2022

COMMUNITY HEALTH NEEDS ASSESSMENT

Saint Francis Health System

EXECUTIVE SUMMARY

April 2022
Prepared by PRC

SaintFrancis Health System

TABLE OF CONTENTS

INTRODUCTION

PROJECT OVERVIEW

Project Goals

This Community Health Needs Assessment is a systematic, data-driven approach to determining the health status, behaviors, and needs of residents in the service area of Saint Francis Health System. Subsequently, this information may be used to inform decisions and guide efforts to improve community health and wellness.

A Community Health Needs Assessment provides information so that communities may identify issues of greatest concern and decide to commit resources to those areas, thereby making the greatest possible impact on community health status. This Community Health Needs Assessment will serve as a tool toward reaching three basic goals:

- To improve residents' health status, increase their life spans, and elevate their overall quality of life. A healthy community is not only one where its residents suffer little from physical and mental illness, but also one where its residents enjoy a high quality of life.
- To reduce the health disparities among residents. By gathering demographic information along with health status and behavior data, it will be possible to identify population segments that are most at-risk for various diseases and injuries. Intervention plans aimed at targeting these individuals may then be developed to combat some of the socio-economic factors that historically have had a negative impact on residents' health.
- To increase accessibility to preventive services for all community residents. More accessible preventive services will prove beneficial in accomplishing the first goal (improving health status, increasing life spans, and elevating the quality of life), as well as lowering the costs associated with caring for late-stage diseases resulting from a lack of preventive care.

This assessment was conducted on behalf of Saint Francis Health System by PRC, a nationally recognized health care consulting firm with extensive experience conducting Community Health Needs Assessments in hundreds of communities across the United States since 1994.

Methodology

This assessment incorporates data from multiple sources, including primary research (through the PRC Community Health Survey and PRC Online Key Informant Survey), as well as secondary research (vital statistics and other existing health-related data). It also allows for comparison to benchmark data at the state and national levels.

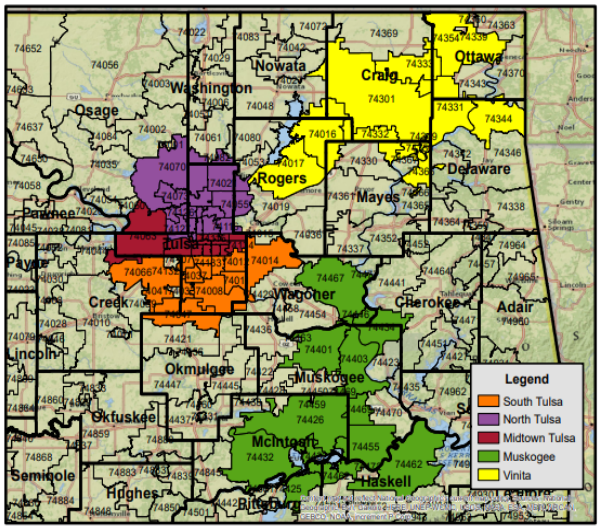
PRC Community Health Survey

Survey Instrument

The survey instrument used for this study is based largely on the Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System (BRFSS), as well as various other public health surveys and customized questions addressing gaps in indicator data relative to health promotion and disease prevention objectives and other recognized health issues. The final survey instrument was developed by Saint Francis Health System and PRC.

Community Defined for This Assessment

The study area for the survey effort (referred to as the "Saint Francis Heath System") includes each of the markets served by Saint Francis Health System facilities (including further breakdown of Tulsa communities), as illustrated in the following map.



Sample Approach & Design

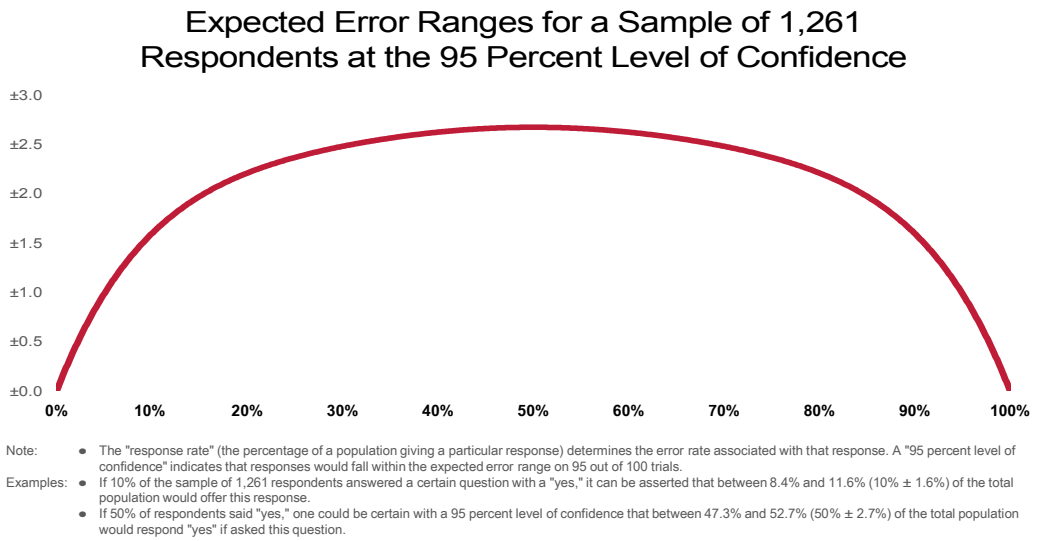
A precise and carefully executed methodology is critical in asserting the validity of the results gathered in the PRC Community Health Survey. Thus, to ensure the best representation of the population surveyed, a mixed-mode methodology was implemented. This included surveys conducted via telephone (landline and cell phone) as well as a community outreach component promoted by Saint Francis Health System through social media posting and other communications. These population based surveys were conducted from December 17, 2020 to March 13,2021.

- **RANDOM-SAMPLE SURVEYS (PRC)** ▶ For the targeted administration, PRC administered 1,001 random-sample interviews by phone among the following strata: 752 surveys in the Tulsa area (188 in North Tulsa, 201 in Midtown, and 363 in South Tulsa); 99 in the Vinita area; and 150 in the Muskogee area.
- **COMMUNITY OUTREACH SURVEYS (SPONSORING ORGANIZATIONS)** ▶ PRC also created a link to an online version of the survey, and Saint Francis Health System promoted this link throughout the various communities in order to drive additional participation and bolster overall samples, yielding an additional 260 surveys to the overall sample.

In all, 1,261 surveys were completed through these mechanisms (979 in the Tulsa area, 115 in the Vinita area, and 167 in the Muskogee area).

Once the interviews were completed, these were weighted in proportion to the actual population distribution so as to appropriately represent Saint Francis Heath System as a whole. All administration of the surveys, data collection, and data analysis was conducted by PRC.

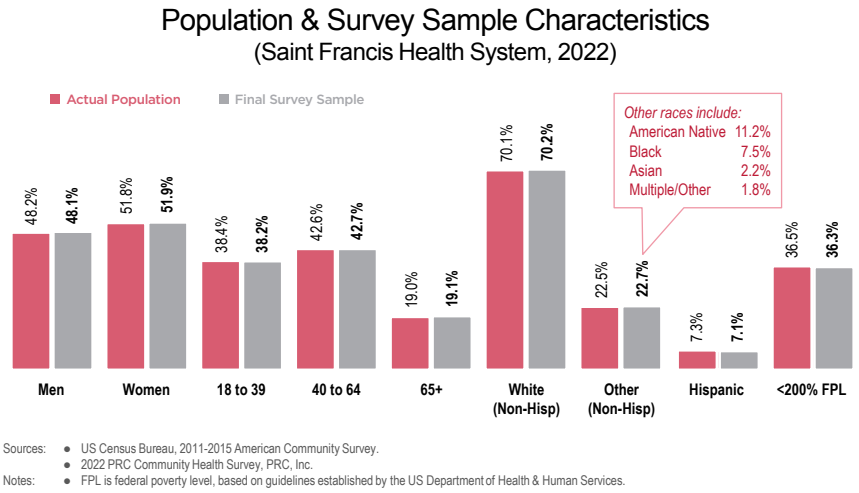
For statistical purposes, the maximum rate of error associated with a sample size of 1,261 respondents is ±2.7% at the 95 percent confidence level.



Sample Characteristics

To accurately represent the population studied, PRC strives to minimize bias through application of a proven telephone methodology and random-selection techniques. While this random sampling of the population produces a highly representative sample, it is a common and preferred practice to "weight" the raw data to improve this representativeness even further. This is accomplished by adjusting the results of a random sample to match the geographic distribution and demographic characteristics of the population surveyed (poststratification), so as to eliminate any naturally occurring bias. Specifically, once the raw data are gathered, respondents are examined by key demographic characteristics (namely sex, age, race, ethnicity, and poverty status), and a statistical application package applies weighting variables that produce a sample which more closely matches the population for these characteristics. Thus, while the integrity of each individual's responses is maintained, one respondent's responses may contribute to the whole the same weight as, for example, 1.1 respondents. Another respondent, whose demographic characteristics may have been slightly oversampled, may contribute the same weight as 0.9 respondents.

The following chart outlines the characteristics of the Saint Francis Health System sample for key demographic variables, compared to actual population characteristics revealed in census data. [Note that the sample consisted solely of area residents age 18 and older; data on children were given by proxy by the person most responsible for that child's health care needs, and these children are not represented demographically in this chart.]



The sample design and the quality control procedures used in the data collection ensure that the sample is representative. Thus, the findings may be generalized to the total population of community members in the defined area with a high degree of confidence.

Online Key Informant Survey

To solicit input from key informants, those individuals who have a broad interest in the health of the community, an Online Key Informant Survey also was implemented as part of this process. A list of recommended participants was provided by Saint Francis Health System; this list included names and contact information for physicians, public health representatives, other health professionals, social service providers, and a variety of other community leaders. Potential participants were chosen because of their ability to identify primary concerns of the populations with whom they work, as well as of the community overall. The Online Key Informant Survey too place between March 9, 2021 and March 30, 2021.

Key informants were contacted by email, introducing the purpose of the survey and providing a link to take the survey online; reminder emails were sent as needed to increase participation. In all, 96 community stakeholders took part in the Online Key Informant Survey, as outlined below:

ONLINE KEY INFORMANT SURVEY PARTICIPATION	
KEY INFORMANT TYPE	NUMBER PARTICIPATING
Physicians	29
Public Health Representatives	17
Other Health Providers	9
Social Services Providers	5
Other Community Leaders	36

Final participation included representatives of the organizations outlined below.

- Ascension St. John Foundation
- Cherokee Nation
- City of Muskogee
- City of Tulsa
- City of Vinita
- Community Advisory Member–Muskogee
- Community Service Council
- Connor's State and Community Advisory Member–Muskogee
- Diocese of Tulsa
- Due North
- EMSA
- George Kaiser Family Foundation
- Grand Lake Mental Health Clinic
- Grand Nation/TSET Craig County
- Greater Muskogee Area Chamber of Commerce
- Green Country Behavior Health
- Greenwood Chamber of Commerce
- Greenwood Cultural Center
- INCOG
- Jenks Public Schools
- John Hope Franklin Center for Reconciliation
- Lake Area United Way
- Laureate Psychiatric Clinic and Hospital
- Life Senior Services
- Make A New Way Foundation
- Met Cares Foundation
- Morton Comprehensive Health Services
- Muskogee County EMS
- Muskogee Health Department
- Muskogee Medical Center Authority
- Muskogee Public Schools
- Oklahoma Center for Community and Justice
- Oklahoma Project Woman
- Oklahoma Public Resource Center
- OSU Center for Public Life
- OSU Cooperative Extension Service
- OU College of Public Health
- OU Health–Tulsa
- Saint Francis Health System
- Saint Francis Hospital
- Saint Francis Hospital Muskogee
- Saint Francis Hospital South
- Saint Francis Hospital Vinita
- Supporters of Families with Sickle Cell Disease

Through this process, input was gathered from several individuals whose organizations work with low-income, minority, or other medically underserved populations.

In the online survey, key informants were asked to rate the degree to which various health issues are a problem in their own community. Follow-up questions asked them to describe why they identify problem areas as such and how these might better be addressed. Results of their ratings are presented at the end of this summary.

Public Health, Vital Statistics & Other Data

A variety of existing (secondary) data sources was consulted to complement the research quality of this Community Health Needs Assessment. Data for Saint Francis Health System were obtained from the following sources (specific citations are included with the graphs throughout this report):

- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension, Spark-Map (sparkmap.org)
- Centers for Disease Control & Prevention, Office of Infectious Disease, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
- Centers for Disease Control & Prevention, Office of Public Health Science Services, Center for Surveillance, Epidemiology and Laboratory Services, Division of Health Informatics and Surveillance (DHIS)
- Centers for Disease Control & Prevention, Office of Public Health Science Services, National Center for Health Statistics
- ESRI ArcGIS Map Gallery
- National Cancer Institute, State Cancer Profiles
- OpenStreetMap (OSM)
- US Census Bureau, American Community Survey
- US Census Bureau, County Business Patterns
- US Census Bureau, Decennial Census
- US Department of Agriculture, Economic Research Service
- US Department of Health & Human Services
- US Department of Health & Human Services, Health Resources and Services Administration (HRSA)
- US Department of Justice, Federal Bureau of Investigation
- US Department of Labor, Bureau of Labor Statistics

Note that secondary data reflect county-level data (reflecting Tulsa, Craig, and Muskogee counties).

Benchmark Data

Oklahoma Risk Factor Data

Statewide risk factor data are provided where available as an additional benchmark against which to compare local survey findings; these data represent the most recent *BRFSS (Behavioral Risk Factor Surveillance System) Prevalence and Trends Data* published online by the Centers for Disease Control and Prevention. State-level vital statistics are also provided for comparison of secondary data indicators.

Nationwide Risk Factor Data

Nationwide risk factor data, which are also provided in comparison charts, are taken from the *2020 PRC National Health Survey*; the methodological approach for the national study is similar to that employed in this assessment, and these data may be generalized to the US population with a high degree of confidence. National-level vital statistics are also provided for comparison of secondary data indicators.

Healthy People 2030

Healthy People provides 10-year, measurable public health objectives — and tools to help track progress toward achieving them. Healthy People identifies public health priorities to help individuals, organizations, and communities across the United States improve health and well-being. Healthy People 2030, the initiative's fifth iteration, builds on knowledge gained over the first four decades.

Healthy People 2030's overarching goals are to:

- Attain healthy, thriving lives and well-being free of preventable disease, disability, injury, and premature death.
- Eliminate health disparities, achieve health equity, and attain health literacy to improve the health and well-being of all.
- Create social, physical, and economic environments that promote attaining the full potential for health and well-being for all.
- Promote healthy development, healthy behaviors, and well-being across all life stages.
- Engage leadership, key constituents, and the public across multiple sectors to take action and design policies that improve the health and well-being of all.

The Healthy People 2030 framework was based on recommendations made by the Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2030. After getting feedback from individuals and organizations and input from subject matter experts, the U.S. Department of Health and Human Services (HHS) approved the framework which helped guide the selection of Healthy People 2030 objectives.

Determining Significance

Differences noted in this report represent those determined to be significant. For survey-derived indicators (which are subject to sampling error), statistical significance is determined based on confidence intervals (at the 95 percent confidence level), using question-specific samples and response rates. For the purpose of this report, "significance" of secondary data indicators (which do not carry sampling error but might be subject to reporting error) is determined by a 15% variation from the comparative measure.

SUMMARY OF FINDINGS

Significant Health Needs of the Community

The following "Areas of Opportunity" represent the significant health needs of the community, based on the information gathered through this Community Health Needs Assessment. From these data, opportunities for health improvement exist in the area with regard to the following health issues (see also the summary tables presented in the following section).

The Areas of Opportunity were determined after consideration of various criteria, including: standing in comparison with benchmark data (particularly national data); the preponderance of significant findings within topic areas; the magnitude of the issue in terms of the number of persons affected; and the potential health impact of a given issue. These also take into account those issues of greatest concern to the community stakeholders (key informants) giving input to this process.

AREAS OF OPPORTUNITY IDENTIFIED THROUGH THIS ASSESSMENT	

ACCESS TO HEALTH CARE SERVICES	• Lack of Health Insurance
	• Barriers to Access
	  • Inconvenient Office Hours
	  • Cost of Prescriptions
	  • Cost of Physician Visits
	  • Appointment Availability
	  • Finding a Physician
	  • Lack of Transportation
	• Skipping/Stretching Prescriptions
	• Routine Medical Care (Adults)
	• Eye Exams
	• Ratings of Local Health Care

CANCER	• Leading Cause of Death • Cancer Deaths • Including Lung Cancer and Colorectal Cancer Deaths
DIABETES	• Key Informants: Diabetes ranked as a top concern.
HEART DISEASE & STROKE	• Leading Cause of Death • Heart Disease Deaths • High Blood Pressure Prevalence • Overall Cardiovascular Risk • Key Informants: Heart disease and stroke ranked as a top concern.
INFANT HEALTH & FAMILY PLANNING	• Prenatal Care • Infant Deaths • Teen Births
INJURY & VIOLENCE	• Firearm-Related Deaths • Homicide Deaths • Violent Crime Rate • Intimate Partner Violence

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AREAS OF OPPORTUNITY (continued)	
MENTAL HEALTH	• "Fair/Poor" Mental Health • Diagnosed Depression • Symptoms of Chronic Depression • Suicide Deaths • Receiving Treatment for Mental Health • Difficulty Obtaining Mental Health Services • Key Informants: Mental health ranked as a top concern.
NUTRITION, PHYSICAL ACTIVITY & WEIGHT	• Difficulty Accessing Fresh Produce • Fruit/Vegetable Consumption • Overweight & Obesity [Adults] • Key Informants: Nutrition, physical activity, and weight ranked as a top concern.
ORAL HEALTH	• Regular Dental Care [Adults]
POTENTIALLY DISABLING CONDITIONS	• Multiple Chronic Conditions • Activity Limitations • High-Impact Chronic Pain • Alzheimer's Disease Deaths • Caregiving
RESPIRATORY DISEASE	• Lung Disease Deaths • Pneumonia/Influenza Deaths
SEXUAL HEALTH	• HIV/AIDS Deaths • Gonorrhea Incidence
SUBSTANCE ABUSE	• Cirrhosis/Liver Disease Deaths • Use of Prescription Opioids • Personally Impacted by Substance Abuse (Self or Other's) • Key Informants: Substance abuse ranked as a top concern.
TOBACCO USE	• Smokers Advised to Quit by a Health Professional • Key Informants: Tobacco use ranked as a top concern.

There is a great deal of commonality among Areas of Opportunity identified for individual facilities systemwide, as shown in the following table.

IDENTIFIED AREAS OF OPPORTUNITY	SFH	SFHV	SFHM	SYSTEM
Access to Health Care Services	X	X	X	X
Cancer	X	X	X	X
Diabetes		X	X	X
Heart Disease & Stroke	X	X	X	X
Infant Health & Family Planning	X	X	X	X
Injury & Violence	X	X	X	X
Mental Health	X	X	X	X
Nutrition, Physical Activity & Weight	X	X	X	X
Oral Health		X	X	X
Potentially Disabling Conditions	X	X	X	X
Respiratory Disease	X	X	X	X
Sexual Health	X		X	X
Substance Abuse	X	X	X	X
Tobacco Use		X	X	X

Prioritization of Health Issues

In May 2022, representatives of Saint Francis Health and individual hospitals gathered to review the data — including feedback from community members and stakeholders (representing a cross-section of community-based agencies and organizations) — and to evaluate, discuss, and prioritize health issues for community, based on findings of this Community Health Needs Assessment (CHNA). Professional Research Consultants, Inc. (PRC) began the online meeting with a presentation of key findings from the CHNA, highlighting the significant health issues identified from the research (see Areas of Opportunity above). Following the data review, PRC answered any questions. Finally, participants were provided an overview of the prioritization exercise that followed.

In order to assign priority to the identified health needs (i.e., Areas of Opportunity), a wireless audience response system was used in which each participant was able to register his/her ratings using a small remote keypad. The participants were asked to evaluate each health issue along two criteria:

- **Scope & Severity —** The first rating was to gauge the magnitude of the problem in consideration of the following:
    - *How many people are affected?*
    - *How does the local community data compare to state or national levels, or Healthy People 2030 targets?*
    - *To what degree does each health issue lead to death or disability, impair quality of life, or impact other health issues?*

  Ratings were entered on a scale of 1 (not very prevalent at all, with only minimal health consequences) to 10 (extremely prevalent, with very serious health consequences).
- **Ability to Impact —** A second rating was designed to measure the perceived likelihood of the hospital having a positive impact on each health issue, given available resources, competencies, spheres of influence, etc. Ratings were entered on a scale of 1 (no ability to impact) to 10 (great ability to impact).

Individuals' ratings for each criteria were averaged for each tested health issue for each of the facilities, and then these composite criteria scores were averaged to produce overall scores. This process yielded the following prioritized list of community health needs for the three hospitals:

Priority	Saint Francis Hospital (Tulsa)	Saint Francis Hospital Vinita	Saint Francis Hospital Muskogee
1	Mental Health	Access to Health Care Services	Heart Disease/Stroke
2	Heart Disease/Stroke	Diabetes	Mental Health
3	Access to Health Care Services	Heart Disease/Stroke	Access to Health Care Services
4	Cancer	Mental Health	Diabetes
5	Substance Abuse	Respiratory Disease	Nutrition/Physical Activity/ Weight
6	Infant Health/Family Planning	Cancer	Cancer
7	Nutrition/Physical Activity/ Weight	Tobacco Use	Substance Abuse
8	Respiratory Disease	Nutrition/Physical Activity/ Weight	Respiratory Disease
9	Potentially Disabling Conditions	Oral Health	Infant Health/Family Planning
10	Injury/Violence	Substance Abuse	Tobacco Use
11	Sexual Health	Infant Health/Family Planning	Injury/Violence
12		Potentially Disabling Conditions	Potentially Disabling Conditions
13		Injury/Violence	Oral Health
14			Sexual Health

Summary Tables: Comparisons With Benchmark Data

Reading the Summary Tables

- In the following tables, composite Saint Francis Health System results are shown in the larger, gray column.
- The columns to the left of the Saint Francis Health System column provide comparisons among the three hospital service areas (SFH in the Tulsa area, SFHV in the Vinita area, SFHM in the Muskogee area), identifying differences for each as "better than" (☀️), "worse than" (🌧️), or "similar to" (☁️) the other two hospital service areas combined.
- The columns to the right of the Saint Francis Health System column provide comparisons between composite system data and any available state and national findings, and Healthy People 2030 objectives. Again, symbols indicate whether the Saint Francis Health System compares favorably (☀️), unfavorably (🌧️), or comparably (☁️) to these external data.

Note that blank table cells signify that data are not available or are not reliable for that area and/or for that indicator.

Tip: Indicator labels beginning with a "%" symbol are taken from the PRC Community Health Survey; the remaining indicators are taken from secondary data sources.

SOCIAL DETERMINANTS	DISPARITY AMONG SERVICE AREAS			Saint Francis Health System	SYSTEM VS. BENCHMARKS		
	SFH	SFHV	SFHM		vs. OK	vs. US	vs. HP2030
Linguistically Isolated Population (Percent)	3.5	0.4	0.5	3.1	2.1	4.3	
Population in Poverty (Percent)	15.0	18.6	21.1	15.6	15.7	13.4	8.0
Children in Poverty (Percent)	21.8	25.1	29.4	22.6	21.5	18.5	8.0
No High School Diploma (Age 25+, Percent)	10.6	13.2	14.8	11.0	12.0	12.0	
% Unable to Pay Cash for a $400 Emergency Expense	28.7	33.2	34.7	29.9		24.6	
% Worry/Stress Over Rent/Mortgage in Past Year	33.3	33.9	30.9	33.1		32.2	
% Unhealthy/Unsafe Housing Conditions	19.0	19.6	18.1	19.0		12.2	
% Food Insecure	29.9	35.7	36.1	31.2		34.1	

Note: In the section above, each service area is compared against the other two combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

OVERALL HEALTH	DISPARITY AMONG SERVICE AREAS			Saint Francis Health System	SYSTEM VS. BENCHMARKS		
	SFH	SFHV	SFHM		vs. OK	vs. US	vs. HP2030
% "Fair/Poor" Overall Health	13.7	23.9	20.7	15.6	21.9	12.6	

Note: In the section above, each service area is compared against the other two combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

Better Similar Worse

	DISPARITY AMONG SERVICE AREAS				SYSTEM VS. BENCHMARKS		
ACCESS TO HEALTH CARE	**SFH**	**SFHV**	**SFHM**	**Saint Francis Health System**	**vs. OK**	**vs. US**	**vs. HP2030**
% [Age 18-64] Lack Health Insurance	11.1	17.3	11.8	**11.8**	19.1	8.7	7.9
% Difficulty Accessing Health Care in Past Year (Composite)	53.6	42.9	45.6	**51.6**		35.0	
% Cost Prevented Physician Visit in Past Year	22.7	20.1	18.0	**21.9**	16.2	12.9	
% Cost Prevented Getting Prescription in Past Year	21.8	16.1	14.6	**20.4**			
% Difficulty Getting Appointment in Past Year	29.1	21.8	27.0	**28.1**		14.5	
% Inconvenient Hrs Prevented Dr Visit in Past Year	19.3	14.6	15.1	**18.4**			
% Difficulty Finding Physician in Past Year	18.9	14.1	20.2	**18.5**		9.4	
% Transportation Hindered Dr Visit in Past Year	11.7	10.7	10.5	**11.4**		8.9	
% Language/Culture Prevented Care in Past Year	1.2	2.5	0.0	**1.2**		2.8	
% Skipped Prescription Doses to Save Costs	20.6	16.1	17.6	**19.8**		12.7	
% Difficulty Getting Child's Health Care in Past Year	9.0			**9.8**		8.0	
Primary Care Doctors per 100,000	130.6	70.9	101.0	**126.9**	85.6	102.0	

Better Similar Worse

ACCESS TO HEALTH CARE (continued)	DISPARITY AMONG SERVICE AREAS			Saint Francis Health System	SYSTEM VS. BENCHMARKS		
	SFH	SFHV	SFHM		vs. OK	vs. US	vs. HP2030
% Have a Specific Source of Ongoing Care	72.1	69.5	71.0	71.7		74.2	84.0
% Have Had Routine Checkup in Past Year	62.2	57.9	64.6	62.0	74.5	70.5	
% Child Has Had Checkup in Past Year	79.2			80.8		77.4	
% Two or More ER Visits in Past Year	11.0	13.3	18.0	12.0		10.1	
% Eye Exam in Past 2 Years	50.3	47.4	60.3	51.2		61.0	61.1
% Rate Local Health Care “Fair/Poor”	15.4	10.6	14.5	14.8		8.0	

Note: In the section above, each service area is compared against the other two combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

CANCER	DISPARITY AMONG SERVICE AREAS			Saint Francis Health System	SYSTEM VS. BENCHMARKS		
	SFH	SFHV	SFHM		vs. OK	vs. US	vs. HP2030
Cancer (Age-Adjusted Death Rate)	162.8	169.9	195.1	166.2	174.1	146.5	122.7
Lung Cancer (Age-Adjusted Death Rate)				41.3	45.5	33.4	25.1
Prostate Cancer (Age-Adjusted Death Rate)				20.2	19.5	18.5	16.9

Better Similar Worse

CANCER (continued)	DISPARITY AMONG SERVICE AREAS			Saint Francis Health System	SYSTEM VS. BENCHMARKS		
	SFH	SFHV	SFHM		vs. OK	vs. US	vs. HP2030
Female Breast Cancer (Age-Adjusted Death Rate)				20.9	22.7	19.4	15.3
Colorectal Cancer (Age-Adjusted Death Rate)				16.6	16.3	13.1	8.9
Cancer Incidence Rate (All Sites)	472.7	462.4	473.5	472.5	450.2	448.6	
Female Breast Cancer Incidence Rate	136.3	117.4	103.8	132.4	124.2	126.8	
Prostate Cancer Incidence Rate	113.9	89.0	91.9	110.8	95.7	106.2	
Lung Cancer Incidence Rate	61.9	74.5	84.7	64.7	66.7	57.3	
Colorectal Cancer Incidence Rate	40.4	49.8	41.4	40.7	41.2	38.0	
% Cancer	6.9	14.4	11.2	8.1	12.2	10.0	
% [Women 50-74] Mammogram in Past 2 Years	73.3			72.2	74.3	76.1	77.1
% [Women 21-65] Cervical Cancer Screening	75.1			74.2	76.1	73.8	84.3
% [Age 50-75] Colorectal Cancer Screening	76.8		69.1	75.1	62.6	77.4	74.4

Note: In the section above, each service area is compared against the other two combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

Better Similar Worse

DIABETES	DISPARITY AMONG SERVICE AREAS			Saint Francis Health System	SYSTEM VS. BENCHMARKS		
	SFH	SFHV	SFHM		vs. OK	vs. US	vs. HP2030
Diabetes (Age-Adjusted Death Rate)	20.9		34.9	22.4	29.9	22.6	
% Diabetes/High Blood Sugar	12.8	18.9	19.9	14.2	12.2	13.8	
% Borderline/Pre-Diabetes				10.5		9.7	
% [Non-Diabetics] Blood Sugar Tested in Past 3 Years	44.5	45.3	45.9	44.7		43.3	

Note: In the section above, each service area is compared against the other two combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

HEART DISEASE & STROKE	DISPARITY AMONG SERVICE AREAS			Saint Francis Health System	SYSTEM VS. BENCHMARKS		
	SFH	SFHV	SFHM		vs. OK	vs. US	vs. HP2030
Diseases of the Heart (Age-Adjusted Death Rate)	244.6	299.2	342.8	256.1	234.7	164.4	127.4
% Heart Disease (Heart Attack, Angina, Coronary Disease)	6.2	14.3	11.7	7.7	8.3	6.1	
Stroke (Age-Adjusted Death Rate)	43.2	36.3	54.6	44.2	39.8	37.6	33.4
% Stroke	3.5	0.6	3.1	3.2	4.4	4.3	
% Told Have High Blood Pressure	44.3	51.0	56.5	46.3	37.8	36.9	27.7

Better Similar Worse

HEART DISEASE & STROKE (continued)	DISPARITY AMONG SERVICE AREAS			Saint Francis Health System	SYSTEM VS. BENCHMARKS		
	SFH	SFHV	SFHM		vs. OK	vs. US	vs. HP2030
% Told Have High Cholesterol	33.0	36.0	41.9	34.3		32.7	
% 1+ Cardiovascular Risk Factor	88.2	94.8	96.1	89.8		84.6	

Note: In the section above, each service area is compared against the other two combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

INFANT HEALTH & FAMILY PLANNING	DISPARITY AMONG SERVICE AREAS			Saint Francis Health System	SYSTEM VS. BENCHMARKS		
	SFH	SFHV	SFHM		vs. OK	vs. US	vs. HP2030
Low Birthweight Births (Percent)	8.3	7.6	8.0	8.2	8.0	8.2	
Infant Death Rate	7.3		7.8	7.4	6.6	5.5	5.0
Late or No Prenatal Care (Percent)	7.5			7.5	6.7	6.1	
Births to Adolescents Age 15 to 19 (Rate per 1,000)	31.0	39.8	43.1	32.3	33.3	20.9	

Note: In the section above, each service area is compared against the other two combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

Better Similar Worse

INJURY & VIOLENCE	DISPARITY AMONG SERVICE AREAS			Saint Francis Health System	SYSTEM VS. BENCHMARKS		
	SFH	SFHV	SFHM		vs. OK	vs. US	vs. HP2030
Unintentional Injury (Age-Adjusted Death Rate)	52.7	61.9	67.7	54.3	60.8	51.6	43.2
Motor Vehicle Crashes (Age-Adjusted Death Rate)	12.3		17.0	12.9	16.7	11.4	10.1
[65+] Falls (Age-Adjusted Death Rate)	70.6		72.2	70.0	106.4	67.1	63.4
Firearm-Related Deaths (Age-Adjusted Death Rate)	19.8		16.1	19.5	18.7	12.5	10.7
Homicide (Age-Adjusted Death Rate)	10.5		12.3	10.5	8.3	6.1	5.5
Violent Crime Rate	699.0	146.8	744.3	692.2	443.5	416.0	
% Victim of Violent Crime in Past 5 Years	6.3	5.8	2.8	5.9		6.2	
% Victim of Intimate Partner Violence	21.4	17.9	19.7	20.9		13.7	

Note: In the section above, each service area is compared against the other two combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

KIDNEY DISEASE	DISPARITY AMONG SERVICE AREAS			Saint Francis Health System	SYSTEM VS. BENCHMARKS		
	SFH	SFHV	SFHM		vs. OK	vs. US	vs. HP2030
Kidney Disease (Age-Adjusted Death Rate)	8.1		10.3	8.4	10.7	12.8	
% Kidney Disease	3.6	3.9	4.2	3.7	4.0	5.0	

Note: In the section above, each service area is compared against the other two combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

Better Similar Worse

MENTAL HEALTH	DISPARITY AMONG SERVICE AREAS			Saint Francis Health System	SYSTEM VS. BENCHMARKS		
	SFH	SFHV	SFHM		vs. OK	vs. US	vs. HP2030
% "Fair/Poor" Mental Health	27.4	24.5	24.3	26.7		13.4	
% Diagnosed Depression	33.8	27.0	37.3	33.5	23.0	20.6	
% Symptoms of Chronic Depression (2+ Years)	43.8	40.0	46.8	43.7		30.3	
% Typical Day Is "Extremely/Very" Stressful	19.5	14.5	15.9	18.6		16.1	
Suicide (Age-Adjusted Death Rate)	19.9		19.0	20.0	20.8	13.9	12.8
Mental Health Providers per 100,000	214.9	801.0	327.1	235.8	219.0	123.1	
% Taking Rx/Receiving Mental Health Trtmt	24.4	21.1	30.5	24.8		16.8	
% Unable to Get Mental Health Svcs in Past Yr	14.6	8.4	8.7	13.3		7.8	
% Spent <7 Hours on Personal Time Last Week	38.5	43.0	35.4	38.6			

Note: In the section above, each service area is compared against the other two combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

Better Similar Worse

NUTRITION, PHYSICAL ACTIVITY & WEIGHT	DISPARITY AMONG SERVICE AREAS			Saint Francis Health System	SYSTEM VS. BENCHMARKS		
	SFH	SFHV	SFHM		vs. OK	vs. US	vs. HP2030
Population With Low Food Access (Percent)	25.5	26.8	14.6	24.4	25.2	22.2	
% "Very/Somewhat" Difficult to Buy Fresh Produce	27.0	32.6	30.6	27.9		21.1	
% 5+ Servings of Fruits/Vegetables per Day	28.5	23.5	26.0	27.7		32.7	
% No Leisure-Time Physical Activity	29.8	36.3	41.9	31.8	34.0	31.3	21.2
% Meeting Physical Activity Guidelines	19.8	18.4	15.4	19.2	15.6	21.4	28.4
% Child [Age 2-17] Physically Active 1+ Hours per Day	35.6			37.7		33.0	
Recreation/Fitness Facilities per 100,000				13.2	9.3	12.2	
% Overweight (BMI 25+)	70.8	73.7	76.6	71.8	71.4	61.0	
% Obese (BMI 30+)	38.9	42.1	48.8	40.4	36.8	31.3	36.0
% Children [Age 5-17] Overweight (85th Percentile)	30.7			31.8		32.3	
% Children [Age 5-17] Obese (95th Percentile)	17.1			18.5		16.0	15.5

Note: In the section above, each service area is compared against the other two combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

Better Similar Worse

ORAL HEALTH	DISPARITY AMONG SERVICE AREAS			Saint Francis Health System	SYSTEM VS. BENCHMARKS		
	SFH	SFHV	SFHM		vs. OK	vs. US	vs. HP2030
% Have Dental Insurance	72.7	60.4	67.7	70.9		68.7	59.8
% [Age 18+] Dental Visit in Past Year	59.9	48.4	47.2	57.3	60.4	62.0	45.0
% Child [Age 2-17] Dental Visit in Past Year	79.5			78.2		72.1	45.0

Note: In the section above, each service area is compared against the other two combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

POTENTIALLY DISABLING CONDITIONS	DISPARITY AMONG SERVICE AREAS			Saint Francis Health System	SYSTEM VS. BENCHMARKS		
	SFH	SFHV	SFHM		vs. OK	vs. US	vs. HP2030
% 3+ Chronic Conditions	41.9	42.8	60.9	44.2		32.5	
% Activity Limitations	30.8	36.3	37.9	32.1		24.0	
% With High-Impact Chronic Pain	18.9	19.0	28.2	19.9		14.1	7.0
Alzheimer's Disease (Age-Adjusted Death Rate)	40.1	35.9	33.4	39.3	38.0	30.9	
% Caregiver to a Friend/Family Member	30.1	28.3	31.8	30.1		22.6	

Note: In the section above, each service area is compared against the other two combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

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RESPIRATORY DISEASE	DISPARITY AMONG SERVICE AREAS			Saint Francis Health System	SYSTEM VS. BENCHMARKS		
	SFH	SFHV	SFHM		vs. OK	vs. US	vs. HP2030
CLRD (Age-Adjusted Death Rate)	49.8	97.7	78.5	54.0	62.0	38.1	
Pneumonia/Influenza (Age-Adjusted Death Rate)	15.1		22.8	16.0	15.1	13.4	
% [Age 65+] Flu Vaccine in Past Year	76.9			77.9	69.5	71.0	
% [Adult] Asthma	13.9	9.2	11.9	13.2	10.2	12.9	
% [Child 0-17] Asthma	8.4			8.7		7.8	
% COPD (Lung Disease)	6.0	8.8	9.0	6.6	8.7	6.4	
COVID-19 (Age-Adjusted Death Rate)	83.3		125.4	87.5	100.3	85.0	

Note: In the section above, each service area is compared against the other two combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

SEPTICEMIA	DISPARITY AMONG SERVICE AREAS			Saint Francis Health System	SYSTEM VS. BENCHMARKS		
	SFH	SFHV	SFHM		vs. OK	vs. US	vs. HP2030
Septicemia (Age-Adjusted Death Rate)	6.8		14.8	7.8	9.2	9.8	

Note: In the section above, each service area is compared against the other two combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

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SEXUAL HEALTH	DISPARITY AMONG SERVICE AREAS			Saint Francis Health System	SYSTEM VS. BENCHMARKS		
	SFH	SFHV	SFHM		vs. OK	vs. US	vs. HP2030
HIV/AIDS (Age-Adjusted Death Rate)				2.2	1.5	1.8	
HIV Prevalence Rate	303.0	223.2	191.6	290.9	192.0	372.8	
Chlamydia Incidence Rate				678.7	559.0		
Gonorrhea Incidence Rate	322.8	111.7	221.5	309.0	228.9	179.1	

Note: In the section above, each service area is compared against the other two combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

SUBSTANCE ABUSE	DISPARITY AMONG SERVICE AREAS			Saint Francis Health System	SYSTEM VS. BENCHMARKS		
	SFH	SFHV	SFHM		vs. OK	vs. US	vs. HP2030
Cirrhosis/Liver Disease (Age-Adjusted Death Rate)	16.2		19.2	16.5	16.2	11.9	10.9
% Excessive Drinker	23.0	23.2	19.6	22.6	13.6	27.2	
Unintentional Drug-Related Deaths (Age-Adjusted Death Rate)	18.6		21.1	18.8	15.9	21.0	
% Illicit Drug Use in Past Month	3.0	0.0	3.6	2.8		2.0	12.0
% Used a Prescription Opioid in Past Year	14.6	18.0	23.2	15.9		12.9	
% Ever Sought Help for Alcohol or Drug Problem	7.4	3.1	6.8	6.9		5.4	
% Personally Impacted by Substance Abuse	46.5	48.9	39.0	46.0		35.8	

Note: In the section above, each service area is compared against the other two combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

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TOBACCO USE	DISPARITY AMONG SERVICE AREAS			Saint Francis Health System	SYSTEM VS. BENCHMARKS		
	SFH	SFHV	SFHM		vs. OK	vs. US	vs. HP2030
% Current Smoker	17.4	25.7	22.1	18.8	18.9	17.4	5.0
% Someone Smokes at Home	14.9	19.5	17.5	15.6		14.6	
% [Household With Children] Someone Smokes in the Home	16.7			18.3		17.4	
% [Smokers] Have Quit Smoking 1+ Days in Past Year	51.7			42.5	58.0	42.8	65.7
% [Smokers] Received Advice to Quit Smoking	54.2			51.1		59.6	66.6
% Currently Use Vaping Products	10.8	7.2	10.0	10.3	7.1	8.9	

Note: In the section above, each service area is compared against the other two combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

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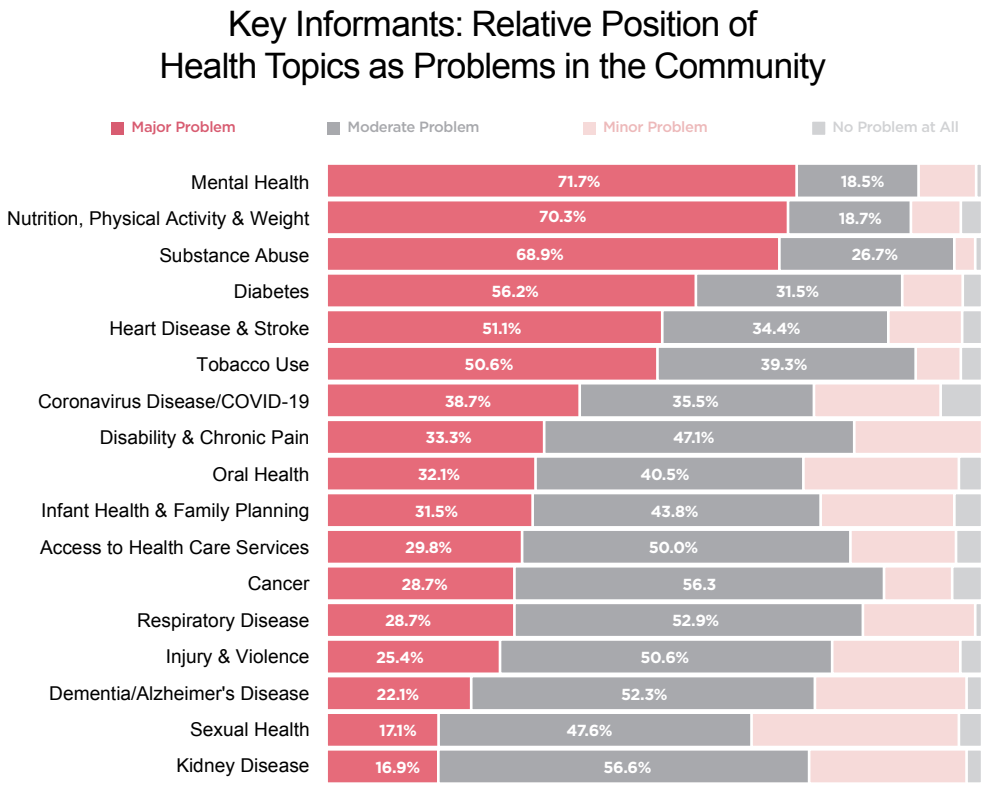
SUMMARY OF KEY INFORMANT PERCEPTIONS

In the Online Key Informant Survey, community stakeholders were asked to rate the degree to which each of 17 health issues is a problem in their own community, using a scale of "major problem," "moderate problem," "minor problem," or "no problem at all." The following chart summarizes their responses; these findings also are outlined throughout this report, along with the qualitative input describing reasons for their concerns. (Note that these ratings alone do not establish priorities for this assessment; rather, they are one of several data inputs considered for the prioritization process described earlier.)



EVALUATION OF PAST ACTIVITIES

Community Benefit

Over the past three years, Saint Francis Health System has invested in improving the health of our community's most vulnerable populations. Our commitment to this goal is reflected in:

- Over $422 Million in community benefit.

Of Which;

- More than $251 Million was given through our charity care and other financial assistance programs.

Our work also reflects a focus on community health improvement, as described below.

2020 • 2021 • 2022

Addressing Significant Health Needs

Saint Francis Health System which includes, Saint Francis Hospital, Saint Francis Hospital Muskogee, Saint Francis Hospital South, Saint Francis Hospital Vinita and Laureate Psychiatric Clinic and Hospital conducted its last CHNA in 2019 and reviewed the health priorities identified through that assessment. Taking into account the top-identified needs — as well as hospital resources and overall alignment with the hospital's mission, goals and strategic priorities — it was determined at that time that Saint Francis Health System would focus on developing and/or supporting strategies and initiatives to improve:

- Access to Health Care Services
- Behavioral Health
- Chronic Disease and Stroke
- Lack of Health Insurance/Ability to Pay for Healthcare

Strategies for addressing these needs were outlined in Saint Francis Health System's Implementation Strategy. Pursuant to IRS requirements, the following sections provide an evaluation of the impact of the actions taken by the health system to address these significant health needs in its communities.

Evaluation of Impact

Priority Area: Access to Health Care Services	
Community Health Need	Improve access to primary care and specialty services.
Goal(s)	• Increase health education and preventative care provided in the community setting through partnerships with community organizations, faith-based organizations and other institutions; • Improve access to health care providers to match the increasing need for services in the region through recruitment of physicians and clinical staff, training and development of health professionals; and • Improve access to healthcare providers by developing virtual visit capabilities.

Strategy 1: COMMUNITY PARTNERSHIPS AND EVENTS

Strategy Was Implemented?	Yes
Target Population(s)	All residents of eastern Oklahoma and the homeless population of Tulsa County
Partnering Organization(s)	Internal: Xavier Medical Clinic, Warren Clinic External: Tulsa Health Department, Muskogee Health Department, Craig County Health Department, John 3:16 Mission, Under the Bridge, Iron Gate, Night Light Tulsa, Catholic Charities of Eastern Oklahoma

Results/Impact	• Flu Vaccination Program:
	  • In FY2020, 248 vaccinations were given at no cost to the homeless population of Tulsa and at Saint Francis' charity clinic. Over the course of the flu campaign, Saint Francis gave 4,662 vaccines to residents of eastern Oklahoma.
	  • In FY2021, 101 vaccinations were given to the homeless population of Tulsa. Overall, Saint Francis gave 10,062 flu shots to residents of eastern Oklahoma
	  • In FY2022, 87 vaccinations were given to the homeless population of Tulsa, Overall, Saint Francis gave 5,849 flu shots to the residents of eastern Oklahoma
	• COVID-19 Vaccination Program:
	  • During the early stages of the pandemic, Saint Francis put out education and information to the public regarding the pandemic. The health system worked closely with the local health departments, local grocery stores in the disbursement of masks and was primary location for storing vaccines for Tulsa and Muskogee County as well as the surrounding communities.
	  • Saint Francis also established a COVID hotline for patients to call with questions, concerns or to schedule an appointment for testing. Over the course of the pandemic the hotline fielded 93,742 calls. Saint Francis was the first drive-thru testing site in Tulsa County, established another in Muskogee County, tested 285,560 patients and gave over 138,671 vaccinations.
	• The Center for Community Health was developed in partnership with the Tulsa Health Department to address the needs of patients who are complex or are high utilizers of healthcare services within Tulsa County. This program was revamped multiple times during the course of the 2019 CHNA implementation to better assist those who were identified and to make the program more effective.
	• In early FY2022, Saint Francis assisted Catholic Charities of Eastern Oklahoma in welcoming 850 Afghan refugees to Tulsa. Specifically, Saint Francis helped with the initial health screenings, donated medical supplies and personal items to support refugees, and helped provide ongoing health assessments of the refugees after their arrival in Tulsa.

Strategy 2: WORKFORCE RECRUITMENT	
Strategy Was Implemented?	Yes
Target Population(s)	Residents of eastern Oklahoma
Partnering Organization(s)	Internal: Warren Clinic External: Oklahoma Manpower Training Commission, OSUCHS
Results/Impact	• In FY2020 the Warren Clinic hired at total of 50 physicians and 25 mid-levels; During this time the Warren Clinic also lost 17 physicians and 30 mid-levels primarily because of the effect on patient volume during the onset of the COVID-19 pandemic. In total the Warren Clinic completed 1,012,285 patient visits in FY2020. • In FY2020 Saint Francis recruited 608 nurses to the system. • In FY2021 the Warren Clinic hired a total of 51 physicians and 33 mid-levels; During this time the Warren Clinic also lost 35 physicians and 17 mid-levels. In total the Warren Clinic completed 1,079,623 patient visits. • In FY2021 Saint Francis recruited 678 nurses to the system. • In FY2022 the Warren Clinic hired a total of 46 physicians and 43 mid-levels; During this time the Warren Clinic also lost 41 physicians 27 mid-levels. In total the Warren Clinic is annualizing to complete 1,131,939 patient visits. • In FY2022 Saint Francis is projecting to recruit a total of 745 nurses.

Strategy 3: TELEHEALTH OUTREACH

Strategy Was Implemented?	Yes
Target Population(s)	Residents of eastern Oklahoma
Partnering Organization(s)	Internal: Saint Francis Health System, Warren Clinic External: US Acute Care Solutions

Results/Impact	• Electronic Visits (E-Visits) – a condition specific online questionnaire that was developed to address patient's non-urgent healthcare needs without requiring a physician visit. (Rash, UTI, etc.)
	  ▪ In FY2020 Saint Francis implemented e-visits and started to enroll employed physicians into the program. A total of 5,935 E-Visits were completed during the year.
	  ▪ In FY2021, there were 8,024 e-visits completed.
	  ▪ In FY2022, the health system is annualizing to complete 7,713 e-visits and increased the number of specific conditions that are allowed to be completed by the questionnaire.
	• Virtual Visits (V-Visits) – Face to Face physician consultations that are being conducted virtually.
	  ▪ Due to the COVID-19 pandemic beginning in the second half of FY2020 and the Public Health Emergency resulting from the pandemic, Saint Francis was able to speed the implementation of its virtual visit capabilities. Commercially available applications such as Facetime, Google Duo and others were made available for virtual visits. In FY2020 Saint Francis conducted 49,164 v-visits.
	  ▪ In FY2021, there were 115,717 v-visits completed. During this time Saint Francis rolled out a 24/7 virtual urgent care option. This option includes a seamless transition from their primary care physician office to the urgent care encounter with all locally based Tulsa providers. Virtual care clinics were also implemented in Vinita and McAlester to allow patients to stay local while seeking specialty care consultations.
	  ▪ In FY2022, Saint Francis transitioned all v-visits to HIPAA compliant software through its EHR System EPIC. In FY2022 Saint Francis is annualizing to complete 78,293 v-visits
	• Saint Francis signed a contract with a remote monitoring vender and gave health monitoring kits to selected patients with a HF diagnosis for ongoing evaluation.

Priority Area: Behavioral Health	
Community Health Need	Improve access and treatment options for behavioral health patients.
Goal(s)	• Improve community access to behavioral health resources, services and education; • Improve access to effective treatments and services for mental health and substance abuse disorders in rural areas; and • Coordinate general and behavioral health to improve outcomes, reduce use of emergency and inpatient care and decrease costs.

Strategy 1: BEHAVIORAL HEALTH COMMUNITY EDUCATION	
Strategy Was Implemented?	Yes
Target Population(s)	Residents and providers of eastern Oklahoma
Partnering Organization(s)	Internal: Laureate Psychiatric Clinic and Hospital External:
Results/Impact	• In FY2020, Dr. John Otis gave a seminar at Laureate Psychiatric Clinic and Hospital on a step-by-step guide of how to use his cognitive behavioral therapy manual for chronic pain with patients. • The Zarrow Symposium at Laureate was held in FY2020 where behavioral health providers from eastern Oklahoma gather to discuss new treatments and protocols around mental health. • Saint Francis conducts major marketing campaigns directed to raising awareness of Mental Health within Tulsa and the surrounding counties. • In FY2022, Laureate begin using their licensed therapist to put together educational sessions and webinars to help educate others within the market about what is going on and how as behavioral health experts they can work to address those issues.

Strategy 2: BEHAVIORAL HEALTH CONTINUUM OF CARE	
Strategy Was Implemented?	Yes
Target Population(s)	Behavioral Health patients throughout the health system
Partnering Organization(s)	Internal: Saint Francis Hospital Vinita, Saint Francis Hospital Muskogee, Saint Francis Hospital, Saint Francis Hospital South and Laureate Psychiatric Clinic and Hospital External: Tulsa Mental Health Association
Results/Impact	• In FY2020 telehealth carts were deployed to SFH-S, SFH-M and SFH-V which gave Laureate physicians the ability to consult with patients at the different locations systemwide. • In order to bring consistency to the psychiatric services within the Saint Francis Health System, all behavioral health services and units on all campuses were consolidated under the Laureate leadership in FY2020. • In FY2022, the Clinical Assessment Department at Laureate gained responsibility for coordinating all behavioral health transfer requests and bed placements across the health system. • In FY2022, Saint Francis rolled out the behavioral health module in EPIC. This module will help with treatment planning and help staff conduct safety checks systemwide.

Strategy 3: BEHAVIORAL HEALTH INTEGRATION WITH PRIMARY CARE AND EMERGENCY SERVICES	
Strategy Was Implemented?	Yes
Target Population(s)	Residents of eastern Oklahoma
Partnering Organization(s)	Internal: Laureate Psychiatric Clinic and Hospital External: Crisis and Recovery Services of Oklahoma, OU School of Community Medicine, Healthy Minds
Results/Impact	• In FY2020 Laureate rolled out a Modified Agitation Severity Scale (MASS) and Behavioral Health Integrated Virtual Clinic (BHIV) to assist with faster response times and awareness of escalating agitation with patients as well as to help with the writing/distributing guidelines for the use of antipsychotic medication for the senior population. MASS generates a set of behaviors for nurses and technicians to be aware of when taking care of mental health patients. When a behavior is recognized, a physician-approved order set can be set in motion to address the behavior in the early stages with physician approval. • In order to help Warren Clinic primary care physicians manage their patients mood disorder medications, a pharmacists at Laureate was made available to help adjust those medications without requiring a psychiatric consult. • In FY2020, the decision was made to remove the embedded licensed clinical social worker (LCSW) in one of the Comprehensive Primary Care Plus offices and instead allow that LCSW to work with multiple offices and extend their reach while also improving their productivity. • In FY2022, Saint Francis Children's Hospital and Laureate worked alongside Crisis and Recovery Services of Oklahoma to establish a pediatric behavioral health urgent care in Tulsa County to help direct behavioral health patients to appropriate care settings. • In FY2022, Saint Francis Health System Board of Directors approved the expansion of Laureate to accommodate a renovation of the clinical assessment department, an observation unit and the addition of a 60 bed geropsychiatric unit. • In FY2022, the BHIV clinic was expanded to help address all behavioral health needs for Warren Clinic patients.

Priority Area: Chronic Disease and Stroke	
Community Health Need	Improving outcomes related to chronic diseases
Goal(s)	• Increase access to high-quality disease prevention and management for chronic diseases and stroke; • Improve access to key specialists in rural areas to improve treatment of chronic diseases and stroke; and • Improve access to high-quality, coordinated cancer care for enrolled Medicare beneficiaries.

Strategy 1: CHRONIC DISEASE OUTREACH PROGRAMS	
Strategy Was Implemented?	Yes
Target Population(s)	Warren Clinic CommunityCare patients
Partnering Organization(s)	Internal: Warren Clinic, Saint Francis Health System External: CommunityCare of Oklahoma, Cipher Health
Results/Impact	• In FY2020, order sets and protocols were standardized and made consistent with scientifically validated clinical practice guidelines across the health system. • In FY2020, Saint Francis Hospital's comprehensive stroke certification was affirmed. • Warren Clinic CommunityCare patients with diabetes receive direct mailings about how to manage their disorder appropriately, encourage the use of screenings and encourage testing. • Every fiscal year during the month of February, Heart month, Saint Francis encourages and markets, heart screening services at all hospital locations. • During the month of October, the health system also markets awareness of breast cancer and encourages residents to get screenings. • In FY2021, the health system rolled out Cipher Health to all hospital locations. Cipher health uses final coded DRGs to match patient cohorts of AMI, HF, COPD and PN. Every patient within the cohort is contacted by an automated phone system after discharge to help the system triage those who may be in need of additional medical care. Each patient receives four outreach calls over 30-days post-discharge.

Strategy 2: RURAL ACCESS TO CHRONIC DISEASE SERVICES

Strategy Was Implemented?	Yes
Target Population(s)	Rural Oklahoma residents
Partnering Organization(s)	Internal: Saint Francis Hospital Muskogee External:
Results/Impact	• In FY2021, after the closure of a large independent physician practice in Muskogee, the Warren Clinic was able to recruit and retain two cardiologists and a rheumatologists down in Muskogee. • In FY2022, Saint Francis Hospital Muskogee was officially certified as a primary care stroke center. This allows patients from the area the ability to stay local if they end up having a stroke by recognizing SFH-M's commitment in establishing a consistent approach to care and improving outcomes.

Strategy 3: ONCOLOGY CARE MODEL

Strategy Was Implemented?	Yes
Target Population(s)	Warren Clinic cancer patients
Partnering Organization(s)	Internal: Warren Clinic Medical Oncology, Saint Francis Hospice External:
Results/Impact	• Throughout the implementation of the 2019 CHNA, the Warren Clinic continued to participate and perform well in the Oncology Care advanced payment model. During this time additional oncologists have also been recruited to the Warren Clinic to help with patient demand. • In FY2021, Saint Francis piloted a palliative care program to provide another layer of support to patients being served by Warren Clinic medical oncologists. This program is run out of the Saint Francis cancer center and supported by Saint Francis' hospice team.

Priority Area: Lack of Health Insurance	
Community Health Need	Delivering health services to the uninsured or underinsured
Goal(s)	• Provide access to free primary care, prenatal healthcare, and other services for uninsured or medically underserved populations; • Improve access to healthcare for uninsured or underinsured community populations and improve awareness of available resources; and • Advocate for increased access at both the state and federal level.

Strategy 1: XAVIER CLINIC	
Strategy Was Implemented?	Yes
Target Population(s)	Low-income adults, primarily Spanish speaking
Partnering Organization(s)	Internal: Saint Francis Health System, Warren Clinic External:
Results/Impact	The Xavier Clinic is Saint Francis' free clinic in northeast Tulsa and provides primary care and prenatal care services. • In FY2020, the Xavier Clinic was officially brought under the operational control of the Warren Clinic and Dr. Rose Sloat was appointed as medical director. In FY2020 the Xavier clinic conducted 14,695 visits. • In FY2021 the Xavier clinic conducted 11,712 visits • In FY2022 annualized the Xavier Clinic is projected to conduct 10,613 visits.

Strategy 2: FINANCIAL AND ELIGIBILITY ASSISTANCE	
Strategy Was Implemented?	Yes
Target Population(s)	Low-income and uninsured residents of eastern Oklahoma
Partnering Organization(s)	Internal: Saint Francis Health System External: Med Data
Results/Impact	• Saint Francis' charity care policy in FY2020 and FY2021 was set at 225 percent of the federal poverty level. In FY2022 Saint Francis increased its charity care policy to 250 percent of the federal poverty level. At the same time, the self-pay discount was increased from 20 percent to 60 percent. • In FY2021, in preparation for Medicaid expansion, Saint Francis contracted with MedData to have staff onsite to meet with patients that present to the hospital as self-pay. MedData helps patients, if they qualify, to enroll in Medicaid. • In FY2022, MedData began assisting Saint Francis with patients that were presenting at ambulatory care locations and as the public health emergency comes to an end, will begin to meet with those currently enrolled in Medicaid to ensure they still qualify or to discuss other options that are available to them moving forward.

Strategy 3: MEDICAID EXPANSION AND MEDICAID CLINICS	
Strategy Was Implemented?	Yes
Target Population(s)	Low-income adults
Partnering Organization(s)	Internal: Saint Francis Health System External: WKWF, Zarrow Foundation, OHA, GKFF, ASJ, Fairness Project, Chickasaw Nation
Results/Impact	• In FY2020 Saint Francis Health System joined the Zarrow Foundation, the Chickasaw Nation, the Oklahoma Hospital Association, the George Kaiser Family Foundation, and the Ascension St. John Foundation in funding a political action organization called the Fairness Project to help organize a ballot initiative entitled Yes on 802 and get Medicaid expansion on a ballot so Oklahoman's can vote on whether to expand Medicaid. The campaign was success in getting the need amount of signatures to get the initiative on the ballot and on June 30, 2020 the initiative passed and effectively directed the Oklahoma legislature to make preparations to expand Medicaid by July 1, 2021. • In FY2022, Medicaid expansion took effect and provided health coverage for those low-income adults making up to 133 percent of the federal poverty level. • In response to the increased number of Medicaid beneficiaries, Saint Francis established two Medicaid clinics in the Tulsa area. One at the Xavier Clinic location and the other at the Broken Arrow Elm location. The Xavier Clinic Medicaid clinic opened on July 6, 2021 and the Elm location opened on March 28, 2022.