HEALTHY OKLAHOMA

2020

Bringing Oklahoma's Health Into Focus

OKLAHOMA HEALTH IMPROVEMENT PLAN

ACKNOWLEDGEMENTS

This plan would not be possible without the effort of numerous partners who contributed to the update of the Oklahoma Health Improvement Plan. The Oklahoma State Department of Health appreciates the executive and full team members for their guidance in providing insight and direction for the report.

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LETTER FROM THE CHAIR OF THE OKLAHOMA HEALTH IMPROVEMENT PLAN

Dear Health Improvement Partners and Residents of Oklahoma:

It has been five years since we responded to a call for action to improve the health of Oklahomans through development of the Oklahoma Health Improvement Plan. Since we issued the report in 2010, we have seen major gains in critical health outcomes. Some examples include:

- Reduction in the percent of public high school students who are obese
- Reduction in the infant mortality rate
- Increase in the number of school districts working to create a healthy environment that incorporates nutritious food and time for physical activity
- Reduction in tobacco use among adults and adolescents
- Increase in the number of schools that are tobacco free 24 hours a day, 7 days a week

Yet, there is still room for improvement. Many Oklahomans continue to be obese. A large percentage of pregnant women do not receive prenatal care and many babies are born with low birth weight, especially among African-American people. Too many youth begin smoking or using tobacco products every year. Some Oklahomans don't have the same access to quality health services as others. We must create and assure conditions where the healthy choice is the easy choice to address the health challenges we face in our state and meet the goals of Healthy Oklahoma 2020.

For the past year it has been an honor to travel across this great state and seek your input. We have heard from business leaders, school teachers, healthcare providers, professional organizations, tribal nations and many others. Your words have been loud and clear; collaboration is the key to our continued success. Our conversations also reaffirmed that best practices exist today which, when implemented, will ensure our efforts lead to sustainable change.

This plan focuses our efforts on making improvements in key strategic areas and creating a culture of health. Making improvements in these flagship issues will have the greatest impact on the health of Oklahomans now and for future generations. These include:

- Tobacco Use
- Obesity
- Children's Health
- Behavioral Health

As you read through this report I urge you to find a place in your local community to connect and actively make a difference where families live, work, play and learn. Please visit our website at **www.OHIP2020.com** where you will find specific suggestions and helpful tools and will learn more about the important role everyone has in Shaping Our Future and creating a culture of health.

Sincerely,

TERRY CLINE, PH.D.
Secretary of Health and Human Services
Commissioner of Health

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VISION

OKLAHOMA WILL BECOME A CULTURE OF HEALTH.

MISSION

OKLAHOMANS WORKING TOGETHER TO IMPROVE AND SUSTAIN OUR HEALTH AND WELLNESS.

VALUES

ACCOUNTABILITY	To the people of Oklahoma for a greater good
ADAPTABILITY	To innovate and think beyond traditional solutions
INTEGRITY	To ensure the health improvement process is transparent, fair and ethical
SUSTAINABILITY	To sustain a culture of health
INCLUSIVITY	To actively engage a diverse range of stakeholders

REFLECTION

SUCCESSES AND CHALLENGES

In recognition of the fifth anniversary of the Oklahoma Health Improvement Plan (OHIP), it is appropriate to celebrate the successes of this initiative as well as to identify remaining health issues and challenges.

SUCCESSES

- The Governor's Executive Order prohibiting the use of all tobacco products on all state property has positively impacted 220 state agencies, boards and commissions as well as the health and well-being of state employees and the public since 2012.[1]
- Adults who smoke cigarettes had decreased from 26.1% in 2011 to 23.3% in 2012 and remained steady at 23.7% in 2013.[2]
- The per capita cigarette consumption decreased from 79.0 packs per capita in 2009 to 67.2 packs per capita in 2013.[3] There were almost 44 million fewer packs of cigarettes sold in Oklahoma in 2014 than in 2009.
- As of 2014, 85% of Oklahoma public school students are now attending a 24/7 tobacco-free school.[4]
- The percentage of public high school students who drank soda one or more times per day decreased from 38.1% in 2009 to 31.3% in 2013.[5]
- The percentage of public high school students who were physically active at least 60 minutes per day on 5 or more of the past 7 days increased from 47.4% in 2009 to 56.6% in 2013.[5]
- The percentage of public high school students who rode with a driver who had been drinking alcohol decreased from 23.1% in 2009 to 17.6% in 2013.[5]
- Oklahoma has achieved dramatic improvement in infant mortality rates, decreasing from 8.6 infant deaths per 1,000 live births in 2007 to 6.8 in 2013, a relative decrease of 21% since 2007.[6]
- Certified Healthy Oklahoma experienced exponential growth. In 2009, two Certified Healthy programs were available that attracted 193 applicants and awarded 186 certifications. In 2014, a total of seven Certified Healthy programs were available attracting 1958 applicants and awarding 1710 certifications. This is a 914.5% increase in applications received and an 819.4% increase in certifications awarded since 2009.[7]

These successes reflect that Oklahomans and communities are implementing effective and sustainable behavior changes and policies that are conducive to health.

CHALLENGES

Despite these notable improvements, there continue to be challenges. Oklahoma is ranked 46th in overall health according to the 2014 United Health Foundation (UHF), up from 49th in 2009.[8] As concerning is the fact that Oklahoma's death rate exceeds the nation's rate and deaths due to individual diseases or conditions are often much higher than other states. Oklahoma has the 4th highest rate of deaths from all causes in the nation, 23% higher than the national rate. Perhaps more disturbing is the fact that while Oklahoma's mortality rate dropped 5% over the past 20 years, the U.S. mortality rate dropped 20%.[9, 10] Oklahoma is not keeping up with the rest of the nation, which means more Oklahomans are dying unnecessarily each and every year.

More needs to be done if we are to achieve optimal health for Oklahomans throughout their lives. Oklahoma intends to meet that challenge through the engagement of the business community through private/public partnerships, collaboration with key stakeholders, coordinated health initiatives with tribal nations and through the involvement of communities in shaping positive health strategies. The OHIP involves broad and diverse stakeholder participation from key state agency and tribal health directors, insurance representatives, members of the public health community, public and private health-care providers, the business community, professional associations, academic officials, and community members.

When the priorities identified in this plan are accomplished, key risk factors contributing to negative health outcomes in Oklahoma will have been reduced. Health system transformation will yield a sustainable health model capable of delivering care that achieves optimal health through the prevention of disease and ensuring access to quality care for all Oklahomans. The OHIP also addresses individual conditions, health behaviors and key populations through a focus on flagship issues targeting tobacco, obesity, children's health and behavioral health. Health must begin where people live, work, play and learn. This plan builds upon that intention.

SETTING THE STAGE OKLAHOMANS' DEMOGRAPHIC, SOCIOECONOMIC, AND PERSONAL HEALTH BEHAVIOR

DEMOGRAPHICS

From 2010 to 2013, the Oklahoma estimated total population has grown from 3,761,702 to 3,850,568 people (2.4%). In 2013, 79.9% of the population were white; 13.3% American Indian; 8.9% were African-American; 3.1% was some other race; 2.4% were Asian; and 0.3% was Native Hawaiian and other Pacific Islander. The estimated percentage of whites has declined 0.6%. American Indians/Alaska Natives have increased 3.2%, while African-Americans and Asian populations remain fairly constant. During this same time period, the Hispanic population has grown 0.8%.[11] In 2013, 35.0% of Oklahomans live in rural communities.[12] The population in rural Oklahoma has steadily declined since the middle of the last century and most of the population growth is concentrated around the metropolitan areas and expanding suburban communities.[13]

EDUCATION

In 2013, 86.7% of Oklahomans 25 years and older have a high school degree or higher and 23.5% have attended college but obtained no degree. Only 16.1% of Oklahomans have a bachelor's degree and 7.7% have a graduate or professional degree. Less than half of Oklahomans over 25 years of age (45.6%) have no college experience.[11]

POVERTY AND INCOME

In 2013, as many as 16.8% of Oklahomans earned income in the past 12 months that is below poverty level, compared to the national average of 15.8%. The child poverty rate for Oklahoman children under 18 is 24.0%. While Oklahoma's unemployment rate is better than the national figure, the state's median household income of $45,690 is 14.6% lower than the national figures.[11]

ACCESS TO HEALTHCARE

The rate of uninsured Oklahoman adults dropped from 18.4% in 2012 to 17.7% in 2013; nevertheless it was still 5.0% higher than the national rate.[14] One in four Oklahoma adults (35th in the nation) reported they did not have a usual source of care.[9] In 2014, Oklahoma only has 84.8 primary care physicians per 100,000 populations (48th in the nation).[8]

The need is greater in rural Oklahoma where 40% of the population is served by only 28% of the 3,660 primary care physicians in Oklahoma.[15] The physician workforce is aging; furthermore, primary care physicians in rural Oklahoma are older compared to their urban counterparts.[16]

ACCESS TO FOOD AND FOOD INSECURITY

In 2012, it is estimated that 17.2% (656,300) of Oklahomans experience lack of access to enough food for all household members and uncertain availability of nutritiously adequate foods, including nearly 239,380 children.[17] Out of the 77 counties in Oklahoma, residents in 43 counties have to travel more than 10 miles to reach a full service grocery store in rural areas and more than a mile to a grocery store in urban areas.[18]

HOUSING

The percentage of Oklahomans paying home mortgages that are 30% or more of their income is 24.4%. Approximately 18% of Oklahomans are paying 35% or more of their income. Approximately 45% of Oklahomans are paying rent at or above 30% of their income and 36.3% pay rent at 35% or more of their income.[11]

AGING

In 2014, Oklahoma was ranked 47th in the health of older adults, an improvement from a 49th ranking in 2013.[19] Significant challenges for the health of older adults in Oklahoma include the highest rate of hip fractures among Medicare beneficiaries, the second highest rate of physical inactivity, the third highest rate of falls, the seventh highest ranking overall on unhealthy behaviors, and the lowest rate of hospitalized older adults who received recommended care for heart attack, heart failure, pneumonia, and surgical procedures. Oklahoma ranked the last overall in public health policies and programs supporting older adults.[19] Older adults are currently 14.2% of Oklahoma's population and their numbers are projected to increase by 36.8% from 2015 to 2030.[11, 19]

DISABILITY

Approximately 15.8% of Oklahomans living at home have a disability.[11] Nearly 9 out of 10 Oklahoma adults have difficulty using everyday information that is routinely available in healthcare facilities, retail outlets, media, and communities.[20]

PERSONAL HEALTH BEHAVIORS AND HEALTH OUTCOMES

Many Oklahomans engage in lifestyles and behaviors that put them at a higher risk for chronic diseases, disabilities, and deaths. These behaviors are directly related to the leading causes of death in Oklahoma, including cardiovascular disease, cancer, stroke, respiratory disease, and unintentional injuries.

In 2013, Oklahoma received the following rankings on personal health behaviors and outcomes in the nation:

49th

50.4%

on fruit consumption of less than 1 time per day among adults[21]

47th

62.7%

on children age 19 to 35 months who are up-to-date on their recommended immunizations[8]

47th

33%

on physical inactivity among adults[21]

45th

23.7%

on smoking among adults[8]

44th

32.5%

on obesity among adults[8]

44th

4.3 DAYS

on number of poor mental health days in the past 30 days reported by adults[8]

42nd

4.4 DAYS

on number of poor physical health days in the past 30 days reported by adults[8]

39th

25.3%

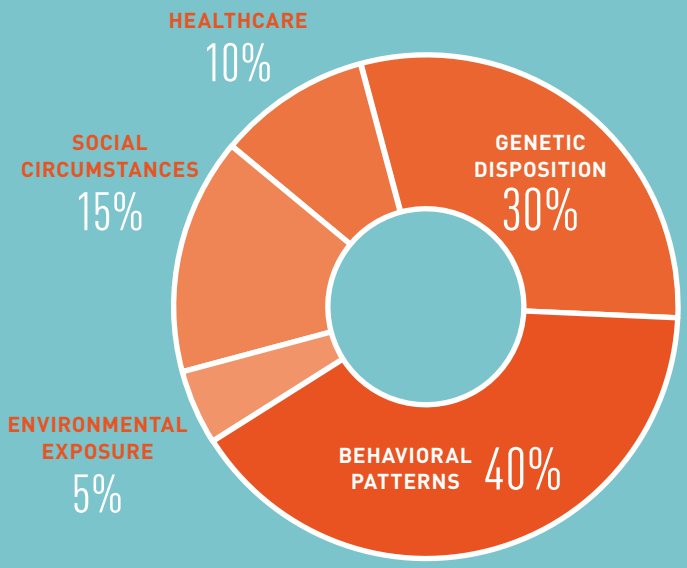
on vegetable consumption of less than 1 time per day among adults[21]

MAKING THE CONNECTION

SOCIAL DETERMINANTS, PERSONAL BEHAVIORS, AND HEALTH OUTCOMES

Poor health outcomes, higher rates of disease and overall higher total deaths are the result of a complex interaction of multiple factors (see Figure 1).[22] Inadequate access to quality healthcare contributes to 10% of poor health and premature death while unhealthy behaviors account for 40% of illnesses and premature death in the United States. Smoking, unhealthy dietary practices, physical inactivity and excessive alcohol consumption are the biggest contributors to chronic disease, premature deaths and disability in Oklahoma and our nation.[23]

FIGURE 1 *Determinants of Health and Their Contribution to Premature Death* [22]



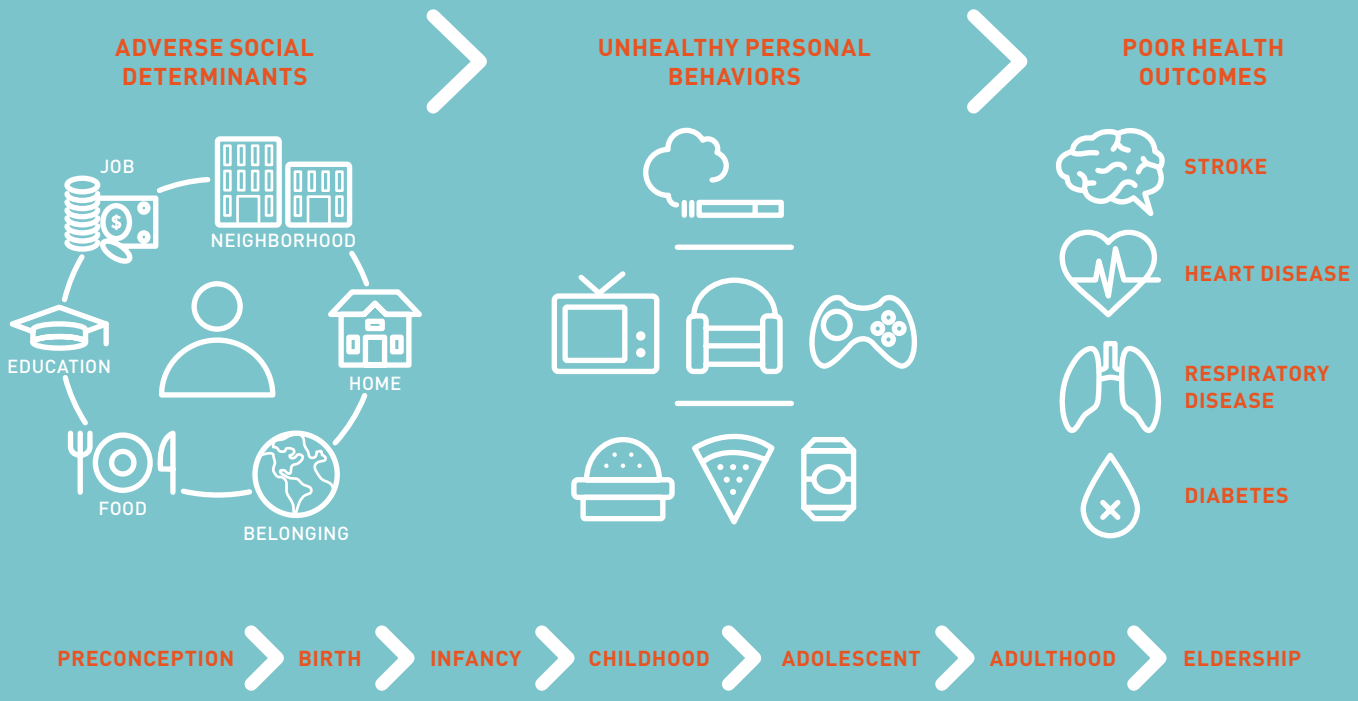
Altering these unhealthy personal behaviors will dramatically improve Oklahoma's health status but people do not make health decisions and behavior choices in isolation. Personal health decisions are made within a larger and complex set of social and physical surroundings, including the people around them; the places they live, work, learn, play, and gather; the options available to them; and practices of their peers. Even those with the healthiest of intentions may be quite limited in the choices they are able to make. How a person interacts with their social and physical surroundings is shaped by one's individual and socioeconomic characteristics such as gender, race/ethnicity, educational attainment, income level, housing condition, and geographic attributes.[24, 25, 26, 27]

For example, people with lower educational attainment are more likely to struggle to support themselves and their families due to unstable employment and low income. They typically spend a significant portion of their income to pay for housing, which takes away money for nutritious food for them and their family.

Living in a low-income neighborhood that has high crime rates and lacks access to safe places for physical activity, to affordable and healthy food, and to affordable high-quality healthcare contributes to high stress levels, tobacco and alcohol addiction, physical inactivity, unhealthy diet, and delays in seeking preventive care and medical treatment. These unhealthy behaviors may lead to heart disease, stroke, cancer, diabetes, depression and many other health and social problems. (See Figure 2)

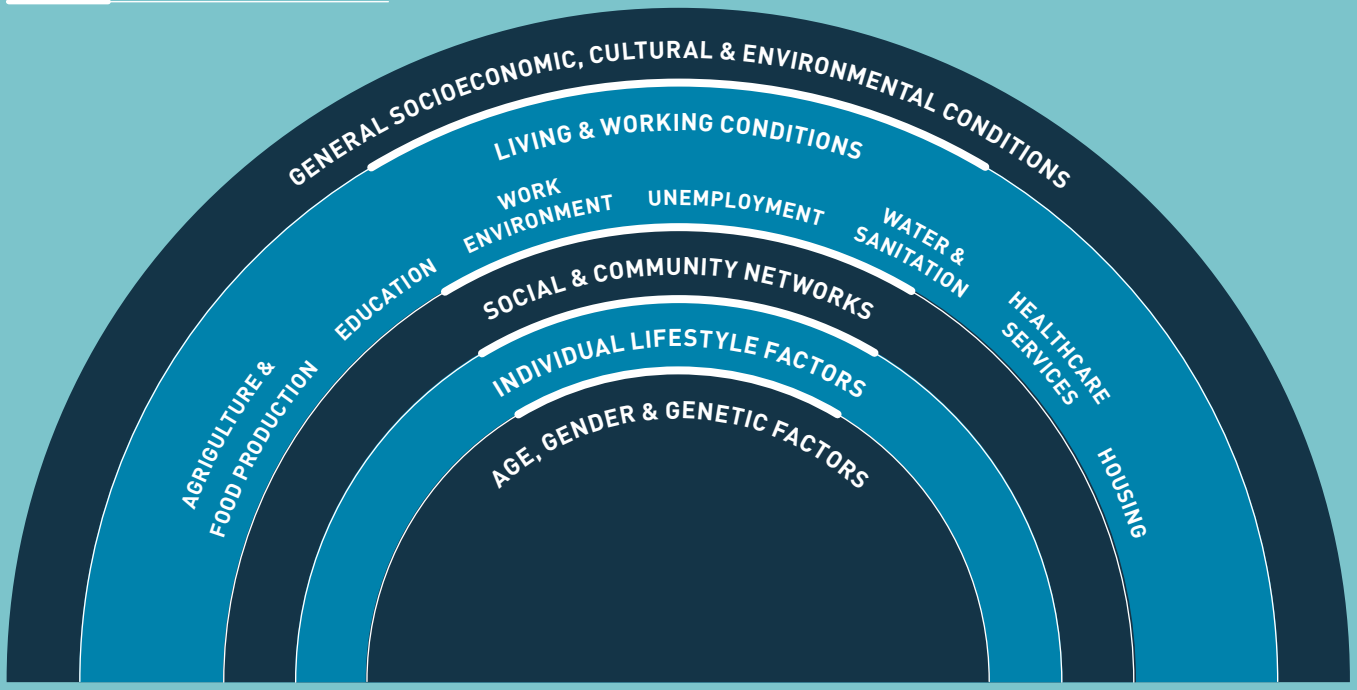
Children who encounter ACEs during their upbringing often have lasting negative effects on their health and well-being. Sadly, the cycle continues as children grow up with poor health. Their well-being deteriorates, which is then passed onto future generations.[28, 29] Thus, achieving optimal health and well-being must go beyond medical care to addressing the broad social, economic, and environmental factors that are the underlying causes of persistent inequalities in health for a wide range of diseases and conditions across the population.

FIGURE 2 *Making the Connection: Social Determinants, Personal Behaviors, and Health Outcomes*



The model below recognizes the interconnection between individuals and their environment (See Figure 3). As the factors that affect health are addressed at individual, interpersonal, organizational, community, and public policy levels, behavior change will become more achievable and sustainable.[30]

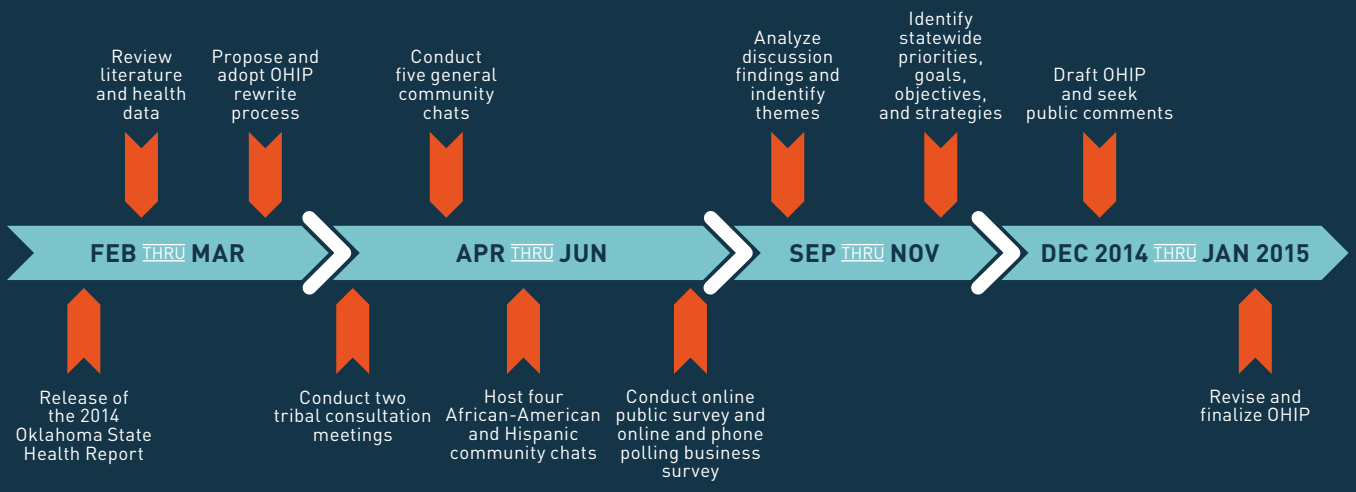
FIGURE 3 *Socio-Ecological Model*



STAKEHOLDER INVOLVEMENT AND METHODS USED

The year 2014 began a year-long process of reviewing published health data and emerging public health frameworks, engaging a diverse group of stakeholders and communities via multiple formats, brainstorming and selecting strategic direction, and consulting with content experts regarding evidence-based practices to improve the health of Oklahomans. Figure 4 summarizes the process involved in creating Healthy Oklahoma 2020 – the updated Oklahoma Health Improvement Plan.

FIGURE 4 *Timeline 2014 OHIP Stakeholder and Community Involvement Process*



HEALTH DATA + COMMUNITY INPUT + EVIDENCE-BASED PRACTICE

Below are highlights of the process utilized to obtain community and sovereign nation input:

GENERAL COMMUNITY CHATS
focused on the local communities of Enid, Lawton, McAlester, Oklahoma City and Tulsa.

FORMAL TRIBAL CONSULTATIONS
were conducted since Oklahoma tribal nations are inherently sovereign. One was hosted by the Cherokee Nation in Tahlequah and the Absentee Shawnee Tribe in Little Axe.

AFRICAN-AMERICAN COMMUNITY CHATS
focused on African-American people in the Oklahoma City and Tulsa areas.

HISPANIC/LATINO COMMUNITY CHATS
focused on Hispanic/Latino people and were held in Guymon and Oklahoma City.

BUSINESS SURVEY
was conducted online and via phone polling. In addition, in-depth interviews were conducted with employers that invest in employee wellness. In total, more than 750 businesses participated in a survey designed to highlight the impact of poor health outcomes and medical costs on Oklahoma businesses and the benefits of investing in employee wellness.

ONLINE SURVEY
was made available for all Oklahomans and reflective of the questions that were posed during the Community Chat process.

The community chats and tribal consultations started with a video presentation by Dr. R. Murali Krishna on the healing connection between the mind, body and spirit, how each one influences the other, and the importance of improving health at the community level. The community chats, tribal consultations and online surveys asked the following essential questions:

1. WHAT IS YOUR VISION FOR A HEALTHY COMMUNITY?
2. WHAT ARE THE BARRIERS THAT PREVENT US FROM ACHIEVING THAT VISION?
3. HOW CAN WE ADDRESS THOSE BARRIERS?

FIGURE 5 *Summarizes the feedback from general community chats, African-American and Hispanic chats.*

GENERAL

ACCESS
Healthy Foods
Physical Activity
Health Services
Health Education

COMMUNITY
Economic Development
Education
Transportation

BEHAVIORAL HEALTH

AFRICAN-AMERICAN

COMMUNITY FOCUS

SAFETY

OUTLETS FOR PHYSICAL ACTIVITY

ECONOMIC DEVELOPMENT

EDUCATION

PREVENTION

HISPANIC

FAMILY FOCUS

HEALTH EDUCATION

ECONOMIC DEVELOPMENT

YOUTH AS KEY FAMILY MEMBER

TRIBAL

INTER-GOVERNMENT COLLABORATION

MIND, BODY, SPIRIT

HEALTH LITERACY

CHRONIC DISEASE

DATA

TRIBAL CONSULTATION SESSIONS AND THE TRIBAL PUBLIC HEALTH ADVISORY COMMITTEE

American Indian people residing in the State of Oklahoma are citizens of the state, and as such possess all the rights and privileges afforded by Oklahoma to its citizens. They are also the citizens of tribal nations. OHIP acknowledges that each of the 38 federally recognized Oklahoma tribal nations have inalienable self-governance power over their citizens and territories, and possess unique culture, beliefs, value systems, and history as sovereign nations.

During the development of OHIP, formal tribal consultation meetings were held in April and June 2014, in Tahlequah, and Little Axe, Oklahoma. These meetings provided valuable information into directing the future actions to improve health outcomes in Oklahoma, such as access to healthy foods, availability of American Indian-specific health data as well as taking a holistic approach to prevention programs. As a result of these consultation sessions, it became apparent that many participants wanted the establishment of a Tribal Public Health Advisory Committee (TPHAC) comprised of various tribal representatives from across the state to inform public health and health practices in the State of Oklahoma and create inter-governmental collaborative partnerships for health improvement.

The TPHAC's primary purpose is to seek consensus, exchange views, share information, provide advice and/or recommendations, or facilitate any other collaborative interaction related to public health responsibilities or implementation of programs. This purpose will be accomplished through forums, meetings and conversations between state public health officials and health directors representing tribal nations, and tribal-serving urban clinics, health boards and other individuals. TPHAC will be a forum for collaboration on OHIP strategies, public health initiatives and key health programs.

BUSINESS SURVEY FEEDBACK

A business survey was conducted in order to gain perspective of the full impact of poor health outcomes and rising healthcare costs to the business community. This serves as an acknowledgement that economic development and personal income are critical to a healthy community and population, and a healthy workforce is the fuel for business growth. Key findings from this survey are as follows:

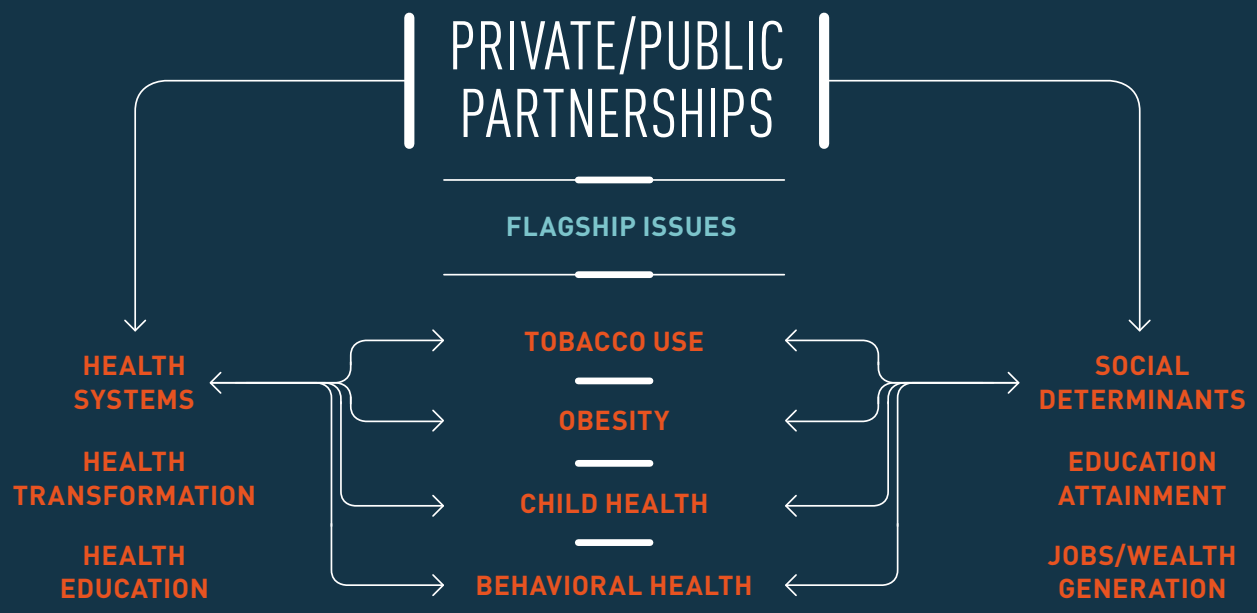
- Rising healthcare costs are impacting the bottom line of businesses reducing potential for growth, reducing growth in employee wages, and increasing benefit share for workers.
- Half of the businesses surveyed indicated that employee health impacts their business. The top three challenges are the following:
  - Making positive lifestyle choices
  - Losing weight
  - Seeing a doctor for preventive care
- Many business owners want tools and assistance to create a healthy work environment.
- Businesses indicated that key health behaviors should be prioritized and addressed by the state:
  - *"Oklahoma has some real challenges that make it hard for us to achieve an impact on the health of our employees. For example, the state is tobacco friendly, and many of our employees use tobacco products."*
- Insure Oklahoma, a locally developed insurance program, is popular among businesses but enhancements, including creating better access to coverage, were recommended.

UPDATING THE OHIP

PROCESS AND FRAMEWORK

The process outlined above and the resulting information yielded the following structure (See Figure 6) for the updated Oklahoma Health Improvement Plan:

FIGURE 6 *OHIP Framework*



A key to success in the implementation of the plan is private / public partnerships directed at common goals. Partnerships will include close collaboration with sovereign tribal nations in Oklahoma. Having gained a commitment and shared understanding by OHIP partners about strategic health issues and priority populations will lead to rapid improvement in the following flagship priorities:

- **TOBACCO USE** – despite significant improvement in recent years, tobacco use remains the leading cause of preventable death in Oklahoma
- **OBESITY** – highly associated with premature death from cardiovascular disease and cancer, it also greatly increases the risk of diabetes and other chronic health conditions
- **CHILD HEALTH** – from infant mortality to immunization rates, the preventive steps taken at the earliest stages of life can have a profound impact on future health status
- **BEHAVIORAL HEALTH** – a newly added flagship issue, the interconnection between one's physical and mental health cannot be ignored, as success in one is dependent upon success in the other

These flagship issues reflect the importance of healthy living as a necessary condition for achieving and maintaining good health and happiness. Yet an individual's ability to live healthy is influenced by his/her environmental conditions, i.e., social determinants of health. Adequate transportation, educational attainment, income, housing, social support and safe neighborhoods are necessary foundations for healthy communities.[25] While the role of individual lifestyle choices cannot be minimized, the social and physical influences of one's surroundings cannot be underestimated. Thus, these social determinants of health are taken into account in the work surrounding the flagship issues of OHIP and find a specific designation within the model.

Educational attainment and wealth creation, important social determinants that impact health outcomes, connect with other statewide efforts currently underway. Oklahoma Works is an initiative to increase the wealth of all Oklahomans through facilitating quality employment for workers and ready availability of highly skilled talent for business and industry. The initiative is a coalition of state agencies, educational institutions, businesses and other partners. The goals of Oklahoma Works are to:

- Align education outcomes and workforce and economic development policy
- Create efficiency and collaboration among partner agencies
- Ensure consistency across the state while encouraging local adaptation
- Create the expectation of stellar customer focus for all

More information regarding Oklahoma Works can be found at **http://oklahomaworks.gov** and specific measures regarding education and workforce training can be found on OK State Stat at **http://www.ok.gov/okstatestat**.

Another important factor in achieving optimal health is strong systems that assist the population in making good health decisions and improving health behavior. This includes access to high-quality, affordable health services and the delivery of health education across the lifespan.


OKC
OKC

OHIP 2020: FLAGSHIP GOALS AND STRATEGIES

TOBACCO USE

The OHIP acknowledges the traditional and sacred use of tobacco among American Indian people living in Oklahoma. Whenever the word tobacco is referenced in this report it refers to the use of commercial tobacco.

Tobacco continues to be the leading preventable cause of death in Oklahoma, causing about 6,000 deaths in our state per year. Smoking kills more Oklahomans than alcohol, auto accidents, AIDS, suicides, murders and illegal drugs combined.[31] Oklahomans spend approximately $1.62 billion per year on smoking-related health costs, while the tobacco industry spends an estimated $160.3 million dollars annually to market tobacco products in Oklahoma.[32, 33, 34]

The Oklahoma adult smoking prevalence decreased from 26.1% in 2011 to 23.3% in 2012 and remained steady at 23.7% in 2013.[2] Oklahoma's adult smoking rate is still far above the national average of 17.8%.[35] Approximately one in four Oklahoma adults smoke compared to one in five nationally.[2] The percentage of public high school students who were current, frequent smokers decreased from 9.1% in 2009 to 5.5% in 2013.[5] Each year about 4,400 Oklahoma children become new daily smokers.[36]

OHIP measures focus on **1)** decreasing the incidence of chronic disease caused by or impacted by tobacco use and secondhand smoke exposure and **2)** decreasing the proportion of Oklahoma children who become new daily smokers.

TOBACCO USE

CORE MEASURES

- *Reduce adult smoking prevalence from 23.7% in 2013 to 18% in 2020 (2018 data).*
- *Reduce adolescent smoking prevalence from 15.1% in 2013 to 10% in 2020 for high school-aged youth and from 4.8% in 2013 to 2% in 2020 for middle school-aged youth (2018 data).*

GOALS	STRATEGIES
GOAL 1 Protect all Oklahomans from exposure to secondhand smoke.	**STRATEGY 1** Extend state law to eliminate smoking in all indoor public places and workspaces, except in private residences, through a comprehensive state law eliminating exemptions by 2020.
	STRATEGY 2 Increase the number of tribal nations that voluntarily adopt laws / policies to eliminate commercial tobacco use in tribally-owned or operated worksites, entertainment (or enterprise venues) and hotels by 2020.
	STRATEGY 3 Increase the proportion of voluntary smoke-free policies as evidenced by a 20% increase in Excellence level certifications in all seven Certified Healthy Oklahoma categories by 2020.
GOAL 2 Prevent initiation of tobacco use by youth and young adults.	**STRATEGY 1** Enact key public policy measures to increase prices on tobacco products by 2020.
	STRATEGY 2 Fully implement evidence-based health communications mass media campaigns according to CDC Best Practices for Comprehensive Tobacco Control Programs by 2020.
	STRATEGY 3 Maintain compliance with laws to prevent illegal sales of tobacco to youth as evidenced by Synar compliance rates greater than 90%.
GOAL 3 Increase by 5% annually the percentage of Oklahoma adults and youth who successfully quit tobacco use.	**STRATEGY 1** Increase the number of hospitals and health systems, healthcare professionals, and community-based clinics that effectively implement the U.S. Public Health Service Clinical Practice Guideline for treating tobacco dependence by 2020 as evidenced by a 10% annual increase in the number of providers completing direct referrals to the Oklahoma Tobacco Helpline via fax or electronic medical record.
	STRATEGY 2 Increase tobacco-free properties at all workplaces including private businesses, state agencies, tribal governments, local governments, hospitals, school districts, universities and colleges, career technology centers and faith-based organizations by 2020.
	STRATEGY 3 Increase by 20% the percentage of smokers utilizing Oklahoma Tobacco Helpline services (treatment reach) by January 2020.
GOAL 4 Increase knowledge of emerging products.	**STRATEGY 1** Develop a tracking system for the sale of electronic cigarettes/electronic devices to youth under the age of 18.
	STRATEGY 2 Routinely conduct assessments that highlight the actual usage of emerging products.

OBESITY

Oklahoma's adult obesity rate at 32.5% puts Oklahoma at the 7th highest adult obesity rate in the nation.[2, 37] Disparities exist wherein obesity rates remain higher among black and Latino communities than among whites. National findings reveal that significant geographic, income, racial and ethnic disparities persist, with similar disparities found in Oklahoma.

The factors leading to obesity are complex. Public health approaches that affect large numbers of different populations in multiple settings—communities, schools, worksites and healthcare facilities—are needed. Policy and environmental initiatives that create incentives to make healthy nutrition choices and physical activity opportunities available will prove most effective in combating obesity.[38]

"A growing number of cities and states have reported decreases in obesity among children, showing that when we make comprehensive changes to policies and community environments, we can build a Culture of Health that makes healthy choices the easy and obvious choices for kids and adults alike."

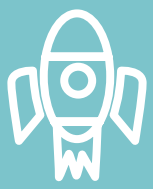
DR. RISA LAVIZZO-MOUREY
President and CEO of Robert Wood Johnson Foundation[39]

OBESITY REDUCTION

CORE MEASURES

- *Reduce adolescent obesity prevalence from 11.8% in 2013 to 10.6% in 2020 (2019 data).*
- *Reduce adult obesity prevalence from 32.5% in 2013 to 29.5% in 2020 (2019 data).*

GOALS	STRATEGIES
GOAL 1 Increase the percentage of the population that have participated in any physical activity in the last 30 days from 71.7% in 2012 to 79.2% by 2020 (2019 data).	**STRATEGY 1** Develop and maintain a scalable Health in All Policies-based partnership framework to address obesity through the targeting of contributing social determinants of health and reducing disparities throughout the state of Oklahoma.
GOAL 2 Increase the median intake of vegetables from 1.6 times per day in 2012 to 2.1 times per day by 2020 (2019 data).	**STRATEGY 2** Build capacity related to evidence-based and promising practices connected with addressing obesity and implementing Health in All Policy models/approaches.
	STRATEGY 3 Improve the built environment infrastructure supportive of physical activity and availability of affordable fruits and vegetables.
GOAL 3 Create a community asset mapping process to identify and monitor obesity reduction efforts currently in place for the purpose of determining gaps and opportunities to supplement local obesity efforts.	**STRATEGY 1** Utilize current surveillance and evaluation systems to collect readily available data and house in a central database.
	STRATEGY 2 Leverage existing and developing networks to identify and locate data and information regarding current local and statewide obesity efforts.
	STRATEGY 3 Communicate with non-traditional partners to determine applicable work that addresses obesity-related social determinants of health for inclusion in the statewide obesity asset map.
GOAL 4 Increase environmental supports for improved nutrition and physical activity as evidenced by a 20% increase in Excellence level certifications in all seven Certified Healthy Oklahoma categories by 2020.	**STRATEGY 1** Increase awareness and utilization of tools available to increase policies and practices addressing obesity that are designated by the Certified Healthy Program as a promising or best practice.
	STRATEGY 2 Target underserved areas to increase the number of entities creating health-promoting environments through policy and environmental strategies.
	STRATEGY 3 Facilitate peer-to-peer learning networks among Certified Healthy entities to foster distribution of evidence-based practices proven effective in Oklahoma.



CHILDREN'S HEALTH

The health and well-being of mothers, infants, children and adolescents are fundamental to our state's future. Of great concern, Oklahoma ranks poorly for many key indicators of maternal and child health which will have long-term consequences for our state's health going forward if improvement for this population is not realized. The Children's Health portion of the OHIP addresses key life course stages – maternal and infant health, child and adolescent health – with goals, objectives and performance measures for each.

According to the Bureau of Health Resources and Services Administration (HRSA), the life course approach to conceptualizing healthcare needs and services evolved from research documenting the important role early life events play in shaping an individual's health trajectory.
The interplay of risk and protective factors, such as socioeconomic status, toxic environmental exposures, health behaviors, stress, and nutrition, influence health throughout one's lifetime.[29]

When examined through the context of a life course model, the work of this particular flagship issue can be summarized by timeline, timing, environment and equity. Today's experiences and exposures influence tomorrow's health (timeline), the path of one's health is particularly affected during critical or sensitive periods (timing), the broader community environment strongly affects the capacity to be healthy (environment) and inequality in health reflects more than genetics and personal choice (equity). If, as a state, we take advantage of these life course opportunities – we will greatly accelerate improvement in our overall health as the next generation arrives equipped to live, work and lead this state with vitality and purpose.

In order to achieve further improvement in birth outcomes, women must practice healthy behaviors and be engaged in primary and preventive healthcare services throughout their reproductive lives, including the time before they become pregnant (preconception) and between pregnancies (inter-conception). Making health a priority for children and adolescents ensures the health of future generations. During this time of physical and mental growth, children and adolescents can learn to build a strong foundation for healthy behavior. Research has shown that many medical conditions affecting adults have roots in childhood.

The Children's Health Workgroup addresses a large number of important objectives for the maternal, infant, child and adolescent populations. A sample of the Children's Health Objectives appears below – for a complete listing, view the Children's Health Workgroup on the OHIP website at www.OHIP2020.com.

CHILDREN'S HEALTH

CORE MEASURES

- *Reduce infant mortality from 6.8 per 1,000 live births in 2013 to 6.4 per 1,000 live births by 2020 (2018 data).*
- *Reduce Maternal Mortality from 29.1 per 100,000 live births to 26.2 per 100,000 live births by 2020 (2018 data).*
- *Reduce Infant, Child and Adolescent Injury Mortality from 15.2 per 100,000 in 2013 to 13.9 per 100,000 by 2020 (2018 data).*

MATERNAL & INFANT – CHILD & ADOLESCENT

GOALS	OBJECTIVES
GOAL 1 Improve Maternal and Infant Health Outcomes.	**OBJECTIVE 1** Increase the percentage of women who receive prenatal care in the first trimester of pregnancy from 68.5% in 2013 to 71.9% by 2020 (2018 data).
	OBJECTIVE 2 Reduce the rate of preterm births (births less than 37 weeks gestation) from 13.0 in 2012 to HP2020 target of 11.4 by 2020 (2018 data).
	OBJECTIVE 3 Reduce the rate of birth (per 1,000) for teenagers aged 15 through 17 years from 20.5 in 2013 to 19.2 by 2020 (2018 data).
GOAL 2 Improve Child and Adolescent Health Outcomes.	**OBJECTIVE 1** Reduce the number of high school youth grades 9 – 12 who report they were bullied on school property during the previous 12 months from 18.6% in 2013 to 17.5% by 2020.
	OBJECTIVE 2 Increase the coverage for the childhood immunization series (4:3:1:3:3:1:4) for children 19 – 35 months from 62.7% in 2013 to 80% by 2020 (2018 data).
	OBJECTIVE 3 Reduce the percentage of children 0 – 17 years experiencing two or more adverse family experiences from 32.9% in 2013 to 30.6% by 2020 (2016 data).
	OBJECTIVE 4 Increase the number of families served in evidence-based home visitation programs from 7,517 in SFY 2014 to 8,269 by 2020.

BEHAVIORAL HEALTH

Mental health and substance abuse issues are among the most pressing concerns facing our state today. In the past year, 21.9% of adult Oklahomans reported having a mental health issue and 12% experienced a substance abuse issue[40] representing 700,000 to 950,000 Oklahomans living with diseases of the brain.

Oklahoma consistently ranks among the highest in the region, and nationally, for rates of mental illness and addiction, as well as prescription drug abuse, underage drinking and suicide. Oklahoma ranks 49th nationally for mental illness among adults,[40] 11th worst for suicide at 17.6 per 100,000 people (670 deaths),[41] 45th at 19.8 per 100,000 people for drug overdose deaths[42] and is tied at 44th in its ranking for the number of "poor mental health days."[8]

Divorce, unemployment, child welfare involvement, academic failures, accidents, unwanted pregnancies, homelessness, crime and incarceration are all potential consequences of these illnesses if left untreated.

Ties to other chronic health issues are also well documented. According to the Medical Expenditure Panel Survey (MEPS) data from 2003, mental disorders are the third leading chronic disease in the nation – behind only cancer and heart disease. The projection of growth percentage in the number of people reporting mental disorders between 2003 to 2023 is 53.8%, which will be more prevalent than heart disease (projected at 41%), diabetes (projected at 53%), and stroke (projected at 29%).[42] Life expectancy for people with untreated behavioral health diseases is significantly less than the general population, upwards of 25 – 30 years.[43] Dedicated attention to diseases of the brain is critical to improving the health of our state.

BEHAVIORAL HEALTH

CORE MEASURES

- *Reduce the prevalence of untreated mental illness from an 86% treatment gap to 76% in 2020 (2018 data).*
- *Reduce the prevalence of addiction disorders from 8.8% to 7.8% by 2020 (2018 data).*
- *Reduce suicide deaths from 22.8 per 100,000 in 2013 to 19.4 per 100,000 by 2020 (2017 data).*

GOALS	STRATEGIES
GOAL 1 Increase the overall health and wellness of Oklahomans.	**STRATEGY 1** Develop a system of health homes by which physical disorder identification and care is integrated into behavioral healthcare.
	STRATEGY 2 Assess and incorporate the treatment of behavioral health disorders into primary care clinic practices.
	STRATEGY 3 Implement unified, evidenced-based screening, assessment, and treatment protocol for suicidality statewide.
GOAL 2 Decrease the prevalence of addiction disorders in Oklahoma.	**STRATEGY 1** Screening, brief intervention and referral for treatment for addiction disorders will be the norm for Oklahoma's primary care practices and hospital emergency departments.
	STRATEGY 2 Explore and assess all funding strategies for addiction treatment.
	STRATEGY 3 Screen all persons with criminal justice involvement for Substance Abuse/Risk and recommend treatment/diversion programs when appropriate.
	STRATEGY 4 Continued expansion of Drug Court and Family Drug Court availability.
	STRATEGY 5 Decrease the rate of unintentional poisoning deaths involving prescription drugs from 13.3 per 100,000 in 2011 to 11 per 100,000 by 2020 (2018 data).
GOAL 3 Decrease the number of Oklahomans with untreated mental illness.	**STRATEGY 1** Continue to assess and identify the efficiency of current behavioral health services.
	STRATEGY 2 Explore and assess all funding strategies for treatment of mental health disorders.
	STRATEGY 3 Screen all persons with criminal justice involvement for Mental Illness/Risk and recommend treatment/diversion programs when appropriate.
	STRATEGY 4 Expand Mental Health Court accessibility statewide.
	STRATEGY 5 All Oklahomans will have access to crisis and urgent care for mental health disorders.
	STRATEGY 6 Oklahoma youth and families will have access to Systems of Care statewide.

OHIP 2020: HEALTH SYSTEMS

HEALTH TRANSFORMATION

The Commonwealth Fund ranks Oklahoma's state health system performance 49th among the 50 states and Washington D.C.[44] Oklahoma has several initiatives underway that aim to transform the health system into one that bends the healthcare cost curve, increases healthcare quality, and improves population health outcomes (the Triple Aim).

In order to accomplish this, Oklahoma will need to implement innovative and evidence-based strategies that accelerate and reinforce the healthcare triple aim and transform Oklahoma's current health system into a more sustainable and value-based model. This includes initiatives that prevent disease at the earliest stage possible, providing care coordination to individuals with chronic conditions (both physical and behavioral) in order to reduce significant health consequences and excessive healthcare utilization, payment strategies that reward health providers and systems for achieving population health improvement and better integrating healthcare systems with community-level health improvement initiatives.

Recent efforts to address Oklahoma's health system transformation have resulted in the identification of four core areas of work: **1)** Health Efficiency and Effectiveness, **2)** Health Information Technology (IT), **3)** Health Workforce, and **4)** Health Finance.

HEALTH TRANSFORMATION

CORE MEASURES

- *Improve Population Health – Reduce heart disease deaths by 11% by 2020 (2018 data).*
- *Improve Quality of Care – Reduce by 20% the rate, per 100,000 Oklahomans, of potentially preventable hospitalizations from 1656 in 2013 to 1324.8 by 2020 (2019 data).*
- *Bend the Healthcare Cost Curve – By 2020, limit annual state-purchased healthcare cost growth, through both the Medicaid Program and the State Employee Group Insurance Plan (EGID), to 2% less than the projected national health expenditures average annual percentage growth rate as set by CMS (estimated baseline for annual state-purchased healthcare cost growth = 5.11%).*

OBJECTIVE 1 Oklahoma's ranking on the Commonwealth Fund Scorecard on State Health System Performance will improve from the 4th quartile (bottom quartile) in 2014 to the third quartile by 2020.

STRATEGY 1 Promoting and pursuing value-based health models across systems that will accelerate health improvement and yield a return on investment, including the use of a Health in All Policy approach.

STRATEGY 2 The State of Oklahoma should lead the health system transformation effort by evolving existing investments in health to value-based models, including the use of new healthcare payment models, evidence-based public health investments, and pursuing partnerships with private investors that yield long-term social and health outcome improvements (i.e., social impact bonds).

HEALTH EFFICIENCY AND EFFECTIVENESS: GOAL – CREATE A SYSTEM OF OUTCOME-DRIVEN HEALTHCARE THAT SUPPORTS PATIENTS AND HEALTHCARE PROVIDERS IN MAKING DECISIONS THAT PROMOTE HEALTH BY EMPHASIZING PREVENTIVE AND PRIMARY CARE AND THE APPROPRIATE USE OF ACUTE CARE FACILITIES.

OBJECTIVE 1 Reduce by 20% the rate, per 100,000 Oklahomans, of potentially preventable hospitalizations from 1656 in 2013 to 1324.8 by 2020.	**STRATEGY 1** Improve the quality and availability of healthcare via care coordination, especially for individuals with chronic, behavioral health, or specific co-morbid conditions.
	STRATEGY 2 Prioritize outcome-driven care.
OBJECTIVE 2 Reduce by 20% the rate, per 1,000 population, of Hospital Emergency Room Visits from 500 in 2012 to 400 Visits by 2020.	**STRATEGY 1** Use of Clinical Preventive Services (CPS) to reduce the need for emergency care.
	STRATEGY 2 Use of Patient-Centered Medical Homes to improve health outcomes.
	STRATEGY 3 Support practice facilitation in order to train providers to achieve National Quality Forum (NQF) Goals.
	STRATEGY 4 Promote the exchange of electronic health records across the care continuum.

HEALTH IT: GOAL – IMPROVE QUALITY, SAFETY, EFFECTIVENESS AND EFFICIENCY OF HEALTH SERVICES THROUGH THE USE OF INTEROPERABLE HEALTH INFORMATION TECHNOLOGY.

OBJECTIVE 1 By 2020, ensure that each Oklahoman's safety, quality, and convenience of care is improved by ensuring that providers access a multi-sourced comprehensive medical record on 30% of patients they treat.	**STRATEGY 1** Facilitate Secure Health Information Exchange (HIE) adoption and implementation.
	STRATEGY 2 Enhance communication among healthcare stakeholders (including patients and families) with respect to the use of health IT.
	STRATEGY 3 Establish training programs to increase provider knowledge and abilities in clinical informatics and health IT.
OBJECTIVE 2 By 2020, a majority of Oklahomans will experience improved health and reduced costs of care by ensuring that population-level, multi-sourced, comprehensive health data is used to support the public health, quality improvement, and value-based payment models.	**STRATEGY 1** Increase adoption of Electronic Health Records (EHR), HIE and achievement of Meaningful Use (MU).
	STRATEGY 2 Extend voluntary participation multi-payer claims databases.

HEALTH WORKFORCE: GOAL – IMPROVE ACCESS TO HEALTH SERVICES OFFERED THROUGH A VALUE-BASED AND PATIENT-CENTERED HEALTH SYSTEM.

OBJECTIVE 1 Statewide health workforce efforts are being coordinated through a single, centralized entity by October 2016.	**STRATEGY 1** Coordinate and leverage health workforce initiatives with state workforce investment and planning activities.
	STRATEGY 2 Formalize collaboration by development of detailed, specific memoranda of agreement (MOAs).
OBJECTIVE 2 Identify and quantify labor demand and program supply for 20 critical healthcare occupations through the development of a longitudinal, multi-sourced data set that is available for public use by January 2016.	**STRATEGY 1** Develop detailed MOAs to establish and adopt minimum data sets; engage partners for research, data collection and analysis as needs are identified.
	STRATEGY 2 Explore "best practices" in health workforce data collection and develop prioritized health workforce research agenda based on Oklahoma's specific needs.
OBJECTIVE 3 Supply gaps for identified 20 critical health occupations are reduced by more than 10% by October 2019.	**STRATEGY 1** Identify and recommend new strategies to train, recruit and retain traditional and emerging health professionals, including pre-baccalaureate health professionals i.e. community health workers, medical assistants.
	STRATEGY 2 Strengthen and expand existing health workforce training programs, including administrators, practice facilitators.
	STRATEGY 3 Increase opportunities for professional development for health professionals on health system transformation, i.e. telemedicine, EHR and population health, team-based, and patient-centered care.
	STRATEGY 4 Develop training and technical assistance that will expand availability and utilization of telehealth services.
OBJECTIVE 4 At least five recommended policies and programs that support and retain an optimized health workforce have been implemented by November 2019.	**STRATEGY 1** Assess current barriers to health workforce flexibility and optimization, including those that prevent healthcare providers from practicing at "top of license."
	STRATEGY 2 Explore strategies to provide bio-psychosocial support to healthcare professionals.
	STRATEGY 3 Explore evidence-based policies and programs for the support of team-based care, medical homes, and patient-centered care.
	STRATEGY 4 Resource value-based health models, such as the Patient-Centered Medical Home.

HEALTH FINANCE – TRANSFORM HEALTHCARE PAYMENT MODELS UTILIZING A MULTI-PAYER APPROACH TO CREATE A VALUE-BASED AND SUSTAINABLE HEALTHCARE SYSTEM AVAILABLE FOR ALL OKLAHOMANS.

OBJECTIVE 1 Decrease the percentage of uninsured individuals from 17% in 2013 to 9.5% by 2020 (2019 data).	**STRATEGY 1** Pursue the use of premium assistance programs, such as Insure Oklahoma or tribal sponsored premium coverage programs, with an emphasis on increasing the uptake of minimal essential insurance coverage.
	STRATEGY 2 Explore opportunities to use waivers, demonstration projects (vehicles that states can use to test new or existing ways to deliver and pay for healthcare services in Medicaid and the Children's Health Insurance Program) and other sources of funding to create sustainable, value-driven healthcare models in order to increase access to care, improve quality and reduce costs.
OBJECTIVE 2 By 2020, limit annual state-purchased (Medicaid & Employee Group Insurance Division (EGID)) healthcare cost growth to 2% less than the projected national health expenditures average annual percentage growth rate as set by Center for Medicare and Medicaid Services (CMS).	**STRATEGY 1** Increase the percentage of healthcare spending in the state that is contracted under value-based payment models that reward providers for quality of care.
	STRATEGY 2 Use payment models that adequately incentivize and support high-quality team-based care focused on the needs and goals of patients and families.
	STRATEGY 3 Align health system incentives, including payer and provider incentives, to better coordinate care, promote health outcomes, and ensure quality measures are achieved which limit health expenditure growth.

** Estimated baseline for annual state-purchased healthcare cost growth: 5.11% in 2013. Includes Medicaid and EGID annual expenditures.*

*** CMS annual percentage growth projections based on "National Health Expenditure Projections 2012-2022."*

HEALTH EDUCATION

Health Promotion and Health Education are needed throughout communities in Oklahoma to improve health by focusing on the behaviors, systems, environments, and policies affecting health at various levels of influence. It also involves the development of individual, group, institutional, community, and systemic strategies to improve health knowledge, attitudes, skills, and behaviors which empower people to take more control over their health and well-being.

COORDINATED SCHOOL HEALTH

The Centers for Disease Control and Prevention (CDC) and the Association for Supervision and Curriculum Development (ASCD) developed The Whole School, Whole Community, Whole Child (WSCC) model to combine and build upon the coordinated school health approach to improve children's cognitive, physical, social, and emotional development. The model provides a framework to address the relationship between learning and health. The focus of the WSCC model is an ecological approach that is directed at the whole school, with the school in turn drawing its resources and influences from the whole community and serving to address the needs of the whole child.

The key to moving from model to action is collaborative development of local school policies, processes, and practices. The day-to-day practices within each sector require examination and collaboration so that they work in tandem, with appropriate complementary processes guiding each decision and action. Developing joint and collaborative policy is half the challenge; putting it into action and making it routine completes the task.[45]

HIGHER EDUCATION

Higher education and career technology centers possess several components of a community and through collaborative efforts of health, academic, student affairs, and administrative colleagues institutions of higher education can foster healthy environments and behaviors. The primary purpose of health promotion in higher education is to support student success by creating health-supporting environments.[46]

Success will require working together to create a comprehensive, strategic framework that unites health issues with a network of multidisciplinary, multisectoral stakeholders at all levels. The development of a positive social and emotional climate increases academic achievement, reduces stress, and improves positive attitudes toward self and others. In turn, academic achievement is an excellent indicator for the overall well-being of youth and a primary predictor and determinant of adult health outcomes. Individuals with more education are likely to live longer; experience better health outcomes; and practice health-promoting behaviors such as exercising regularly, refraining from smoking, and obtaining timely healthcare check-ups and screenings.

* *Estimated baseline for annual state-purchased healthcare cost growth: 5.11% in 2013. Includes Medicaid and EGID annual expenditures.*

** *CMS annual percentage growth projections based on "National Health Expenditure Projections 2012-2022."*

GOAL – INCREASE THE APPLICATION OF PROVEN HEALTH EDUCATION AND HEALTH PROMOTION STRATEGIES BY HEALTHCARE PROVIDERS, SCHOOL SYSTEMS AND INSTITUTIONS OF HIGHER EDUCATION.

MEASURE Increase the number of schools achieving the Excellence level of certification as a Certified Healthy School from 300 in 2014 to 500 in 2020.	**STRATEGY** Increase the number of school systems that adopt a coordinated school health model.
MEASURE Increase the number of institutions of higher education, including career technology centers, achieving the Excellence level of certification as a Certified Healthy Campus from 12 awarded in 2014 to 40 awarded by 2020.	**STRATEGY** Increase the number of Institutes of Higher Education (IHE) who adopt documented standards of practice for Health Promotion in Higher Education.

TOOL FOR HEALTH BEHAVIOR CHANGE

MOTIVATIONAL INTERVIEWING

Motivational Interviewing (MI) is a collaborative, goal-oriented style of communication with particular attention to the language of change. It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion.[47]

MI is considered an Effective Best Practice (EBP) by the Substance Abuse and Mental Health Services Administration and utilized across the country to address mental health and substance use disorders as well as other chronic conditions such as diabetes, cardiovascular conditions and asthma to encourage positive behavioral changes to support better health.[48]

Numerous research studies indicate that MI is an effective method for facilitating behavior change. Specifically using brief motivational interviewing around nutrition and physical activity in the context of an office visit has shown positive results in terms of health behavior change and weight lost in both the pediatric and adult populations.[48]

Through the use of MI a collaborative conversation is utilized to strengthen a person's own motivation and commitment to change toward a specific goal by eliciting and exploring the person's own reasons for change.[48] MI is low-cost, high-impact, and versatile across multiple health issues where behavior change is necessary. This approach will be utilized statewide through a patient-centered system.

MOTIVATIONAL INTERVIEWING COMMUNITY OF PRACTICE

While MI is an evidence-based practice, it does require practitioners to receive adequate training and ongoing consultation and technical assistance to implement with model fidelity.

According to the Centers for Disease Control and Prevention a Community of Practice (CoP)[49] is considered an effective approach to introduce, enhance and encourage the development of skills and knowledge. A CoP is defined as "a group of people who share a concern, a set of problems, or a passion about a topic, and who deepen their knowledge and expertise by interacting on an ongoing basis."[49] This approach enables providers and professionals to grow and mature while focusing on efforts to share knowledge and solve problems.

An MI CoP will be established to provide more Motivational Interviewing Network of Trainers (MINT) certified trainers in Oklahoma, encourage partnership development across agencies and organizations, and provide formal and informal training opportunities to a broad range of professionals. MI may be used with individuals, families and communities. Emphasis will be placed on enhancing knowledge, skills and abilities to address the flagship issues illustrated in OHIP.

A MOTIVATIONAL INTERVIEWING COMMUNITY OF PRACTICE WILL BE ESTABLISHED TO PROVIDE TECHNICAL ASSISTANCE, CONSULTATION AND ONGOING SUPPORT TO A TEAM OF PROFESSIONALS WHO WANT TO EMPLOY THIS TECHNIQUE IN THEIR PRACTICE OR COMMUNITY.

MEASURE Number of MINT providers in the state increased to 40 by 2020.

STRATEGY Increase the number of providers who adopt documented standards of practice for Motivational Interviewing (MI) or refer patients to MI skilled individuals.

HEALTH LITERACY

Health literacy is defined as the degree to which an individual has the capacity to obtain, communicate, process, and understand basic health information and services to make appropriate health decisions.

HEALTH LITERACY CAPACITY AND SKILLS

Capacity is a person's potential to do or accomplish something. Health literacy skills are those skills people use to realize their potential in health situations. They apply these skills either to make sense of health information and services or to provide health information and services to others.[50]

Anyone who needs health information and services also needs health literacy skills in order to:

- Find information and services
- Communicate their needs and preferences and respond to information and services
- Process the meaning and usefulness of the information and services
- Understand the choices, consequences and context of the information and services
- Decide which information and services match their needs and preferences so they can act

Anyone who provides health information and services to others, such as a doctor, nurse, dentist, pharmacist, or public health worker, also needs health literacy skills to:

- Help people find information and services
- Communicate about health and healthcare
- Process what people are explicitly and implicitly asking for
- Understand how to provide useful information and services
- Decide which information and services work best for different situations so they can act

GOAL – DEVELOP AND DISSEMINATE HEALTH AND SAFETY INFORMATION THAT IS ACCURATE, ACCESSIBLE, AND ACTIONABLE.

Health Literacy	**MEASURE** Four OHIP flagship programs developing health messages will involve members of their target audience in the design and testing of communication products by 2020.

GOAL – PROMOTE CHANGES IN THE HEALTHCARE SYSTEM THAT IMPROVE HEALTH INFORMATION, COMMUNICATION, INFORMED DECISION MAKING, AND ACCESS TO HEALTH SERVICES.

Health Literacy	**MEASURE** Two organizational assessments will be completed by 2020 in order to measure how well a health or social service agency is responding to the health literacy of their patients.

MAKING OHIP HAPPEN

PRIVATE-PUBLIC PARTNERSHIPS

Creating a thriving economy and vital workforce are critical elements of population health improvement. Likewise, in order to help achieve these economic goals, Oklahoma must attend to the health of its residents. Investing in education and a work-ready population will create greater opportunities for economic development, job expansion and personal income. These investments will return savings or improvements, not just to the healthcare system, but to many sectors that impact the bottom line of our state and our businesses.

In undertaking the OHIP update, a business survey was developed to assess the outcomes of poor health, increasing medical costs and poor access to care in Oklahoma on their business. Of the more than 700 responses received, about half reported that employee health negatively impacts their business. Oklahoma businesses indicated the following as the most common negative impacts due to rising healthcare costs:

- Less profitable for general business growth
- Held off on salary increases for employees
- Increased medical deductible/increase employee share of medical costs
- Held off on hiring new employees

These outcomes of poor health on business create significant limitations for a growing economy, increased job creation and wealth generation in Oklahoma. Thus, they create challenges for many private organizations working toward improvement of the well-being of our residents. Private foundations, congregations, non-profit organizations and associations working toward economic, educational, social and health improvement goals should be concerned with the impacts of poor health outcomes on business.

When asked the leading challenges that businesses face in terms of employee health, results were similar to the challenges identified in community chats and include the following:

- Making positive health lifestyle choices
- Losing weight
- Seeing a doctor for preventive care
- Quitting tobacco
- Reducing stress

Everyone has a stake in tackling these health improvement initiatives. The OHIP seeks to create robust and diverse private partnerships that identify areas most amenable for joint private and public sector investment, to yield specific value for that investment and leverage the innovation and efficiency of the private sector. The following are the goals and strategies of the 2020 OHIP plan for private/public partnerships:

PRIVATE / PUBLIC PARTNERSHIPS (P3)

GOAL 1 Increase private-public joint partnerships and investment opportunities (monetary, policy, programs, etc.) to improve population health and yield a return for businesses, government and Oklahoma residents.

STRATEGY 1 Create a P3 Action Team comprised of business, faith-based, foundation, non-profit, association and government representatives to undertake the following:

- Communicate the impact and value of health investment to business and the economy
- Accelerate the adoption of evidence-based health programs and policies among the private sector utilizing the Certified Healthy Oklahoma program
- Develop a proposed health investment portfolio by December 31, 2015

STRATEGY 2 Adopt legislation to establish a P3 Trust responsible for administering investment programs between private organizations and government for the benefit of Oklahoma by May 31, 2016

STRATEGY 3 Establish a P3 investment and oversight board to govern the Trust and determine criteria and value of investment no later than July 1, 2017

STRATEGY 4 Award at least one private-public health improvement initiative by January 2019:

- Assess current P3 investment opportunities and projects throughout country for application in Oklahoma (for example, social impact bonds)
- Utilize business planning processes to identify health areas with the largest potential to return value and the most impactful investment tool (i.e. policy, program, etc.)
- Utilize transparent processes to determine best value to the state and investors

CALL TO ACTION

MAKING OHIP LOCAL

The Oklahoma Health Improvement Plan is designed to inspire an entire state to work collaboratively together to help Oklahomans live healthier, happier, and longer lives. While great strides have been made in recent years, more work is needed as many Oklahomans are dying unnecessarily and prematurely. Integrating the input and findings derived from published health data, stakeholder and community engagement, and evidence-based frameworks and practices, the 2015-2019 OHIP proposes new ways of interacting, new structures for communication, and a renewed hope that progress on issues of mutual interest can be achieved through private-public and tribal partnerships as well as individual Oklahomans' commitment and involvement.

ALL OKLAHOMANS ARE ASKED TO DO THEIR PART AND PARTICIPATE IN CREATING A CULTURE OF HEALTH THROUGH THE FOLLOWING ACTIONS:

Adopt recommended healthy lifestyle changes and encourage your friends and family.

Adopt recommended health policies within businesses, schools, congregations and communities.

Get connected with a local Turning Point or other community partnership to plan and implement local community health improvement efforts. Visit www.health.ok.gov for a complete listing of Turning Point Coalitions in Oklahoma.

Encourage local businesses, schools, communities, and congregations to apply for and achieve Certified Healthy Oklahoma recognition.

Visit www.OHIP2020.com to explore Oklahoma flagship issues in more detail and get connected with OHIP workgroups to offer suggestions for local health improvement.

The OHIP represents a living document which will be revisited and monitored on a regular basis, including alignment with the feedback and suggestions received from communities and individuals in the field. Ongoing open communication and strategic collaboration are both monumental and critical as it takes all stakeholders and communities to advance health and well-being. Oklahoma's culture of health awaits in the year 2020.

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EVIDENCE-BASED PRACTICES

TOBACCO USE REDUCTION

- CDC - Best Practices for Comprehensive Tobacco Control Programs – 2014
- CDC - Treating Tobacco Use and Dependence, 2008 Update
- The Guide to Community Preventive Services
  - Reduce tobacco product initiation
  - Increase cessation
  - Reduce exposure to environmental tobacco smoke

OBESITY REDUCTION

- The Guide to Community Preventive Services
  - Increasing Physical Activity
  - Worksite Health Promotion
  - Obesity Prevention and Control

CHILD HEALTH

- CoIIN (Collaborative Improvement and Innovation Network to Reduce Infant Mortality)
- CDC – Recommendations to Improve Preconception Health and Healthcare
- AAP / ACOG Guidelines for Perinatal Care
- Fetal / Infant Mortality Review
- Maternal Mortality Review
- Every Week Counts Initiative
- Preparing for a Lifetime: It's Everyone's Responsibility
- Every Mother Initiative
- Patient Safety Council's Three Bundles

- Adolescent Pregnancy Prevention
  - PREP – Personal Responsibility Education Program
  - Making a Difference
  - Making Proud Choices
  - Reducing the Risk
- Parents as Teachers
- Nurse Family Partnership
- Healthy Families America
- Infant Car Seat Installation

BEHAVIORAL HEALTH

- Substance Abuse and Mental Health Service Administration – NREPP (National Registry of Evidence Based Practices and Programs)
- Suicide Prevention Resource Center Best Practices Registry
- The Guide to Clinical Preventive Services, U.S. Preventive Services Task Force
- Substance Abuse and Mental Health Service Administration Overdose Prevention Toolkit
- Office of National Drug Control Policy (ONDCP) Prescription Drug Abuse Prevention Plan
- Drug Court
- Mental Health Court
- Health Homes
- Systems of Care

HEALTH TRANSFORMATION

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    - Ensuring that Patient-Centered Medical Homes Effectively Serve Patients with Complex Health Needs, Agency for Healthcare Research and Quality Patient Centered Medical Home Resources Center,

- Health Finance strategies
  - National Health Expenditure Projections 2012-2022 Forecast Summary
  - Comprehensive Annual Financial Report Year Ended December 31, 2013
  - Health Coverage and Care in the South in 2014 and Beyond (Brief)

HEALTH EDUCATION

- CDC Coordinated School Health Model
- Motivational Interviewing for Behavior Change

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