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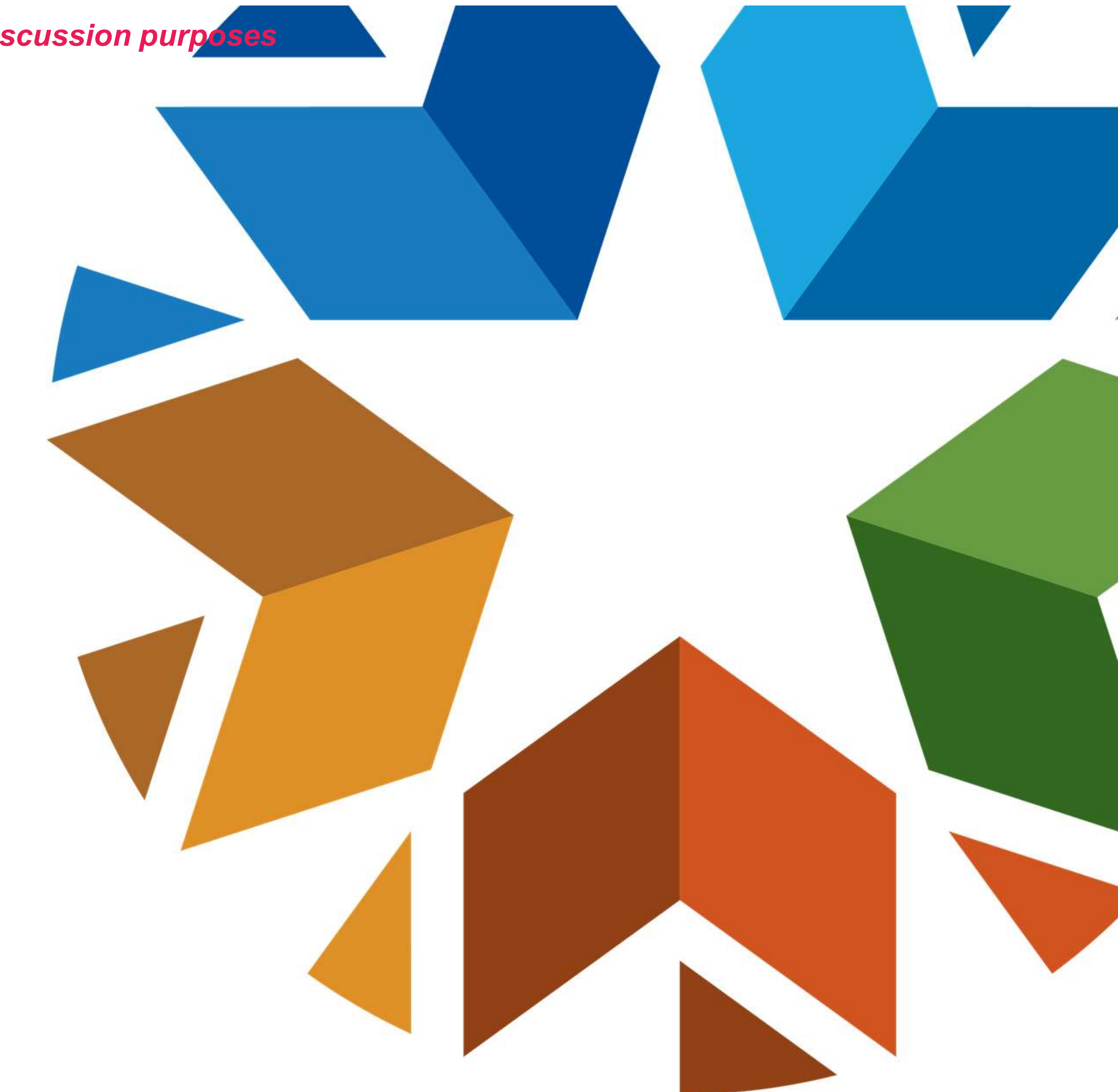
September 26, 2023

Oklahoma State Health Improvement Plan

Drivers of Health Taskforce meeting



OKLAHOMA
State Department of Health

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HEALTHY OKLAHOMA

2020

Bringing Oklahoma's Health Into Focus

OKLAHOMA HEALTH IMPROVEMENT PLAN

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Research & Organize Methods/Framework, Training, Data Collection

MAY-JULY 2022

Ongoing Planning & TA/Consultation, Strategic Planning

AUG.-OCT. 2022

Data Analysis

DEC. 2022-JAN. 2023

Statewide Health Assessment Report Development

JAN. 2023-FEB. 2023

Statewide Health Assessment Released

FEB. 2023

Statewide Partner Meetings & Planning

MAY 2023-AUG. 2023

State Health Improvement Plan Draft, Workplan finalized and Taskforces established

AUG. 2023-SEPT. 2023

State Health Improvement Plan Released

OCT. 2023

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Center for Health Statistics

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COMMON THEMES FOR HEALTH IMPROVEMENT

Based upon evaluation of the statewide data provided on health concerns, common themes have emerged. Areas identified as opportunities for health improvement across Oklahoma included:

Drivers of Health

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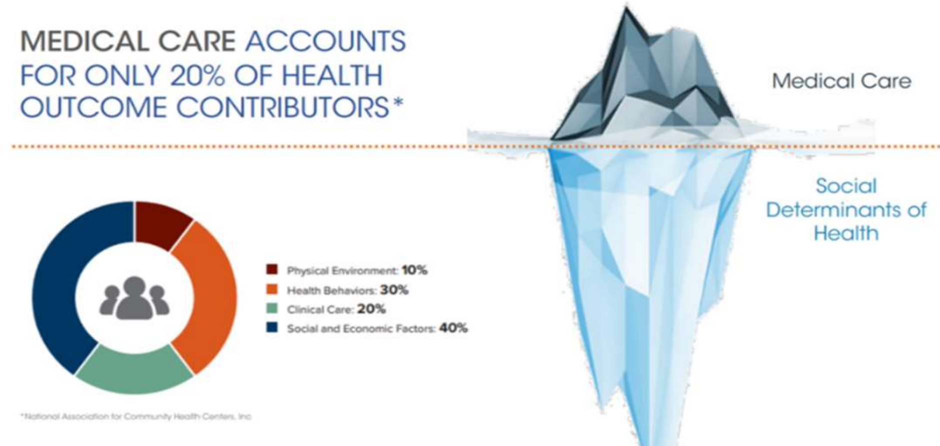
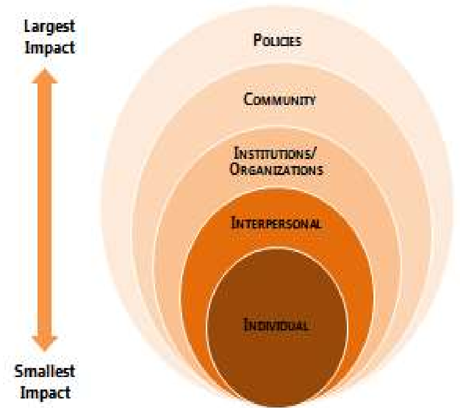
- Underlying causes of poor health outcomes are often linked to the conditions in which people are born, grow, live, learn, play, work, and age.
- Drivers of Health
    - can drive as much as 80% of health outcomes and
    - are the contributing factors of widespread health disparities and health inequities.



- Fundamental framework to understand and address the DoH
- SEM suggests
    - poor health is the result of number of intertwined individual, social and environmental factors.
    - population health improvement requires multipronged interventions.
    - policy, systems, and environmental (PSE) level interventions spanning across the outer three circles that are likely to have a broader and more sustainable population impact.

The Social-Ecological Model

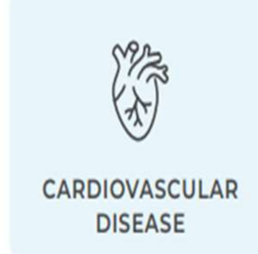


MENTAL HEALTH

SUBSTANCE USE

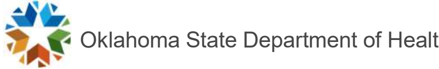
OBESITY

DIABETES



CARDIOVASCULAR DISEASE

DRIVERS OF HEALTH



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Priorities: MENTAL HEALTH & SUBSTANCE USE

2023-2028
Oklahoma
State Health Improvement Plan
(SHIP)

MENTAL HEALTH

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Goal	Strategy	Measure	CY Targets	CY Actuals	Data Source	Partners
Goal 1. Reduce overall suicide rates.[11]	1.1 Continue to expand call volume to 988 by 5% year over year monthly growth.[11]	% of growth in call volume[11]	Workplan in development	CY23: CY24: CY25: CY26 CY27: CY28:	ODMHSAS/ Governors Dashboard[11]	ODMHSAS[11], OSDH
	1.2 Increase participation in trauma trainings such as NEAR and Mental Health First Aid (MHFA) training to teach 3,000 people on how to identify, understand and respond to signs and symptoms of mental health and substance use challenges by June 30, 2024.[11]	# of people trained in Neuroscience Epigenetics Adverse Childhood Experiences Resilience (NEAR) and Mental Health First Aid (MHFA)[11]	Workplan in development	CY23: CY24: CY25: CY26: CY27: CY28:	ODMHSAS/ Governors Dashboard[11]	ODMHSAS[11], OSDH, OJA, Potts Family Foundation
	1.3 Distribute 1,100 gun locks to prevent unintentional firearm deaths.[14]	# of gun locks distributed[14]	Workplan in development	CY23: CY24: CY25: CY26: CY27: CY28:	OSDH	CHDs, OSDH PHOG, CHWs, OSDH Home Visiting Staff[14]

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SUBSTANCE USE

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Goal	Strategy	Measure	CY Targets	CY 2023-2028 Actuals	Data Source	Partners
Goal 2. Reduce Overall Substance Use[11]	2.1 Increase primary substance use prevention education (Botvin LifeSkills, AlcoholEdu, PAX Good Behavior Game, ASPIRE). [11]	# sites with primary substance use prevention services [11]	Workplan in development	CY23: CY24: CY25: CY26: CY27: CY28:	ODMHSAS/ Governors Dashboard [11]	ODMHSAS [11], OSDH, TSET, OSDE
	2.2 Decrease overdose deaths by distributing ______ medication lockboxes. [11]	# of medication lockboxes distributed [11]	Workplan in development	CY23: CY24: CY25: CY26: CY27: CY28:	ODMHSAS/ Governors Dashboard [11]	ODMHSAS [11], OSDH
	2.3 Distribute _______ overdose reversal medications. [11]	# of overdose reversal medications distributed [11]	Workplan in development	CY23: CY24: CY25: CY26: CY27: CY28:	ODMHSAS/ Governors Dashboard [11]	ODMHSAS [11], OSDH
	2.4 Distribute _______ fentanyl test strips. [11]	# of fentanyl test strips distributed [11]	Workplan in development	CY23: CY24: CY25: CY26: CY27: CY28:	ODMHSAS/ Governors Dashboard [11]	ODMHSAS [11], OSDH

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Priority: OBESITY

2023-2028
Oklahoma
State Health Improvement Plan
(SHIP)

OBESITY

Draft – for discussion purposes

Goal	Strategy	Measure	CY Targets	CY Actuals	Data Source	Partners
Goal 1. Increase the percent of children in areas with 50% or greater free and reduced-price meal eligibility (high-need areas) with access to nutrition programs year-round.[15]	By 2024, have 100% of counties with an implemented summer feeding program.[15]	% of counties with an implemented summer feed program [15]	Workplan in development	CY23: CY24: CY25: CY26: CY27: CY28:	HFO[15]	OSDE, Regional Food Bank of Oklahoma, Community Food Bank of Eastern Oklahoma, Oklahoma Child Food Security Coalition, Oklahoma School Nutrition Association, YMCA/Salvation Army, Faith based organizations, Oklahoma Partnership for Expanded Learning [15]
Goal 2. Increase built environment infrastructure which promotes safe biking and walking. [15]	By 2024, have 1 adopted planning and/or design guidance document adopted by a statewide planning organization or Oklahoma Municipal League or Oklahoma Chapter of the American Planning Association.[15]	# of adopted planning and/or design guidance document adopted by a statewide planning organization or Oklahoma Municipal League or Oklahoma Chapter of the American Planning Association[15]	Workplan in development	CY23: CY24: CY25: CY26: CY27: CY28	Oklahoma Municipal League, ODOT [15]	ODOT, Association of Central Oklahoma Governments, Indian Nations Council of Governments, Regional Transportation Plan Organization, Bike Oklahoma, Blue Zones POTT, Avedis Foundation, America Walks, Partnership for Active Transportation, Rails to Trails, TSET Health Promotion Research Center, American Heart Association, American Association of Retired Persons, Bicycle Corporation, The Institute for Quality Communities, City planners association, American society for civil engineers, National Association of City Transportation Officials (Technical training partner) [15]
Goal 3. Improve the early care environment supports for appropriate physical activity and nutrition.[15]	By 2026, 40 licensed childcare and education programs in high-risk areas will have participated in the GO Nutrition and Physical Activity Health Assessment for Childcare (GoNAPSACC) program. [15]	# of childcare programs that have participated in the GoNAPSACC program [15]	Workplan in development	CY23: CY24: CY25: CY26: CY27: CY28	Workplan in development	
Goal 4. Increase the health promoting environment of employers across Oklahoma. [15]	By 2026, 100 businesses will be trained in the CDC's Work@Health program. [15]	# of businesses trained in CDC's Work@Health program [15]	Workplan in development	CY23: CY24: CY25: CY26: CY27: CY28:	OSDH-work@health Program	TSET, Employers, Department of Insurance, Department of Commerce, Healthcare Providers, Insurance Providers, Third Party Payers, Town of Jones, Chamber of Commerce, City Government, Oklahoma Municipal League, Congress of Mayors, Local businesses, Oklahoma Cross Country Racing Association, Congregations [15]

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Priority: DIABETES

2023-2028
Oklahoma
State Health Improvement Plan
(SHIP)

DIABETES

Draft – for discussion purposes

Goal	Strategy	Measure	CY Targets	CY Actuals	Data Source	Partners
Goal 1. Strengthen self-care practices by improving access, appropriateness, and feasibility of diabetes self-management education and support (DSMES) services for priority population.[18]	1.1 By 6/30/2024, Oklahoma State Department of Health, Chronic Disease Prevention Service, will identify and train staff from county health departments in the DSMES program and protocols. Training will be provided to (10) county districts that serve rural and urban populations in becoming Association of Diabetes Care and Education Specialists (ADCES) accredited/American Diabetes Association (ADA) recognized.[18]	# and proportion of new recognized/accredited Diabetes Self-Management Education and Support programs [18]	Workplan in development	CY23: CY24: CY25: CY26: CY27: CY28:	OSDH [18]	OSDH County Health Departments [18]
	1.2 By 6/30/2024, Development of two (2) complementary diabetes support programs and services by partnering with community partners in areas of the state where the priority population(s) has a high burden of diabetes [18]	# of new diabetes support programs [18]	Workplan in development	CY23: CY24: CY25: CY26: CY27: CY28:	OSDH-CHDs [18]	SWOSU-RHC, OKPCA, OFMQ [18]

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Goal 2. Prevent diabetes complications for priority populations through early detection. [18]	2.1 By 6/30/2024, increase the number of priority populations who receive regular diabetes screenings by 5% in areas with high burden of diabetes. [18]	# of priority populations who receive regular diabetes screenings [18]	Workplan in development	CY23: CY24: CY25: CY26: CY27: CY28:	OSDH-CHDs [18]	SWOSU-RHC, OKPCA, OFMQ [18]
	2.2 By 6/30/2024, increase the number of priority populations with diabetes who receive diabetic retinopathy screening by 5% in areas with high burden of diabetes. [18]	# of health care organizations working with the recipient to increase diabetic retinopathy screening [18]	Workplan in development	CY23: CY24: CY25: CY26: CY27: CY28:	OSDH-CHDs [18]	OKPCA, OFMQ [18]
	2.3 By 6/30/2024, Increase the number of individuals in priority populations with diabetes who receive an annual CKD screening by 5% in areas with a high burden of diabetes. [18]	# of health care organizations working with the recipient to improve early detection of CKD in priority populations with diabetes. [18]	Workplan in development	CY23: CY24: CY25: CY26: CY27: CY28:	OSDH-CHDs [18]	OKPCA, OFMQ [18]

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Goal 3. Increase enrollment and retention of priority populations in the National Diabetes Prevention Program (National DPP) lifestyle intervention and the MDPP by improving access, appropriateness, and feasibility of the programs. 18	3.1 By 6/30/2024, Increase enrollment and retention in the National DPP Lifestyle intervention and MDPP, of priority populations with diabetes by 10%.	# of participants and # of priority populations enrolled by CDC-recognized DPP delivery organizations.	Workplan in development	CY23: CY24: CY25: CY26: CY27: CY28:	OSDH-CHDs [18]	OKPCA, OFMQ, SWOSU-RHC, OSU-OCES [18]
	3.2 By 6/30/2024, increase enrollment and retention in the National DPP lifestyle intervention and MDPP, utilizing the Oklahoma county extension offices. [18]	# of participants and # of priority populations enrolled by Oklahoma county extension offices [18]	Workplan in development	CY23: CY24: CY25: CY26: CY27: CY28:	OSDH-CHDs [18]	OKPCA, OFMQ, SWOSU-RHC, OSU-OCES [18]

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Goal 4. Improve the sustainability of Community Health Workers (CHWs) by building or strengthening a supportive infrastructure to expand their involvement in evidence-based diabetes prevention and management programs and services. [18]	4.1 By 6/30/2024, increase the number of CHWs who are actively involved in evidence-based diabetes prevention and management programs and services by 100%. [18]	# of CHWs who are actively involved in evidence-based diabetes prevention and management programs and services [18]	Workplan in development	CY23: CY24: CY25: CY26: CY27: CY28	OSDH-CHDs, OSDH Community Development-CHW Section [18]	OKPCA, OFMQ, OSU-OCES [18]
	4.2 By 6/30/2024, increase the awareness of CHWs within the community by 10%, and increase the availability of CHWs to provide services to the community by 10%, as measured by surveys and interviews with community members. [18]	% of increase in CHW awareness & availability within the community [18]	Workplan in development	CY23: CY24: CY25: CY26: CY27: CY28	OSDH-CHDs, OSDH Community Development CHWs [18]	OKPCA, OFMQ, OSU-OCES [18]
	4.3 By 6/3/2024, increase the sustainability of Community Health Workers (CHWs) by 10% through the implementation of data collection and best practices to promote CHWs. [18]	% of increase in CHW sustainability through the implementation of data collection and best practices to promote CHWs [18]	Workplan in development	CY23: CY24: CY25: CY26: CY27: CY28:	OSDH-CHDs, OSDH Community Development CHWs [18]	OKPCA, OFMQ, OSU-OCES [18]

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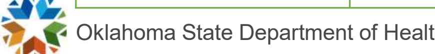

Goal 5. Improve the capacity of the diabetes workforce to address factors related to the DoH that impact health outcomes for priority population with and at risk for diabetes. [18]	5.1 By 6/30/2024, increase the number of diabetes healthcare providers who are trained in DoH-related topics by 5%, as measured by the number of providers who have completed an DoH-related training program. This will impact health outcomes for priority populations with and at risk for diabetes. [18]	# and type of staff trained on DoH strategies and training type [18]	Workplan in development	CY23: CY24: CY25: CY26: CY27: CY28:	OSDH-CHDs, OSDH Community Development CHWs [18]	OKPCA, OFMQ, OSU-OCES, SWOSU-RHC [18]
	5.2 By 6/30/2024, increase the capacity of the diabetes workforce to assess and address factors related to the DoH that impact health outcomes for priority populations with and at risk for diabetes by 10%, as measured by a survey of diabetes workforce members and review of diabetes-related health outcomes data. [18]	% increase in the capacity of the diabetes workforce to assess and address factors related to the DoH that impact health outcomes for priority populations with and at risk for diabetes [18]	Workplan in development	CY23: CY24: CY25: CY26: CY27: CY28:	OSDH-CHDs, OSDH Community Development CHWs [18]	OKPCA, OFMQ, OSU-OCES, SWOSU-RHC [18]

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Priority: CARDIOVASCULAR DISEASE

2023-2028
Oklahoma
State Health Improvement Plan
(SHIP)

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CARDIOVASCULAR DISEASE (CVD)

Goal	Strategy	Measure	CY Targets	CY Actuals	Data Source	Partners
Goal 1. Track and monitor clinical and social services and support needs measures shown to improve health and wellness, health care quality, and identify patients at high risk of cardiovascular disease (CVD) with a focus on hypertension and high cholesterol.[20]	1.1 Advance the adoption use of electronic health records (EHR) or health information technology (HIT), to identify, track, and monitor for clinical and social services and support needs to address health care disparities and health outcomes for patients at highest risk of CVD with a focus on hypertension and high cholesterol.[20]	# and % of clinics or health care systems that have policies/protocols in place requiring the use of EHRs and standardized clinical quality measures to track hypertension control measures by race, ethnicity, and other population of focus.[20]	Workplan in development	CY23: CY24: CY25: CY26: CY27: CY28:	OSDH[20]	OKPCA, OFMQ, OSU-OCES[20]
	1.2 Promote the use of standardized processes or tools to identify the social services and support needs of patient populations at highest risk of CVD, with a focus on hypertension and high cholesterol, and monitor and assess the referral and utilization of those services, such as food assistance, transportation, housing, childcare, etc.[20]	# and % of clinics or health care systems that use the standardized processes or tools to identify, assess, track, and address the social services and support needs of patient populations at highest risk for CVD.[20]	Workplan in development	CY23: CY24: CY25: CY26: CY27: CY28:	OSDH[20]	OKPCA, OFMQ, OSU-OCES[20]

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CARDIOVASCULAR DISEASE (CVD)

Goal	Strategy	Measure	Status	Years	Lead	Partners
Goal 2. Implement Team-Based Care to prevent and reduce CVD risk with a focus on hypertension and high cholesterol prevention, detection, control, and management through the mitigation of social support barriers to improve outcomes. [20]	2.1 Advance the use of health information systems that support team-based care to monitor population health with a focus on health disparities, hypertension, and high cholesterol. [20]	# and % of clinics or health systems that have policies / protocols in place requiring the use of clinical data from EHRs or HIT to support communication with the care team to coordinate care for patients with hypertension and high cholesterol. [20]	Workplan in development	CY23: CY24: CY25: CY26: CY27: CY28:	OSDH [20]	OKPCA, OFMQ, OHCA, CHD's, SWOSU-RHC, OKPCA, OSU-OCES, OU-PMC [20]
	2.2 Assemble or create multidisciplinary teams (e.g., nurses, nurse practitioners, pharmacists, nutritionists, physical therapists, social workers, and community-based workers) to identify patients' social services and support needs and to improve the management and treatment of hypertension and high cholesterol. [20]	Current # of adults within clinics or health care systems that use multidisciplinary care teams that adhere to evidence-based guidelines is 1,898, which is baseline data collected from 1815 counties, it is not statewide reach. Baseline will be updated once data is collected from selected partners. Target of 1,993, was set based upon a 5% increase from baseline. [20]	Workplan in development	CY23: CY24: CY25: CY26: CY27: CY28:	OSDH [20]	CHD, SWOSU-RHC, OKPCA, OFMQ, OSU-OCES, OU-PMC [20]
	2.3 Build and manage a coordinated network of multi-disciplinary partnerships that address identified barriers to social services and support needs (e.g., childcare, transportation, language translation, food assistance, and housing) within populations at highest risk of CVD. [20]	# and type of social services and support within the recipient's network that address the social needs at highest risk of CVD. [20]	Workplan in development	CY23: CY24: CY25: CY26: CY27: CY28:	OSDH [20]	CHD, OKPCA, OFMQ, OSU-OCES, SWOSU-REC, OU-PMC [20]

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CARDIOVASCULAR DISEASE (CVD)

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Goal 3. Link community resources and clinical services that support bidirectional referrals, self-management, and lifestyle change to address social determinants that put the priority populations at increased risk of cardiovascular disease with a focus on hypertension and high cholesterol. [20]	3.1 Create and enhance community-clinical links to identify DoH (e.g., inferior housing, lack of transportation, inadequate access to care, and limited community resources) and respond to the social services and support needs of populations at highest risk of CVD with a focus on hypertension and high cholesterol. [20]	# of adults with hypertension, high cholesterol, or other risk of cardiovascular disease who are referred to lifestyle change programs or social services and support. [20]	Workplan in development	CY23: CY24: CY25: CY26: CY27: CY28:	OSDH[20]	OKCHD, OKPCA, OFMQ, OSU-OCES, OSDH, CAL, SWOSU-RHC, OU-PMC[20]
	3.2 Identify and deploy dedicated CHWs (or their equivalents) to provide a continuum of care and services which extend the benefits of clinical interventions and address social services and support needs leading to optimal health outcomes. [20]	# of CHWs (or their equivalent) who engage with community organizations to extend care beyond the clinical environment to address social services and support needs for those with hypertension, high cholesterol, or other risk of cardiovascular disease. [20]	Workplan in development	CY23: CY24: CY25: CY26: CY27: CY28:	OSDH [20]	OSDH, CAL, OKPCA, OFMQ, OSU-OCES, OKCHD, ODMHSAS, DMH-CCBHC [20]
	3.3 Promote use of self-measured blood pressure monitoring (SMBP) with clinical support within populations at highest risk of hypertension. [20]	# of patients participating in SMBP programs with clinical support. [20]	Workplan in development	CY23: CY24: CY25: CY26: CY27: CY28:	OSDH [20]	OKPCA, OFMQ, OSU-OCES, SWOSU, OU-PMC, OKCHD [20]

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Priority: DRIVERS OF HEALTH

2023-2028
Oklahoma
State Health Improvement Plan
(SHIP)

★Drivers of Health (DOH)

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Goal	Strategy	Measure	CY Targets	CY Actuals	Data Source	Partners
Goal 1. Improve Health Outcomes and Reduce Health Disparities in Oklahoma. [21,22]	1.1 Identify and engage advisory boards to include youth advisory boards and parent advisory boards[21]	# of community advisory boards[21] # of youth advisory boards (work plan in development) # of parent advisory boards (work plan in development)	Workplan in Development	CY23: CY24: CY25: CY26: CY27: CY28:	University of Oklahoma-Hudson College of Public Health[21] University of Oklahoma-Health Sciences Center[22]	OUHSC[21,22], ODMHSAS, OSDH, PHIO
	1.2 Strengthen and grow collaborations with state and local health departments, tribal nations, non-governmental organizations, policymakers, and private businesses to implement evidence-based practices for reducing health disparities and improving Oklahoma's population health.[21,22]	# of evidence-based programs targeting health inequities that are implemented[21] # service agreements focused on health disparities[21]	Workplan in Development	CY23: CY24: CY25: CY26: CY27: CY28:	University of Oklahoma-Hudson College of Public Health[21] University of Oklahoma-Health Sciences Center[22]	OUHSC[21,22], OSU Center for Health Sciences, OSDH, PHIO, OTPC
	1.3 Collaborate with community partners and networks to grow multi-disciplinary research designed to improve health outcomes[21]	# of professional service agreements established[21]	Workplan in Development:	CY23: CY24: CY25: CY26: CY27: CY28:	University of Oklahoma-Hudson College of Public Health[21] University of Oklahoma-Health Sciences Center[22]	OUHSC[21,22], OSU Center of Health Sciences, OSDH, PHIO
	1.4 Increase the number of federal grants that directly involve community partners that address health disparities and improved health outcomes.[22]	# of grants or service agreements focused on health disparities[22]	Workplan in Development	CY23: CY24: CY25: CY26: CY27: CY28:	University of Oklahoma-Hudson College of Public Health[21] University of Oklahoma- Health Sciences Center[22]	OUHSC[21,22], OSU Center for Health Sciences, PHIO, OTPC
	1.5 Partner with business, governmental public health and social service agencies, and non-governmental charitable and community volunteer agencies to provide education, health, and social service to marginalized communities[22]	# of professional service agreements established[22]	Workplan in Development	CY23: CY24: CY25: CY26: CY27: CY28:	University of Oklahoma-Hudson College of Public Health[21] University of Oklahoma- Health Sciences Center[22]	OUHSC[21,22], OSDH

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Drivers of Health (DOH)

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Goal 2. Develop and grow partnerships to enhance the impact of our education, research, and service. [21]	2.1 Assemble experts and facilitate workgroup action planning from 5 main sectors (education, business, community engagement, health care, and tribal) to develop solutions for protecting the public health and preventing premature death, disability, and excessive demands on population health system in the spirit of the Achieving a Healthy Oklahoma initiative. [21]	Sustain participation by partners from all 5 sectors and produce a portfolio of solutions and recommendations [21]	Workplan in Development	CY23: CY24: CY25: CY26: CY27: CY28:	University of Oklahoma -Hudson College of Public Health [21]	OUHSC [21], OSU Center for Health Sciences, OSDH, PHIO, OTPC
	2.2 Facilitate the production of a comprehensive action plan to enhance the readiness and sustainability of Oklahoma's healthcare, business, education, community, and tribal sectors in a public health crisis. [21]	Publish plan by end of five years. [21]	Workplan in Development	CY23: CY24: CY25: CY26: CY27: CY28:	University of Oklahoma -Hudson College of Public Health [21]	OUHSC [21], OSDH
	2.3 Partner with school districts and teacher training programs to strengthen population health strategies within Oklahoma schools. [21]	# of partnerships with school districts and teacher training programs. [21]	Workplan in Development	CY23: CY24: CY25: CY26: CY27: CY28:	University of Oklahoma -Hudson College of Public Health [21]	OUHSC [21], OSDH
	2.4 Be a resource to policy makers for recommendations on how to improve the health of Oklahoma. [21]	# of consultations with policy makers. [21]	Workplan in Development	CY23: CY24: CY25: CY26: CY27: CY28:	University of Oklahoma -Hudson College of Public Health [21]	OUHSC [21], OSDH
	2.5 Grow statewide preparedness initiatives with support of private, community based and philanthropic organizations, businesses, tribes, and health departments for best long-term impact across populations. [21]	# of preparedness initiatives with community partners. [21]	Workplan in Development	CY23: CY24: CY25: CY26: CY27: CY28:	University of Oklahoma -Hudson College of Public Health [21]	OUHSC [21], OSDH
	2.6 Provide data driven programming concepts and collaborative training for business, education, health care, tribes, and community engagement organizations across the State. [21]	# of trainings. [21]	Workplan in Development	CY23: CY24: CY25: CY26: CY27: CY28:	University of Oklahoma -Hudson College of Public Health [21]	OUHSC [21], OSDH

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WHO
Collaborate with Others to Maximize Efforts
PEOPLE
COMMUNITY DEVELOPERS
BUSINESSES
EDUCATION
GOVERNMENT
PHILANTHROPISTS & INVESTORS
FAITH-BASED ORGANIZATIONS
HEALTH CARE PROVIDERS
PUBLIC HEALTH
HEALTH INSURANCE
NONPROFITS
COLLECTIVE VISION

NEXT STEPS

Thank You!

OKLAHOMA
State Department of Health