

2022

# Oklahoma County COMMUNITY HEALTH NEEDS ASSESSMENT



CENTRAL OKLAHOMA HEALTH IMPACT TEAM (COHIT)



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# Acknowledgments

The Central Oklahoma Health Impact Team's FY22 Community Health Needs Assessment (CHNA) was developed under the direction of each nonprofit hospital systems' Community Health leader, along with leadership and facilitation of the collaborative process by the Oklahoma City Community Foundation (OCCF).

Special thanks and consideration go to Tracey Strader, Public Health Consultant, Community Health and Wellness for the OCCF, who worked tirelessly to shepherd the CHNA process over a two-year period. Tracey has worn many hats throughout the process, bringing the appropriate parties to the table, engaging stakeholders, coordinating a plethora of meetings to ensure no voice was left behind, keeping the committee focused on the mission, and serving as a wonderful and effective leader, facilitator, collaborator and friend.

Appreciation also goes to Nancy Anthony, President, Oklahoma City Community Foundation, for her support of this collaborative effort and allowing Tracey to spearhead the effort, and to Kelley Barnes, VP Community Engagement, OCCF, for her participation and guidance in the process.

We would like to thank the Research, Design, and Analysis Center (RDAC) at the University of Oklahoma, Hudson College of Public Health, Ashley White, Director, and Spencer Hall, Biostatistician, James Cutler, Biostatistician and Blakeley Pearson, Project Interviewer, for assisting with the determination of the CHNA process design and methodology, primary and secondary data collection, interpretation, and analysis, and report development.

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# Executive Summary

Four non-profit hospitals engaged in a joint Community Health Needs Assessment: INTEGRIS Health, Mercy Hospital Oklahoma City, OU Health, and SSM Health St. Anthony. This assessment evaluated the health needs of Oklahoma County. As federally required by the Affordable Care Act, this report provides an overview of the methods and processes used to identify and prioritize significant health needs in the service area.

The goal of this report is to provide residents with a deeper understanding of the health needs in their community as well as to help guide the hospitals in their community benefit planning efforts and development of an implementation strategy to address assessed needs. In addition, this report seeks to align local planning efforts with assessments and interventions conducted by the Oklahoma City-County Health Department (OCCHD).

Throughout the needs assessment process, we focused on the interconnectedness of social determinants and health outcomes in Oklahoma County. Social determinants of health (SDoH) are the conditions in which people are born, grow, live, work and age that shape health.<sup>1</sup> SDoH are primary drivers of health disparities and include factors like economic stability, education access and quality, health care access and quality, neighborhood and the built environment, and social and community context. This CHNA process was designed to use data to identify those who may not be thriving; use information provided from Community Chats and key stakeholder interviews to help community members and organizations identify systems that perpetuate inequity; recognize potentially replicable bright spots; and test policy and programmatic changes that have the potential to disrupt systems perpetuating inequity.<sup>2</sup> By doing this we hope the long-term outcome will be the creation of conditions where everyone has the opportunity to achieve health and well-being, by addressing the root causes of poor health outcomes.<sup>3</sup>

### **The team used the following methods to understand the community health needs:**

- **Stakeholder meetings** – assembled a group of 65 community stakeholders representing 45 organizations including those that serve populations experiencing health inequities
- **Secondary data research** – information related to the current state of our community’s economic, social, and health status published by established sources
- **Community survey** – a survey of the general public to better understand what they view as the most significant health issues.
- **Community Chats** – discussions with community members and community champions to delve deeper into individual experiences with health-related issues
- **Informational interviews** – with key community leaders to gain insights into their priorities and plans to address the social determinants of health.

**This process led to the identification of four priority areas. Although there is no single factor that predicts a health outcome, the areas identified as priority for Oklahoma County, by the hospital systems and community stakeholders, include:**

**Access to education**

**Access to meaningful employment**

**Access to healthy food**

**Access to healthcare**

# Prioritized Social Determinants of Health

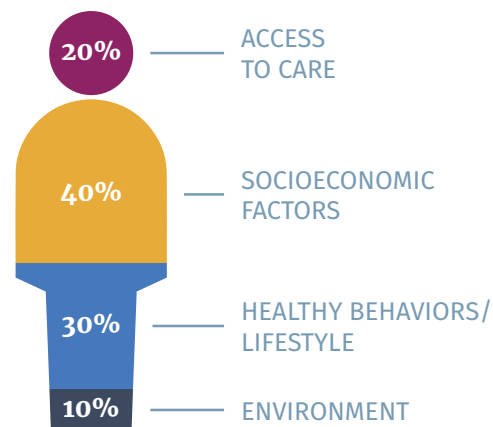
**Household income is an indicator of financial stability. Household income is a measure of employment status, educational attainment, and economic opportunities.** Households with lower income levels tend to experience adverse social and health outcomes such as less access to safe housing and fewer healthy food options, shorter life expectancy, lack of access to health care, and increased incidence of illness.

Household income includes the income of the householder and all other individuals 15 years and older in the household, whether they are related to the householder or not, in the past 12 months.<sup>4,5</sup> Median household income (MHI) is based on the income distribution of all households in Oklahoma County. MHI helps to identify socioeconomic barriers in the community.

## SOCIO-ECOLOGICAL MODEL



## WHAT IMPACTS HEALTH?



Source: Robert Wood Johnson Foundation, County Health Rankings and Roadmaps



The median household income for Oklahoma County was slightly higher than that of the state (\$52,855 vs. \$51,424) but varied widely by gender and race/ethnicity. This is important because income is a driving force behind striking health disparities that many minorities experience. “The greater one’s income, the lower one’s likelihood of disease and premature death”.<sup>1</sup> Black residents in Oklahoma County earned almost half as much as White residents (\$34,462 vs \$62,343).

Chronic disease is a significant source of burden for Oklahoma County. Residents with one or more chronic conditions have poorer health, use more health services, and spend more on health care. The all-cause mortality rate for Oklahoma County is slightly higher than the state and significantly higher than the United States.<sup>5</sup> The three top causes of death are cardiovascular disease, heart disease, and cancer.

Poverty is more than income alone and is a complex and insidious determinant of health caused by factors that can persist for generations in a family. Poverty occurs when an individual or family lacks the resources to provide life necessities such as food, clean water, shelter, and clothing. It also includes a lack of access to such resources as quality employment, education, and transportation.

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***“The greater one’s income, the lower one’s likelihood of disease and premature death.”***

# Education

Educational attainment is a fundamental social determinant of health. It is both a process and a product. Access to education and training can lead to conditions more conducive to good health; lack of good health can make it difficult to get an education.<sup>6,7</sup> Stakeholders and Community Chat participants identified the **need for programs that close gaps** in educational outcomes between low-income or racial and ethnic minority populations and higher-income or majority populations to promote health equity. Of all adults 18 and older in Oklahoma County, 12.9% did not have a high school diploma. This was higher than the state of Oklahoma, 12.6%, and the United States, 12.4%.<sup>5,8</sup> When asked what would help them go back to school, Oklahoma County residents indicated “more financial aid” (36%) and “weekend and evening courses” (33%).

Education not only includes access to formal education, but access to information, relationships with mentors and advisors, and community resources. In our Community Chats, a common theme that emerged was the **need to increase resources at high schools to help students find ways to continue their education**. This could be through relationship building or access to information.

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# Employment

**The issue of employment is more than the number of jobs available in the community but should also consider the quality of those jobs. In our stakeholder meetings and Community Chats, several job quality issues were highlighted:**

- **Living wage:** Does the job provide sufficient income to afford a basic standard of living or at a minimum offer financial remuneration closer to a living wage than the employer's competitors?
- **Benefits:** Does the employer offer health insurance, paid sick leave, and maternity and paternity leave?
- **Career-building opportunities:** Do employers offer training, mentorship, and opportunities for advancement within the company?
- **Opportunities to build wealth:** Are employees given retirement plans with company match, ownership options, merit-based bonuses, or financial literacy training?
- **Employee-focused work environment:** Are staff members at all levels treated with respect and dignity? Are employees empowered and engaged? Are there strong relationships between management and staff? Are employees given advance notice of their schedules and flexibility to take care of family emergencies without fear of being fired?

As with education, employment is both a process and a product. Quality employment can lead to better health outcomes and poor health can decrease the ability of residents to get and/or keep a quality job. In our community survey, surprisingly, 31% of Oklahoma County residents said that in the past year, their own health made it hard for them to work and 18% said a family member's health made it hard to work.

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# Access to Healthy Food

Poor diets lead to chronic illnesses such as heart disease, type 2 diabetes, and obesity. Eating a healthy diet is difficult without access to nutritious foods. In our community survey, 56% of Oklahoma County residents said they can always get healthy food for their family. **As with other social determinants of health, there was a linear relationship between educational attainment and ability to get healthy food.**

Supplemental Security Income (SSI) is a federal income program that provides monthly financial assistance to low-income individuals, persons who are blind, or those aged 65 and older, as well as children and adults with disabilities. Supplemental Nutrition Assistance Program (SNAP) is a federal program that provides monthly food and nutrition benefits to low-income households to supplement their food budget. Why is it important? The SSI and SNAP programs help improve the overall health and wellness of a community by helping low-income individuals and families meet nutritional needs. These data help measure the socioeconomic and health status of a community.

The majority of Oklahoma residents reported that the biggest challenge to accessing healthy food is cost. Supplemental Nutrition Assistance Program (SNAP) is a federal program that provides monthly food and nutrition benefits to low-income households. The SNAP rate for Oklahoma County was 13.3% which is higher than the rates for the state of Oklahoma and the United States.<sup>5</sup>

In our Community Chats, it was discussed that **even when quality foods are available, sometimes people lack the nutritional knowledge to select these foods.** It was also noted that having a variety of foods from which to choose was just as important for food access as quality.

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# Access to Health Care

**Access to health care services affects a person's health and well-being. Regular and reliable access to health services can:**

- Prevent disease and disability
- Detect and treat illnesses or other health conditions
- Increase quality of life
- Reduce the likelihood of premature (early) death
- Increase life expectancy

SoonerCare (Oklahoma Medicaid) covers 26% of Oklahoma County residents.<sup>9</sup> There are pockets of high enrollment throughout Oklahoma County which could benefit most from interventions to bring preventive care and education to residents.

In our community survey, Oklahoma County residents said that **financial barriers and lack of insurance were the biggest challenges to healthcare. Dental health services were reported to be the most difficult to get for their household members.** Hispanic respondents had the lowest level of insurance coverage at 38% compared to 88% of Whites. Stakeholders felt that a large portion of the uninsured in Oklahoma County would qualify for some level of Medicaid, but they may not have the information or resources to enroll.

## Special Note on COVID-19 and the CHNA

Between March 12, 2020 (the beginning of the pandemic), and October 21, 2021, there were 141,088 cases of COVID-19, 2,153 deaths and 4,686 ever-hospitalized in Oklahoma City-County. While this report looks at how social determinants of health have impacts on health outcomes throughout Oklahoma City, any summary document would be remiss to exclude the impact of COVID-19 on the community. Providing a detailed summary of COVID-19 impacts and outcomes is beyond the scope of the Community Health Needs Assessment; however, no aspect of health and social well-being has been left untouched. COVID-19 has led

to mental health issues leading to anxiety, stress, stigma, and xenophobia. Lockdowns contribute to isolation, loneliness and depression. Economics impacts have caused job loss, business closures, and evictions from homes. Health care workers are suffering burnout and exhaustion to a degree never before experienced. Certain populations are experiencing disproportionately high rates of COVID-19 cases and consequences as a result of many of the social determinants of health. While COVID-19 is not, in itself, a key element of measure in this report, it is clearly an impact on nearly everything and everyone discussed in this report.



# Introduction

The 2022 Oklahoma County Community Health Needs Assessment (CHNA) represents an important and powerful collaboration between four nonprofit health systems: INTEGRIS Health, Mercy Hospital Oklahoma City, OU Health, and SSM Health St. Anthony. INTEGRIS Health, Mercy and SSM Health St. Anthony have held nonprofit status for decades, and OU Health became a nonprofit hospital system on February 1, 2018, when a newly formed nonprofit group, OU Medicine Inc., officially completed its takeover of the OU Medical System from Hospital Corporation of America

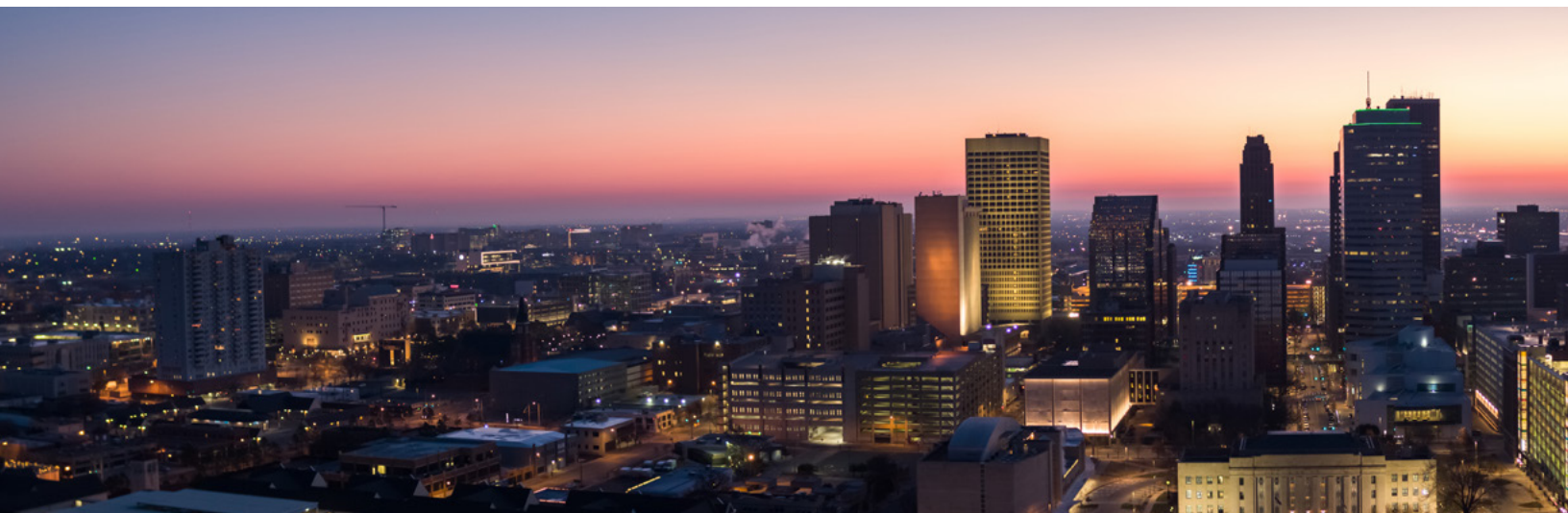
INTEGRIS Health, Mercy, and SSM Health St. Anthony conducted a joint CHNA for the first time in 2018 and collaborated to implement certain community health improvement strategies throughout 2019-2021, under the name, “Central Oklahoma Health Impact Team” or COHIT. OU Health joined the community health collaborative in 2019 after they transitioned to nonprofit status. Today, COHIT consists of the four nonprofit health systems and the Oklahoma City-County Health Department (OCCHD). The Oklahoma City Community Foundation serves as the neutral convener for COHIT.

Nonprofit hospitals are required to complete a CHNA and corresponding implementation strategy (IS) at least once every three years in accordance with 501(r) Regulations developed by the Internal Revenue Service as a result of the Patient Protection and Affordable Care Act (ACA), 2010.<sup>10</sup> In looking at the community population served by the four systems’ hospitals, it was clear that all four health systems define their community as Oklahoma County. Similar to the hospital CHNAs, local and state health departments must seek accreditation through the Public Health Accreditation Board (“PHAB”) by completing a Comprehensive Health Assessment (“CHA”) and a corresponding Community Health Improvement Plan (“CHIP”).

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# Moving from Separate Health Assessments toward Greater Collaboration for Collective Impact

COHIT has created this joint CHNA in collaboration with a diverse group of community stakeholders (see [Appendix A](#)) throughout the process to identify priority areas, community assets, and potential interventions. This CHNA recognizes health disparities are the result of inequities rooted in social, racial/ethnic, and economic injustice. As we journey collaboratively to identify and meet the needs of community residents in OK county, creating health equity is a guiding priority of COHIT. **By health equity, we mean everyone has the opportunity to attain their highest level of health.** In order to do this, we want to be intentional about addressing the root cause of health outcomes, (SDOH), so that we can shift from a culture of ‘sick care’ to building a sustainable ‘culture of health’. Social determinants of health include housing, education, employment, environmental exposure, access to health care, public safety, food access, income and health and social services.





This CHNA provides an overview of the health needs and priorities in Oklahoma County. The goals of this report are to provide residents with a deeper understanding of the health needs in their community and to guide the hospitals in their community benefit planning (including the development of their Community Health Improvement Plan to address identified priorities). In addition, this report aims to align local planning efforts with assessments and interventions conducted by OCCHD. This planning process represents a commitment to a more deliberate approach to working together. By planning together, COHIT members hope to gain a deeper understanding of those most affected by poor health outcomes in Oklahoma County, and mobilize resources to have a collective impact on improving health and well-being for all community residents.

At the beginning of the planning process the four health systems agreed to conduct the CHNA with a health equity lens, reflective of our respective identities as faith-based organizations or an academic medical center. We also agreed to take an assets-based approach to the CHNA, recognizing that the solutions to many of the needs we would identify already exist in the community.

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# Present Shift to Conducting Joint Health Assessments: Definition of Community

OCCHD and the health systems that conducted the 2018 Oklahoma County CHNA recognized a county-level definition of the community would allow them to comprehensively assess the health needs of their patients and the community in which their hospitals are located. In addition, this approach allows the hospitals to identify strengths and assets on which to build additional community capacity. This shift to a joint needs assessment allows the hospitals to more readily collaborate with public health partners and other key stakeholders to assess and address needs with a focus on health equity.

This health equity lens places an increased emphasis on understanding the needs of those who are most affected by poor outcomes; no groups within the community were excluded from the scope of this CHNA. Lastly, the majority of patient discharges from each of the hospitals partnering on this CHNA were from Oklahoma County. Per 501(r) federal compliance, a joint CHNA is only allowable if it meets all the requirements of a separate CHNA, clearly identifies the hospital facilities involved, and if all the collaborating hospital facilities and organizations included in the joint CHNA define their community to be the same.<sup>10</sup>

This Assessment meets the requirements set forth under Treas. Reg. § 1.501(r) (“501(r) Regulations”) and for the purposes of meeting these requirements, serves as the \*2022 Community Health Needs Assessment (“CHNA”) for the following hospitals:

\*The SSM Health Oklahoma Board of Directors approved this report on December 1, 2021.

## **INTEGRIS Health**

- INTEGRIS Health Edmond
- INTEGRIS Baptist Medical Center
- INTEGRIS Southwest Medical Center
- Lakeside Women’s Hospital
- INTEGRIS Cancer Institute
- HPI Community Hospital North
- HPI Community Hospital South
- HPI Northwest Surgical Hospital
- Oklahoma Center for Orthopaedic & Multi-Specialty Surgery
- INTEGRIS Community Hospital Council Crossing
- INTEGRIS Community Hospital Del City
- INTEGRIS Community Hospital OKC West

## **Mercy Hospital**

- Mercy Hospital Oklahoma City
- Mercy Hospital South Oklahoma City
- Mercy Clinics

## **OU Health**

- University of Oklahoma Medical Center at OU Health
- Oklahoma Children’s Hospital OU Health
- University of Oklahoma Medical Center at OU Health, Edmond
- OU Health Clinical Services

## **SSM Health St. Anthony**

- SSM Health St. Anthony Hospital - Oklahoma City
- SSM Health St. Anthony South
- SSM Health St. Anthony Hospital - Midwest
- SSM Health Bone and Joint Hospital at St. Anthony

# 2019 CHNA Feedback

To offer the public a means to provide written input on the FY 2019 CHNA, the hospitals posted the documents and provided a contact where written feedback could be provided. This approach allows for continued public comments on historical reports, including the 2019 CHNA and FY 2020-2022 CHIPs.

At the time this CHNA report was completed INTEGRIS Health, Mercy Hospital, and SSM Health had not received written comments about the 2019 CHNA report or 2020-2022 CHIPs. The hospitals will continue to track any submissions made and will ensure that all relevant comments are reviewed and addressed by appropriate staff.

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# Overview of COHIT Members





**INTEGRIS Health, the largest Oklahoma-owned not-for-profit health system in the state, is**

**known for innovation and unparalleled quality offering advanced treatment options and specialties found nowhere else in the region.**

The \$2.3 billion, 10,000-plus caregiver integrated delivery system includes hospitals, rehabilitation centers, physician clinics, virtual care, mental health facilities and home health agencies. INTEGRIS Health operates more than 1,800 licensed beds in 18 hospitals and has more than 63 specialties and subspecialties among its Medical Group and affiliate physicians. INTEGRIS Health Medical Group employs 670 providers and has 160+ primary and specialty care clinics.

The health system’s name, INTEGRIS Health, resulted from a merger in 1995 between Oklahoma Health System and Southwest Medical Center in Oklahoma City. However, the roots of INTEGRIS Health can be traced all the way to the early beginnings of statehood. INTEGRIS Bass Baptist Health Center, as it’s known today in Enid, opened in 1910, INTEGRIS Baptist Medical Center opened in 1959 when it began as Baptist Memorial Hospital. In the mid-’90s the new organization expanded into the largest state-wide health system through a series of mergers with hospitals across the state. Today, corporate headquarters are located in Oklahoma City.

INTEGRIS Health and its affiliated entities are recognized as leaders in providing quality health care to Oklahoma for more than 100 years.

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## Mission

Partnering with people to live healthier lives



## Vision

The Most Trusted Partner for Health



## Values (iCare)

- **Integrity.** We are honest and consistently adhere to the highest standards of ethical and professional behavior.
- **Compassion.** We are kind and suspend judgement to appreciate others' perspectives and situations.
- **Accountability.** We take ownership for our actions and outcomes.
- **Respect.** We embrace diversity and inclusion, and value others.
- **Excellence.** We seek to continuously improve, leading to exceptional outcomes.

## At a Glance

**INTEGRIS HEALTH**  
Oklahoma County

40,578  
Admissions

5,831  
Births

1,672\*  
Medical Staff

746,527  
Outpatient visits

1,380  
Beds (licensed)

421+  
Volunteers

159,978  
ER visits

7,500  
Employees

\$35,974,915  
Charity care

\*Medical staff- Employed and Contract Physicians and Advanced Practice Clinicians



Mercy is proud to serve the Oklahoma City metro area now with two hospitals, one in northwest Oklahoma City and another in south Oklahoma City.

**Mercy Hospital Oklahoma City was recently named a Best Maternity Hospital by Newsweek, a 100 Top Hospital by IBM Watson Health for the sixth time and received its eighth consecutive A grade for patient safety from The Leapfrog Group.**

These achievements reflect Mercy's continued focus on delivering the quality patient experience hallmark to its healing ministry.

The first health facility in Oklahoma to be named an advanced comprehensive stroke center by The Joint Commission, Mercy Hospital Oklahoma City is a leader in stroke treatment, as well as oncology, breast imaging and research, and robotic surgery.

Mercy also has a Level III neonatal intensive care unit that provides lifesaving care for critically ill newborns.

Mercy Clinic has a broad network of primary care and specialty physicians across the state.

For treatment of non-emergency medical conditions patients can visit one of the eight Mercy-GoHealth locations across the metro area.

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## Mission

As the Sisters of Mercy before us, we bring to life the healing ministry of Jesus through our compassionate care and exceptional service.



## Vision

We are the people of Mercy Health Ministry. Together, we are pioneering a new model of care. We will relentlessly pursue our goal to get health care right. Everywhere and every way that Mercy serves, we will deliver a transformative health experience.



## Values

- **Dignity.** We cherish each person as created in the image of God.
- **Excellence.** We give only the best for those entrusted to our care.
- **Justice.** We pledge to be in right relationship with one another with a particular concern for people who are economically poor.
- **Service.** We seek out and put the needs of others first.
- **Stewardship.** We wisely use our talents and resources to strengthen Mercy as a ministry of the Church.

## At a Glance

### MERCY

Oklahoma County

15,895  
Admissions

3,952  
Births

856  
Medical Staff

1,127,422  
Outpatient visits

349  
Beds (licensed)

130+  
Volunteers

50,496  
ER visits

4,070  
Employees

\$20,480,000  
Charity care



OU Health is the state's only comprehensive academic health system of hospitals, clinics and centers of excellence. With 11,000 employees and more than 1,300 physicians and advanced practice providers, OU Health is home to Oklahoma's largest doctor network with a complete range of specialty care.

**OU Health serves Oklahoma and the region with the state's only freestanding children's hospital, the only National Cancer Institute-Designated OU Health Stephenson Cancer Center and Oklahoma's flagship hospital, which serves as the state's only Level 1 trauma center.**

OU Health's mission is to lead healthcare in patient care, education and research. With historic ties to the University of Oklahoma's educational mission, OU Health has deep roots and a heritage of community engagement.

Oklahoma's growth is steady, but slower than the national average. With nearly a third of its population in rural settings, Oklahoma remains less urban than most other states in the nation. Rural and suburban communities tend to be less racially diverse than the national average. However, Oklahoma County is more diverse than what might be expected. Neighborhoods of color surrounding Oklahoma Health Campus still experience the residual effects of historic displacement and systemic redlining. This history innately impacts housing stability – significant because shelter is among the most basic of human needs.

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## Mission

At OU Health our Mission is leading healthcare - in patient care, education, and research. Through our combined efforts, we strive to improve the lives of all people.



## Vision

Our vision is to be the premier health system in Oklahoma and a top tier academic health system leader nationally based on measurable results in delivering high-quality, multidisciplinary care, education focused on the needs of our state, and funded research.



## Values: PACCT

- To respect the **P**eople we serve and serve with,
- To be **A**ccountable to them, to ourselves and to our communities to passionately deliver excellence in patient care, education, and research,
- To be **C**ollaborative and **C**ompassionate in all our efforts, and
- To be **T**ransparent and act with integrity in all of our work as a premier academic health system.

# At a Glance

## OU HEALTH

Oklahoma County

33,404

Admissions

3,591

Births

3,895

Medical Staff

338,379

Outpatient visits

804

Beds (licensed)

200+\*

Volunteers

101,970

ER visits

1,407

Employees

\$298,523,220

Charity care

\*OU Health reporting numbers were impacted due to the COVID-19 pandemic and restrictions put in place to keep our patients, staff and volunteers safe.



SSM Health St. Anthony is a Catholic, non-profit health system that has served the people of central Oklahoma since 1898. Our hospitals in Oklahoma County include SSM Health St.

Anthony Hospital (Oklahoma City), Bone and Joint Hospital at St. Anthony (Oklahoma City), St. Anthony South (Oklahoma City), and St. Anthony Hospital - Midwest (Midwest City). Our network across Oklahoma also includes St. Anthony Hospital - Shawnee, five SSM Health St. Anthony Healthplex campuses, six managed rural hospitals, 10 affiliated rural hospitals, and SSM Health Medical Group with nearly 300 physicians and providers.

SSM Health St. Anthony provides general, acute care services including cardiology, oncology, surgery, orthopedics, behavioral medicine, and a variety of other disciplines including a growing neurosciences service line.

**We are the largest provider of emergency services in the Oklahoma City metropolitan area, providing more than 100,000 emergency room visits annually. Our behavioral health program is the largest private provider of comprehensive mental health services for children, teens, adults, and seniors in Oklahoma.**

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## Mission

Through our exceptional health care services, we reveal the healing presence of God.



## Vision

Through our participation in the healing ministry of Jesus Christ, communities, especially those that are economically, physically and socially marginalized, will experience improved health in mind, body, spirit and environment within the financial limits of the system.



## Values

Inspired by our founding religious sisters, we value the sacredness and dignity of each person. Therefore, we find these five values consistent with our heritage and ministry:

- **Compassion.** We reveal the healing presence of God through compassionate care focused on the fullness of the person.
- **Respect.** We respect life at all stages and promote the dignity and well-being of every person.
- **Excellence.** We provide exceptional care and service through employees and physicians dedicated to our Mission.
- **Stewardship.** We use financial, human and natural resources responsibly and care for the environment.
- **Community.** We cultivate relationships that inspire service and promote justice in our organization and throughout our communities, with special concern for the poor and marginalized.

## At a Glance

**SSM HEALTH ST. ANTHONY**  
Oklahoma County

26,323  
Admissions

1,497  
Births

948  
Medical Staff

312,339  
Outpatient visits

1,016  
Beds (licensed)

150+  
Volunteers

126,207  
ER visits

3,824  
Employees

\$41,049,043  
Charity care



Established in 1910, the Oklahoma City-County Health Department is committed to protecting health, promoting wellness and preventing disease to ensure a healthy future for the citizens of Oklahoma County.

**OCCHD was one of the first public health departments in the entire country to be accredited by the Public Health Accreditation Board.**

For more information, visit [occhd.org](http://occhd.org).

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## Mission

Protect health, promote wellness, prevent disease, and partner in the community.



## Values

- Caring
- Service
- Excellence
- Integrity



## Vision

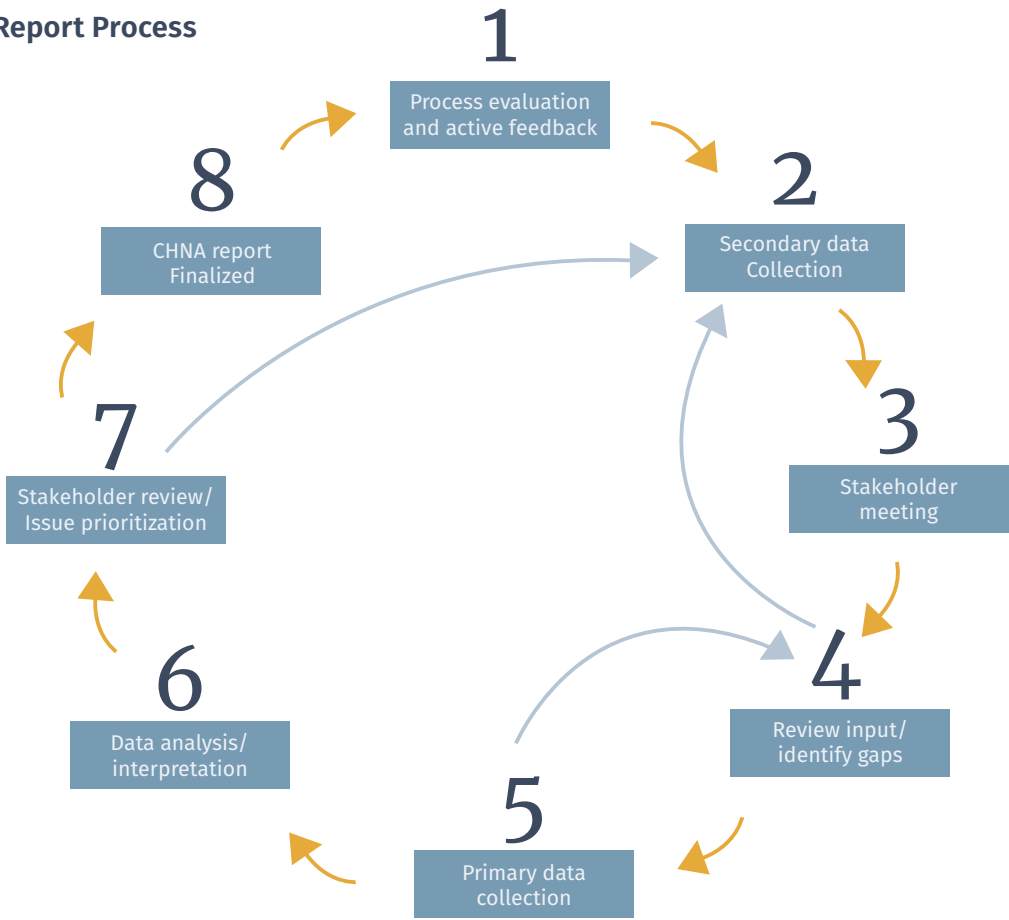
Working with the community for a healthy future.



# Description of Process and Methods

This report includes both **qualitative** and **quantitative** data to provide insights about the biggest and most pressing health needs affecting people in Oklahoma County. We began the CHNA process with a review of the previous CHNA report and gathered feedback from internal and external stakeholders.

Fig 1. CHNA Report Process





# Quantitative data

## Secondary Data Sources

### Public Health and Population Based Data Sources

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The secondary data indicators included in this CHNA were based on the top health priority areas identified by the *2021 Oklahoma City-County Wellness Score* completed by the Oklahoma City-County Health Department. Throughout the iterative process, indicators were also included if they related to one of the **four main priority areas or themes** identified through the qualitative data from the stakeholder meetings and community chats. Data representing the most recent year available are reported for all sources.

We reviewed approximately 100 indicators including health outcomes and associated health factors for Oklahoma County residents. Indicators included demographic data, mortality data, economic and social factors, education, built environment, and health care access and quality. All indicators were assessed through the lens of health equity, keeping in mind the social determinants of health.

### Stakeholder Meeting

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We assembled a group of 65 community stakeholders representing 45 organizations including health care providers, social service providers, foundations, chambers of commerce, community development and finance organizations, education and employment training services, government services, transportation services, food and food security services, and elected officials. Populations experiencing health inequities were represented throughout the various stakeholder organizations involved. We presented a comprehensive overview of health indicator findings for Oklahoma County, and used a “real time” survey process to engage stakeholders and assess their views on the greatest factors for poor health outcomes in Oklahoma County.

Four main health topics emerged from this process: **access to meaningful employment, access to education, access to healthy food, and access to healthcare.** We divided the stakeholders into discussion groups for each problem area. Each group further defined the problem using the “five whys exercise” in order to determine the root causes of each problem.

## Primary Data Sources

### Convenience Sample Survey

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We used the findings from the stakeholder meeting to create a community survey to collect information from Oklahoma County residents. To create the community survey, we contacted the Robert Wood Johnson Foundation for examples of surveys from other states that were successful in gathering information related to social determinants of health. We also considered questions from the Behavioral Risk Factor Surveillance Survey and other surveys.

Through our partnership with the Oklahoma City-County Health Department, we utilized COVID-19 vaccination events to collect surveys. In addition, we enlisted the help of our stakeholders to send targeted emails to specific population groups. Surveys were made available in English and Spanish. After exclusion of incomplete surveys and those with a ZIP code outside of Oklahoma County, we had a final sample size of 956.

Although this was not a probability sample, the demographics of the survey respondents are comparable to that of Oklahoma County with a few exceptions.

To make the results more generalizable to Oklahoma County, we used post-stratification weighting. We used the American Community Survey to create benchmark totals for the following variables: Age, Sex, and Race. The survey questionnaire and full results are available in [Appendix B](#).



# Qualitative Data

## Community Chats

A full needs assessment consists of both **quantitative** analysis using demographics and statistics for local areas and **qualitative** analysis using perspectives and experiences from members within the community being served. Each hospital was responsible for Community Chats related to one of the following priority areas: Education, Employment, Food Access, Health Care Access. Each Community Chat was moderated by a staff member from one of the partner hospitals and recorded for transcription.

### Methods

**Table 2. CHNA Community Chat Demographics Data.**

\*Full reporting was not available from all community chat topic areas for this demographic

Community Chat Demographics	Category	Count (%)
Total participants with demographic information		107 (100%)
Participants by topic area	Access to Food	36 (34%)
	Access to Healthcare	34 (32%)
	Access to Employment	21 (20%)
	Access to Education	16 (15%)
Employed in healthcare-related field		35 (33%)
Employed in field related to Community Chat topic		41 (38%)
Not employed in field related to Community Chat topic		66 (62%)
Median Age*		51 (range: 26-85)
Gender*	Female	42 (82%)
	Male	9 (18%)
Race/Ethnicity*	White	14 (26%)
	Black	19 (36%)
	Asian	1 (2%)
	Hispanic	12 (23%)
	American Indian/Alaska Native	3 (6%)
	Other	4 (7%)
	Marital status*	Married
	Single	9 (20%)
	Divorced	8 (17%)
	Member of a couple	2 (4%)
	Widowed	1 (2%)

We facilitated sixteen “Community Chats” in the form of guided community chats to delve deeper into how people experience each of the four priority topic areas. We created facilitation guides for each priority topic to collect information on personal experiences, barriers to access, community perceptions, and opportunities to improve conditions in the community. Each Community Chat was moderated by a staff member from one of the partner health systems.

As an expression of this CHNA’s emphasis on health equity, we used intentional recruiting strategies to ensure Community Chat participants were representative of underserved members of the community. These strategies included partnering with charity clinics to recruit and host the conversations using a purposive, snowball sampling approach to recruit participants, and providing small gift-card incentives for participation. Our partners in recruitment included the Oklahoma City and Millwood Public School Districts, Good Shepherd Clinic, Crossings Community Clinic, Hilltop Clinic, Mary Mahoney Health Center, and the Health Alliance for the Uninsured.

We were intentional about inviting Community Health Workers, frontline public health workers who are trusted members of the community, and those with lived and/or shared experiences of the underserved populations in Oklahoma County.

**Between May 23 and June 30, 2021, 111 participants engaged in 16 Community Chats: 4 on Health Care Access, 4 on Food Access, 3 on Education and 5 on Employment.**

All sessions were recorded, and audio files were anonymously transcribed to text documents. Text documents were uploaded to the qualitative data analysis software tool “Dedoose” for coding. Dedoose is a web-based program that allowed the researchers to organize and analyze research data into text formats for quantitative and qualitative data and facilitated mixed methods research output.



## Analysis Techniques:

The first stage in the research process was initial coding. A team of two primary and two secondary coders was established to generate codes and read through each transcript to draw relationships and identify keywords. We created a codebook with definitions for each code through an iterative process of testing codes and reconciling coding differences until an acceptable level of coding agreement was reached.<sup>11</sup> We calculated intercoder reliability by having multiple coders code random excerpts of text representing about 10% of the data. A second round of interrater reliability tests were administered to Community Chat facilitators to establish clarity on coding applications across administrative levels of the qualitative research efforts.<sup>12</sup>

The second stage of analysis involved focus coding to eliminate, combine, and subdivide coding categories identified in the first step. The process yielded quantitative results that drew comparisons across each Community Chat topic area. The content analysis enabled us to systematically code data by organizing the statements into categories allowing us to discover patterns that could be undetectable with listening and reading alone.



An aerial, high-angle photograph of a city skyline, likely Oklahoma City, featuring several skyscrapers and a dense urban layout. The image is overlaid with a dark blue gradient. The text "COUNTY PROFILE:" is in a smaller, white, sans-serif font, and "Key Indicators" is in a larger, bold, white, serif font.

COUNTY PROFILE:  
**Key Indicators**

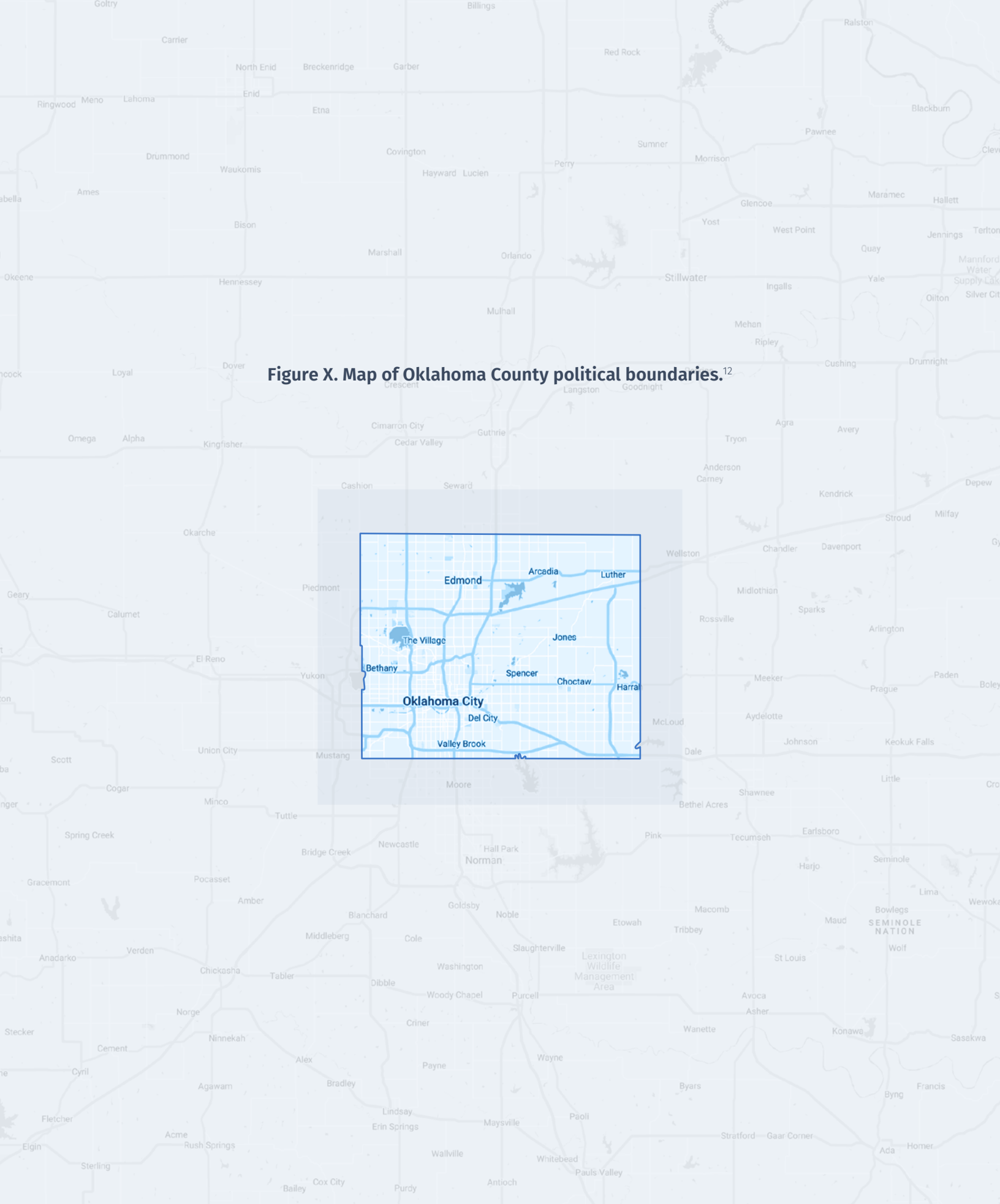


Figure X. Map of Oklahoma County political boundaries.<sup>12</sup>

# Description of Community

Oklahoma County is the largest county in Oklahoma in terms of population. Oklahoma County housed an estimated 797,434 residents in 2019, and the total population in the City-County health system served by OCCHD is estimated to be around 24% of Oklahoma's total population.<sup>514</sup> It sits within Central Oklahoma and includes Oklahoma City, the largest city in Oklahoma and the state capitol.

**The population of Oklahoma county is more racially and ethnically diverse than the rest of the state.**

Two local health departments as well as the state health department are located in the county. The four health systems conducting this CHNA have facilities located throughout the county and define Oklahoma County to be their community for the purpose of IRS compliance.

The following data provide an initial snapshot of the Oklahoma County community and associated population health status. These key indicators provide foundational information about the community captured in this assessment and will set the stage for advancing collaborative community health improvement planning efforts. Furthermore, **data combined from sources available to OCCHD and the four health systems provide a rich picture of the complexity of health outcomes and their associated determinants of health.**

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**Table 3. Oklahoma County Demographic Data**

Oklahoma County Demographics		Count (%)
Sex	Female	401,863 (51.0%)
	Male	385,353 (49.0%)
Age Group	0-17	201,456 (25.6%)
	18-24	71,838 (9.1%)
	25-34	124,082 (15.8%)
	35-44	100,744 (12.8%)
	45-54	90,678 (11.5%)
	55-64	93,291 (11.9%)
	65+	105,127 (13.4%)
Race/Ethnicity*	Non-Hispanic White	440,742 (56.0%)
	Non-Hispanic Black	116,115 (14.8%)
	Hispanic/Latino	136,829 (17.4%)
	American Indian/Alaska Native	52,429 (6.7%)
	Asian/Pacific Islander	36,822 (4.7%)
	Some other race	32,352 (4.1%)
Education Level	Less than HS Diploma	75,539 (12.9%)
	HS Diploma/GED	155,063 (26.5%)
	Some college	183,690 (31.4%)
	4-year degree or higher	171,378 (29.3%)

# Demographic Characteristics: Age, Gender and Race / Ethnicity

Demographic characteristics include measures of total population and the percent of the total population by certain characteristics such as age group, gender, and race/ethnicity.<sup>15</sup> Because Oklahoma County comprises about 24% of the population of Oklahoma, and includes a higher proportion of demographic groups experiencing greater inequities and disparities in health outcomes, comparisons will be made between the County and the State throughout this report.

\*Estimates including those who identify as more than one race are presented for American Indians and Alaska Natives, Asians and Pacific Islanders, and some other race. Percentage may not sum to 100%.

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# Overarching Themes

Oklahoma County's population is growing across all racial and ethnic groups. There was a 5.9% increase in the total population from 2014 to 2019.<sup>14,16</sup> Hispanics had the highest rate of population increase according to American Community Survey (Census Bureau) data between 2014 and 2019. American Indians and Alaska Natives had the smallest recorded increase in the ACS data used, but estimates comparing American Indians and Alaska Natives between the 2010 and 2020 decennial censuses actually show their population doubled over the 10-year period.<sup>17,18</sup>

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**Table 4. Oklahoma County Population Growth Data, 2014-2019<sup>14,16</sup>**

Population Growth by Race and Ethnicity	
Hispanic	17.0% increase
Other	11.9% increase
Multiracial	15.9% increase
Asian/Pacific Islander	11.6% increase
American Indian	3.2% increase
Black or African American	5.9% increase
White	5.7% increase

# Quality of life

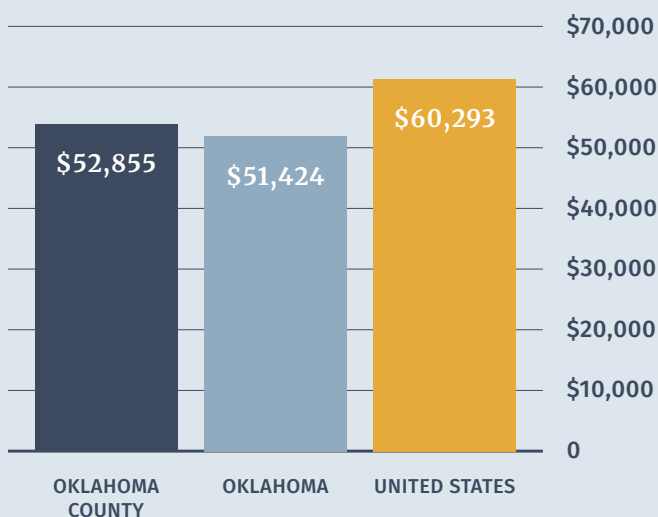
## Poverty/education

The 2021 Wellness Score presents median household income in Oklahoma County from 2018, compared to state and national benchmarks. Median household income is also presented among racial and ethnic groups in the community, as well as between men and women. The overall median household income in Oklahoma County was \$52,855. This was \$1500 over the state median income of \$51,424 but lagged by \$7500 behind the national median household income of \$60,293.

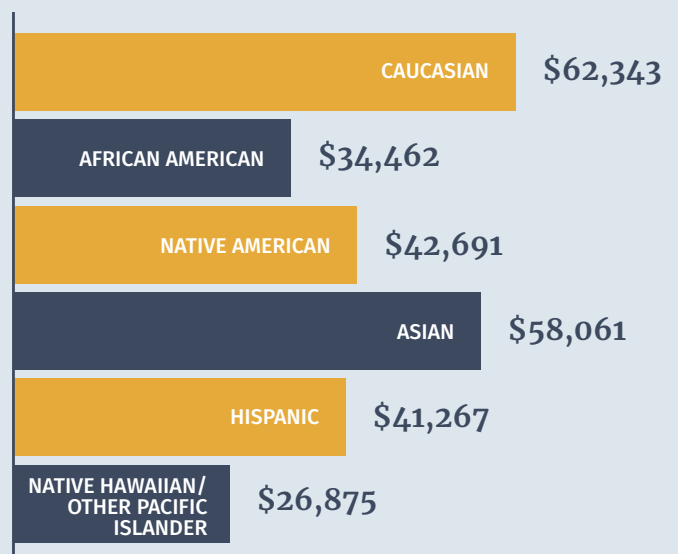
Median income for Whites and Asians in Oklahoma County was above the overall median income in 2018 at \$62,343 and \$58,061 respectively; for all other racial groups, there was a \$10,000 or greater deficit in median income compared to the overall median income for the county. Men in Oklahoma County had a median income of \$46,620, while women had a median income of \$36,577.

**The number of people living in poverty in Oklahoma County was estimated as one in six in 2018 (16.7%).** This figure was higher than both the state poverty rate of 16.0% and the national poverty rate of 14.1% in 2018.

**Fig 2. Median Household Income Comparison for Oklahoma County, Oklahoma State, and the United States median, 2018.<sup>5</sup>**



**Fig 3. Median Household Income in Oklahoma County by Race/Ethnicity, 2018<sup>5</sup>**



## SNAP and SSI

More Oklahoma County residents received Supplemental Nutrition Assistance Program (SNAP) benefits than the state rate in 2018 (13.3% vs 13.1%). An additional 1.1% of the population in Oklahoma County claimed SNAP benefits compared to the national rate for those using SNAP. Five percent of Oklahoma County residents were receiving Social Security Income (SSI) benefits in 2018. This proportion was lower than the state rate of 5.6% and the national rate of 5.4%.<sup>5</sup>

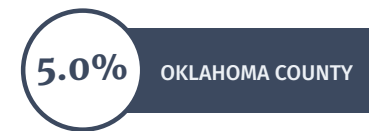
Percent of Population that received SNAP Benefits in 2018:

**13.3%**  
OKLAHOMA COUNTY

**13.1%**  
OKLAHOMA

**12.2%**  
UNITED STATES

Percent of Population that received SSI Benefits in 2018:



## Education

Among Oklahoma County residents 18 and older, 30% held a bachelor's degree or higher in 2019.<sup>8</sup> 48.6% of the Asian population older than 18 had a bachelor's degree or higher. Of non-Hispanic Whites in Oklahoma County, 39.2% held a bachelor's degree or higher. American Indians

and Alaska Natives had bachelors' degrees or higher at a rate of 22.8%, a higher rate than 20.6% for Blacks and 11.9% for those of Hispanic or Latino origin in Oklahoma County. Members of other races not specified by the US Census held a bachelor's degree at a rate of 6.7%.

## Employment

The unemployment rate in Oklahoma County was 4.9% in 2018.<sup>5</sup> This was lower than the rate for both the state (5.3%) and the national unemployment rate (5.9%).

Unemployment is among the factors that contribute to poverty and negative health outcomes. Some of the effects of unemployment include depression, anxiety, chronic diseases, low quality of life, and even premature death. Community-based programs intended to improve quality of life advocate for policies and services that keep unemployment low. Programs such as increased access to job training and business recruitment and retention are important services related to health and quality of life.<sup>5</sup>

The Wellness score data representing unemployment was collected prior to the COVID-19 pandemic. Since the pandemic, the employment situation has changed in Oklahoma City. **On September 30, 2021, new unemployment numbers were released from the U.S. Bureau of Labor Statistics showing Oklahoma City ranks first for Metropolitan communities with a 2010 Census population of one million or more. Oklahoma City has an unemployment rate of 2.6%.<sup>19</sup> This is the lowest rate since December 2019.** According to David Holt, Oklahoma City's Mayor, unemployment in Oklahoma City has only dipped lower than 2.6% on two occasions, both occurring in 2019.

## Food insecurity

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Food deserts are areas with limited availability of supermarkets with fresh fruit, vegetables, and other healthful whole foods.<sup>20</sup> These areas also include populations without access to transportation who rely on local stores without healthy food options.<sup>21</sup> Measuring grocery store availability within a community can help identify areas where focused interventions can take place. Local public health efforts, such as Wellness Now Coalition and TSET Healthy Living Program along with community partnerships, can identify resources that impact social inequalities and assure policies and programs are in place to address decreased grocery store accessibility.

According to 2017 data from the Oklahoma Food Bank, 25.2% of the Oklahoma County population lived in an area with low supermarket access.<sup>22</sup> In 18 ZIP codes within Oklahoma County, less than 5% of the population lives within a mile of a supermarket.



# Health behaviors

## Tobacco use

According to the CDC, 18.9% of adults in Oklahoma had smoked at least one cigarette in the past 30 days in 2019.<sup>23</sup> Smokeless tobacco was used by 7.4% of Oklahomans captured in the 2019 BRFSS.

**Among youth, 30.8% of Oklahoma high schoolers reported current use of any tobacco product (including e-cigarettes).**

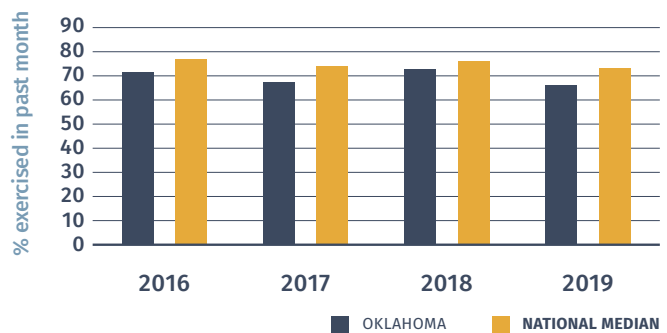
Of that same group, 9.1% reported currently smoking cigarettes.<sup>25</sup>

The OCCHD Wellness Score showed approximately 7% of babies born from 2016-2018 were born to mothers who smoke--a reduction from 8% in 2013-2015. In 2018, the maternal smoking rate for mothers was 6%, 4.6% lower than the state rate of 10.6%.<sup>5</sup>

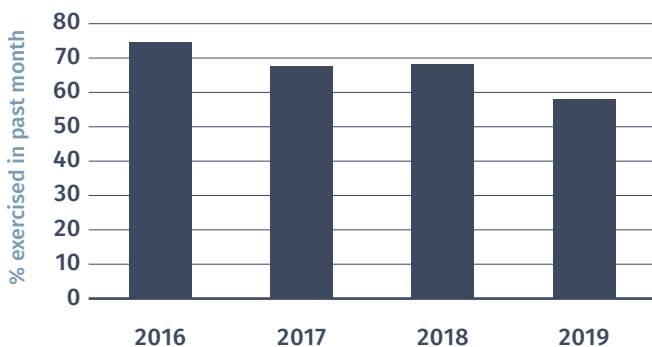
## Physical activity

Adults in Oklahoma engaged in physical exercise at a lower rate than the national median every year from 2016 to 2019. Physical exercise in Oklahoma fell from 72.8% to 66% between 2018 and 2019, and the gap between Oklahoma's exercise rate and the national rate grew from a 5.4% difference in 2016 to a 7.7% difference in 2019.<sup>23</sup>

**Adult engagement in leisure time physical activity in Oklahoma, 2016-2019**



**Hispanic adult engagement in leisure time physical activity, 2016-2019**



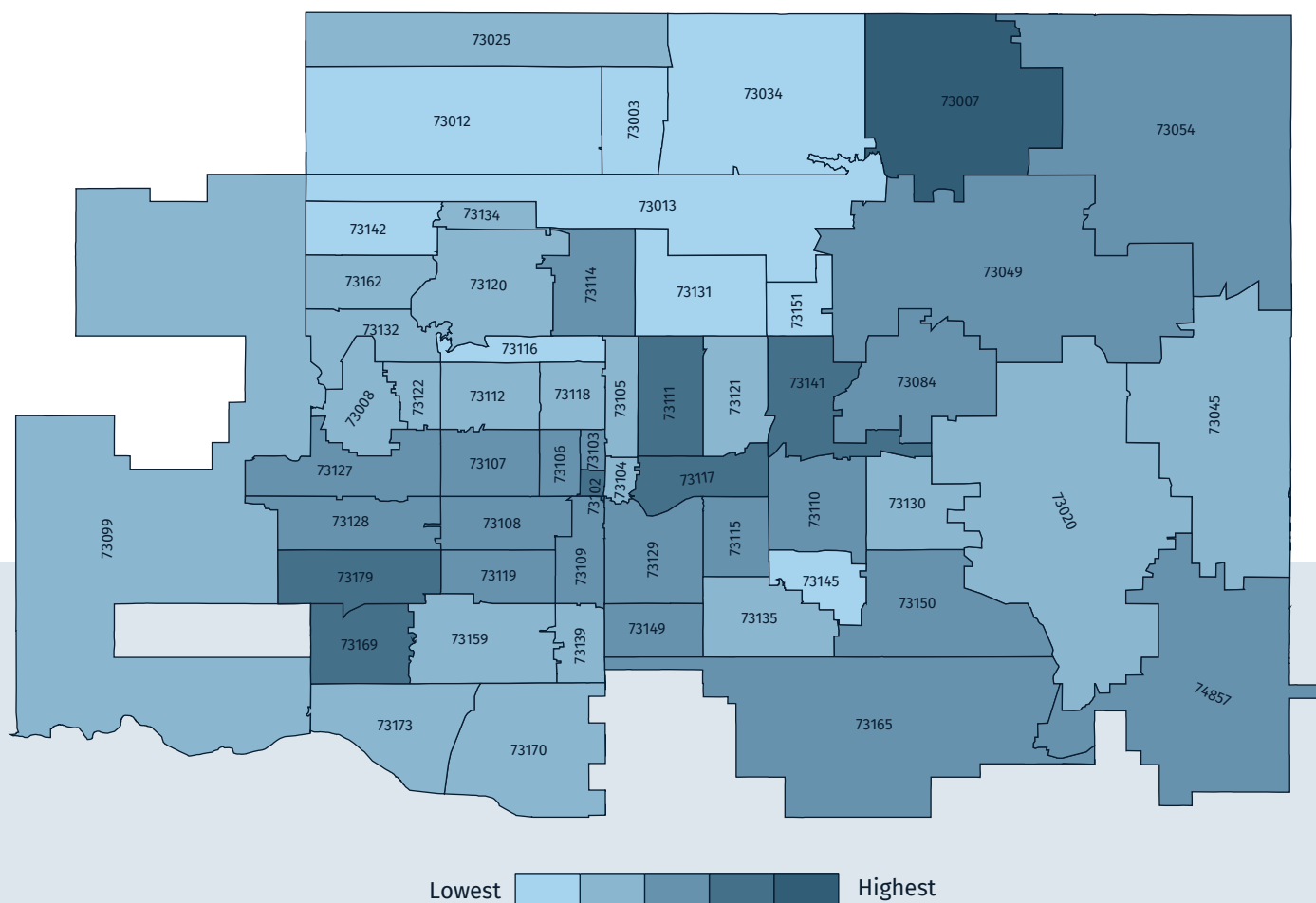
Race and ethnicity were a factor in physical activity participation in Oklahoma. **From 2016 to 2019, Hispanics declined from the highest exercise rates to the lowest in Oklahoma.** In 2016, 74.6% of Hispanics reported they had exercised in leisure time in the past month; by 2019, fewer than 60% of Hispanics in the Oklahoma had exercised in the past month. Black respondents also exercised under the overall state exercise rate, with 64.5% of Blacks having exercised in the previous month.<sup>23</sup>

# Chronic disease

## Mortality

The overall mortality rate for Oklahoma City-County from 2016-2018 was 932.6 deaths per 100,000 people. This was higher than the national rate of 728.0 and the state rate of 894.7 deaths per 100,000. Mortality rates were highest among American Indians. Non-Hispanics had a higher mortality rate than Hispanics. The mortality rate for males (1090.1) was higher than the rate for females (806.0). **The ZIP codes with the highest rates were 73007, 73141, and 73102.**

**Fig 5. Map of all-cause mortality in Oklahoma County by ZIP code, 2016-2018 (OCCHD, 2021).**

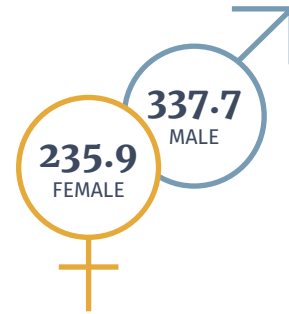




## Cardiovascular Disease

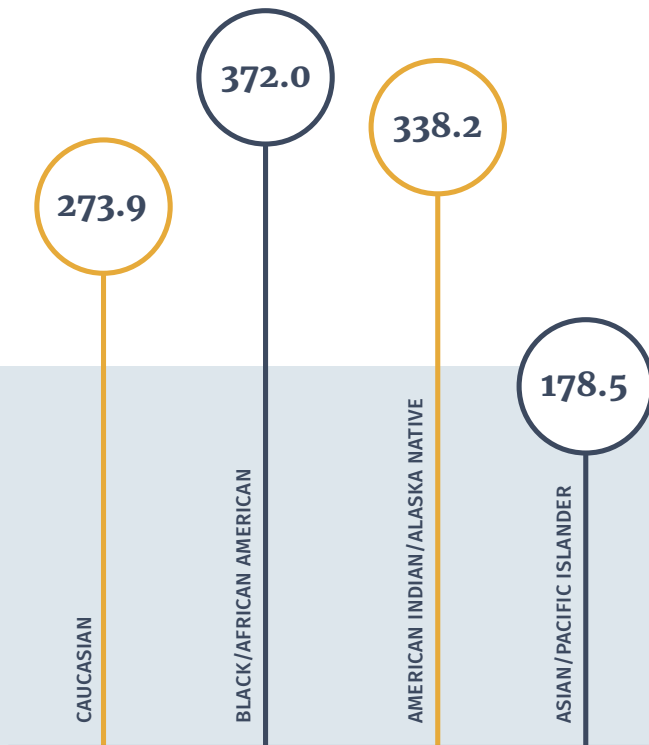
Cardiovascular disease was the leading cause of death in Oklahoma County between 2016-2018, with a combined 281.1 deaths per 100,000, adjusting for age. At 337.7 deaths per 100,000, males in Oklahoma City-County had 100 more deaths per 100,000 compared to females with a rate of 235.9 deaths per 100,000.<sup>5</sup>

**Age-Adjusted CVD Mortality Rates by Gender, 2016-2018 Oklahoma City - County**

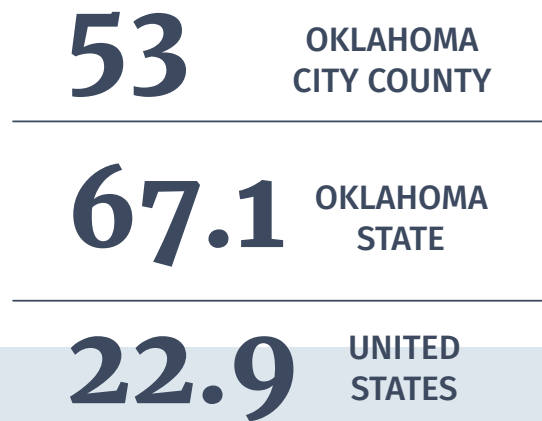


Asians and Pacific Islanders had the lowest age-adjusted cardiovascular mortality rate of any ethnic group with a rate of 178.5 deaths per 100,000; Blacks and African Americans had the highest rate at 372.0 deaths per 100,000.

**Fig 6. Age-Adjusted CVD Mortality Rates by Race, 2016-2018<sup>5</sup>**



**Fig 7. Death Rate Comparisons, 2016-2018<sup>5</sup> (Rate per 100,000)**



## Hypertension and Heart Disease

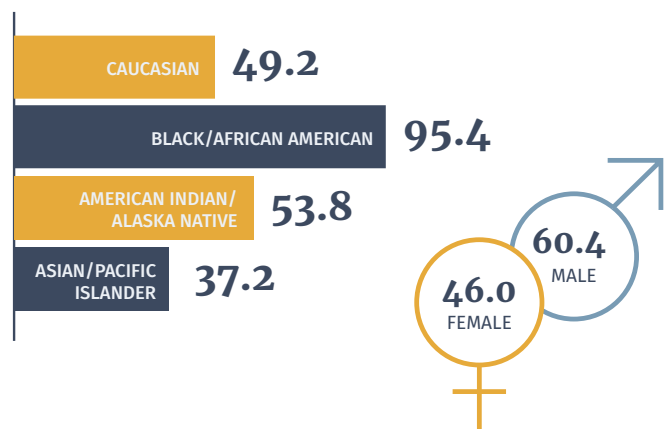
Hypertension mortality rates in Oklahoma City-County and the State of Oklahoma were well above the national age-adjusted death rate of 22.9 deaths per 100,000 between 2016-2018. The death rate in Oklahoma County was 53.0 deaths per 100,000.

**Rates were highest among males, who had a death rate of 60.4 per 100,000; Blacks and African Americans with a rate of 95.4 per 100,000; and non-Hispanics at a rate of 51.4 per 100,000.**

In total, 1,388 deaths in Oklahoma County were reported between 2016-2018 as a direct result of hypertension.<sup>5</sup>

When considering only heart disease mortality, Oklahoma City-County and the State of Oklahoma were also well above the national mortality rate of 164.7 deaths per 100,000. Oklahoma City-County had an age-adjusted heart disease mortality rate of 217.4, lower than the state rate of 231.3 deaths per 100,000.

**Fig 8. Age-Adjusted Hypertension Mortality Rates by Gender, 2016-2018<sup>5</sup>**

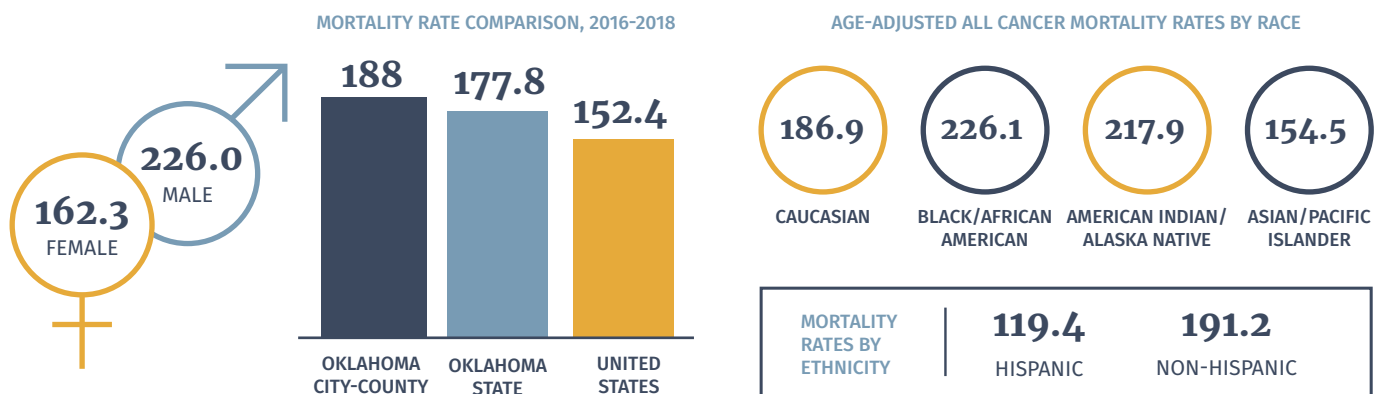


## Cancer

Cancer was the second leading cause of death in Oklahoma City-County between 2016-2018, ranking only behind cardiovascular disease. The age-adjusted mortality rate in Oklahoma County was 188.0 per 100,000, only slightly higher than the state rate of 177.8 per 100,000 deaths but 27.6 deaths per 100,000 greater than the national cancer death rate. Non-Hispanics had a far higher cancer death rate compared to their Hispanic counterparts, with a rate of 191.2 deaths per 100,000 (vs. 119.4 per 100,000 among Hispanics).

American Indians and Alaska Natives had high cancer death rates, at 217.9 deaths per 100,000 population.<sup>5</sup> However, African Americans have the highest cancer death rate at 226.1 deaths per 100,000 population.

**Fig 10. Age-Adjusted All Cancer Mortality Rates by Gender, 2016-2018<sup>5</sup>**



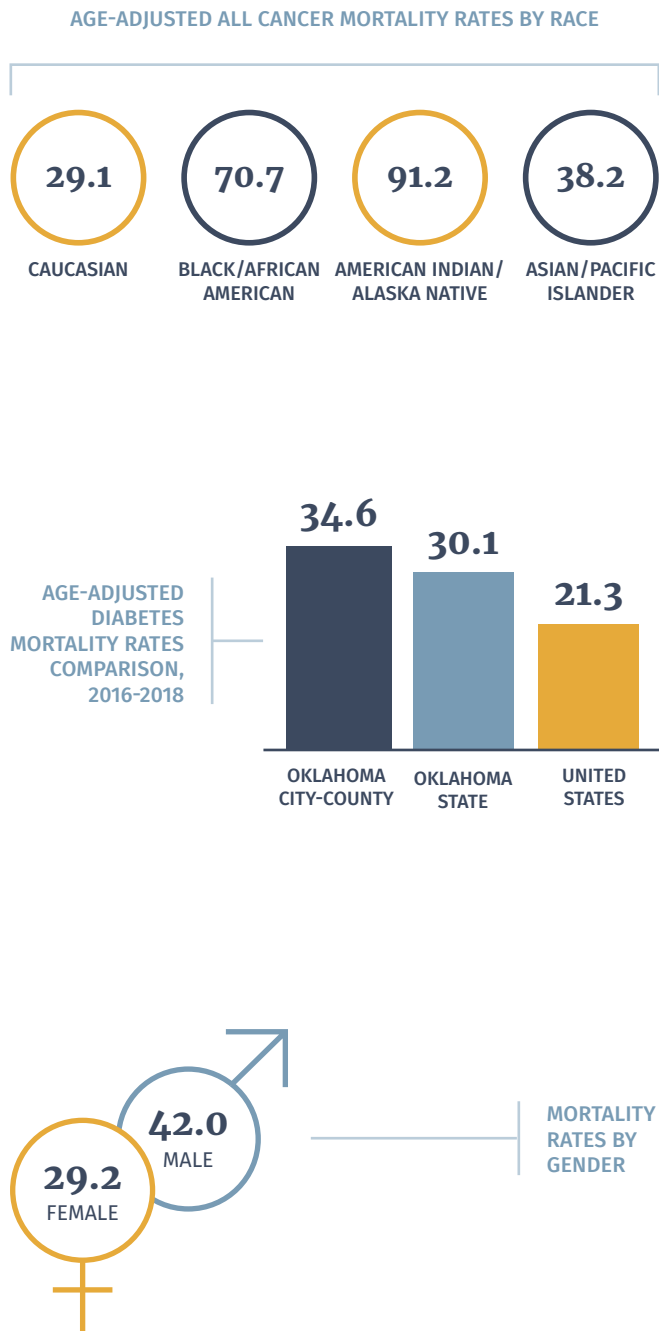
## Diabetes

Oklahoma County had higher diabetes mortality between 2016-2018 compared to state and national rates. The overall age-adjusted diabetes mortality rate in the county was 34.6 deaths per 100,000. The rates were higher among Hispanics compared to non-Hispanics (38.6 vs. 34.6), males compared to females (42.0 vs. 29.2), and **American Indian and Alaska Natives with a rate of 91.2 deaths per 100,000 across 2016-2018.**<sup>5</sup>

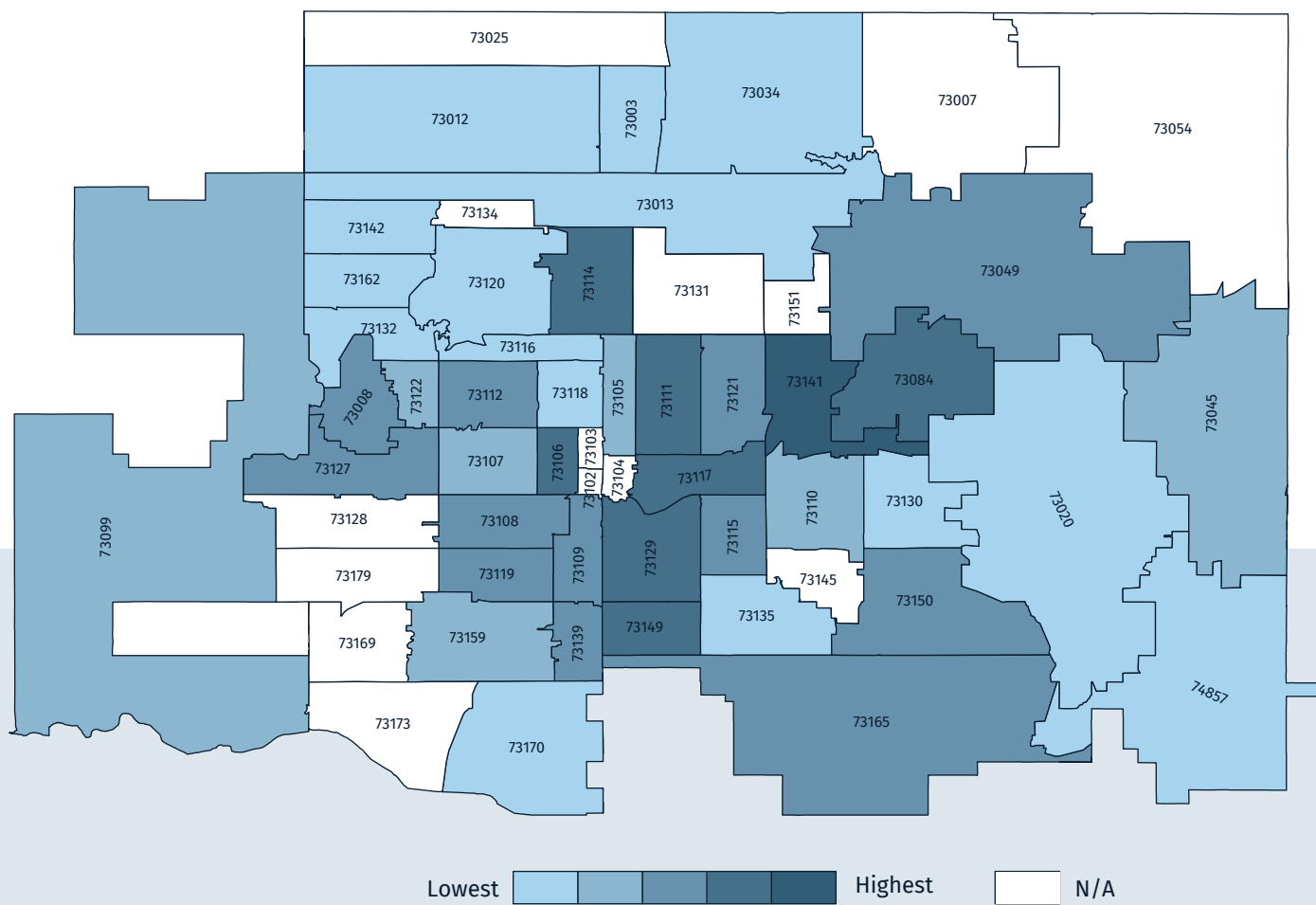
Oklahoma County ZIP codes 73141, 73111, 73117 had high rates of diabetes from 2016-2018. ZIP codes in the western region of Oklahoma County had lower rates of diabetes during this time period.<sup>5</sup>



**Fig 11. Age-Adjusted Diabetes Mortality Rates by Race and Gender, 2016-2018<sup>5</sup>**



**Fig 12. Map of diabetes mortality in Oklahoma County by ZIP code, 2016-2018.**<sup>5</sup>

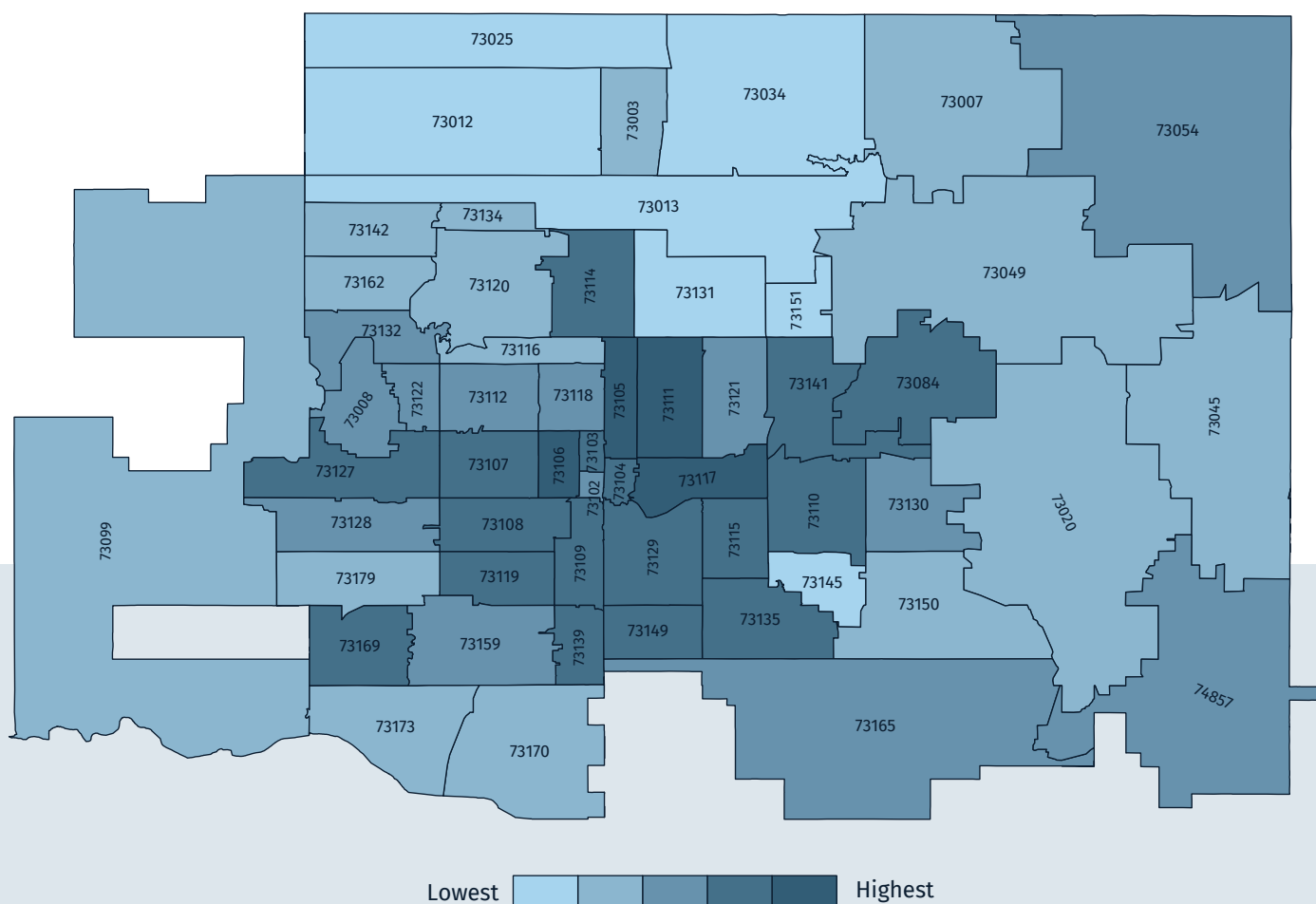


# Mental health and addiction

## Mental health visits

Poor mental health can be comorbid with poor physical health, and stress- and anxiety-related mental health issues can manifest as physical symptoms. Between 2016-2018 there were 30.5 mental health visits per 1,000 population in Oklahoma County at publicly funded behavioral health programs. Black and African Americans had the highest rate of mental health visit utilization, at 56.2 visits per 1,000 people. American Indians and Alaska Natives also had high utilization, with 47.6 visits per 1,000 people during this time period.<sup>5</sup>

**Fig 12. Map of public mental health provider utilization in Oklahoma County by ZIP code, 2016-2018.<sup>5</sup>**





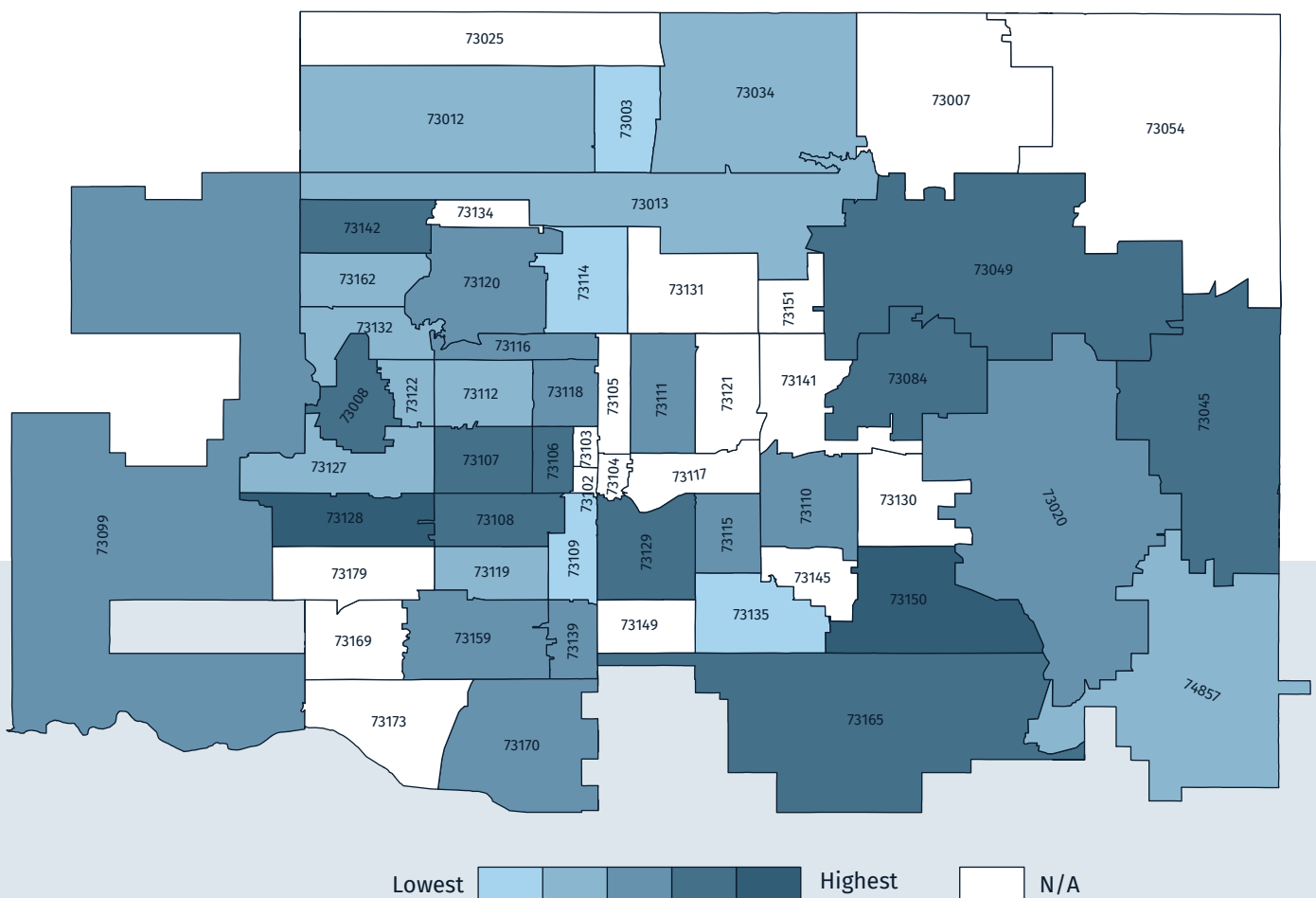
## Suicide

Suicide is a preventable cause of death related to mental health. The suicide rates in Oklahoma County and the State of Oklahoma were higher than the national average between 2016-2018. The age-adjusted suicide rate in Oklahoma County was 18 deaths per 100,000 people during this time period, less than the state rate of 20 deaths per 100,000 people. The national suicide mortality rate was 13.9 deaths to suicide per 100,000 people from 2016-2018.

**The highest rate of suicide mortality was experienced among American Indians and Alaska Natives with 25.9 deaths per 100,000 people.**

Blacks and Asians both had lower suicide mortality rates in Oklahoma County than the national rate. Men in Oklahoma County had a suicide mortality rate of 28.3 deaths per 100,000 people, compared to a rate of 8.4 for women.<sup>5</sup>

**Fig 12. Map of suicide mortality rate in Oklahoma County by ZIP code, 2016-2018.<sup>5</sup>**



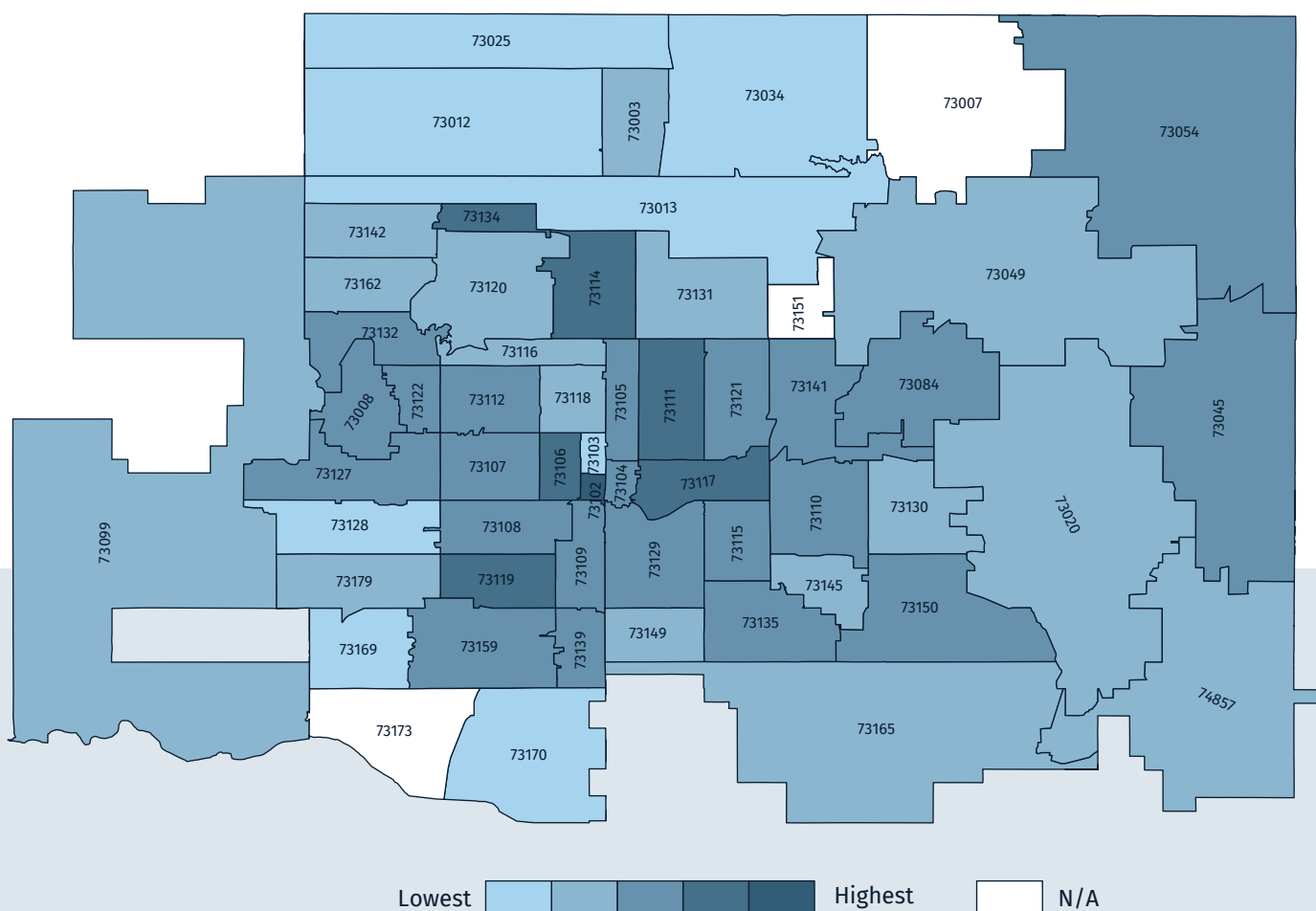


# Maternal and child health

## Prenatal care

The education, resources, and care offered to expecting mothers and their infant children are determinants of healthy outcomes for infants, as well as successful pregnancies for mothers. Behavioral determinants like diet, tobacco and alcohol use, and exercise during pregnancy can have lasting impacts on the health of a newborn. Substantial prenatal care given early in pregnancy can help prepare mothers for delivering healthy babies. Mothers who do not receive prenatal care, or who receive it too late, may have increased risk of complications at birth or infant mortality.<sup>25</sup> In 2018, 7.7% of women received late or no prenatal care in Oklahoma County. This was equal to the state rate, but 1.5% above the national rate of 6.2%. American Indians were the most likely to receive late or no care, with 14.6% of births among that population not having adequate prenatal care between 2016-2018.<sup>5</sup>

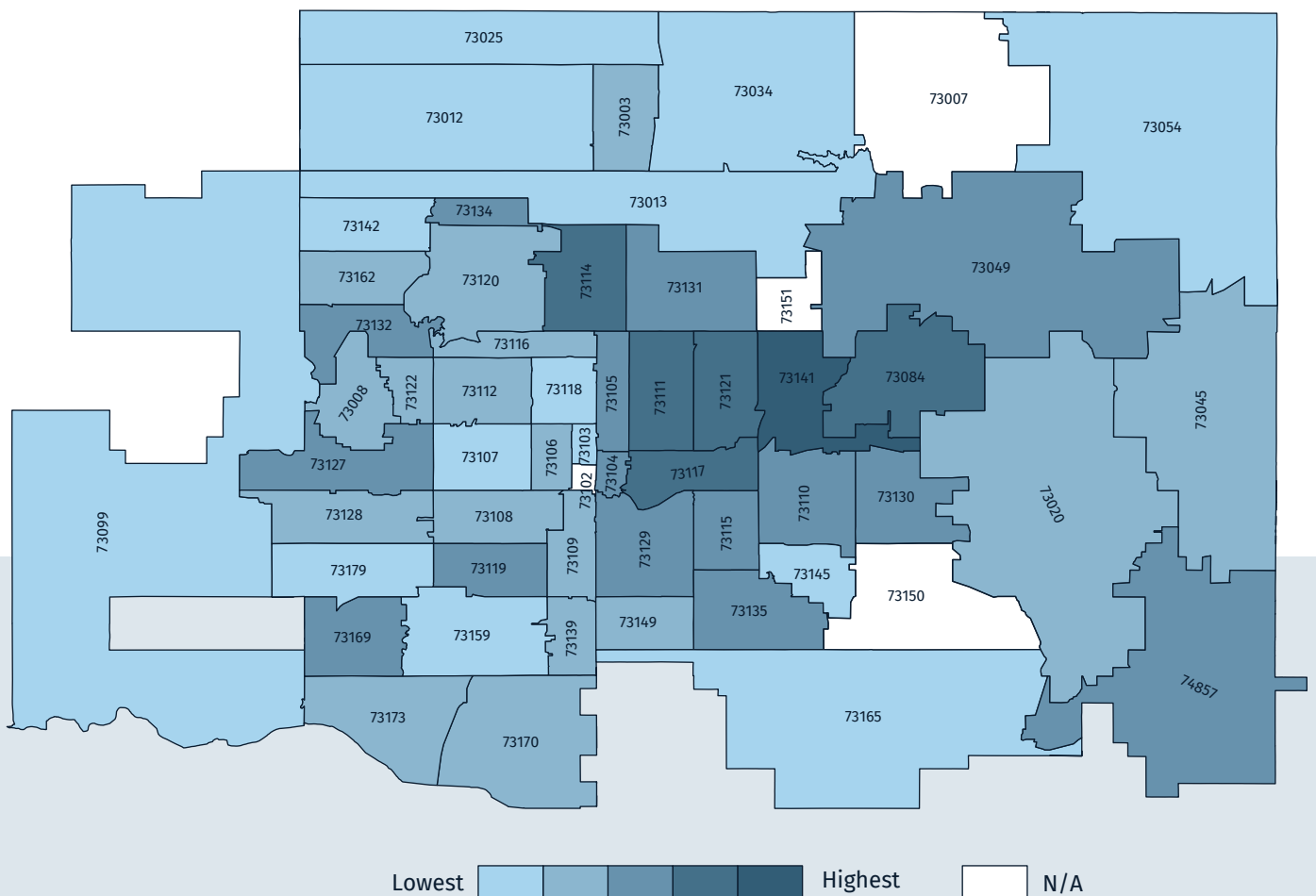
**Fig 12. Map showing late or no prenatal care in Oklahoma County by ZIP code, 2016-2018.<sup>5</sup>**



## Low birth weight

Low birth weight is an indicator of potential complications as a newborn, and can arise from environmental, social, and economic factors. The rate of low weight births in Oklahoma County was 8.9% from 2016-2018. This rate was higher during this time period than the low birth weight rate from 2013-2015. Oklahoma County had a higher rate of low weight births compared to the state and national average of 8.3%. Blacks and African Americans had a low birth weight rate of 14.4%, nearly twice the rate of Whites (7.5%).<sup>5</sup>

**Fig 12. Map of low birth weight rates in Oklahoma County by ZIP code, 2016-2018.<sup>5</sup>**



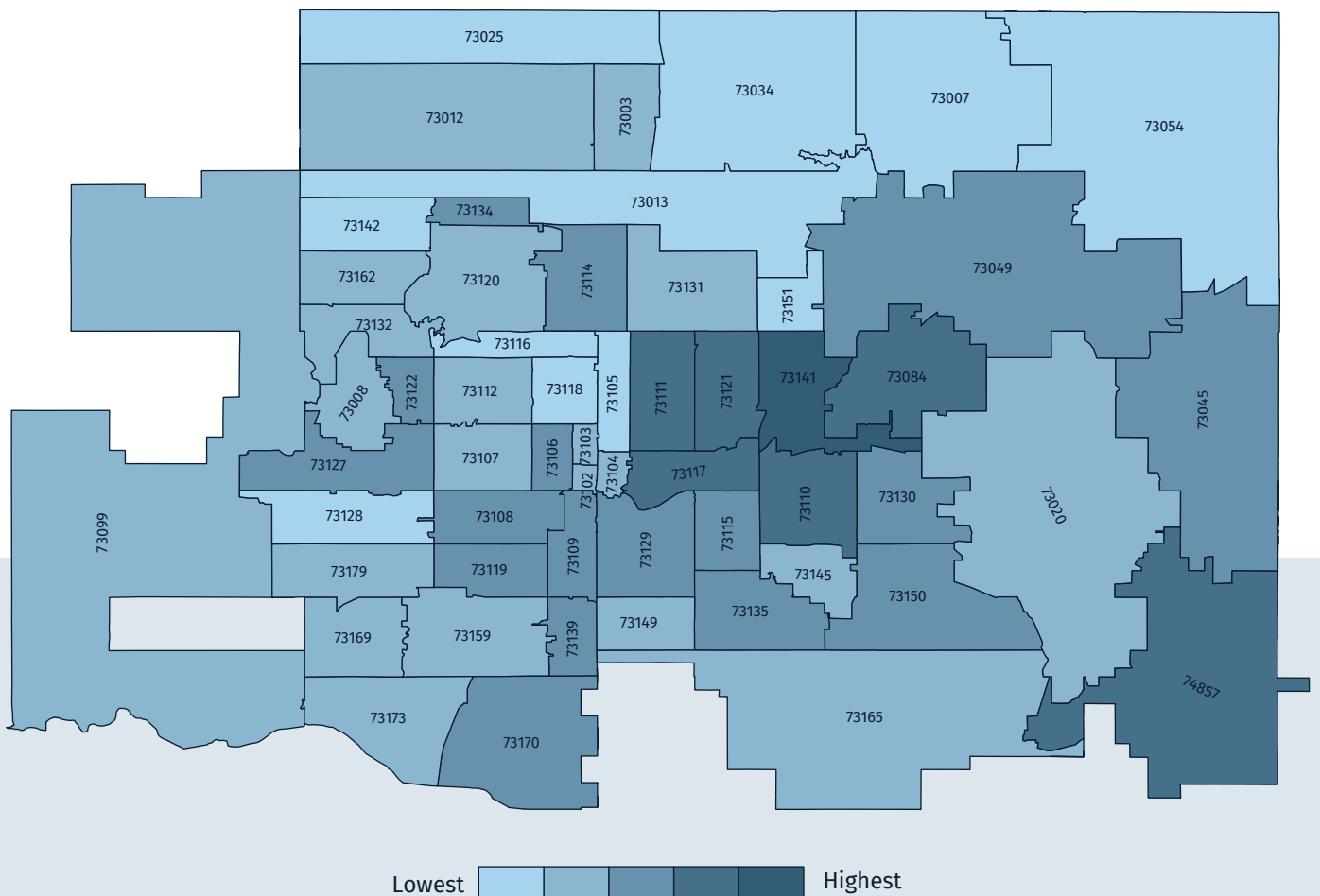
## Premature births

The rate of premature births is also an important metric when studying maternal and infant health. Not only are premature infants often born with low birth weights, but they are also still developing brain, lung, and liver function needed to survive outside the womb.<sup>5,26</sup> Nutrition, history of premature births, and circumstances with multiple offspring or inadequate room in the uterus can contribute to a premature birth. The premature birth rate in Oklahoma County was 11.1% in 2018, 1.1% higher than the national rate of 10.0%. As with low weight births, African Americans had the highest percentage of premature births in Oklahoma County, with 14.8% of live births being premature. Asians and Pacific Islanders had the lowest rate of premature births, at 9.4% of all live births being premature.<sup>5</sup>

**Fig 12. Map of premature birth rates in Oklahoma County by ZIP code, 2016-2018.<sup>5</sup>**

The maps for preterm births and low birth weight births for the county are very similar due to the overlap in potential causes for premature labor and low birth weight.

**ZIP code 73141 had the highest rates for both preterm births and low infant weight births during this time period.** From 2016-2018, this ZIP code had 22.9% of all live births recorded as low birth weight, and 23.2% of all live births were premature. The rate of late prenatal care in 73141 was average relative to the county, with 7.2% of mothers receiving late or no prenatal care.<sup>5</sup>



## Infant mortality

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Infant mortality is a measure of infant death risk, but it is also a useful proxy for the health resources and practices available within a population. Infant mortality rates are often compared across regions or populations to evaluate the quality of community health and socioeconomics within the society.<sup>5,27</sup> The infant mortality rate for Oklahoma County was 6.7 per 1,000 live births in 2018. This figure was lower than the state average of 7.1 infant deaths per 1,000 live births. Oklahoma County still lagged by 1.0 infant death per 1,000 live births compared to the national average of 5.7 infant deaths per 1,000 live births.

Sudden Infant Death Syndrome (SIDS) is an infant death unexplained by medical history or autopsy. Across the State of Oklahoma, this condition was the cause of 86.3 infant deaths per 1,000 live births in 2018<sup>29</sup>, accounting for 12.3% of all infant deaths during that year. OCCHD has published a page on their public website explaining SIDS, as well as giving advice for parents to help infants sleep safely to avoid sleep-related deaths attributed to SIDS.<sup>30</sup> The Oklahoma State Department of Health provides “sleep sacks” to some Oklahoma hospitals in place of swaddling blankets to prevent sleep-related deaths that may be mistaken for SIDS.<sup>31</sup>

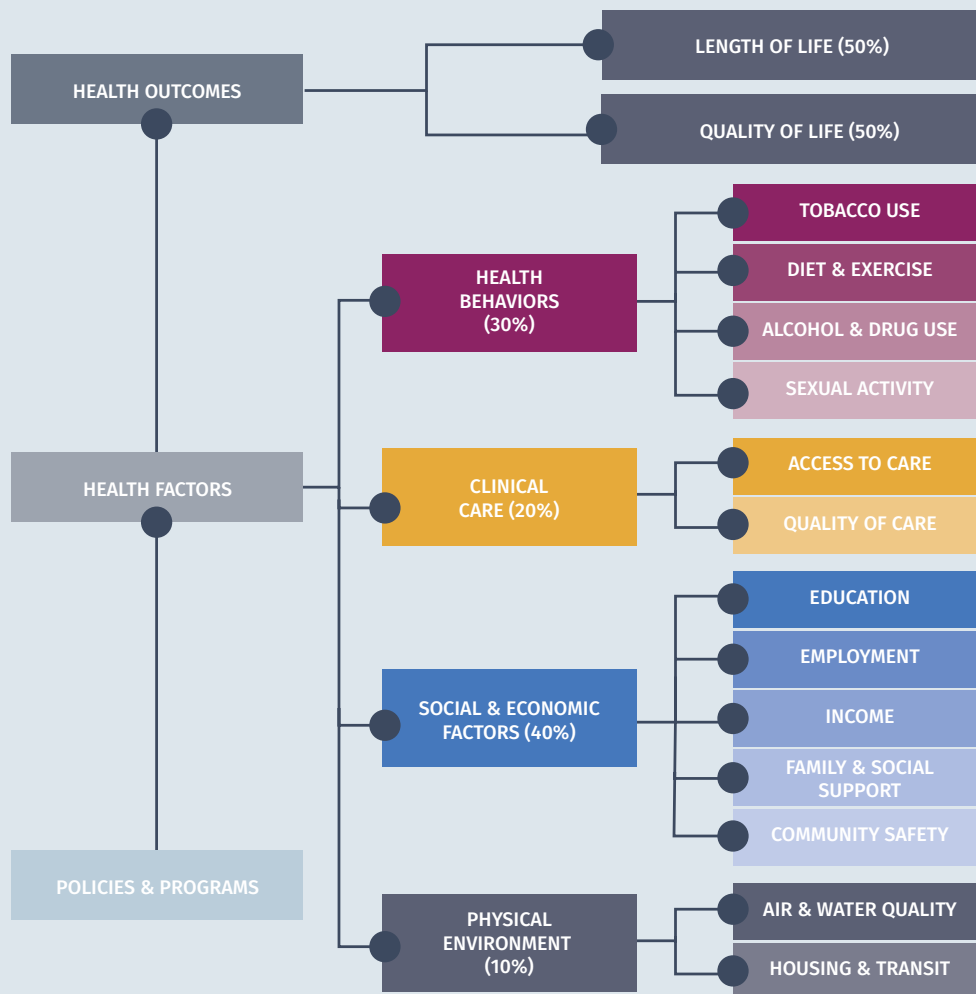
**The infant mortality rate among African Americans in Oklahoma County was nearly three times the rate of Whites during 2016–2018, with 13.2 per 1,000 African American infants dying before their first birthday.<sup>5</sup>**



# Links Between Social Determinants of Health and Health Outcomes

ZIP code is now a stronger predictor of a person’s health than their genetic code.<sup>32</sup> Social determinants have a major impact on health outcomes-especially for the most vulnerable populations. Factors such as a patient’s education, income level, and environment must be considered when providing treatment and care.

Figure 13. County Health Rankings Model – 2016<sup>28</sup>



According to the CDC, it has been well established that poverty inhibits access to healthy foods and safe neighborhoods, and that higher levels of education influence better health.<sup>33</sup> Negative social determinants of health can impact both an individual’s knowledge about healthcare and resources, and limit access to them. A growing body of research<sup>1,33,34</sup> indicates:

- Children born to parents who haven’t completed high school are more likely to live in environments that contain barriers to health.
- Poor individuals who are white are less likely to live in areas of concentrated poverty than poor racial and ethnic minorities.
- As income decreases, the likelihood of premature death increases.
- There is a direct link between the likelihood of smoking, shorter life expectancy, and lower income.
- The environment in which an individual lives may impact future generations.
- Stress related to disparities has a direct link to health, and often results from overlapping factors.
- Growing evidence highlights the negative impact of stress on both children and adults across the lifespan. Commonly referred to as allostatic load, chronic exposure to social and environmental stressors often results in biological “wear-and-tear” that places individuals at higher health risk.

There is a growing need for a “Health in All Policies” approach that incorporates health considerations into decision making across sectors and policy areas.<sup>35</sup> In order to improve population health, health equity needs to become a priority in the health sector.



## Overarching themes

Outcome	All Races	Caucasian Change from 2017 WS	Black/African American Change from 2017 WS	American Indian/ Alaska Native Change from 2017 WS	Asian/Pacific Islander Change from 2017 WS	Hispanic Change from 2017 WS
All Cause Mortality	2.2% ↓	3.7% ↓	1.5% ↓	5.4% ↓	8.6% ↑	3.2% ↑
Cardiovascular Disease (CVD) Mortality	3.0% ↓	2.8% ↓	9.7% ↓	0.9% ↑	1.1% ↓	8.8% ↑
Stroke Mortality	1.7% ↓	0.0% →	11.5% ↓	12.1% ↑	39.7% ↓	8.5% ↓
Heart Disease Mortality	4.0% ↓	3.9% ↓	12.1% ↓	3.4% ↓	11.9% ↑	18.5% ↑
Diabetes Mortality	8.5% ↑	5.1% ↑	12.0% ↑	36.3% ↑	6.7% ↑	1.0% ↑
All Cancer Mortality	3.4% ↓	4.4% ↓	2.5% ↓	9.5% ↓	23.2% ↑	2.6% ↑
Lung Cancer Mortality	14.3% ↓	13.0% ↓	20.8% ↓	46.3% ↓	47.5% ↑	36.7% ↓
Breast Cancer Mortality	3.4% ↓	2.9% ↓	9.5% ↓	3.0% ↑	2.3% ↑	33.6% ↓
Prostate Cancer Mortality	8.8% ↑	6.3% ↓	35.1% ↑	9.0% ↓	INSUFFICIENT DATA	69.0% ↓
Chronic Lower Respiratory Disease Mortality	8.9% ↓	10.1% ↓	12.9% ↑	21.9% ↓	85.3% ↑	4.3% ↓
Unintentional Injury Mortality	5.1% ↑	0.3% ↓	35.6% ↑	0.5% ↓	88.0% ↑	8.9% ↓
Suicide Mortality	4.0% ↑	3.4% ↓	29.9% ↑	25.1% ↑	24.7% ↑	78.7% ↑
Homicide Mortality	8.2% ↑	6.5% ↓	1.6% ↑	70.7% ↑	INSUFFICIENT DATA	45.1% ↑
Alzheimer Mortality	18.8% ↑	18.2% ↑	9.9% ↑	69.0% ↑	12.2% ↓	91.5% ↑
Infant Mortality	4.3% ↑	20.7% ↓	3.9% ↑	104.5% ↑	INSUFFICIENT DATA	20.3% ↑

These results in the above chart show specific indicators where change was significant between 2017 and 2020. In the cases where improvements were seen, these results were often due to health benefits among the White population and not due to overall improvements across all populations.

When looking at each of the ethnic/racial populations in the chart above, the health disparities can be easily seen between the white population that has only three indicators that show a worsening trend since the last wellness score (red arrows), while the other racial/ethnic groups have many more health disparities that show negative trends.



# Priority Topic Areas



# Access to Health Care

SoonerCare (Oklahoma Medicaid) provides health coverage for vulnerable Oklahomans, including eligible low-income adults, children, pregnant women, elderly adults and people with disabilities, and is jointly funded by the federal and state government. The Oklahoma Health Care Authority (OHCA) administers the program for the State of Oklahoma. Twenty-six percent of Oklahoma County residents were enrolled in SoonerCare in 2018, similar to the state rate of 25%.<sup>9</sup> (This was prior to Medicaid Expansion in 2021.)

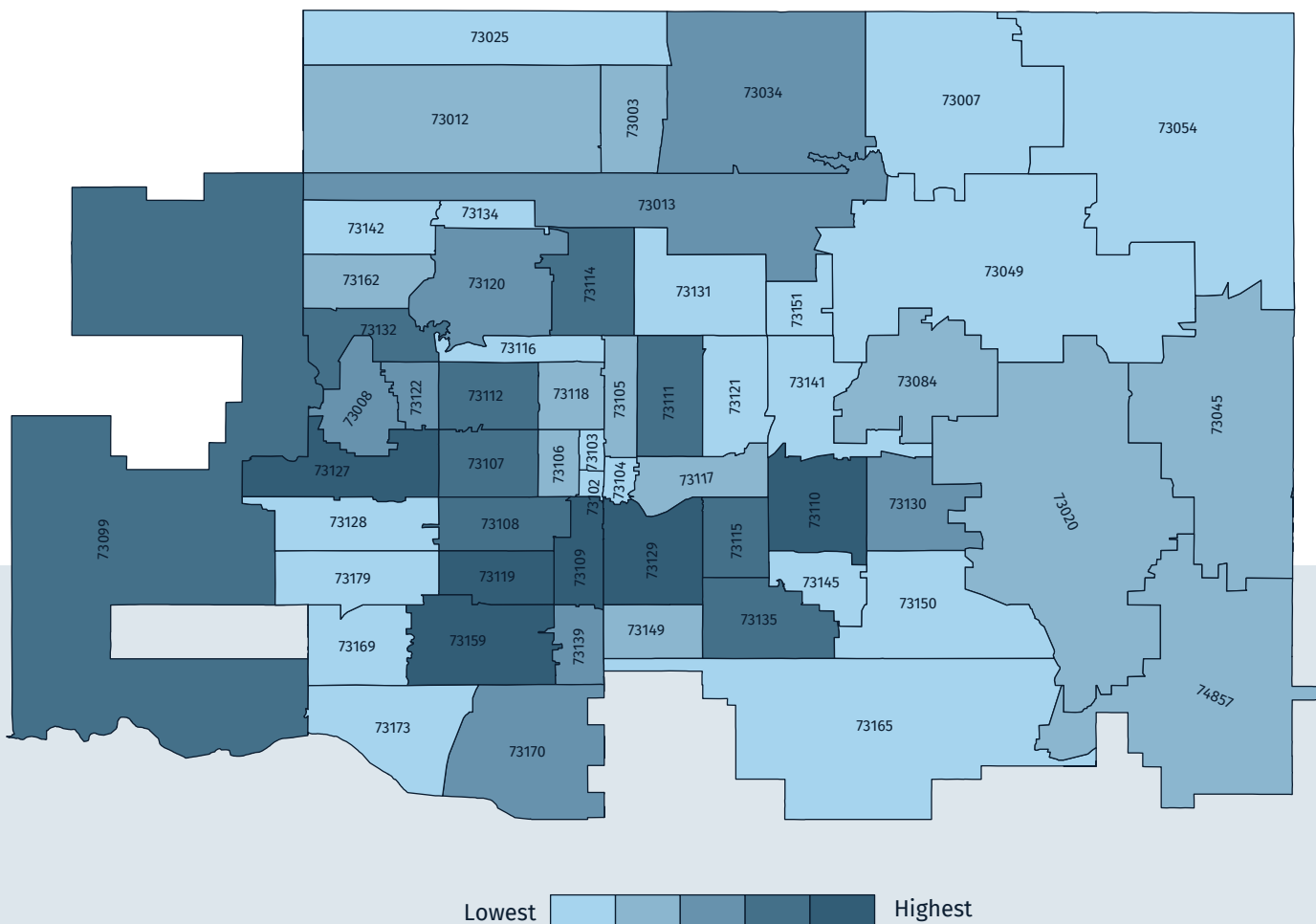
Emergency Department visits for non-emergency services cause a burden on health care systems and result in higher costs for health care services.<sup>36</sup>

**At a national level, studies have shown that Medicaid beneficiaries utilize the emergency department at nearly twice the rate of those with private insurance.**

Within Oklahoma County, there are areas of high SoonerCare coverage which could benefit most from interventions to bring preventative care and education to residents. The ZIP codes with the highest emergency room visits were 73119, 73129, and 73110.<sup>5</sup>

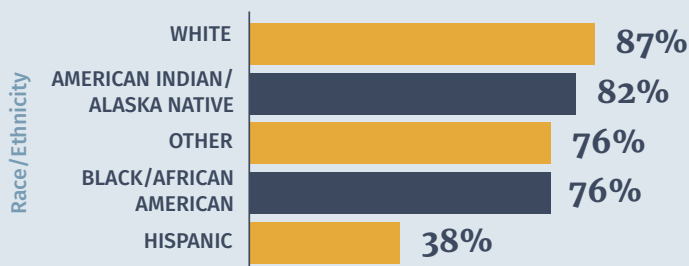
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**Fig 14. Distribution of SoonerCare emergency department in Oklahoma County by ZIP code, 2016-2018.<sup>5</sup>**

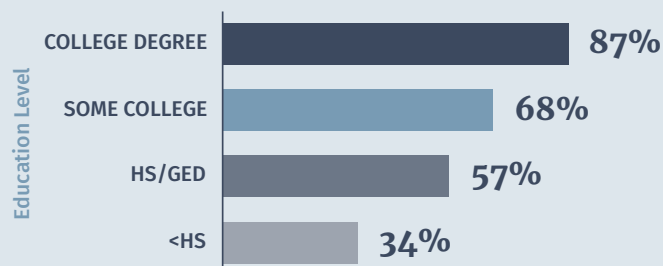


We wanted to further understand the issue of access to healthcare in Oklahoma County through quantitative and qualitative data collection. The CHNA Community Survey respondents were asked if they had any kind of health care coverage and 69% reported that they did. However, when we look at subgroups, there were significant disparities by race/ethnicity and education.

**Fig 15. Respondents with Health Care Coverage Across Race & Ethnicity**

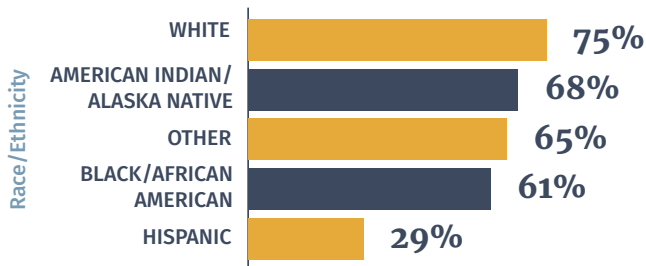


**Fig 16. Respondents with Health Care Coverage by Education Level**

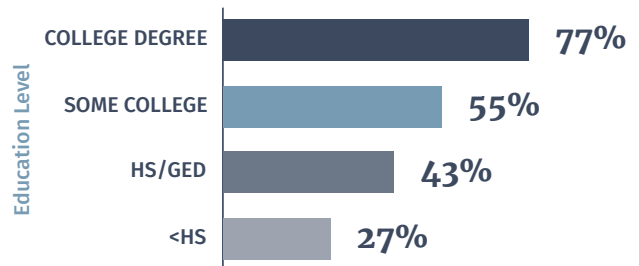


We also asked about dental insurance coverage, and the subgroup responses followed a similar pattern as health insurance.

**Fig 17. Respondents with Dental Coverage Across Race & Ethnicity**



**Fig 18. Respondents with Dental Coverage Across Education Level**



Respondents reported that the most difficult type of health services to get for their household were dental health services (74%). A common thread running throughout the topic of access to healthcare is that Oklahoma County residents who identify as Hispanic report lower insurance coverage, lower ability to get the health services they need, and lower likelihood of visiting a healthcare provider when they are sick. These factors contribute to increased utilization of emergency departments and increased health care costs.

In our Community Chats, **a common theme that emerged across all groups was that trusted relationships are key and are tied to access to resources.** The main consensus from these Community Chats was a widespread perception in vulnerable parts of Oklahoma County that not enough people have access to healthcare. As a result, marginalized members of the community do not seek needed treatment for minor or even major healthcare concerns. This limited preventative healthcare utilization likely increases emergency room visits for non-emergent cases.

*I do have a physician (affiliated with one of the large systems in Oklahoma City), but I don't trust the guy at all. ... I've gone there a few times, and he just blows me off. Doesn't really listen to what I'm saying. ... I don't really feel welcome. ... All I felt was, like, 'Oh, here's the bill. Make sure you pay that on time, too.'*

- Community Chat Participant

## Healthcare Access and Public Resources/ Community Institutions

In our Community Chats, there were 38 instances where healthcare access and public resources/community institutions were mentioned together. Healthcare access is a major challenge in racial minority communities in Oklahoma County. Specific barriers include perceived financial barriers, transportation and scheduling challenges, and cultural barriers. **These cultural barriers are due to a lack of trust in physicians and healthcare institutions, and a lack of racial diversity and cultural competence in the medical community.** Many Community Chat participants described how fellow community members do not see physicians regularly. There was discussion about how their families prefer to receive healthcare from a friend or acquaintance. This was due to lack of accessibility, such as transportation or culture-related barriers. Some individuals discussed how they would not see certain physicians due their reputation in the community and lack of trust.

*“ Speaking to the issue of culture, I don’t have a doctor here in the United States. If I need something, I will go to my hometown: Juarez (Mexico). ... I hate to say this, but I don’t really trust any doctors here. ... The system is more about money than what is going on in my body. ”*

- Community Chat Participant

# Healthcare and Time

During the Community Chats, health care and time were mentioned together in 23 instances, indicating that access to healthcare is related to time. **Time was described as not only lacking time to dedicate to a healthcare visit, but also the delay in care because of poor coordination among healthcare settings, as well as poor access to information about how to access care.** Participants noted that care is often delayed due to financial barriers and lack of health insurance; people do not receive quality healthcare in a timely manner due to these financial barriers. Lastly, participants reported they do not have sufficient time to take off work for healthcare appointments. Some of the participants discussed how telehealth could help improve time-related access issues and how this could allow vulnerable patients to see a provider during their lunch break instead of having to take the entire day off.

Relationships were also tied to trust in health care which affects utilization. Trust, in turn, is tied to many factors including culture, family, and education.

*“ So we’re gonna have to find creative ways to wrap around these communities and embed in the communities...we can’t just depend on the teacher.... we can’t just depend on the church... We have to all come together and find out collaboratively, how can we embed resources within these communities. ”*

- Community Chat Participant

# Healthcare Access and Financial Barriers

Financial barriers to health care were also a common theme tied to healthcare access. Within the Community Chats, there were 47 instances where financial barriers and health care access were highlighted together by participants; the relationship between health care and affordability was therefore a major topic across the four Community Chats. Many individuals discussed how expensive hospital bills can be. Participants described how there is no way to know how much the bill will be until after they receive care; at that point the provider tells the patient to go to the financial department for help, but the bill still has to be paid in full. **Many participants explained that these concerns about affordability lead to delayed or foregone health care.** Many community members live paycheck to paycheck and physician visit copays are too expensive. Participants described how this then leads to increases in emergency department visits. Participants recognized that there are resources in the county that help individuals pay their bills, but they stated there is a need for support to cover hospital bills. Many discussed how healthcare organizations, insurance companies, and other providers should collaborate in order to meet this need.

“ *Well, from my perspective, it’s all really expensive. And if you ask them upfront, what does this cost or what is that cost? You don’t get the answer. And then when it’s over, you get this enormous bill. And then they say, you can go to the financial [office] and get some assistance. But it’s so difficult. Just awful.* ”

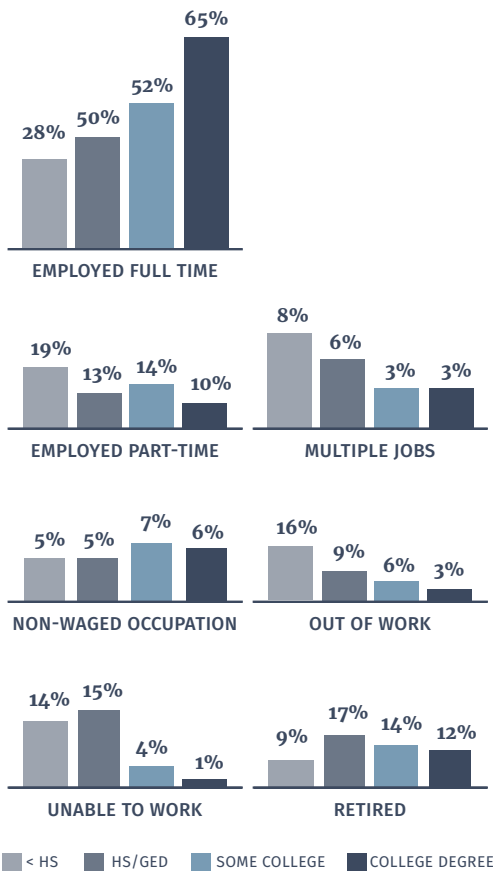
- Community Chat Participant

# Access to Meaningful Employment

One component of a thriving community is the availability of quality employment opportunities. In the CHNA Community Survey, we asked about employment status and things that make it difficult to work, if any.

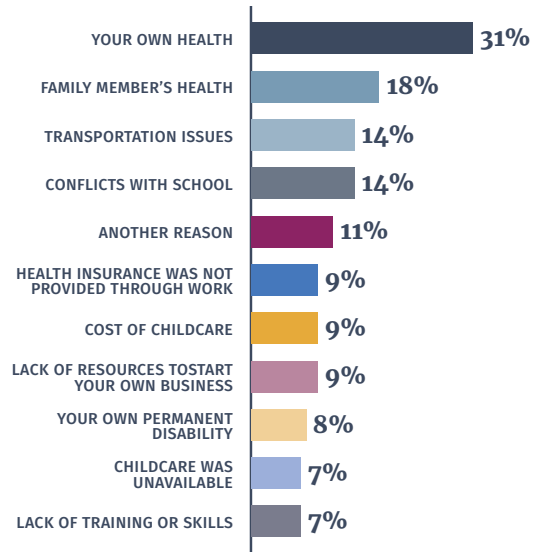
The majority of respondents were employed full-time (53%), but this varied dramatically by education level. Sixty-five percent of Oklahoma County residents with a college degree were employed full-time compared to only 28% with less than a high school degree.

**Fig 21. Employment Status by Education Level and Employment Type**



Community survey respondents were asked what things made it hard to work, if any, in the past year. The two most frequently reported reasons were their own health (31%) and a family member's health (18%). This is an important finding because it shows that poor health directly and significantly impacts access to employment in Oklahoma County.

**Fig 22. Self-Reported Most Common Barriers to Work During 2020**



In our Community Chats, we discussed participant experiences with employment and what a “quality job” meant to them. Work-related resources and work/life balance were important factors to job satisfaction.

Community Chat members often discussed having jobs, but frequently noted the need to have jobs that were meaningful and fulfilling. They also discussed how they wanted a job they love, but also one which provides a work-life balance. Participants discussed how there are many job opportunities in the Oklahoma City area right now, but many don't meet the standard of a quality job.

# Quality Employment

The qualitative analysis team found frequent alignment between a person’s employment status and job-specific, work-related resources as well as the ability to achieve a healthy work-life balance. The quality of a person’s employment was mentioned frequently and was a main factor when describing enjoyment of a job. Jobs could be maintained as long as they were allowed sufficient work-life balance and individuals had dependable work-related resources. If someone is being asked to work 80+ hours a week for minimum wage just to pay rent, they would not have enough time to raise a family. If they didn’t have sufficient resources at work to do the job they needed to do, that added stressors to their work – limiting their desire to be at work.

“ *Another thing is stability and then a job that I’m going to continue to be able to enjoy and not be like oh my god, I don’t want to work.* ”

– Community Chat Participant





Mentorship was also frequently mentioned in the context of employment and many agreed vulnerable members of the community may not have someone to look up to. The teams suggested having the support of a mentor could increase employee retention. As a result, a mentorship program was suggested to connect a mentor with a mentee.

If jobs provide very clear career ladders that include educational opportunities, the employee can gain a tremendous amount while being employed on top of a salary and peace of mind.

“ *... it doesn't take extra time away from their families. But it actually pays them to say yes, 'this is part of your, your commitment to the hospital system.' And believe it or not, we've had people go from being janitors to nurse practitioners in our system. They've gone from being housekeepers to nurses.* ”

– Community Chat Participant



# Employment and Income

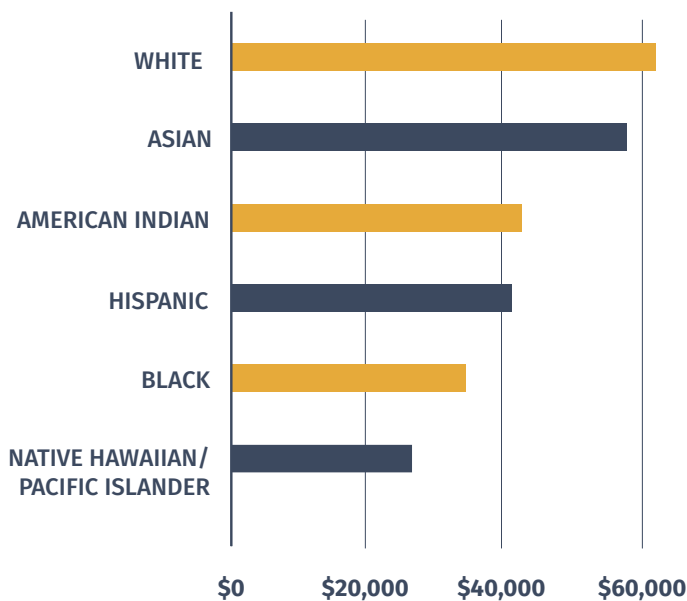
The theme of income was frequently brought up with work-related resources, employment status, and financial barriers. Income naturally is a major determinant of whether a person seeks employment. Community Chat participants felt it was important to receive an income that reflected their investment in their workplace. They also discussed having financial barriers due to their income. Some are living paycheck to paycheck, and in some cases that is a situation they can never escape. This makes it difficult to have a good quality work-life balance.

Residents of Oklahoma County are slightly younger on average than the state (median age 34.5 vs. 36.4). The median household income in Oklahoma County is higher than the state (\$52,855 vs. \$51,424) but varies widely by race/ethnicity.

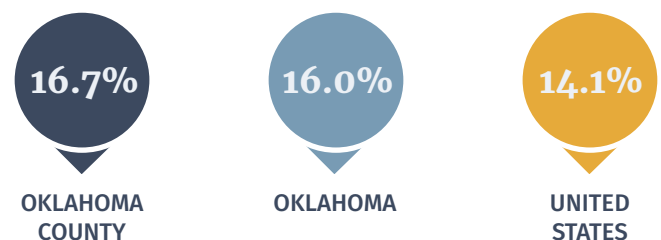
Income is one of several factors that contribute to poverty. Communities with higher poverty rates are more likely to experience poorer health

outcomes including increased risk of disease and premature death (WS 2021). About 17% of Oklahoma County residents lived below the poverty level in 2018 which is higher than the state and national proportions (16% and 14%, respectively) (WS 2021). As with other social determinants of health, poverty varies by demographic subgroups like race/ethnicity and ZIP code.

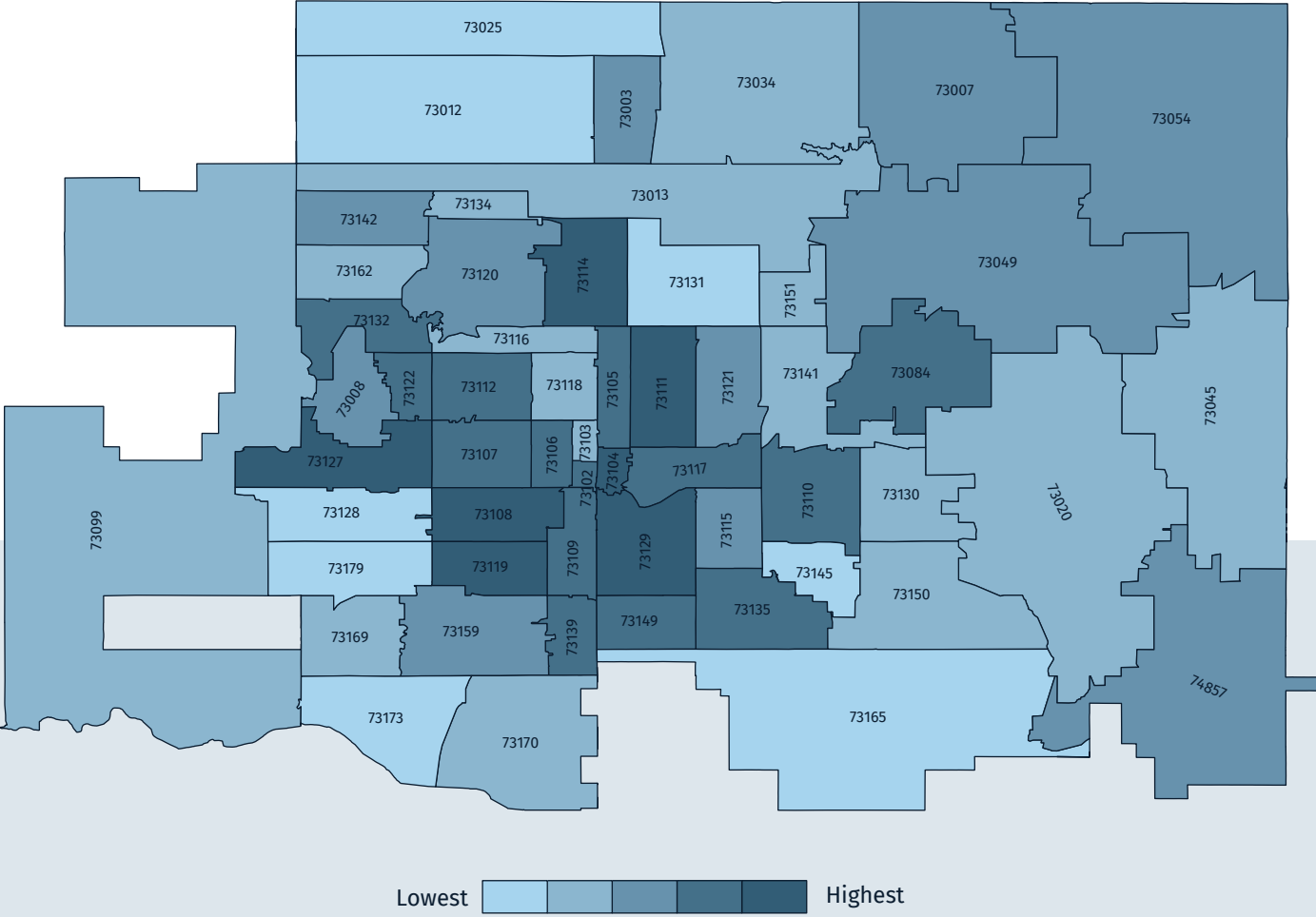
**Fig 19. Median Household Income by Race/Ethnicity**



**Figure X. Percent of Oklahoma County population below poverty line compared to state and national data, 2018<sup>5</sup>**



**Fig 20. Distribution of Oklahoma County residents living below poverty level by ZIP code, 2018<sup>5</sup>**



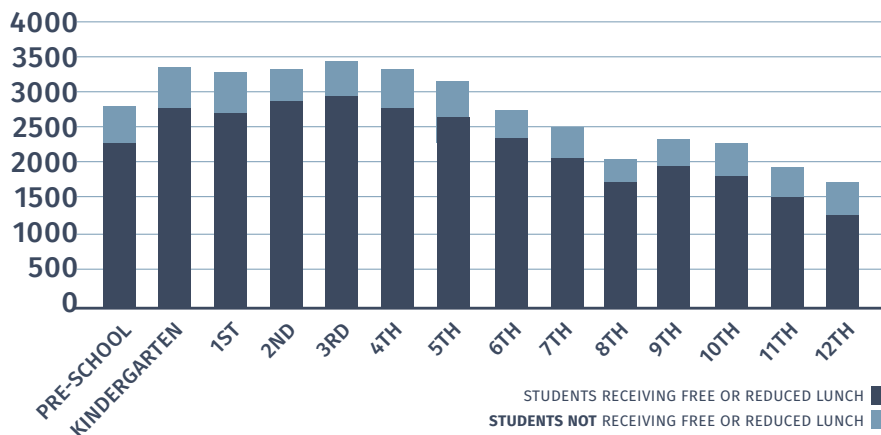
# Access to Healthy Food

A healthy diet can protect against many chronic noncommunicable diseases, such as heart disease, diabetes, and cancer. These conditions are among the deadliest in Oklahoma County and disproportionately affect residents in certain ZIP codes and by race/ethnicity.

Supplemental Nutrition Assistance Program (SNAP) is a federal program that provides monthly food and nutrition benefits to low-income households to supplement their food budget. About 13% of Oklahoma residents received SNAP benefits in 2018, the same proportion as the state as a whole.<sup>5</sup>

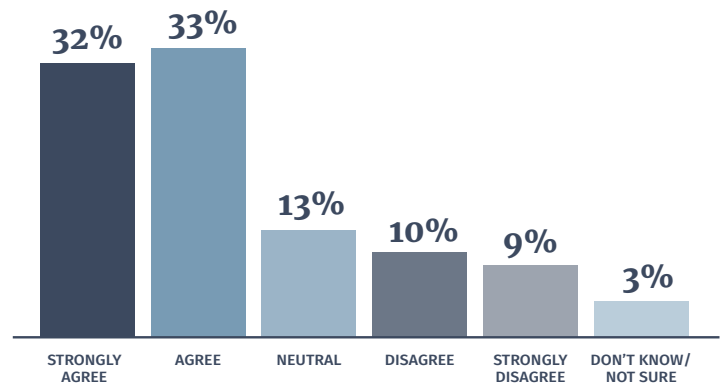
Information about free or reduced lunches can be used in conjunction with socioeconomic data to identify areas of the community to target for social and health services. Local public health and community partnerships can identify resources to impact social inequalities, and assure policies and programs are in place to address childhood nutrition in high-poverty areas. Free or reduced lunch is not used as a direct measure of poverty because some students who qualify for Free and Reduced Lunches are above the poverty threshold.<sup>5,37</sup>

**Fig 23. OKCPS Students Receiving Free and Reduced Lunches by Grade Level, School Year 2018-2019<sup>5</sup>**

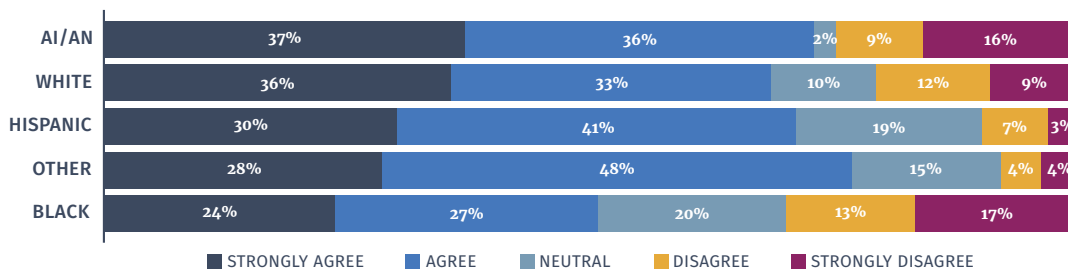


We asked community members about their ability to get healthy food for their family. The majority of survey respondents (54%) said they could always get healthy food for their family, but this varied by race/ethnicity and education level. The CHNA survey asked participants how easy it was to find fresh fruits and vegetables in their neighborhood. Overall, 65% of the sample agreed or strongly agreed that it was easy to find fresh produce in their neighborhood.

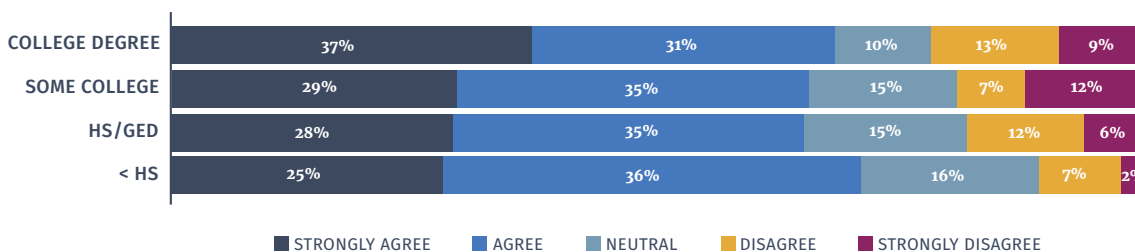
**Fig 24. It is easy to purchase fresh fruits and vegetables in my neighborhood**



**Fig 25. It is easy to purchase fresh fruits and vegetables in my neighborhood (stratified by race/ethnicity).**



**Fig 26. It is easy to purchase fresh fruits and vegetables in my neighborhood (stratified by education level). Some categories do not add up to 100% due to non-response.**

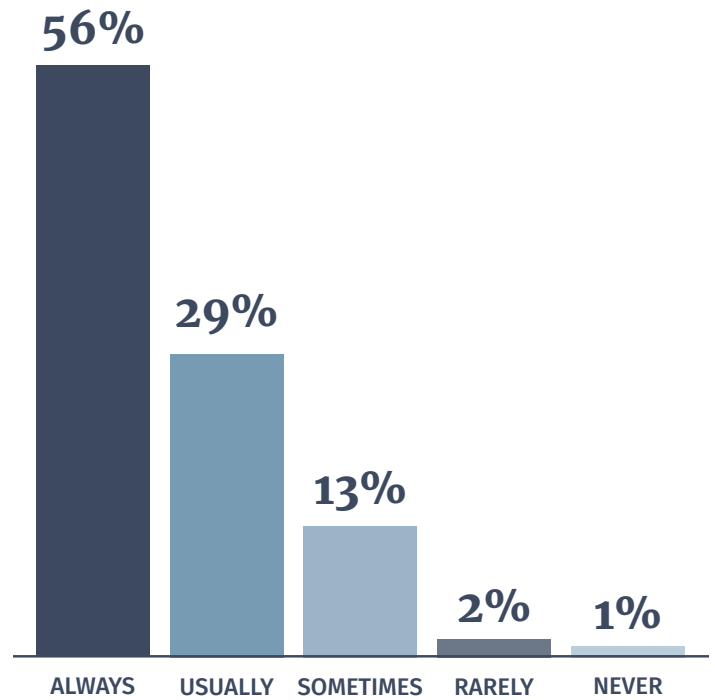


While more respondents with four-year degrees strongly agreed with their ability to find fresh produce in their neighborhood compared to that of other education groups, those with four-year degrees also had the highest proportion of respondents who disagreed and strongly disagreed with this statement. Across the four education groups, participants without a college degree were more similar to each other than to those with four-year degrees.

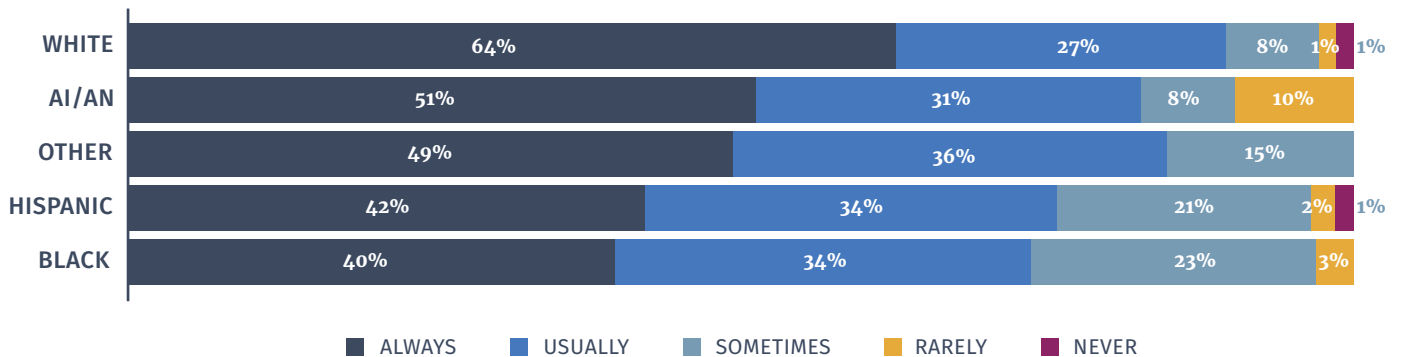
The CHNA Community Survey broadened this topic by asking a similar question, “I can get healthy food for my family.” This question was unbounded by neighborhood, and the scale was in terms of how often the respondent could access healthy food, rather than their level of agreement with the question. **About 85% of the sample felt they were always or usually able to access healthy food for their family.**

Across racial and ethnic groups, Black and Hispanic respondents felt they could always or usually access healthy food only 74% and 76% of the time, compared to 91% of whites who felt the same. Among groups, 23% and 21% felt they could only sometimes access healthy food. American Indians and Alaska Natives were most likely to report scarce access to healthy food, with 18% reporting they were sometimes or rarely able to get healthy food.

**Fig. 27 I can get healthy food for my family...**



**Fig. 28 I can get healthy food for my family...(stratified by race)**



**One quarter of those with a high school diploma or GED, and one third of those without a high school diploma or GED, felt that they were only sometimes or rarely able to access healthy food.** The proportion of people always or usually able to access healthy food increased with education level. Those with four-year degrees felt that they were always or usually able to access healthy foods 92% of the time.

We asked which factors made accessing healthy food difficult. The most frequent answer (64%) was the cost of healthy food in the community. Nearly one in four felt that they did not have the time to buy or prepare healthy meals. Food access infrastructure in the community was also a barrier; transportation prevented 13% of the sample from claiming adequate access to healthy food, and scheduling prevented 6% of the sample.

**Fig. 31 Self-reported barriers access to healthy food**



**The top reason that community members felt they couldn't get healthy food for their family was cost.**

Community members were asked about healthy food access in four Community Chat groups. Initially food access was defined using a singular definition that included grocery stores, community gardens and presence of healthy food. As the analysis process continued, it became clear that the definition needed more nuance. Choice of foods was just as critical for food access as was the presence of quality foods. Additionally, the affordability of the foods became a commonly highlighted concern restricting food access.



*When you say fresh fruits and vegetables. Nothing in these stores is fresh. They are just put out.*

-Community Chat Participant



*You know, when it comes down to people and their income, and you look at...what they have to pay for...: their rent and other utilities and stuff in and out of it, you have inflation... They're not making enough to be able to afford what they need...in rent, but, you know, sacrifice ... having the healthy food that they need, as well.*

- Community Chat Participant



During the community chats, there were 22 mentions of food access being related to public resources and community institutions. These themes were connected as people were sometimes able to access healthy foods but lacked the nutritional education to know what to eat or how to cook healthy foods. When there were nutrition classes available, often those were not marketed sufficiently, and many community members were unaware of the opportunity. Additionally, it was noted that many individuals lacked the income to purchase healthy foods because oftentimes healthy, fresh foods can be more expensive. Along these lines the time necessary to cook a healthy meal may seem to be longer than to pick up fast food or cook an unhealthy meal. **Additional public resources may be helpful in connecting community members to existing inexpensive healthy foods.** Public programs including free and reduced lunch programs, WIC, SNAP and entities like the Regional Food Bank of Oklahoma are all supporting food insecure Oklahomans and are critical infrastructure.

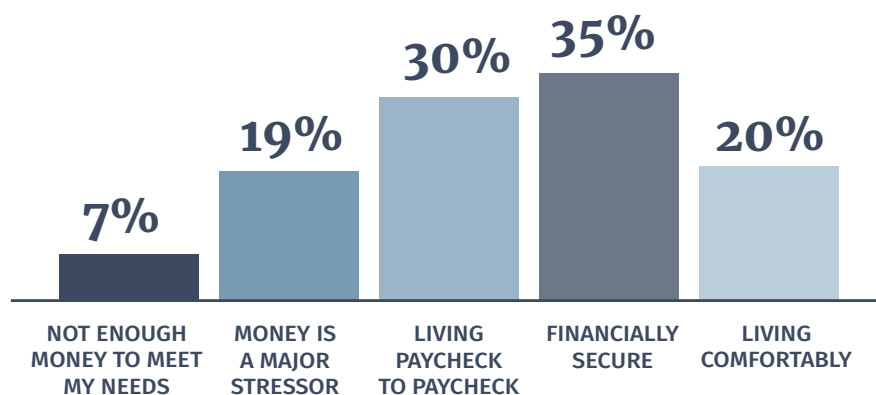
# Access to Education

Education and health have always been linked, but never as greatly as they are now. Americans with less education are—now, more than ever—dying earlier than their peers. The relationship between education and health is complex and tied closely to income, skills, and opportunities that people have to lead healthy lives in their communities. Education can create opportunities for better health; conversely, poor health can put education at risk.

For the purpose of this report, we considered education to be both formal education and informal information gained through relationships (e.g. how to navigate the healthcare system).

The CHNA Community Survey asked respondents about their current financial situation. **While 35% of the sample felt financially secure in meeting their family’s needs, an almost equal 30% reported that they live paycheck to paycheck. Money was a major stressor for nearly one in five respondents, and 7% reported they were not making enough to meet their needs.**

**Fig. 32 Self-reported financial situations**





In the Community Survey, we asked respondents what would help them go back to school. Thirty six percent of respondents, interested in obtaining more education said more financial aid would be helpful, while 33% of respondents said weekend and evening courses would be helpful.

We asked Community Chat participants about access to education, to determine facilitators and barriers. Financial challenges were noted several times as barriers to higher education, including universities and training programs. Participants also frequently mentioned that there were very few or no resources at high schools to help students go to and pay for college. The Community Chat participants agreed that, especially in the more rural parts of Oklahoma, higher education is not sought after, and it was very much linked to being a generational decision. Not many respondents whose parents did not go to college went to college themselves because of financial barriers and thinking it was not an option.

**Community Chat participants felt that everyone should have the opportunity to go to college and have access to the necessary resources.**

There were 31 co-occurrences when discussing education, classroom-based resources and information/knowledge. In the education Community Chats, participants frequently mentioned a need for more access to jobs, dietary needs, and more at the schools. Many participants said they would have attended college if their school had provided information about financial assistance options.

**Many participants said there is a need for proper resources at the schools that can discuss childcare, finances, healthcare resources, and more educational support.**

They said that if these resources are given to students, it could help them become more successful in the future and open more doors for them than they would have known. These school education programs could help support families in the community by offering parents more connection with their children and allow the child to focus on school and the parent to receive resources they were unaware of. Education needs to be more meaningful than just graduating.



# Potentially Available Resources

On August 11, 2021 we reconvened the original stakeholder group. We reviewed progress on the CHNA, presented data, and asked for feedback including community assets.

## Community Assets discussed at 2<sup>nd</sup> Stakeholder meeting:

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### Access to Education

- Langston University is using some of their COVID relief dollars toward loan forgiveness.
- Metro Tech and career techs are continuing to expand and are experiencing higher enrollment. Career Techs are a valuable resource for people who are seeking to change careers or obtain more education to further their careers.
- Education in secondary schools before college is a time to introduce how one navigates insurance and health care in addition to traditional nutrition, education, etc.

### Access to Health Care

- Collaborations among healthcare organizations and community non-profits are a tremendous asset in Oklahoma County – including the COHIT’s collaboration, and the collaborations that have formed in response to the COVID-19 pandemic.
- The group discussed interventions related to COHIT’s desire to take a health equity approach to the CHNA and implementation plans

### Access to Employment and Quality Jobs

- Career techs were mentioned as an asset to the community to reach those who need to enhance their job skills and employment opportunities.
- The group acknowledged that people receive information differently, whether via radio, text, social media, or other avenues.
- The group also discussed reaching out to adolescents to explore careers.

### Access to Food and Healthy Food

- The Regional Food Bank is trying to work to end hunger by addressing the root causes, through partnerships, which relates back to the COHIT focus on the social determinants of health, including access to education, transportation, employment, etc.
- Recommendations for interventions included collaborations among organizations to avoid overlap or duplication, and to identify and address gaps and resources, and eliminating territorial thinking.

# Evaluation of Impact

## Joint Impact – INTEGRIS Health, Mercy Hospital, OU Health, and SSM Health St. Anthony

- The four nonprofit hospitals partnered, along with Blue Cross/Blue Shield of Oklahoma, and the Oklahoma City Community Foundation (OCCF) to form the Central Oklahoma Health Impact Team (COHIT). The team is collaborating on this joint Community Health Needs Assessment (CHNA) and community projects that improve the health and well-being of Oklahomans. Each of the health systems contributed to the funding needed to support the agreement with the Research, Design, and Analysis Center (RDAC) to ensure appropriate methodology for the CHNA process including data collection, analysis and reporting.
- After the previous CHNA, COHIT members reviewed their Community Health Improvement Plans (CHIPs) and jointly selected the Food for Health or Food Pharmacy program as a common strategy. Each health system established a protocol for assessing food insecurity among their patients in one or more specialty areas and provided a food box from the Regional Food Bank of Oklahoma to those in need.
- COHIT members also jointly provided and served meals at the Salvation Army “Red Shield Diner” each Thursday in the month of September 2019. This was the first COHIT effort and helped build relationships among health system employees and volunteers. All four health systems and OCCF staff were present for each Thursday meal.
- During the COVID-19 pandemic, COHIT members came together to collaborate on a variety of vaccine clinics and helped to establish an Alternative Care Shelter (ACS) for individuals experiencing homelessness who had tested positive for COVID-19 and needed a safe place to recover after discharge from the hospital, or for those in the community in need of quarantine. The Oklahoma City Community Foundation provided \$150,000 toward this effort contingent upon COHIT member hospitals creating the solution with community partners and reaching consensus on its operation. This collaboration involved the Homeless Alliance, serving as the operations manager for the ACS, as well as City Care, City Rescue Mission, Grace Rescue Mission, the City of Oklahoma City, Oklahoma County Government officials, Healing Hands clinic, and others.
- In addition to the ACS, COHIT also brought community stakeholders together to better understand the impact of the pandemic on Food Insecurity and Access to Health Care. These relationships and findings provided a strong foundation for the 2021 CHNA. As one outcome of the stakeholder meeting, COHIT hosted a meeting of the Care Coordination, IT departments, and Community Benefit staff of each hospital to discuss care coordination platforms and assess the status of each hospital’s interest and process in obtaining such a platform.

# INTEGRIS Health

INTEGRIS Baptist Medical Center, INTEGRIS Health Edmond and INTEGRIS Southwest Medical Center developed a CHIP (Community Health Improvement Plan) designed to meet the needs of the community based on the results of a CHNA (Community Health Needs Assessment). This health improvement plan focuses on Obesity, Mental Health, Access to Care/Food Insecurity and Tobacco. These issues were chosen based on state and local data, surveys, identifiable gaps, available resources, and small community chats. The CHIP was developed using the results of the

community’s health priorities. Implementation steps are based upon the key strategies of prevention, education, and collaboration. Though the plan focuses on creating positive health-related change at both the micro- and macro-levels within the community environment, special effort is made to reach the underserved, marginalized and minority populations. Major partnerships include the Lions Club, Lynn Institute for Healthcare Research, Oklahoma City Community Foundation, Oklahoma City-County Health Department, and Regional Food Bank of Oklahoma.



## INTEGRIS Health Oklahoma County

FY 2020 - FY 2021	FY 2020	FY 2021
Total CHIP Events	364	442
Total CHIP Facility Participants	17,668	49,966
Total Screened	1,582	104,630

## Obesity

- DEEP: Diabetes Empowerment Education Program is a six-week program that provides the community tools to better manage their diabetes. INTEGRIS Community Benefit partnered with Good Shepherd Clinic and OKC-County Health Department to provide three classes during fiscal year 2021.
- Nutrition classes in English and Spanish are offered monthly to educate on the importance of cooking at home, reading food labels, managing food while living with chronic conditions and offering food demonstrations.

## Access to Care

- INTEGRIS Community Clinic (ICC) is a free medical clinic in the inner city of Oklahoma City. The clinic offers care of chronic diseases, diabetes classes, some vision services and a pharmacy. In fiscal year 2021, ICC provided 3,573 telehealth/ in person visits and had 455 active patients.
- INTEGRIS and Lions Club Mobile Care Clinic is designed to address transportation issues and reach uninsured/underinsured community members in the most vulnerable zip codes of Oklahoma County. In fiscal year 2021, the mobile care clinic provided 880 screenings, 3,648 COVID-19 vaccines, and nutrition education to 677 community members.

## Tobacco

- INTEGRIS Health tracks referrals made to the Oklahoma Tobacco Helpline. Reports are made available quarterly. INTEGRIS Health provided 2,617 referrals in FY 2020 and 2,002 referrals in FY 2021.

## Food Insecurity

- Food for Health is a partnership between INTEGRIS Health and the Regional Food Bank of Oklahoma. The program offers INTEGRIS Community Clinic patients fresh produce every month during clinic hours.
- INTEGRIS and Lions Club Mobile Care Clinic has partnered with the Regional Food Bank of Oklahoma to provide the mobile clinic patients that need healthy food a shelf stable pantry box to take home. Approximately 436 Healthy Living Pantry Boxes have been distributed to needy families during FY 2020 and FY 2021.

## Mental Health

- Various support groups provide the community with the support they need to cope with grief, cancer and loved ones suffering from Alzheimer's. Cancer support groups are also offered in Spanish.

## Community Grants

- INTEGRIS Health implemented a community giving program in 2020, offering grants to other not-for-profit organizations whose evidence-based programs align with our Community Health Improvement Plan goals, to maximize community impact through partnerships.

# Mercy

## Access to Care

Community Health Workers (CHWs) serve as liaisons/links between health care and community and social services, screening for health-related social needs, facilitating access to services and improving the quality and cultural competence of care. CHWs work one-on-one with at-risk patients and community members, acting as patient advocates, assisting patients in applying for insurance, Medicaid, and financial assistance and connecting patients with community resources.

## Food Access/ Insecurity

To address food insecurity, the Community Health and Outreach program implements an initiative called Food for Health, which provides patients that have been screened positive for food insecurity a food box (four meals but provided more than 1 for larger families) upon discharge or checkout. Patients are also provided with recipes for food items within the food box and resources to access additional community food pantries.

## Mental/ Behavioral Health:

Call SAM is a program that assists students, staff, and families in mental/behavioral health education, referral to services, and crisis support for the Edmond, Bethany, Deer Creek school districts and Catholic Schools in the Archdiocese of Oklahoma City. Student Assistance by Mercy (SAM) is a 24-hour help line operated by Mercy Counselors who provide confidential education, support, and referrals for individuals in need of help to address mental/ behavioral health issues, such as drug and substance use, anxiety and depression, or being bullied, day or night.

## Obesity Prevention

To combat obesity in Oklahoma City, Community Health recently implemented the Diabetes Prevention Program (DPP), which is a CDC evidence-based lifestyle change program, led by a trained lifestyle coach, to reduce the risk of developing type 2 diabetes in adults with prediabetes or who are at risk for diabetes. The program began in the Summer of 2020 and is looking forward to expanding to community residents in South OKC.

## Tobacco Prevention

The Community Health and Outreach program collaborates with the Wellness Now Tobacco Use Prevention Workgroup, which is dedicated to improving health outcomes by ensuring clean indoor/outdoor air, strengthening policies for limiting youth access to all tobacco products, and providing cessation support services.

Each priority area listed above is not mutually exclusive. Our co-workers help connect patients to partners within and external to Mercy, to ensure needs are met. With support from the Mercy Foundation, we can enhance our services by increasing our reach within the community, connecting with poor and marginalized communities, and linking them to the right care, at the right time and in the right setting.

## IMPACT: FY2019-FY2021

- Partnered with Mercy Emergency Department for implementation of the Community Health Worker Program, an innovative program to support reduction of preventable ED visits, by hiring Community Health workers to serve as liaisons between patients and health & social services- ensuring patients are connected to the right care, at the right time and in the right setting. As a result, over 700 patients were served and over 1200 encounters conducted, to link patients with the appropriate support needed to self-manage their health conditions and reduce costs for both patients and the ED.
- Partnered with three non-profit hospital systems, BlueCross Blue Shield of Oklahoma, and the Oklahoma City Community Foundation, to form the Central Oklahoma Health Impact Team. This team is collaborating on a joint Community Health Needs Assessment and community projects that improve the health and well-being of Oklahomans. One example is our collaboration with the Homeless Alliance, City Care and City Rescue Mission to create a plan for Alternative Care Shelters. Alternative Care Shelters were used to provide a safe space for individuals who are homeless, to recover from COVID-19.
- Partnered with St. Luke's Methodist Church Meals on Wheels program, to provide "Friday Mercy Meals" to Seniors experiencing food insecurity in the community. Over the past three years we've been able to provide 7,296 meals to senior adults. In this same vein of helping combat food insecurity, the Community Health and Outreach team launched a "Food for Health" Pilot in partnership with the Regional Food Bank, in FY2019. As a result of the pilot 235 patients were served 940 meals. We know COVID-19 exacerbated some of the social needs of patients, including food insecurity, and for that reason during FY21 we were able to partner with the Regional Food Bank to provide COVID-19 emergency food boxes for patients as well as co-workers. During FY21, we've been able to serve more than 100 individuals and families. We are looking to expand food insecurity services for FY22.
- Partnered with Mercy OKC clinic's Behavioral Health team to provide the Call "SAM" (Students Assisted by Mercy) program. Call SAM provides a 24-hour helpline for urgent mental health situations, providing resources and referrals for agency and community mental health and medical health needs. In fiscal year 2020, the CALL SAM program served 437 students/families and school staff. Call SAM also provided mental health support during the time out of school (due to COVID-19) to over 100 students and families.

## OU Health

OU Health serves Oklahoma and the region with the state's only freestanding children's hospital, the only National Cancer Institute-Designated OU Health Stephenson Cancer Center and Oklahoma's flagship hospital, which houses the state's only Level 1 trauma center. With historic ties to the University of Oklahoma's educational mission, OU Health has a heritage of community engagement.

Oklahoma's growth is steady, but slower than the national average. With nearly a third of its population in rural settings, Oklahoma remains less urban than most states in the nation. While rural and suburban areas tend to be less racially diverse than the national average, Oklahoma County is an exception. Neighborhoods of color surrounding Oklahoma Health Sciences Center campus still experience residual effects of historic displacement and systemic redlining. This history innately impacts housing stability – significant because shelter is among the most basic of human needs.

Over the past decade Oklahoma has maintained a consistently lower unemployment rate than the national average, yet underemployment and availability of quality, safe jobs are common and significant concerns. With a notably lower median income than the national average, many Oklahoma households struggle to feed all family members and more Oklahoma children grow up in poverty than what would be expected given the national average.

It is unclear how the COVID-19 pandemic may alter social and economic landscapes. Oklahoma workers tend to be at higher risk of occupation-related fatalities than in other states. In the social environment, Oklahoma ranks well with the religiosity of the population when compared to other states. Its rural character, with abundant green spaces and natural habitats, supplies natural resources that innately promote health. However, built environments and urban sprawl of the inhabited landscape must be successfully addressed. In addition, amenities that promote healthy behaviors such as adequate physical activity and healthy eating, are limited.

### Patient Access

Established in 2017, the **Unity Clinic** is a student-led initiative offering inter-professional clinical experiences to students. Partner support includes a range of professional, educational, community- and faith-based entities. These partnerships were optimized to include vaccination clinics hosted throughout communities, particularly in areas known to have limited resources.

The pandemic created urgency that brought **virtual visits** to the forefront of healthcare. While COVID-19 disrupted continuum of care for many patients, virtual visits are more widely available to more patients, including vulnerable and underserved populations.



## 2020

- 78,119 ambulatory virtual visits

## 2021

- 51,364 ambulatory virtual visits
- 27 pediatric virtual visits
- 13 tele stroke visits

OU Health's Community Partnerships team is aggressive in presenting a broad scope of **educational events** that engage health system leaders with communities across the state. Informal "Doc Talks" leverage virtual tools and in-person, family-friendly venues. Providers speak on relevant topics with community focus and answer questions posed by participants on matters ranging from preventive medicine, women's health, nutrition, vaccination recommendations and more. Since 2020, OU Health has presented 42 such events with a total attendance of 2,400.

### **Medicaid Expansion Outreach through Oklahoma City Public Schools**

With the recent expansion of Medicaid services, OU Health leveraged its partnership with Oklahoma City Public Schools to promote enrollment in state and federally funded healthcare services. Facebook Live events and on-site "parent universities" were hosted to educate and assist patrons with enrollment. Funding through Federal Medical Assistance Percentage was awarded for OU Health's work with the district to implement additional programs and efforts to reach more eligible families who need the newly available resources.

### **Mitigation of Food Insecurity**

Oklahoma Children's Hospital has participated in federally subsidized summer feeding programs for school-age children. "Kids Eat Free" is an ongoing initiative to provide a healthy meal to children up to age 18, who may miss meals when schools are not in session.

Additionally, Oklahoma Children's Hospital launched a Food for Health program in 2019, which continues to serve hundreds of families each year.

### **Pandemic Effects on the Homeless**

Collaborative initiatives were successful in limiting hospitalizations of homeless individuals. Outcomes included reduced extreme operational costs of COVID-specific care as well as offering additional resources to the homeless community

### **Physician Outreach**

The OU Health Frontline Pandemic Response Training Webinar was developed to support community providers, especially those in non-urban locations, in a time when pandemic precautions and practices were evolving hourly. The weekly, 90-minute presentation features a rotating panel of experts from OU Health discussing protocols to manage COVID-19 and care specific to COVID-19 patients. The panel includes experts in an array of specialties, with both adult and pediatric expertise represented. These specialists were routinely joined by representatives from Oklahoma's Regional Medical Response System, in a coordinated effort to assess needs for most appropriate placement and care.

The event has reached nearly 300 healthcare professionals every role from administration to highly specialized direct patient care.

# SSM Health St. Anthony

In its 2019-2021 Community Health Improvement Plan (CHIP), SSM Health St. Anthony Hospital - Oklahoma City committed to addressing three social determinants of health identified in the 2018 CHNA: Food Insecurity, Access to Behavioral Health Services, and Tobacco Cessation.

## Food Insecurity

SSM Health St. Anthony established a Backpacks for Kids program, partnering with Regional Food Bank of Oklahoma to provide nutritional support on the weekends for food insecure families at Rockwood Elementary School. SSM Health St. Anthony invests \$15,000 in this program annually. Our partnership with Rockwood Elementary also developed beyond the Backpacks program to include donations of P.E. equipment, water bottles, and other resources to support the health of the students and the school's response during the COVID-19 pandemic.

In the 2018 CHNA, INTEGRIS Health and Mercy joined us in a commitment to launch food pharmacy programs in our health systems. SSM Health St. Anthony launched its food pharmacy in 2021 in conjunction with Regional Food Bank of Oklahoma at the St. Anthony Family Medicine Center, a primary care clinic located on our Midtown campus that serves a high number of vulnerable families. This program provides food to over 125 food insecure patients per month. Resources provided to these food insecure patients include a food box with non-perishable items for up to 4 meals for a family of 4, fresh produce, healthy cooking tips, and information about SNAP enrollment and food pantries in the patient's neighborhood.

SSM Health St. Anthony's partnership with Regional Food Bank of Oklahoma also included 6 volunteer nights at their distribution center, each of which included over 30 SSM Health volunteers. Unfortunately, these volunteer nights had to be discontinued after March 2020 due to the pandemic.

In keeping with SSM Health's commitment to Care for God's Creation, SSM Health St. Anthony partnered with the 8th Street Community Foundation to establish an urban farm on our Midtown campus. A portion of the produce harvested from the farm goes to feeding persons struggling with food insecurity, including patients served by the Family Medicine Center Food Pharmacy.



## Mental Health Access

In our 2019-2021 CHIP we committed to increasing the number of mental health screenings done in the primary care setting in SSM Health Medical Group. Starting from a baseline of 730 in 2018, we increased the number of screenings to over 40,000 per year during the 2019-2021 CHIP period.

SSM Health St. Anthony also partnered with Catholic Charities of the Archdiocese of Oklahoma City to increase access to counseling services in the underserved Hispanic population in south Oklahoma City. In 2020 SSM Health issued a \$50,000 grant to support Catholic Charities' St. Joseph Counseling program, with targeted outreach and education in five vulnerable zip codes. This partnership with Catholic Charities has reached over 200 members of the Hispanic community.

## Tobacco

During the 2019-2021 period, SSM Health partnered with the Oklahoma Hospital Association and the Oklahoma City Chamber of Commerce to lead advocacy efforts to remove smokers as a protected class in employment status in Oklahoma. Our ministry also partnered with OHA and the Chamber of Commerce to support "clean air" legislative efforts to make all bars and restaurants in Oklahoma smoke-free.

SSM Health participated in multiple public awareness campaigns to encourage the public to quit using tobacco products. Our ministry served on the steering committee for the annual "OK to Quit Week," a public education campaign that takes place in late January to encourage Oklahomans to remain committed to their New Year's resolutions to quit smoking, vaping, and chewing tobacco. In 2021 the campaign focused on the connection between poor COVID-19 outcomes and smoking and combating teen vaping. SSM Health also continued to participate in the annual Great American Smokeout.

To support our patients' efforts to quit tobacco products, SSM Health created an electronic referral system to the Oklahoma Tobacco Helpline. This mechanism allows providers in the inpatient and outpatient setting to seamlessly connect our patients to resources that will support them in their efforts to quit using tobacco products. Along with other area hospitals, we work with the Oklahoma Hospital Association to track referrals to the Helpline on a monthly basis.

As a complement to the electronic referral system, SSM Health also launched a "Bridge Medication" program in collaboration with the Oklahoma Hospital Association. This program offers SSM Health patients a 2-week supply of nicotine replacement therapy (NRT) medication to help them transition from the time they receive care in our health ministry to when they receive their first NRT shipment from the Oklahoma Tobacco Helpline.



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# Appendices

# Appendix A – COLLABORATIVE PARTNERS

## Stakeholder Meeting Participants

- Alliance for Economic Development of Oklahoma City
- Areawide Aging Agency
- Butterfield Foundation
- Centennial Health
- City Councilwoman, Ward 7
- City of Oklahoma City
- County Commissioner, District 1
- Crossings Community Clinic
- Dentists for the Disabled and Elderly in Need of Treatment (D-Dent)
- El Latino News
- Embark OKC (transportation)
- Goodwill Industries of Central Oklahoma
- Greater Oklahoma City Chamber of Commerce
- Greater OKC Hispanic Chamber of Commerce
- Homeless Alliance
- Health Alliance for the Uninsured
- Hunger Free Oklahoma
- Inasmuch Foundation
- Langston University
- Latino Community Development Agency
- Lynn Institute
- Metafund (CDFI)
- MetroTech
- Millwood Public Schools
- OKC Black Eats
- Oklahoma Center for Nonprofits
- Oklahoma Children’s Hospital at OU Health
- Oklahoma City Black Chamber
- Oklahoma City-County Health Department
- Oklahoma City Indian Clinic
- Oklahoma City Innovation District
- Oklahoma Dental Foundation
- Oklahoma Department of Human Services
- Oklahoma Department of Human Services, Aging Services
- Oklahoma Health Care Authority (Medicaid)
- Oklahoma Hospital Association
- Oklahoma State University
- Oklahoma Tobacco Settlement Endowment Trust (TSET)
- Potts Family Foundation
- Regional Food Bank
- Restore OKC
- St. Luke’s United Methodist Church (Meals on Wheels)
- State Representative, District 99
- Sunbeam Family Services
- United Way of Central Oklahoma

- University of Oklahoma College of Nursing
- VarietyCare (FQHC)

## Community Chat Hosts & Partners

- Crossings Community Clinic
- Good Shepherd Clinic
- Goodwill Industries of Central Oklahoma
- Health Alliance for the Uninsured
- Hilltop Clinic
- Lynn Institute
- Mary Mahoney Memorial Health Center (FQHC)
- Millwood Public Schools
- Skyline Urban Ministry
- Stanley Hupfeld Academy

## Informational Interview Participants

- Choctaw Chamber of Commerce
- Greater OKC Hispanic Chamber of Commerce
- Health Alliance for the Uninsured
- Latino Community Development Agency
- Lynn Institute

# Appendix B - COMMUNITY SURVEY

## Community Survey

### Methods

The purpose of this survey was to fill gaps in existing data for OK County in order to learn more about the health needs in the community and, ultimately, better serve our community.

The survey focused on the four health access topic areas identified earlier in the CHNA process:

- Access to healthcare
- Access to healthy foods
- Access to meaningful employment
- Access to education

Data collection occurred April – July by the Sooner Survey Center in the OU Hudson College of Public Health. The target population for the survey consisted of adults who met the following inclusion criteria: Oklahoma County resident, 18 years of age and older, English or Spanish speaking, and willing and able to complete the survey.



Recruitment for the survey was completed through a combination of convenience and purposive sampling.

**Vaccine clinics: 1148**

**Social media / email recruitment: 216**

**Paper surveys: 262**

**Total attempted surveys: 1626**

Some attempted surveys did not have any or very minimal data and some were excluded due to eligibility criteria.

**Total final sample size: 956**

Estimates in this presentation should be considered preliminary and representative of the sample of respondents only. Estimates will be adjusted for non-coverage and non-response, creating estimates more representative of the Oklahoma County population.

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## Survey Instrument

### Central Oklahoma Community Health Impact Team (COHIT) Community Health Survey



We are looking to better understand ways that we can serve our community. Please take this 10 minute survey. Thank you!

**Why is this survey being done?** The purpose is to learn more about the health needs in the community. **How many people will take part in this survey?** We hope to get opinions from as many community members as possible. **What are the risks, benefits, and options of the survey?** There are no risks or specific benefits to you for participating. You will be given the opportunity to voice your experiences and suggestions. You may choose not to participate. **What about confidentiality?** You will not be asked to provide your name, email, or any other identifiable information in this survey. The information you provide will not be linked to information you have provided for the vaccine. **What are my rights as a participant?** Taking part in this survey is voluntary. You may choose not to take part or may stop answering questions at any time. **Whom do I contact if I have questions?** If you have any questions about the survey, you may contact us at [COHITsurvey@gmail.com](mailto:COHITsurvey@gmail.com) Your participation in the survey signifies your consent.

Please select "agree" below to continue with the survey or "Do not agree" to end the survey.

- Agree  Do not agree

Are you...

- Less than 18,  
 18 to 24,  
 25 to 34,  
 35 to 44,  
 45 to 54,  
 55 to 64, or  
 Over 65 years of age?.

*If you answered that you are less than 18 years old or prefer not to answer, we apologize you are not eligible to complete this survey.*

In general, would you say your health is...?

- |                                    |  |
|------------------------------------|--|
| <input type="checkbox"/> Excellent | <input type="checkbox"/> Fair                  |
| <input type="checkbox"/> Very good | <input type="checkbox"/> Poor                  |
| <input type="checkbox"/> Good      | <input type="checkbox"/> Don't know / not sure |

Which of the following have a negative effect on your health and well-being?  
(Select up to 5 that are most important to you)

- |  |  |
|--|--|
| <input type="checkbox"/> Bad air quality   | <input type="checkbox"/> Hunger  |
| <input type="checkbox"/> Bad/unsafe housing                                      | <input type="checkbox"/> Immigration status/papers                         |
| <input type="checkbox"/> Cannot find medical care/doctor in my area              | <input type="checkbox"/> Jail/prison-my own/partner/family member          |
| <input type="checkbox"/> Car accidents/dangerous roads                           | <input type="checkbox"/> Lead in my home                                   |
| <input type="checkbox"/> Childcare   | <input type="checkbox"/> No high school diploma/GED                        |
| <input type="checkbox"/> Discrimination/racism                                   | <input type="checkbox"/> Not a good reader                                 |
| <input type="checkbox"/> Don't feel safe in my neighborhood                      | <input type="checkbox"/> Not enough healthy/nutritious food                |
| <input type="checkbox"/> Don't feel safe in my relationship                      | <input type="checkbox"/> Not enough job opportunities                      |
| <input type="checkbox"/> Feeling alone or isolated                               | <input type="checkbox"/> Not enough spaces for exercise                    |
| <input type="checkbox"/> Fruits and vegetable cost too much                      | <input type="checkbox"/> Public transit route/schedules don't fit my needs |
| <input type="checkbox"/> Homelessness (living in shelter housing or with others) | <input type="checkbox"/> Trouble paying for medications/care               |
| <input type="checkbox"/> Housing is unstable or costs too much                   | <input type="checkbox"/> Water isn't safe to drink                         |
|  | <input type="checkbox"/> No health concerns                                |
|  | <input type="checkbox"/> Other (Please specify)                            |

About how long has it been since you last visited a doctor for a routine checkup? A routine checkup is a general physical exam, not an exam for a specific injury, illness, or condition.

- |  |
|--|
| <input type="checkbox"/> Within the past year (anytime less than 12 months ago)      |
| <input type="checkbox"/> Within the past 2 years (1 year but less than 2 years ago)  |
| <input type="checkbox"/> Within the past 5 years (2 years but less than 5 years ago) |
| <input type="checkbox"/> 5 or more years ago   |
| <input type="checkbox"/> Never   |
| <input type="checkbox"/> Don't know / Not sure                                       |

When you are sick, how likely are you to visit a healthcare provider?

- |                                    |                                    |
|------------------------------------|------------------------------------|
| <input type="checkbox"/> Always    | <input type="checkbox"/> Always    |
| <input type="checkbox"/> Usually   | <input type="checkbox"/> Usually   |
| <input type="checkbox"/> Sometimes | <input type="checkbox"/> Sometimes |
| <input type="checkbox"/> Rarely    | <input type="checkbox"/> Rarely    |
| <input type="checkbox"/> Never     | <input type="checkbox"/> Never     |

Everyone in my household can get the health services we want and need including physical, mental and dental health services.

2

Which types of health services are difficult to get for your household members? Please select all that apply.

- Dental Health Services Mental
- Health Services Physical
- Health Services

Why is getting these health services a challenge for your household members? Please select all that apply.

- Healthcare services are too expensive and/or the deductible or copay is too high.
- Healthcare providers do not accept my health insurance.
- I do not have health insurance.
- We can't get an appointment and/or waitlists are too long.
- We don't feel welcome.
- We don't know how to find the healthcare providers we need.
- We have language and/or cultural barriers.
- We have schedule problems (when we are available, healthcare services are closed).
- We have transportation problems.
- Other (please describe) \_\_\_\_\_

Do you have any kind of health care coverage, including health insurance, prepaid plans such as HMOs, government plans such as Medicare, or Indian Health Service?

- Yes
- No
- Don't know / Not sure

Do you currently have dental insurance?

- Yes
- No
- Don't know / Not sure

Consider your neighborhood as the area within a 20-minute walk or about a mile from your home. How much do you agree with this statement, "It is easy to purchase a variety of affordable fresh fruits and vegetables in my neighborhood."

- Strongly agree
- Agree
- Neutral (neither agree nor disagree) Disagree
- Strongly disagree
- Don't know / Not sure

I can get healthy food for my family.

- Always
- Often
- Sometimes
- Rarely
- Never

Why is getting healthy food a challenge for you? Please select all that apply.

- Healthy food is not available in my community.
- Healthy food is too expensive in my community.
- I don't have the time to buy or prepare healthy food.
- I don't know how to find food pantries and other sources of free food.
- I have schedule problems in accessing stores with healthy foods.
- I have transportation problems.
- The store I go to does not take EBT/FoodShare.
- The store I go to does not take WIC.
- Other (please specify) \_\_\_\_\_

How would you describe your current financial situation? Please select all that apply.

- I don't have enough money to pay the bills to meet household needs.
- Money is a major stressor in my life.
- I live paycheck to paycheck.
- I am financially secure and meet my and my family's needs.
- I have enough money to live comfortably without stress.

What is your employment status? Please select all that apply.

- Full-time (includes self-employed)
- Employed part-time (includes self-employed)
- Working more than one job to make ends meet
- Out of work for more than 1 year
- Out of work for less than 1 year
- Caregiver
- Student
- Retired
- Veteran
- Unable to work
- Living with my own disability that prevents me from working

In the past year, have any of the following things made it hard for you to work? Please select all that apply.

- Cost of childcare
- Childcare was unavailable
- Transportation issues
- Health insurance not provided through your work
- Your own health
- Family member's health
- Your own permanent disability
- Lack of training or skills
- Lack of resources to start your own business
- Conflicts with school
- None
- Other (please specify) \_\_\_\_\_

What is the highest grade or year of school you completed?

- Never attended school or only attended kindergarten
- Grades 1 through 8 (Elementary)
- Grades 9 through 11 (Some high school)
- Grade 12 (High school graduate)
- GED
- College 1 year to 3 years (Some college or technical school)
- College 4 years or more (College graduate)
- Don't know / not sure

If you would like to go back to school, which of the following would help you go back to school? Please select all that apply.

- Classes at a convenient location in my neighborhood or community
- Weekend and evening courses
- Transportation to school
- More education about various career opportunities
- College or Career Tech tied directly with work internships
- More financial aid for educational opportunities
- More individual help when having trouble
- Ways to get college general ed requirements completed while in high school
- Instruction to help me learn how to be a better test taker
- Shorter degree programs
- Less expensive, more available childcare
- More opportunities for partial online and partial in-class courses or more online classes
- Counselors and enrollment personnel available after hours
- Courses offered in my native language
- I am not interested in going back to school

5

Are you a registered voter in the state of Oklahoma?

- Yes
- No
- Don't know / Not sure

Did you vote in the past year?

- Yes
- No
- Don't know / Not sure

What is your main reason for not voting?

- I don't feel my voice is heard
- I don't feel my vote matters
- I don't have enough time to get to the polls
- I don't know where my poll is located
- I don't have the appropriate identification
- Other (please specify) \_\_\_\_\_

Have you faced challenges to voting?

- Yes
- No
- Don't know / Not sure

What challenges have you faced? \_\_\_\_\_

What sex were you assigned at birth?  
Were you...?

- Male
- Female
- Prefer not to say

Are you Spanish, Hispanic, or Latino origin?

- Mexican, Mexican-American, Chicano/a, Puerto Rican,
- Cuban, or
- Another Hispanic, Latino/a, or Spanish origin? (Please specify) \_\_\_\_\_
- No (not of Hispanic/Latino origin)
- Don't Know / Not sure

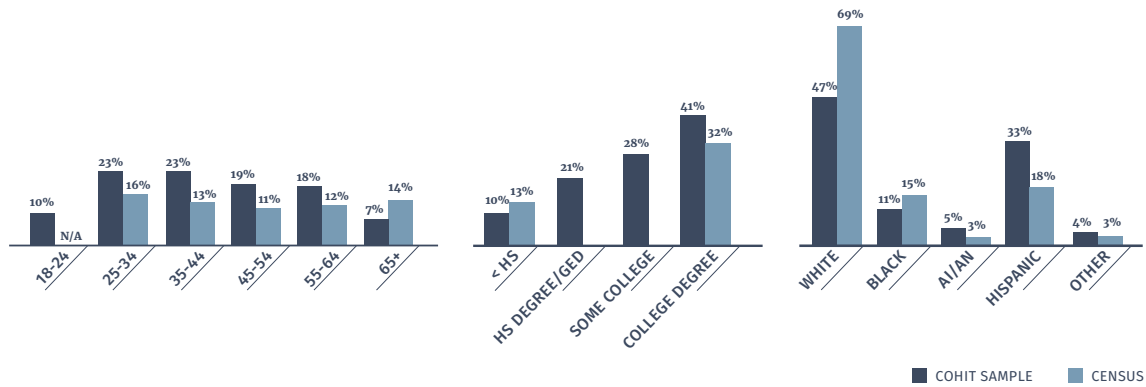
Which one or more of the following would you say is your race? Please select all that apply.

- White
- Black or African-American
- American Indian or Alaska Native
- Asian
- Native Hawaiian or Other Pacific
- Other (please specify) \_\_\_\_\_

What is your zip code?  
\_\_\_\_\_

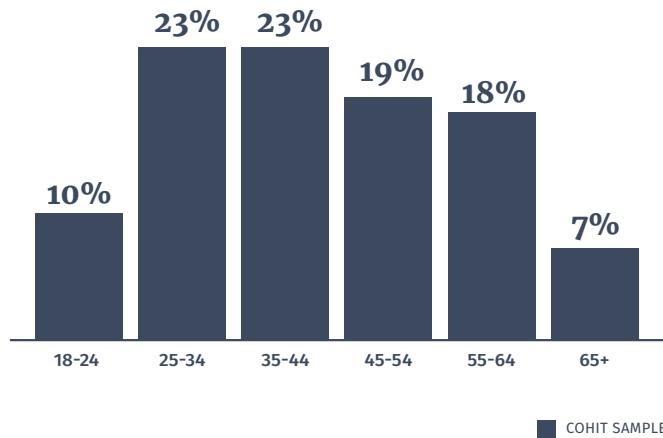
# Community Survey Results

## Respondent characteristics



## Slide 7

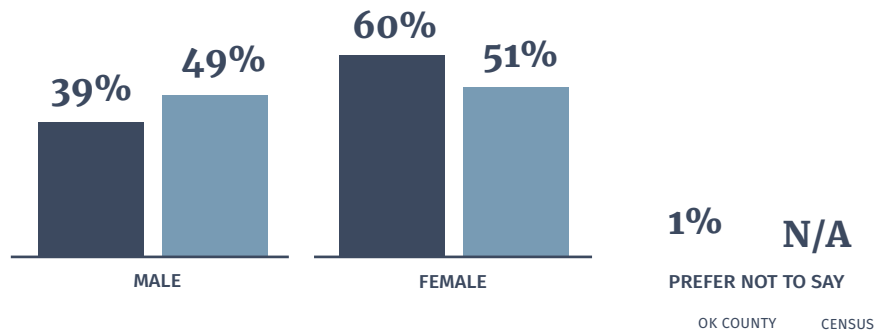
### Age distribution of COHIT Survey Sample from 2021 Vaccination Clinics





## Slide 8

### Respondent characteristics - Gender

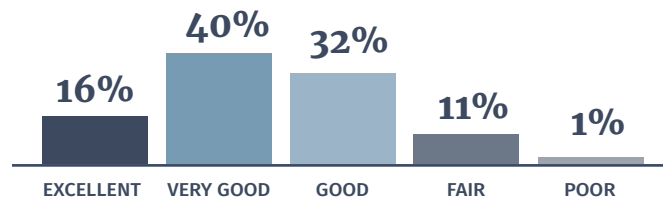


## Slide 9

### General Health, Weighted

In general, would you say your health is...

Figure 1. General Health

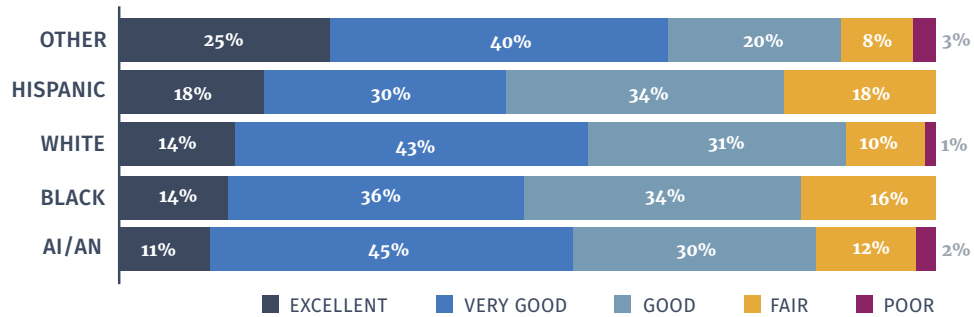


## Slide 10

### General Health, Weighted

In general, would you say your health is...

Figure 1. General Health (weighted data)

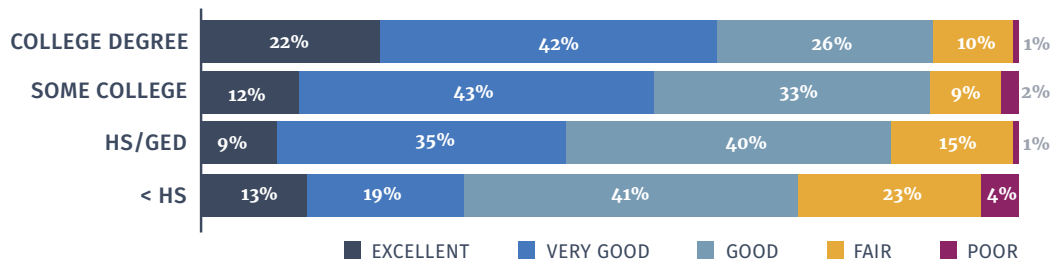


## Slide 11

### General Health, Weighted

In general, would you say your health is...

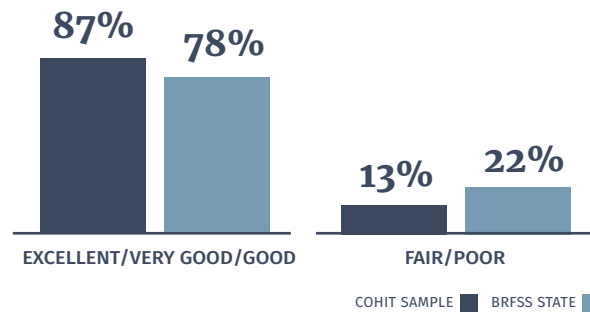
Figure 1. General Health



## Slide 12

### General Health

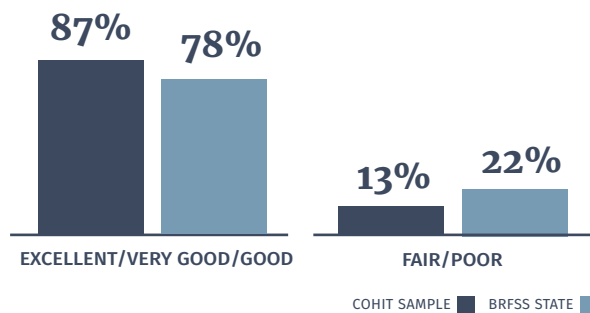
In general, would you say your health is...



## Slide 13

### General Health, Weighted

In general, would you say your health is...



## Slide 14

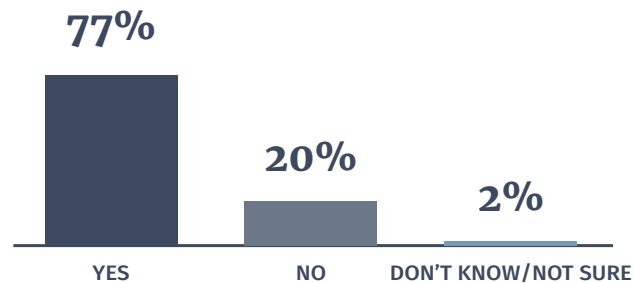
# RESULTS: Access to Healthcare

## Slide 15

### Access to Healthcare, Weighted

Do you have any kind of health care coverage, including health insurance, prepaid plans such as HMOs, government plans such as Medicare, or Indian Health Service?

Figure 1. Health care coverage

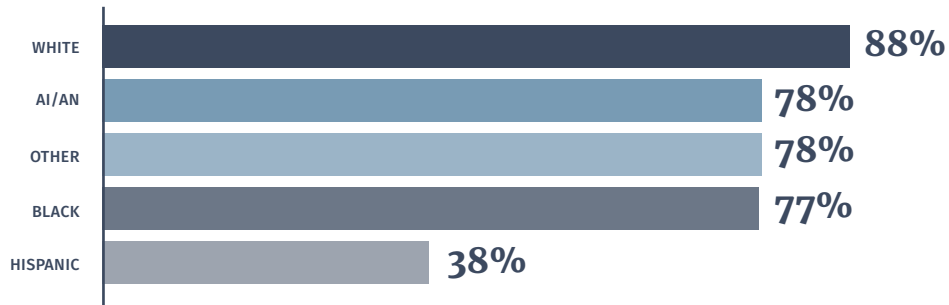


## Slide 16

### Access to Healthcare, Weighted

Do you have any kind of health care coverage, including health insurance, prepaid plans such as HMOs, government plans such as Medicare, or Indian Health Service?

Figure 1. Health care coverage by race, weighted

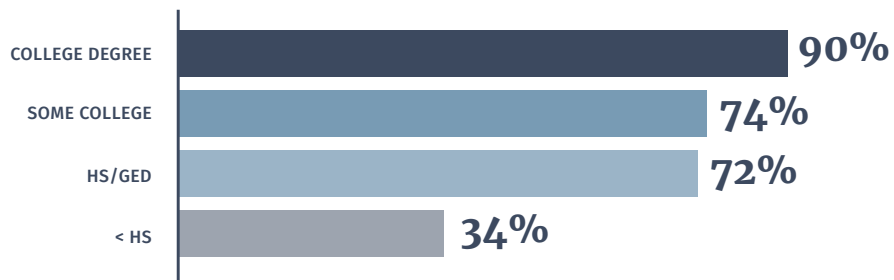


## Slide 17

### Access to Healthcare, Weighted

Do you have any kind of health care coverage, including health insurance, prepaid plans such as HMOs, government plans such as Medicare, or Indian Health Service?

Figure 2. Health care coverage by race, weighted

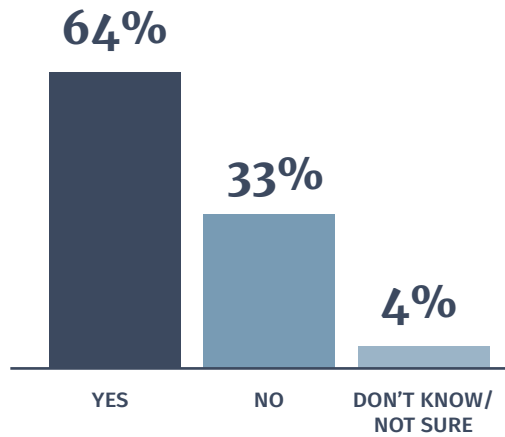


## Slide 18

### Access to Healthcare, Weighted

Do you currently have dental insurance?

Figure 1. Dental insurance

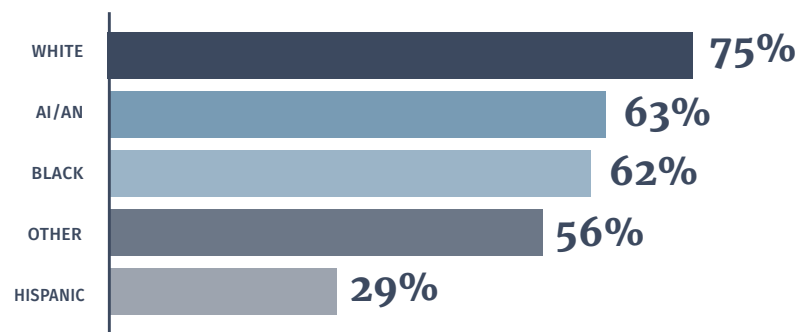


## Slide 19

### Access to Healthcare, Weighted

Do you currently have dental insurance?

Figure 1. Dental insurance by race/ethnicity, weighted data

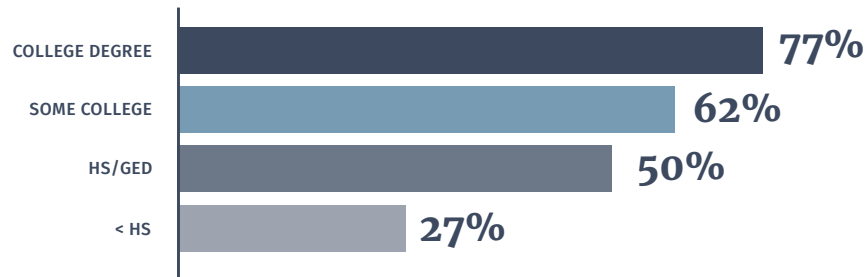


## Slide 20

### Access to Healthcare, Weighted

Do you currently have dental insurance?

Figure 1. Dental insurance by education, weighted

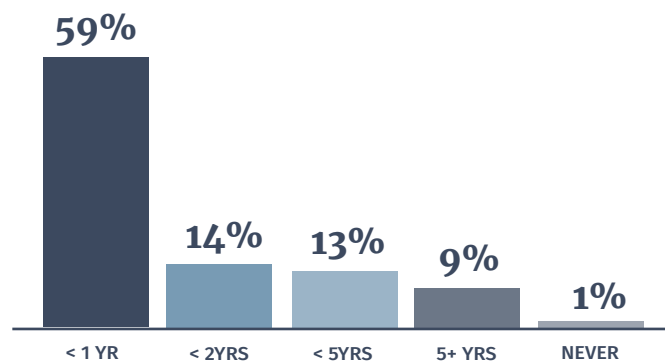


## Slide 21

### Access to Healthcare, Weighted

About how long has it been since you last visited a doctor for a routine checkup? A routine checkup is a general physical exam, not an exam for a specific injury, illness, or condition.

Figure 1. Routine checkup

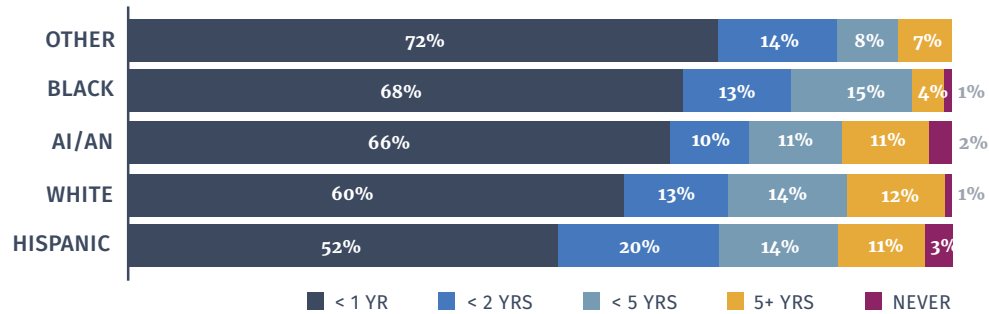


## Slide 22

### Access to Healthcare, Weighted

About how long has it been since you last visited a doctor for a routine checkup? A routine checkup is a general physical exam, not an exam for a specific injury, illness, or condition.

Figure 1. Routine checkup by race/ethnicity, weighted data

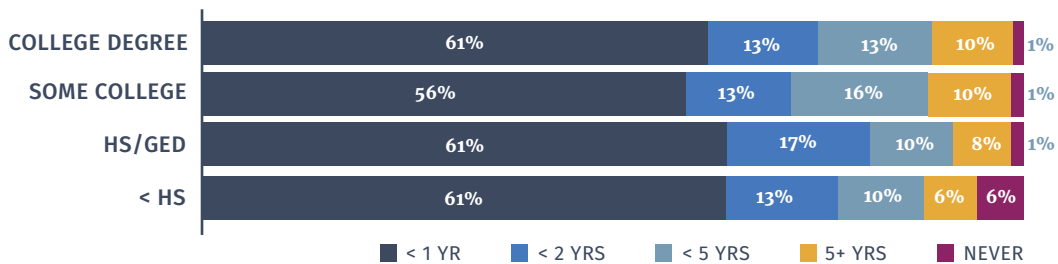


## Slide 23

### Access to Healthcare, Weighted

About how long has it been since you last visited a doctor for a routine checkup? A routine checkup is a general physical exam, not an exam for a specific injury, illness, or condition.

Figure 1. Routine checkup by education, weighted



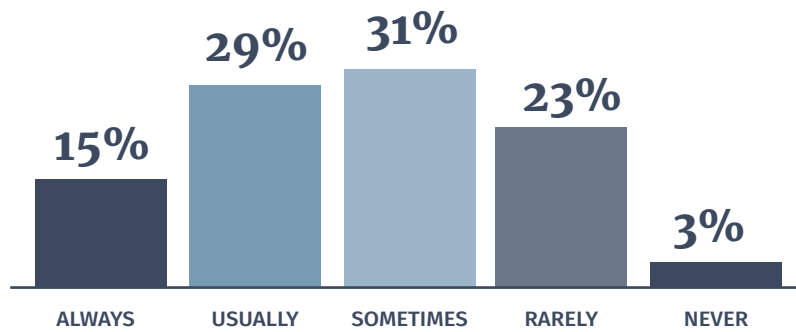


## Slide 24

### Access to Healthcare, Weighted

When you are sick, how likely are you to visit a healthcare provider?

Figure 1. Sick visit, weighted

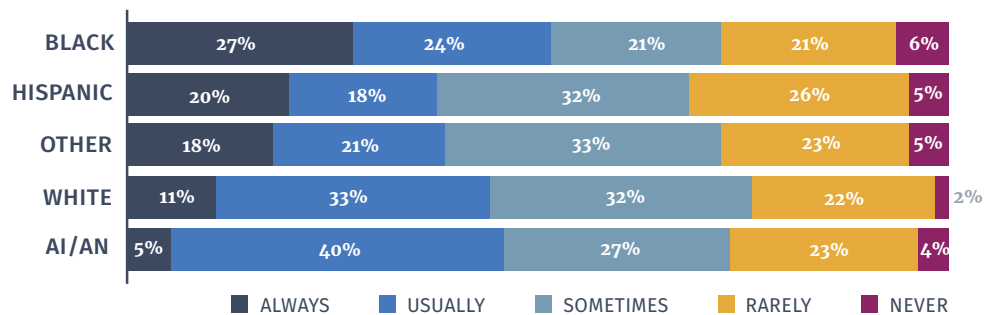


## Slide 25

### Access to Healthcare, Weighted

When you are sick, how likely are you to visit a healthcare provider?

Figure 1. Sick visit by race, ethnicity, weighted

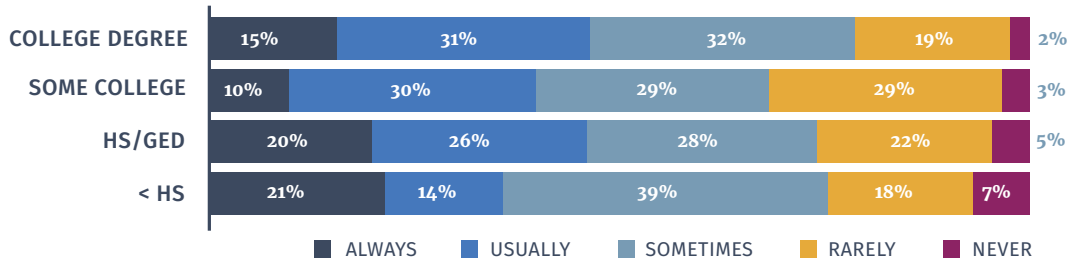


## Slide 26

### Access to Healthcare, Weighted

When you are sick, how likely are you to visit a healthcare provider?

Figure 1. Sick visit by education, weighted

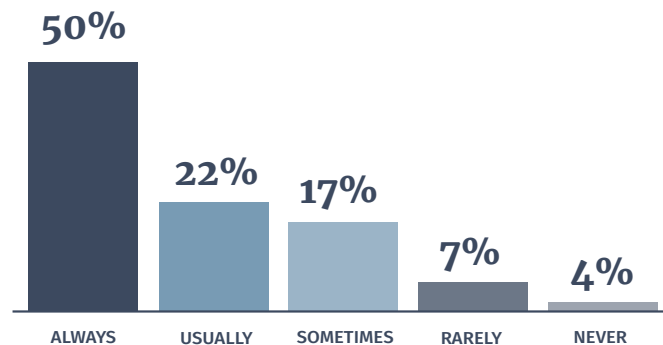


## Slide 27

### Access to Healthcare, Weighted

Everyone in my household can get the health services we want and need including physical, mental and dental health services

Figure 1. Health Services

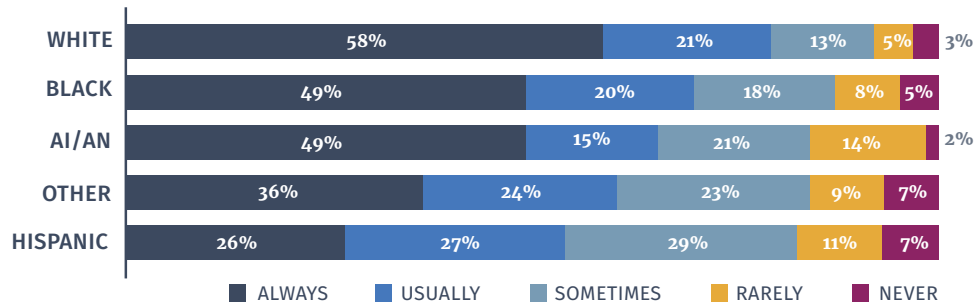


## Slide 28

### Access to Healthcare, Weighted

Everyone in my household can get the health services we want and need including Physical, mental and dental health services.

Figure 1. Health services by race/ethnicity, weighted

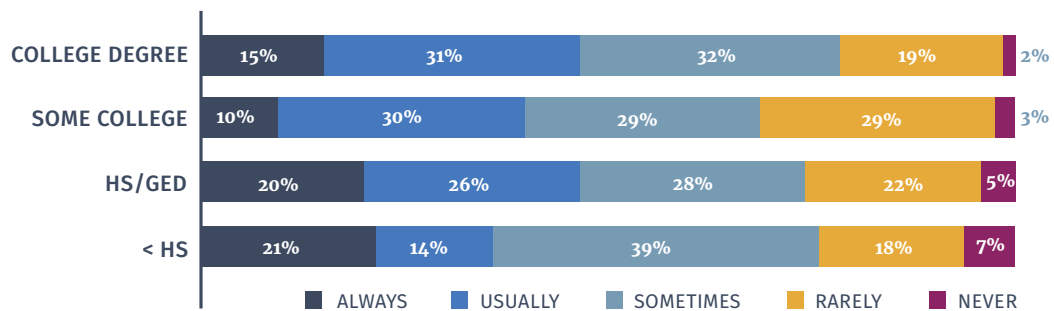


## Slide 29

### Access to Healthcare, Weighted

Everyone in my household can get the health services we want and need including Physical, mental and dental health services.

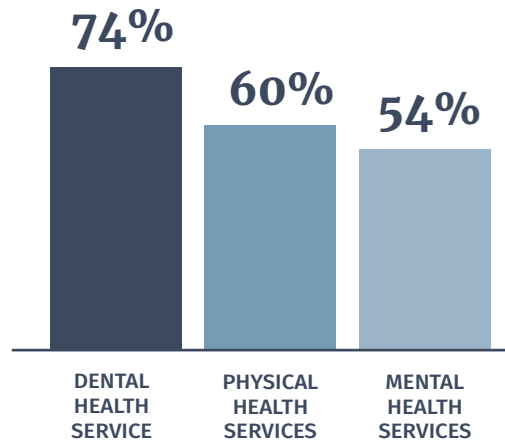
Figure 1. Health services by education, weighted



## Slide 30

### Access to Healthcare, Weighted

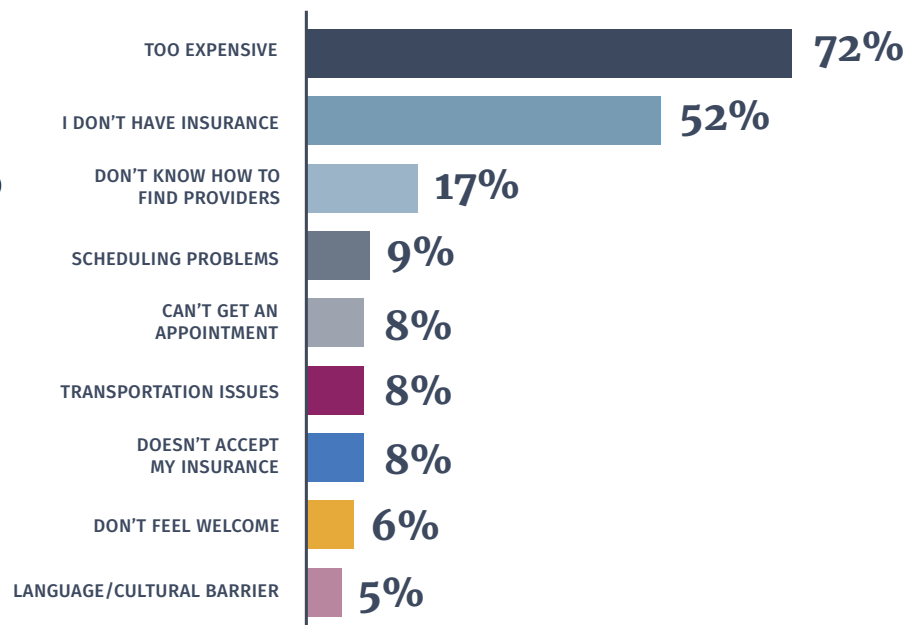
Which types of health services are difficult to get for your household members? Please select all that apply. Weighted



## Slide 31

### Access to Healthcare

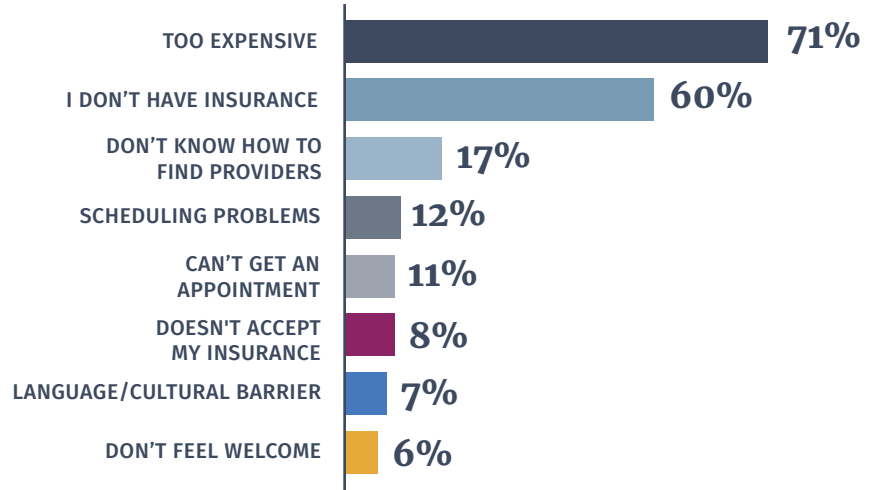
Why is getting these health services a challenge for your household members? Please select all that apply. (weighted)



## Slide 32

### Access to Healthcare, Weighted

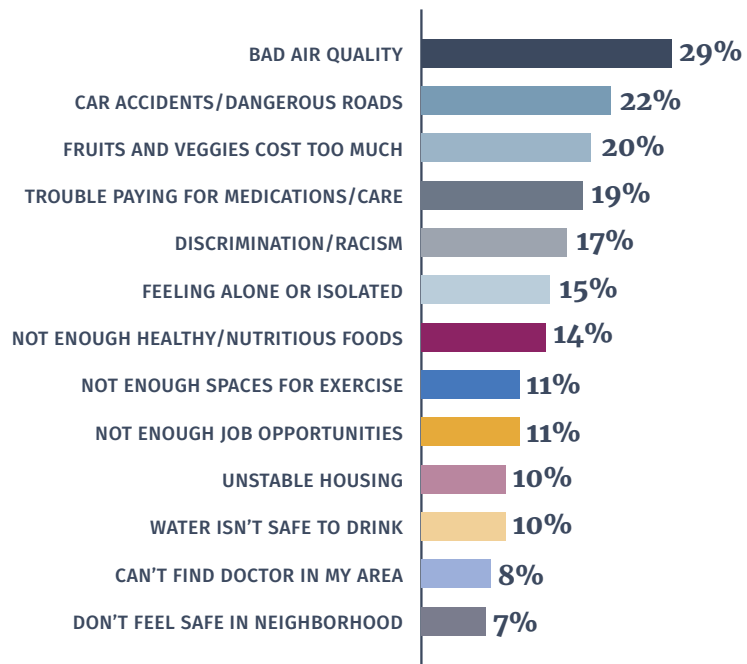
Why is getting these health services a challenge for your household members? Please select all that apply. (Weighted data)



## Slide 33

### Access to Healthcare, Weighted

Which of the following have a negative effect on your health and well-being? (weighted)



## Slide 34

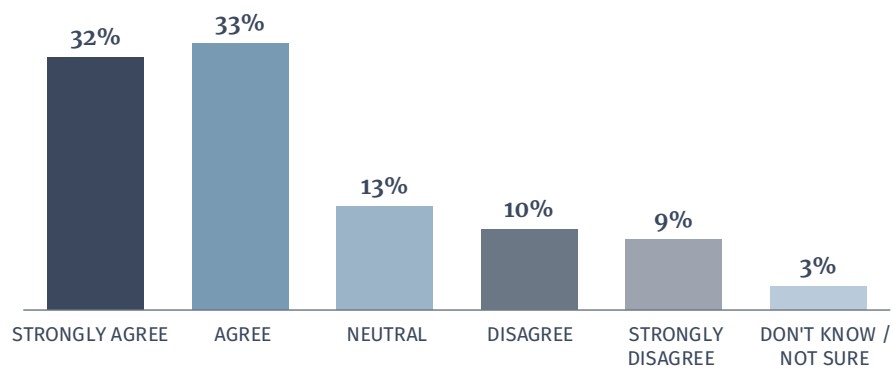
# RESULTS: Access to Healthy Food

## Slide 35

### Access to Healthy Food, Weighted

How much do you agree with this statement, "It is easy to purchase a variety of affordable fresh fruits and vegetables in my neighborhood."

Figure 1. Ease of purchase

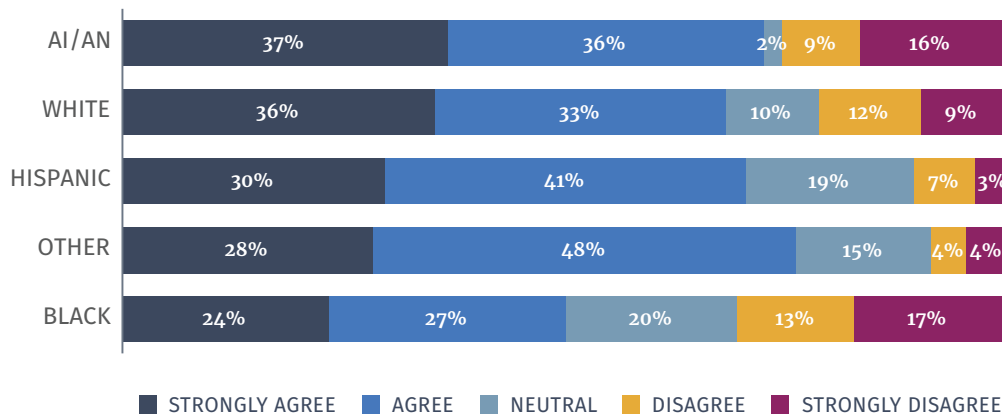


## Slide 36

### Access to Healthy Food, Weighted

How much do you agree with this statement, "It is easy to purchase a variety of affordable fresh fruits and vegetables in my neighborhood."

Figure 1. Ease of purchase by race/ethnicity, weighted

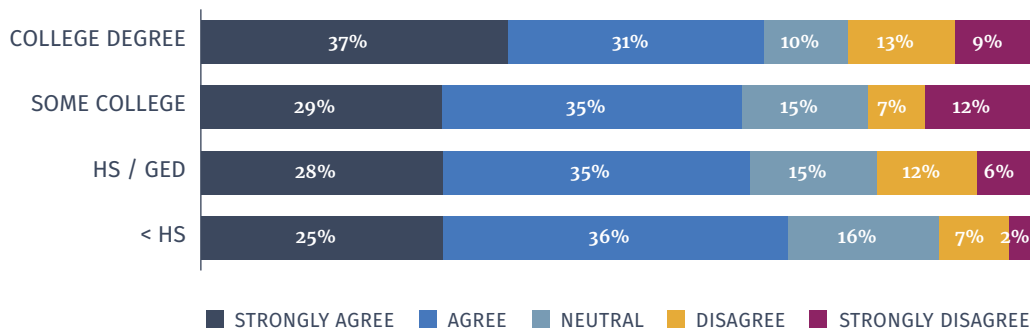


## Slide 37

### Access to Healthy Food, Weighted

How much do you agree with this statement, "It is easy to purchase a variety of affordable fresh fruits and vegetables in my neighborhood."

Figure 1. Ease of purchase by education, weighted

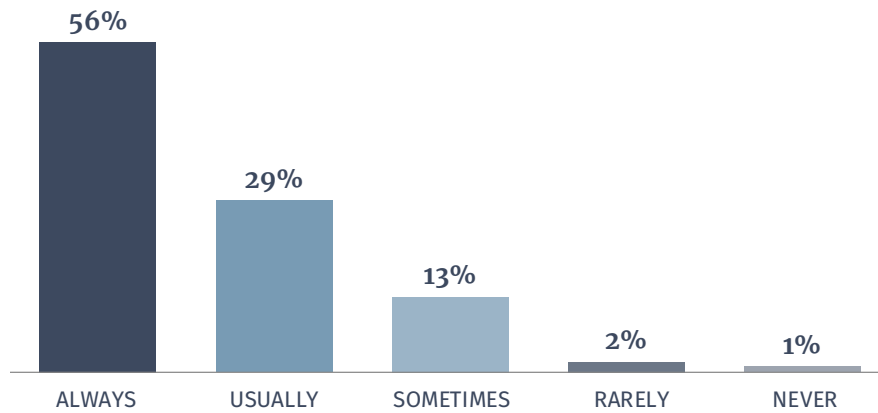


## Slide 38

### Access to Healthy Food, Weighted

I can get healthy food for my family...

Figure 1. Can get healthy food, weighted

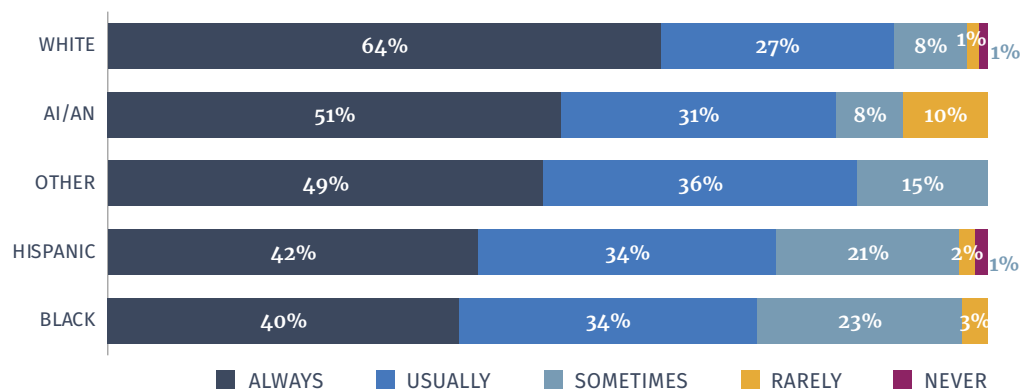


## Slide 39

### Access to Healthy Food, Weighted

I can get healthy food for my family...

Figure 1. Can get healthy food by race/ethnicity, weighted



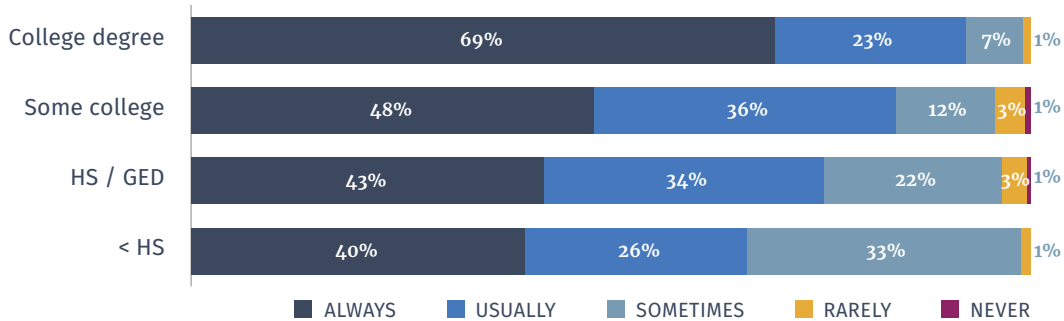


## Slide 40

### Access to Healthy Food, Weighted

I can get healthy food for my family...

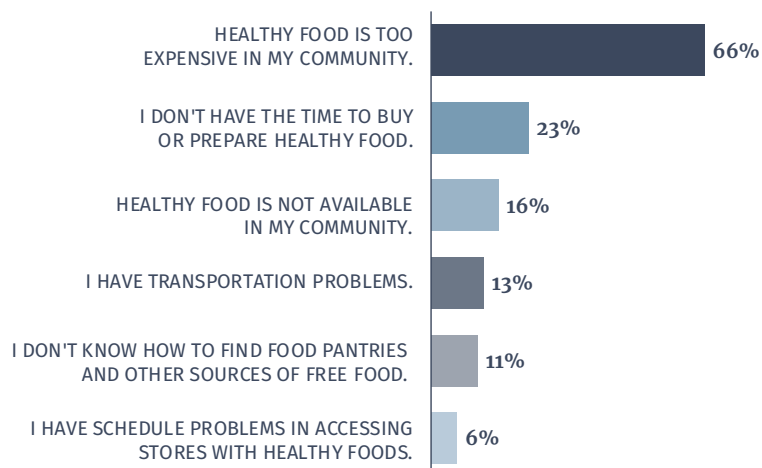
Figure 1. Can get healthy food by education, weighted



## Slide 41

### Access to Healthy Food, Weighted

Why is accessing healthy food a challenge? Please select all that apply. (weighted)



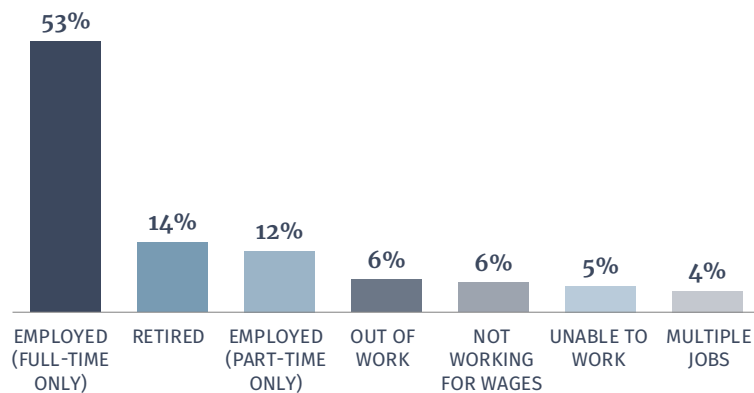
## Slide 42

# RESULTS: Access to Employment

## Slide 43

### Access to Employment, Weighted

What is your employment status? Please select all that apply. (weighted data)

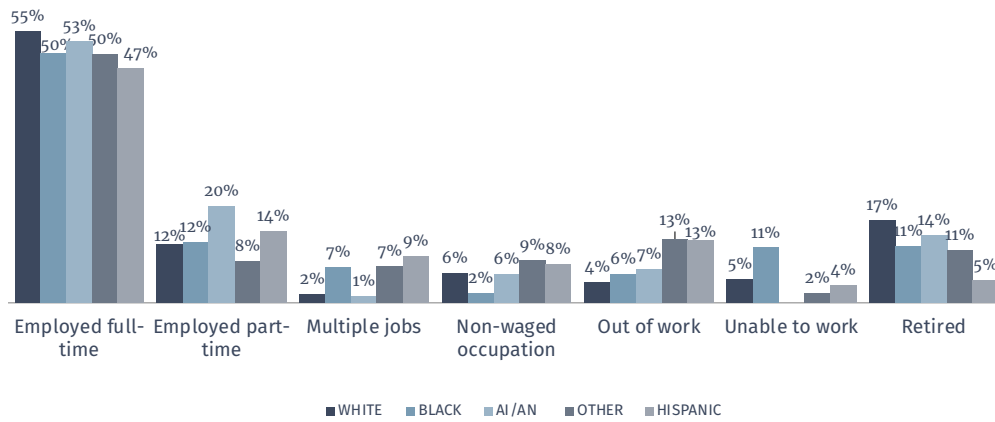


# Slide 44

## Access to Employment, Weighted

What is your employment status? (weighted data)

Figure 1. Employment status, stratified by race

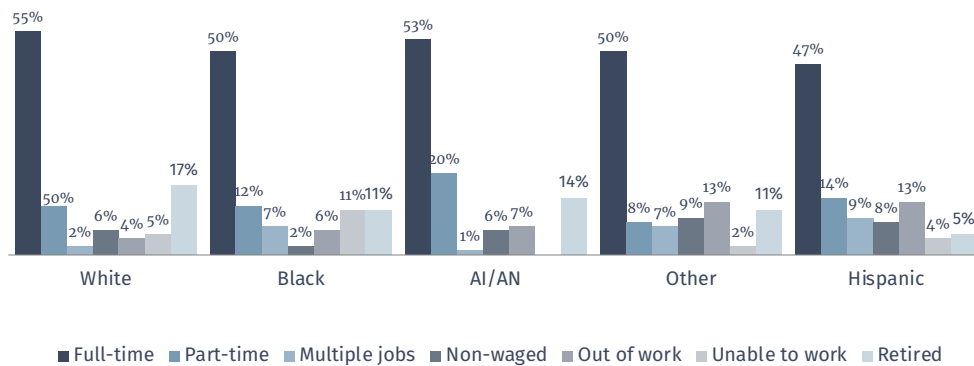


# Slide 45

## Access to Employment, Weighted

What is your employment status? (weighted data)

Figure 1. Employment status, stratified by race

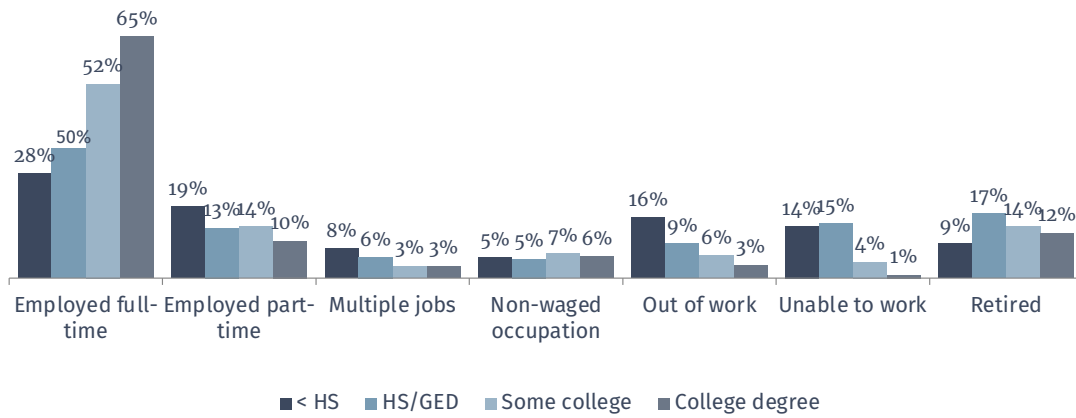


## Slide 46

### Access to Employment, Weighted

What is your employment status? (weighted data)

Figure 1. Employment status, stratified by education

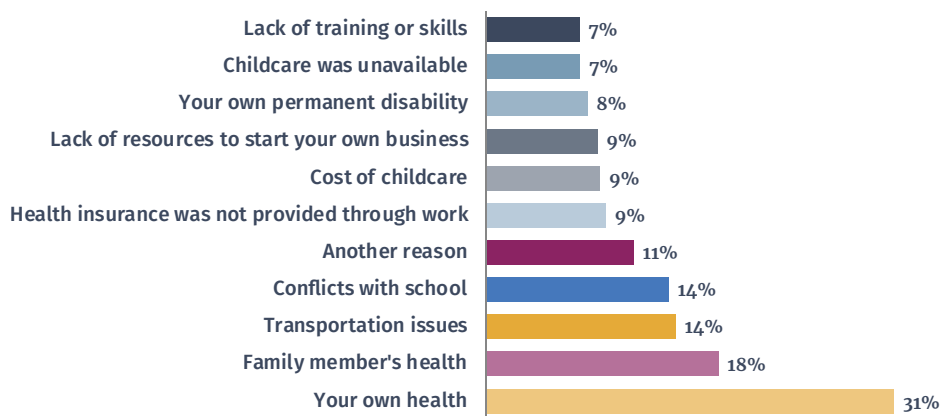


## Slide 47

### Access to Employment

In the past year, have any of the following things made it hard for you to work? Please select all that apply.

Figure 1. Reasons it was hard to work

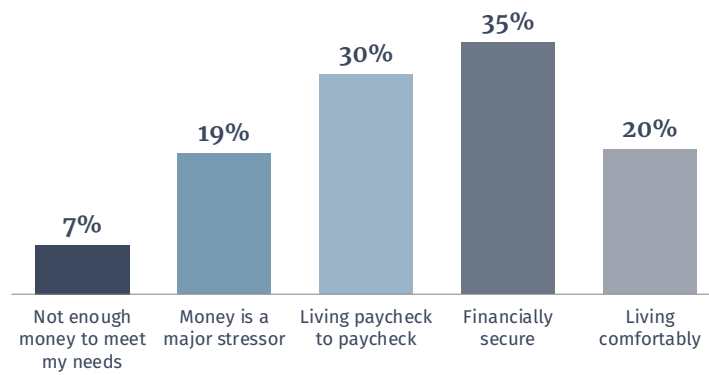


## Slide 48

### Access to Employment

How would you describe your current financial situation? Please select all that apply.

Figure 1. Current perceptions about money



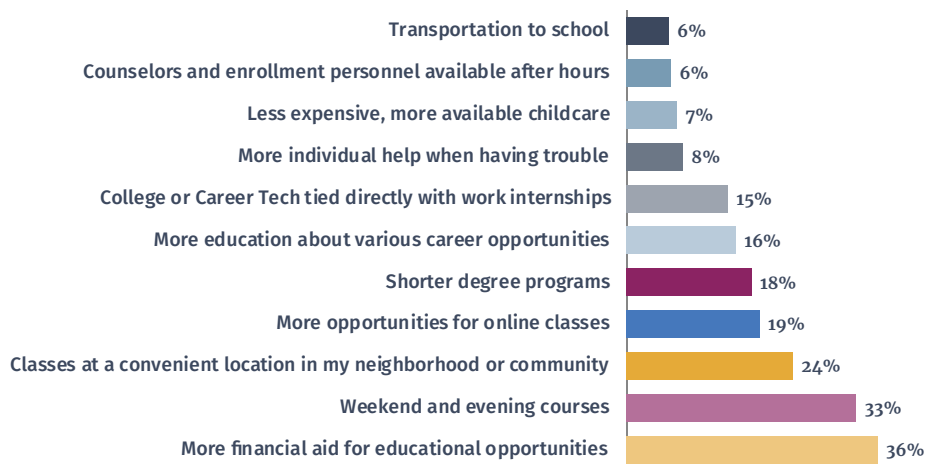
## Slide 49

# RESULTS: Access to Education

## Slide 50

### Access to Education

Which of the following would help you go back to school? Please select all that apply.

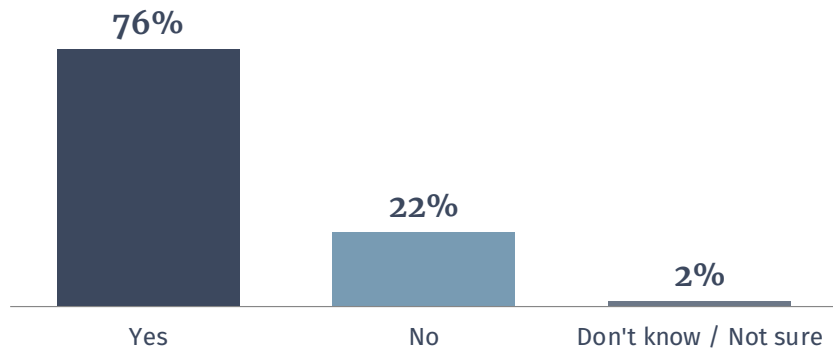


## Slide 51

### Access to Education, Weighted

Are you a registered voter in the state of Oklahoma?

Figure 1. Registered to vote (weighted data)

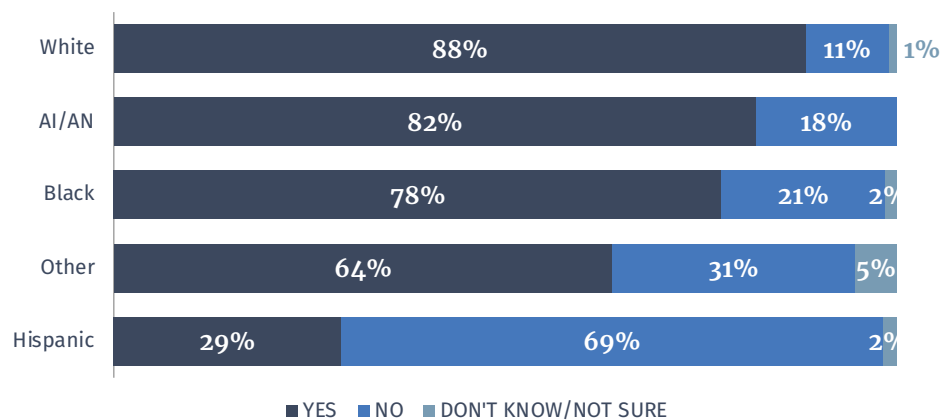


## Slide 52

### Access to Education, Weighted

Are you a registered voter in the state of Oklahoma?

Figure 1. Registered to vote by race/ethnicity, weighted

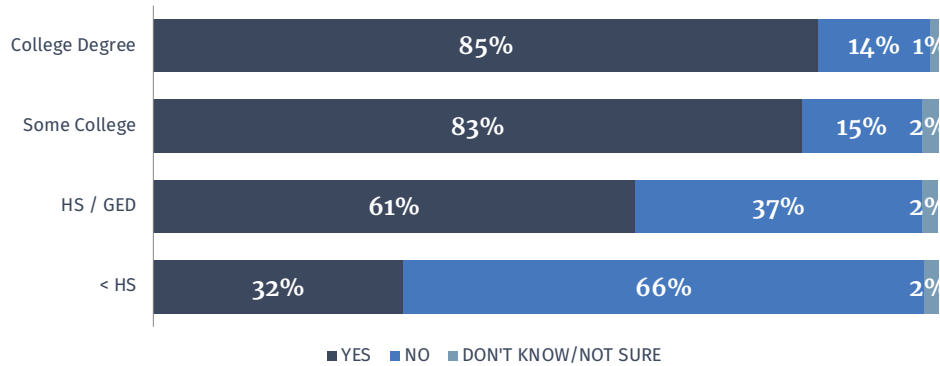


## Slide 53

### Access to Education, Weighted

Are you a registered voter in the state of Oklahoma?

Figure 1. Registered to vote by education, weighted

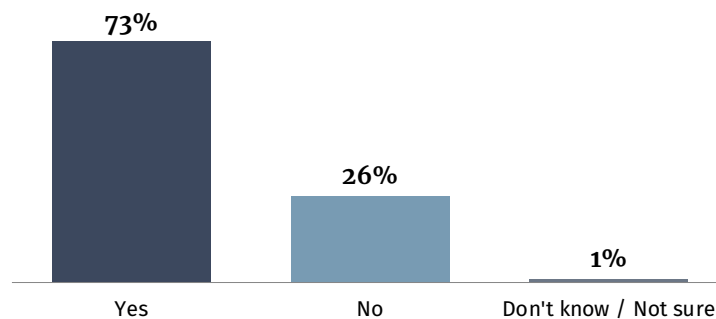


## Slide 54

### Access to Education, Weighted

Did you vote in the past year?

Figure 1. Voted in the past year, weighted data



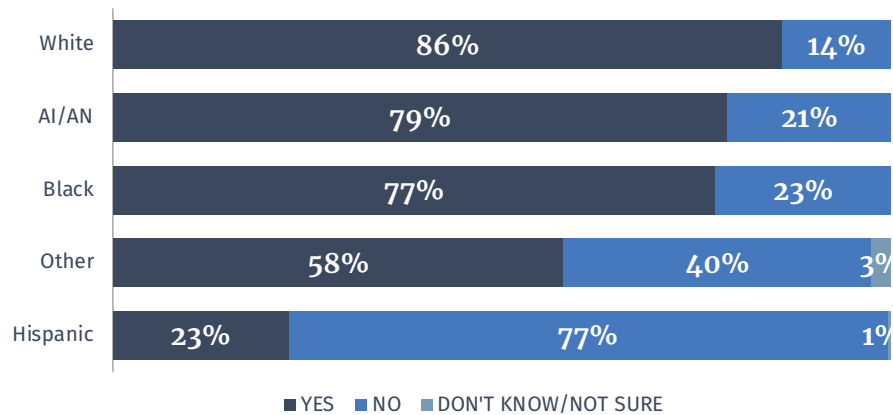


## Slide 55

### Access to Education, Weighted

Did you vote in the past year?

Figure 1. Past year voted by race/ethnicity, weighted

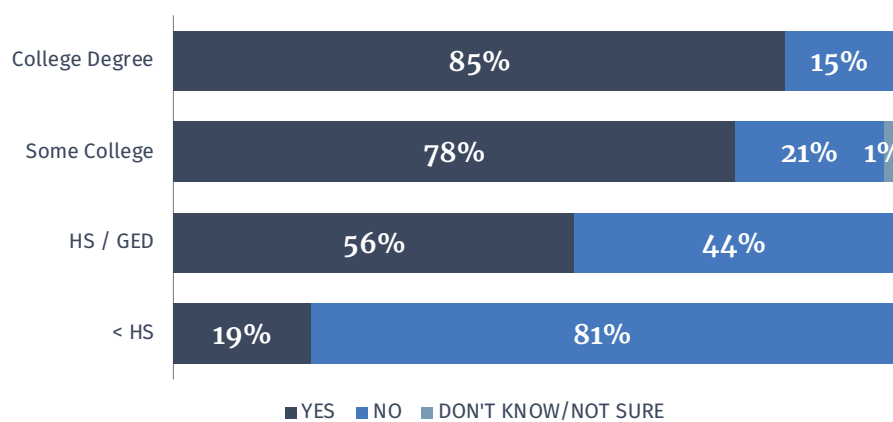


## Slide 56

### Access to Education, Weighted

Did you vote in the past year?

Figure 1. Past year voted by education, weighted

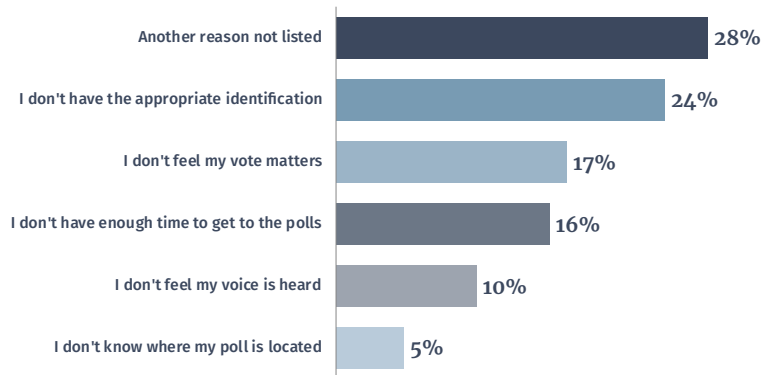


## Slide 57

### Access to Education, Weighted

What is your main reason for not voting?

Figure 1. Reason for not voting, weighted data

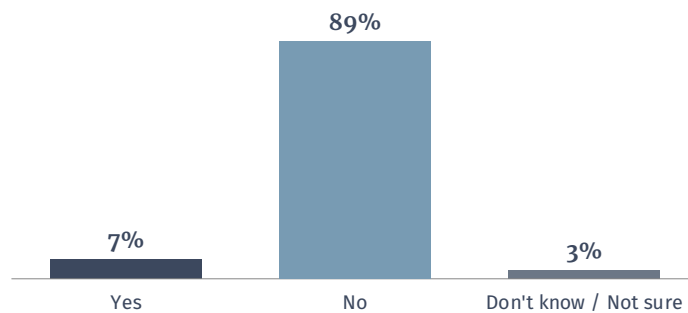


## Slide 58

### Access to Education, Weighted

Have you faced challenges to voting?

Figure 1. Challenges to voting, weighted

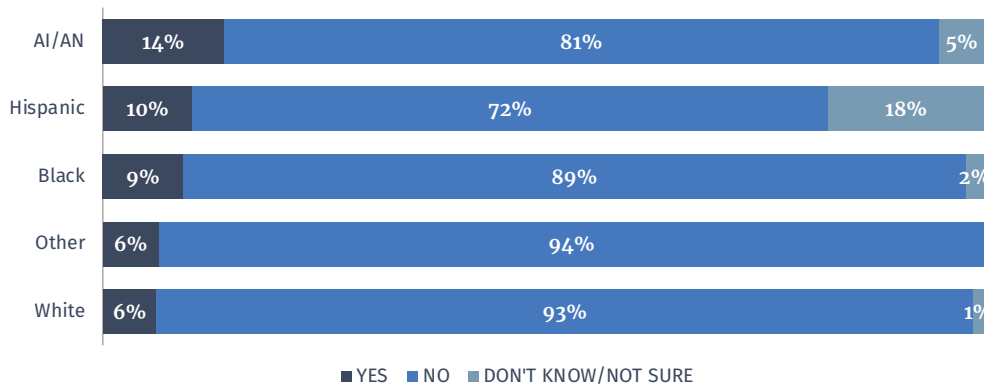


## Slide 59

### Access to Education, Weighted

Have you faced challenges to voting?

Figure 1. Challenges to voting by race/ethnicity, weighted

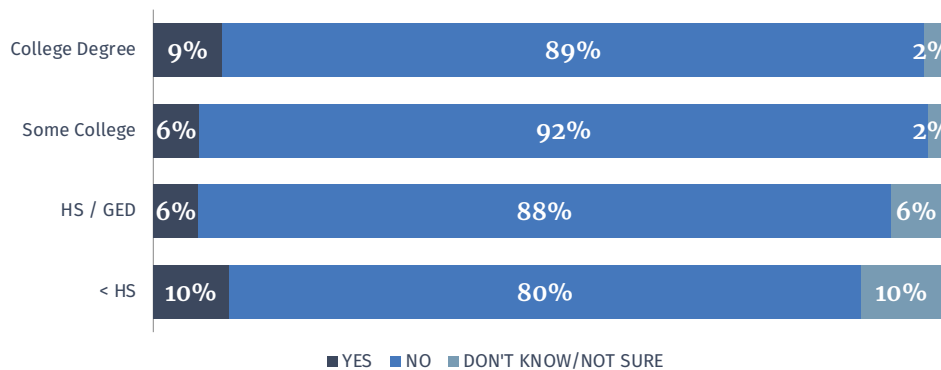


## Slide 60

### Access to Education, Weighted

Have you faced challenges to voting?

Figure 1. Challenges to voting by education, weighted



# Appendix C – COMMUNITY CHATS

## Access to Healthcare

### Facilitation guide

The facilitation of community chats, informational interviews with prominent community members were conducted using questions that focused on themes that were uncovered in the group discussions. These methods were used to obtain data from community members with strong, rich opinions on the challenges facing the Oklahoma County population. Thus, our sample was comprised of purposefully selected groups of individuals rather than from a statistically representative sample of Oklahoma County's population. Based on the research objectives, a list of questions were prepared as guidance for each community chat discussion session. The community chat discussion was reliant on the ability and capacity of the participants to provide relevant information. Each facilitator was given a guide covering the four topics and were taught to lead the discussion towards personal experiences, barriers, perceptions of others and opportunities moving forward.

The facilitator managed the discussion and created a relaxed and comfortable environment for all participants. The main method of the data collection included audio tape recording and participant observations. The duration of the meetings was also considered due to participation fatigue and complexity of the topics being investigated. Therefore, each facilitator was allowed one hour per community chat meeting.

### Analysis Techniques:

Themes were identified and defined in a series of reviews and investigator meetings using the transcripts until there was theme approval. Once the community chat recordings were transcribed, they were uploaded to a data analysis software system, Dedoose ([www.dedoose.com](http://www.dedoose.com)). The system is a web-based program that allowed the researchers to organize and analyze the research data into text formats for quantitative and qualitative data, and facilitated mixed methods research output.

The first stage in the research process was initial coding. The method involved the generation of numerous category codes with no limitations. A team of two primary and two secondary coders was established to generate codes and read through each transcript to draw relationships and identify keywords. From these initial reads, coders determined frequent and important indicators and themes. The interview transcripts were then analyzed to clarify cross-cutting themes. The coding team independently investigated identifying themes. They also collectively created a codebook<sup>1</sup> with definitions for each individual code and met daily to strategize appropriate coding applications.

There were three separate categories of codes parent codes, child codes and secondary child codes. Parent Codes were the main codes used for a specific topic. Child codes retained within the parent code and referred to more specific elements within the parent code. This code was either used individually or double coded with a parent code. The secondary child code was the child code of the child code and was retained for more specific information within the original child code and could also be grouped with the parent code and child code.

The second stage of coding involved focus coding, which is where the coding team eliminates, combines or subdivides the coding categories identified in the first step. The process yielded quantitative results that drew comparisons across the different community chats in the participation statements. The content analysis enabled the systematic coding of data by organizing the statements into categories which allowed the coding team to discover patterns that could be undetectable with listening and reading.

The visual representation of research findings such as charts, tables, and plots are designed to be informative, intuitive, and transparent. With the use and design the research team is able to use numerous combinations of codes to drill deeper into findings and expose patterns of variation in the qualitative data and coding.

Pooled Cohen’s Kappa estimates were calculated by Dedoose to measure the interrater reliability for the qualitative analysis. It is a measure that gives a percentage calculation that helped the team account for the possibility of the agreement between the codes.

**The interpretation of a Kappa score is as follows:**

>0.8	Almost Perfect Agreement
0.61- 0.80	Substantial Agreement
0.41- 0.60	Moderate Agreement
0.21- 0.40	Fair Agreement
0.00- 0.20	Slight Agreement
<0.00	Poor Agreement (Landis & Koch, 1977)

The team took the mean of the overall test scores and broke them down by each individual coder who took the test. The coding team each individually took five tests with the subject; Social Environment, Food Access, Employment and Housing, Education, and Access to Health.

## **WELCOME AND BACKGROUND ON THE COMMUNITY CHAT (1 MINUTE)**

Welcome. Thank you for making time to be here today. My name is \_\_\_\_\_ and I am with COHIT  
*(COHIT description and purpose)*

Before we get started, I'll give you an introduction about what we're going to do tonight and the reasons that we're doing it. COHIT is interested in hearing from citizens like yourselves to assess your feelings, perceptions and knowledge of health care in Oklahoma County. This community chat is part of a health needs assessment being conducted in Oklahoma County to determine the current and future health needs of residents here. The feedback we get tonight will be combined with other research in order to create a long-term strategy for health care in Oklahoma County.

## **LOGISTICS (1 MINUTE)**

So that's the big picture. Now let's talk about how this process will work. We'll be here for 90 minutes. Please help yourself to refreshments if you haven't done so already. If you want to get up to get more to eat or drink, or go to the bathroom, feel free to do so. We do have people observing to take notes, and we are also audio recording the session for reporting purposes. Your comments will be summarized and reported anonymously, though, and we won't ever identify you personally as a participant. Finally, we promised to pay you \$X for participating today, and you will be paid at the end of the session.

## **GROUND RULES (2 MINUTES)**

Have any of you have participated in a community chat before? The rules are simple: I'll bring up a topic, and I want to get your thoughts and opinions. Sometimes I'll ask a question and we'll just go around the table and get everyone's thoughts, and other times I'll just wait for anyone to answer. Feel free to respond to something that someone else says, and feel free to disagree, but please show respect for others even if you disagree with their opinions. There are no wrong answers. At certain points during our discussion I may poll the group to determine how many of you agree or disagree about a certain issue. This will be done to summarize opinions for reporting. Keep in mind that we want everyone to participate. If you're not talking, I'll eventually notice and ask you for your opinions. On the other hand, if you're the only one talking, please recognize that and give others a chance to participate. Finally, I may politely interrupt if you're talking about something that strays off our topics. No disrespect is intended if I do this, but we have a lot to accomplish tonight so we need to stay focused so we can make sure that we don't need to keep you beyond our scheduled time.

## **INTRODUCTIONS (10 MINUTES)**

First, let's briefly introduce ourselves, using a "one-minute biography." In one minute or less, tell us the important facts about yourself: your first name, family status, and what you do for a living or where you go to school. You can also tell us how long you've been a resident of Oklahoma County and what you like best about living here. [Follow-up: ask movers what brought them to Oklahoma County.]

## **HEALTHCARE NETWORK IN OKLAHOMA COUNTY (15 MINUTES)**

We'll begin by asking some general questions about healthcare services in Oklahoma County.

1. We're going to start with an exercise. I'm going to give you a map, and write on it the names of people and organizations who are involved in your household's health. Put them in the circle that corresponds to their location. We don't need to know names of people, just the services you receive.
2. [For those who go outside the county] Why do you leave Oklahoma County for those services?
3. How well do current services in the county meet your or your household's needs? Why do you say this?
4. [Ask if necessary.] Do factors that are not directly healthcare related impact your health? How do they fit into your health network? Behavioral, environmental, etc.

## **CONSTRAINED HEALTHCARE NETWORK IN OKLAHOMA COUNTY (10 MINUTES)**

5. Do you have your own vehicle? Now if you have your own vehicle, imagine what your health care network would be like if you didn't. And if you don't have your own vehicle, how would it be different if you did? Tell me the differences, if any.
6. Now if you have insurance, imagine what your health care network would be like if you did not have insurance. And if you don't have insurance, how would it be different if you did? Tell me the differences, if any.

## **LOW-INCOME HEALTH IN OKLAHOMA COUNTY (15 MINUTES)**

7. What do people do if they don't have insurance and they have lower incomes?
8. How much of an issue are the following things in terms of access for people with lower incomes?
  - i. Transportation
  - ii. Insurance
  - iii. Health facilities that will accept low-income patients on a sliding scale, voucher, etc.
9. What is the most valuable thing that the community could do to help improve health for lower income people?

## **YOUTH HEALTH IN OKLAHOMA COUNTY (15 MINUTES)**

10. 10. Anyone have kids, or had them? Think back to the general network you drew earlier. Is it any different for youth? If you have experience or knowledge of teens roughly age 12 to 19, concentrate on that group. Otherwise, you can go younger.
11. Are there different needs that youth have? [Listen for drugs/alcohol, sex education, nutrition, obesity, bullying, pediatric specialties.]
12. Do your kids have a safe place to go if they have a health issue they don't know how to handle? [ Does drugs/alcohol (and mental health), sex education fall into the realm of health? How about health care? Who should they be targeted to How do we think it might be different for seniors?
13. What is the most valuable thing that the community could do to help improve health for youth?

**SENIOR HEALTH IN OKLAHOMA COUNTY  
(10 MINUTES)**

- 14. Think back to the general health network we drew earlier. Is anything different for seniors?
- 15. We talked about issues like transportation, insurance, and health services that are offered. Do those impact seniors differently?
- 16. Is it possible to grow old in Oklahoma County and stay in your home? Is Oklahoma County different than other places in Oklahoma or the U.S. in that regard?

**SPECIFIC HEALTH ISSUES, RESOURCES, AND SERVICES  
(10 MINUTES)**

Now let's discuss some more specific public health issues and the availability of services for these.

- 17. What area of health-related services could be improved the most in Oklahoma County? Please explain. 1
- 18. What do you think should be the top public health priority areas for Oklahoma County to concentrate on in the next five years? Please explain.

**CONCLUSION**

Thank you very much for your time! This information will be very useful to the County as it considers how to best continue to serve and communicate to folks like yourselves. Now, we've promised you a payment...

**Access to Education**

**Facilitation Guide**

**Date:**

**Facilitator name:**

**Location:**

**WELCOME AND BACKGROUND ON THE COMMUNITY  
CHAT (1 MINUTE)**

Welcome. Thank you for making time to be here today. My name is \_\_\_\_\_ and I am with Central Oklahoma Community Health Impact Team (COHIT).

Before we get started, I'll give you an introduction about what we're going to do tonight and the reasons that we're doing it. COHIT is interested in hearing from citizens like yourselves to assess your feelings, perceptions and knowledge of educational opportunities in Oklahoma County. This community chat is part of a health needs assessment being conducted in Oklahoma County to determine the current and future health needs of residents here. The feedback we get tonight will be combined with other research in order to create a long-term strategy for health care in Oklahoma County.

**LOGISTICS (1 MINUTE)**

So that's the big picture. Now let's talk about how this process will work. We'll be here for about an hour. Please help yourself to refreshments if you haven't done so already. If you want to get up to get more to eat or drink, or go to the bathroom, feel free to do so. We do have people observing to take notes, and we are also audio recording the session for reporting purposes. Your comments will be summarized and reported anonymously, though, and we won't ever identify you personally as a participant.



## GROUND RULES (2 MINUTES)

Have any of you participated in a community chat before?

The rules are simple: I'll bring up a topic, and I want to get your thoughts and opinions.

Sometimes I'll ask a question and we'll just go around the table and get everyone's thoughts, and other times I'll just wait for anyone to answer.

Feel free to respond to something that someone else says, and feel free to disagree. Please keep in mind there are no wrong answers.

At certain points during our discussion I may poll the group to determine how many of you agree or disagree about a certain issue. This will be done to summarize opinions for reporting.

To help guide our "way of being" today, we invite you to review the Touchstones for collaboration in front of you.

Keep in mind that respect for others, even if you disagree with their opinions is key during this time, and we want everyone to participate. If you're not talking, I'll eventually notice and ask you for your opinions.

On the other hand, if you're the only one talking, please recognize that and give others a chance to participate.

Finally, I may politely interrupt if you're talking about something that strays off our topics. We can add it to the parking lot and revisit at the end of the session, if time permits. No disrespect is intended if I do this, but we have a lot to accomplish tonight so we need to stay focused so we can make sure that we don't need to keep you beyond our scheduled time.

## Educational Experience

1. Talk about your overall experience with education from grade school up to now. This could be public education, technical school, college, etc.

*Positives?*

*Negatives?*

*Interactions with teachers?*

*Interactions with other students?*

2. Did you have any role models or mentors along the way?
3. How do your friends and neighbors view education?
4. What are some things that made you decide not to seek more education?

*Money?*

*Needed to work?*

*Didn't like school?*

*Are there benefits to having a higher education degree?*

5. As you think back to earlier schooling, what were your aspirations about school, work? How did they change over time, as you grew older?
6. What are your goals for school and work in the future?

*How do you imagine getting there?*

*What are the barriers you face in getting there?*

*What support exists or do you wish existed?*

7. What do you think would make it easier for students to enroll in school?
8. What do you think would make it easier for students to stay in school?
9. Is there anything else you would like to share?

## Conclusion

Thank you for participating in this discussion. The information you have provided will be very helpful.

## Access to Healthy Food

## Facilitation Guide

**Date:**

**Facilitator name:**

**Location:**

## WELCOME AND BACKGROUND ON THE COMMUNITY CHAT (1 MINUTE)

Welcome. Thank you for making time to be here today. My name is \_\_\_\_\_ and I am with the Central Oklahoma Health Impact Team or what we refer to as COHIT. COHIT includes the four non-profit hospitals in Oklahoma County: INTEGRIS Health, Mercy, OU, and SSM St. Anthony; working in partnership with other community partners such as the City-County Health Department, the Oklahoma City Community Foundation, Blue Cross/Blue Shield of Oklahoma, and many other stakeholders to improve the health of the community, outside the walls of their hospitals.

Before we get started, I'll give you an introduction about what we're going to do tonight and the reasons that we're doing it. COHIT is interested in hearing from citizens like yourselves to assess your feelings, perceptions and knowledge of meaningful employment in Oklahoma County. This community chat is part of a health needs assessment being conducted in Oklahoma County to determine the current and future health needs of residents here. The feedback we get tonight will be combined with other research in order to create a long-term strategy for health care in Oklahoma County.

## LOGISTICS (1 MINUTE)

So that's the big picture. Now let's talk about how this process will work. We'll be here for about an hour. Please help yourself to refreshments if you haven't

done so already. If you want to get up to get more to eat or drink, or go to the bathroom, feel free to do so. We do have people observing to take notes, and we are also audio recording the session for reporting purposes. Your comments will be summarized and reported anonymously, though, and we won't ever identify you personally as a participant.

## GROUND RULES (2 MINUTES)

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Finally, I may politely interrupt if you're talking about something that strays off our topics. We can add it to the parking lot and revisit at the end of the session, if time permits. No disrespect is intended if I do this, but we have a lot to accomplish tonight so we need to stay focused so we can make sure that we don't need to keep you beyond our scheduled time.

## Ideal Job

*[Rationale | To elicit participants' ideas about what meaningful employment means to them.]*

1. Take a few moments to think about your ideal job. We will take turns sharing our thoughts.
  - a. Question 1A| What is your ideal job? Give examples.
  - b. Question 1B| Complete this sentence [When I work as a [1 ideal job], I can . . .
  - c. Question 1C | On a scale of 1 (not confident) to 5 (super confident), how confident do you feel that you will achieve your ideal job in 1 | 3 | or 5 years?
  - d. Question 1D | Who would like to share why they selected their number?

2. *[Rationale | To elicit participants' experiences about how they are supported to achieve their ideal job.]*

- a. Question 2A| Who helps you on your path to achieve your ideal job? How?
- b. Question 2B| What programs help you on your path to achieve your ideal job? How?
- c. Are there any programs that...
  - Prepare you to apply for a specific job?
  - Help you obtain a certificate?
  - Train you on specific skills?
  - Connect you with potential employers?

3. What are the top three (3) challenges most people face on the path to their ideal job? *The top two (2) challenges (per participant vote) are used in this following discussion: [Rationale | To elicit participants' perceptions of challenges that most people face when seeking meaningful employment.]*
  - a. Question 3A | Why do so many people face [Challenge 1 |2 ]?
  - b. Question 3B | On a scale of 1 to 5, how difficult is it for most people to overcome [Challenge 1 |2 ]?
  - c. Question 3C | What do most people need to overcome [Challenge 1 |2 ]?
4. Do you have anything else to add about finding meaningful employment?

## Conclusion

Thank you for participating in this discussion. The information you have provided will be very helpful.

## Access to Healthy Food

### Facilitation Guide

**Date:**

**Facilitator name:**

**Location:**

## WELCOME AND BACKGROUND ON THE COMMUNITY CHAT (1 MINUTE)

Welcome. Thank you for making time to be here today. My name is \_\_\_\_\_ and I am with the Central Oklahoma Health Impact Team or what we refer to as COHIT. COHIT includes the four non-profit hospitals in Oklahoma County: INTEGRIS Health, Mercy, OU, and SSM St. Anthony; working in partnership with other community partners such as the City-County Health Department, the Oklahoma City Community Foundation, Blue Cross/Blue Shield of Oklahoma, and many other stakeholders to improve the health of the community, outside the walls of their hospitals.

Before we get started, I'll give you an introduction about what we're going to do tonight and the reasons that we're doing it. COHIT is interested in hearing from citizens like yourselves to assess your feelings, perceptions and knowledge of access to healthy food in Oklahoma County. This community chat is part of a health needs assessment being conducted in Oklahoma County to determine the current and future health needs of residents here. The feedback we get tonight will be combined with other research in order to create a long-term strategy for health care in Oklahoma County.

## LOGISTICS (1 MINUTE)

So that's the big picture. Now let's talk about how this process will work. We'll be here for about an hour. Please help yourself to refreshments if you haven't done so already. If you want to get up to get more to eat or drink, or go to the bathroom, feel free to do so. We do have people observing to take notes, and we are also audio recording the session for reporting purposes. Your comments will be summarized and reported anonymously, though, and we won't ever identify you personally as a participant.

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These three areas will be covered:

1. Food routines
2. Access to health foods
3. Food and health

### Ice Breaker: (10 min)

*[Go around the room and have participants introduce themselves and answer the icebreaker.]*

1. Please tell us your name and share a favorite memory where you and friends or family gathered and shared food.

*[To warm up the room, go around the room for the first one or two questions. Then, ask for volunteers to answer questions. Try to get 3-4 people to respond to each question. If at some point no one responds to a question, you can try to rephrase the question or just move on. If participants quiet down, on the next question, go around the room again.]*

*[Also, if questions have been answered along the way, skip them.]*

### Food Routines (15 min)

*We are going to start by talking about some of your food routines:*

2. Tell us about a typical dinner in your household. What foods do you eat? Who is there? **Preparing foods at home or eating out?**
3. Describe how you or your family members get food. Describe what you like and don't like about the experience? *(How often do you shop, what are your top priority/staple foods?)*
4. Talk to us now about fresh food (fruits, vegetables, meat, fish, etc.) – can you get the kinds of fresh food that you want in your neighborhood?

*Where do you get these?  
How far from your home?  
Culturally appropriate?*

### Access to Healthy Foods (20 min)

5. Do you feel that many households in the community have difficulty getting the foods they need?

*Why or why not?*

6. Do members of your community ever run out of food?

*How did they deal with that?*

*Where did they turn for help?*

*Are there certain times this is worse?*

7. What programs or resources are available that help people get the food they need?

*(food pantries, SNAP, WIC, free/reduced lunch, etc.)*

8. If you could open the ideal “healthy food place” in your community, what would it be and what products and services would it provide? Where would you put it?

Or

Imagine you have the opportunity to do something in your community to help people have an easier time getting the foods that they want or need. What would you do?

*If no suggestions, probe:*

- Bring stores closer
- Start a food co-op
- Start a farmers' market
- Create outreach programs
- Establish a community garden
- Outreach or information programs
- Application assistance programs
- One application for all programs
- Change in hours of program operation
- Transportation improvements
- Training for professional staff on the programs and on the community's culture
- Provide better public transportation
- Establish and enforce cleanliness in stores
- Try to get more choice in supermarkets

## Health [15 min]

9. Are there any diet related issues you notice in your community? What are these?
10. Do you know someone who has been told (by a doctor or other health professional) to eat differently, do they?

Why/ why not? *(We're looking for behavior change as a result of medical diagnosis as well as success/barriers in accessing the foods.)*

11. What makes it hard to eat a healthy diet?
12. Where locally can you get information about healthy eating or healthy foods? Is the information helpful? If no, what else would you like to have available? *(e.g. nutrition education, cooking techniques and recipes, other)?*
13. If you are interested in participating in healthy food classes, what specifically do you want to know more about? *(food preparation, diet for diabetes, – label literacy, budgeting for food, shopping tips. Label literacy helps decipher the jargon found on nutrition labels and various components of a nutrition labels such as Carbohydrates, Protein, Sugar, Fiber, Sodium, etc and their effects on the body.)*
14. Are there ways you would like to be involved in improving the availability of healthy foods or helping community members make healthier food choices?
  - Individual level? (i.e. providing education to neighbors on how to access healthy foods)
  - Community level? (i.e. partnering with community-led initiatives, like Mobile Markets or the Market at Eastpoint)
  - Policy level? (i.e. establishing food policy councils in cities and counties to explore ways to increase production, consumption and overall availability of health local foods; farm to school/ local store initiatives)
15. Is there anything else you would like to say about food and your community?

## Conclusion

Thank you for participating in this discussion. The information you have provided will be very helpful.

## Methods:

Using a sample of nonprofit hospitals in the Oklahoma City area, the research team conducted structured in-depth qualitative and quantitative analysis using ethnographic examination of community chat interviews. The interviews were then analyzed and coded by a team of experts to ascertain major themes. After all interviews were coded, coders took interrater reliability tests to confirm coding applications based on random samples of excerpts where codes were applied. A second round of interrater reliability tests were administered to community chat facilitators to establish clarity on coding applications across administrative levels of the qualitative research efforts.

This is a qualitative study with multiple methods used to collect and provide data that will help organizations in the Oklahoma City area for their Health Needs Assessment. Between May 23 until June 30,2021, 111 participants with the average age of 51, engaged in 16 community chats aimed to discuss issues on four categories; 4 community chats on Healthcare Access, 4 community chats on Food Access, 3 community chats on Education and 5 community chats on Employment.

2022 OKLAHOMA COUNTY COMMUNITY HEALTH NEEDS ASSESSMENT | COHIT

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