

Updated June 2022

Florida Department of Health in Gilchrist County

Gilchrist County Health Equity Plan

November 2021 – December 2027

Florida HEALTH Gilchrist County

Nestled in North Central Florida, the county covers 355 square miles. Gilchrist County was created in 1925 and named after the state's governor from 1909-1913, Albert W. Gilchrist. Gilchrist County home buyers appreciate the area's small town feel and relaxed pace. Gilchrist County is home to several natural springs and is the "Springs Capital of the World". There are many places for residents and visitors to enjoy swimming, snorkeling, scuba diving, canoe/kayaking, boating, fishing or just relaxing in a peaceful natural setting.

Gilchrist County Florida
IN GOD WE TRUST


UF IFAS
UNIVERSITY of FLORIDA
Central Florida Community Action Agency, Inc.
AMERICA'S POVERTY FIGHTING NETWORK
Serving Alachua, Marion, & Levy Counties
Gilchrist Prevention Coalition
Caring. Hope. Health.
LSF HEALTH SYSTEMS
Quit Doc
Research and Education Foundation
WellFlorida Council
GILCHRIST COUNTY SCHOOL DISTRICT
HEALTHSTREET
UNIVERSITY OF FLORIDA
TRI-COUNTY COMMUNITY RESOURCE CENTER
DIXIE
GILCHRIST
LEVY
CFEC
AHEC
SUWANNEE RIVER
AREA HEALTH EDUCATION CENTER
EPISCOPAL
Children's Services
FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
MYFLFAMILIES.COM
EM
GILCHRIST COUNTY
VET CENTER
Palms Medical Group
Your home for health, wellness, life
Gilchrist County
Board of County Commissioners
Another Way, Inc.
Domestic Violence & Rape Crisis Center
THE GREAT SEAL OF TRENTON FLORIDA
County Seat
A Community of Friends
Early Learning Coalition
of the Nature Coast
REAL FIT METABOLIC
One more step to health
TOWN OF BELL, FLORIDA
In God We Trust
INCORPORATED AUGUST 18, 1902
GILCHRIST COUNTY FIRE RESCUE
FIRE
EMS
SHERIFF'S OFFICE
GILCHRIST
COUNTY
PARTNERSHIP FOR STRONG FAMILIES
RWHP
Rural Women's Health Project

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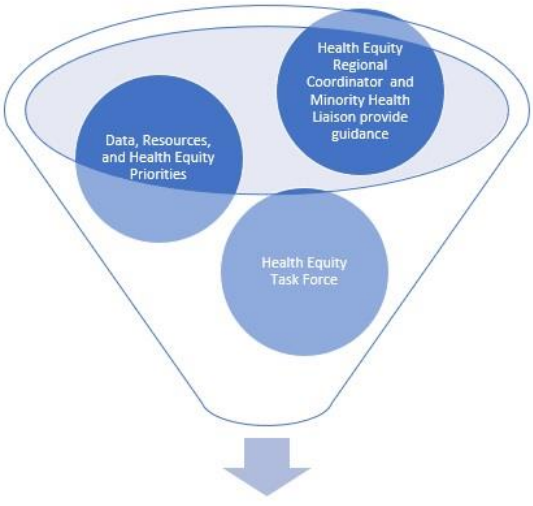
I. VISION

November 1, 2021, the Florida Department of Health in Gilchrist County integrated a health equity approach in all programmatic aspects of the health department. DOH-Gilchrist began with the hiring of a minority health liaison. From there a CHD Health Equity team was developed with leads from every program. Representation from each program is important, so that Health Equity is integrated into every aspect of DOH. This was crucial to the success of our plan. The Health Equity team was asked to define health equity, determine what health disparities existed throughout our county, and develop a plan to address these disparities, so that our counties' residents can be as healthy as possible.

When choosing a vision and mission statement the Gilchrist County Health Equity Team wanted to make sure that everyone's idea behind what is a vision and mission statement was considered. Two groups were formed, and it was the job of the groups to each come up with a statement. From there we combined it into at least three different statement combinations and then chose one to represent all of what we are trying to accomplish for our Health Equity Plan and what we should constantly strive towards in Gilchrist County.

Mission: Create equitable distribution of resident's cardiovascular health through community involvement, outreach, and education.

Vision: Improve the health of Gilchrist County residents through a health equity lens.



II. PURPOSE

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 Section 381.735, Florida Statutes, which became effective on July 1, 2021, provided resources to each county health department (CHD) 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 Gilchrist County. To develop this plan, Gilchrist County Health Department followed the Florida Department of Health's approach of multi-sector engagement to analyze data and resources, coordinate existing efforts, and establish collaborative initiatives. This plan addresses key SDOH indicators affecting health disparities within Gilchrist 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 opportunity's groups that one must achieve to have access to 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.

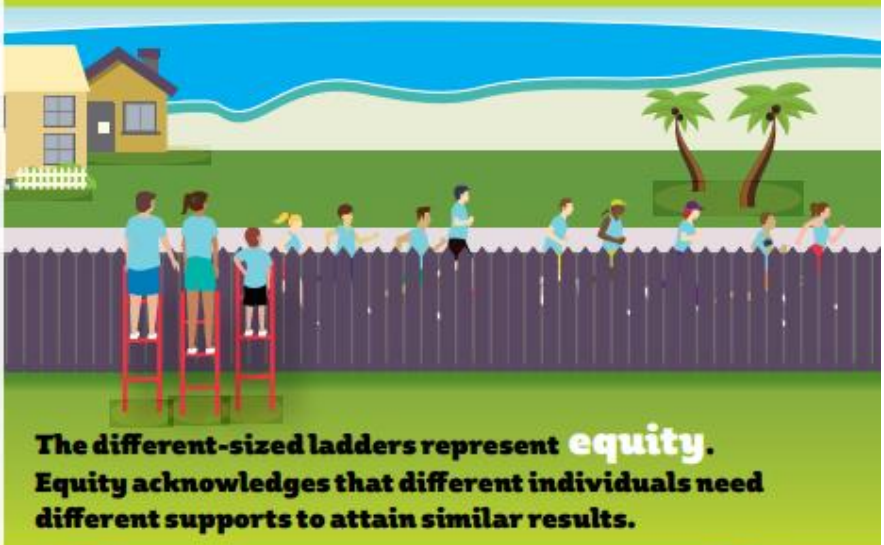
Social determinants of health are the conditions in which people are born, grow, learn, work, live, worship, and age that influence the health of people and communities.

Health Equality, Health Equity & Health Barriers

Health equality is equal treatment and availability of health care services for all people. The goal of equality is to promote fairness, but it can only work if everyone starts from the same place and needs the same things. Realistically, people with diseases like diabetes or physical disabilities, and people who live in communities where health care services are limited, will need different things to achieve and maintain their overall level of wellness.

The same-sized ladders represent equality. Equality assumes that everyone will benefit from the same supports.

Health equity is the availability of health care while taking in to account the other factors that influence health such as employment, housing, transportation, education, socio-economic status, food access, etc. When health equity is achieved, no one is excluded because of a pre-existing health condition or external circumstances. Health equity acknowledges that everyone does not start from the same place or need the same things.



The different-sized ladders represent equity. Equity acknowledges that different individuals need different supports to attain similar results.

Health barriers to services include the high cost of care, inadequate insurance coverage, unavailability of services in a community and lack of culturally-competent care. Often linked to socioeconomic status, education level, age, sex, disability, geographical location, race and ethnicity, barriers can lead to unmet health care needs such as delays in receiving appropriate care and inability to secure preventative services.

With the fence removed, all the runners can join the race. When barriers are removed, needs for all people are more likely to be met.

Source: Centers for Disease Control and Prevention

Florida HEALTH

10/17/17 Florida Health Office of Communications

Essential Health Equity Terms to Further Public Health Discussions

Health Equity

Health equity is attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.[1]

Health Disparities

Health disparities are differences in health outcomes and their determinants between segments of the population, as defined by social, demographic, environmental, and geographic attributes.[2]

Health Inequalities

Health inequalities is a term sometimes used interchangeably with the term health disparities. It is more often used in scientific and economic literature to refer to summary measures of population health associated with individual- or group-specific attributes (e.g., income, education, or race/ethnicity).

Health Inequities

Health inequities are a subset of health inequalities that are modifiable; associated with social disadvantage, and considered ethically unfair.[2]

Social Determinants of Health

Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.[3]

Florida HEALTH

1. Centers for Disease Control and Prevention: A Practitioner's Guide for Advancing Health Equity: Community Strategies for Preventing Chronic Disease www.cdc.gov/nccdphp/dch/pdfs/health-equity-guide/Health-Equity-Guide-intro.pdf. www.floridahealth.gov/programs-and-services/minority-health/

2. Centers for Disease Control and Prevention. CDC health disparities and inequalities report—United States, 2011. MMWR Morb Mortal Wkly Rep. 2011;60(Supplement):1-113.

3. US Department of Health and Human Services. Social determinants of health. www.healthypeople.gov/2020US Department of Health and Human Services. Social determinants of health. /www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39.

A. About Us

"Our role is to improve your life. It is important that we work together not only within our agency but also with other state and county agencies, community, and faith-based organizations to create a diversity of leaders. We recognize that systemic barriers have produced health, financial, educational, and housing disparities. These differences are complex and impact how well an individual can achieve the best life possible. However, the health of each person in the community is important. Pick an area of interest and expand the work you are doing. The complexities of the problem call us all to do more and achieve more together."

– Owen Quinonez, MD, Senior Health Equity Officer

According to the Robert Wood Johnson Foundation County health rankings, Gilchrist County is ranked in the lower middle range of counties in Florida (25 to 50 range percent) for health outcomes and is ranked among the lower-middle among the least healthy counties for health factors in Florida (25 to 50 percent). **(**www.countyhealthrankings.org).

According to the Centers for Disease Control and Prevention (CDC), health equity is achieved when every person can "attain his or her full health potential" and no one is "disadvantaged from achieving this potential because of social position or other socially determined circumstances." Health inequities are reflected in differences in length of life; quality of life; rates of disease, disability, and death; severity of disease; and access to treatment.

Equity or inequity in health and wellbeing are largely determined by race, ethnicity, income, housing, community environments, education, access to health care and childhood experiences. Public health and community actions that address the contributing factors to health inequities and disparities in health outcomes will overtly lead to improved wellbeing for all residents of Gilchrist County.

The Florida Department of Health in Gilchrist County and its partners present this first health equity plan to the Gilchrist County community to help support the concepts of population and individual health improvement through a variety of evidence-based public health initiatives that

will promote wellness through grassroots policy change, researching funding opportunities and community dialogue and engagement that will advance health equity.

This plan provides definitions and narratives related to health equity and health disparities and the five social determinants of health which impact people's health. Local and state data are incorporated into this plan under each of the five social determinants of health to demonstrate the areas of need for areas where continuous effort is needed to reach optimum health for all residents of Gilchrist County. Data in this plan can be a catalyst for improving community health and well-being. Understanding data on social determinants of health, such as income, educational level, and employment, can help focus efforts to improve community health.

This plan is intended to serve as a resource for our community partners for initiating conversations, setting goals, and planning programs and processes to improve health outcomes for all residents of Gilchrist County.

B. Health Equity Brochure

Health Department Programs

- COMMUNICABLE DISEASE TESTING
  - Sexually Transmitted Diseases
  - HIV/AIDS
  - Hepatitis
  - Tuberculosis
- ADULT IMMUNIZATIONS
  - HPV, Tdap, Flu, Pneumonia, Meningitis, Hepatitis A & B.
- CHILD IMMUNIZATIONS–0 to 18 Years
- SCHOOL PHYSICALS
- VITAL STATISTICS
  - Birth Certificates/Death Certificates
- CHILDREN'S DENTAL: 0 to 20 Years
- FAMILY PLANNING
  - Exam and birth control methods (All methods of birth control available, including Nexplanon and IUDs).
  - Provided on a sliding fee scale.
- BREAST & CERVICAL CANCER SCREENING PROGRAM
  - For uninsured women ages 50 to 64.
  - Resident of Florida.
  - No insurance, or medically needy.
  - Income at or below 200% of federal poverty guidelines.
  - Not screened within the prior year.
  - A client aged 40 to 49 with CBE suspicious for cancer may be eligible for limited diagnostic funds as available.
  - For Applications contact your local health department.
- EPIDEMIOLOGY INVESTIGATION
  - Infectious disease investigations and/or potential disease outbreaks in the community.
- EPILEPSY & INSULIN MEDICATION PROGRAM

Health Department Programs

- ENVIRONMENTAL HEALTH
  - Septic Tank Permits
  - Food Hygiene/Food Service Inspections
  - Animal Bite Investigations
  - Well Water Testing
  - Nuisance Complaint Investigations
- PREPAREDNESS & RESPONSE
  - Coordinate's planning and preparedness activities for all hazards, public health emergencies, or events and disasters that threaten the health of communities or groups of people.
- CHRONIC DISEASE PREVENTION and HEALTH PROMOTION
  - Blood Pressure Self-Monitoring Classes/Blood Pressure Community Health Screenings.
  - Healthiest Weight Initiative.
  - Community Health Improvement Planning.
  - Healthy Babies
- HEALTHY START
  - Statewide voluntary and free service for eligible pregnant women, infants, and children to age three.
- HEALTHY FAMILIES
  - Healthy Families provides free, voluntary, home visiting services that increase parenting knowledge and skills.
- SCHOOL HEALTH SERVICES
- SMOKING CESSATION PROGRAMS
- COMMUNITY PRESENTATIONS RELATED TO PUBLIC HEALTH TOPICS.
- OTHER SERVICES:
  - WIC – Women, Infants, and Children
    Call 1-800-494-2543 for an appointment.

Please call your local County Health Department for an appointment or for more information regarding our programs and services.

Florida HEALTH

Florida Department of Health in Dixie, Gilchrist, and Levy Counties

Dixie County Health Department
149 NE 241st Street Cross City, FL 32628
352-498-1360

Gilchrist County Health Department
119 NE 1st Street Trenton, FL 32693
352-463-3120

Levy County Health Department
66 West Main Street, Bronson, FL 32621
352-486-5300

Administration

Natalie McKellips, Administrator

Kelly Adams, DO – Medical Director

Elizabeth Powers, RN BSN – Nursing Director

Wesley Asbell, Environmental Manager

Kyle Roberts, Health Educator Consultant

Kathy J. Smith, Business Manager

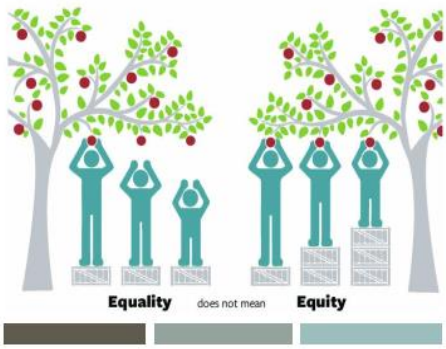
Rekeesha Duncan, Health Equity Program Manager

Medical Provider

Marinda Norton, APRN

Dental Providers

David Turner, DMD
Christine Elam, DMD



Health Equity

All Dixie, Gilchrist and Levy County residents should have the opportunity to make choices that allow them to live a long, healthy life, regardless of their income, education, or background.

Achieving health equity requires focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.

Equality versus Equity

Equality means everyone is treated the same exact way, regardless of differences.

- When looking at the image above everyone was given one box to stand on regardless of difference in height.

Equity means everyone is provided with what they need to succeed.

- With the Equity image you can see height is considered and everyone is able to reach the apples.

Social Determinants of Health

Powerful, complex relationships exist between health and biology, individual behavior, health services, socioeconomic status, the physical environment, discrimination, racism, literacy levels, and legislative policies.

These factors, which influence an individual's or population's health, are known as determinants of health:

- Education Access and Quality
- Health Care Access and Quality
- Neighborhood and Built Environment
- Social and Community Context
- Economic Stability

Examples of determinants of health:

- High-quality education
- Nutritious food
- Testing and Vaccination efforts
- Affordable, reliable public transportation
- Clean water and non-polluted air

Social Determinants of Health

According to the Center for Disease Control,

"Health equity is achieved when everyone has the opportunity to be as healthy as possible."

Meet our Health Equity Team

Dixie County Health Department
149 NE 241st Street Cross City, FL 32628
Rekeesha Duncan – Program Manager
Email: Rekeesha.Duncan@flhealth.gov
Phone: 352-498-1360

Gilchrist County Health Department
119 NE 1st Street Trenton, FL 32693
Jan Gonthier – Health Educator
Email: Jan.Gonthier@flhealth.gov
Phone: 352-463-3120
Cell: 352-441-4381

Levy County Health Department
66 West Main Street Bronson, FL 32621
Alex Santana – Health Educator
Email: Alex.Santana@flhealth.gov
Phone: 352-486-5300
Cell: 850-661-4302

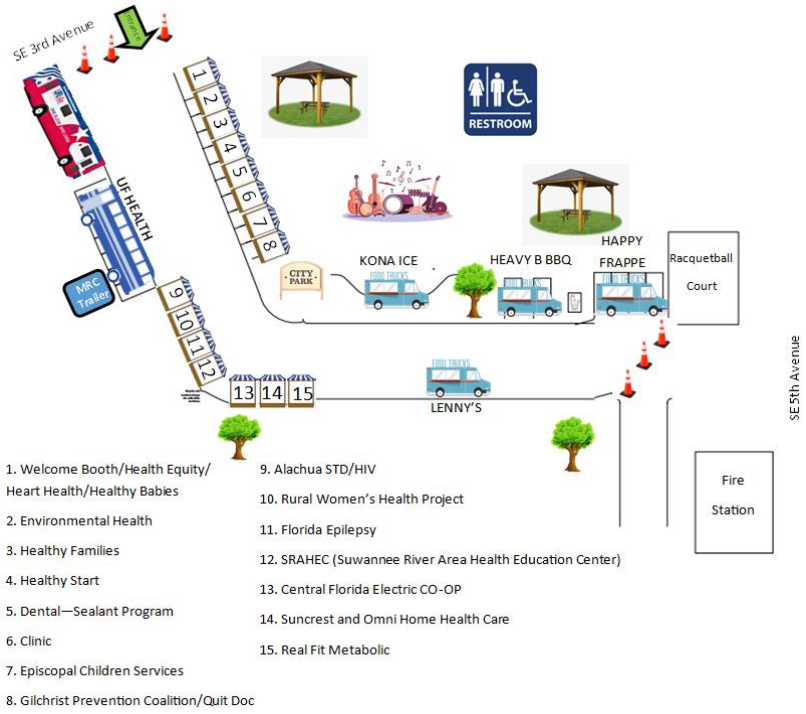
This Health Equity Brochure was created to distribute out to residents of Gilchrist County and external organization partners. Within the brochure DOH-Gilchrist felt that it was important to discuss what our programs can offer within the health department, what health equity is, the difference between equality and equity, the social determinants of health, and the team.

The brochure was created because it is important to talk to the community about what all the Health Department can do and what can be offered. Also, it is to show that no matter what program the Florida Department of Health in Gilchrist County will have a health equity lens and approach when addressing any issue, complaint, or request.

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.

One collaboration was the creation of a Minority Health Month Event: From Surviving to Thriving Health Fest. DOH-Gilchrist partnered with multiple agencies, so that our organization could help influence the wellbeing of the Gilchrist population. This partnership was so successful because these are already the members that are a part of the Health Equity Taskforce and the Health Equity Coalition. Plus, new partnerships with these individuals and the recruit them for the completion of our Health Equity Plan. DOH-Gilchrist provided free health screenings, education, and access to resources. This event focused on Health care access and quality. It was important because it was providing people with the opportunity to have face to face interactions with the workers behind the organization. Residents could ask questions and have opportunities to learn more about what these groups can offer.



Another collaboration was talking to the Gilchrist County Rotary Club. The mission of The Rotary Foundation is to enable Rotarians to advance world understanding, goodwill, and peace through the improvement of health, the support of education, and the alleviation of poverty. The Foundation is a not-for-profit corporation supported solely by voluntary contributions from Rotarians and friends of the Foundation who share its vision of a better world. The Gilchrist County Rotary Club is filled with members from several organizations t in the area. There is representation from Palms, The Advocate (Newspaper), Tri-County Metals, Suwanee River Water Management, For Vets, Board of County Commissioners, Gilchrist County School Board, Ayers Health and Rehabilitation, Gilchrist County Government, etc.

It is important to attend these meetings because individuals can connect to these members of the community and gain additional resources and connections to offer to the public. These are already the members that are a part of the Health Equity Taskforce and the Health Equity Coalition. Plus, DOH-Gilchrist was able to form new partnerships with these individuals and recruit them for the completion of our Health Equity Plan. Also, when there are new items that are going on within their respective injuries, they discuss what is going on and how it will affect the public.

Pictured left to right: Donna Lee (Senior Disaster Program Manager for the American Red Cross), Jan Gonthier, Alex Santana, and Rick Washburn (Tri-County Metals).

Overall, the Florida Department of Health in Gilchrist County is constantly working on strengthening our relationship with external partners. These partners also help our programs and assist clients and the residents of Gilchrist County. We keep open community channels with community partners, so that DOH-Gilchrist can better serve the community.

C. 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: Jan Gonthier

D. 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 Gilchrist County to the Health Equity Taskforce. The Minority Health Liaison guides these discussions and the implementation of initiatives. The membership of the Health Equity Team is listed below. Dixie, Gilchrist, and Levy Workers will be listed as DGL.

Name	Title	Program
Jan Gonthier	Health Educator Consultant – Gilchrist Minority Health Liaison	Health Equity
Alex Santana	Health Educator – Levy Minority Health Liaison	Health Equity
Elizabeth Powers	Nursing Director	Clinic/Senior Leadership - DGL
Rekeesha Duncan	Senior Human Services Program Manager/ Health Educator – Dixie Minority Health Liaison	Healthy Families/ Health Equity - DGL

Kyle Roberts	Health Educator Consultant - Accreditation Coordinator	Environmental Health/Accreditation
Wesley Asbell	Environmental Health Manager	Environmental Health - DGL
Cheryl Turner	RN Supervisor	Healthy Start - DGL
Angela (Angie) Phillips	RN - School Health Coordinator	School Health - DGL
Marinda Norton	ARNP	Clinic - DGL
Tiffany Owens	Health Educator	Healthy Babies and Heart Health - DGL
Lynda Malloy	Health Operation Specialist - A	HR and Environmental Health - DGL
David (Dave) Turner	Dentist	Dental - DG
Krista Coates	Dental Assistant	Dental - DG
Tara Campbell	RN Supervisor	Healthy Start
Gilma Carranza	Senior Clerk	Environmental Health
Fred Eichler	OPS Planner III	Preparedness - GL
Caleb Hardee	OPS Government Operations Consultant II	Preparedness - DGL
Garrison Vandegrift	OPS Planner I	Preparedness - DGL
Mark Johnson	Planner III	Preparedness - GL
Sandra (Renee) Jenkins	LPN	Clinic
Trinity Williams	RN - Nursing Lead	Clinic
Crystal Rodgers	RN - School Health	School Health
Paige Borcyk	OPS Biological Scientist lll	COVID
Christen Summers	Administrative Assistant II	Front Desk/Administration

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

Meeting Date	Topic/Purpose
Tuesday February 1st, 2022.	• Onboarding – official welcoming/recruitment for CHD Health Equity Team. • Discussed what role the CHD team will have in plan execution.
Tuesday February 15th, 2022.	• Discuss each need for each program and how to integrate health equity within our DOH.
Tuesday March 1st, 2022.	• Discuss and choose prioritized health disparity. • Prioritized health disparity is hypertension. • Discuss using existing CHIP for task force membership.
Monday March 7th, 2022.	Meeting 1 for Planning of Minority Health Month – • Discuss where to hold the event. • Discuss representatives for each booth. • Choose location and discuss who to contact to get permissions for shutdown of roads, parking area, etc.
Tuesday March 15th, 2022.	Discuss break down of what was asked of Well Florida and how the funding for contracted services will be sent. Discuss Board of County Commissioners, town council, etc. as Health Equity Coalition. Meeting 2 for Planning of Minority Health Month – • Location: Southside City Park chosen. • Discuss external organizations to invite. • Contact and meet with emergency management. • Take measurements to plot out allotted space and where to place booths.
Monday April 4th, 2022.	Meeting 3 for Planning of Minority Health Month – • Location: Southside City Park chosen, and special permissions granted. • Discuss traffic flow and parking. • Share Map of how the event will be executed – spaces for booths, where buses will be, etc.

Wednesday April 20th, 2022.	Meeting 4 for Planning of Minority Health Month – • Discuss final logistics: what time to meet, allocated jobs, final check-ins. Discuss how creation of the plan is going. • Discuss date for meeting with Well Florida. • Ask for representation for internal team. • Share current completion of plan.
Wednesday May 4th, 2022.	Well Florida Meeting • Complete Gilchrist County health disparity, SDOH, and Health Equity Profile data report. • Facilitate prioritization of disparities and identification of focus for Health Equity Plan. • Complete One meeting up to 3 hours in duration. • Well Florida will provide meeting materials, facilitation, data resources; if held virtually Well Florida will provide zoom platform.
Monday June 20, 2022	Come up with Ideas to ask at the next Gilchrist CHIP/Task Force Meeting, so that there is full partner interest and investment into the Plan. • What types of projects are the different organizations already doing/planning? • Adding a health equity lens to everything to promote inclusivity for all populations. • What are the barriers in your organizations and ask if there any ideas that will help fix those barriers? • Looking at the possible development of projects that can help fix shared barriers within the task force. • What opportunities are there to collaborate to make our activities more efficient, effective, and comprehensive to our community's needs?
Thursday June 30th, 2022.	Discuss Final Revisions and Edits for the Health Equity Plan. Make sure everyone is on board with completion and submittal of Plan.

E. Health Equity Taskforce

The Health Equity Taskforce includes CHD staff and representatives from various organizations that provide services to address various SDOH. The Health Equity Task Force was created with the existing Community Health Improvement Plan (CHIP) members. These individuals are the ones who are in the community already doing projects and working with the

citizens that the Community partners are looking to assist with. The Health Equity Taskforce members will also assist with the creation of the Community Health Assessment because that will allow DOH staff to have more opportunities to work towards gathering more data that is specific to bettering our community. Also, it will provide the group with additional goals and objectives to work towards that will not only add to the CHIP, but the Health Equity Plan as well. 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 Task Force helped to prioritize health disparities and the specific SDOH that impact them in our county. They contributed their expert knowledge, experience, and guidance that informed the development of the Gilchrist County Health Equity Plan and the projects that will work to address the prioritized SDOH.

Gilchrist County Health Equity Taskforce members are listed below:

Name	Title	Organization	Social Determinant of Health
Jan Gonthier	Health Educator Consultant	Dixie, Gilchrist, and Levy County Health Department	education access and quality, health care access and quality, neighborhood and built environment, social and community context, and economic stability.
Alex Santana	Health Educator	Dixie, Gilchrist, and Levy County Health Department	education access and quality, health care access and quality, neighborhood and built environment, social and community context, and economic stability.
Rekeesha Duncan	Senior Human Services Program Manger	Dixie, Gilchrist, and Levy County Health Department	education access and quality, health care access and quality, neighborhood and built environment, social and community context, and economic stability.
Natalie McKellips	Administrator	Dixie, Gilchrist, and Levy County Health Department	education access and quality, health care access and quality, neighborhood and built environment, social and community context, and economic stability.
Elizabeth Powers	Nursing Director	Dixie, Gilchrist, and Levy County Health Department	education access and quality, health care access and quality, neighborhood and built environment, social and community context, and economic stability.

Kyle Roberts	Environmental Health Supervisor/Health Educator Consultant	Dixie, Gilchrist, and Levy County Health Department	education access and quality, health care access and quality, neighborhood and built environment, social and community context, and economic stability.
Wesley Asbell	Environmental Health Manager	Dixie, Gilchrist, and Levy County Health Department	education access and quality, health care access and quality, neighborhood and built environment, social and community context, and economic stability.
Cheryl Turner	RN Supervisor	Dixie, Gilchrist, and Levy County Health Department	education access and quality, health care access and quality, neighborhood and built environment, social and community context, and economic stability.
Angela (Angie) Phillips	RN - School Health Coordinator	Dixie, Gilchrist, and Levy County Health Department	education access and quality, health care access and quality, neighborhood and built environment, social and community context, and economic stability.
Marinda Norton	ARNP	Dixie, Gilchrist, and Levy County Health Department	education access and quality, health care access and quality, neighborhood and built environment, social and community context, and economic stability.
Tiffany Owens	Health Educator	Dixie, Gilchrist, and Levy County Health Department	education access and quality, health care access and quality, neighborhood and built environment, social and community context, and economic stability.
Lynda Malloy	Health Operation Specialist - A	Dixie, Gilchrist, and Levy County Health Department	education access and quality, health care access and quality, neighborhood and built environment, social and community context, and economic stability.
David (Dave) Turner	Dentist	Dixie, Gilchrist, and Levy County Health Department	education access and quality, health care access and quality, neighborhood and built environment, social and community context, and economic stability.
Krista Coates	Dental Assistant	Dixie, Gilchrist, and Levy County Health Department	education access and quality, health care access and quality, neighborhood and built environment, social and community context, and economic stability.

Tara Campbell	RN	Dixie, Gilchrist, and Levy County Health Department	education access and quality, health care access and quality, neighborhood and built environment, social and community context, and economic stability.
Gilma Carranza	Senior Clerk	Dixie, Gilchrist, and Levy County Health Department	education access and quality, health care access and quality, neighborhood and built environment, social and community context, and economic stability.
Fred Eichler	OPS Planner III	Dixie, Gilchrist, and Levy County Health Department	education access and quality, health care access and quality, neighborhood and built environment, social and community context, and economic stability.
Garrison Vandegrift	OPS Planner I	Dixie, Gilchrist, and Levy County Health Department	education access and quality, health care access and quality, neighborhood and built environment, social and community context, and economic stability.
Caleb Hardee	OPS Government Operations Consultant II	Dixie, Gilchrist, and Levy County Health Department	education access and quality, health care access and quality, neighborhood and built environment, social and community context, and economic stability.
Mark Johnson	Planner III	Dixie, Gilchrist, and Levy County Health Department	education access and quality, health care access and quality, neighborhood and built environment, social and community context, and economic stability.
Sandra (Renee) Jenkins	LPN	Dixie, Gilchrist, and Levy County Health Department	education access and quality, health care access and quality, neighborhood and built environment, social and community context, and economic stability.
Trinity Williams	RN - Nursing Lead	Dixie, Gilchrist, and Levy County Health Department	education access and quality, health care access and quality, neighborhood and built environment, social and community context, and economic stability.
Crystal Rodgers	RN - School Health	Dixie, Gilchrist, and Levy County Health Department	education access and quality, health care access and quality, neighborhood and built environment, social and community context, and economic stability.

Paige Borcyk	OPS Biological Scientist lll	Dixie, Gilchrist, and Levy County Health Department	education access and quality, health care access and quality, neighborhood and built environment, social and community context, and economic stability.
Christen Summers	Administrative Assistant II	Dixie, Gilchrist, and Levy County Health Department	education access and quality, health care access and quality, neighborhood and built environment, social and community context, and economic stability.
Polly Smith	Home Base Program Specialist	Episcopal Children's Services	education, social and community context
Daniel Murray	Tobacco Prevention Specialist	Quit Doc Foundation	education, Social and Community context, neighborhood and built environment
Cristina Benitez	Fair Housing Outreach Advocate	Florida Legal Services	economic stability, neighborhood and build environment and social and community context.
Lauren Mollman	Healthy Communities Director	Suwannee River Area Health Education Center (SRAHEC)	neighborhood and built environment, education, economic stability, health and healthcare, social and community context.
Cheryl Twombly	Board Member	Children's Trust of Alachua County	neighborhood and build environment, economic stability, education, and social and community context.
Ingrid Rincon	Veteran Outreach Program Specialist	Gainesville Vet Center	education access and quality, health care access and quality, neighborhood and built environment, social and community context, and economic stability.
Sandra Woodard	Director of Communications	Early Learning Coalition of the Nature Coast	education, neighborhood and built environment
Lisa Berrios De Jesus	CEO	Real Fit Metabolic Inc.	Education, social and community context
Robert Wells	CEO	Gilchrist Prevention Coalition	neighborhood and built environment, economic stability, education, social and community context.
Darby Allen	Assistant Superintendent/District Title IX Coordinator	Gilchrist County School District	education
Jessica Altum Cooper	County Extension Director and Extension Agent I	UF IFAS - 4-H Youth Development/CRD	education, economic stability, social and community context.

Beverly Goodman	Manager	Tri-County Resource Center and Partnership for Strong Families	education access and quality, health care access and quality, neighborhood and built environment, social and community context, and economic stability.
Lesley Hersey	Community Engagement Specialist	Lutheran Services Florida (LSF) Health Systems	education access and quality, health care access and quality, neighborhood and built environment, social and community context, and economic stability.
Erin Peterson	Community Liaison - Nurse Family Partnership and Healthy Start Coalition	Well Florida Council	education access and quality, health care access and quality, neighborhood and built environment, social and community context, and economic stability.
Cristine Crews	Clinical Care Coordinator	Palms Medical Group	education access and quality, health care access and quality, neighborhood and built environment, social and community context, and economic stability.
Shrishti Singh	Tobacco Treatment Specialist	Suwannee River Area Health Education Center (SRAHEC)	neighborhood and built environment, education, economic stability, health, and healthcare
Monique Bessette	Tobacco Treatment Specialist	Suwannee River Area Health Education Center (SRAHEC)	neighborhood and built environment, education, economic stability, health and healthcare, social and community context.
Jamie Holton	Outreach Coordinator	Suwannee River Area Health Education Center (SRAHEC)	neighborhood and built environment, education, economic stability, health and healthcare, social and community context.

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
Tuesday September 21, 2021, at 10 am	Gilchrist CHIP – Gilchrist Department of Health, UF IFAS, Well Florida, Tri-County Resource Center, Quit Doc, Episcopal Children's Services, Early Learning	Talking about possibly introducing the Health Equity Program to Department of Health Agencies.

	Coalition – Nature Coast, Gilchrist Prevention Coalition, Palms Medical Group	
Tuesday December 07, 2021, at 10:00 am	Gilchrist CHIP Members – Gilchrist Department of Health, Gilchrist County School Board/School District, UF IFAS, Tobacco Free Florida, LSF Health Systems, Episcopal Children Services – Home Base and Head Start, Well Florida	Brief Introduction – Introduce Minority Health Liaisons.
Tuesday March 15, 2022, at 10:00 a.m.	Gilchrist CHIP – Gilchrist Department of Health, Florida Legal Systems, Episcopal Children Services – Home Base and Head Start, Tobacco Free Florida, Meridian, Partnership for Strong Families (Children's Trust of Alachua County), Real Fit Metabolic, Gainesville VA Hospital, Early Learning Coalition of the Nature Coast, Gilchrist County Prevention Coalition, Well Florida	Introduce Minority Health Liaisons. What the Health Equity Task Force is. What the Health Equity Coalition is. Discuss the Health Equity Plan.
Tuesday June 9th, 2022	Episcopal Children's Services, Tri-County Resource Center, Well Florida Council, UF IFAS, Gilchrist County School Board and School District, Trenton Senior Center, Gilchrist County Health Department, Another Way, Suwanee River Area Health Education Center (SRAHEC), Quit Doc, Palms Medical Group	Discuss CHA, Surveys - gather data that is specific to the county and our residents. Talk about the data that received from Well Florida and the Health Equity Plan.
Tuesday June 21, 2022, at 10:00 am	Gilchrist CHIP – Suwannee River Area Health Education Center, Gilchrist County Health Department, Gilchrist Prevention	What types of projects are the different organizations already doing/planning?

	Coalition, Well Florida Council, Quit Doc	Adding a health equity lens to everything to promote inclusivity for all populations. What are the barriers in your organizations and ask if there any ideas that will help fix those barriers? Looking at the possible development of projects that can help fix shared barriers within the task force. What opportunities are there to collaborate to make our activities more efficient, effective, and comprehensive to our community's needs?
Tuesday September 20, 2022, at 10:00 am	TBD	TBD
Tuesday December 6, 2022, at 10:00 am	TBD	TBD

F. 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. See addendum for a list of Coalition members.

G. 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	Expertise
Carrie Rickman	Emerald Coast	Technical Assistance, Training and Project Coordination
Quincy Wimberly	Capitol	Technical Assistance, Training and Project Coordination
Ida Wright	North Central	Technical Assistance, Training and Project Coordination
Diane Padilla	Northeast	Technical Assistance, Training and Project Coordination
Rafik Brooks	West	Technical Assistance, Training and Project Coordination
Lesli Ahonkhai	Central	Technical Assistance, Training and Project Coordination Faith-Based Engagement
Frank Diaz-Gines	Southwest	Technical Assistance, Training and Project Coordination
Kimberly Watts	Southeast	Technical Assistance, Training and Project Coordination

V. HEALTH EQUITY ASSESSMENT, TRAINING, AND PROMOTION

A. Health Equity Assessments

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

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

Gilchrist County conducted a health equity assessment(s) to examine the capacity and knowledge of Gilchrist County Health Department staff and county partners to address social determinants of health. Below are the dates assessments were distributed and the partners who participated.

Date	Assessment Name	Organizations Assessed
04/2022	Gilchrist County Health and Medical ESF 8 Profile	Palms, Gilchrist Emergency Operations Center, Gilchrist Sheriff’s Office, Gilchrist County Health Department, Gilchrist Board of County Commissioners, City of Trenton, City of Bell, City of Fanning Springs, Palms Medical Group, Bell High School, WIC

05/2022	Gilchrist Health Equity Snapshot	Palms, UF Health, Family Medical, Partnership for Strong Families, Quit Doc, Suwannee River Area Health Education Center, Gilchrist Prevention Coalition, Episcopal Children Services, Tri-County Resource Center
05/2022	Gilchrist Health Equity Profile	Palms, UF Health, Family Medical, Partnership for Strong Families, Quit Doc, Suwannee River Area Health Education Center, Gilchrist Prevention Coalition, Tri-County Resource Center
09/2022	Health Equity and Cultural Competence Assessment – Workforce Development	DOH Dixie, Gilchrist, and Levy Staff

B. County Health Equity Training

Assessing the capacity and knowledge of health equity, through the 2022 Community Health Assessment Process, 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
Tuesday March 15, 2022,	Health Equity – Overview of the program (what is health equity, what is the coalition, what your role will be, how you can contribute, etc.), what was learned, what kind of projects, etc.	Gilchrist CHIP – Gilchrist Department of Health, Florida Legal Systems, Episcopal Children Services – Home Base and Head Start, Tobacco Free Florida, Meridian, Partnership for Strong Families (Children's Trust of Alachua County), Real Fit Metabolic, Gainesville VA Hospital, Early Learning Coalition of the Nature Coast, Gilchrist County Prevention Coalition, Well Florida

Wednesday June 8th, 2022,	Community Health Needs Assessment Process Overview, Health and Quality of Life in Gilchrist County, Community Survey – input, provider survey – input	Early Learning Coalition of the Nature Coast, Gilchrist County Prevention Coalition, Well Florida, Gilchrist Department of Health, Episcopal Children Services – Home Base and Head Start, Suwannee River Area Health Education Center (SRAHEC)
TBD	Cultural Awareness: Introduction to Cultural Competency	TBD

C. County Health Department Health Equity Training

The Florida Department of Health in Gilchrist (DOH - Gilchrist) recognizes that ongoing training in health equity and cultural competency are critical for creating a sustainable health equity focus. At a minimum, all DOH - Gilchrist staff receive the *Cultural Awareness: Introduction to Cultural Competency* and *Addressing Health Equity: A Public Health Essential* training.

DOH-Gilchrist plans to create and implement a comprehensive training plan for staff members based on the results of a brief assessment that will be given September 2022 to assess training needs for members of the CHD Health Equity Team. Areas of need will be looked at that may include research and policy development, organizing communities for advocacy, advocating/supporting external partners, and program evaluation. The Health Equity Team will create and implement a comprehensive work plan that seeks to address these training needs.

Each individual training will be evaluated, and feedback will be applied to make trainings more engaging or applicable in the future. One year after the training plan is implemented, the Health Equity Team will re-evaluate the training needs of CHD staff members. This will ensure that training needs are being met, and that relevant, applicable trainings are provided to the current workforce. In addition, the Health Equity Team provides regular training to staff on health equity and cultural competency. The trainings are recorded below:

Date	Topics	Number of Staff in Attendance
Tuesday January 7th, 2022	Introduction to Health Equity	12
Tuesday May 25th, 2022 – Monday June 13th, 2022,	Addressing Health Equity: A Public Health Essential	10
TBD	Cultural Awareness: Introduction to Cultural Competency	TBD

D. Minority Health Liaison Training

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

Date	Topics
07/25/22, 07/26/22, 07/28/22, 07/29/22	Diabetes Empowerment Education Program™(DEEP™) Workshop Peer Educator Training Workshop
07/15/22	ClearPoint Health Equity Plan Training
06/16/22	Human Trafficking Symposium – LSF Health Systems
06/14/22	Closing The Racial Wealth Gap with Innovative Solutions
06/08/22-06/10/22	2022 Florida Chronic Disease Prevention Conference – Thrive Through Health: Promoting Wellness in Florida Communities Through Improving Whole Person Care with Health Policy, Access, and Prevention Services

06/06/2022	FDOH SpNS: Body Mechanics – Bell Elementary School
05/24/22	Addressing Health Equity: A Public Health Essential
05/12/2022	Northeast Consortium Minority Health Liaison Onboarding Orientation Meeting
03/16/22	Integrating Health and Social Services through a Novel Independent Practice Association
03/14/22	ClearPoint Training – Reporting Tool
03/02/2022	Social Bonds as a Pooled Financing Mechanism to Address Social Drivers of Health Equity
02/23/22	Focusing on the Heart of the Matter – Center for Change
02/10/22	Moving from Health Disparities to Healthcare Access & Affordability: A Conversation with African American Faith Leaders
02/10/22	Sustainability for the Community Health System: Takeaways for 2022
02/03/22	The Latest on COVID-19 Testing: What Your Community Needs to Know
01/25/22	Cultural Competency and Health Equity Training
01/19/22	Ensuring Health Equity in Preventing Cardiovascular Disease
11/04/22	PACE-EH Action Planning Workshop

E. National Minority Health Month – From Surviving to Thriving Health Fest

The Florida Department of Health in Gilchrist County hosted a Minority Health Month Event at the Southside City Park Saturday April 30th. The event had the theme of "From Surviving to Thriving". COVID was difficult for the Gilchrist County community, and it was a good time for the community to show that our residents were able to preserve and come out even stronger than before. DOH-Gilchrist was there to offer services and bring new organizations to the citizens, so that they have better opportunities for their health.

Purpose of this event:

The purpose of this event is to offer the community a chance to see multiple health care organizations that are local to our area. It provided them a platform to provide education and to tell participants about their services. It also was a key opportunity to promote the Health Department services. COVID has really put the Department of Health in the forefront of the community, the public was coming to us for our advice and our knowledge, but the Health Department can offer so much more than that. The Health Department is sometimes forgotten as a health facility, so it is important that people know all of what DOH-Gilchrist can do. DOH-Gilchrist offers family planning, environmental health, community health promotion, dental, healthy start, healthy families, and so much more. DOH-Gilchrist just wanted the public to know that help is a lot closer than one might think and while the Health Department cannot provide provider services, but can still assist in other matters.

Populations reached:

Regarding populations served; all were welcome to the event. DOH-Gilchrist did try to advertise to the minority populations, so flyers and other resources to communities with high populations of Blacks and Hispanic individuals were the populations that Gilchrist strived to reach. DOH-Gilchrist distributed flyers to grocery stores, the pharmacies, family dollars and dollar generals, churches, other faith-based organizations, etc. Yard signs were posted at street corners of neighborhoods in both Spanish and English.

Topics Promoted:

Topics being promoted are migrant worker awareness where Gilchrist CHD highlighted the importance of migrant workers in our rural communities. Our rural communities would not be able to have produce without these workers. The workers wake up at dawn and sometimes do not get back to rest until sunset and the cycle continues. Gilchrist CHD wanted to stress that these workers are people too and they deserve to be treated with respect. DOH-Gilchrist wanted to educate the public on these matters. The workers are heavily underserved, so to provide free health screenings, so that they may utilize services they might have been unable to do in the past.

Also, DOH-Gilchrist heavily pushed cardiovascular health, for the white and black population where there is a disproportionate number of cardiovascular issues. The Health Department has a Heart Health program where we provide Blood Pressure Self-Monitoring Classes. CHD workers would provide education, then they would send participants over to the Health Street Bus where they would get a break down of information such as BMI, Blood Pressure, Blood Glucose levels, etc.

Overall, it was a success because there was general education on health screenings and health information from all programs from the Gilchrist County Health Department, UF Health Street, Community Organization Booths and what these organizations can offer participants. In the future Gilchrist CHD hopes to continue these events and not only continue the relationships made but look to add more partnerships so that resources can be provided that can better serve our community and its members.

Minority Health Liaisons Alex Santana and Jan Gonthier at the Health Equity Booth. The priority focus was discussing the Heart Health Program pushing the importance of Blood Pressure Self-Monitoring Classes and Heart Health Screenings. Since Hypertension is our Health Disparity, it is necessary to educate the community on these matters.

A scavenger hunt for the children was also created, and kids had to visit each booth and answer questions about specific programs and organizations. This hunt fostered an opportunity to let participants learn about organizations in the community and to foster learning about new topics.

Health Promotional items given out such as pedometers, frisbees, lunch totes with salad containers, first aid kits (antiseptic towelette, bandages, and alcohol prep pad) and outdoor skin kits (sunscreen, bug repellant, poison ivy formula cleaners and solutions, insect repellant towelette, burn gel, insect sting relief, lip balm with sunscreen, etc.)

Pictured above: Minority Health Liaisons Alex Santana and Jan Gonthier at the Health Equity Booth.

The Clinic had a booth that focused on spreading information about the many programs that are within the clinic DOH umbrella. COVID-19 shots and other vaccinations, birth control and contraception's, STD testing, pregnancy tests, cervical cancer screenings and breast cancer screenings, etc.

There also was information on the many vaccinations that school children under the age of 19 can receive for free. Many of which they will need for college.

Pictured: Jan Gonthier, Alex Santana, Renee Jenkins, Trinity Williams, and Crystal Rodgers

Local Food Trucks were invited to try to gather up public participation. An opportunity to support local members of the community that have opened a food truck is what DOH-Gilchrist wanted to do and achieve.

Food Trucks invited: Suzie Belles, Lenny's Taste Tour, Heavy B BBQ, Happy Frappe and Kona Ice.

Pictured: Angela Phillips, Marcia Smith, and Jan Gonthier.

The Life South Blood Bus was a partner for the Minority Health Month Event.

There is currently a national shortage of all blood types, especially Type O Blood.

It was important to partner with the Blood Bus because they partner with local hospitals, which assist the community.

Pictured: Minority Health Liaisons Jan Gonthier and Alex Santana with Life South Blood Bus Workers.

UF Health Street offered a plethora of free health screenings. There were blood pressure checks, blood glucose tests, cholesterol tests, and weight, height, BMI, and vitals checks. COVID-19 vaccinations were also given on our behalf.

Once checks were done, the nurse would go over what the results meant and gave patients reports to take home. Also, UF Health Street connected participants with resources and educational materials.

Pictured: Jan Gonthier, Alex Santana and UF Health Street Worker.

VI. PRIORITIZING A HEALTH DISPARITY

The Health Equity Team identified and reviewed health disparities data in Gilchrist County. Data was pulled from multiple sources including Florida Health CHARTS, Florida Behavioral Risk Factor Surveillance System Telephone Survey (BRFSS), Florida Department of Health - Bureau of Vital Statistics, Florida Agency for Health Care Administration, Feeding America – Map the Meal Gap, US Census Bureau – American Community Survey, Florida Department of Education, Education Information and Accountability Services (EIAS), Heart Health Screenings, and the AARP Livability Index.

The following health disparities were identified in Gilchrist County: Heart Health, which was broken down into Hypertension, Stroke, Diabetes. Using data sources such as FL Health Charts the Health Equity Team decided to work on Hypertension in the Health Equity Plan. Data concerning Hypertension is below.

Gilchrist County is an extremely rural community, so there is constantly a struggle with finding data that is outside of factors such as race, ethnicity, and overall population information. Regarding our LGBTQ+ population, this group is especially difficult to collect data for because the numbers are too small to have data that would be statistically significant. Nevertheless, there still needed to be representation for this population, so DOH-Gilchrist will be working on something internally whether it will be adding an anonymous questionnaire or passing out information in case they need any assistance from Department of Health. Office of Minority Health and Health Equity (OMHHE) will be collecting data for the LGBTQ+ population that is lacking in the community. DOH-Gilchrist is hoping to use these tools, so that will help us reach these populations to at least get demographic data.

To bridge the gap in veteran data, Doh-Gilchrist is working to partner with the Veteran of Foreign Wars (VFW's) and American Veterans (AMVETS) organizations because they have data that can be utilized and represented in our Health Equity Plan. The OMHHE is currently working on gathering county-level veteran data. Upon receiving this data, the Gilchrist County Health Equity Plan will be updated to reflect any new findings.

A. Gilchrist County Population Data

The total population of Gilchrist County was 18,027 in 2020. The White population comprises 91.2 percent of the total population while the Black population comprises 5.7 percent and the Hispanic and other comprises 9.1 percent (6 percent Hispanic and 3.1 percent Other).

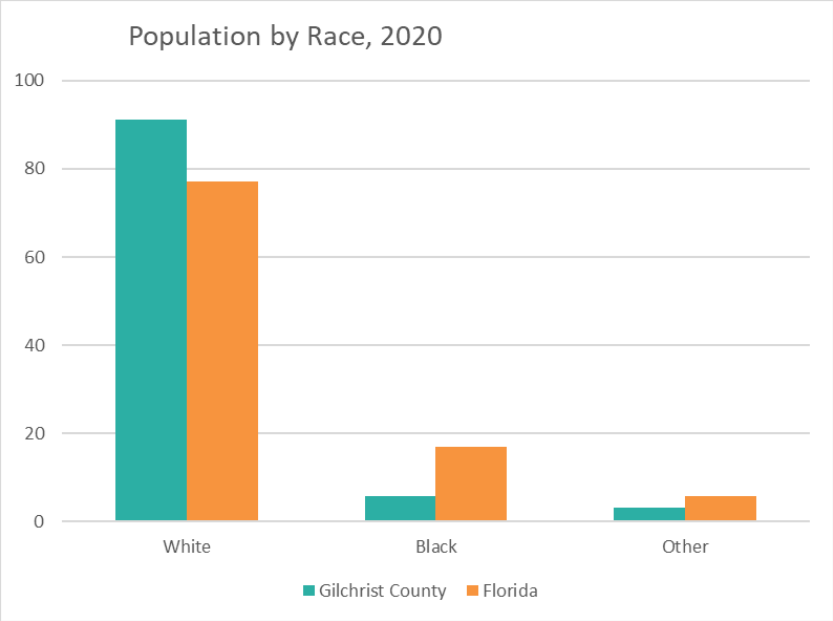
The percent of the state's White population is 77.2 percent, and the percent Black population is 16.9 percent. The state's Hispanic population is 26.7 percent.

Gilchrist County has a higher percentage of White population and a much lower percentage of the Black and Hispanic populations than the state. While the Black population and Hispanic population percentages are lower than the state rates, it is meaningful for this health equity plan and the public health interventions to be undertaken to alleviate existing health disparities for these populations and to improve health outcomes for all.

Minorities are unequally impacted by factors that impose many barriers to healthy living such as less income, access to healthy foods, medical care, education, and recreational facilities; and greater exposure to environmental toxins such as lead paint.

Indicator	Gilchrist County	Florida	Source:
Demographics			
Population			
Total Population (2020)	18,027	21,640,766	www.flhealthcharts.gov; Population Estimates Query
Total Population Under 18 (2020)	3,707	4,282,262	www.flhealthcharts.gov; Population Estimates Query
Total Population 18-64 (2020)	10,590	12,843,483	www.flhealthcharts.gov; Population Estimates Query
Total Population 65 and Over (2020)	3,730	4,515,021	www.flhealthcharts.gov; Population Estimates Query

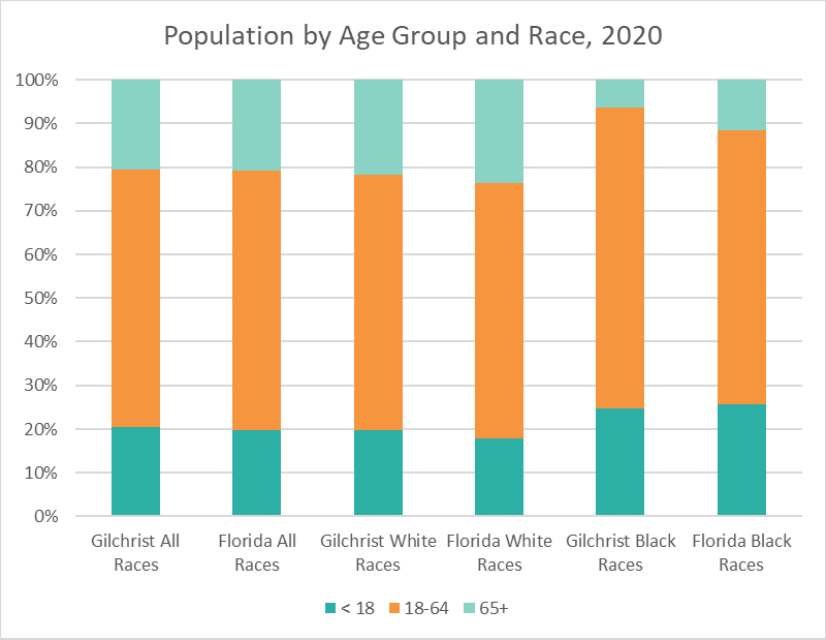
POPULATION BY RACE, GILCHRIST COUNTY, AND FLORIDA, 2020.



Race	Gilchrist County	Florida
White	91.1743496	77.233546
Black	5.66927387	16.96421
Other	3.15637655	5.8022438

Source: flhealthcharts.gov; Population Estimates Query.

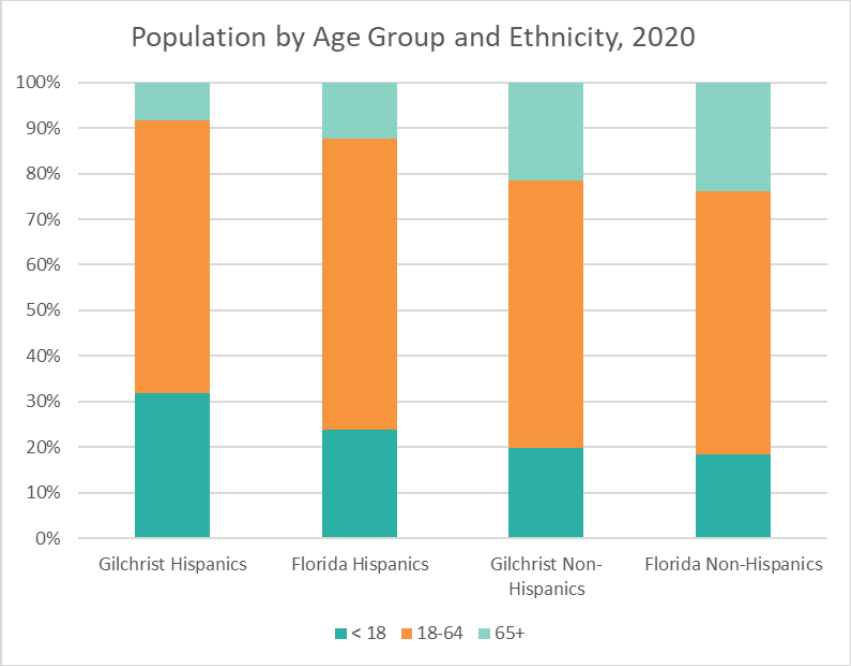
POPULATION BY AGE GROUP AND RACE, GILCHRIST COUNTY, AND FLORIDA, 2020.



Race	< 18	18-64	65+
Gilchrist All Races	20.6	58.7	20.7
Florida All Races	19.8	59.3	20.9
Gilchrist White Races	19.8	58.5	21.7
Florida White Races	17.8	58.5	23.6
Gilchrist Black Races	24.8	68.8	6.5
Florida Black Races	25.8	62.6	11.6

Source: flhealthcharts.gov; Population Estimates Query

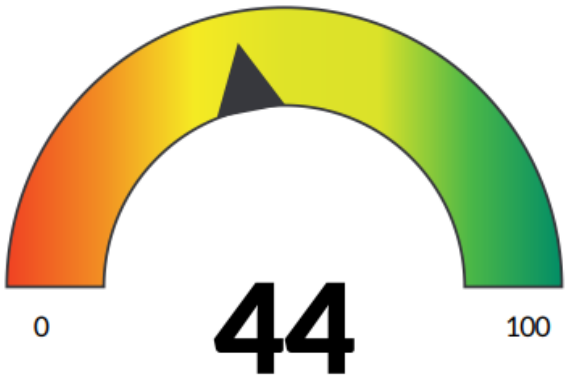
POPULATION BY AGE GROUP AND ETHNICITY, GILCHRIST COUNTY, AND FLORIDA 2020.



Ethnicity	< 18	18-64	65+
Gilchrist Hispanics	31.8	60.0	8.2
Florida Hispanics	23.8	63.8	12.4
Gilchrist Non-Hispanics	19.8	58.7	21.5
Florida Non-Hispanics	18.3	57.7	23.9

Source: flhealthcharts.gov; Population Estimates Query

GILCHRIST COUNTY LIVABILITY INDEX: COUNTY DEMOGRAPHICS.



The overall livability index score for **Gilchrist County, Florida** is **44**.

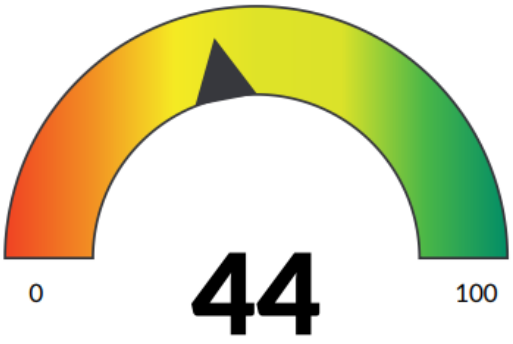
Demographics

Total Population:
17,953

African American: 6%
Asian: 0%
Hispanic: 6%
White: 91%
Age 50+: 41%
Age 65+: 20%
Households w/Disabilities: 21%
Life Expectancy: 77 years old
Households Without a Vehicle: 6%
Median Income: $44,309
Poverty: 17%
Upward Mobility: 41

Source: AARP Livability Index

GILCHRIST COUNTY LIVABILITY INDEX: DEMOGRAPHICS AREA CODE 32693.



The overall livability index score for **Zip Code 32693** is **44**.

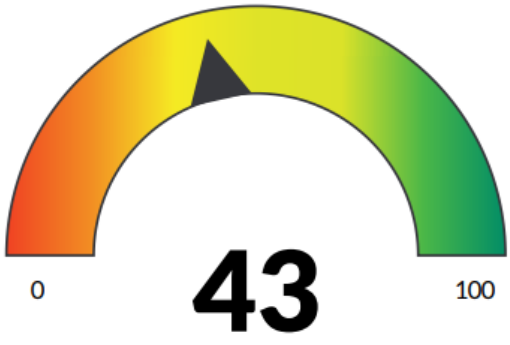
Demographics

Total Population:
12,119

African American: 7%
Asian: 1%
Hispanic: 6%
White: 89%
Age 50+: 42%
Age 65+: 21%
Households w/Disabilities: 21%
Life Expectancy: 77 years old
Households Without a Vehicle: 6%
Median Income: $42,128
Poverty: 17%
Upward Mobility: 41

Source: AARP Livability Index

GILCHRIST COUTY LIVABILITY INDEX: DEMOGRAPHICS AREA CODE 32619



The overall livability index score for **Zip Code 32619** is **43**.

Demographics

Total Population:
5,818

African American: 5%
Asian: 0%
Hispanic: 6%
White: 93%
Age 50+: 36%
Age 65+: 17%
Households w/Disabilities: 22%
Life Expectancy: 77 years old
Households Without a Vehicle: 8%
Median Income: $42,024
Poverty: 20%
Upward Mobility: 41

Source: AARP Livability Index

B. Key Health Outcomes in Gilchrist County

Persistent poverty, economic instability, unaffordable housing, lack of ability to access health and social services and other barriers such as transportation and lack of access to nutritious foods contribute to chronic diseases and poor mental and dental health.

As noted earlier in this profile, Gilchrist County is ranked in the lower middle range of counties in Florida (25 to 50 percent) for health outcomes and is ranked in the lower-middle among the least healthy counties in Florida for health factors (25 to 50 percent). (Robert Wood Johnson Foundation County health rankings; (www.countyhealthrankings.org)).

The health conditions associated with chronic diseases are complex, develop over long periods of time, and can lead to other health complications and disabilities. Chronic diseases include conditions such as diabetes, high blood pressure, stroke, heart disease and cancer. Research has demonstrated that social determinants of health are associated with the disproportionate development of chronic conditions and challenges encountered when managing them.

The Gilchrist County Health Equity Community Partnership (Health Equity Task Force, Health Equity Coalition, and the County Health Department Team) has identified hypertension as a health disparity priority. Addressing the related social determinants of health may, over time, result in improved health status for all in the county. People with high blood pressure, or hypertension, are more likely to have coronary heart disease, stroke, heart failure, and kidney disease. Strategies to help people eat healthier, lose weight, and get more physical activity can reduce the risk of high blood pressure. The reason Hypertension was chosen was because there was a disproportionate burden for all populations, and it is the second leading causes of death in the county. Cardiovascular issues in general are huge within rural communities, due to issues such as lack of nutritious foods, lack of physical exercise and lack of medical adherence just to name a few. After analyzing various data points and hypertension indicators, Black/African Americans, Hispanics, and people living with disabilities are priority populations in Gilchrist County. This plan includes data reflecting access to healthy activities and access to healthy food sources as well as data reflective of hypertension, which uncontrolled may lead to a variety of other chronic disease conditions.

C. GILCHRIST COUNTY HEALTH & MEDICAL (ESF8) PROFILE

Profile Objective: Assure responders entering an impacted area have access to key data regarding the health & medical infrastructure, resources, and related systems.

Summary of Vulnerabilities

Summarize the high-risk issues and considerations that affect the county.

- Include specific characteristics that will affect responders' effectiveness
- If applicable, include location most vulnerable
- Arrows indicate trend compared to previous year of data

Vulnerable Populations: • Special Needs • Homeless • Undocumented Populations • Etc.	**Approximately 94 special needs clients, 1 pediatric client.** **Approximately 84 ↑ clients receiving oxygen tanks and 171 ↓ oxygen concentrator clients in the county** **Approximately 214 ↓ electrically dependent devises in the county** **Approximately 26 ↑ ventilator clients in the county** **Approximately 24 ↑ in-facility dialysis clients, and 22 ↔ home dialysis clients in the county** **Approximately 150 ↓ home health clients in the county** **Approximately 93 CMS clients in the county** **Approximately 48 developmentally disabled clients in the county**
Specific Hazards: • Local Features • Annual Events in Community • Population flux due to season • Area in recovery from past events • Etc.	**Very rural area, large number of mobile homes in county.** **Lancaster Correctional Institute – 524** *(Data Sources: 2020 Florida CHARTS, 2022 CMS Electrically Dependent Florida Data)* **Fires – 50% of county is forest lands, remainder of county agricultural.** **Flooding – Suwannee River, Santa Fe River, Waccasassa Flats, north and west part of county prone to flooding. Central portion of the county consists of the low lying Waccasassa Flats.** **Sinkholes – several small reported. Dialysis center half swallowed by a sink hole in 2004.** **Natural Gas – high pressure natural gas pipeline and compressor station in the county.** **Transportation – US 129, US 19, SR 26, SR 47.**

County Government Structure

Describe the county government structure. Include management structure and hierarchy during emergency response:

Gilchrist Board of County Commissioners

Number of municipalities:

Trenton, Bell, Fanning Springs

Do other special jurisdictions or districts exist (e.g. military bases, tribal communities)? If yes explain:

No

Emergency Management Structure

The lead emergency management (EM) agency is: **Gilchrist County Emergency Management**

3250 NW US Highway 129

Bell, FL 32619

Ralph Smith (386) 935-5400

What is the county's emergency management structure (e.g. National Response Plan's ESF structure implemented? or another structure?)

ESF Structure

Describe the county EOC structure during activations e.g. command/communication structure among/between local governments:

Gilchrist County Emergency Management serves the entire county.

How many local EOCs are in the county? **One**

What is the local EOC reporting structure? **Local to State EOC**

Summarize the scope of responsibility for each ESF (if applicable):

Follows Florida ESF structure

Describe the county warning point system for after-hours emergencies:

Gilchrist Dispatch Center located at the Gilchrist County Sheriff's Office is the official warning point for Gilchrist County. (352) 463-3410

What system(s) are utilized to track resources at the County Emergency Operations Center (e.g. Tracker/Groove/WebEOC)?

State WebEOC

Who enters resource requests (missions) to the state?

ESF 5

Communication Systems

What are the key methods for communication among emergency responders (e.g. handheld radios, satellite phones, blackberries)

- County to field: **UHF/VHF Radio, mobile phones, satellite phones (EM)**
- Field to field: **UHF/VHF Radio, mobile phones, satellite phones (EM)**

Is there a written emergency communications plan? ☒Y ☐ N

Are deployable interoperable communication equipment available? ☐Y ☒ N

Logistical Systems

Has the county worked with the state to identify PODs? ☒Y ☐ N

Has the county identified local points of distribution for resources (e.g. distribution points that allow public pick-up e.g. vaccinations, comfort stations)? ☒Y ☐ N

Does the county maintain logistical caches? ☐Y ☒ N

Describe the cache types:

Does the county utilize (check all that apply):

☒ Staging Areas

☐ Warehouse based system

☐ Cache based system

Does the county have the capacity to deliver resources to facilities or home-bound populations? ☒Y ☐ N

If yes, explain- **2020/21/22: Delivered COVID vaccine & testing capabilities**

Are there any formal or informal mutual aid agreements in place related to key response resources e.g. water, ice?
☐Y ☒ N

If yes, specify for which resources:

GIS/Mapping Resources *(As of 2020)*

Does the county have GIS mapping services above and beyond the state's capacity for any of the following?

☒ Health Facilities (e.g. Hospitals, assisted living facilities, dialysis centers, oncology outpatient centers)

☒ Points of Distribution/Dispensing (PODs)

☒ Roads/Bridges

☒ Electric Grid Systems

☐ Surge Zones

☒ Critical Facilities (e.g. fire department, police stations)

☐ Airports

☐ Power Plants

☒ Correctional Facilities

☒ HazMat Sites

☒ Super Fund Sites

☒ Water Systems

☒ Sewage Systems

☒ Communication Infrastructure (e.g. radio towers, radio and TV stations)

☒ Food Suppliers

- Retail
- Wholesale

☒ Large Warehouse/Distribution Sites

☐ Other, specify

Describe the software used for GIS? **ESRI**

ESF8 Health and Medical System

The lead ESF8 agency is: **Florida Department of Health in Gilchrist County**

119 NE 1st Street

Trenton, FL 32693

(352) 463-3120

What is the ESF8 staffing structure during activations e.g. command/communication structure among/between local governments (do all cities report to one EOC?). *Please provide a table of organization, including agency/position titles, if available.*

What is the scope of county ESF8?

ESF8 Responsibilities *Check All the Apply*	Agency(ies)/Coalitions Responsible *Indicate which ESF8 Partner addresses this Area of ESF8 [Operational Lead(s) AND Coordinating Agency(ies)]* ***Please indicate the responsible agency in the county even if the responsibility is not in the scope of ESF8*** ***Based on AHCA Designations***
Healthcare Facility Assessments (including emergency plans)/Support	
☐ Hospitals	
☐ Assisted Living Facilities (ALFs)	
☒ Nursing Homes----------	**2 nursing homes– Ayers: 120 beds and** **Tri-County: 81 beds**
☐ Oncology Facilities	
☐ Dialysis, End Stage Renal Disease Facilities (including water support)	
☐ Crisis Stabilization Units	
☒ Home Health----------	**On Point Home Health Services**
☐ Hospices	
☐ Intermediate Care Facilities	
☐ Independent Living Facilities	

☐ Rehab Centers	
☒ Special/Medical Needs Shelters [food, oxygen, pharmaceuticals, additional------ supplies, transportation]	**Bell High School – capacity 40, generator supports AC, not pet friendly** **School Board provides meals, Gilchrist EMS** **Oxygen from Rotech, DOH supplies oxygen during shelter activation**
☐ Blood Therapy	
☒ EMS Services----------	**Gilchrist County EMS**
☒ Environmental Health Services----------	**DOH-Gilchrist EH**
☒ Food Station Inspections, Food Service---------- Regulation	**DOH-Gilchrist EH, DBPR**
☒ Lab Services----------	**Jacksonville State Lab**
☐ Sanitation Services	
☒ Oxygen----------	- **Home Respiratory Solutions** - **Rotech Oxygen and Medical Equipment** - ****DOH has independent capabilities preparing for/during shelter activation**
☒ Fatality Management----------	**District 8 Medical Examiner in Alachua County**
☒ Nutritional Services----------	**WIC Coalition**
☒ Bug Spray----------	**Gilchrist EM**
☐ Behavioral Health/ Critical Incident Stress Debriefings (Responders and Victims)	
☒ Pharmaceuticals, Public & Private----------	**2 pharmacies in county**
☒ Epidemiology/ Disease Control----------	**DOH-Gilchrist Epi**
☒ Immunizations/Vaccination----------	**DOH-Gilchrist**

☐ Evacuation/Repopulation of Healthcare Facilities	
☐ Mass Migration/Repatriation Support	
☒ Rapid Impact Assessments----------	**Gilchrist EM, Gilchrist SO**
☒ Health Risk Communications----------	**DOH-Gilchrist Natalie McKellips, Wesley Asbell**
☒ WIC----------	**WIC Coalition**

☐ Additional ESF8 Responsibilities & Agencies Responsible (please list):

Mission Tracking Systems

What mission tracking System(s) is/are utilized by the local ESF8 partners?

State WebEOC

Describe ESF8's role in developing, submitting, and tracking missions?

Hand-written mission given to ESF 5

Who enters ESF8 resource requests (missions) to the state?

ESF 5

Base of Operations

During activations, how many ESF8 staff work in the County Emergency Operations Center (CEOC)? **2**

How many ESF8 staff work outside of the CEOC to support ESF8 Operations and where is their base of operations? **Per county health officer, all CHD staff deployed as needed**

Have formal or informal mutual aid agreements been developed for support of key ESF8 responsibilities?

☐Y ☒ N

If yes, explain what resources/services have been arranged:

What are the key methods for communication among ESF8 emergency responders (e.g. handheld radios, satellite phones, mobile phones)

- County EOC to field: **mobile phones**
- Field to field: **mobile phones**
- County to state: **mobile phones**

Is there a written ESF8 communications plan? ☒Y ☐ N **Annex 5 to the County EOP**

Are deployable interoperable communication equipment available to ESF8 staff? ☒Y ☐ N **5 Med 8-2 radios**

County ESF8 Staff Resources

Other Medical Response Teams?

- ☒ Medical Reserve Corp(s)- **Per County Health Officer, MRC suspended temporarily due to COVID-19**
- ☐ Private staffing agencies (e.g. health and medical staff)
- ☐ Other, specify (e.g. faith based)

County ESF8 Material Resources

What ESF8 material resources are available for deployment (check all that apply)?

- ☐ Mobile IT/Communications Equipment
- ☐ Mobile Pharmacy
- ☐ Mobile Labs
- ☐ Mobile Hospitals
- ☐ Mobile Clinics
- ☐ Medical Supply Caches
- ☐ Pharmaceutical Caches
- ☐ Alternate Treatment Sites
- ☐ Mini-Mass Casualty Systems
- ☒ Other, specify self**-contained travel trailer (2) Gilchrist/Dixie**

What is the county's body storage capacity? **15-30**

Which option below best describes the relationship between local ESF8 and County Emergency Management?

- ☒ Highly collaborative, integrated planning and training efforts, strong communication during and between activations
- ☐ Collaborative, some integrated planning and training, periodic communication
- ☐ Co-existent, work together during activations, communication mainly during activations
- ☐ Detached, work independently with minimum communication

Web Links

CHARTS County Demographical Profile: http://www.FloridaCHARTS.com

ESF8 Dashboard: http://esf8-dashboard.com/

Persons with Access and Functional needs data profile http://www.floridahealth.gov/programs-and-services/emergency-preparedness-and-response/community-preparedness/access-functional-needs/afn-profile.html

AHCA Health Facility Locator site: http://www.floridahealthfinder.gov/FacilityLocator/facloc.aspx

State WebEOC: : https://eoc.floridadisaster.org/eoc7/default.aspx

SERT GATOR: https://floridadisaster.maps.arcgis.com/apps/webappviewer/index.html?id=f5628cfc02ca42b4a3853c69d8ff804b

NIOSH Pocket Guide to Chemical Hazards: http://www.cdc.gov/niosh/npg/

Florida Forestry Service – Wild land fires: http://www.floridaforestservice.com/wildfire/

Florida Department of Health

Bureau of Community Health Assessment Division of Public Health

Statistics and Performance Management

Florida Access and Functional Needs Profile, Gilchrist County - 2020

2020 is the most recent available Functional Needs Assessment			County	County	State	State
Indicator	**Year(s)**	**Rate Type**				
↑- Increase from previous year						
↓- Decrease from previous year						
↔- Same as previous year			**Count**	**Rate**	**Count**	**Rate**
Demographic Data						
Resident Live Births	2020	Per 1,000 Population	↓ 184	↓ 10.2	↓ 209,645	↓ 9.7
Total Population	2020	Count	18,027	↑	21,640,766	↑
Children under 18 in Foster Care	2020	per 100,000 Population, Under 18	↑ 18	↑485.6	↑ 23,517	↑549.2
Population 65-84 Years Old	2020	Percent of Total Population	↑3,260	↑18.1%	↑3,931,444	↑18.2 %
Population 85+ Years Old	2020	Percent of Total Population	↑ 470	↔2.6%	↑ 583,577	↔ 2.7%
Individuals 65 years and over living alone	2020	Percent of Population 65+	↑ 803	↑22.9%	↑1,040,208	↑ 24.4%
Socioeconomic Data						

WIC Eligible Served	2020	Percent of WIC Eligible	↓ 653	↓ 89.9%	↓ 420,640	↑ 64.8%
WIC Eligible	2020	Percent of Total Population	↓ 726	↓ 4%	↓ 648,828	↓ 3%
Census Population Below Poverty Level	2020	Population for Whom Poverty Status is Determined	↓ 2,193	↓ 13%	↓2,772,939	↓13.3%
Population 5+ that speak English less than very well	2020	Percent of Census Population 5+	↑ 497	↑ 2.9%	↑ 2,370,626	↓ 11.8%
Median Monthly Medicaid Enrollment	2020	per 100,000 Population	↑ 4,168	↑ 23,120.9	↑ 4,315,244	↑ 19,940.3
Households receiving cash public assistance or food stamps	2020	Percent of Households	↓ 1,172	↓ 17.5%	↑ 1,098,966	↓ 13.9%
Homeless Estimate	2020	Percent of Total Population	↔ 0	↔ 0%	↓ 27,679	↔ 0.1%
Census Population Uninsured (Under 65)	2020	Percent of Population Under 65	↓ 2,630		↑ 2,596,073	
Vulnerability Data						
Percent of Adults Limited in Activities because of Physical, Mental, or Emotional Problems	2016	Percent of Surveyed		35.3%		21.2%

Percent of Adults Who Use Special Equipment because of a Health Problem	2016	Percent of Surveyed		18.6%		9.9%
Civilian non-institutionalized population with a disability	2020	Percent of Civilian non-institutionalized population	↑ 3,624	↑ 21.4%	↑ 2,840,938	↑ 13.6%
Developmentally Disabled Clients	2020	Count	↑ 48		↑ 62,364	
Brain and/or Spinal Cord Injured Clients	2019	Count	4		2,230	
Seriously Mentally Ill Adults	2020	Count	↑ 558		↑ 676,982	
Census Population 18-64 with Vision Difficulty	2020	Percent of Census Population 18-64	↑ 269	↑ 2.5%	↑ 251,833	↑ 2%
Census Population 18-64 with Hearing Difficulty	2020	Percent of Census Population 18-64	↓ 378	↓ 3.6%	↑ 222,298	↑ 1.8%
Medicare Beneficiaries Enrolled in Medical Essential Electric Utility Program	2020	Count	↓ 216		↓ 168,855	
Substance Abuse Program Enrollees - Adult	2018	Count	102		104,906	
Census Population 18-64 with Independent Living Difficulty	2020	Percent of Census Population 18-64	↓477	↓4.5%	↑ 453,099	↑ 3.6%
Children Through Age 20						
Seriously Emotionally Disturbed Children (9-17)	2020	Count	↑ 175		↑ 197,235	
Census Population Under 18 with Vision Difficulty	2020	Percent of Census	↑ 54	↑ 1.4%	↑ 33,640	↑ 0.8%

		Population Under 18				
Census Population Under 18 with Hearing Difficulty	2020	Percent of Census Population Under 18	↑ 30	↔ 0.8%	↑ 23,215	↑ 0.6%
Medical Foster Care Children	2020	Count	↔ 1		↓ 443	
CMS Clients	2020	Percent of Population Under 21	↔93	↔2.1%	↑ 98,219	↑ 2%
Substance Abuse Program Enrollees - Children	2018	Count	0		27,007	
Elderly Ages 65+						
Census Population 65+ with Vision Difficulty	2020	Percent of Census Population 65+	↓ 266	↓ 7.2%	↑ 264,392	↑ 6.1%
Census Population 65+ with Hearing Difficulty	2020	Percent of Census Population 65+	↓ 808	↓ 21.9%	↑ 559,685	↓ 12.9%
Probable Alzheimer's Cases (65+)	2020	Percent of Population 65+	↑ 471	↓ 12.6%	↑ 572,997	↓ 12.7%

Leading Causes of Death Profile, Gilchrist County, Florida – 2020

Arrows reflect departure from previous year

Causes of Death *(Previous Rank)*	Deaths	Percent of Total Deaths	Crude Rate Per 100,000	Age-Adjusted Death Rate Per 100,000
All Causes	↑ 229	100.00	↑ 1,270.3	↑ 850.4
1. Cancer *(1)*	↑ 55	↑ 24.02	↑ 305.1	↑ 190.9
2. Heart Disease *(2)*	↓ 40	↓ 17.47	↓ 221.9	↓ 150.2
3. Unintentional Injury *(6)*	↑ 14	↑ 6.11	↑ 77.7	↑ 68.4
4. COVID-19 *(New)*	↑ 13	↑ 5.68	↑ 72.1	↑ 43.2
5. Chronic Lower Respiratory Disease *(3)*	↓ 12	↓ 5.24	↓ 66.6	↓ 40.9
6. Stroke *(4)*	↓ 9	↓ 3.93	↓ 49.9	↓ 35.6

D. Gilchrist County Hypertension Data

Hypertension was chosen because it is the second leading cause of death in Gilchrist County. It negatively affects all populations within Gilchrist County, but when looking at data there is a disproportionate burden on our priority populations i.e., African American individuals. For example, when looking at the data, ER visits are higher in Gilchrist County than in Florida especially for our African American individuals. It is important to note though that across-the-board Hypertension is an issue for all populations. When you look at Gilchrist County, there are not many opportunities for nutrient dense foods, there is a lack of individuals that participate in physical activity, education on certain health topics, lack of access to healthcare, etc.

It is a rural town that faces many barriers, so the community partners within Gilchrist County are striving to relieve that burden by addressing projects that are being conducted in Gilchrist County that will have a focus on providing better opportunities and making the place that our residents live in a better place. These projects also help with Hypertension rates for Gilchrist County Residents, and there will be tying in Hypertension into our projects to better help the community. Below you will see multiple graphs depicting Hypertension rates for Gilchrist County in Comparison to Florida Data. There are provided summaries of the data, so that the public can better understand the data points.

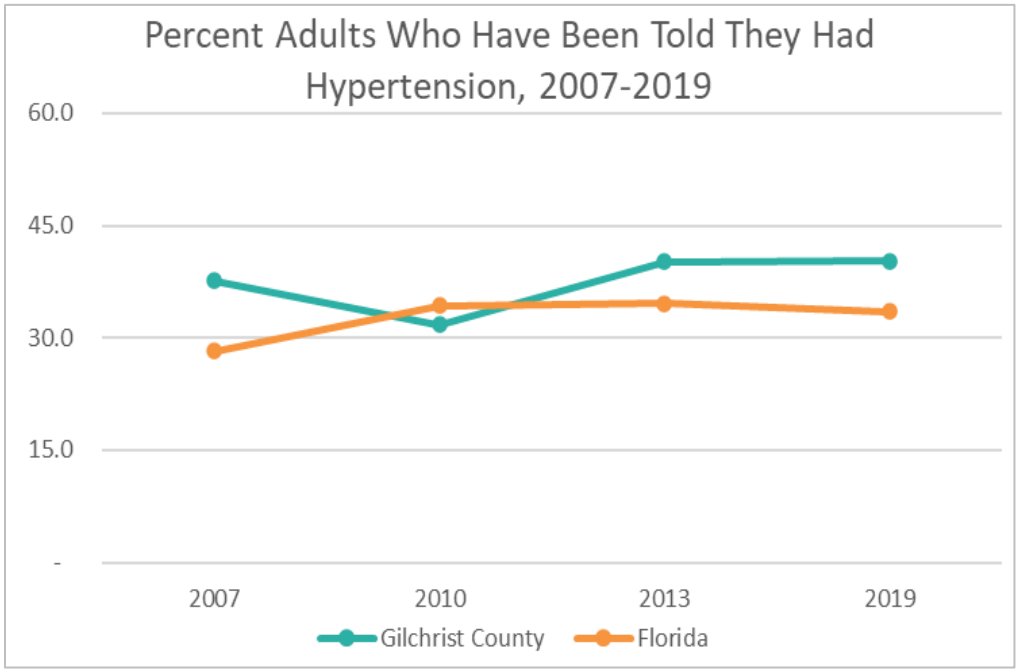
There is no current data to sufficiently support accurate data to show hypertension rates for American Indian and Alaskan Native, Asians, Native Hawaiian, people with disabilities, Veterans, and the LGBTQ in Dixie County. The Health Equity team will work to develop a more grassroot approach to identify these specific groups of individuals in the area.

Data Sources for Additional Information on Hypertension in general:

- Facts About Hypertension
- Hypertension Maps and Data Sources
- High Blood Pressure Symptoms and Causes /Know Your Risk for High Blood Pressure
- Prevent and Manage High Blood Pressure
- Hypertension in Florida: Data From the One Florida Clinical Data Research Network
- Racial/Ethnic Differences in Hypertension Prevalence, Treatment, and Control for Outpatients in Northern California 2010–2012

PERCENT OF ADULTS WHO HAVE BEEN TOLD THEY HAVE HYPERTENSION, GILCHRIST COUNTY, AND FLORIDA, 2007-2019

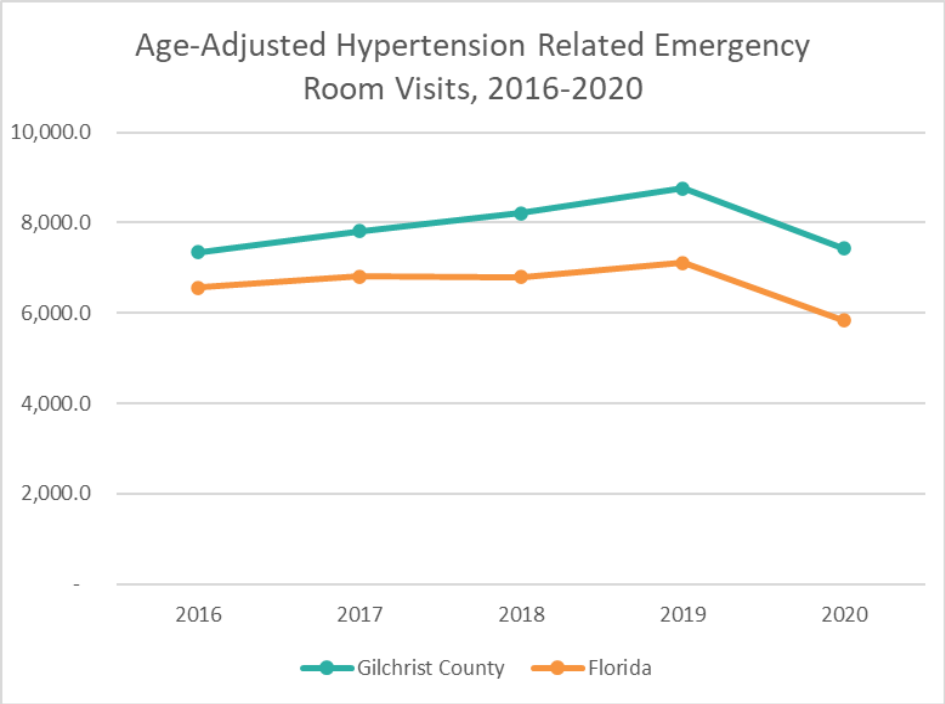
The following figure depicts the Percentage of Adults Who Have Been Told They Had Hypertension in Gilchrist County compared to Florida from 2007-2019. When breaking down the points, in 2007 Gilchrist County was at 37.6% in comparison to Florida which was sitting at 28.2%. In 2010 there was a dip in the numbers and Gilchrist was sitting at 31.8% in comparison to Florida's 34.3%. In 2013 the rate was at 40.2% for Gilchrist and 34.6% for Florida. Finally, in 2019 there was a .1% increase for Gilchrist County and the percentage went from 40.2% to 40.3% and Florida saw a downward trend from 34.6% (2013) to 33.5% (2019).



Source: Florida Behavioral Risk Factor Surveillance System Telephone Survey (BRFSS), 2007-2019

AGE- ADJUSTED HYPERTENSION RELATED EMERGENCY ROOM VISITS PER 100,000 POPULATION, GILCHRIST COUNTY AND FLORIDA, 2016-2020.

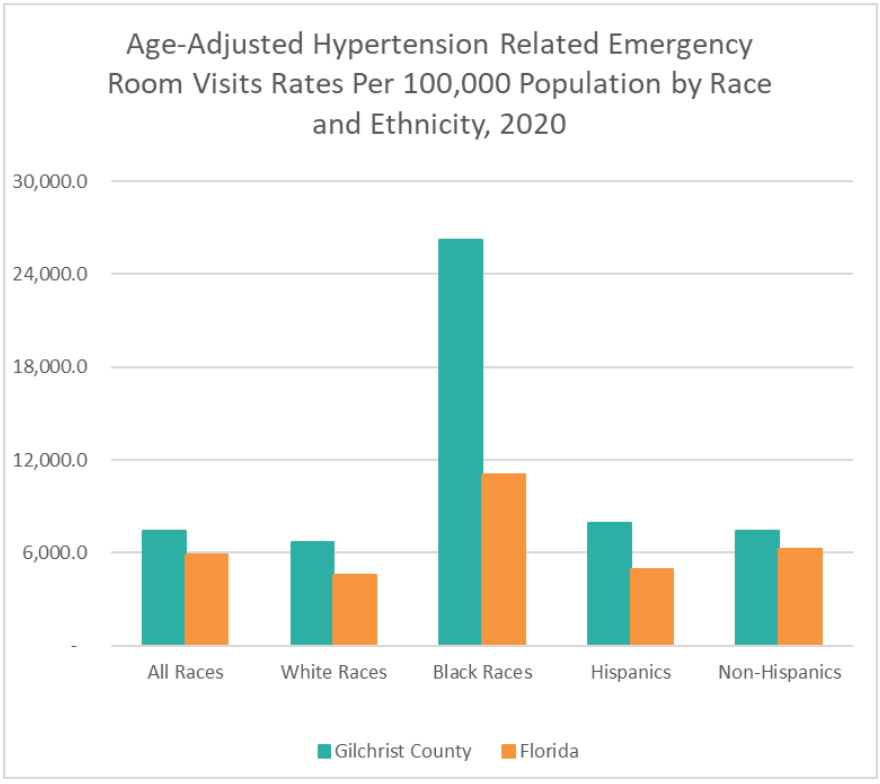
The following figure depicts the Age-Adjusted Hypertension Related Emergency Room Visit Rates in Gilchrist County compared to Florida from 2016-2020. Starting with 2016, Gilchrist County had a rate of 7,341.3 in comparison to Florida's rate of 6,556.0. In 2017, you notice it starts to trend upwards with Gilchrist County at a rate of 7,816.4 in comparison to Florida's 6,804.3. In 2018, you notice that it is still that upward trend where the rate in Gilchrist is 8,207.5 in comparison to Florida's 6,795.8. Then in 2019 there is a peak to the data where you see that Gilchrist has a rate of 8,762.0 in comparison to Florida's 7,107.2. For both Gilchrist and Florida there is a steep drop with Gilchrist at 7,421.0 and Florida sitting at a rate of 5,838.1.



Source: Florida Agency for Health Care Administration, 2016-2020

AGE-ADJUSTED HYPERTENSION RELATED EMERGENCY ROOM VISITS PER 100,000 POPULATION, BY RACE AND ETHNICITY, GILCHRIST COUNTY, AND FLORIDA 2020.

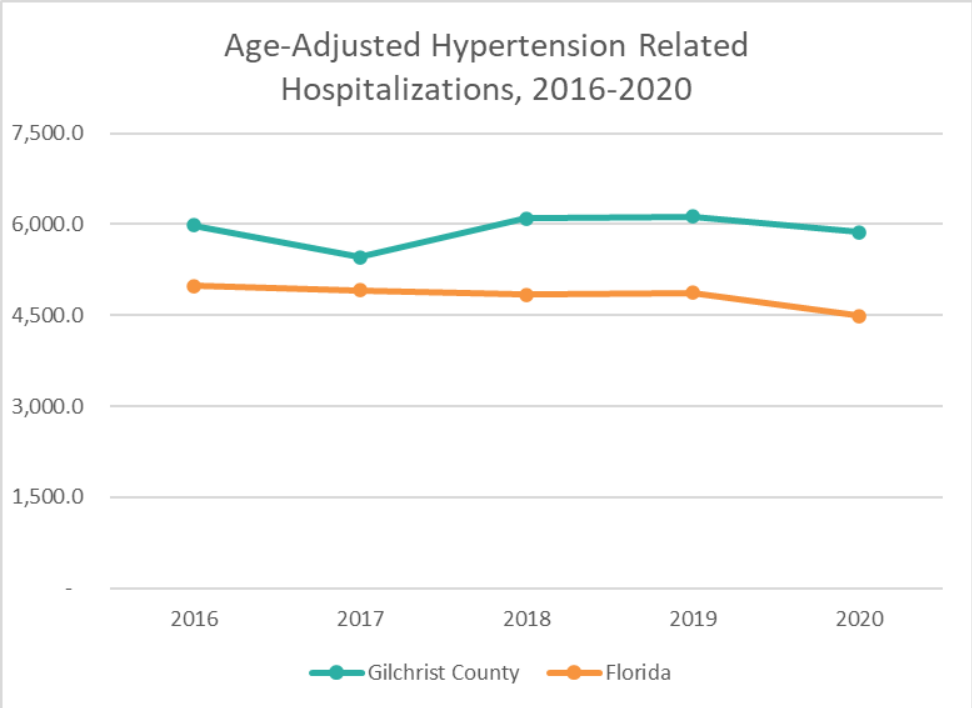
The following figure depicts the Age-Adjusted Hypertension Related Emergency Room Visit Rates per 100,000 Population by Race and Ethnicity in Gilchrist County compared to Florida for 2020. In all races/ethnicities you will notice that Gilchrist County has a higher rate across the board. When looking at all races Gilchrist County is sitting at a rate of 7,421.0 in comparison to Florida's rate of 5,838.1. For the White population Gilchrist's rate is sitting at 6,709.2 in comparison to Florida's which is at 4,592.7. For the Black population you will notice that there is a huge disparity between Gilchrist data and Florida data. Gilchrist is at a whopping rate of 26,246.0 in comparison to Florida's which is 11,078.0. For those that fall within the Hispanic population Gilchrist's rate is at 7,926.5 in comparison to Florida's 4,929.1. Finally, to round out this table at non-Hispanics which are sitting at a rate of 7,396.7 for Gilchrist County in comparison to Florida's 6,202.1. The Black population in Gilchrist County has a much greater rate of Hypertension Related ER visits as compared to the majority, White population. This health disparity prioritizes the Black/African American community in Gilchrist County as a priority population in the Gilchrist County Health Equity Plan.



Source: Florida Agency for Health Care Administration, 2020

AGE-ADJUSTED HYPERTENSION RELATED HOSPITALIZATIONS PER 100,000 POPULATION, GILCHRIST COUNTY, AND FLORIDA, 2016-2020.

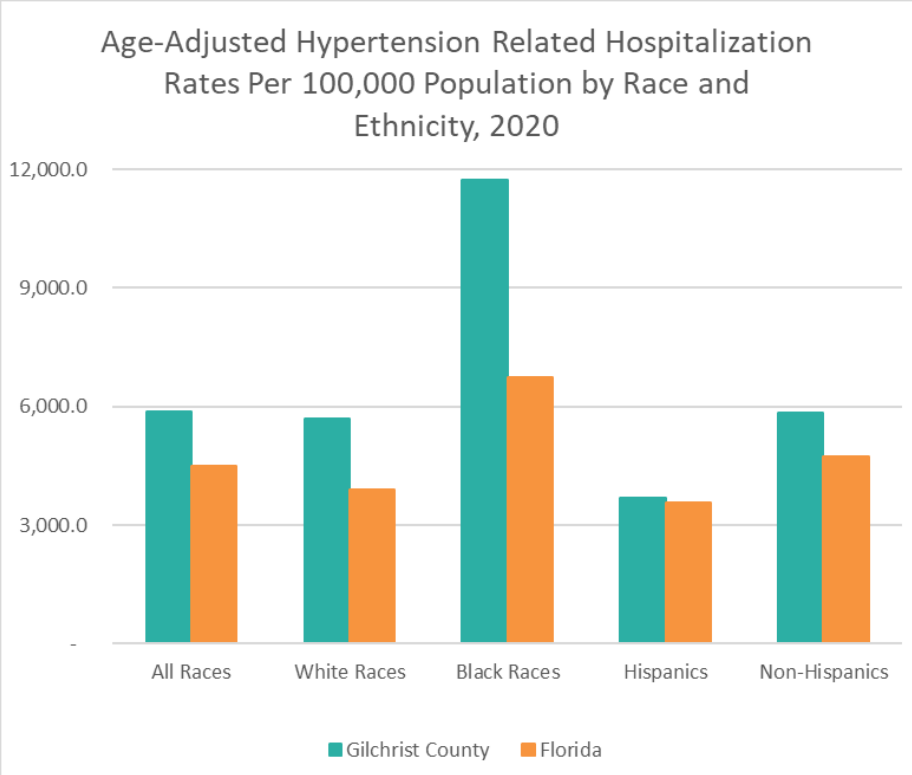
The following figure depicts the Age-Adjusted Hypertension Related Hospitalization Rates per 100,000 Population in Gilchrist County compared to Florida from 2016-2020. First, in 2016 which had Gilchrist at a rate of 5,979.0 in comparison to Florida's rate which is 4,984.1. In 2017, Gilchrist's rate slightly dips to 5,455.4 and Florida's rate was at 4,910.7. In 2018 there is an upward trend for Gilchrist at the rate was 6,092.2 and Florida took a slight downward trend from 4,910.7 (2017) to 4,841.9 (2018). In 2019 there was an increase in both Gilchrist and Florida data. Gilchrist was at a rate of 6,129.0 and Florida was at 4,871.4. In 2020 that downward trend continues with Gilchrist sitting at a rate of 5,872.7 and Florida at 4,491.5.



Source: Florida Agency for Health Care Administration, 2016-2020

AGE-ADJUSTED HYPERTENSION RELATED HOSPITALIZATIONS PER 100,000 BY RACE AND ETHNICITY GILCHRIST COUNTY AND FLORIDA, 2020.

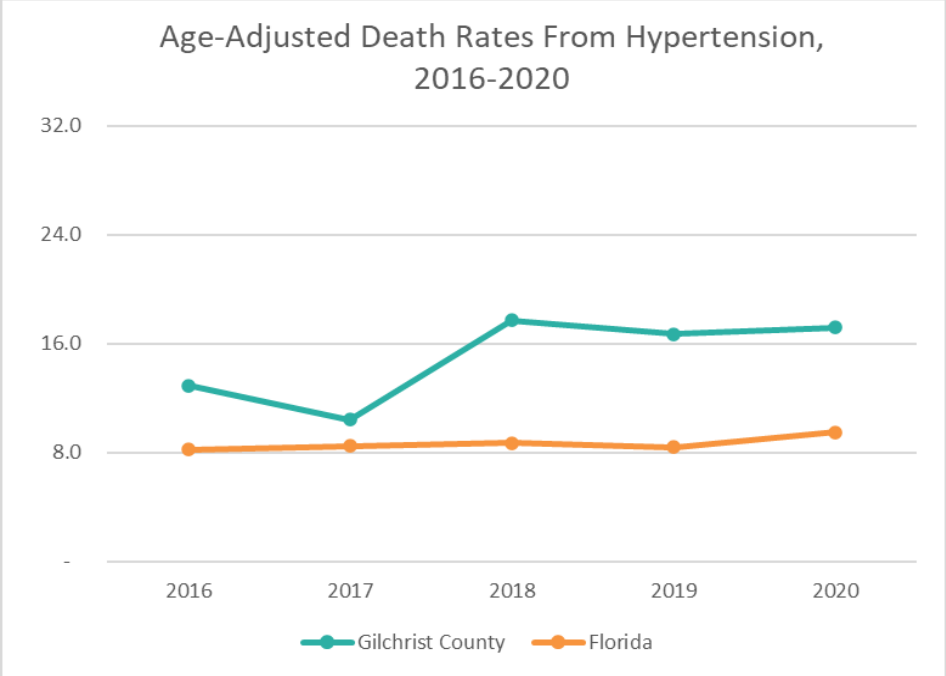
The following figure depicts the Age-Adjusted Hypertension Related Hospitalization Rates per 100,000 Population by Race and Ethnicity in Gilchrist County compared to Florida for 2020. All data across the board you will notice that Gilchrist is at a higher rate than Florida. Starting with All Races, Gilchrist was sitting at a rate of 5,872.7 in comparison to Florida's 4,491.5. The White population was at a rate of 5,693.0 in comparison to Florida's 3,894.4. The Black population, you will notice that disparity between Gilchrist Blacks and Florida's blacks yet again. Gilchrist Blacks are sitting at a rate of 11,725.5 in comparison to Florida's Black at a rate of 6,737.7. The Hispanic population for Gilchrist and Florida is similar with Gilchrist at a rate of 3,700.5 and Florida at a rate of 3,579.0. The Non-Hispanic population has a rate of 5,838.2 for Gilchrist and 4,729.7 for Florida. Overall, Hypertension related hospitalization rates per 100,000 population for Gilchrist Blacks were more than double than the rate of Gilchrist Whites. This disparity continues to highlight Gilchrist Blacks as a priority population.



Source: Florida Agency for Health Care Administration, 2020

AGE-ADJUSTED DEATH RATE PER 100,000 POPULATION FROM HYPERTENSION GILCHRIST COUNTY AND FLORIDA, 2016-2020.

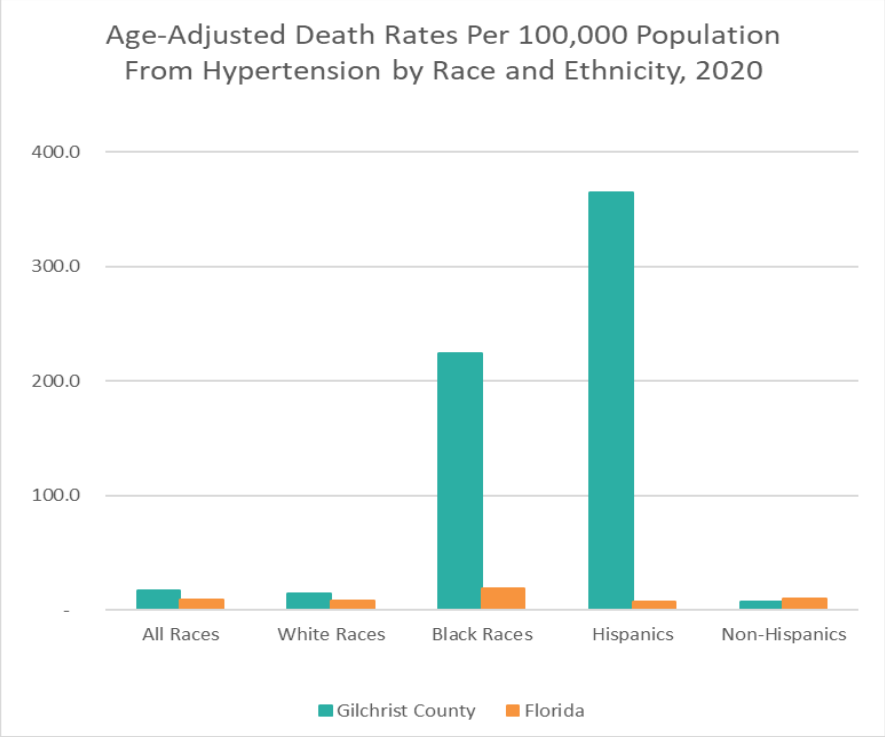
The following figure depicts the Age-Adjusted Death Rates from Hypertension in Gilchrist County compared to Florida from 2016-2020. Florida's data is stationary with a slight increase in 2020. Gilchrist is a bit of a downward and upward trend. In 2016 which had Gilchrist at a rate of 12.9 in comparison to Florida's rate which is 8.2. In 2017, Gilchrist's rate drops to 10.4 and Florida's rate was at 8.5. In 2018 there is an upward trend for Gilchrist at the rate was 17.7 and Florida's rate was at 8.7. In 2019 you can see that Gilchrist's data is becoming more stationary and does not have as many dips in the data. Gilchrist was at a rate of 16.7 and Florida was at 8.4. In 2020 Gilchrist trending upwards a little with them sitting at a rate of 17.2 and Florida also has an upward trend of 9.5.



Source: Florida Department of Health, Bureau of Vital Statistics, 2016-2020

AGE-ADJUSTED DEATH RATES PER 100,000 POPULATION FROM HYPERTENSION BY RACE AND ETHNICITY, GILCHRIST COUNTY AND FLORIDA, 2020.

The following figure depicts the Age-Adjusted Death Rates per 100,000 Population from Hypertension by Race and Ethnicity in Gilchrist County compared to Florida for 2020. Starting with All Races, Gilchrist was sitting at a rate of 17.2 in comparison to Florida's 9.5. The White population was at a rate of 14.1 in comparison to Florida's 8.3. The Black population, you will notice that disparity between Gilchrist Blacks and Florida's blacks yet again. Gilchrist Blacks are sitting at a rate of 224.2 in comparison to Florida's Black at a rate of 18.9. The Hispanic population for Gilchrist was much higher than in Florida, with the Gilchrist rate at 365.1 and Florida at a rate of 6.9. The Non-Hispanic population has a rate of 7.6 for Gilchrist and 10.0 for Florida. The rate of Hispanic deaths from hypertension is significantly higher than the rate of deaths for non-Hispanics and even Gilchrist Blacks who had higher rates of hypertension related ER visits comparatively. This disparity highlights Hispanics as a priority population.



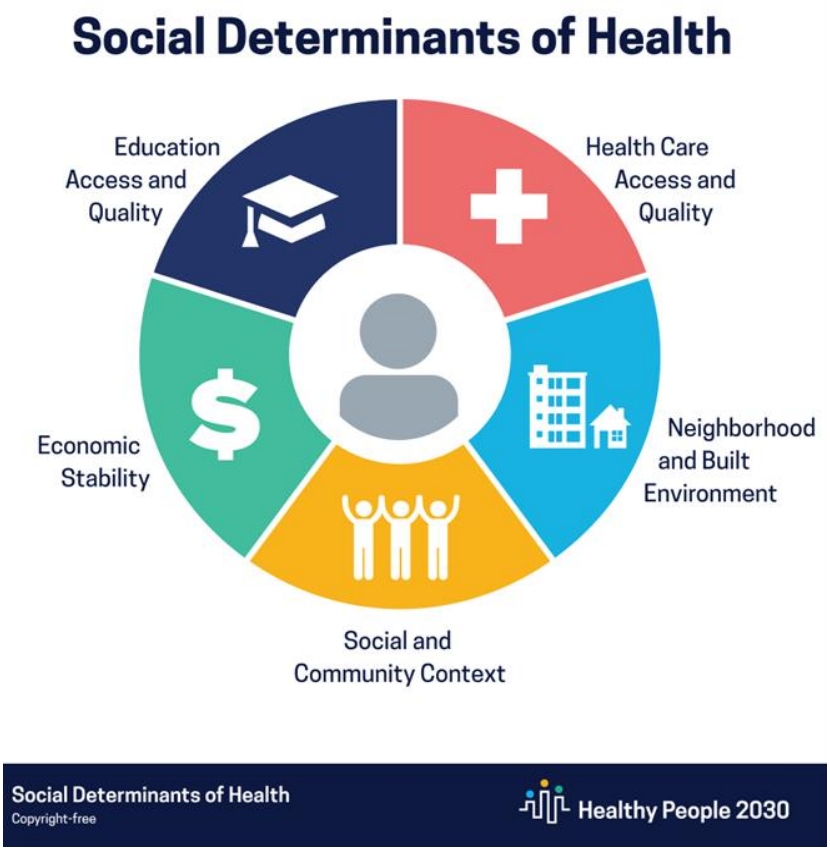
Source: Florida Department of Health, Bureau of Vital Statistics, 2020

ANALYSIS OF THE HEALTH DISPARITIES AMONG PEOPLE LIVING WITH A DISABILITY, GILCHRIST COUNTY.

The Office of Minority Health and Health Equity partnered with Knowli Data Science to analyze county-level disability data across Florida. This data was pulled from the county-level Behavioral Risk Factor Surveillance System (BRFSS) and analyzed for people living with a disability. All questions and results are framed by the BRFSS survey. As related to hypertension, these findings showed statistically significant results for people living with at least one disability in Gilchrist County. Of the individuals surveyed 85% of people with at least one disability, ages 18-65, responded yes to having high blood pressure as compared to 6% of people with no disabilities, ages 18-65. Another measure of cardiovascular health is high cholesterol. High cholesterol increases the risk of heart disease. Higher cholesterol levels are influenced by diet and lifestyle. Of the people with at least one disability 15% responded yes to having high cholesterol as compared to 13% of people with no disabilities. Based on these results, people living with at least one disability are a priority population in Gilchrist County.

VII. SDOH DATA

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



SDOH can be grouped into five (5) domains:

- Education Access and Quality
- Health Care Access and Quality
- Economic Stability
- Neighborhood and Built Environment
- Social and Community Context

SDOH have a major impact on people's health, well-being, and quality of life.

Examples of SDOH's include:

- Safe housing, transportation, and neighborhoods
- Racism, discrimination, and violence
- Education, job opportunities, and income
- Access to nutritious foods and physical activity opportunities
- Polluted air and water
- Language and literacy skills

SDOH also contribute to wide health disparities and inequities. For example, people who do not have access to grocery stores with healthy foods are less likely to have good nutrition. That raises their risk of health conditions like heart disease, diabetes, and obesity — and even lowers life expectancy relative to people who do have access to healthy foods. Just promoting healthy choices will not eliminate these and other health disparities. Instead, public health organizations and their partners in sectors like education, transportation, and housing need to take action to improve the conditions in people's environments.

I. Education Access and Quality

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

People with higher levels of education are more likely to be healthier and live longer. Healthy People 2030 focuses on providing high-quality educational opportunities for children and adolescents and on helping them do well in school.

Children from low-income families, children with disabilities, and children who routinely experience forms of social discrimination — like bullying — are more likely to struggle with math and reading. They are also less likely to graduate from high school or go to college. This means they are less likely to get safe, high-paying jobs and more likely to have health problems like heart disease, diabetes, and depression.

In addition, some children live in places with poorly performing schools, and many families cannot afford to send their children to college. The stress of living in poverty can also affect children's brain development, making it harder for them to do well in school. Interventions to help children and adolescents do well in school and help families pay for college can have long-term health benefits.

High School Graduation Rates

Educational attainment is a crucial social determinant of health because it is the foundation for overall health and is one of the only ones that you can directly change yourself. According to data pulled by the US Census Bureau, American Community Survey you can see that about 13.4 percent of Gilchrist County's population of individuals over twenty-five years of age have no high school diploma. The state percentage of individuals over age twenty-five with no high school diploma is lower at 11.5 percent. Breaking that further down is where you can see that Black individuals were at a rate of 40.2 versus the state rate of 16.3. Also, Hispanic individuals were at an even higher rate of 48.7 versus the state average of 19.6. The overall high school

graduation rate for Gilchrist County in 2020-2021 for all races was at 86.7 percent, and it is at a lower rate than the state rate which is sitting at 90 percent. When dealing with a health disparity such as Hypertension, education plays an important factor. Without the proper education and knowledge, it can lead to terrible health outcomes.

Lack of a high school diploma impacts Hypertension because education is associated with greater health care awareness that may overcome the risk related to things such as low physical activity and lack of knowledge about healthy eating. Also, lower education levels impact many areas such as less opportunities for jobs. If one does not have a college degree, it lowers the amounts of jobs that they can apply for and hold. If they do not have a job that is able to provide them with items such as nutritious foods, or access to items such as blood pressure monitors/medication, or even have the insurance to go to a physician, then how would we expect them to be able to monitor and control their high blood pressure? To improve Hypertension, Gilchrist County is addressing ethnic disparities related to achieving a high school diploma by going to local schools to address heart health issues. Also, to local communities with higher populations of ethnic populations and addressing the importance of primary prevention.

In a national study conducted based on data from the United States National Survey on Drug Use and Health, high school graduates reported overall lower levels of chronic health conditions compared to high school dropouts[1]. Highschool graduates reported an overall lower percentage of heart disease at 3.90% compared to high school dropouts, of whom 6.17% reported having heart disease[1]. This study found individuals who did not receive a high school diploma reported having a serious chronic health condition at a higher percentage than high school graduates.

In a study of 40,000 employed Chicagoans, researchers were assessing men and women of both white and black populations[2]. Educational statuses were categorized by not a high school graduate, high school graduate, some college and college graduates[2]. Findings were that there was a significant inverse association for younger black males between education level and blood pressure[2]. Regarding older black males according to the article there was a clear inverse association[2]. For the older black males, with the small numbers it did not achieve statistical significance[2].

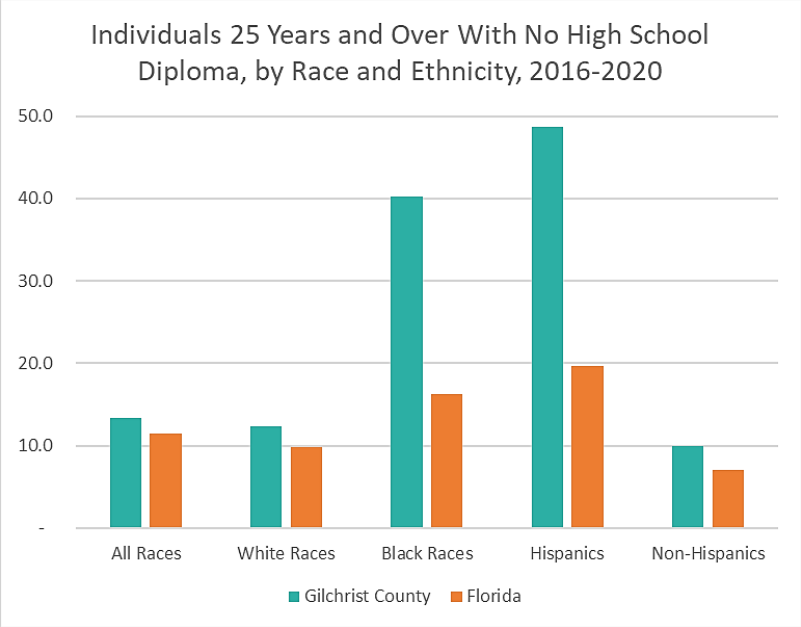
Education and Hypertension Sources:

1. Vaughn, M. G., Salas-Wright, C. P., & Maynard, B. R. (2014). Dropping out of school and chronic disease in the United States. National Library of Medicine PubMed Central Journal of Public Health, 22(3), 265–270. https://doi.org/10.1007/s10389-014-0615-x.

2. Dyer, A. R., Stamler, J., Shekelle, R. B., & Schoenberger, J. (1976). The relationship of education to blood pressure: findings on 40,000 employed Chicagoans. *Circulation*, *54*(6), 987–992. https://doi.org/10.1161/01.cir.54.6.987.

Education			
	Gilchrist County	Florida	Data Source:
Percent of Individuals 25 Years and Over With no High School Diploma (2016-2020)	13.4	11.5	US Census Bureau, American Community Survey, Table C15002A-I, 2016-2020
High School Graduation Rate (Percent) (2021)	86.7	90.0	Florida Department of Education, Education Information and Accountability Services (EIAS)
Out-of-School Suspensions Grades K-12 Rate Per 100,000 Population (2020)	5,469.6	4,354.2	Florida Department of Education, Education Information and Accountability Services (EIAS)
Out-of-School Suspensions Grades K-12 Rate Per 1,000 K-12 Students (2021)	55.5	34.7	Florida Department of Education, 2021

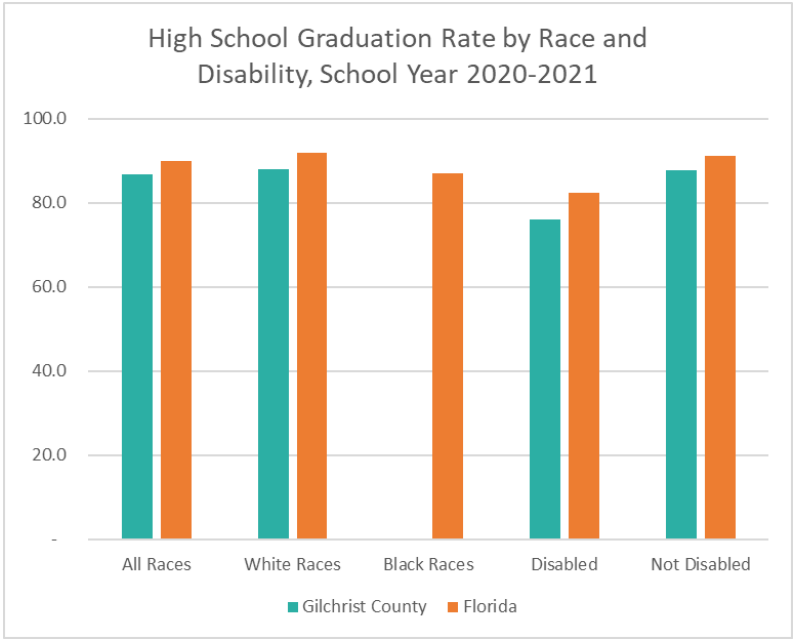
INDIVIDUALS 25 YEARS AND OVER WITH NO HIGH SCHOOL DIPLOMA BY RACE AND ETHNICITY, GILCHRIST COUNTY AND FLORIDA, 2015-2019.



Race/Ethnicity	Gilchrist County Rate	Florida Rate
All Races	13.4	11.5
White Races	12.3	9.8
Black Races	40.2	16.3
Hispanics	48.7	19.6
Non-Hispanics	10.0	7.0

Source: US Census Bureau, American Community Survey, Table C15002A-I, 2016-2020

HIGH SCHOOL GRADUATION RATES, BY RACE AND DISABILITY, GILCHRIST COUNTY AND FLORIDA, SCHOOL YEAR 2020-2021.



Race/Disability	Gilchrist County Rate	Florida Rate
All Races	86.7	90.0
White Races	88.0	91.8
Black Races	0.0	87.1
Disabled	76.0	82.3
Not Disabled	87.8	91.2

Source: Florida Department of Education, Education Information and Accountability Services (EIAS), 2020-2021.

Data for Black races were not found from Florida Department of Education.

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

Education Access and Quality		
SDOH	**Vulnerable Populations Impacted**	**How the SDOH Impacts (Hypertension)**
Literacy Health literacy and health outcomes in hypertension: An integrative review The role of Health Literacy in Hypertension Control: a cross-sectional study in Iran ECHO: A Pilot Health Literacy Intervention to Improve Hypertension Self-Care	Hispanics, and Blacks	Health Literacy is a huge issue. Average reading levels are at an 8th grade level, but many documents are written in a way that makes it difficult for the reader to understand. Hypertensive patients with lower literacy usually have a poorer knowledge of health information and what is needed for them to lead a healthy life. Graphics and infographics that are easy to understand and are age appropriate are a successful way to distribute information. External partners make sure that any kind of written documents that are given to the public are easy to understand as well as lots of graphics/pictures that are on these information packets. A lot of people are great visual learners, so it is a successful tactic to use.
Language Association between Language and Risk Factor Levels among Hispanic Adults with Hypertension, Hypercholesterolemia, or Diabetes	Hispanics and Blacks	Lack of access to materials. Many documents are English and there is no Spanish documentation. We are combating this by translating our Heart Health Materials into Spanish for these populations. If there are lower rates of education for these vulnerable populations, they are not being exposed to the education that they need to make decisions for their health that will help them.

II. Economic Stability

- ## Economic stability data for Gilchrist County

According to the 2016 Live United, Asset Limited Income Challenged, Employed (ALICE) report, 20 percent of Gilchrist County households exist in poverty and a third (34.0 percent) are considered ALICE households. For 2016-2020 the U.S. Census Bureau reports that 13 percent of individuals of all races in Gilchrist County live below the federal poverty level. Nearly twelve percent (11.8) of the White population live in poverty. For Blacks and Hispanics in Gilchrist those percentages are 54.6 percent and 23.8 percent, respectively. For Gilchrist County children under 18 years of age, the poverty rate is 16.6 percent. In 2018-2020 about 17.5 percent of households in Gilchrist County received cash public assistance or food stamps compared to 14.2 percent of households statewide.

About four percent (4.2 percent) of Gilchrist County residents are unemployed compared to the state rate of 5.4 percent for 2016-2020. Median household income in Gilchrist County for 2020 was 47,381 dollars. The median household income in Florida was 57,703 dollars for the same time period. The low incomes of those employed in Gilchrist County contributes to the percentage of persons living below poverty. In 2019, the Gilchrist County Black population had a median household income of 26,711 dollars compared to the White population with a median household income of 47,829 dollars and the Gilchrist County Hispanic median household income of 31,220 dollars.

People with steady employment that provides adequate income are less likely to live in poverty and more likely to be healthy, but many people have trouble finding and keeping a job. People with disabilities, injuries, or conditions like arthritis may be especially limited in their ability to work. In addition, many people with steady work still do not earn enough to afford the things they need to stay healthy. Employment programs, career counseling, and high-quality childcare opportunities can help more people find and keep jobs. In addition, policies to help people pay for food, housing, health care, and education can reduce poverty and improve health and well-being.

Housing is the single largest expense for most households, and far too many pay too much for housing, particularly low-income families, and households of color. High housing costs squeeze household budgets leaving few resources to pay for other expenses, save for emergencies, or make long-term investments.

Thirty-six percent of households in Gilchrist County have housing costs that are more than 30 percent of their income. Renter-occupied households have gross rent costing 36.2 percent or more of their household income.

Low socioeconomic status is a huge indicator when it comes to Hypertension and controlling Hypertension rates within the community. When looking at the data you can see there is a major disparity, especially for the Black and the Hispanic populations. If one is not stable when it comes to income, then it puts up multiple barriers on the journey to control their Hypertension. Lack of income attributes to less opportunity for resources, if they are working multiple jobs to make ends meet it attributes to less time to exercise or take care of themselves. They might be under chronic stressors due to bills and different payments which makes your heart work harder, therefore putting greater stress on your body. If one's income is lower, then they will also have less access to nutritious foods. If you have a limited amount of money, you may be reaching for options that will last a long time and are not as experience. A lot of times those are non-perishable foods and they will be making meals that will stretch and last a longer time.

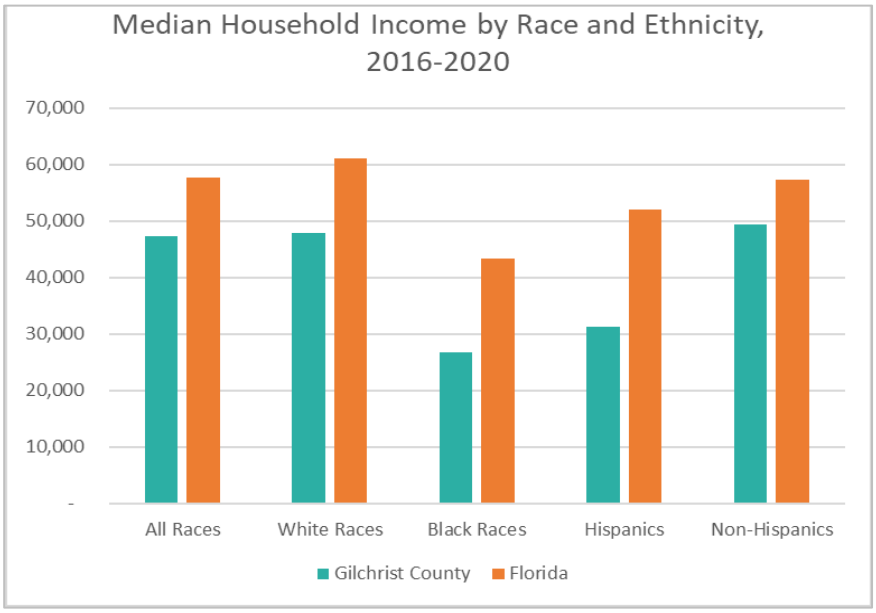
Socioeconomic status, employment status, income level and educational attainment have been consistently associated with cardiovascular disease[3]. Individuals that are grouped within a low SES category are at a higher risk of having a cardiovascular event and poorer outcomes[3]. Anstey et al. observed "low socioeconomic status (SES), as represented by household income, was associated with worse blood pressure control and an increased risk of outcomes in an environment that provided access to uniform hypertension treatment for all participants, regardless of SES"[4]. Further research is still being done to understand the link between cardiovascular risk and a lower SES[3,4].

Socioeconomic Status and Hypertension Sources:

3. Schultz, W. M., Kelli, H. M., Lisko, J. C., Varghese, T., Shen, J., Sandesara, P., Quyyumi, A. A., Taylor, H. A., Gulati, M., Harold, J. G., Mieres, J. H., Ferdinand, K. C., Mensah, G. A., & Sperling, L. S. (2018). Socioeconomic Status and Cardiovascular Outcomes. *Circulation*, *137*(20), 2166–2178. https://doi.org/10.1161/circulationaha.117.029652.

4. Anstey, Edmund D., Christian, Jessica, Shimbo, Daichi, (2019) Income Inequality and Hypertension Control. Journal of the American Heart Association. https://www.ahajournals.org/doi/10.1161/JAHA.119.013636.

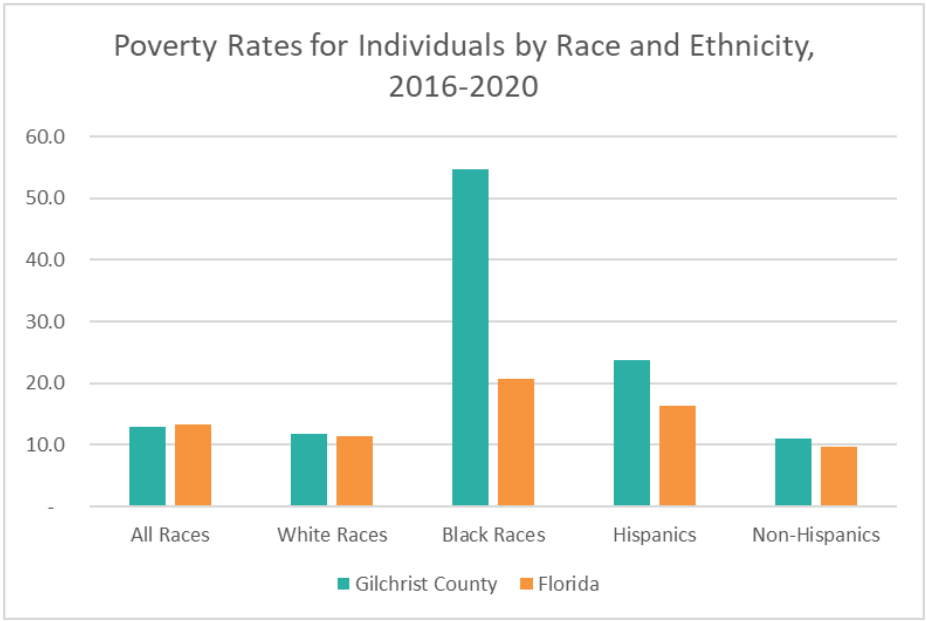
MEDIAN HOUSEHOLD INCOME BY RACE AND ETHNICITY, GILCHRIST COUNTY AND FLORIDA, 2016-2020.



Race/Ethnicity	Gilchrist County Rate	Florida Rate
All Races	47,381	57,703
White Races	47,829	61,065
Black Races	26,711	43,418
Hispanics	31,220	52,092
Non-Hispanics	49,327	57,295

Source: US Census Bureau, American Community Survey, Table B19013, 2016-2020

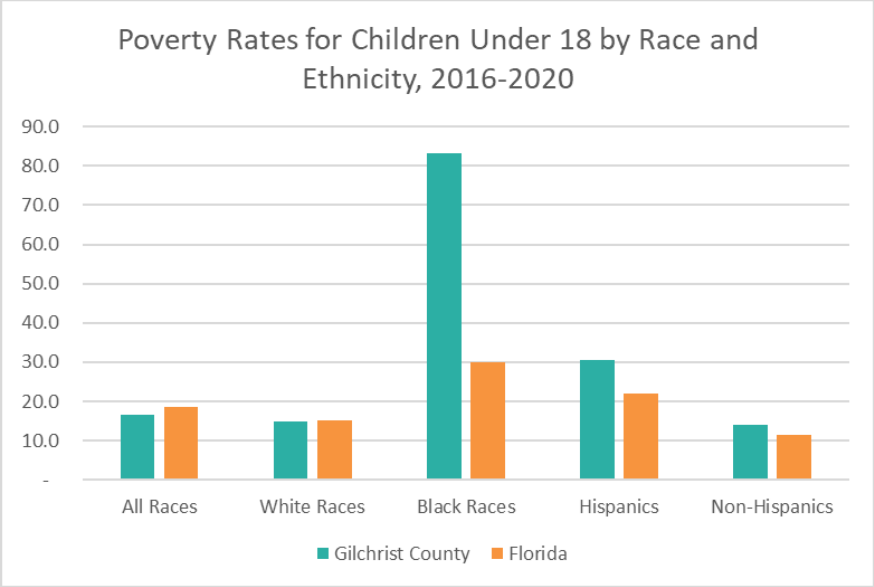
POVERTY RATES FOR INDIVIDUALS BY RACE AND ETHNICITY, GILCHRIST COUNTY AND FLORIDA, 2016-2020.



Race/Ethnicity	Gilchrist County Rate	Florida Rate
All Races	13.0	13.3
White Races	11.8	11.5
Black Races	54.6	20.7
Hispanics	23.8	16.4
Non-Hispanics	11.1	9.7

Source: US Census Bureau, American Community Survey, Tables B17001 and DPO30, 2016-2020

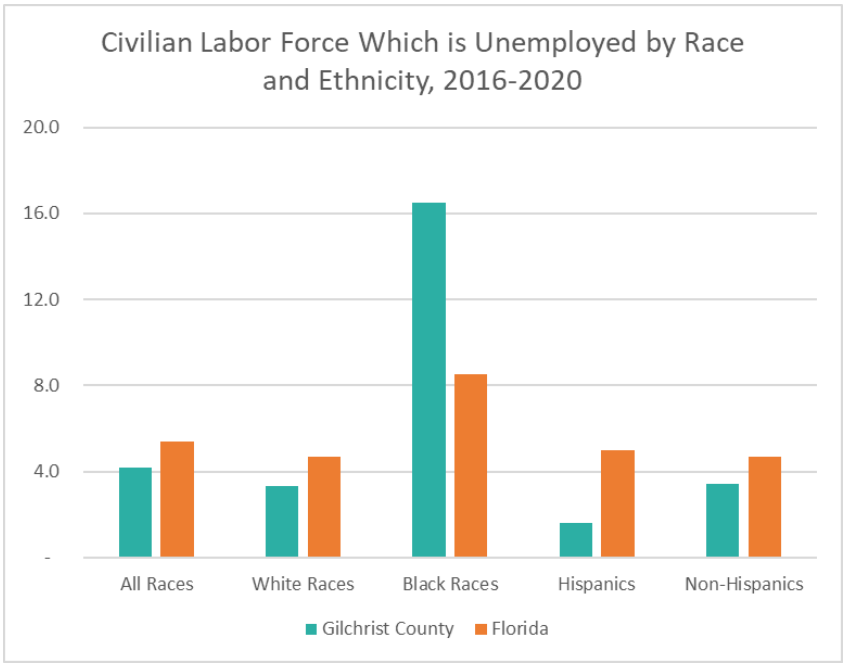
POVERTY RATES FOR CHILDREN UNDER 18 BY RACE AND ETHNICITY, GILCHRIST COUNTY AND FLORIDA, 2016-2020.



Race/Ethnicity	Gilchrist County Rate	Florida Rate
All Races	16.6	18.7
White Races	14.9	15.2
Black Races	83.3	29.9
Hispanics	30.6	21.9
Non-Hispanics	13.9	11.6

Source: US Census Bureau, American Community Survey, Tables B17001 and DPO30, 2016-2020

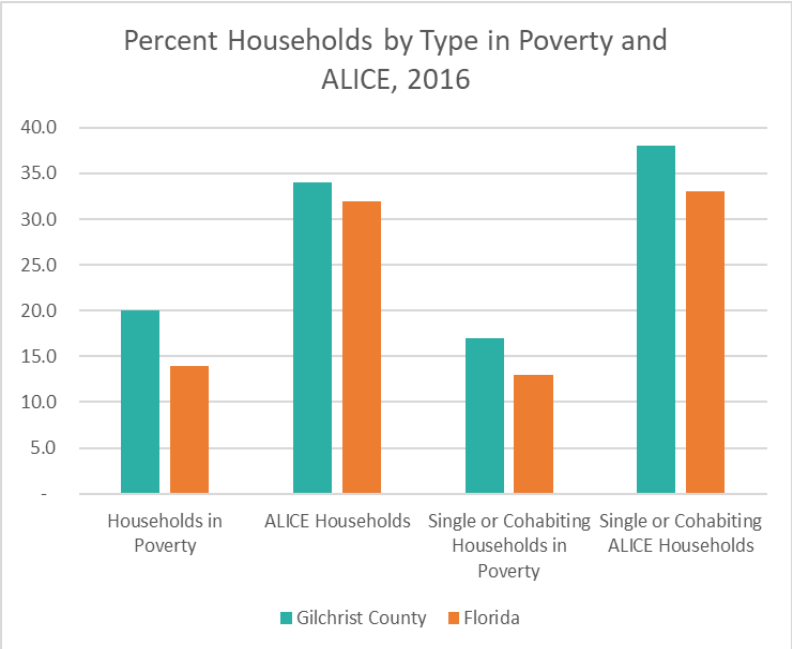
CIVILIAN LABOR FORCE, WHICH IS UNEMPLOYED BY RACE AND ETHNICITY, GILCHRIST COUNTY AND FLORIDA, 2016-2020.



Race/Ethnicity	Gilchrist County Rate	Florida Rate
All Races	4.2	5.4
White Races	3.3	4.7
Black Races	16.5	8.5
Hispanics	1.6	5.0
Non-Hispanics	3.4	4.7

Source: US Census Bureau, American Community Survey, Table DPO30, 2016-2020

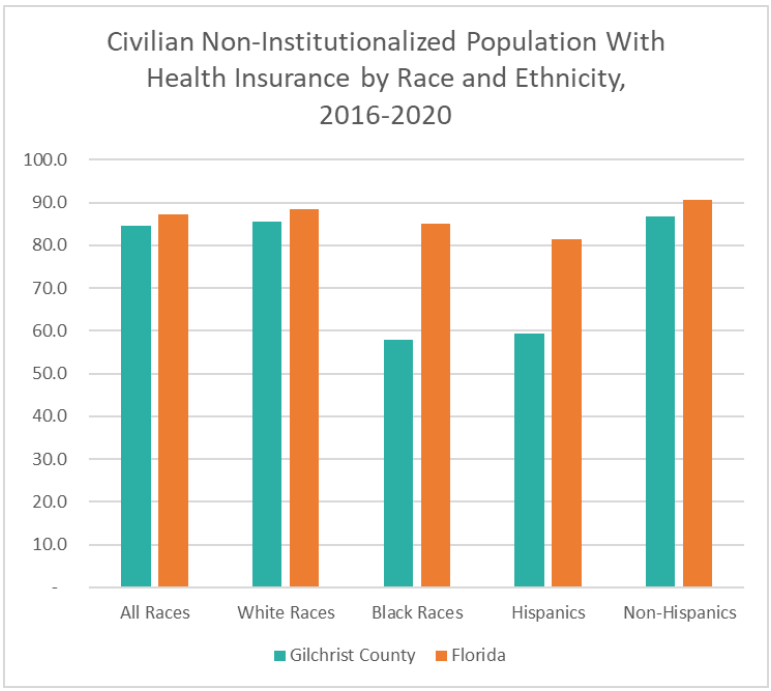
PERCENT HOUSEHOLDS BY TYPE IN POVERTY AND ALICE, 2016



Percent	Gilchrist County Rate	Florida Rate
Households in Poverty	20.0	14.0
ALICE Households	34.0	32.0
Single or Cohabiting Households in Poverty	17.0	13.0
Single or Cohabiting ALICE Households	38.0	33.0

Source: ALICE: A Study of Financial Hardship in Florida, Live United, 2018 Report

CIVILIAN NON-INSTITUTIONALIZED POPULATION WITH HEALTH INSURANCE, GILCHRIST COUNTY COMPARED TO FLORIDA BY RACE AND ETHNICITY, 2016-2020.



Race/Ethnicity	Gilchrist County Rate	Florida Rate
All Races	84.5	87.3
White Races	85.6	88.5
Black Races	58.0	85.1
Hispanics	59.4	81.4
Non-Hispanics	86.8	90.7

Source: US Census Bureau, American Community Survey, Table S2701, 2016-2020

GILCHRIST COUNTY OVERALL OPPORTUNITY LIVABILITY INDEX

Opportunity

Range — National Average 50

0 — 100

56

Opportunity Metrics	2015		2022	2022 US Median Neighborhood
Income inequality	0.47 (Index from 0 to 1)	↑	0.43 (Index from 0 to 1)	0.46
Jobs per worker	0.77 jobs per person	↑	0.78 jobs per person	0.80
High school graduation rate			87.0% of students graduate	88.5%
Age diversity	0.87 (Index from 0 to 1)	↓	0.82 (Index from 0 to 1)	0.85

Key: ↑ Getting Better ↓ Getting Worse = No Change * Imputed Data

Opportunity Policies	Is there a policy here?
Local government creditworthiness	✗ No Policy
State and local minimum wage increase	✓ State Policy
State expansion of the Family and Medical Leave Act	✗ No Policy
State and local plans to create age-friendly communities	✓ State Policy

Source: AARP Livability Index

GILCHRIST COUNTY OPPORTUNITY LIVABILITY INDEX AREA CODE 32693

Opportunity

Range

National Average 50

0 — 100

55

Opportunity Metrics	2015		2022	2022 US Median Neighborhood
Income inequality	0.46 (Index from 0 to 1)	↑	0.43 (Index from 0 to 1)	0.46
Jobs per worker	0.67 jobs per person	↑	0.78 jobs per person	0.80
High school graduation rate			87.0% of students graduate	88.5%
Age diversity	0.88 (Index from 0 to 1)	↓	0.84 (Index from 0 to 1)	0.85

Key: ↑ Getting Better ↓ Getting Worse = No Change * Imputed Data

Opportunity Policies	Is there a policy here?
Local government creditworthiness	✗ No Policy
State and local minimum wage increase	✓ State Policy
State expansion of the Family and Medical Leave Act	✗ No Policy
State and local plans to create age-friendly communities	✓ State Policy

Source: AARP Livability Index

GILCHRIST COUNTY OPPORTUNITY LIVABILITY INDEX AREA CODE 32619

Opportunity

Range

National Average 50

0 — 100

56

Opportunity Metrics	2015		2022	2022 US Median Neighborhood
Income inequality	0.47 (Index from 0 to 1)	↑	0.43 (Index from 0 to 1)	0.46
Jobs per worker	0.77 jobs per person	↑	0.78 jobs per person	0.80
High school graduation rate			87.0% of students graduate	88.5%
Age diversity	0.84 (Index from 0 to 1)	↓	0.83 (Index from 0 to 1)	0.85

Key: ↑ Getting Better ↓ Getting Worse = No Change * Imputed Data

Opportunity Policies	Is there a policy here?
Local government creditworthiness	✗ No Policy
State and local minimum wage increase	✓ State Policy
State expansion of the Family and Medical Leave Act	✗ No Policy
State and local plans to create age-friendly communities	✓ State Policy

Source: AARP Livability Index

PEOPLE LIVING WITH AT LEAST ONE DISABILITY INCOME AND POVERTY RATES

Unfortunately, county-level data for individuals with a disability was not statistically significant for this indicator according to findings from Knowli. Respondent results for this measure were too low to determine statistical significance in Gilchrist County. A statistically significant measure in Gilchrist County was food security, 7% of people living with at least one disability indicated they were food insecure and did not have enough money for food as compared to 4% of individuals with no disability. Statistically significant results at the State level showed 14.7% of people living with at least one disability made less than $25,000 a year, as compared to 12.2% of people with no disabilities. These measures show a disparity in income for individuals living with disabilities.

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

Economic Stability		
SDOH	**Vulnerable Populations Impacted**	**How the SDOH Impacts (Hypertension)**
Income Hypertension in Low- and Middle-Income Countries	Hispanics, Blacks, Whites, People living with disabilities	Individuals have issues with income due to lack of opportunity or lower wages. With Hypertension a lack of income means that they may have less access to healthcare, health insurance, job insecurity, etc. In Gilchrist County there is a disparity with income because many Black and Hispanic households make significantly less than white counterparts.
Expenses A global perspective on the costs of hypertension: a systematic review	Hispanics, Blacks, Whites	If individuals cannot afford items such as their medication, pay for their doctor visits, pay for health insurance, or pay for the resources then they are not able to help with Individuals have issues with income due to lack of opportunity or lower wage.
Unemployment Effect of unemployment on cardiovascular risk factors and mental health	Hispanics, Blacks, Whites	If an individual is unemployed, they do not have access to their basic care needs. They will be unable to go to their doctor and may wait until it is too long to get the help they need. Even if they do go to the doctor they will run into the situation of payment because they may not have insurance. If they are unemployed, they may run into being stressed that they are unable to pay their bills which can then lead to more strain on their heart.

III. Neighborhood and Built Environment

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

The neighborhoods people live in have a major impact on their health and well-being. Health interventions that focus on improving health and safety in the places where people live, work, learn, and play. Many people live in neighborhoods with limited access to nutritious food sources, parks, and community centers and fluoridated community water systems. Households vary by how far they must travel to find needed social services such as healthcare, dental offices, schools, libraries, daycare facilities, and senior centers. These are often less accessible to low-income persons.

Interventions and policy changes at the local, state, and federal level can help reduce these health and safety risks and promote health. For example, providing opportunities for people to walk and bike in their communities, like by adding sidewalks and bike lanes, can increase safety and help improve health and quality of life.

In Gilchrist County:

- For 2017-2019 only 14.6 percent of the Gilchrist County population was served by community water systems, compared to 95 percent of Florida's communities (Florida Department of Environmental Protection (DEP).
- There is no access to a fluoridated water compared to about 78 percent of Floridians statewide having such access. (Florida Department of Health, Public Health Dental Program (PHDP).
- In 2019, Feeding America reports that 21.1 percent of Gilchrist County children experienced food insecurity, compared to 17.1 percent of children statewide.

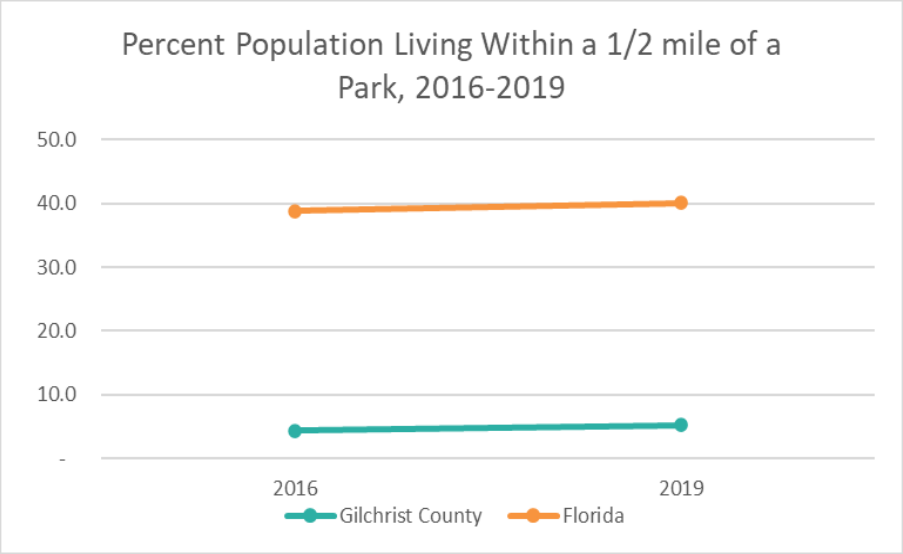
A citizen science study was conducted to assess neighborhood social and built environment and disparity risk when it comes to Hypertension[4]. When looking at some of the study findings they found that the neighborhood environment may have an influence on health outcomes of

cardiovascular issues such as Hypertension[4]. Overall conclusions of the study were that low physical activity, lower SES status, and low greenness levels can be associated with hypertension risk[4]. Also, quality of built environment paired with social environment provided evidence that there was a higher risk of Hypertension[4]. Future studies are still being conducted to look further into these relationships[4].

Neighborhood and Built Environment Sources:

5. Grazuleviciene, R., Andrusaityte, S., Gražulevičius, T., & Dėdelė, A. (2020). Neighborhood Social and Built Environment and Disparities in the Risk of Hypertension: A Cross-Sectional Study. *International Journal of Environmental Research and Public Health*, *17*(20), 7696. https://doi.org/10.3390/ijerph17207696.

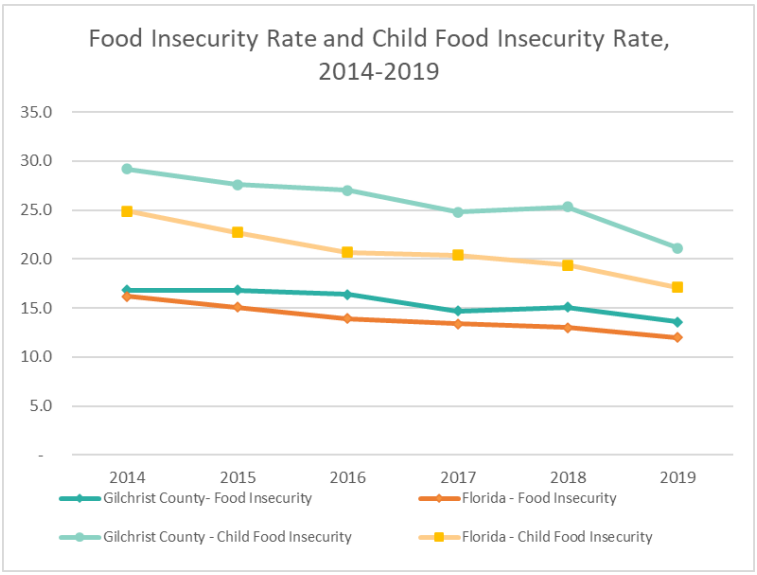
PERCENT OF POPULATION LIVING WITHIN A ½ MILE OF A PARK, GILCHRIST COUNTY AND FLORIDA, 2016-2019.



Year	Gilchrist County Rate	Florida Rate
2016	4.4	38.8
2019	5.2	40.1

Source: Florida Behavioral Risk Factor Surveillance System Telephone Survey (BRFSS), 2016-2019

FOOD INSECURITY RATE AND CHILD FOOD INSECURITY RATE, GILCHRIST COUNTY AND FLORIDA, 2014-2019.



Year	Food Insecurity Rate		Child Food Insecurity Rate	
	Gilchrist County	Florida	Gilchrist County	Florida
2014	16.8	16.2	29.2	24.9
2015	16.8	15.1	27.6	22.7
2016	16.4	13.9	27.0	20.7
2017	14.7	13.4	24.8	20.4
2018	15.1	13.0	25.3	19.4
2019	13.6	12.0	21.1	17.1

Source: Feeding America, Map the Meal Gap, 2014-2019

AARP HOUSING LIVABILITY INDEX GILCHRIST COUNTY OVERALL.

Housing

Range

National Average 50

0 — 100

57

Housing Metrics	2015		2022	2022 US Median Neighborhood
Zero-step entrances			* 50.1% of units	50.1%
Availability of multi-family housing	2.4% of units are multi-family	=	2.4% of units are multi-family	18%
Housing costs	$704 per month	↑	$603 per month	$1,057
Housing cost burden	15.4% of income spent on housing	↑	10.4% of income spent on housing	16.3%
Availability of subsidized housing			27 units per 10,000 people	0

Key: ↑ Getting Better ↓ Getting Worse = No Change * Imputed Data

Housing Policies	Is there a policy here?
State and local inclusive design laws	✗ No Policy
State and local housing trust funds	✗ No Policy
State manufactured housing protections	✗ No Policy
State foreclosure prevention and protection	✗ No Policy
State accessory dwelling unit support	✗ No Policy
State and local plans to create age-friendly communities	✓ State Policy

Source: AARP Livability Index

AARP HOUSING LIVABILITY INDEX GILCHRIST COUNTY AREA CODE 32693.

Housing

Range

National Average 50

0 — 59 — 100

Housing Metrics	2015		2022	2022 US Median Neighborhood
Zero-step entrances			* 50.1% of units	50.1%
Availability of multi-family housing	7.3% of units are multi-family	↓	3.4% of units are multi-family	18%
Housing costs	$670 per month	↑	$603 per month	$1,057
Housing cost burden	15.7% of income spent on housing	↑	11.4% of income spent on housing	16.3%
Availability of subsidized housing			56 units per 10,000 people	0

Key: ↑ Getting Better ↓ Getting Worse = No Change * Imputed Data

Housing Policies	Is there a policy here?
State and local inclusive design laws	✗ No Policy
State and local housing trust funds	✗ No Policy
State manufactured housing protections	✗ No Policy
State foreclosure prevention and protection	✗ No Policy
State accessory dwelling unit support	✓ State Policy
State and local plans to create age-friendly communities	✓ State Policy

Source: AARP Livability Index

AARP HOUSING LIVABILITY INDEX GILCHRIST COUNTY AREA CODE 32619

Housing

Range

National Average 50

0 — 100

56

Housing Metrics	2015		2022	2022 US Median Neighborhood
Zero-step entrances			* 50.1% of units	50.1%
Availability of multi-family housing	0.6% of units are multi-family	↑	0.9% of units are multi-family	18%
Housing costs	$674 per month	↑	$584 per month	$1,057
Housing cost burden	14.8% of income spent on housing	↑	10.0% of income spent on housing	16.3%
Availability of subsidized housing			5 units per 10,000 people	0

Key: ↑ Getting Better ↓ Getting Worse = No Change * Imputed Data

Housing Policies	Is there a policy here?
State and local inclusive design laws	✗ No Policy
State and local housing trust funds	✗ No Policy
State manufactured housing protections	✗ No Policy
State foreclosure prevention and protection	✗ No Policy
State accessory dwelling unit support	✓ State Policy
State and local plans to create age-friendly communities	✓ State Policy

Source: AARP Livability Index

AARP NEIGHBORHOOD LIVABILITY INDEX GILCHRIST COUNTY OVERALL

Neighborhood

Range **National Average 50**

0 — 29 — 100

Neighborhood Metrics	2015		2022	2022 US Median Neighborhood
Access to grocery stores and farmers markets			0 stores and markets	0.0
Access to parks			0.1 parks	1
Access to libraries	0 libraries	=	0 libraries	0.0
Access to jobs by transit			* 0 jobs	0
Access to jobs by auto			1,655 jobs	44,198
Diversity of destinations	0.2 (Index from 0 to 1)	↓	0.08 (Index from 0 to 1)	0.65
Activity density	74 jobs and people per sq. mi.	↓	73 jobs and people per sq. mi.	3,056
Crime rate			131 crimes per 10,000 people	217.4
Vacancy rate	15% of units are vacant	↑	13% of units are vacant	8.6%

Key: ↑ Getting Better ↓ Getting Worse = No Change * Imputed Data

Neighborhood Policies	Is there a policy here?
State and local TOD programs	✗ No Policy
State and local plans to create age-friendly communities	✓ State Policy

***Please note, there are two libraries in Gilchrist County – data on this has not been updated.**

Source: AARP Livability Index

AARP NEIGHBORHOOD LIVABILITY INDEX GILCHRIST COUNTY AREA CODE 32693

Neighborhood

Range **National Average 50**

0 — 31 — 100

Neighborhood Metrics	2015		2022	2022 US Median Neighborhood
Access to grocery stores and farmers markets			0 stores and markets	0.0
Access to parks			0.2 parks	1
Access to libraries	0 libraries	=	0 libraries	0.0
Access to jobs by transit			* 0 jobs	0
Access to jobs by auto			1,824 jobs	44,198
Diversity of destinations	0.26 (Index from 0 to 1)	↓	0.12 (Index from 0 to 1)	0.65
Activity density	100 jobs and people per sq. mi.	↓	96 jobs and people per sq. mi.	3,056
Crime rate			124 crimes per 10,000 people	217.4
Vacancy rate	12% of units are vacant	↓	16% of units are vacant	8.6%

Key: ↑ Getting Better ↓ Getting Worse = No Change * Imputed Data

Neighborhood Policies	Is there a policy here?
State and local TOD programs	✗ No Policy
State and local plans to create age-friendly communities	✓ State Policy

***Please note, there is one library in the zip code 32693– data on this has not been updated.**

Source: AARP Livability Index

AARP NEIGHBOORHOOD LIVABILITY INDEX GILCHRIST COUNTY AREA CODE 32619

Neighborhood

Range **National Average 50**

0 — 27 — 100

Neighborhood Metrics	2015		2022	2022 US Median Neighborhood
Access to grocery stores and farmers markets			0 stores and markets	0.0
Access to parks			0 parks	1
Access to libraries	0 libraries	=	0 libraries	0.0
Access to jobs by transit			* 0 jobs	0
Access to jobs by auto			1,074 jobs	44,198
Diversity of destinations	0 (Index from 0 to 1)	=	0 (Index from 0 to 1)	0.65
Activity density	50 jobs and people per sq. mi.	=	50 jobs and people per sq. mi.	3,056
Crime rate			131 crimes per 10,000 people	217.4
Vacancy rate	18% of units are vacant	↑	13% of units are vacant	8.6%

Key: ↑ Getting Better ↓ Getting Worse = No Change * Imputed Data

Neighborhood Policies	Is there a policy here?
State and local TOD programs	✗ No Policy
State and local plans to create age-friendly communities	✓ State Policy

***Please note, there is one library in the zip code 32619– data on this has not been updated.**

Source: AARP Livability Index

AARP TRANSPORTATION LIVABILITY INDEX GILCHRIST COUNTY OVERALL.

Transportation

Range

National Average 50

0 — 41 — 100

Transportation Metrics	2015	2022	2022 US Median Neighborhood
Frequency of local transit service		0 buses and trains per hour	0
ADA-accessible stations and vehicles		* 82.9% of stations and vehicles are accessible	82.9%
Walk trips		0.54 trips per household per day	0.73
Congestion		0 hours per person per year	25.5
Household transportation costs		$17,062 per year	$15,331
Speed limits		28.9 miles per hour	28.0
Crash rate	36.1 fatal crashes per 100,000 people per year ↓	40 fatal crashes per 100,000 people per year	7.7

Key: ↑ Getting Better ↓ Getting Worse = No Change * Imputed Data

Transportation Policies	Is there a policy here?
State and local Complete Streets policies	✓ State Policy
State human services transportation coordination	✓ State Policy
State volunteer driver policies	✓ State Policy
State and local plans to create age-friendly communities	✓ State Policy

Source: AARP Livability Index

AARP TRANSPORTATION LIVABILITY INDEX GILCHRIST COUNTY AREA CODE 32693.

Transportation

Range 0 – 100 | National Average 50

41

Transportation Metrics	2015	2022	2022 US Median Neighborhood
Frequency of local transit service		0 buses and trains per hour	0
ADA-accessible stations and vehicles		* 82.9% of stations and vehicles are accessible	82.9%
Walk trips		0.57 trips per household per day	0.73
Congestion		0 hours per person per year	25.5
Household transportation costs		$16,728 per year	$15,331
Speed limits		29.2 miles per hour	28.0
Crash rate	40.1 fatal crashes per 100,000 people per year ↓	43.5 fatal crashes per 100,000 people per year	7.7

Key: ↑ Getting Better ↓ Getting Worse = No Change * Imputed Data

Transportation Policies	Is there a policy here?
State and local Complete Streets policies	✓ State Policy
State human services transportation coordination	✓ State Policy
State volunteer driver policies	✓ State Policy
State and local plans to create age-friendly communities	✓ State Policy

Source: AARP Livability Index

AARP TRANSPORTATION LIVABILITY INDEX GILCHRIST COUNTY AREA CODE 32693.

Transportation

Range **National Average 50**

0 — 38 — 100

Transportation Metrics	2015	2022	2022 US Median Neighborhood
Frequency of local transit service		0 buses and trains per hour	0
ADA-accessible stations and vehicles		* 82.9% of stations and vehicles are accessible	82.9%
Walk trips		0.52 trips per household per day	0.73
Congestion		0 hours per person per year	25.5
Household transportation costs		$16,978 per year	$15,331
Speed limits		29.5 miles per hour	28.0
Crash rate	28.9 fatal crashes per 100,000 people per year ↓	52.1 fatal crashes per 100,000 people per year	7.7

Key: ↑ Getting Better ↓ Getting Worse = No Change * Imputed Data

Transportation Policies	Is there a policy here?
State and local Complete Streets policies	✓ State Policy
State human services transportation coordination	✓ State Policy
State volunteer driver policies	✓ State Policy
State and local plans to create age-friendly communities	✓ State Policy

Source: AARP Livability Index

AARP ENVIRONMENT LIVABILITY INDEX GILCHRIST COUNTY OVERALL.

Environment

Range

National Average 50

0 — 100

65

Environment Metrics	2015		2022	2022 US Median Neighborhood
Drinking water quality	0.00% of people are exposed to violations	=	0.00% of people are exposed to violations	0%
Regional air quality	* 14.3 unhealthy air quality days per year		* 4.4 unhealthy air quality days per year	4.37
Near-roadway pollution			0.00% of people are exposed	0.00%
Local industrial pollution			0 RSEI Score from 0 to 9,070	0.00

Key: ↑ Getting Better ↓ Getting Worse = No Change * Imputed Data

Environment Policies	Is there a policy here?
State utility disconnection policies	✗ No Policy
Local multi-hazard mitigation plans	✓ County Policy
State energy efficiency scorecard	✗ No Policy
State and local plans to create age-friendly communities	✓ State Policy

Source: AARP Livability Index

AARP ENVIRONMENT LIVABILITY INDEX GILCHRIST COUNTY AREA CODE 32693.

Environment

Range **National Average 50**

0 — 100

62

Environment Metrics	2015	2022	2022 US Median Neighborhood
Drinking water quality	0.90% of people are exposed to violations ↑	0.42% of people are exposed to violations	0%
Regional air quality	* 14.3 unhealthy air quality days per year	* 4.4 unhealthy air quality days per year	4.37
Near-roadway pollution		0.00% of people are exposed	0.00%
Local industrial pollution		0 RSEI Score from 0 to 9,070	0.00

Key: ↑ Getting Better ↓ Getting Worse = No Change * Imputed Data

Environment Policies	Is there a policy here?
State utility disconnection policies	✗ No Policy
Local multi-hazard mitigation plans	✓ County Policy
State energy efficiency scorecard	✗ No Policy
State and local plans to create age-friendly communities	✓ State Policy

Source: AARP Livability Index

AARP ENVIRONMENT LIVABILITY INDEX GILCHRIST COUNTY AREA CODE 32619.

Environment

Range

National Average 50

0 — 100

65

Environment Metrics	2015	2022	2022 US Median Neighborhood
Drinking water quality	0.20% of people are exposed to violations ↑	0.00% of people are exposed to violations	0%
Regional air quality	* 14.3 unhealthy air quality days per year	* 4.4 unhealthy air quality days per year	4.37
Near-roadway pollution		0.00% of people are exposed	0.00%
Local industrial pollution		0 RSEI Score from 0 to 9,070	0.00

Key: ↑ Getting Better ↓ Getting Worse = No Change * Imputed Data

Environment Policies	Is there a policy here?
State utility disconnection policies	✗ No Policy
Local multi-hazard mitigation plans	✓ County Policy
State energy efficiency scorecard	✗ No Policy
State and local plans to create age-friendly communities	✓ State Policy

Source: AARP Livability Index

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

Neighborhood and Built Environment		
SDOH	**Vulnerable Populations Impacted**	**How the SDOH Impacts Hypertension**
Transportation Commuting by Public Transportation is Associated With Lower Prevalence of Excess Body Weight, Hypertension, and Diabetes	Hispanics, Blacks, Whites	Lack of transportation is huge. Many people rely on neighbors, family, friends to provides rides. We have a few agencies that help out with this. We have Suwannee River Economic Council which takes people to their doctors' appointments. With our Blood Pressure Self-Monitoring classes, DOH-Gilchrist staff goes to clients and where they will be. For example: If they go to church already, staff will set up a class there. Also, to utilize this service, they can only take a certain amount of people. There are no other public transportation avenues to utilize, so it is a limited resource. Transportation as a whole is a huge issue especially when regarding Hypertension. People are unable to go visit their doctor (since telehealth is not an option), go to the pharmacy to pick up their medication, receive education for Hypertension, go to the gym to exercise, go to the store to pick up nutrient dense foods, etc. Transportation is the backbone issue for small counties. If one does not have a way to transport themselves, they limit themselves severely especially in regards to their health.
Accessibility to Parks Neighborhood Social and Built Environment and Disparities in the Risk of Hypertension: A Cross-Sectional Study Community design and hypertension: Walkability and park access relationships with cardiovascular health	Hispanics, Blacks, Whites	Access to parks is another issue within Gilchrist because it not only provides an avenue for children to get their exercise, but adults as well. Currently there are a few different courts that adults can utilize and a playground for the children. Access to green areas in general is a necessity because it provides multiple opportunities for individuals. It not only helps provide a space for people to exercise, but it also promotes an opportunity to socially interact (both adults and children). Exercise promotes heart health and can alleviate issues if paired with medical adherence and a nutritious diet. One of the projects is to revamp the Trenton City Park.

Housing Importance of Housing and Cardiovascular Health and Well-Being: A Scientific Statement From the American Heart Association	Hispanics, Blacks, Whites	If one does not have an opportunity to be in a living situation that is a safe dwelling, have access to a stable job or income flow that will allow them to afford housing, neighborhood and built environment, stable housing market, etc. than how can we expect them to be able to treat and manage their Hypertension? If quality and safety of housing is not within the proper standards then you will notice that an individual might be exposed to factors such as mold, poor air quality, and structure deterioration which can then lead to higher rates or chronic diseases in general. Stress is another huge factor if you are experiencing housing issues. If you are in a constant state of stress, then you are putting more strain on your heart which can then lead to bigger issues than even Hypertension.
Neighborhood and Environment Neighborhood Social and Built Environment and Disparities in the Risk of Hypertension: A Cross-Sectional Study Socioeconomic Status and Cardiovascular Outcomes	Hispanics, Blacks, Whites	Individuals that live in areas with higher rates of poverty experience higher rates of cardiovascular issues. Findings from the Jackson Heart Study found an association between neighborhood disadvantage and cumulative biological risk*. *" Cumulative biological risk is a score derived from biomarkers representing cardiovascular, metabolic, inflammatory, and neuroendocrine health". If individuals do not have spaces that they feel that they can safely reside in, connect with individuals, exercise in, etc. then it will open them up to a higher risk of having Hypertension. If they do not feel safe, they will not exit their houses. If they do not form connections within their neighborhood, they can harbor feelings of loneliness and will stay inside their homes. If they do not have a space to exercise, then they will just stay in their homes. It just is a vicious cycle.

IV. Social and Community Context

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

Gilchrist County is located in a rural area with a large percentage of the population living in poverty with limited access to employment that provides the necessary income to access affordable housing, food, and transportation to health and social services, and community activities. These conditions are especially prevalent for the Black population; however, all Gilchrist County residents may experience barriers as a consequence of low medium incomes and distances to services. People's relationships and interactions with family, friends, co-workers, and community members can have a major impact on their health and well-being. Actions that help people get the social support they need in the places where they live, work, learn, and play. Many people face challenges and dangers they cannot control, such as unsafe neighborhoods, discrimination, or trouble affording the things they need. This can have a negative impact on health and safety throughout life. Positive relationships at home, at work, and in the community can help reduce these negative impacts. Interventions to help people get the social and community support they need are critical for improving health and well-being.

When accessing an article on "Neighborhood Characteristics and Hypertension", researchers looked at specific neighborhood features and tried to see if there was a connection to Hypertension[6]. There was a total of 495 neighborhoods that were assessed for the duration of this research period[6]. The findings were that the neighborhoods they assessed that had more access to healthy nutritious foods, had a safe environment to reside in/walk in, and had more social cohesion/connection had members that were less likely to be Hypertensive[6]. This is a new study, so to say for sure would be too early at this time, research is continuing to be completed to further study these connections[6]. It provides us with a good background to work on because we can try to make our community a better place through PACE-EH projects

(more information on PACE-EH in the projects section). DOH Gilchrist and external partners can provide our community with a better chance for them to meet and connect with people that are residing in the same place as them, that have children that live, play, and go to school in the same places as them, etc. It just gives them a platform to meet individuals that may be going through the same issues as them or even connect them to new people that they might have never met.

Social and Community Context Sources:

6. Mujahid, M. S., Diez Roux, A. V., Morenoff, J. D., Raghunathan, T. E., Cooper, R. S., Ni, H., & Shea, S. (2008). Neighborhood Characteristics and Hypertension. *Epidemiology*, *19*(4), 590–598. https://doi.org/10.1097/ede.0b013e3181772cb2.

- ## Health Impact Pyramid

There is growing recognition that social and economic factors shape individuals' ability to engage in healthy behaviors. Evidence shows that stress negatively affects health across the lifespan and that environmental factors may have multi-generational impacts. Addressing social determinants of health is not only important for improving overall health, but also for reducing health disparities that are often rooted in social and economic disadvantages. The five-tier health impact pyramid depicts the potential impacts of different types of public health interventions. Efforts that address the SDOH are at the base of the pyramid, indicating their higher potential for positive impact. Interventions at the pyramid base tend to be effective because of their broad societal reach. Health improvement interventions targeted at all levels are needed to attain the best and most sustainable health benefits.

Source: Frieden, T.R. (2010). A framework for public health action: The health impact pyramid. American Journal of Public Health, 100(4):590-595. Retrieved April 4, 2022, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2836340/

AARP ENGAGEMENT LIVABILITY INDEX GILCHRIST COUNTY OVERALL.

Engagement

Range **National Average 50**

0 — 37 — 100

Engagement Metrics	2015	2022	2022 US Median Neighborhood
Broadband cost and speed		20.7% of residents have high-speed, competitively-priced service	93.7%
Opportunity for civic involvement		6.5 organizations per 10,000 people	1.18
Voting rate		68.3% of people voted	61.9%
Social involvement index		0.9 (Index from 0 to 2.5)	0.96
Cultural, arts, and entertainment institutions		0.1 institutions per 100 people	8.01

Key: ↑ Getting Better ↓ Getting Worse = No Change * Imputed Data

Engagement Policies	Is there a policy here?
State barriers to community broadband	✗ No Policy
Early, absentee, or mail-in state voting laws	✗ No Policy
Local human rights commissions	✗ No Policy
Municipal LGBTQ+ anti-discrimination laws	✗ No Policy
State and local plans to create age-friendly communities	✓ State Policy

Source: AARP Livability Index

AARP ENGAGEMENT LIVABILITY INDEX GILCHRIST COUNTY AREA CODE 32693.

Engagement

Range **National Average 50**

0 — 100

38

Engagement Metrics	2015	2022	2022 US Median Neighborhood
Broadband cost and speed		5.8% of residents have high-speed, competitively-priced service	93.7%
Opportunity for civic involvement		7 organizations per 10,000 people	1.18
Voting rate		68.1% of people voted	61.9%
Social involvement index		0.9 (Index from 0 to 2.5)	0.96
Cultural, arts, and entertainment institutions		0.1 institutions per 100 people	8.01

Key: ↑ Getting Better ↓ Getting Worse = No Change * Imputed Data

Engagement Policies	Is there a policy here?
State barriers to community broadband	✗ No Policy
Early, absentee, or mail-in state voting laws	✓ State Policy
Local human rights commissions	✗ No Policy
Municipal LGBTQ+ anti-discrimination laws	✗ No Policy
State and local plans to create age-friendly communities	✓ State Policy

Source: AARP Livability Index

AARP ENGAGEMENT LIVABILITY INDEX GILCHRIST COUNTY AREA CODE 32619.

Engagement

Range

National Average 50

0 — 34 — 100

Engagement Metrics	2015	2022	2022 US Median Neighborhood
Broadband cost and speed		25.1% of residents have high-speed, competitively-priced service	93.7%
Opportunity for civic involvement		6.5 organizations per 10,000 people	1.18
Voting rate		68.3% of people voted	61.9%
Social involvement index		0.9 (Index from 0 to 2.5)	0.96
Cultural, arts, and entertainment institutions		0.1 institutions per 100 people	8.01

Key: ↑ Getting Better ↓ Getting Worse = No Change * Imputed Data

Engagement Policies	Is there a policy here?
State barriers to community broadband	✗ No Policy
Early, absentee, or mail-in state voting laws	✓ State Policy
Local human rights commissions	✗ No Policy
Municipal LGBTQ+ anti-discrimination laws	✗ No Policy
State and local plans to create age-friendly communities	✓ State Policy

Source: AARP Livability Index

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

Social and Community Context		
SDOH	**Vulnerable Populations Impacted**	**How the SDOH Impacts Hypertension**
Community Engagement Unraveling health disparities: Examining the dimensions of hypertension and diabetes through community engagement	Blacks, Hispanics, Whites	Lack of Community Engagement is huge. It is hard to get buy-in from the Gilchrist County population. People do not have enough time, resources, opportunities therefore it is hard to involve them. Also, sometimes there is a disconnect within organizations. Community engagement enables a more contextualized understanding of community members' perceptions of the topics and contexts and facilitates stronger relationships among and between community members. Having strong community engagement is what will make Gilchrist Counties projects succeed. It also will provide with greater resource sharing, so that DOH-Gilchrist and participants may get Hypertension issues under control. Individuals have a lack of access to internet, so they have greater feelings of loneliness because they are missing that social connection.
Discrimination Discrimination and Hypertension Risk Among African Americans in the Jackson Heart Study Racial/Ethnic Differences in Hypertension Prevalence, Treatment, and Control for Outpatients in Northern California 2010–2012	Blacks, Hispanics	Migrant workers, Hispanics and blacks have a difficult time in our communities due to stigma and lack of education. Without the migrant workers the community would not have a lot of our crops that are in stores, farmers market, etc. DOH-Gilchrist did a "where does your food come from" slideshow at our minority health month to emphasize the importance of migrant workers. For Hispanics and Blacks, it can be difficult because Gilchrist is a primarily white population, so that can be an issue for these populations. Discrimination can become an issue because it is a constant stressor therefore putting unnecessary strain on the heart. People may also be uncomfortable and avoid seeking medical attention.
Stress Chronic Psychosocial Stress and Hypertension	Blacks, Hispanics	Stress is in everyone's life, but it is especially pertinent in these populations because they have stress of their job, kids, housing, etc. Healthy stress is important, but to make sure that they take time for themselves. Stress triggers a rise in hormones that causes peoples blood vessels to narrow which in turn makes their heartbeat faster and will eventually lead to their blood pressure rising.

V. Health Care Access and Quality

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

About 84.5 percent of Gilchrist County residents of all races had health insurance (2016-2020) which was lower than the to the state percentage of 87.3. While it is encouraging that such a large percentage of residents have health insurance, many people may face barriers that prevent them from utilizing health care services. Such barriers may include health literacy, transportation, and finances.

Sometimes people do not get recommended health care services, like cancer screenings, because they do not have a primary care provider. Other times, it is because they live too far away from healthcare providers who offer services. Interventions to increase access to healthcare professionals and improve communication, whether in person or remotely, can help more people get the care they need and trust in the healthcare system.

Persons without insurance are less likely to have a primary care provider, and they may not be able to afford the healthcare services and medications they need. Strategies to increase insurance coverage rates are critical for making sure more people get important health care services, like preventive care and treatment for chronic illnesses.

An article on “Effect of geographic accessibility to primary care on treatment status of hypertension”, did a study to see the difference of geographic accessibility – areas that had more access to primary care facilities versus access that had less access to these facilities[7]. When looking at the findings, they notice that areas that had a greater accessibility range were

at a decreased risk of hypertension and an inverse effect was done at a lesser accessibility range[7]. Another study that is referenced within this article touched on access to care issues[8]. Multiple areas across the U.S. reported barriers to care such as lack of insurance, cost of healthcare in general, lower income levels, health care providers not responding to patients concerns, etc[8]. These are important to discuss as well when it comes to health care access, because if individuals are not able to afford health care, even if they are in areas of higher geographic accessibility, they will be unable to utilize these resources[8]. If they are unable to utilize these health care facilities, then they will be unable to sustain blood pressure control and reduce their risk of cardiovascular disease[8]. Individuals that don't have access to quality care and healthcare are more likely to go longer periods without seeing a healthcare professional.

According to Duru et al, being uninsured is associated with lower rates of blood pressure control among individuals who are treating their hypertension[9]. This finding suggests that consistent health care coverage encourages individuals to adhere to treatment and receive continuous care to improve hypertension. Increasing healthcare coverage may decrease the deaths from Hypertension. Uninsured individuals pay more out of pocket for physician visits, thus increasing their financial burden. Increased healthcare coverage in Gilchrist County would alleviate the burden of high-cost medical services and increase the percentage of individuals who could see a physician.

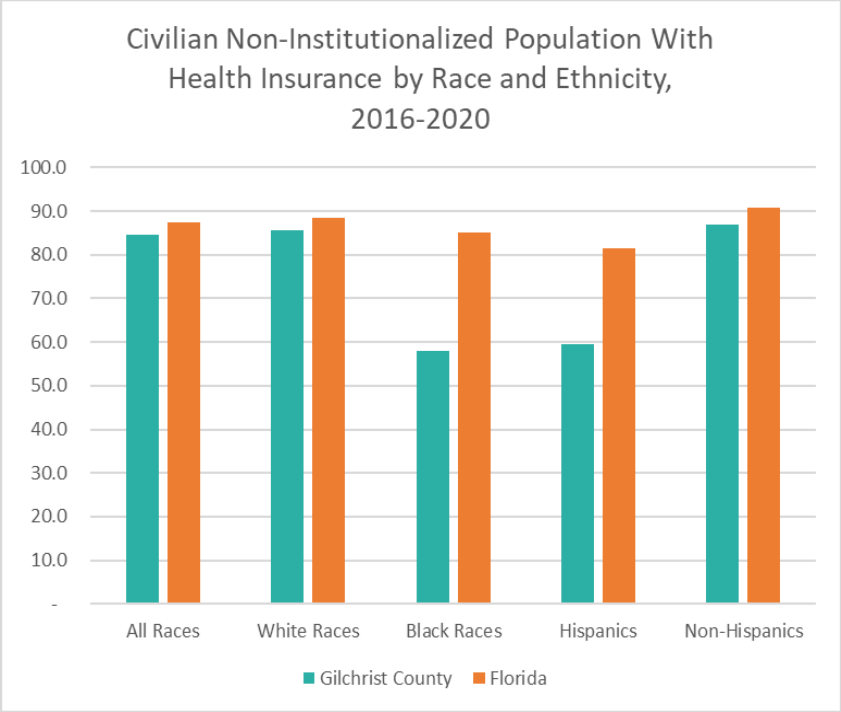
Health Care Access Sources:

7. Okuyama, K., Akai, K., Kijima, T., Abe, T., Isomura, M., & Nabika, T. (2019). Effect of geographic accessibility to primary care on treatment status of hypertension. *PLOS ONE*, *14*(3), e0213098. https://doi.org/10.1371/journal.pone.0213098.

8. Fang, J., Yang, Q., Ayala, C., & Loustalot, F. (2014). Disparities in Access to Care Among US Adults with Self-Reported Hypertension. *American Journal of Hypertension*, *27*(11), 1377–1386. https://doi.org/10.1093/ajh/hpu061.

9. O. Kenrik Duru, Roberto B. Vargas, Dulcie Kermah, Deyu Pan, Keith C. Norris, Health Insurance Status and Hypertension Monitoring and Control in the United States:, *American Journal of Hypertension*, Volume 20, Issue 4, April 2007, Pages 348–353, https://doi.org/10.1016/j.amjhyper.2006.11.007

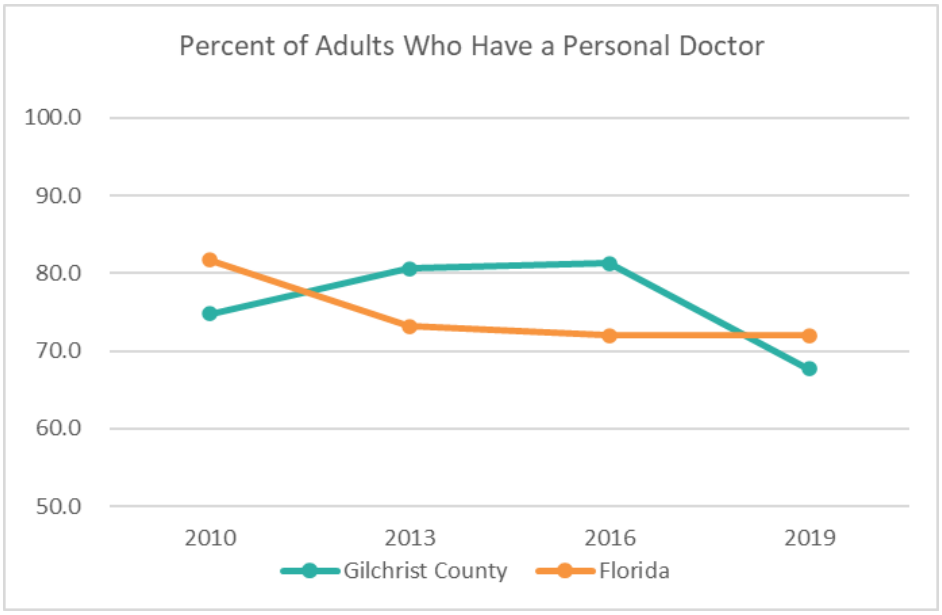
CIVILIAN NON-INSTITUTIONALIZED POPULATION WITH HEALTH INSURANCE, TO BY RACE AND ETHNICITY, GILCHRIST COUNTY AND FLORIDA, 2016-2020.



Race/Ethnicity	Gilchrist County Rate	Florida Rate
All Races	84.5	87.3
White Races	85.6	88.5
Black Races	58.0	85.1
Hispanics	59.4	81.4
Non-Hispanics	86.8	90.7

Source: US Census Bureau, American Community Survey, Table S2701, 2016-2020

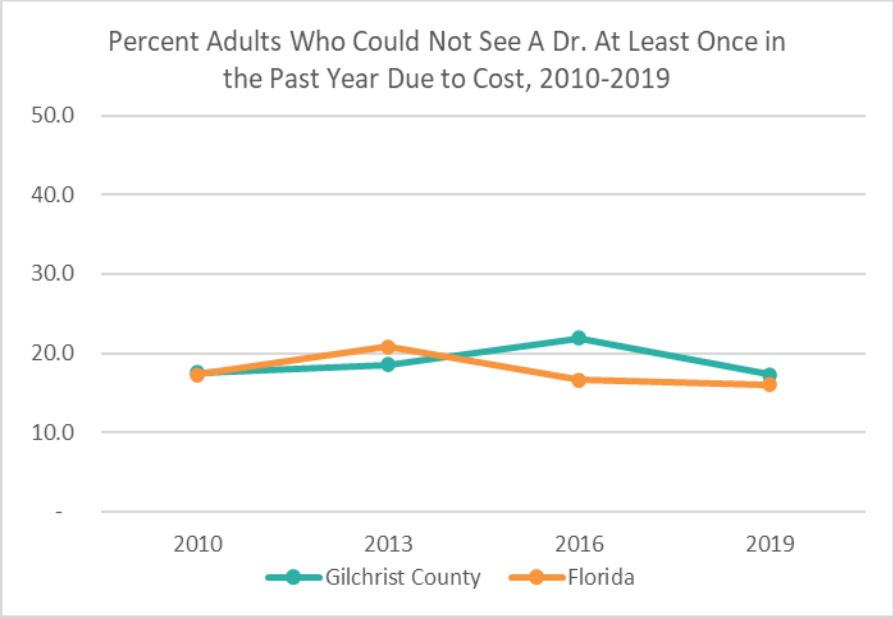
PERCENT ADULTS WHO HAVE A PERSONAL DOCTOR, GILCHRIST COUNTY AND FLORIDA, 2010-2019.



Year	Have a Personal Doctor	
	Gilchrist County Rate	Florida Rate
2010	74.8	81.7
2013	80.6	73.2
2016	81.3	72.0
2019	67.7	72.0

Source: Florida Behavioral Risk Factor Surveillance System Telephone Survey (BRFSS) 2019

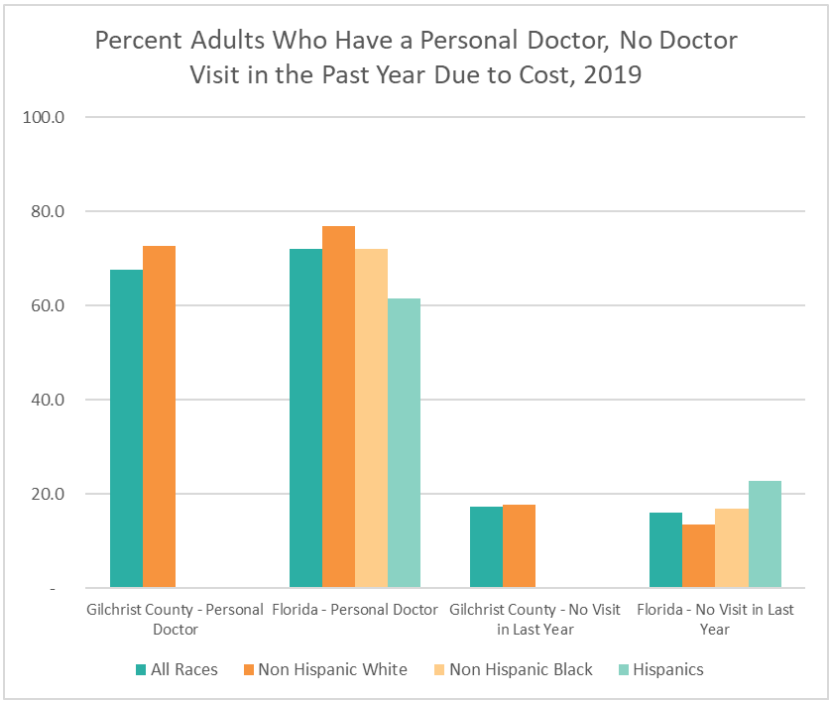
PERCENT OF ADULTS WHO COULD NOT SEE A DOCTOR AT LEAST ONCE IN THE PAST YEAR DUE TO COST, GILCHRIST COUNTY AND FLORIDA, 2010-2019



Year	Did Not See a Doctor At Least Once in the Past Year Due to Cost	
	Gilchrist County Rate	Florida Rate
2010	17.5	17.3
2013	18.5	20.8
2016	21.9	16.6
2019	17.3	16.0

Source: Florida Behavioral Risk Factor Surveillance System Telephone Survey (BRFSS) 2019.

PERCENT ADULTS WHO HAVE A PERSONAL DOCTOR, NO DOCTOR VISIT IN THE PAST YEAR DUE TO COST, GILCHRIST COUNTY AND FLORIDA, 2019.



Race/Ethnicity	Have a Personal Doctor	
	Gilchrist County	Florida
All Races	67.7	72.0
Non-Hispanic White	72.6	76.8
Non-Hispanic Black	NA	72.1
Hispanics	NA	61.5

Source: Florida Behavioral Risk Factor Surveillance System Telephone Survey (BRFSS) 2019.

AARP HEALTH LIVABILITY INDEX GILCHRIST COUNTY OVERALL

Health

Range **National Average 50**

0 — 23 — 100

Health Metrics	2015	2022	2022 US Median Neighborhood
Smoking prevalence		24.3% of people smoke regularly	18%
Obesity prevalence		32.5% of adults are obese	32.2%
Access to exercise opportunities		22.4% of people have access	90.1%
Healthcare professional shortage areas	9 (Index from 0 to 25) ↓	11 (Index from 0 to 25)	0
Preventable hospitalization rate		66.7 preventable hospitalizations per 100,000 patients	48.5
Patient satisfaction	28.6% of patients are satisfied ↑	73.3% of patients are satisfied	71.8%

Key: ↑ Getting Better ↓ Getting Worse = No Change * Imputed Data

Health Policies	Is there a policy here?
State and local smoke-free laws	✗ No Policy
State and local plans to create age-friendly communities	✓ State Policy

Source: AARP Livability Index

AARP HEALTH LIVABILITY INDEX GILCHRIST COUNTY AREA CODE 32693.

Health

Range **National Average 50**

0 — 100

24

Health Metrics	2015		2022	2022 US Median Neighborhood
Smoking prevalence			23.6% of people smoke regularly	18%
Obesity prevalence			33.0% of adults are obese	32.2%
Access to exercise opportunities			28.3% of people have access	90.1%
Healthcare professional shortage areas	11 (Index from 0 to 25)	↓	13 (Index from 0 to 25)	0
Preventable hospitalization rate			66.7 preventable hospitalizations per 100,000 patients	48.5
Patient satisfaction	28.6% of patients are satisfied	↑	73.3% of patients are satisfied	71.8%

Key: ↑ Getting Better ↓ Getting Worse = No Change * Imputed Data

Health Policies	Is there a policy here?
State and local smoke-free laws	✗ No Policy
State and local plans to create age-friendly communities	✓ State Policy

Source: AARP Livability Index

AARP HEALTH LIVABILITY INDEX GILCHRIST COUNTY AREA CODE 32619.

Health

Range

National Average 50

0 — 21 — 100

Health Metrics	2015	2022	2022 US Median Neighborhood
Smoking prevalence		26.1% of people smoke regularly	18%
Obesity prevalence		34.5% of adults are obese	32.2%
Access to exercise opportunities		22.4% of people have access	90.1%
Healthcare professional shortage areas	9 (Index from 0 to 25) ↓	11 (Index from 0 to 25)	0
Preventable hospitalization rate		66.7 preventable hospitalizations per 100,000 patients	48.5
Patient satisfaction	28.6% of patients are satisfied ↑	73.3% of patients are satisfied	71.8%

Key: ↑ Getting Better ↓ Getting Worse = No Change * Imputed Data

Health Policies	Is there a policy here?
State and local smoke-free laws	✗ No Policy
State and local plans to create age-friendly communities	✓ State Policy

Source: AARP Livability Index

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

Health Care Access and Quality		
SDOH	**Vulnerable Populations Impacted**	**How the SDOH Impacts Hypertension**
Health Coverage Health care access among young adults with hypertension Health insurance status affects hypertension control in a hospital based internal medicine clinic	Hispanics, Blacks, Whites	Lack of health care. There are some organizations that do not offer health insurance, they provide little to no coverage. We refer individuals to Tri-County Resource Center to deal with applying for Medicaid and Medicare. If there is a lack of health coverage, they are not able to go to their doctors to get the help that they need in regard to Hypertension.
Provider Linguistic and Cultural Competency Integrating Literacy, Culture, and Language to Improve Health Care Quality for Diverse Populations	Hispanics, Blacks, Whites	Lack of cultural competency. Not taking in account how someone innately is. Everyone's needs are different if a provider does not take in account cultural differences then they have missed the mark especially in regards to Hypertension. Tailoring their health plans according to their culture and their needs can cause significant success with their hypertension goals.
Provider Availability Effect of geographic accessibility to primary care on treatment status of hypertension	Hispanics, Blacks, Whites	Lack of providers in the area is huge, For Gilchrist there is only Palms. DOH-Gilchrist tries to offer other services at the health department and have been trying to restructure how programs present ourselves to the public. If there are a lack of doctors for specialty care such as cardiovascular they are unable to get the help that they need. Also, there are a few doctors within Gilchrist County so that means less time spent with patients. Therefore, leading to less opportunities to talk about their Hypertension, Hypertensive episodes, etc.

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 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.

B. Barrier Identification

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

Gilchrist County is a very small and rural county. Within the county the same issues are heard again and again. Please see the chart below for some continual barriers that community partners have within Gilchrist County.

SDOH	Partner Barriers	Theme	Collaborative Strategies
Economic Stability	Economic Instability	• Funding. • Lack of Resources. • Lack of staff.	Applying for grants and other opportunities. Sharing the workload and resource load, so multiple organizations partnering to work towards a common goal. PACE-EH Projects.
Social and Community Context	Partnerships	• Buy-in from stakeholders. • Community Buy-in. • Shared vision.	When working towards specific goals find ways to include them – even if there is not a direct connection you can stress the importance of representation (Example: if there is a transportation issue you would

		• Alignment of goals and objectives.	have your usual partners of DOT, Road Department, etc. and the school district might not think they have a direct role, but they do because the roads are how the children get access to the schools, so just making that connection is crucial). Community buy-in can be addressed by taking a poll of the citizens, allowing them to be included in the process (if you have a needs assessment – provide surveys links where people frequently attend, make it accessible to them and even assist them in taking it) and advertising items such as town halls where they can voice their opinions to county, city, and town representatives. PACE-EH Projects.
Neighborhood and Built Environment	Infrastructure	• Transportation. • Connectivity (Broadband).	Transportation is huge in our counties. It is so rural and stretched out that a lot of times it is difficult for residents to attend doctors' appointments, go into town for groceries, etc. There is a transportation shuttle service called Suwanee River Economic Council that assists residents, home visits are huge, some agencies offer telehealth, when doing classes organizations will set up a class when residents and participants are already planning on be there. Connectivity issues are being addressed with the broadband committee, to help Gilchrist County residents in that way. PACE-EH Projects.
Education Access and Quality	Education	• Health Literacy	When advertising information to the public it is important that it can be understand at an 8th grade reading level. Stressing that importance is crucial, because the flyers,

			the brochures, the education that push out is used by and made for the consumer. Also, please note that it is important that they not only understand but are able to comprehend it. PACE-EH Projects.
Health Care Access and Quality	Providers	• Lack of hospitals. • Specialty care. • Health Insurance.	PACE-EH Projects. Referrals between different agencies. Introducing mobile care units – example at our events: Health Street came with their mobile bus and did BMI, Height, Blood Pressure, Blood Glucose, Vaccines, etc. Health Insurance: Sliding scale fees if they do not have insurance, Tri-County Resource Center helps with Medicaid/Medicare help.

C. Community Projects

The Health Equity Taskforce researched evidence-based strategies to overcome the identified barriers and improve the SDOH that impact the prioritized health disparity. The Health Equity Taskforce used this information to collaboratively design community projects to address the 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.

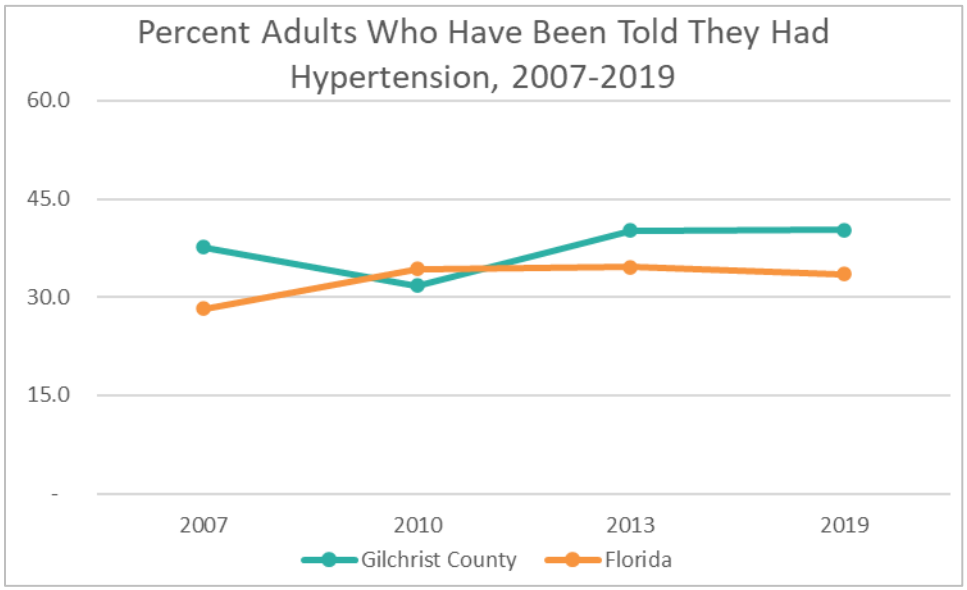
Project 1: Hypertension Education and Nutrition Education

Florida Department of Health in Gilchrist County

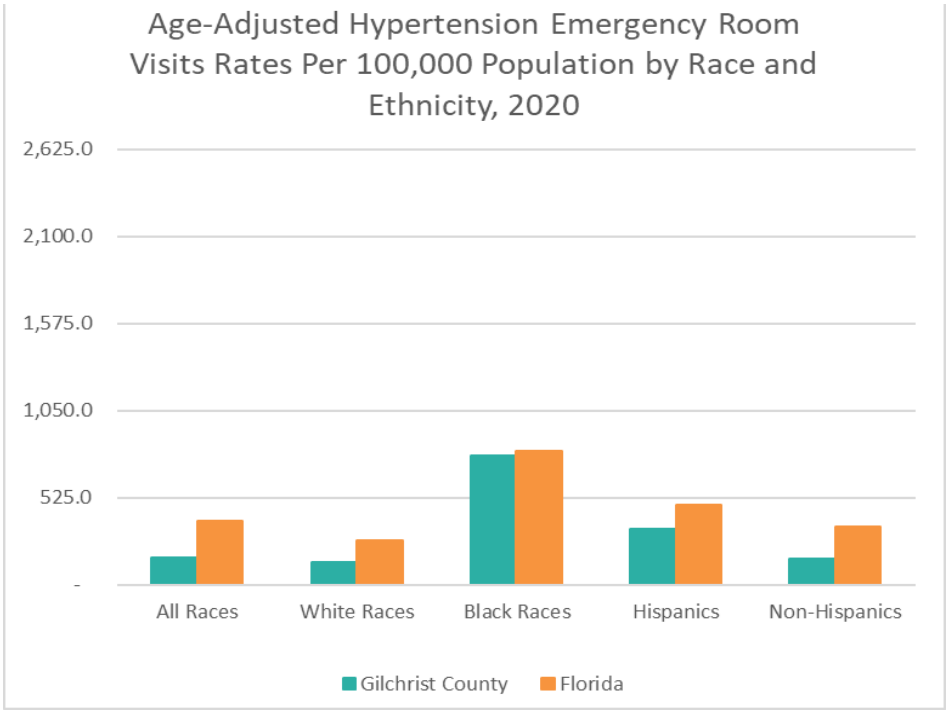
Background

- Gilchrist County has always struggled with Cardiovascular related issues. Barriers were lack of funding, lack of staff allocated to this specific project, and lack of resources that could start up a program. Gilchrist County had just missed the opportunity to be included within the Heart Health program. Staff at the Health Department, realized that the disparity for Hypertension was there and just because it had met the objectives for the Heart Health Grant at that time, did not mean that they did not deserve the opportunity to have education on high blood pressure and nutrition education.
- Rates of hypertension are always on the incline within these rural counties, and a lot of it is lack of education. If an individual is seen at a provider office, the doctor may not always have the time to explain all that goes into being diagnosed with hypertension. The doctor has a plethora of patients and sometimes even when there is an opportunity for questions, patients do not even know where to start.
- That is where the Health Department can come in. Providing education is crucial, because it gives them the opportunity to go into a doctor's office and be able to understand what is being said. It gives them the opportunity to have autonomy over their health and be accountable for keeping up with their health. A 4 month or 4-week class will be implemented focused on Introductory topics about Hypertension and then moving onto Nutrition Education Courses.
- Education should be a priority for all aspects of health because you cannot make systematic changes without first addressing lack of education. Please note, regarding program requirements there will be none, everyone deserves the opportunity to be educated and have these tools that will make them successful in life.
- When looking at Hypertensive data, not just for the county, but nationwide averages, priority populations that should and are being addressed are African Americans and Hispanic individuals. DOH-Gilchrist offers the classes in both Spanish and English and we have data specific to our priority populations and for all populations of Gilchrist County.
- Education is crucial, but so are partnerships with other external partners. Gilchrist County Health Department will also look to starting a referral program, so that the program can provide education to the residents and give them the tools to lead a happy and healthy life.

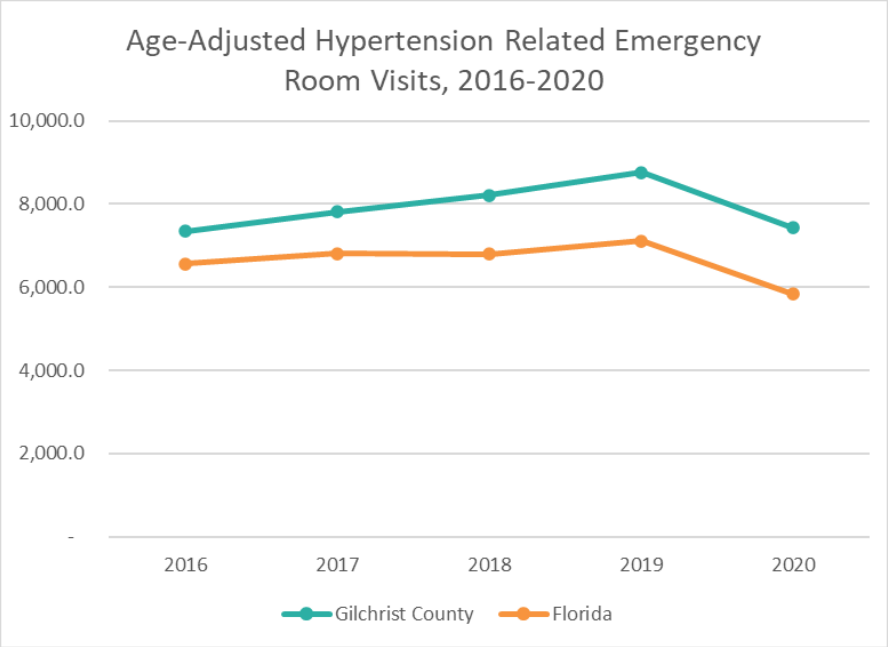
1. Data and Infographics



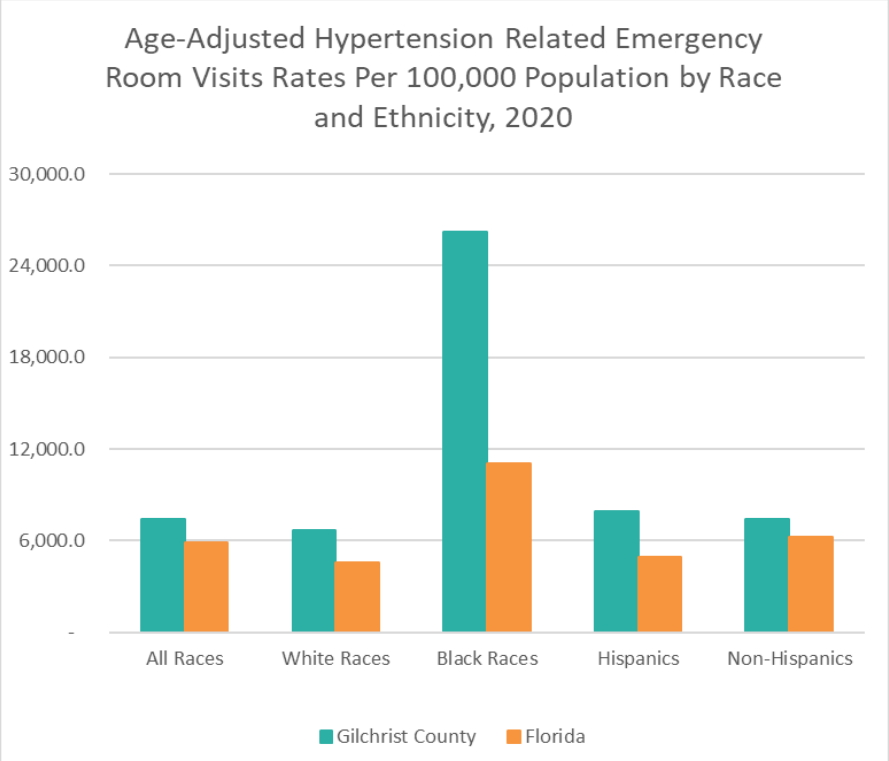
Source: Florida Behavioral Risk Factor Surveillance System Telephone Survey (BRFSS), 2007-2019



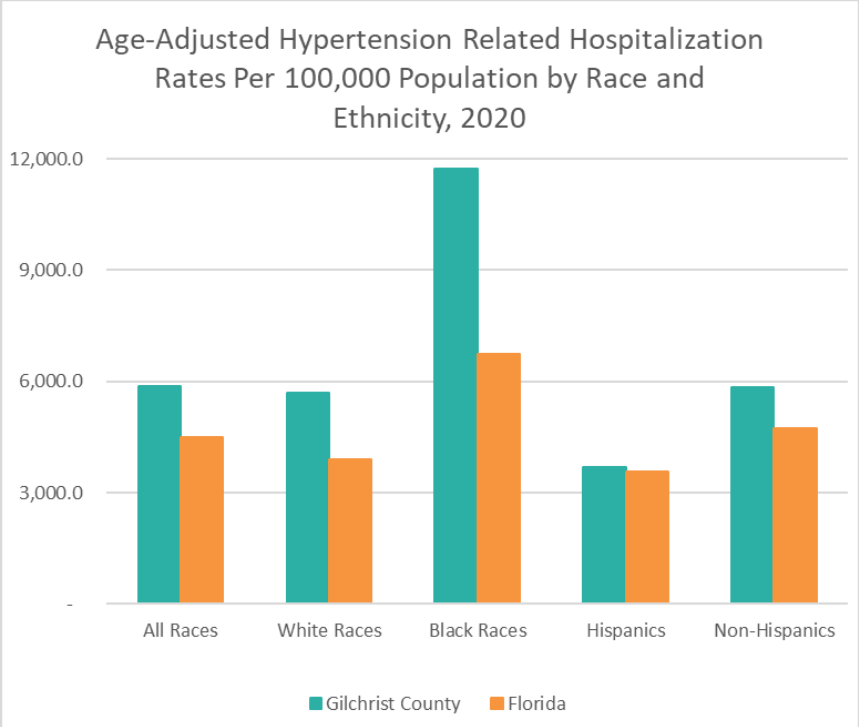
Source: Florida Agency for Health Care Administration, 2020



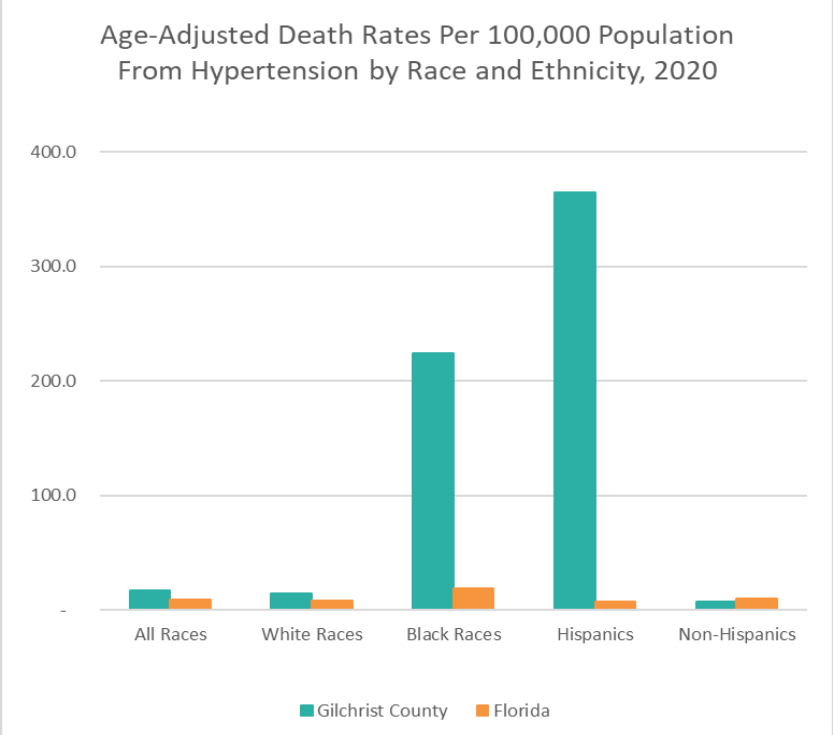
Source: Florida Agency for Health Care Administration, 2016-2020



Source: Florida Agency for Health Care Administration, 2020



Source: Florida Agency for Health Care Administration, 2020



Source: Florida Department of Health, Bureau of Vital Statistics, 2020

2. Description and Deliverables

- Currently Gilchrist County has high rates of Hypertension. Secondary data collection was done to look at rates and determine priority populations. Once data was shifted through, decisions through the Gilchrist CHIP/Health Equity Task Force were completed, so that progress could be made towards developing a Heart Health Program.
- Overall, DOH-Gilchrist wanted to make sure that effective, equitable, understandable, and respectful quality care and services that is responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. Also, to promote inclusivity staff offers classes in not just English, but Spanish as well. All information will be transcribed into Spanish for those that need that service. Language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
- Future partnerships of enlisting agencies such as FQHC's in the area for the referral system, and UF IFAS Family Nutrition Program to provide demonstration of Heart Healthy Foods on a budget are being done at this time.

3. Goals and Objectives – please see Health Equity Plan Objectives Table - Hypertension Education and Nutrition Education

4. Progress

- As of June 15th, 2022, groundwork for the program is being completed. Advertising the program through flyers, word of mouth, etc. is being done.

SDOH: Health and Health Care: addressed by creating a referral system with local partners of the FQHC's, health centers, quick centers, etc. that will help with our Hypertension patients.

SDOH: Education: Creating a new program that consists of educational classes on our prioritized disparity of Hypertension with a focus on nutrition education and introductory topics of Hypertension.

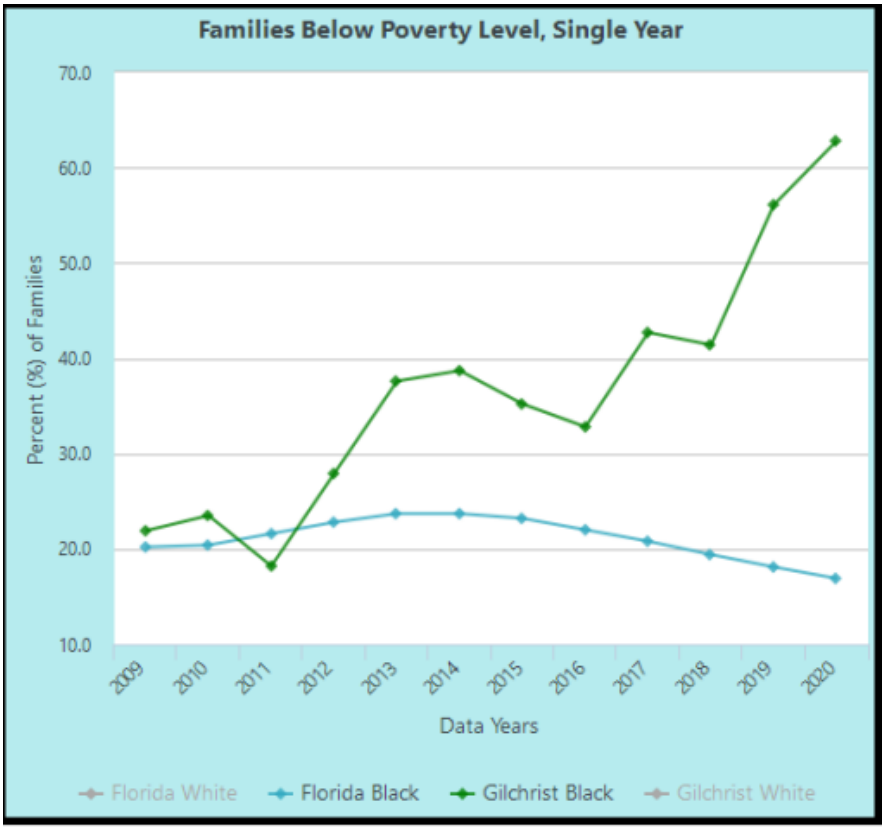
Project 2: Summer Camp

Gilchrist County Prevention Coalition

1. Background

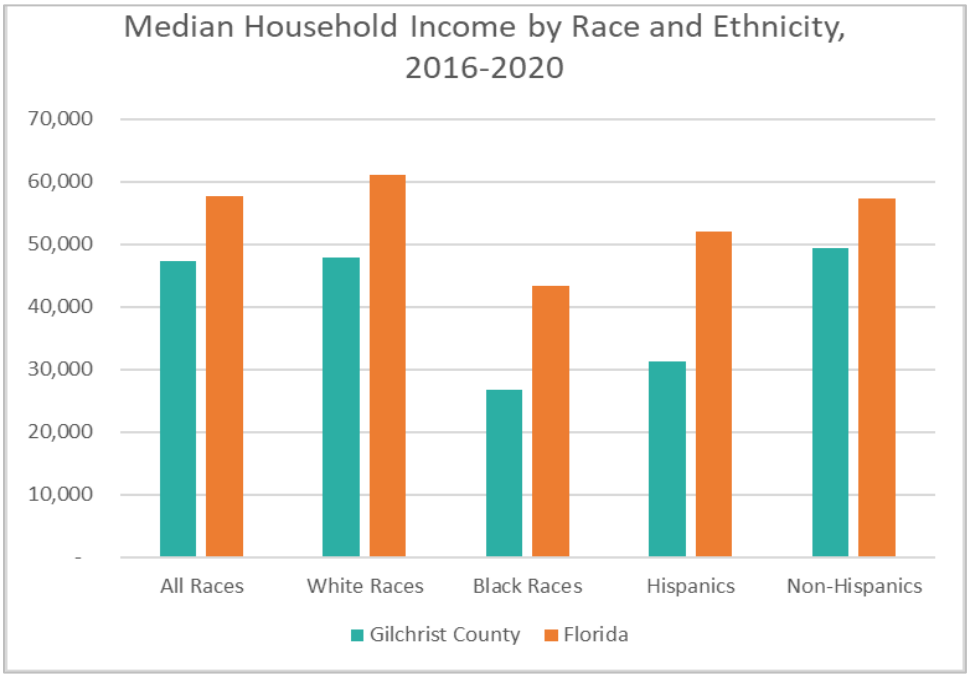
- By starting with our youth population, the community believes that it will be beneficial. While they may not be the populations that are specifically struggling with stroke, hypertension, etc. it is important to speak with them early on and stress the importance of nutrition and exercise. The projects that DOH-Gilchrist would help with will have a focus on cardiovascular health – why it is important to eat right to keep your heart healthy, why it is important to exercise to strengthen their bodies and increase overall health.
- "Pediatric hypertension is on the rise. Over the last 30 to 40 years, pediatric hypertension in the United States has increased fourfold. Currently up to 4.5 percent — or 3.34 million — of children in the United States have this condition. Recent American Heart Association heart disease and stroke statistics suggest the number affected may be higher, estimating that 15 percent of adolescents have abnormal blood pressure. While the reason for the increase in pediatric hypertension is not entirely clear, many consider it to be due to the coincident obesity epidemic." – John Hopkins Medicine. retrieved from https://www.hopkinsmedicine.org/health/conditions-and-diseases/high-blood-pressure-hypertension/pediatric-hypertension
- It is important to work on this summer camp because it will be a free resource for parents and guardians. Poverty rates in Gilchrist County can be an issue, especially for our priority populations, so by providing a free resource hopefully it will relieve them of that issue. The priority populations of African Americans and Hispanics need the opportunity to have access to childcare, transportation, etc. Barriers are that there are no existing summer camps in the area, pricing for summer camps, transportation to and from the facility, etc.
- These barriers are hard to address especially in Gilchrist County because of funding and having enough organizations and workers to make it successful and utilized by our county. There always is an issue of finding who will fund these opportunities, so we are looking at partnering with other organizations and grant opportunities. Regarding staffing, by partnering with external partners and have them either teach a weeks' worth of material or once a week for 6 weeks will help lessen that load.
- It is important to note that the Gilchrist County community has a member of our priority population that is taking the lead with this project. He can provide the community with an opportunity to voice their concerns and is there to gather any feedback that can help make this summer camp into a program that is accessible for not only our priority population, but for all individuals.

2. Data and Infographics

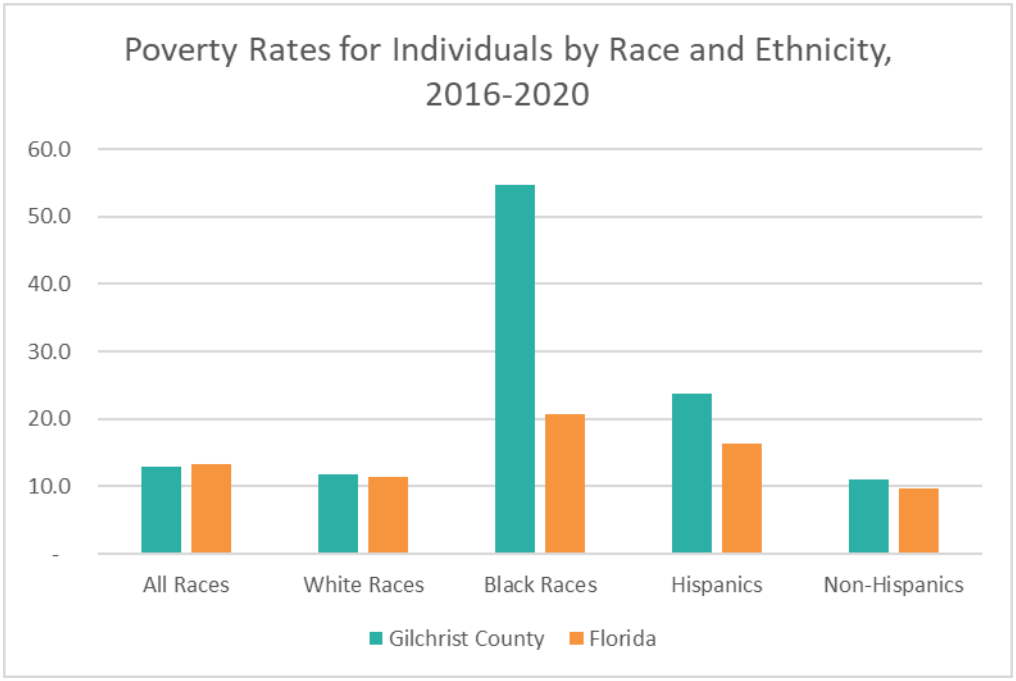


Source: Florida Health Charts

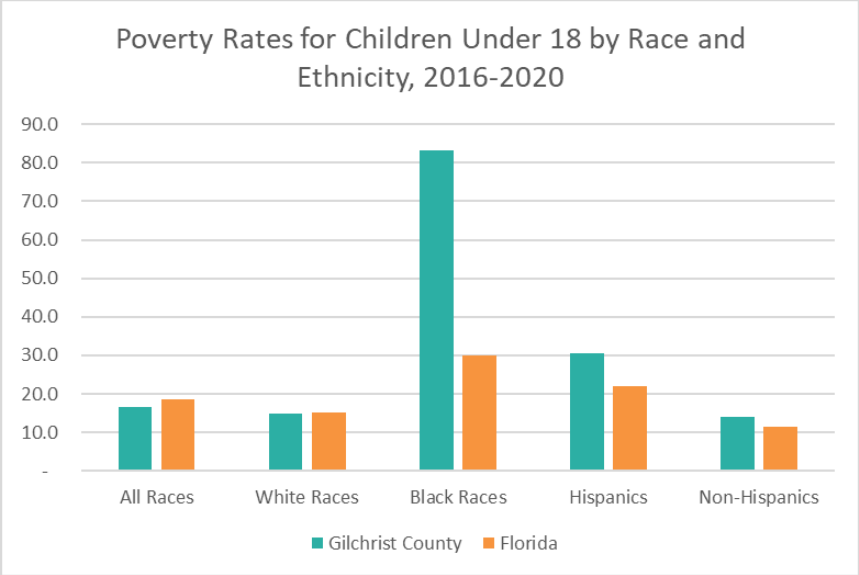
Source: Florida Health Charts



Source: US Census Bureau, American Community Survey, Table B19013, 2016-2020



Source: US Census Bureau, American Community Survey, Tables B17001 and DPO30, 2016-2020



Source: US Census Bureau, American Community Survey, Tables B17001 and DPO30, 2016-2020

3. Description and Deliverables

- Gilchrist County Prevention Coalition has participated in previous summer camps and when looking at the need for not only educational opportunities for the kids, but free transportation opportunities and accessible summer camp pricing.
- Once data was shifted through, decisions through the Gilchrist CHIP/Health Equity Task Force were completed, so that progress could be made towards developing a Heart Health Program.
- Overall, effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs are to be provided. All information will be transcribed into Spanish for those that need that service. Language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services will be offered. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
- Future partnerships will be looked at to see if there are any opportunities to garner funding through sponsorships through agencies or if there are agencies that have grants or programs that can help with funding, etc.

4. **Goals and Objectives – please see Health Equity Plan Objectives Table - Hypertension Education and Nutrition Education**

5. **Progress**

- As of June 15th, 2022, groundwork for the program is being completed. Future updates to come.

Project 2 Notes

SDOH: Social and Community Context: Providing children with opportunities to connect with other kids and providing that social cohesion.

SDOH: Education: Early Childhood Education and Development that is specifically targeted to address cardiovascular issues, while making sure that we are using words, terms and phrases that are appropriate for their specific age-group. Summer camp will be focused on educating these children with the partnership of external partners – each external partner will base educational materials off specific themes for the week. For example: the health department can educate on handwashing, physical activity, nutrition, etc. It provides an opportunity to educate the young kids on different types of programs. Also, there are teachers on staff that help with educating the students, so there will be an education network in place for these individuals that directly has to do with the school.

SDOH: Neighborhood and Built Environment: Providing a transportation resource for children to and from the summer camp, so that they can attend these programs that will educate them about heart health issues.

SDOH: Economic Stability: Providing a FREE summer camp. Summer camps in our area range from 50-120 dollars, which our residents are unable to pay for due to poverty levels.

Project 3: Roads

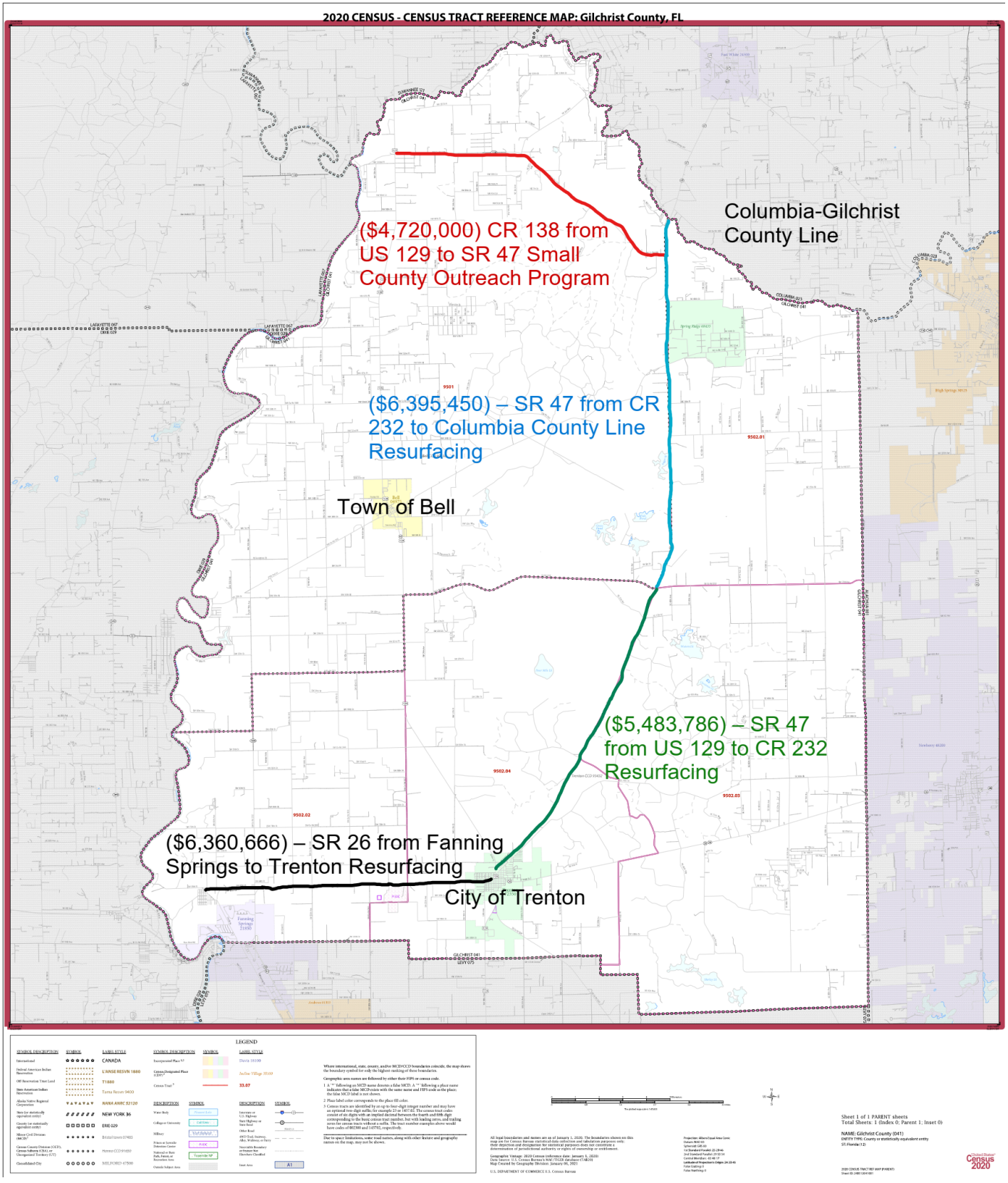
Gilchrist County Board of County Commissioners

1. Background

- Gilchrist County always has a need for resurfacing roads and overall bridge and road maintenance. Throughout the year Gilchrist County keeps in constant communication with the Road Department. The Road Department gives ideas of which roads need updating and vice versa. As a County residents rely on the expertise of the Road Department on determining which roads need to be fixed.
- The following roads that are being utilized for the Gilchrist County-specific needs will be funded following the Governor's signing of the 2022-2023 General Appropriations Act:
  ($6,360,666) – SR 26 from Fanning Springs to Trenton Resurfacing
  ($6,395,450) – SR 47 from CR 232 to Columbia County Line Resurfacing
  ($5,483,786) – SR 47 from US 129 to CR 232 Resurfacing
  ($4,720,000) – CR 138 from US 129 to SR 47 Small County Outreach Program
- Small County Outreach Program: The purpose of this program is to assist small county governments in repairing or rehabilitating county bridges, paving unpaved roads, addressing road-related drainage improvements, resurfacing, or reconstructing county roads, or constructing capacity or safety improvements to county roads.

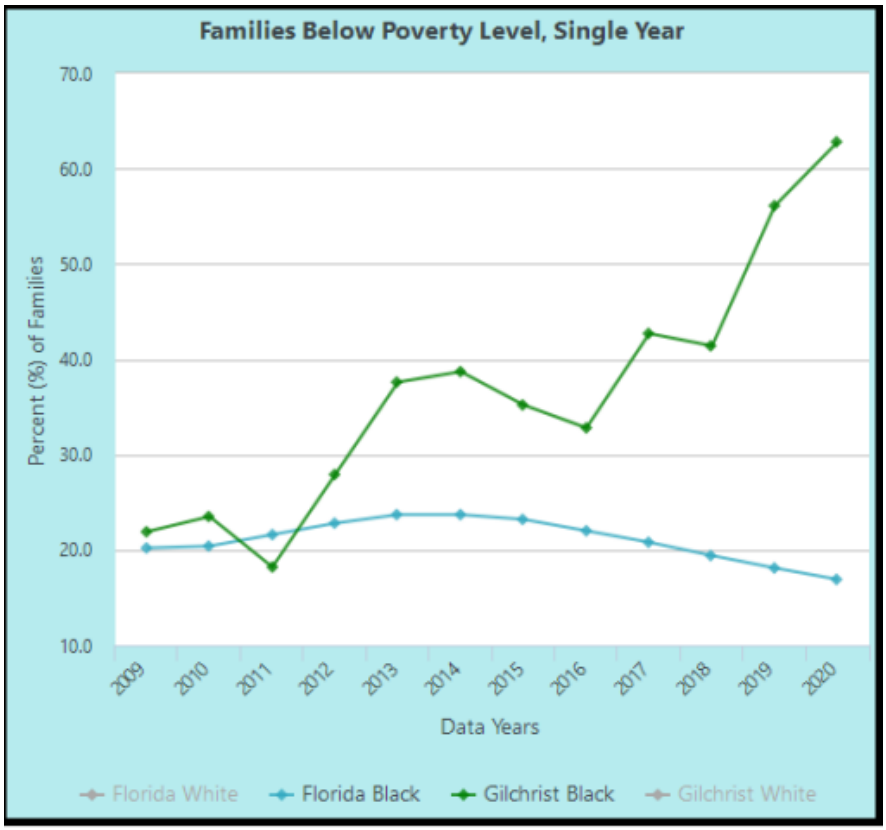
  – FDOT https://www.fdot.gov/programmanagement/LP/SCOP/Default.shtm
- If there are any specific roads that residents would like fixed the Gilchrist County Board of County Commissioners have a Road Department Work Request where you can list what roads/streets that need to be fixed and the description of work needed.

2. Data and Infographics

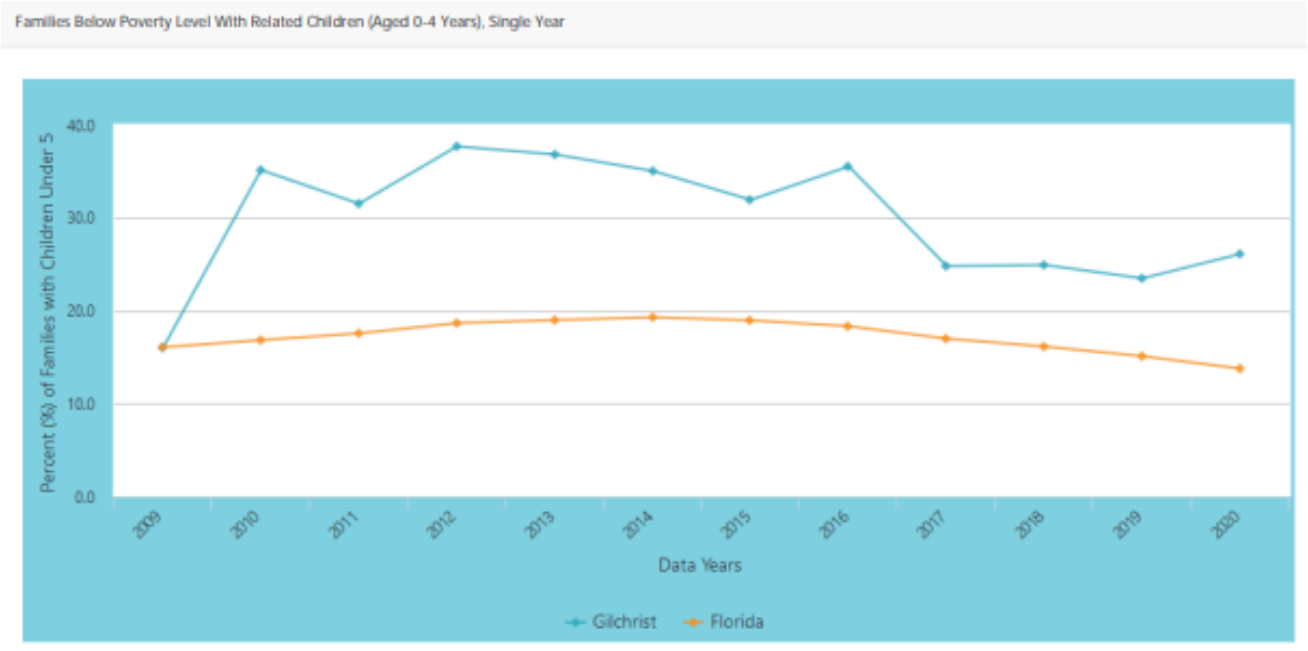


Gilchrist County Road Department Work Request – click here to access the form.

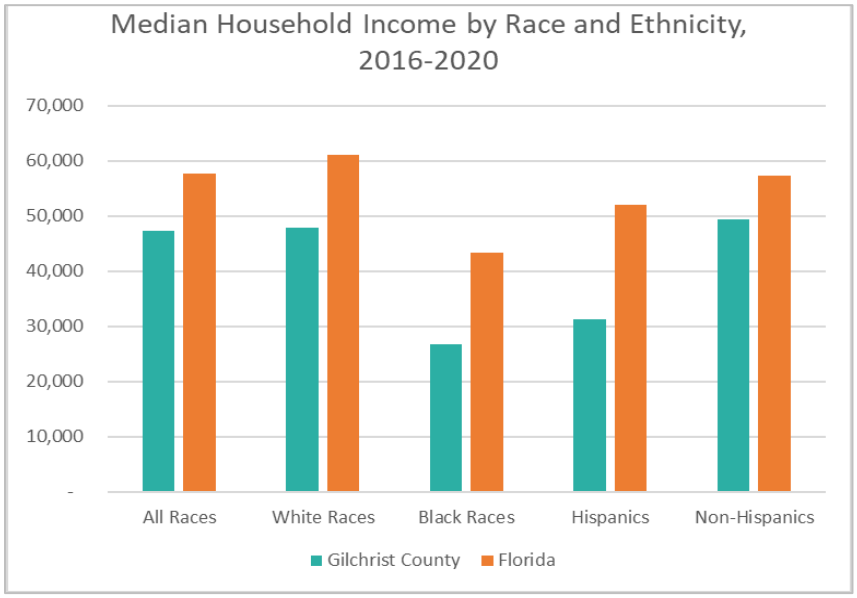
Source: Gilchrist County Board of County Commissioners – Road Department Work Request



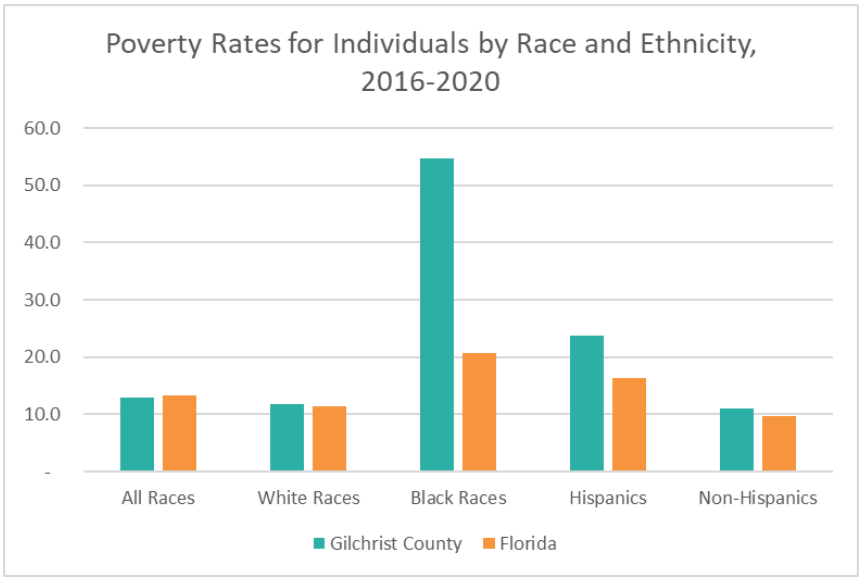
Source: Florida Health Charts



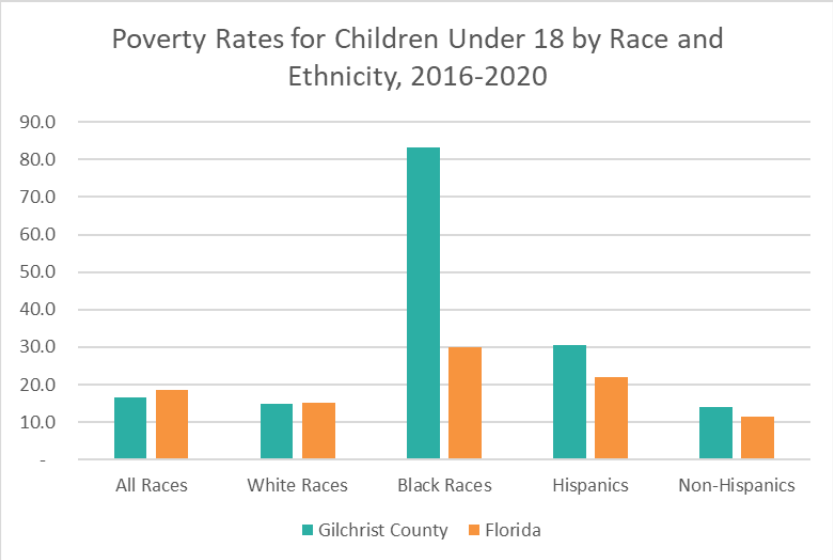
Source: Florida Health Charts



Source: US Census Bureau, American Community Survey, Table B19013, 2016-2020



Source: US Census Bureau, American Community Survey, Tables B17001 and DPO30, 2016-2020



Source: US Census Bureau, American Community Survey, Tables B17001 and DPO30, 2016-2020

3. Description and Deliverables

- When addressing roads within Gilchrist County the community can fill out an application on the Board of County Commissioners Website that will ask the applicant to fill out their contact information, the road that is in questions, and any pictures of the road issues. Residents of the county can also speak with our board members and speak about roads that they are concerned about. The data is compiled within the system and then the Road Department and the Board convene at their regularly scheduled meetings and discuss the possibility of funding, time, resources, etc. There they vote on what roads can and will be worked on.
- Now with the Funding that was received for Gilchrist County they can work on some roads that need maintenance. Many are major county roads or roads that will connect you to the county or state roads.
- Since roads have already been decided, there is still a wait on the funding to funnel down to the appropriate channels.

4. **Goals and Objectives – please see Health Equity Plan Objectives Table - Hypertension Education and Nutrition Education**
5. **Progress**

- As of May 11th, 2022, the roads have been decided according to the 2022-2023 General Appropriations Act.

Project 3 Notes:

SDOH: Neighborhood and Built Environment: Working on bettering our infrastructure and our environmental conditions.

SDOH: Health and Health Care: If our roads are better, it provides better driving conditions for our residents to visit their doctors, providers, and other health facilities.

SDOH: Economic Stability: If our roads are better people can travel to and from their jobs.

SDOH: Education: Our school district utilizes these roads to transport children to and from school.

SDOH: Social and Community Context: Roads are also the center of how people are able to connect with friends, family, etc. They have to have a safe road to travel.

Project 4: Broadband

Gilchrist County School District and Gilchrist County Broadband Committee

1. Background

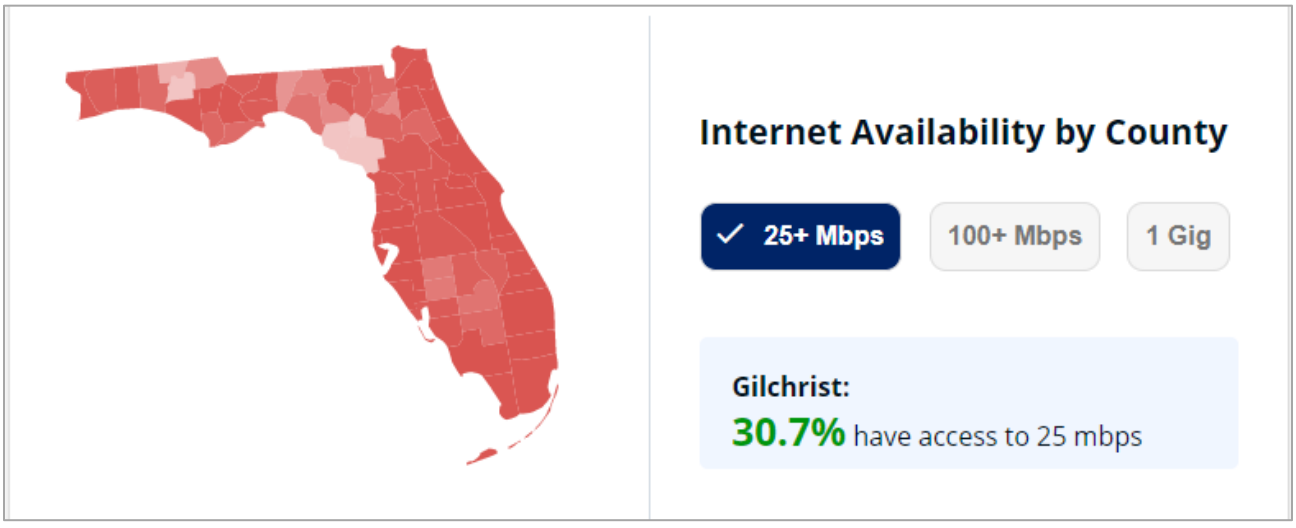
- Gilchrist County has struggled with broadband issues for a very long time. There is a surplus of issues that stems from broadband issues. Without a reliable internet connection, it really causes a barrier for residents no matter what situation they are dealing with. If they want to use internet for healthcare, schooling, to connect socially, etc. they are unable to do so. The infrastructure is just not there, and people have been struggling with it for a long time.
- Governor DeSantis also announced his intent to approve a $400 million appropriation supporting Florida's Broadband Opportunity Grant Program and a $30 million appropriation for the state's Rural Infrastructure Fund.
- The Broadband Opportunity Grant Program will provide grant funding to expand high-speed internet connection to communities in need of the essential service, addressing historical broadband deficiencies and paving the way for future economic growth. The Rural Infrastructure Fund, administered by DEO, is used to facilitate the planning, preparation, and financing of infrastructure projects in rural communities. Funded projects encourage job creation, capital investment, and the strengthening and diversification of rural economies.
- With broadband it can get very expensive rather quickly. If counties want to run fiber wire for instance throughout the county, steep installation cost for expanding broadband in sparsely populated regions is a huge issue.

2. Data and Infographics

100 Mbps Coverage By County, Highest and Lowest

Highest		Lowest	
Pinellas	99.95%	Liberty	0%
Brevard	99.93%	Calhoun	0.27%
Seminole	99.85%	Dixie	0.40%
Orange	99.60%	Levy	7.25%
Hillsborough	99.56%	Jefferson	20.03%
Manatee	99.47%	Gilchrist	25.49%
Broward	99.36%	Washington	31.31%
Palm Beach	99.04%	Holmes	34.79%
Flagler	98.95%	Glades	41.83%
Osceola	98.93%	Bradford	47.04%

Source: BroadbandNow.com



Source: BroadbandNow.com

Internet Access in Trenton, Florida

The average download speed in Trenton is 7.28 Mbps. This is 95.8% slower than the average in Florida and 1458.0% slower than the national average.

- There are 8 internet providers in Trenton with 4 of those offering residential service
- Trenton is the 400th most connected city in Florida behind Bell, Newberry, Bronson, Old Town, and Chiefland.
- Fiber optic internet is available to just 1% of Gilchrist County residents.

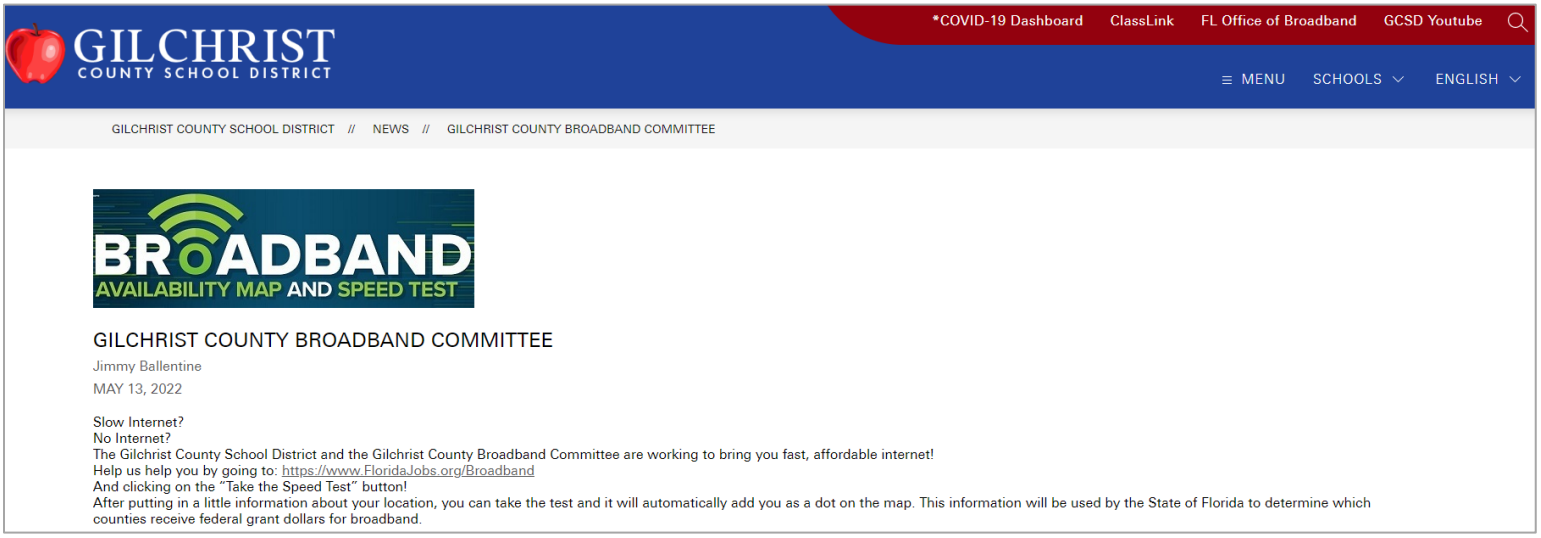
Source: BroadbandNow.com

Internet Access in Bell, Florida

The average download speed in Bell is 14.34 Mbps. This is 91.6% slower than the average in Florida and 690.9% slower than the national average.

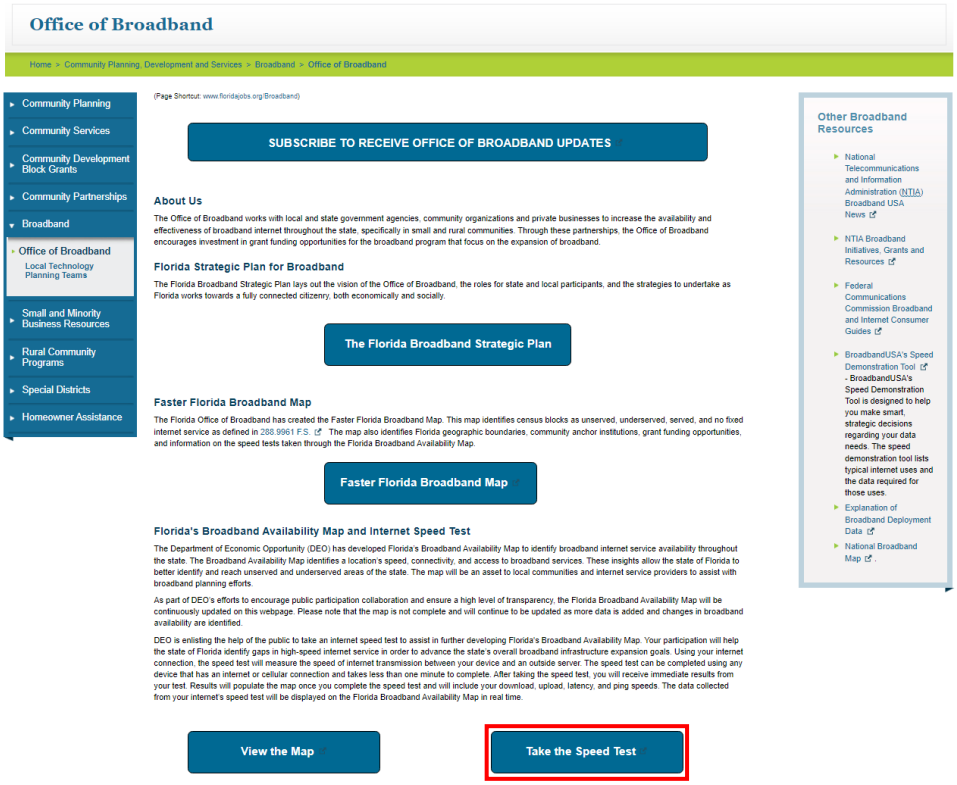
- There are 7 internet providers in Bell with 4 of those offering residential service
- Bell is the 251st most connected city in Florida ahead of Newberry, Fort White, Old Town, Trenton, and Branford.
- Florida is the 9th most connected state in the U.S.
- 88% of Bell residents are still severely limited in wired broadband choices.

Source: BroadbandNow.com



Gilchrist County Broadband Committee - News Article – Click here to access the article.

Source: Gilchrist School District



Residents can take this speed test and it will add them as a dot on the map, from there the information will be used to determine which counties are to receive funding.

Office of Broadband - Take the Speed Test – click here to access the speed test and the map.

Source: Florida Department of Economic Opportunity: Office of Broadband

3. Description and Deliverables

- Gilchrist County is an extremely rural community that needs better opportunities for broadband across the board. Without broadband opportunities there are so many issues such as kids are unable to do their schoolwork, people are unable to utilize services such as telehealth, they cannot even browse the internet, etc. From there a committee was made to look at different avenues and gather enough data, so that funding can be rewarded.
- “Slow Internet? No Internet? The Gilchrist County School District and the Gilchrist County Broadband Committee are working to bring you fast, affordable internet! Help us help you by going to: https://www.FloridaJobs.org/Broadband and clicking on the “Take the Speed Test” button! After putting in a little information about your location, you can take the test and it will automatically add you as a dot on the map. This information will be used by the State of Florida to determine which counties receive federal grant dollars for broadband.” – Gilchrist School District

4. **Goals and Objectives – please see Health Equity Plan Objectives Table - Hypertension Education and Nutrition Education**
5. **Progress**

- As of May 13th, the link is advertised and up on the Gilchrist County School District website.

Project 4 Notes:

SDOH: Neighborhood and Built Environment: Working on bettering our infrastructure and our environmental conditions.

SDOH: Health and Health Care: If residents have broadband, then residents can work on extending healthcare framework and work on items such as telehealth.

SDOH: Economic Stability: By eliminating the barriers of distance and time, these networks enable rural residents to participate in the modern world's economy.

SDOH: Education: Efforts to expand K-12 and postsecondary education, can be negatively impacted by limited access to broadband. By completing this project, the Gilchrist County community is addressing this disparity.

SDOH: Social and Community Context: Being in the modern age, internet and broadband allows us to connect with people which is crucial to allow people to socially feel connected to one another.

Project 5: Trenton City Park

Trenton City Council

1. Background

- The Trenton City Council is working towards revamping the Trenton City Park. First on the agenda, there has been a focus on cleaning up the environment and the space. They have cleared some trees in the area to provide an outdoor seating area with picnic tables and new garbage cans. From there the hope is to implement bigger projects that will focus on the importance of utilizing the park. The creation of a PACE-EH project will be beneficial because the connection of multiple external partners. Hopefully with multiple funding resources, staffing and resources we can create something that will benefit the public.
- What is PACE-EH? PACE EH (Protocol for Assessing Community Excellence in Environmental Health) is a program developed by the National Association of County & City Health Officials (NACCHO) and the Centers for Disease Control and Prevention (CDC) to assess and improve the environmental health of communities. The philosophy and methodology offered in PACE EH incorporates the notion that environmental health (one of the foundations of public health) is protected and improved most effectively when it is defined, understood, and acted upon locally. It is a collaborative effort between residents, local government, and other stakeholders. The bottom line is the prevention of illness, injury and death related to environmental factors through educational outreach, human behavior change, and county and community collaborations. We identify environmental health issues that are important to the community and develop and implement actions plans to address these issues.
- If resources are put into our park, it allows the opportunities for a safe space for people to exercise, congregate, hold events, and overall enjoy. Parks are environments that are not only for children, but adults as well. If we can pick a PACE-EH program that can focus on what we can give to better the community then we will be in good shape.
- A current project within the park is the creation of a shuffleboard court. This idea was brought forth to the Trenton City Council and after unanimous decision it was passed. The City of Trenton would work towards using the existing racquetball court which is dilapidated and unusable to something hopefully all residents will enjoy.

2. Data and Infographics

Protocol for Assessing Community Excellence in Environmental Health:
Tool for Community Environmental Health Assessment

Many communities face disproportionate health risks. Environmental factors and underlying economic and social challenges can generate some of those risks. And a lack of trust between residents and government can worsen them. The Protocol for Assessing Community Excellence in Environmental Health (PACE EH) offers a method for engaging communities to identify their health concerns, take action on their environmental health problems, and improve their health and quality of life.

Protocol for Assessing Community Excellence in Environmental Health

PACE EH is a community involvement tool. The National Association of County and City Health Officials (NACCHO) and the Centers for Disease Control and Prevention (CDC) collaborated to develop it. PACE EH guides communities and local health officials in conducting community-based environmental health assessments. PACE EH draws on community collaboration and environmental justice principles to involve the public and other stakeholders in

- Identifying local environmental health issues,
- Setting priorities for action,
- Targeting populations most at risk, and
- Addressing identified issues.

Why Use PACE EH in Your Community?

Most importantly, PACE EH processes can lead to action on those environmental health issues that both affect health and address community needs. The Florida Department of Public Health used a PACE EH process in the community of Wabasso. Private and public leaders in Wabasso identified their top health issues as

- Safe and healthy housing,
- Community safety from violence and drug trafficking,
- Street lighting,
- Accessible areas for safe physical activity and recreation,
- Access to safe drinking water, and
- Solutions to septic system failures and access to a municipal wastewater system.

National Center for Environmental Health
Division of Emergency and Environmental Health Services

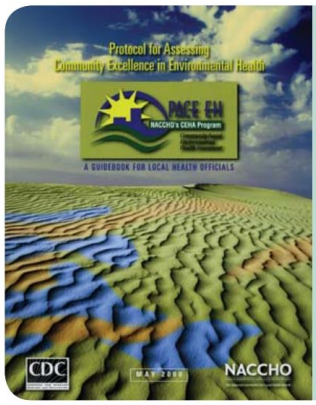
CS218117A

The PACE EH process led to several civic improvements. Streetlights and sidewalks were installed. Abandoned homes were removed and existing homes repaired. Water lines were installed, septic systems improved, and parks enhanced, including addition of a walking trail. The local health agency could not address these problems on its own. But health agency staff often knew whom to contact within the local government or community. Because of the improvements, survey respondents reported several benefits. Outdoor physical activity increased (80%), sense of well-being improved (94%), and trust in government to address concerns increased (91%). A $30,000 investment in the local health department's staff time yielded more than $1.5 million in improvements.

Not all communities that have undertaken PACE EH have conducted short- and long-term impact evaluations. Still, a process evaluation across several sites noted that implementing a community environmental health assessment such as PACE EH resulted in

- Built networks and collaboration
- Improved knowledge and skills in environmental health and collaboration
- Increased awareness of environmental health concerns
- Increased trust between collaborators
- Strengthened perception of the health agency as leader

PACE EH can also help to implement several of the 10 Essential Environmental Public Health Services. These services are modeled on the 10 Essential Public Health Services and can be a tool for quality improvement. One of the services is to inform, educate, and empower people about environmental health issues, and another is to mobilize community partnerships and actions to identify and solve environmental health problems. PACE EH can also help assure a competent environmental health workforce—another essential service. PACE EH improves the environmental health decision-making process by strengthening community involvement so that public values and priorities are considered.



PACE EH and Community Involvement Resources

Several free resources are available for local health officials and community organizations:

www.cdc.gov/nceh/ehs/ceha

http://www.naccho.org/topics/environmental/CEHA/

http://www.cdc.gov/nceh/ehs/Home/HealthService.htm

http://www.cdc.gov/od/ocphp/nphpsp/essentialphservices.htm

Source: CDC – PACE-EH
Protocol for Assessing Community Excellence in Environmental Health

Sample Survey Tool

(The following tool was designed for Allegheny County's Environmental Comparative Risk Project and is reprinted with permission from Professor Paul S. Fischbeck, Department of Engineering and Public Policy, Carnegie Mellon University, Pittsburgh, PA)

Part 1. As you know, we are interested in evaluating and ranking health and environmental risks in Allegheny County. At the last meeting, many of you filled out a questionnaire listing what you considered some of those risks to be. At this meeting, we would like to find out the answer to a related, but different question: What is it about a particular risk that makes it a concern? We know that we want to consider the impact each risk has on human health, on the eco-system, and on quality of life, but we would like to define these major types of impacts more clearly – to know what specific factors (or impacts) characterize these impacts.

In the spaces below, please list the risk impacts that you consider important under each of these major categories. Please spend about 5 minutes and list as many factors as you can. To help you think about this, you might consider the following questions:

> At the end of this project, you will rank issues in the county, with the "worst" risk at the top. What factors do you think will characterize the "worst" risk?
>
> Do not list the risks themselves, instead consider what it is about a risk that makes it a concern.
>
> Imagine that you are being asked to rank two risks that have exactly the same expected health impacts (in terms of fatalities and illnesses). What questions would you ask to help distinguish between these risks? How would you decide which is the greater risk?

Human Health:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Eco-System:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

PACE EH
NACCHO's CEHA Program
Community-based Environmental Health Assessment

Quality of Life:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Part 2. Below are 18 of the most frequently mentioned risks from the last meeting (in random order). Please look them over and circle the 5 that you consider to be the greatest risks in Allegheny County.

Indoor air pollution

Depletion of natural resources

Hazardous waste disposal

Drinking water quality

Motor vehicle accidents

Loss of biodiversity

Violence

Use/abuse of alcohol & controlled substances

Natural disasters

Food safety

Water pollution

Infectious diseases

Ambient (outdoor) air pollution

Pesticides

Global climate change

Overpopulation

Radon

AIDS

Now please write down those 5 risks in the numbered spaces below (on the left). In the column on the right, list the factors that distinguish these risks from the other risks listed above. Why do you consider these five to be the most important?

1. _____ _____

_____

_____

_____

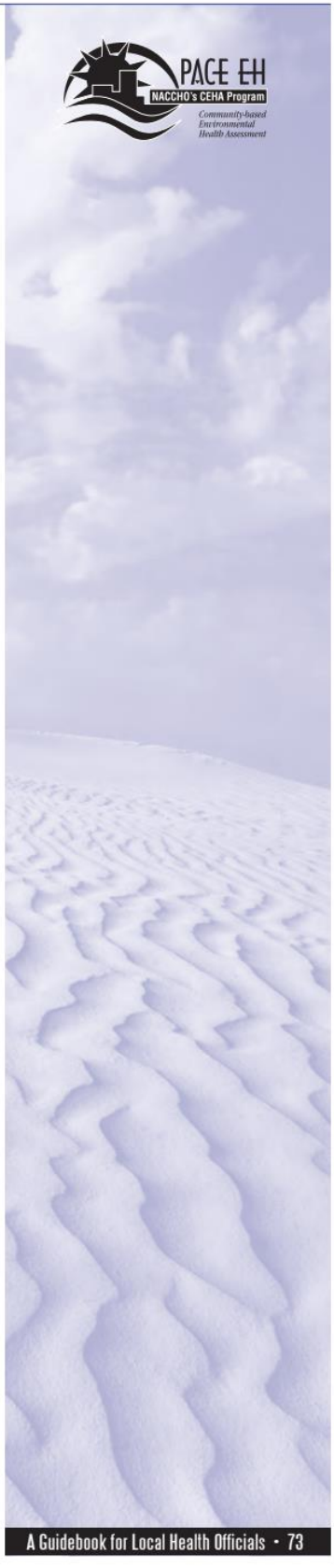
_____

2. _____

3. _____

4. _____

5. _____


PACE EH
NACCHO's CEHA Program
Community-based Environmental Health Assessment

PACE EH
NACCHO's CEHA Program
Community-based Environmental Health Assessment

Part 3. Below you will see several pairs of risks. For each pair, please circle the one that you consider to be the greater risk, and tell us why you feel that it is so. If you do not have an opinion as to which is greater, list what you would like to know about the risks in order to decide.

Indoor air pollution or **Drinking water quality**

Why? _____

_____

Radon in the home or **Violence**

Why? _____

_____

Infectious diseases or **Loss of habitat**

Why? _____

_____

AIDS or **Natural disasters**

Why? _____

_____

Motor vehicle accidents or **Food safety**

Why? _____

_____

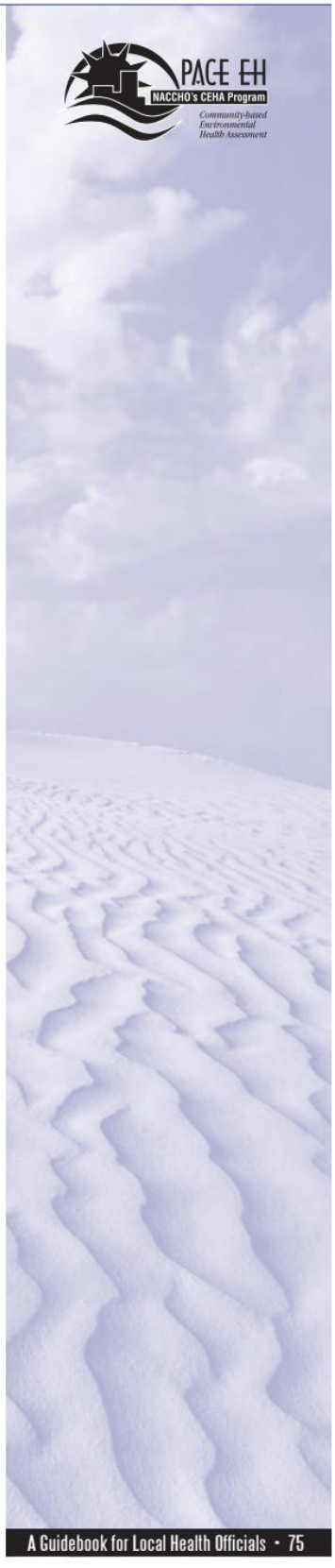
Part 4. Now look back at the issues and factors that you considered in thinking about the questions on the previous two pages of this survey. If there are any factors that you did not list on the first page, please fee free to add them to the list. In considering all of these factors, please list what you consider to be the three most important factors in each major category.

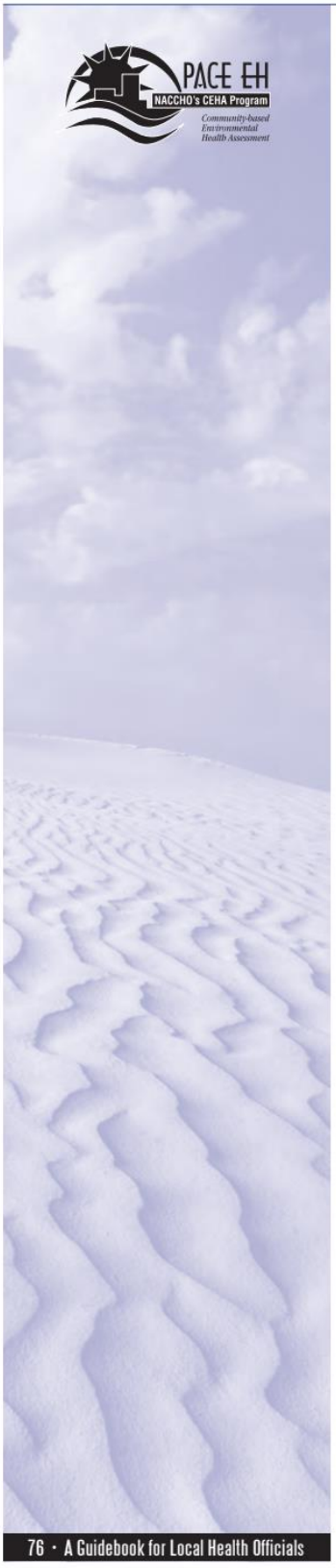
Human health	Most important factor:	_____
	Second most important:	_____
	Third most important:	_____
Eco-systems	Most important factor:	_____
	Second most important:	_____
	Third most important:	_____
Quality of Life	Most important factor:	_____
	Second most important:	_____
	Third most important:	_____

Part 5. Below are six risks that have been mentioned on the previous survey. Using the seven-point scales on the right, please rate each risk.

Please circle the appropriate number	When this risk occurs, how likely is it that the consequence will be fatal?	To what extent are the impacts from this risk changing?
Indoor air pollution	1 2 3 4 5 6 7 certain not to be fatal — certain to be fatal	1 2 3 4 5 6 7 increasing greatly — decreasing greatly
Radon	1 2 3 4 5 6 7 certain not to be fatal — certain to be fatal	1 2 3 4 5 6 7 increasing greatly — decreasing greatly
Infectious diseases	1 2 3 4 5 6 7 certain not to be fatal — certain to be fatal	1 2 3 4 5 6 7 increasing greatly — decreasing greatly
Motor vehicle accidents	1 2 3 4 5 6 7 certain not to be fatal — certain to be fatal	1 2 3 4 5 6 7 increasing greatly — decreasing greatly
Natural disasters	1 2 3 4 5 6 7 certain not to be fatal — certain to be fatal	1 2 3 4 5 6 7 increasing greatly — decreasing greatly
Drinking water quality	1 2 3 4 5 6 7 certain not to be fatal — certain to be fatal	1 2 3 4 5 6 7 increasing greatly — decreasing greatly

	To what extent can people, by their actions, prevent mishaps or illnesses from this risk from occurring?	To what extent is the risk of death from this cause immediate—or is death likely to occur at some later time?
Indoor air pollution	1 2 3 4 5 6 7 much control — little control	1 2 3 4 5 6 7 effect immediate — effect delayed
Radon	1 2 3 4 5 6 7 much control — little control	1 2 3 4 5 6 7 effect immediate — effect delayed
Infectious diseases	1 2 3 4 5 6 7 much control — little control	1 2 3 4 5 6 7 effect immediate — effect delayed
Motor vehicle accidents	1 2 3 4 5 6 7 much control — little control	1 2 3 4 5 6 7 effect immediate — effect delayed





Natural disasters	1 2 3 4 5 6 7 much control — little control	1 2 3 4 5 6 7 effect immediate — effect delayed
Drinking water quality	1 2 3 4 5 6 7 much control — little control	1 2 3 4 5 6 7 effect immediate — effect delayed

	To what extent are these risks understood by science?	**How many people are exposed to these risks in Allegheny County?**
Indoor air pollution	1 2 3 4 5 6 7 risk levels known precisely — risk levels not known precisely	1 2 3 4 5 6 7 few — many
Radon	1 2 3 4 5 6 7 risk levels known precisely — risk levels not known precisely	1 2 3 4 5 6 7 few — many
Infectious diseases	1 2 3 4 5 6 7 risk levels known precisely — risk levels not known precisely	1 2 3 4 5 6 7 few — many
Motor vehicle accidents	1 2 3 4 5 6 7 risk levels known precisely — risk levels not known precisely	1 2 3 4 5 6 7 few — many
Natural disasters	1 2 3 4 5 6 7 risk levels known precisely — risk levels not known precisely	1 2 3 4 5 6 7 few — many
Drinking water quality	1 2 3 4 5 6 7 risk levels known precisely — risk levels not known precisely	1 2 3 4 5 6 7 few — many

Part 6. Please complete the following.

1. Highest level of formal education:
   - ❒ Some high school
   - ❒ Completed high school
   - ❒ Some college or trade school
   - ❒ Completed college
   - ❒ Graduate school

2. Are you: ❒ Homeowner ❒ Renter ❒ Live with family or friends without rent

   What is your Zipcode: _____

3. Number of people who live with you: _____

4. Your approximate age is: ❒ 20 or under ❒ 21-40 ❒ 41-60 ❒ Over 60

5. How would you describe your health over the past few years?
   - ❒ Excellent
   - ❒ Good
   - ❒ Fair
   - ❒ Poor

6. Your Sex: ❒ M ❒ F

7. What is your present status? ❒ Employed ❒ Unemployed ❒ Student ❒ Retired

8. How would you describe your career?
   - ❒ Homemaker
   - ❒ "White collar"
   - ❒ "Blue collar"
   - ❒ Service/clerical/secretarial

9. Do you consider yourself to be active in the environmental movement? ❒ Yes ❒ No

10. How often do you read newspapers?
    ❒ daily, over 30 min. ❒ daily, under 30 min. ❒ occasionally ❒ rarely

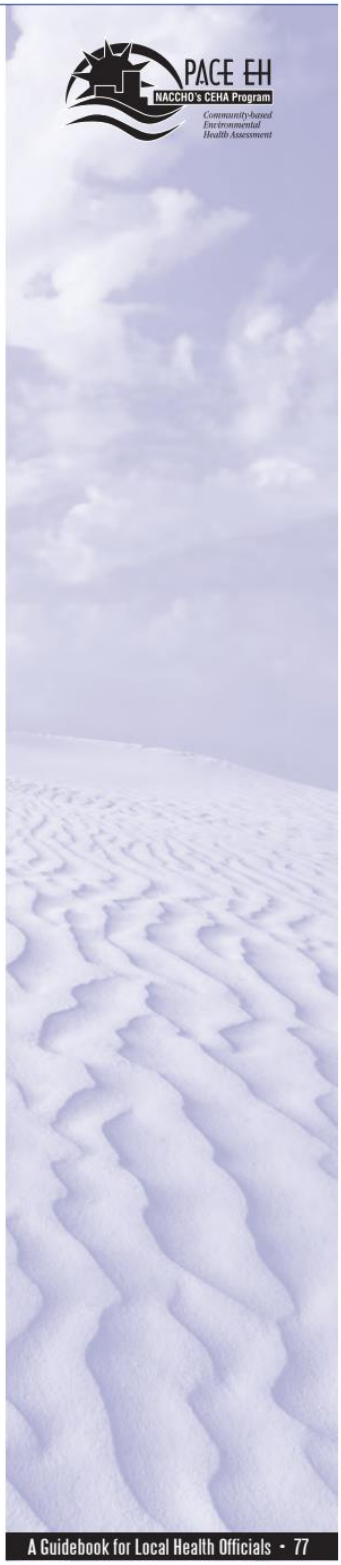
    How often do you read magazines?
    ❒ daily, over 30 min. ❒ daily, under 30 min. ❒ occasionally ❒ rarely

    How often do you read books?
    ❒ daily, over 30 min. ❒ daily, under 30 min. ❒ occasionally ❒ rarely

11. How often do you watch TV?
    ❒ daily, over 60 min. ❒ daily, under 60 min. ❒ occasionally ❒ rarely

    How often do you watch TV news, news magazines, science or health shows?
    ❒ daily, over 30 min. ❒ daily, under 30 min. ❒ occasionally ❒ rarely

Thank you for helping out with the project.



Source: [Protocol for Assessing Community Excellence in Environmental Health (PACE EH) (cdc.gov)] – click here for additional information on PACE-EH.

3. Description and Deliverables

- Overall, community partners are looking to provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. When choosing a PACE-EH project that will be at the forefront of our mind.
- With PACE-EH Projects it is important to involve the community. By creating a taskforce, multiple agencies can gather to conduct this project. It not only helps with staffing, but also the pooling of resources. Also, this information can be brought forth into town hall meetings. These are the individuals who oversee the park and the projects that are being run.

4. Goals and Objectives – please see Health Equity Plan Objectives Table – Trenton City Park.

5. Progress

- As of May 23rd, Gilchrist County is awaiting Duke Energy to remove meter boxes for the creation of the shuffleboard court. PACE-EH taskforce will be created and will start working towards creating a project.

Project 5 Notes:

SDOH: Neighborhood and Built Environment: Green spaces usually are safe places; it can foster environments where neighborhoods support and protect each other. It also is a great place that people can walk, and exercise.

SDOH: Economic Stability: Parks enhance things such as property values, increase government revenue and bring forth homebuyers. People like the idea of peaceful living and if

they are by the park they have opportunities for leisure activities, children have a safe space to play and adults can congregate and meet to do group exercises, socialize, etc.

SDOH: Education: When at parks kids are at hands-on learning environments. They are able to learn how to critically think about how to utilize the playground. They learn new ways to utilize playground equipment which helps with not only their minds, but their dexterity as well.

SDOH: Social and Community Context: Community engagement is huge. If you put money back into the community it allows people to congregate in a central location and allows not only kids, but parents the opportunities to build relationships. Kids can meet new friends; adults are able to connect. It overall allows for an opportunity to be around others, and it is a conducive environment for social cohesion.

IX. HEALTH EQUITY PLAN OBJECTIVES

A. Hypertension

- **Health Disparity Objective: By June 30, 2027, reduce the age-adjusted rate per 100,000 population of Deaths from Hypertension (all populations) in Gilchrist County from a rate of 17.2 (2020) to 15.2 (2027).**

Project 1: Hypertension Education and Nutrition Education

SDOH: Health and Health Care, Social and Community, and Education	Lead Entity and Unit	Lead Point Person	Data Source	Baseline Value	Target Value	Plan Alignment
Long-Term SDOH Goal: Conduct Heart Health Classes for the Gilchrist County Residents and implement a referral system between partners.						
Objective: By June 30th, 2027, create a referral system between existing organizations such as FQHC's, Health Centers, and Quick Cares from 0 to 1.	FDOH – Gilchrist County	Jan Gonthier	Florida Health CHARTS, Million Heart Campaign, Heart Healthy Ambassadors	0	1	Community Health Improvement Plan, Community Health Assessment, Strategic Plan
By June 30th, 2026, complete Blood Pressure Self-Monitoring classes for Gilchrist County Residents from 0 classes to 10.	FDOH – Gilchrist	Jan Gonthier	Florida Health CHARTS, Million Heart Campaign, Heart Healthy Ambassadors	0	10	Community Health Improvement Plan, Community Health Assessment, Strategic Plan

Medium-Term SDOH Goal: Implement a Heart Health Class for Gilchrist County Residents that focuses on nutrition education and introductory topics to blood pressure self-monitoring.						
Objective: By December 31st, 2023, partner with local agencies such as UF IFAS Family Nutrition Program from 0 agencies to 3 agencies.	FDOH-Gilchrist County	Jan Gonthier, Katie Trimm, DeeDee Smith	Florida Health CHARTS, Million Heart Campaign, Heart Healthy Ambassadors	0	3	Community Health Improvement Plan, Community Health Assessment, Strategic Plan
Objective: By December 31st, 2023, implement a free heart health class that focuses on nutrition education and blood pressure self-monitoring from 0 programs in the county to 1 program.	FDOH – Gilchrist County	Jan Gonthier	Florida Health CHARTS, Million Heart Campaign, Heart Healthy Ambassadors	0	1	Community Health Improvement Plan, Community Health Assessment, Strategic Plan
Short-Term SDOH Goal: Create a Heart Health Education Class for Gilchrist County Residents. Spanish and English Versions available.						
Objective: By July 30th, 2022, create a blood pressure cuff loaner program for participants from 0 to 1.	FDOH – Gilchrist County	Jan Gonthier	Florida Health CHARTS, Million Heart Campaign, Heart Healthy Ambassadors	0	1	Community Health Improvement Plan, Community Health Assessment, Strategic Plan

Objective: By December 31, 2022, create a heart health program similar to the Million Hearts Campaign promoted by the Centers for Disease Control.	FDOH – Gilchrist County	Jan Gonthier	Florida Health CHARTS, Million Heart Campaign, Heart Healthy Ambassadors	0	1	Community Health Improvement Plan, Community Health Assessment, Strategic Plan

Project 2: Summer Camp

SDOH: Social and Community Context, Education, Neighborhood and Built Environment, Economic Stability	**Lead Entity and Unit**	**Lead Point Person**	**Data Source**	**Baseline Value**	**Target Value**	**Plan Alignment**
Long-Term SDOH Goal: Create a transportation system for the summer camp children.						
Objective: By June 30th, 2026, provide a transportation service to and from the summer camp from 0 to 1.	Gilchrist County Prevention Coalition	Robert Wells	Community Partnership with local elementary schools.	0	1	CHIP, CHA
Medium-Term SDOH Goal: Create a free summer camp program for Gilchrist County Children since there are no free summer programs available within the county.						
Objective: By June 30th, 2024, provide a free summer camp for Gilchrist County Elementary school-aged children from 0	Gilchrist County Prevention Coalition	Robert Wells	Community Partnership with local elementary schools.	0	1	CHIP, CHA

free camps available in the county to 1.						
Objective: By June 30th, 2024, coordinate with local businesses, organizations, chamber of commerce, to discuss funding allocation or sponsorships from 0 to 10.	Gilchrist County Prevention Coalition	Robert Wells	Community Partnership with local elementary schools.	0	10	CHIP, CHA
Short-Term SDOH Goal: Research funding for grants and create a partnership group of interested parties.						
Objective: By August 30th, 2023, create a partnership group to decide funding and implementation from 0 to 1.	Gilchrist County Prevention Coalition	Robert Wells	Community Partnership with local elementary schools.	0	1	CHIP, CHA
Objective: By December 31st, 2022, research and compile a list of 3 grants for funding purposes from 0.	Gilchrist County Prevention Coalition	Robert Wells	Community Partnership with local elementary schools.	0	3	CHIP, CHA

Project 3: Roads

SDOH: Neighborhood and Built Environment, Health and Health Care Access, Economic Stability	Lead Entity and Unit	Lead Point Person	Data Source	Baseline Value	Target Value	Plan Alignment
Long-Term SDOH Goal: With the money allocated for Gilchrist County have the 4 roads chosen resurfaced or maintained accordingly.						
Objective: By December 31st, 2025, Gilchrist Counties roads will be completed and resurfaced from 0 roads to 4.	Board of County Commissioners (BOCC)	BOCC	Community Input-Town Hall and, County Meetings	0	1	BOCC Objectives.
Medium-Term SDOH Goal: Award project funds to the necessary organization that will be conducting the work.						
Objective: By September 30th, 2022, conduct and complete a notice of bids from 0 to 1.	Board of County Commissioners	BOCC	Community Input-Town Hall and County Meetings	0	1	BOCC Objectives.
Short-Term SDOH Goal: Funding to be allocated to specific programs within Gilchrist County for the implementation on resurfacing and pouring new roads.						
Objective: By May 11th, 2022, allocate funds and choose which roads are to be resurfaced or created within Gilchrist County from 0 roads to 4 roads.	Board of County Commissioners	BOCC	Community Input-Town Hall and County Meetings	0	4	BOCC Objectives.

Project 4: Broadband

	Lead Entity and Unit	Lead Point Person	Data Source	Baseline Value	Target Value	Plan Alignment
Long-Term SDOH Goal: Have a broadband system set up for Gilchrist County Residents.						
Objective: By December 31st, 2027, create a county-wide broadband system change for Gilchrist County residents from 0 to 1.	Gilchrist County School District (GCSD) and Gilchrist County Broadband Committee	Darby Allen	Community Needs Assessment and Community Input.	0	1	CHIP, CHA
Medium-Term SDOH Goal: Complete the application process, implement the necessary plans, and secure funding.						
Objective: By January 31st, 2024, begin the application process and from there create an implementation plan from 0 to 1 after securing the necessary funding.	GCSD and Gilchrist County Broadband Committee	Darby Allen	Community Needs Assessment and Community Input.	0	1	Board of County Commissioners Objectives.
Objective: By May 13th, 2022, create a broadband committee from 0 to 1 and establish all the necessary bylaws.	GCSD and Gilchrist County Broadband Committee	Darby Allen	Community Needs Assessment and Community Input.	0	1	Board of County Commissioners Objectives.

Short-Term SDOH Goal: Advertise a link for Gilchrist County Residents to complete that will help with funding allocation.						
Objective: By May 11th, 2022, advertise a link to a speed test on the Gilchrist County School Districts website for Gilchrist County Residents to complete and have 50 people complete the survey from 0.	Gilchrist County School District and Gilchrist County Broadband Committee	Darby Allen	Community Needs Assessment and Community Input.	0	50	Board of County Commissioners Objectives.

Project 5: Trenton City Park

SDOH: Neighborhood and Built Environment	Lead Entity and Unit	Lead Point Person	Data Source	Baseline Value	Target Value	Plan Alignment
Long-term SDOH Goal: Provide parkland and a variety of recreation facilities and programs to meet the changing recreational needs and desires of the City of Trenton's population.						
By June 30th, 2027, provide recreational facilities that address the needs of all age groups, young and old, active, and passive, and in all socio-economic categories from 3 recreational facilities (Community center, playground, seating areas) to 4.	City of Trenton	City of Trenton	Community Input – Town Hall and County Meetings, Community Needs Assessment	3	4	City of Trenton Council Objectives.
Medium-Term SDOH Goal 1: Create and implement a PACE-EH project for the City of Trenton Park. Goal 2: Create a new shuffleboard court.						
Goal 2: Objective: By June 30th, 2027, create a shuffleboard court from 0 to 1 for City of Trenton Residents.	City of Trenton	City of Trenton	Community Input – Town Hall and County Meetings	0	1	City of Trenton Council Objectives.

Goal 1: Objective: By June 30th, 2027, implement a PACE-EH project for the City of Trenton from 0 to 1.	City of Trenton / FDOH – Gilchrist	City of Trenton / FDOH – Gilchrist	Community Input – Town Hall and County Meetings	0	1	City of Trenton Council Objectives. CHIP PACE-EH
Goal 1: Objective: December 31st, 2024, develop an implementation plan based off the PACE-EH project chosen from 0 to 1.	City of Trenton / FDOH – Gilchrist	City of Trenton / FDOH – Gilchrist	Community Input – Town Hall and County Meetings	0	1	City of Trenton Council Objectives. CHIP PACE-EH
Goal 1: Objective: By June 30th, 2024, create a PACE-EH project for the City of Trenton Park from 0 to 1.	City of Trenton / FDOH – Gilchrist	City of Trenton / FDOH – Gilchrist	Community Input – Town Hall and County Meetings	0	1	City of Trenton Council Objectives. CHIP PACE-EH
Goal 1: Objective: By January 31st, 2023, create a PACE-EH task force of existing community members and town council members from 0 to 1.	City of Trenton / FDOH – Gilchrist	City of Trenton / FDOH – Gilchrist	Community Input – Town Hall and County Meetings	0	1	City of Trenton Council Objectives. PACE-EH CHIP, PACE-EH

Short-Term SDOH Goal: Park Clean-up and general revamping of the park. Goal 2: Funding process decision making for City of Trenton Shuffleboard Court.						
Goal 1: Objective: By May 30th, 2022, create a new outside seating area for park residents from 4 picnic tables to 7 and from 3 trash cans to 6.	City of Trenton	City of Trenton Council	Community Input – Town Hall and County Meetings	4 picnic tables 3 trash cans	7 picnic tables 6 trash cans	City of Trenton Council Objectives.
Goal 2: Objective: By March 28th, 2022, received quotes for the removal and demolition of the current racquetball court from 0 to 1.	City of Trenton	City of Trenton Council	Community Input – Town Hall and County Meetings	0	1	City of Trenton Council Objectives.
Goal 2: Objective: By March 14th, 2022, receive bids for the pole barn structure that will be built from 0 to 4 bids received.	City of Trenton	City of Trenton Council	Community Input – Town Hall and County Meetings	0	4	City of Trenton Council Objectives.

X. PERFORMANCE TRACKING AND REPORTING

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

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

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

XI. ADDENDUM – HEALTH EQUITY COALITION

Name	Title	Organization	Social Determinant of Health
Robert Wells	CEO	Gilchrist Prevention Coalition	neighborhood and built environment, economic stability, education, social and community context.
Darby Allen	Assistant Superintendent/District Title IX Coordinator	Gilchrist County School District	education
Beverly Goodman	Manager	Tri-County Resource Center and Partnership for Strong Families	education access and quality, health care access and quality, neighborhood and built environment, social and community context, and economic stability.
Cloud Haley	Vice-Mayor	City of Trenton	neighborhood and built environment, economic stability, education, social and community context.
Marcia Hellams	Commissioner	City of Trenton	neighborhood and built environment, economic stability, education, social and community context.
Craig Ruede	Commissioner	City of Trenton	education access and quality, health care access and quality, neighborhood and built environment, social and community context, and economic stability.
Randy Rutter	Commissioner	City of Trenton	neighborhood and built environment, economic stability, education, social and community context.
Lyle Wilkerson	City Manager	City of Trenton	neighborhood and built environment, economic stability, education, social and community context.
David “Duke” Lang, Jr.	City Attorney	City of Trenton	education access and quality, health care access and quality, neighborhood and built environment, social and community context, and economic stability.

Captain Sheryl Brown	Captain	Gilchrist County Sherriff's Office	neighborhood and built environment, social and community context, and economic stability.
Thomas Brown	Mayor	Town of Bell	education access and quality, health care access and quality, neighborhood and built environment, social and community context, and economic stability.
Kenny Bass	Councilmember	Town of Bell	education access and quality, health care access and quality, neighborhood and built environment, social and community context, and economic stability.
Gary Blankenship	Councilmember	Town of Bell	education access and quality, health care access and quality, neighborhood and built environment, social and community context, and economic stability.
Michael Moore	Councilmember	Town of Bell	education access and quality, health care access and quality, neighborhood and built environment, social and community context, and economic stability.
Christopher Sandlin	Councilman	Town of Bell	education access and quality, health care access and quality, neighborhood and built environment, social and community context, and economic stability.
Kathryn M Lancaster	Financial Advisor	Edward Jones/Alzheimer's Association	education access and quality, health care access and quality, neighborhood and built environment, social and community context, and economic stability.
Christine Smith	President	Gilchrist County Women's Club	education access and quality, neighborhood and built environment, social and community context,

XII. ADDENDUM – LITERARY SOURCES

A. Hypertension Data Section Sources

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C. Socioeconomic Status and Hypertension Sources

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XIII. 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