Ascension St. John Sapulpa

2024 Community Health Needs Assessment
Creek County, Oklahoma

Conducted July 1, 2024, to June 30, 2025

Ascension

The goal of this report is to offer a meaningful understanding of the most significant health needs across Creek County, with emphasis on identifying any barriers to health equity for all people, as well as to inform planning efforts to respond to those needs. Special attention has been given to the needs of individuals and populations who are at increased risk for poor health outcomes or experiencing social factors that place them at risk. Findings from this report can be used to identify, develop, and focus hospital, health system, and community initiatives and programming to better serve the health and wellness needs of the community.

St. John Sapulpa Inc. (dba Ascension St. John Sapulpa)
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https://healthcare.ascension.org/locations/oklahoma/oktul/sapulpa-ascension-st-john-sapulpa
918-224-4280
Hospital EIN: 73-0662663

The 2024 Community Health Needs Assessment was approved by the Community Hospital Board of Directors on April 17, 2025 (2024 tax year), and applies to the following three-year cycle: July 2025 to June 2028. This report, as well as the previous report, can be found on our public website: **https://healthcare.ascension.org/chna**.

We value the community's voice and welcome feedback on this report. Please visit our public website to submit your comments.

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Executive Statement

The 2024 Community Health Needs Assessment (CHNA) represents a true collaborative effort to gain a meaningful understanding of the most pressing health needs across Creek County. Ascension St. John Sapulpa is exceedingly thankful to the many community organizations and individuals who shared their views, knowledge, expertise, and skills with us. In particular, we would like to recognize the editors and consultants of this report:

Editors

Ascension St. John

- Kimberly Will, MPH
- Wendy Frankenburger, MPH, CPH, CHES

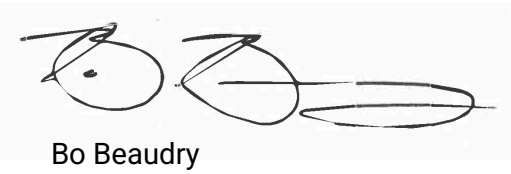
Consultants

University of Oklahoma Hudson College of Public Health

- Halley Reeves, MPH, MCP
- Rahma Osman, MHA, PMP
- Gabrielle Westbrook, MPH
- Neil Hann, MPH, CHES

A complete description of community partner contributions is included in this report. We look forward to our continued collaborative work to promote a healthier, more equitable place to live, work, and play.

We would also like to thank you for reading this report, and your interest and commitment to improving the health and well-being of Creek County.



Bo Beaudry
Ministry Market CEO
Ascension St. John

Mike Christian
President
Ascension St. John Sapulpa

Executive Summary

The goal of the 2024 Community Health Needs Assessment (CHNA) is to offer a meaningful understanding of the most significant health needs across Creek County. Findings from this report can be used to identify, develop, and focus hospital, health system, and community initiatives and programming to better serve the health and wellness needs of the community.

Purpose of the CHNA

Pursuant to the Patient Protection and Affordable Care Act of 2010, all not-for-profit hospitals are required to conduct a CHNA and adopt an implementation strategy every three years. The purpose of the CHNA is to understand the health needs and priorities of the community served by the hospital, with emphasis on identifying any barriers to health equity. The goal is to respond to those needs through the development of an implementation strategy plan.

Community Served

Although Ascension St. John Sapulpa serves eastern Oklahoma and southeastern Kansas, the hospital has defined its community served as Creek County for the 2024 CHNA. Creek County was selected because it is our primary service area as well as our partners' primary service area. Additionally, community health data is readily available at the county level.

Data Analysis Methodology

The 2024 CHNA was conducted from July 2024 to June 2025 and utilized the County Health Rankings & Roadmaps model developed by the University of Wisconsin Population Health Institute and Robert Wood Johnson Foundation, which utilizes a social determinants of health framework for community health improvement. The process incorporated data from both primary and secondary sources. A community-wide, 40-question survey and two key informant engagement sessions were conducted to obtain community input from across Creek County. Community input sources included information provided by groups/individuals, e.g., community members, healthcare consumers, healthcare professionals, relevant groups, and multi-sector representatives. Special attention was given to the needs of individuals and populations who are more marginalized and to unmet health needs or gaps in services. Secondary data was compiled and reviewed to understand the health status of the community. Gathered from reputable and reliable sources, measures reviewed included chronic disease outcomes, social and economic factors, and healthcare access and utilization trends in the community.

Community Needs

Ascension St. John Sapulpa, with contracted assistance from the University of Oklahoma Hudson College of Public Health, analyzed secondary data of more than 50 indicators and gathered community input through key informant engagement sessions and a survey of the broader community to identify the needs of the Creek County. In collaboration with community partners, Ascension St. John Sapulpa used a phased prioritization approach to determine the most crucial needs for relevant groups to address. The significant needs are as follows:

- Mental and behavioral health
- Housing
- Transportation
- Access to care
- Food security
- Income (i.e., ability to afford basic needs)
- Employment

Next Steps and Conclusion

The 2024 CHNA was presented to the Community Hospital Board of Directors for approval and adoption on April 17, 2025. Following the assessment, Ascension St. John Sapulpa, in collaboration with the Mission Committee of the Ascension St. John board of directors, selected the prioritized needs outlined below for its 2024 CHNA Implementation Strategy. The implementation strategy will describe how the hospital intends to respond to these prioritized needs throughout the same three-year CHNA cycle: July 2025 to June 2028.

- Access to care
- Mental and behavioral health
- Food security
- Housing

Ascension St. John Sapulpa hopes this report offers a meaningful and comprehensive understanding of the most significant needs of Creek County. The hospital values the community's voice and welcomes feedback on this report; comments or questions can be submitted via Ascension's public website (https://healthcare.ascension.org/chna).

About Ascension

As one of the leading nonprofit and Catholic health systems in the United States, Ascension is committed to delivering compassionate, personalized care to all, with special attention to individuals and communities who are at increased risk for poor health outcomes.

Ascension

Ascension is a faith-based healthcare organization dedicated to transformation through innovation across the continuum of care. The national health system includes approximately 131,000 associates, 136 hospitals, and 37,000 affiliated providers, serving communities in 18 states and the District of Columbia. In fiscal year 2024, Ascension provided $2.1 billion in care of persons living in poverty and other community benefit programs.

Ascension's Mission provides a strong framework and guidance for the work done to meet the needs of communities across the U.S. It is foundational to transform health care and express priorities when providing care and services, particularly to those most in need.

> **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.

For more information about Ascension, visit https://www.ascension.org.

Ascension St. John

Serving eastern Oklahoma and southeastern Kansas for nearly a century, Ascension St. John operates six hospitals and more than 80 healthcare clinics and facilities that together employ around 6,000 associates. In fiscal year 2024, Ascension St. John provided more than $66.5 million in total community benefit, which includes care for persons living in poverty.

On Valentine's Day in 1926, Lillian Patricia Brown was born at a 50-bed hospital in Tulsa that was newly constructed but not yet opened. Just six days later, the Sisters of Sorrowful Mother officially opened the doors to St. John's Hospital (now Ascension St. John Medical Center), beginning our legacy.

Ascension St. John Sapulpa

As a Ministry of the Catholic Church, Ascension St. John Sapulpa is a nonprofit hospital governed by a local board of trustees represented by community members, medical staff, and sister sponsorships. With one hospital campus, Ascension St. John Sapulpa has been providing care to Creek County for more than 28 years.

Ascension St. John Sapulpa is a two-story, 25-bed facility located in the city of Sapulpa, Okla. The facility joined the health system in 1997 with the acquisition of Bartlett Memorial Hospital and was renamed in 2000. Designated as a critical access hospital, Ascension St. John Sapulpa 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. Services include primary care, heart and vascular health, wound care, general surgery, rehabilitation, lab services, and imaging. In addition, the hospital 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 home or to a long-term care facility and to help rehabilitate patients from an illness, accident or surgery. Ascension St. John Sapulpa serves the behavioral health needs of those 65 and older through a group counseling service known as Senior Life Solutions.

Ascension St. John Sapulpa continues the long and valued tradition of responding to the health needs of the people in our community, following in the footsteps of our legacy sponsor, the Sisters of the Sorrowful Mother. For more information about Ascension St. John Sapulpa, visit https://healthcare.ascension.org/locations/oklahoma/oktul/sapulpa-ascension-st-john-sapulpa.

About the Community Health Needs Assessment

A community health needs assessment is essential for community building, health improvement efforts, and directing resources where they are most needed. CHNAs can be powerful tools with the potential to be catalysts for immense community change.

Purpose of the CHNA

A CHNA is defined as "a systematic process involving the community that identifies and analyzes community health needs and assets to plan and act upon priority community health needs."[1] The process serves as a foundation for promoting the health and well-being of the community by identifying the most pressing needs, leveraging existing assets and resources, developing strategic plans, and mobilizing hospital programs and community partners to work together. This community-driven approach aligns with Ascension St. John Sapulpa's commitment to offer programs designed to respond to the health needs of a community, with special attention to persons who are medically underserved and at risk for poorer health outcomes because of social factors that put them at increased risk.

Advancing Health Equity

Health equity is the state in which everyone has a fair and just opportunity to attain their highest level of health.[2] Progress toward achieving health equity can be measured by reducing health disparities. Health disparities are particular health differences closely linked with economic, social, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced such obstacles to health based on their race or ethnicity; religion; socioeconomic status; gender identity; sexual orientation; age; cognitive, sensory, or physical disability; geographic location; or other characteristics historically linked to discrimination or exclusion.[3]

Focusing on the root causes that have perpetuated these differences contributes to the advancement of health equity. By identifying the conditions, practices, and policies that perpetuate differences in health outcomes, we can better respond to root causes when pursuing health equity.

Ascension acknowledges that health disparities in our communities go beyond individual health behaviors. Ascension's Mission calls us to be "advocates for a compassionate and just society through our actions and words"; therefore, health equity is a matter of great importance to Ascension.

[1] Catholic Health Association of the United States. (2022). *A guide for planning and reporting community benefit*. https://tinyurl.com/bdcsub64
[2] National Center for Chronic Disease Prevention and Health Promotion. (2023, January 4). *Advancing health equity in chronic disease prevention and management*. Centers for Disease Control and Prevention. https://www.cdc.gov/chronicdisease/healthequity/index.htm
[3] Braveman, P. (2014). What are health disparities and health equity? We need to be clear. *Public Health Reports*, *129*(Suppl 2), 5–8. https://doi.org/10.1177/00333549141291S203

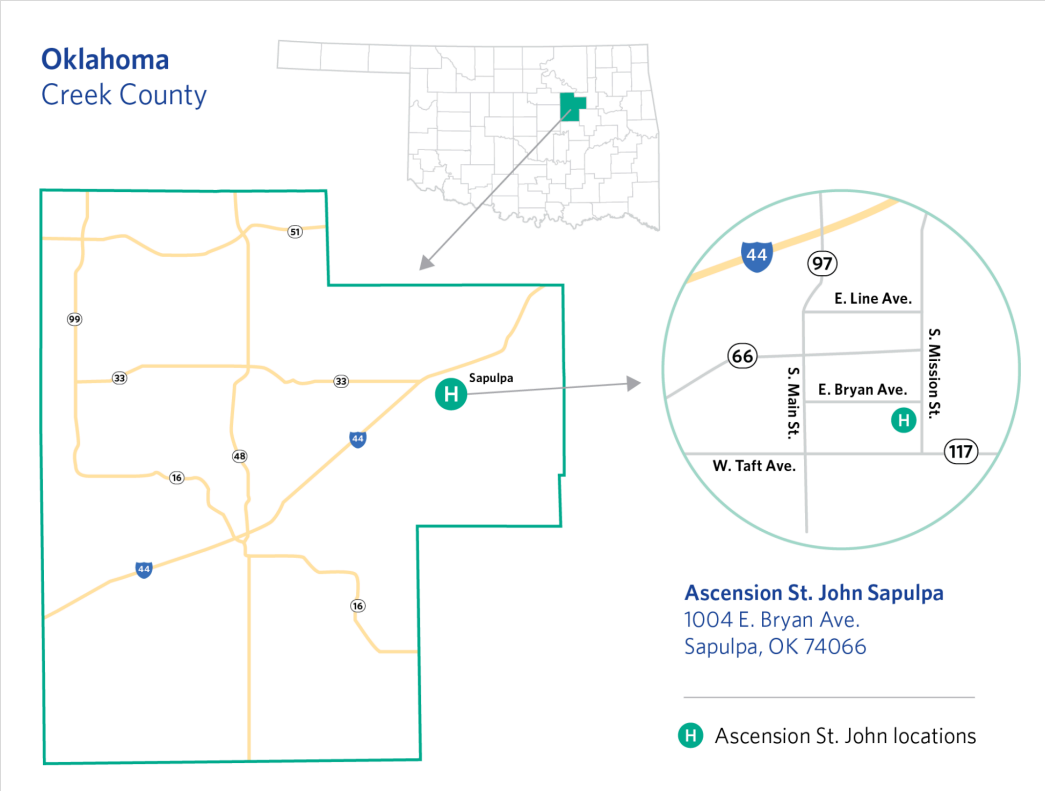
IRS 501(r)(3) and Form 990 Schedule H Compliance

The CHNA also serves to satisfy certain requirements of tax reporting, pursuant to provisions of the Patient Protection and Affordable Care Act of 2010, more commonly known as the Affordable Care Act (ACA). As part of the ACA, all not-for-profit hospitals are required to conduct a CHNA and adopt an implementation strategy every three years. Requirements for 501(c)(3) hospitals under the ACA are described in Code Section 501(r)(3), and include making both current and previous CHNA and implementation strategy reports widely available to the public. In accordance with this requirement, electronic versions of these reports can be accessed at https://healthcare.ascension.org/CHNA, and paper versions can be requested at Ascension St. John Sapulpa administration office by calling 918-227-8601 or from the health system's Mission Integration office by calling 918-744-2504.

Community Served and Demographics

Community Served

For the purpose of the 2024 CHNA, Ascension St. John Sapulpa has defined its community served as Creek County. Although Ascension St. John Sapulpa serves eastern Oklahoma and southeastern Kansas, the "community served" was defined as such because (a) most of our service area is in each county; (b) most of our assessment partners define their service area at the county level; and (c) most community health data is available at the county level.



Creek County is located in northeastern Oklahoma and is part of the Tulsa-Broken Arrow-Owasso Metropolitan Statistical Area. The county seat and the largest city in Creek County is Sapulpa. Other significant towns include Bristow, Mannford, and Drumright. According to the U.S. Census Bureau, Creek County grew by 2.6 percent from 2010 to 2020. The largest industries in the county include manufacturing, retail, healthcare and social assistance. Some of Creek County's top employers are the City of Sapulpa, Muscogee Creek Nation, Ardagh Group, and SeneGence.

Sources: DataUSA, SapulpaOK.gov

Demographic Data

Located in Northeast Oklahoma, Creek County has a population of 72,699 and is the 10th largest county by area in the state. Below are demographic data highlights for Creek County:

- 18.5 percent of the community members of Creek are 65 or older, compared to 16.4 percent in Oklahoma
- 76.2 percent of community members are non-Hispanic; 5.4 percent are Hispanic or Latino (any race)
- 74.0 percent of community members are non-Hispanic white; .8 percent are Asian; 11 percent are American Indian or Alaska Native, and 2.2 percent are non-Hispanic Black or African American
- The total population increase from 2020 to 2023 was 2.2 percent, The percentage of people identifying as Hispanic or Latinx in Creek County in 2020 has increased from 2010
- The median household income is below the state median income $57,500 for Creek; $59,600 for Oklahoma)
- The percent of all ages of people in poverty was lower than the state (14.7 percent for Creek; 15.9 percent for Oklahoma)
- The uninsured rate for Creek County is higher than the state 13.0 percent for Creek County; 11.4 percent for Oklahoma)

Demographic Highlights			
Population			
Indicator	**Creek**	**Oklahoma**	**Description**
Percentage living in rural communities	62.5%	35.4%	N/A
Percentage below 18 years of age	23%	23.7%	N/A
Percentage 65 years of age and over	18.5%	16.4%	N/A
Percentage Asian	0.8%	2.6%	N/A
Percentage American Indian or Alaska Native	11%	9.5%	N/A
Percentage Hispanic	5.4%	12.1%	N/A
Percentage non-Hispanic Black	2.2%	7.5%	N/A
Percentage non-Hispanic White	74%	63.4%	N/A

Social and Community Context			
English proficiency	1%	2%	Proportion of community members who speak English “less than well”
Median household income	$57,500	$59,600	Income level at which half of households in a county earn more and half of households earn less
Percentage of children in poverty	19%	20%	Percentage of people under age 18 in poverty
Percentage of uninsured	13%	21%	Percentage of population under age 65 without health insurance
Percentage of educational attainment	90.%	89%	Percentage of adults ages 25 and over with a high school diploma or equivalent
Percentage of unemployment	3.5%	3%	Percentage of population ages 16 and older unemployed but seeking work

Sources: County Health Rankings & Roadmaps. (2024). Health outcomes and factors. https://www.countyhealthrankings.org/health-data/oklahoma

U.S. Census Bureau. (2023). QuickFacts. https://www.census.gov/quickfacts

To view community demographic data in their entirety, see Appendix B (Page 45).

Process and Methods Used

Consultant

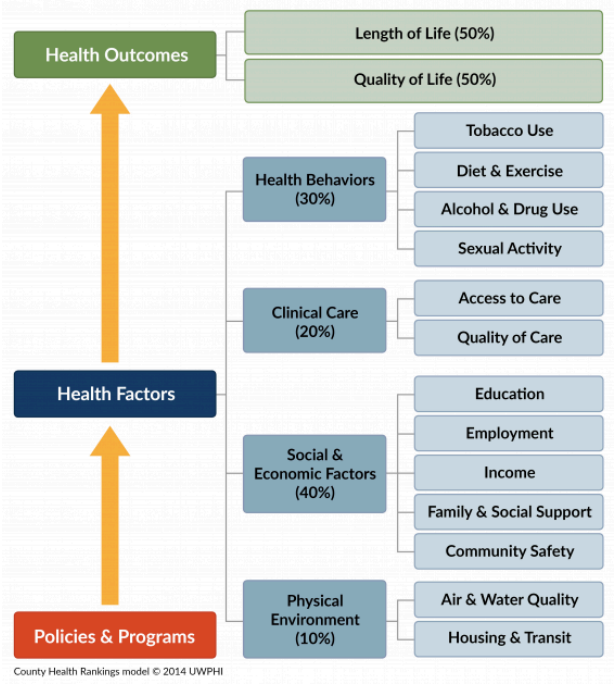
Ascension St. John Sapulpa completed its 2024 CHNA with the contracted assistance of the **University of Oklahoma (OU) Hudson College of Public Health**.

The OU Hudson College of Public Health works collaboratively with community organizations, tribal communities, nonprofits, and health departments to advance public health outcomes across Oklahoma. These efforts encompass a wide range of initiatives, including conducting CHNAs for health systems and organizations statewide, fostering community partnerships and driving innovative research to address critical health challenges.

Additionally, Ascension St. John Sapulpa conducted its CHNA alongside **Ascension St. John Medical Center**, **Ascension St. John Owasso**, **Ascension St. John Broken Arrow**, **Ascension St. John Jane Phillips**, and **Ascension St. John Nowata**, sharing a unified vision and coordinated approach to resources, data collection, and prioritization.

Data Collection Methodology

Ascension St. John Sapulpa is committed to using national best practices in conducting the CHNA. In collaboration with various community partners, Ascension St. John Sapulpa's approach followed the County Health Rankings & Roadmaps (CHRR) model developed by CHRR and the Robert Wood Johnson Foundation, utilizing a social determinants of health (SDoH) framework for community health improvement, as studies estimate that clinical care impacts only 20 percent of health outcomes. The model emphasizes the various factors that influence how long and how well the residents of a community live. According to CHRR, the set of secondary data measures helps communities understand how healthy their residents are today (health outcomes) and what will impact their health in the future (health factors).



Ascension St. John Sapulpa employed a mixed-methods approach to identify community needs. Grounded in the SDoH framework, the assessment aimed to understand the underlying factors influencing health outcomes in Creek County and begin to identify areas to intervene. Key components included a community survey with a broad

range of questions designed to capture residents' experiences, concerns, and priorities, and direction was provided by a community advisory board throughout the process.

Additionally, key informant engagement sessions were facilitated to gather qualitative insights directly from community leaders and local organizations. Secondary data analysis was conducted to complement these findings, providing a fuller view of existing resources and gaps in Creek County. This integrated approach ensured a thorough understanding of both the needs and assets within the community.

Summary of Community Input

Community input, also referred to as "primary data," is an integral part of a community health needs assessment (CHNA) and is meant to reflect the voice of the community. This input is invaluable for efforts to accurately assess a community's health needs. A concerted effort was made to ensure that the individuals and organizations represented the needs and perspectives of 1) public health practice and research; 2) individuals who are medically underserved, low-income, or considered among the minority populations served by the hospital; and 3) the broader community at large and those who represent the broad interests and needs of the community served.

Multiple methods were used to gather community input, including a community survey and key informant engagement sessions. These methods provided additional perspectives on selecting and responding to top health issues facing Creek County. A summary of the process and results is outlined below.

Community Survey

A community-wide survey consisting of 40 questions was conducted to better understand perceptions, thoughts, experiences, and concerns of the community regarding social determinants of health (SDoH) and health behaviors for Creek County. The questions were derived from reliable sources such as the U.S. Census Bureau and structured using an SDoH framework. The survey also incorporated elements from the PRAPARE (Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences) screening tool, a nationally recognized instrument designed to assess social risk factors impacting health outcomes. By integrating these validated measures, the survey aimed to capture a comprehensive picture of the community's needs and inform targeted interventions.

To enhance accessibility, the survey was made available in English, Spanish, and Burmese. As a result, the questions were primarily multiple-choice rather than open-ended, enabling consistent responses across languages.

The survey was piloted with community members to ensure clarity, relevance, and ease of understanding before distribution. It was disseminated over a period of nine weeks, from September to November 2024, through digital QR codes on flyers and randomized mailings to various zip codes in Creek County. To reach individuals who are medically underserved, have low income, or are in a minority group, extensive efforts were made to promote the survey and distribute flyers among local nonprofits and other community-based organizations serving target populations (e.g., food banks, community centers, and public schools).

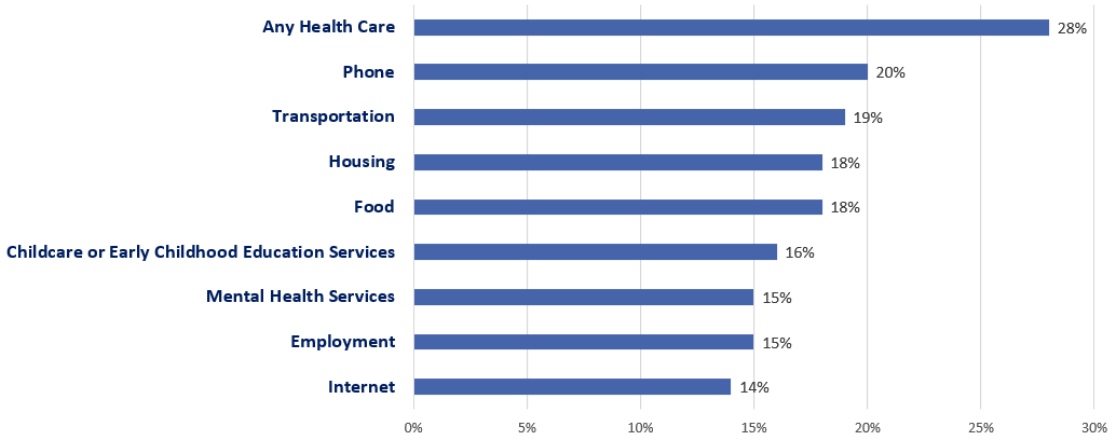
In total, 275 surveys were completed. A completed survey was defined as at least half of the survey questions answered. There were 32 surveys completed through the mailed survey to random addresses, and there were 243 completed through engagement of relevant groups.

Upon collection, the data were analyzed and visualized in graphics to clearly reflect the findings and highlight key insights. These findings are reflected in the pages dedicated to the significant needs, which can be found further along in the document. A copy of the survey questions is included in Appendix C for reference.

Community Survey

Key Summary Points

- The survey explored respondents' barriers in accessing integral services and supports to achieve a standard quality of life. One of the first questions of the survey asked whether the respondent or anyone in their family, in the past year, experienced barriers to any integral services (e.g., healthcare). Below is Creek County population-adjusted output for those who responded yes to that question:



- Of the survey respondents, 59 percent noted they had varying degrees of difficulty paying for basic needs, including food, housing, clothing, medical care, and/or utilities over the past year.

Populations Represented

- Because the survey was completed by 275 respondents, data was unable to be normalized to the U.S. Census Bureau population estimates. Despite that analytic capacity, the assessment team attempted to collect a representative sample. Where data was available, demographics of the survey respondents were compared with the Census demographics for Creek County.
- **Sex:** When asked what sex was assigned at birth, 85 percent of the survey respondents answered "female," while the other 15 percent answered "male." The county breakdown is 50.4 percent and 49.6 percent, respectively.
- **Ethnicity:** When asked whether the respondents were of Hispanic, Latino, or Spanish origin, 94 percent noted they were not, while 2.8 percent said they were Mexican, Mexican American, or Chicano; 2 percent were Puerto Rican; 0 percent were Cuban; and 1.2 percent were another Hispanic, Latino, or Spanish origin.
- **Race:** The survey captured a far greater volume of races compared with the Census. The majority of respondents identified as white (80 percent, compared with the 76.1-percent Census estimate for Creek County[4]), Black or African American (3.3 percent, compared with 2.1 percent), and American Indian or Alaska Native (19 percent, compared with 11.4 percent).
- **Age:** In general, the survey sampled middle-aged and older populations while under-sampling younger populations.

Key Informant Engagement Sessions

Two key informant engagement sessions were held in Creek County to provide opportunities for the community to come together and participate in a dialogue about the pressing needs and issues faced in Creek County. These sessions were facilitated by the OU Hudson College of Public Health and included leaders from various community organizations and representatives of vulnerable populations.

The first session took place in October 2024, and the second took place in December 2024. In total, 13 individuals participated. Participants were guided through a group activity regarding social determinants of health (SDoH) root causes. Once completed as a larger group, individual participants were asked to select a priority area they deemed important for Creek County, describe how this area represents a critical need, and provide examples from their own experiences. A list of organizations represented at the engagement sessions can be found in Appendix C, along with a list of agenda topics and activities.

The qualitative input gathered from these meetings was transcribed, and key themes and priorities were identified using the Framework method[5]. This systematic approach for managing and analyzing qualitative data consists of five key stages: familiarization, identifying a thematic framework, indexing, charting, mapping, and interpretation. Relevant quotes were also summarized to capture participants' perspectives on the priority areas. The findings are further detailed in the table on the following page.

[4] U.S. Census Bureau. (2023). *American Community Survey 5-year data (2009-2023)*.

[5] Gale, N. K., Heath, G., Cameron, E., Rashid, S., & Redwood, S. (2013). Using the framework method for the analysis of qualitative data in multi-disciplinary health research. *BMC Medical Research Methodology, 13*(1), 117. https://doi.org/10.1186/1471-2288-13-117

Ritchie, J., & Spencer, L. (1994). Qualitative data analysis for applied policy research. In A. Bryman & R. G. Burgess (Eds.), *Analysing Qualitative Data* (pp. 173-194). Routledge. https://doi.org/10.4135/9781412986274.n12

Key Informant Engagement Sessions	
Key Summary Points	**Organizations/Sectors Represented**

• **Social determinants of health (SDoHs):** SDoHs are factors that influence health outcomes and are oftentimes at the roots of the leading causes of death in Oklahoma.
• **Access to care:** Residents expressed concerns about the lack of healthcare providers, barriers to accessing care, limited healthcare access, and shortages reducing the availability of care.
• **Housing:** Homelessness in Creek County is a growing concern, often linked to a lack of affordable housing. Housing issues are further compounded by poorly maintained properties and exploitative practices by landlords, making it difficult for residents to secure safe and stable living conditions.
• **Mental and behavioral health:** Community members highlighted the growing psychiatric population, driven by a lack of access to outpatient care and necessary medications.
• **Substance misuse:** The county also faces challenges related to mental health issues and substance misuse among the unhoused population.
• **Transportation:** Public transit infrastructure is poor, limiting residents' mobility to connecting towns and access to resources.
• **Food security:** Rising food costs have placed additional financial strain on families. Many struggle to provide meals. Unreliable transportation and limited proximity to food pantries make accessing food assistance more difficult.
	• Organizations serving:
	  ○ Unhoused individuals
	  ○ Individuals below or near the FPL
	  ○ Black and African American individuals
	  ○ Native American individuals
	  ○ Hispanic/Latino and Spanish-speaking individuals
	  ○ LBGTQ+ individuals
	  ○ Veterans
	  ○ Individuals with disabilities
	• Public health
	• Healthcare
	• Tribal healthcare
	• Education

Meaningful Quotes	
• "[There is a] rise in un-homed on the streets, under bridges in the CR." • "The City of Sapulpa has 250 employees, yet only one-third of them live in Sapulpa, stating they can't afford the new developments." • "Creek County does not have good ways to get from one town to the next unless you own a car." • "Housing is mainly rental properties. [There is a] lack of newer neighborhoods to encourage home ownership."	

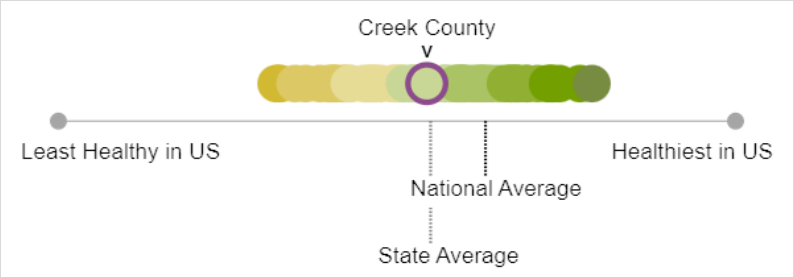
To view additional information from these community input methods, see Appendix C (Page 48).

Summary of Secondary Data

Secondary data are data that have already been collected and published by another party. Both governmental and non-governmental agencies routinely collect secondary data reflective of the population's health status at the state and county levels through surveys and surveillance systems. Secondary data for this report was compiled from various reputable and reliable sources.

Health indicators in the following categories were reviewed:

- Health outcomes
- Physical environment
- Clinical care
- Social determinants of health
- Disparities



Source: County Health Rankings & Roadmaps

Secondary data for Creek County were collected and analyzed primarily from County Health Rankings & Roadmaps reports, and several key insights were revealed. For example, 17 percent of adults under the age of 65 are uninsured, which is equal to the state average but significantly higher than the national average.[6] This highlights the opportunity for targeted outreach and healthcare access programs. Similarly, Creek County faces higher absolute unemployment rates relative to their smaller labor forces, emphasizing economic disparities that could benefit from workforce development initiatives. Transportation data reveals a heavy reliance on personal vehicles, with Creek County reporting up to 83 percent of residents driving alone.[6] This dependency highlights the need for improved public transportation options, particularly for vulnerable populations such as Black[7] and American Indian residents. These observations demonstrate that addressing disparities in health, employment, and infrastructure across the county could improve overall community well-being.

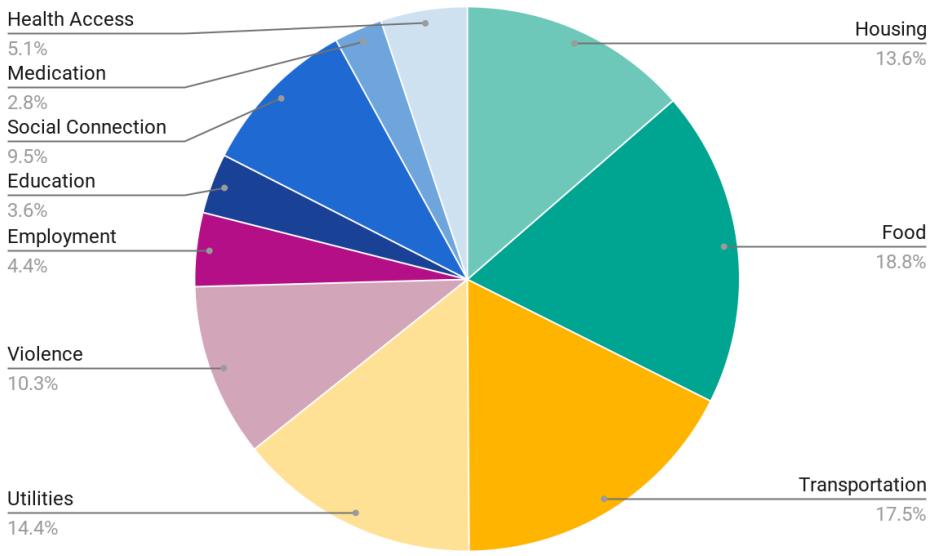
From a social perspective, Creek County faces challenges in community integration across various platforms. For example, 10 percent of youth are disconnected,[6] neither in school nor employed. Additionally, voter turnout in Creek County is 56.8 percent, slightly higher than the state average but lower than the national average,[6] reflecting a moderate level of community engagement. These challenges contribute to social fragmentation, which can exacerbate mental health issues as individuals may feel isolated from their community. Furthermore, Creek County's firearm fatalities rate is 20 per 100,000, significantly higher than the national average, and there were 19 suicide deaths per 100,000 in the county.[6] These indicators emphasize the urgent need for enhanced community engagement and mental health support to address underlying issues.

Additionally, the assessment team took into account the de-identified social determinant of health (SDoH) screening responses by Ascension St. John's patient population at Creek County clinics and facilities for calendar year 2024, considering the patient population is representative of the community served. In Ascension's 10-question SDoH screening, which is administered in person, the three questions that received the most positive responses were:

- "In the last 12 months did you ever eat less than you felt you should because there wasn't enough money for food?"
- "In the last 12 months, have you ever had to go without healthcare because you didn't have a way to get there?"

[6] County Health Rankings & Roadmaps. (2024). *Creek, OK*. https://www.countyhealthrankings.org/health-data/oklahoma/creek?year=2024
[7] Blumenberg, E., Brown, A., & Schouten, A. (2020). Car-deficit households: determinants and implications for household travel in the US. *Transportation, 47*, 1103–1125. https://doi.org/10.1007/S11116-018-9956-6

- "In the past 12 months, has the electric, gas, oil or water company threatened to shut off services in your home?"



To view the secondary data and sources in their entirety, see Appendix D (Page 54).

Written Comments on Previous CHNA and Implementation Strategy

Ascension St. John Sapulpa's previous CHNA and implementation strategy were made available to the public and open for public comment via the website: https://healthcare.ascension.org/chna. The following comments were received:

- "Thank you for this report. It has so much valuable data. I've passed this along to our team."
- "This report is invaluable. I am so glad that the information is public. Thank you for sharing."

Data Limitations and Information Gaps

Although it is quite comprehensive, this assessment cannot measure all possible aspects of health and cannot represent every possible population within Creek County. This constraint limits the ability to assess all the community's needs fully.

For this assessment, three types of limitations were identified:

- **Representation of vulnerable populations:** Some groups of individuals may not have been adequately represented through the community input process. These groups may include those who are transient; speak a language other than English, Spanish, or Burmese; or identify as members of underserved or marginalized communities, such as Indigenous populations or LGBTQ+ individuals. This lack of representation may lead to gaps in understanding the unique needs of these populations across rural counties like Creek County.

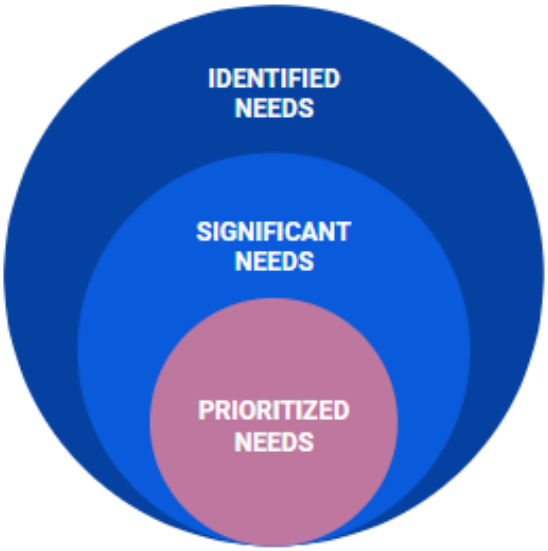
- **Limitations of secondary data:** Secondary data remains constrained in several ways, including timeliness, geographical granularity, and the ability to capture the nuances of rural communities. While county-level data provides an overview, disparities within the county — between more populous centers like Sapulpa and rural regions — may not be fully captured. Additionally, much of the data relies on older surveys such as the Behavioral Risk Factor Surveillance System (BRFSS) or American Community Survey, which may not reflect the most current socioeconomic conditions or healthcare access challenges as of 2024.
- **Impact of acute community concerns:** An "acute community concern" is defined by Ascension as an event or situation that may be severe and sudden in onset or newly affects a community. Such an event or situation may impact the ability to collect community input, may not be captured in secondary data, and/or can present in the middle of the three-year CHNA cycle. For the 2024 CHNA, the following acute community concerns were identified, reflecting the evolving needs and challenges of the region:
    - Lingering negative effects of the COVID-19 pandemic, particularly in more rural parts of the county with limited healthcare resources.
    - Continued economic instability and high inflation, disproportionately impacting lower-income households across the county.
    - Increasing confusion and barriers to accessing Medicaid under recent expansion efforts in Oklahoma.
    - Climate-related events such as severe droughts or flooding, exacerbating environmental health issues and access to clean water in rural areas.

Despite these data limitations, the findings provide critical insights into the health needs of Creek County. A combination of quantitative and qualitative methods, including a collection of key informant stories and community surveys, was utilized to ensure diverse perspectives were involved. These methods have strengthened the reliability of the assessment, although opportunities for further improvement remain, particularly in better representing underserved and marginalized populations.

Community Needs

Ascension St. John Sapulpa, with contracted assistance from the University of Oklahoma (OU) Hudson College of Public Health, analyzed secondary data of 53 indicators and gathered community input through a community survey and key informant engagement sessions to identify the needs in Creek County. In collaboration with community partners, Ascension St. John Sapulpa used a phased prioritization approach to identify the needs.

- First phase: Determine the broader set of **identified needs**.
- Second phase: Narrow identified needs to a set of **significant needs**.
- Third phase: Narrow the significant needs to a set of **prioritized needs** to be addressed in the implementation strategy plan.



Following the completion of the CHNA, Ascension St. John Sapulpa will develop a formal, three-year implementation strategy to respond to the hospital's **prioritized needs**. Although the hospital may respond to many needs, the prioritized needs will be at the center of the implementation strategy and corresponding tracking and reporting. The image above portrays the relationship among the need categories of the phased prioritization approach.

Identified Needs

The first phase was to determine the broader set of **identified needs**. Ascension has defined "identified needs" as the health outcomes or related conditions (e.g., social determinants of health) impacting the health status of Creek County. The identified needs were categorized into health behaviors, social determinants of health, length of life, quality of life, clinical care, and systemic issues to develop better measures and evidence-based interventions that respond to the determined condition.

Significant Needs

In the second phase, identified needs were then narrowed to a set of "significant needs" determined most crucial for relevant groups to address. In collaboration with various community partners, Ascension St. John Sapulpa synthesized and analyzed the data to determine which of the identified needs were most significant. Ascension has defined **significant needs** as the identified needs deemed most significant to respond to based on established criteria and/or prioritization methods. A list of criteria was developed in collaboration with the consultant to serve as a framework for evaluating and

narrowing the needs identified in the larger assessment. The criteria include:

- Impact of the problem on certain groups: Identified groups within Creek County that are more significantly impacted than others.
- Known effective interventions: The availability and ease of implementing proven solutions.
- Resources, feasibility, and sustainability: The availability of resources for addressing the issue in a sustainable manner.
- Severity of the problem: The risk of disease or death associated with the issue.
- Size of the problem: The number or percentage of people affected by a health condition in Creek County.
- Social and economic impact:
    - Social: The potential for solutions to create ripple effects in improving other social determinants of health.
    - Economic: The costs associated with not addressing the issue, such as healthcare expenses and lost productivity.

During the second key informant engagement session, where key insights on the barriers observed in Creek County were shared, participants were asked to vote on the criteria. The exercise revealed that, for Creek County, the severity of the problem emerged as the top concern for evaluating the identified needs, indicating that the potential risk to health or life was a critical factor.

Criteria	Weight	Rank
Severity of the problem: Risk of disease/death among population associated with the problem	2.6	1
Impact of the problem on certain groups (or populations): Groups in the county that are more significantly impacted than others	3.2	2
Resources, Feasibility and Sustainability: Availability of resources for addressing the problem in sustainable manner	3.4	3
Size of the problem: Number or percentage of people affected by a health condition	3.5	4
Known Effective Interventions: Availability and ease of proven solutions	4.1	5
Social and Economic Impact: Social: Ability of solution to create ripple effects in improving other social determinants of health / Economic: Costs associated with not addressing this issue (e.g. healthcare costs, lost productivity)	4.2	6

The impact of the problem on certain groups and the resources, feasibility, and sustainability of addressing the issue followed closely in importance, ranking second and third, respectively. These results reflect the community's focus on addressing the most urgent issues first while ensuring that solutions are both viable and sustainable over time.

Based on the synthesis and analysis of the data, incorporating the outcome of the criteria voting activity, the significant needs for the 2024 CHNA are as follows:

- Mental and behavioral health
- Housing
- Transportation
- Access to care
- Food security
- Income
- Employment

To view healthcare facilities and community resources available to respond to the significant needs, please see Appendix E (Page 60).

The following pages contain a description (including data highlights, community challenges and perceptions, and local assets and resources) of each significant need.

Mental and Behavioral Health

Significance

Good mental and behavioral health are essential for overall well-being and productivity.[8] Poor mental health can affect physical health, workplace performance, family stability, and community safety. Addressing mental health challenges is crucial to reducing healthcare costs, improving quality of life, and ensuring equitable access to care.[9]

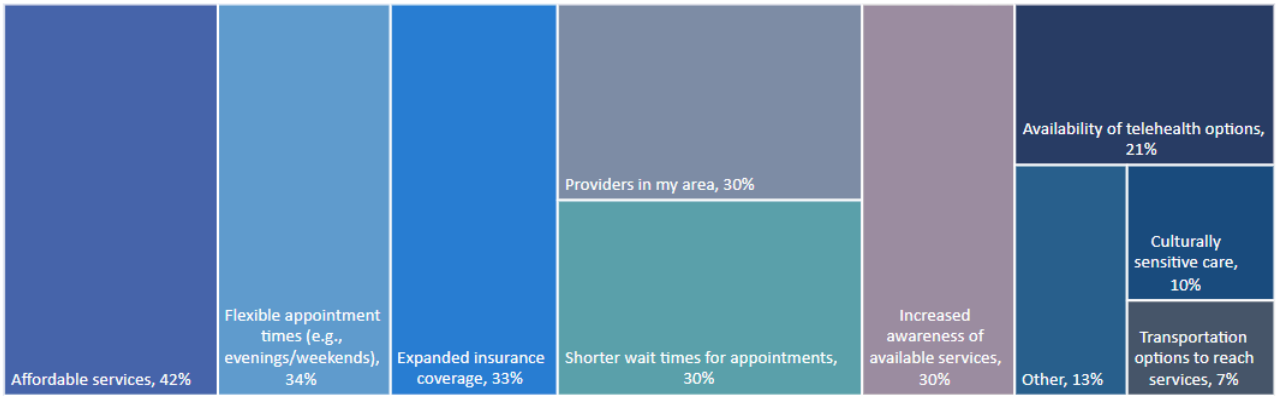
Populations Most Impacted

- **Residents of rural areas** face higher barriers to accessing care due to fewer local providers and resources.[10]
- Cost and transportation challenges may prevent **low-income families** from seeking timely mental healthcare.[10]
- **Youth and adolescents** are a critical group facing increasing mental health challenges, particularly in underserved schools.[11]
- Mental health issues in **elders** often go unaddressed and cause feelings of isolation, especially in rural areas.[12]
- **Individuals with a co-occurring disorder**, such as substance misuse, may require integrated services.[13]

Community Input Highlights

When survey respondents were asked what would improve access to mental and behavioral healthcare services, 42 percent highlighted affordable services, while 34 percent identified flexible appointment times as a key factor for improving access.

What would most improve access to mental/behavioral healthcare services?



[8] Galson, S. K. (2009). Mental health matters. *Public Health Reports, 124*(2), 189–191. https://tinyurl.com/4w8myjzh

[9] Knapp, M., & Wong, G. (2020). Economics and mental health: The current scenario. *World Psychiatry, 19*(1), 3–14. https://pubmed.ncbi.nlm.nih.gov/31922693/

[10] Mojtabai, R. (2021). U.S. health care reform and enduring barriers to mental health care among low-income adults with psychological distress. *Psychiatric Services, 72*(3), 338–342. https://pubmed.ncbi.nlm.nih.gov/33467868/

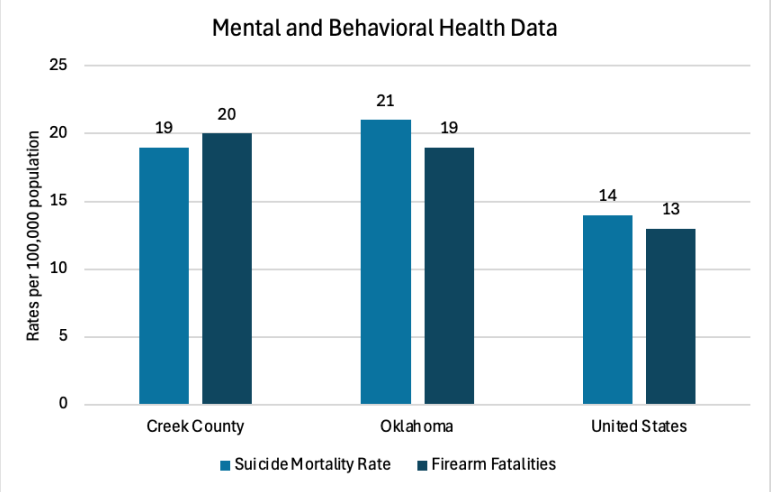
[11] Kourgiantakis, T., Markoulakis, R., Lee, E., Hussain, A., Lau, C., Ashcroft, R., ... & Levitt, A. (2023). Access to mental health and addiction services for youth and their families in Ontario: Perspectives of parents, youth, and service providers. *International Journal of Mental Health Systems, 17*(1), 4. https://ijmhs.biomedcentral.com/articles/10.1186/s13033-023-00572-z

[12] Lavingia, R., Jones, K., & Asghar-Ali, A. A. (2020). A systematic review of barriers faced by older adults in seeking and accessing mental health care. *Journal of Psychiatric Practice, 26*(5), 367–382. https://pubmed.ncbi.nlm.nih.gov/32936584/

[13] Priester, M. A., Browne, T., Iachini, A., Clone, S., DeHart, D., & Seay, K. D. (2016). Treatment access barriers and disparities among individuals with co-occurring mental health and substance use disorders: An integrative literature review. *Journal of Substance Abuse Treatment, 61*, 47–59. https://pmc.ncbi.nlm.nih.gov/articles/PMC4695242/

Secondary Data Highlights

- Persistent stigma surrounding mental health deters individuals from seeking help.[14]
- A prominent level of mentally unhealthy days may contribute to a sense of community neglect or hopelessness if not addressed.[15]
- Compared with the state and national averages, Creek County has a higher percentage of disconnected youth. Creek County has slightly higher voter turnout percentage than the state average, but it is still below the national average.[15]
- Compared with the national average, Creek County experiences substantially higher rates of fatalities from suicide and firearms, at 19 and 20 per 100,000, respectively.[15] See the chart to the right.



What Health Systems and Policymakers Can Do

- Expand access to telehealth and mobile mental health clinics to reach underserved areas.[16]
- Advocate to increase coverage of mental and behavioral health services.
- Support local healthy democracy initiatives to improve citizen engagement in systems that impact their lives.
- Develop public awareness campaigns to reduce stigma and encourage early intervention.[17]
- Provide incentives for mental health professionals to practice in rural and underserved communities.[18]
- Integrate mental health into primary care settings to improve access and reduce stigma.[19]
- Expand crisis intervention programs and ensure 24/7 availability of services like suicide prevention hotlines. Promote 988.
- Collaborate with schools to implement youth mental health programs and early screening initiatives.[20]
- Offer culturally competent care to address diverse needs, particularly in rural and minority populations.[21]

[14] Corrigan, P. W., Druss, B. G., & Perlick, D. A. (2014). The impact of mental illness stigma on seeking and participating in mental health care. *Psychological Science in the Public Interest, 15*(2), 37–70. https://pubmed.ncbi.nlm.nih.gov/26171956/

[15] County Health Rankings & Roadmaps. (2024). *Creek, OK*. https://www.countyhealthrankings.org/health-data/oklahoma/creek?year=2024

[16] Franciosi, E. B., Tan, A. J., Kassamali, B., Leonard, N., Zhou, G., Krueger, S., Rashighi, M., & LaChance, A. (2021). The impact of telehealth implementation on underserved populations and no-show rates by medical specialty during the COVID-19 pandemic. *Telemedicine Journal and e-Health, 27*(8), 874–880. https://doi.org/10.1089/tmj.2020.0525

[17] Semrau, M., Gronholm, P. C., Eaton, J., Maulik, P. K., Ayele, B., Bakolis, I., Mendon, G. B., Bhattarai, K., Brohan, E., Cherian, A. V., Daniel, M., Girma, E., Gurung, D., Hailemariam, A., Hanlon, C., Healey, A., Kallakuri, S., Li, J., Loganathan, S., Ma, N., … Votruba, N. (2024). Reducing stigma and improving access to care for people with mental health conditions in the community: Protocol for a multi-site feasibility intervention study (Indigo-Local). *International Journal of Mental Health Systems, 18*, 35. https://doi.org/10.1186/s13033-024-00649-3

[18] Morales, D. A., Barksdale, C. L., & Beckel-Mitchener, A. C. (2020). A call to action to address rural mental health disparities. *Journal of Clinical and Translational Science, 4*(5), 463–467. https://doi.org/10.1017/cts.2020.42

[19] Chu, C., Roxas, N., Aguocha, C. M., Nwefoh, E., Wang, K., Dike, C., & Iheanacho, T. (2022). Integrating mental health into primary care: Evaluation of the Health Action for Psychiatric Problems In Nigeria including Epilepsy and SubstanceS (HAPPINESS) pilot project. *BMC Health Services Research, 22*. https://doi.org/10.1186/s12913-022-07703-1

[20] Richter, A., Sjunnestrand, M., Romare Strandh, M., & Hasson, H. (2022). Implementing school-based mental health services: A scoping review of the literature summarizing the factors that affect implementation. *International Journal of Environmental Research and Public Health, 19*(6), 3489. https://doi.org/10.3390/ijerph19063489

[21] James, C. V., Moonesinghe, R., Wilson-Frederick, S. M., Hall, J. E., Penman-Aguilar, A., & Bouye, K. Racial/ethnic health disparities among rural adults — United States, 2012–2015. *Morbidity and Mortality Weekly Report, 66*(23), 1–9. https://doi.org/10.15585/mmwr.ss6623a1

Housing

Significance

Housing significantly influences health outcomes.[22] Severe housing cost burdens, overcrowding, and inadequate facilities directly affect residents' well-being. Addressing housing issues is crucial for reducing financial strain, improving mental and physical health, and creating stable environments that foster healthier communities.

Populations Most Impacted

- **Low-income families** are disproportionately affected by severe housing cost burdens, limiting access to healthcare and education.[23]
- Historical and systemic inequities make housing challenges more severe for **racial and ethnic minorities** in both urban and rural settings.[24]

Community Input Highlights

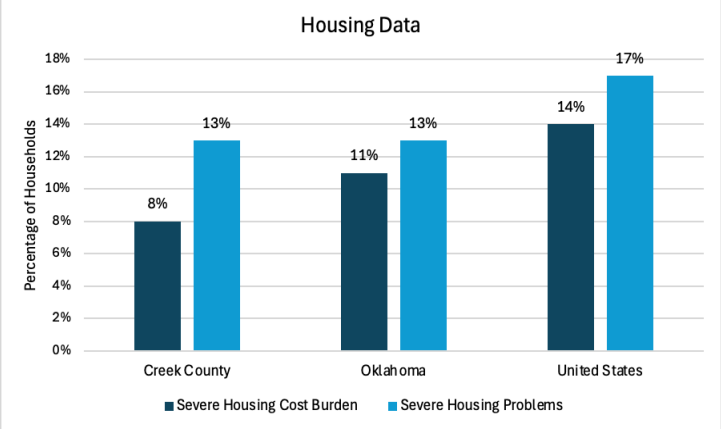
About one in three (34 percent) of the CHNA survey respondents expressed some level of worry about potential housing instability.

Are you worried about losing your housing?

Very worried	3.70%
Slightly worried	20%
Somewhat worried	10%
Not at all worried	66%

Secondary Data Highlights

- About 39 percent of families in Creek County spend more than 30 percent of their income on rent, leaving limited resources for other essentials like food and healthcare.[25]
- Limited access to safe and functional utilities, especially in rural and underserved areas, contributes to health risks.[26]
- In Creek County, 13 percent of households experienced severe housing problems.[26] County Health Rankings & Roadmaps defines severe housing problems as households that experience one of the following housing problems: "overcrowding, high housing costs, lack of kitchen facilities or lack of plumbing facilities."



What Health Systems and Policymakers Can Do

- Advocate to expand subsidies and incentives for developing low-cost housing.[27]
- Prioritize funding for repairs and upgrades to inadequate housing facilities for weatherization, safe respiratory environments, and aging in place, especially in rural areas.[28]
- Strengthen programs for housing assistance and financial literacy to empower families to access better living conditions.
- Work with utility service provides to lessen the utilities burden on low-income households.
- Ensure that when patients are discharged from the hospital they go home to a safe environment where they can heal.
- Support and/or hire community health workers to do home visits for discharged patients.

[22] Healthy People 2030. (n.d.). *Housing instability*. https://tinyurl.com/2c5k957h
[23] U.S. Department of Health and Human Services. (n.d.). *Housing instability*. Healthy People 2030. https://tinyurl.com/4v4w3n6w
[24] Israel Cross, R., Huỳnh, J., Bradford, N. J., & Francis, B. (2023). Racialized housing discrimination and population health: A scoping review and research agenda. *Journal of Urban Health, 100*(2), 355–388. https://doi.org/10.1007/s11524-023-00725-y
[25] U.S. Census Bureau. (2023). *American Community Survey 5-year data (2009-2023)*.
[26] County Health Rankings & Roadmaps. (2024). *Creek, OK*. https://www.countyhealthrankings.org/health-data/oklahoma/creek?year=2024
[27] Bailey, P. (2022, October 27). *Addressing the affordable housing crisis requires expanding rental assistance and adding housing units*. Center on Budget and Policy Priorities. https://tinyurl.com/3hmhjdy7
[28] U.S. Department of Housing and Urban Development. (n.d.). *The Healthy Homes Program*. https://tinyurl.com/mr2bskbu

Transportation

Significance

Transportation is essential for accessing employment, education, healthcare, and community resources.[29] Reliable transportation ensures individuals can participate fully in life socially and economically. However, challenges such as dependence on driving alone, lack of public transit, and disparities among racial and ethnic groups can limit opportunities and exacerbate inequities.[30]

Populations Most Impacted

- Limited access to vehicles or funds for fuel and maintenance can hinder mobility for some **low-income residents**.
- **Rural residents** face greater challenges due to sparse transit options and longer travel distances.[31]
- The **American Indian/Alaska Native (AIAN) and Black populations** have high rates of driving alone, which may reflect a lack of equitable transportation resources.[32]
- Dependence on public transit or specialized transportation services can limit access to essential services for **elders and individuals who are disabled**.[33]
- **Hispanic individuals** show lower rates of driving alone, possibly reflecting greater reliance on carpooling or alternative transit.[34]

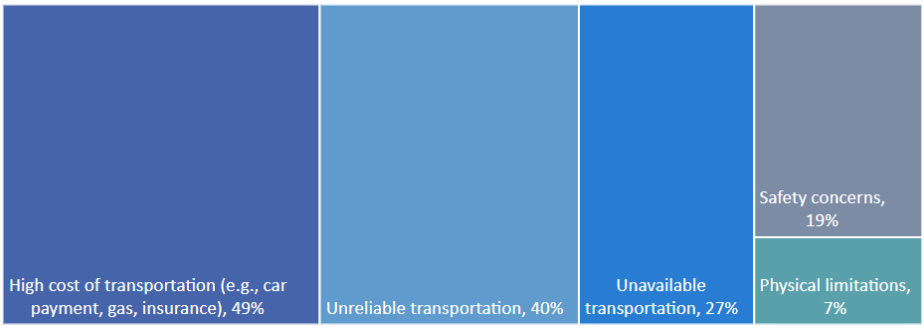
Community Input Highlights

When Creek County survey respondents were asked to identify transportation barriers, 49 percent cited high costs associated with car payments, gas, and auto insurance. Additionally, 40 percent mentioned unreliable transportation, likely referring to challenges with the county's public transportation system and unreliable personal vehicles.

When respondents who cited unreliable transportation were asked what it prevented them from, approximately 30 percent reported challenges with reaching work, attending medical appointments, or completing daily tasks such as grocery shopping.

As part of the transportation section, respondents were also asked to suggest improvements that could help increase their physical activity. The top two solutions identified were financial incentives or subsidies for exercise-related expenses (43 percent) and improved access to exercise facilities, such as gyms and parks (40 percent).

In the past 12 months, have you experienced any of the following problems with your transportation?



In the past 12 months, has unreliable transportation or lack of transportation kept you from:

None	79%
Work	10%
Accessing things needed for daily living (e.g., grocery)	9.80%
Medical appointments	9.50%
Non-medical appointments	5.10%
Other	0.70%

[29] Rural Health Information Hub. (n.d.). *Needs related to transportation in rural areas*. https://tinyurl.com/ms3kprrh

[30] Labban, M., Chen, C. R., Frego, N., Nguyen, D. D., Lipsitz, S. R., Reich, A. J., Rebbeck, T. R., Choueiri, T. K., Kibel, A. S., Iyer, H. S., & Trinh, Q. D. (2023). Disparities in travel-related barriers to accessing health care from the 2017 national household travel survey. *JAMA Network Open, 6*(7), e2325291. https://doi.org/10.1001/jamanetworkopen.2023.25291

[31] Yu, Y., Appiah, D., Zulu, B., & Adu-Poku, K. A. (2024). Integrating rural development, education, and management: Challenges and strategies. *Sustainability, 16*(15), 6474. https://doi.org/10.3390/su16156474

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[33] Rosenbloom, S. (2007). Transportation patterns and problems of people with disabilities. In Field, M. J., & Jette, A. M. (Eds.), *The future of disability in America*. National Academies Press (US). https://www.ncbi.nlm.nih.gov/books/NBK11420/

[34] U.S. Census Bureau. *Table S0802: Means of transportation to work by selected characteristics*. https://data.census.gov/table?q=S0802

Secondary Data Highlights

- A high percentage of workers driving alone to work suggests a lack of alternative transportation options, particularly in rural counties.[35]
- A lack of sufficient public transportation can isolate residents without personal vehicles.
- About 87 percent of Black individuals in Creek County show high rates of driving alone, possibly reflecting limited public transit options or financial barriers to carpooling.
- Heavy reliance on single-occupancy vehicles contributes to environmental concerns such as traffic congestion and air pollution.[36]
- Rural residents may perceive transportation systems as underfunded and insufficient for their needs including limited access to places for physical activity.
- Creek County experiences higher percentages of the workforce that drives alone and motor vehicle crash deaths in comparison with state and national averages.[37] Creek County also has a higher percentage of individuals not meeting physical activity guidelines.[37]

What Health Systems and Policymakers Can Do

- Advocate to expand bus routes and schedules, particularly in underserved rural areas.[38]
- Advocate to enhance roads, bike paths, and pedestrian walkways to encourage diverse transportation modes. Expand access to physical activity options on the healthcare campus.[38]
- Offer free rides or partner with rideshare services to ensure patients can access medical appointments.[39]
- Collaborate with clinics and nonprofits to address transportation needs in remote areas.
- Work with community leaders to highlight transportation challenges and advocate for funding and policy changes.[38]

Access to Care

Significance	Populations Most Impacted
Access to healthcare is fundamental for preventing disease, managing chronic conditions, and improving overall health outcomes.[40] Without adequate insurance, individuals may delay or avoid necessary care, leading to worse health outcomes, higher healthcare costs, and increased health disparities.	• Out-of-pocket healthcare expenses are often increased for **uninsured adults**. Substantially higher than the national average, 17 percent of individuals under the age of 65 in Creek County are uninsured.[41] • Limited provider availability and transportation challenges disproportionately affect **residents of rural areas**.[42] • Financial barriers exacerbate challenges in accessing affordable insurance or care for **low-income families**.[43] • **Minority communities** often face compounded disparities, lacking both insurance coverage and access to culturally competent care.[44]

[35] Alswaeer, T. K., Safapour, E., Rouhanizadeh, B., & Tafazzoli, M. (2024). Overlooked factors contributing to U.S. highway fatalities. Canadian Journal of Civil Engineering. https://doi.org/10.1139/cjce-2024-0236

[36] Levy, J. I., Buonocore, J. J., & Von Stackelberg, K. (2010). Evaluation of the public health impacts of traffic congestion: A health risk assessment. Environmental Health, 9, 65. https://doi.org/10.1186/1476-069X-9-65

[37] County Health Rankings & Roadmaps. (2024). *Creek, OK*. https://www.countyhealthrankings.org/health-data/oklahoma/creek?year=2024

[38] Summers, P., Chao, E., McCoy, P., Perry, J., & Rhodes, S. D. (2020). Influencing public transportation policy through community engagement and coalition building: Process and preliminary outcomes. *Progress in Community Health Partnerships: Research, Education, and Action, 14*(4), 489–498. https://doi.org/10.1353/cpr.2020.0054

[39] Wolfe, M. K., & McDonald, N. C. (2020). Innovative health care mobility services in the US. *BMC Public Health, 20*(1), 906. https://doi.org/10.1186/s12889-020-08803-5

[40] U.S. Department of Health and Human Services. (n.d.). *Access to primary care*. Healthy People 2030. https://tinyurl.com/myjwjfpw

[41] County Health Rankings & Roadmaps. (2024). *Creek, OK*. https://www.countyhealthrankings.org/health-data/oklahoma/creek?year=2024

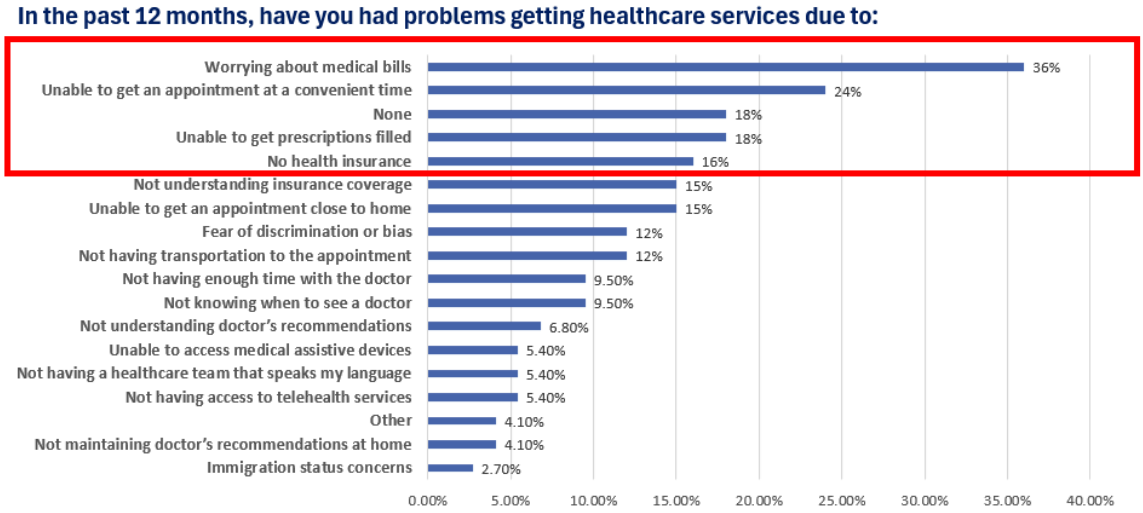
[42] Maganty, A., Byrnes, M. E., Hamm, M., Wasilko, R., Sabik, L. M., Davies, B. J., & Jacobs, B. L. (2023). Barriers to rural health care from the provider perspective. *Rural and Remote Health, 23*(2), 7769. https://doi.org/10.22605/RRH7769

[43] Lazar, M., & Davenport, L. (2018). Barriers to health care access for low income families: A review of literature. *Journal of Community Health Nursing, 35*(1), 28–37. https://doi.org/10.1080/07370016.2018.1404832

[44] Yearby, R., Clark, B., & Figueroa, J. F. (2022). Structural racism in historical and modern US health care policy. *Health Affairs, 41*(2), 187–194. https://doi.org/10.1377/hlthaff.2021.01466

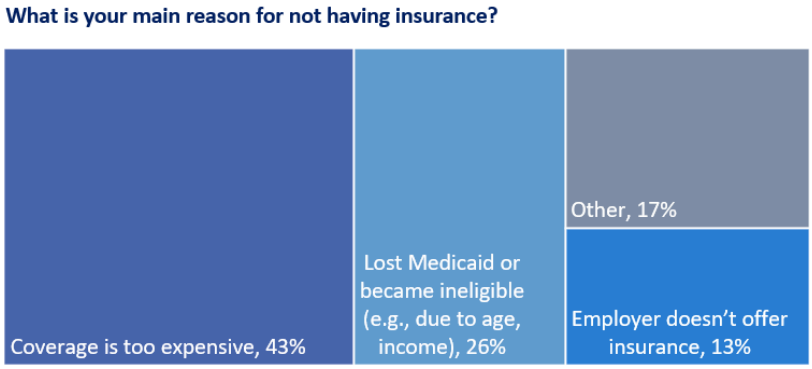
Community Input Highlights

When survey respondents were asked to identify access barriers they and/or their family members faced over the past year, healthcare services emerged as the leading area, with multiple barriers reported by 28 percent of respondents.



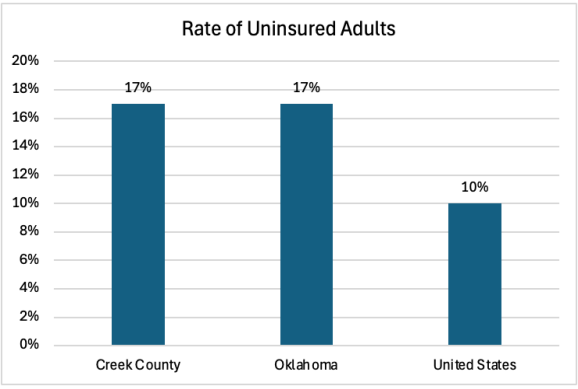
When respondents provided additional details about these barriers, the top five reasons cited by Creek County residents struggling to access care included difficulty paying medical bills, inability to secure appointments, challenges in getting prescriptions filled, and lack of health insurance.

Delving deeper into the CHNA survey data, respondents were asked to identify reasons for not having insurance. Notably, 43 percent cited the high cost of coverage as the primary barrier.



Secondary Data Highlights

- High uninsured rates in a community lead to reduced access to healthcare services, resulting in poorer health outcomes and increased financial strain on both individuals and local health systems.[45]
- Inconvenient appointment times may lead patients to not seek timely care and cause additional gaps in coverage among the population.[46]
- In Creek County, 17 percent of individuals under the age of 65 did not have health insurance, coming in at the same average as for the state of Oklahoma as a whole.[45] See the chart to the right.



[45] County Health Rankings & Roadmaps. (2024). *Creek, OK*. https://www.countyhealthrankings.org/health-data/oklahoma/creek?year=2024

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What Health Systems and Policymakers Can Do

- Increase support for and expand access to community health centers and mobile clinics in rural areas.[47]
- Help community members enroll in Medicaid and the Children's Health Insurance Program (CHIP) to ensure eligible individuals can access health insurance coverage. For those already enrolled, counsel or support them in accessing benefits they may need.[48]
- Partner with schools and community organizations that enroll uninsured children in CHIP or Medicaid.[48]
- Develop a sliding-scale payment option and maintain financial assistance programs to support uninsured patients.[49]
- Implement outreach initiatives to educate uninsured individuals about available resources and services.
- Expand telehealth services to community partners, including schools, libraries, and shelters.[47]

Food Security

Significance

Access to healthy foods is a cornerstone of public health.[50] Limited access can lead to poor nutrition, increasing the risk of chronic diseases like diabetes, obesity, and cardiovascular issues.[51] Persistent food access challenges can undermine trust in public health systems. Addressing this issue is essential for improving community health outcomes and reducing healthcare costs.

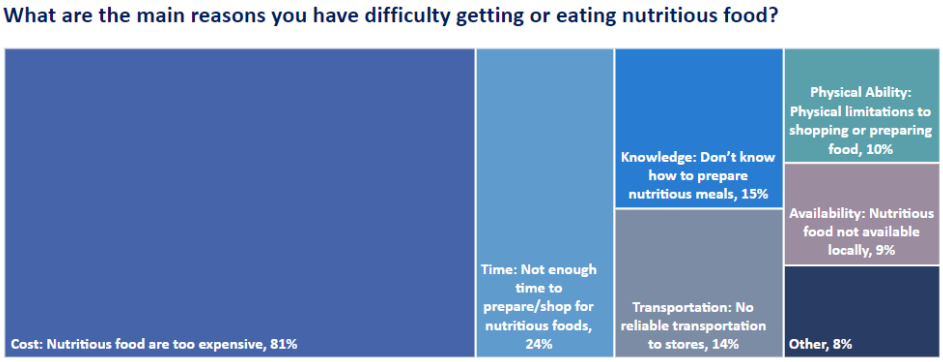
Populations Most Impacted

- Geographic isolation limits food access for **rural residents**.[52]
- **Elders and individuals with disabilities** may struggle to travel to food sources.[53]
- **Low-income families** may face financial barriers to purchasing healthy foods, even when available.[54]
- **Children in households with limited food access** often experience impacts on their long-term health and academic performance.[55]

Community Input Highlights

In the survey, participants were asked to identify reasons why accessing or consuming nutritious foods was difficult. About 81 percent cited the high cost of nutritious foods, while 24 percent mentioned a lack of time to prepare or shop for healthy options.

Additionally, about 30 percent of respondents indicated they were worried about running out of food before having enough money to buy more.



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Secondary Data Highlights

- Creek County's food environment index is higher than the state average and equal to the national average.[56]
- Creek County also has a lower percentage of individuals who have limited access to healthy foods in comparison with state and national averages.[56] County Health Rankings & Roadmaps defines the food environment index as an "index of factors that contribute to a healthy food environment, from 0 (worst) to 10 (best)."

	Creek County	Oklahoma	U.S.
Food environment index	7.7	5.6	7.7
Limited access to healthy foods	5%	9%	6%

- Limited food access in smaller communities can contribute to perceptions of neglect and underinvestment in essential infrastructure.[57]

What Health Systems and Policymakers Can Do

- Support the development of transportation infrastructure to connect rural areas with urban food resources.
- Support the development of grocery stores to operate in underserved rural areas.[58]
- Support programs like mobile markets and food co-ops to respond to food deserts.[59]
- Offer nutrition education programs targeting high-risk communities.[60]
- Collaborate with local organizations to distribute healthy foods through clinics or outreach programs.
- Advocate for policies that integrate food access into broader health and economic development strategies.
- Provide healthy groceries upon discharge from hospital for patients identified as food-insecure.

Income

Significance	Populations Most Impacted
Child care (mapped to "income" as the need) is critical for supporting families, enabling parents to work or pursue education, and fostering early childhood development.[61] High-quality child-care programs lay the foundation for school readiness, cognitive development, and social-emotional skills. However, when child care is unaffordable or inaccessible, it can strain household finances, limit employment opportunities, and hinder children's early education.[62]	• Spending a significant amount of their income on child care disproportionately affects **low-income families**, leaving less for other necessities.[63] • High child-care costs place a significant strain on **single-parent households**, limiting workforce participation and financial stability. • Access to child care is crucial for **young mothers** pursuing education or entering the workforce. • Without access to affordable, high-quality child care, **children in poverty** may miss critical early education opportunities.

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[57] Ver Ploeg, M., Breneman, V., Farrigan, T., Hamrick, K., Hopkins, D., Lin, B., Nord, M., Smith, T. A., Williams, R., Kinnison, K., Olander, C., Singh, A., & Tuckermanty, E. (2009). *Access to affordable and nutritious food – measuring and understanding food deserts and their consequences: Report to congress*. U.S. Department of Agriculture. https://www.ers.usda.gov/publications/pub-details?pubid=42729
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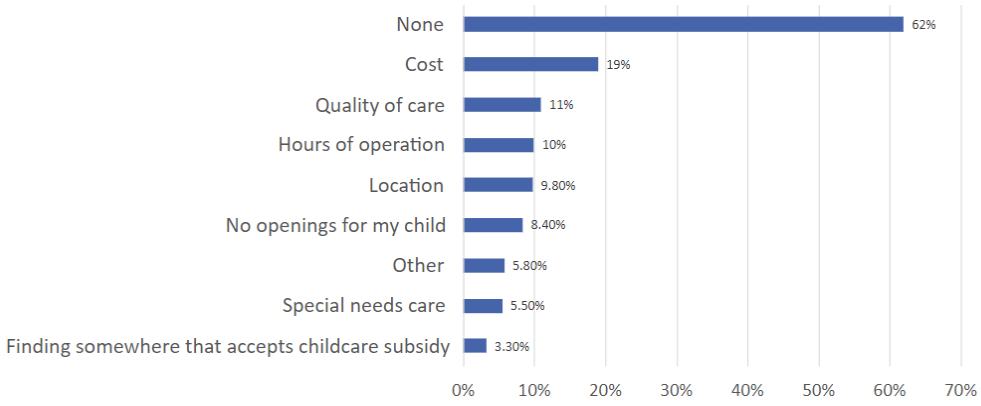
[61] Peeks, C. (2024). Early childhood education: Setting a foundation for all children to thrive. In Bass, J. C. (Ed.), *A progressive vision for education in the 21st century*. Center for American Progress. https://tinyurl.com/4tndbupe
[62] Horowitz, B., Townsend Kiernan, K., & Birken, B. (2022). *Childcare affordability affects labor market and family choices*. Federal Reserve Bank of Atlanta. https://tinyurl.com/y56c43fa
[63] U.S. Department of the Treasury. (2021). *The economics of child care supply in the United States*. https://tinyurl.com/mr2b5vbj

Community Input Highlights

While an overwhelming majority of respondents (62 percent) indicated they faced no barriers in accessing child care, the cost of services and quality of care ranked as the second and third most commonly observed barriers to child care and early childhood education services.

What are the main barriers you face in getting childcare or early childhood education services?



Secondary Data Highlights

- Families spend well above the federal affordability benchmark of 7 percent, highlighting a significant financial burden.[63]
- Families in Creek County spend 29 percent of their income on childcare, which — while slightly lower than other parts of the state — remains unsustainable for many households. According to the U.S. Department of Health & Human Services, child care is generally considered affordable if it accounts for less than 10 percent of household income. More recently, this threshold was updated to 7 percent.[64] See the graphic to the right.
- Rural counties may have fewer licensed childcare providers, limiting options for families.[65]
- The child-care sector faces staffing shortages and low wages, affecting availability and quality of services.[65]

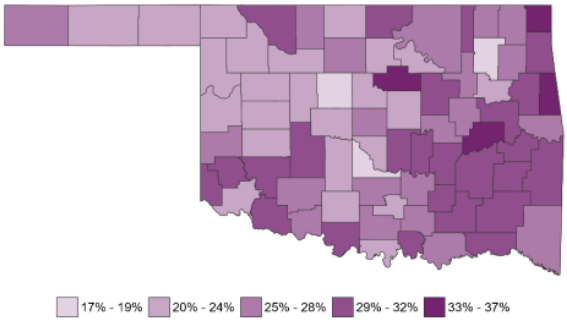


Figure 3. Childcare cost burden in Oklahoma by county

What Health Systems and Policymakers Can Do

- Advocate to expand funding for childcare subsidies and tax credits to alleviate financial burdens for families.[66]
- Support universal preschool programs and advocate to integrate early education with child-care services to ensure all children enter school ready to learn.[67]
- Offer grants and incentives to increase the availability and quality of child care, particularly in rural areas.
- Invest in training and wage increases for child-care workers to address staffing shortages and improve service quality.[68]
- Offer resources and workshops to help parents navigate child-care options and promote early learning at home.[69]

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[64] County Health Rankings & Roadmaps. (2024). *Creek, OK*. https://www.countyhealthrankings.org/health-data/oklahoma/creek?year=2024

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[69] Eunice Kennedy Shriver National Institute of Child Health and Human Development. (2021, July 8). *How can parents and caregivers promote early learning?* U.S. Department of Health & Human Services. https://tinyurl.com/2defawj6

Employment

Significance

Employment data provides insight into the economic stability and health of a community.[70] High unemployment can signal economic distress, affecting access to healthcare, housing stability, and overall quality of life. Tracking unemployment allows policymakers to target economic development efforts effectively.

Unemployment can lead to economic hardships and reduced access to health and social services.[71] Communities with employment challenges may perceive gaps in job opportunities or access to education and skills training as barriers.

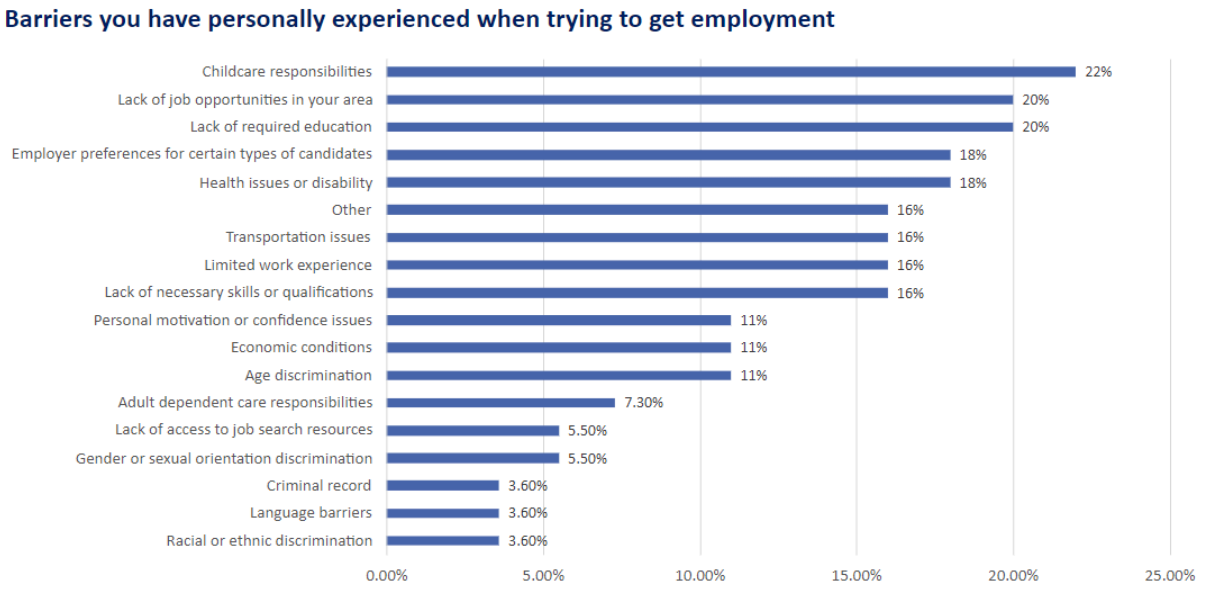
Populations Most Impacted

- **Individuals who are unemployed**, particularly in rural counties, face greater challenges in accessing employment opportunities.[72]
- Commuting to work is difficult for **individuals with unreliable transportation or limited access to transportation**.[73]

Community Input Highlights

The survey results on the employment status of Creek County respondents closely aligned with the unemployment rate reported by County Health Rankings & Roadmaps. According to the survey, 3 percent of respondents were not currently employed but were actively seeking paid work.

Additionally, when survey respondents were asked to identify barriers to employment, 22 percent cited childcare responsibilities as the primary challenge. Other top barriers included a lack of job opportunities, insufficient education or qualifications to meet employer preferences, and health issues or disabilities.



[70] U.S. Department of Health and Human Services Office of Disease Prevention and Health Promotion. (n.d.). *Employment*. Healthy People 2030. https://tinyurl.com/t3sj9avb

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Secondary Data Highlights

Unemployment rates in Creek County are slightly higher than the state average but below the national average.[74] The percentage of children in poverty in Creek County is higher than the national average but slightly below the state average.[74]

	Creek County	Oklahoma	U.S.
Unemployment rate	3.5%	3.0%	3.7%
Children in poverty	19%	20%	16%

What Health Systems and Policymakers Can Do

- Invest in and support local job creation programs aligned with market demand and service providers that support the healthcare industry.[75]
- Enhance funding for vocational training and education.[76]
- Partner with local businesses to create job-training initiatives. Provide support for mental health issues and financial stress associated with unemployment.
- Improve access through advocacy and specific programs to affordable childcare and transportation to reduce barriers to employment.
- Support businesses in the community by locally sourcing goods and services used by the health system regularly.[77]
- Consider exploring income disparities within the health system's own workforce by examining the gap between the lowest paid workers and highest paid workers. Invest in job creation programs tailored to local industries and healthcare-related sectors.[78]

[74] County Health Rankings & Roadmaps. (2024). *Creek, OK*. https://www.countyhealthrankings.org/health-data/oklahoma/creek?year=2024
[75] U.S. Department of Commerce. (2024, May 14). *Investing in America, investing in Americans workforce development programs at the U.S. Department of Commerce*. https://tinyurl.com/2s447bx9
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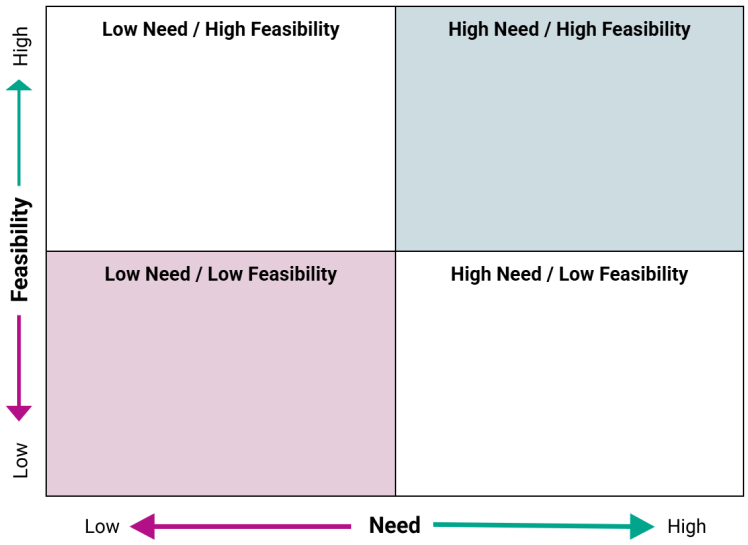
[78] Frogner, B. K., & Schwartz, M. (2021). Examining wage disparities by race and ethnicity of health care workers. *Medical Care, 59*(Suppl 5), S471–S478. https://doi.org/10.1097/MLR.0000000000001613

Prioritized Needs

In the third phase, significant needs were further narrowed to a set of "prioritized needs." Ascension defines **prioritized needs** as the significant needs that the hospital has prioritized to respond to through the three-year CHNA implementation strategy. To prioritize the significant needs, Ascension St. John created a strategy grid based on the prioritization model as outlined by the National Association of County & City Health Officials (NACCHO)[79]. According to NACCHO, strategy grids can "provide a mechanism to take a thoughtful approach to achieving maximum results with limited resources" (p. 4), allowing for a more focused plan of action.

First, the Community Benefit team facilitated a prioritization activity at a January 2025 meeting of the Mission Committee of the Ascension St. John Board of Directors, which included diverse internal representation of board members, market executives, and key department leads. The group was instructed to complete the strategy grid from the market perspective, listing the significant needs from all six of Ascension St. John's CHNAs. Additionally, the group used Nominal Group Technique to anonymously rank the county-specific needs for each hospital.



Using the two-criteria grid, the participants placed each significant need into the box they felt was the best fit:

- High Need / High Feasibility – These needs are the highest priority.
- Low Need / High Feasibility – Often difficult to eliminate but not a priority, these needs may need to be reassessed for impact.
- High Need / Low Feasibility – These needs will require significant investments of time and resources.
- Low Need / Low Feasibility – These needs are the lowest priority.

[79] National Association of County & City Health Officials. (n.d.). *Guide to prioritization techniques*. Quality improvement. https://www.naccho.org/uploads/downloadable-resources/Gudie-to-Prioritization-Techniques.pdf

Needs were then weighed and ranked for priority-setting using numeric values, with 1 being the highest importance to address. The significant needs that received the lowest scores were those that appeared the most in the High Need / High Feasibility box. The top three needs in this category were prioritized for all six hospitals. The significant needs that received the highest scores were those that appeared the most in the Low Need / Low Feasibility box and will not be addressed. Significant needs that appeared more frequently in the Low Need / High Feasibility and High Need / Low Feasibility boxes received middle-rank scores and would not be addressed in the implementation strategy unless given priority by an individual hospital.

Through the Nominal Group Technique, the significant needs of each county were ranked based on total weighted scores, with 1 being the highest priority and the last number being the lowest. Each significant need was tallied, receiving a weighted average and sum. They were then ranked based on the scores received. These two identifiers were compared with each other and solidified the results of the strategy grid exercise.

Next, the Community Benefit team met individually with each hospital leadership team to guide them in completion of a strategy grid from only the perspective of their respective community. Results from the Mission Committee exercises were not revealed until after the exercise. Results from the hospital leadership team meetings strongly aligned with those of the Mission Committee.

As a result of these activities, Ascension St. John Sapulpa selected the prioritized needs outlined below for its 2024 CHNA implementation strategy:

- **Access to care:** This need was selected because access to timely diagnosis, treatment, and preventive care leads to improved health outcomes, reduced mortality, and a higher quality of life. Individuals who experience barriers to care are more likely to experience worsening of chronic diseases that could have been better managed, leading to higher healthcare costs and increased health inequities. Access to care was ranked high in both need and feasibility.
- **Mental and behavioral health:** This need was selected due to its severity and far-reaching impact on community well-being. Provider shortages negatively impact individual health by delaying or preventing access to necessary care, potentially worsening existing mental health conditions. Shortages can also lead to longer wait times for appointments, reduced availability of specialized services, and increased costs for individuals and healthcare providers. Selection of this need also aligns with the Oklahoma State Department of Health's 2023-2028 Oklahoma State Health Improvement Plan.
- **Food security:** This need was selected because of its size and severity, as well as its contribution to broader systemic challenges. Limited access to healthy, affordable food options can lead to chronic diseases, particularly for low-income and rural populations. With higher feasibility, interventions would reduce barriers to nutritious food, which impacts overall health and well-being. Selection of this need also aligns with Ascension's commitment to the White House Challenge to End Hunger and Build Healthy Communities.
- **Housing:** This need was selected because the size of the issue was evident, with high rates of homelessness and a lack of affordable housing affecting Creek County residents. The severity

of housing instability was underscored, given its significant impact on physical and mental health outcomes.

These results reflect the community's focus on addressing urgent issues while ensuring that solutions are both viable and sustainable over time.

Needs That Will Not Be Addressed

Transportation, income/childcare, and employment were not selected in this CHNA cycle and therefore will not be addressed through the subsequent implementation strategy. After thoughtful analysis and discussion during the prioritization exercise, these needs were deemed important but did not rise to the same level of prioritization as the four needs listed above.

While all of these issues continue to impact residents across the county, they did not match the severity impact and feasibility of access to care, mental and behavioral health, food security, and housing. Still, these issues deserve further attention and study by health systems, as they reflect important secondary factors adversely affecting health and prosperity in Creek County.

Summary of Impact of the Previous CHNA Implementation Strategy

An important piece of the three-year CHNA cycle is revisiting the progress made on priority needs set forth in the preceding CHNA. By reviewing the actions taken to respond to the prioritized needs and evaluating the impact those actions have made in the community, it is possible to better target resources and efforts during the next CHNA cycle.

Ascension St. John Sapulpa's previous CHNA implementation strategy was completed in November 2022 and responded to the following priority health needs: access to care, mental and behavioral health, food security, and alcohol and drug use.

Highlights from the Ascension St. John Sapulpa's previous implementation strategy include:

- More than **$4.7 million in subsidized claims** from partner healthcare organizations
- **9,624 free rides** to/from non-emergency medical appointments for patients experiencing barriers to reliable transportation
- Training of all Behavioral Health associates in **Assessing and Managing Suicide Risk** (AMSR)
- Assistance with (re)enrollment in Medicaid and other public programs for **1,923 individuals**
- Implementation of **multiple new models of care** to improve maternal and infant health outcomes, including:
    - Implementation of the Edinburgh Postnatal Depression Scale screening tool
    - A multi-level approach to prevent postpartum hemorrhage
    - A blood pressure cuff program in partnership with the American Heart Association
- More than **$15.9 million in grants** to community initiatives addressing access to care, mental and behavioral health, food security, and/or alcohol and drug use
- **24,260 prescriptions** through the Dispensary of Hope program
- An estimated **1,968 hours** spent by associates on **527 human trafficking assessments or cases**
- Launch of the **Opioid Overdose Prevention Project** to distribute naloxone kits to patients at risk for substance misuse

Written input received from the community and a report on the actions taken to respond to the significant health needs prioritized in the 2021 CHNA implementation strategy can be found in Appendix F (Page 63).

Approval by Boards of Directors

To ensure Ascension St. John Sapulpa's efforts meet the needs of the community and have a lasting and meaningful impact, the 2024 CHNA was presented to the Community Hospital Board of Directors for approval and adoption on April 17, 2025, as well as the Ascension St. John Market Board of Directors on April 30, 2025. Although an authorized body of the hospital must adopt the CHNA and implementation strategy reports to be compliant with the provisions in the Affordable Care Act, adoption of the reports also demonstrates that the board is aware of the findings from the CHNA, endorses the health needs identified, and supports the strategies developed to respond to those needs.

Conclusion

Ascension St. John Sapulpa hopes this report offers a meaningful and comprehensive understanding of the most significant needs of Creek County. This report will be used by internal teams, nonprofit organizations, government agencies, and other Ascension St. John Sapulpa partners to guide the implementation strategies and community health improvement efforts as required by the Affordable Care Act. The 2024 CHNA will also be available to the broader community as a useful resource for further health improvement efforts.

As a Catholic health ministry, Ascension St. John Sapulpa is dedicated to spiritually centered, holistic care that sustains and improves the health of not only individuals but the communities it serves. With special attention to those who are underserved and marginalized, we are advocates for a compassionate and just society through our actions and words. Ascension St. John Sapulpa is dedicated to serving patients with compassionate care and medical excellence, making a difference in every life we touch. The hospital values the community's voice and welcomes feedback on this report. Please visit Ascension's public website (https://healthcare.ascension.org/chna) to submit any comments or questions.

Appendices

Table of Contents

Appendix A: Definitions and Terms

Advisory Group

An advisory group or committee typically includes hospital staff and public health experts and/or other key informants who represent the broad interests of the community to foster bidirectional communication, often with facilitation. The group's main role is to gather information and reach consensus on approaches to engage the community for the needs assessment process.

Source: Greater New York Hospital Association Center on Community Health Equity Policy and Services. (2021). *Community health needs assessment toolkit*. https://www.gnyha.org/wp-content/uploads/2021/12/CHNA-Toolkit-update.pdf

Collaborator

A collaborator is a community partner that works with the hospital to conduct the needs assessment. A collaborator might help shape the approach, select methodologies, set the timeline, identify key informants, and contribute funds. Collaborative identification of community needs strengthens the needs assessment process.

Community Input

Community input is a meaningful way to gain insight into the needs and assets of a community, especially its vulnerable/underserved populations. By drawing upon the knowledge and experiences of community members, hospitals can better identify mutually beneficial opportunities for the greatest impact and enable greater acceptability with the community and, thus, sustainability of subsequent interventions. Community input methods vary among needs assessments; examples include interviews, focus groups, and surveys.

Source: Centers for Disease Control and Prevention. (n.d.). *Engage the community*. CDC archive. https://archive.cdc.gov/www_cdc_gov/chinav/tools/engage.html [original URL: https://www.cdc.gov/chinav/tools/engage.html]

Consultant

A consultant, alternatively referred to as a vendor, is a third-party, external entity paid to complete specific deliverables on behalf of the hospital or a collaboration.

Demographics

Demographics are the population characteristics of your community. Data points may include population size, age structure, racial and ethnic composition, population growth, and density.

Source: Catholic Health Association of the United States. (2015). *Assessing & Addressing Community Health Needs, 2015 Edition II*. https://www.chausa.org/communitybenefit/a-guide-for-planning-and-reporting-community-benefit

Key Informant

Key informants may include leaders of community organizations, service providers, and elected officials. Individuals with special knowledge or expertise in public health may include representatives from a local or state health department, faculty from schools of public health, and providers with a background in public health.

Source: Catholic Health Association of the United States. (2015). *Assessing & Addressing Community Health Needs, 2015 Edition II*. https://www.chausa.org/communitybenefit/a-guide-for-planning-and-reporting-community-benefit

Medically Underserved Populations

Medically underserved populations include populations experiencing health disparities or that are at risk of not receiving adequate medical care because of being uninsured or underinsured or due to geographic, language, financial, or other barriers. Populations with language barriers include those with limited English proficiency. Medically underserved populations also include those living within a hospital facility's service area but not receiving adequate medical care from the facility because of cost, transportation difficulties, stigma, or other barriers.

Source: Catholic Health Association of the United States. (2015). *Assessing & Addressing Community Health Needs, 2015 Edition II*. https://www.chausa.org/communitybenefit/a-guide-for-planning-and-reporting-community-benefit

Secondary Data

Secondary data is data that has already been collected and published by another party. Secondary data is often free or inexpensive and is accessible directly from the original source. Local and state public health departments and federal agencies provide the majority of reliable secondary data related to community health. Secondary data from other public agencies can help identify the social determinants behind health needs.

Source: Catholic Health Association of the United States. (2015). *Assessing & Addressing Community Health Needs, 2015 Edition II*. https://www.chausa.org/communitybenefit/a-guide-for-planning-and-reporting-community-benefit

Social Determinants of Health

Social determinants of health (SDoH) are conditions in the environments where people live, learn, work, play, worship, and age that affect a wide range of health risks and outcomes. These non-medical factors can have a major impact on people's physical and mental health, well-being, and quality of life.

Source: U.S. Department of Health and Human Services Office of Disease Prevention and Health Promotion. (n.d.). *Healthy People 2030*. https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health

Survey

A survey is a method of community input used to collect information from community members, relevant groups, providers, and/or public health experts for the purpose of understanding the community's perception of needs. Surveys can be administered in person, over the telephone, online, or in print. Surveys can consist of both forced-choice and open-ended questions.

Source: Catholic Health Association of the United States. (2015). *Assessing & Addressing Community Health Needs, 2015 Edition II*. https://www.chausa.org/communitybenefit/a-guide-for-planning-and-reporting-community-benefit

Appendix B: Community Demographic Data and Sources

The tables below provide further information on the community's demographics. The descriptions of the data's importance are largely drawn from the County Health Rankings & Roadmaps website.

Table 1: Population

Why it is important: The composition of a population, including related trends, is important for understanding the community context and informing community planning.

Population	Creek County	Oklahoma	U.S.
Total	73,332	4,095,800	340,110,988
Male	49.6%	49.7%	49.5%
Female	50.4%	50.3%	50.5%

Source: U.S. Census Bureau. (2024). QuickFacts. https://www.census.gov/quickfacts

Table 2: Population by Race and Ethnicity

Why it is important: The racial and ethnic composition of a population is important in understanding the cultural context of a community. The information can also be used to better identify and understand health disparities.

Race or ethnicity	Creek County	Oklahoma	U.S.
Asian	.8%	2.6%	6.4%
Non-Hispanic Black / African American	2.3%	7.9%	13.7%
Hispanic / Latino	5.7%	12.9%	19.5%
American Indian or Alaska Native	10.9%	9.5%	1.3%
Non-Hispanic White	73.8%	72.9%	75.3%

Source: U.S. Census Bureau. (2024). QuickFacts. https://www.census.gov/quickfacts

Table 3: Population by Age

Why it is important: The age structure of a population is important in planning for the future of a community, particularly for schools, community centers, healthcare, and child care. A population with more youths will have greater education and childcare needs, while an older population may have greater healthcare needs.

Age	Creek County	Oklahoma	U.S.
Median age	41.3	37.1	39.2
Ages 0-17	23.2%	23.8%	21.7%
Ages 18-64	58%	59.6%	60.6%
Ages 65+	18.8%	16.6%	17.7%

Source: U.S. Census Bureau. (2024). QuickFacts. https://www.census.gov/quickfacts

Table 4: Income

Why it is important: Median household income and the percentage of children living in poverty, which can compromise physical and mental health, are well-recognized indicators. People with higher incomes tend to live longer than people with lower incomes. In addition to affecting access to health insurance, income affects access to healthy choices, safe housing, safe neighborhoods, and quality schools. Chronic stress related to not having enough money can have an impact on mental and physical health as well. ALICE, an acronym for Asset Limited, Income Constrained, Employed, are households that earn more than the U.S. poverty level but less than the basic cost of living for the county. Combined, the number of poverty and ALICE households equals the total population struggling to afford basic needs.

Income	Creek County	Oklahoma	U.S.
Median household income	$61,849	$63,603	$78,538
Per capita income	$31,986	$34,859	$43,289
People with incomes below the federal poverty guideline	15.7%	15.9%	11.1%
ALICE households	34%	29%	29%

Sources: U.S. Census Bureau. (2024). QuickFacts. https://www.census.gov/quickfacts
United for Alice. (2022). Research center. https://www.unitedforalice.org/national-overview

Table 5: Education

Why is it important: There is a strong relationship between health, lifespan, and education. In general, as income increases, so does lifespan. The relationship between more schooling, higher income, job opportunities (e.g., pay, safe work environment), and social support helps create opportunities for healthier choices.

Income	Creek County	Oklahoma	U.S.
High school diploma or higher	90.5%	89.1%	89.4%
Bachelor's degree or higher	18.4%	27.8%	35%

Source: U.S. Census Bureau. (2024). QuickFacts. https://www.census.gov/quickfacts

Table 6: Insured/Uninsured

Why it is important: Lack of health insurance can have serious health consequences due to lack of preventive care and delays in care that can lead to serious illness or other health problems.

Income	Creek County	Oklahoma	U.S.
Uninsured	13%	13.5%	9.5%
Medicaid participation	3.6%	22%	21%

Sources: U.S. Census Bureau. (2024). QuickFacts. https://www.census.gov/quickfacts
Oklahoma Health Care Authority. (2024). Data and reports. https://oklahoma.gov/ohca/research/data-and-reports.html
KFF. (2024). Medicaid state fact sheets. https://www.kff.org/interactive/medicaid-state-fact-sheets/

Appendix C: Community Input Data and Sources

Community survey

Conducted both electronically via Qualtrics and in print via randomized mailings, the community survey consisted of the following questions. Many of the questions used skip logic based on Question 4.

1. Please enter your survey ID number (skip if not applicable).
2. What county do you live in?
    a. Craig
    b. Creek
    c. Muskogee
    d. Nowata
    e. Tulsa
    f. Washington
    g. Don't know / Not sure
3. What is the ZIP code of where you live?
4. In the past year, have you or any family members you live with been unable to get any of the following when it was really needed? Select all that apply.
    ❑ Employment
    ❑ Food
    ❑ Housing (e.g., rent, utilities, mortgage)
    ❑ Transportation
    ❑ Any Health Care (e.g., medical, vision, prescription medications)
    ❑ Mental Health Services
    ❑ Phone
    ❑ Internet
    ❑ Childcare or Early Childhood Education Services
5. What is the highest level of school or degree you have completed?
    a. No schooling completed
    b. Some primary school (1st – 8th grade)
    c. Some high school, no diploma
    d. High school graduate or equivalent (e.g., GED)
    e. Some college, no degree
    f. Associate's degree (this includes vocational or trade school)
    g. Bachelor's degree
    h. Master's degree
    i. Professional school degree (e.g., law or medical degree)
    j. Doctorate degree
6. What is your current work situation? (Bureau of Labor Statistics)
    a. Not working for pay but actively looking for paid work
    b. Not working for pay and not looking for paid work
    c. Working for pay: Part-time or seasonal work (less than 35 hours a week) d. Working for pay: Full-time work (35 or more hours a week)
    d. Other
7. How hard is it for you to pay for the very basics like food, housing, clothing, medical care, and utilities?
    a. Very hard
    b. Somewhat hard
    c. Not hard at all
8. In the past year, which of the following barriers have you personally experienced when trying to get employment? Select all that apply.
    ❑ Lack of necessary skills or qualifications
    ❑ Limited work experience
    ❑ Lack of required education
    ❑ Transportation issues
    ❑ Childcare responsibilities
    ❑ Adult dependent care responsibilities
    ❑ Health issues or disability
    ❑ Age discrimination
    ❑ Gender or sexual orientation discrimination
    ❑ Racial or ethnic discrimination
    ❑ Language barriers
    ❑ Criminal record
    ❑ Lack of job opportunities in your area
    ❑ Lack of access to job search resources
    ❑ Economic conditions
    ❑ Employer preferences for certain types of candidates
    ❑ Personal motivation or confidence issues
    ❑ Other

9. Within the past 12 months the food I/we bought just didn't last and I/we didn't have the money to get more.
    a. Often True
    b. Sometimes True
    c. Never True
10. Within the past 12 months I/we were worried whether our food would run out before I/we got money to buy more.
    a. Yes
    b. No
    c. Don't know / Not Sure
11. What are the main reasons you have difficulty getting or eating nutritious foods? Select all that apply.
    - ❑ Cost: Nutritious foods are too expensive
    - ❑ Availability: Nutritious foods are not available in my local stores
    - ❑ Transportation: I do not have reliable transportation to get to stores that sell nutritious foods
    - ❑ Time: I do not have enough time to prepare or shop for nutritious foods
    - ❑ Knowledge: I do not know how to prepare nutritious meals
    - ❑ Physical Ability: I have physical limitations that make it difficult to shop for or prepare nutritious foods
    - ❑ Other
12. Which of the following improvements would most encourage you to increase your physical activity? Select all that apply.
    - ❑ Improved access to exercise facilities (e.g., gyms, parks)
    - ❑ Better transportation options to reach exercise locations
    - ❑ Increased availability of exercise programs or fitness classes
    - ❑ More flexible scheduling options for workouts
    - ❑ Financial incentives or subsidies for exercise-related expenses
    - ❑ Increased social support (e.g., workout groups, community activities)
    - ❑ Enhanced safety and security in exercise environments
    - ❑ Better information and resources on effective exercise
    - ❑ Personalized exercise plans or coaching
    - ❑ Other
13. What is your housing situation today?
    a. Own
    b. Rent
    c. Staying with friends or family
    d. Hotel / motel
    e. Long-term care / skilled nursing
    f. Group home
    g. Halfway house
    h. I do not have shelter right now (unhoused)
    i. Other
14. Are you worried about losing your housing?
    a. Very worried
    b. Somewhat worried
    c. Slightly worried
    d. Not at all worried
15. Do you feel physically and emotionally safe where you currently live?
    a. Yes
    b. No
    c. Unsure
16. In the past 12 months, have you experienced any of the following problems with your housing? Select all that apply or skip if none.
    - ❑ Structural maintenance issues (e.g., plumbing or flooring problems)
    - ❑ Neighborhood safety issues
    - ❑ Rent or mortgage too expensive
    - ❑ Utility bills are too expensive (e.g., water, electricity, or heating/cooling)
    - ❑ Unhealthy housing (e.g., pest problems, lead, asbestos, mold or poor air quality)
    - ❑ Unsafe relationships in the home
    - ❑ Too many people in the household (overcrowding)
17. What are the main barriers you face in getting childcare or early childhood education services? Select all that apply.
    - ❑ Cost
    - ❑ Location
    - ❑ No openings for my child
    - ❑ Hours of operation
    - ❑ Quality of care
    - ❑ Special needs care
    - ❑ None
    - ❑ Finding somewhere that accepts childcare subsidy
    - ❑ Other

18. What is your primary mode of transportation?
    a. Private car
    b. Public transit (e.g., bus)
    c. Walking
    d. Biking
    e. Carpooling
    f. Ride-sharing (e.g., friends, family, Uber, or Lyft)
    g. Other
19. In the past 12 months, has unreliable transportation or lack of transportation kept you from any of the following? Select all that apply.
    ❑ Medical appointments
    ❑ Non-medical appointments
    ❑ Work
    ❑ Accessing things needed for daily living (e.g., grocery, shopping)
    ❑ Other
    ❑ No
20. In the past 12 months, have you experienced any of the following problems with your transportation? Select all that apply.
    ❑ High cost of transportation (e.g., car payment, gas, insurance)
    ❑ Unavailable transportation
    ❑ Unreliable transportation
    ❑ Safety concerns
    ❑ Physical limitations
21. Where do you get trusted information about health for yourself and/or your family? Select all that apply.
    ❑ Doctor or other healthcare provider
    ❑ Health care system (either in person or calling the nurse line)
    ❑ Handouts/ Pamphlets
    ❑ Internet
    ❑ Books/ Magazine
    ❑ Friends
    ❑ Family
    ❑ Church
    ❑ Social Media
    ❑ News
    ❑ Other
22. What is your main source of health insurance or healthcare coverage?
    a. Employer based insurance
    b. Medicare
    c. Medicaid or other state program (e.g., CHIP or SoonerCare, SoonerSelect, and Oklahoma Insure)
    d. Tricare or other military health care (e.g., VA)
    e. None/ Uninsured – Using a Tribal Clinic or Hospital
    f. None/ Uninsured – Using Other Tribal Health Services, including IHS
    g. Private insurance purchased directly from an insurance company
    h. No health insurance
    i. Other
23. What is your main reason for NOT having insurance?
    a. Coverage is too expensive
    b. Lost job or changed employers
    c. Lost Medicaid or became ineligible (e.g., due to age, increase in income)
    d. Employer doesn't offer insurance
    e. Don't need insurance
    f. Insurance company refused coverage
    g. I do not know how to get it
    h. Other
24. In the past 12 months, have you had problems getting healthcare services due to any of the following? Select all that apply.
    ❑ Not knowing when I need to see a doctor
    ❑ Unable to get an appointment at a time that works for me
    ❑ No health insurance
    ❑ Not having transportation to my appointment
    ❑ Unable to get an appointment close to home
    ❑ Not having access to telehealth services (e.g., no internet)
    ❑ Not having enough time with my doctor
    ❑ Not understanding what or who my insurance covers
    ❑ Worrying about medical bills from my visit
    ❑ Not having a healthcare team that speaks my primary language
    ❑ Fear of discrimination or bias by people at the hospital or doctor's office
    ❑ Not understanding doctor's recommendations/orders
    ❑ Unable to get prescriptions filled
    ❑ Unable to access medical assistive devices (e.g., hearing aids)
    ❑ Not maintaining doctor's recommendations at home
    ❑ Immigration status concerns
    ❑ None
    ❑ Other

25. Do you have at least one person you think of as your personal doctor or health care provider?
    a. Yes
    b. No
    c. Not sure
26. Where do you most frequently go to receive healthcare services? Select all that apply.
    - ❑ University Clinic
    - ❑ Federally Qualified Health Center (e.g., Morton or Community Health Connection)
    - ❑ VA Clinic
    - ❑ American Indian/ Tribal Health Clinic
    - ❑ Health Department
    - ❑ Emergency Room
    - ❑ Urgent Care Center
    - ❑ Doctor's Office
    - ❑ Free Clinic
    - ❑ I don't have a place
    - ❑ Other
27. Have you ever used drugs (narcotic or illegal) other than tobacco or alcohol?
    a. Never
    b. Once a month or less
    c. 2-4 times a month
    d. 2-3 times a week
    e. 4 or more times a week
28. Which of the following would improve your access to mental/behavioral healthcare services? Select all that apply.
    - ❑ Affordable services
    - ❑ Providers in my area
    - ❑ Shorter wait times for appointments
    - ❑ Expanded insurance coverage
    - ❑ Transportation options to reach services
    - ❑ Culturally sensitive care
    - ❑ Availability of telehealth options
    - ❑ Flexible appointment times (e.g., evenings or weekends)
    - ❑ Increased awareness of available services
    - ❑ Other
29. How would you describe your health in general?
    a. Excellent (Extremely Healthy)
    b. Very Good (Very Healthy)
    c. Good (Healthy)
    d. Fair (Somewhat Unhealthy)
    e. Poor (Very Unhealthy)
30. How often do you see or talk to people that you care about and feel close to? (For example: talking to friends on the phone, visiting friends or family, going to church or club meetings)
    a. I do not have anyone that I feel close to
    b. Less than once a week
    c. 1 or 2 times a week
    d. 3 to 5 times a week
    e. 6 or more times a week
31. If for any reason you need help with activities of daily living such as bathing, preparing meals, shopping, managing finances, etc., do you get the help that you need?
    a. I don't need any help
    b. I get all the help I need
    c. I could use a little more help
    d. I need a lot more help
32. I feel I am accepted in my community.
    a. Strongly Agree
    b. Agree
    c. Neutral
    d. Disagree
    e. Strongly disagree
33. What is your age?
    a. 18-24 years
    b. 25 to 34 years
    c. 35 to 44 years
    d. 45 to 64 years
    e. 65+
34. What was your total household income before taxes in the past 12 months?
    a. Less than $10,000
    b. $10,000 to $14,999
    c. $15,000 to $24,999
    d. $25,000 to $34,999
    e. $35,000 to $49,999
    f. $50,000 to $74,999
    g. $75,000 to $99,999
    h. $100,000 to $149,999
    i. $150,000 to $199,999
    j. $200,000 or more
35. How many people does this income support? (free response)
    a. Adults (18+): _____
    b. Children (Under 18): _____

36. What sex were you assigned at birth on your original birth certificate?
    a. Male
    b. Female
37. Do you currently describe yourself as male, female or transgender? (U.S. Census)
    a. Male
    b. Female
    c. Transgender
    d. None of these
38. Are you of Hispanic, Latino, or Spanish origin? (U.S. Census)
    a. No, not of Hispanic, Latino or Spanish origin
    b. Yes, Mexican, Mexican Am., Chicano
    c. Yes, Puerto Rican
    d. Yes, Cuban
    e. Yes, another Hispanic, Latino or Spanish origin
39. What is your race? Select all that apply.
    ❑ White (e.g., German, Irish, English, Italian, Lebanese, Egyptian, etc.)
    ❑ Black or African American (e.g., African American, Jamaican, Haitian, Nigerian, Ethiopian, Somali, etc.)
    ❑ American Indian or Alaska Native (e.g., Navajo Nation, Blackfeet Tribe, Mayan, Aztec)
    ❑ Asian Indian
    ❑ Chinese
    ❑ Filipino
    ❑ Other Asian (e.g., Pakistani, Cambodian, Hmong, Burmese, etc.)
    ❑ Japanese
    ❑ Korean
    ❑ Vietnamese
    ❑ Native Hawaiian
    ❑ Samoan
    ❑ Chamorro
    ❑ Other Pacific Islander (e.g., Tongan, Fijian, Marshallese, etc.)
    ❑ Some other race
40. How did you hear about this survey?
    a. Ascension St. John
    b. Saint Francis Health System
    c. County health department
    d. Mail
    e. Church
    f. Community-based organization or community meeting
    g. Grocery store or shopping mall
    h. Newspaper
    i. Newsletter
    j. Word of mouth
    k. Facebook or other social media
    l. Other

Community partners were integral in distribution efforts for the survey.

Key informant engagement sessions

The two engagement sessions in Creek County entailed activities and robust discussion facilitated by the OU Hudson College of Public Health.

Session 1:

1. Brief history of the CHNA, requirements for non-profit hospitals, etc.
2. Collaborative approach this cycle
3. Health needs discussion and dot-voting type activity to ensure input
4. Group exercises to learn about social determinant of health (SDoH) root causes and individual questions regarding community needs
5. Pilot and promotion of the survey

Session 2:

1. Presentation on initial CHNA survey data
2. Ranking activity to help weight the criteria that would be used by the hospital to prioritize needs
3. Next steps and timeline of the CHNA

The first session was held in the Community Room at BancFirst in Sapulpa, Okla. The second session was held virtually.

We are deeply grateful for the community's participation. The following organizations were represented at the sessions:

- Ascension St. John Sapulpa
- Caring Community Friends
- City of Sapulpa
- Creek County Health Department
- Creek County TSET Healthy Living Program
- Family & Children's Services
- Sapulpa Public Library
- Sapulpa Public Schools

Appendix D: Secondary Data and Sources

The tables below are based on data vetted, compiled, and made available on the County Health Rankings and Roadmaps (CHRR) website (https://www.countyhealthrankings.org/). The site is maintained by the University of Wisconsin Population Health Institute, School of Medicine and Public Health, with funding from the Robert Wood Johnson Foundation. CHRR obtains and cites data from other public sources that are reliable. CHRR also shares trending data on some indicators.

CHRR compiles new data annually and shares it with the public. The data below is from the calendar year 2024 publication. It is important to understand that reliable data is generally two to three years behind due to the importance of careful analysis.

How to Read These Charts

Why they are important: Explains why we monitor and track these measures in a community and how it relates to health. The descriptions for "why they are important" are largely drawn from the CHRR website.

County vs. state: Describes how the county's most recent data for the health issue compares to the state average.

Trends: CHRR provides a calculation for some measures to explain if a measure is worsening or improving.

- Red: The measure is worsening in this county.
- Green: The measure is improving in this county.
- Empty: There is no data trend to share, or the measure has remained the same.

United States (U.S.): Describes how the county's most recent data for the health issue compares to the U.S.

Description: Explains what the indicator measures, how it is measured, and who is included in the measure.

N/A: Not available or not applicable. There might not be available data for the community on every measure. Some measures will not be comparable.

Table 7: Health Outcomes

Why they are important: Health outcomes reflect how healthy a county is right now. They reflect the physical and mental well-being of members within a community.

Indicators	Trend	Creek	Oklahoma	U.S.	Description
Length of Life					
Premature death	▼	11,400	10,300	8,000	Years of potential life lost before age 75 per 100,000 population (age-adjusted)
Life expectancy		73.5	74.4	77.6	How long the average person is expected to live
Infant mortality		7	7	6	Number of all infant deaths (within one year) per 1,000 live births
Physical Health					
Poor or fair health		20%	19%	14%	Percentage of adults reporting fair or poor health
Poor physical health Days		4.3	3.8	3.3	Average number of physically unhealthy days reported in the past 30 days (age-adjusted)
Frequent physical distress		13%	12%	14%	Percentage of adults with 14 or more days of poor physical health per month
Low birth weight		8%	8%	8%	Percentage of babies born too small (less than 2,500 grams)
Falls 65+ (by state)		N/A	29.6%	N/A	Older adult falls reported by state
Fall fatalities 65+ (by state)		N/A	130.6%	78%	Number of injury deaths due to falls among those 65 years of age and over per 100,000 population
Mental Health					
Poor mental health days		5.9	5.5	4.8	Average number of mentally unhealthy days reported in the past 30 days
Frequent mental distress		19%	18%	15%	Percentage of adults reporting 14 or more days of poor mental health per month
Suicide		19	21	14	Number of deaths due to suicide per 100,000
Morbidity					
Diabetes prevalence		11%	12%	10%	Percentage of adults ages 20 and above with diagnosed diabetes
Cancer deaths (by state)		197.3	171.6	N/A	Average annual cancer death rate per 100,000
Communicable Disease					
HIV prevalence		154	210	382	Number of people ages 13 years and over with a diagnosis of HIV per 100,000
Sexually transmitted infections	▼	358.2	519.5	495.5	Number of newly diagnosed chlamydia cases per 100,000

Sources: County Health Rankings & Roadmaps. (2024). Health outcomes and factors. https://www.countyhealthrankings.org/health-data/oklahoma/creek?year=2024

U.S. Center for Disease Control and Prevention. (2024). Older adult falls data. https://www.cdc.gov/falls/data-research/index.html

National Cancer Institute. (2024). State cancer profiles. https://statecancerprofiles.cancer.gov

Table 8: Social and Economic Factors

Why they are important: These factors have a significant effect on our health. They affect our ability to make healthy decisions, afford medical care, afford housing and food, manage stress, and more.

Indicator	Trend	Creek	Oklahoma	U.S.	Description
Economic Stability					
Median household income		$57,500	$59,600	$74,800	The income where half of households in a county earn more and half of households earn less
Unemployment	▲	3.5%	3%	3.7%	Percentage of population ages 16 and older unemployed but seeking work
Poverty		14.7%	15.9%	11.1%	Percentage of population living below the federal poverty line
Childhood poverty		19%	20%	16%	Percentage of people under age 18 in poverty
Educational Attainment					
High school completion		90%	89%	89%	Percentage of adults ages 25 and over with a high school diploma or equivalent
Some college		53%	60%	68%	Percentage of adults ages 25-44 with some post-secondary education
Social/Community					
Children in single-parent homes		22%	26%	25%	Percentage of children who live in a household headed by a single parent
Social associations		11.5	11.3	9.1	Number of membership associations per 10,000 population
Disconnected youth		10%	8%	7%	Percentage of teens and young adults ages 16-19 who are neither working nor in school
Violent crime		N/A	420	380	Number of reported violent crime offenses per 100,000 population
Access to Healthy Foods					
Food environment index		7.7	5.6	7.7	Index of factors that contribute to a healthy food environment (0 = worst, 10 = best)
Food insecurity		12	14%	10%	Percentage of the population who lack adequate access to food
Limited access to healthy foods		5%	9%	6%	Percentage of the population who are low-income and do not live close to a grocery store

Sources: County Health Rankings & Roadmaps. (2024). Health outcomes and factors. https://www.countyhealthrankings.org/health-data/oklahoma/creek?year=2024

Federal Bureau of Investigation. (2019). Crime in the United States. https://ucr.fbi.gov/crime-in-the-u.s/2019/crime-in-the-u.s.-2019/topic-pages/tables/table-6

Table 9: Physical Environment

Why it is important: The physical environment is where people live, learn, work, and play. It impacts our water, air, housing, and transportation to work or school.

Indicator	Trend	Creek	Oklahoma	U.S.	Description
Physical Environment					
Severe housing cost burden		8%	11%	14%	Percentage of households that spend 50 percent or more of their household income on housing
Severe housing problems		13%	13%	17%	Percentage of households with at least one of four housing problems: overcrowding, high housing costs, lack of kitchen facilities, and/or lack of plumbing facilities
Air pollution: particulate matter	▲	9.3	8.7	7.4	Average daily density of fine particulate matter in micrograms per cubic meter (PM2.5)
Home ownership		75%	66%	65%	Percentage of occupied housing units that are owned

Source: County Health Rankings & Roadmaps. (2024). Health outcomes and factors. https://www.countyhealthrankings.org/health-data/oklahoma/creek?year=2024

Table 10: Clinical Care

Why it is important: Access to affordable, quality care can help detect issues sooner and prevent disease. This can help individuals live longer and have healthier lives.

Indicator	Trend	Creek	Oklahoma	U.S.	Description
Healthcare Access					
Uninsured	▲	17%	17%	10%	Percentage of population under age 65 without health insurance
Uninsured adults	▲	20%	21%	12%	Percentage of adults under age 65 without health insurance
Uninsured children	▲	8%	17%	5%	Percentage of children under age 19 without health insurance
Primary care physicians	▼	4,500:1	1,690:1	1,330:1	Ratio of the population to primary care physicians
Mental healthcare providers		400:1	230:1	320:1	Ratio of the population to mental healthcare providers
Hospital Utilization					
Preventable hospital stays	▲	3,069	3,069	2,681	Rate of hospital stays for ambulatory-care sensitive conditions per 100,000 Medicare enrollees
Preventive Healthcare					
Flu vaccinations	▼	42%	42%	46%	Percentage of fee-for-service Medicare enrollees who had an annual flu vaccination
Mammography screenings	▲	37%	40%	43%	Percentage of female Medicare enrollees ages 65-74 who received an annual mammography screening

Source: County Health Rankings & Roadmaps. (2024). Health outcomes and factors. https://www.countyhealthrankings.org/health-data/oklahoma/creek?year=2024

Table 11: Health Behaviors

Why they are important: Health behaviors are actions individuals take that can affect their health. These actions can lead to positive health outcomes or they can increase someone's risk of disease and premature death. It is important to understand that not all people have the same opportunities to engage in healthier behaviors.

Indicator	Trend	Creek	Oklahoma	U.S.	Description
Healthy Lifestyle					
Adult obesity		42%	40%	34%	Percentage of the adult population (ages 20 and older) that reports a body mass index (BMI) greater than or equal to 30 kg/m2
Physical inactivity		30%	27%	23%	Percentage of adults ages 20 and over reporting no leisure-time physical activity
Access to exercise opportunities		59%	71%	84%	Percentage of population with adequate access to locations for physical activity
Insufficient sleep		32%	34%	33%	Percentage of adults who report fewer than seven hours of sleep on average
Motor vehicle crash deaths		20	18	12	Number of motor vehicle crash deaths per 100,000 population
Teen births		27	27	17	Number of births per 1,000 female population ages 15-19
Substance Misuse					
Adult smoking		22%	18%	15%	Percentage of adults who are current smokers
Excessive drinking		16%	14%	18%	Percentage of adults reporting binge or heavy alcohol drinking
Alcohol-impaired driving deaths	▲	18%	27%	26%	Percentage of all vehicle crash deaths that involved alcohol
Overdose deaths: any opioids by state		26.2	19.3	28.7	Rate of opioid-related deaths by state per 100,000 persons

Sources: County Health Rankings & Roadmaps. (2024). Health outcomes and factors. https://www.countyhealthrankings.org/health-data/oklahoma/creek?year=2024

U.S. Center for Disease Control and Prevention. (2024). SUDORS dashboard: Fatal drug overdose data. www.cdc.gov/overdose-prevention/data-research/facts-stats/sudors-dashboard-fatal-overdose-data-accessible.html

Table 12: Disparities

Why they are important: Differences in access to opportunities that affect health can create differences between groups of people in the community. A focus on equity is important to improve health for everyone in the community.

Indicator	Population (Creek County)	Measure
Health Disparities		
Premature death: Years of potential life lost before age 75 per 100,000 population (age-adjusted)	**Overall**	11,4000 per 100,000
	Non-Hispanic Asian	N/A
	Non-Hispanic Black / African American	N/A
	Hispanic (all races)	11,000 per 100,000
	Non-Hispanic American Indian or Alaskan Native	16,900 per 100,000
	Non-Hispanic White	N/A
Low birthweight: Percentage of live births with low birthweight (< 2,500 grams)	**Overall**	8%
	Non-Hispanic Asian	N/A
	Non-Hispanic Black / African American	13%
	Hispanic (all races)	7%
	Non-Hispanic American Indian or Alaskan Native	8%
	Non-Hispanic White	8%

Source: County Health Rankings & Roadmaps. (2024). Health outcomes and factors. https://www.countyhealthrankings.org/health-data/oklahoma/creek?year=2024

Appendix E: Health Care Facilities and Community Resources

As part of the CHNA process, Ascension St. John Sapulpa has cataloged resources available in Creek County that respond to the significant needs identified in this CHNA. Resources may include acute care facilities (hospitals), primary and specialty care clinics and practices, mental health providers, and other non-profit services. State and national resources can also provide information regarding programs that can better serve the needs of a person experiencing a specific problem.

The resources listed under each significant need heading are not intended to be exhaustive.

Mental and Behavioral Health

Organization	Phone	Website
Ascension St. John Sapulpa Senior Life Solutions	918-227-8691	https://healthcare.ascension.org/locations/oklahoma/oktul/sapulpa-ascension-st-john-senior-life-solutions-program?utm_campaign=gmb&utm_medium=organic&utm_source=local
CREOKS Health Services	918-227-2016	https://creoks.org/locations
Improving Lives	918-268-7263	https://improvinglivescounseling.com/
Sapulpa Indian Health Center (Muscogee Nation Department of Health)	918-224-9185	https://www.creekhealth.org/services/behavioral-healh-and-substance-use/

Housing

Organization	Phone	Website
Bristow Housing Authority	918-367-5558	https://www.homelessnessinamerica.com/html/Low_Income_Housing/Oklahoma
Bristow Social Services	918-367-5400	https://bristowsocialservices.org/
Caring Community Friends	918-224-6464	https://www.caringcommunityfriends.org/
CREOKS Housing Team	918-227-2016	https://creoks.org/wp-content/uploads/2024/03/b_CREOKS-Housing-Services-Brochure.pdf
Hope Community Outreach Center of Sapulpa	918-991-0928	https://www.facebook.com/hopeoutreachcentersapulpa/
Salvation Army	918-224-4415	https://www.facebook.com/redshieldcreekcountysapulpa/
Youth Services of Creek County	918-227-4644	https://yscc.net/

Transportation

Organization	Phone	Website
Cimarron Public Transit	918-762-3041	https://ucapinc.org/cpts
Pick Transportation	855-735-4826	https://picktransportation.org
SoonerRide	877-404-4500	https://oklahoma.gov/ohca/individuals/soonerride.html

Access to Care

Organization	Phone	Website
Ascension St. John Sapulpa	918-227-1000	https://healthcare.ascension.org/locations/oklahoma/oktul/sapulpa-ascension-st-john-sapulpa/departments/primary-care
Creek County Health Department	918-224-5531 (Sapulpa) 918-367-3341 (Bristow)	https://oklahoma.gov/health/county-health-departmes/creek-county-health-department.html
CURA for the World	918-347-9221	https://www.curafortheworld.org/oklahoma-clinic
RX for Oklahoma	918-253-4683, ext. 29	https://www.rx4okla.com
Sapulpa Indian Health Center (Muscogee Nation Department of Health)	918-224-9310	https://www.creekhealth.org/clinics/sapulpa-indian-halth-center/
TruHealth Integrated Care	918-216-4628	https://creoks.org/locations/
Tulsa Healthcare Coverage Project (healthcare insurance enrollment assistance; located in Tulsa, Okla.)	918-619-4749	N/A

Food Security

Organization	Phone	Website
Bristow Social Services	918-367-5400	https://bristowsocialservices.org/
Caring Community Friends	918-224-6464	https://www.caringcommunityfriends.org/
Muskogee Creek Nation WIC	918-549-2790	https://www.muscogeenation.com/department-of-community-and-human-services/wic/
Supplemental Nutrition Assistance Program SNAP	877-760-0114	https://okdhslive.org/Default.aspx
The Women, Infants, and Children Supplemental Nutrition Program WIC	888-655-2942	https://oklahoma.gov/health/services/children-family-health/wic.html

Income/Childcare

Organization	Phone	Website
Muscogee Creek Nation Child Care Assistance Program	918-732-7680	https://www.muscogeenation.com/department-of-community-and-human-services/child-care-assistance/
Muskogee Creek Nation Head Start	918-249-4262	https://www.muscogeenation.com/det/headstart/
Oklahoma Human Services	405-521-3431	https://oklahoma.gov/okdhs/services/adult/ccsubsidy/child-care-subsidy.html
UCAP Early Head Start Sapulpa	918-224-1094	https://ucapinc.org/hs-ehs
UCAP Head Start Bristow	918-364-9662	https://ucapinc.org/hs-ehs
UCAP Head Start Drumright	918-729-0903	https://ucapinc.org/hs-ehs
UCAP Head Start Sapulpa	918-224-1083	https://ucapinc.org/hs-ehs

Employment

Organization	Phone	Website
Dynamic Recruiting Specialists	918-224-2200	http://dynamicrecruitingspecialist.com/
Oklahoma Works Employment	918-224-9430	https://oklahoma.gov/workforce.html

Appendix F: Evaluation of Impact from the Previous CHNA Implementation Strategy

Ascension St. John Sapulpa's previous CHNA implementation strategy was completed in November 2022 and responded to the following priority health needs: access to care, mental and behavioral health, food security, and alcohol and drug use.

The tables below describe the actions taken during the TY 2022-2024 CHNA implementation strategy cycle to respond to each priority need. Ascension St. John took a marketwide approach to many of its strategies, combining resources and efforts among Ascension St. John Medical Center, Ascension St. John Owasso, Ascension St. John Broken Arrow, Ascension St. John Sapulpa, Ascension St. John Jane Phillips, and Ascension St. John Nowata. By the third quarter of TY 2024, an estimated 96 percent of tactics were considered complete or on track to meet the strategy. It is notable that during the fourth quarter (Q4) of TY 2023, a major cybersecurity event occurred that impacted activities and data collection included in the implementation strategy.

Note: At the time of this report's publication (June 2025), the third year of the cycle will not yet be complete. The hospital will accommodate for that variable; results from the last year of this cycle will be reported and attached to the TY 2024 IRS Form 990 Schedule H.

Access to Care

Strategy 1: Expand access to care in the community.	
Tactic	**Impact**
Partner with community organizations to provide medical care to underserved populations.	• TY22: The Medical Access Program (MAP) subsidized more than $1.88 million in approved provider claims for 20 different medical facilities/entities. • TY23: MAP subsidized nearly $1.97 million in approved provider claims for 19 different medical facilities/entities. Ascension St. John partnered with the Tulsa Health Department to embed a community health worker in the Tulsa emergency department to identify high utilizers (more than 10 visits within the last 12 months) and offer additional care coordination and community resource navigation. • TY24 year-to-date (YTD): MAP subsidized $903,512 in approved provider claims during Q1 and Q2 for 19 different medical facilities/entities. In Q3, the Ascension St. John Health Equity Initiative partnered with churches in North Tulsa to launch the Bedrock Initiative, which will use a community health worker framework to enhance cardiovascular and mental/behavioral health.
Provide grant funding to community access to care initiatives, with a focus on those serving vulnerable populations.	• TY22: The Community Health Equity Catalyst Strategy (CHECS) and Community Benefit & Engagement Committee (CBEC) funding programs awarded more than $3.2 million in grants to 28 community-based initiatives through 26 organizations. • TY23: The CHECS and CBEC funding programs awarded more than $4.3 million in grants to 40 community-based initiatives through 36 organizations. In addition to grant funding, Ascension St. John donated more than $180,000 worth of medical supplies to Medical Bridges, a regional nonprofit that

	redistributes them free of cost to where they are most needed locally or internationally. Ascension St. John also donated 100 boxes of flu vaccines to the Eastern Oklahoma Black Nurses Association. • TY24 YTD: During Q1 and Q2, the CHECS and Community Investment Council (CIC), formerly CBEC, funding programs awarded more than $2 million in grants to 20 community-based initiatives through 17 organizations.
Identify and analyze top health equity issues in the community to drive improvement efforts.	• TY22: The system office developed an index of equity algorithms that aggregates race, ethnicity and language (REaL) data with Ascension St. John's total quality care (TQC) data. The system office produced a health equity report specific to diabetes in the Oklahoma market. The report was socialized within the market, revealing disparities by race/ethnicity for key diabetes measures. The Community Benefit and Community Health Equity teams met to discuss the market's potential next steps to address the report's findings. An initiative to develop similar reports on maternal health and cancer screenings was written into the market-level FY24 strategic plan. • TY23: Data aggregation and analysis began for the health equity reports on maternal health and cancer screenings. The health equity report on cancer screenings was released in Q4, along with a health equity analysis guide, "Advancing Health Equity." The report focuses on disparities in breast and colorectal cancer screenings in the Oklahoma market. • TY24 YTD: During Q1, the health equity report on cancer screenings was socialized within the market, revealing disparities by race/ethnicity for key cancer screening measures. Data aggregation and analysis continued for the health equity report on maternal health.
Support community organizations in efforts to reduce transportation barriers.	• TY22: The Community Health Equity team met with members of INCOG's transportation department and Area Agency on Aging to discuss relaunching a program INCOG operated to transport vulnerable individuals in North Tulsa to and from grocery stores. The program provided a way for individuals to access nutritious food in a food desert, but ran out of funding. Hospital administrators and the Community Health Equity team met with Grand Gateway Economic Development Association and Pelivan Transit. Notable points of discussion included 1) the driver shortage among all agencies/organizations and 2) the potential for Pelivan to cover Nowata-to-Bartlesville transport. The Community Benefit team met with the lead of an Ascension workgroup formed to address this disparity. Plans may ultimately involve community partners. The Community Health Equity Catalyst Strategy (CHECS) funding program financially supported the Mobile Testing Program at Health Outreach Prevention Education (H.O.P.E.) and the Mobile Medical Intervention Team at Mental Health Association Oklahoma, which both serve individuals with barriers to transportation. The Community Benefit, Community Health Equity, and Physician Practice Operations teams met with Modivcare, the Oklahoma Health Care Authority's SoonerRide contractor, to discuss concerns with the process for Medicaid patients to access their non-emergency medical transportation benefit. The Community Benefit & Engagement Committee (CBEC) funding program financially supported the American Cancer Society local chapter's program to provide gas cards for cancer patients in need of transportation to medical appointments.

	• TY23: A HoverJack Air Patient Lift was purchased and donated to the Bartlesville Ambulance Service to enhance emergency transport of patients in the community. The CHECS funding program financially supported His House Outreach Ministries (dba She Brews) for a passenger van to take Glory House residents and their children to healthcare and other appointments, and the Tulsa Dream Center to purchase an ADA-accessible, multi-passenger van to transport seniors to and from the organization, including its medical clinic. Both programs serve individuals with barriers to transportation. Throughout FY24, CHECS financially supported Skillz on Wheelz, a mobile mental/behavioral health services provider. The CHECS program, in collaboration with the Strategy team, had preliminary discussions with Oklahoma Project Woman about the possibility of a mobile mammography initiative. The CBEC funding program supported transportation to medical and social service appointments for vulnerable populations through grants to Modus Drive and Flourish Homes. The Community Benefit and Advocacy teams met with This Machine, a local bike-share nonprofit, on separate occasions to provide neighborhood-level insight on transportation barriers and discuss potential collaboration opportunities to address these disparities in all counties served by Ascension St. John. The Community Benefit team attended two community forums facilitated by Cimarron Public Transit to voice concerns with transportation-related barriers to care. • TY24 YTD: During Q1, the CIC funding program supported the lodging program at Hospitality House of Tulsa to ensure families and caregivers can be close to inpatients who live more than 30 miles away. Throughout the CHNA implementation strategy cycle, the CHECS program continuously funded Good Samaritan Health Services' mobile medical clinics, which provide care at various locations so community members do not have to travel far to see a primary care provider. During Q2, hospital leaders and the Community Benefit team discussed transportation barriers with key informants of each county during a series of community engagement sessions facilitated by The University of Oklahoma Hudson College of Public Health.

Strategy 2: Provide initiatives for improved access to care for patients.	
Tactic	**Impact**
Assist patients and other community members with enrollment/re-enrollment in Medicaid and other government assistance programs.	• TY22: The Financial Counseling team dedicated 19,791 hours to assist 874 approved patients and family members with enrollment and re-enrollment in Medicaid and other public programs. The Community Health Equity Catalyst Strategy (CHECS) funding program financially supported the Tulsa Healthcare Coverage Program through the OU-TU School of Community Medicine, which identifies uninsured residents, provides them with an eligibility screening for coverage options, and assists qualifying individuals with enrollment. The system office distributed educational materials on the public health emergency unwinding to all clinical associates. • TY23: The Financial Counseling team dedicated 19,394 hours to assist 714 approved patients and family members with enrollment and re-enrollment in Medicaid and other public programs.

	• TY24 YTD: The Financial Counseling team dedicated 9,342 hours during Q1 and Q2 to assist 335 approved patients and family members with enrollment and re-enrollment in Medicaid and other public programs.
Screen patients for social barriers to health and well-being, and connect them with local resources as appropriate.	• TY22: Patients opted into text responded affirmatively 17,331 times to 10 different questions through an online screening on social determinants of health (SDoH) in Q1 and Q2. Due to a grant ending, metrics from the online screening were no longer available in Q3 and Q4. However, the screening and resource pushes continued. Patients not opted into text responded affirmatively 7,498 times to 10 different questions through an in-person SDoH screening in FY23. In Q1, an executive sponsor and project manager were identified for the Oklahoma market's Neighborhood Resource implementation. In Q2, the Neighborhood Resource Steering Committee was established, with biweekly meetings to plan market implementation. User provisioning was completed. In Q3, the internal-facing Neighborhood Resource platform launched. Virtual training sessions for advanced users were held the week before go-live. All other users were provided access to a myLearning training (pre-recorded video) via e-blast. In Q4, the Neighborhood Resource steering committee focused on post-implementation assessment and adjustments. • TY23: Ambulatory patients not opted into text responded affirmatively 5,614 times to 10 different questions through an in-person SDoH screening. (Note: Totals for Q4 were significantly lower due to the cybersecurity event.) The Nursing team expanded the screening to inpatient areas. For these areas, the screening was modified to five question domains. Intake nurses now conduct the screening as part of the admission assessment. While data was not yet synthesized, inpatients and ambulatory patients opted into text were screened as well. As part of Phase 2 of the SDoH inpatient screening, Community Impact began collaboration with local Nursing leadership on how to integrate data with that from the ambulatory screening. Discussions included the design of an automated notification process to the Case Management team for patients with a positive screening response. • TY24 YTD: Ambulatory patients not opted into text responded affirmatively 3,376 times to 10 different questions through an in-person SDoH screening. Phase 2 of the inpatient SDoH screening was implemented, meaning the data for inpatients could be synthesized with that of ambulatory patients, allowing Ascension St. John to better analyze and draw meaning. However, for trend analysis purposes, inpatient data is not reflected in this reporting. Patients opted into text continued to receive the online SDoH screening. Internal research was conducted on associate utilization of Neighborhood Resource for connections to free and reduced-cost social services and other community resources. Simultaneously, an awareness campaign helped increase utilization metrics across the board for the market.
Reduce barriers to prescription medications for uninsured individuals with low incomes.	• TY22: The Dispensary of Hope (DoH) programs totaled $153,830 in non-salary expenses, 8,918 prescriptions, and 2,471 patient encounters. • TY23: The DoH programs totaled $136,185 in non-salary expenses, 9,356 prescriptions, and 2,757 patient encounters. • TY24 YTD: During Q1 and Q2, the DoH programs totaled $74,741 in non-salary expenses, 5,986 prescriptions, and 1,911 patient encounters. The Pharmacy

	team implemented a new charitable patient assistance program that increases access to prescription medications for individuals who do not qualify for DoH based on income (<300% of the federal poverty level) but still lack insurance coverage for prescriptions and are <400% of the FPL. Throughout the CHNA implementation strategy cycle, Ascension St. John Medical Center and Ascension St. John Sapulpa participated in the 340B Drug Pricing Program, extending reduced prices on outpatient pharmaceuticals to patients.
Offer free transportation options to patients without reliable transportation.	• TY22: Through a partnership with Lyft Inc., 3,099 rides were provided to patients experiencing transportation barriers (primarily inpatients), costing the market $69,297. Through a partnership with Morton Comprehensive Health Services, 862 rides were provided to patients (primarily outpatients), costing $41,957. Donations of $145 per ride were made to Miller EMS, 10-33, and Bartlesville Ambulance Service for round-trip transportation for nine patients in rural areas. Awareness of these programs was extended to the Outpatient Rehab and Center for Women's Health teams. A primary care clinic was set up with its own log-in for the Lyft program to address disparities in the Medicaid patient population there. • TY23: Through the Lyft partnership, 3,206 rides were provided to patients experiencing transportation barriers, costing the market $91,872. Through the Morton partnership, 436 rides were provided to patients, costing $19,925. Donations of $145 per ride were made for non-emergency medical transportation in rural areas: 10-33 for two patients, Miller EMS for two patients, Bartlesville EMS for three patients, Oologah-Talala Emergency Medical Services (OTEMS) for two patients, and Nowata EMS for one patient. Another notable initiative that relates to transportation barriers is the market's new mobile PET/CT scan that can travel to the outlying hospitals. • TY24 YTD: Through the Lyft partnership, 1,731 rides were provided to patients in need during Q1 and Q2, costing the market $46,067. Through the Morton partnership, 270 rides were provided to patients in need, costing $16,630. One donation of $135 was made to Oklahoma Med Connect for round-trip transportation for one patient in a rural area.
Offer virtual care options to reduce transfers and improve access to care for individuals without reliable transportation.	• TY22: The market virtually completed nine cardiovascular consults, 61 infectious disease consults, three neurology consults, one nephrology consult, and eight palliative care consults. The Neurology team conducted a review of telehealth service options, including costs and care delivery methods, to develop plans to provide acute and non-acute stroke care virtually to community hospitals. • TY23: The market virtually completed 10 cardiovascular consults, 221 infectious disease consults, two neurology consults, one nephrology consult, two internal medicine consults, and two palliative care consults. • TY24 YTD: The market virtually completed four family medicine consults, 157 infectious disease consults, seven neurology consults, two neurosurgery consults, and four palliative care consults. The Neurology team launched telestroke services for Oklahoma State University Medical Center (in addition to general neurology services).

Explore innovative models of care to improve maternal and infant health outcomes.	• TY22: 1) The chief advocacy officer met with Tulsa Birth Through Eight Strategy (BEST) to gather information on the BEST care model for pregnant women on Medicaid to share with the system-level workgroup on maternal health disparities. The chief medical officer was assigned to lead implementation of the BEST care model at Ascension St. John, with support from the Community Health Equity team. 2) The chief advocacy officer dedicated time to the proposed policy to increase Medicaid coverage of postpartum care from 60 days to 12 months after birth, which would impact around 2,500 patients statewide. In Q2, the Oklahoma Health Care Authority announced federal approval of the expansion to 12 months and up to 205 percent of the poverty rate. This project is considered completed. 3) The Center for Women's Health team implemented surveys of mothers post-delivery on the new TeamBirth model of care in Q1. In Q3, the Center for Women's Health team reported improved patient satisfaction scores since implementation of the TeamBirth model. This project is considered completed. 4) The Center for Women's Health team implemented a new, multi-level approach to prevent postpartum hemorrhage, one of the biggest maternal co-morbidities. The approach includes medication management, the Jada System, risk assessments at multiple points, education at discharge, and emergency department collaboration. This new care model has cut in half the average of around 140 units of blood per quarter to around 70 units of blood. 5) In collaboration with the American Heart Association (AHA), the Center for Women's Health established a new process to send home free blood pressure cuffs with pregnant women who met criteria for hypertension or preeclampsia. 6) The Center for Women's Health team connected In His Image Family Medicine Residency with local nonprofits Tulsa Birth Equity Initiative and Family & Children's Services so they can partner to care for pregnant and parenting families with substance abuse concerns and implement the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSA) Family Care Plan. 7) Several associates from the Center for Women's Health team took the March of Dimes implicit bias training for health-care professionals, "Awareness to Action: Dismantling Bias in Maternal and Infant Healthcare." • TY23: 5) The Center for Women's Health team explored options to expand the AHA blood pressure cuff program to postpartum mothers. 8) The Center for Women's Health team implemented the Edinburgh Postnatal Depression Scale (EPDS) screening tool. The tool, built into Cerner, helps identify mothers at risk for depression before discharge. The team continued to educate patients' partners about signs and symptoms of depression to spread awareness. 9) A system-wide program to reduce falls extended to the Center for Women's Health. 10) The Center for Women's Health team partnered with the Pharmacy team to add naloxone kits to the medication dispensing system on their floor. The kits are available for distribution to patients who have been identified as high-risk for opioid overdose. • TY24 YTD: This tactic is considered complete, although efforts to explore innovative models of care are ongoing.

Mental and Behavioral Health

Strategy 1: Support positive mental and behavioral health in the community.	
Tactic	**Impact**
Support community organizations and coalitions in efforts to increase access to mental and behavioral healthcare for adolescents.	• TY22: The chief advocacy officer participated in biweekly meetings of the Tulsa Pediatric Behavioral Health Work Group to explore a concept for a mental/behavioral health facility specifically for adolescents. A Shadow Mountain facility would cost an estimated $20 million and yield 24 beds. The old Parkside building would yield 40 beds. The committee expanded to include "key player" organizations, such as Parkside and Oklahoma State University Center for Health Sciences. The Behavioral Health team participated in monthly meetings of the Parkside committee specific to children and adolescent mental/behavioral health. A strategy for which planning was initiated in Q1 was a shared online platform where all area facilities can log in to update bed statuses, identify bed openings, etc. in real time. By Q3, the Parkside committee was disbanded, and the Tulsa Pediatric Behavioral Health Work Group temporarily suspended meetings. • TY23: It was confirmed that the Tulsa Pediatric Behavioral Health Work Group permanently disbanded due to lack of resources. • TY24 YTD: This tactic is considered discontinued, although Ascension St. John recognizes the importance of mental and behavioral healthcare for adolescents and continues to seek ways to support the community's efforts.
Support community organizations and coalitions in efforts to increase access to mental and behavioral healthcare for adults.	• TY22: The Behavioral Health manager participated in quarterly meetings of the community's Program of Assertive Community Treatment (PACT) committees for high utilizers of psychiatric hospitalization. The Ascension St. John Ministry & Mission Committee conducted a donation collection of hygiene items, winter clothing, etc. for PACT families. In Q2, a counselor from the Behavioral Health team started to attend PACT meetings with the manager. Ascension St. John donated space for the PACT committee meetings throughout the year. The Community Benefit director joined the Stress & Mental Health Workgroup for Tulsa Health Department's five-year community health improvement plan (CHIP). • TY23: The Behavioral Health team continued to participate on the PACT committees. Ascension St. John donated space for those meetings. The Community Benefit director continued to participate on the CHIP Stress & Mental Health Workgroup. The Behavioral Health manager participated in the Sequential Intercept Model (SIM) Mapping Workshop on how individuals with mental/behavioral health disorders move through the criminal justice system. The Psychiatric Emergency Provider community meeting series restarted; the Behavioral Health team participated, most recently discussing updates to the "Blue Streets" agreement related to patient medical clearance and placement. • TY24 YTD: The Behavioral Health team continued to participate on the PACT committees. Ascension St. John donated space for those meetings. The Behavioral Health team continued to participate in the Psychiatric Emergency Provider community meetings. The Community Benefit director continued to participate on the CHIP Stress & Mental Health Workgroup.

Provide grant funding to community mental and behavioral health initiatives, with a focus on those serving vulnerable populations.	• TY22: The Community Health Equity Catalyst Strategy (CHECS) and Community Benefit & Engagement Committee (CBEC) funding programs awarded $619,753 in grants to 16 community-based initiatives through 16 organizations. • TY23: The CHECS and Community Investment Council (CIC) (formerly Community Benefit & Engagement Committee) funding programs awarded nearly $1.3 million in grants to 19 community-based initiatives through 19 organizations. • TY24 YTD: During Q1 and Q2, the CHECS and CIC funding programs awarded $381,650 in grants to seven community-based initiatives through seven organizations.

Strategy 2: Improve mental and behavioral health services for patients.	
Tactic	**Impact**
Implement and evaluate different models of care to improve access to and timeliness of mental and behavioral health care.	• TY22: Meetings between Community Impact and Ascension Medical Group St. John were held to discuss implementation readiness for the Collaborative Care Model (CoCM). CoCM tools and a guide were provided. Various meetings among market and hospital administration and Community Impact were held to initiate plans for an EmPATH unit on the main campus. The Behavioral Health team met with Ascension Indiana to discuss Zero Suicide, a holistic suicide prevention program to be funded through a shared Substance Abuse & Mental Health Services Administration (SAMHSA) grant. The discussion included logistics and allocation of funds. Through the program, all Behavioral Health associates and other associates as appropriate will receive Assessing and Managing Suicide Risk (AMSR) training — details reported separately below — and a process will be implemented to conduct follow-up calls with patients identified as at-risk for suicide through the Columbia Suicide Severity Rating Scale (C-SSRS) screening. In Q2, the CoCM initiative was put on hold due to limited clinical bandwidth. The EmPATH unit initiative was put on hold due to economic recovery. The Behavioral Health team kickstarted follow-up calls to patients identified as at-risk for suicide, as part of the Zero Suicide initiative. The Behavioral Health team maintained contact information for all PACT leaders so they could interface with them immediately when one of their patients presented in an Ascension St. John emergency room. In Q3, Ascension St. John signed on with Ascension Indiana to participate in the SAMHSA-funded Zero Suicide program for another year. • TY23: The Behavioral Health team began data collection for follow-up calls to patients identified as at-risk for suicide, as part of the Zero Suicide initiative. The team attempted contact with 91.4 percent of patients identified as at-risk for suicide. (Note: Totals for Q4 were significantly lower due to the cybersecurity event.) They made direct contact with 260 of the 799 patients, left unanswered voicemails for 287, and found contact information to be incorrect or nonexistent for 183. • TY24 YTD: During Q1, the Behavioral Health team attempted contact with 74 percent of patients identified as at-risk for suicide; they made direct contact with 65 of the 219 patients, left unanswered voicemails for 51, and found

	contact information to be incorrect or nonexistent for 46. Due to shortages on the Behavioral Health team, the Zero Suicide follow-up calls were paused in Q2.
Provide trauma-informed care to patients at risk of trauma-related mental and behavioral health conditions (e.g., suspected victims of human trafficking).	• TY22: More than 360 hours were spent by associates on 103 human trafficking assessments or case management cases. The Human Trafficking Education & Response Program hired a dedicated patient advocate to increase community partnerships. • TY23: An estimated 1,121 hours were spent by associates on 224 human trafficking assessments or case management cases. • TY24 YTD: About 487 hours were spent by associates on 200 human trafficking assessments or case management cases during Q1 and Q2.
Offer virtual care options to reduce barriers to mental and behavioral health care.	• TY22: The market virtually completed 151 behavioral health assessments and 229 psychiatry consults. The Behavioral Health team expanded virtual behavioral health care to Broken Arrow. • TY23: The market virtually completed 213 behavioral health assessments and 368 psychiatry consults. Through a program of the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS), Ascension St. John Jane Phillips has iPads throughout the hospital to virtually connect patients in mental health crisis with GRAND Mental Health Center when the Behavioral Health team is unavailable. • TY24 YTD: The market virtually completed 360 psychiatry consults in Q1 and Q2. Due to shortages on the Behavioral Health team, the total behavioral health assessments were unavailable.
Explore internal opportunities to provide suicide prevention training.	• TY22: Through the SAMHSA-funded Zero Suicide program mentioned above, the planning process began for all Behavioral Health associates and other associates as appropriate to receive Assessing and Managing Suicide Risk (AMSR) training by the end of calendar year 2023. Eight Behavioral Health associates, six ambulatory therapists, and some primary care associates were trained in AMSR. One Behavioral Health associate attended the Oklahoma Department of Mental Health & Substance Abuse (OSDMHS) Zero Suicide Summit. • TY23-TY24: This tactic is considered complete. All Behavioral Health associates are now AMSR-trained.
Connect patients with community resources for mental and behavioral health care coordination, closing referral gaps.	• TY22: During the first two quarters, the Behavioral Health team referred patients to community resources via CHESS Health as needed. Due to system restrictions, specific metrics were unable to be reported at the time. In Q3, the Behavioral Health team gained access to the Neighborhood Resource internal-facing site and was set up as a group. The team began to use Neighborhood Resource to seek out community resources for patients and, therefore, discontinued use of CHESS. • TY23: The Behavioral Health team began to discharge patients with complimentary transportation to Family & Children's Services (F&CS) for a walk-in appointment, when deemed necessary. Throughout the year, the team continued to refine the process with F&CS to bridge patients directly to their outpatient services. The Behavioral Health team added cancer-specific resources for patients with a cancer diagnosis. The Behavioral Health team also continued to utilize Neighborhood Resource to guide patients to

	appropriate community resources. ● TY24 YTD: The Behavioral Health team continued to utilize Neighborhood Resource to guide patients to appropriate community resources.

Food Security

Strategy 1: Increase access to healthy food to address food insecurity.	
Tactic	**Impact**
Provide grant funding to community food security initiatives, with a focus on those serving vulnerable populations.	● TY22: The Community Health Equity Catalyst Strategy (CHECS) and Community Benefit & Engagement Committee (CBEC) funding programs awarded more than $1.5 million in grants to 23 community-based initiatives through 21 organizations. ● TY23: The CHECS and Community Investment Council (CIC) (formerly Community Benefit & Engagement Committee) funding programs awarded more than $1.4 million in grants to 19 community-based initiatives through 18 organizations. ● TY24 YTD: During Q1 and Q2, the CHECS and CIC funding programs awarded $968,500 in grants and donations to nine community-based initiatives through eight organizations.
Engage with community organizations and coalitions on efforts to address food insecurity.	● TY22: Potential partnerships and sponsorships specific to food security were discussed with the Nowata Community Foundation. A Community Benefit associate participated on the board of directors for Caring Community Friends. The Community Benefit team toured Global Gardens to learn more about how school-based gardening programs address food insecurity. Ascension St. John hospitals donated meeting room space to organizations focused on food security throughout the fiscal year, e.g., TSET Healthy Living. ● TY23: The Community Benefit team met with Global Gardens to explore additional partnership opportunities. The Community Benefit team met with St. Andrew Community Mission to discuss barriers to food security in North Tulsa and explore opportunities for Ascension St. John support. A Community Benefit associate continued to participate on the Caring Community Friends board. ● TY24 YTD: The Community Benefit team met with Global Gardens to stay in touch on the community's food security needs. A Community Benefit associate continued to participate on the Caring Community Friends board of directors. A senior leader participated on the board of Catholic Charities of Eastern Oklahoma, the largest provider of food to individuals in need in the state of Oklahoma. For Mission Week, the hospitals partnered with an organization in their respective community addressing food insecurity. They each hosted an associate drive for nonperishable food items in need and also donated $1,000 to their partner organization.

Strategy 2: Provide patient screenings and referrals for improved access to healthy food.	
Tactic	**Impact**
Screen patients for barriers to healthy food and connect them with local resources as appropriate.	• TY22: Patients opted into text responded affirmatively 9,209 times to two different questions on food insecurity through an online social determinants of health (SDoH) screening during Q1 and Q2. (Due to a grant ending, metrics from the online screening's two food insecurity questions were no longer available beginning Q3. However, the screening and resource pushes continued.) Patients not opted into text responded affirmatively 707 times to a question on food insecurity through an in-person SDoH screening in FY23. • TY23: Ambulatory patients not opted into text responded affirmatively 517 times to a question on food insecurity through an in-person SDoH screening. (Note: Totals for Q4 were significantly lower due to the cybersecurity event.) The Nursing team expanded the screening to inpatient areas. Intake nurses conduct the screening as part of the admission assessment. For these areas, the screening was modified to five question domains to alleviate bandwidth concerns. The food insecurity question was included: "In the last 12 months did you ever eat less than you felt you should because there wasn't enough money for food?" (Metrics from the online and inpatient screenings were unavailable.) While data was not synthesized, ambulatory patients opted into text were screened as well. • TY24 YTD: Ambulatory patients not opted into text responded affirmatively 305 times to a question on food insecurity through an in-person SDoH screening. While data was not yet synthesized, inpatients and ambulatory patients opted into text were screened as well.

Alcohol and Drug Use

Strategy 1: Increase access to community resources to mitigate alcohol and drug use.	
Tactic	**Impact**
Provide grant funding to community initiatives that help address alcohol and drug use, including prevention and harm reduction, with a focus on those serving vulnerable populations.	• TY22: The Community Benefit & Engagement Committee (CBEC) funding program awarded a $10,000 grant to one community-based initiative through one organization. • TY23: The CBEC funding program awarded $22,000 in grants to three community-based initiatives through three organizations. • TY24 YTD: During Q1, the CHECS funding program awarded $46,483 in grants to one community-based initiative through one organization.

Strategy 2: Provide internal initiatives for improved care of patients experiencing or at risk of alcohol and/or drug use.	
Tactic	**Impact**
Increase access to a variety of substance use treatment including medication-assisted treatment and innovative models of care.	• TY22: The chief advocacy officer helped get the Pharmacy team reconnected with and approved for the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSA) Opioid Overdose Prevention Project to receive naloxone kits. The Screening, Brief Intervention, and Referral to

	Treatment (SBIRT) process was used with trauma patients and inpatients. A system-level initiative was established to expand SBIRT to all patients 12+ in family medicine, pediatrics, and internal medicine. The Pharmacy team went live with the naloxone kit project. Nine kits were dispensed to patients in need. The Behavioral Health team estimated that more than 50 percent of its consultations were for alcohol and drug use. ● TY23: Thirty-one (31) naloxone kits were dispensed to patients in need. The Pharmacy team partnered with the Center for Women's Health team to add naloxone kits to the medication dispensing system on their floor. The kits are available for distribution to patients who have been identified as high-risk for opioid overdose. The SBIRT process continued to be used with trauma patients and inpatients. The system-level initiative to expand SBIRT was scoped for Q1; however, due to funding barriers, the project was put on hold. ● TY24 YTD: Seven naloxone kits were dispensed to patients in need. Ascension St. John adopted the oxytocin guidelines established by Ascension's Perinatal Quality & Health Equity Committee to standardize the use of this high-risk drug for augmentation or induction of labor (with a live fetus).
Connect patients with community resources for care coordination to address alcohol and drug use, closing referral gaps.	● TY22: During the first two quarters, the Behavioral Health team referred patients to community resources via CHESS Health as needed. Due to system restrictions, specific metrics were unable to be reported at the time. In Q3, the Behavioral Health team gained access to the Neighborhood Resource internal-facing site and was set up as a group. The team began to use Neighborhood Resource to seek out community resources for patients and, therefore, discontinued use of CHESS. Among the top 15 terms searched by all associates were "substance abuse counseling," "detox" and "sober living." The Center for Women's Health team connected In His Image Family Medicine Residency with local nonprofit Tulsa Birth Equity Initiative so they can partner to care for pregnant and parenting families with substance abuse concerns. ● TY23: The Behavioral Health team continued to utilize Neighborhood Resource to guide patients to appropriate community resources. Throughout TY 2022 and TY 2023, Community Benefit and Ascension St. John Sapulpa associates participated in the Creek County Alcohol & Substance Abuse Coalition to form and strengthen community connections. ● TY24 YTD: The Behavioral Health team continued to utilize Neighborhood Resource to guide patients to appropriate community resources.