DOH-Orange Health Equity Plan

July 2022 – December 2025

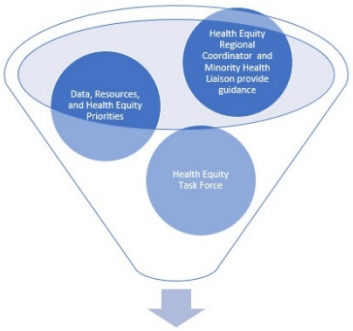
Florida HEALTH Orange County

Table of Contents

I. VISION

Achieving Health Equity encompasses so much more than focusing only on reducing disparities in clinical care and providing education to the priority population. It's about addressing the social determinants of individuals and population health through leader driven priority, developing structures and processes that support equity and partnering with community organizations to make system level changes.

The Health Equity Team and the Health Equity Taskforce are the multiprogram/multisector partners formed to address the identified disparity in Orange County by strategically addressing the social determinants of health that negatively influence populations that experience health disparity. These partners further extend the efforts of the county Community Health Improvement Plan (CHIP) to improve the quality of life of Orange County residents.



Health Equity Vision

To best execute Orange County's Health Equity Plan an overall vision was created. After researching local data on several health disparities and discussion among the Health Equity Team and Health Equity Task Force, it was a consensus of the group to adopt as a vision, "All Orange County residents are healthy through the use of high-quality health and wellness services provided within their communities."

The identified disparity outlined in this plan is based on the review of primary and secondary data from various sources. Based on this data, the Heath Equity Taskforce decided to focus on Black infant mortality as the identified health disparity, focusing on community projects geared towards addressing all social determinants of health. The commitment, continuous engagement, and dedication of the taskforce serves as the foundation to effectively take a collaborative approach towards improving birth outcomes in our community.

II. PURPOSE OF THE HEALTH EQUITY PLAN

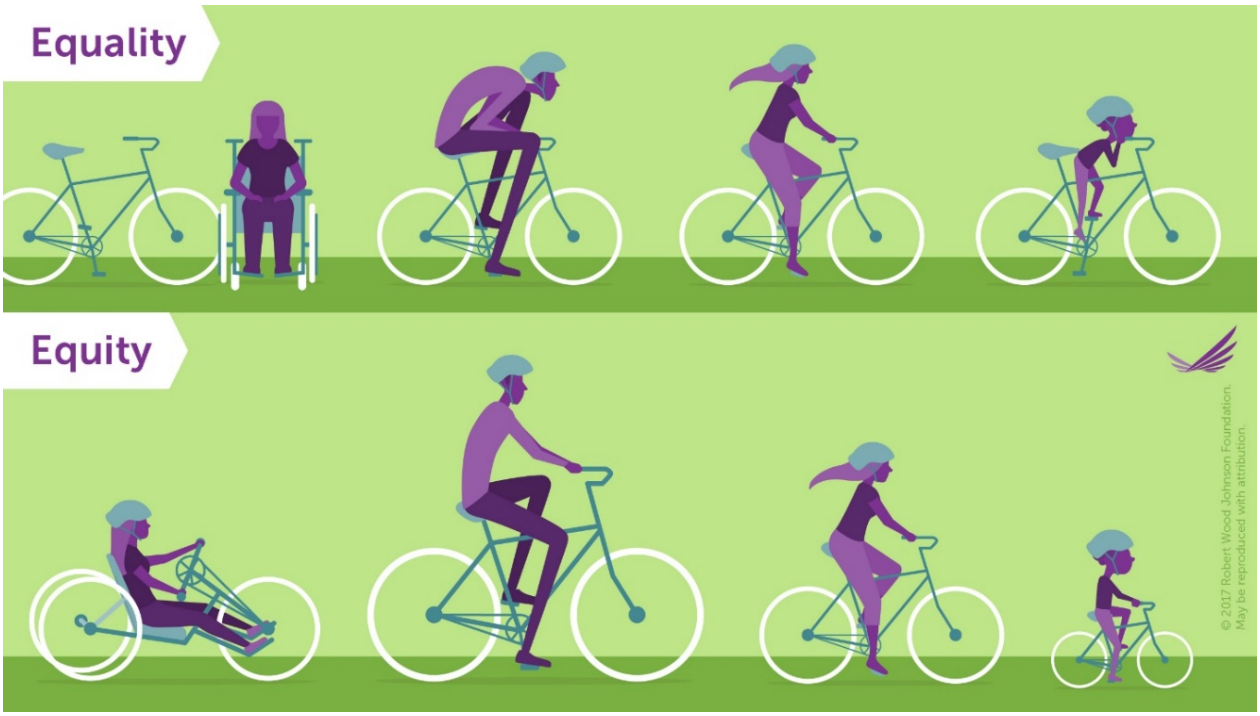
Health Equity is achieved when everyone can attain optimal health.

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

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

The purpose of the Health Equity Plan is to increase health equity within Orange County. To develop this plan, the Florida Department of Health in Orange County 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 Orange 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 on 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 groups have to achieve optimal health, leading to avoidable differences in health outcomes.

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

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

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

Culturally and Linguistically Appropriate Services: The National CLAS Standards are a set of 15 action steps intended to advance health equity, improve quality, and help eliminate health care disparities by providing a blueprint for individuals and health and health care organizations to implement culturally and linguistically appropriate services.

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.

Throughout the process of creating the Health Equity Task Force, a myriad of cross-sector partners has come aboard to collectively identify and address the SDOH most effective at reducing health disparities. Several strategies were employed to recruit and engage collaboration including incorporating members of the Community Health Improvement Plan (CHIP). In the early planning stage for the National Minority Health Month (NMHM) event, a local university contacted our office to offer major support, by having students enrolled in one of their courses, assist in the planning and implementation of the event. To further recognize NMHM, Health Equity Heroes are nominated by their peers for their commitment to accelerating health equity throughout the community. Many of the awardees joined the Task Force after being recognized. Other partners expressed interest after hearing presentations about the Health Equity Task Force as well as responding to an advertisement in a local newsletter. Partners have been engaged in every aspect of creating this plan, from creating the vision to identifying the health disparity to undertake to determining projects and participating in focus groups to provide input. Throughout the process, partners were continuously reminded the Health Equity Plan is not the Department of Health in Orange County's plan but rather a county-wide plan that is reflective of all partners.

Steps for recruitment included the following: advertisements in newsletters (MidTown Press); presentations to a group of a diverse community partners (May 24, 2022, presentation (virtual and in-person) to the Central Florida HIV network); flyers and word of mouth to recruit community members; presentation in community meetings; and collaboration with the College of Health Professions and Sciences at the University of Central Florida. These efforts gained community interest in being part of the process by attending monthly meetings, increasing interested and capacity in health equity, providing resources to implement the plan, providing expertise, and support to address SDOH.

A. Minority Health Liaison

The Minority Health Liaison supports the Office of Minority Health and Health Equity in advancing health equity and improving health outcomes of racial and ethnic minorities and other vulnerable populations through partnership engagement, health equity planning, and implementation of health equity projects to improve social determinants of health. The Minority

Health Liaison facilitates health equity discussions, initiatives, and collaborations related to elevating the shared efforts of the county.

Minority Health Liaison: Audrey Alexander
Minority Health Liaison Backup: Dahlia Scafe
Minority Health Liaison Backup: Dr. Annette Thomas

B. Health Equity Team

The Health Equity Team (HET) includes individuals that each represent a different program within the CHD. The HET 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 Orange County to the Health Equity Taskforce. The Minority Health Liaison guides these discussions and the implementation of initiatives. The membership of the Health Equity Team is listed below.

Name	Title	Division
Charnae DeBose	Community Engagement Coordinator	Maternal Child Health
Clifford Youngblood	Environmental Specialist III	Environmental Health Services
Gissella Suarez	Immunizations Program Manager	Nursing
Quenesha Lennon	Human Service Program Specialist	Infectious Disease

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 will continue to meet as-needed, no less than quarterly to track progress.

Meeting Date	Topic/Purpose
January 7, 2022	Overview of Health Equity, Health Disparities, Social Determinants of Health, Health Equity Plan, CLAS and their roles and responsibilities.
January 26, 2022	Presentation on CLAS and the survey within DOH-Orange; Health Equity Plan; the Minority Health Month event and their role in planning and implementing.

February 8, 2022	Finalized the Health Equity Plan's Vision. Discussed the upcoming minority health event. CLAS training was conducted for the HET. Also discussed internal DOH program participation at the event.
March 3, 2022	Discussion focused around selecting a health disparity.
April 6, 2022	Discussed the roles and responsibilities for each member of the team for the upcoming Minority Health event. Also discussed the Health Equity Plan and the agenda for the Task Force meeting in May.
May 18, 2022	Brief overview of the Minority Health Month event; discussed the CLAS surveys and the Health Equity Plan; also discussed the Health Equity Task Force meeting scheduled for June 3rd and the role each team member will play.
May 23, 2022	Discussed in greater detail the agenda for the Health Equity Task Force meeting on June 3, 2022, and the additional information needed for the Health Equity Plan.
May 31, 2022	The team discussed strategy to execute the SDOH workshop for the meeting on June 3rd. Discussed facilitator roles and topics for discussion within each group with community partners.
June 2, 2022	Discussed in further detail how the SDOH workshop meeting with community partners on June 3rd will be executed. All meeting materials were reviewed and modified where needed. All facilitators were prepared to obtain discussion materials from participants.

C. Health Equity Taskforce

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

Name	Title	Organization	Social Determinant of Health
Aleika Arboleda	Mission Manager	Libby's Legacy	Health Care Access
Arthur Howell	Program Manager	DOH-Orange	Health Care Access
Brian Postlewait	Chief Operating Officer	Homeless Services Network of CFL	Economic Stability
Bridget Monroe	Director of Community Engagement	Alzheimer's & Dementia Resource Center	Health Care Access
Charlene Tolbert	Grant & Compliance Manager	Hope and Help	Social and Community Context
Charnae DeBose	Community Engagement Coordinator	DOH-Orange	Health Care Access, Social and Community Context
Clifford Youngblood	Environmental Specialist III	DOH-Orange	Neighborhood and Built Environment
Colette McLeod	Regional Manager	AdventHealth	Health Care Access and Quality
Dahlia Scafe	Community Health Senior Health Educator	DOH-Orange	Health Care Access and Quality/ Economic Stability
Delitza Fernandez	Partner Agencies and Diversity Initiatives Manager	Heart of Florida United Way	Education Access; Health Care Access and Quality, Economic Stability; Social and Community Context
Dr. Deanna Wathington	CEO	Commonsense Childbirth	Health Care Access and Quality
Debra Moffa	Program Manager	Ability Housing	Neighborhood and Built Environment
Elaine Cauthen	Operations and Communications Director	Healthy Start Coalition	Health Care Access and Quality/ Economic Stability
Erick Sanchez	Community Impact Director	American Heart Association	Health Care Access and Quality
Evelyn Dillard	BCCED Program Coordinator	DOH-Orange	Health Care Access and Quality
Glen Providence	Director	Hebni Nutrition Consultants	Economic Stability/Health Care Access
Gissella Suarez	Operations & Management Consultant	DOH-Orange	Health Care Access and Quality
Griselda Payne	Organizer	Farmworkers Association	Economic Stability; Social and Community Context

Jason Doll	Business Director	Zebra Youth	Social and Community Context
Jonathan Morgan	Program Administrator	Scale It Up Florida	Economic Stability; Social and Community Context; Health Care Access and Quality
Jeff Hayward	President & CEO	Heart of FL United Way	Economic Stability; Social and Community Context
Kelsey Williams	Program Director	Covenant House	Economic Stability
Kisha Gaines	OC Tobacco Policy Manager	Civic Communications	Neighborhood and Built Environment
LaDawn Lyons	Program Manager	Miracle of Love	Health Care Access and Quality
LaJuana Raines	Community Engagement Liaison	Orange County Sheriff's Office	Social and Community Context
Larry Williams	Executive Director	Simeon Resource & Development Ctr for Men	Education Access/Health Care Access/Economic Stability
Marcia Romero	CEO	People Who Make a Difference	Economic Stability/Health Care Access
Maria Buckley	Director, PrePare Program	Aspire Health Partners	Health Care Access and Quality
Maria Garcia-Rolon	Associate Director of Patient Care	26Health	Health Care Access and Quality
Maureen Ferguson	Director of Govt. Relations & Grant Management	Community Health Centers	Health Care Access and Quality
Maxine Arena	Home Delivery Quality Assurance Manager	Second Harvest Food Bank	Neighborhood and Built Environment/Economic Stability
Melody Griffin	Community Outreach Director	Winter Park Health Foundation	Health Care Access and Quality /Economic Stability
Michael Alonso	Community & Puerto Rico Liaison	Gilead	Health Care Access and Quality
Neza Xiuhtecutli	General Coordinator	Farmworkers Association	Neighborhood and Built Environment/Economic Stability
Olivia Smith	Development Assistant	Ability Housing	Neighborhood and Built Environment
Peggie Burgess	Executive Director	Center for Change	Health Care Access and Quality
Penny Smith	Maternal Child Health Division Director	DOH-Orange	Health Care Access and Quality

Quenesha Lennon	Human Services Program Manager	DOH-Orange	Health Care Access
Rebecca Desir	Program Manager	AdventHealth	Health Care Access and Quality
Sarah Larsen	Transportation Planner	Metro Plan Orlando	Neighborhood and Built Environment
Sara Osborne	Community Benefit Director	Orlando Health	Health Care Access and Quality
Stephanie Arguello	Director of Community Health	AdventHealth	Health Care Access and Quality
Susan Makowski	Grant Writer	United Against Poverty	Economic Stability
Tanya Adams	Director of Development & Engagement	Ability Housing	Neighborhood and Built Environment /Economic Stability
Tatiana Thomas	Community Services Coordinator	Covenant House	Social and Community Context/Economic Stability
Tracy Harris	Executive Director	Libby's Legacy	Health Care Access and Quality
Vickie Cobb-Lucien	Nurse Practitioner	Embrace Health	Health Care Access and Quality
Vicky Smith	Women's Health Nurse Practitioner	Commonsense Childbirth	Health Care Access and Quality
Vickie Smith	Nurse Manager	AdventHealth	Health Care Access and Quality
Yvette Shelton-Edmonds	Manager	Orange County Community Action	Neighborhood and Built Environment
Sharon Warner	Director	Family and Friends United	Neighborhood and Built Environment

The Health Equity Taskforce met on the dates below during the health equity planning process. Since the Health Equity Plan has been completed, the Health Equity Taskforce continues to meet as needed, no less than quarterly to track progress.

Meeting Date	Organizations	Topic/Purpose
March 2, 2022	People Who Make a Difference; Community Health Centers; Metro Plan Orlando; AdventHealth; Orlando Health; Simeon Resource and Development Ctr. for Men; Covenant House; HEBNI; Winter Park Health Foundation; Ability	Overview the Health Equity Plan Discussed the Minority Health event Health Equity Plan overview (purpose/vision/CLAS)

	Housing; Commonsense Childbirth; Libby's Legacy; Healthy Start Coalition of Orange County; DOH-Orange	
April 12, 2022	Ability Housing; Civic Communications; Metro Plan Orlando; Orlando Health; American Heart Association; AdventHealth; People Who Make a Difference; Alzheimer's & Dementia Resource Ctr.; Common Sense Childbirth; Covenant House; Libby's Legacy; Heart of Florida United Way; DOH-Orange	Chosen health disparity (Infant Mortality); Overview of CHIP and SDOH data review; National Minority Health Month and Health Equity Heroes
May 10, 2022	Community Health Centers; Heart of FL United Way; Miracle of Love; Covenant House; Metro Plan Orlando; Second Harvest Food Bank; Civic Communications; Advent Health; Ability Housing; People Who Make a Difference	Minority Health Month event outcomes; Meeting poll results discussion on the county social determinates of health status and organizational CLAS; Discussion on Health Equity Plan: Two system level change projects: 1- A county-wide referral program and, 2- Cultural Linguistic Appropriate Standards (CLAS) awareness and training for all Orange County organizations and agencies.
June 3, 2022	American Heart Association; Farmworkers Association; People Who Make a Difference; Second Harvest Food Bank; Orange County Public Schools; Family & Friends United; Healthy Start Coalition; Orlando Health; Embrace Health; Orange County Community Action Partnership; Civic Communications; AdventHealth; Community residents; DOH-Orange staff	SDOH workshop: Data review, barriers identification, and community project discussions.

D. Coalition

The Healthy Start Coalition of Orange County's mission is to improve maternal and child health in Orange County through community partnerships. Therefore, this coalition was selected as the agency to oversee and provide continuous guidance to the Health Equity Taskforce as we execute the Health Equity Plan. The Coalition discussed strategies to improve the health of the community. The strategies focused on the SDOH: 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 other relevant sub-SDOH. The Coalition assisted the Health Equity Taskforce by reviewing their Health Equity Plan for feasibility. See Appendix A for the list of Coalition members. The Health Equity Plan was presented to the Coalition on June 7, 2022, by the Minority Health Liaison. This presentation detailed the coalition's responsibilities in guiding the plan, the different components of the plan and information on what the taskforce needed from the coalition to move the plan forward. Each member was provided with a draft copy of the plan for review and were given a week to provide any comments of feedback on the plan. The coalition accepted the role as the group to review and guide the plan, they agreed with plan focus, goals, and objectives, and provided comments on items to add to the plan. The comments and feedback were reviewed and accepted by the Minority Health Liaison and Health Equity Taskforce and adopted in the plan.

E. Regional Health Equity Coordinators

There are eight Regional Health Equity Coordinators. These coordinators provide the Minority Health Liaison, Health Equity Team, and Health Equity Taskforce with technical assistance, training, and project coordination. DOH-Orange is part of the Central Region lead by Lesli Ahonkhai.

Name	Region	Expertise
Carrie Rickman	Emerald Coast	Nursing
Quincy Wimberly	Capitol	Inclusive Strategies in Public Health and Technical Assistance

Diane Padilla	North Central	Non-Profit Engagement
Ida Wright	Northeast	Community Engagement and Project Management
Rafik Brooks	West	Health Care Leadership
Lesli Ahonkhai	Central	Faith-Based Engagement, Public Health Leadership, PH Workforce Capacity Building and Mentoring
Frank Diaz-Gines	Southwest	Health Insurance
Natasha McCoy (Interim)	Southeast	Public Health Practice, Grant Writing, and Partnerships

V. HEALTH EQUITY ASSESSMENT, TRAINING, AND PROMOTION

A. Health Equity Assessments

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

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

DOH-Orange conducted a health equity assessment(s) to examine the capacity and knowledge of DOH-Orange staff and county partners to address social determinants of health. The Culturally and Linguistically Appropriate Service (CLAS) Standards were used to assess DOH-Orange compliance to the standards. In addition, a CLAS survey was created to assess staff and client's perspective on how health equity and cultural awareness is being implemented in the agency (see results of DOH-Orange CLAS standard assessment and surveys in Appendix B). A general survey and conversation were also conducted within the Health Equity Taskforce meetings to examine if our partnering agencies have knowledge of what CLAS is and if it's being implemented in their agencies. In addition, SDOH training was provided to the Health Equity Taskforce to gain a comprehensive understanding of SDOH as we moved forward in designing a community project.

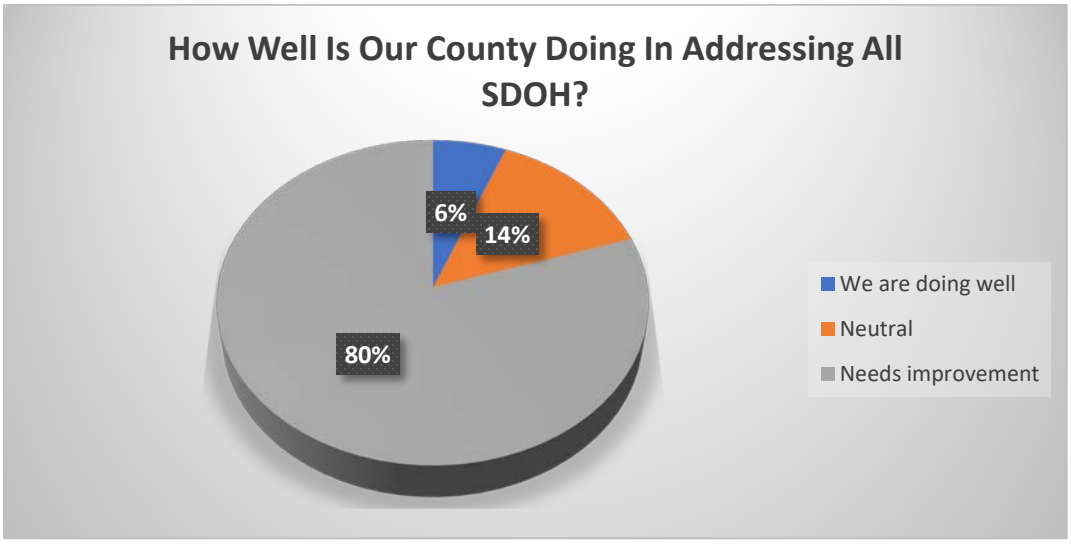
Below are the dates assessments were distributed and the partners who participated.

Date	Assessment Name	Organizations Assessed
February 8, 2022	CLAS Training	DOH-Orange Health Equity Team
February 8 – May 31, 2022	CLAS Survey	DOH-Orange Staff
May 16 – May 31, 2022	CLAS Survey	DOH-Orange Clients
April 4, 2022	CLAS Training	DOH-Orange Program Managers
April 12, 2022	CLAS discussion and poll	Community Health Centers; Heart of FL United Way; Miracle of Love; Covenant House; Metro Plan Orlando; Second Harvest Food Bank; Civic Communications; AdventHealth; Ability Housing; People Who Make a Difference; DOH-Orange
May 10, 2022	SDOH Overview & Data	Community Health Centers; Heart of FL United Way; Miracle of Love; Covenant House; Metro Plan Orlando; Second Harvest Food Bank; Civic Communications; AdventHealth; Ability Housing; People Who Make a Difference; DOH-Orange
June 1, 2022	SDOH Discussion and Feedback	Community Members: Priority population (pregnant Black moms)
June 3, 2022	SDOH workshop	American Heart Association; Farmworkers Association; People Who Make a Difference; Second Harvest Food Bank; Orange County Public Schools; Family & Friends United; Healthy Start Coalition; Orlando Health; Embrace Health; Orange County Community Action Partnership; Civic Communications; AdventHealth; Community residents; DOH-Orange staff

B. County Health Equity Training

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

The Health Equity Taskforce was assessed to determine knowledge of CLAS in their organization and to assess their perspective on how well the county is addressing SDOH. The following data was gathered:



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

Date	Topics	Organization(s) receiving trainings
April 12, 2022	CLAS discussion and Poll SDOH Overview & Data Meeting participants were provided with additional SDOH training via the SDOHacademy.com website. The taskforce learned the following topics: Improving Access to Quality Healthcare and services; Building and sustaining an inclusive workforce; addressing inequity through community partnership; and addressing SDOH issues for essential workers in emergency management.	Community Health Centers; Heart of FL United Way; Miracle of Love; Covenant House; Metro Plan Orlando; Second Harvest Food Bank; Civic Communications; AdventHealth; Ability Housing; People Who Make a Difference; DOH-Orange
May 9, 2022	CLAS Training Tools and Resources	A link to the E-Learning modules instituted by the State of Washington Governor's Interagency Council on Health Disparities was sent to all members of the Health Equity Task Force.
June 3, 2022	SDOH workshop: Data Review, barriers identification, and community project discussion	American Heart Association; Farmworkers Association; People Who Make a Difference; Second Harvest Food Bank; Orange County Public Schools; Family & Friends United; Healthy Start Coalition; Orlando Health; Embrace Health; Orange County Community Action Partnership; Civic Communications; AdventHealth; Community residents; DOH-Orange

C. County Health Department Health Equity Training

The Florida Department of Health in Orange County recognizes that ongoing training in health equity and cultural competency are critical for creating a sustainable health equity focus. At a minimum, all DOH-Orange staff receive the *Cultural Awareness: Introduction to Cultural*

Competency and *Addressing Health Equity: A Public Health Essential* training. In addition, the Health Equity Team provides regular training to staff on health equity and cultural competency. The training is recorded below. Post assessments were conducted to assess the knowledge of staff on Health equity. An average score of 90% was obtained by all trained staff.

Date	Topics	Number of Staff in Attendance
May 31, 2022	Health Equity Training Plan: Cultural Awareness: Introduction to Cultural Competencies and Humility Addressing Health Equity: A Public Health Essential	469

The table below show to total number of staff who completed the Health Equity training and the program they represent.

Row Labels	Total Staff
ADMINISTRATION	6
AREA7	21
BUSINESS OFFICE	25
COVID19	59
DENTAL	7
DIRECTOR'S OFFICE	2
ENVIRONMENTAL HEALTH	50
EPIDEMIOLOGY	10
FACILITIES	9
FPPH	17
HEALTH INFORMATICS	10
HEALTH PROTECTION	2
HEALTHY START	44
HIM	5
IMMUNIZATIONS	10
INFORMATION TECHNOLOGY	11
LEGAL	4
MEDICAL DIRECTOR'S OFFICE	1
NCF	3
NURSING DIRECTOR'S OFFICE	1
OFFICE OF COMMUNITY HEALTH	7

OPQI	3
SCHOOL HEALTH	4
STD PROGRAM	24
SUNSHINE CARE CENTER	32
TB/REFUGEE HEALTH	14
TRAINING, PREPAREDNESS & RESPONSE	5
VITAL STATISTICS	1
WIC	82
Grand Total	**469**

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
Feb. 16, March 16, April 22, May 18, and June 15, 2022	Peer Sharing, Updates and Technical Assistance
March 29, & 30, 2022	Onboarding Meeting
April 27 & 28, 2022	Technology of Participation (TOP) Training
March 18, 2022	Clear Point Training
June 9-10, 2022	Thriving Through Health: Promoting Wellness in Florida Communities

National Minority Health Month Promotion

In recognition of National Minority Health Month, DOH-Orange partnered with Orlando City Commissioner Regina I. Hill to host the *O-Town Spring Fest*. The event was held on April 30, 2022, at what is known as the “gem of the community”, Lake Lorna Doone Park. The event kicked off with the entrance of a local youth drumming corps followed by a message from

Orange County Mayor, Jerry L. Demings who also gave a proclamation declaring April 30, 2022, as National Minority Health Day in Orange County. In keeping with this year's theme, Giving Our Community a Boost! DOH-Orange programs and other community partners provided COVID-19, Hepatitis A, and meningitis vaccinations as well as PSA screenings, STD and HIV testing, and blood pressure checks. The event focused on providing minority residents with resources to address social determinants of health and decreasing health inequities. A plethora of vendors also offered education and awareness on breast cancer, colon cancer, dental hygiene, Alzheimer's and dementia, suicide prevention, epilepsy, and vision loss.

Five Loaves and Two Fish, a nutrition-based vendor operated by a local pharmacist and chef, gave two presentations and cooking demonstrations on healthy eating, provided samples and recipes. HEBNI, another local nutrition-based agency featured a blender bike where attendees could peddle their own smoothie. Women, Infant and Children (WIC) also provided nutrition education materials.

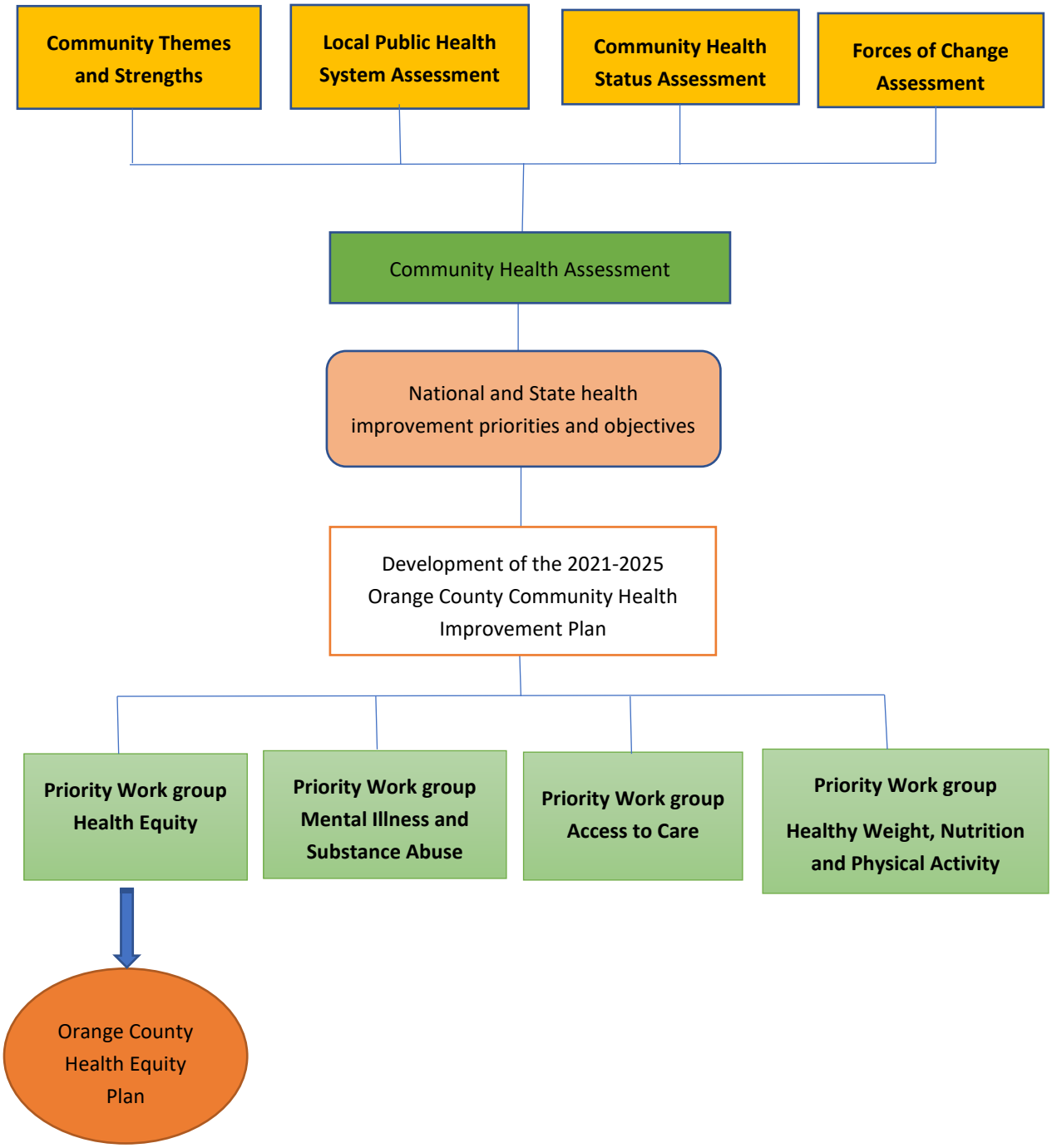
Our Florida Healthy Babies program gifted and gave one-on-one car seat installation training to twenty attendees in their respective vehicles. Participants were afforded an opportunity to apply for a voter registration card through the Supervisor of Elections Office and apply for bus driver and fleet technician positions through Orange County Public Schools. Vendors offering

low-cost health insurance were on hand to answer questions along with representatives of the Marketplace Navigator Project.

On a fun note, the crowd participated in group dance and aerobic sessions led by a certified fitness instructor, hula hoop contests for youth and adults, and African hopscotch. Four lucky attendees won $50.00 gas cards! A kid's zone kept youngsters engaged with oversized bowling, face painting, football, helmet fitting and give-a-way, and other fun activities. If that wasn't enough, they had ice cream and popcorn! Family and individual photos were available. 40 households received food boxes as they exited the event. Overall, approximately 327 residents attended the O-Town Spring Fest including children and adults with 37 vendors participating to make it a resounding success.

VI. PRIORITIZING A HEALTH DISPARITY

The Health Equity Team identified and reviewed data in Orange County to determine the health disparity of focus for this plan. Data was pulled from multiple sources:



The Community Health Need Assessment was used to build the county's current Community Health Improvement Plan and now the Health Equity Plan.

Community Health Status Assessment | This explains the health standing of our community. Between September 2018 and June 2019, the assessment helped us identify our key community health problems by reviewing data about health conditions, quality of life and risk factors in the community.

Community Themes and Strengths Assessment | Information was collected between October 2018 and May 2019 from nine focus groups, 18 individual stakeholder interviews and 1,240 community survey participants, 86 intercept survey participants and 11 key informant survey participants. This data helped us learn what issues are important to our community, how the quality of life is seen in our community and what resources our community has that can be used to improve health.

Local Public Health System Assessment | Facts and figures were collected from four public health system scoring groups. This data helped us learn how well public health services are being provided to our community and the performance and abilities of our community health system.

Forces of Change Assessment | Focuses on identifying forces that affect the community and its public health system, such as legislation, technology, and other upcoming changes. Using data from primary and secondary research, the following major findings were established.

Leaders from Orange County undertook prioritization exercises for this CHNA, which resulted in the following top health disparities, which were used to build the Community Health Improvement Planning process:

- White residents of Orange County (89.2%) are more likely to have any type of health insurance compared to Black residents (82.2%) and Hispanics (67.9%)
- Whites in Orange County have the highest rate of colorectal cancer incidence (36.8) compared to Blacks (32.3) and Hispanics (33.4)
- Whites have the highest rate of breast cancer incidence (114.9) compared to Blacks (96.7) and Hispanics (88.5)

- Whites (55.0) also have the highest rate of lung cancer in Orange County compared to Blacks (39.6) and Hispanics (27.1)
- Blacks have the highest rates of asthma (10.2%) compared to Whites (6.8%) and Hispanics (4.9%)
- Non-Hispanic Blacks (34.2) have the highest diabetes death rates compared to Whites (26.0), White Hispanics (20.8) and Black Hispanics (8.0)
- Infant mortality per 1,000 births in Orange County is highest among Blacks (15.5) compared to Whites (3.8) and Hispanics (5.5)
- Births to mothers with less than high school education is highest among Blacks (16.5%) compared to Hispanics (13.6%) and Whites (9.6%)
- Births to women who were obese during pregnancy is highest among Blacks (34.9%) compared to 23.9% for Hispanics and 22.0% for Whites

Orange County Community Health Improvement Plan (CHIP) is a data gathering and collaboration endeavor of community members from the Department of Health, coalition, community members, and local partners. It is a community-driven initiative to improve the health of all Orange County residents and tourists.

The administrative support is provided by the Florida Department of Health in Orange County, which tracks and collects data and reports outcomes. The Community Health Improvement Planning process was facilitated by the Orange County Department of Health, which used the Mobilizing for Action through Planning and Partnership (MAPP) strategic planning model, which is made up of four specific assessment workgroups, developed by the National Association of City and County Health Officials.

CHIP's four areas of focus are as follows: Health Equity, Mental Illness and Substance Abuse, Access to Care, and Healthy Weight, Nutrition, and Physical Activity.

1. The Health Equity program aims to enhance the general health of the Black community and lower the prevalence of STDs in the Black community by utilizing referral systems to promote testing, counseling, and screening of residents and visitors in Orange County, as well as reducing Black infant mortality rates.

2. Behavioral health, which encompasses mental illness and substance abuse. The emphasis is on minimizing dangerous substance use, such as tobacco, alcohol, and OPIODs. To help people quit smoking, the objective is to educate them and send them to cessation programs such as the Florida Area Health Education Centers (AHEC).
3. Access to Care focuses on lowering readmission rates in Orange County hospitals, increasing cancer screening rates for specific demographics, and providing outpatient care. The goal is to decrease hospital readmissions while also increasing health screenings for early detection.
4. The Healthy Weight, Nutrition, and Physical Education program focuses on the rate of health conditions caused by poor nutrition practices, the implementation and maintenance of community health improvement services, and nutrition education for adults, all of which will help to reduce diabetes, overweight populations, provide best eating practices for pregnant women, and educate communities on the importance of healthy lifestyles.

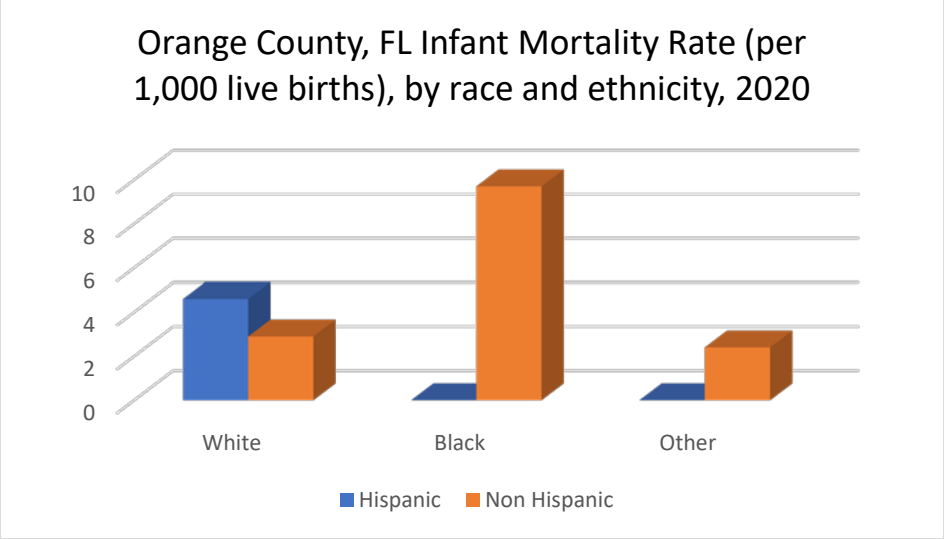
Using the Strategy Grid Prioritization technique, the Health Equity Team used the list of health disparities identified in the CHA to reach a consensus on the disparity of choice for the Health Equity Plan. The selected health disparity the team decided to work on is Infant Mortality among the black community, for the four-year period 2022-2025, to align with CHIP.

Infant mortality (IM) is the death of a live-born baby during the first year of life. The rate is the number of infant deaths per 1,000 live births. Infant mortality and the infant mortality rate reflect the health and well-being of the population's women of reproductive age and their infants as well as the quality of the health care available. When comparing the Black and White population in the community, Blacks are more than two times more likely to experience poverty, two times more likely to be unemployed, less likely to graduate from high school, and have a median household income 42% less than Whites[1]. Public health professionals and advocates have taken the responsibility to assure that the needs of women, infant and families continue to be met regardless of environmental, social, and economic changes. However, high IM rates continue to exist and are known to constitute more than half of all deaths occurring in

[1] https://www.flhealthcharts.gov/ChartsReports/rdPage.aspx?rdReport=ChartsProfiles.CountyHealthProfile

children aged 1-19 years in the United States. For the past several years, Orange County Black Non-Hispanic babies have faced a disproportionate rate (more than double) of IM when compared to White non-Hispanic babies. In 2017, the county experienced an exponential increase in Black infant deaths (15.8/1,000 live births), an IM death rate not seen that high since 2008 (17.8/1,000 live birth).

When taking a broader look of racial and ethnicity disparities in the county, as it pertains to infant mortality, Non-Hispanic Black still experience a disproportionate rate of disparity. As shown in the graph below, Hispanic whites have a higher infant mortality rate than non-Hispanic whites, and the White race overall experiences higher rates than "other" race (American Indian, Chinese, Japanese, Hawaiian, Filipino, Korean, Vietnamese, Asian Indian, Asian other, Guam, Samoan, pacific islander, more than one race). However, Black non-Hispanics surpass all rates from all races and ethnic backgrounds. Other priority populations such as LGBTQ and elders are non-applicable to this health disparity.



The population of focus in the Health Equity Plan will be Black (Non-Hispanic) women and their babies. As illustrated in the table below, Black babies are more than twice as likely to die compared to White babies. The county has a yearly average birth count of 16,555, of which 4,190 are Black non-Hispanic, (82,774 total birth/5 years (2016-2020)). This population of focus has an excess annual death of 31.4 for Black non-Hispanic babies as calculated by the five-year absolute IM rate difference (10.9 Five-year average infant death rate for non-Hispanic

Black minus 3.4 five average for non-Hispanic White infant = 7.5 /1000= 0.0075) multiplied by the 4,190 average annual non-Hispanic Black births. Table 1 below shows the Orange County IM rates by race and ethnicity and absolute gap through the 5-year period and Table 2 shows Florida IM rates by race and ethnicity and absolute through the 5-year period.

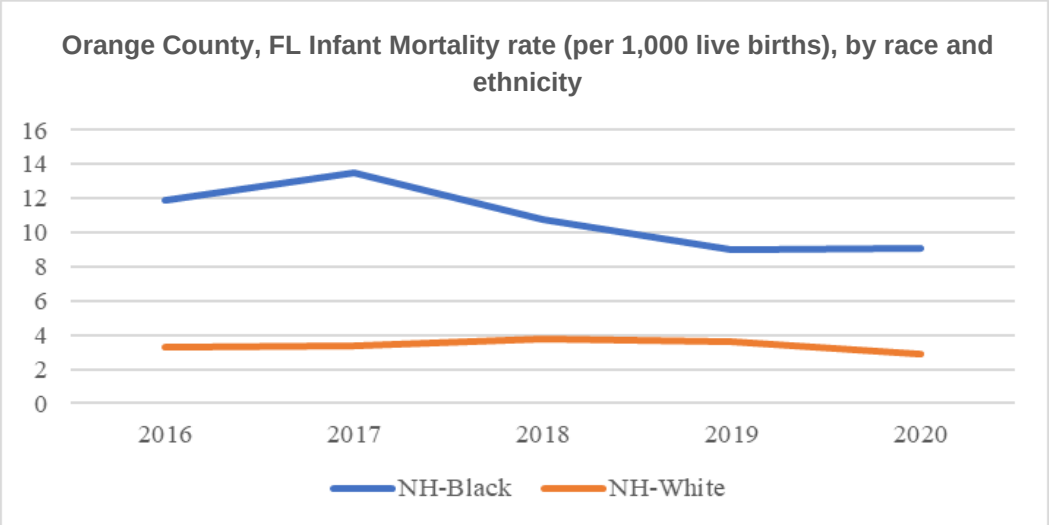
The tables below demonstrate how the county rates compare to state rates. As displayed in the tables, Orange County showed higher absolute gap rates for three consecutive years from 2016- 2018 than the state. Although the data trends downward from the past 5 years, the IM rate does not meet Healthy People 2030 goal of 6.0; therefore, there is still a lot to accomplish as a community to reach that goal.

Table 1: Orange County, FL Infant Mortality Rate (Per 1,000 live birth), by race and ethnicity[1]

	2016	2017	2018	2019	2020	Total (Average)
Black Non-Hispanic	11.9	13.5	10.8	9.0	9.7	11
White Non- Hispanic	3.3	3.4	3.8	3.6	2.9	3.4
Absolute Gap	8.9	10.1	7.0	5.7	6.2	7.5

Table 2: Florida Infant Mortality Rate (Per 1,000 live birth), by race and ethnicity[1]

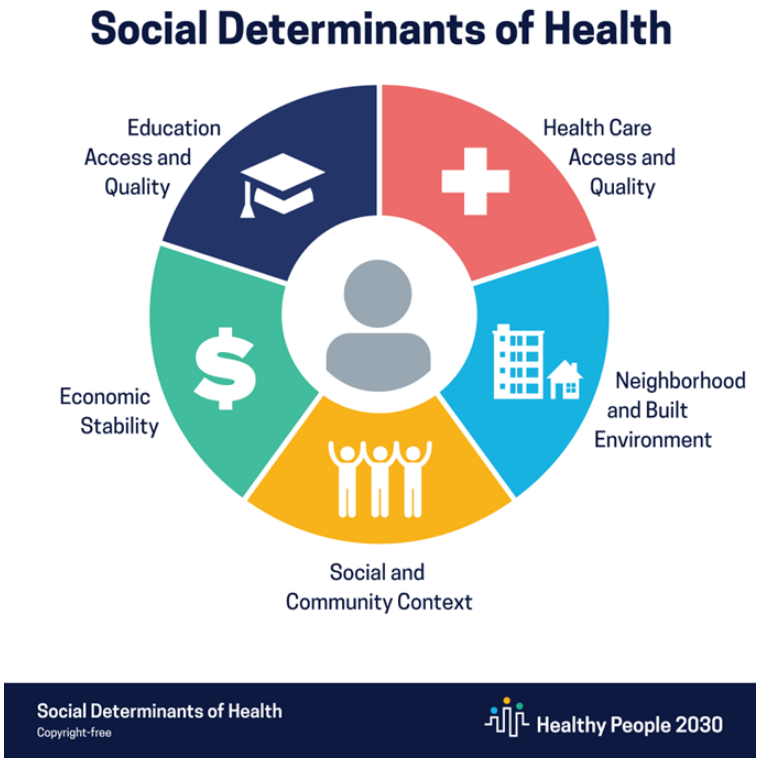
	2016	2017	2018	2019	2020	Total (Average)
Black Non-Hispanic	11.6	10.8	11.3	10.9	10.7	10.9
White Non- Hispanic	4.3	4.4	4.3	4.4	4.2	3.4
Absolute Gap	7.3	6.4	7.0	6.5	6.5	7.5



After a more thorough analysis of several indicators that contribute to infant mortality (See analysis results in Appendix G). It was statistically determined that *infant infections, maternal pre-pregnancy diabetes, maternal hypertension, maternal obesity, maternal infectious, low prenatal visits, and premature birth/low birth weight* contributed the most to Black infant mortality and displayed great disparity gap when compared to Whites. Being a person of color is not a cause for having most of these contributing characteristics. However, communities of color are disproportionately affected by racism. This affects their health and well-being and increases the risk of pregnancy complications. Since all of these indicators are associated with one or several SDOH, yearly these indicators will be measured, tracked, and monitored (see Appendix G for template and baseline with highlighted focused indicators selected).

VII. SDOH DATA

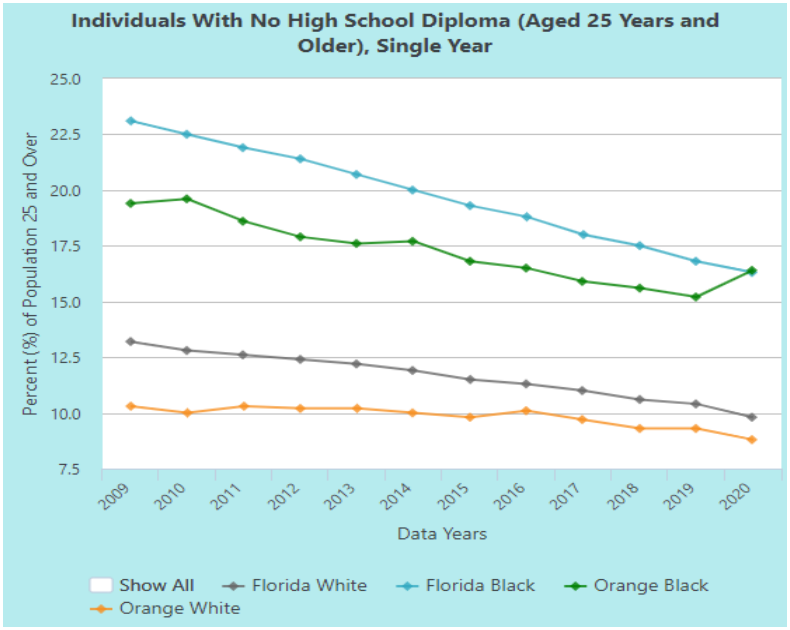
Social Determinants of Health (SDOH) are conditions in the places where people live, learn, work, and play that affect a wide range of health and quality-of life-risks and outcomes. The SDOH can be broken into the following categories: education access and quality, health care access and quality, neighborhood and built environment, social and community context, and economic stability. The Health Equity Team identified multiple SDOH that impact Black infant mortality with the help and input of the Health Equity Taskforce and community members. They are listed below. Community focus group discussion results on SDOH, held on June 3, 2022, are referenced in this section to further explain the challenges and perspectives the priority population share based on their personal experiences. In addition to SDOH data collection, a community assets assessment was conducted to obtain a general overview of all the resources available in county. A list of all the resources can be found in Appendix H.



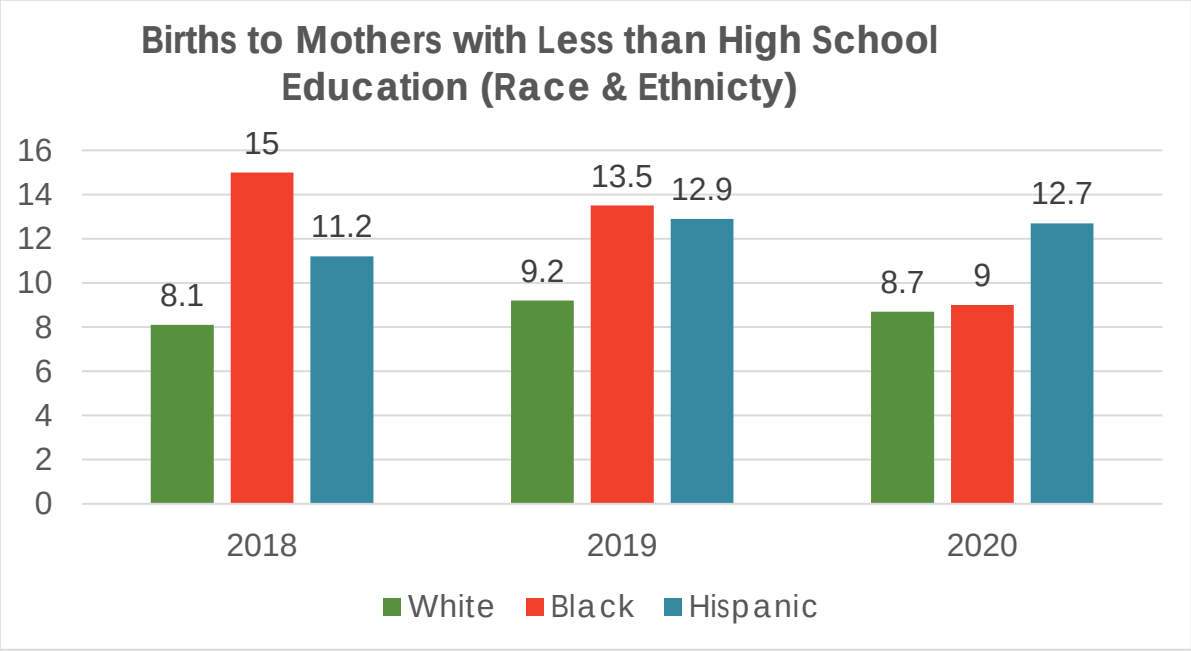
A. Education Access and Quality

Education Access and Quality Data for Orange County

Educational attainment is an indicator of economic prosperity and is inversely associated with poverty. In 2020, the percentage of individuals with no high school diploma (aged 25 years and older) in Orange County was 11.3% compared to Florida at 11.5%. The percentage of Black individuals 25 years and over in Orange County, with no high school diploma, was 16.4% compared to Whites individuals at 8.8%. The line graph shows change over time by race in Orange County compared to the state of Florida.



Lack of a high school diploma impacts infant mortality. Educational level of mothers is one of the most significant social determinists of infant mortality. Higher education levels are associated with higher paying jobs with better benefits. The graph below shows the educational attainment disparity among races and ethnicity in Orange County. To improve Black infant mortality, Orange County is addressing racial disparities related to achieving a high school diploma, by linking and referring Black moms to educational resources.



Priority population focus group discussion results on SDOH (Education):

- "Stopped going to school to care for my child"
- "Lost interest of going back to school after having my baby"

The Impact of Education Access and Quality on Infant Mortality

Education Access and Quality		
SDOH	**Priority Populations Impacted**	**How the SDOH Impacts infant mortality**
Literacy	Black women	Female literacy is considered as one of the important parameters for determining socio-economic progress. Some patients don't know what questions to ask; improving service provider training to explain to patients in a language level, and tone they are able to understand can increase the quality of service and relationship with the patient/client. Many women don't have the academic education; therefore, providing classes and/or training can help women make better decisions about themselves and their families.
Language	Foreigners	Many Hispanics, Asian, and Creole populations do not understand the English language enough to be able to navigate the health care system for the resources they need. This becomes a barrier in obtaining optimal health. Cultural relevance, translation services, and visual aids can help foreigners understand the information to make better informed decisions about themselves and their families.
Early Childhood Development	Black babies	Providing resources to moms about what to expect as their child grows in the very early stage can reduce challenges to making better decisions for the child as they grow. Providing more resources to women, such as Supplemental Nutrition Assistance Programs (SNAP) and Women Infants and Children (WIC) can help address infant mortality.
Vocational Training	Black women	Vocational training expansion increase employment and economic opportunities provide better health outcomes, childcare, and scholarship opportunities.
Higher Education	Black women	Higher education leads to both higher earnings and higher rates of health insurance.

B. Economic Stability

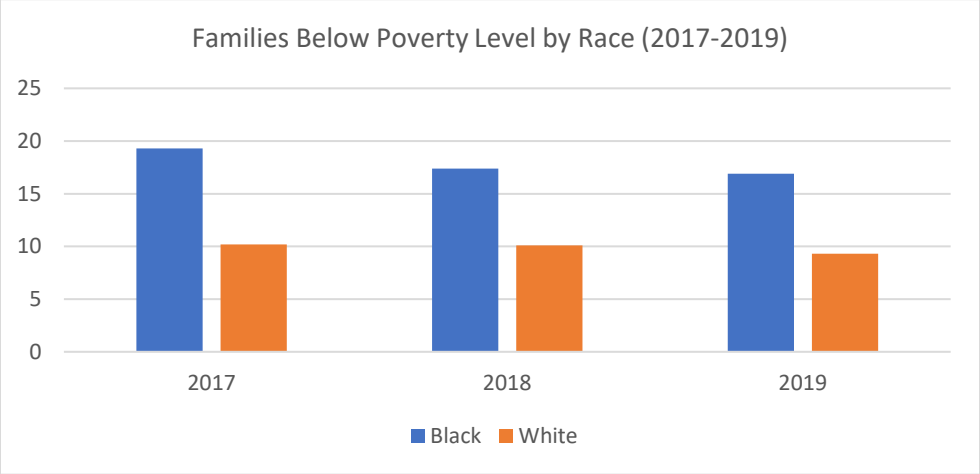
Economic Stability Data for Orange County

There is a significant association between maternal and infant mortality and economic stability. Poverty, employment status, food insecurity, and housing are among the indicators that can affect birth outcomes. Studies have shown how the odds of infant mortality increase with mothers living in low poverty communities. Families in poverty are less likely to afford adequate housing conditions, healthy food, transportation, health necessities, and health insurance. Although poverty level rates in Orange County have slightly decreased year by year, Black families are still disproportionally affected by poverty when compared to White families, as shown in figure on the following page. Employer pay inequity can affect these circumstances when a family is unable to make ends meet with their current salary. Food insecurity is highly correlated with societal unrest, physical and mental issues, as well as short- and long-term health effects[2], which negatively influence disparities and excess infant deaths. Disadvantaged communities in Orange County have limited expansion of employment and access to healthy foods. Creating employment opportunities in these communities by expanding public private infrastructure investments and investing in health services can be of benefit. Housing has become a burden in our community. According to a new research report by Apartment List, a rental listing company, Florida leads the nation in housing unaffordability

[2] Fafanyo Asiseh, Cephas Naanwaab, Obed Quaicoe; The Association between Food Insecurity and Child Health Outcomes in Low and Middle-income Countries.. *Journal of African Development* 1 October 2018; 20 (2): 79–90. doi: https://doi.org/10.5325/jafrideve.20.2.0079

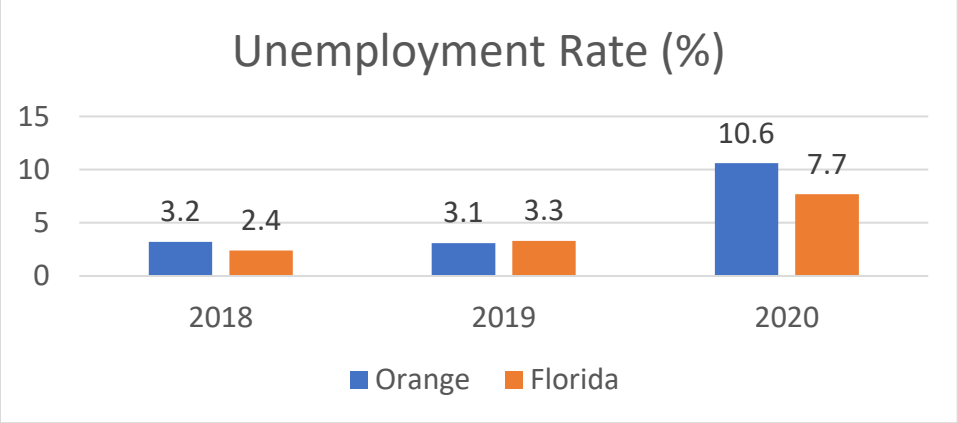
with the percentage of renters — 56.5 percent — who spend 30 percent or more of their income on housing.[3] In 2019, Orlando was ranked the worst metropolitan city in the nation for affordable housing by the National Low Income Housing Coalition, with only 13 units available for every 100 extremely low-income renters — those whose income is at or below the poverty guideline.[4] More opportunities for affordable housing is also needed in the community to reduce disparities.

The graph below shows how the Black population in Orange County have been disproportionally affected by poverty when compared to Whites and how the unemployment rate in the county compared to the rate of Florida overall, which recently the county has experienced an unemployment rate much higher than previous years. To improve black infant mortality, Orange County is addressing racial disparities related to increasing economic stability by linking and referring Black moms to rental assistance programs, food access, and employment opportunities.



[3] *Amid Florida's affordable housing crisis, DeSantis proposes highest spending in a decade*. (2021, December 10). Tampa Bay Times. https://www.tampabay.com/news/florida-politics/2021/12/10/amid-floridas-affordable-housing-crisis-desantis-proposes-highest-spending-in-a-decade

[4] Out of moves: The affordable housing crisis in Central Florida. (2020, March 16). Pegasus Magazine. https://www.ucf.edu/pegasus/out-of-moves



Priority population focus group discussion results on SDOH (Economic Stability):

- **"**My husband works, but is trying to look for a better paying job"
- "I have great economic support to care for my family"
- "With the inflation, things are hard right now, but we try to manage"
- "I work all day to support my family"
- "The dream to become more prosperous is not as easy anymore"

The Impact of Economic Stability on Infant Mortality

Economic Stability		
SDOH	**Priority Populations Impacted**	**How the SDOH Impacts Infant Mortality**
Employment	Black women	Having stable employment would reduce stress placed on moms as well as job benefits that allows mothers to access prenatal care.
Income	Black women	Stable incomes help increase access to prenatal care.
Expenses	Black women	Having lots of expenses also places stress on mothers; finding ways to manage stress could be helpful.
Debt	Black women	Access to health insurance and stable income will help decrease debt and medical bills that could lead to debt.
Medical Bills	Black women	
Support	Black women	Two parent incomes, childcare for existing children, and family support also helps decrease stress and burden to mothers.
Hunger	Black women	Having access to healthy food options has been proven to contribute to healthy term deliveries.

C. Neighborhood and Built Environment

Neighborhood and Built Environment Data for Orange County

All the locations in which we live, work, learn, and play are considered part of the Neighborhood and Built Environment. Workplaces and residences, businesses and schools, landscapes, garbage disposal facilities, parks/recreation areas, business districts, and roadways and infrastructure are all part of it. All structures, locations, and objects that are created or modified by people are considered part of the Neighborhood and Built Environment. It has an impact on both the physical and social settings (for example, weather conditions and indoor/outdoor air quality). The table below displays rates of county residents as it pertains to proximity to fast food restaurants, healthy food sources, and park access compared to Florida rates. Compared to Florida, Orange County residents have more access to fast-food, less access to healthy foods and less access to parks. To improve Black infant mortality, Orange County is addressing racial disparities related to increasing neighborhood and built environment by linking and referring Black moms to resources to be able to walk with their child (strollers), have access to nutritional foods, and access to transportation services to make their healthcare appointments.

Population Living Within ½ Mile of a Fast-Food Restaurant, Percentage of Population, Single Year[1]		
	Orange	**Florida**
Data Year	**Percent (%)**	**Percent (%)**
2019	29.6	27.7
2016	32.0	31.1
Population Living Within ½ Mile of a Healthy Food Source, Percentage of Population, Single Year		
	Orange	**Florida**
Data Year	**Percent (%)**	**Percent (%)**
2019	27.0	27.7
2016	26.0	27.9
Population Living Within ½ Mile of a Park, Percentage of Population, Single Year		
	Orange	Florida
Data Year	**Percent (%)**	**Percent (%)**
2019	25.5	40.1
2016	24.5	38.8

Priority population focus group discussion results on SDOH (Neighborhood and Built Environment):

- "I feel safe in my neighborhood"
- "The Park is about a 10-15 min drive from where I live"
- "I have good access to healthy foods"
- "When my husband is away, I don't have access to transportation"
- "I use uber sometimes, but it gets expensive"

The Impact of Neighborhood and Built Environment on Infant Mortality

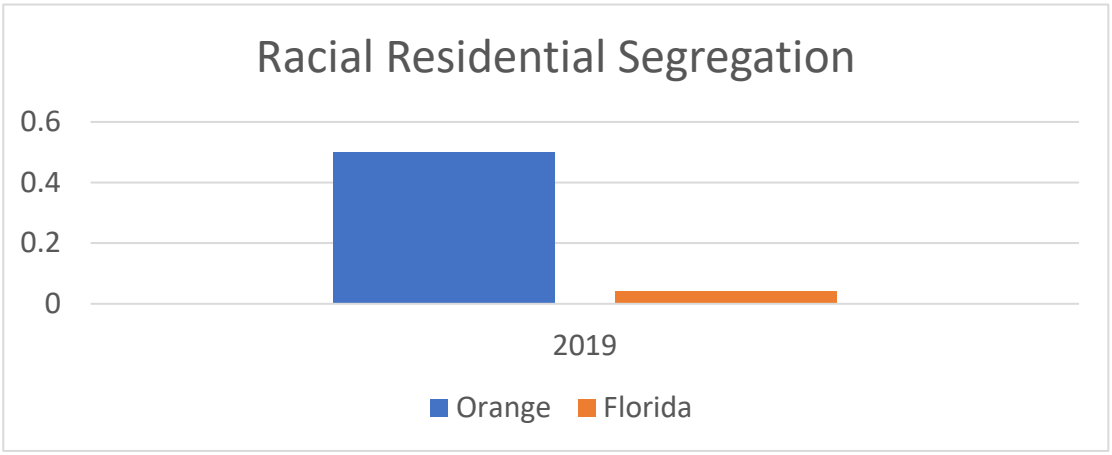
Neighborhood and Built Environment		
SDOH	**Priority Populations Impacted**	**How the SDOH Impacts Infant Mortality**
Housing	Black Families	Having a safe, clean, and affordable home reduces stress. Infants are more at risk for sleep-related death in homes with poor housing condition, due to crowding, unstable temperatures, and infestation.

Transportation	Black Families	Lack of reliable transportation is a barrier to many families. Some cannot afford a personal vehicle and rely on public transportation to get the service they need. Public transportation barriers such as timing to get to destination, taking several busses to get to their destination and lack of knowledge to navigate the public transportation.
Safety	Black Families	Gun violence and unsafe neighborhoods increase women's stress level by worrying about what will happen to their family. Not feeling safe hinders a mom to seek support.
Parks & Playgrounds	Black Families	Parks and playgrounds promote healthy physical activity. Parks are limited in the community, but when available some are not perceived as a safe environment. This can increase stress level and limit women and families to increased physical activities.
Walkability	Black Women	Ensuring sidewalks are in certain areas helps women feel safe as they take a walk. This can increase women's ability to keep active by going for a walk in the neighborhood.
Access To Nutritional Food	Black Families	Maternal nutrition is a critical determinant of infant health; thus, it is not hard to see that poor maternal nutrition can contribute, directly or indirectly, to infant mortality. Gestational weight gain is associated with greater risk for preterm birth and fetal growth restriction. Therefore, if women don't have access to nutritional foods, it can limit their ability to maintain a healthy lifestyle. More community gardens and access to fresh fruits and veggies is needed in the community.

D. Social and Community Context

Social and Community Context Data for Orange County

Research has linked segregation with higher rates of mortality. Racial residential segregation is associated with unequal access to health care resources, including health care settings and quality of treatment. Racial residential segregation contributes to poor health in minority populations, not just through Social Economic Status (SES) differences but also through neighborhood effects. Differences in quality of neighborhood exist at all SES levels between Black and White families. Segregated, urban residential areas are less conducive to optimal health due to reduced access to civic services, substandard housing conditions, higher exposure to pollutants and allergens, and reduced access to high-quality medical care. To improve Black infant mortality, Orange County is addressing racial disparities related to increasing Social and Community Context by linking and referring Black moms to resources to



the support they need (i.e., mental health, social support), and increasing organizational capacity to incorporate cultural and linguistically appropriate client services.

Priority population focus group discussion results on SDOH (Social & Community Context):

- "I have a good support system"
- "I am aware of community resources by word of mouth"
- 'The current environmental factors cause uncertainty; however, I have a good support system to cope"

The Impact of Social and Community Context on Infant Mortality

Social and Community Context		
SDOH	**Priority Populations Impacted**	**How the SDOH Impacts Infant Mortality**
Social Integration	Black Women	Social integration enables persons, regardless of their attributes, to enjoy equal opportunities, rights, and services to the group. If black moms don't experience social integration, it can limit their ability to feel comfortable to seek help when needed.
Support Systems	Black Women	A strong support network can be critical to help black pregnant women deal with stress and the burden of preparing to support a child/family. Lack of social support can lead to isolation and loneliness which can negatively impact the health of the mom and baby.
Community Engagement	Black Women	Community engagement builds and sustains cohesive communities. A community that is engaged in addressing the needs to black women can be impactful in the success of improving birth outcomes by ensuring access and community empowerment.

Discrimination	Black Women	Disparities in maternal and infant mortality are rooted in racism. Structural racism in health care and social service delivery means that Black women often receive poorer quality care than white women. It means the denial of care when Black women seek help when enduring pain or that health care and social service providers fail to treat them with dignity and respect. These stressors and the cumulative experience of racism and sexism, especially during sensitive developmental periods, trigger a chain of biological processes, known as weathering, that undermine African-American women's physical and mental health[5]. The long-term psychological toll of racism puts African American women at higher risk for a range of medical conditions that threaten their lives and their infants' lives, including preeclampsia (pregnancy-related high blood pressure), eclampsia (a complication of preeclampsia characterized by seizures), embolisms (blood vessel obstructions), and mental health conditions[6].
Stress	Black Women	

E. Health Care Access and Quality

Health Care Access and Quality Data for Orange County

Health insurance makes a difference in whether and when people get necessary medical care, where they get their care, and ultimately, how healthy they are. Uninsured people are far more likely than those with insurance to postpone health care or forgo it altogether. In 2020, the

[5] Cristina Novoa and Jamila Taylor, "Exploring African American High Maternal and Infant Death Rates," (Washington: Center for American Progress, 2018), available at https://americanprogress.org/issues/early-childhood/reports/2018/02/01/445576/exploring-african-americans-high-maternal-infant-death-rates/.
[6] "Building U.S. Capacity to Review and Prevent Maternal Deaths: Report from Nine Maternal Mortality Review Committees," available at https://reviewtoaction.org/sites/default/files/national-portal-material/Report%20from%20Nine%20MMRCs%20final_0.pdf (last accessed January 2019).

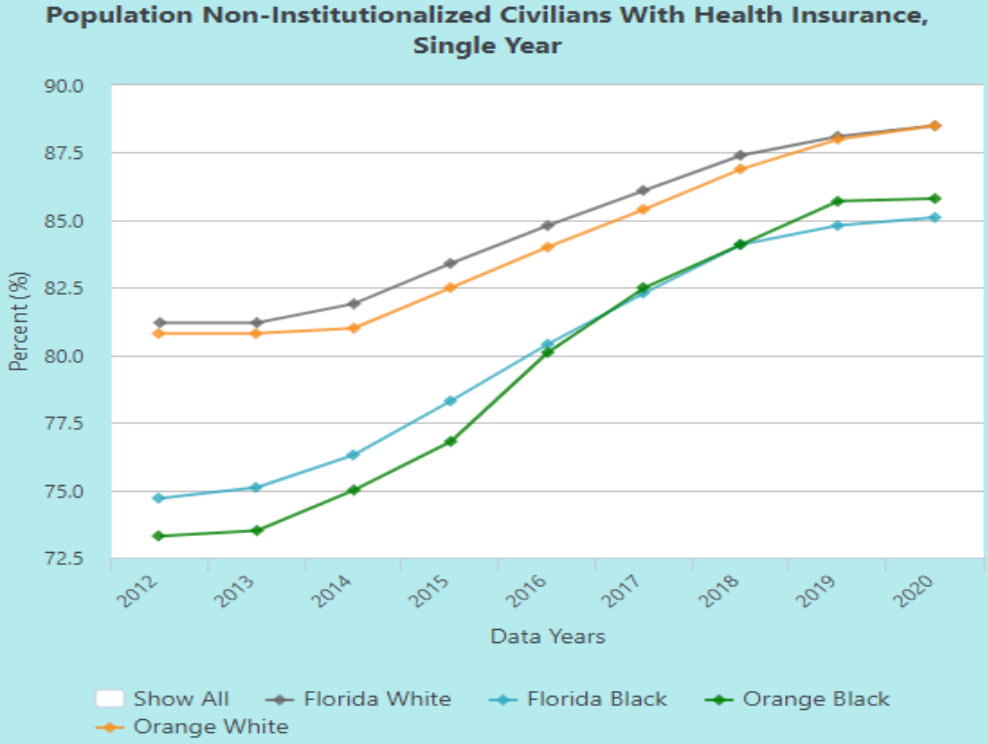
percentage of Population Non-Institutionalized Civilians with Health Insurance in Orange County was 86.8% compared to Florida at 87.3%. The line graph on the following page shows changes over time when there are at least three years of data. Blacks in Orange County are less likely to have coverage compared to Whites (2020: Blacks 85.8 vs Whites 88.5). This has been an issue for many years.

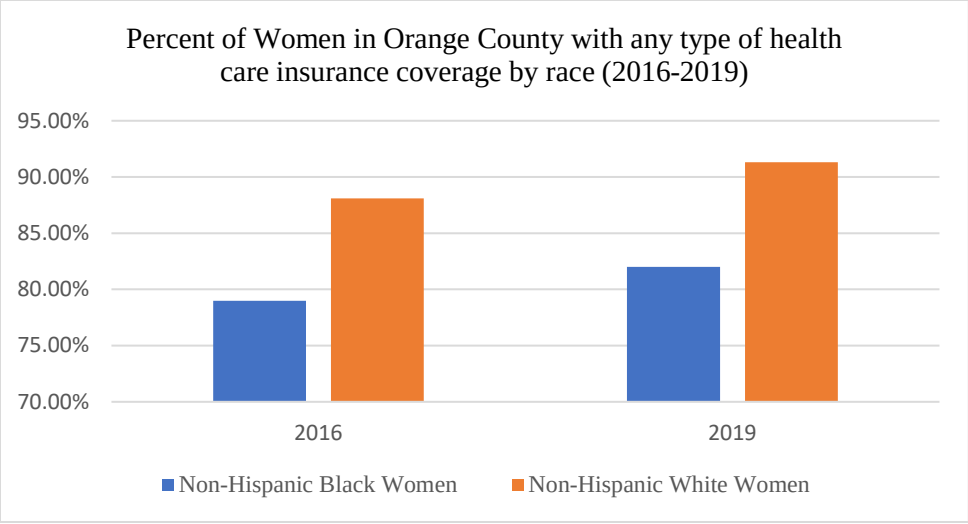
Access to healthcare can be evaluated as availability, accessibility, accommodation, affordability, and acceptability, which are assessed by patient perception[2]. Access to affordable, quality, and timely health care can help prevent disease and detect issues sooner, enabling individuals to live longer healthy lives. Based on data from the county's community health needs assessment, Orange County residents believe that the health care system needs to change and are concerned about the affordability of care[7]. In Orange County, not all women have access to health insurance coverage. Through-out the years coverage rates have decreased, non-Hispanic Black women experiencing more of the disparity; in 2019 (most recent data) 79% of Non- Hispanic Black women had health care insurance, compared to 88.1% of non-Hispanic White women[8] (see figure below). When women don't have access to health insurance, it becomes less affordable to obtain health services, they are less likely to have a primary care provider to assess and/or treat any conditions experienced during their pre-conceptive years. This can also reduce their ability to receive early prenatal care and postnatal care. In addition to not being medically insured or being underinsured, women in the community experience barriers due to unreliable transportation, health literacy, and language barriers. All these factors and more play a role in the infant mortality disparities and excess infant death in Orange County. To improve Black infant mortality, Orange County is addressing racial disparities related to increasing Healthcare access & quality by linking and referring black moms to resources to the support their preceptive, prenatal, and post-natal health care

[7] https://orange.floridahealth.gov/programs-and-services/community-health-planning-and-statistics/_documents/Orange_CHA.pdf

HYPERLINK "https://orange.floridahealth.gov/programs-and-services/community-health-planning-and-statistics/_documents/Orange_CHA.pdf" https://orange.floridahealth.gov/programs-and-services/com

needs (i.e., telehealth, doula services, nutritional services), and increasing organizational capacity to incorporate cultural and linguistically appropriate client services.





Priority population focus group discussion results on SDOH (Healthcare Access & Quality

- "I feel like I receive great quality healthcare during my prenatal visits"

- "Sometimes I don't understand the terminology the doctors use"

The Impact of Health Care Access and Quality on Infant Mortality

Health Care Access and Quality		
SDOH	**Priority Populations Impacted**	**How the SDOH Impacts Infant Mortality**
Health Coverage	Black Women	Access to healthcare coverage increases prenatal and postnatal care services. Not being able to afford insurance premiums can be a challenge in women getting the care they need.
Provider Linguistic and Cultural Competency	Black Women & Foreigners	If providers are not linguistically and culturally competent it increases patient provider mistrust, which limits health literacy. Having a provider who looks like the patient and understands the patient can help increase rapport. Patients are more comfortable communicating with the provider about their needs and the needs of their families.
Provider Availability	Black Women	Having access to the appropriate providers a mom needs is vital to improve birth outcomes. Providers having flexible schedules to service patients is very important, as well as having providers within proximity to residents to reduce barriers in access. Increasing awareness of provider services and resources also impacts infant mortality. Long wait times for appointments can decrease birth outcomes, if women are not being seen in an appropriate timeframe to address their pregnancy needs.
Quality Of Care	Black Women	Providing adequate time with patients can reduce infant mortality. Taking the time to talk and listen to the patient and provide them with details and making sure they understand procedures and health recommendation before, during, and after pregnancy can improve birth outcomes.

VIII. SDOH PROJECTS

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

A. Data Review

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

B. Barrier Identification

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

Partners	SDOH	Partner Barriers	Theme	Collaborative Strategies
Farmworkers Association	Education	Lack of protection for the farm workers' community regarding their health	Health & Wellness	Create or change new laws and policies to protect workers
Healthy Start Coalition of Orange County	Education Access and Quality & Healthcare Access and Quality	Screenings	Health & Wellness	Work with providers & resources to ensure that every patient is screened at their first prenatal appointment

Orange County Public Schools	Education Access and Quality	Student transportation	Accessibility	Expand availability of programs throughout county, for pregnant teenagers
American Heart Association	Education Access and Quality	Understand the role education plays in overall heart health	Knowledge & Awareness	Create networks/partnerships that expand education opportunities for communities in need
Second Harvest Food Bank of Central Florida	Economic Stability	Food Access to at risk moms	Accessibility	Using grant opportunities to partner with healthcare organizations that work with at risk mothers
Community Member	Economic Stability	Income	Financial Resources	Change policies to increase the income level for residents to receive services (rental assistance, food access, etc.)
DOH-Orange	Economic Stability	Hours of service	Accessibility	Provide flexible staff schedule
Civic Communication	Health Care Access and Quality	Provider and patient awareness of service availability	Knowledge & Awareness	Increase of marketing and promotion services
People Making a Difference	Health Care Access and Quality	Funding	Financial Resources	Seeking more grant opportunities
Community Member	Health Care Access and Quality	Lack of knowledge of resources	Knowledge & Awareness	Market resources in priority populations and neighborhoods
Embrace Health	Health Care Access and Quality	People do not know about services provided	Knowledge & Awareness	More marketing and partnerships

Holden Heights Community Center	Neighborhood and Built Environment	Prioritizing community needs	Health & Wellness	Input from community. Community-led discussion
DOH-Orange	Neighborhood and Built Environment	Access to services	Accessibility	More outreach opportunities
Community Member	Neighborhood and Built Environment	Walkability	Accessibility	Community and City grants to provide strollers
DOH-Orange	Social & Community Context	Funding	Financial Resources	Seek more grant opportunities
Center For Change	Social & Community Context	Discrimination	Knowledge & Awareness	Policy changes
Advent Health	Social & Community Context	Medical Distrust	Health & Wellness	Minority doctors, policy changes, increase mental health providers

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 Healthy Start Coalition of Orange County to ensure feasibility (see Appendix D & E for project management plan (D) and project Logic model (E)). To maximize impact on disparities in Black infant mortality, and for continued sustainability, a grant was submitted on April 26, 2022, (Health Resources & Services Administration (HRSA): Catalyst for Infant Health Equity (requested amount for 5 years: $2,369,424). The details, action plan, and workplan for the proposed grant can be viewed in Appendix F.

IX. HEALTH EQUITY PLAN OBJECTIVES

A. Health Disparity: Infant Mortality

Health Disparity Objective: By December 2025, decrease the three-year rolling infant mortality rate among Black infants in Orange County from 12.5 in 2017-2019 to 10.0 per 1,000 live births. [Florida Charts]

Project #1: Expanding the Findhelp.org referral system

	Lead Entity and Unit	Lead Point Person	Data Source & Measurement	Baseline Value	Target Value	Plan Alignment
Long-Term SDOH Goal: Improve support systems by enhancing the Findhelp.org referral system						
Objective: By December 31, 2025, community partners are linked to the Findhelp.org referral system from 50% to 95%	AdventHealth	Rebecca Desir	Findhelp.org Referral and linkage logs Number of Organizations enrolled: Number of referrals by SDOH (see log example in Appendix I)	50%	95%	CHIP: Strategy HE1.1
Medium-Term SDOH Goal: Improve support systems through capacity building						
Objective: By December 31, 2023, increase patient and health provider education/training on findhelp.org from 0 to 100 for partners and 500 for clients	FindHelp.org American Heart Association Family and Friends United	Renee Rivers Eric Sanchez Sharon Warner	Training session logs and participant attendance logs Number of providers and Black women clients educated and trained	Partners: 0 Patients/Clients: 0	Partners: 100 Clients: 500	CHIP: Strategy HE1.1

(1) Short-Term SDOH Goal: Improve community engagement by increasing knowledge and awareness						
Objective: By December 31, 2023, increase knowledge and awareness through marketing and promotion efforts on findhelp.org from 0 to 50% of the population	Families and Friends United	Sharon Warner	Marketing efforts tracking log; marketing view data	0	50%	CHIP: Strategy HE1.1

Project #2: County-wide Culturally Linguistically Appropriate Standard Assessment and Implementation

	Lead Entity and Unit	Lead Point Person	Data Source	Baseline Value	Target Value	Plan Alignment
Long-Term SDOH Goal: Improve Provider Linguistic and Cultural Competency & Quality of Care						
Objective: By December 31, 2025, address partnering organizations barriers to comply to CLAS standards from 0 to 20	DOH-Orange	Audrey Alexander Dahlia Scafe Dhanya Varghese	CLAS inventory evaluation tool	21	40	CHIP: Strategy HE1.1
Medium-Term SDOH Goal: Improve Provider Linguistic and Cultural Competency & Quality of Care						
Objective: By December 31, 2023, evaluate partnering agencies compliance to the 15 CLAS standards from 0 to 20	Heart of Florida United Way DOH-Orange	Delitza Fernandez Dahlia Scafe Dhanya Varghese	CLAS inventory evaluation tool	41	60	CHIP: Strategy HE1.1

Short-Term SDOH Goal: Improve Provider Linguistic and Cultural Competency & Quality of Care						
Objective: By December 31, 2022, educate and train partnering organizations on CLAS standards from 0 to 20	Winter Park Health Foundation DOH-Orange	Melody Griffin Audrey Alexander Dahlia Scafe Dhanya Varghese	Sign-in sheets and pre-post evaluations	0	20	CHIP: Strategy HE1.1

Project data will be collected quarterly from entity/lead point person. Information will be provided to the Minority Health Liaison for gathering and importing of the data. A data importing template will be designed for community members to enter their information. The data will be monitored via a dashboard and all data will be disseminated to the Health Equity Task Force, Health Equity Coalition, DOH-Orange leadership team, and the public via newsletter.

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's end.

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

XI. REVISIONS

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

Revision	Revised By	Revision Date	Rationale for Revision

XII. APPENCICES

A. Healthy Start Coalition Members

Name	Organization
Unnati Shah	DOH-Orange
Sandra Algarin	Community Health Centers
Rebecca Desir	AdventHealth
Marie Jose Francois	Community Health Center
Sabrina Alfred Forbes	Children's Home Society
Gail Garvin	HSCOC/FIMR/Board of Directors
Kimberly Huber	Winner Palmer Hospital
Latanya Jones	4-C
Evelyn Dillard	DOH-Orange
Esma Dennis	Foster Care Recruiter Embrace Families
Sharon Lyles	Central Florida Diaper Bank
Patricia Gaige	WIC DOH-Orange
Courtney Gleaton	Injury Prevention - Trauma Administration
LaJuana Raines	Orange County Sheriff's Office
Adrian Lawson	DOH-Orange
Christina Sparks	Community Member/Board of Directors
Dr. Tara Williams	Nemours
Matthew Stewart	AETNA

Theresa M Cesar	AETNA Better Health
William Reyes	AETNA
LaVegas Engram	WellCare / Centene
Renae Oxford	Sunshine Health
Denise Petrie	Sunshine Health
Julie Ruiz	Sunshine Health
Christa Chestnut	Sunshine Health
Valencia Norton	Sunshine Health
Sakialynn Johnson	DOH-Seminole
Carissa Johns	Orange County Government
Danielle Campbell	City of Orlando
Keya Brandon	Kreative Concepts, Inc.
Andrea Branagan	Community Member
Mareshah Smith	Family Preservation Stabilization & Parenting Support Squad – Orange County
Linda Sutherland	Advocate
Jarred McCovery	Healthy Start Coalition of Orange County (HSCOC)
Elaine Cauthen	HSCOC
Thelisha Thomas	HSCOC
Anajara Gazzalle	Community Member
Arthur Howell Charnae DeBose	DOH-Orange DOH-Orange
Chaithanya Renduchintala	Community Member
Nancy Hagan	Community Member/Board of Directors

Penny Smith	DOH-Orange
Sara Osborne Trinity Compton Alyson Watson	Orlando Health Orlando Health Orlando Health
Tina Morgan Latrelle Williams	Dept. of Children and Families Dept. of Children and Families
Valerie Gore	HSCOC/Board of Directors

B. DOH-Orange CLAS Standard

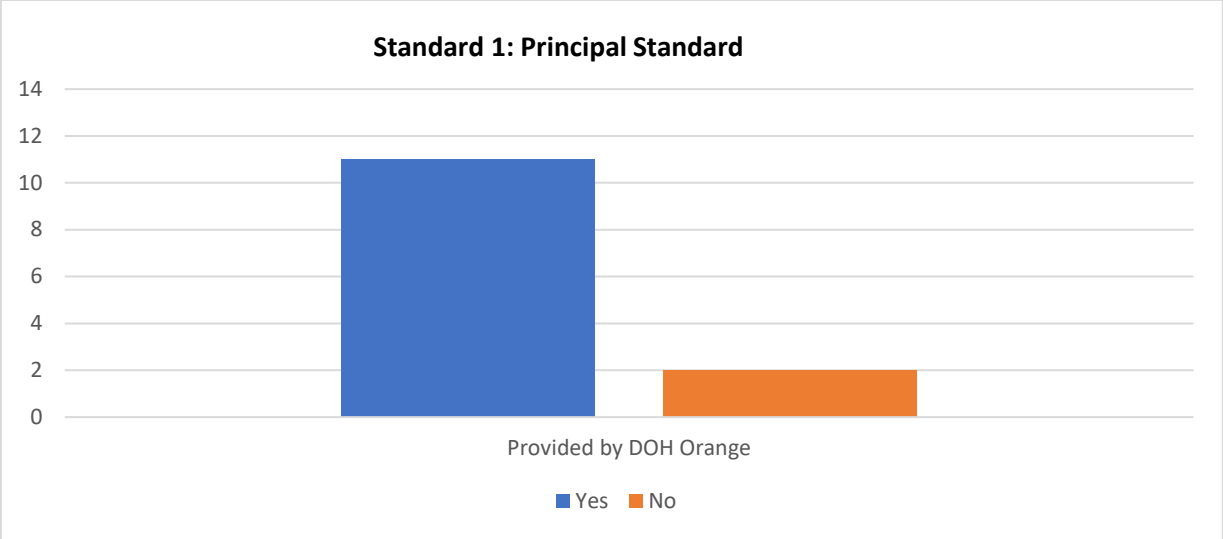
Summary:

The 2013 version of the National CLAS standards was used to assess 13 DOH-Orange programs (Epidemiology, Sexually Transmitted Disease, Immunizations, Office of Performance and Quality Improvement, Healthy Start, Women Infant and Children, Vital Statistics, Information Technology, Human Information Management, Family Planning Prenatal Health, Dental, Environmental Health, School Health) compliance to the 15 standards in 2022. All program managers were provided with the inventory tool to assess if their departments are in compliance with providing the standards. The inventory tool provided open and closed ended questions to fully evaluate the standard. Program managers had the opportunity to describe the barriers, success, and improvement strategies pertaining the specific standards. Ninety percent of respondents want more linguistic, cultural diversity, and health equity training, workshops, or education. The others want more effective ways to communicate with employees and clients, improve public relations for referral processing and deliver beneficial services to clients. Some departments try to provide interpreters and a wide range of languages for clients to provide good patient care. The goal of these reviews is to assess and determine the opportunities to improve compliance with each standard and address any identified barriers and/or needs within the agency.

The charts below show the departments results (13) of standard compliance:

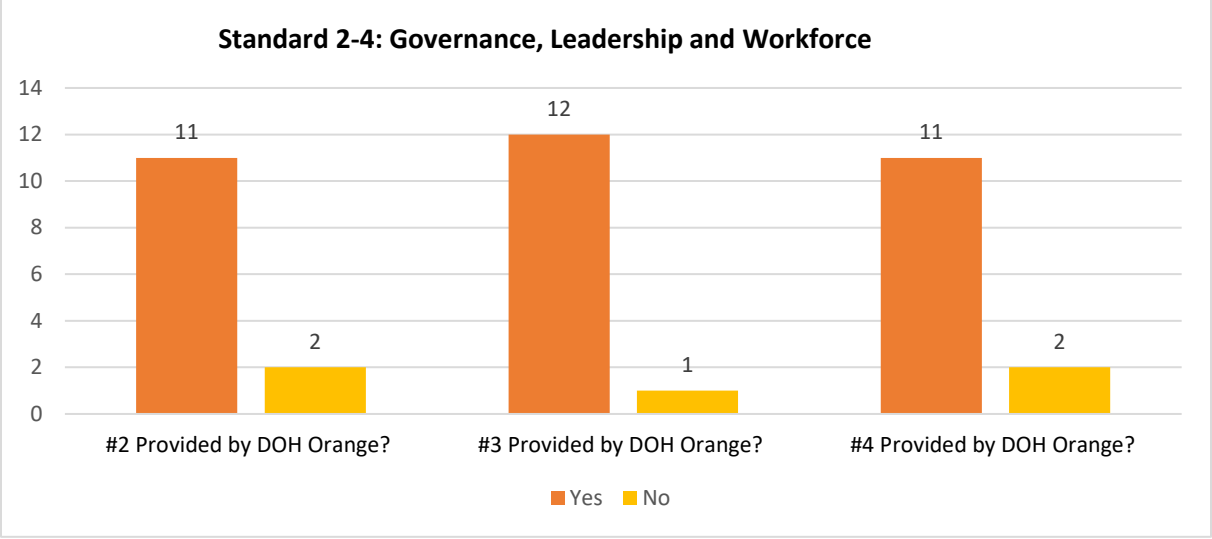
Principal Standard

1. 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.



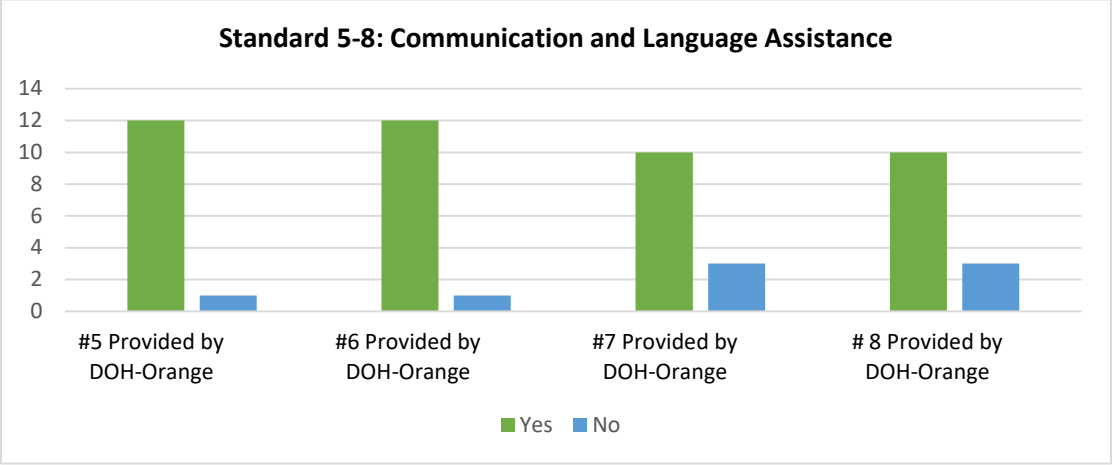
Governance, Leadership and Workforce

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.



Communication and Language Assistance

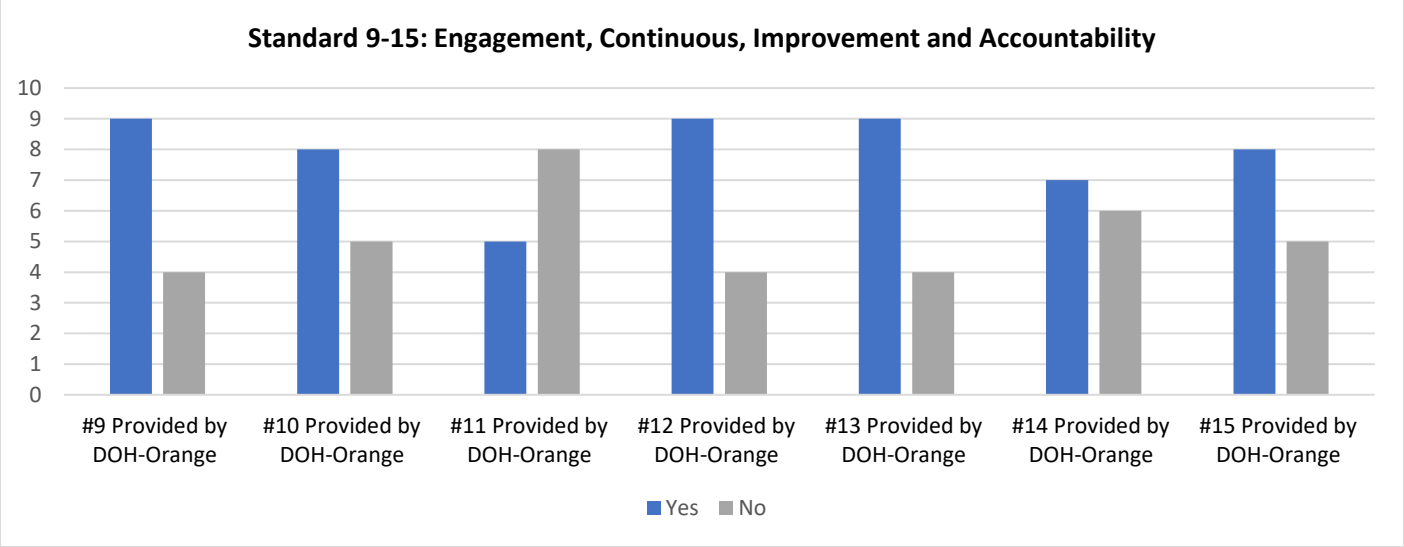
5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.



Engagement, Continuous Improvement, and Accountability

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.

12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the public.



Barriers Summary: Most departments were impacted by staffing and financial constraints. As a result, barriers such as a lack of interdepartmental employee training, finding interpreters, providing a diverse staff for outreach education in different communities, and printed information for community communication were encountered. Better facilities, which can aid in better care, and better system migration, which will allow data to flow more efficiently and effectively while providing client feedback, are the other two impediments. If these barriers are removed, communication will become more effective and diverse. Please see the survey bulleted list below:

- Outreach with wrong staff language barrier
- Funding
- Better facilities
- Employees needing continual training
- Multiple systems do not communicate with each other
- Connecting translator with clients via phone (i.e., call drops)
- Staffing shortages

Needs: Even though the department needs a diverse staff to deliver better customer service to the communities, most departments struggled with the process of hiring new workers or volunteers. One of the primary findings of this survey was that cultural diversity is confined to Spanish and English, and that we need more open language lines for outreach (i.e., deaf, and hearing-impaired customers) 24 hours a day, seven days a week, to better serve the entire community.

- Have a designated CLAS champion for diversity and inclusion who focuses efforts around ensuring the department is being culturally competent in its effort
- Recruiting more staff
- Quicker on-boarding process for new hires and volunteers
- Services for deaf and hard of hearing clients
- Recruit, promote, and hire individuals from the community for the department.
- Diverse (race/ethnicity) Epidemiology department staff and leadership

C. CLAS Survey Results (Client & Staff)

Summary:

DOH-Orange is committed to providing the best service to its clients through health equity, improved quality and helping to eliminate healthcare disparities by implementing the Cultural and Linguistic Appropriate Service (CLAS) standards; 15 standards provided by the U.S Department of Health & Human Services.

To prepare staff with CLAS implementation the Health Equity Team issued a web-based survey to staff and a paper survey to clients. The clients who received clinical services (STD, Family Planning, WIC, and Dental) during the week of May 23, 2022, to May 27, 2022, completed the survey while waiting to be seen by DOH-Orange staff. The staff was asked to complete the survey from May 1, 2022, to May 31, 2022.

The results from the clients will be displayed along with a side-by-side comparison of the same questions asked to both clients and staff to illustrate how clients and staff perceive the same issues. The data displayed is based on a diverse 111 completed client surveys and 70 (15% of agency staff) completed staff surveys. The Staff CLAS charts below depicts how DOH in Orange County interacts with their clients on a regular basis, giving care and cultural diversity. DOH-Orange serves a wide culture of clients, but with dedicated efforts, DOH-Orange provides training, materials in many languages, hires staff from a variety of backgrounds, and provides assistance to a variety of age groups. Overall, DOH-Orange employees agree that the department delivers appropriate health care to its clients in accordance with the National CLAS Standard.

The report will include questions and frequencies of survey responses. The survey results will provide a snapshot of client and staff perception towards the service and experience that is being provided to the people served in the community. The results will also help to adequately train and increase the competency of staff to better serve the clients.

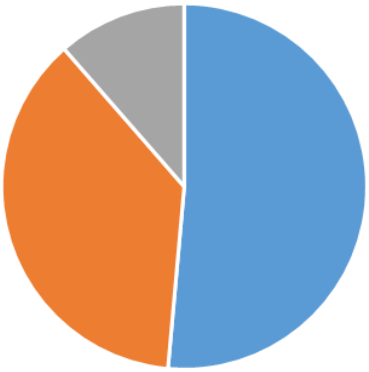
1. What is your ethnicity?

DOH - Staff

Hispanic	17
Non-Hispanic	39
I do not wish to answer	13

DOH - Clients

Hispanic	54
Non-Hispanic	39
I do not wish to answer	12

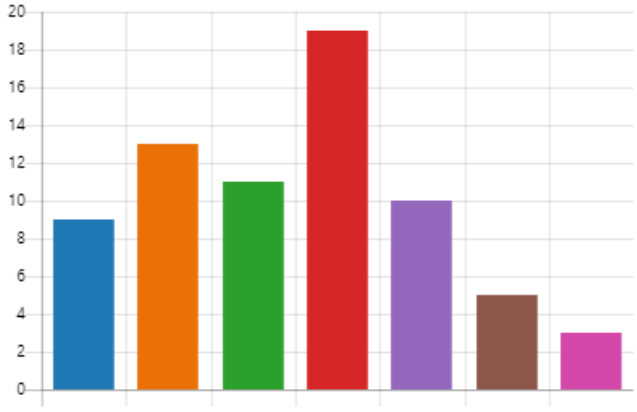


According to the client's CLAS surveys, a high percentage of Hispanic respondents completed the survey. The highest average in the staff poll was non-Hispanic. These polls reveal a wide range of responses from the community.

2. What is your age range?

DOH - Staff

18-29	9
30-39	13
40-49	11
50-59	19
60+	10
Do not wish to answer	5
Other	3



DOH - Clients

18-39	91
40-59	14
60+	0
Do not wish to answer	0
Other	1

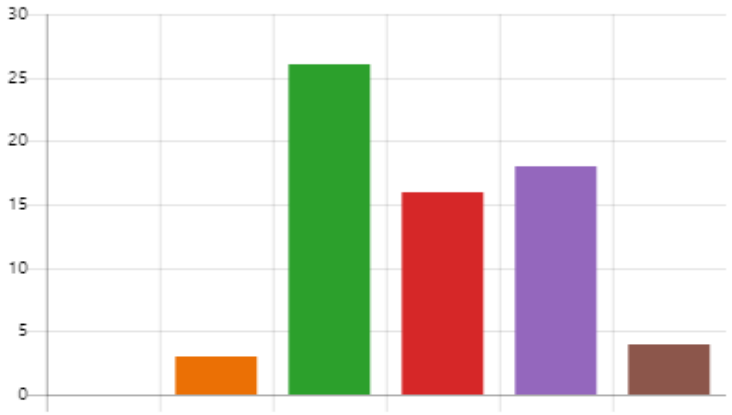
The 18-39 age group receives the greatest responses in the client surveys. The majority of DOH staff respondents' range in age from 40 to 59 years old.

3. What is your race?

More Details

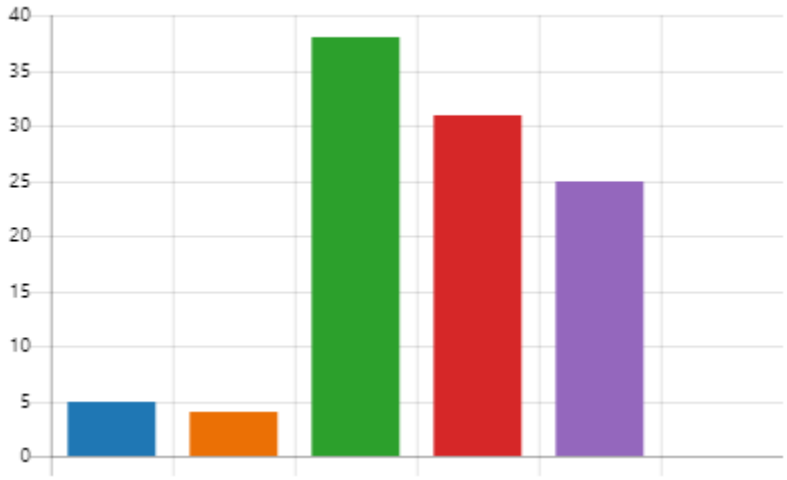
DOH - Staff

American Indian	0
Asian	3
Black or African American	26
White Caucasian	16
I do not wish to answer	18
Other	4



DOH - Clients

American Indian	5
Asian	4
Black or African American	38
White Caucasian	31
I do not wish to answer	25
Other	0



The charts reveal that the majority of respondents were Black/African-American, for both clients and staff. Other major categories included White Caucasian and other / I don't want to know the answer.

4. The agency's printed materials (brochures, flyers, pamphlets, etc.) reflect the various cultural backgrounds of people served.

DOH - Staff

Strongly Agree	10
Agree	36
Disagree	6
Strongly Disagree	4
Don't Know	14

DOH - Clients

Strongly Agree	43
Agree	38
Disagree	2
Strongly Disagree	0
Don't Know	25

The cultural background presented in both the chart for staff and the client indicates that the Department of Health provides a variety of printed materials to reach clients. The charts illustrate that clients and employees believe that the variety of printed materials allows for good communication between them.

5. The cultural diversity among staff and volunteers of the agency is reflective of the diversity among people served by the agency.

DOH - Staff

Strongly Agree	17
Agree	40
Disagree	3
Strongly Disagree	2
Don't Know	7

DOH - Clients

Strongly Agree	44
Agree	37
Disagree	3
Strongly Disagree	0
Don't Know	24

Cultural diversity is provided in DOH-Orange, as evidenced by the client and staff charts. This demonstrates that the DOH-Orange delivers cultural diversity not only in printed materials, but also person-to-person involvement and interaction with the community.

6. The cultural diversity of clients currently served by the agency is reflective of the cultural diversity of persons most in need of service in the broader community.

DOH - Staff

Strongly Agree	17
Agree	41
Disagree	6
Strongly Disagree	0
Don't Know	6

DOH - Clients

Strongly Agree	42
Agree	41
Disagree	4
Strongly Disagree	0
Don't Know	20

Both charts illustrate that DOH-Orange met the cultural needs of their clients and cared for them. Clients and staff agree or strongly believe that DOH-Orange community care is centered on the services that their clients or communities require.

7. Staff understand the communication needs of clients.

DOH - Staff

Strongly Agree	12
Agree	42
Disagree	6
Strongly Disagree	3
Don't Know	6

DOH - Clients

Strongly Agree	61
Agree	34
Disagree	2
Strongly Disagree	0
Don't Know	10

Both charts demonstrate that DOH-Orange staff and clients agree on the communication needs of the clients served.

8. Staff respect the communication needs of clients.

DOH - Staff

Strongly Agree	17
Agree	36
Disagree	5
Strongly Disagree	1
Don't Know	5

DOH - Clients

Strongly Agree	65
Agree	36
Disagree	0
Strongly Disagree	0
Don't Know	5

These results represent both staff and client's perspective on the respect of communication needs of clients. Because of the respect shown, our clients and staff will continue to provide and return to DOH-Orange clinics for care, as well as hiring new diverse personnel to maintain successful communication.

9. Staff members are culturally competent.

DOH - Staff

Strongly Agree	11
Agree	36
Disagree	12
Strongly Disagree	2
Don't Know	9

DOH - Clients

Strongly Agree	56
Agree	32
Disagree	0
Strongly Disagree	1
Don't Know	12

Client and staff charts both agree that the staff is culturally competent and effective in always communicating with their clients and the community providing great health-care services to their community.

10. In general, I feel that the agency does a good job in serving customers from diverse cultures.

DOH - Staff

Strongly Agree	14
Agree	38
Disagree	8
Strongly Disagree	1
Don't Know	9

DOH - Clients

Strongly Agree	76
Agree	19
Disagree	0
Strongly Disagree	0
Don't Know	7

DOH-Orange delivers outstanding care services to the community while also giving a diverse culture of employees and communication to their clients on a daily basis, as shown by the overall charts between client and staff.

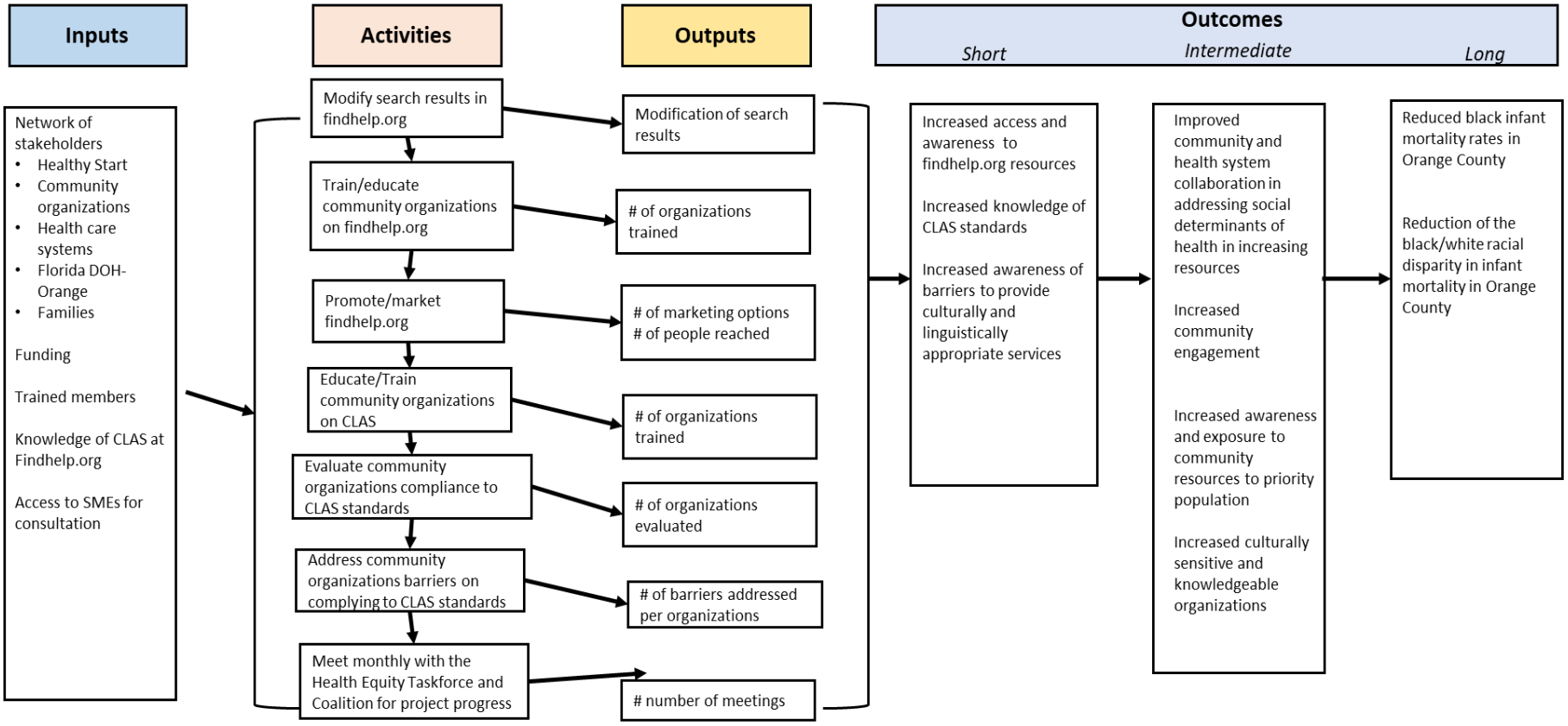
D. Project 1 & 2: Project Management

Please click on file below to view the project management plan

SDOH_ProjectManagmentTool.xlsx

E. Project Logic Model

Goal: Address all social determinates of health through organizational system change and linkage of care to reduce black infant mortality in Orange County



F. Infant Mortality Grant Action Plan & Workplan

ACTION PLAN

PROJECT NAME	PROJECT MANAGER
Orange County Fetal and Infant Mortality Review (FIMR) Initiative	Ellis Perez

Plan Description: Implement a multi-sector collaborative approach to reduce black infant deaths, health disparities, and increase health equity through capacity building to address social determinants of health.

Long-Term Goal: Reduce infant mortality rates among black non-Hispanics in Orange County, FL

Priority SDOH (Domains)	ACTION	RESPONSIBLE	Measure	STATUS	START	END
Health Care Access and Quality/ Economic Stability	**Priority Goal #1: Mitigate access to health services**					
	Increase Health Literacy Knowledge	Healthy Start Coalition	Number of community members educated	In progress	2022	2027
	Increase Mass Media Messaging and health Promotion	Healthy Start Coalition	Number of messages, number of views, number of viewer engagement	In Progress	2022	2027
	Expand access to care in underserved communities	PCAN	Percent increase in health care access	In Progress	2022	2027
	Increase and promote postpartum telehealth services	DOH-Orange	Number of clients using telehealth services	In Progress	2022	2027
	Increase family planning counseling	DOH-Orange	Number of clients counseled	In Progress	2022	2027
	Increase and improve client referred for a medical home	DOH-Orange; PCAN	Number of clients referred	In Progress	2022	2027
	Increase access to mental health services	Aspire	Percent increase of mental health services	In Progress	2022	2027

	Expand services that address transportation barriers	Lynx, Uber Health	Number of clients using language lines and transportation services	In Progress	2022	2027
	Improve quality of care and services at the clinical sites by using culturally and linguistically appropriate service delivery and practices	DOH-Orange	Number of clients using language lines and/or number of trained interpreters' bilingual staff at clinical sites	In progress	2022	2027
	Increase Doula services	Empower Black Doula; Common Sense Childbirth	Percent increase in use of doula services	In Progress	2022	2027
	Eliminate barriers to COVID-19 testing & vaccination	DOH-Orange/Orange County Government	Percent increase in testing and vaccination	In Progress	2022	2027
	Priority Goal #2: Understand, enhance, and increase, evidence-based interventions to eliminate infant death					
	Conduct continuous fetal & Infant Mortality review standards	DOH-Orange	Number of fetal/infant cases reviewed monthly	In progress	2022	2027
	Increase utilization of maternal and child health data collection and analysis methods	DOH-Orange	Number of completed Data collection and analysis reports	In progress	2022	2027
	Increase access to obesity, diabetes, and hypertension prevention programs to women of reproductive age and pregnant	Center for change	Number of intervention education sessions; number of participants	In progress	2022	2027
	Implement and conduct home blood pressure monitoring of pregnant gestational hypertensive women to reduce adversely birth outcomes and/or maternal mortality incidences.	DOH-Orange	Number of home blood pressure monitoring participants, number of adversely affected birth outcomes. maternal mortalities.	In progress	2022	2027

	Increase health education & resources (breastfeeding, car seat, safe sleep, food vouchers etc.) to childbearing age women	Healthy Start Coalition; DOH-Orange; Second Harvest	Number if education sessions; number of participants	In progress	2022	2027
	Priority Goal #3: Advance multi-sector collaboration, capacity, and health equity					
	Execute and Implement the Community Health Improvement Plan & Health Equity Plan	DOH-Orange	Number of community meetings; number of participants; number of participants	In progress	2022	2027
	Share resources to Implementation the Culturally linguistically appropriate Services (CLAS) across sectors	DOH-Orange	Number of organizations who implement CLAS	In progress	2022	2027
	Increase training on ACEs	Children's Cabinet	Number of training sessions; number of participants	In progress	2022	2027
	Review and align partnerships and/or policies that incorporate implicit bias processes to ensure pregnant and parenting women/families are linked appropriately to resources to address SDH (i.e., transportation access and food security) and reduce infant mortality.	Healthy Start CAN	Number of partnerships participating in a seamless referral linkage for pregnant and parenting women/families	In progress	2022	2027
	Provide training and ongoing professional development on equity that builds understanding of any competencies to advance health equity.	DOH-Orange	Number of training sessions; number of participants	In progress	2022	2027

Work Plan

Goal: Reduce infant mortality rates among Black non-Hispanics in Orange County, FL					
Objective 1: Complete the infant health equity action plan implementation in Orange County FL by August 31st, 2027					
Activity	**Measure**	**Responsible Personnel**	**Resources**	**Timeline**	**Communication Plan**
Conduct project kick-off community meeting to educate and commit community partners on the 5-year project plan and its sustainability plan	Scheduled meeting; Number of attendees	Project Director	Meeting space/room;	October 2022	Email, phone calls, video conferencing, press release
Budget Re-assessment	Completed Budget Re-assessment	Project Director	Staff time, excel,	September 2022	Email, Phone
Hire project personnel	Number of personnel hired	Project Director	Recruitment platform, Human Resource Department staff,	September 2022 – January 2022	Email, Phone, position advertisement platform, face to face interview, video conferencing interview
Conduct monthly Health Equity Taskforce meetings ad trainings to address the community Health Equity plan	Number of Meeting conducted; Number of community partners reporting activity data	DOH-Orange Minority Health Liaison	Meeting platform, community partners	September 2022 – December 2027	Email, video conferencing, phone, reports
Conduct monthly FIMR meetings and case review (2-4 cases)	Number of FIMR Meetings; Number of infant death cases reviewed	Community Engagement Coordinator; MCH epidemiologist; Nurse Abstractor	Meeting space; multi sector community partners; medical records, vital statistics; community mothers; mental health partnership; office supplies	September 2022 – August 2027	Email, video conferencing, phone, reports

G. Data Analysis of Maternal and infant Characteristics by race: Health Disparity Indicator

Maternal and Infant Characteristics of Black and White Infant Deaths, Orange County, (2019)			
	Black Infants	**White Infants**	
	n (%)	**n (%)**	**Unadjusted OR (95% CI)**
	N=170	**N=138**	
Causes of Death			
Congenital disorder/birth defects	24 (14.1)	25 (18.1)	0.7 (0.4-1.4)
Homicide	1 (0.6)	1 (0.7)	0.8 (0.1-13.1)
Infection	12 (7.1)	3 (2.1)	3.4 (0.9-12.4)[c]
Perinatal conditions	65 (38.2)	58 (42.0)	0.9 (0.5-1.4)
Premature birth	45 (26.5)	24 (17.4)	1.7 (1.0-3.0)[c]
SIDS	9 (5.3)	16 (11.6)	**0.4 (0.3-1.0)[c,d]**
Unintentional injury	1 (0.6)	2 (1.5)	0.4 (0.0-4.5)
Other condition	13 (7.7)	9 (6.5)	1.2 (0.5-2.9)
Sex			
Male	95 (55.9)	77 (55.8)	1.0 (0.7-1.6)
Infant Age at Death			
<28 days	132 (77.7)	107 (77.5)	1.0 (0.6-1.7)
28 – 364 days	38 (22.4)	31 (22.5)	Ref
Gestational Age			
<37 weeks	141 (82.9)	103 (74.6)	1.7 (1.0-2.9)[c]
>=37 weeks	29 (17.1)	35 (25.4)	Ref
Birth weight			
<2500 g	142 (85.0)	100 (73.5)	**2.0 (1.2-3.6)[c, d]**
>=2500 g	25 (13.8)	36 (26.5)	Ref
Maternal age (yrs), median (IQR)	28.5 (23 – 34)	28.0 (25 – 32)	1.0 (1.0-1.0)
Maternal Conditions			
None	54 (31.8)	38 (27.5)	1.2 (0.7-2.0)
Diabetes (pre-pregnancy)	5 (3.0)	2 (1.5)	2.1 (0.4-10.8)
Diabetes (gestational)	4 (2.4)	6 (4.4)	0.5 (0.1-1.9)
Hypertension (pre-pregnancy)	10 (5.9)	6 (4.4)	1.4 (0.5-3.9)
Hypertension (gestational)	9 (5.3)	17 (12.3)	**0.4 (0.2-0.9)[c, d]**
Overweight/Obese (BMI ≥ 25 [a])	85 (66.4)	56 (54.4)	1.7 (1.0-2.8)[c]
Previous Preterm	8 (4.7)	4 (2.9)	1.7 (0.5-5.6)
Previous Live Birth Now Dead	9 (5.6)	5 (3.9)	1.5 (0.5-4.5)
Maternal Infection [b]	34 (20.4)	25 (18.4)	3.4 (0.9-12.4)[c]
Maternal Complications During Labor			
None	66 (38.9)	37 (26.8)	**1.7 (1.1-2.8)[c, d]**
Precipitous Labor	3 (1.8)	3 (2.2)	0.8 (0.2-4.2)
Premature ROM	14 (8.2)	16 (11.6)	0.7 (0.3-1.5)

Prenatal Care			
Received no prenatal care [a]	10 (6.4)	10 (8.3)	0.8 (0.3-1.9)
≤ 10 prenatal visits [a]	111 (96.5)	84 (90.3)	3.0 (0.9-10.0)[c]
Maternal highest degree obtained			
No high school	25 (16.1)	29 (22.8)	0.7 (0.4-1.2)
High school	96 (61.9)	65 (51.2)	1.6 (1.0-2.5)[c]
Associate/Bachelor	28 (18.1)	24 (18.9)	0.9 (0.5-1.7)
Graduate/Professional	6 (3.9)	9 (7.1)	0.5 (0.2-1.5)
Insurance status			
Medicaid	105 (61.8)	75 (54.4)	1.4 (0.9-2.1)
Private insurance	48 (28.2)	50 (36.2)	0.7 (0.4-1.1)
Self-pay	14 (8.2)	11 (8.0)	1.0 (0.5-2.4)
Other	1 (0.6)	0 (0.0)	--
Positive Healthy Start Screen (score ≥4)	133 (85.8)	103 (79.2)	1.6 (0.9-2.9)[c]
Births with interpregnancy interval < 18 months [a]	20 (31.8)	21 (34.4)	0.9 (0.4-1.9)
Mother not married	115 (68.1)	82 (60.3)	1.4 (0.9-2.2)
Substance use during pregnancy			
Alcohol	0 (0.0)	0 (0.0)	--
Tobacco	2 (1.2)	9 (6.7)	0.2
Mother received WIC*	78 (49.4)	46 (36.8)	**1.7 (1.0-2.7)[c, d]**
Infant not breastfed	83 (49.7)	60 (43.8)	1.3 (0.8-2.0)

Missing >10% of values
b. Includes chlamydia, gonorrhea, syphilis, hepatitis b, hepatitis c, or other infection
c. P≤0.1
d. P≤0.05
Note: This data was analyzed with SAS 9.5 software

H. Community Resources Assets

Community Organization	Social Determinants of Health
Advent Health	Healthcare Access / Education Access
American Lung Association	Healthcare Access and Quality
Apopka Family Learning Center	Education Access and Quality
Aspire Health Partners	Healthcare Access and Quality
Assisted Living Facilities	Economic Stability
BETA/UCP	Education Access and Quality
Boys & Girls Club of Central Florida	Education Access and Economic Stability
Catholic Charities	Social and Community Context
Center for Change	Healthcare Access & Quality / Education
Center for Multicultural Wellness & Prevention	Healthcare Access and Quality
Central Florida Commission on Homeless	Economic Stability
Central Florida Diaper Bank	Economic Stability
Central Florida Employment Council	Economic Stability
Central Florida Family Medicine	Healthcare Access and Quality
Central Florida Partnerships on Health Disparities	Healthcare Access and Quality
Central Florida Pharmacy Council	Healthcare Access and Quality
Central Florida Urban League	Neighborhood and Built Environment
Central Florida YMCA	Economic Stability
Children Safety Village	Economic Stability/ Healthcare Access
Children's Home Society of Central Florida	Healthcare Access and Quality
Christian Services Center of Central Florida	Economic Stability
Cincinnati Children's Toyota	Healthcare Access and Quality
City of Orlando Parks & Recreation	Built Environment
Coalition for the Homeless of Central Florida	Economic Stability
Common Sense Childbirth	Healthcare Access and Quality
Community Health Centers	Healthcare Access and Quality
Community Vision	Healthcare Access and Quality
County Chamber of Commerce	Economic Stability
Covenant House	Economic Stability
Dental Care Assess Foundation	Healthcare Access and Quality

Destiny Institution	Education Access and Quality
Downtown Orlando Partnership	Economic Stability
Empower Black Doula	Healthcare Access and Quality
Florida Department of Health in Orange County	Healthcare Access and Quality
Florida Nurses Association	Healthcare Access and Quality
Goodwill	Economic Stability
Healthy Start Coalition of Orange County	Economic Stability / Healthcare Access & Quality / Education Access and Quality
Interfaith Hospitality Network Orlando	Healthcare Access and Quality
La Amistad Residential Treatment Center	Healthcare Access and Quality
Leadership Orlando	Education Access and Quality
Local Physicians	Healthcare Access and Quality
Long Term Care Facilities	Healthcare Access and Quality
Metro Orlando Economic Development	Economic Stability/ Built Environment
Mission Fit Kids	Healthcare Access and Quality
National Alliance on Mental Health	Healthcare Access and Quality
National Association of County and City Health Officials (NACCHO)	Healthcare Access and Quality
Nemours	Healthcare Access and Quality
New Family Resource Center	Education Access and Quality
Nurse Family Partnership	Healthcare Access and Quality
Orange Blossom Family Health	Healthcare Access and Quality
Orange County Emergency Rental Assistance	Neighborhood & Build Environment
Orange County Government	Healthcare Access and Quality /Economic Stability
Orange County Parks & Recreation	Neighborhood and Built Environment
Orange County Public Library	Education Access and Quality
Orange County Public School System	Education Access and Quality
Orlando Health	Healthcare Access and Quality
Orlando Rental Assistance Program	Neighborhood and Build Environment
Orlando Union Rescue Mission Men's Division	Social and Community Context
Orlando VA Medical Center	Healthcare Access and Quality
Overeater Anonymous	Healthcare Access and Quality
Parenting Support Squad	Education Access and Quality

Park Place Behavioral HealthCare	Healthcare Access and Quality
Pathways Drop In Center	Healthcare Access and Quality
Primary Care Access Network (PCAN)	Healthcare Access and Quality
Prosperitas Leadership Academy	Education Access and Quality
Reduce Obesity in Central Florida	Healthcare Access and Quality
Second Harvest Food Bank	Economic Stability
Seniors Resource Alliance	Healthcare Access and Quality
Shepherds Hope	Healthcare Access and Quality
Teen Express	Education Access and Quality
Teen Parenting OPS	Education Access and Quality
The Center for Disease Control and Prevention	Healthcare Access and Quality / Education
The Center Orlando	Economic Stability/ Healthcare Access
The Chrysalis Center, Inc	Healthcare Access and Quality
The Collaborative Obesity Prevention Program	Healthcare Access and Quality
The Grove Counseling Center	Healthcare Access and Quality
The Mental Association of Central Florida	Healthcare Access and Quality
The National Kidney Foundation	Healthcare Access and Quality
The Transition House	Healthcare Access and Quality
True Health	Healthcare Access and Quality
Uber Health	Neighborhood and Built Environment
United Against Poverty	Economic Stability
WellCare	Healthcare Access and Quality

I: SDOH Tracking Log

SDOH Indicator	Organization Name	Population Referred	Number Of Referrals
Literacy			
Language			
Early Childhood Development			
Vocational Training			
Higher Education			
Employment			
Debt/ Medical Bills Assistance			
Food Access			
Domestic Support			
Housing Assistance			
Transportation Assistance			
Health Coverage			
Linkage To Provider			