

FY 2020-2022 Implementation Strategy

St. John Sapulpa | Creek County, Okla.

 St. John

 Ascension

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Introduction

It's said that home is where the heart is. And the home of Ascension St. John is our community. Since the arrival of its founding sponsor, the Sisters of the Sorrowful Mother, in Tulsa in 1914 and its groundbreaking in 1920, the heart of St. John's mission has been to meet the needs of the communities it serves, especially those most vulnerable.

To ensure our efforts best meet the needs of our communities and will have a lasting and meaningful impact, each of St. John's six hospitals conduct a triennial community health needs assessment (CHNA). The needs of populations deemed vulnerable are a central focus of the assessment.

CHNAs help identify the most pressing needs of our communities, build relationships with community partners, and direct resources where they are most needed. This community-driven process has the potential to leverage resources, enhance program effectiveness and strengthen communities. The process serves as the foundation for identifying those in greatest need, recognizing existing assets and resources, developing strategic plans and mobilizing hospital programs and community partners to work together to promote the health and well-being of the community. CHNAs are essential to community building and health improvement efforts. These powerful tools have the potential to be catalysts for immense community change.

The 2010 Patient Protection and Affordable Care Act, more commonly known as the Affordable Care Act (ACA), requires nonprofit, tax-exempt hospitals to conduct a CHNA every three years. To meet requirements, hospitals must analyze and identify the health needs of their communities, then develop and adopt an implementation strategy to meet the identified needs. The findings from the assessment and implementation strategy are made widely available to the public.

St. John's six hospital facilities — St. John Medical Center, St. John Owasso, St. John Broken Arrow, St. John Sapulpa, Jane Phillips Medical Center and Jane Phillips Nowata Health Center — conducted the first set of CHNAs and implementation strategies in fiscal year 2013. The second cycle of CHNAs and implementation strategies was completed in FY 2016. Over the past three years, the health system and its hospitals have worked diligently to address a set of prioritized health needs based on our FY 2016 assessments and implementation strategy. An updated set of CHNAs and implementation strategy were conducted by St. John's six hospitals during FY 2019 and early FY 2020.

The goal of the CHNA process is to offer a meaningful understanding of the most pressing health needs across our communities, as well as to guide planning efforts to address those needs. Special attention was given to the needs of vulnerable populations, unmet health needs or gaps in services, and input gathered from the community. Findings from St. John's six hospital facility CHNA reports were used to identify, develop and target hospital, health system and community initiatives and programming to better serve the health and wellness needs of our community.

According to the Catholic Health Association of the United States, a CHNA is "a systematic process involving the community to identify and analyze community health needs and assets in order to prioritize, plan and act upon unmet community health needs." The CHNA report includes the following:

- A description of the community served by the hospital
- The process and methods used to obtain, analyze and synthesize secondary and primary (community input) data
- The significant health needs in the community, taking into account the needs of those most vulnerable and geographic areas of greatest need
- The process and criteria used to prioritize the most significant health needs of the community
- An overview of the prioritized health needs to be addressed in this CHNA cycle, as well as needs that will not be part of the implementation strategy
- An evaluation of the impact of any actions that were taken by the hospital and health system since the preceding CHNA to address those priority health needs

The 2019 CHNA reports for each of St. John's six hospitals are available at www.stjohnhealthsystem.com/chna and provide an overview of the significant community health needs identified in the communities served by each hospital.

St. John is pleased to present the CHNA implementation strategy reports for each of its six hospitals, providing an overview of how we will work with the communities served by each hospital to address the community's most pressing health needs as identified in our most recent set of CHNAs. Some actions noted in this report are applicable to the entire health system while other measures are specific to the hospital. This report is the St. John Sapulpa (SJS) CHNA Implementation Strategy. For the purposes of this assessment, SJS's primary service area, or community, is defined as Creek County, Okla.

An implementation strategy (IS) is the hospital's plan for addressing the most pressing community health needs identified in the CHNA.

The Implementation Strategy report includes the following:

- An overview of the health system, hospital, and mission
- A description of the community served by the hospital including geographic areas and populations that will be addressed by the implementation strategy
- A summary of the significant health needs in the community as identified through this CHNA cycle, taking into account the needs of those most vulnerable and geographic areas of greatest need
- The process and criteria used to prioritize the most significant health needs of the community
- An overview of the prioritized health needs to be addressed in this CHNA cycle, as well as needs that will not be part of the implementation strategy and any reason(s) they are not being addressed
- Actions the hospital will do to address the prioritized health needs, the anticipated impact of these actions, any planned collaboration between the hospital and other community organizations, and resources the hospital plans to commit to address the most pressing health needs of the community

The CHNA implementation strategy will be used by leaders at SJS to understand and communicate the goals, objectives and approaches the hospital will undertake to address community needs, and by community members to understand the hospital's role in community health. The strategy will also serve as a resource for community organizations who want to work with the hospital on community-based approaches.

For an executive summary of this report, see Appendix 1.

Our Health System



Established in 1926 with the opening of St. John’s Hospital (now St. John Medical Center) in Tulsa, Okla., Ascension St. John is a fully integrated healthcare delivery system encompassing six hospitals and more than 90 clinics and facilities in eastern Oklahoma and southeastern Kansas. St. John was founded by our legacy sponsors, the Sisters of the Sorrowful Mother.

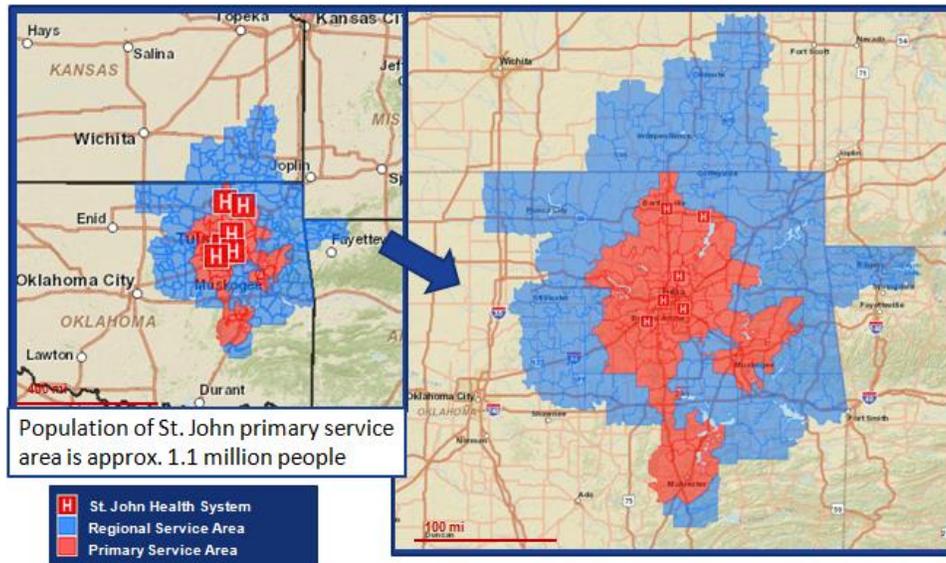
Now, St. John is part of Ascension, the largest nonprofit health system in the U.S. and the world’s largest Catholic health system. Ascension is dedicated to transformation through innovation across the continuum of care and committed to delivering compassionate, personalized care to all, with special attention to those living in poverty or otherwise deemed vulnerable. Ascension operates about 2,500 sites of care — including 141 hospitals and more than 30 senior living facilities — in 22 states and the District of Columbia. With Ascension, St. John has access to additional resources to help us continue to transform the quality of care we provide our patients.

St. John is organized as a tax-exempt integrated healthcare delivery system. Our mission is to continue the healing ministry of Jesus Christ by providing medical excellence and compassionate care to everyone we serve. Across the region, St. John provided more than \$109 million in community benefit and care of people living in poverty in fiscal year 2018. In fiscal year 2018, Ascension provided nearly \$2 billion in care of people living in poverty and other community benefit programs.

Together, St. John and Ascension are focused on delivering healthcare that is safe, healthcare that works and healthcare that leaves no one behind. St. John serves as an important safety-net provider of a broad continuum of healthcare services to the citizens of northeastern Oklahoma and the surrounding region. The health system’s service area contains 260 ZIP codes in 32 counties in Oklahoma, Kansas and Arkansas. The health system’s primary service area is around 1.1 million people (Figure 1). We are working to transform healthcare not just in our local communities, but across the nation, promoting high quality and cost effectiveness and emphasizing prevention, holistic wellness and episodic care.

St. John hospitals include St. John Medical Center, St. John Owasso, St. John Broken Arrow, St. John Sapulpa, Jane Phillips Medical Center and Jane Phillips Nowata Health Center, together having about 800 beds in service. Each of these six hospitals operates a full-service, 24-hour, 365-day emergency room providing both urgent and emergency care to all individuals, regardless of their ability to pay. St. John also has an array of partner and subsidiary healthcare facilities. Other St. John entities include Regional Medical Laboratory (RML), St. John Clinic and St. John Urgent Care. St. John joint ventures include Oklahoma Cancer Specialists and Research Institute, Prairie House Assisted Living & Memory Care, and Tulsa Bone & Joint Associates.

Figure 1: St. John service area



Facts and figures

- St. John owns six hospitals in northeastern Oklahoma, with about 800 total beds in service.
- Around 7,000 associates work within St. John (not including ministry-wide functions or joint ventures).
- St. John owns and operates St. John Clinic, which operates as a multi-specialty physician clinic, employing more than 500 physicians, physician assistants, nurse practitioners and certified nurse anesthetists. St. John Clinic has dozens of physician offices and clinics (including Urgent Care clinics) throughout Tulsa and northeastern Oklahoma.
- St. John owns RML, one of the region’s largest reference laboratories, providing services to many hospitals and physician practices throughout the area.
- St. John owns 50 percent of CommunityCare Managed Health Care Plans of Oklahoma, one of the area’s largest health insurers. CommunityCare offers many healthcare insurance options for individuals and families, including the region’s highest-rated Medicare Advantage plan for those 65 or older.
- St. John touches the lives of thousands of patients every day:
 - More than 52,000 annual hospital admissions, including 14,000 “observation” patients.
 - More than 31,000 annual surgeries performed in St. John hospitals. St. John also is a minority owner in two ambulatory surgery centers that perform more than 28,000 annual outpatient surgeries.
 - More than 3,800 annual births at St. John hospitals.
 - More than 148,000 annual patient visits to St. John hospital emergency departments.
 - More than 83,000 annual urgent care visits to Urgent Care clinics.
 - Nearly 500,000 annual patient visits to St. John Clinic physician offices.
 - RML performs more than 9.1 million annual laboratory tests.

Mission, Vision and Values

Our Mission, Vision and Values guide everything we do at St. John and Ascension. They are foundational to our work to transform healthcare and express our priorities when providing care and services, particularly to those most in

need. As the health system develops initiatives to address needs within the communities we serve, we strive to ensure that our Mission, Vision, and Values are upheld.

Mission

Rooted in the loving ministry of Jesus as healer, we commit ourselves to serving all persons with special attention to those who are poor and vulnerable. Our Catholic health ministry is dedicated to spiritually-centered, holistic care which sustains and improves the health of individuals and communities. We are advocates for a compassionate and just society through our actions and our words.

Vision

We envision a strong, vibrant Catholic health ministry in the United States which will lead to the transformation of healthcare. We will ensure service that is committed to health and well-being for our communities and that responds to the needs of individuals throughout the life cycle. We will expand the role of laity, in both leadership and sponsorship, to ensure a Catholic health ministry in the future.

Values

Service of the poor: generosity of spirit, especially for people most in need

Reverence: respect and compassion for the dignity and diversity of life

Integrity: inspiring trust through personal leadership

Wisdom: integrating excellence and stewardship

Creativity: courageous innovation

Dedication: affirming the hope and joy of our ministry

St. John Sapulpa

St. John Sapulpa (SJS) is a two-story, 25-bed facility located in the city of Sapulpa, Okla. SJS joined the health system in 1997 with the acquisition of Bartlett Memorial Hospital. The facility was renamed in 2000. Designated as a critical access hospital, SJS offers Creek County residents much-needed quality medical care, including a fully equipped, 24/7 emergency center and the capability to accept acute care patients. SJS offers full-service primary care, as well as gastroenterology, general surgery, ophthalmology and podiatry. In addition, it has “swing beds” for easy transition from acute care to skilled care. Swing beds can also be utilized for rehabilitation therapy to help patients transition to home or a long-term care facility and to help rehabilitate patients from an illness, accident or surgery.

SJS touches the lives of thousands of patients and their loved ones every day:

- More than 1,700 annual hospital admissions, including “observation” patients
- More than 100 annual surgeries performed
- More than 16,000 annual patient visits to the emergency department
- More than 21,000 “other” annual patient visits for diagnostic testing and treatment

Community Served

The definition of the community served by the hospital provided the foundation on which our community health needs assessment (CHNA) and subsequent implementation strategy decisions were based. In defining the community served by St. John Sapulpa (SJS), the following were taken into consideration:

- General geographic area
- Geopolitical definitions
- Primary and regional service areas
- Patient population
- Areas and populations served by the hospital’s community benefit programs
- Opportunity areas, or geographic areas encompassing at-risk, vulnerable and/or underserved populations
- Availability of health information and data

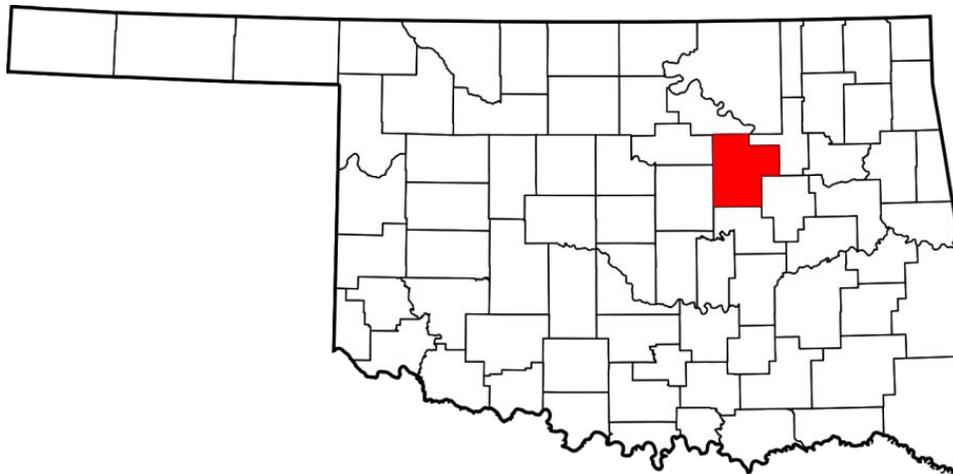


SJS is a growing community hospital serving northeastern Oklahoma. The primary service area is Creek County, Okla., and the surrounding counties. However, SJS serves patients who live throughout the northeastern Oklahoma region and beyond. For the purposes of this CHNA, the “community served” is defined as Creek County (see Figure 2). The decision to focus on the geopolitical definition of Creek County was largely influenced by the fact that a significant number of patients who utilize SJS services reside in Creek County. In fact, an estimated 66.3 percent of inpatient and outpatient visits originated from Creek County in the 2018 calendar year. Within Creek County, the top five ZIP codes of patient origin in CY 2018 were 74066, 74039, 74010, 74044 and 74041.

In addition to the fact that a large number of patients served by the hospital reside in Creek County, most public data is available at the county level. Additional factors influencing the definition of the community were the areas and populations served by the hospital’s community benefit programs and the geographic areas for populations deemed heavily at-risk or vulnerable.

SJS is based out of the city of Sapulpa. Accordingly, Sapulpa serves as the primary area of focus within the Creek County community. SJS’s community health improvement efforts that result from this CHNA will primarily center on Sapulpa. However, an effort was made to focus on the health needs and assets of Creek County as a whole, and our efforts will also extend to other cities and towns within Creek County based on lessons learned through our work with the Sapulpa community.

Figure 2: Creek County map



Creek County

Creek County is located in the U.S. state of Oklahoma. Its county seat and largest city is Sapulpa. Founded at statehood in 1907, it was named after the Creek tribe. Before statehood, the area was part of the Creek Nation in Indian Territory.¹ The area has a rich history that includes early Native American inhabitants, the advent of the railroads, and the oil boom.

Located in east-central Oklahoma, Creek County is bordered by Pawnee County on the north, Tulsa and Okmulgee counties on the east, Okfuskee County on the south, and Lincoln and Payne counties on the west. The cities and towns officially recognized in Creek County are Bristow, Depew, Drumright, Kellyville, Kiefer, Lawrence Creek, Mannford, Mounds, Oilton, Sapulpa, Slick, Stroud and Shamrock. Major highways include Interstate 44, U.S. Historic Route 66, U.S. Route 75 and state highways 33, 97 and 117. With about 970 square miles of land and water, the county is drained by the Cimarron River, tributaries of the Arkansas River, and the Deep Fork and Little Deep Fork of the North Canadian River.¹

According to the American Community Survey, Creek County had an estimated population of 70,899 in 2017.² The population density for the county is about 74 people per square mile.³ The median age is 40 years, and 86.7 percent of adult residents have attained a high school diploma or higher. An estimated 15.2 percent of residents live below the poverty line.² Creek County's largest industries by employment are manufacturing, healthcare, retail, education and construction.

City of Sapulpa

SJS is based out of Sapulpa, the largest city in Creek County with an estimated population of 20,843 in 2017.³ Sapulpa is located primarily in Creek County, but a small portion of the city is located in Tulsa County. The population density of Sapulpa is about 844 people per square mile, which is far greater than that of Creek County as a whole. An estimated 17.5 percent of residents live below the poverty line.²

¹ The Encyclopedia of Oklahoma History and Culture by the Oklahoma Historical Society (retrieved from www.okhistory.org/publications)

² 2013-2017 American Community Survey 5-Year Estimates by the American Community Survey (retrieved from <https://factfinder.census.gov>)

³ QuickFacts by the U.S. Census Bureau (retrieved from www.census.gov/quickfacts)

CHNA Process: Methodology

Community health needs and assets for Creek County were determined using a combination of secondary and primary data (community input). Secondary data is existing data that has already been collected and published by another party. Secondary data about the health status of the population at the state and county level is routinely collected by governmental and non-governmental agencies through surveys and surveillance systems. In contrast, primary data is new data and is collected or observed directly through firsthand experience. Many methods can be used to gather community input, including key informant interviews, focus groups, listening circles, community meetings and forums, and surveys.

Including multiple data sources as well as resident and stakeholder input is especially important when prioritizing community health needs. If alternative data sources support similar conclusions, then confidence is increased regarding the most pressing health needs in a community. Data included 2019 St. John Sapulpa (SJS) community health needs assessment (CHNA) were obtained through multiple sources and methods designed to gather both qualitative and quantitative information. Qualitative data is descriptive information, and quantitative data is numeric information.

Secondary Data

A comprehensive review of secondary data sources served as the foundation for assessing the community. Ascension St. John consulted with the Tulsa Health Department to collect and analyze the secondary data used in the assessment's community overview. A review of publicly available secondary data was conducted. Some data comparisons were made at the ZIP code, region, county, state and national levels. Other data considerations included trends over time, county and state level rankings, benchmark comparisons at the state and national levels, disparities by age, gender, race/ethnicity, income level and educational attainment.

St. John also consulted with Conduent Healthy Communities Corp. for support with secondary data analysis. The analysis included a comprehensive set of more than 100 community health and quality-of-life indicators covering more than 20 topic areas. Indicator values for Creek County were compared with other counties in Oklahoma and nationwide to compare social, economic and health topics. Other considerations for areas of health need included trends over time; Healthy People 2020 targets; Oklahoma targets; and disparities by age, gender and race/ethnicity. The value for each of these indicators was compared with other communities, nationally or locally set targets and previous time periods. A data scoring tool was used to systematically summarize multiple comparisons of the data to rank indicators based on highest need.

In addition, St. John consulted with Conduent Healthy Communities Corp. for support with identifying geographic areas of greatest need in Creek County. To do so, Conduent developed the SocioNeeds Index[®] to easily compare multiple socioeconomic factors across geographies. This tool incorporates estimates for six different social and economic determinants of health — income, poverty, unemployment, occupation, educational attainment and linguistic barriers — that are associated with poor health outcomes, including preventable hospitalizations and premature death.

Primary Data (Community Input)

Recognizing its vital importance in understanding the health needs and assets of the community, the assessment primarily focused on gathering and summarizing community input, a form of primary data. Accordingly, input from community members, community leaders and representatives, local coalitions/partnerships, and health system leadership was obtained to expand upon information gleaned from the secondary data review. St. John employed several methods of community input to yield the desired results, including the following:

- Six community health forums with around 120 community leaders and 13 health system leaders (one forum with 16 community leaders and two health system leaders in Creek County)

- Twenty-two focus groups with 233 community members (one focus group with 10 community members in Creek County)
- Online survey of 801 community members (13 in Creek County)
- Input from the public health workforce and local coalitions/partnerships
- Input from the health system’s Community Engagement Committee

Community input is best obtained from a diverse set of community stakeholders such as community members, community organizations and the public health workforce. A variety of sources ensures that as many different perspectives as possible are represented while satisfying the broad interests of the community. Sources of community input for this assessment were as follows:

- Community members who participated in the online survey and focus groups
- Community leaders and representatives
- Public health workforce and local coalitions/partnerships
- Members and representatives of medically underserved, low-income, minority, at-risk and otherwise vulnerable populations
- Health system and hospital leadership



Community stakeholders who provided input represented a variety of community sectors, including healthcare, education and academia, nonprofit, private business, community development, faith-based communities and organizations, government, safety-net services, economic and workforce development, behavioral health, law enforcement and first responders, public health and other interest groups working with at-risk and vulnerable populations. A concerted effort was made to obtain community input from with special knowledge or expertise in public health, as well as members and representatives of medically underserved, low-income, minority, at-risk or otherwise vulnerable populations.

A detailed description of our approach is included in the section below. A comprehensive overview of the secondary data and community input used in the assessment, and the methods of collecting and analyzing this information, can be found in the 2019 SJS CHNA report, available at www.stjohnhealthsystem.com/chna.

Our Approach

To effectively identify and address the health needs of a community, it is essential to have an understanding of health and the conditions that contribute to health and well-being. According to the World Health Organization, health is defined as a “state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity.”⁴ A person’s state of health is a result of several interwoven and contributing factors and levels of influence. Accordingly, our goal was to follow a more holistic approach to assessment and community health improvement. The 2019 SJS CHNA reflects a multitude of factors influencing the health of our community.

Social-ecological model

The social-ecological model (SEM) of health is a public health framework used to describe the multilevel systems of influence that explain the complex interaction between individuals and the social context in which they live and work (see Figure 3). The SEM provides a framework to help understand the various factors and behaviors that affect health and wellness. Health and well-being is shaped not only by behavior choices of individuals, but also by complex factors

⁴ World Health Organization. (1948). *Preamble to the Constitution of the World Health Organization*. Adopted by the International Health Conference, N.Y. 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

that influence those choices within the social environment through reciprocal causation.^{5,6} With this model, we can closely examine a specific health issue in a particular setting or context. For example, the model can help identify factors that contribute to heart disease in specific populations. With this knowledge, effective heart disease interventions can be developed for a specific population with the greatest impact in mind.

Human behavior is difficult to change and is nearly impossible to modify without understanding the environment in which one lives. To promote behavior that supports health and wellness, efforts need to focus on behavior choices and the multitude of factors that influence those choices. The SEM helps identify factors that influence behavior by considering the complex interplay between five hierarchical levels of influence: 1) individual or intrapersonal, 2) interpersonal, 3) institutional or organizational, 4) community, and 5) societal/public policy factors (see Figure 3). The model demonstrates how the changes and interactions between these five levels over the course of one's life affect health and wellness. Through utilizing the SEM, the likelihood of developing sustainable interventions with the broadest impact on health and wellness is increased.

Figure 3: social-ecological model of health



Source adapted from: Hanson, D., Hanson, J., Vardon, P., McFarlane K., Lloyd, J., Muller, R., et al. (2005). The injury iceberg. An ecological approach to planning sustainable community safety interventions. *Health Promotion of Australia*, 16(1), 5-10.

Source: McLeroy, K.R., Bibeau, D., Steckler, A. & Glanz, K. (1988). An ecological perspective on health promotion programs. *Health Education Quarterly*, 15(4), 351-377.

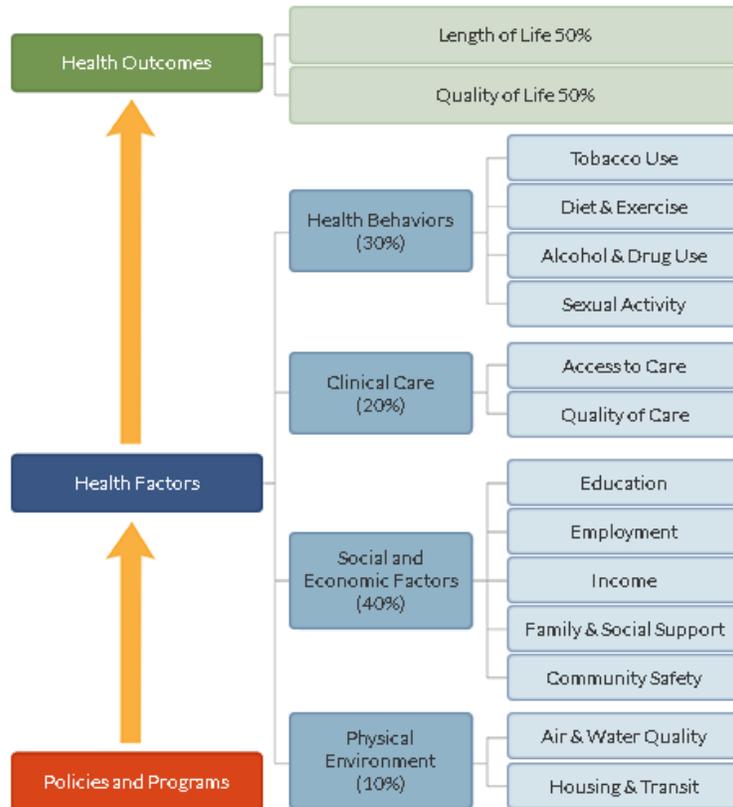
⁵ Hanson, D., Hanson, J., Vardon, P., McFarlane K., Lloyd, J., Muller, R., et al. (2005). The injury iceberg. An ecological approach to planning sustainable community safety interventions. *Health Promotion of Australia*, 16(1), 5-10.

⁶ McLeroy, K.R., Bibeau, D., Steckler, A. & Glanz, K. (1988). An ecological perspective on health promotion programs. *Health Education Quarterly*, 15(4), 351-377.

Determinants of health

Health is a complex and multidimensional concept. The Centers for Disease Control and Prevention describes health as “influenced by the health care we receive, our own choices and our communities.”⁷ To better understand the factors that contribute to the health of our community, the assessment utilized a population health model developed by the University of Wisconsin Population Health Institute known as the county health rankings model (see Figure 4).

Figure 4: University of Wisconsin Population Health Institute’s county health rankings model



Source: Courtesy of University of Wisconsin Population Health Institute. (2016). County Health Rankings & Roadmaps. Retrieved from: www.countyhealthrankings.org.

Health outcomes signify a community’s overall health. Two types of health outcomes are typically assessed: length of life (how long people live) and quality of life (how healthy people feel while alive).⁸ Health factors contribute to health and are otherwise known as determinants of health. There are five commonly recognized determinants of health⁹:

1. Biology and genetics
2. Clinical care
3. Health behaviors
4. Physical environment
5. Social and economic factors

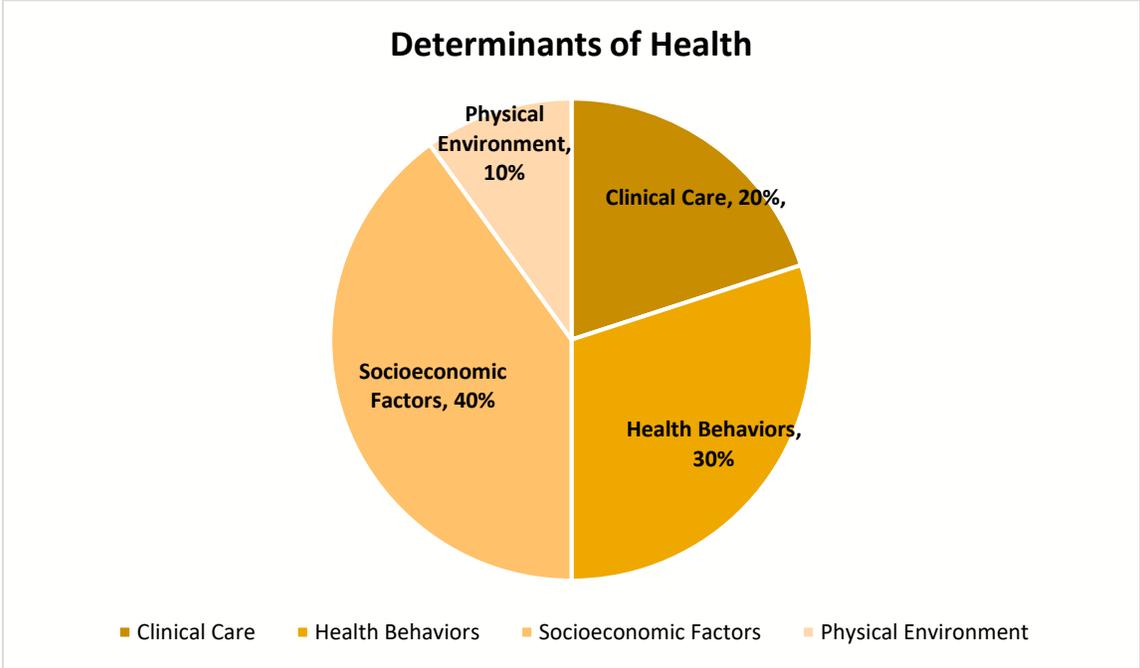
⁷ Centers for Disease Control and Prevention. (2015). *Community Health Improvement Navigator*. Retrieved from: <http://www.cdc.gov/chinav/>.

⁸ University of Wisconsin Population Health Institute. (2016). *County Health Rankings & Roadmaps*. Retrieved from: www.countyhealthrankings.org.

⁹ Centers for Disease Control and Prevention. (2014). *NCHHSTP Social Determinants of Health: Definitions*. Retrieved from: <http://www.cdc.gov/nchhstp/socialdeterminants/definitions.html>.

The assessment focused on four of the five aforementioned determinants of health: clinical care, health behaviors, physical environment and socioeconomic factors. Each of these determinants of health is, in turn, based on several measures (see Figure 4).⁹Some determinants of health are more modifiable than others. It is important to note that clinical care alone is not enough to improve community health, as it only accounts for 20 percent of the factors that influence health.⁸ Together, clinical care and health behaviors account for only 50 percent of the intervenable factors that contribute to health. Socioeconomic factors and the physical environment account for the remaining 50 percent of impactable health determinants (see Figure 5)¹⁰. Therefore, to have a greater impact on the health of the community, it is important to focus on all four determinants of health for assessment and intervention.

Figure 5: social determinants of health



Source: University of Wisconsin Population Health Institute. (2016). County Health Rankings & Roadmaps. Retrieved from: www.countyhealthrankings.org.

Health disparities

As aforementioned, the CHNA process included input from the broad community, as well as populations deemed underserved, at-risk or otherwise vulnerable. To highlight the health needs of these populations, the assessment examines health disparities in the community served. Health disparities are defined by Healthy People 2020 as “a particular type of health difference that is closely linked with social, economic and environmental disadvantage.”¹⁰

Certain disadvantaged populations are at greater risk of experiencing of health disparities. Healthy People 2020 asserts “health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.”¹¹

¹⁰ U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (2010). *The Secretary’s Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020. Phase I report: Recommendations for the framework and format of Healthy People 2020. Section IV: Advisory Committee findings and recommendations.* Retrieved from: http://www.healthypeople.gov/sites/default/files/PhaseI_0.pdf.

Health inequities and health equity

Health inequities are closely linked to health disparities and are also closely examined in this assessment. Health inequities are “differences in health that are avoidable, unfair and unjust.”¹¹ Health inequities are closely associated with social, economic and environmental conditions. In contrast, health equity is focused on the elimination of health and healthcare disparities. Healthy People 2020 defines health equity as the “attainment of the highest level of health for all people.”¹¹ In short, health equity pertains to efforts to ensure that all people have full and equal access to opportunities that enable them to lead healthy lives.

Social determinants of health

When examining health disparities health inequities, it is important to consider the social determinants of health. These conditions include the social, economic and physical factors and resources contributing to a range of environments and settings and are often responsible for health disparities and inequities. According to Healthy People 2020, there are five generally recognized categorical types of social determinants of health¹²:

1. Economic stability
 - Access to economic and job opportunities
 - Poverty
 - Food security
 - Housing stability
2. Education
 - Access to higher education opportunities
 - High school graduation
 - Early childhood education and development
 - Language
 - Literacy
3. Social and community context
 - Social cohesion and support
 - Availability of community-based resources and resources to meet daily living needs
 - Discrimination
 - Incarceration
4. Health and healthcare
 - Access to healthcare services (e.g., primary and specialty care)
 - Health literacy
5. Neighborhood and physical (built) environment
 - Environmental conditions (e.g., exposure to toxins and other physical hazards, green spaces, physical barriers, aesthetics of environment)
 - Access to sidewalks and bike lanes
 - Safe and affordable housing

Healthy People 2020 describes social determinants of health as the “conditions in the places where people live, learn, work and play” that affect a wide range of health risks and outcomes.”

¹¹ U.S. Department of Health and Human Services, Office of Minority Health. National Partnership for Action to End Health Disparities. (2010). *The National Plan for Action*. Retrieved from: <http://www.minorityhealth.hhs.gov/npa/templates/browse.aspx?&lvi=2&lvid=34>.

- Access to healthy foods
- Public safety (e.g., crime and violence)

Addressing health disparities, health equity and social determinants of health through community building and improvement initiatives is an important component of improving the health of the community. Therefore, indicators of health-related health disparities, health equity and social determinants of health are a central focus of the 2019 assessment and our health system's community health improvement efforts. Central to our efforts to improve the health of individuals and communities is our focus on promoting health and well-being of all people — and a commitment to health equity and eliminating barriers to good health.

Geographic Areas of Greatest Need

Our health and well-being are products of not only the health care we receive, but also the places where we live, learn, work and play.⁸ As a result, our ZIP code can be more important than our genetic code. Identifying areas of greatest need was an important component of this assessment, as it helped us to identify where there are at-risk and vulnerable populations most in need. This allows us to ensure our efforts include programs to address vulnerable populations, as such programs and populations have the potential for greatest gains.⁸

Priority Populations

Although the assessment aimed to include information on all populations in the geographic area, a special effort was made to incorporate information on the health and well-being of priority populations, or those most in need. Priority populations focused on in the assessment included, but were not limited to, people living in poverty, children, pregnant women, older adults, people who are uninsured and underinsured, members of ethnic or minority groups, members of medically underserved populations, and otherwise vulnerable or at-risk populations. This focus ensures alignment with our mission and that our implementation strategies specifically meet the needs of the most vulnerable.

Community Engagement and Collaboration

The process of conducting CHNAs and developing implementation strategies serves as an ideal opportunity for St. John to initiate and strengthen mutually beneficial relationships within the communities we serve. Recognizing this opportunity and the fact that we cannot do this work alone, we engaged, partnered and collaborated with a diverse set of community stakeholders in this process. These stakeholders represented a variety of community sectors, including community members, nonprofit and community-based organizations, safety-net providers, local schools and educational institutions, local government officials and agencies, churches and other faith-based organizations, healthcare providers, private businesses, community developers, law enforcement agencies, community health centers, healthcare consumer advocates, and the public health workforce. It is important to note that each sector in the community, including community members, has a unique role. Each sector brings critical strengths and insights to our collaboration.

Working together has a greater impact than working alone. Engaging the community and joining forces with community stakeholders allows all involved to share in the experience of understanding community health needs and to work collaboratively with the communities we serve. Working in partnership with a diverse set of community stakeholders ensures we are well-positioned to help improve health outcomes among vulnerable and disparate populations. This work will ultimately allow us to address the social determinants of health to measurably improve the health outcomes of the entire community. Furthermore, it is our hope that our engagement of the community will serve to empower community-driven solutions for community health improvement.

Limitations and Information Gaps

Although it is quite comprehensive, the 2019 assessment could not measure all possible aspects of health nor represent every type of population within Creek County. This constraint limited the ability to fully assess all of the community's health needs.

For example, certain population groups, such as those who are transient, those who are institutionalized or those who only speak a language other than English or Spanish, may not be adequately represented in the secondary data or community input. Other population groups, such as those who are lesbian, gay, bisexual, transgender, queer, etc. (LGBTQ+); undocumented residents; and members of certain racial/ethnic or immigrant groups, might not be identifiable or might not be represented in numbers sufficient for independent analysis. In addition, the following challenges resulted in limitations for assessing the health needs of the community:

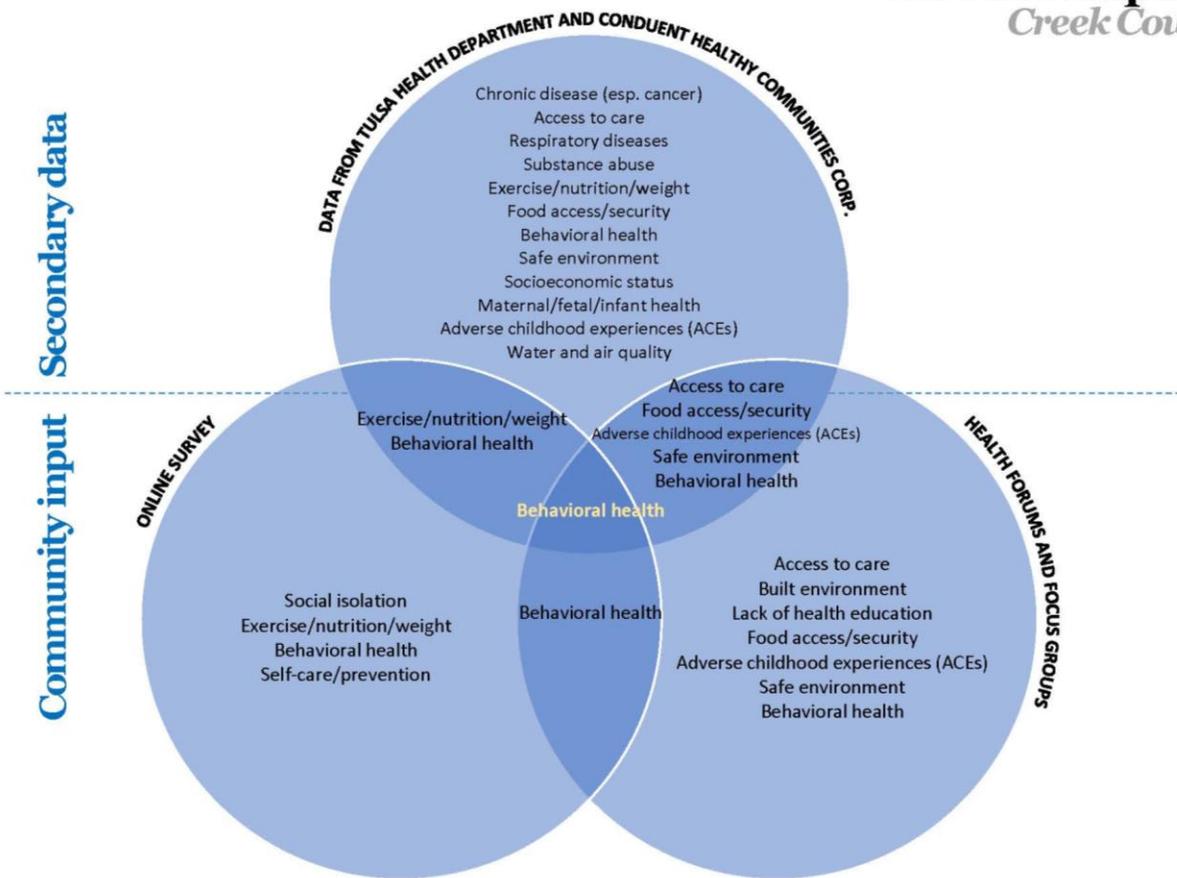
- Irregular intervals of time in which indicators are measured
- Changes in standards used for measuring indicators
- True service area encompasses several partial counties, but most health data is not available at that level
- Some sources of valuable data are completed with grant funds or budgeted under a prior administration and not repeated, so comparisons cannot be made
- Inconsistencies in reported data
- Limitation in representation from all sectors of the community
- Not all health process and outcome measures available through secondary health data were reviewed due to the broad focus of the assessment

Despite the data limitations, we are reasonably confident of the overarching themes and health needs represented through our assessment data. This is based on the fact that the data collection included multiple methods, both qualitative and quantitative, and engaged the hospital as well as a variety of participants from the community.

Summary of CHNA Findings

The community health needs assessment (CHNA) findings were drawn from a comprehensive review and analysis of secondary data and primary data, otherwise known as community input, from community leaders, public health professionals, organizations that serve the community at large, vulnerable populations and/or populations with unmet health needs. The results of the analysis were visually displayed in synthesis charts. Below is the St. John Sapulpa (SJS) chart, with the most significant health needs that arose from each CHNA activity for SJS and Creek County.

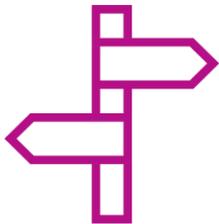
St. John Sapulpa Creek County



Through the six syntheses, the following top health needs were determined:

- Behavioral health
- Exercise/nutrition/weight
- Prevention/health behaviors (e.g., smoking, missing doctor’s visits, etc.)
- Access to care
- Chronic disease (esp. cancer)
- Adverse childhood experiences (ACEs)
- Food access/security
- Safe environment
- Substance abuse
- Socioeconomic status
- Immunizations and infectious diseases
- Lack of health education
- Maternal/fetal/infant health

Disparities and Geographic Areas of Greatest Need



The identification of disparities along race/ethnicity, gender, age, and geographic lines is important for informing and focusing strategies that will address the prioritized health needs. Primary and secondary data revealed community health disparities along racial lines, with American Indian/Alaskan Native populations more negatively impacted in Creek County. In many ways, women and children face a variety of challenges in Creek County. Many families struggle to be self-sufficient, even while holding down jobs. Medically underserved, low-income, minority, at-risk or otherwise vulnerable populations such as LGBTQ+ and individuals

experiencing homelessness face discrimination and a myriad of barriers to healthy lifestyles and accessing healthcare and other resources, negatively impacting health outcomes. Further, the data shows that older adults face increased health issues, while populations in certain geographic areas were identified as having higher socioeconomic need and potentially poorer health outcomes. Kellyville (ZIP code 74039) has the highest socioeconomic need identified for the county. Women and minority populations experience the highest socioeconomic need in the county.

Prioritization of Community Health Needs

On March 24, 2019, 13 members of Ascension St. John’s Community Engagement Committee (CEC) came together to participate in an individual assessment exercise and group discussion to help prioritize the most significant community health needs identified through community health needs assessment (CHNA) secondary and primary (community input) data analysis and synthesis.

Participants

Members of the CEC were invited to participate in the prioritization exercise because the committee includes top health system and hospital leaders, who have a high-level scope of clinical and community knowledge, manage services for the underserved and vulnerable, and are familiar with the significance of the CHNA process. The following CEC members participated:

- Ann Paul, DrPH, MPH, chief strategy officer for Ascension St. John
- Lucky Lamons, MCJ, MPA, MHR, foundation president and chief state advocacy officer for Ascension St. John
- Monica Barczak, PhD, director of indigent healthcare funding for Ascension St. John
- Annie Smith, LMSW, MPH, director of community engagement for Ascension St. John
- Stacy Brklacich, JD, senior attorney for Ascension St. John
- Kimberly Will, community engagement coordinator for Ascension St. John
- Jeff Nowlin, FACHE, president and chief operating officer of St. John Medical Center
- Ron Hoffman, vice president of clinical services for St. John Medical Center
- David Phillips, president and chief operating officer of St. John Owasso and St. John Broken Arrow
- Mike Christian, president of St. John Sapulpa
- Mike Moore, president and chief operating officer of Jane Phillips Medical Center and Jane Phillips Nowata Health Center
- Jason McCauley, regional administrator of Jane Phillips Nowata Health Center
- Wilford “Wick” Watson, RN, nursing manager at Jane Phillips Nowata Health Center

Process

On March 25, 2019, the individuals listed above convened on the St. John Medical Center campus to participate in a community health needs prioritization exercise. First, participants reviewed the results of secondary and primary data analysis on the following synthesis charts. Each chart visually displays the most significant health needs that arose from each CHNA activity by hospital and respective county. Also included for consideration were the final social determinants of health scores by county, provided by data consultant Conduent Healthy Communities Corp.

From there, participants utilized a prioritization toolkit (see Appendix 2) to examine how well each of the preliminary health needs aligned with criteria specific to the health system, hospital, community and level of impact. The participants scored each health need based on five criteria on a scale from 1-3, with 1 meaning it does not meet the criterion, 2 meaning it somewhat meets the criterion, and 3 meaning it meets the criterion. The criteria for prioritization were as follows:

- Alignment with St. John’s mission, vision and values (weighted x2)
- Alignment with community priorities (weighted x3)
- Existing programs and resources at the health system as well as any respective hospital
- Opportunities for partnership (weighted x2)

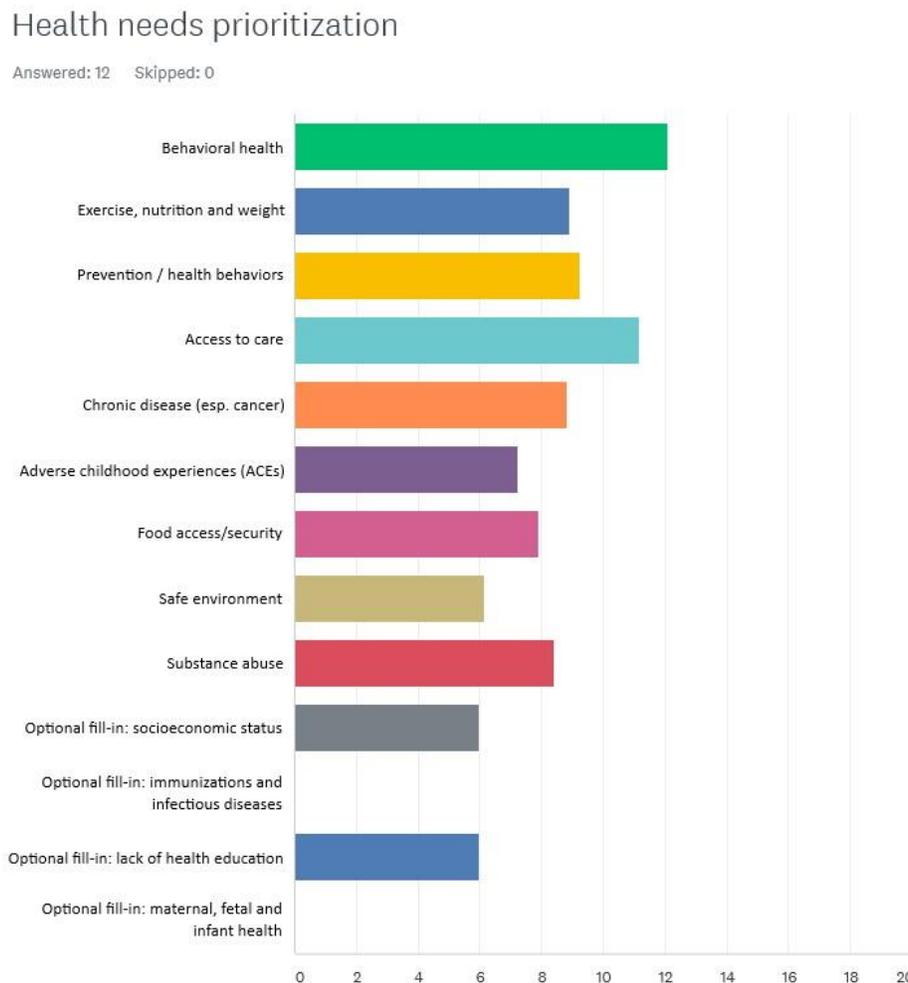
- Solution could impact multiple problems

Completion of this exercise allowed participants to arrive at a total score for each health need that correlated with how well it met the criteria for prioritization. Participants then ranked the health needs according to those scores, with the highest-scoring health need receiving the highest ranking. They were encouraged to use their own judgment in the event of a tied score. Afterward, participants shared answers and engaged in a group discussion on reasoning behind scoring and ranking. This exercise was modeled after a similar exercise previously performed by Conduent.

The rankings were later submitted into an online polling platform, Survey Monkey, that collated the responses, resulting in an aggregate ranking of the health needs (see Figure 15). The top health needs, which would be considered for fiscal year 2020-2022 health system priorities and subsequent implementation strategy planning, were:

- Behavioral health
- Access to care
- Prevention / health behaviors
- Exercise, nutrition and weight
- Chronic disease (esp. cancer)
- Substance abuse

Figure 6: prioritization exercise results



Prioritized Needs to Be Addressed

A final, deeper analysis of these rankings and the CHNAs as a whole determined that St. John would focus on the following health needs:



Behavioral health



Access to care



Healthy lifestyles



Adverse childhood experiences (ACEs)

It was decided that substance abuse will be a component of the behavioral health category. The areas of prevention / health behaviors and exercise, nutrition and weight were combined to become “healthy lifestyles,” with food insecurity/access and chronic disease as components of this category. Finally, adverse childhood experiences (ACEs) was moved into the fourth priority spot.

Social determinants of health were deemed an underlying current of all priorities. It was also important that the four chosen priorities correlated strongly with the St. John mission to serve all people, with special attention to those who are poor and vulnerable, as well as the organization’s internal Catholic Identity Matrix, which in part evaluates work related to “solidarity with those who live in poverty.”

Needs That Will Not Be Addressed Directly

Ascension St. John and the hospital are committed to improving community health by directly — and indirectly — addressing prioritized health needs. The 2019 CHNA inevitably identified more significant health needs than the health system, hospitals and community partners can or should address as priority health needs. It would not be prudent to spread hospital and community resources across too many initiatives. Accordingly, Ascension St. John, the hospital and community partners instead decided to focus attention on priority areas to help ensure sufficient resources are available. Certain factors impact the hospital’s ability to fully address all priorities health needs and include the following:

- Need being addressed by others
- Insufficient resources (financial and personnel) to address the need
- Issue is not a priority for community members and therefore approach is unlikely to succeed
- Lack of evidence-based approach for addressing the problem
- Need is not as pressing as other problems
- Need is not as likely to be resolved as other problems
- Hospital and/or health system does not have expertise to effectively address the need

The following significant health needs were identified but will not be addressed directly by Ascension St. John or the hospital as priority health needs:

- Safe environment

- Socio-economic status
- Immunizations and infectious diseases
- Health education
- Maternal, fetal and infant health

It was discussed at length that these remaining health topics, while not chosen as priorities, are interrelated to the four chosen priorities and will therefore be addressed indirectly. Furthermore, and as aforementioned, social determinants of health were deemed an underlying current of the chosen priorities, which will ultimately cross over efforts into other need areas. All direct and indirect efforts to improve the community's health are intended to uphold St. John's mission to serve all people, with special attention to those who are poor and vulnerable.

Implementation Strategy

Similar to the community health needs assessment (CHNA), the implementation strategy is both a process and a product. The implementation strategy is the hospital's plan for how we will address priority health needs identified through the CHNA process. According to IRS regulations, the implementation strategy must:

- Describe how the hospital plans to meet each identified health need; or
- Identify certain health needs the hospital does not intend to address and explain why the hospital does not intend to address the health need.

Participants

The input of system-wide leadership is vital to the design and completion of an effective implementation strategy. Accordingly, a steering committee consisting of leadership from the health system, each of the six hospital facilities, Ascension Medical Group, the foundation and other entities was formed to oversee the development of our implementation strategy under the guidance of the Community Benefit team. (See the Acknowledgments section for a full list of steering committee members.) The steering committee was formed in a collaborative effort to also oversee Ascension St. John's Catholic Identity Matrix (CIM), an internally focused initiative that similarly functions on a three-year cycle. The purpose of CIM is to evaluate the degree to which an institution's current practices and processes are consistent with the aspirations of the Catholic moral tradition by translating principles into behavioral benchmarks.

On June 5, 2019, the steering committee held its first meeting. In regard to the CHNAs, the steering committee had a high-level discussion of the prioritized health needs based on findings from the reports, then determined co-leads and members for task forces that would spearhead initiatives for those health needs. The task forces later met independently to begin developing goals and strategies for their respective health need. Task force members include a variety of associates from throughout the health system with special knowledge of or skills related to the particular health need. Task forces were encouraged to work with community partners and the Community Benefit team as appropriate. The steering committee reconvened the following month to review and finalize the goals and strategies for each health need that the task forces had drafted. The task forces will meet regularly throughout FY 2020-2022 to ensure continuation of work toward goals and report progress on a quarterly basis.

Process

St. John Sapulpa's (SJS's) implementation strategy process included the following steps:

- Planning and preparation for the implementation strategy
- Formation and convening of an Ascension St. John steering committee to oversee implementation strategy development, including four task forces designated to address each of the priority health needs identified in the CHNA
- Review of key findings from the CHNA in conjunction with the Ascension St. John's internal FY 2019-2021 Integrated, Strategic, Operational and Financial Plan (ISOFP)
- Identification of two executive leaders and additional members for each of the four CHNA priority health need task forces to address findings
- Consideration of approaches to address prioritized needs and selection of approaches with guidance from Community Benefit team
- Through task forces, development of goals, strategies and objectives and identification of indicators for addressing community health needs with guidance from Community Benefit team
- Identification of operational owners/champions within the health system for this work
- Presentation by task forces to steering committee of plans for addressing community health needs

- Development of a written implementation strategy by Community Benefit team
- Adoption of the implementation strategy by hospital and health system boards of directors
- Alignment of implementation strategy with hospital and community plans
- Ongoing updates and modifications to sustain the implementation strategy

Strategy Development

Each task force worked together to develop goals, strategies, objectives and indicators to address their respective prioritized health need. To select strategies most likely to succeed, the task forces followed an approach that encompassed the following:

- Understanding of the prioritized health need and its causes
- Identification of a range of possible strategies
- Investigation of evidence-based interventions
- Review of community assets and existing hospital programs and resources
- Consideration of the use of a collective impact framework with the understanding that needs cannot be solved by one organization alone
- Discussion of resource needs, timetables and other implementation logistics

Below is an outline of the four significant health needs selected as priorities for FY 2020-2022 with key opportunities for improvement, as based on findings from the CHNAs and discussed during the steering committee's initial meeting.

Access to care

Key opportunities identified in CHNAs:

- Inability to pay or insufficient health insurance coverage
- Special populations feel healthcare system is closed off to them
- Transportation inequity
- Difficulty understanding or navigating the healthcare system
- Regional inequity in healthcare providers, services and resources

Behavioral health

Key opportunities identified in CHNAs:

- High suicide rate
- Lack of resources (inpatient behavioral health beds, outpatient services)
- Chronic stress, anxiety and depression
- Social isolation
- Substance abuse and high rates of overdose

Healthy lifestyles

Key opportunities identified in CHNAs:

- Inequity in food access and security
- Inequity in opportunities for physical activity (safe built environment)
- Lack of health education / health literacy; chronic disease prevention
- Tobacco use

Adverse childhood experiences (ACEs)

Key opportunities identified in CHNAs:

- High rates of child abuse and neglect
- High rates of childhood poverty
- High rates of incarceration (including women with children)
- Human trafficking
- High rates of ACEs in Oklahoma
- Opportunities to implement or improve trauma-informed care
- Opportunities to improve scope of awareness; self-care/self-awareness

This FY 2020-2022 SJS CHNA implementation strategy report provides an explanation of how the hospital will address the community's most pressing needs. It provides a comprehensive overview of how SJS and other Ascension St. John hospitals and entities will work both jointly and independently to address the priority health needs identified by the 2019 CHNAs. Some actions in this report are specific to this hospital, while other actions are applicable to all six hospitals and other entities.

Adoption and Reporting

Upon completion, this implementation strategy was formally adopted by the health system's board of directors in August 2019 and the hospital's board of directors in October 2019. To fulfill public reporting requirements, the strategy is posted and housed on the Ascension website at <https://healthcare.ascension.org/CHNA>.

It is important to note that the implementation strategy is an ongoing and dynamic process. Therefore, modifications and adjustments can be made to the strategy as needed based on changes in community needs or priorities, changes in hospital resources, and/or evaluation results. Because the goal of the implementation strategy process is to guide evaluation so that impact can be demonstrated, modifications may be made to the goals and targets as needed.

Summary of Action Plans

Prioritized Need 1: Access to Care

GOAL 1: Remove barriers of access to healthcare for those living in poverty and/or otherwise deemed vulnerable within our service area.

STRATEGY 1: Work to expand Medicaid to the point that it increases coverage for those most vulnerable in Oklahoma (Medicaid expansion).

Background information:

- The target population is Oklahoma residents who are without health insurance coverage.
- This strategy targets those who are without access to health insurance and thus are typically medically underserved.
- The strategy utilized for expanding Medicaid to remove barriers of access to healthcare will be approached through both policy and system change. The strategy draws upon the following evidence-base:
 - In other states that have expanded Medicaid coverage up to 133 percent of the FPL, analysis has found significantly improved health equity and have closed the gap on health disparities, particularly in the gap that disproportionately affects people of color and low-SES communities.

Resources:

- Members of the Access to Care task force, Ascension St. John and hospital facilities, Ascension's Advocacy team, St. John Chief of Advocacy, community benefit department, & financial support from Ascension system office.

Collaboration:

- George Kaiser Family Foundation, Zarrow Family Foundation, Saint Francis Health System, Oklahoma Hospital Association, Chickasaw Nation, Fairness Project and Ascension Advocacy

Anticipated impact:

- By the end of CY 2019, the collaborating partners of the Yes to 802 campaign, which includes Ascension St. John, will have attained 178,000 signatures to put a question on the 2020 ballot to expand Medicaid coverage to eligible residents with an income of up to 133 percent of the FPL.
- By the end of CY 2020, voters in the state of Oklahoma will have adopted a ballot initiative to expand Medicaid coverage to eligible residents with an income of up to 133 percent of the FPL.
- By July 2021, SoonerCare will begin offering coverage services to new recipients due to expansion of Medicaid coverage with as limited restrictions to eligibility as possible.

Local alignment:

While Creek County coalitions do not have specified written plans for improving access to care, the coalitions do support efforts to improve access.

State alignment:

- Yes to 802 Oklahoman's Decide Healthcare Campaign – coalition of Oklahoma doctors, nurses, patients, business executives, non-profit organizations, healthcare advocates and hospitals with goal to expand Medicaid to nearly 200,000 Oklahomans. Campaign will give voters a direct say on Medicaid expansion as an issue for the November 2020 ballot if enough signatures are obtained by that time.

- Oklahoma Health Improvement Plan 2020 (OHIP 2020) health transformation: health finance goal 1 – decrease the percentage of uninsured individuals from 17% in 2013 to 9.5% by 2020; Strategy 1 & 2 – pursue opportunities for Medicaid expansion.

Oklahoma Plan 2030 has not yet been released but is anticipated to include Medicaid expansion as a priority.

National alignment:

- Healthy People 2020 Objective AHS-1 – Increase the proportion of persons with health insurance.
- Healthy People 2020 Objective AHS-6 – Reduce the proportion of people who are unable to obtain or delay in obtaining necessary medical care, dental care, and prescription medication.

Healthy People 2030 has not yet been released but is anticipated to continue to include a goal to increase the proportion of persons with health insurance and promote access to care.

STRATEGY 2: Create a welcoming environment by developing and implementing a plan to assist those living in poverty and/or populations otherwise deemed vulnerable as well as their caregivers with navigating our healthcare facilities.

Background information:

- The target population is persons living in poverty and/or otherwise deemed vulnerable residing in communities we serve.
- This strategy address health disparities and challenges of underserved populations. Focus groups recently conducted as part of the FY 2019 community health needs assessments revealed that some individuals feel disenfranchised in seeking health services; trying to access healthcare at Ascension St. John and other locations is confusing and individuals seeking care do not feel welcome.
- This strategy is considered a system change because it entails an employee education and communication plan as well as improved signage expected through Ascension St. John’s new brand roll-out. This strategy utilizes some best practices for training as developed on a national scale by Ascension.

Resources:

- Members of the Access to Care task force, Ascension St. John and hospital facilities, human resources, clinical education, quality department, brand roll-out team, mission integration (community benefit department, ethics, and mission formation).

Will also seek collaboration and cooperation from our affiliate organizations and vendors such as R1 (revenue cycle management), Touchpoint (environmental services), etc.

Collaboration:

- Community partners as identified throughout FY 2020-2022.

Anticipated impact:

- By the end of each fiscal year (FY 2020-2022), assess improved trends in related patient experience measure outcomes for FY 2020, FY 2021 and FY 2022, using FY 2019 as baseline.
- By end of FY 2021, assess results of SOGI training in FY 2021 – number of associates trained and scores.
- By the end of each fiscal year (FY 2020-2022), assess reduction in reports of bullying for FY 2020, FY 2021 and FY 2022 submitted through variance process to Quality/Risk Management with FY 2019 as baseline.

Local alignment:

While Creek County coalitions do not have specified written plans for improving access to care, the coalitions do support efforts to improve access.

State alignment:

Oklahoma Plan 2030 has not yet been released but is anticipated to include similar objectives to promote access to care.

National alignment:

- Healthy People 2020 Objective AHS-1 – Increase the proportion of persons with health insurance.
- Healthy People 2020 Objective AHS-6 – Reduce the proportion of people who are unable to obtain or delay in obtaining necessary medical care, dental care, and prescription medication.

Healthy People 2030 has not yet been released but is anticipated to include similar objectives to promote access to care.

GOAL 2: Reduce regional inequity in accessing healthcare providers, services and resources.

STRATEGY 1: Promote awareness of, and access to, healthcare for underserved populations within communities we serve through Medical Mission at Home (MM@H) events and other opportunities to reach those in need.

Background information:

- The target population is uninsured, underinsured and underserved community members who need a medical home through which they can obtain both primary and specialty care and other ways to access care. The Community Health Needs Assessment showed vulnerable populations in Creek County (Sapulpa).
- This strategy seeks to provide a medical home and other opportunities to access care for individuals, who are medically underserved due to financial or other barriers to obtaining care.
- This is a systems change, adjusting the organization's infrastructure to respond to community needs. This strategy is built upon the evidence base cited by Healthy People's 2020's Access to Health Services topic: People with a usual source of care have better health outcomes and fewer disparities and costs. Medical Mission at Home (MM@H) was created by Ascension and at least one event is required of each Ministry per year.

Resources:

- Members of the Access to Care task force, Ascension St. John and hospital facilities, Ascension Medical Group, FY19 community health needs assessments, In His Image, MedXcel, Regional Medical Laboratory, Transitional Care Clinic, Mission Integration (community benefit and mission formation departments).

Collaboration:

- Local government: (City of Sapulpa, Mayor's office, Governor's office); Catholic Church: (Bishop Konderla, Christ the King Catholic Church, Diocese of Eastern Oklahoma); local social work, public health, nursing, physician residency and other healthcare-oriented school programs; local public schools, and additional community partners as identified, with a focus on community organizations addressing social determinants of health.
- Host facility: Good Shepherd Episcopal Church - Sapulpa

Anticipated impact:

- Plan and host one Medical Mission at Home (MM@H) event to address healthcare needs of three vulnerable communities, as identified in the CHNAs by the end of FY 2020.
 - Sapulpa event in April 2020 – to address Creek County
- Obtain survey feedback from at least 25 percent of patients and volunteers to determine effectiveness of services offered by end of FY 2020.
- Fiscal year list of activities performed within the health system to promote access to healthcare submitted to Ascension VP of Mission Integration and Community Benefit Inventory for Social Accountability (CBISA) taskforce by end of each fiscal year (FY 2020-2022).

- Enter FY 2020 MM@H survey data into spreadsheet for evaluation by MM@H steering committee; plan and implement MM@H in FY 2021 by end of FY 2021.
- Enter FY 2021 MM@H survey data into spreadsheet for evaluation by MM@H steering committee; plan and implement MM@H in FY 2022 by end of FY 2022.

Local alignment:

- Hosting Medical Mission at Home events in the communities we serve is a strategic FY 2020 goal for Ascension St. John.

State alignment:

- Oklahoma Health Improvement Plan 2020 (OHIP 2020) health transformation: health efficiency and effectiveness goal 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 potentially preventable hospitalizations & Objective 2 – reduce hospital emergency room visits; Strategy 1 – Improve the quality and availability of healthcare via care coordination, especially for individuals with chronic, behavioral health, or specific co-morbid conditions.

National alignment:

- Ascension’s Medical Mission at Home was launched in 2008 to deliver quality healthcare to the uninsured and underinsured. Ascension has made a commitment to expand the Medical Mission at Home nationally — a proactive demonstration of our One Mission in the community and our commitment to Healthcare That Leaves No One Behind.

Prioritized Need 2: Behavioral Health

GOAL 1: Assess the opportunity for and/or implement intensive outpatient geriatric psychiatric programs, if viable, for seniors 65+ with behavioral health issues in areas of need in northeastern Oklahoma.

STRATEGY 1: Implement intensive outpatient geriatric psychiatric program in Creek County.

Background information:

- The target population is seniors 65+ in need of intensive psychiatric services in Creek County.
- The strategy addresses the inequity of behavioral health services/resources in Creek County as well as health disparities experienced by the community as evidenced by the disproportionately high rates of suicide and other poor behavioral health outcomes in Creek County as compared to other counties in Oklahoma and the US.
- This strategy is an environmental change and is an opportunity for the hospital to fill gaps in care in community. An emerging evidence base supports the efficacy of geriatric mental health interventions. The anticipated growth in the population of older persons with mental disorders underscores the need for a strategy to facilitate the systematic and effective implementation of evidence-based practices in geriatric mental healthcare.

Resources:

- Members of the Behavioral Health Task Force, Ascension St. John, St. John Sapulpa (SJS), MedExcel facilities management, R1 (revenue cycle management), Ascension Technology, Ascension St. John forms committee, hospital facility space, funding, transportation resources, community benefit department.

Collaboration:

- Senior Life Solutions – vendor, collaboration with surrounding community referral sources, other community partners as identified.

Anticipated impact:

- Roll-out intensive outpatient geriatric psychiatric program at St. John Sapulpa by the end of the first quarter, FY 2020.
- Market intensive outpatient geriatric psychiatric program internally within Ascension St. John as well as to 10 potential community referral sources within service area beginning by end of FY2021.
- Complete annual review of St. John Sapulpa intensive outpatient geriatric psychiatric program by the end of each fiscal year (FY 2020-2022). Implement modifications to program as necessary based on findings from annual review.

Local alignment:

While local Creek County coalitions do not have specified written plans for improving behavioral health, the coalitions do support efforts to improve behavioral health outcomes.

State alignment:

- The Oklahoma Health Improvement Plan 2020 (OHIP2020) identified behavioral health services as one of four “flagship issues” for the state. OHIP 2020 behavioral health goal 1 – increase the overall health and wellness of Oklahomans; Strategy 3 – implement unified, evidenced-based screening, assessment, and treatment protocol for suicidality statewide.

Oklahoma Plan 2030 has not yet been released but is anticipated to include similar objectives to promote behavioral health and reduce the suicide rate.

National alignment:

- Healthy People 2020 Objective MHMD1– Reduce the suicide rate

Healthy People 2030 has not yet been released but is anticipated to include similar objectives to promote behavioral health and reduce the suicide rate.

- Zero Suicide Initiative: Zero Suicide is a key concept of the 2012 National Strategy for Suicide Prevention, a priority of the National Action Alliance for Suicide Prevention (Action Alliance), a project of Education Development Center's Suicide Prevention Resource Center (SPRC) and supported by the Substance Abuse and Mental Health Services Administration (SAMHSA).

GOAL 2: Advance Ascension St. John engagement in community coalitions and collaboratives to promote behavioral health wellness in the communities we serve.

STRATEGY 1: Identify community coalitions and other collaboratives with partnership opportunities to promote behavioral health wellness; encourage health system representation/involvement by associates as deemed appropriate.

Background information:

- Individuals experiencing and/or at risk of experiencing behavioral health needs in communities we serve.
- The strategy addresses the inequity of behavioral health services/resources in Creek County. It addresses health disparities experienced by the community as evidenced by the disproportionately high rates of suicide, substance abuse and other poor behavioral health outcomes in the county as compared with other counties in Oklahoma and the U.S. In addition, this strategy utilizes community collaboration and resources to address social determinants of health and inequity of resources for at risk populations with a focus on those most in need.
- The strategy is a system change and is informed by evidence found on What Works for Health and The Guide to Community Preventive Services.

Resources:

- Members of the Behavioral Health Task Force, Ascension St. John, St. John hospital facilities, St. John Clinic, associates who are identified to participate in coalitions and collaboratives, community benefit department, financial support where appropriate.

Collaboration:

- Healthy Minds - mental health policy organization funded by the Anne & Henry Zarrow Foundation, Tulsa Regional Mental Health Plan, CAPSAT – coalition against prescription and substance abuse of Tulsa, Program for Assertive Community Treatment (PACT) Council, Creek County Community Partnership, Oklahoma Coalition Against Human Trafficking, Nowata Community Advancement Network (CAN), Mental Health Association of Oklahoma, Washington County Wellness Initiative (WCWI), Advisory Council for vulnerable populations and emerging programs, inpatient provider group, other community partners as identified.

Anticipated impact:

- By end of FY 2020 ensure one associate per community health needs assessment (CHNA) defined county (Creek) is engaged with a community coalition or collaborative.
- Increase overall Ascension St. John associate participation by 5% with behavioral health coalitions and collaboratives in the communities we serve, and which Ascension St. John is not currently in partnership by the end of FY 2022.

Local alignment:

- Funded by the Anne and Henry Zarrow Foundation and coordinated by the University of Tulsa, the Tulsa Regional Mental Health Plan is a 10-year communitywide effort to focus on regional mental health improvements and includes a leadership council with philanthropy, business, university, state and nonprofit representation. The plan aims to:
 - Close the gap in life expectancy between Tulsans living with mental illness and all Oklahomans.
 - Lower the rates of overdoses, and associated deaths from both causes.
 - Lower the share of Tulsans who experience poor mental health.
 - Reduce criminal justice system, first responder, and hospital emergency room costs caused by untreated or poorly treated mental illness.

While Creek County coalitions do not have specified written plans for improving behavioral health, the coalitions do support efforts to improve behavioral health outcomes.

State alignment:

- The Oklahoma Health Improvement Plan 2020 (OHIP2020) identified behavioral health services as one of four “flagship issues” for the state. OHIP 2020 behavioral health goal 1 – increase the overall health and wellness of Oklahomans; Strategy 3 – implement unified, evidenced-based screening, assessment, and treatment protocol for suicidality statewide.
- The Oklahoma Health Improvement Plan 2020 (OHIP2020) identified behavioral health services as one of four “flagship issues” for the state. OHIP 2020 behavioral health 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 and 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).
- OHIP 2020 behavioral health goal 3 – decrease the number of Oklahomans with untreated mental illness; Strategy 5 – all Oklahomans will have access to crisis and urgent care for mental health disorders.

Oklahoma Plan 2030 has not yet been released but is anticipated to include similar objectives to promote behavioral health and reduce the suicide rate.

National alignment:

- Healthy People 2020 Objective MHMD1– Reduce the suicide rate
- Healthy People 2020 Objective MHMD9 – Increase the proportion of adults with mental health disorders who receive treatment.
- Healthy People 2020 Objective MHMD10 – Increase the proportion of persons with co-occurring substance abuse and mental disorders who receive treatment for both disorders.

Healthy People 2030 has not yet been released but is anticipated to include similar objectives to promote behavioral health and reduce the suicide rate.

- Zero Suicide Initiative: Zero Suicide is a key concept of the 2012 National Strategy for Suicide Prevention, a priority of the National Action Alliance for Suicide Prevention (Action Alliance), a project of Education Development Center's Suicide Prevention Resource Center (SPRC) and supported by the Substance Abuse and Mental Health Services Administration (SAMHSA).

Prioritized Need 3: Healthy Lifestyles

GOAL 1: Address food insecurity through community collaboration and strengthening of community resources.

STRATEGY 1: Explore collaborative opportunities to develop an initiative(s) to address food insecurity in communities we serve in northeastern Oklahoma. If viable, develop and implement initiative(s).

Background information:

- The strategy’s target population is food insecure communities in northeastern Oklahoma (Creek County), as identified by the fiscal year 2019 community health needs assessments conducted by each hospital and community.
- This strategy addresses social determinants of health and health disparities in our communities by addressing inequity in access to healthy food. Accordingly, the strategy plays a vital role in the promotion of healthy lifestyles and improving health outcomes in the communities we serve.
- This strategy is a system change and is modeled off national evidence-based programs addressing food insecurity in healthcare settings. In addition, the Nutrition and Weight Status objectives for Healthy People 2020 reflect strong science supporting the health benefits of eating a healthful diet and maintaining a healthy body weight. The goal of promoting healthful diets and healthy weight encompasses increasing household food security and eliminating hunger.

Resources:

- Members of the Healthy Lifestyles Task Force, TouchPoint / food services (TBD), Ascension St. John, St. John hospital facilities, St. John Clinic, Community Engagement Committee, facility space, community benefit department.

Collaboration:

- Potential sources include: Pathways to Health (P2H), Creek County Community Partnership (CCCP), Creek County Health Living Program (CCHLP), local public schools, local health department, local food pantries, regional food bank, faith-based nutrition programs, Hunger Free Oklahoma, Healthy Community Store Initiatives, SNAP and WIC programs, local farmers markets, community gardens, nutrition programs (e.g., Meals on Wheels).

Anticipated impact:

- Meet with 5-10 potential community partners (encompasses communities surrounding all six St. John hospitals) by the end of CY 2019 (12/31/19).
- Develop assessment plan to outline research on evidence-based programs and track partnership opportunities by the end of FY 2020 (year 1).
- If deemed viable, develop and implement initiative(s) for identified opportunities on a pilot basis during FY 2021 (year 2).
- During FY 2022 (year 3), perform assessment of pilot and develop plan to expand throughout the St. John Health System, if viable.

Local alignment:

- Healthy Community Store Initiative aims to enhance the health of northeast Oklahoma through food-based community revitalization.
- One priority of the Creek County Healthy Living Partnership (CCHLP) is to increase nutrition opportunities in Creek County.
- A priority of the Creek County Community Partnership (CCCP) is to address obesity in Creek County.

State alignment:

- Hunger Free Oklahoma is working to end hunger by focusing on collaboration, research, policy, advocacy, and practice. Hunger Free Oklahoma and collaborators are undertaking a comprehensive and sustainable approach to ending hunger in Oklahoma.
- Obesity is a flagship goal of the Oklahoma Health Improvement Plan 2020 (OHIP 2020). A focus of this goal is food access and healthy nutrition. OHIP 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 3 – improve the built environment infrastructure supportive of physical activity and availability of affordable fruits and vegetables.

Oklahoma Plan 2030 has not yet been released but is anticipated to include similar objectives to increase food access and healthy nutrition as well as address food insecurity.

National alignment:

- The Nutrition and Weight Status objectives for Healthy People 2020 aim to promote health and reduce chronic disease risk through the consumption of healthful diets and achievement and maintenance of healthy body weights. The objectives emphasize that efforts to change diet and weight should address individual behaviors, as well as the policies and environments that support these behaviors in settings such as schools, worksites, healthcare organizations, and communities. The NWS-1 through 22 objectives are all in alignment.
- The Healthy People 2020 NWS-12 and 13 objectives are particularly relevant as they work to address food insecurity. The goal of promoting healthful diets and healthy weight encompasses increasing household food security and eliminating hunger.

Healthy People 2030 has not yet been released but is anticipated to include similar objectives to increase food access and healthy nutrition as well as address food insecurity.

GOAL 2: Reduce the health impact of tobacco use in communities we serve.

Ascension St. John acknowledges the traditional and sacred use of tobacco among American Indian people living in Oklahoma.

STRATEGY 1: Assess opportunities for systematic screening and intervention for patients identified as tobacco users in ambulatory and inpatient settings in communities we serve.

Background information:

- The target population is patients identified as tobacco users in ambulatory and inpatient settings in communities we serve.
- This strategy addresses health disparities as certain populations in the communities we serve, remain at high risk and suffer disproportionately from tobacco-related illness and death despite progress made in reducing tobacco use. 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.
- This strategy is a system change. The strategy builds upon evidence base from the CDC and Healthy People 2020.
 - The CDC has also established reducing tobacco use as one of its “winnable battles.” These are public health priorities with large-scale impact on health that have proven effective strategies to address them. CDC believes that with additional effort and support for evidence-based, cost-effective policy and program strategies to reduce tobacco use, we can reduce smoking substantially, prevent millions of people from being killed by tobacco, and protect future generations from smoking.
 - Healthy People 2020 provides a framework for action to reduce tobacco use to the point that it is no longer a public health problem for the Nation. Research has identified effective strategies that will contribute to ending the tobacco use epidemic which includes expanding cessation treatment in clinical care settings and providing access to proven cessation treatment to all smokers.
- Tobacco control interventions are known to reduce tobacco use and, as a result, tobacco’s extraordinary toll of death and disease. But to free the next generation from these burdens, we must redouble our tobacco control efforts and enlist non-governmental partners—and society as a whole—to share in this responsibility.

Resources:

- Members of the Healthy Lifestyles Task Force, Ascension St. John, St. John hospital facilities, St. John Clinic, Ascension Technology, Community benefit department and additional resources as identified during process.

Collaboration:

- Hospitals Helping Patients Quit (TSET-funded), Oklahoma Tobacco Helpline (OKhelpline.com) and additional community organizations as identified during process.

Anticipated impact:

- By end of Year 1 (FY 2020): Develop assessment plan to outline research on evidence-based tobacco screening and intervention programs.
- By end of Year 2 (FY 2021): Assess and complete informatics needed for screening and intervention services, if viable, to enable systematic screening and intervention for tobacco users in facilities.
- By end of Year 3 (FY 2022): Implement and/or advance systematic screening and intervention in inpatient and ambulatory settings based on Year 1 findings.

Local alignment:

- One priority of the Creek County Healthy Living Partnership (CCHLP) is lowering the rates of tobacco use.

State alignment:

- Tobacco use is a flagship goal in the Oklahoma Health Improvement Plan 2020 (OHIP 2020). 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.

Oklahoma Plan 2030 has not yet been released but is anticipated to include similar objectives to promote tobacco cessation.

- Tobacco cessation services are available to all Oklahomans through the Oklahoma Tobacco Helpline. The Helpline offers free, customizable services and tools to help Oklahomans quit tobacco on their own terms. Patients enrolled in SoonerCare are eligible for extra tobacco cessation services.

National alignment:

- The Healthy People 2020 Tobacco Use objectives (TU 1-10.6 are in alignment) are organized into 3 key areas:
 - Tobacco Use Prevalence: Implementing policies to reduce tobacco use and initiation among youth and adults.
 - Health System Changes: Adopting policies and strategies to increase access, affordability, and use of smoking cessation services and treatments.
 - Social and Environmental Changes: Establishing policies to reduce exposure to secondhand smoke, increase the cost of tobacco, restrict tobacco advertising, and reduce illegal sales to minors.

Healthy People 2030 has not yet been released but is anticipated to include similar objectives to promote tobacco cessation.

STRATEGY 2: Explore opportunities to help identify and work with our associates requesting assistance with tobacco cessation.

Background information:

- The target population is Ascension St. John associates and their families.
- This strategy addresses health disparities as certain populations in the communities we serve, remain at high risk and suffer disproportionately from tobacco-related illness and death despite progress made in reducing tobacco use. 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.
- This strategy is a system change. The strategy builds upon evidence base from the CDC and Healthy People 2020.
 - The CDC has also established reducing tobacco use as one of its “winnable battles.” These are public health priorities with large-scale impact on health that have proven effective strategies to address them. CDC believes that with additional effort and support for evidence-based, cost-effective policy and program strategies to reduce tobacco use, we can reduce smoking substantially, prevent millions of people from being killed by tobacco, and protect future generations from smoking.
 - Healthy People 2020 provides a framework for action to reduce tobacco use to the point that it is no longer a public health problem for the Nation. Research has identified effective strategies that will contribute to ending the tobacco use epidemic which includes expanding cessation treatment in clinical care settings and providing access to proven cessation treatment to all smokers.
 - Tobacco control interventions are known to reduce tobacco use and, as a result, tobacco’s extraordinary toll of death and disease. But in order to free the next generation from these burdens, we must redouble our tobacco control efforts and enlist non-governmental partners—and society as a whole—to share in this responsibility.

Resources:

- Members of the Healthy Lifestyles Task Force, Ascension St. John, St. John hospital facilities, St. John Clinic, Ministry-wide-function (MWF) associates, local and ministry-wide-function (MWF) human resources, Ascension Smart Health, Community benefit department and additional resources as identified through process.

Collaboration:

- Community organizations as identified through process as appropriate.

Anticipated impact:

- By end of Year 1 (FY 2020): Develop assessment plan to outline research on evidence-based programs.
- By end of Year 2 (FY 2021): If opportunities available, present findings to health system and hospital leadership to advocate for program implementation.
- If viable, implement program in Year 3 (FY 2022).

Local alignment:

- One priority of the Creek County Healthy Living Partnership (CCHLP) is lowering the rates of tobacco use.

State alignment:

- Tobacco use is a flagship goal in the Oklahoma Health Improvement Plan 2020 (OHIP 2020). 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.

Oklahoma Plan 2030 has not yet been released but is anticipated to include similar objectives to promote tobacco cessation.

- Tobacco cessation services are available to all Oklahomans through the Oklahoma Tobacco Helpline. The Helpline offers free, customizable services and tools to help Oklahomans quit tobacco on their own terms. Patients enrolled in SoonerCare are eligible for extra tobacco cessation services.

National alignment:

- The Healthy People 2020 Tobacco Use objectives (TU 1-10.6 are in alignment) are organized into 3 key areas:
 - Tobacco Use Prevalence: Implementing policies to reduce tobacco use and initiation among youth and adults.
 - Health System Changes: Adopting policies and strategies to increase access, affordability, and use of smoking cessation services and treatments.
 - Social and Environmental Changes: Establishing policies to reduce exposure to secondhand smoke, increase the cost of tobacco, restrict tobacco advertising, and reduce illegal sales to minors.

Healthy People 2030 has not yet been released but is anticipated to include similar objectives to promote tobacco cessation.

GOAL 3: Advance St. John engagement in community coalitions and collaboratives to promote healthy lifestyles and chronic disease prevention in the communities we serve.

STRATEGY 1: Identify community coalitions and collaboratives with partnership opportunities to promote healthy lifestyles and chronic disease prevention. Encourage Ascension St. John representation/involvement by associates as deemed appropriate.

Background information:

- The strategy's target population is communities in need surrounding our hospital facilities in northeastern Oklahoma (Creek County), as identified by the FY 2019 CHNAs.
- Unhealthy lifestyles and chronic disease are more prevalent among those living in poverty and/or populations deemed otherwise vulnerable. This strategy addresses social determinants of health, health disparities, and challenges experienced by underserved populations, through community-based, collaborative efforts to improve prevention, increase wellness opportunities, and reduce poor health outcomes.
- The strategy is a system change and is informed by evidence found on Healthy People 2020, What Works for Health, and The Guide to Community Preventive Services. In particular, Healthy People 2020 emphasizes the importance of health-related quality of life and well-being by including it as one of the initiative's 4 overarching

goals, promoting quality of life, healthy development, and health behaviors across all life stages. It also was established as one of the HP2020 4 foundation health measures.

Resources:

- Members of the Healthy Lifestyles Task Force, Ascension St. John, St. John hospital facilities, St. John Clinic, Ministry-wide-function (MWF) associates, JPMC diabetes prevention program and Community benefit department.

Collaboration:

- Pathways to Health (P2H), Creek County Community Partnership (CCCP), Creek County Healthy Living Partnership (CCHLP), local public schools, local health department and other community coalitions and collaboratives as identified through process.

Anticipated impact:

- Have at least one associate per hospital facility (encompasses all six St. John hospitals) involved with a community coalition or similar organization in the respective community served by the end of FY 2020 (year 1).
- Increase overall tracked participation by associates with community organizations and events by 5% from FY 2019 to FY 2020 (encompasses all six St. John hospitals).
- Increase overall tracked participation by associates with community organizations and events by another 5% from FY 2020 to FY 2021 (encompasses all six St. John hospitals).

Local alignment:

- Two priorities of the Creek County Healthy Living Partnership (CCHLP) are to increase nutrition and physical activity opportunities in Creek County.
- A priority of the Creek County Community Partnership (CCCP) is to address obesity in Creek County.

State alignment:

- Obesity is a flagship goal of the Oklahoma Health Improvement Plan 2020 (OHIP 2020). Food access, healthy nutrition, and physical activity are focuses of this goal. OHIP 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); OHIP 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 3 – improve the built environment infrastructure supportive of physical activity and availability of affordable fruits and vegetables.

Oklahoma Plan 2030 has not yet been released but is anticipated to include similar objectives to reduce obesity through the promotion of food access, healthy nutrition, and physical activity.

National alignment:

- Healthy People 2020 Objective HRQOL/WB-1—increase the proportion of adults who self-report good or better health.
- Released in 2008, the Physical Activity Guidelines for Americans (PAG) is the first-ever publication of national guidelines for physical activity. The Physical Activity objectives for Healthy People 2020 (PA-1 through PA-15) reflect the strong state of the science supporting the health benefits of regular physical activity among youth and adults, as identified in the PAG. Regular physical activity includes participation in moderate- and vigorous-intensity physical activities and muscle-strengthening activities.
- The Nutrition and Weight Status objectives for Healthy People 2020 aim to promote health and reduce chronic disease risk through the consumption of healthful diets and achievement and maintenance of healthy body weights. The objectives emphasize that efforts to change diet and weight should address individual behaviors, as

well as the policies and environments that support these behaviors in settings such as schools, worksites, healthcare organizations, and communities. The NWS-1 through 22 objectives are all in alignment.

- Healthy People 2020 addresses chronic disease with goals and objectives related to the following chronic conditions: arthritis, osteoporosis, and chronic back conditions; chronic kidney disease, diabetes, heart disease and stroke, and respiratory diseases.
- Healthy People 2020 goal to increase the quality, availability, and effectiveness of educational and community-based programs designed to prevent disease and injury, improve health, and enhance quality of life.

Healthy People 2030 has not yet been released but is anticipated to include similar objectives to reduce obesity and chronic disease through the promotion of food access, healthy nutrition, physical activity, and educational and community-based programming.

Prioritized Need 4: Adverse Childhood Experiences (ACEs)

GOAL 1: Combat human trafficking in the communities we serve through efforts to support the needs of human trafficking victims or those at risk of being trafficked in a trauma-informed manner, taking into consideration the correlation between ACEs and human trafficking.

STRATEGY 1: Increase community awareness on the correlation between high ACE scores and human trafficking as well as the impact of ACEs on health outcomes.

Background information:

- The target population are victims of human trafficking or those that are at high risk of being trafficked in the communities we serve.
- This strategy addresses high ACE scores in Oklahoma, human trafficking, and opportunities to implement or improve trauma-informed care. Accordingly, this strategy addresses social determinants of health and health disparities by expanding awareness on ACEs and health outcomes in a population that is vulnerable and often underserved in the communities we serve.
- Current literature demonstrates a correlation between high ACE scores and human trafficking. This strategy is a systems and environmental change. The strategy is built upon evidence-based programming developed and successfully operated at Via Christi Health in Wichita, Kan. It is also informed by evidence from HEAL, a united group of multidisciplinary professionals dedicated to ending human trafficking and supporting its survivors, from a public health perspective.

Resources:

- Members of the Adverse Childhood Experiences (ACEs) Task Force, Human trafficking program manager, Ascension St. John, St. John hospital facilities, St. John Clinic, Ascension St. John Human Trafficking Education and Response Program, training materials, including St. John's human trafficking assessment and community pocket tools and the Community benefit department.

Collaboration:

- The Oklahoma Coalition Against Human Trafficking (consists of numerous social services, nonprofits, schools and other educational institutions, and law enforcement agencies), community members, community organizations and first responders that have the potential to come into contact with human trafficking victims or those at high risk of being trafficked in the communities we serve, Center for Integrative Research on Childhood Adversity, University of Oklahoma Medicine Center on Child Abuse and Neglect and additional community organizations as identified.

Anticipated impact:

- By the end of the second quarter of FY 2020, meet with the Oklahoma Coalition Against Human Trafficking to identify education needs in the community.
- Conduct education on ACEs and human trafficking to at least 15 community agencies or organizations by the end of FY 2022.

Local alignment:

- The Oklahoma Coalition Against Human Trafficking Strategic Plan developed to address human trafficking in the region. The plan includes five main objectives. These objectives are, increased collaborative partnerships, increased community awareness, the development of comprehensive victim services, demand reduction, and task force and community sustainability.
- Local partners have begun a capital campaign to build a new crisis stabilization center for trafficked youth (females).
- Center for Integrative Research on Childhood Adversity is a federally funded Centers of Biomedical Research Excellence (COBRE) grant research center located in Tulsa, Oklahoma determined to create a research infrastructure to expand knowledge on the effects of early stress and trauma leading to the development of evidence-based programs and interventions to address the high rate of ACEs within Tulsa, Okla., and abroad.
- One of the current priorities of the Creek County Community Partnership is to address child abuse and neglect.

State alignment:

- 2019 legislation change to Title 21, Section 856 adding human trafficking to the gang statutes for increased penalties on certified gang members convicted of human trafficking.
- 2019 legislation change to Title 70, Section 24-100.5 adding human trafficking awareness to the Oklahoma's Safe School Committee. This change directs the committee to study and make recommendations to principals regarding the needs of faculty and staff to recognize and report suspected human trafficking.
- ACEs are targeted in the Oklahoma Health Improvement Plan 2020 (OHIP 2020) flagship goal for children's health: goal 2 – improve child and adolescent health outcomes; Strategy 2 – 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).

Oklahoma Plan 2030 has not yet been released but is anticipated to include ACEs as a priority.

- OK State Dept. of Health included an ACEs strategy into their state plan for the prevention of child abuse and neglect.

National alignment:

- Addressing human trafficking is a strategic priority of Ascension as evidenced by the Ascension Human Trafficking policy and procedure as well as advocacy on state and national levels.
- The Catholic Health Association, in collaboration with other Catholic organizations through the Catholic Campaign Against Human Trafficking, hosts twice-annual networking conference calls and serves as a convening platform to allow for an exchange of information among CHA members and other partner organizations on their and activities and to explore what, as a united ministry, we can do together.
- The American Hospital Association, along with its nearly 5,000-member hospitals, health systems and other healthcare organizations, are committed to addressing all forms of violence affecting our staff as well as the patients and communities we serve including human trafficking. As urged by the American Hospital Association's Hospitals Against Violence initiative, the first ICD-10-CM codes for classifying human trafficking abuse were released in June 2018. AHA's Central Office on ICD-10, in partnership with Catholic Health Initiatives and Massachusetts General Hospital's Human Trafficking Initiative and Freedom Clinic, proposed the change.

- The Polaris Project, an active organization in the global fight to eradicate modern slavery and restore freedom to survivors of human trafficking, operates the National Human Trafficking Hotline serving victims and survivors of human trafficking and the anti-trafficking community in the United States since 2007.
- HEAL Trafficking is a united group of over 2,600 survivors and multidisciplinary professionals in 35 countries dedicated to ending human trafficking and supporting its survivors, from a public health perspective.
- The US Administration for Children and Families is committed to preventing human trafficking and ensuring that victims of all forms of human trafficking have access to the services they need through its Office on Trafficking in Persons.
- SOAR Online is a new series of CE/CME training modules jointly provided by Postgraduate Institute for Medicine, the U.S. Department of Health and Human Services, and the National Human Trafficking Training and Technical Assistance Center in collaboration with the Administration for Children and Families, Office on Trafficking in Persons and Office on Women’s Health. SOAR Online is designed to educate healthcare providers, social workers, public health professionals, and behavioral health professionals on how to identify, treat, and respond appropriately to individuals who are at risk or who have been trafficked.
- The Center for Disease Control’s (CDC) Division of Violence Prevention’s 5-year vision and areas of strategic focus on the prevention of violence across the lifespan.
- Healthy People 2020 places ACEs as an indirect priority through its objectives on maternal, infant, & child health as well as objectives on injury and violence prevention.

Healthy People 2030 has not yet been released but is anticipated to include ACEs as a priority.

STRATEGY 2: Advance the Ascension St. John Human Trafficking Education and Response Program to serve victims of human trafficking.

Background information:

- The target population is human trafficking victims or those who are at high risk of being trafficked in the communities we serve.
- This strategy provides standard training and resources to assist our healthcare associates as well as community partners to identify and respond to the needs of human trafficking victims or those at high risk of being trafficked in a trauma-informed manner, including referrals to resources as needed. Accordingly, this strategy addresses social determinants of health, health disparities and challenges experienced by a population that is often underserved and most in need.
- This strategy is a policy systems and environmental change. The strategy is built upon evidence-based programming developed and successfully operated at Ascension Via Christi in Wichita, Kansas. It is also informed by evidence from HEAL, a united group of multidisciplinary professionals dedicated to ending human trafficking and supporting its survivors, from a public health perspective.

Resources:

- Members of the Adverse Childhood Experiences (ACEs) Task Force, Human trafficking program manager, Ascension St. John, St. John hospital facilities, St. John Clinic, Ascension St. John Human Trafficking Education and Response Program, training materials, including St. John’s human trafficking assessment and community pocket tools, St. John human trafficking policy and the Community benefit department.

Collaboration:

- The Oklahoma Coalition Against Human Trafficking (consists of numerous social services, nonprofits, schools and other educational institutions, and law enforcement agencies), community members, community organizations and first responders that have the potential to come into contact with human trafficking victims or those at high risk of being trafficked in the communities we serve, and additional community organizations as identified.

Anticipated impact:

- Develop at least three additional community partnerships to strengthen community awareness and collaboration to combat human trafficking in the communities we serve by the end of FY 2020.
- Conduct at least two human trafficking education/awareness events for each of the six hospital facilities and St. John Clinic by the end of FY 2020.
- Complete dissemination of assessment pocket tools to key entry points at St. John hospitals by the end of FY 2020.
- Complete dissemination of assessment pocket tools to St. John Clinic by the end of FY 2022.

Local alignment:

- The Oklahoma Coalition Against Human Trafficking Strategic Plan developed to address human trafficking in the region. The plan includes five main objectives. These objectives are, increased collaborative partnerships, increased community awareness, the development of comprehensive victim services, demand reduction, and task force and community sustainability.
- Local partners have begun a capital campaign to build a new crisis stabilization center for trafficked youth (females).

State alignment:

- 2019 legislation change to Title 21, Section 856 adding human trafficking to the gang statutes for increased penalties on certified gang members convicted of human trafficking.
- 2019 legislation change to Title 70, Section 24-100.5 adding human trafficking awareness to the Oklahoma's Safe School Committee. This change directs the committee to study and make recommendations to principals regarding the needs of faculty and staff to recognize and report suspected human trafficking.

National alignment:

- Addressing human trafficking is a strategic priority of Ascension as evidenced by the Ascension Human Trafficking policy and procedure as well as advocacy on state and national levels.
- The Catholic Health Association, in collaboration with other Catholic organizations through the Catholic Campaign Against Human Trafficking, hosts twice-annual networking conference calls and serves as a convening platform to allow for an exchange of information among CHA members and other partner organizations on their and activities and to explore what, as a united ministry, we can do together.
- The American Hospital Association, along with its nearly 5,000-member hospitals, health systems and other healthcare organizations, are committed to addressing all forms of violence affecting our staff as well as the patients and communities we serve including human trafficking. As urged by the American Hospital Association's Hospitals Against Violence initiative, the first ICD-10-CM codes for classifying human trafficking abuse were released in June 2018. AHA's Central Office on ICD-10, in partnership with Catholic Health Initiatives and Massachusetts General Hospital's Human Trafficking Initiative and Freedom Clinic, proposed the change.
- The Polaris Project, an active organization in the global fight to eradicate modern slavery and restore freedom to survivors of human trafficking, operates the National Human Trafficking Hotline serving victims and survivors of human trafficking and the anti-trafficking community in the United States since 2007.
- HEAL Trafficking is a united group of over 2,600 survivors and multidisciplinary professionals in 35 countries dedicated to ending human trafficking and supporting its survivors, from a public health perspective.
- The US Administration for Children and Families is committed to preventing human trafficking and ensuring that victims of all forms of human trafficking have access to the services they need through its Office on Trafficking in Persons.
- SOAR Online is a new series of CE/CME training modules jointly provided by Postgraduate Institute for Medicine, the U.S. Department of Health and Human Services, and the National Human Trafficking Training and Technical Assistance Center in collaboration with the Administration for Children and Families, Office on Trafficking in

Persons and Office on Women’s Health. SOAR Online is designed to educate healthcare providers, social workers, public health professionals, and behavioral health professionals on how to identify, treat, and respond appropriately to individuals who are at risk or who have been trafficked.

GOAL 2: Address and mitigate adverse health outcomes prenatally and birth to 18 years of age in communities we serve.

STRATEGY 1: Expand the Ascension St. John suspected child abuse and neglect committee to include community experts and/or liaisons, as well as hospital representation.

Background information:

- The target population is community members who present for care at St. John hospitals in northeastern Oklahoma.
- Oklahoma is ranked 41st in the nation and had ninth highest percentage of children with two or more ACEs (26.6 percent) in 2019. In addition, Oklahoma and communities we serve in Creek County have high rates of infant mortality and high incidences of child abuse and neglect, as evidenced by data collected in the FY 2019 community health needs assessments. Through work to address and mitigate ACEs, this strategy targets social determinants of health, health disparities and challenges of underserved populations.
- This strategy is a system change and is informed by the following evidence:
 - The American Academy of Pediatrics recognizes that the biological response to toxic stress caused by ACEs “can be incredibly destructive and last a lifetime.” Critical periods of human development occur prenatally through the first 2-3 years of life.
 - The Agency for Healthcare Research and Quality includes trauma-informed care as part of its healthy pregnancy care.

Resources:

- Members of the Adverse Childhood Experiences (ACEs) Task Force, Ascension St. John, St. John hospital facilities, members of the suspected child abuse and neglect (SCAN) committee, APRN clinical nurse specialist, the social work / case management department, pediatric department, community benefit department and other departments where pediatric patients may present for care (e.g., emergency department).

Collaboration:

- Child abuse and neglect community experts and/or liaisons, University of Oklahoma Medicine Center on Child Abuse and Neglect, Center for Integrative Research on Childhood Adversity, and other community partners as identified.

Anticipated impact:

- Explore opportunities for the expansion of the SCAN committee, as evidenced by committee meeting minutes by the end of FY 2020.
- Implement opportunities for SCAN committee improvement, as identified in FY 2020 and as evidenced by a revised SCAN committee charter, if appropriate, by the end of FY 2021.
- If appropriate, define a reporting structure of the quality metrics related to SCAN by the end of FY 2022.

Local alignment:

- Center for Integrative Research on Childhood Adversity is a federally funded Centers of Biomedical Research Excellence (COBRE) grant research center located in Tulsa, Oklahoma determined to create a research infrastructure to expand knowledge on the effects of early stress and trauma leading to the development of evidence-based programs and interventions to address the high rate of ACEs within Tulsa, Okla., and abroad.

- One of the current priorities of the Creek County Community Partnership is to address child abuse and neglect.

State alignment:

- ACEs are targeted in the Oklahoma Health Improvement Plan 2020 (OHIP 2020) flagship goal for children’s health: goal 2 – improve child and adolescent health outcomes; Strategy 2 – 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).

Oklahoma Plan 2030 has not yet been released but is anticipated to include ACEs as a priority.

- OK State Dept. of Health included an ACEs strategy into their state plan for the prevention of child abuse and neglect.

National alignment:

- The Center for Disease Control’s (CDC) Division of Violence Prevention’s 5-year vision and areas of strategic focus on the prevention of violence across the lifespan.
- Healthy People 2020 places ACEs as an indirect priority through its objectives on maternal, infant, & child health as well as objectives on injury and violence prevention.

Healthy People 2030 has not yet been released but is anticipated to include ACEs as a priority.

STRATEGY 2: Sustain and/or expand current services and partnerships targeting care of pregnant women and children birth to 3 years of age throughout Ascension St. John.

Background information:

- The target population includes women of childbearing age who are currently and/or likely to become pregnant, as well as children under 3 years of age.
- Oklahoma is ranked 41st in the nation and had ninth highest percentage of children with two or more ACEs (26.6 percent) in 2019. In addition, Oklahoma and communities we serve in Creek County have high rates of infant mortality, high rates of low birth weights, high rates of lack of or delayed prenatal care, high teen birth rates, high rates of smoking during pregnancy, and high incidences of child abuse and neglect, as evidenced by data collected in the FY 2019 community health needs assessments. Through work to support pregnant women and children birth to 3 years of age, this strategy targets social determinants of health, health disparities and challenges of underserved populations.
- This strategy is a system change and is informed by the following evidence:
 - The American Academy of Pediatrics recognizes that the biological response to toxic stress caused by ACEs “can be incredibly destructive and last a lifetime.” Critical periods of human development occur prenatally through the first 2-3 years of life.
 - The Agency for Healthcare Research and Quality includes trauma-informed care as part of its healthy pregnancy care.

Resources:

- Members of the Adverse Childhood Experiences (ACEs) Task Force, Ascension St. John, St. John hospital facilities, St. John Clinic, APRN clinical nurse specialist, women and children’s services, Trauma outreach coordinator, Community benefit department, and other St. John departments where pregnant and/or pediatric patients may present for care, as identified.

Collaboration:

- Reach Out and Read – a partnership that supports St. John’s early literacy programming in pediatric care sites, Safe Kids, Oklahoma Perinatal Quality Improvement Collaborative, ConnectFirst, local health department, local

public schools, CAP, Educare, Center for Integrative Research on Childhood Adversity, and other community partners, as identified.

Anticipated impact:

- Assess current programs, activities and community partnerships throughout St. John, including but not limited to capacity, utilization and opportunity for expansion to other areas of St. John to support the care of pregnant women and children birth to 3 years of age and develop an action plan by the end of FY 2020.
- If viable, implement pilot and/or expansion of collaboration with community partners to support the care of pregnant women and children birth to 3 years of age by the end of FY 2022.

Local alignment:

- Center for Integrative Research on Childhood Adversity is a federally funded Centers of Biomedical Research Excellence (COBRE) grant research center located in Tulsa, Oklahoma determined to create a research infrastructure to expand knowledge on the effects of early stress and trauma leading to the development of evidence-based programs and interventions to address the high rate of ACEs within Tulsa, Okla., and abroad.
- One of the current priorities of the Creek County Community Partnership is to address child abuse and neglect.

State alignment:

- ACEs are targeted in the Oklahoma Health Improvement Plan 2020 (OHIP 2020) flagship goal for children’s health: goal 2 – improve child and adolescent health outcomes; Strategy 2 –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).

Oklahoma Plan 2030 has not yet been released but is anticipated to include ACEs as a priority.

- OK State Dept. of Health included an ACEs strategy into their state plan for the prevention of child abuse and neglect.

National alignment:

- The Center for Disease Control’s (CDC) Division of Violence Prevention’s 5-year vision and areas of strategic focus on the prevention of violence across the lifespan.
- Healthy People 2020 places ACEs as an indirect priority through its objectives on maternal, infant, & child health as well as objectives on injury and violence prevention.

Healthy People 2030 has not yet been released but is anticipated to include ACEs as a priority.

GOAL 3: Strengthen Ascension St. John associate awareness of the role of ACEs in health outcomes, as well as to how best to respond to the needs of those most vulnerable.

STRATEGY 1: Partner with community agencies and coalitions to increase St. John associate awareness of the role of ACEs in adverse health outcomes and homelessness and how best to respond to the needs of individuals experiencing or at risk for homelessness through collaborative care coordination and linkage to community resources and support.

Background information:

- The strategy’s target population is individuals experiencing or at risk for homelessness in the communities we serve.
- Oklahoma is ranked 41st in the nation and had the ninth highest percentage of children with two or more ACEs (26.6 percent) in 2019. In addition, Oklahoma and communities we serve in Creek County have high rates of childhood poverty and homelessness, as evidenced by data collected in the FY 2019 community health needs assessments.
- Through collaborative efforts to increase the scope of awareness and better support the needs of individuals experiencing or at risk for homelessness, this strategy targets social determinants of health, health disparities and

challenges of an underserved population. While homelessness is not recognized as one of the ACEs, it is closely correlated with ACEs, as are other adverse outcomes, including poor health. Furthermore, children experiencing homelessness have everyday exposure to these risks. In addition, poor health is a major cause of homelessness, and homelessness creates new health problems and exacerbates existing ones.

- This strategy is a system change and is informed by evidence from the National Healthcare for the Homeless Council.

Resources:

- Members of the Adverse Childhood Experiences (ACEs) Task Force, Ascension St. John, St. John hospital facilities, St. John Clinic, Clinical education department, Social work / case management department, St. John Medical Center and Jane Phillips Medical Center behavioral assessment teams, Community benefit department, and other St. John departments that may come into contact with individuals experiencing or at risk of homelessness.

Collaboration:

- A Way Home for Tulsa, Community Service Council of Greater Tulsa, All Doors Open, Area shelters and services for those experiencing homelessness, National Healthcare for the Homeless Council, Mental Health Association Oklahoma (homeless outreach, drop-in center and supportive housing), Family and Children’s Services (homeless outreach and support services), Youth Services of Tulsa (homeless outreach, support services, drop-in shelter and supportive housing), Creek County Community Partnership, Housing Authority and other housing resources, and other community partners, as identified.

Anticipated impact:

- By the end of the second quarter of FY 2020, identify key community and associate leaders to participate in a St. John ACEs and homelessness sub-task force and form the sub-task force.
- By the end of the third quarter of FY 2020, meet with identified community and St. John leaders/stakeholders to determine education needs.
- By the end of the fourth quarter of FY 2020, finalize a comprehensive list of community resources available for those experiencing or at risk of homelessness and finalize education resources for associates.
- By the end of the first quarter of FY 2021, complete associate education on ACEs and homelessness and incorporate resources for associates to give patients upon discharge from any point of service.

Further impact will be determined through ongoing work with community partners on education needs and prioritization of agencies to coordinate education schedule. Specific objectives will be dependent upon the actions and interventions selected by the ACEs and homelessness sub-task force and community partners. Impact will be updated throughout FY 2020-2022.

Local alignment:

- A Way Home for Tulsa (AWH4T) is a collective impact of 30 voting organizations that exists to plan and implement strategies that support a system of outreach, engagement, assessment, prevention and evaluation for those experiencing homelessness, or those persons at risk of homelessness, within Tulsa City/County. AWH4T supports programs such as All Doors Open, Coordinated Outreach and the Homeless Management Information System.

While Creek County does not have specified written plans, the area agencies and coalitions do support efforts to improve address homelessness and ACEs.

- Center for Integrative Research on Childhood Adversity is a federally funded Centers of Biomedical Research Excellence (COBRE) grant research center located in Tulsa, Oklahoma determined to create a research infrastructure to expand knowledge on the effects of early stress and trauma leading to the development of evidence-based programs and interventions to address the high rate of ACEs within Tulsa, Okla., and abroad.
- One of the current priorities of the Creek County Community Partnership is to address child abuse and neglect.

State alignment:

- Oklahoma Governor’s Interagency Council on Homelessness released a 5-year plan to end homelessness in 2019.
- Oklahoma has eight Continuums of Care (CoCs) assisting individuals and families experiencing homelessness by connecting them to local services and resources.

The Oklahoma Plan for 2030 has not yet been released but is anticipated to include social determinants of health as a priority which address homelessness and ACEs.

- ACEs are targeted in the Oklahoma Health Improvement Plan 2020 (OHIP 2020) flagship goal for children’s health: goal 2 – improve child and adolescent health outcomes; Strategy 2 – 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).

Oklahoma Plan 2030 has not yet been released but is anticipated to include ACEs as a priority.

- OK State Dept. of Health included an ACEs strategy into their state plan for the prevention of child abuse and neglect.

National alignment:

- National Healthcare for the Homeless Council (NHHHC) is working to end homelessness by ensuring healthcare and housing for all. The Council is a membership organization uniting thousands of healthcare professionals, people with lived experience of homelessness, and advocates in homeless healthcare.
- Healthy People 2020 highlights the importance of addressing the social determinants of health by including “Create social and physical environments that promote good health for all” as one of the four overarching goals for the decade.
- The emphasis is also shared by other U.S. health initiatives such as the National Partnership for Action to End Health Disparities and the National Prevention and Health Promotion Strategy.
- The Center for Disease Control’s (CDC) Division of Violence Prevention’s 5-year vision and areas of strategic focus on the prevention of violence across the lifespan.
- Healthy People 2020 places ACEs as an indirect priority through its objectives on maternal, infant, & child health as well as objectives on injury and violence prevention.

Healthy People 2030 has not yet been released but is anticipated to include social determinants of health as a priority which address homelessness and ACEs.

GOAL 4: Implement education and assessment tools to raise awareness of the impact of ACEs on Ascension St. John associates and their families in support the whole person and a model community of engaged associates.

STRATEGY 1: Provide education to Ascension St. John leaders on the prevalence of ACEs, their impact on health and other outcomes, and how to identify risk factors and available resources to support associates who experience or are at risk of adverse outcomes as result of ACEs.

Background information:

- The target population is St. John associates who experience or are at risk of adverse outcomes as a result of ACEs.
- Oklahoma is ranked 41st in the nation and had the ninth highest percentage of children with two or more ACEs (26.6 percent) in 2019. This strategy addresses social determinants of health and health disparities among vulnerable populations through work to recognize the impact of ACEs on adults and their families, and opportunities to increase awareness among St. John leaders to identify and respond to the needs of associates who are experiencing or at risk of adverse outcomes as result of ACEs. This strategy provides tools for associate self-assessment and resources.

- This strategy is a system change and is informed by evidence from the Centers for Disease Control (CDC) as well as a growing body of literature.
 - Current literature demonstrates a correlation between high ACE scores and increased likelihood that individuals are more likely to engage in unhealthy behaviors and experience poor health outcomes. These adverse outcomes can impact the ability to concentrate and complete daily tasks, which could also impact work. The long-term effects of ACEs on the work force impose major human and economic costs that are preventable. Organizations, agencies and employers across the country are becoming more aware of the impact of ACEs and are integrating trauma-informed and resilience-based practices into their culture.

Resources:

- Members of the adverse childhood experiences task force, Ascension St. John, St. John hospital facilities, St. John Clinic, Clinical education / clinical professional development department, Human resources department, St. John leaders, Mission integration departments (Community benefit department, Mission formation department, Spiritual care department), Ministry-wide-function associates, Risk management department - provider associate care team (PACT), Centers for Disease Control (CDC) ACEs training course and other training materials, ACEs assessment tools and other resources as identified.

Collaboration:

- Community partners as identified.

Anticipated impact:

- By the end of the second quarter for FY 2020, assess CDC ACEs training and meet with the Ascension St. John provider associate care team (PACT) to confirm if training material is viable for Ascension St. John leader training.
- Compile list of local resources and support to share with Ascension St. John leaders by the end of the first quarter of FY 2021.
- Determine method of self-assessment for associates and implement selected self-assessment tool by the end of the third quarter of FY 2021.

Local alignment:

- Center for Integrative Research on Childhood Adversity is a federally funded Centers of Biomedical Research Excellence (COBRE) grant research center located in Tulsa, Oklahoma determined to create a research infrastructure to expand knowledge on the effects of early stress and trauma leading to the development of evidence-based programs and interventions to address the high rate of ACEs within Tulsa, Okla., and abroad.
- One of the current priorities of the Creek County Community Partnership is to address child abuse and neglect.

State alignment:

- ACEs are targeted in the Oklahoma Health Improvement Plan 2020 (OHIP 2020) flagship goal for children’s health: goal 2 – improve child and adolescent health outcomes; Strategy 2 –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).

Oklahoma Plan 2030 has not yet been released but is anticipated to include ACEs as a priority.

- OK State Dept. of Health included an ACEs strategy into their state plan for the prevention of child abuse and neglect.

National alignment:

- The Center for Disease Control’s (CDC) Division of Violence Prevention’s 5-year vision and areas of strategic focus on the prevention of violence across the lifespan.
- Healthy People 2020 places ACEs as an indirect priority through its objectives on maternal, infant, & child health as well as objectives on injury and violence prevention.

Healthy People 2030 has not yet been released but is anticipated to include social determinants of health as a priority which address homelessness and ACEs.

Action Plans

Below are the action plans for each prioritized health need to be addressed during FY 2020-2022, including internal resources, proposed actions, collaborative opportunities and anticipated impact of each strategy.

Prioritized Need 1: Access to Care

GOAL 1: Remove barriers of access to healthcare for those living in poverty and/or otherwise deemed vulnerable within our service area.

ACTION PLAN

STRATEGY 1: Work to expand Medicaid to the point that it increases coverage for those most vulnerable in Oklahoma (Medicaid expansion).

BACKGROUND INFORMATION:

- The target population is Oklahoma residents who are without health insurance coverage.
- This strategy targets those who are without access to health insurance and thus are typically medically underserved:
 - With approximately 15 percent of Oklahomans lacking health insurance coverage, it continues to be a barrier to accessing healthcare services for the most vulnerable and poor in our service areas.
 - If the state were to expand Medicaid coverage to 133 percent of the FPL, it would ensure that nearly 200,000 Oklahomans, including many of the most poor and vulnerable in our service areas, would no longer face the financial barrier of accessing healthcare services.
 - Apart from mitigating the financial barrier to accessing care, being a SoonerCare recipient can remove other barriers to care, including appropriate connection of the patient to appropriate healthcare providers, provide coordination of care best to address chronic illnesses, and encouragement to access regular preventative care.
- The strategy utilized for expanding Medicaid to remove barriers of access to healthcare will be approached through both policy and system change. The strategy draws upon the following evidence-base:
 - In other states that have expanded Medicaid coverage up to 133 percent of the FPL, analysis has found significantly improved health equity and have closed the gap on health disparities, particularly in the gap that disproportionately affects people of color and low-SES communities.¹

¹ Griffith, K. Evans, L. & Bor, J. (2017, August). The Affordable Care Act Reduced Socioeconomic Disparities in Health Care Access. *Health Affairs*; Hayes, S., Riley, P., Radley, D. & McCarthy, D. (2017, August). Reducing Racial and Ethnic Disparities in Access to Care: Has the Affordable Care Act Made a Difference? *The Commonwealth Fund*; Garfield, R., Orgera, K. & Damico, A. (2019, March). The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid. *Kaiser Family Foundation*.

- Having access to a Medicaid program enables an appropriate coordination of care from patients in the hospital to enabling recipients to age in place; whether it's long-term care services or accessing resources for transportation and housing, having access to SoonerCare offers a central and coordinated point of access to address key social determinants impacting health outcomes.²

RESOURCES:

- Members of the Access to Care Task Force
- Ascension St. John
- St. John hospital facilities
 - St. John Medical Center (SJMC)
 - St. John Owasso (SJO)
 - St. John Broken Arrow (SJBA)
 - St. John Sapulpa (SJS)
 - Jane Phillips Medical Center (JPMC)
 - Jane Phillips Nowata Health Center (JPNHC)
- Ascension's system office has committed \$156,000 in financial support over the next two years to implement this strategy.
- Ascension's system office Advocacy team has provided one of its staffers to work under the leadership of Ascension St. John's Chief of Advocacy for up to five to seven hours per work during implementation.
- When required, collaboration and staff time will be necessary with Marketing and Communications.
- Community benefit department

COLLABORATION:

- Local partners of George Kaiser Family Foundation, Zarrow Family Foundation, and Saint Francis Health System
- State partners of the Oklahoma Hospital Association and Chickasaw Nation
- National partners of the Fairness Project and Ascension Advocacy

ACTIONS AND RESPONSIBLE PARTIES:

The Access to Care Task Force will support the following efforts led by the Ascension Advocacy Team:

- Maintain weekly communication with ballot initiative collaborative partners and participate in weekly meetings to identify opportunities to leverage our skillset to advance the initiative.
- When appropriate and as dictated by our collaborative partners, build out an education and awareness campaign to ensure Ascension St. John associates are aware of ballot initiative.
- participant in dialogue around any proposal from the Governor's office and legislative leadership around an alternative and more restrictive effort to expand Medicaid coverage; ensure that

² Desalvo, K. & Leavitt, M. (2019, July). For an option to address social determinants of health, look to Medicaid. *Health Affairs*; Brooks, T. & Whitener, K. (2018, February). Leveraging Medicaid to Address Social Determinants and Improve Child and Population Health. *Georgetown University Health Policy Institute, Center for Children and Families*.

Ascension St. John's policy priorities of how best to provide access to coverage and care for the poor and vulnerable are effectively communicated.

- Effectively communicate with and educate state and local elected officials and critical community stakeholders in our service areas on the value and benefits of Medicaid expansion coverage of up to 133 percent of the FPL without restrictive eligibility requirements.

ANTICIPATED IMPACT:

- I. By the end of CY 2019, the collaborating partners of the Yes to 802 campaign, which includes Ascension St. John, will have attained 178,000 signatures to put a question on the 2020 ballot to expand Medicaid coverage to eligible residents with an income of up to 133 percent of the FPL.
- II. By the end of CY 2020, voters in the state of Oklahoma will have adopted a ballot initiative to expand Medicaid coverage to eligible residents with an income of up to 133 percent of the FPL.
- III. By July 2021, SoonerCare will begin offering coverage services to new recipients due to expansion of Medicaid coverage with as limited restrictions to eligibility as possible.

STRATEGY 2: Create a welcoming environment by developing and implementing a plan to assist those living in poverty and/or populations otherwise deemed vulnerable as well as their caregivers with navigating our healthcare facilities.

BACKGROUND INFORMATION:

- The target population is persons living in poverty and/or otherwise deemed vulnerable residing in communities we serve.
- This strategy address health disparities and challenges of underserved populations. Focus groups recently conducted as part of the FY 2019 community health needs assessments revealed that some individuals feel disenfranchised in seeking health services; trying to access healthcare at Ascension St. John and other locations is confusing and individuals seeking care do not feel welcome.
- This strategy is considered a system change because it entails an employee education and communication plan as well as improved signage expected through Ascension St. John's new brand roll-out. This strategy utilizes some best practices for training as developed on a national scale by Ascension.

RESOURCES:

- Members of the Access to Care Task Force
- Ascension St. John
- St. John hospital facilities
 - St. John Medical Center (SJMC)
 - St. John Owasso (SJO)
 - St. John Broken Arrow (SJBA)
 - St. John Sapulpa (SJS)
 - Jane Phillips Medical Center (JPMC)
 - Jane Phillips Nowata Health Center (JPNHC)
- Human resources
- Clinical education
- Quality department
- Brand roll-out team
- Mission Integration
 - Mission Formation
 - Community Benefit
 - Ethics

Will also seek collaboration and cooperation from our affiliate organizations and vendors such as R1 (revenue cycle management), Touchpoint (environmental services), etc.

COLLABORATION:

- Community partners as identified throughout FY 2020-2022.

ACTIONS AND RESPONSIBLE PARTIES:

The Access to Care Task Force will lead and/or support the following:

- Raise awareness and explore how to engage affiliate organization associates in customer service training by the end of FY 2020.
- Continue “One Community for One Mission: Living the Mission” orientation for new associates and explore opportunities to re-educate existing associates, as led by the mission formation department in collaboration with the human resources department by the end of FY 2020.
- Complete brand roll-out and placement of new signage by end of FY 2021 as led by the brand-out team.
- Encourage associates to complete the internal Sexual Orientation and Gender Identity (SOGI) training by the end of FY 2021 to help address disenfranchisement among the LGBTQ+ community and increase cultural awareness among associates, as led by the ethics department.
- Plan and implement “civility training” in response to variance report complaints as led by Human Resources and the Quality department:
 - FY 2020 – Pilot program
 - FY 2021 – Conduct as part of LDFR session (leadership development formation)
 - FY 2022 – Refresh and assess impact

ANTICIPATED IMPACT:

- IV. By the end of each fiscal year (FY 2020-2022), assess improved trends in related patient experience measure outcomes for FY 2020, FY 2021 and FY 2022, using FY 2019 as baseline.
- V. By end of FY 2021, assess results of SOGI training in FY 2021 – number of associates trained and scores.
- VI. By the end of each fiscal year (FY 2020-2022), assess reduction in reports of bullying for FY 2020, FY 2021 and FY 2022 submitted through variance process to Quality/Risk Management with FY 2019 as baseline.

GOAL 2: Reduce regional inequity in accessing healthcare providers, services and resources.

ACTION PLAN

STRATEGY 1: Promote awareness of, and access to, healthcare for underserved populations within communities we serve through Medical Mission at Home (MM@H) events and other opportunities to reach those in need.

BACKGROUND INFORMATION:

- The target population is uninsured, underinsured and underserved community members who need a medical home through which they can obtain both primary and specialty care and other ways to access care. The Community Health Needs Assessment showed vulnerable populations in Creek County.
- This strategy seeks to provide a medical home and other opportunities to access care for individuals, who are medically underserved due to financial or other barriers to obtaining care.
- This is a systems change, adjusting the organization's infrastructure to respond to community needs. This strategy is built upon the evidence base cited by Healthy People's 2020's Access to Health Services topic: People with a usual source of care have better health outcomes and fewer disparities and costs. Medical Mission at Home (MM@H) was created by Ascension and at least one event is required of each Ministry per year.

RESOURCES:

- Members of the Access to Care Task Force
- Ascension
- Ascension Medical Group
- FY 2019 community health needs assessments
- Good Samaritan
- In His Image
- MedXcel
- Regional Medical Laboratory
- Resource Group
- Ascension St. John
- St. John hospital facilities
 - St. John Medical Center (SJMC)
 - St. John Owasso (SJO)
 - St. John Broken Arrow (SJBA)
 - St. John Sapulpa (SJS)
 - Jane Phillips Medical Center (JPMC)
 - Jane Phillips Nowata Health Center (JPNHC)
- Mission integration departments
 - Mission formation department
 - Community benefit department

- Transitional Care Clinic

Resources may be revised over time, depending on direction of plan.

COLLABORATION:

- Local government: (City of Sapulpa, Mayor’s office, Governor’s office)
- Catholic Church: (Bishop Konderla, Christ the King Catholic Church, Diocese of Eastern Oklahoma)
- Local social work, public health, nursing, physician residency and other healthcare-oriented school programs
- Host facility:
 - Good Shepherd Episcopal Church - Sapulpa
- Local public schools
- Additional community partners as identified, with a focus on community organizations addressing social determinants of health

Community partners may change over time, depending on direction of plan.

ACTIONS AND RESPONSIBLE PARTIES:

The Access to Care Task Force will lead or support the following:

- FY 2020 – Plan and host one Medical Mission at Home (MM@H) event as lead by Mission Integration and hospital leadership:
 - Sapulpa event in April 2020 – St. John Sapulpa President and Chief Operating Officer and Chief Nursing Officer
- FY 2020 – Gather survey data from patients and volunteers and enter information into a spreadsheet for analysis as led by Mission Integration
- FY 2020 – Identify and compile additional activities performed within the health system to promote access to healthcare as led by Mission Integration
- FY 2020 – Ongoing reporting to Community Benefit Inventory for Social Accountability (CBISA) Task Force and community benefit department regarding Medical Mission at Home and other activities to promote access to healthcare
- FY 2021 – Evaluate the patient and volunteer survey data from FY 2020 MM@H event to create an event strategy for FY 2021; schedule at least one MM@H for FY 2021 as led by Mission Integration, Hospital Presidents and Chief Operating Officers and Chief Nursing Officers and SJMC Chief Medical Officer
- FY 2021 – Report learnings regarding FY 2020 outreach efforts to the Ascension VP of Mission Integration as led by Mission Integration
- FY 2021 – Ongoing reporting to Community Benefit Inventory for Social Accountability (CBISA) Task Force regarding Medical Mission at Home and other activities to promote access to healthcare
- FY 2022 – Evaluate the survey data from FY 2021 MM@H event(s) to create an event strategy for FY22.- as led by Mission Integration, Hospital Presidents and Chief Operating Officers and Chief Nursing Officers and SJMC Chief Medical Officer
- FY 2022 – Report learnings regarding FY 2021 outreach efforts to the Ascension VP of Mission Integration as led by Mission Integration

- FY 2022 – Ongoing reporting to Community Benefit Inventory for Social Accountability (CBISA) Task Force regarding Medical Mission at Home and other activities to promote access to healthcare

ANTICIPATED IMPACT:

- VII. Plan and host one Medical Mission at Home (MM@H) event to address healthcare needs of those most vulnerable, as identified in the CHNAs by the end of FY 2020.
 - Sapulpa event in April 2020 – to address Creek County
- VIII. Obtain survey feedback from at least 25 percent of patients and volunteers to determine effectiveness of services offered by end of FY 2020.
- IX. Fiscal year list of activities performed within the health system to promote access to healthcare submitted to Ascension VP of Mission Integration and Community Benefit Inventory for Social Accountability (CBISA) taskforce by end of each fiscal year (FY 2020-2022).
- X. Enter FY 2020 MM@H survey data into spreadsheet for evaluation by MM@H steering committee; plan and implement MM@H in FY 2021 by end of FY 2021.
- XI. Enter FY 2021 MM@H survey data into spreadsheet for evaluation by MM@H steering committee; plan and implement MM@H in FY 2022 by end of FY 2022.

Alignment with local, state and national priorities (long-term outcomes for Prioritized Need 1: Access to Care)

| OBJECTIVE: | LOCAL/COMMUNITY PLAN: | STATE PLAN: | “HEALTHY PEOPLE 2030” (OR OTHER NAT’L PLAN): |
|------------|--|--|--|
| I-III | <p><i>While Creek County coalitions do not have specified written plans for improving access to care, the coalitions do support efforts to improve access.</i></p> | <p>Yes to 802 Oklahoman’s Decide Healthcare Campaign – coalition of Oklahoma doctors, nurses, patients, business executives, non-profit organizations, healthcare advocates and hospitals with goal to expand Medicaid to nearly 200,000 Oklahomans. Campaign will give voters a direct say on Medicaid expansion as an issue for the November 2020 ballot if enough signatures are obtained by that time.</p> <p>Oklahoma Health Improvement Plan 2020 (OHIP 2020) health transformation: health finance goal 1 – decrease the percentage of uninsured individuals from 17% in 2013 to 9.5% by 2020; Strategy 1 & 2 – pursue opportunities for Medicaid expansion.</p> <p><i>Oklahoma Plan 2030 has not yet been released but is anticipated to include Medicaid expansion as a priority.</i></p> | <p>Healthy People 2020 Objective AHS-1 – Increase the proportion of persons with health insurance.</p> <p><i>Healthy People 2030 has not yet been released but is anticipated to continue to include a goal to increase the proportion of persons with health insurance.</i></p> |
| I-XI | <p><i>While Creek County coalitions do not have specified written plans for improving access to care, the coalitions do support efforts to improve access.</i></p> | <p><i>Oklahoma Plan 2030 has not yet been released but is anticipated to include similar objectives to promote access to care.</i></p> | <p>Healthy People 2020 Objective AHS-6 – Reduce the proportion of people who are unable to obtain or delay in obtaining necessary medical care,</p> |

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| | | | <p>dental care, and prescription medication</p> <p><i>Healthy People 2030 has not yet been released but is anticipated to include similar objectives to promote access to care.</i></p> |
| I-XI | <p><i>While Creek County coalitions do not have specified written plans for improving access to care, the coalitions do support efforts to improve access.</i></p> | <p><i>Oklahoma Plan 2030 has not yet been released but is anticipated to include similar objectives to promote access to care.</i></p> | <p>Healthy People 2020 Objective AHS-5 – Increase the proportion of persons who have a specific source of ongoing care</p> <p>Healthy People 2020 Objective AHS-3 – Increase the proportion of persons with a usual primary care provider</p> <p><i>Healthy People 2030 has not yet been released but is anticipated to include similar objectives to promote access to care.</i></p> |
| XII-XI | <p>Hosting Medical Mission at Home events in the communities we serve is a strategic FY 2020 goal for Ascension St. John.</p> | <p>Oklahoma Health Improvement Plan 2020 (OHIP 2020) health transformation: health efficiency and effectiveness goal 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 potentially preventable hospitalizations & Objective 2. – reduce hospital emergency room visits; Strategy 1 – Improve</p> | <p>Ascension’s Medical Mission at Home was launched in 2008 as a way to deliver quality healthcare to the uninsured and underinsured. Ascension has made a commitment to expand the Medical Mission at Home nationally – a proactive demonstration of our One Mission in the community and our commitment to Healthcare That Leaves No One Behind.</p> |

the quality and availability of healthcare via care coordination, especially for individuals with chronic, behavioral health, or specific co-morbid conditions.

Oklahoma Plan 2030 has not yet been released but is anticipated to include similar objectives to promote access to care.

Prioritized Need 2: Behavioral Health

GOAL 1: Assess the opportunity for and/or implement intensive outpatient geriatric psychiatric programs, if viable, for seniors 65+ with behavioral health issues in areas of need in northeastern Oklahoma.

ACTION PLAN

STRATEGY 1: Implement intensive outpatient geriatric psychiatric program in Creek County.

BACKGROUND INFORMATION:

- The target population is seniors 65+ in need of intensive psychiatric services in Creek County.
- The strategy addresses the inequity of behavioral health services/resources in Creek County as well as health disparities experienced by the community as evidenced by the disproportionately high rates of suicide and other poor behavioral health outcomes in Creek County as compared to other counties in Oklahoma and the US.
- This strategy is an environmental change and is an opportunity for the hospital to fill gaps in care in community. An emerging evidence base supports the efficacy of geriatric mental health interventions. The anticipated growth in the population of older persons with mental disorders underscores the need for a strategy to facilitate the systematic and effective implementation of evidence-based practices in geriatric mental healthcare.

RESOURCES:

- Members of the Behavioral Health Task Force
- Ascension St. John
- St. John Sapulpa (SJS)
- MedExcel facilities management
- R1 (revenue cycle management)
- Ascension technology
- Ascension St. John forms committee
- Hospital facility space
- Funding
- Transportation resources
- Community benefit department

COLLABORATION:

- Senior Life Solutions – vendor
- Collaboration with surrounding community referral sources
- Other community partners as identified

ACTIONS AND RESPONSIBLE PARTIES:

The Behavioral Health Task Force will lead or support the following:

- Complete contract process as led by the St. John Sapulpa hospital administrator.
- Complete proforma as led by the St. John Sapulpa hospital administrator.
- Prepare hospital space as led by the St. John Sapulpa hospital administrator and MedExcel facilities management.
- File use of space with State of Oklahoma as led by the St. John Sapulpa hospital administrator.
- Preparation for billing, coding, medical records as led by R1 (revenue cycle management).
- Build out of Cerner (electronic health record) interfaces, etc. as led by Ascension Technology.
- Completion of forms as needed as led by Ascension St. John forms committee.
- Set-up contingent worker access contract associates as led by the St. John Sapulpa hospital administrator.
- Explore transportation resources for the program's patients as led by the St. John Sapulpa hospital administrator.
- Pursue capital funding as led by the St. John Sapulpa hospital administrator.

ANTICIPATED IMPACT:

- I. Roll-out intensive outpatient geriatric psychiatric program at St. John Sapulpa by the end of the first quarter, FY 2020.
- II. Market intensive outpatient geriatric psychiatric program internally within Ascension St. John as well as to 10 potential community referral sources within service area beginning by end of FY2021.
- III. Complete annual review of St. John Sapulpa intensive outpatient geriatric psychiatric program by the end of each fiscal year (FY 2020-2022). Implement modifications to program as necessary based on findings from annual review.

GOAL 2: Advance Ascension St. John engagement in community coalitions and collaboratives to promote behavioral health wellness in the communities we serve.

ACTION PLAN

STRATEGY 1: Identify community coalitions and other collaboratives with partnership opportunities to promote behavioral health wellness; encourage health system representation/involvement by associates as deemed appropriate.

BACKGROUND INFORMATION:

- Individuals experiencing and/or at risk of experiencing behavioral health needs in communities we serve.
- The strategy addresses the inequity of behavioral health services/resources in Creek County. It addresses health disparities experienced by the community as evidenced by the disproportionately high rates of suicide, substance abuse and other poor behavioral health outcomes in the county as compared with other counties in Oklahoma and the U.S. In addition, this strategy utilizes community collaboration and resources to address social determinants of health and inequity of resources for at risk populations with a focus on those most in need.
- The strategy is a system change and is informed by evidence found on What Works for Health and The Guide to Community Preventive Services.

RESOURCES:

- Members of the Behavioral Health Task Force
- Ascension St. John
- St. John hospital facilities
 - St. John Medical Center (SJMC)
 - St. John Owasso (SJO)
 - St. John Broken Arrow (SJBA)
 - St. John Sapulpa (SJS)
 - Jane Phillips Medical Center (JPMC)
 - Jane Phillips Nowata Health Center (JPNHC)
- St. John Clinic
- Associates who are identified to participate in coalitions and collaboratives
- Community benefit department
- Financial support where appropriate

COLLABORATION:

- Healthy Minds, mental health policy organization funded by the Anne & Henry Zarrow Foundation
- Tulsa Regional Mental Health Plan
- Program for Assertive Community Treatment (PACT) Council

- Creek County Community Partnership
- Oklahoma Coalition Against Human Trafficking
- Mental Health Association of Oklahoma
- Advisory Council for vulnerable populations and emerging programs
- Inpatient provider group
- Other community partners as identified

ACTIONS AND RESPONSIBLE PARTIES:

The Behavioral Health Task Force will lead or support the following:

- Identify currently engaged associates who are part of community coalitions and collaboratives working to address behavioral health in communities we serve.
- Identify additional community coalitions and collaboratives addressing behavioral health with which to become involved.
- Identify additional Ascension St. John associates to participate in community coalitions and collaboratives addressing behavioral health as appropriate.
- Ascension St. John associates who are serving as community coalition and collaborative representatives to attend meetings as scheduled.
- Ascension St. John associates who are serving as community coalition and collaborative representatives to identify behavioral health opportunities such as activities / initiatives, for Ascension St. John to support and/or assist.

ANTICIPATED IMPACT:

- IV. By end of FY 2020 ensure one associate per community health needs assessment (CHNA) defined county (Creek County) is engaged with a community coalition or collaborative.
- V. Increase overall Ascension St. John associate participation by 5% with behavioral health coalitions and collaboratives in the communities we serve, and which Ascension St. John is not currently in partnership by the end of FY 2022.

Alignment with local, state and national priorities (long-term outcomes for Prioritized Need 2: Behavioral Health)

| OBJECTIVE: | LOCAL/COMMUNITY PLAN: | STATE PLAN: | “HEALTHY PEOPLE 2030” (OR OTHER NAT’L PLAN): |
|-------------|---|---|--|
| <p>IV-V</p> | <p>Funded by the Anne and Henry Zarrow Foundation and coordinated by the University of Tulsa, the Tulsa Regional Mental Health Plan is a 10-year communitywide effort to focus on regional mental health improvements and includes a leadership council with philanthropy, business, university, state and nonprofit representation. The plan aims to lower the rates of suicide attempts and deaths.</p> <p><i>While Creek County coalitions do not have specified written plans for improving behavioral health, the coalitions do support efforts to improve behavioral health outcomes.</i></p> | <p>The Oklahoma Health Improvement Plan 2020 (OHIP2020) identified behavioral health services as one of four “flagship issues” for the state. OHIP 2020 behavioral health goal 1 – increase the overall health and wellness of Oklahomans; Strategy 3 – implement unified, evidenced-based screening, assessment, and treatment protocol for suicidality statewide.</p> <p><i>Oklahoma Plan 2030 has not yet been released but is anticipated to include similar objectives to promote behavioral health and reduce the suicide rate.</i></p> | <p>Healthy People 2020 Objective MHMD1– Reduce the suicide rate</p> <p><i>Healthy People 2030 has not yet been released but is anticipated to include similar objectives to promote behavioral health and reduce the suicide rate.</i></p> <p>Zero Suicide Initiative: Zero Suicide is a key concept of the 2012 National Strategy for Suicide Prevention, a priority of the National Action Alliance for Suicide Prevention (Action Alliance), a project of Education Development Center's Suicide Prevention Resource Center (SPRC) and supported by the Substance Abuse and Mental Health Services Administration (SAMHSA). The foundational belief of Zero Suicide is that suicide deaths for individuals under care within health and behavioral health systems are preventable. It presents both a bold goal and an aspirational challenge.</p> <p>For healthcare systems, this approach represents a commitment:</p> <ul style="list-style-type: none"> • To patient safety, the most fundamental responsibility of healthcare |

| | | |
|--|--|--|
| | | <ul style="list-style-type: none"> • To the safety and support of clinical staff, who do the demanding work of treating and supporting suicidal patients <p>The programmatic approach of Zero Suicide is based on the realization that suicidal individuals often fall through cracks in a fragmented, and sometimes distracted, healthcare system. A systematic approach to quality improvement in these settings is both available and necessary.</p> |
| <p>IV-V</p> <p>One priority of the Creek County Community Partnership (CCCP) is lowering the rates of substance abuse and associated deaths.</p> <p>Funded by the Anne and Henry Zarrow Foundation and coordinated by the University of Tulsa, the Tulsa Regional Mental Health Plan is a 10-year communitywide effort to focus on regional mental health improvements and includes a leadership council with philanthropy, business, university, state and nonprofit representation. The plan aims to:</p> <ul style="list-style-type: none"> • Close the gap in life expectancy between Tulsans living with mental illness and all Oklahomans. • Lower the rates of overdoses, and | <p>The Oklahoma Health Improvement Plan2020 (OHIP2020) identified behavioral health services as one of four “flagship issues” for the state. OHIP 2020 behavioral health 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 and 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).</p> <p>OHIP 2020 behavioral health goal 3 –decrease the number of Oklahomans with untreated mental</p> | <p>Healthy People 2020 Objective MHMD9 – Increase the proportion of adults with mental health disorders who receive treatment.</p> <p>Healthy People 2020 Objective MHMD10 – Increase the proportion of persons with co-occurring substance abuse and mental disorders who receive treatment for both disorders.</p> <p><i>Healthy People 2030 has not yet been released but is anticipated to include similar objectives to promote behavioral health.</i></p> |

I-V

associated deaths from both causes.

- Lower the share of residents who experience poor mental health.
- Reduce criminal justice system, first responder, and hospital emergency room costs caused by untreated or poorly treated mental illness.

illness.; Strategy 5 – all Oklahomans will have access to crisis and urgent care for mental health disorders.

Oklahoma Plan 2030 has not yet been released but is anticipated to include similar objectives to promote behavioral health.

Prioritized Need 3: Healthy Lifestyles

GOAL 1: Address food insecurity through community collaboration and strengthening of community resources.

ACTION PLAN

STRATEGY 1: Explore collaborative opportunities to develop an initiative(s) to address food insecurity in communities we serve in northeastern Oklahoma. If viable, develop and implement initiative(s).

BACKGROUND INFORMATION:

- The strategy's target population is food insecure communities in northeastern Oklahoma (Creek County), as identified by the fiscal year 2019 community health needs assessments conducted by each hospital and community.
- This strategy addresses social determinants of health and health disparities in our communities by addressing inequity in access to healthy food. Accordingly, the strategy plays a vital role in the promotion of healthy lifestyles and improving health outcomes in the communities we serve.
- This strategy is a system change and is modeled off national evidence-based programs addressing food insecurity in healthcare settings. In addition, the Nutrition and Weight Status objectives for Healthy People 2020 reflect strong science supporting the health benefits of eating a healthful diet and maintaining a healthy body weight. The goal of promoting healthful diets and healthy weight encompasses increasing household food security and eliminating hunger.

RESOURCES:

- Members of the Healthy Lifestyles Task Force
- TouchPoint / food services (TBD)
- Ascension St. John
- St. John hospital facilities
 - St. John Medical Center (SJMC)
 - St. John Owasso (SJO)
 - St. John Broken Arrow (SJBA)
 - St. John Sapulpa (SJS)
 - Jane Phillips Medical Center (JPMC)
 - Jane Phillips Nowata Health Center (JPNHC)
- St. John Clinic
- Community Engagement Committee
- Facility space
- Community benefit department

Resources may be revised over time, depending on direction and viability of plan.

COLLABORATION:

Potential sources include:

- Pathways to Health (P2H)
- Creek County Community Partnership (CCCP)
- Creek County Health Living Program (CCHLP)
- Local public schools
- Creek County Health Department
- Local food pantries
- Regional food bank
- Faith-based nutrition programs
- Hunger Free Oklahoma
- Healthy Community Store Initiatives
- SNAP and WIC programs
- Local farmers markets
- Community gardens
- Nutrition programs (e.g., Meals on Wheels)

Community partners may change over time, depending on direction and viability of plan.

ACTIONS AND RESPONSIBLE PARTIES:

The Healthy Lifestyles Task Force will lead or support the following:

- Research evidence-based programs in healthcare settings that address food insecurity.
- Identify local food pantries, regional food banks, and other food assistance resources. Develop comprehensive list/resource for communities served.
- Meet with potential community partners to explore opportunities for collaboration.
- Research and develop healthy eating education/awareness resources, as appropriate.
- If viable, implement initiative in clinics and/or hospitals as led by Ascension St. John Clinic leadership and hospital administration.

ANTICIPATED IMPACT:

- I. Meet with 5-10 potential community partners (encompasses communities surrounding all six St. John hospitals) by the end of CY 2019 (12/31/19).
- II. Develop assessment plan to outline research on evidence-based programs and track partnership opportunities by the end of FY 2020 (year 1).
- III. If deemed viable, develop and implement initiative(s) for identified opportunities on a pilot basis during FY 2021 (year 2).
- IV. During FY 2022 (year 3), perform assessment of pilot and develop plan to expand throughout the St. John Health System, if viable.

GOAL 2: Reduce the health impact of tobacco³ use in communities we serve.

ACTION PLAN

STRATEGY 1: Assess opportunities for systematic screening and intervention for patients identified as tobacco users in ambulatory and inpatient settings in communities we serve.

BACKGROUND INFORMATION:

- The target population is patients identified as tobacco users in ambulatory and inpatient settings in communities we serve.
- This strategy addresses health disparities as certain populations in the communities we serve, remain at high risk and suffer disproportionately from tobacco-related illness and death despite progress made in reducing tobacco use. 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.⁴
- This strategy is a system change. The strategy builds upon evidence base from the CDC and Healthy People 2020.
 - The CDC has also established reducing tobacco use as one of its “winnable battles.” These are public health priorities with large-scale impact on health that have proven effective strategies to address them. CDC believes that with additional effort and support for evidence-based, cost-effective policy and program strategies to reduce tobacco use, we can reduce smoking substantially, prevent millions of people from being killed by tobacco, and protect future generations from smoking.
 - Healthy People 2020 provides a framework for action to reduce tobacco use to the point that it is no longer a public health problem for the Nation. Research has identified effective strategies that will contribute to ending the tobacco use epidemic which includes expanding cessation treatment in clinical care settings and providing access to proven cessation treatment to all smokers.
- Tobacco control interventions are known to reduce tobacco use and, as a result, tobacco’s extraordinary toll of death and disease. But to free the next generation from these burdens, we must redouble our tobacco control efforts and enlist non-governmental partners—and society as a whole—to share in this responsibility.

RESOURCES:

- Members of the Healthy Lifestyles Task Force
- Ascension St. John
- St. John hospital facilities
 - St. John Medical Center (SJMC)
 - St. John Owasso (SJO)
 - St. John Broken Arrow (SJBA)

³ Ascension St. John 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.

⁴ Jamal A., Agaku I.T., O’Connor E., King B.A., Kenemer J.B., & Neff L. (November 2014). Current cigarette smoking among adults — United States, 2005–2013. *Mortality and Morbidity Weekly Report*, 63(47), 1108- 1112. Retrieved from <http://www.cdc.gov/mmwr/pdf/wk/mm6347.pdf>

- St. John Sapulpa (SJS)
- Jane Phillips Medical Center (JPMC)
- Jane Phillips Nowata Health Center (JPNHC)
- St. John Clinic
- Ascension Technology
- Community benefit department
- Additional resources as identified during process

COLLABORATION:

- Hospitals Helping Patients Quit (TSET-funded)
- Oklahoma Tobacco Helpline (OKhelpline.com)
- Additional community organizations as identified during process

ACTIONS AND RESPONSIBLE PARTIES:

The Healthy Lifestyles Task Force will lead or support the following:

- Explore ways to engage Nursing and Pulmonary as led by the St. John Medical Center and Jane Phillips Medical Center nursing managers.
- Build bridges / reduce barriers among facilities as led by the Healthy Lifestyles Task Force co-chairs – presidents/chief operating officers of Jane Phillips Medical Center and St. John Owasso/St. John Broken Arrow.
- Investigate education and counseling resources from *Hospitals Helping Patients Quit*. If usable, personalize for Ascension St. John internal training as led by Jane Phillips Medical Center wellness manager.
- Build out ambulatory and inpatient electronic referral order to Oklahoma Quit Line, if viable as led by St. John Clinic medical director and Jane Phillips Medical Center president/chief operating officer.

ANTICIPATED IMPACT:

- V. By end of Year 1 (FY 2020): Develop assessment plan to outline research on evidence-based tobacco screening and intervention programs.
- VI. By end of Year 2 (FY 2021): Assess and complete informatics needed for screening and intervention services, if viable, to enable systematic screening and intervention for tobacco users in facilities.
- VII. By end of Year 3 (FY 2022): Implement and/or advance systematic screening and intervention in inpatient and ambulatory settings based on Year 1 findings.

STRATEGY 2: Explore opportunities to help identify and work with our associates requesting assistance with tobacco cessation.

BACKGROUND INFORMATION:

- The target population is Ascension St. John associates and their families
- This strategy addresses health disparities as certain populations in the communities we serve, remain at high risk and suffer disproportionately from tobacco-related illness and death despite progress made in reducing tobacco use. 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.⁵
- This strategy is a system change. The strategy builds upon evidence base from the CDC and Healthy People 2020.
 - The CDC has also established reducing tobacco use as one of its “winnable battles.” These are public health priorities with large-scale impact on health that have proven effective strategies to address them. CDC believes that with additional effort and support for evidence-based, cost-effective policy and program strategies to reduce tobacco use, we can reduce smoking substantially, prevent millions of people from being killed by tobacco, and protect future generations from smoking.
 - Healthy People 2020 provides a framework for action to reduce tobacco use to the point that it is no longer a public health problem for the Nation. Research has identified effective strategies that will contribute to ending the tobacco use epidemic which includes expanding cessation treatment in clinical care settings and providing access to proven cessation treatment to all smokers.
 - Tobacco control interventions are known to reduce tobacco use and, as a result, tobacco’s extraordinary toll of death and disease. But in order to free the next generation from these burdens, we must redouble our tobacco control efforts and enlist non-governmental partners—and society as a whole—to share in this responsibility.

RESOURCES:

- Members of the Healthy Lifestyles Task Force
- Ascension St. John
- St. John hospital facilities
 - St. John Medical Center (SJMC)
 - St. John Owasso (SJO)
 - St. John Broken Arrow (SJBA)
 - St. John Sapulpa (SJS)
 - Jane Phillips Medical Center (JPMC)
 - Jane Phillips Nowata Health Center (JPNHC)
- St. John Clinic
- Ministry-wide-function (MWF) associates
- Local and ministry-wide-function (MWF) human resources, Ascension Smart Health
- Community benefit department
- Additional resources as identified through process

COLLABORATION:

- Community organizations as identified through process as appropriate

ACTIONS AND RESPONSIBLE PARTIES:

The Healthy Lifestyles Task Force will lead or support the following:

- Explore Ascension Smart Health opportunities with local and ministry-wide-function (MWF) human resources as led by president and chief operating officer of Jane Phillips Medical Center.
- Assess data sources on tobacco use among associates as led by president and chief operating officer of Jane Phillips Medical Center and Human Resources.
- If opportunities available, present findings to health system and hospital leadership as led by president and chief operating officer of St. John Broken Arrow and Owasso.

ANTICIPATED IMPACT:

- VIII. By end of Year 1 (FY 2020): Develop assessment plan to outline research on evidence-based programs.
- IX. By end of Year 2 (FY 2021): If opportunities available, present findings to health system and hospital leadership to advocate for program implementation.
- X. If viable, implement program in Year 3 (FY 2022).

⁵ Jamal A., Agaku I.T., O'Connor E., King B.A., Kenemer J.B., & Neff L. (November 2014). Current cigarette smoking among adults — United States, 2005–2013. *Mortality and Morbidity Weekly Report*, 63(47), 1108- 1112. Retrieved from <http://www.cdc.gov/mmwr/pdf/wk/mm6347.pdf>

GOAL 3: Advance St. John engagement in community coalitions and collaboratives to promote healthy lifestyles and chronic disease prevention in the communities we serve.

ACTION PLAN

STRATEGY 1: Identify community coalitions and collaboratives with partnership opportunities to promote healthy lifestyles and chronic disease prevention. Encourage Ascension St. John representation/involvement by associates as deemed appropriate.

BACKGROUND INFORMATION:

- The strategy's target population is communities in need surrounding our hospital facilities in northeastern Oklahoma (Creek County), as identified by the FY 2019 CHNAs.
- Unhealthy lifestyles and chronic disease are more prevalent among those living in poverty and/or populations deemed otherwise vulnerable. This strategy addresses social determinants of health, health disparities, and challenges experienced by underserved populations, through community-based, collaborative efforts to improve prevention, increase wellness opportunities, and reduce poor health outcomes.
- The strategy is a system change and is informed by evidence found on Healthy People 2020, What Works for Health, and The Guide to Community Preventive Services. In particular, Healthy People 2020 emphasizes the importance of health-related quality of life and well-being by including it as one of the initiative's 4 overarching goals, promoting quality of life, healthy development, and health behaviors across all life stages. It also was established as one of the HP2020 4 foundation health measures.

RESOURCES:

- Members of the Healthy Lifestyles Task Force
- Ascension St. John
- St. John hospital facilities
 - St. John Medical Center (SJMC)
 - St. John Owasso (SJO)
 - St. John Broken Arrow (SJBA)
 - St. John Sapulpa (SJS)
 - Jane Phillips Medical Center (JPMC)
 - Jane Phillips Nowata Health Center (JPNHC)
- St. John Clinic
- Ministry-wide-function (MWF) associates
- JPMC diabetes prevention program
- Community benefit department

COLLABORATION:

Existing and/or potential partner organizations to collaborate with in the communities we serve:

- Pathways to Health (P2H)

- Creek County Community Partnership (CCCP)
- Creek County Healthy Living Partnership (CCHLP)
- Local public schools
- Creek County health department
- Other community coalitions and collaboratives as identified through process

ACTIONS AND RESPONSIBLE PARTIES:

The Healthy Lifestyles Task Force will lead or support the following:

- Identify currently engaged associates who are part of community coalitions and collaboratives related to healthy lifestyles and chronic disease prevention.
- Identify additional community coalitions and collaboratives related to healthy lifestyles and chronic disease prevention with which to become involved.
- Identify additional associates to participate / attend meetings as appropriate.
- Associates identify and engage in opportunities (e.g. activities, initiatives, etc.) for Ascension St. John and hospitals to drive or support / assist with related to healthy lifestyles and chronic disease prevention.
- Explore with leadership the opportunity to allow associates time to volunteer in the community as led by Jane Phillips Medical Center president and chief operating officer.
- Educate associates on ways to share information on volunteer/community activities to be tracked in Community Benefit Inventory for Social Accountability (CBISA) or other platform as led by community benefit department.

ANTICIPATED IMPACT:

- XI. Have at least one associate per hospital facility involved with a community coalition or similar organization in the respective community served by the end of FY 2020 (year 1).
- XII. Increase overall tracked participation by associates with community organizations and events by 5% from FY 2019 to FY 2020.
- XIII. Increase overall tracked participation by associates with community organizations and events by another 5% from FY 2020 to FY 2021.

Alignment with local, state and national priorities (long-term outcomes for Prioritized Need 2: Behavioral Health)

| OBJECTIVE: | LOCAL/COMMUNITY PLAN: | STATE PLAN: | “HEALTHY PEOPLE 2030” (OR OTHER NAT’L PLAN): |
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| I-IV | <p>Healthy Community Store Initiative aims to enhance the health of northeast Oklahoma through food-based community revitalization.</p> <p>One priority of the Creek County Healthy Living Partnership (CCHLP) is to increase nutrition opportunities in Creek County.</p> <p>A priority of the Creek County Community Partnership (CCCP) is to address obesity in Creek County.</p> | <p>Hunger Free Oklahoma is working to end hunger by focusing on collaboration, research, policy, advocacy, and practice. Hunger Free Oklahoma and collaborators are undertaking a comprehensive and sustainable approach to ending hunger in Oklahoma.</p> <p>Obesity is a flagship goal of the Oklahoma Health Improvement Plan 2020 (OHIP 2020). A focus of this goal is food access and healthy nutrition. OHIP 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 3 – improve the built environment infrastructure supportive of physical activity and availability of affordable fruits and vegetables.</p> <p><i>Oklahoma Plan 2030 has not yet been released but is anticipated to include similar objectives to increase food access and healthy nutrition as well as address food insecurity.</i></p> | <p>The Nutrition and Weight Status objectives for Healthy People 2020 aim to promote health and reduce chronic disease risk through the consumption of healthful diets and achievement and maintenance of healthy body weights. The objectives emphasize that efforts to change diet and weight should address individual behaviors, as well as the policies and environments that support these behaviors in settings such as schools, worksites, healthcare organizations, and communities. The NWS-1 through 22 objectives are all in alignment.</p> <p>The Healthy People 2020 NWS-12 and 13 objectives are particularly relevant as they work to address food insecurity. The goal of promoting healthful diets and healthy weight encompasses increasing household food security and eliminating hunger.</p> <p><i>Healthy People 2030 has not yet been released but is anticipated to include similar objectives to increase food access and healthy nutrition as well as address food insecurity.</i></p> |

| | | | |
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| <p>V-X</p> | <p>One priority of the Creek County Healthy Living Partnership (CCHLP) is lowering the rates of tobacco use.</p> <p>A priority of the Creek County Community Partnership (CCCP) is to address obesity in Creek County.</p> | <p>Tobacco use is a flagship goal in the Oklahoma Health Improvement Plan 2020 (OHIP 2020). 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.</p> <p><i>Oklahoma Plan 2030 has not yet been released but is anticipated to include similar objectives to promote tobacco cessation.</i></p> <p>Tobacco cessation services are available to all Oklahomans through the Oklahoma Tobacco Helpline. The Helpline offers free, customizable services and tools to help Oklahomans quit tobacco on their own terms. Patients enrolled in SoonerCare are eligible for extra tobacco cessation services.</p> | <p>The Healthy People 2020 Tobacco Use objectives (TU 1-10.6 are in alignment) are organized into 3 key areas:</p> <ul style="list-style-type: none"> • Tobacco Use Prevalence: Implementing policies to reduce tobacco use and initiation among youth and adults. • Health System Changes: Adopting policies and strategies to increase access, affordability, and use of smoking cessation services and treatments. • Social and Environmental Changes: Establishing policies to reduce exposure to secondhand smoke, increase the cost of tobacco, restrict tobacco advertising, and reduce illegal sales to minors. <p><i>Healthy People 2030 has not yet been released but is anticipated to include similar objectives to promote tobacco cessation.</i></p> |
| <p>I-XIII</p> | <p>Two priorities of the Creek County Healthy Living Partnership (CCHLP) are to increase nutrition and physical activity opportunities in Creek County.</p> <p>A priority of the Creek County Community Partnership (CCCP) is to address obesity in Creek County.</p> | <p>Obesity is a flagship goal of the Oklahoma Health Improvement Plan 2020 (OHIP 2020). Food access, healthy nutrition, and physical activity are focuses of this goal. OHIP 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);</p> | <p>Healthy People 2020 Objective HRQOL/WB-1– increase the proportion of adults who self-report good or better health.</p> <p>Released in 2008, the Physical Activity Guidelines for Americans (PAG) is the first-ever publication of national guidelines for physical activity. The Physical Activity objectives</p> |

OHIP 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 3 – improve the built environment infrastructure supportive of physical activity and availability of affordable fruits and vegetables.

Oklahoma Plan 2030 has not yet been released but is anticipated to include similar objectives to reduce obesity through the promotion of food access, healthy nutrition, and physical activity.

for Healthy People 2020 (PA-1 through PA-15) reflect the strong state of the science supporting the health benefits of regular physical activity among youth and adults, as identified in the PAG. Regular physical activity includes participation in moderate- and vigorous-intensity physical activities and muscle-strengthening activities.

The Nutrition and Weight Status objectives for Healthy People 2020 aim to promote health and reduce chronic disease risk through the consumption of healthful diets and achievement and maintenance of healthy body weights. The objectives emphasize that efforts to change diet and weight should address individual behaviors, as well as the policies and environments that support these behaviors in settings such as schools, worksites, healthcare organizations, and communities. The NWS-1 through 22 objectives are all in alignment.

Healthy People 2020 addresses chronic disease with goals and objectives related to the following chronic conditions: arthritis, osteoporosis, and chronic back conditions; chronic kidney disease, diabetes, heart disease and stroke, and respiratory diseases.

Healthy People 2020 goal to increase the quality, availability, and effectiveness of educational and community-based programs designed to prevent disease and injury, improve health, and enhance quality of life.

Healthy People 2030 has not yet been released but is anticipated to include similar objectives to reduce obesity and chronic disease through the promotion of food access, healthy nutrition, physical activity, and educational and community-based programming.

Prioritized Need 4: Adverse Childhood Experiences (ACEs)

GOAL 1: Combat human trafficking in the communities we serve through efforts to support the needs of human trafficking victims or those at risk of being trafficked in a trauma-informed manner, taking into consideration the correlation between ACEs and human trafficking.

ACTION PLAN

STRATEGY 1: Increase community awareness on the correlation between high ACE scores and human trafficking as well as the impact of ACEs on health outcomes.

BACKGROUND INFORMATION:

- The target population are victims of human trafficking or those that are at high risk of being trafficked in the communities we serve.
- This strategy addresses high ACE scores in Oklahoma⁶, human trafficking, and opportunities to implement or improve trauma-informed care. Accordingly, this strategy addresses social determinants of health and health disparities by expanding awareness on ACEs and health outcomes in a population that is vulnerable and often underserved in the communities we serve.
- Current literature demonstrates a correlation between high ACE scores and human trafficking. This strategy is a systems and environmental change. The strategy is built upon evidence-based programming developed and successfully operated at Via Christi Health in Wichita, Kan. It is also informed by evidence from HEAL, a united group of multidisciplinary professionals dedicated to ending human trafficking and supporting its survivors, from a public health perspective.

RESOURCES:

- Members of the Adverse Childhood Experiences (ACEs) Task Force
- Human trafficking program manager
- Ascension St. John
- St. John hospital facilities
 - St. John Medical Center (SJMC)
 - St. John Owasso (SJO)
 - St. John Broken Arrow (SJBA)
 - St. John Sapulpa (SJS)
 - Jane Phillips Medical Center (JPMC)
 - Jane Phillips Nowata Health Center (JPNHC)
- St. John Clinic
- Ascension St. John Human Trafficking Education and Response Program
- Training materials, including St. John's human trafficking assessment and community pocket tools
- Community benefit department

⁶ Oklahoma State Department of Health. (September 2018). ACEs in Oklahoma: Lemonade for Life: A Guide to Using ACEs to Build Hope and Resilience. http://www.oksenate.gov/publications/senate_studies/Interim%20Studies%20-%202018/18-17,18-26/ACE%20Interim%20Study%20September%202018.pdf

COLLABORATION:

- The Oklahoma Coalition Against Human Trafficking (consists of numerous social services, nonprofits, schools and other educational institutions, and law enforcement agencies)
- Community members, community organizations and first responders that have the potential to come into contact with human trafficking victims or those at high risk of being trafficked in the communities we serve
- Center for Integrative Research on Childhood Adversity
- University of Oklahoma Medicine Center on Child Abuse and Neglect
- Additional community organizations as identified

ACTIONS AND RESPONSIBLE PARTIES:

The Adverse Childhood Experiences (ACEs) Task Force will lead or support the following:

- Assess current level of community awareness of ACEs and the correlation between high ACE scores and the increased risk for being a human trafficking victim, as led by St. John's human trafficking program manager.
- Meet with the Oklahoma Coalition Against Human Trafficking to discuss community education needs regarding ACEs as led by St. John's human trafficking program manager and director of community benefit.
- Develop training materials on ACEs and the effects on health and safety of human trafficking victims, as led by St. John's human trafficking program manager and director of community benefit.
- Deliver education on ACEs and the effects on health and safety of human trafficking victims to first responders, medical professionals, social service agencies and other identified community groups, as led by St. John's human trafficking program manager and director of community benefit.
- Develop a list of local resources for human trafficking victims to disseminate to the communities we serve as led by St. John's human trafficking program manager and director of community benefit.
- If viable, expand education on ACEs to those who are human trafficking victims or are at high risk of becoming victims, by adapting community education materials to include self-assessments and links to local resources, as led by St. John's human trafficking program manager and director of community benefit.

ANTICIPATED IMPACT:

- I. By the end of the second quarter of FY 2020, meet with the Oklahoma Coalition Against Human Trafficking to identify education needs in the community.
- II. Conduct education on ACEs and human trafficking to at least 15 community agencies or organizations by the end of FY 2022.

STRATEGY 2: Advance the Ascension St. John Human Trafficking Education and Response Program to serve victims of human trafficking.

BACKGROUND INFORMATION:

- The target population is human trafficking victims or those who are at high risk of being trafficked in the communities we serve.
- This strategy provides standard training and resources to assist our healthcare associates as well as community partners to identify and respond to the needs of human trafficking victims or those at high risk of being trafficked in a trauma-informed manner, including referrals to resources as needed. Accordingly, this strategy addresses social determinants of health, health disparities and challenges experienced by a population that is often underserved and most in need.
- This strategy is a policy systems and environmental change. The strategy is built upon evidence-based programming developed and successfully operated at Ascension Via Christi in Wichita, Kansas. It is also informed by evidence from HEAL, a united group of multidisciplinary professionals dedicated to ending human trafficking and supporting its survivors, from a public health perspective.

RESOURCES:

- Members of the Adverse Childhood Experiences (ACEs) Task Force
- Human trafficking program manager
- Community benefit department
- Ascension St. John
- St. John hospital facilities
 - St. John Medical Center (SJMC)
 - St. John Owasso (SJO)
 - St. John Broken Arrow (SJBA)
 - St. John Sapulpa (SJS)
 - Jane Phillips Medical Center (JPMC)
 - Jane Phillips Nowata Health Center (JPNHC)
- St. John Clinic
- Human Trafficking Education and Response Program
- Training materials, including St. John’s human trafficking assessment pocket tools
- St. John human trafficking policy

COLLABORATION:

- The Oklahoma Coalition Against Human Trafficking (consists of numerous social services, nonprofits, schools and other educational institutions, and law enforcement agencies)
- Community members, community organizations and first responders that have the potential to come into contact with human trafficking victims or those at high risk of being trafficked in the communities we serve
- Additional community organizations as identified

ACTIONS AND RESPONSIBLE PARTIES:

The Adverse Childhood Experiences (ACEs) Task Force will lead or support the following:

- Develop partnerships with community members, community organizations and first responders that have the potential to come into contact with human trafficking victims or those at high risk of being trafficked to increase awareness/education, as led by St. John’s human trafficking program manager and director of community benefit.
- Continue to identify and target key points of entry at all St. John hospitals and disseminate assessment pocket tools to each identified area, as led by St. John’s human trafficking program manager and director of community benefit.
- Continue to provide the Human Trafficking Education and Response Program training to St. John associates, as led by St. John’s human trafficking program manager.

ANTICIPATED IMPACT:

- III. Develop at least three additional community partnerships to strengthen community awareness and collaboration to combat human trafficking in the communities we serve by the end of FY 2020.
- IV. Conduct at least two human trafficking education/awareness events for each of the six hospital facilities and St. John Clinic by the end of FY 2020.
- V. Complete dissemination of assessment pocket tools to key entry points at St. John hospitals by the end of FY 2020.
- VI. Complete dissemination of assessment pocket tools to St. John Clinic by the end of FY 2022.

GOAL 2: Address and mitigate adverse health outcomes prenatally and birth to 18 years of age in communities we serve.

ACTION PLAN

STRATEGY 1: Expand the Ascension St. John suspected child abuse and neglect committee to include community experts and/or liaisons, as well as hospital representation.

BACKGROUND INFORMATION:

- The target population is community members who present for care at St. John hospitals in northeastern Oklahoma.
- Oklahoma is ranked 41st in the nation and had ninth highest percentage of children with two or more ACEs (26.6 percent) in 2019.⁷ In addition, Oklahoma and communities we serve in Creek County have high rates of infant mortality and high incidences of child abuse and neglect, as evidenced by data collected in the FY 2019 community health needs assessments. Through work to address and mitigate ACEs, this strategy targets social determinants of health, health disparities and challenges of underserved populations.
- This strategy is a system change and is informed by the following evidence:
 - The American Academy of Pediatrics recognizes that the biological response to toxic stress caused by ACEs “can be incredibly destructive and last a lifetime.” Critical periods of human development occur prenatally through the first 2-3 years of life.⁸
 - The Agency for Healthcare Research and Quality includes trauma-informed care as part of its healthy pregnancy care.⁹

RESOURCES:

- Members of the Adverse Childhood Experiences (ACEs) Task Force
- Ascension St. John
- St. John hospital facilities
 - St. John Medical Center (SJMC)
 - St. John Owasso (SJO)
 - St. John Broken Arrow (SJBA)
 - St. John Sapulpa (SJS)
 - Jane Phillips Medical Center (JPMC)
 - Jane Phillips Nowata Health Center (JPNHC)
- Members of the suspected child abuse and neglect (SCAN) committee
- APRN clinical nurse specialist
- Social work / case management department

⁷ Oklahoma State Department of Health. (September 2018). ACEs in Oklahoma: Lemonade for Life: A Guide to Using ACEs to Build Hope and Resilience. http://www.oksenate.gov/publications/senate_studies/Interim%20Studies%20-%202018/18-17,18-26/ACE%20Interim%20Study%20September%202018.pdf

⁸ American Academy of Pediatrics. (2014). Adverse childhood experiences and the lifelong consequences of trauma. Retrieved from https://www.aap.org/en-us/Documents/ttb_aces_consequences.pdf

⁹ Agency for Healthcare Research and Quality Trauma-Informed Care – health pregnancy care <https://www.ahrq.gov/professionals/prevention-chronic-care/healthier-pregnancy/preventive/trauma.html>

- Pediatric department
- Community benefit department
- Other departments where pediatric patients may present for care (e.g., emergency department)

COLLABORATION:

- Child abuse and neglect community experts and/or liaisons
- University of Oklahoma Medicine Center on Child Abuse and Neglect
- Center for Integrative Research on Childhood Adversity
- Other community partners as identified

ACTIONS AND RESPONSIBLE PARTIES:

The Adverse Childhood Experiences (ACEs) Task Force will lead or support the following:

- Discuss expansion with the existing St. John suspected child abuse and neglect (SCAN) committee, as led by an APRN clinical nurse specialist.
- Identify and invite new members, both internally and from the community, to participate in the SCAN committee, as led by the SCAN committee and Ascension St. John leadership.
- Revise the SCAN charter as needed, as led by the SCAN committee and Ascension St. John leadership.
- Explore opportunities to track and potentially report quality metrics related to SCAN cases, as led by the SCAN committee and Ascension St. John leadership.

ANTICIPATED IMPACT:

- VII. Explore opportunities for the expansion of the SCAN committee, as evidenced by committee meeting minutes by the end of FY 2020.
- VIII. Implement opportunities for SCAN committee improvement, as identified in FY 2020 and as evidenced by a revised SCAN committee charter, if appropriate, by the end of FY 2021.
- IX. If appropriate, define a reporting structure of the quality metrics related to SCAN by the end of FY 2022.

STRATEGY 2: Sustain and/or expand current services and partnerships targeting care of pregnant women and children birth to 3 years of age throughout Ascension St. John.

BACKGROUND INFORMATION:

- The target population includes women of childbearing age who are currently and/or likely to become pregnant, as well as children under 3 years of age.
- Oklahoma is ranked 41st in the nation and had ninth highest percentage of children with two or more ACEs (26.6 percent) in 2019.¹⁰ In addition, Oklahoma and communities we serve in Creek County have high rates of infant mortality, high rates of low birth weights, high rates of lack of or delayed prenatal care, high teen birth rates, high rates of smoking during pregnancy, and high incidences of child abuse and neglect, as evidenced by data collected in the FY 2019 community health needs assessments. Through work to support pregnant women and children birth to 3 years of age, this strategy targets social determinants of health, health disparities and challenges of underserved populations.
- This strategy is a system change and is informed by the following evidence:
 - The American Academy of Pediatrics recognizes that the biological response to toxic stress caused by ACEs “can be incredibly destructive and last a lifetime.” Critical periods of human development occur prenatally through the first 2-3 years of life.¹¹
 - The Agency for Healthcare Research and Quality includes trauma-informed care as part of its healthy pregnancy care.¹²

RESOURCES:

- Members of the Adverse Childhood Experiences (ACEs) Task Force
- Ascension St. John
- St. John hospital facilities
 - St. John Medical Center (SJMC)
 - St. John Owasso (SJO)
 - St. John Broken Arrow (SJBA)
 - St. John Sapulpa (SJS)
 - Jane Phillips Medical Center (JPMC)
 - Jane Phillips Nowata Health Center (JPNHC)
- St. John Clinic
- APRN clinical nurse specialist
- Women and children’s services
- Trauma outreach coordinator

¹⁰ Oklahoma State Department of Health. (September 2018). ACEs in Oklahoma: Lemonade for Life: A Guide to Using ACEs to Build Hope and Resilience. http://www.oksenate.gov/publications/senate_studies/Interim%20Studies%20-%202018/18-17,18-26/ACE%20Interim%20Study%20September%202018.pdf

¹¹ American Academy of Pediatrics. (2014). Adverse childhood experiences and the lifelong consequences of trauma. Retrieved from https://www.aap.org/en-us/Documents/ttb_aces_consequences.pdf

¹² Agency for Healthcare Research and Quality Trauma-Informed Care – health pregnancy care <https://www.ahrq.gov/professionals/prevention-chronic-care/healthier-pregnancy/preventive/trauma.html>

- Community benefit department
- Other St. John departments where pregnant and/or pediatric patients may present for care, as identified

COLLABORATION:

- Reach Out and Read – a partnership that supports St. John’s early literacy programming in pediatric care sites
- Safe Kids
- Oklahoma Perinatal Quality Improvement Collaborative
- ConnectFirst
- Creek County health department
- Local public schools
- CAP
- Educare
- Center for Integrative Research on Childhood Adversity
- Other community partners, as identified

ACTIONS AND RESPONSIBLE PARTIES:

The Adverse Childhood Experiences (ACEs) Task Force will lead or support the following:

- Assess current programs, activities and community partnerships throughout St. John, including but not limited to capacity, utilization, opportunity for expansion to other areas of St. John to support the care of pregnant women and children birth to 3 years of age.
- Meet with the Safe Kids program director to discuss the potential to add education on ACEs to their programming, as led by St. John’s trauma outreach coordinator.
- Meet with local experts and potential community partners on ACEs to explore best practices and opportunities for collaboration.
- Partner with key stakeholders across St. John hospitals and St. John Clinic to perform exploration, piloting, expansion and evaluation of activities to support the care of pregnant women and children birth to 3 years of age.

ANTICIPATED IMPACT:

- X. Assess current programs, activities and community partnerships throughout St. John, including but not limited to capacity, utilization and opportunity for expansion to other areas of St. John to support the care of pregnant women and children birth to 3 years of age and develop an action plan by the end of FY 2020.
- XI. If viable, implement pilot and/or expansion of collaboration with community partners to support the care of pregnant women and children birth to 3 years of age by the end of FY 2022.

GOAL 3: Strengthen Ascension St. John associate awareness of the role of ACEs in health outcomes, as well as to how best to respond to the needs of those most vulnerable.

ACTION PLAN

STRATEGY 1: Partner with community agencies and coalitions to increase St. John associate awareness of the role of ACEs in adverse health outcomes and homelessness and how best to respond to the needs of individuals experiencing or at risk for homelessness through collaborative care coordination and linkage to community resources and support.

BACKGROUND INFORMATION:

- The strategy's target population is individuals experiencing or at risk for homelessness in the communities we serve.
- Oklahoma is ranked 41st in the nation and had the ninth highest percentage of children with two or more ACEs (26.6 percent) in 2019.¹³ In addition, Oklahoma and communities we serve in Creek County have high rates of childhood poverty and homelessness, as evidenced by data collected in the FY 2019 community health needs assessments.
- Through collaborative efforts to increase the scope of awareness and better support the needs of individuals experiencing or at risk for homelessness, this strategy targets social determinants of health, health disparities and challenges of an underserved population. While homelessness is not recognized as one of the ACEs, it is closely correlated with ACEs, as are other adverse outcomes, including poor health. Furthermore, children experiencing homelessness have everyday exposure to these risks.¹⁴ In addition, poor health is a major cause of homelessness, and homelessness creates new health problems and exacerbates existing ones.¹⁵
- This strategy is a system change and is informed by evidence from the National Healthcare for the Homeless Council.

RESOURCES:

- Members of the Adverse Childhood Experiences (ACEs) Task Force
- Ascension St. John
- St. John hospital facilities
 - St. John Medical Center (SJMC)
 - St. John Owasso (SJO)
 - St. John Broken Arrow (SJBA)
 - St. John Sapulpa (SJS)
 - Jane Phillips Medical Center (JPMC)
 - Jane Phillips Nowata Health Center (JPNHC)

¹³ Oklahoma State Department of Health. (September 2018). ACEs in Oklahoma: Lemonade for Life: A Guide to Using ACEs to Build Hope and Resilience. http://www.oksenate.gov/publications/senate_studies/Interim%20Studies%20-%202018/18-17,18-26/ACE%20Interim%20Study%20September%202018.pdf

¹⁴ National Health Care for the Homeless Council and National Network to End Family Homelessness. (January 2019.) Homelessness & Adverse Childhood Experiences: The health and behavioral health consequences of childhood trauma (Authors: Avery Brien, Program Manager NNEFH; Marvin So, Co-Chair, NNEFH; Christine Ma, Pediatrician, NNEFH; Lauryn Berner, Project Manager, NHCHC) Available at: <http://www.nhchc.org/aces>

¹⁵ National Health Care for the Homeless Council (February 2019). Homelessness and health: What's the connection?. <https://nhchc.org/wp-content/uploads/2019/08/homelessness-and-health.pdf>.

- St. John Clinic
- Clinical education department
- Social work / case management department
- St. John Medical Center and Jane Phillips Medical Center behavioral assessment teams
- Community benefit department
- Other St. John departments that may come into contact with individuals experiencing or at risk of homelessness

COLLABORATION:

- A Way Home for Tulsa
- Community Service Council
- All Doors Open
- Area shelters and services for those experiencing homelessness
- National Healthcare for the Homeless Council
- Mental Health Association Oklahoma (homeless outreach, drop-in center and supportive housing)
- Family and Children’s Services (homeless outreach and support services)
- Youth Services of Tulsa (homeless outreach, support services, drop-in shelter and supportive housing)
- Creek County Community Partnership
- Housing Authority and other housing resources
- Other community partners, as identified

ACTIONS AND RESPONSIBLE PARTIES:

The Adverse Childhood Experiences (ACEs) Task Force will lead or support the following:

- Identify associates to form a St. John ACEs and homelessness sub-task force to carry out the work of this strategy.
- Analyze A Way Home for Tulsa data regarding homelessness in the Tulsa area then expand data collection methods to Creek county, as led by the ACEs and homelessness sub-task force.
- Partner with A Way Home for Tulsa to participate in one of six committees developing strategies for implementation and expand methods to Creek County, as led by the ACEs and homelessness sub-task force.
- Provide education for associates to understand the most effective ways to assist individuals and families experiencing homelessness or at risk of homelessness, as led by the ACEs and homelessness sub-task force and clinical education department.
- Implement an education program for St. John associates related to ACEs and risks for homelessness and incorporate transition to community resources for aftercare, as led by the ACEs and homelessness sub-task force and clinical education department.
- Provide education and a comprehensive resource list to patients experiencing or at risk of homelessness, as led by the ACEs and homelessness sub-task force.

ANTICIPATED IMPACT:

- XII. By the end of the second quarter of FY 2020, identify key community and associate leaders to participate in a St. John ACEs and homelessness sub-task force and form the sub-task force.
- XIII. By the end of the third quarter of FY 2020, meet with identified community and St. John leaders/stakeholders to determine education needs.
- XIV. By the end of the fourth quarter of FY 2020, finalize a comprehensive list of community resources available for those experiencing or at risk of homelessness and finalize education resources for associates.
- XV. By the end of the first quarter of FY 2021, complete associate education on ACEs and homelessness and incorporate resources for associates to give patients upon discharge from any point of service.

Further impact will be determined through ongoing work with community partners on education needs and prioritization of agencies to coordinate education schedule. Specific objectives will be dependent upon the actions and interventions selected by the ACEs and homelessness sub-task force and community partners. Impact will be updated throughout FY 2020-2022.

GOAL 4: Implement education and assessment tools to raise awareness of the impact of ACEs on Ascension St. John associates and their families in support of the whole person and a model community of engaged associates.

ACTION PLAN

STRATEGY 1: Provide education to Ascension St. John leaders on the prevalence of ACEs, their impact on health and other outcomes, and how to identify risk factors and available resources to support associates who experience or are at risk of adverse outcomes as result of ACEs.

BACKGROUND INFORMATION:

- The target population is St. John associates who experience or are at risk of adverse outcomes as a result of ACEs.
- Oklahoma is ranked 41st in the nation and had the ninth highest percentage of children with two or more ACEs (26.6 percent) in 2019.¹⁶ This strategy addresses social determinants of health and health disparities among vulnerable populations through work to recognize the impact of ACEs on adults and their families, and opportunities to increase awareness among St. John leaders to identify and respond to the needs of associates who are experiencing or at risk of adverse outcomes as result of ACEs. This strategy provides tools for associate self-assessment and resources.
- This strategy is a system change and is informed by evidence from the Centers for Disease Control (CDC) as well as a growing body of literature.
 - Current literature demonstrates a correlation between high ACE scores and increased likelihood that individuals are more likely to engage in unhealthy behaviors and experience poor health outcomes. These adverse outcomes can impact the ability to concentrate and complete daily tasks, which could also impact work. The long-term effects of ACEs on the work force impose major human and economic costs that are preventable. Organizations, agencies and employers across the country are becoming more aware of the impact of ACEs and are integrating trauma-informed and resilience-based practices into their culture.¹⁷

RESOURCES:

- Members of the adverse childhood experiences task force
- Ascension St. John
- St. John hospital facilities
 - St. John Medical Center (SJMC)
 - St. John Owasso (SJO)
 - St. John Broken Arrow (SJBA)
 - St. John Sapulpa (SJS)
 - Jane Phillips Medical Center (JPMC)
 - Jane Phillips Nowata Health Center (JPNHC)

¹⁶ Oklahoma State Department of Health. (September 2018). ACEs in Oklahoma: Lemonade for Life: A Guide to Using ACEs to Build Hope and Resilience. http://www.oksenate.gov/publications/senate_studies/Interim%20Studies%20-%202018/18-17,18-26/ACE%20Interim%20Study%20September%202018.pdf

¹⁷ Anda, R. F., Fleisher, V. I., Felitti, V. J., Edwards, V. J., Whitfield, C. L., Dube, S. R., & Williamson, D. F. (2004). Childhood Abuse, Household Dysfunction, and Indicators of Impaired Adult Worker Performance. *The Permanente journal*, 8(1), 30–38. doi:10.7812/tpp/03-089

- St. John Clinic
- Clinical education / clinical professional development department
- Human resources department
- St. John leaders
- Mission integration departments:
 - Community benefit department
 - Mission formation department
 - Spiritual care department
- Ministry-wide-function associates
- Risk management department - provider associate care team (PACT)
- Centers for Disease Control (CDC) ACEs training course and other training materials
- ACEs assessment tools
- Other resources as identified

COLLABORATION:

- Community partners as identified

ACTIONS AND RESPONSIBLE PARTIES:

The Adverse Childhood Experiences (ACEs) Task Force will lead or support the following:

- Assess CDC training on ACEs and determine the viability of utilizing it to educate Ascension St. John Leaders as led by Ascension St. John clinical education/ professional development.
- Meet with the Ascension St. John provider associate care team (PACT) to discuss opportunities to incorporate ACE information in current education programming as led by Ascension St. John human resources.
- Develop training materials on ACEs, the impact of ACEs on health and other outcomes, the impact on the workplace, and how to identify risk factors among associates as led by Ascension St. John clinical education/clinical professional development and human resources.
- Develop a list of local resources and support to disseminate to the Ascension St. John leaders as led by the Ascension community benefit department.
- Assess methods to provide self-assessment tools to associates and investigate how information may be utilized to provide resources based on results as led by Ascension St. John clinical education/clinical professional development and human resources.

ANTICIPATED IMPACT:

- XVI. By the end of the second quarter for FY 2020, assess CDC ACEs training and meet with the Ascension St. John provider associate care team (PACT) to confirm if training material is viable for Ascension St. John leader training.
- XVII. Compile list of local resources and support to share with Ascension St. John leaders by the end of the first quarter of FY 2021.
- XVIII. Conduct education on ACEs to Ascension St. John leaders by the end of the second quarter of FY 2021.

XIX. Determine method of self-assessment for associates and implement selected self-assessment tool by the end of the third quarter of FY 2021.

Alignment with local, state and national priorities (long-term outcomes for Prioritized Need 4: Adverse Childhood Experiences (ACEs))

| OBJECTIVE: | LOCAL/COMMUNITY PLAN: | STATE PLAN: | “HEALTHY PEOPLE 2030” (OR OTHER NAT’L PLAN): |
|------------|--|--|--|
| I-VI | <p>Oklahoma Human Trafficking Task Force Strategic Plan developed to address human trafficking in the region. The plan includes five main objectives. These objectives are, increased collaborative partnerships, increased community awareness, the development of comprehensive victim services, demand reduction, and task force and community sustainability.</p> <p>Local partners have begun a capital campaign to build a new crisis stabilization center for trafficked youth (females).</p> | <p>2019 legislation change to Title 21, Section 856 adding human trafficking to the gang statutes for increased penalties on certified gang members convicted of human trafficking.</p> <p>2019 legislation change to Title 70, Section 24-100.5 adding human trafficking awareness to the Oklahoma’s Safe School Committee. This change directs the committee to study and make recommendations to principals regarding the needs of faculty and staff to recognize and report suspected human trafficking.</p> | <p>Addressing human trafficking is a strategic priority of Ascension as evidenced by the Ascension Human Trafficking policy and procedure as well as advocacy on state and national levels.</p> <p>The Catholic Health Association, in collaboration with other Catholic organizations through the Catholic Campaign Against Human Trafficking, hosts twice-annual networking conference calls and serves as a convening platform to allow for an exchange of information among CHA members and other partner organizations on their and activities and to explore what, as a united ministry, we can do together.</p> <p>The American Hospital Association, along with its nearly 5,000 member hospitals, health systems and other healthcare organizations, are committed to addressing all forms of violence affecting our staff as well as the patients and communities we serve including human trafficking. As urged by the American Hospital Association’s Hospitals Against Violence initiative, the first ICD-10-CM codes</p> |

for classifying human trafficking abuse were released in June 2018. AHA's Central Office on ICD-10, in partnership with Catholic Health Initiatives and Massachusetts General Hospital's Human Trafficking Initiative and Freedom Clinic, proposed the change.

The Polaris Project, an active organization in the global fight to eradicate modern slavery and restore freedom to survivors of human trafficking, operates the National Human Trafficking Hotline serving victims and survivors of human trafficking and the anti-trafficking community in the United States since 2007.

HEAL Trafficking is a united group of over 2,600 survivors and multidisciplinary professionals in 35 countries dedicated to ending human trafficking and supporting its survivors, from a public health perspective.

The US Administration for Children and Families is committed to preventing human trafficking and ensuring that victims of all forms of human trafficking have access to the services they need through its Office on Trafficking in Persons.

SOAR Online is a new series of CE/CME training modules

jointly provided by Postgraduate Institute for Medicine, the U.S. Department of Health and Human Services, and the National Human Trafficking Training and Technical Assistance Center in collaboration with the Administration for Children and Families, Office on Trafficking in Persons and Office on Women’s Health. SOAR Online is designed to educate healthcare providers, social workers, public health professionals, and behavioral health professionals on how to identify, treat, and respond appropriately to individuals who are at risk or who have been trafficked.

| | | | |
|-------|--|--|--|
| I-XIX | <p>Center for Integrative Research on Childhood Adversity is a federally funded Centers of Biomedical Research Excellence (COBRE) grant research center located in Tulsa, Oklahoma determined to create a research infrastructure to expand knowledge on the effects of early stress and trauma leading to the development of evidence-based programs and interventions to address the high rate of ACEs within Tulsa, Okla. area, and abroad.</p> | <p>ACEs are targeted in the Oklahoma Health Improvement Plan 2020 (OHIP 2020) flagship goal for children’s health: goal 2 – improve child and adolescent health outcomes; Strategy 2 – 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).</p> | <p>The Center for Disease Control’s (CDC) Division of Violence Prevention’s 5-year vision and areas of strategic focus on the prevention of violence across the lifespan.</p> |
| | <p>One of the current priorities of the Creek County Community Partnership is to address child abuse and neglect.</p> | <p><i>Oklahoma Plan 2030 has not yet been released but is anticipated to include ACEs as a priority.</i></p> <p>OK State Dept. of Health included an ACEs strategy into their state plan for the prevention of child abuse and neglect.</p> | <p>Healthy People 2020 places ACEs as an indirect priority through its objectives on maternal, infant, & child health as well as objectives on injury and violence prevention.</p> <p><i>Healthy People 2030 has not yet been released but is anticipated to include ACEs as a priority.</i></p> |

XII-XV

A Way Home for Tulsa (AWH4T) is a collective impact of 30 voting organizations that exists to plan and implement strategies that support a system of outreach, engagement, assessment, prevention and evaluation for those experiencing homelessness, or those persons at risk of homelessness, within Tulsa City/County. AWH4T supports programs such as All Doors Open, Coordinated Outreach and the Homeless Management Information System.

While Creek County does not have specified written plans, the area agencies and coalitions do support efforts to improve address homelessness and ACEs.

Oklahoma Governor's Interagency Council on Homelessness released a 5-year plan to end homelessness in 2019.

Oklahoma has eight Continuums of Care (CoCs) assisting individuals and families experiencing homelessness by connecting them to local services and resources.

The Oklahoma Plan for 2030 has not yet been released but is anticipated to include social determinants of health as a priority which address homelessness and ACEs.

National Healthcare for the Homeless Council (NHHHC) is working to end homelessness by ensuring healthcare and housing for all. The Council is a membership organization uniting thousands of healthcare professionals, people with lived experience of homelessness, and advocates in homeless healthcare.

Healthy People 2020 highlights the importance of addressing the social determinants of health by including "Create social and physical environments that promote good health for all" as one of the four overarching goals for the decade.

The emphasis is also shared by other U.S. health initiatives such as the National Partnership for Action to End Health Disparities and the National Prevention and Health Promotion Strategy.

Healthy People 2030 has not yet been released but is anticipated to include social determinants of health as a priority which address homelessness and ACEs.

Community Feedback

St. John Sapulpa’s community health needs assessment (CHNA) and implementation strategy are made available to the public via the Ascension website at <https://healthcare.ascension.org/CHNA>. To collect community feedback on the preceding CHNA and implementation strategy, a contact form was embedded on the CHNA Web page. No comments were received.

Conclusion

This report provides detailed, three-year action plans to address the significant health needs that were identified and prioritized through the community health needs assessment process. The plans include goals and specific strategies for each goal, the anticipated impact of our actions, any planned collaboration with other community organizations, and resources the hospital or health system plans to commit to help meet goals and address these health needs.

Our Catholic health ministry is dedicated to spiritually centered, holistic care that sustains and improves the health of not only individuals, but the communities we serve. With special attention to those who are poor and vulnerable, we are advocates for a compassionate and just society through our actions and words. St. John is dedicated to serving patients with compassionate care and medical excellence, making a difference in every life we touch.

Appendix 1: Executive Summary

It's said that home is where the heart is. And the home of Ascension St. John is our community. Since its groundbreaking in 1920, St. John's mission has been to meet the needs of the communities it serves, especially those most vulnerable. To ensure our efforts will have a lasting and meaningful impact, each of St. John's six hospitals conduct a triennial **community health needs assessment** (CHNA). CHNAs help identify the most pressing needs of our communities, build relationships with community partners, and direct resources where they are most needed. Visit

<https://healthcare.ascension.org/chna> to view the St. John Sapulpa (SJS) CHNA.

An **implementation strategy** is a hospital's plan for addressing the most pressing community health needs identified in the CHNA.

The subsequent **implementation strategies** developed as a result of SJS's CHNA will be used by hospital and health

system leaders to understand and communicate the goals, objectives and approaches the hospital will undertake to address the community health needs identified and prioritized through the CHNA process. The implementation strategy is also used by community members to understand the hospital's role in community health.

CHNA Findings

The CHNA findings were drawn from a comprehensive review and analysis of secondary data and primary data, otherwise known as community input. Through the analysis, St. John determined all six hospitals would focus on the following health needs:

-  Behavioral health
-  Access to care
-  Healthy lifestyles
-  Adverse childhood experiences (ACEs)

To capture multiple high-ranking health need categories in the analysis, it was decided that "substance abuse" would be a component of the behavioral health category. The areas of prevention / health behaviors and exercise, nutrition and weight were combined to become "healthy lifestyles," with food insecurity/access and chronic disease as components of this category.

Social determinants of health were deemed an underlying current of all priorities. It was also important that the four chosen priorities correlated strongly with the St. John mission to serve all people, with special attention to those who are most vulnerable.

Implementation Strategy Process

The input of system-wide leadership is vital to the design and completion of an effective implementation strategy.



Accordingly, a steering committee consisting of leadership from the health system, each of the six hospital facilities, Ascension Medical Group, the foundation and other entities was formed to oversee the development of our implementation strategies under the guidance of the community benefit department.

Following finalization of the CHNAs in summer 2019, the steering committee had a high-level discussion of the prioritized health needs based on findings from the reports. Task forces were then formed to

spearhead initiatives for their respective health needs. Task force members include executive co-leads and a variety of associates from throughout the health system with special knowledge of or skills related to the particular health need. The task forces will meet regularly throughout FY 2020-2022 to ensure continuation of work toward goals and report progress on a quarterly basis, and will work with community partners and the community benefit department as appropriate.

FY 2020-2022 Action Plans

Each task force worked together to develop goals, strategies, objectives and indicators to address their respective prioritized health need. To select strategies most likely to succeed, the task forces followed an approach that encompassed the following:

- Understanding of the prioritized health need and its causes
- Identification of a range of possible strategies
- Investigation of evidence-based interventions
- Review of community assets and existing hospital programs and resources
- Consideration of the use of a collective impact framework with the understanding that needs cannot be solved by one organization alone
- Discussion of resource needs, timetables and other implementation logistics



The action plans below reflect how SJS and other Ascension St. John hospitals and entities will work both jointly and independently to address the priority health needs identified by the 2019 CHNAs. Some actions in these plans are specific to this hospital, while other actions are applicable to all six hospitals and other entities.

| PRIORITIZED NEED 1: Access to Care | |
|--|---|
| GOAL 1: Remove barriers of access to healthcare for those living in poverty and/or otherwise deemed vulnerable within our service area. | STRATEGY 1: Work to expand Medicaid to the point that it increases coverage for those most vulnerable in Oklahoma (Medicaid expansion). |
| | STRATEGY 2: Create a welcoming environment by developing and implementing a plan to assist those living in poverty and/or populations otherwise deemed vulnerable as well as their caregivers with navigating our healthcare facilities. |
| GOAL 2: Reduce regional inequity in accessing healthcare providers, services and resources. | STRATEGY 1: Promote awareness of, and access to, health care for underserved populations within communities we serve through Medical Mission at Home (MM@H) events and other opportunities to reach those in need. |

| PRIORITIZED NEED 2: Behavioral Health | |
|---|--|
| GOAL 1: Assess the opportunity for and/or implement intensive outpatient geriatric psychiatric programs, if viable, for seniors 65+ with behavioral health issues in areas of need in northeastern Oklahoma. | STRATEGY 1: Implement intensive outpatient geriatric psychiatric program in Creek County. |

| | |
|---|--|
| <p>GOAL 2: Advance Ascension St. John engagement in community coalitions and collaboratives to promote behavioral health wellness in the communities we serve.</p> | <p>STRATEGY 1: Identify community coalitions and other collaboratives with partnership opportunities to promote behavioral health wellness; encourage health system representation/involvement by associates as deemed appropriate.</p> |
|---|--|

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| PRIORITIZED NEED 3: Healthy Lifestyles |
|---|

| | |
|--|---|
| <p>GOAL 1: Address food insecurity through community collaboration and strengthening of community resources.</p> | <p>STRATEGY 1: Explore collaborative opportunities to develop an initiative(s) to address food insecurity in communities we serve in northeastern Oklahoma. If viable, develop and implement initiative(s).</p> |
| <p>GOAL 2: Reduce the health impact of tobacco use in communities we serve.</p> | <p>STRATEGY 1: Assess opportunities for systematic screening and intervention for patients identified as tobacco users in ambulatory and inpatient settings in communities we serve.</p> <p>STRATEGY 2: Explore opportunities to help identify and work with our associates requesting assistance with tobacco cessation.</p> |
| <p>GOAL 3: Advance St. John engagement in community coalitions and collaboratives to promote healthy lifestyles and chronic disease prevention in the communities we serve.</p> | <p>STRATEGY 1: Identify community coalitions and collaboratives with partnership opportunities to promote healthy lifestyles and chronic disease prevention. Encourage Ascension St. John representation/involvement by associates as deemed appropriate.</p> |

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| PRIORITIZED NEED 4: Adverse Childhood Experiences (ACEs) |
|---|

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| <p>GOAL 1: Combat human trafficking in the communities we serve through efforts to support the needs of human trafficking victims or those at risk of being trafficked in a trauma-informed manner, taking into consideration the correlation between ACEs and human trafficking.</p> | <p>STRATEGY 1: Increase community awareness on the correlation between high ACE scores and human trafficking as well as the impact of ACEs on health outcomes.</p> <p>STRATEGY 2: Advance the Ascension St. John Human Trafficking Education and Response Program to serve victims of human trafficking.</p> |
| <p>GOAL 2: Address and mitigate adverse health outcomes prenatally and birth to 18 years of age in communities we serve.</p> | <p>STRATEGY 1: Expand the Ascension St. John suspected child abuse and neglect committee to include community experts and/or liaisons, as well as hospital representation.</p> <p>STRATEGY 2: Sustain and/or expand current services and partnerships targeting care of pregnant women and children birth to 3 years of age throughout Ascension St. John.</p> |
| <p>GOAL 3: Strengthen Ascension St. John associate awareness of the role of ACEs in health outcomes, as well as to how best to respond to the needs of those most vulnerable.</p> | <p>STRATEGY 1: Partner with community agencies and coalitions to increase St. John associate awareness of the role of ACEs in adverse health outcomes and homelessness and how best to respond to the needs of individuals experiencing or at risk for homelessness through collaborative care coordination and linkage to community resources and support.</p> |

| | |
|---|---|
| <p>GOAL 4: Implement education and assessment tools to raise awareness of the impact of ACEs on Ascension St. John associates and their families in support of the whole person and a model community of engaged associates.</p> | <p>STRATEGY 1: Provide education to Ascension St. John leaders on the prevalence of ACEs, their impact on health and other outcomes, and how to identify risk factors and available resources to support associates who experience or are at risk of adverse outcomes as result of ACEs.</p> |
|---|---|

Appendix 2: Prioritization Toolkit

Prioritization Matrix

The purpose of this exercise is to individually assess then collectively discuss each of the pressing health concerns identified by the St. John Community Engagement team's analysis of data collected through the community health needs assessment (CHNA) process. CHNA data collection strategies included:

- Secondary data from Conduent Healthy Communities Corp.
- Secondary data from the Tulsa Health Department
- An online public survey conducted in collaboration with The University of Oklahoma Anne and Henry Zarrow School of Social Work
- Community focus groups conducted in collaboration with OU Anne and Henry Zarrow School of Social Work
- Community health forums hosted by each hospital facility

Please see the included synthesis charts for overviews of results by hospital. In your assessment of these identified health concerns, you will score and rank them based on the criteria set forth by the Community Engagement team for prioritizing health concerns for St. John Health System. After you have completed the charts below, the group's answers will be discussed and collected.

Instructions

1. In the first chart below, score each identified health concern for how well it meets each criterion (1 = does not meet criterion; 2 = somewhat meets criterion; and 3 = meets criterion). Note that some criteria are weighted, so look for directions to multiply certain scores in the column headers.
2. Add together the scores for each health concern and write the total in the last column.
3. Based on your total scores in the first chart, assign a ranking to each health concern in the second chart below, with the highest score receiving a ranking of 1. If you have tied scores, break the tie by personally assigning rank as you see best fit.

| Health need | Alignment w/ St. John mission (weighted x2) | Alignment w/ community priorities (weighted x3) | Existing programs, resources at SJHS, hospital | Opportunities for partnership (weighted x2) | Solution could impact multiple problems | TOTAL |
|---|---|--|---|---|---|-------|
| Behavioral health | | | | | | |
| Exercise/nutrition/weight | | | | | | |
| Prevention/health behaviors | | | | | | |
| Access to care | | | | | | |
| Chronic disease (esp. cancer) | | | | | | |
| Adverse childhood experiences (ACEs) | | | | | | |
| Food access/security | | | | | | |
| Safe environment | | | | | | |
| Substance abuse | | | | | | |
| Optional fill-in (circle one): - Socioeconomic status - Immunizations and infectious diseases - Lack of health education - Maternal/fetal/infant health | | | | | | |

| Health topics (listed in order of data frequency) | Rank (1-9 or 1-10) |
|---|--------------------|
| Behavioral health | |
| Exercise/nutrition/weight | |
| Prevention/health behaviors | |
| Access to care | |
| Chronic disease (esp. cancer) | |
| Adverse childhood experiences (ACEs) | |
| Food access/security | |
| Safe environment | |
| Substance abuse | |
| Optional fill-in (circle one): - Socioeconomic status - Immunizations and infectious diseases - Lack of health education - Maternal/fetal/infant health | |

Please note that "social determinants of health" may be an underlying current for any health concern selected to be a health system priority.

Appendix 3: Board Resolutions

RESOLUTIONS OF THE BOARD OF DIRECTORS OF ST. JOHN SAPULPA, INC.

The Board of Directors of St. John Sapulpa, Inc. (“Corporation” or “Hospital”) adopts the following resolutions at a meeting duly held on October 17, 2019, at which a quorum of Directors was present.

RECITALS

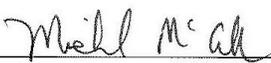
- A. Section 501(r) of the Internal Revenue Code and the regulations promulgated hereunder (collectively, “501(r)”) imposes certain requirements on 501(c)(3) “hospital organizations” and “hospital facilities” (as those terms are defined in 501(r)). Each hospital facility is required, among other things, to conduct a community health needs assessment (“CHNA”) and adopt an implementation strategy (“IS”) to meet the identified health needs at least once every three (3) tax years.
- B. Pursuant to 501(r), Hospital conducted a CHNA for the community the Hospital serves, which the Board of Directors approved at its meeting on April 18, 2019.
- C. Pursuant to 501(r), Hospital prepared an IS to meet the community health needs identified through the CHNA (each a “health need”) that, with respect to each significant health need, either (1) describes how the Hospital plans to address the health need, or (2) identifies the health need as one the Hospital does not intend to address and explains the reason(s) for that determination.
- D. The Hospital’s IS report is attached as Exhibit A.
- E. 501(r) requires that the Corporation’s Board of Directors adopt the IS.

NOW, THEREFORE, in consideration of the foregoing:

BE IT RESOLVED that the Board of Directors of Corporation hereby approves and adopts the IS that meets the community health needs identified in the CHNA for Corporation, attached as Exhibit A.

BE IT FURTHER RESOLVED that the officers and management of the Corporation be, and they hereby are authorized and directed to take such other actions necessary or advisable to effect the IS in accordance with 501(r).

The above resolutions are adopted this 17th day of October, 2019, and made effective as of the same day.



Secretary

**UNANIMOUS CONSENT IN LIEU OF MEETING
OF THE BOARD OF DIRECTORS
OF ST. JOHN HEALTH SYSTEM, INC.**

The undersigned, being all of the members of the Board of Directors of St. John Health System, Inc., an Oklahoma corporation (the "Corporation"), in lieu of holding a special meeting of the Board of Directors of the Corporation, do hereby take the following actions and adopt the following resolutions by written consent pursuant to Section 1027 of the Oklahoma General Corporation Act and the Bylaws of the Corporation:

RECITALS

- A. Section 501(r) of the Internal Revenue Code and the regulations promulgated hereunder (collectively, "501(r)") imposes certain requirements on 501(c)(3) "hospital organizations" and "hospital facilities" (as those terms are defined in 501(r)). Each hospital facility is required, among other things, to conduct a community health needs assessment ("CHNA") and adopt an implementation strategy ("IS") to meet the identified health needs at least once every three (3) tax years.
- B. Pursuant to 501(r), Hospital conducted a CHNA for the community the Hospital serves, which the Board of Directors approved at its meeting on May 15, 2019.
- C. Pursuant to 501(r), Hospital prepared an IS to meet the community health needs identified through the CHNA (each a "health need") that, with respect to each significant health need, either (1) describes how the Hospital plans to address the health need, or (2) identifies the health need as one the Hospital does not intend to address and explains the reason(s) for that determination.
- D. The Hospital's IS report is attached as Exhibit A.
- E. 501(r) requires that the Corporation's Board of Directors adopt the IS.

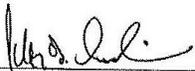
NOW, THEREFORE, in consideration of the foregoing:

BE IT RESOLVED that the Board of Directors of Corporation hereby approves and adopts the IS that meets the community health needs identified in the CHNA for Corporation, attached as Exhibit A.

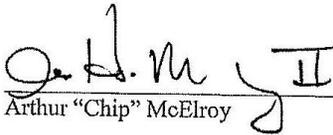
BE IT FURTHER RESOLVED that the officers and management of the Corporation be, and they hereby are authorized and directed to take such other actions necessary or advisable to effect the IS in accordance with 501(r).

The action taken by this consent shall have the same force and effect as if taken by the undersigned at a special meeting of the Board of Directors of the Corporation, duly called and constituted pursuant to the Bylaws of the Corporation and the laws of the State of Oklahoma.

IN WITNESS WHEREOF, each of the undersigned has executed this Consent as of the
23 day of October, 2019.



Jeff Nowlin, CEO



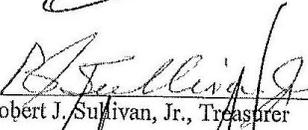
Arthur "Chip" McElroy



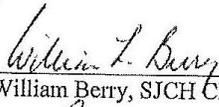
David Sigmon, Chair



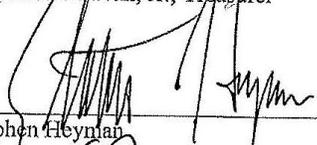
Joseph Moran, III, SJMC Chair



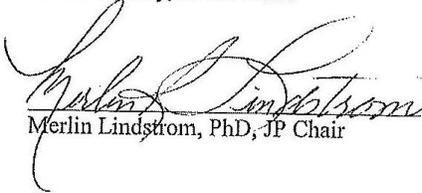
Robert J. Sullivan, Jr., Treasurer



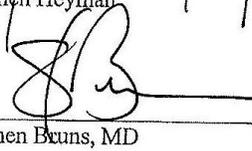
William Berry, SJCH Chair



Stephen Heyman



Merlin Lindstrom, PhD, JP Chair



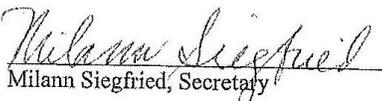
Stephen Bruns, MD



Robert Farris, Vice Chair



Jeff Sanders



Milann Siegfried, Secretary