OKLAHOMA HEALTH IMPROVEMENT PLAN

A COMPREHENSIVE PLAN TO IMPROVE THE HEALTH OF ALL OKLAHOMANS · 2010-2014

The first wealth is health.

- Ralph Waldo Emerson

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OHIP Online: www.ok.gov/health [click 'Oklahoma Health Improvement Plan' link]

In health, there is freedom.
- Henri Frederic Amiel

Dear Health Improvement Partners & Citizens of Oklahoma,

Oklahoma ranks near the bottom in multiple key health status indicators. Many of these outcomes are related to conditions that Oklahomans must live with every day. Poverty, lack of insurance, limited access to primary care, and inadequate prenatal care, along with risky health behaviors associated with these determinants, such as low fruit/vegetable consumption, low physical activity, and a high prevalence of smoking contributes to the poor health status of our citizens.

Based upon these findings, it is essential for us to work together, across multiple health care systems, to improve the health of the citizens of our state. Oklahoma's poor health status is unacceptable and change must occur. Our goal is to make the change that, for the sake of our neighbors, friends, family, and fellow citizens, must occur. Your assistance in that process is crucial.

For the past year it has been our honor to work collaboratively on the Oklahoma Health Improvement Planning (OHIP) process. It has been a privilege to work with committed individuals representing business, labor, legislature, health care providers, tribes, academia, non-profit health organizations, state and local government agencies, professional affiliations, and parents.

The Plan envisions working together to lead a process to improve and sustain the physical, social and mental well being of all people in Oklahoma.

The Plan focuses on several key priorities and outcomes that, when achieved, will support health improvement throughout the state. These include improving health outcomes through targeted flagship initiatives of children's health improvement, tobacco use prevention, and obesity reduction; increasing public health infrastructure effectiveness and accountability; initiating social determinants of health and health equity approaches to address foundational causes of health status; and developing and initiating appropriate policies and legislation to maximize opportunities for all Oklahomans to lead healthy lives.

It is the desire of the State Board of Health and the Oklahoma Health Improvement Planning (OHIP) Team that you will use this plan to assist you in future actions to improve the public health system and the health of all Oklahomans. We look forward to working with you as we strive together to improve the health of the citizens of our state and make Oklahoma a healthier place to live.

Sincerely,

Barry L. Smith

Barry L. Smith, JD
President
Oklahoma State Board of Health

Terry Cline, Ph.D.

Terry L. Cline, PhD
Commissioner of Health and Chair,
OHIP Team

Happiness lies,
first of all, in health.

- Henri Frederic Amiel

EXECUTIVE SUMMARY

The United Health Foundation states that "Health is a result of our personal behaviors, our individual genetic predisposition to disease, the environment and the community in which we live, the clinical care we receive and the policies and practices of our health care and prevention systems."[1] This view of health is a challenge in our state.

The Oklahoma State Board of Health and health partners throughout the state are very concerned that Oklahoma ranks near the bottom of all states in important health status indicators and we are determined to change the status quo. In 2008, Senate Joint Resolution No. 41 was enacted to endorse Oklahoma State Board of Health activities, and required the Board to prepare and present to the Legislature a health improvement plan for Oklahoma for the general improvement of the physical, social, and mental well-being of all people in Oklahoma through a high-functioning public health system. The Board of Health convened a broad-based group and charged it with developing a statewide health improvement plan.

The group is guided by strategic planning principles, and framed by a vision and mission that drives formation of goals and objectives. The Oklahoma Health Improvement Plan (OHIP) is a culmination of this group's work. What follows is a description of key health measures that determined priorities recommended in the plan.

Identifying Health Problems

Oklahoma ranks poorly in multiple key health status indicators, when measured at both state and national levels.[2] The 2009 Commonwealth Fund's *State Scorecard on Health System Performance* ranks Oklahoma 50th in overall health system performance, with the state in the bottom tenth percentile on dimensions of access, quality, avoidable hospital use and costs, equity and healthy lives. Only on the dimension of avoidable hospital use and costs did the state improve from prior year rankings.[3] The *2009 United Health Foundation America's Health Rankings Report* rated Oklahoma 49th both in primary care providers per 100,000 and in the nation overall. Oklahoma was in the bottom tenth percentile for 50 percent of the cited measures. The report indicated challenges facing the state include a high prevalence of smoking, limited availability of primary care physicians, a high rate of preventable hospitalizations, many poor mental and physical health days, a high prevalence of obesity and a high rate of deaths from cardiovascular disease. Health disparities show obesity is more prevalent among non-Hispanic American Indians than non-Hispanic whites. The prevalence of diabetes also varies by race and ethnicity in the state.[1]

The *2008 State of the State's Health Report* issued by the Oklahoma State Board of Health and Oklahoma State Department of Health confirms national findings. Oklahoma still leads much of the nation with deaths due to heart disease. The state's rates for cerebrovascular disease deaths (strokes) are much higher than most of the nation. Of particular concern with both heart disease and cerebrovascular disease deaths is a large disparity among blacks, with higher rates than any other ethnic group in Oklahoma. Chronic lower respiratory diseases and lung cancer continue to plague Oklahoma at higher than national average rates, primarily because of Oklahoma's high use of cigarettes. Older adults (age 55+) in Oklahoma have significantly higher rates of diabetes and cancer than younger age groups, and between 36 to 40 percent report no physical activity in the past thirty days. Taken together, these conditions result in a much higher total mortality rate for Oklahoma than the rest of the nation.[2]

Many factors contribute to our poor health outcomes, higher rates of disease and overall higher total mortality. Personal behavior provides the single greatest opportunity to improve health and reduce premature deaths.[4] However, people do not make behavior choices in isolation, but in a larger, complex content. While individuals are responsible for instituting and maintaining the lifestyle changes necessary to reduce risk and improve health, individual behavior is also influenced to a large extent by the social environment, e.g. community norms and values, regulations, and policies.[5] The OHIP plan takes both behavioral and social determinants into consideration in analyzing the problems and framing recommendations.

Behavioral causes account for nearly 40 percent of all deaths in the United States.[4,6] Tobacco use and obesity are major factors influencing Oklahomans' health. These activities combined with physical inactivity are the top behavioral causes of premature death in the country.[4,6]

Key social determinants impacting Oklahomans' health include the following: 1) the number of individuals with low income, 2) low educational attainment levels, 3) high rates of uninsured, 4) racial and ethnic disparities, 5) inadequate access to transportation, and 6) unavailable or substandard housing. The OHIP plan recognizes the most effective approach to tackling these barriers is to increase healthy behaviors through a combination of efforts at the individual, interpersonal, organizational, community, and public policy levels.[5]

Planning Team

An outgrowth of a strategic planning retreat was the creation of an Oklahoma Health Improvement Planning (OHIP) Team, Executive Committee and Work Groups. Representatives on the team include legislative leaders, the private sector, key state agency directors, members of the public health community, professional associations and academic officials. Flagship issues were identified with work groups in the areas of tobacco use prevention, obesity reduction and children's health improvement. A reporting template was developed to identify goals, objectives, necessary actions and parties responsible for implementation. Other key work groups were created around health infrastructure issues in the areas of workforce development, public health financing, access to care and public health systems effectiveness.

Listening Sessions & Public Comments

Flagship and infrastructure issues were informed and modified appropriately by a statewide outreach effort. Listening sessions were held in each quadrant of the state (NE, NW, SE, and SW) and the two major metropolitan areas of the state including the communities of Ada, Enid, Grove, Guymon, Hugo, Lawton, Oklahoma City, Okmulgee, Tulsa, and Weatherford. A diverse group of stakeholders participated representing legislators, public health and health care professions, businesses, media, community coalitions, and schools. Participants learned about the OHIP process, received general findings from the work groups and provided feedback on these and other health issues. Attendees also received area-specific health care report cards measuring communities against state and federal benchmarks. The OHIP Team emphasized that input from local communities is critical to the health improvement process. This concurs with findings of the Robert Wood Johnson Commission to Build a Healthier America that identify collaboration as a necessary condition to create a broad base of support.[7] Overarching themes identified at these sessions included the following:

School Health

There is a need for comprehensive school health initiatives from prekindergarten through 12th grade. School interventions need to address health education curriculum, school nurses or like services, physical education, and nutrition. Participants stressed that schools are critical partners in addressing child health issues. Schools could contribute to the reduction in child obesity by offering healthy menus for lunch and increasing physical activity. An example is the state of Tennessee which found activities implemented through its Coordinated School Health Expansion and Physical Activity Law reduced absenteeism due to school nurses providing routine care on-site. Additionally, students' body mass index (BMI) measures improved.[7,8]

Access to Health Services

Impediments to access cited by local participants were insurance limitations, availability of providers and appointments, and transportation barriers.

Workforce

Feedback at community meetings indicated the lack of available health care providers, especially in rural areas. Individuals also cited the lack of providers willing to take Medicaid. Recommendations included the need for incentives to recruit and retain health care providers and workers.

Prevention

Preventive health services are currently not a priority as more emphasis and funding are placed upon treatment services.

Tobacco Use Prevention

Tobacco use cessation and prevention was seen as a priority by those in attendance at the listening sessions. However, the community representatives felt it was not a high enough priority in their communities.

Poverty

Inadequate income limits the ability to engage in healthy behaviors (healthy foods which cost more, etc.) and limits access to jobs offering health insurance.

Educational Achievement

There is a need for better high school and post-high school completion rates and knowledge of what is involved to achieve and maintain personal health.

These listening sessions also identified several model practices or initiatives that could be helpful to other communities as they proceed toward improving health in the areas in which they live. These initiatives are being shared statewide as they become available so that others can use these proven models to improve health in their communities. (See Appendix, Model Community Initiatives.)

In addition to the listening session themes above, commonly referenced public comments were solicited and included the following recommendations: Encouraging employers to provide employees time during work to exercise, passing legislation requiring coverage for smoking cessation, taxes for unhealthy food and requirements for fast food restaurants to post calories, implementing health disparity reduction plans, improving disease management, requiring the purchase of healthy food only under the federal Supplemental Nutrition Assistance Program (SNAP), and addressing mental health and depression, food quality/insufficiency, and urban planning. Other comments identified additional strategies to increase education about breastfeeding in hospitals, taking personal responsibility for health behaviors, and increasing taxes on tobacco at all point-of-sale locations.

Flagship Goals

Tobacco Use Prevention

The tobacco use prevention work group builds on recommendations in the *Oklahoma State Plan for Tobacco Use Prevention and Cessation* (State Plan). OHIP goals align with the cessation, prevention and protection measures outlined in the State Plan. These include: 1) preventing initiation of tobacco use by youth and young adults; 2) increasing the percentage of Oklahoma adults and youth who successfully quit tobacco use; 3) protecting all Oklahomans from exposure to secondhand smoke; and 4) fully implementing recommendations from the State Plan. Key state and local policy changes will be essential to effectively counter tobacco industry influences and change social norms around tobacco use.

Obesity Reduction

The determinants of obesity in the United States are complex. Public health approaches that affect large numbers of different populations in multiple settings—communities, schools, worksites and health care facilities— are needed.[7] Policy and environmental change initiatives that make healthy choices in nutrition and physical activity available will prove most effective in combating obesity. The obesity reduction work group recommendations endorse the state plan developed around physical activity and nutrition. They include: 1) implementing strategies identified in the *Get Fit Eat Smart Oklahoma Physical Activity and Nutrition State Plan;* 2) evaluating and implementing evidence-based programs that address obesity issues; 3) integrating and coordinating nutrition and obesity programs across the state; and 4) proposing public policy changes needed to improve Oklahoma's health and fitness.

Children's Health

The children's health work group identified three strategic areas. The first set of goals addresses the need to improve perinatal and infant care to accelerate rates of reduction in infant mortality and morbidity. Objectives cover increasing preconception care, minimizing prenatal sexually transmitted diseases, increasing the number of women who receive prenatal care in the first trimester, minimizing unintended pregnancies and increasing safe sleep education. The second and third sets of goals address the need to develop a comprehensive child health plan to improve said outcomes for the early years of a child's life (age 1 through 8) as well as the pre-adolescent and adolescent time frames. The plan will incorporate strategies to address a variety of health-related issues ranging from early intervention to behavioral health. The work group determined there is no single plan covering the full array of children's health issues. This plan would address goals, objectives and outcomes covering children's health issues as well as recommendations to address socioeconomic variables around low educational and income levels of adult, racial and ethnic group variation and the impact of evidence-based practices. The work group will also take advantage of existing reports covering topical issues in children's health to ensure a synthesis of existing and new initiatives.

Infrastructure Goals

Public Health Finance

This work group will analyze and evaluate the current public health finance system. This assessment could be benchmarked against public health accreditation standards. The efforts of this work group may have an impact on how public health services are delivered in the future.

Access to Care

In 2008, 687,625 Oklahomans under the age of 65 had no health insurance, representing 22.3 percent of this population.[9] Racial and income figures mirror national trends in 2008 and uninsured rates vary by age, race and ethnicity, household income, educational attainment and region.[10, 11, 12] Approximately 474,000 Oklahomans in 2007 could not see a doctor because of cost, ranking the state 47th in the nation.[13]

The access to care work group has been formed based on the above data findings. A State Coverage Initiative proposal funded by the Robert Wood Johnson Foundation has recently been completed. This work group will review this proposal and recommend actions that align with OHIP objectives.

Workforce Development

The *Oklahoma's Health Care Industry Workforce 2006 Report* examined 2005 health care worker vacancies and projected shortages of 1) nurses, 2) lab technicians, 3) physical therapists, 4) surgical technologists, 5) occupational therapists, 6) pharmacists, and 7) radiology and respiratory professionals for 2012. In a follow-up study completed by the Oklahoma Healthcare Workforce Center in 2008, it was noted there were

also high vacancy rates and predicted shortage concerns for emergency medical technicians and chemical dependency counselors. In 2008, Oklahoma ranked 49th in the nation for primary care physicians per 100,000 population, with five rural counties having only one physician covering primary care services in those counties. Nationally, public health workforce studies have concluded that there are: 1) insufficient numbers of health professionals within specific skilled public health occupations, such as public health nurses and epidemiologists; 2) trends toward additional shortages of experienced workers who are approaching retirement age [By 2012 over 50 percent of some state health agency workforces will be eligible to retire[14]]; 3) inadequate workplace incentives for recruitment, retention, and recognition of qualified professionals and students into the field of study; and 4) insufficient preparation in professional education programs and orientation and assimilation into the public health system.

This information provided the impetus for formation of the workforce development work group to assess current and long-term needs of the Oklahoma public health and health services workforce. The group's long-term outcome is a private and public health workforce that is well prepared, adequate in number, and distributed according to the health care needs of both rural and urban Oklahomans. Given Oklahoma's rural demographics and the critical need today to provide primary care coverage to its citizens, state leaders must explore creative ways in which to expand the number of physicians as well as highly skilled and educated physician extenders including physician assistants, advanced practice nurses, certified registered nurse anesthetists, clinical nurse specialists and certified nurse midwives.

Health Systems Effectiveness

This work group has been formed to identify and strengthen private-public partnerships throughout the state of Oklahoma. The work group co-chairs are committed to bringing together a diverse set of Oklahoma health professionals in both public and private settings to help identify best practices to improve health outcomes for residents of Oklahoma. The primary goal of this work group is to identify gaps in our current health systems operations that are preventing Oklahomans from achieving the best health outcomes possible and to provide recommendations to address them. Over the next nine to twelve months this work group will meet to generate a comprehensive plan.

Objectives

What follows is a list of specific objectives by topical area with milestones for accomplishment.

Tobacco Use Prevention

By May 2010, extend state law to eliminate smoking in all indoor public places and workplaces, except in private residences; currently, Oklahoma state laws contain exceptions for certain workplaces.

By September 2010, fully implement evidence-based health communications mass media campaigns targeting youth and young adults according to Best Practices for Comprehensive Tobacco Control Programs.

By December 2011, increase compliance with laws and ordinances to prevent illegal sales of tobacco to youth to 90% from 82% (December 2008).

Between 2010 and 2014, enact key public policy measures including repeal of all preemptive clauses in state tobacco control laws, prohibiting use of state driver's license information scans for marketing of tobacco products, and increasing taxes on tobacco products (indexed to at least the national average); anticipate consequences and opportunities of new Food and Drug Administration (FDA) regulation of tobacco products as related to state-level legislative initiatives.

By State Fiscal Year 2014, increase utilization of the Oklahoma Tobacco Helpline from 35,000 to 70,000 registered callers. (Baseline FY 2009.)

By January 2015, increase the number of hospitals, health care professionals, and community-based clinics that effectively implement the Public Health Service Clinical Practice Guideline for treating tobacco dependence.

By January 2015, increase tobacco-free properties at all workplaces including private businesses, state agencies (10% to 100%), tribal governments (from 5% to 50%), local governments (75%), hospitals (38% to 100%), school districts (from 29% to 100%), universities and colleges (16% to 100%), career tech centers (7% to 100%) and faith-based organizations (Baseline June 2009).

By January 2015, increase the number of tribal nations that voluntarily adopt laws to eliminate commercial tobacco abuse in tribally-owned or -operated worksites, including casinos; currently no tribal nations in Oklahoma have adopted such 100 percent smoke-free workplace laws.

By January 2015, increase the proportion of multi-unit housing facilities (from 1% to 25%), homes (from 74% to 90%) and motor vehicles (from 69% to 80%) with voluntary smoke-free policies.

Obesity Reduction

By May 2010, mandate utilization of the School Health Index for assessment and action planning by each public school's site-based Healthy and Fit School Advisory Committee.

By June 2010, OSDH will have available an online searchable inventory database identifying evidence-based or promising programs that address physical activity, nutrition, and obesity issues.

By July 2010, develop and facilitate a multi-level surveillance and evaluation system to monitor implementation of the plan.

By October 2010, the Strong and Healthy Oklahoma Division of OSDH, in collaboration with Oklahoma Fit Kids Coalition and other stakeholders, will have developed the capacity to provide technical assistance, consulting, and training in the integration, coordination, and implementation of evidence-based or promising programs addressing physical activity, nutrition, and obesity in an effort to reduce cost and increase accessibility to those programs for schools and communities.

By May 2011, mandate health-related fitness testing in all public schools for all students.

By May 2012, pass legislation to provide financial incentives for grocery stores or farmers markets to locate in under-served communities (Nutrition and Physical Activity: a Policy Resource guide, Feb, 2005 pg 25 "promising").

By May 2013 implement Oklahoma Health Care Authority rule change to provide financial incentives for Baby Friendly Hospitals in Oklahoma. (Reference Baby Friendly Hospital Initiative (BFHI) USA – www.babyfriendlyusa.org/eng/index.html).

By May 2013, pass legislation to ensure that the safety and mobility of all users of all transportation systems (pedestrians, bicyclists, drivers) are considered equally through all phases of state transportation projects and that not less than one percent of the total budget for construction, restoration, rehabilitation or relocation projects is expended to provide facilities for all users, including but not limited to, bikeways and sidewalks with appropriate curb cuts and ramps so that even the most vulnerable (children, those with disabilities, the elderly) can feel and be safe with the public right of way.[7,15,16,17]

Children's Health

By 2011, develop a comprehensive statewide plan for children's health including, but not limited to, the following areas of concern: access to care; primary health care; dental health; mental health; injury reduction; child abuse and neglect; self esteem improvement; and parent education programs. The plan will also incorporate content and processes described below:

- Build state and community infrastructure.
- Develop supporting policy.
- Address health inequities.
- Promote youth development opportunities.
- Provide education and skill building for youth and families.
- Provide services for youth and families.
- Collect and monitor data with assurances and measured effectiveness.

By 2012, increase the number of women receiving quality [American College of Obstetrics and Gynecology (ACOG) standards] preconception care from 13.5% to 16% [Maternal and Child Health (MCH) Plan].

By 2012, improve identification and early treatment of maternal infections.

By 2012, increase the number of mothers receiving (ACOG Standard) first trimester prenatal care from 73.9% to 85.7%.

By 2012, reduce sleep-related deaths for infants.

By 2012, reduce the proportion of unintended pregnancy from 48.4% to 47.2%.

Infrastructure

All four work groups — public health finance, access to care, workforce development, and health systems effectiveness — will be analyzing plans and data in preparation for comprehensive reports to OHIP team members on specific strategies in these areas.

Outcomes

Outcomes include important reports from the infrastructure work group that assess findings of the State Coverage Initiative report, recommend directions in public health financing, recognize public/private partnerships that further health improvements, and identify strategies to strengthen the health care workforce. Flagship groups will report progress around objectives recommended in the *Get Fit Eat Smart Oklahoma Physical Activity and Nutrition Plan* and the *Oklahoma State Plan for Tobacco Use Prevention and Cessation.* A comprehensive plan covering children ages 1 to 18 will be completed. There will also be monitoring of strategies designed to reduce infant mortality. OHIP will provide a scorecard by which the goals and objectives referenced in this plan can be measured.

Future Actions & Recommendations

The OHIP process will remain dynamic. We will continually review OHIP goals and objectives to assess our progress. Outreach to local communities will be ongoing. We plan on conducting listening sessions in new communities, along with keeping in contact with communities visited previously to solicit ideas, note concerns and learn about their progress. These sessions should set the stage for building local support for health improvement activities and serve as one of our primary advocacy tools. Work groups will also activate public/private partnerships. This will build upon the existing health infrastructure and serve as another vehicle for obtaining broader support. OHIP will serve as a key strategic tool for use with legislative leaders in framing policy and budgetary priorities.

The Oklahoma Health Improvement Planning Team recognizes the state has many health care needs, each supported by its own individual constituency. Our recommendations address priorities identified as leading causes of both mortality and morbidity in the state. The team challenges our partners to work with us on these initial critical implementation strategies as we move forward in realizing our vision of a healthier Oklahoma.

True enjoyment comes from activity
of the mind and exercise of the body;
the two are ever united.
- Humboldt

INTRODUCTION & BACKGROUND

The World Health Organization defines health as a "state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity." Achieving this requires broad societal action.[18] The US Centers for Disease Control and Prevention (CDC) recognize this in their view of the public health system as "the collection of public, private and voluntary entities as well as individual and informal associations that contribute to the public's health."[19]

Achieving the vision of healthy people in healthy communities is a difficult and complex task that cannot be accomplished through a single plan of action or by a single governmental agency or nongovernmental entity. The Institute of Medicine (IOM) committee recommends six areas of action.

- Adoption of a population health approach that builds on evidence of the multiple determinants of health;
- Strengthening the governmental public health infrastructure;
- Creation of a new generation of partnerships to build consensus on health priorities and support community and individual health actions;
- Development of systems of accountability at all levels;
- Assurance that action is based on evidence; and
- Communication as the key to forging partnerships, assuring accountability and utilizing evidence for decision making and action.[17]

State Characteristics

The importance of a multi-faceted approach is needed in response to Oklahoma's diversity seen along a number of demographic and health measures. Table 1 describes Oklahoma demographically.

TABLE 1 · 2008 OKLAHOMA DEMOGRAPHICS[9]

Total Population	3,642,361	
Age		
Under 18 Years	906,137	24.9%
· 18-64 Years	2,244,951	61.6%
· 65+ Years	491,273	13.5%
Race/Ethnicity		
· One Race	3,402,309	93.4%
· Whites	2,761,321	75.8%
· Blacks	261,001	7.2%
· Native Americans	235,008	6.5%
· Asians	61,807	1.7%
· Pacific Islanders	3,382	0.1%
· Some other race	79,790	2.2%
· Two or More Races	240,052	6.6%
· Hispanics (of any race)	278,760	7.7%

Oklahoma faces income challenges. The state's poverty rate is higher than the national average.[9] The poverty rates for children under 18, adults 18 to 64 and those over 65 are 22.6 percent, 14.3 percent and 10.9 percent respectively. There is variation across race with Blacks and Hispanics having twice the poverty rate of Whites.[20]

Health care services in the state are delivered through numerous types of providers. What follows is an overview of both public and private providers, types of coverage and financing in Oklahoma.

The Oklahoma State Department of Health (OSDH), Oklahoma City-County Health Department (OCCHD) and the Tulsa Health Department (THD) are public health authorities responsible for protecting and promoting the health of the citizens of Oklahoma by preventing disease and injury and assuring the conditions by which Oklahomans can be healthy. The Oklahoma State Department of Health has 68 organized county health departments and an additional 20 satellite clinics in 18 counties. Seven counties do not have organized health departments (Nowata, Alfalfa, Cimarron, Ellis, Dewey, Roger Mills, and Washita.) The city-county health departments located in Oklahoma City (OCCHD) and Tulsa (THD) operate autonomously from the local county health department network. A sampling of services offered by these three entities includes:

- *Reproductive and Sexual Health* - Family Planning and Sexually Transmitted Disease (STD) Clinical and Outreach Services
- *Immunization Program Services* - Childhood, Adult and Overseas Vaccines, Seasonal Influenza Initiative; Pandemic Influenza Planning
- *Tuberculosis Center* - Diagnosis, Preventive, and Treatment Services
- *Child Guidance Services* - Child Development, Speech and Language, and Behavioral Health Services for Childbearing and Childrearing Families with emphasis on Parenting and Child Abuse Prevention
- *WIC* - Nutrition Program for Women, Infants and Children

- *Maternal and Child Health* - Preventive and Primary Care Services for Infants, Children, Adolescents, Females and Males of Reproductive Age, and their Families
- *Early Intervention* - Early Intervention Services for Infants and Toddlers, and their Families.
- *Community Health Promotion* - Community-based programs such as tobacco use prevention, child abuse prevention, chronic disease screening and prevention, fetal and infant mortality review, injury prevention, healthy businesses, and CATCH (Coordinated Approach to Child Health) programs
- *Consumer Protection* - Restaurant and food vendor inspection and licensure, well water testing for the public, pool inspection and operator courses, food handler courses on request, and other inspections to fulfill regulatory, statutory, and contractual requirements
- *Epidemiology Service* - Communicable disease surveillance, investigation, and prevention, as well as data analysis to identify trends within the community related to health status
- *Emergency Response Program* - Development of community level plans for all-hazards response to natural or manmade events that impact the health of the population

Additionally, the OSDH inspects all hospitals and long-term care facilities for safety and compliance with state and federal regulations, licenses several trades and professions and issues more than 300,000 birth and death records each year. The Oklahoma Public Health Laboratory processes thousands of laboratory specimens for infectious and chronic diseases and birth defects.

Oklahoma has 39 tribes; 38 are federally recognized in the state. This unique characteristic has resulted in varying health delivery systems dedicated to serving our American Indian population. The Snyder Act of 1921 and the Indian Health Care Improvement Act of 1976 are the authorities for Congress to appropriate funds to the Indian Health Service (IHS). Titles I and V of Public Law 93-638 provide tribes the authority to contract directly with the federal government to deliver health services. Thirty-six Oklahoma tribes operate their own health programs ranging from large-scale hospitals to smaller preventive and behavioral health programs. The IHS operates 10 facilities in the state with two Indian clinics providing ambulatory outpatient health care to urban communities. [21, 22]

The Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) provides mental health and substance abuse services. There are 15 community mental health centers that offer emergency intervention, assessment, counseling, psychosocial rehabilitation case management and community support services designed to assist adult mental health clients live as independently as possible and to provide therapeutic services for children who are demonstrating symptoms of emotional disturbance. In some cases, the centers also provide short term hospitalization and substance abuse treatment. The Department operates a psychiatric hospital for adults, a facility for children under the age of 18 and a Forensic Psychiatric Evaluation and Treatment Center. ODMHSAS operates or contracts with over 90 substance abuse treatment programs offering a range of outpatient, residential and aftercare services. The Department also operates or contracts for residential treatment for persons with co-occurring disorders (both mental illness and substance abuse). ODMHSAS contracts with approximately 28 residential care homes to provide individuals with mental illness social and recreational experiences. ODMHSAS also funds a network of 20 Area Prevention Resource Centers offering substance abuse prevention education and community prevention project development. [23]

There are 33 federally qualified health center sites (FQHCs). These clinics provide comprehensive primary health care as well as supportive services (education, translation and transportation, etc.) for individuals with low incomes.[24]

School-based clinic services are limited in the state. There are 10 school-based health centers in public schools located in Tulsa County. These clinics are associated with the University of Oklahoma Tulsa Campus and the Tulsa Alliance for Community Health and are open to families of students attending the host schools. There are 285 certified school nurses in the state (2007-2008 school years). [24]

Services to Oklahoma veterans are also available via the United States Department of Veterans Affairs (VHA) through the Veterans Healthcare System. The Oklahoma City Veterans Administration Medical Center (VAMC) is a 169 bed VHA facility located in Central Oklahoma serving 48 Oklahoma counties. The Oklahoma City VAMC also includes community-based outpatient clinics in Lawton, Oklahoma City and contracted community based outpatient clinics in Konawa, Ponca City, and Ardmore, Oklahoma and Wichita Falls, Texas.

The Geriatric Rehabilitation and Extended Care Center is a 20 bed facility serving the metropolitan area. There are also seven veterans centers providing intermediate to skilled nursing care and domiciliary care in Ardmore, Claremore, Clinton, Lawton, Norman, Sulphur and Talihina.[25,26] These services are in addition to potential eligibility under various health insurance programs which will be described under the health coverage section.[27]

The majority of health care is provided by nonpublic personnel. Table 2 identifies the major categories of private providers in Oklahoma.

TABLE 2 · PRIVATE HEALTH CARE PROVIDERS

Provider Type	#	Licensed	Practicing
Community Hospital[24]	97		
Psychiatric Hospital[24]	11		
Rehabilitation Hospital[24]	6		
Critical Access Hospital[24]	35		
Ambulatory Surgical Center[24]	5		
Home Care Agency[24]	343		
Hospice[24]	141		
Adult Day Care Center[24]	44		
Assisted Living Center[24]	117		
Continuum of Care Facility (both nursing facility and assisted living center)[24]	12		
Hospital-based Skilled Nursing Unit[24]	8		
Nursing Facility[24]	317		
Residential Care Home[24]	86		
Specialized Facility for Developmentally Disabled Persons[24]	83		
Allopathic Physician[28]		9,358	6,014
Osteopathic Physician[29]		2,162	1,566
Registered Nurse[30]		39,625	24,504
Advanced Practice Nurse[30]		1,667	
Licensed Practical Nurse[30]		18,424	12,196
Physician Assistant[28]		1,042	964
Occupational Therapist[28]		759	653
Physical Therapist[28]		1,866	1,638
Respiratory Care Practitioner[28]		1,944	1,751
Dentist[31]		1,838	N/A
Dental Hygienist[31]		1,484	N/A

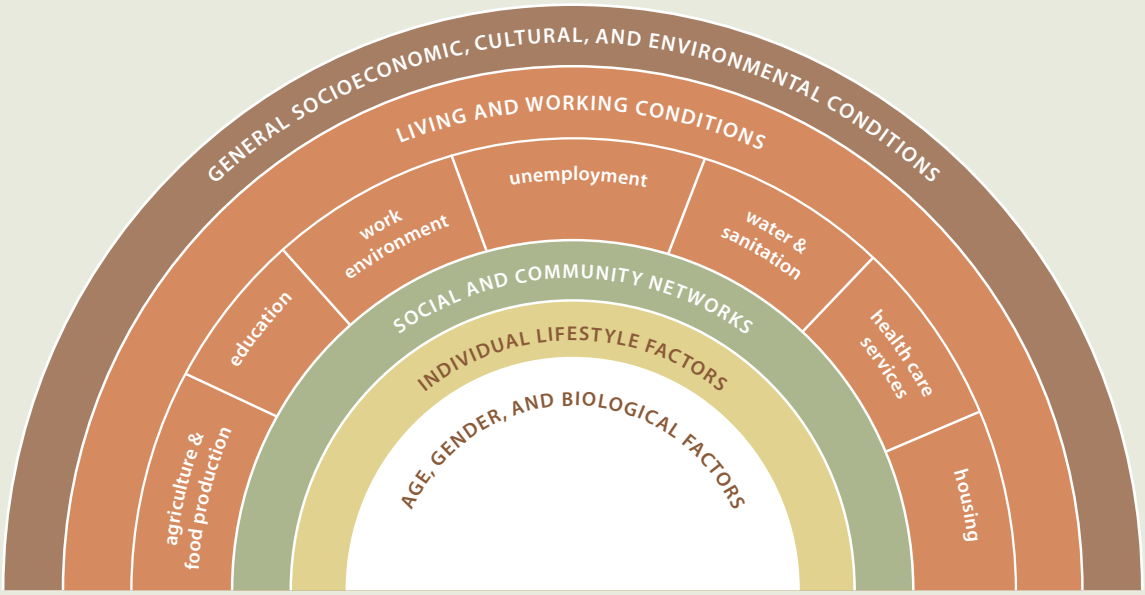
Health coverage is provided by a wide array of public and private sources. Public sources include Medicare, Medicaid, the state Children's Health Insurance Program, federal and state employee health plans, the military (TRICARE) and the Veterans Administration. Private health coverage is provided primarily through benefit plans sponsored by employers. People without access to employer-sponsored insurance may obtain health insurance on their own, usually through the individual health insurance market, although in some instances health insurance may be available through professional associations or similar arrangements.[32]

Oklahoma State and Education employees' insurance choices include a provider network through the Employees Benefits Council. For private coverage, there are 25 insurers exclusively offering health insurance with over 300 firms offering health insurance along with other lines of business. Dominant insurers in the Oklahoma market are Blue Cross/Blue Shield of Oklahoma, Community Care, Aetna and United Health.[33]

Employer-sponsored health insurance continues to be the main source of coverage in Oklahoma. In 2008, 45.1 percent of Oklahomans had health insurance coverage through their own employer or through a family member's employer. The second most common source of health insurance coverage, at 33.3 percent, was through public health insurance programs (i.e., Medicare, Medicaid, Insure Oklahoma/O-EPIC, Oklahoma High Risk Pool and railroad retirement plans).[34,35]

Health care financing involves multiple payer sources. Total personal health care expenditures in Oklahoma were $17.3 billion in 2004. Hospital care represented 38.4 percent; physician and other professional services, 28.1 percent; drugs and other medical nondurables, 14.3 percent; nursing home care, 6.7 percent; dental services, 4.9 percent; home health care, 2.7 percent; medical durables, 1.4 percent ; and other personal health care, 3.6 percent. Spending for Medicare and Medicaid represented 37 percent of total personal health care expenditures.[36] Fiscal year 2008 expenditures for the public health system were $356,905,867 for OSDH, $20,186,416 for OCCHD and $23,948,203 for THD.

HEALTH DETERMINANTS MODEL



Adapted from the Dahlgren-Whitehead Model[37]

With this description of Oklahoma's demographic and health care characteristics, we now proceed to identify critical health indicators for the state and factors contributing to these findings. The Oklahoma Health Improvement Plan (OHIP) considers all levels of influence on health. The socio-ecological model recognizes there is an interrelationship between the individual and their environment. While individuals are responsible for instituting and maintaining the lifestyle changes necessary to reduce risk and improve health, individual behavior is determined to a large extent by the social environment, including community norms and values, regulations, and policies. The most effective approach leading to healthy behaviors is a combination of efforts at all levels: individual, interpersonal, organizational, community, and public policy.[5]

State Health Assessment Findings

Oklahoma ranks near the bottom in multiple key health status indicators, when measured at both state and national levels.[2] The *2009 Commonwealth Fund State Scorecard on Health System Performance* ranks Oklahoma 50th in overall health system performance, with the state in the bottom tenth percentile on dimensions of access, quality, avoidable hospital use and costs, equity and healthy lives.[3] Only on the dimension of avoidable hospital use and costs did the state improve from prior year rankings.

The *2009 United Health Foundation America's Health Rankings Report* rated Oklahoma 49th both in primary care providers per 100,000 and in the nation overall. The 2009 rankings varied from 9th in prevalence of binge drinking to 49th in the ratio of primary care physicians per 100,000 population. Oklahoma improved in nine indicators, declined in nine and remained the same in four.

The 2008 data shows 2.4 physicians per 1000 population, ranking the state 6th worst.[38,39] Public Citizen ranked Oklahoma 50th in 2007 on quality of care issues related to nursing home care and performance outcomes associated with child health.[40]

The *2008 State of the State's Health Report* confirms national findings.[2] Oklahoma still leads much of the nation with deaths due to heart disease. The state's rates for cerebrovascular disease deaths (strokes) are much higher than most of the nation. Of particular concern with both heart disease and cerebrovascular disease deaths is a large disparity among Blacks, with higher rates than any other ethnic group in Oklahoma. Chronic lower respiratory diseases continue to plague Oklahoma at higher than national average rates, primarily because of Oklahoma's continued high use of cigarettes.

Dental health also ranks poorly in Oklahoma. Oklahoma ranks worst in the nation for adults with a dental visit in the last year[2] and according to *Oral Health in America: A Report of the Surgeon General*[41] and the *National Call to Action to Promote Oral Health: Office of the Surgeon General*[42] dental caries (tooth decay) is the single most common chronic childhood disease. For each child without medical insurance, there are at least 2.6 children without dental insurance. The Governor's Task Force on Children and Oral Health has developed recommendations and a state oral health plan to help lay the groundwork for improved care and access to dental services. The report presents a strong, viable oral health plan for Oklahoma and is divided into five main strategic areas including

prevention, education programs, access to care, state disaster response, and children with special healthcare needs.[43]

Taken together these conditions result in a much higher total mortality rate for Oklahoma than the rest of the nation. But more disturbing than our overall mortality rate is Oklahoma's infant mortality rate (IMR), which has consistently remained above the national average since 1992.[44] While some improvement has occurred, the IMR has seen only a 4.8 percent reduction from 8.4 infant deaths per 1000 in 1992 to 8.0 per 1000 in 2006. The U.S. rate declined 21.2 percent for the same time frame.[45] Rates among Black infants were twice as high as White infants.[44] Educational levels are correlated with higher infant mortality. Mothers with less than a high school education have higher rates. For 2006, Oklahoma ranked 41st in its infant mortality rate.[45]

Health is influenced by factors in five domains — genetics, social circumstances, environmental exposures, behavioral patterns and health care.[4, 46, 47] Many factors contribute to Oklahoma's poor health outcomes, higher rates of disease and overall higher total mortality. Personal behavior provides the single greatest opportunity to improve health and reduce premature deaths.[4] However, many of these health outcomes are related to social conditions that our citizens must live with on a daily basis.[5] What follows is an in-depth description of behavioral and social factors.

Personal Behavior

Medical care is important, particularly after diseases develop, but many major diseases develop largely as a result of unhealthy habits.[17] Behavioral causes account for nearly 40 percent of all deaths in the United States.[4, 6] Most of the leading causes of death today are chronic diseases related to individual lifestyles and behaviors. Common factors contributing to the state's high heart disease mortality rate (250.4 per 100,000) include unhealthy lifestyle behavior and risk factors such as obesity, physical inactivity, diabetes, hypertension, high cholesterol and smoking. Personal behaviors such as diet, exercise and tobacco use also affect the incidence of cancer.[2]

The *2008 State of the State's Health Report* indicates two-thirds of Oklahomans are either overweight or obese.[2] Childhood obesity rates have tripled since 1980 from 6.5 percent to 16.3 percent. Oklahoma, at 29.5 percent, is the 6th worst state for adult obesity rates.[48]

For 2008, Oklahoma's prevalence rate for smoking was 24.7 percent. Smoking is a major contributor to the four leading causes of death: heart disease, cancer, stroke and chronic obstructive pulmonary disease. Smoking during pregnancy increases the risk of miscarriages and nearly triples the risk of low birth-weight babies. Smoking during pregnancy is also strongly associated with behavioral disorders in children, including attention disorders (e.g. ADHD). The primary risk factor for development and progression of chronic lower respiratory disease deaths is smoking.[49] The voter-approved state tobacco tax that took effect in 2005 is beginning to have an impact on cigarette consumption, but Oklahoma must do much more in terms of policy efforts to reduce tobacco use. The impact of smoking on poor health is so profound that transformation of Oklahoma's health status from a very unhealthy state, to a healthy state, will not be possible unless there is a major reduction in tobacco use.

A priority area that drives unintentional injury rates is substance abuse in young and middle age adults. Oklahoma's suicide rate is 30 to 40 percent higher than the national rate. Factors that increase the risk include a history of depression or mental illness, previous attempts, drug and alcohol abuse, social isolation, trauma, physical health problems and communication and intimacy problems.[2]

Modification of individual lifestyles and behaviors can reduce premature deaths and increase the number of years of healthy life.[4]

Social Determinants & Health Equity

Social determinants of health are the economic and social conditions that shape the health of individuals, communities, and jurisdictions as a whole. Social determinants of health are the primary determinants of whether individuals stay healthy or become ill. They also determine the extent to which a person possesses the physical, social, and personal resources to identify and achieve personal aspirations, satisfy needs, and cope with the environment. Social determinants of health are about the quantity and quality of a variety of resources that a society makes available to its members.[50]

Virtually all major diseases are primarily determined by a network of interacting exposures that increase or decrease the risk for the disease.[51] Social determinants of health intersect with health equity concerns in tracing differences in population health to unequal economic and social conditions that are systemic and avoidable.[52] Modifiable social factors — including income, education, and childhood and neighborhood socioeconomic conditions may be more important in explaining health differences by race or ethnicity.[17] Inequities exist across the state in such areas as access to health services and health insurance, healthy foods including fresh fruits and vegetables, safe places for physical activity, and available transportation. Major social determinants of health such as poverty, lack of insurance and inadequate prenatal care along with risky health behaviors associated with these determinants contribute to the poor health status of our citizens.[2] What follows is a description of Oklahoma determinants and their impact on our residents' health.

Income and Poverty

Studies confirm a positive relationship between income, education, and good health.[7,53,54,55] People with lower socioeconomic status die earlier and have more disability.[4] Oklahoma ranks 17th in the nation for the percent of Oklahomans in poverty and 2nd worst for Oklahomans with incomes between 100 percent and 133 percent of poverty.[10] Oklahoma ranks 6th lowest in median household income in 2008.[56,57] There are significant health disparities for individuals earning $25,000 a year or less.[2]

Education

There are also significant health disparities among individuals with a high school education or less.[2] One example is babies born to mothers who do not finish high school are nearly twice as likely to die before their first birthdays as babies born to college graduates. Children whose parents have not finished high school are over six times as likely to be in poor or fair health as children whose parents are college graduates.[17] One sees other troublesome areas. Approximately 5,214 Oklahoma students dropped out of school in 2008. While Oklahoma ranked 22nd in high school graduation rates, there was significant disparity across racial and ethnic groups.[58]

TABLE 3 · 2006 GRADUATION RATES[58]

Asians	79.2%
Whites	73.2%
American Indians	64.1%
Hispanics	57.1%
Black	54.9%

In 2007, Oklahoma ranked 6th worst for children in households where the householder had a bachelor's degree.[59] For both men and women, more education often means longer life. College graduates can expect to live at least five years longer than individuals who have not finished high school.[17,60]

Access to Health Services

The gaps in our health care system affect people of all ages, races and ethnicities and income levels. However, those with the lowest income face the greatest risk of being uninsured. Nationally two-thirds of the uninsured are individuals and families who are poor (incomes less than the poverty level) or near poor (incomes between one and two times the poverty level). The AARP Public Policy Institute reports that nationally, 36 percent of the uninsured between the ages of 50 to 65, had family incomes of less than $20,000. This makes the ability to afford individual coverage difficult if not impossible. Those who have coverage often pay high premiums since most states allow insurers to charge higher rates based on age and health. Sixty-three percent of nonelderly uninsured adults have no education beyond high school, making them less able to get higher skilled jobs that are more likely to provide health coverage. Those with less education are more likely to be uninsured for longer periods of time. Minorities are more likely to be uninsured than Whites. About one-third of Hispanics and American Indians are uninsured compared to 12 percent of Whites. The uninsured rate among Blacks at 21 percent is also much higher than that of Whites.[55] Oklahoma's distribution of uninsured by race mirrors national indicators.[10]

Data from the Oklahoma Behavioral Risk Factor Surveillance System (BRFSS) survey in 2007 indicate that the rate of uninsured varies by age, race and ethnicity, household income, educational attainment and region. Adults of Hispanic origin had the highest rate of uninsured, three times that of Whites. Blacks were twice as likely as Whites to be without insurance coverage. Individuals in low-income households or at low levels of educational achievement have the highest rates of being uninsured. Thirty-eight percent of individuals with a household income of less than $15,000 or individuals with less than a high school diploma were found to be uninsured.[13] Oklahoma ranks 9th worst in the percent of all ages and the percent of children age 18 and under that are uninsured.[61]

Geographic location affects access. There is a lack of medical, mental and dental professionals and facilities in the rural areas. The Rural Assistance Center (RAC) reports higher unemployment rates, increased high school dropout rates, and higher poverty rates in rural Oklahoma.[62] These factors play an intricate role in the medical community's reluctance to practice in the rural areas. The lack of public transportation plays a significant role in accessing health care in rural Oklahoma. The net result is significant gaps in health care coverage in rural Oklahoma.[63]

Housing

Research shows good affordable housing can:

- reduce health problems associated with exposure to allergens, neurotoxins and other dangers in the home by allowing families to access better quality housing;
- increase residential stability, allowing families to avoid unwanted moves that lead children to change schools, which may impair their educational progress; and
- decrease residential crowding and other sources of housing-related stress that leads to negative development and educational outcomes for children.[7,64]

Housing can make a significant difference in the economic well being of low-income families. As is the case with many families, housing costs are the single largest budget item in a low-income family's budget. However, the typical rent burden is much higher for poor than for non-poor families. Housing

assistance may come in the form of Section 8 rental assistance where families receive a voucher to assist in paying rent for a private sector unit, a subsidized housing unit for which building owners receive government payments to reduce tenants' rents, or a public housing unit which is owned by the government.[65] There are also low income housing tax credits that serve as incentives for individuals and corporations to invest in affordable housing.[66] The HOME program provides assistance for home purchase or rehabilitation work and rental assistance.[67] Unlike many other income support programs, housing assistance is not an entitlement. Benefits typically have been targeted towards families with the greatest needs. Housing assistance is largely administered by local housing authorities.[65]

Oklahoma housing services are decentralized throughout the state. There are 104 local housing authorities, and 21 tribal housing authorities located in Oklahoma with the Oklahoma Housing Finance Agency (OHFA) serving as the state's housing agency. A Housing Affordability Study compiled by OHFA shows many working Oklahomans have difficulty when it comes to making rent or mortgage payments. According to Dennis Shockley, OHFA Executive Director, "Even though Oklahoma has some of the most affordable housing in America, many wage earners cannot afford to own a home or even rent one without paying an unreasonable percentage of their income. This really sheds light on the need for affordable places to live for working Oklahomans all across the state."[67]

Conversations with state and local housing staff confirm this view. They indicate the demand for affordable housing greatly exceeds the available supply and note there is much substandard housing in the state. Table 4 identifies the demand cited by staff with OHFA, Housing Authority of the City of Tulsa, and Oklahoma City Housing Authority in two major housing assistance programs.

TABLE 4 · HOUSING SERVICE DEMAND[a]

Program	Persons Served	Waiting List
OHFA		
· Section 8	10,000	40,000
Tulsa Housing Authority		
· Section 8	4,681	4,813
· Public Housing	2,502[b]	1,517[b]
Oklahoma City Housing Authority		
· Section 8	4,034	9,000
· Public Housing	2,959[b]	1,095[b]

[a] July 2009 data [b] Households served

Transportation

Research shows a relationship between transportation and health inequity. Nearly one- third of the US population is transportation disadvantaged.[68] These individuals cannot easily access basic needs such as healthy food choices, medical care, gainful employment and educational opportunities. Many families with low-incomes are forced to live outside city centers where housing is more affordable and access to public transportation is limited. These families often spend more on driving than health care, education or food. The poorest fifth of U.S. families, earning less than $13,060 per year, pay 42 percent of their income to own and drive a vehicle.[69] Families earning $20,000 to $50,000 spend as much as 30 percent of their budget on transportation.[70] In addition, lower-income neighborhoods often lack safe places to walk, bike, or play; along with access to healthy and affordable foods.[71,72]

Transportation and housing are the two biggest household costs for most families.[68] Often affordable housing and employment are not accessible to lower income families who want to use public transportation.[69] Some family members may take multiple bus or other public transit routes to obtain employment. Car purchases, even when affordable, constitute a huge financial drain in urban settings. Busy roads and transit facilities (e.g., bus and train stations) are often located in low-income neighborhoods and in minority communities. Living near a transit station or a busy road is linked to poor air quality and increased respiratory illness.[72]

There are 62 federal transit programs offered by 13 federal agencies. Major programs offered by the Oklahoma Department of Transportation (ODOT) include services funded under the Safe, Accountable, Flexible, and Efficient Transportation Equity Act: A Legacy for Users (SAFETEA-LU). Additionally transit services are paid under the Temporary Aid to Needy Families (TANF) program designed to help eligible individuals meeting work requirements. The state's Medicaid program, SoonerCare, also pays for medical transit for eligible individuals. Table 5 describes major programs, targeted populations and program intent.

TABLE 5 · TRANSIT SERVICES

Program	Target Population & Intent
Section 5310 of SAFETEA-LU	Elderly and individuals with disabilities
Section 5316, Job Access and Reverse Commute Program of SAFETEA-LU	Low income individuals to connect transit to suburban employment centers
Section 5317, New Freedom Program of SAFETEA-LU	Individuals with disabilities; Overcome barriers to work and integration into society
TANF	Low income individuals eligible for program to support employment and education
Medicaid	Low income individuals eligible for program to access medical care

The Oklahoma Department of Transportation administers the Safe Routes to School Program that is designed to get children to walk and bike to school. The Department is also responsible for infrastructure and accessibility along state highways that intersect with cities and towns.

In 2007, ODOT's transit division conducted a comprehensive study as part of their development of a locally coordinated public transit/human services transportation plan. Three primary sources of information were used to document the transportation gaps and issues for senior citizens, individuals with low incomes, and persons with disabilities in the state of Oklahoma. First, demographic and socioeconomic data about the three target populations was compiled and reviewed. Second, a survey distributed to transportation providers and human service agencies across the state asked them to identify their consumers' unmet transportation needs. And third, identifying transportation gaps and issues was the primary topic of stakeholder roundtable meetings held across the state.

Major issues identified at community meetings that centered on the need for services, access to jobs and marketing of services are:[73]

- Transportation for those Not Eligible for a Transportation Program
- Awareness of Services
- Intercity Transportation
- Transportation from Rural Areas to Cities/Towns
- Need for Greater Geographic Coverage of Service
- Greater Geographic Coverage of Existing Services
- Americans with Disabilities Act (ADA) Accessibility
- Long Wait Times for Return Trips
- Second and Third Shift Access to Jobs
- Evening and Weekend Transportation
- Rising Cost of Providing Transportation

Aggregate Effects

An example of how multiple factors impact health is individuals diagnosed with diabetes. Adults with lower annual household incomes or fewer years of education tend to report a higher prevalence of diabetes.[17] Oklahoma ranks among the ten worst states in diabetes, with significant disparities seen among American Indians and Blacks. Oklahoma has one of the highest diabetes mortality rates with higher levels in Blacks and American Indians than other racial/ethnic groups. This can be attributed to poverty, lack of access to quality care and higher hypertension rates. Although not traditionally the areas of focus of public health, the state must address social determinants if it ever hopes to improve Oklahoma's overall health status to even average levels when compared to the rest of the United States.[2] Major economic impacts could also accrue from the gains expected from better health and longer lives in the form of increased productivity.[17]

State Board of Health Response

The Oklahoma State Board of Health is concerned that the health status of Oklahomans ranks near the bottom of all states. At its annual retreat in August 2007, the Board looked at metrics from national and state reports ranking Oklahoma in the bottom 10 percent in most health indicators. Board members affirmed the unacceptability of the status quo. The Board convened a broadly based group called the Oklahoma Health Improvement Planning (OHIP) Team and charged it with developing a statewide health improvement plan. To assist in the process, OSDH contracted with Milne and Associates in 2008 to design and execute a strategic planning process to create a vision and mission for the OHIP team and develop processes to complete and implement the plan.

Passage of SJR 41

To respond to these challenges and endorse State Board of Health activities, the Oklahoma Legislature, in 2008, passed Senate Joint Resolution 41, which required the Oklahoma State Board of Health to prepare and present to the Legislature a health improvement plan for Oklahoma for the general improvement of the physical, social, and mental well-being of all people in Oklahoma through a high functioning public health system.

Planning Process

An outgrowth of the strategic planning retreat was creation of an Oklahoma Health Improvement Planning (OHIP) Team, Executive Committee and Work Groups. Flagship issues were identified with work groups developed in the areas of tobacco use prevention, obesity reduction and children's health improvement. A reporting template was developed to identify goals, objectives, necessary actions and parties responsible for implementation. Other key work groups were created around health infrastructure issues in the areas of workforce development, public health financing, access to care, and public health system effectiveness.

Flagship and infrastructure issues were informed and driven by a statewide outreach effort. Listening sessions were held in each quadrant of the state (NE, NW, SE, and SW) and the two major metropolitan areas including: the communities of Ada, Enid, Grove, Guymon, Hugo, Lawton, Okmulgee, Oklahoma City, Tulsa, and Weatherford. A diverse group of stakeholders participated representing legislators, public health, health professions, businesses, media, community coalitions, and schools. Participants learned about the OHIP process, received general findings from the work groups and provided feedback on these and other health issues. Attendees also received area-specific health care report cards measuring communities against state and federal benchmarks. The OHIP Team feels strongly that listening to the local communities is critical to the health improvement process. This concurs with findings of the Robert Wood Johnson Commission to Build a Healthier America that identify collaboration as a necessary condition to create a broad base of support.[7] The community is where one sees the suffering that results from bad health. Without the involvement of local communities, the plan is marginalized. Overarching themes identified at these sessions included the following:

School Health

There is a need for comprehensive school health initiatives from prekindergarten through 12th grade. School interventions needed to address health education curriculum, school nurses or like services, physical education, and nutrition. Participants stressed that schools are critical partners in addressing child health issues. Schools could contribute to the reduction in child obesity by offering healthy menus for lunch and increased physical activity. An example is the state of Tennessee which found activities implemented through its Coordinated School Health Expansion and Physical Activity Law reduced absenteeism due to school nurses providing routine care on-site. Additionally, students' body mass index (BMI) measures improved.[7,8]

Access to Health Services

Impediments to access cited by local participants were insurance limitations, availability of providers and appointments, and transportation barriers.

Workforce

Feedback at community meetings indicated the lack of available health care providers, especially in rural areas. Individuals cited the lack of providers willing to take Medicaid. Recommendations included the need for incentives to recruit and retain health care providers.

Prevention

Preventive health services are not a priority as more emphasis and funding are placed upon treatment services.

Tobacco Use Prevention

Tobacco use cessation and prevention was seen as a priority by those in attendance at the listening sessions. However, the community representatives felt it was not given the priority level it should have in their communities.

Poverty

Inadequate income limits the ability to engage in healthy behaviors (healthy foods which cost more); increases the likelihood of risky behaviors, i.e., obesity and smoking, and limits access to jobs offering health insurance.

Educational Achievement

There is a need for better high school completion rates and knowledge of what is involved in being healthy.

These listening sessions also identified several model practices or initiatives that could be helpful to other communities as they proceed towards improving health in the areas in which they live. These initiatives are being shared statewide as they become available so that others can use these proven models to improve health in their communities. (See Appendix, Model Community Initiatives.)

In addition to the listening session themes above, commonly referenced public comments were solicited and included the following recommendations: Encouraging employers to provide employees time during work to exercise, passing legislation requiring coverage for smoking cessation, taxes for unhealthy food and requirements for fast food restaurants to post calories, implementing health disparity reduction plans, improving disease management, requiring the purchase of healthy food only under the federal Supplemental Nutrition Assistance Program (SNAP), and addressing mental health and depression, food quality/insufficiency, and urban planning. Other comments identified additional strategies to increase education about breastfeeding in hospitals, taking personal responsibility for health behaviors, and increasing taxes on tobacco at all point-of-sale locations.

The health of the people is really the foundation
upon which all their happiness and
all their powers as a state depend.
- Benjamin Disraeli

STRATEGIC GOALS & RECOMMENDATIONS

The results of the OHIP planning process culminated in formation of comprehensive goals and objectives to improve health outcomes in the state. What follows is a description of the OHIP Team's vision, mission, values, and strategic map, along with a detailed description of strategies identified by the work groups.

VISION

Oklahomans will achieve optimal physical, mental and social health and the state health status will be in the top quartile of states by 2014.

MISSION

Working together to lead a process to improve and sustain the physical, social and mental well being of all people in Oklahoma.

VALUES

Accountability
To the people of Oklahoma, to the legislature, to the process, to the outcomes and to each other through a personal responsibility and commitment to work together for a greater good.

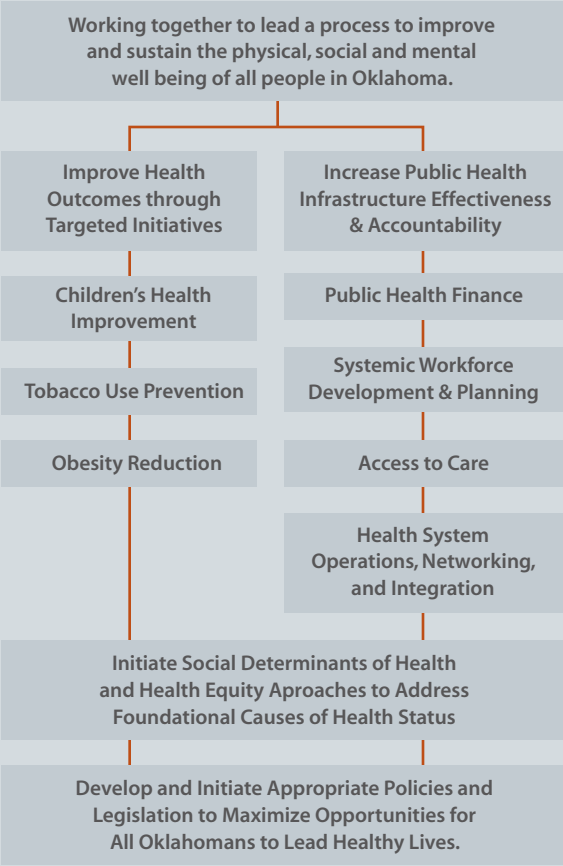
Adaptability
To innovate and think outside the traditional solutions.

Integrity
To ensure the process is transparent, equitable and void of conflicting interests.

Sustainability
To assure commitment to the process.

Inclusivity
Encouraging a collaborative spirit by engaging a broader range of stakeholders.

OHIP STRATEGIC MAP



Flagship Issues

Tobacco Use Prevention

Tobacco kills more Oklahomans than alcohol, auto accidents, AIDS, suicides, murders and illegal drugs combined. Smoking causes 82 percent of lung cancer cases, 80 percent of deaths from chronic obstructive pulmonary disease (COPD), 17 percent of deaths from heart disease and 11 percent of deaths from strokes. Exposure to secondhand smoke causes heart and vascular disease, cancers, sudden infant death syndrome, asthma, bronchitis and pneumonia. Smoking among pregnant women is a major contributor to premature births and infant mortality.[4,74] Every pack of cigarettes sold costs Oklahoma's economy $7.62 in medical costs and lost productivity due to premature death and disease. Tobacco use is the single most preventable cause of death and disease in the United States. The Oklahoma Tobacco Settlement Endowment Trust (TSET) was established in 2000 through a constitutional amendment and a vote of the people. One of the top priorities of the TSET Board of Directors is to support recommendations of the *Oklahoma State Plan for Tobacco Use Prevention and Cessation* (State Plan). The tobacco use prevention work group builds on recommendations in the State Plan. OHIP goals align with the cessation, prevention and protection measures outlined in the State Plan. These include: 1) preventing initiation of tobacco use by youth and young adults; 2) increasing the percentage of Oklahoma adults and youth who successfully quit tobacco use; 3) protecting all Oklahomans from exposure to secondhand smoke and 4) fully implementing recommendations from the State Plan. Key state and local policy changes will be essential to effectively counter tobacco industry influences and change social norms around tobacco use. What follows are specific goals and objectives.

TABLE 6 · TOBACCO USE PREVENTION GOALS & OBJECTIVES

Prevent initiation of tobacco use by youth and young adults.

Between 2010 and 2014, enact key public policy measures including repeal of all preemptive clauses in state tobacco control laws, prohibiting use of driver's license scans for marketing of tobacco products, and increasing taxes on tobacco products (indexed to at least the national average); anticipate consequences and opportunities of new Food and Drug (FDA) regulation of tobacco products as related to state and local level policy initiatives.

By September 2010, fully implement evidence-based health communications mass media campaigns targeting youth and young adults according to Best Practices for Comprehensive Tobacco Control Programs.

By December 2011, increase compliance with laws and ordinances to prevent illegal sales of tobacco to youth to 90% from 82% (December-2008.)

Increase the percentage of Oklahoma adults and youth who successfully quit tobacco use.

By Fiscal Year 2014, increase utilization of the Oklahoma Tobacco Helpline from 35,000 to 70,000 registered callers. (Baseline FY 2009.)

By January 2015, increase the number of hospitals, health care professionals, and community-based clinics that effectively implement the Public Health Service Clinical Practice Guideline for treating tobacco dependence.

By January 2015, increase tobacco-free properties at all workplaces including private businesses, state agencies (10% to 100%), tribal governments (from 5% to 50%), local governments (75%), hospitals (38% to 100%), school districts (from 29% to 100%), universities and colleges (16% to 100%), career tech centers (7% to 100%) and faith-based organizations (Baseline June 2009.)

Protect all Oklahomans from exposure to secondhand smoke.

By May 2010, extend state law to eliminate smoking in all indoor public places and workplaces, except in private residences; currently, Oklahoma state laws contain exceptions for certain workplaces.

By January 2015, increase the number of tribal nations that voluntarily adopt laws to eliminate commercial tobacco abuse in tribally owned or operated worksites, including casinos.

By January 2015, increase the proportion of multi-unit housing facilities (from 1% to 25%), homes (from 74% to 90%) and motor vehicles (from 69% to 80%) with voluntary smoke-free policies.

Obesity Reduction

Sixty-five (65) percent of Oklahoma adults are either overweight or obese, and 31 percent of Oklahoma youth are either overweight or at risk of being overweight. The latest information from the *2009 Trust for America's Health Report* ranked Oklahoma 6th in its adult obesity rate and 33rd in the percentage of obese and overweight children.[48] Oklahomans' lack of consumption of nutrient dense calories and physical inactivity are troublesome behaviors. Only 16.3 percent of adults consume adequate amounts of fruits and vegetables; and among youth it is at 15.7 percent. Only 45.5 percent of adults engage in recommended physical activity with youth at 49.6 percent.[13, 75] The economic consequences of physical inactivity include both substantial health care costs and even greater costs related to lost productivity and lower economic output due to illness, disability and premature death.[7] Overweight and obesity are associated with many health risks such as heart disease, high blood pressure, high cholesterol, type 2 diabetes, some types of cancers, arthritis, depression and possibly stroke. Oklahoma ranks 5th in adult diabetes rates and 8th in hypertension rates. There are also disparities across racial/ethnic groups. The prevalence of obesity was higher among adolescent (12-19) Hispanic boys (22.1%) than among non-Hispanic White boys (17.3%) and Black boys (18.5%). Non-Hispanic Black girls had the highest prevalence of obesity (27.7%) compared to that of non-Hispanic White (14.5%) and Hispanic (19.9%) girls.[76] The estimated cost associated with obesity in Oklahoma is $854 million each year.[77] This problem affects the health of individuals, families and communities throughout the state.

In 2004, the Oklahoma State Department of Health's Chronic Disease Service was awarded a cooperative agreement from the Centers for Disease Control and Prevention to address obesity issues in Oklahoma. From this came the Oklahoma Physical Activity and Nutrition Program (OKPAN). The OKPAN plan addressed issues surrounding obesity and obesity-related chronic diseases across the lifespan. Strategies in the OHIP plan reflect recommendations from this comprehensive effort. They include: 1) implementing the recommended strategies identified in the *Get Fit, Eat Smart Oklahoma Physical Activity and Nutrition State Plan;* 2) implementing and evaluating the impact of evidence-based programs; 3) providing integration and coordination of nutrition and obesity programs across the state and 4) proposing public policy changes needed to improve Oklahoma's health and fitness.

The determinants of obesity in the United States are complex, numerous, and operate at social, economic, environmental, and individual levels. Public health approaches that affect large numbers of different populations in multiple settings — communities, schools, worksites, and health care facilities — are needed.[7] Policy and environmental change initiatives that make healthy choices in nutrition and physical activity available, affordable, and accessible will likely prove most effective in combating obesity. These approaches are proposed in Oklahoma's physical activity and nutrition state plan, *Get Fit, Eat Smart,* for obesity prevention across the lifespan. The recommendation of the obesity work group is to identify the barriers and find solutions to fully implement this state plan.

TABLE 7 · OBESITY REDUCTION GOALS & OBJECTIVES

Implement strategies identified in *Oklahoma's Get Fit Eat Smart Physical Activity and Nutrition Plan.*

By June 2010, OSDH will have an online, searchable inventory database identifying evidence-based or promising programs that address physical activity, nutrition, and obesity issues.

By July 2010, develop and facilitate a multi-level surveillance and evaluation system to monitor the plan.

By October 2010, the Strong and Healthy Oklahoma Division of OSDH, in collaboration with Oklahoma Fit Kids Coalition and other stakeholders, will develop the capacity to provide technical assistance, consulting, and training in the integration, coordination, and implementation of evidence-based or promising programs addressing physical activity, nutrition, and obesity to reduce cost and increase accessibility for schools and communities.

Implement public policies identified in *Oklahoma's Get Fit Eat Smart Physical Activity and Nutrition Plan.*

By May, 2010 mandate utilization of School Health Index for assessment and action planning by each public school's site-based Healthy and Fit School Advisory Committee.

By May 2011, mandate health-related fitness testing in all public schools.

By May 2012, pass legislation to provide financial incentives for grocery stores or farmers markets to locate in underserved communities (Nutrition and Physical Activity: a Policy Resource Guide, Feb. 2005 pg 25 "promising".)

By May 2013, implement Oklahoma Health Care Authority rule change to provide financial incentives for Baby Friendly Hospitals in Oklahoma. (Reference Baby Friendly Hospital Initiative (BFHI) USA – www.baby friendlyusa.org/eng/index/html).

By May 2013, pass legislation to ensure that the safety and mobility of all users of all transportation systems (pedestrians, bicyclists, drivers) are considered equally through all phases of state transportation projects and that not less than 1 percent of the total budget for construction, restoration, rehabilitation or relocation projects is expended to provide facilities for all users, including but not limited to, bikeways and sidewalks with appropriate curb cuts and ramps so that even the most vulnerable (children, those with disabilities, the elderly) can feel and be safe with the public right of way.[7, 15, 16, 17]

Children's Health

Our children are our future and their good health must be our priority. However, for the first time in history, children are not expected to live as long as their parents before them. Change must occur to reverse this trend.

According to the *2009 Oklahoma KIDS Count Factbook*, there are close to 900,000 children in Oklahoma representing 24.9 percent of the population (2007). Over 196,000 children are poor (2007) representing a 22.2 percent child poverty rate. [78] Over half of all children enrolled in Oklahoma public schools participate daily in the Federal Free and Reduced Meals program. Over 59 percent of Oklahoma children receive medical benefits through the state Medicaid program.[79] Key indicators such as low and very low birthweight worsened (2005-2008) and confirmed child abuse and neglect slowed their steep decline (2006-2008) as compared to the mid-1990s. There is a slowdown in improvement rates in the areas of infant mortality and child and/or teen deaths.[78] For 2006, Oklahoma ranked 41st in the U.S. for infant mortality rates.[39] Recent (school year 2005/2006 through school year 2007/2008) high school dropout rates at 3.3 percent are virtually the same as high school dropout rates for the three-year period just one year earlier (school year 2004/2005 through school year 2006/2007). Over 6,500 (school year 2005/2006 through school year 2007/2008) young Oklahomans quit school without graduating each year. Close to 6,000 of those are under age 19 and quit attending school in a single year.[78]

Data show some progress in children's preventive services in the area of immunization. In the past 10 years immunization coverage in Oklahoma increased from 42.3 percent to 73.6 percent of children between the ages of 19 to 35 months receiving complete immunizations.[1]

A 2000 Institute of Medicine Report confirms the importance of early childhood programs. The early years of life are crucial in terms of paths leading towards or away from good health. Brain, cognitive and behavioral development early in life are strongly linked to an array of important health outcomes later in life, including cardiovascular disease and stroke, hypertension, diabetes, obesity, smoking, drug use and depression. There is a powerful argument for early enrichment based on cost-benefit analyses of future increased productivity resulting from this intervention.[7, 80, 81]

Oklahoma has made advancements in early childhood education. In Oklahoma, a variety of initiatives have been implemented to improve the level of child care quality. The "Reach for the Stars" Program provides tiered reimbursement tied to quality criteria in child care facilities related to provider and director education as well as parental involvement. Approximately 92 percent of children receiving Oklahoma Department of Human Services subsidies receive child care in 2 or 3 star facilities. The Scholars for Excellence in Child Care Program awards scholarships to eligible child care professionals for coursework in the area of child development or early childhood education. The Reward program provides education-based salary supplements to teachers, directors and family child care providers working with young children in child care settings by rewarding education and continuity of care.[82, 83, 84]

There are also early childhood programs that provide comprehensive child development services to economically disadvantaged children and families.[85] Educare programs in Oklahoma City and Tulsa are a partnership between the private and public sectors to create high-quality, learning environments for families and their children (ages prenatal to five years) who are at-risk for school failure.[86] Head Start programs promote school readiness by enhancing the social and cognitive development of children through the provision of educational, health, nutritional, social and other services to enrolled children and families. Early Head Start programs serve children from birth to three years of age.[85, 87] There are 22 Headstart/Early Head start programs in the state serving close to 20,000 children in fiscal year 2008.[87]

Ongoing education enrichment is seen in expansion of prekindergarten and kindergarten education programs. Approximately 69.5 percent of four-year-olds and 98.7 percent of five-year-olds are enrolled in a full or part day prekindergarten or kindergarten program.[83] However, even with these accomplishments, there are ongoing statewide needs to increase and sustain the quality in early childhood education settings.[84]

Another vehicle for preventive health services is in school systems. Improvement is needed in this area; Oklahoma is one of two states in the nation that does not require health education in grades K-12. There are only 10 school-based health centers in one county out of a total of 537 school districts in the state.

Close to 90,000 children ages 9 through 17 suffer from mental or behavioral impairments and one out of every 10 young Oklahomans may have a substance disorder .[75, 79] The 2007 Youth Risk Behavior Survey (YRBS) data shows that 33.2 percent of adolescents in Oklahoma have used marijuana one or more times and 75.6 percent of adolescents have had at least one drink of alcohol on one or more days during their life. Even more discouraging is that almost 14 percent of Oklahoma adolescents have seriously considered attempting suicide during the past 12 months and 5.9 percent have actually attempted suicide one or more times in that same time period. Additionally, over one-fourth of adolescents in Oklahoma have felt sad or hopeless almost every day for two weeks or more in a row resulting in a decrease in their

usual activities during the past 12 months. Children facing significant adverse experiences often have childhood mental illness or substance abuse. Those who live to adulthood face an increased likelihood of poor adult health status and early death.[75, 79]

Access issues impact children. Both financial and demographic factors have forced health care providers to move or restrict their pediatric practices.

Racial, educational and age disparities exist. The infant mortality rate is twice as high for Black infants versus their White and American Indian counterparts (15.9, 7.0 and 8.9 respectively, 2004-2006). The infant mortality rate for mothers with less than a high school education is 1.25 to 2.7 times higher than for mothers with at least a high school education.[88] Between 2004-2006, 13.2 percent of all births were to mothers between the ages of 15 and 19 and 96.4 percent of those births occurred to mothers between the ages of 18-19. The four leading causes of death for children of all races and both sexes for ages 1 through 8 are: unintentional Injury (58), malignant neoplasm (15), homicide (11), and anomalies (8). The five leading causes of unintentional injury deaths for all races and both sexes for the ages 1 through 8 are: motor vehicle traffic deaths (20), drowning (13), fires/burns (10), natural/environmental (2), and pedestrian (2).[2]

Given this backdrop, the children's health work group identified three strategic areas. The first set of goals addresses the need to improve perinatal and infant care outcomes to accelerate rates of reduction in infant mortality and morbidity. Objectives include increasing preconception care, minimizing prenatal sexually transmitted diseases, increasing the number of women who receive prenatal care in the first trimester, minimizing unintended pregnancies and increasing safe sleep education. The second and third set of goals addresses the need to develop a comprehensive child health plan to improve health outcomes for the early years of a child's life (age 1 through 8) as well as the pre- and adolescent time frames. The work group determined there is no single plan covering the full array of children's issues. This plan would include recommendations addressing socioeconomic determinants that impede progress in both physical and mental health outcomes incorporating evidence-based practices with proven efficacy. The group will take advantage of existing reports covering topical issues in children's health to ensure a synthesis of existing and new initiatives.

TABLE 8 · CHILDREN'S HEALTH GOALS & OBJECTIVES

Improve health outcomes for children age 1 year to 18 years old.

By 2011, develop a comprehensive statewide plan for children's health.

- Build state and community infrastructure.
- Develop supporting policy.
- Address health inequities.
- Promote youth development opportunities.
- Provide education and skill building for youth and families.
- Provide services for youth and families.
- Collect and monitor data.
- Assure measured effectiveness.

Focus areas to include: access to care; primary health care; dental health; mental health; injury reduction; child abuse and neglect; self esteem improvement; and parent education programs.

Improve infant health outcomes

By 2012, reduce sleep-related deaths.

By 2012, reduce the proportion of unintended pregnancy from 48.4% to 47.2%.

Improve perinatal health outcomes.

By 2012, increase the number of women receiving quality [American College of Obstetrics and Gynecology (ACOG)] preconception care from 13.5% to 16% [Maternal and Child Health (MCH) Plan].

By 2012, improve identification and early treatment of maternal infections.

By 2012, increase the number of mothers receiving (ACOG Standards) first trimester prenatal care from 73.9% to 85.7%.

Infrastructure Opportunities

Public Health Finance

Approximately 89 percent of all public health funds in Oklahoma are allocated to the OSDH, where they are spent on statewide activities or local services. A 2006 comprehensive report of public health resource allocation in Oklahoma showed 29 percent of all public health spending was allocated to the OSDH for 1) statewide activities such as health facility licensure, disease surveillance, vaccine dissemination, and laboratory services statewide; and 2) a centralized infrastructure for both administrative (accounting, personnel, etc) and technology functions. The remaining 71 percent of the funds was either allocated directly or transferred from the OSDH to Oklahoma County (19%), Tulsa County (17%), or to the remaining 68 county health departments (35%).[89]

The role of the public health finance work group will be to analyze and evaluate the current public health finance system. This assessment could be benchmarked against public health accreditation standards. The efforts of this work group may have an impact on how public health services are delivered in the future.

Workforce Development

In 2008, Oklahoma ranked 49th in the nation for primary care physicians per 100,000 population, with five rural counties having only one physician covering primary care services in those counties. The total number of medical school graduates in 2008 was 218.[90, 91] There are 735 RNs per 100,000 in 2008 ranking the state 10th lowest.[39, 92] The *Oklahoma's Health Care Industry Workforce 2006 Report* incorporated a review of 2005 health care worker vacancies and projected the following shortages for 2012: 3,000 nurses, 500 lab technicians, 400 physical therapists, 300 surgical technologists and 200 occupational therapists. The need for radiology and respiratory professionals, pharmacists, emergency medical technicians, and chemical dependency counselors has also been documented.

The Oklahoma public health community acknowledges that an adequately prepared workforce does not simply materialize and that sustaining a drive toward high performance and improved health outcomes requires long-term public health workforce development. Further, there is an understanding that new approaches will be necessary to assure that a competent public health workforce is available throughout the state to meet diverse needs in many settings and provide a wide range of services. Given Oklahoma's rural demographics and the critical need today to provide primary care coverage to its citizens, we must explore creative ways in which to expand the number of physicians as well as highly skilled and educated physician extenders including physician assistants, advanced practice nurses, certified registered nurse anesthetists, clinical nurse specialists and certified nurse midwives.

Nationally, public health workforce studies have concluded that there are 1) insufficient numbers of health professionals within specific skilled public health occupations, such as public health nurses and epidemiologists; 2) trends toward additional shortages of experienced workers who are approaching retirement age [by 2012, over 50 percent of some state health agency workforces will be eligible to retire;[14]] 3) inadequate workplace incentives for recruitment, retention, and recognition of qualified professionals and students into the field of study; and 4) insufficient preparation in professional education programs and orientation and assimilation into the public health system.

While national data can provide guidance on potential workforce issues, current information on the Oklahoma public health workforce is lacking. In order to appropriately address Oklahoma issues there is the need to enumerate the current Oklahoma public health workforce and develop a strategic plan to meet future needs by collecting information about size, composition, distribution, skills, and performance of the public health workforce; projecting future changes in public health workforce roles and the impact of these changes on workforce composition; and identifying education and training needs for core practices and essential public health services for multiple professional categories working in diverse public health settings.

In 2001, a coalition of many organizations — including the Oklahoma Hospital and Nurses Associations, the Oklahoma Board of Nursing, the Oklahoma Department of Career and Technology Education, the Oklahoma State Regents for Higher Education, and many others — began working together to identify solutions to Oklahoma's health care worker shortages. The culmination of this work resulted in the creation, in 2006, of the Oklahoma Health Care Workforce Center (OHCWC). Created by SB 1394, the purpose of the OHCWC is to serve as a clearinghouse to coordinate, communicate and facilitate statewide efforts to meet the supply and demand needs of Oklahoma's health care workforce.

The alarming statistics in regard to the private and public sector health services workforce provided the impetus for formation of the workforce development work group to assess current and long-term needs of the Oklahoma health services workforce. The group's outcomes include:

Long Term Outcomes

A private and public health services workforce that is well prepared, adequate in number, and distributed according to the health care needs of both rural and urban Oklahomans.

Intermediate Outcomes

A coordinated system that effectively prepares the public and private health care workforce in numbers sufficient to meet the needs of Oklahomans.

A coordinated system to effectively distribute the public and private health care workforce to meet the needs of both urban and rural Oklahomans.

Work group participants include representatives from: 1) workforce development and training; 2) physicians; 3) nurses; 4) nurse practitioners; 5) physician assistants; 6) allied health; 7) pharmacy; 8) academia; and 9) related state agencies. This work group is in the preliminary stages of identifying health care and public health workforce issues. Common issues identified by the work group include:

- *Rural vs. urban distribution of health care resources and practitioners* – Distribution of health care resources is not parallel to the population. Rural areas have shortages but there are also medically underserved urban areas as well. The distribution of health care resources should not compete with underserved areas (i.e., FQHC, rural clinic, and physician located in the same rural area).
- *Focus on increased provision of primary health care and preventive services* – There needs to be a coordinated effort among all disciplines to focus on the provision of primary care. There are large numbers of uninsured in rural areas. Funding mechanisms must be in place to support primary care health services in these areas. Behavioral/mental and dental health must also be considered part of primary care services. There should also be more support for primary care training in both rural and medically underserved urban areas.
- *Need to reduce bottlenecks and faculty shortages in training programs* – Training programs require that faculty in nursing programs have PhDs. There are many highly qualified professionals who could teach that don't meet that requirement. Another constraint is that faculty can earn more in the private sector. Many faculty will retire in the next 10 years. This will necessitate more partnerships between training programs to ensure an adequate supply of health education professionals.
- *Better information on our health care workforce, especially the public health workforce* – We need a better picture of the status of health care professionals who are licensed and practice in the state versus those who no longer practice. Data show more professionals practicing than is actually the case. There needs to be an accurate assessment of the size of the workforce available to the population and their distribution throughout the state. The private and public health care workforce is aging. This will create shortages as they retire.
- *Increase the number of health care professionals who practice in rural areas* - It is difficult to get health care professionals to go to rural areas to practice. Many of those who live in rural areas come to urban areas to study then do not return to practice. How can Oklahoma train people in rural areas so that they will stay and practice in those locations? The state also needs to address retention, keeping those we train in the state to practice.
- *Need to build a bridge between public and private health care systems* – Public and private health care professionals need to join as a group to educate legislators and advocate for common needs. The OHIP process has the potential to be a unified voice for the health care professions.

Access to Care

In 2008, 687,625 Oklahomans under the age of 65 had no health insurance, representing 22.3 percent of this population.[9] Uninsured rates vary by age, race and ethnicity, household income, educational attainment and region.[11,12] Approximately 474,000 Oklahomans in 2007 could not see a doctor because of cost, ranking the state 47th in the nation.[13]

The access to care work group has been formed based on the above data findings. The co-chairs of this work group have identified members of the ongoing State Coverage Initiative (SCI) as appropriate persons to identify barriers to accessing care. The SCI proposal has the following strategies:

Expand Insure Oklahoma and SoonerCare

The SCI proposal calls for an accelerated effort to implement programs that are already approved and authorized but are not yet at capacity. This includes both "Insure Oklahoma" and "SoonerCare" programs that receive about two dollars in federal funds for every dollar Oklahoma spends. Full enrollment of all eligible Oklahomans for whom funding is currently available would reduce the number of uninsured by 80,000; another 370,000 could be covered if a new revenue source for the Oklahoma share is established.

Create Affordable Commercial Health Plans

This strategy assumes an evaluation of the feasibility of "affordable" plans that 1) trigger eligibility for federal matching funds; 2) exist using state funds that are matched with private expenditures; or 3) are available as lower cost yet comprehensive options. One option is to create "mandate free" plans that will be allowed by the Legislature through suspension of state insurance mandates. The exploration of other options assumes that broadly affordable and attractive individual insurance plans are not likely to survive in the marketplace without the adoption of a fair and equitable requirement for all individuals to purchase health insurance coverage.

Generate Revenue through a Dedicated Insurance Fee

As public revenue is required, the SCI Plan proposes an innovative recirculation of what is known as the "embedded cost shift" in health expenditures. This approach assesses all third party health care claims and directs those assessments into a dedicated fund to generate the public revenue required to support premium assistance purchases. The rate and frequency of assessment will be calibrated to actual need, and the application of the fee will only be activated as the numbers of uninsured are reduced. All payers — insurers, HMOs and third party administrators — will participate, as each is a potential beneficiary.

Encourage Oklahomans to Obtain Insurance Coverage

A variety of enrollment strategies will be employed to induce Oklahomans to acquire applicable private or public health insurance. The failure of these strategies will require policymakers to consider mandating that all individuals secure health insurance.

Complimentary Initiatives

The issue of health insurance coverage for Oklahomans is as broad as it is deep. Nothing will be accomplished solely by a single group or even a single government. All of the proposed strategies are interdependent and require sequencing. This SCI proposal provides the suggested actions, benchmarks, and sequencing to significantly reduce the number of uninsured in Oklahoma, and recommends coordination with and support for complimentary initiatives in the state.[93]

The following objectives will be accomplished over the next five years:

- conduct on-going research regarding the effectiveness and practical use of the SCI Plan as it is being implemented;
- launch educational and informational campaigns about the essential elements of the SCI Plan;
- ensure that the Governor publicly supports the establishment of a permanent revenue source for Insure Oklahoma and encourages the Legislature to enact necessary legislation in early 2010; and
- work with the Legislature on a continuous basis to ensure a public revenue source is identified and that transparency is maintained through the use of hearings and public debate.

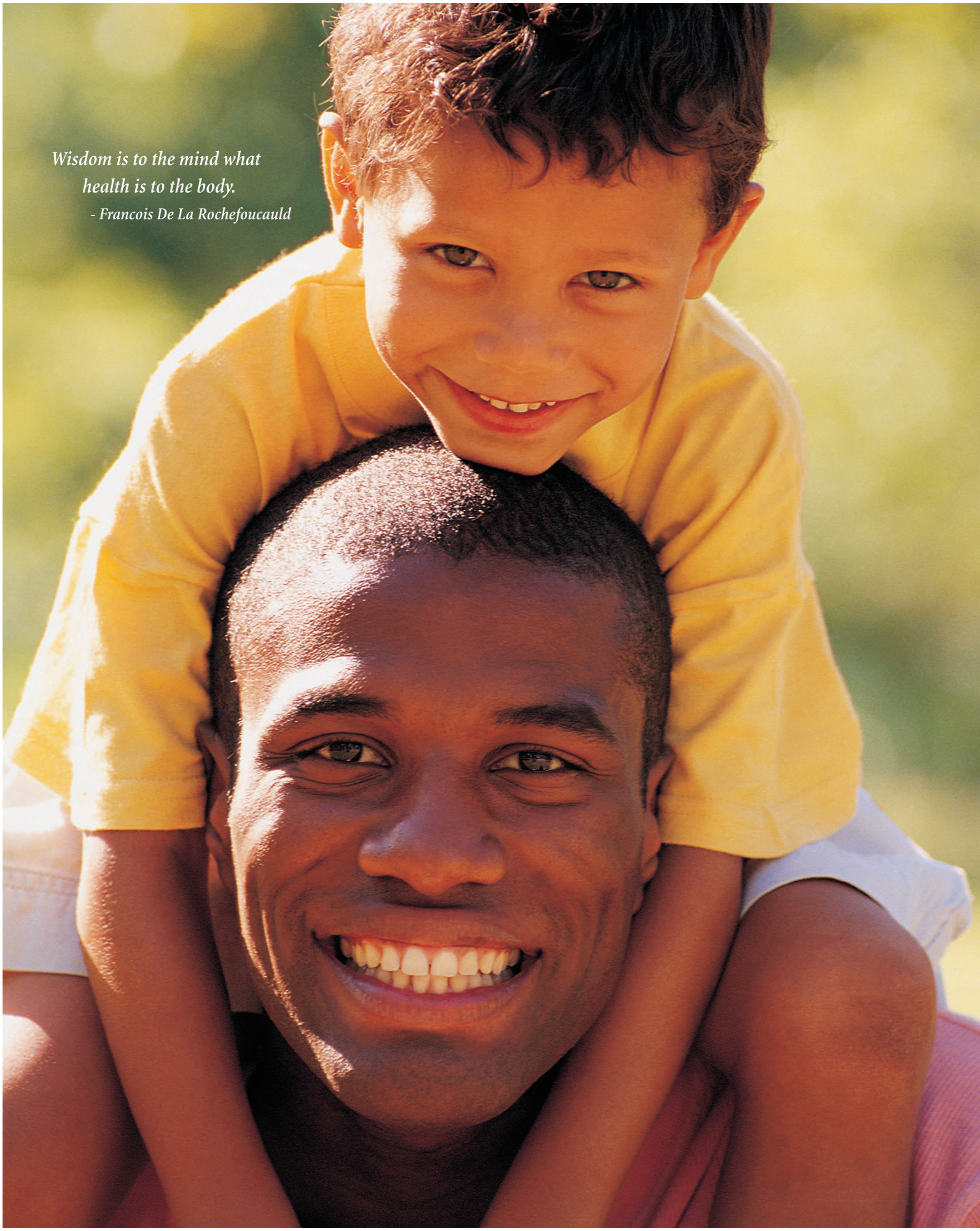
Health Systems Effectiveness

The health systems effectiveness work group has been formed to identify and strengthen private-public partnerships throughout the state of Oklahoma. The work group chair and co-chairs are committed to bringing together a diverse set of Oklahoma health professionals in both public and private settings to help identify best practices to improve health outcomes for residents of Oklahoma. The primary goal of this work group is to identify gaps in our current health systems operations that are preventing Oklahomans from achieving the best health outcomes possible.

The role of technology is at the forefront of federal activities to improve quality of care. The American Recovery and Reinvestment Act (ARRA) and the Children's Health Insurance Plan Reauthorization Act (CHIPRA) include provisions covering health information technology and health information exchanges including the use of electronic medical records. Limited funding is available to states to evaluate these systems.

Over the next nine to twelve months this work group will meet to generate a comprehensive plan that identifies the following:

- systematic methods for identifying appropriate partnerships
- methodologies and processes to reduce duplication of efforts
- utility of Health Information Technology (HIT) and Health Information Exchange (HIE) Systems
- key/responsible parties to champion these efforts


Wisdom is to the mind what health is to the body.
- Francois De La Rochefoucauld

FUTURE ACTIONS

This is an exciting time to work on state health improvement. The OHIP plan is being done against the backdrop of national health care reform and these recommendations are consistent with national goals and objectives in the areas of expansion of health care coverage, premium subsidies, cost containment, prevention and wellness, training of primary care providers, access to health services in rural and underserved areas, core public health infrastructure needs, and health systems quality and performance. This report is not a static document. It is a living document which will be monitored on a regular basis. We will continuously seek feedback from community stakeholders about our current efforts and to identify new initiatives.

Outcomes

Outcomes will include important reports from the infrastructure work groups that assess findings of the *State Coverage Initiative Report,* recommend directions in public health care financing, recognize public/private partnerships that further health improvements, and identify strategies to strengthen the health care workforce. Flagship groups will present progress reports about outcomes recommended in the *Get Fit Eat Smart Oklahoma Physical Activity and Nutrition State Plan* and the *Oklahoma State Plan for Tobacco Use Prevention and Cessation.* A comprehensive plan covering children ages 1 to 18 will be completed. There will also be monitoring of strategies designed to reduce infant mortality. OHIP will provide a scorecard by which the goals and objectives referenced in this plan can be measured.

Involvement

Legislature

Legislative involvement is critical to OHIP's success. Recommendations in this report include public policy recommendations that require statutory changes. The OHIP Plan will be the blueprint to present these requests during the next legislative session. Furthermore, recommendations may require a different allocation of funding. OHIP leaders look forward to working with legislative leadership to ensure support in these areas.

Schools

Listening sessions emphasized the important role schools can play in promoting health and wellness and in serving as a community focal point for healthy family activities. The OHIP plan assumes activities to sustain and expand partnerships with community school leaders to further evidence-based practices in this sector.

Businesses

OHIP incorporated private sector leaders in its planning process; the plan recommends public/private partnerships as an important component in improving health outcomes. The work of the health systems effectiveness work group will be critical in identifying ways the business community can work with the public to expand health care initiatives and advocate for needed public policy changes.

Localities

Local communities are essential to the success of the OHIP process. With 66 Turning Point partnerships across the state, we are reaching critical mass where localities can make a positive impact on health indicators tailored to specific community characteristics. The OHIP process will continue to seek community input to elicit feedback about this plan as well as to solicit suggestions for priority areas in which to focus. This plan and improvement of health outcomes cannot move forward without the involvement, creativity, and advocacy of local communities.

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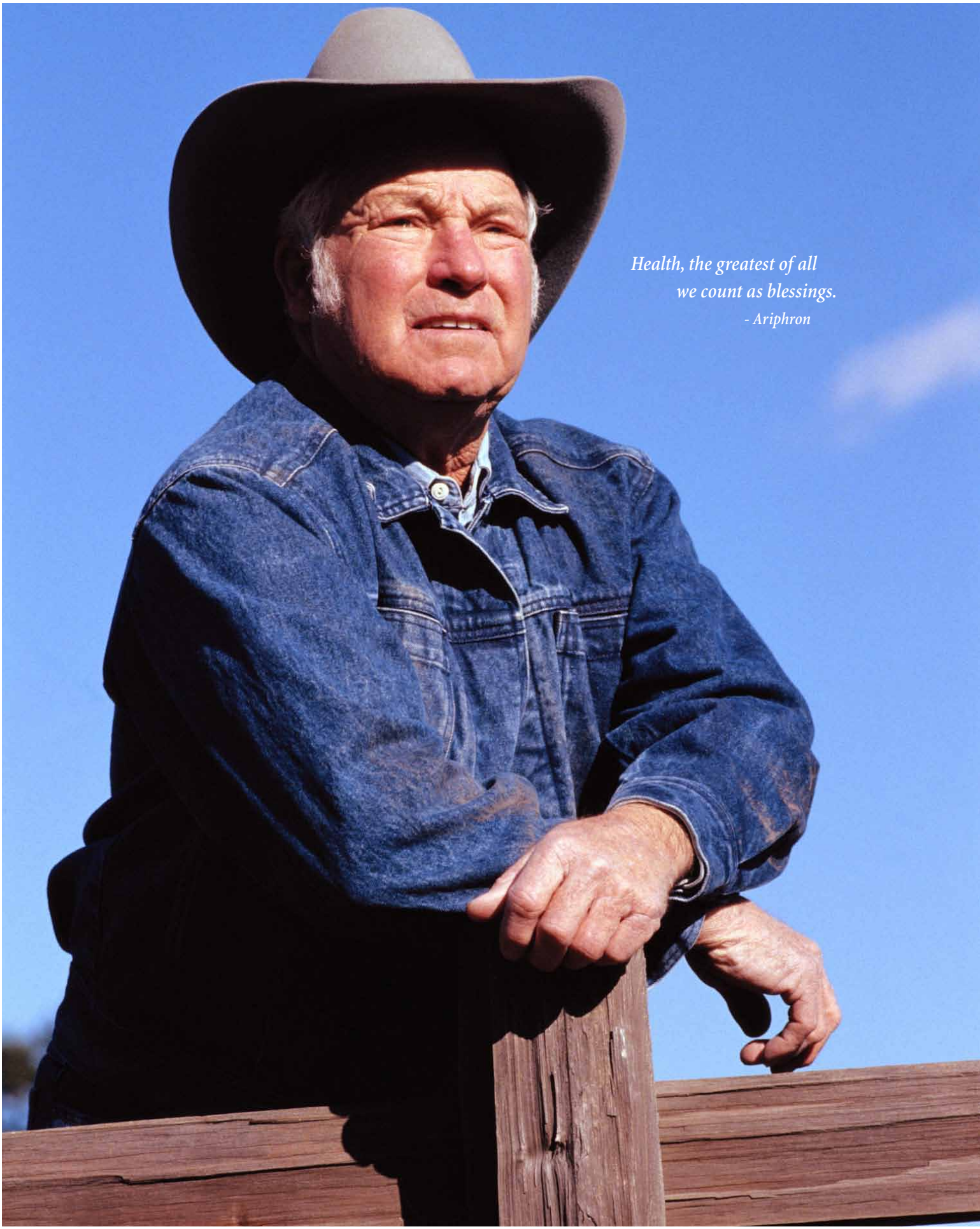
Health, the greatest of all
we count as blessings.
- Ariphron

APPENDIX

Oklahoma Health Improvement Planning Team

CHAIR (July 2008 - July 2009)
Barry Smith, President, Oklahoma State Board of Health

CHAIR (July 2009 - Present)
Dr. Terry Cline, Commissioner, Oklahoma State Department of Health

Tom Adelson, State Senator

Dr. Jenny Alexopulos, Vice President, Oklahoma State Board of Health

Brad Carson, Cherokee Nation Business

Dr. Doug Cox, State Representative

Gary Cox, Director, Oklahoma City-County Health Department

Brian Crain, State Senator

Mike Fogarty, Chief Executive Officer, Oklahoma Health Care Authority

Sandy Garrett, State Superintendent, Oklahoma State Department of Education

Neil Hann, Oklahoma Turning Point

Rik Helmerich, Chair, Board of Health, Tulsa Health Department

Howard Hendrick, Secretary of Human Services and Director, Oklahoma Department of Human Services

Dr. Timothy Hill, President Board of Health, Oklahoma City-County Health Department

Kim Holland, Commissioner, Oklahoma Insurance Department

Reggie Ivey, Interim Director, Tulsa Health Department

Craig Jones, President, Oklahoma Hospital Association

Kenneth LaRue, Transit Programs Manager, Oklahoma Department of Transportation

Marjorie Lyons, President, AARP Oklahoma

Danny Morgan, State Representative

Dr. William Oehlert, Oklahoma State Medical Association

Dr. C Michael Ogle, Oklahoma Osteopathic Association

Dr. Gary Raskob, Dean, College of Public Health, OU Health Sciences Center

Anne Roberts, Director of Legislative Affairs, INTEGRIS Health

Matt Robison, Vice President, Small Business and Workforce Development, The State Chamber of Oklahoma

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Dennis Shockley, Executive Director, Oklahoma Housing Finance Agency

Scot Stirton, Public Member at Large

Tracey Strader, Executive Director, Tobacco Settlement Endowment Trust

Ann Trudgeon, Executive Director, Oklahoma Developmental Disability Council

Terri White, Secretary of Health and Commissioner, Oklahoma Department of Mental Health and Substance Abuse Services

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Robert McPherson, Director, Physical Education/Health, Oklahoma State Department of Education

Cindy Roberts, Deputy Chief Executive Officer, Oklahoma Health Care Authority

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Dr. Hank Hartsell, Grace Kelley, Joyce Marshall, Patrick McGough, Sharon Neuwald, and Mark Newman

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Jenny Alexopulos, DO, Vice President
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Michael D Anderson, PhD
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Jan Figart, Tulsa Healthy Start/ Community Service Council

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Craig Jones, Oklahoma Hospital Association

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Sheryl McLain, Executive Director, Oklahoma Healthcare Workforce Center

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Kammie Monarch, Chief Nursing Officer, Oklahoma Healthcare Workforce Center

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Cynthia Clubb, Oklahoma University Health Sciences Center

Lynn Gray, Oklahoma Employment Security Commission

Jane Nelson, Oklahoma Nurses Association

Dr. William Pettit, Oklahoma State University

Dr. P. Kevin Rudeen, Oklahoma University Health Sciences Center

Val Schott, OSU Center for Rural Health

Senate Joint Resolution No. 41

A joint resolution requiring the State Board of Health to prepare a state health improvement plan; and directing distribution.

~ By Crain and Johnson of the Senate and Cox, Kiesel, and Lamons of the House

WHEREAS, Oklahoma has the eighth highest rate of diabetes in the nation; and

WHEREAS, one out of four Oklahomans smokes; and

WHEREAS, the state ranks eighth in the nation for its rate of obesity;

WHEREAS, only five other states in the nation have lower physical activity rates; and

WHEREAS, twenty percent (20%) of Oklahoma children ages nineteen (19) to thirty-five (35) months do not receive recommended immunizations; and

WHEREAS, thirty percent (30%) of women in Oklahoma do not receive adequate prenatal care; and

WHEREAS, Oklahoma ranks forty-third in the nation for its rate of cancer deaths; and

WHEREAS, Oklahoma has the highest rate of cardiovascular deaths in the nation; and

WHEREAS, the United Health Foundation ranked Oklahoma forty-seventh in the nation for overall health in 2007, down from forty second in the nation in 2000 and thirty-first in the nation in 1990.

NOW, THEREFORE, BE IT RESOLVED by the Senate and the House of Representatives of the 2nd Session of the 51st Oklahoma Legislature:

SECTION 1. The State Board of Health shall prepare and return to the Legislature a health improvement plan for Oklahoma for the general improvement of the physical, social, and mental well-being of all people in Oklahoma through a high functioning public health system.

SECTION 2. The Secretary of State shall distribute copies of this resolution to the members of the State Board of Health.

Passed the Senate the 11th day of March, 2008

Passed the House of Representatives the 24th day of April, 2008

Acronyms & Key Terms

AADS	American Association of Dental Schools
AAMC	American Association of Medical Colleges
AAPA	American Academy of Physician Assistants
AAPD	American Academy of Pediatric Dentistry
ACOG	American College of Obstetrics & Gynecology
ACS	American Community Survey
ADA	American Dental Association
ADA	Americans with Disability Act
AMA	American Medical Association
ASEC	Annual Social and Economic Supplements
BLS	Bureau of Labor Statistics
BRFSS	Behavioral Risk Factor Surveillance System
CCD	Common Core of Data (from U.S. Department of Education)
CDC	Centers for Disease Control and Prevention
CHD	County Health Departments
CHP	Community Health Promotion
CMS	Center for Medicare and Medicaid Services
COPD	Chronic Obstructive Pulmonary Disease
CPI	Cumulative Promotion Index
CPS	Current Population Survey
DDS	Doctor of Dental Surgery
DMD	Doctor of Dental Medicine
DO	Doctor of Osteopathic Medicine
DOE	Department of Education
GED	General Education Development
EPA	Environmental Protection Agency
EPE	Research Center Division of Editorial Projects in Education, the non-profit organization that publishes Education Week
FDA	Food and Drug Administration
FQHC	Federally Qualified Health Center
HACT	Housing Authority of the City of Tulsa
HCI	Health Care Information (from BRFSS)
HIE	Health Information Exchange
HIT	Health Information Technology
HHS	Health and Human Services
HPDP	Health Promotion and Disease Prevention
HSC	Health Sciences Center
IHS	Indian Health Service
IMR	Infant Mortality Rate
IOM	Institute of Medicine
KCMU	Kaiser Commission on Medicaid and the Uninsured
MCH	Maternal and Child Health
MD	Medical Doctor (Allopathic Physician)
NCHS	National Center for Health Statistics
NHANES	National Health and Nutrition Examination Survey
NHIS	National Health Interview Survey
ODA	Oklahoma Dental Association
ODOT	Oklahoma Department of Transportation
OESC	Oklahoma Employment Security Commission
OHFA	Oklahoma Housing Finance Agency
OHWC	Oklahoma Healthcare Workforce Center
OKPAN	Oklahoma Physical Activity and Nutrition Program
OSBMLS	Oklahoma State Board of Medical Licensure and Supervision
O-EPIC	Oklahoma Employer/Employee Partnership for Insurance Coverage (aka *Insure Oklahoma*)
OSU	Oklahoma State University
OU	University of Oklahoma
OCCHD	Oklahoma City-County Health Department
OCHA	Oklahoma City Housing Authority
ODMHSAS	Oklahoma Department of Mental Health and Substance Abuse Services
OESC	Oklahoma Employment Security Commission
OHCA	Oklahoma Health Care Authority
OHIP	Oklahoma Health Improvement Plan
OSDH	Oklahoma State Department of Health
PMTC	Physician Manpower Training Commission
PPD	Physicians Professional Data (from AMA)
RAC	Rural Assistance Center
RDH	Registered Dental Hygienist
RWJF	Robert Wood Johnson Foundation
SAFETEA-U	Safe, Accountable, Flexible, Efficient Transportation Equity Act: A Legacy for Users
SCI	State Coverage Initiative
SoonerCare	Name of Oklahoma Medicaid program
State Plan	Oklahoma State Plan for Tobacco Use Prevention and Cessation
STD	Sexually Transmitted Diseases
TANF	Temporary Aid to Needy Families
TFAH	Trust for America's Health
THD	Tulsa Health Department
TSET	Tobacco Settlement Endowment Trust
UHF	United Health Foundation
WHO	World Health Organization
YRBS	Youth Risk Behavior Surveillance System

Model Community Initiatives

Central Oklahoma Turning Point

Jackie Jones
Executive Director, Turning Point
United Way of Central Oklahoma E. College Ave.
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Parents, Let's Talk

In 2006, participants at a Youth Summit identified one of their major concerns as a lack of reliable sex education and life skills training. The Central Oklahoma Turning Point (COTP) Community Engagement committee felt that the most effective intervention they could offer was training for parents so that they could communicate better with their children on these topics, using their own standards and values. They partnered with the Oklahoma State Department of Health and the Oklahoma Institute for Child Advocacy, who supplied trainers, and have now offered three sessions of "Parents, Let's Talk," a train-the-trainer workshop. Many youth clubs, civic groups, educators, and church youth leaders have participated in this training, and the result has been that hundreds of parents have benefitted, along with their children.

Corporate Wellness Coordinators

More than 40 companies and organizations have participated in the OKC Wellness Workgroup, which brings together wellness coordinators to share best practices, brainstorm new ideas, and find ways to share their experience with others seeking to improve the health of their workforce through wellness programs. Through the coordination and funding provided by the Oklahoma City-County Health Department, a website has been developed by the group, <www.healthatworkokc.org>. The group meets monthly at COTP.

Custer-Washita Health Action Team

Brandie O'Connor, MPH
Turning Point Coordinator
Jackson County Health Department
401 W Tamarack · Altus, OK 73521
(580) 482-7308

Weatherford Walking for Wellness

The City of Weatherford Parks and Recreation Department's volunteer-driven Walking for Wellness Program is in its third year. Residents are encouraged to begin the program at anytime by simply registering online. By submitting miles or steps individuals are included in the current totals for the City of Weatherford.

Tobacco Prevention Grant Funded through TSET

Activities through this grant have included successful passage of 24/7 tobacco-free school properties, promotion of Quitline activities, and active Students Working Against Tobacco (SWAT) teams in county schools.

Underage Drinking

Successful activities include passage of Social Host Ordinance in Clinton and Weatherford and active 2 Much 2 Lose (2M2L) teams throughout the community to curtail underage drinking.

Convenient Care Clinic

This clinic was opened to serve those accessing the emergency room who were not in need of urgent care, but more convenient and affordable access to health care services. The clinic's target population includes those who do not have a regular doctor; those who cannot get in to see a doctor; and those whose medical conditions do not warrant a visit to the emergency room. Patients are charged a co-payment and are billed under the hospital billing system. A payment assistance program is offered, and if the patient is uninsured, they receive a 40 percent discount on services received.

Delaware County Community Partnership

Susan Waldron
Ottawa County Health Department
1930 North Elm · Miami, OK 74354
(918) 540-2481

Drug and Alcohol Prevention and Awareness

The Delaware County Community Partnership (DCCP) has been successful in drug and alcohol prevention and awareness efforts. In 2007 the DCCP received a grant from the Cherokee Nation for alcohol and drug abuse prevention efforts for 3 years, which has served all the citizens of Delaware County, particularly youth. A major success from this effort was an underage drinking awareness town hall meeting which was highly attended by over 100 residents of this rural community.

Health and Wellness Needs Assessment

In order to expand community health improvement interventions and broaden the efforts of community partners, the DCCP has developed a comprehensive health and wellness needs assessment which is currently being distributed throughout the county. The data collected will help shape DCCP's goals of improving the quality of life of Delaware County residents by encouraging healthy attitudes and behaviors, and will provide baseline measures from which future planned evidence-based programs can be evaluated for impact and effectiveness.

School Nurses Coalition

Delaware County has been successful in obtaining school nurses for seven of its nine school districts which is a major accomplishment towards child health. Delaware County Health Department (DCHD) and the DCCP brought together these special nurses for regular meetings to discuss and support strategies to increase child health in the school environment.

CATCH Afterschool Program and Community Garden

The CATCH (Coordinated Approach to Child Health) program encourages physical activity and nutritious foods in a fun environment for children in the critical afterschool time period. The DCHD and OSU Extension Center started the YMCA Garden in their CATCH program. After the youth planted their garden, they took what they could pick from the garden and made healthy snacks such as fresh salsa while discussing ways to consume more fruits and vegetables.

Enid Metropolitan Human Service Commission's Health Planning Committee

Lana M. Shaffer
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Medical Supply Cooperative

The Medical Supply Cooperative project is a win/win situation for Enid. Disposable medical supplies are often bought in bulk for patients in medical facilities or those utilizing home health. When these patients no longer need or use these supplies there is the question of what to do with the extra supplies as they cannot be resold. The Community Health Clinic began receiving these supplies but did not have room to store them. The Committee has partnered with the Community Health Clinic to start the Medical Supply Cooperative to provide these supplies to home health nurses, discharge planners, and other health care providers to distribute to those citizens in need of these items.

Walk This Weigh

A Walk This Weigh program was sponsored by the Committee. This program provided community walking periods on four Saturdays during the six week program. There were between 600 – 800 participants throughout the program. Healthy snack stations provided community walkers with nutritious snacks during the events.

Fit Kids of Southwest Oklahoma

Brandie O'Connor, MPH
Turning Point Coordinator
Jackson County Health Department
401 W Tamarack · Altus, OK 73521
(580) 482-7308

There is a partnership between Comanche County Memorial Hospital (CCMH) Foundation and Lawton Public Schools to fund a Healthy Schools Coordinator and to implement the Healthy School Program through the Alliance for a Healthier Generation. This program will provide necessary child health data and will empower the schools to adopt evidence-based strategies which will begin changing the culture and attitudes of students, parents and staff. The second core project was the PLAY program with CCMH. This program started prior to Fit Kids and has provided hard data from 4th grade students in Lawton. While this program has been changed to the CATCH program, its results and impact are at the core of Fit Kids of Southwest Oklahoma.

Okmulgee County Wellness Coalition

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After School Program

After school hours are a critical time for youth. A variety of community members have come together to make a positive change in their community. This year Okmulgee will have their first after school program for children ages 8 to 14 at two school sites, Monday - Friday from 3:00 p.m. to 6:00 p.m. First and foremost the after school program will provide a safe haven for the children. With more and more area children growing up with two working parents or in a single parent home, today's families can benefit from the safe, structured learning opportunities that the after school program can provide. The after school program will focus on physical health and fitness as well as academic gains. Beyond issues of safety and health, the rewards for students and their communities can be enormous.

Tobacco and Alcohol Compliance

Okmulgee County community members had a concern about local retailers selling alcohol and tobacco products to minors. A group of concerned citizens including the Area Prevention Resource Center, Oklahoma Highway Patrol, ABLE Commission, Sheriff's Department, local police, and others partnered to conduct compliance checks around the county. They are now checking tobacco sales at least four times per year and alcohol sales at least three times per year. They utilize youth to attempt to purchase alcohol or tobacco and upon an agreed sale the retailer is either fined by law enforcement or provided education on sales to minors, underage drinking or the importance of preventing youth initiation to tobacco products. They have also used area youth to conduct "shoulder tap" buys where youth ask an adult to purchase alcohol for them. They have seen a decrease in the sales of tobacco to minors and have baseline data to see if the initiative is affecting sales of alcohol to minors as well. With the information learned from the project they have developed a comprehensive media campaign on underage drinking issues in Okmulgee County and are now working at the state level to strengthen laws on sales to minors.

Pathways to Health Partnership

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(918) 582-9355

Pathways to Health

Pathways to Health represents a broad partnership of agencies playing a vital role in improving the health of Tulsa County residents. The partnership has developed a Community Health Improvement Plan identifying six strategic health issues prevalent in all regions of the Tulsa area. These include childhood and adolescent obesity; nutritional access; safe, affordable and healthy housing; mental health; tobacco use; and access to health care. Each of the six areas has been assessed from a variety of angles including individual community and societal factors in order to develop multi-faceted intervention strategies. Over 35 interventions have been identified that are in either planning or implementation phases covering the six domains.

Pontotoc County Turning Point

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Turning Point Regional Field Consultant
Pittsburg County Health Department
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Walk This Weigh & Play This Weigh

In Pontotoc County there has been an initiative to address inactivity and combat sedentary lifestyles based on the Oklahoma Turning Point Initiative Walk This Weigh. Community members have partnered to hold monthly walks and walking events for the past three years. The Ada Area United Way oversees the initiative and has incorporated the area Oklahoma Smart Start Program to include Play This Weigh. This adds an interactive children's component to get kids active while teaching them fun ways to be active. The goal of the initiative is to incorporate regular exercise and activity into the lives of area community members and encourage active play among our children leading to better health outcomes.

Crystal Darkness

Pontotoc County citizens have been extremely concerned about substance abuse in their area. According to the Oklahoma Department of Mental Health and Substance Abuse Services they currently have the third highest rate of methamphetamine (meth) use in the state. The recent Oklahoma Crystal Darkness documentary and follow-up activities gave community members the opportunity, resources and knowledge to take an active role in addressing the issue. They held a watch party for the documentary that had the highest attendance of any in Oklahoma as well as held secondary watch parties after the documentary aired. They have developed an active committee dedicated to developing and implementing a plan for Pontotoc County to decrease methamphetamine and other drug use rates. The committee is currently working on getting curriculum into county schools, community outreach and education, and a media campaign for the county. The group is committed to decreasing substance use in the county and improving the lives of its residents.

Texas County Turning Point

Lana M. Shaffer
Harper County Health Department
PO Box 290 · Laverne, OK 73848
(580) 921-2029

Texas County Children's Health Fair

The 7th annual Children's Health Fair was just held in late July. This event helps parents get their children ready for back to school. The health fair is held at the fairgrounds and allows a one-stop shop for parents with many health screenings being held in one location. An average of 250 children attends each year. Children receive immunizations, vision, spine, and dental screenings. In addition, many service organizations and agencies are there to provide activities for the children and information on their services.

School-Based Social Worker

Guymon is a rapidly growing community and experiences high demands on its education system, service organizations and medical facilities. Schools provide an excellent place for providing support for families. Frequently, children are having difficulty at school due to physical, emotional, and economic problems. The coalition worked to create collaboration between Guymon Public Schools and the local Department of Human Services agency to create a comprehensive, coordinated school-based service worker. The worker was employed in August 2007 to respond to the social service needs of students and families through a referral system. She coordinates resources for families by making applications to any DHS program from the school office and is available for questions and support to teachers and families.

Tri-County Coalition

(Choctaw County Coalition, Pushmataha County Turning Point Coalition, and McCurtain County Coalition for Change)
Arlinda Copeland
Pushmataha County Health Department
318 West Main · Antlers, OK 74523
(580) 298-6624

Alliance for a Healthier Generation

As a direct result of the Oklahoma Health Improvement Plan community listening session, the Hugo Public Schools signed a Memorandum of Understanding to implement the School Health Program with the Alliance for a Healthier Generation.

The Alliance believes that helping schools is one of the most efficient and effective ways to shape the lifelong health and well-being of children and adolescents. The Healthy Schools Program will assist the schools and community to improve the schools in the areas of nutrition, physical activity, and wellness. CATCH (Coordinated Approach to Child Health) is a great example of interventions that schools are utilizing in this area.

Substance Abuse Prevention

Goals and objectives have been identified to target safe and drug-free schools, as well as tobacco control since 2002. However, it was not until 2008, when a comprehensive substance abuse strategic plan was discussed and developed among coalition members. This decision was based on community assessment, youth survey data, existing county statistics and input from the community. Town hall meetings and community forums were held to gather input on community needs and strategies for change. The Strategic Plan was the result of efforts by many coalition members and partnering organizations. Efforts are being made to combat underage drinking, methamphetamine use, and tobacco/alcohol sales to minors. Further, Project S.P.I.T. (Stop Prevent Intervene Tobacco use) works to change the attitudes and social norms of Southeast Oklahoma residents toward tobacco use. Education is the key to their success. They work closely with school districts, cities, tribes and the general public using every possible opportunity to educate youth, lawmakers, and specific populations toward the dangers of tobacco use. Identifying and educating those people who are influential and who are willing to lead is always a top priority for this project.

Community Health and Recreation

Resources have been leveraged through community support, grant dollars, and private donations to develop and build a community walking trail — the Elephant Walk — and a Youth Skate Park. Both facilities are beautiful and promote a healthy and non-sedentary lifestyle.

Project R.A.I.S.E.

The mission of Project R.A.I.S.E. (Rural Assistance Initiative for Special Education) is to raise the buying power and cost efficiency of special needs services, to raise service consistency and stability, to raise professional recruitment and retention, and to raise the availability of support and resources for small rural school district special needs children. Market efficiency is accomplished through a process of clustering services around qualified professionals strategically positioned in the market place to save travel time and dollars.

Note: As OHIP listening sessions continue throughout the state, this appendix will be updated on the web site to provide the latest information in regard to model community initiatives.

Electronic Supporting Documents

2008 State of the State's Health Report
www.ok.gov/health/pub/boh/state/index.html

2009 United Health Foundation Report
www.americashealthrankings.org/2009/report.AGR2998%29Final%20Report.pdf

2009 Commonwealth Fund State Scorecard on Health System Performance
www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2009/Oct/1326_McCarthy_state_scorecard_2009_full_report_Final.pdf

Children's Behavioral Health Strategic Plan
www.odmhsas.org/2009PCBHStrategicActionPlan.pdf>

Get Fit Eat Smart Physical Activity and Nutrition State Plan
www.ok.gov/health/Disease,_Prevention,_Preparedness/Chronic_Disease_Service/Oklahoma_Physical_Activity_and_Nutrition_Program_(OKPAN)_/index.html

Healthy People 2010 Goals for Tobacco Use Prevention, Obesity Reduction and Children's Health:

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  www.healthypeople.gov/Document/tableofcontents.htm#Volume2
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  www.healthypeople.gov/Document/HTML/Volume1/01Access.htm
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  www.healthypeople.gov/Document/HTML/Volume1/07Ed.htm
- **Maternal, Infant, and Child Health**
  www.healthypeople.gov/Document/HTML/Volume2/16MICH.htm
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- **Substance Abuse**
  www.healthypeople.gov/Document/HTML/Volume2/26Substance.htm
- **Tobacco Use**
  www.healthypeople.gov/Document/HTML/Volume2/27Tobacco.htm

Oklahoma Department of Mental Health (2008, September). State of the State Children's Behavioral Health in Oklahoma
www.odmhsas.org/StateofState2008.pdf

Oklahoma State Plan for Tobacco Use Prevention and Cessation
ww.ok.gov/health/documents/StatePlan.pdf

Oklahoma Turning Point
www.okturningpoint.org

State Coverage Initiative Report
www.ok.gov/oid/documents/July14-2009-SCI-Final.pdf

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