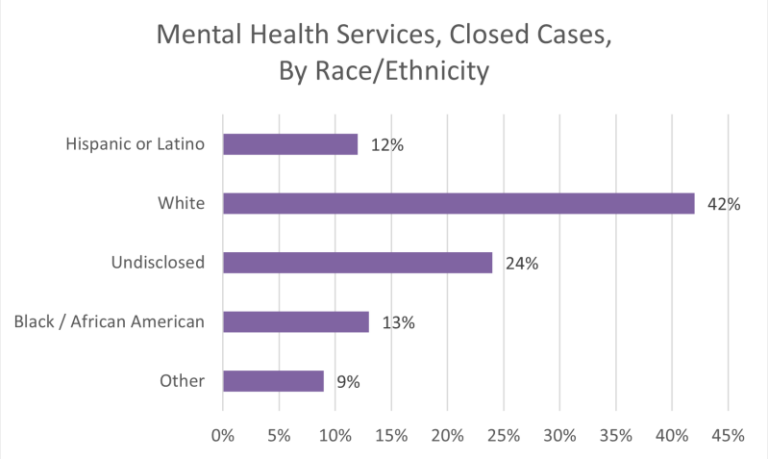
Sarasota County has access to local needs by utilizing the Unite Us Dashboard. From August of 2020 through April of 2022, 554 cases were created to address the needs of health care access and quality.

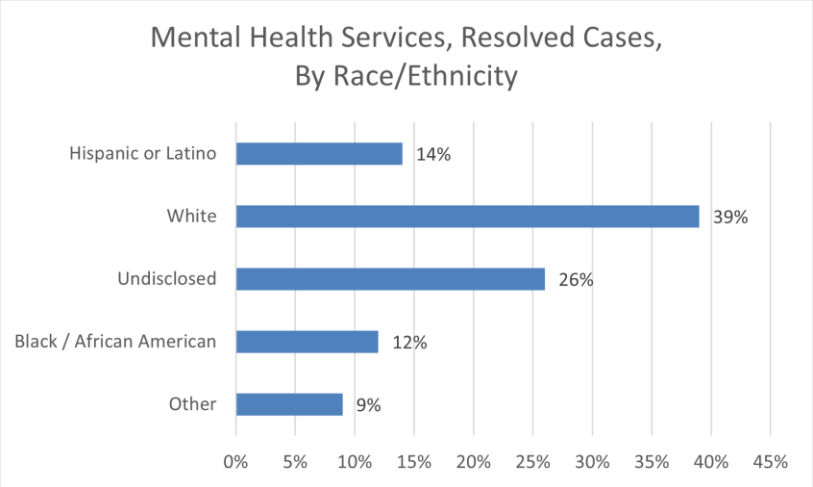







Mental Health Services Provided,
By Race/Ethnicity
Hispanic or Latino
13%
White
71%
Undisclosed
22%
Black / African American
13%
Other
9%
0%
10%
20%
30%
40%
50%
60%
70%
80%


Mental Health Services, Closed Cases,
By Race/Ethnicity
Hispanic or Latino
12%
White
42%
Undisclosed
24%
Black / African American
13%
Other
9%
0%
5%
10%
15%
20%
25%
30%
35%
40%
45%


Mental Health Services, Resolved Cases,
By Race/Ethnicity
Hispanic or Latino
14%
White
39%
Undisclosed
26%
Black / African American
12%
Other
9%
0%
5%
10%
15%
20%
25%
30%
35%
40%
45%

The Impact of Health Care Access and Quality on Diabetes

Health Care Access and Quality		
SDoH	**Vulnerable Populations Impacted**	**How the SDOH Impacts Diabetes**
Health Coverage	Black, Hispanic	Uninsured residents may be less likely to see a provider, be diagnosed, seek treatment, or manage diabetes.
Health Literacy	Black, Hispanic, Older adults, People living with disabilities	Being able to understand and discuss needed care, programs, and information to address prevention, progression, or treatments for diabetes impacts outcomes. This includes accessing chronic disease self-management type programs.

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.

A. Data Review

The Health Equity Taskforce reviewed data, including health disparities and the 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. This is detailed below in Community Projects.

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. During the Health Equity Task Force meetings, discussion themed around a *no wrong door approach*. This means that if residents are engaged or seeking help with one need, screening takes place to ensure other needs are addressed as well. Along with the *no wrong door approach* as a solution, the group discussed language, transportation, and cost as barriers when trying to get diabetes issues addressed.

C. Community Projects

The Health Equity Taskforce designed the community project based on research, discussion, and education. Each focused on SDoH and health disparities in Sarasota County.

First, the group researched evidence-based strategies to overcome the identified barriers and improve the SDoH impacting the prioritized health disparity. Literature review, examination of currently funded SDoH Accelerator Plans, and Steps to Move Your Community (a model outlined in the County Health Rankings & Roadmaps) helped guide the project outline.

Second, the Health Equity Taskforce used this written information, along with working experience with priority populations in Sarasota County, to collaboratively design the community project to address the SDoH.

Third, priority populations confirmed barriers mentioned of language, transportation, and cost and expanded with trust and access barriers. This feedback confirmed the approach to the project design.

Fourth, the Health Equity Taskforce considered the policies, systems and environments leading to inequities. The Newtown Alive Trolley Tour provided clear examples of community policies resulting in health disparities for generations in the lowest income tract of Sarasota County. This includes *sundowning* and *redlining*. Healthcare access and school placement were additional examples of policies, systems, and environments leading to health disparities for our lowest income tract. Additionally, the group looked at referral policies for many Coalition members and found *Unite Us* as a potential solution that has been expanded by Sarasota Memorial Healthcare System. This system includes a SDoH screening and links agencies more efficiently. Further, the transportation and food systems were examined in the lowest income tract. For example, inequities in access to healthy food in the lowest income tract guided the project design in terms of providing healthy food and a location for nutrition classes.

Based on the steps used to design the community project, the Taskforce assured that short, medium, and long-term goals were included with measurable objectives tied to CHARTS data. One aspiration is to apply for the CDC Closing the Gap the Social Determinants of Health Accelerator Plans funding. Although it was not possible with this inaugural plan, future years can be impacted. A Plan, Do, Check, Act (PDCA) Model will be used throughout implementation to assure success. These projects were reviewed, edited, and approved by the Coalition to ensure feasibility after the Taskforce completed the design.

The Coalition approved the plan to focus the project on Black residents with diabetes, knowing this would ultimately impact other vulnerable populations in Sarasota County. The ultimate goals are to reduce hospitalizations and emergency department visits for Black residents with diabetes. The project addresses all SDoH: education access and quality, health care access and quality, economic stability, social and community context, and neighborhood and built environment. The project is called Early Detection and Connection. It includes an awareness campaign, expands, and targets self-management classes, expands use of community health workers, and establishes a kitchen, store, and mobile medical unit.

IX. HEALTH EQUITY PLAN OBJECTIVES

A. Diabetes

- **Health Disparity Objective: By June 30, 2027, decrease the rate of emergency department visits from diabetes in Sarasota County for Black residents from 401.8 in 2020 to 100.7 (county average in 2020).**
  (Data Source: Florida Agency for Health Care Administration; Retrieved from: FLHealthCharts.gov)

- **Health Disparity Objective: By June 30, 2027, decrease the rate of age-adjusted hospitalizations from diabetes in Sarasota County for Black residents from 586.8 in 2020 to 148.3 (county average in 2020).**
  (Data Source: Florida Agency for Health Care Administration; Retrieved from: FLHealthCharts.gov)

Project 1 – Early Detection and Connection

	Lead Entity and Unit	Lead Point Person	Data Source	Baseline Value	Target Value	Plan Alignment
Long-Term SDOH Goal and Objective address neighborhood and build environment, social and community context and health care access and quality: By June 30, 2027, increase the percent of Sarasota County adults who had a medical checkup in the past year for non-Hispanic Black residents from 71.6% to 78.8% (78.1% county average). **Long-Term SDOH Goal and Objective address neighborhood and build environment, social and community context and health care access and quality:** By June 30, 2027, increase the percent of Sarasota County adults who had a medical checkup in the past year for Hispanic residents from 63.3% to 69.9% (78.1% county average). Data Source: Florida Behavioral Risk Factor Surveillance System telephone survey conducted by the Centers for Disease Control and Prevention (CDC) and Florida Department of Health Division of Community Health Promotion.						
Objective: By June 30, 2027, assure a mobile medical unit is operating in Sarasota County	Center Place Health	James Reid, CEO	FQHC BRFSS	0	43 visits per month	SHIP CHIP HP2030

and documents at least 520 unique visits with Sarasota County residents annually for a medical check-up and SDOH screening for free or low-cost resulting in a decrease in non-Hispanic Black adults who could not see a doctor due to cost from 15.2% 2019 to 10.0% in 2027 (County rate 10.8% in 2019).						
Medium-Term SDOH Goal and Objectives address health care access and quality, education access and quality, social and community context, economic stability and neighborhood and built environment: By June 30, 2025, increase the number of Sarasota County adults with diabetes who ever had diabetes self-management education from 56.8% (2019) to 65.0% (Florida rate in 2019 - 66.3%). Data Source: Florida Behavioral Risk Factor Surveillance System telephone survey conducted by the Centers for Disease Control and Prevention (CDC) and Florida Department of Health Division of Community Health Promotion.						
Objective: By June 2024, assure each trained personnel conduct at least two DSMES classes in low-income census tracts resulting in	Area Agency on Aging	Norma Adorno, CEO	Internal AAA tracking	0	6 classes	SHIP CHIP HP2030

increased number of adults with diabetes who have ever had diabetes self-management education from 56.8% in 2019 to 65.0% in 2025.						
Objective: By June 2025, a community health worker will be housed or employed at 50% of Health Equity Coalition Partner organizations resulting in an increase in non-Hispanic Black adults who have a personal doctor from 56.9% in 2019 to 68.1% (Hispanic rate in 2019) by 2024.	MHI and First 1,000 Days	Lisa Merritt, MD, and Chelsea Arnold	MHI	TBD	15 organizations	SHIP CHIP HP2030
Objective: By June 2027, establish a community commercial kitchen in census tract 3 which is low-income/low-access and low vehicle access resulting in an increase in the	All Faiths Food Bank	Adeana Osika	Foundation USDA FA Atlas	0	1 – community commercial kitchen	SHIP CHIP HP2030

population living with ½ mile of a healthy food source from 21.9% in 2019 to 25.0% in 2027. (Florida rate in 2019 – 27.7%).						
Objective: By June 2027, establish a grocery store in census tract 3 which is low-income/low-access and low vehicle access resulting in an increase in the population living within ½ mile of a healthy food source from 21.9% in 2019 to 25.0% in 2027. (Florida rate in 2019 – 27.7%).	Charles & Margery Barancik Foundation and Gulf Coast Community Foundation	Matt Sauer	Foundation USDA FA Atlas	0	1 – grocery store	SHIP CHIP HP2030
Short-Term SDOH Goal addresses health care access and quality, education access and quality and social and community context: By December 31, 2023, increase the percent of Sarasota County non-Hispanic Black adults who have ever been told they had pre-diabetes from 1.9% (2019) to 5% (Florida rate in 2019 – 8.7%). **Short-Term SDOH Goal addresses health care access and quality, education access and quality and social and community context**: By December 31, 2023, increase the percent of Sarasota County Hispanic adults who have ever been told they had pre-diabetes from 6.1% (2019) to 7.0% (Florida rate in 2019 – 7.9%) Data Source: Florida Behavioral Risk Factor Surveillance System telephone survey conducted by the Centers for Disease Control and Prevention (CDC) and Florida Department of Health Division of Community Health Promotion.						
Objective: Objective: By December 2023,	DOH	Beth Kregenow	DOH	0	50% of each – Hispanic and non-	SHIP CHIP

implement communication plans about early detection reaching 50% of Hispanic residents and 50% non-Hispanic Black residents resulting in an increase in adults who have ever been told they have pre-diabetes to 5.0% for non-Hispanic Black residents and to 7.0% for Hispanic residents for 2024.					Hispanic Black residents	HP2030

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 Sarasota County for sharing progress updates and implementation barriers associated with the Health Equity Plan. The Minority Health Liaison is responsible for monitoring progress and gathering data quarterly through CHARTS and local lead entities outlined in the Plan. This will be done approximately one month prior to each Health Equity Taskforce and Coalition meeting. Specific local data will be provided by CenterPlace Health, Area Agency on Aging, MHI, All Faiths Food Bank, Barancik and Gulf Coast Community Foundations, and DOH-Sarasota. Reports will align with each Objective and track classes, visits, organizations, and progress. Some reports will need to be created with guidance from the Minority Health Liaison to assure progress is evaluated and tracked by collecting key data and measures. For example, in addition to demonstrating that a community kitchen is established, All Faiths Food Bank will be instrumental in collecting data to assure there is in increase in the population living within ½ mile of a healthy food source. This may include mapping of services and/or tracking services on a special spreadsheet. Local data will be collected for each Objective in this manner.

The Sarasota County Health Equity Taskforce meets monthly, and the Coalition is combined with the CHIP Leadership council which meets 3 times annually. The Taskforce meets approximately one week prior to Coalition meeting and

approves the agenda and goals for the Coalition meeting. Agendas are sent approximately one week prior to each meeting.

Moving forward, the Taskforce meets at least quarterly to discuss progress and barriers on the Sarasota County goals and objectives of the Health Equity Plan. The agenda is sent approximately one week before the meeting and includes time for discussion and potential revision of the Plan along with an option to vote on those revisions. The Minority Health Liaison tracks and submits revisions to the OMHHE within 15 days of the quarter end.

At least annually, the Minority Health Liaison meets with the Health Equity Coalition to share progress toward reaching goals and objectives as well as revisions to the Plan as voted on by the Health Equity Taskforce. The Coalition reviews and approves a Health Equity Annual Report. The Annual Report includes progress toward goals, objectives, achievements, obstacles, and revisions discussed at quarterly Taskforce meetings.

The Minority Health Liaison submits the Health Equity Plan Annual Report to the Regional Health Equity Coordinator each June. The Regional Health Equity Coordinator provides feedback to the Minority Health Liaison on this Annual Report. Once feedback is incorporated, the Sarasota County 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
2023			
2024			
2025			
2026			
2027			
2028			
2029			
2030			

XII. ADDENDUMS

A. Health Equity Coalition Members

Name	Group/Organization/Area Representing
Maria Jose (MJ) Horen	All Faiths Food Bank
Alicia Diaz	Sarasota County Library System
Amber Whittle	Southface Sarasota
Ashley Spangler	Community Member
Bernice Pelea	Alzheimer's Association Florida Gulf Coast Chapter
Beth Kregenow	DOH Sarasota (Health Equity Liaison)
Bonnie Saxman	On the Spot Aid, Inc
Champaigne Spivey	Children First
Charlene Altenheim	Glasser Schoenbaum
Charles Henry	Sarasota County Health and Human Services
Chelsea Arnold	First 1000 Days
Cynthia Samra	Florida State Un College of Medicine, Sarasota Regional Campus
Dana LeBlanc	Safe Children Coalition
Emily Grant	UF/IFAS Extension, FNP
Finolia Idahose	Community Member
James Reid	CenterPlace Health
Joseph Mack	Amaryllis Park Neighborhood Association
Judy Brown	WATCH/Safe Children Coalition
Kameron Hodgens	Gulf Coast Community Foundation
Kelly Logan	Jewish Family and Children Service
Kim Kutch	Florida Dept. of Children & Families
Kristopher Fennie	New College of Florida (epidemiology)
Lisa Merritt MD	Multicultural Health Institute
Lorrie Young	Early Learning Coalition of Sarasota County
Lou Murray	Manasota Food Action council
Louis Galterio	Suncoast RHIO
Lynette Herbert	Sarasota County Health and Human Services (Health Equity Liaison Back Up)
Mari Barnes	Lab Services
Matthew Elmer Sauer	Charles and Margery Barancik Foundation
Michael Weddle	League of Women Voters Health Committee
Monique Myers	Safe Children Coalition
Nathan Scott	Family Safety Alliance/Child Welfare
Nina Tortelli	Racial Justice Coordinating Team at the Unitarian Universalist Church of Sarasota
Norma Adorno	Area Agency on Aging for Southwest Florida

Pam Beitlich	Sarasota Memorial Health Care System
Odessa Ammons	Unique Unity, LLC
Peter Casamento	Laurel Civic Agency
Phillip Brooks	Community Assisted and Supported Living, Inc.
Ranata Reeder	Community Foundation of Sarasota County
Rebecca Whittle	Multicultural Health Institute
Renee Di Pilato	Sarasota County
Rev Dr Brian Armen	Faith-Rotonda West/Englewood CC
Roscelyn Guenther	Boys & Girls Clubs of Sarasota and DeSoto Counties
Samantha McKee	Tidewell
Sandra Terry	Laurel Community
Sara Olesen	Healthy Start Coalition of Sarasota County, Inc.
Shellbiann Henry	Safe Children Coalition
Shon Ewens	Healthy Start Coalition of Sarasota County
Susan Berger	Sarasota County HHS/Age-Friendly
Vicki Guy	Multicultural Health Institute
Washington Hill MD	Sarasota Memorial Health Care System
Yusif Addae MD MBA MPH	Gulf Coast Medical Society