2022

COMMUNITY HEALTH NEEDS ASSESSMENT

Tulsa Area

Sponsored by

Saint Francis Hospital

Laureate Psychiatric Hospital and Clinic

Saint Francis Hospital South

In collaboration with

Tulsa Health Department

April 2022

Prepared by PRC

SaintFrancis Health System

INTRODUCTION

PROJECT OVERVIEW

This Community Health Needs Assessment is a systematic, data-driven approach to determining the health status, behaviors, and needs of residents in the Tulsa area. 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 assessment was implemented on behalf of Saint Francis Hospital, Laureate Psychiatric Hospital and Clinic, and Saint Francis Hospital South, in collaboration with Tulsa Health Department. 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, conducted the assessment. For purposes of this report, the service area will be presented as the Saint Francis Hospital Service Area.

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.

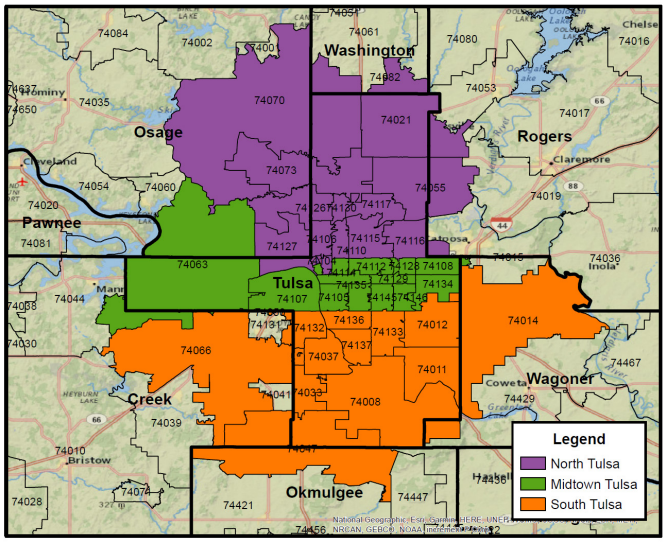
PRC Community Health Survey

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, Tulsa Health Department, and PRC.

Community Defined for This Assessment

The study area for the survey effort is referred to as the “Saint Francis Hospital Service Area” or “SFH” in this report, but reflects the service areas of Laureate Psychiatric Hospital and Clinic and Saint Francis Hospital South as well. The study area is defined as each of the residential ZIP Codes with a presence in Tulsa County, with strata created for North Tulsa, Midtown, and South Tulsa. This community definition, determined based on the ZIP Codes of residence of recent patients of Saint Francis Hospital, is 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 targeted surveys conducted by PRC 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 752 random-sample interviews by phone among the following strata: 188 surveys in North Tulsa; 201 in the Midtown area; and 363 in South Tulsa.
- **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 227 surveys to the overall sample.

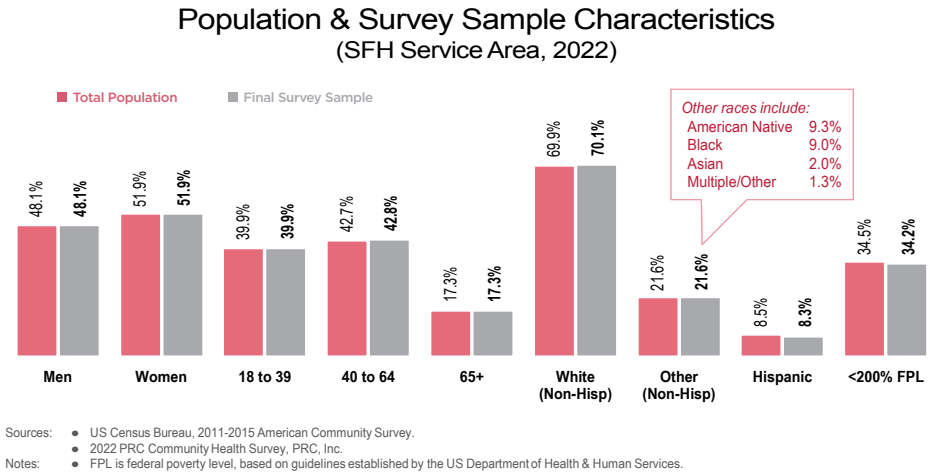
In all, 979 surveys were completed through these mechanisms (221 in North Tulsa, 268 in Midtown, and 490 in South Tulsa). Once the interviews were completed, these were weighted in proportion to the actual population distribution so as to appropriately represent the Saint Francis Hospital Service Area 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 979 respondents is ±3.1% 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.

The following chart outlines the characteristics of the 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.

INCOME & RACE/ETHNICITY

INCOME ▶ Poverty descriptions and segmentation used in this report are based on administrative poverty thresholds determined by the US Department of Health & Human Services. These guidelines define poverty status by household income level and number of persons in the household (e.g., the 2021 guidelines place the poverty threshold for a family of four at $26,500 annual household income or lower). In sample segmentation: "low income" refers to community members living in a household with defined poverty status or living just above the poverty level, earning up to twice (<200% of) the poverty threshold; "mid/high income" refers to those households living on incomes which are twice or more (≥200% of) the federal poverty level.

RACE & ETHNICITY ▶ In analyzing survey results, mutually exclusive race and ethnicity categories are used. All Hispanic respondents are grouped, regardless of identity with any other race group. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents). Groups with fewer than 50 respondents are not shown.

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, 65 community stakeholders took part in the Online Key Informant Survey, as outlined below:

ONLINE KEY INFORMANT SURVEY PARTICIPATION	
KEY INFORMANT TYPE	NUMBER PARTICIPATING
Physicians	22
Public Health Representatives	11
Other Health Providers	49
Social Services Providers	5
Other Community Leaders	23

Final participation included representatives of the organizations outlined below.

- Ascension St. John Foundation
- City of Tulsa
- Community Service Council
- Diocese of Tulsa
- Due North
- EMSA
- George Kaiser Family Foundation
- Greenwood Chamber of Commerce
- Greenwood Cultural Center
- INCOG
- Jenks Public Schools
- John Hope Franklin Center for Reconciliation
- Laureate Psychiatric Clinic and Hospital
- Life Senior Services
- Make A New Way Foundation
- Met Cares Foundation
- Morton Comprehensive Health Services
- 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 South
- Supporters of Families with Sickle Cell Disease
- Tulsa Bicycle/Pedestrian Advisory Committee
- Tulsa City–County Library
- Tulsa County
- Tulsa Day Center
- Tulsa Honor Academy
- Tulsa Parks and Rec
- Uma Tulsa
- Union Public Schools
- Vibrant Neighborhoods Partnership
- Volunteers of America
- Warren Clinic
- Zarrow Healthy Minds Initiative

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, as well as their verbatim comments, are included throughout this report as they relate to the various other data presented.

NOTE ► These findings represent qualitative rather than quantitative data. The Online Key Informant Survey was designed to gather input regarding participants' opinions and perceptions of the health needs of the residents in the area.

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 the service area 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, SparkMap (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 is county-wide (Tulsa County) data.

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.

Information Gaps

While this assessment is quite comprehensive, it cannot measure all possible aspects of health in the community, nor can it adequately represent all possible populations of interest. It must be recognized that these information gaps might in some ways limit the ability to assess all of the community's health needs.

For example, certain population groups — such as the homeless, institutionalized persons, or those who only speak a language other than English or Spanish — are not represented in the survey data. Other population groups — for example, pregnant women, undocumented residents, and members of certain racial/ethnic or immigrant groups — might not be identifiable or might not be represented in numbers sufficient for independent analyses.

In terms of content, this assessment was designed to provide a comprehensive and broad picture of the health of the overall community. However, there are certainly medical conditions that are not specifically addressed.

Public Comment

Saint Francis Hospital made its prior Community Health Needs Assessment (CHNA) report publicly available on its website; through that mechanism, the hospital requested from the public written comments and feedback regarding the CHNA and implementation strategy. At the time of this writing, Saint Francis Hospital had not received any written comments. However, through population surveys and key informant feedback for this assessment, input from the broader community was considered and taken into account when identifying and prioritizing the significant health needs of the community. Saint Francis Hospital will continue to use its website as a tool to solicit public comments and ensure that these comments are considered in the development of future CHNAs.

IRS Form 990, Schedule H Compliance

For non-profit hospitals, a Community Health Needs Assessment (CHNA) also serves to satisfy certain requirements of tax reporting, pursuant to provisions of the Patient Protection & Affordable Care Act of 2010. To understand which elements of this report relate to those requested as part of hospitals' reporting on IRS Schedule H (Form 990), the following table cross-references related sections.

IRS FORM 990, SCHEDULE H (2019)	See Report Page
Part V Section B Line 3a A definition of the community served by the hospital facility	4
Part V Section B Line 3b Demographics of the community	31
Part V Section B Line 3c Existing health care facilities and resources within the community that are available to respond to the health needs of the community	131
Part V Section B Line 3d How data was obtained	4
Part V Section B Line 3e The significant health needs of the community	12
Part V Section B Line 3f Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups	Addressed Throughout
Part V Section B Line 3g The process for identifying and prioritizing community health needs and services to meet the community health needs	13
Part V Section B Line 3h The process for consulting with persons representing the community's interests	6
Part V Section B Line 3i The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)	138

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	• 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 • Colorectal Cancer Deaths
HEART DISEASE & STROKE	• Leading Cause of Death • Heart Disease Deaths • High Blood Pressure Prevalence • Overall Cardiovascular Risk
INFANT HEALTH & FAMILY PLANNING	• Prenatal Care • Infant Deaths • Teen Births
INJURY & VIOLENCE	• Firearm-Related Deaths • Homicide Deaths • Violent Crime Rate • Intimate Partner Violence

—continued on the following page—

AREAS OF OPPORTUNITY (continued)	
MENTAL HEALTH	• "Fair/Poor" Mental Health • Diagnosed Depression • Symptoms of Chronic Depression • Stress • 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.
POTENTIALLY DISABLING CONDITIONS	• Multiple Chronic Conditions • Activity Limitations • High-Impact Chronic Pain • Alzheimer's Disease Deaths • Caregiving
RESPIRATORY DISEASE	• Lung Disease Deaths
SEXUAL HEALTH	• HIV Deaths • Chlamydia Incidence • Gonorrhea Incidence
SUBSTANCE ABUSE	• Cirrhosis/Liver Disease Deaths • Personally Impacted by Substance Abuse (Self or Other's) • Key Informants: Substance abuse ranked as a top concern.

Prioritization of Health Needs

On May 4, 2022, representatives of Saint Francis Health and Saint Francis Hospital 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 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, and then these composite criteria scores were averaged to produce an overall score. This process yielded the following prioritized list of community health needs:

1. Mental Health
2. Heart Disease/Stroke
3. Access to Health Care Services
4. Cancer
5. Substance Abuse
6. Infant Health/Family Planning
7. Nutrition/Physical Activity/Weight
8. Respiratory Disease
9. Potentially Disabling Conditions
10. Injury/Violence
11. Sexual Health

Hospital Implementation Strategy

Saint Francis Hospital will use the information from this Community Health Needs Assessment to develop an Implementation Strategy to address the significant health needs in the community. While the hospital will likely not implement strategies for all of the health issues listed above, the results of this prioritization exercise will be used to inform the development of the hospital's action plan to guide community health improvement efforts in the coming years.

Note: An evaluation of the hospital's past activities to address the needs identified in prior CHNAs can be found as an appendix to this report.

Summary Tables: Comparisons With Benchmark Data

The following tables provide an overview of indicators in the Saint Francis Hospital Service Area, including comparisons among the individual communities. These data are grouped by health topic.

Reading the Summary Tables

- In the following tables, composite Saint Francis Hospital (SFH) Service Area results are shown in the larger, gray column.
- The columns to the left of the SFH column provide comparisons among the three Tulsa strata, identifying differences for each as "better than" (☀️), "worse than" (🌧️), or "similar to" (☁️) the combined opposing areas
- The columns to the right of the SFH column provide comparisons between local data and any available state and national findings, and Healthy People 2030 objectives. Again, symbols indicate whether the service area 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 SUBAREAS			SFH	SFH vs. BENCHMARKS		
	North Tulsa	Midtown	South Tulsa		vs. OK	vs. US	vs. HP2030
Linguistically Isolated Population (Percent)				3.5	2.1	4.3	
Population in Poverty (Percent)				15.0	15.7	13.4	8.0
Children in Poverty (Percent)				21.8	21.5	18.5	8.0
No High School Diploma (Age 25+, Percent)				10.6	12.0	12.0	
% Unable to Pay Cash for a $400 Emergency Expense	36.3	26.4	26.5	28.7		24.6	
% Worry/Stress Over Rent/Mortgage in Past Year	31.8	34.7	32.9	33.3		32.2	
% Unhealthy/Unsafe Housing Conditions	17.7	25.5	14.8	19.0		12.2	
% Food Insecure	33.5	31.2	26.9	29.9		34.1	

Note: In the section above, each subarea is compared against all other areas 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 SUBAREAS			SFH	SFH vs. BENCHMARKS		
	North Tulsa	Midtown	South Tulsa		vs. OK	vs. US	vs. HP2030
% "Fair/Poor" Overall Health	17.0	12.7	12.9	13.7	21.9	12.6	

Note: In the section above, each subarea is compared against all other areas 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

ACCESS TO HEALTH CARE	DISPARITY AMONG SUBAREAS			SFH	SFH vs. BENCHMARKS		
	North Tulsa	Midtown	South Tulsa		vs. OK	vs. US	vs. HP2030
% [Age 18-64] Lack Health Insurance	15.9	11.6	8.2	11.1	19.1	8.7	7.9
% Difficulty Accessing Health Care in Past Year (Composite)	54.8	54.5	52.3	53.6		35.0	
% Cost Prevented Physician Visit in Past Year	28.8	22.7	19.6	22.7	16.2	12.9	
% Cost Prevented Getting Prescription in Past Year	21.4	24.8	19.8	21.8		12.8	
% Difficulty Getting Appointment in Past Year	29.6	26.6	30.7	29.1		14.5	
% Inconvenient Hrs Prevented Dr Visit in Past Year	24.4	18.2	17.5	19.3		12.5	
% Difficulty Finding Physician in Past Year	20.2	18.0	18.8	18.9		9.4	
% Transportation Hindered Dr Visit in Past Year	12.7	15.8	8.0	11.7		8.9	
% Language/Culture Prevented Care in Past Year	1.4	0.8	1.5	1.2		2.8	
% Skipped Prescription Doses to Save Costs	23.7	22.6	17.4	20.6		12.7	
% Difficulty Getting Child's Health Care in Past Year	7.1	13.8	6.9	9.0		8.0	
Primary Care Doctors per 100,000				130.6	85.6	102.0	

Better Similar Worse

ACCESS TO HEALTH CARE (continued)	DISPARITY AMONG SUBAREAS			SFH	SFH vs. BENCHMARKS		
	North Tulsa	Midtown	South Tulsa		vs. OK	vs. US	vs. HP2030
% Have a Specific Source of Ongoing Care	34.7	72.0	76.1	72.1		74.2	84.0
% Have Had Routine Checkup in Past Year	60.5	66.1	60.2	62.2	74.5	70.5	
% Child Has Had Checkup in Past Year	76.7	83.2	77.7	79.2		77.4	
% Two or More ER Visits in Past Year	11.6	10.7	10.8	11.0		10.1	
% Eye Exam in Past 2 Years	46.7	48.7	53.4	50.3		61.0	61.1
% Rate Local Health Care "Fair/Poor"	20.2	15.5	12.9	15.4		8.0	

Note: In the section above, each subarea is compared against all other areas 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 SUBAREAS			SFH	SFH vs. BENCHMARKS		
	North Tulsa	Midtown	South Tulsa		vs. OK	vs. US	vs. HP2030
Cancer (Age-Adjusted Death Rate)				162.8	174.1	146.5	122.7
Lung Cancer (Age-Adjusted Death Rate)				39.2	45.5	33.4	25.1
Prostate Cancer (Age-Adjusted Death Rate)				20.6	19.5	18.5	16.9

Better Similar Worse

CANCER (continued)	DISPARITY AMONG SUBAREAS			SFH	SFH vs. BENCHMARKS		
	North Tulsa	Midtown	South Tulsa		vs. OK	vs. US	vs. HP2030
Female Breast Cancer (Age-Adjusted Death Rate)				**21.2**	22.7	19.4	15.3
Colorectal Cancer (Age-Adjusted Death Rate)				**16.1**	16.3	13.1	8.9
Cancer Incidence Rate (All Sites)				**472.7**	450.2	448.6	
Female Breast Cancer Incidence Rate				**136.3**	124.2	126.8	
Prostate Cancer Incidence Rate				**113.9**	95.7	106.2	
Lung Cancer Incidence Rate				**61.9**	66.7	57.3	
Colorectal Cancer Incidence Rate				**40.4**	41.2	38.0	
% Cancer	6.2	7.7	6.6	**6.9**	12.2	10.0	
% [Women 50-74] Mammogram in Past 2 Years	63.7			**73.3**	74.3	76.1	77.1
% [Women 21-65] Cervical Cancer Screening	75.3			**75.1**	76.1	73.8	84.3
% [Age 50-75] Colorectal Cancer Screening	79.4		75.0	**76.8**	62.6	77.4	74.4

Note: In the section above, each subarea is compared against all other areas 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 SUBAREAS			SFH	SFH vs. BENCHMARKS		
	North Tulsa	Midtown	South Tulsa		vs. OK	vs. US	vs. HP2030
Diabetes (Age-Adjusted Death Rate)				20.9	29.9	22.6	
% Diabetes/High Blood Sugar	14.6	13.9	10.9	12.8	12.2	13.8	
% Borderline/Pre-Diabetes	7.6	12.9	9.4	10.1		9.7	
% [Non-Diabetics] Blood Sugar Tested in Past 3 Years	41.1	46.3	44.9	44.5		43.3	

Note: In the section above, each subarea is compared against all other areas 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 SUBAREAS			SFH	SFH vs. BENCHMARKS		
	North Tulsa	Midtown	South Tulsa		vs. OK	vs. US	vs. HP2030
Diseases of the Heart (Age-Adjusted Death Rate)				244.6	234.7	164.4	127.4
% Heart Disease (Heart Attack, Angina, Coronary Disease)	7.9	6.8	5.0	6.2	8.3	6.1	
Stroke (Age-Adjusted Death Rate)				43.2	39.8	37.6	33.4
% Stroke	3.4	4.3	3.1	3.5	4.4	4.3	
% Told Have High Blood Pressure	46.6	43.9	43.3	44.3	37.8	36.9	27.7

Better Similar Worse

HEART DISEASE & STROKE (continued)	DISPARITY AMONG SUBAREAS			SFH	SFH vs. BENCHMARKS		
	North Tulsa	Midtown	South Tulsa		vs. OK	vs. US	vs. HP2030
% Told Have High Cholesterol	26.3	36.2	34.1	33.0		32.7	
% 1+ Cardiovascular Risk Factor	87.5	86.4	89.9	88.2		84.6	

Note: In the section above, each subarea is compared against all other areas 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 SUBAREAS			SFH	SFH vs. BENCHMARKS		
	North Tulsa	Midtown	South Tulsa		vs. OK	vs. US	vs. HP2030
Low Birthweight Births (Percent)				8.3	8.0	8.2	
Infant Death Rate				7.3	6.6	5.5	5.0
Late or No Prenatal Care (Percent)				7.5	6.7	6.1	
Births to Adolescents Age 15 to 19 (Rate per 1,000)				31.0	33.3	20.9	

Note: In the section above, each subarea is compared against all other areas 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.

INJURY & VIOLENCE	DISPARITY AMONG SUBAREAS			SFH	SFH vs. BENCHMARKS		
	North Tulsa	Midtown	South Tulsa		vs. OK	vs. US	vs. HP2030
Unintentional Injury (Age-Adjusted Death Rate)				52.7	60.8	51.6	43.2

Better Similar Worse

INJURY & VIOLENCE (continued)	DISPARITY AMONG SUBAREAS			SFH	SFH vs. BENCHMARKS		
	North Tulsa	Midtown	South Tulsa		vs. OK	vs. US	vs. HP2030
Motor Vehicle Crashes (Age-Adjusted Death Rate)				12.3	16.7	11.4	10.1
[65+] Falls (Age-Adjusted Death Rate)				70.6	106.4	67.1	63.4
Firearm-Related Deaths (Age-Adjusted Death Rate)				19.8	18.7	12.5	10.7
Homicide (Age-Adjusted Death Rate)				10.5	8.3	6.1	5.5
Violent Crime Rate				699.0	443.5	416.0	
% Victim of Violent Crime in Past 5 Years	6.4	7.4	5.5	6.3		6.2	
% Victim of Intimate Partner Violence	20.6	23.2	20.5	21.4		13.7	

Note: In the section above, each subarea is compared against all other areas 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 SUBAREAS			SFH	SFH vs. BENCHMARKS		
	North Tulsa	Midtown	South Tulsa		vs. OK	vs. US	vs. HP2030
Kidney Disease (Age-Adjusted Death Rate)				8.1	10.7	12.8	
% Kidney Disease	4.2	5.2	2.2	3.6	4.0	5.0	

Note: In the section above, each subarea is compared against all other areas 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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MENTAL HEALTH	DISPARITY AMONG SUBAREAS			SFH	SFH vs. BENCHMARKS		
	North Tulsa	Midtown	South Tulsa		vs. OK	vs. US	vs. HP2030
% "Fair/Poor" Mental Health	30.2	25.1	27.7	27.4		13.4	
% Diagnosed Depression	37.0	33.2	32.5	33.8	23.0	20.6	
% Symptoms of Chronic Depression (2+ Years)	46.0	45.2	41.6	43.8		30.3	
% Typical Day Is "Extremely/Very" Stressful	21.3	16.4	20.8	19.5		16.1	
Suicide (Age-Adjusted Death Rate)				19.9	20.8	13.9	12.8
Mental Health Providers per 100,000				214.9	219.0	123.1	
% Taking Rx/Receiving Mental Health Trtmt	22.4	24.8	25.3	24.4		16.8	
% Unable to Get Mental Health Svcs in Past Yr	15.7	14.1	14.4	14.6		7.8	
% Spent <7 Hours on Personal Time Last Week	41.0	36.8	38.7	38.5			

Note: In the section above, each subarea is compared against all other areas 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 SUBAREAS			SFH	SFH vs. BENCHMARKS		
	North Tulsa	Midtown	South Tulsa		vs. OK	vs. US	vs. HP2030
Population With Low Food Access (Percent)				25.5	25.2	22.2	
% "Very/Somewhat" Difficult to Buy Fresh Produce	32.4	29.8	22.0	27.0		21.1	
% 5+ Servings of Fruits/Vegetables per Day	27.1	29.2	28.7	28.5		32.7	
% No Leisure-Time Physical Activity	35.2	28.2	28.2	29.8	34.0	31.3	21.2
% Meeting Physical Activity Guidelines	17.5	19.2	21.5	19.8	15.6	21.4	28.4
% Child [Age 2-17] Physically Active 1+ Hours per Day	35.7	40.0	32.9	35.6		33.0	
Recreation/Fitness Facilities per 100,000				14.3	9.3	12.2	
% Overweight (BMI 25+)	65.0	70.2	74.5	70.8	71.4	61.0	
% Obese (BMI 30+)	39.0	39.0	38.9	38.9	36.8	31.3	36.0
% Children [Age 5-17] Overweight (85th Percentile)	35.1	28.1	30.2	30.7		32.3	
% Children [Age 5-17] Obese (95th Percentile)	21.2	19.2	14.1	17.1		16.0	15.5

Note: In the section above, each subarea is compared against all other areas 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 SUBAREAS			SFH	SFH vs. BENCHMARKS		
	North Tulsa	Midtown	South Tulsa		vs. OK	vs. US	vs. HP2030
% Have Dental Insurance	67.4	73.1	75.2	72.7		68.7	59.8
% [Age 18+] Dental Visit in Past Year	55.5	56.3	65.0	59.9	60.4	62.0	45.0
% Child [Age 2-17] Dental Visit in Past Year	87.4	74.6	79.1	79.5		72.1	45.0

Note: In the section above, each subarea is compared against all other areas 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 SUBAREAS			SFH	SFH vs. BENCHMARKS		
	North Tulsa	Midtown	South Tulsa		vs. OK	vs. US	vs. HP2030
% 3+ Chronic Conditions	40.2	47.2	38.9	41.9		32.5	
% Activity Limitations	31.3	32.7	29.0	30.8		24.0	
% With High-Impact Chronic Pain	21.8	18.6	17.5	18.9		14.1	7.0
Alzheimer's Disease (Age-Adjusted Death Rate)				40.1	38.0	30.9	
% Caregiver to a Friend/Family Member	27.0	32.3	30.1	30.1		22.6	

Note: In the section above, each subarea is compared against all other areas 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

RESPIRATORY DISEASE	DISPARITY AMONG SUBAREAS			SFH	SFH vs. BENCHMARKS		
	North Tulsa	Midtown	South Tulsa		vs. OK	vs. US	vs. HP2030
CLRD (Age-Adjusted Death Rate)				49.8	62.0	38.1	
Pneumonia/Influenza (Age-Adjusted Death Rate)				15.1	15.1	13.4	
% [Age 65+] Flu Vaccine in Past Year	56.9	90.7	76.2	76.9	69.5	71.0	
% [Adult] Asthma	16.2	12.9	13.4	13.9	10.2	12.9	
% [Child 0-17] Asthma	5.5	11.2	7.9	8.4		7.8	
% COPD (Lung Disease)	7.8	5.9	5.1	6.0	8.7	6.4	
COVID-19 (Age-Adjusted Death Rate)				83.3	100.3	85.0	

Note: In the section above, each subarea is compared against all other areas 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 SUBAREAS			SFH	SFH vs. BENCHMARKS		
	North Tulsa	Midtown	South Tulsa		vs. OK	vs. US	vs. HP2030
Septicemia (Age-Adjusted Death Rate)				6.8	9.2	9.8	

Note: In the section above, each subarea is compared against all other areas 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

SEXUAL HEALTH	DISPARITY AMONG SUBAREAS			SFH	SFH vs. BENCHMARKS		
	North Tulsa	Midtown	South Tulsa		vs. OK	vs. US	vs. HP2030
HIV/AIDS (Age-Adjusted Death Rate)				2.3	1.5	1.8	
HIV Prevalence Rate				303.0	192.0	372.8	
Chlamydia Incidence Rate				678.7	559.0	539.9	
Gonorrhea Incidence Rate				322.8	228.9	179.1	

Note: In the section above, each subarea is compared against all other areas 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 SUBAREAS			SFH	SFH vs. BENCHMARKS		
	North Tulsa	Midtown	South Tulsa		vs. OK	vs. US	vs. HP2030
Cirrhosis/Liver Disease (Age-Adjusted Death Rate)				16.2	16.2	11.9	10.9
% Excessive Drinker	20.4	23.1	24.3	23.0	13.6	27.2	
Unintentional Drug-Related Deaths (Age-Adjusted Death Rate)				18.6	15.9	21.0	
% Illicit Drug Use in Past Month	2.5	3.8	2.9	3.0		2.0	12.0
% Used a Prescription Opioid in Past Year	15.8	17.3	11.9	14.6		12.9	

Better Similar Worse

SUBSTANCE ABUSE (continued)	DISPARITY AMONG SUBAREAS			SFH	SFH vs. BENCHMARKS		
	North Tulsa	Midtown	South Tulsa		vs. OK	vs. US	vs. HP2030
% Ever Sought Help for Alcohol or Drug Problem	6.4	6.9	8.2	7.4		5.4	
% Personally Impacted by Substance Abuse	42.2	47.5	48.2	46.5		35.8	

Note: In the section above, each subarea is compared against all other areas 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.

TOBACCO USE	DISPARITY AMONG SUBAREAS			SFH	SFH vs. BENCHMARKS		
	North Tulsa	Midtown	South Tulsa		vs. OK	vs. US	vs. HP2030
% Current Smoker	21.8	16.2	16.1	17.4	18.9	17.4	5.0
% Someone Smokes at Home	20.4	16.0	11.1	14.9		14.6	
% [Household With Children] Someone Smokes in the Home	17.4			16.7		17.4	
% [Smokers] Have Quit Smoking 1+ Days in Past Year				51.7	58.0	42.8	65.7
% [Smokers] Received Advice to Quit Smoking	67.9			54.2		59.6	66.6
% Currently Use Vaping Products	11.0	10.3	11.1	10.8	7.1	8.9	

Note: In the section above, each subarea is compared against all other areas 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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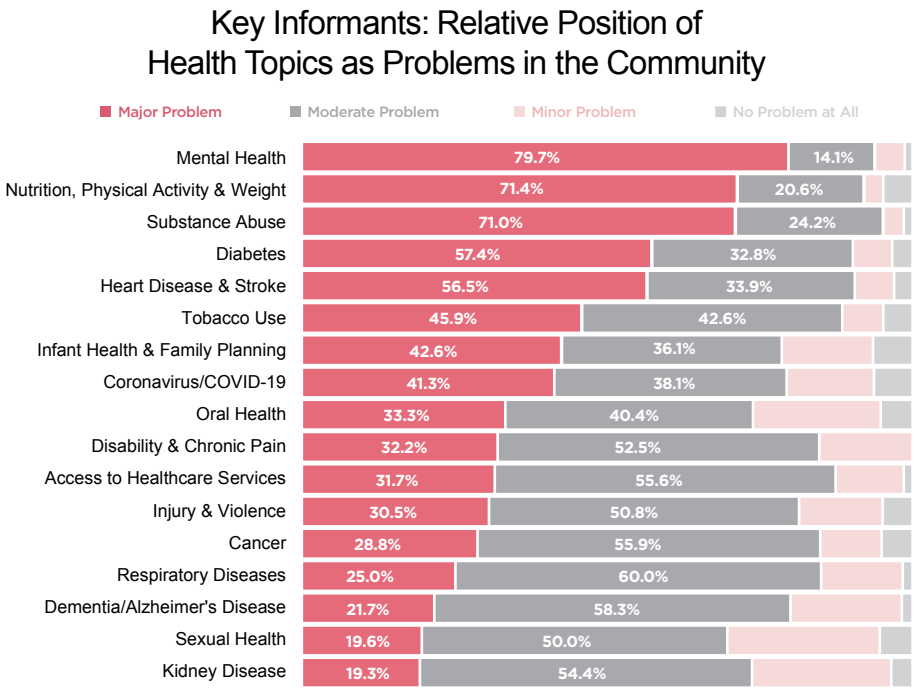
SUMMARY OF KEY INFORMANT PERCEPTIONS

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.)



DATA CHARTS & KEY INFORMANT INPUT

The following sections present data from multiple sources, including the population-based PRC Community Health Survey, public health and other existing data sets (secondary data), as well as qualitative input from the Online Key Informant Survey.

Data indicators from these sources are intermingled and organized by health topic. To better understand the source data for specific indicators, please refer to the footnotes accompanying each chart.

Community Characteristics

Population Characteristics

Land Area, Population Size & Density

Data from the US Census Bureau reveal the following statistics for our community relative to size, population, and density.

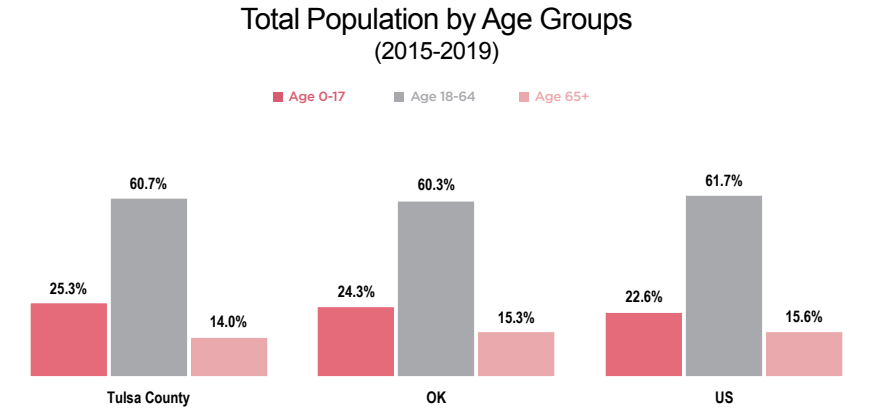
Total Population
(Estimated Population, 2015-2019)

	TOTAL POPULATION	TOTAL LAND AREA (SQUARE MILES)	POPULATION DENSITY (PER SQUARE MILE)
Tulsa County	646,419	570.32	1,133
Oklahoma	3,932,870	68,596.35	57
United States	324,697,795	3,532,068.58	92

Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved March 2022 via SparkMap (sparkmap.org).

Age

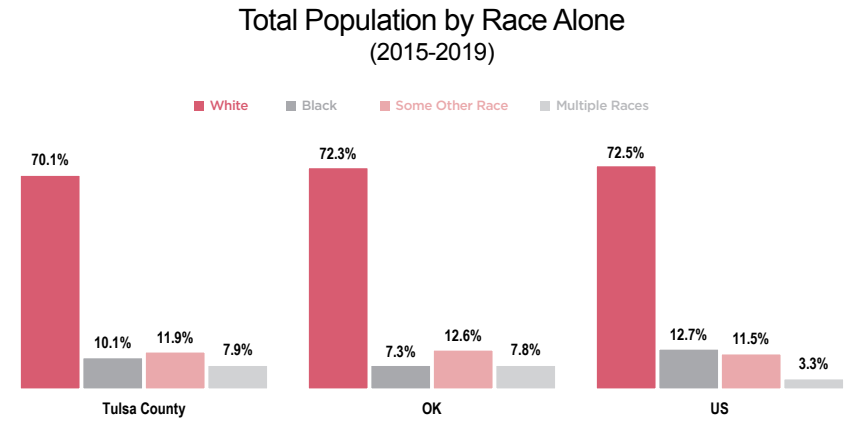
It is important to understand the age distribution of the population, as different age groups have unique health needs that should be considered separately from others along the age spectrum.



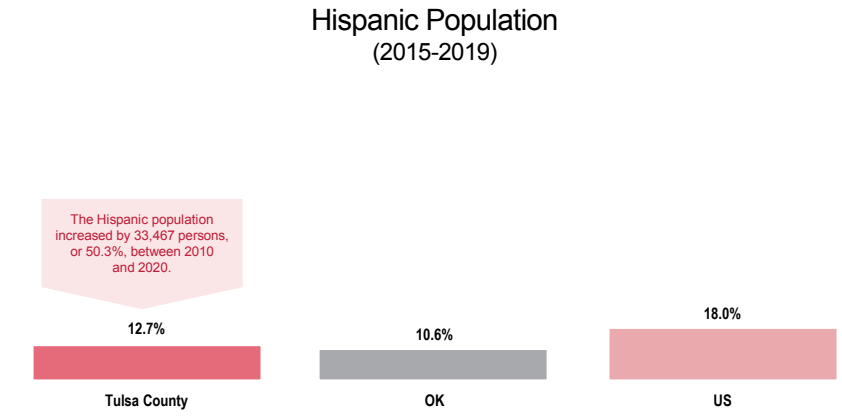
Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved March 2022 via SparkMap (sparkmap.org).

Race & Ethnicity

The following charts illustrate the racial and ethnic makeup of our community. Note that ethnicity (Hispanic or Latino) can be of any race.



Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved March 2022 via SparkMap (sparkmap.org).



Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved March 2022 via SparkMap (sparkmap.org).

Notes:
- Origin can be viewed as the heritage, nationality group, lineage, or country of birth of the person or the person's parents or ancestors before their arrival in the United States. People who identify their origin as Hispanic, Latino, or Spanish may be of any race.

Social Determinants of Health

About Social Determinants Of Health

Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

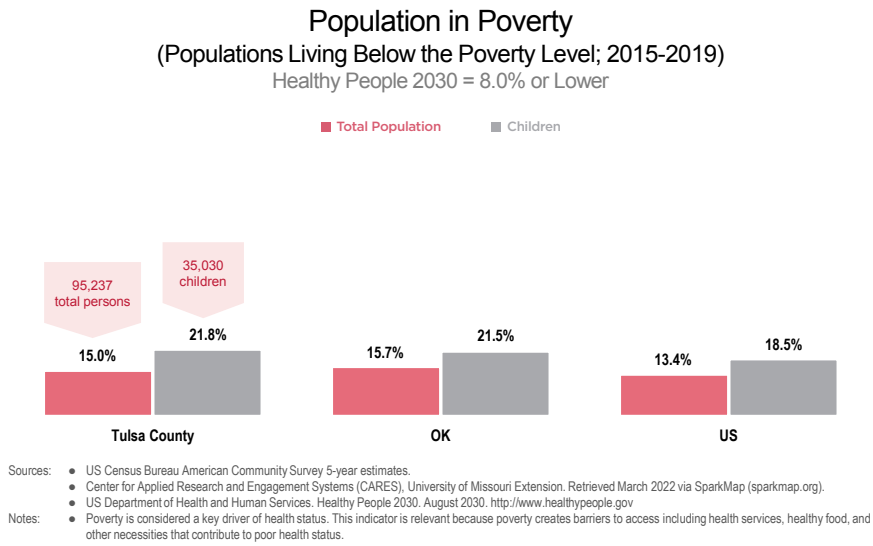
Social determinants of health (SDOH) have a major impact on people's health, well-being, and quality of life. Examples of SDOH include:

- Safe housing, transportation, and neighborhoods
- Racism, discrimination, and violence
- Education, job opportunities, and income
- Access to nutritious foods and physical activity opportunities
- Polluted air and water
- Language and literacy skills

SDOH also contribute to wide health disparities and inequities. For example, people who don't have access to grocery stores with healthy foods are less likely to have good nutrition. That raises their risk of health conditions like heart disease, diabetes, and obesity — and even lowers life expectancy relative to people who do have access to healthy foods.

Just promoting healthy choices won't eliminate these and other health disparities. Instead, public health organizations and their partners in sectors like education, transportation, and housing need to take action to improve the conditions in people's environments.

– *Healthy People 2030 (https://health.gov/healthypeople)*



Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved March 2022 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Notes:
- Poverty is considered a key driver of health status. This indicator is relevant because poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status.

Income & Poverty

Poverty

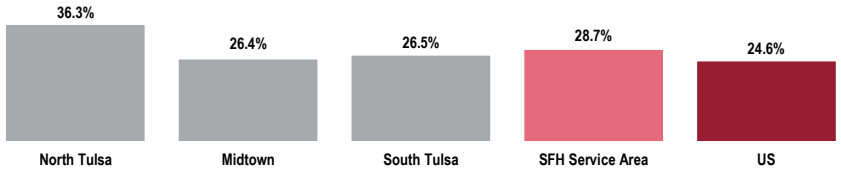
The following chart outlines the proportion of our population below the federal poverty threshold in comparison to state and national proportions.

Financial Resilience

"Suppose that you have an emergency expense that costs $400. Based on your current financial situation, would you be able to pay for this expense either with cash, by taking money from your checking or savings account, or by putting it on a credit card that you could pay in full at the next statement?"

The following charts further detail percentage responses among survey respondents in the Saint Francis Hospital Service Area in comparison to benchmark data, as well as by basic demographic characteristics (namely by gender, age groupings, income [based on poverty status], race/ethnicity, and LGBTQ+ identification).

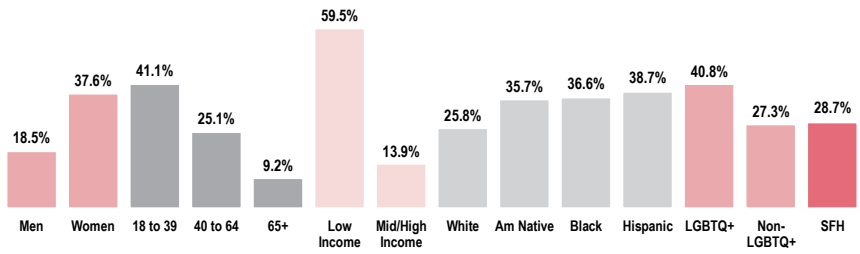
Do Not Have Cash on
Hand to Cover a $400 Emergency Expense



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 63]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes respondents who say they would not be able to pay for a $400 emergency expense either with cash, by taking money from their checking or savings account, or by putting it on a credit card that they could pay in full at the next statement.

Do Not Have Cash on
Hand to Cover a $400 Emergency Expense
(SFH Service Area, 2022)



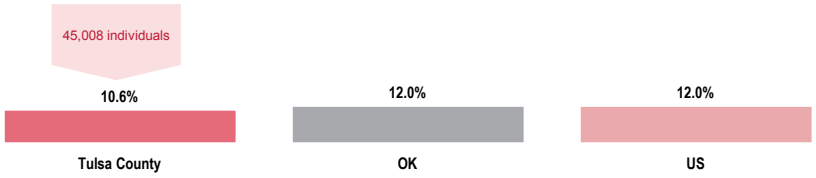
Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 63]

Notes:
- Asked of all respondents.
- Includes respondents who say they would not be able to pay for a $400 emergency expense either with cash, by taking money from their checking or savings account, or by putting it on a credit card that they could pay in full at the next statement.

Education

Education levels are reflected in the proportion of our population without a high school diploma.

Population With No High School Diploma
(Population Age 25+ Without a High School Diploma or Equivalent, 2015-2019)



Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved March 2022 via SparkMap (sparkmap.org).

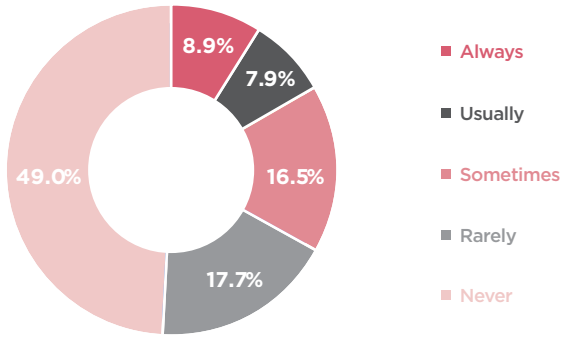
Notes:
- This indicator is relevant because educational attainment is linked to positive health outcomes.

Housing

Housing Insecurity

"In the past 12 months, how often were you worried or stressed about having enough money to pay your rent or mortgage? Would you say you were worried or stressed: always, usually, sometimes, rarely, or never?"

Frequency of Worry or Stress
About Paying Rent or Mortgage in the Past Year
(SFH Service Area, 2022)



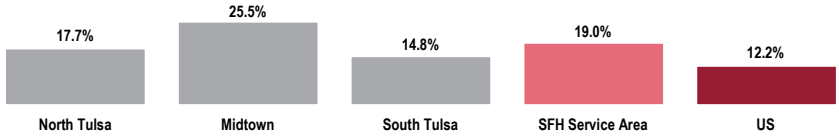
Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 66]

Notes:
- Asked of all respondents.

Unhealthy or Unsafe Housing

"Thinking about your current home, over the past 12 months have you experienced ongoing problems with water leaks, rodents, insects, mold, or other housing conditions that might make living there unhealthy or unsafe?"

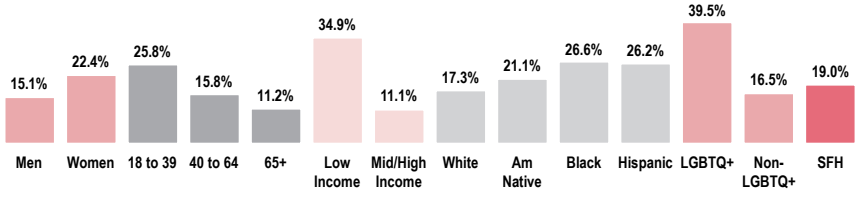
Unhealthy or Unsafe Housing Conditions in the Past Year



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 65]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes respondents who say they experienced ongoing problems in their current home with water leaks, rodents, insects, mold, or other housing conditions that might make living there unhealthy or unsafe.

Unhealthy or Unsafe Housing Conditions in the Past Year
(SFH Service Area, 2022)



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 65]

Notes:
- Asked of all respondents.
- Includes respondents who say they experienced ongoing problems in their current home with water leaks, rodents, insects, mold, or other housing conditions that might make living there unhealthy or unsafe.

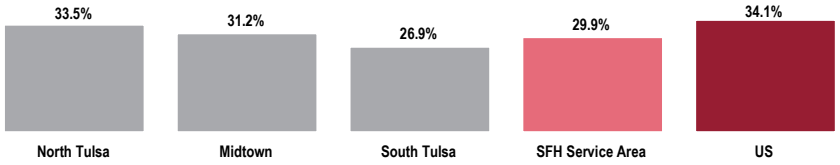
Food Insecurity

"Now I am going to read two statements that people have made about their food situation. Please tell me whether each statement was 'often true,' 'sometimes true,' or 'never true' for you in the past 12 months.

- The first statement is: 'I worried about whether our food would run out before we got money to buy more.'
- The next statement is: 'The food that we bought just did not last, and we did not have money to get more.'"

Agreement with either or both of these statements ("often true" or "sometimes true") defines food insecurity for respondents.

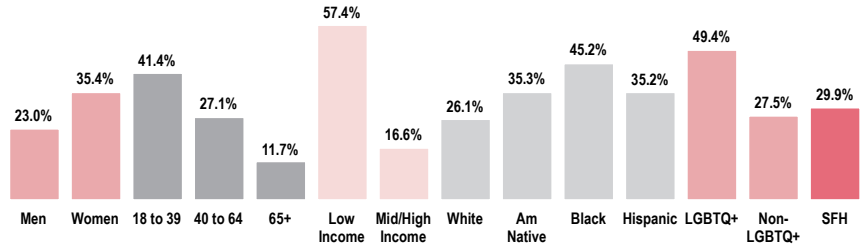
Food Insecurity



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 112]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes adults who A) ran out of food at least once in the past year and/or B) worried about running out of food in the past year.

Food Insecurity
(SFH Service Area, 2022)



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 112]

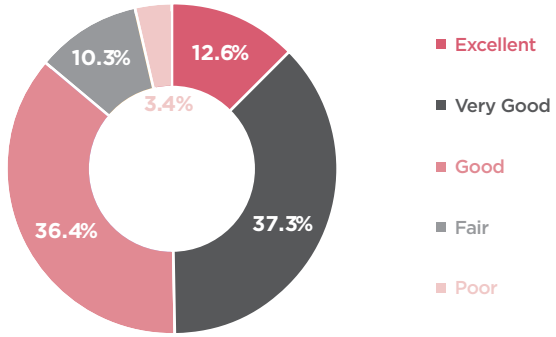
Notes:
- Asked of all respondents.
- Includes adults who A) ran out of food at least once in the past year and/or B) worried about running out of food in the past year.

HEALTH STATUS

Overall Health

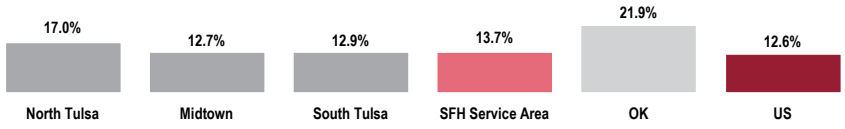
"Would you say that in general your health is: excellent, very good, good, fair, or poor?"

Self-Reported Health Status
(SFH Service Area, 2022)



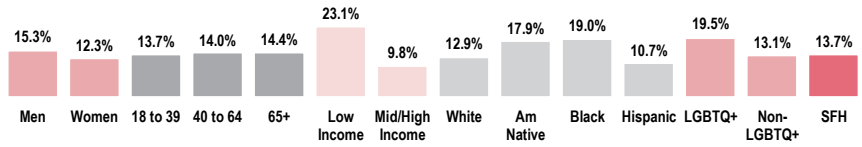
Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 5]
Notes: • Asked of all respondents.

Experience "Fair" or "Poor" Overall Health



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 5]
• Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Oklahoma data.
• 2020 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.

Experience “Fair” or “Poor” Overall Health
(SFH Service Area, 2022)



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 5]
Notes: • Asked of all respondents.

MENTAL HEALTH

ABOUT MENTAL HEALTH & MENTAL DISORDERS

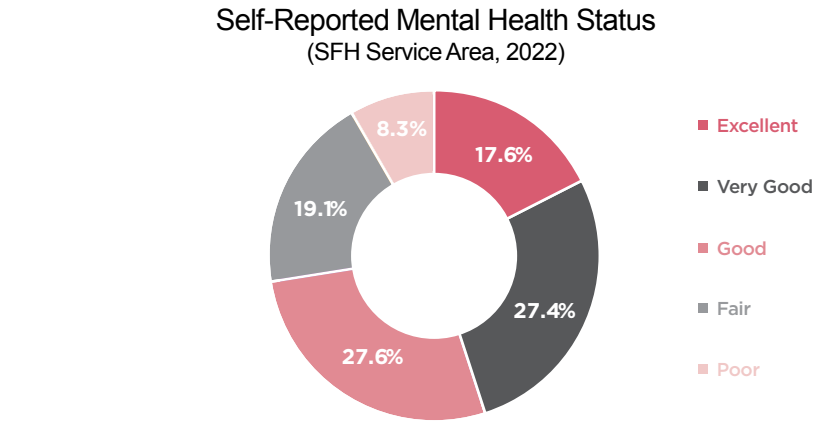
About half of all people in the United States will be diagnosed with a mental disorder at some point in their lifetime. ...Mental disorders affect people of all age and racial/ethnic groups, but some populations are disproportionately affected. And estimates suggest that only half of all people with mental disorders get the treatment they need.

In addition, mental health and physical health are closely connected. Mental disorders like depression and anxiety can affect people's ability to take part in healthy behaviors. Similarly, physical health problems can make it harder for people to get treatment for mental disorders. Increasing screening for mental disorders can help people get the treatment they need.

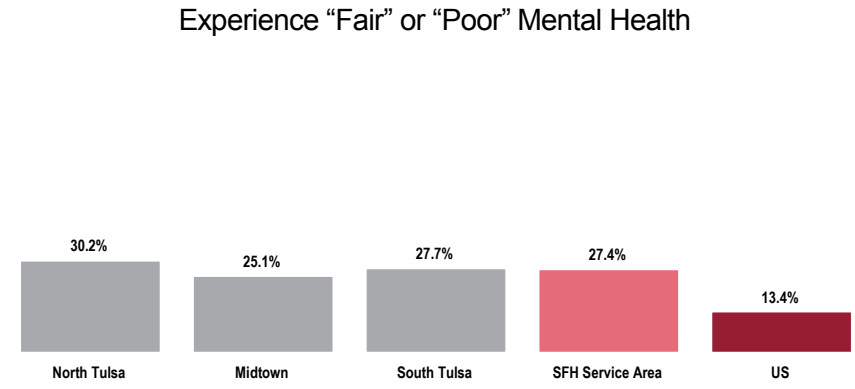
– *Healthy People 2030 (https://health.gov/healthypeople)*

Mental Health Status

"Now thinking about your mental health, which includes stress, depression and problems with emotions, would you say that, in general, your mental health is: excellent, very good, good, fair, or poor?"



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 90]
Notes: • Asked of all respondents.

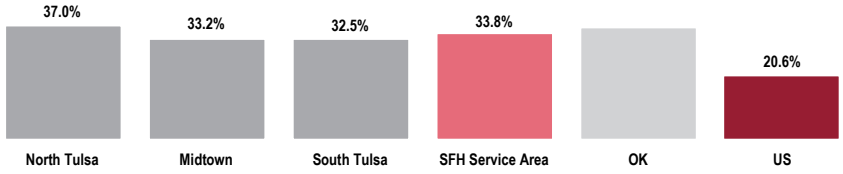


Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 90]
• 2020 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.

Depression

DIAGNOSED DEPRESSION ▶ "Has a doctor or other healthcare provider ever told you that you have a depressive disorder, including depression, major depression, dysthymia, or minor depression?"

Have Been Diagnosed With a Depressive Disorder

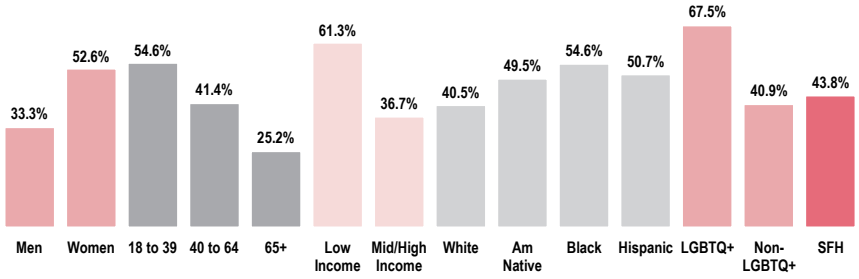


Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 93]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Oklahoma data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Depressive disorders include depression, major depression, dysthymia, or minor depression.

SYMPTOMS OF CHRONIC DEPRESSION ▶ "Have you had two years or more in your life when you felt depressed or sad most days, even if you felt okay sometimes?"

Have Experienced Symptoms of Chronic Depression
(SFH Service Area, 2022)

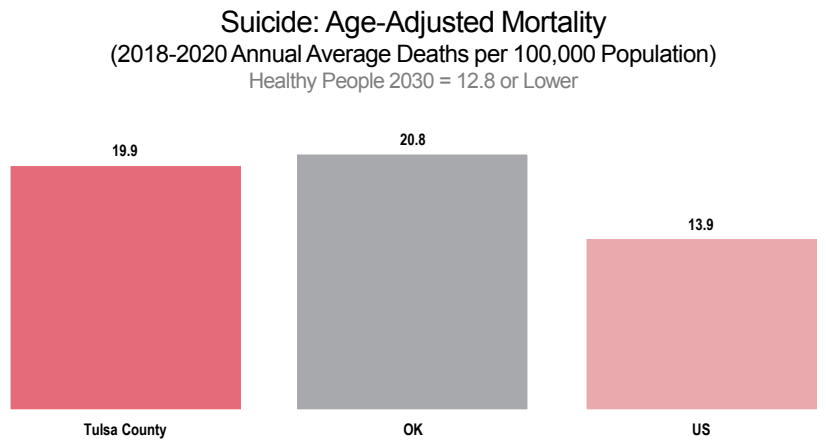


Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 91]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Chronic depression includes periods of two or more years during which the respondent felt depressed or sad on most days, even if (s)he felt okay sometimes.

Suicide

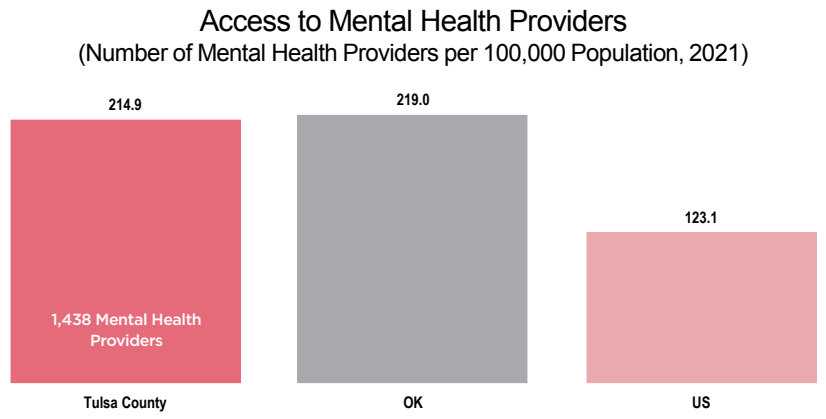
The following chart outlines the most current age-adjusted mortality rates attributed to suicide in our population (refer to "Leading Causes of Death" for an explanation of the use of age-adjusting for these rates).



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted March 2022.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Mental Health Treatment

The following chart outlines access to mental health providers, expressed as the number of providers (psychiatrists, psychologists, clinical social workers, and counselors who specialize in mental health care) per 100,000 residents.



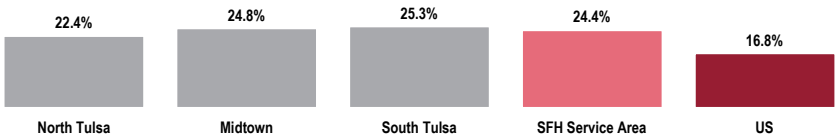
Sources:
- University of Wisconsin Population Health Institute, County Health Rankings.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved March 2022 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the rate of the county population to the number of mental health providers including psychiatrists, psychologists, clinical social workers, and counsellors that specialize in mental health care.

"Are you now taking medication or receiving treatment from a doctor or other health professional for any type of mental health condition or emotional problem?"

Currently Receiving Mental Health Treatment

Among respondents ever diagnosed with a depressive disorder, 60.1% are currently receiving treatment.

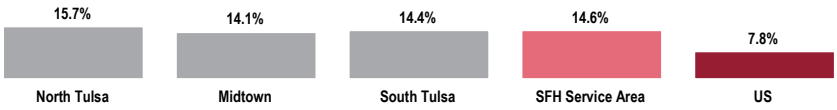


Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Items 93-94]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- "Treatment" can include taking medications for mental health.

"Was there a time in the past 12 months when you needed mental health services but were not able to get them?"

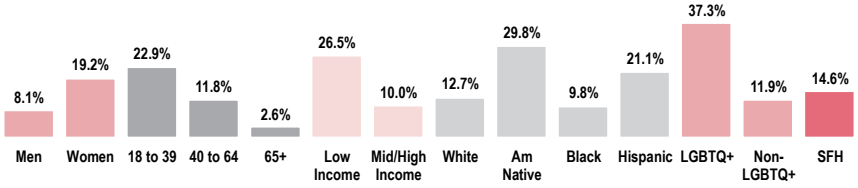
Unable to Get Mental Health Services When Needed in the Past Year



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 95]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Unable to Get Mental Health Services When Needed in the Past Year
(SFH Service Area, 2022)



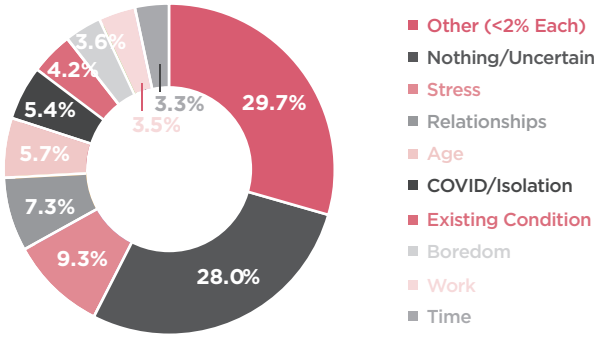
Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 95]

Notes:
- Asked of all respondents.

Barriers to Maintaining Mental Health

"For you, what is the biggest barrier to maintaining your mental health?"

Biggest Barrier to Maintaining Mental Health
(SFH Service Area, 2022)



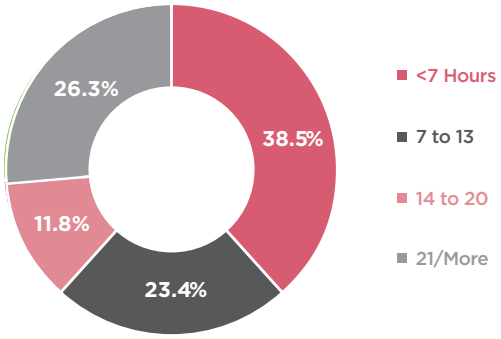
Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 304]
Notes: • Asked of all respondents.

Personal Time

There are many demands on peoples' time, such as working, doing housework, running errands, caregiving, and otherwise taking care of obligations. The following survey question was asked in the interest of gauging how much time people have for themselves.

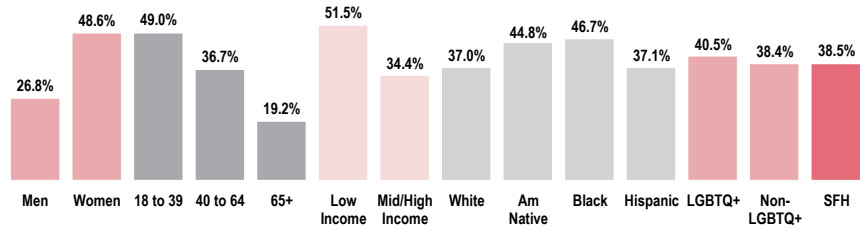
"In the past seven days, how many hours would you say that you spent doing the things you wanted to do, such as relaxing, socializing, pursuing hobbies, traveling, or otherwise taking care of yourself?"

Hours Spent in the Past Week On Personal Time
(SFH Service Area, 2022)



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 305]
Notes: • Asked of all respondents.

Spent <7 Hours on Personal Time Last Week
(SFH Service Area, 2022)

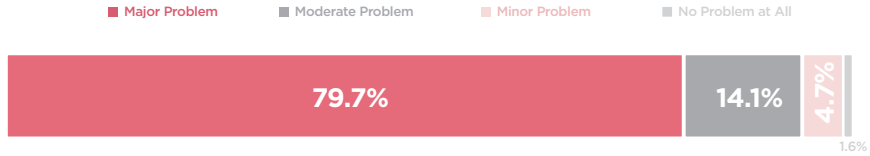


Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 305]
Notes: • Asked of all respondents.

Key Informant Input: Mental Health

The following chart outlines key informants' perceptions of the severity of Mental Health as a problem in the community:

Perceptions of Mental Health
as a Problem in the Community
(Key Informants, 2022)



Sources: • PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Access to Care/Services

Lack of sufficient treatment services, especially for inpatient needs. – Other Health Provider

Staffing organizations that provide mental health support for children/families and funding to ensure that children/families can access these resources. – Community Leader

Access to mental health services and supports for the BIPOC communities. We need more access to mental health services for the minority community. These services should represent the communities that is being served with varies resources that incorporate the person and their family. – Public Health Representative

Lack of insurance, lack of access, lack of beds and lack of psychiatrists, counselors and social workers. We need more beds for adults and many more for children. We especially need more child psychiatrists and counselors, and we need to promote and support for programs in our public schools. Teachers need training and help to deal with a 4th grader that is threatening suicide – Community Leader

Availability and accessibility of mental health practitioners. Information is not shared across providers. Post treatment care/support is limited. – Community Leader

Tremendous lack of services and unaffordable for most, even those employed and with health insurance. – Public Health Representative

Lack of access to mental health facilities in our community. At agencies outside of the community, the onboarding process is long and tedious. It is difficult to get your immediate needs met regarding mental health. There is a lot of inconsistency! – Community Leader

Not enough providers and resources. – Public Health Representative

Access to mental health providers. Mental health emergencies. Social isolation from pandemic. Resuming in person counseling/therapy. Availability of inpatient treatment facilities. – Physician

Lack of long term inpatient treatment. – Social Service Agency

Lack of mental health resources and providers within the community. – Physician

Lack of services. – Public Health Representative

Poor access. Without private insurance it is extremely difficult to be seen regularly by a psychiatrist. – Physician

Lack of access. This is worst for pediatric psychiatry. I have seen pediatric psychiatric patients in an acute suicidal crisis wait for more than 1 week for treatment in a pediatric psychiatric hospital. It is horrible that a young teen in the Tulsa area is actively suicidal and then told no one wants to treat them for a week. State and local government officials in Oklahoma and Tulsa do not care about the children of Oklahoma and their health care needs. There should be multiple pediatric psychiatric hospitals in Tulsa. There should be multiple hospitals in Tulsa that admit general pediatric patients. Right now, there is only one general pediatric, Saint Francis. The only major psychiatric hospital that admits pediatric patients is Parkside. – Physician

Timely access to care. – Physician

Contributing Factors

Access. Very few inpatient care facilities. Long wait for appointments. Social stigma of having a mental health diagnosis. – Physician

None of these health issues is a standalone issue. Behavioral health should not be separated from physical health. Services are available, however, the demand for therapists and psychiatrists has created a shortage of skilled practitioners. Substance use is a contributing factor. – Other Health Provider

Stigma around acknowledging issues. Ability to access services on a timely basis, particularly for low-income individuals (but also broadly across the entire population). Prevalence of mental health issues among those in the criminal justice system (and lack of resources to support within the system). Declining services in the region and state (i.e. – loss of services for children). – Community Leader

Lack of mental health awareness, awareness of evidence-based practices, and service connections in general health care settings and by general health care practitioners. This prohibits early detection and intervention of mental health conditions resulting in higher ER utilization, criminal justice involvement, homelessness and escalating crises. Lack of insurance network adequacy resulting in limited access and long wait times for outpatient therapy for individuals who aren't on Medicaid and can't afford self-pay. Limited mental health workforce for master-level practitioners and psychologists/psychiatrist preventing wider adoption of integrated care practices and intensive services. Lack of intensive services for those with chronic and high needs, resulting in increased ER utilization and criminal justice involvement. (Examples: Home-based services and intensive outpatient). This is especially true for children, resulting in higher demand on limited inpatient beds.5) – Public Health Representative

Lack of services. High crime area. Lack of transportation to services. – Community Leader

Lack of facilities for treatment and the whole stigma for needing treatment for mental health issues. – Other Health Provider

The biggest challenges relate to treatment adherence, wait times and access, and reliance on street drugs. The children's mental health access problem is particularly acute. – Community Leader

Access to care/medication secondary to homelessness, addiction, transportation, and cost of prescriptions. – Physician

Diagnosis/Treatment

Mental health is not the goal of our community or the providers. We treat people who have crossed the threshold and present with a diagnosis of a disorder. The money is in the treatment of disease. And even then, we do not have clear guidance of what is effective treatment to restore good mental health. Most insurance companies will cover psychotropic medications and counseling sessions. Community Mental Health agencies spend a relatively small amount of tax dollars on treatment, rather providing case management and more indirect care. The correlation between trauma, as revealed in the ACEs study, is generally unrecognized and Oklahoma citizens continue to be among the most traumatized population in our country, as evidenced by rates of domestic violence, violent crimes, imprisonment, child abuse, drug and alcohol abuse, and other indicators. – Public Health Representative

Poor initial community response to suspected initial or subsequent psychosis as the police are usually called, then poor access to inpatient psychiatric care. After discharge there is nonexistent proactive community follow up, which is worse with patients not having a permanent home or job – Physician

Need to take medication. – Community Leader

Not seeking help. – Community Leader

Denial/Stigma

> The community does not address their mental health care needs because it is a taboo subject and the cost. – Social Service Agency
>
> Mental health is taboo in the Latino community, yet many suffer from undiagnosed and untreated mental health issues. The lack of health insurance also prevents them from accessing care. There are very few mental health professionals who speak Spanish. – Community Leader
>
> Stigma of the disease and an unwillingness to seek help. Cost. Lack of physicians. – Community Leader

Health Education

> Not enough information, services, and education available. – Community Leader
>
> Continuing to help people understand that it's ok to not "feel" ok. Asking for help is not a sign of weakness. Making mental health resources more easily accessible for all. – Social Service Agency
>
> Lack of understanding of the issues. Lack of access to treatment. – Social Service Agency

Affordable Care/Services

> Access for poorer people. – Physician
>
> Affordable care/housing for homeless. – Community Leader
>
> Access and affordability of care. There is a large gap in the need to address mental health challenges and the capacity to meet that need. – Public Health Representative

Prevalence/Incidence

> Mental health has been a challenge in the community, but the numbers have increased since the pandemic. – Community Leader
>
> Oklahoma has some of the highest average ACE scores for young people in the nation. – Public Health Representative

Homelessness

> Our homeless population is growing and in need of mental health treatment. – Community Leader
>
> So many of the homeless people have mental health issues. Many people do not want to be tagged with the "mental illness" label and do not go to get help, or know where to get help, or cannot afford to do so. Increases in suicide, child abuse, and COVID that result in mental health issues. Feelings of isolation, stress, depression, hopelessness seem to be increasing. – Community Leader

Funding

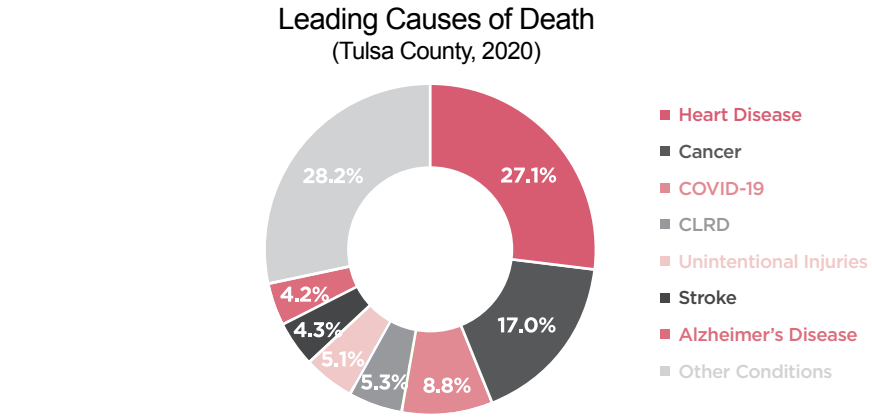
> Limited funding for providers and facilities. – Physician

DEATH, DISEASE & CHRONIC CONDITIONS

Leading Causes of Death

Distribution of Deaths by Cause

Heart disease and cancers are leading causes of death in the community.



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted March 2022.

Notes: • Lung disease is CLRD, or chronic lower respiratory disease.

Age-Adjusted Death Rates for Selected Causes

AGE-ADJUSTED DEATH RATES

In order to compare mortality in the region with other localities (in this case, Oklahoma and the United States), it is necessary to look at rates of death — these are figures which represent the number of deaths in relation to the population size (such as deaths per 100,000 population, as is used here). Furthermore, in order to compare localities without undue bias toward younger or older populations, the common convention is to adjust the data to some common baseline age distribution. Use of these "age-adjusted" rates provides the most valuable means of gauging mortality against benchmark data, as well as Healthy People 2030 objectives.

The following chart outlines annual average age-adjusted death rates per 100,000 population for selected causes of death in Tulsa County.

For infant mortality data, see Birth Outcomes & Risks in the Births section of this report.

Age-Adjusted Death Rates for Selected Causes
(2018-2020 Deaths per 100,000 Population)

	TULSA COUNTY	OK	US	HP2030
Diseases of the Heart	244.6	234.7	164.4	127.4*
Malignant Neoplasms (Cancers)	162.8	174.1	146.5	122.7
COVID-19 (2020)	83.3	100.3	85.0	
Falls (Age 65+)	70.6	106.4	67.1	63.4
Unintentional Injuries	52.7	60.8	51.6	43.2
Chronic Lower Respiratory Disease (CLRD)	49.8	62.0	38.1	—
Cerebrovascular Disease (Stroke)	43.2	39.8	37.6	33.4
Alzheimer's Disease	40.1	38.0	30.9	—
Diabetes	20.9	29.9	22.6	—
Intentional Self-Harm (Suicide)	19.9	20.8	13.9	12.8
Firearm-Related	19.8	18.7	12.5	10.7
Unintentional Drug-Related Deaths	18.6	15.9	21.0	—
Cirrhosis/Liver Disease	16.2	16.2	11.9	10.9
Pneumonia/Influenza	15.1	15.1	13.4	—
Motor Vehicle Deaths	12.3	16.7	11.4	10.1
Homicide/Legal Intervention	10.5	8.3	6.1	5.5
Kidney Disease	8.1	10.7	12.8	—
HIV	2.3	1.5	1.8	—

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted March 2022.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov.

Note:
- *The Healthy People 2030 Heart Disease target is adjusted to account for all diseases of the heart.

Cardiovascular Disease

ABOUT HEART DISEASE & STROKE

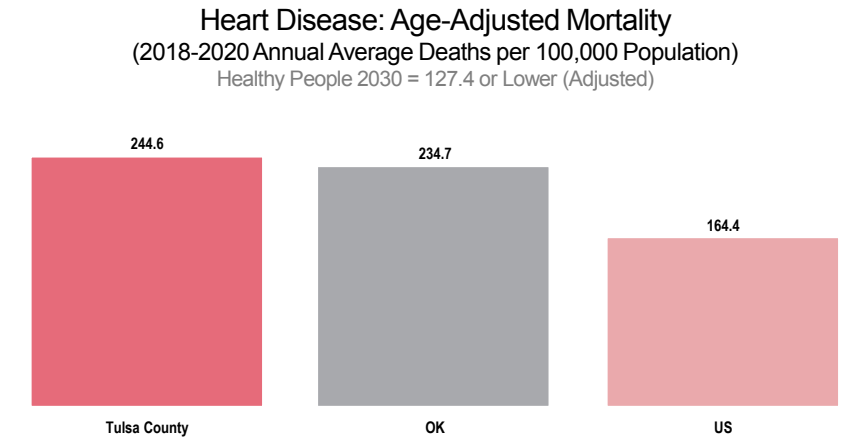
Heart disease is the leading cause of death in the United States, and stroke is the fifth leading cause. ...Heart disease and stroke can result in poor quality of life, disability, and death. Though both diseases are common, they can often be prevented by controlling risk factors like high blood pressure and high cholesterol through treatment.

In addition, making sure people who experience a cardiovascular emergency — like stroke, heart attack, or cardiac arrest — get timely recommended treatment can reduce their risk for long-term disability and death. Teaching people to recognize symptoms is key to helping more people get the treatment they need.

– *Healthy People 2030 (https://health.gov/healthypeople)*

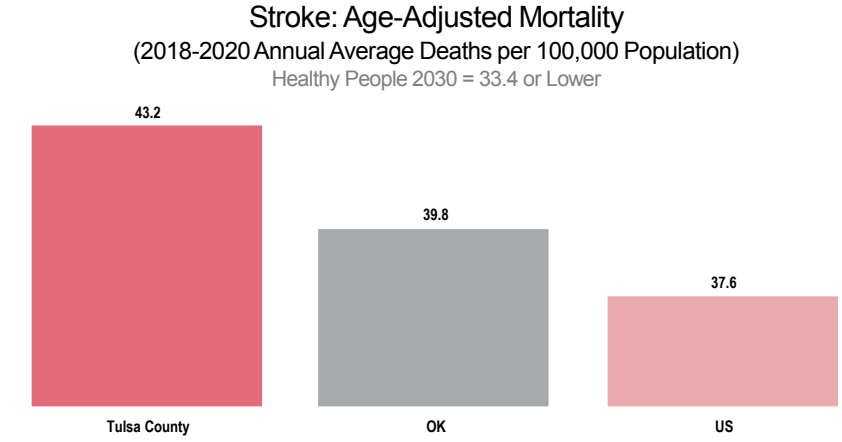
Age-Adjusted Heart Disease & Stroke Deaths

The greatest share of cardiovascular deaths is attributed to heart disease. The following charts outline age-adjusted mortality rates for heart disease and for stroke in our community.



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted March 2022.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Notes:
- The Healthy People 2030 Heart Disease target is adjusted to account for all diseases of the heart.



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted March 2022.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

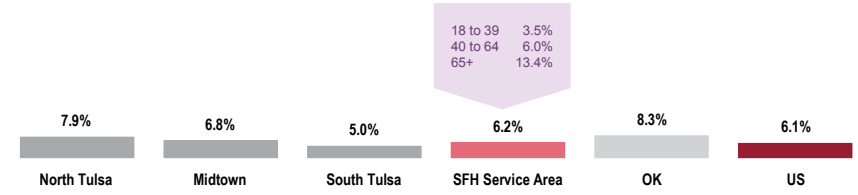
Prevalence of Heart Disease & Stroke

"Has a doctor, nurse, or other health professional ever told you that you had:

- A heart attack, also called a myocardial infarction?
- Angina or coronary heart disease?"

Heart disease prevalence here is a calculated prevalence that includes those responding affirmatively to either.

Prevalence of Heart Disease

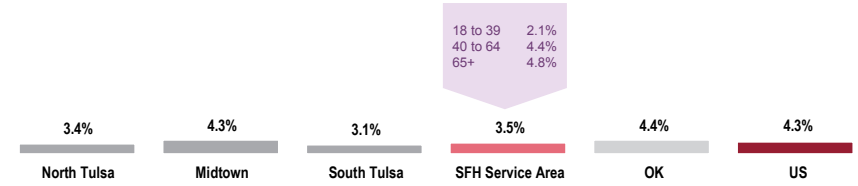


Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 114]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Oklahoma data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes diagnoses of heart attack, angina, or coronary heart disease.

"Has a doctor, nurse, or other health professional ever told you that you had a stroke?"

Prevalence of Stroke



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 29]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Oklahoma data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

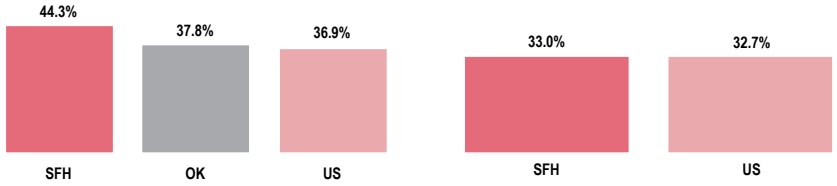
Cardiovascular Risk Factors

Blood Pressure & Cholesterol

"Have you ever been told by a doctor, nurse, or other health care professional that you had high blood pressure?"

"Blood cholesterol is a fatty substance found in the blood. Have you ever been told by a doctor, nurse, or other health care professional that your blood cholesterol is high?"

Prevalence of
High Blood Pressure
Healthy People 2030 = 27.7% or Lower



Prevalence of
High Blood Cholesterol

Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Items 35-36]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Oklahoma data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Notes:
- Asked of all respondents.

Total Cardiovascular Risk

Total cardiovascular risk reflects the individual-level risk factors which put a person at increased risk for cardiovascular disease, including:

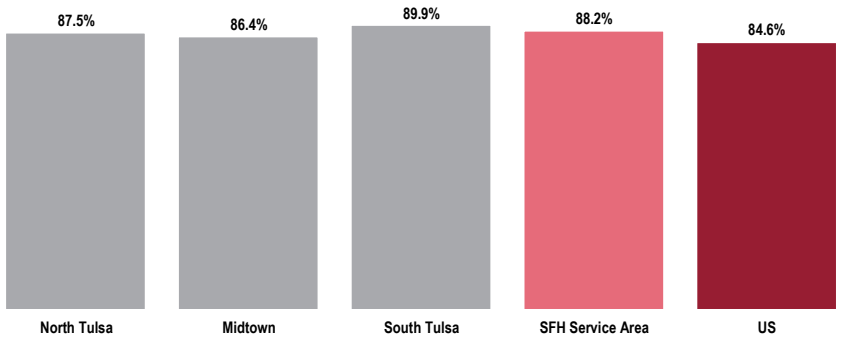
- High Blood Pressure
- High Blood Cholesterol
- Cigarette Smoking
- Physical Inactivity
- Overweight/Obesity

Modifying these behaviors and adhering to treatment for high blood pressure and cholesterol are critical both for preventing and for controlling cardiovascular disease.

The following chart reflects the percentage of adults in the Saint Francis Hospital Service Area who report one or more of the following: being overweight; smoking cigarettes; being physically inactive; or having high blood pressure or cholesterol.

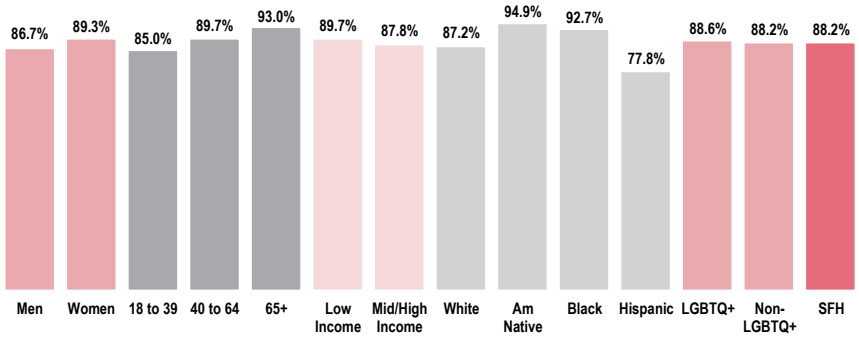
RELATED ISSUE
See also Nutrition, Physical Activity & Weight and Tobacco Use in the Modifiable Health Risks section of this report.

Present One or More Cardiovascular Risks or Behaviors



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 115]
- 2020 PRC National Health Survey, PRC, Inc.

Present One or More Cardiovascular Risks or Behaviors
(SFH Service Area, 2022)

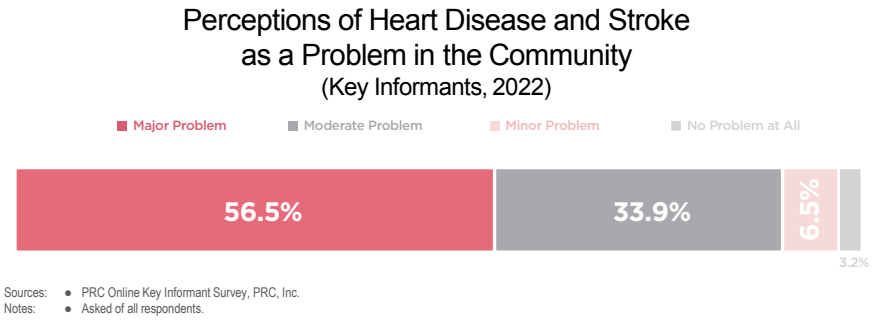


Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 115]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Reflects all respondents.
- Cardiovascular risk is defined as exhibiting one or more of the following: 1) no leisure-time physical activity; 2) regular/occasional cigarette smoking; 3) high blood pressure; 4) high blood cholesterol; and/or 5) being overweight/obese.

Key Informant Input: Heart Disease & Stroke

The following chart outlines key informants' perceptions of the severity of Heart Disease & Stroke as a problem in the community:



Among those rating this issue as a "major problem," reasons related to the following:

Prevalence/Incidence

One of the highest incidences of death by heart attack. – Public Health Representative

Leading cause of death in Tulsa. – Community Leader

The number of patients being seen every day is a good indication that we have a major problem with this. – Other Health Provider

According to CDC, Oklahoma has the third highest death rate of all states. – Community Leader

Have seen data related to the prevalence of these issues in the community and their impact on mortality rates. – Community Leader

Data indicates that one in every 173 Tulsans will lose their life to a cardiovascular illness. – Public Health Representative

These conditions debilitate or kill many. They cause extensive economic damage. – Community Leader

A large portion of our population suffer from heart disease and stroke. Lifestyle changes could have prevented this or reduced the risk in many of the cases. – Physician

Top Oklahoma health concern. – Community Leader

Obesity

Obesity and untreated diabetes are rampant, leading to an increase in risk for these diseases. Unless the issue of obesity is addressed, these related illnesses will continue to cause fatalities. – Physician

Obesity and rate of heart disease and stroke. – Community Leader

We are an obese state and an obese county with much lower than average activity levels. This contributes to diabetes and heart disease, which contributes to inequity on lifespans from one area or demographic to the next. – Public Health Representative

Obesity is an issue for many community members. There needs to be a focus on more active lifestyles and healthy food choices. – Community Leader

Contributing Factors

I still believe women do not know or take seriously some symptoms of heart attacks and get medical care or get preventative care. There is an obesity problem that leads to heart disease/stroke, a diabetes problem, a lack of exercise/movement, eating out a lot and not choosing healthy foods or knowing what are healthy foods at these dining establishments. – Community Leader

Oklahoma has a high rate of obesity. It may in part be due to many food deserts where people do not have access to fresh fruits and vegetables and may not be able to afford them. That with a lack of primary health care, smoking, and drug use add to the problem. – Community Leader

Diet choices, stress/hypertension. – Community Leader

Poor nutrition, prevalent diabetes, tobacco use. – Physician

Prevention/Screenings

> Prevention. Not seeking regular medical care. – Community Leader

> Not a lot of services for preventative services and education. – Community Leader

Health Disparities

> Especially in North Tulsa where life expectancy is lower due to diet, physical activity, and economic limitations. – Community Leader

> There is a large disparity in incidence of heart disease by race. We need better answers. – Other Health Provider

Access to Care/Services

> There is very limited neurology services in the community. Both inpatient and outpatient. The wait list to see an outpatient neurologist in Tulsa can be more than one year. This is like seeking healthcare in a third world country. – Physician

> Once again, due to Covid, the lack of accessing providers for treatment. – Public Health Representative

Comorbidities

> All of the chronic illnesses in Tulsa and Oklahoma, diabetes, obesity, heart disease, etc. are interrelated. If one is diabetic, one is at risk of heart disease. If one is obese, the same. The handful of metrics in Oklahoma and Tulsa tell the story. – Other Health Provider

Affordable Medications/Supplies

> It is one of the chronic illnesses Morton treats. Unmanaged hypertension due to the high cost of medication. – Social Service Agency

Aging Population

> Aging, unhealthy population (high smoking/diabetes rates). – Physician

Homelessness

> Most of our clients are experiencing homelessness, are smokers, addiction to alcohol and drugs, and trauma related issues. – Social Service Agency

Lifestyle

> Smokers, drug and alcohol abuse, casinos, and the lifestyle of people who patronize them. Rampant obesity. – Community Leader

Cancer

ABOUT CANCER

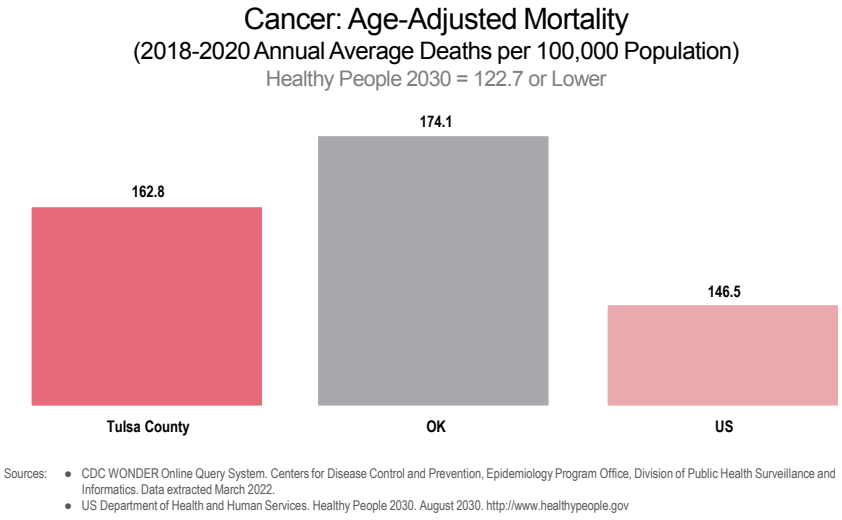
Cancer is the second leading cause of death in the United States. ...The cancer death rate has declined in recent decades, but over 600,000 people still die from cancer each year in the United States. Death rates are higher for some cancers and in some racial/ethnic minority groups. These disparities are often linked to social determinants of health, including education, economic status, and access to health care.

Interventions to promote evidence-based cancer screenings — such as screenings for lung, breast, cervical, and colorectal cancer — can help reduce cancer deaths. Other effective prevention strategies include programs that increase HPV vaccine use, prevent tobacco use and promote quitting, and promote healthy eating and physical activity. In addition, effective targeted therapies and personalized treatment are key to helping people with cancer live longer.

– *Healthy People 2030 (https://health.gov/healthypeople)*

Age-Adjusted Cancer Deaths

The following chart illustrates age-adjusted cancer mortality (all types) in Tulsa County.



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted March 2022.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Age-Adjusted Cancer Death Rates by Site
(2018-2020 Annual Average Deaths per 100,000 Population)

	TULSA COUNTY	OK	US	HP2030
ALL CANCERS	**162.8**	**174.1**	**146.5**	**122.7**
Lung Cancer	39.2	45.5	33.4	25.1
Prostate Cancer	21.2	19.5	18.5	16.9
Female Breast Cancer	20.6	22.7	19.4	15.3
Colorectal Cancer	16.1	16.3	13.1	8.9

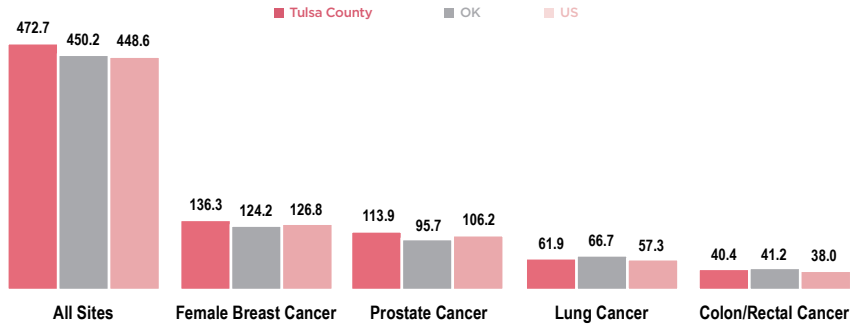
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted March 2022.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Lung cancer is by far the leading cause of cancer deaths in the county.

Cancer Incidence

"Incidence rate" or "case rate" is the number of newly diagnosed cases in a given population in a given year, regardless of outcome. These rates are also age-adjusted. It is usually expressed as cases per 100,000 population per year.

Cancer Incidence Rates by Site
(Annual Average Age-Adjusted Incidence per 100,000 Population, 2014-2018)



Sources:
- State Cancer Profiles.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved March 2022 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the age adjusted incidence rate (cases per 100,000 population per year) of cancers, adjusted to 2000 US standard population age groups (under age 1, 1-4, 5-9, ..., 80-84, 85 and older). This indicator is relevant because cancer is a leading cause of death, and it is important to identify cancers separately to better target interventions.

Prevalence of Cancer

"Have you ever suffered from or been diagnosed with cancer?"

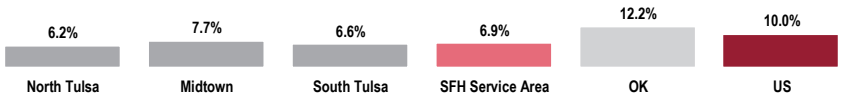
"Which type of cancer were you diagnosed with? (If more than one past diagnosis, respondent was asked about the most recent.)

RELATED ISSUE
See also Nutrition, Physical Activity & Weight and Tobacco Use in the Modifiable Health Risks section of this report.

Prevalence of Cancer

The most common types of cancers cited include:

1) Skin/Melanoma 24.4%
2) Breast Cancer 20.9%



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Items 25-26]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Oklahoma data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Reflects all respondents.

ABOUT CANCER RISK

Reducing the nation's cancer burden requires reducing the prevalence of behavioral and environmental factors that increase cancer risk.

- All cancers caused by cigarette smoking could be prevented. At least one-third of cancer deaths that occur in the United States are due to cigarette smoking.
- According to the American Cancer Society, about one-third of cancer deaths that occur in the United States each year are due to nutrition and physical activity factors, including obesity.

– National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention

Cancer Screenings

The American Cancer Society recommends that both men and women get a cancer-related checkup during a regular doctor's checkup. It should include examination for cancers of the thyroid, testicles, ovaries, lymph nodes, oral cavity, and skin, as well as health counseling about tobacco, sun exposure, diet and nutrition, risk factors, sexual practices, and environmental and occupational exposures.

FEMALE BREAST CANCER

The US Preventive Services Task Force (USPSTF) recommends biennial screening mammography for women aged 50 to 74 years.

CERVICAL CANCER

The US Preventive Services Task Force (USPSTF) recommends screening for cervical cancer every 3 years with cervical cytology alone in women aged 21 to 29 years. For women aged 30 to 65 years, the USPSTF recommends screening every 3 years with cervical cytology alone, every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or every 5 years with hrHPV testing in combination with cytology (cotesting). The USPSTF recommends against screening for cervical cancer in women who have had a hysterectomy with removal of the cervix and do not have a history of a high-grade precancerous lesion (i.e., cervical intraepithelial neoplasia [CIN] grade 2 or 3) or cervical cancer.

COLORECTAL CANCER

The US Preventive Services Task Force (USPSTF) recommends screening for colorectal cancer starting at age 50 years and continuing until age 75 years.

– *US Preventive Services Task Force, Agency for Healthcare Research and Quality, US Department of Health & Human Services*

Note that other organizations (e.g., American Cancer Society, American Academy of Family Physicians, American College of Physicians, National Cancer Institute) may have slightly different screening guidelines.

Screening levels in the community were measured in the PRC Community Health Survey relative to three cancer sites: female breast cancer (mammography); cervical cancer (Pap smear testing); and colorectal cancer (sigmoidoscopy and fecal occult blood testing).

Breast Cancer Screening ▶ "A mammogram is an x-ray of each breast to look for cancer. How long has it been since you had your last mammogram?"

Breast cancer screening is calculated here among women age 50 to 74 who indicate mammography within the past 2 years.

Cervical Cancer Screening ▶ "A Pap test is a test for cancer of the cervix. How long has it been since you had your last Pap test?"

[If Pap test in the past five years] "HPV, or the human papillomavirus, is a common infection that can cause several types of cancer. When you received your last Pap test, were you screened for HPV?"

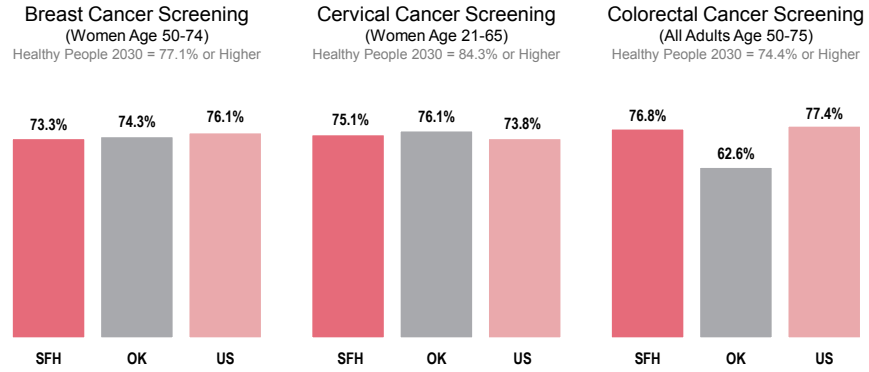
"Have you ever had a hysterectomy?"

"Appropriate cervical cancer screening" includes Pap smear testing (cervical cytology) every three years in women age 21 to 29 and Pap smear testing and/or HPV testing every 5 years in women age 30 to 65. Women 21 to 65 with hysterectomy are excluded.

Colorectal Cancer Screening ▶ "Sigmoidoscopy and colonoscopy are exams in which a tube is inserted in the rectum to view the colon for signs of cancer or other health problems. How long has it been since your last sigmoidoscopy or colonoscopy?"

"A blood stool test is a test that may use a special kit at home to determine whether the stool contains blood. How long has it been since you had your last blood stool test?"

"Appropriate colorectal cancer screening" is calculated here among men and women age 50 to 75 years who have had a fecal occult blood test within the past year and/or a lower endoscopy (sigmoidoscopy or colonoscopy) within the past 10 years.

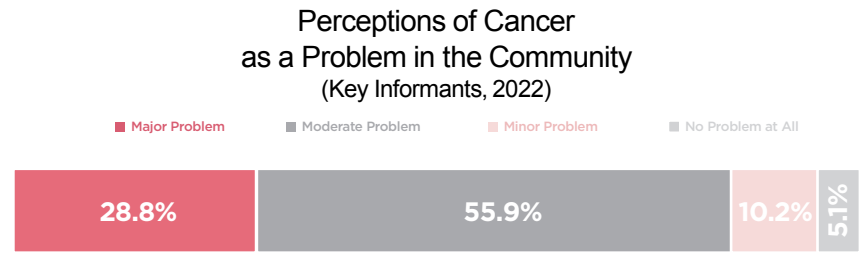


Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Items 116-118]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Oklahoma data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Notes:
- Each indicator is shown among the gender and/or age group specified.

Key Informant Input: Cancer

The following chart outlines key informants' perceptions of the severity of Cancer as a problem in the community:



Sources:
- PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Prevalence/Incidence

> Oklahoma has one of the highest cancer rates in the country and some of the worst health screening rates and tobacco use rates. – Physician
>
> Rate of occurrence, emphasis on treatment rather than prevention, deferred primary health care options prior to expanded Medicaid. – Other Health Provider
>
> Current data suggests that roughly one in every 200 residents in Tulsa County will be diagnosed with cancer. This rate is above both the state and national average. – Public Health Representative
>
> It's one of the leading causes of death. One must seek treatment in Oklahoma City or outside the state for some forms of cancer. – Community Leader
>
> I have known a number of people with cancer in the last few years. – Public Health Representative
>
> It is a leading cause of death. – Community Leader

Prevention/Screenings

> There are no preventative services, and the community does not have any healthy options for food. – Community Leader
>
> No regular and consistent medical exams, therefore no prevention, just intervention. – Community Leader
>
> Due to COVID, many folks have put aside preventive care, including cancer screenings. – Public Health Representative
>
> Need more screenings, even with blood work, etc. Too many people dying with treatable cancer. – Community Leader

Access to Care/Services

> Finding an organization to treat individuals who have cancer and are uninsured is a challenge. – Social Service Agency
>
> I was formerly involved with a women's cancer health organization. There are very limited resources for women, particularly those with limited income, those who live in rural communities, and those belonging to marginalized populations. This health organization no longer has a presence in Oklahoma, leaving an even greater void in our community for women facing certain types of cancer. – Social Service Agency

Contributing Factors

> Poor access to primary care service, leading to lack of screening combined with persistent tobacco use, alcohol abuse and obesity. – Physician
>
> Smoking and obesity. – Physician

Overall Health Status

> Oklahoma's poor health rankings. – Community Leader

Respiratory Disease

ABOUT RESPIRATORY DISEASE

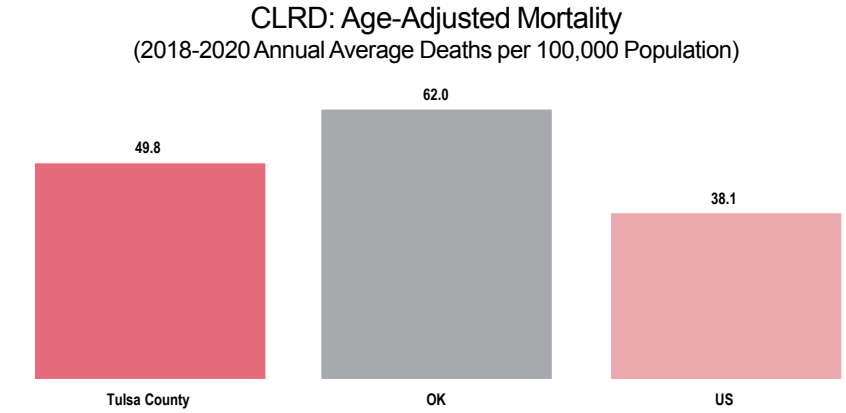
Respiratory diseases affect millions of people in the United States. ...More than 25 million people in the United States have asthma. Strategies to reduce environmental triggers and make sure people get the right medications can help prevent hospital visits for asthma. In addition, more than 16 million people in the United States have COPD (chronic obstructive pulmonary disease), which is a major cause of death. Strategies to prevent the disease — like reducing air pollution and helping people quit smoking — are key to reducing deaths from COPD.

Interventions tailored to at-risk groups can also help prevent and treat other respiratory diseases — for example, pneumonia in older adults and pneumoconiosis in coal miners. And increasing lung cancer screening rates can help reduce deaths from lung cancer through early detection and treatment.

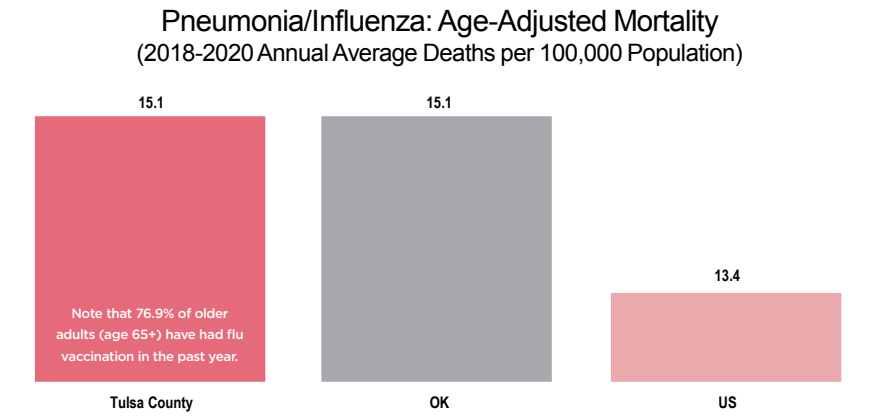
– *Healthy People 2030 (https://health.gov/healthypeople)*

Age-Adjusted Respiratory Disease Deaths

Chronic lower respiratory diseases (CLRD) are diseases affecting the lungs; the most deadly of these is chronic obstructive pulmonary disease (COPD), which includes emphysema and chronic bronchitis. Mortality for CLRD is illustrated in the charts that follow.



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted March 2022.
Notes: • CLRD is chronic lower respiratory disease.



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 124]
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted March 2022.

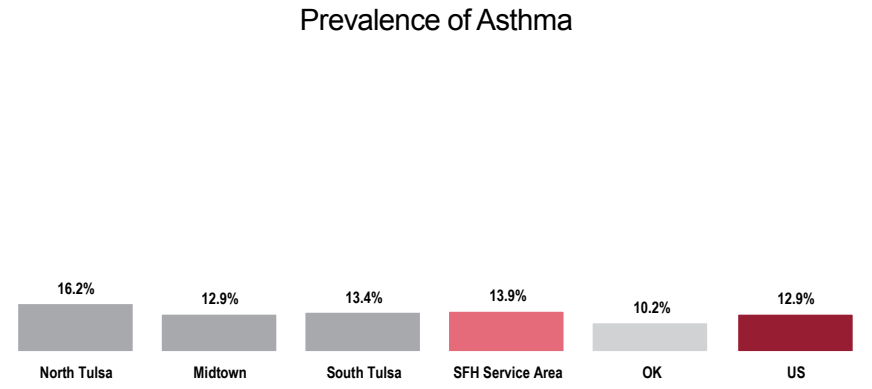
Pneumonia and influenza mortality is also illustrated.

Prevalence of Respiratory Disease

ASTHMA

Adults ▶ "Have you ever been told by a doctor, nurse, or other health professional that you had asthma?" and "Do you still have asthma?" (Calculated here as a prevalence of all adults who have ever been diagnosed with asthma and who still have asthma.)

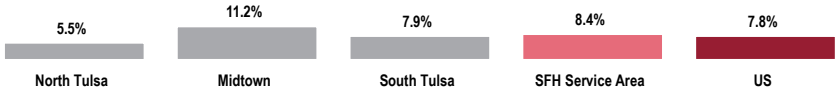
Children ▶ "Has a doctor or other health professional ever told you that this child had asthma?" and "Does this child still have asthma?" (Calculated here as a prevalence of all children who have ever been diagnosed with asthma and who still have asthma.)



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 119]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Oklahoma data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes those who have ever been diagnosed with asthma and report that they still have asthma.

Prevalence of Asthma in Children
(Parents of Children Age 0-17)



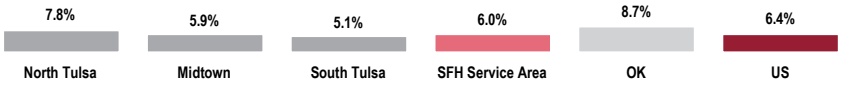
Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 120]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents with children 0 to 17 in the household.
- Includes children who have ever been diagnosed with asthma and are reported to still have asthma.

Chronic Obstructive Pulmonary Disease (COPD)

"Would you please tell me if you have ever suffered from or been diagnosed with COPD or chronic obstructive pulmonary disease, including bronchitis or emphysema?"

Prevalence of Chronic Obstructive Pulmonary Disease (COPD)

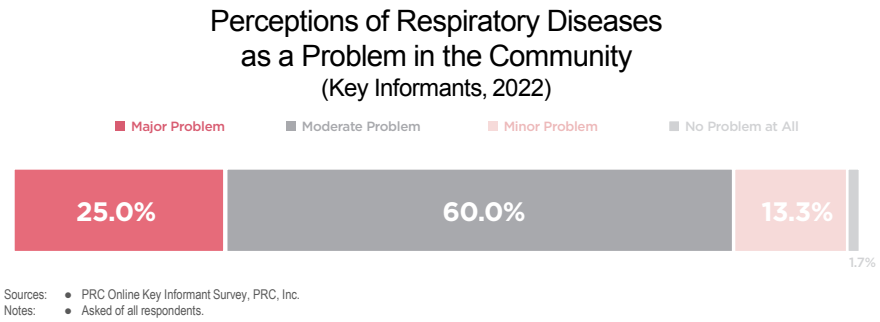


Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 23]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Oklahoma data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes those having ever suffered from or been diagnosed with COPD or chronic obstructive pulmonary disease, including bronchitis or emphysema.

Key Informant Input: Respiratory Disease

The following chart outlines key informants' perceptions of the severity of Respiratory Disease as a problem in the community:



Among those rating this issue as a "major problem," reasons related to the following:

Tobacco Use

> Due to our high number of smokers. – Public Health Representative
>
> Addiction to tobacco. – Social Service Agency
>
> Prevalence of smoking. – Physician

Contributing Factors

> I have seen stats stating we have higher than average numbers, but don't know myself. I believe poor air quality, limited urban tree canopy, and poor health due to low activity are drives. – Public Health Representative
>
> This is related to being inactive and fat. – Community Leader
>
> There are few outpatient pulmonary practitioners. Although there is adequate coverage for acute hospitalizations, the follow up and more importantly the prevention of acute hospitalization is lacking. The tobacco use and other untreated respiratory disease (some of this is financial since medications are costly for many people in the community) are also major factors. – Physician

Prevalence/Incidence

> EMS services run numerous calls daily and with so many ethnic groups who are prone to respiratory disease in this area, it is clearly a major problem in all of Oklahoma. – Other Health Provider
>
> Number of staff members who continually suffer with sinus infections and respiratory illnesses. – Social Service Agency

COVID-19

> Covid. – Community Leader

Lifestyle

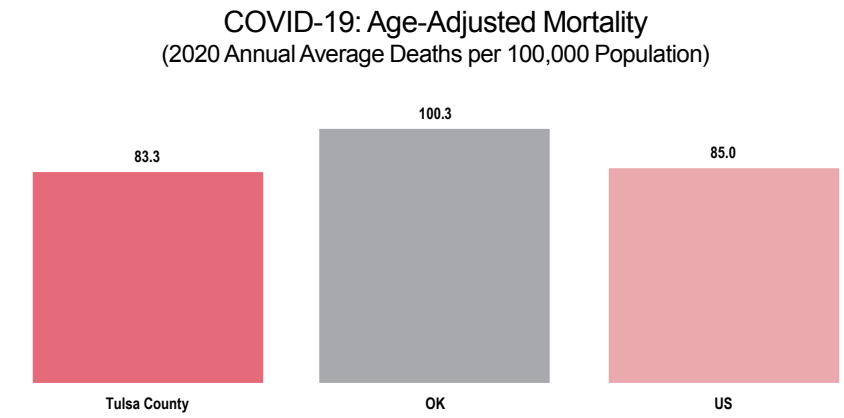
> Lifestyle. – Community Leader

Prevention/Screenings

> Not enough preventative services and education. – Community Leader

Age-Adjusted COVID-19 Deaths

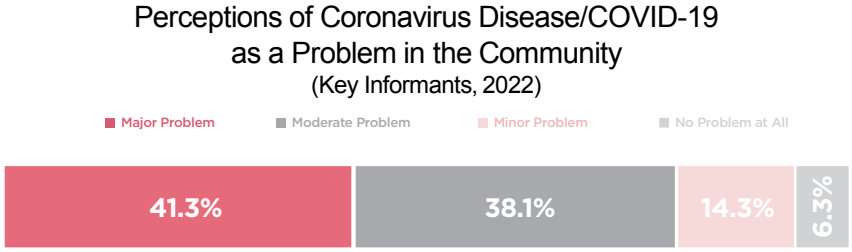
2020 death rates for COVID-19 are illustrated in the following chart.



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted March 2022.

Key Informant Input: Coronavirus Disease/COVID-19

The following chart outlines key informants' perceptions of the severity of Coronavirus Disease/COVID-19 as a problem in the community:



Sources: • PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Health Education

> Misinformation leading to lower vaccination rates, especially in "conservative" circles. – Community Leader
>
> It's a major problem worldwide. Citizens in our community don't tend to follow science or the advice from public health officials. As a result, the community suffers prolonged community spread. – Community Leader
>
> Suspicion of public health directives and vaccine hesitancy. – Physician
>
> Lack of knowledge. – Community Leader
>
> Guidance from all sides, at times politically motivated, results in low confidence in public health and a failure of the citizens to act on them, thus increasing risks for others, particularly the most vulnerable to the virus. – Public Health Representative

Lack of Adherence to Public Health Mitigation Measures

Rates of infection due to resistance to prevention/mitigation measures. Vaccine hesitancy and low rates of vaccination and lack of political leadership to support community and state solutions. – Other Health Provider

High death and infection rates. Poor adherence to precautions, vaccination hesitation. – Physician

Many people do not take the recommendations seriously. It can be a fatal disease, but those that do not follow mask and hand washing guidance put the entire population at risk. More should be done to encourage the general public to get vaccinated. – Physician

People are getting tired of COVID restrictions, and many have doubted science. This puts the most vulnerable in our community at great risk of serious health conditions, including death. – Social Service Agency

Contributing Factors

There was not enough hospital capacity or resources to take care of the large number of patients that needed hospitalization. There was a valiant effort at education and offering immunization and medication to the community, but the amount of misinformation was too great. – Physician

We have a relatively small percentage of vaccinated people and no desire for people to wear masks. And we are experiencing staffing issues at area hospitals. – Public Health Representative

General denial that Covid still exists. Failure to maintain proven methods to reduce transmission, i.e., masking. Low vaccination rates. – Other Health Provider

Low vaccination rates, misinformation, displeasure with masking protocols. – Social Service Agency

People are not vaccinated still in 2022. Need more Covid testing sites. – Community Leader

Vaccination Rates

Too many unvaccinated people. Inequities in reaching people with testing and vaccines. – Other Health Provider

A lot of individuals are not vaccinated, which is their choice, and the virus is preyed upon underserved communities. – Community Leader

There is still a resistance in the community to get vaccinated. – Social Service Agency

Prevalence/Incidence

Community spread and fatality rate. – Community Leader

Prevalence and politics. – Physician

It is a major problem due to the specificity rate for our state and the numbers with Covid. – Public Health Representative

Diagnosis/Treatment

There has been a major number of cases that have negatively impacted our ability to diagnose, treat and manage other people with new or chronic health care conditions. For example, people have not been getting access to care or not coming to appointments secondary to lack of access for heart disease, diabetes and particularly oncology care. I believe that our screening and monitoring systems for cancer (lung, GI, breast, etc.) are not functioning well now. We will have late presentations of disease in the months to come. – Physician

Impact on Quality of Life

Because it has affected the most people and has some lasting effects on health, some effects are still not known. It has caused children to not be able to attend school in person and learn, and they may never learn what they need to know and/or may cause more dropouts. It's increased anxiety/stress, behavior issues and mental health issues, and has created business/and financial loss, with less available people to work (we need more employees). – Community Leader

Vulnerable Populations

Many Latinos experienced language, cultural, and documentation barriers to accessing Covid education and vaccination. My organization, The Uma Center Inc, helped ameliorate these barriers through our Covid initiative. Initially, Latinos were hit pretty badly with Covid infections, hospitalizations, and deaths. – Community Leader

Injury & Violence

ABOUT INJURY & VIOLENCE

INJURY ▶ In the United States, unintentional injuries are the leading cause of death in children, adolescents, and adults younger than 45 years. ...Many unintentional injuries are caused by motor vehicle crashes and falls, and many intentional injuries involve gun violence and physical assaults. Interventions to prevent different types of injuries are key to keeping people safe in their homes, workplaces, and communities.

Drug overdoses are now the leading cause of injury deaths in the United States, and most overdoses involve opioids. Interventions to change health care providers' prescribing behaviors, distribute naloxone to reverse overdoses, and provide medications for addiction treatment for people with opioid use disorder can help reduce overdose deaths involving opioids.

VIOLENCE ▶ Almost 20,000 people die from homicide every year in the United States, and many more people are injured by violence. ...Many people in the United States experience physical assaults, sexual violence, and gun-related injuries. Adolescents are especially at risk for experiencing violence. Interventions to reduce violence are needed to keep people safe in their homes, schools, workplaces, and communities.

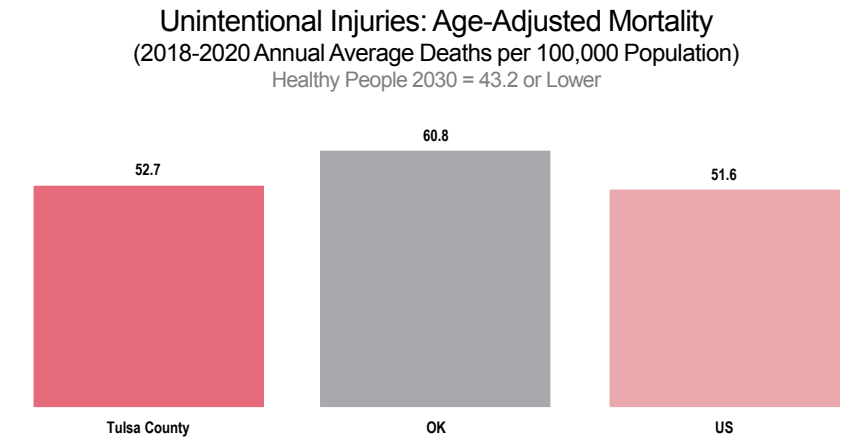
Children who experience violence are at risk for long-term physical, behavioral, and mental health problems. Strategies to protect children from violence can help improve their health and well-being later in life.

– Healthy People 2030 (https://health.gov/healthypeople)

Unintentional Injury

Age-Adjusted Unintentional Injury Deaths

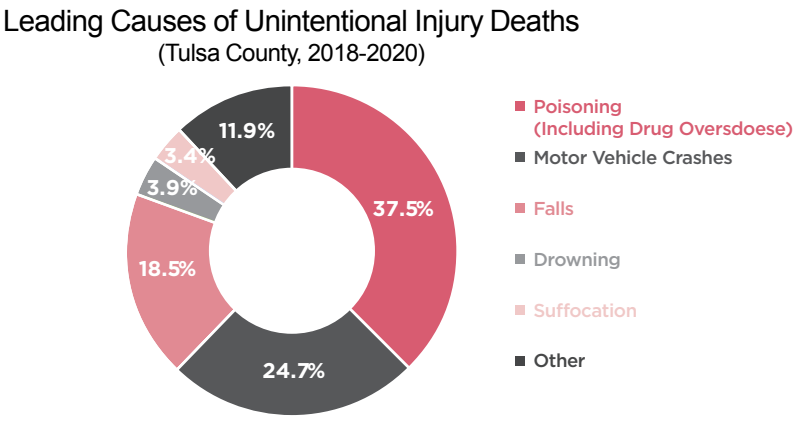
The following chart outlines age-adjusted mortality rates for unintentional injury in the area.



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted March 2022.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Leading Causes of Unintentional Injury Deaths

Leading causes of accidental death in the county include the following:



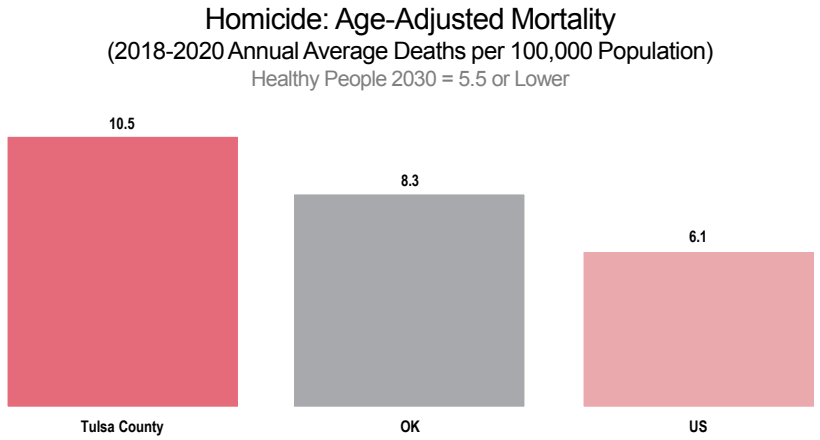
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted March 2022.

RELATED ISSUE
For more information about unintentional drugrelated deaths, see also Substance Abuse in the Modifiable Health Risks section of this report.

Intentional Injury (Violence)

Age-Adjusted Homicide Deaths

Age-adjusted mortality attributed to homicide is shown in the following chart.



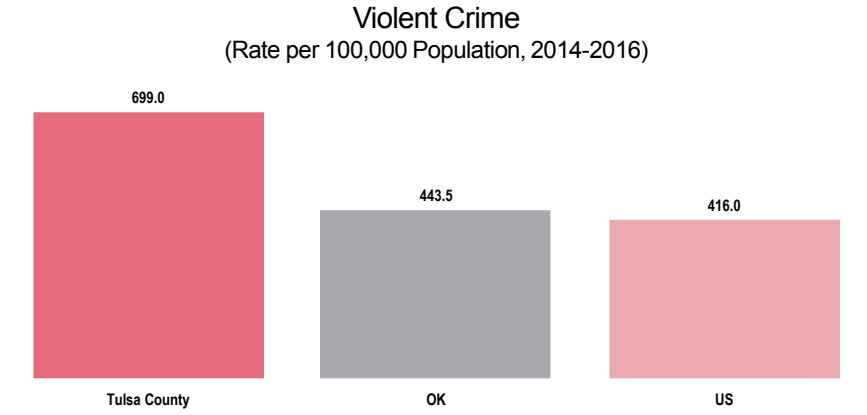
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted March 2022.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

RELATED ISSUE
See also Mental Health (Suicide) in the General Health Status section of this report.

Violent Crime

Violent crime is composed of four offenses (FBI Index offenses): murder and non-negligent manslaughter; forcible rape; robbery; and aggravated assault.

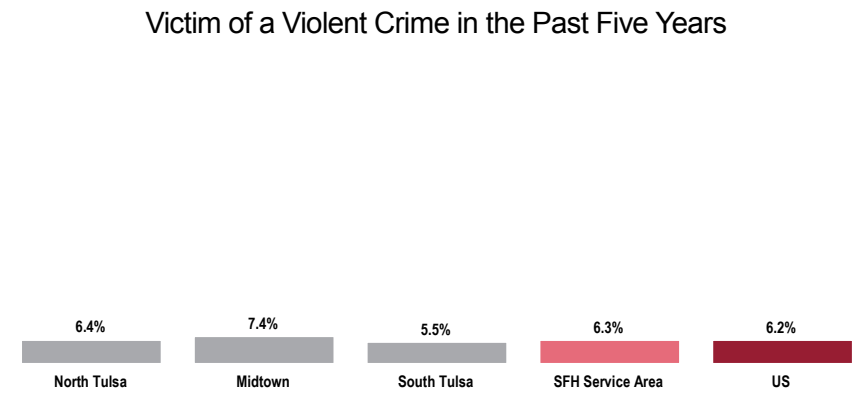
Note that the quality of crime data can vary widely from location to location, depending on the consistency and completeness of reporting among various jurisdictions.



Sources:
- Federal Bureau of Investigation, FBI Uniform Crime Reports.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved March 2022 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the rate of violent crime offenses reported by the sheriff's office or county police department per 100,000 residents. Violent crime includes homicide, rape, robbery, and aggravated assault. This indicator is relevant because it assesses community safety.
- Participation by law enforcement agencies in the UCR program is voluntary. Sub-state data do not necessarily represent an exhaustive list of crimes due to gaps in reporting. Also, some institutions of higher education have their own police departments, which handle offenses occurring within campus grounds; these offenses are not included in the violent crime statistics but can be obtained from the Uniform Crime Reports Universities and Colleges data tables.

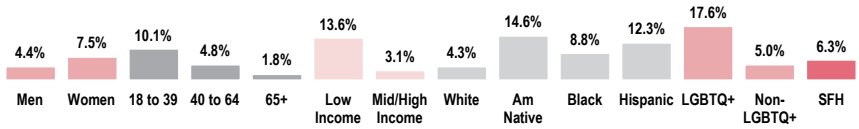
VIOLENT CRIME EXPERIENCE ▶ "Have you been the victim of a violent crime in your area in the past 5 years?"



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 38]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

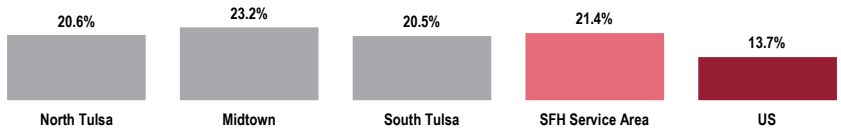
Victim of a Violent Crime in the Past Five Years
(SFH Service Area, 2022)



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 38]
Notes: • Asked of all respondents.

INTIMATE PARTNER VIOLENCE ▶ "The next questions are about different types of violence in relationships with an intimate partner. By an intimate partner, I mean any current or former spouse, boyfriend, or girlfriend. Someone you were dating, or romantically or sexually intimate with, would also be considered an intimate partner. Has an intimate partner ever hit, slapped, pushed, kicked, or hurt you in any way?"

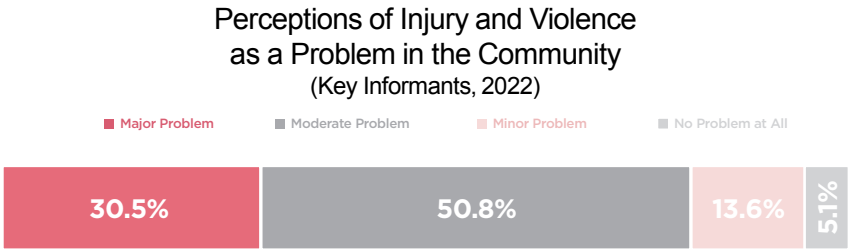
Have Ever Been Hit, Slapped, Pushed, Kicked, or Hurt in Any Way by an Intimate Partner



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 39]
• 2020 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.

Key Informant Input: Injury & Violence

The following chart outlines key informants' perceptions of the severity of Injury & Violence as a problem in the community:



Among those rating this issue as a "major problem," reasons related to the following:

Prevalence/Incidence

> Increasing crime rates. – Other Health Provider
>
> It is consistently one of the top 10 causes of early death/mortality in Tulsa. – Public Health Representative
>
> Incidence of domestic violence, homicide, and traffic fatalities. – Community Leader
>
> There are more and more reports of this on the news daily and the need for trauma care continues to climb. With only two level 2 trauma hospitals in Tulsa, their Emergency Departments stay busy. – Other Health Provider

Impact of Violence

> Gun violence is still a major issue, as are spousal and child abuse. These types of abuse feed into mental health challenges, homelessness, dropout rates, and more. – Social Service Agency

Gun Violence

> Gun deaths are one of the drivers to inequities in life expectancy from north and south Tulsa. – Public Health Representative

Vulnerable Populations

> Our clients experiencing homelessness are the most vulnerable, staying outside, on the streets and even shelters. – Social Service Agency
>
> Latinos get injured at work often because they work in dangerous occupations. They also often live in unsafe neighborhoods, where they are exposed to violence. – Community Leader

Crime

> Crime. – Community Leader

Media

> Media perpetuates violence and there are hardly any positive outlets in the community. – Community Leader

Systemic Neglect

> Systemic neglect. – Community Leader

Contributing Factors

> Historical trauma, at-risk behavior, addiction, not enough employment opportunities, not enough community-based activities and programs. – Community Leader

Diabetes

ABOUT DIABETES

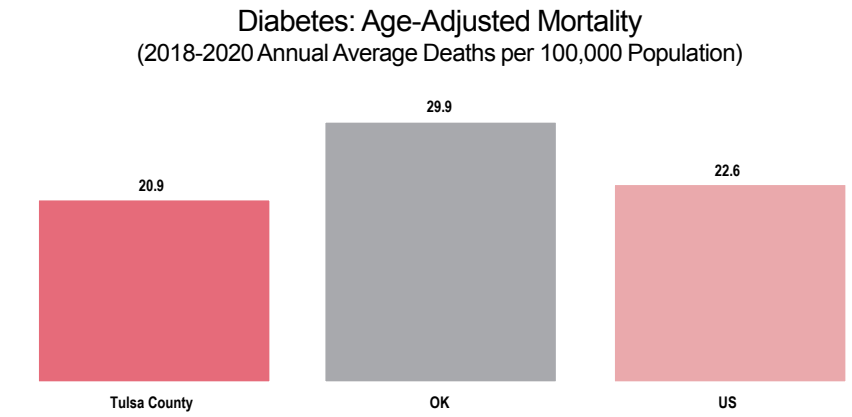
More than 30 million people in the United States have diabetes, and it's the seventh leading cause of death. ... Some racial/ethnic minorities are more likely to have diabetes. And many people with diabetes don't know they have it.

Poorly controlled or untreated diabetes can lead to leg or foot amputations, vision loss, and kidney damage. But interventions to help people manage diabetes can help reduce the risk of complications. In addition, strategies to help people who don't have diabetes eat healthier, get physical activity, and lose weight can help prevent new cases.

– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Diabetes Deaths

Age-adjusted diabetes mortality for the area is shown in the following chart.



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted March 2022.
Notes: • The Healthy People 2030 target for Diabetes is adjusted to account for only diabetes mellitus coded deaths.

Prevalence of Diabetes

"Have you ever been told by a doctor, nurse, or other health professional that you have diabetes? (If female, add: not counting diabetes only occurring during pregnancy?)"

"Have you ever been told by a doctor, nurse, or other health professional that you have pre-diabetes or borderline diabetes? (If female, add: other than during pregnancy?)"

[Adults who do not have diabetes] "Have you had a test for high blood sugar or diabetes within the past three years?"

Prevalence of Diabetes

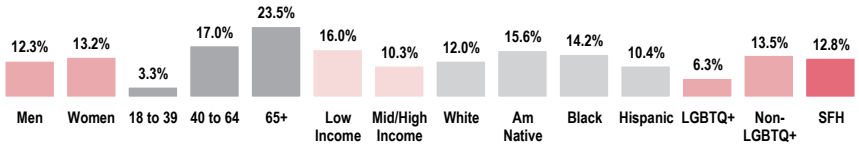
Another 10.1% of adults have been diagnosed with "pre-diabetes" or "borderline" diabetes.

Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 121]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Oklahoma data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Prevalence of Diabetes
(SFH Service Area, 2022)

Note that among adults who have not been diagnosed with diabetes, 44.5% report having had their blood sugar level tested within the past three years.

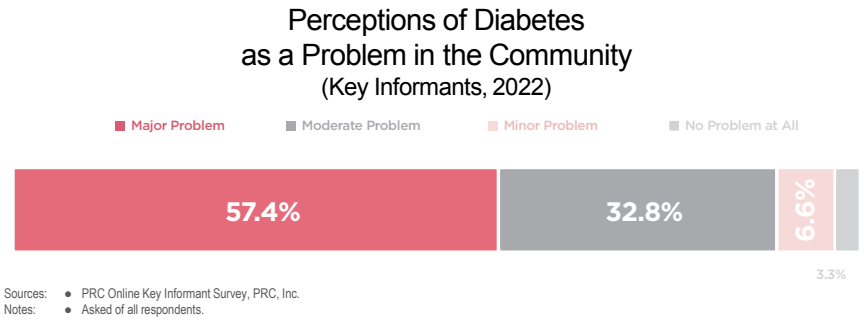


Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Items 33, 121]

Notes:
- Asked of all respondents.
- Excludes gestational diabetes (occurring only during pregnancy).

Key Informant Input: Diabetes

The following chart outlines key informants' perceptions of the severity of Diabetes as a problem in the community:



Among those rating this issue as a "major problem," reasons related to the following:

Contributing Factors

> Affordable access to medications, test strips, supplies, access to nutritious food. – Public Health Representative
>
> Expensive care for the co-morbid issues related. Strong public narrative of indulging with fast foods and alcohol to increase happiness. Low public attention to the promotion of healthy lifestyles. – Public Health Representative
>
> Access to care, access to medications for treatment, very limited diabetes education and the education available is only a few sessions instead of longer term, very few resources for gyms/exercise particularly for those that do not live in safe areas for walking, the cost of well-fitting shoes like those purchased at running stores after foot mapping is done so that you know they are a good fit for ankle/knee/hip support during exercise. – Physician
>
> People with diabetes lack access to medical care and options for exercise and healthy food choices. There are few opportunities to learn more about living with or preventing diabetes. Cost of treatment, lack of understanding of the disease and nutrition. Food deserts and transportation barriers. – Social Service Agency
>
> Self-care, education, and costs of medications. – Physician
>
> Obesity-poverty connection. Lack of nutritional awareness/knowledge. – Community Leader
>
> Obesity, diet, lack of exercise, and build environments to encourage outdoor activity. – Public Health Representative
>
> Affordable nutritious food, easy accessibility to gyms, parks and trails. Affordability of medications especially injectables. Affordable electric power for refrigerator to store insulin. Access to glucose monitors and associated strips. Access to free or cheap transportation to healthcare appointments. – Physician

Affordable Medications/Supplies

> Access to affordable insulin. – Public Health Representative
>
> Not being able to afford their medication. – Social Service Agency
>
> Access to affordable medications. – Physician
>
> Cost of drugs. – Physician
>
> Medications, keeping up with their supplies and being able to manage the diabetic condition. – Social Service Agency

Affordable Care/Services

> Costs. – Community Leader
>
> Cost, access to services, getting initial diagnosis. – Public Health Representative

Access to Care/Services

> No close access to health services. – Community Leader
>
> It is difficult to get an appointment with an endocrinologist. – Physician

Prevention/Screenings

> The biggest challenges are on prevention and chronic disease maintenance. – Community Leader
>
> Several preventative programs exist, but they remain small in scale and coverage. – Community Leader
>
> Prevention care. – Community Leader
>
> There are hardly any preventative services or constant education in the community. – Community Leader

Lifestyle

> Poor habits that develop at a young age, which become hard to break. Cheap, unhealthy food. Costly healthy food. Lack of education. – Social Service Agency
>
> Nutrition and lifestyle plans, and advice and support for people with type 2. – Community Leader

Health Education

> Access to adequate education regarding long term consequences if the disease is not treated properly. I care for newborns, and we see so many infants with serious complications because the mother does not control her sugars during pregnancy. – Physician
>
> Educating individuals on how to avoid diabetes, when possible, and then how to control diabetes. – Social Service Agency

Comorbidities

> Multiple health issues, including heart, kidney, eye, cardiovascular, nerve issues, and disability, early death, or loss of quality health as a result. – Community Leader
>
> Generally poor health conditions. – Community Leader

Vulnerable Populations

> The Latino community has high levels of diabetes and pre-diabetes, and high BMIs. Many Latinos lack health insurance and thus don't have a primary care physician. – Community Leader

Diagnosis/Treatment

> Early diagnosis; understanding of relationship between nutrition and lifestyle; understanding of risk factors; seamless services and continuity of care, especially for those with chronic conditions. Because Oklahoma has only had expanded Medicaid coverage for less than one year, the high percentage of uninsured are unaccustomed to health insurance that provides resources for prevention and management of diabetes. Morton has a highly integrated and specialized program that has shown great success.
> – Other Health Provider

Follow-Up/Support

> Sufficient support to make the necessary behavior changes for healthy behavior. – Other Health Provider

Kidney Disease

ABOUT KIDNEY DISEASE

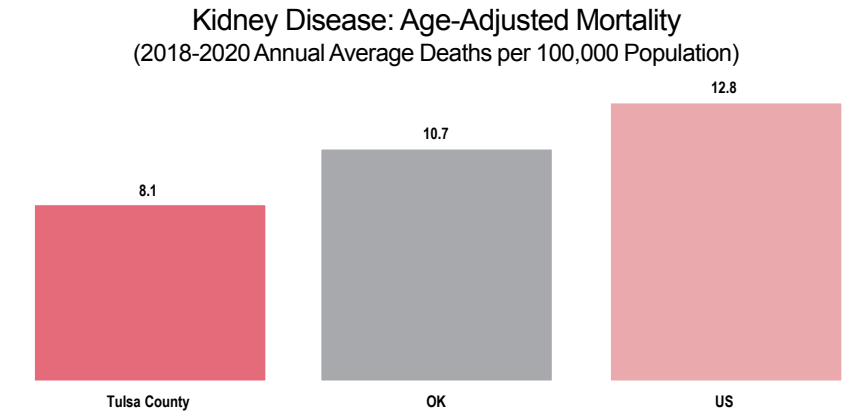
More than 1 in 7 adults in the United States may have chronic kidney disease (CKD), with higher rates in low-income and racial/ethnic minority groups. And most people with CKD don't know they have it. ...People with CKD are more likely to have heart disease and stroke — and to die early. Managing risk factors like diabetes and high blood pressure can help prevent or delay CKD. Strategies to make sure more people with CKD are diagnosed early can help people get the treatment they need.

Recommended tests can help identify people with CKD to make sure they get treatments and education that may help prevent or delay kidney failure and end-stage kidney disease (ESKD). In addition, strategies to make sure more people with ESKD get kidney transplants can increase survival rates and improve quality of life.

– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Kidney Disease Deaths

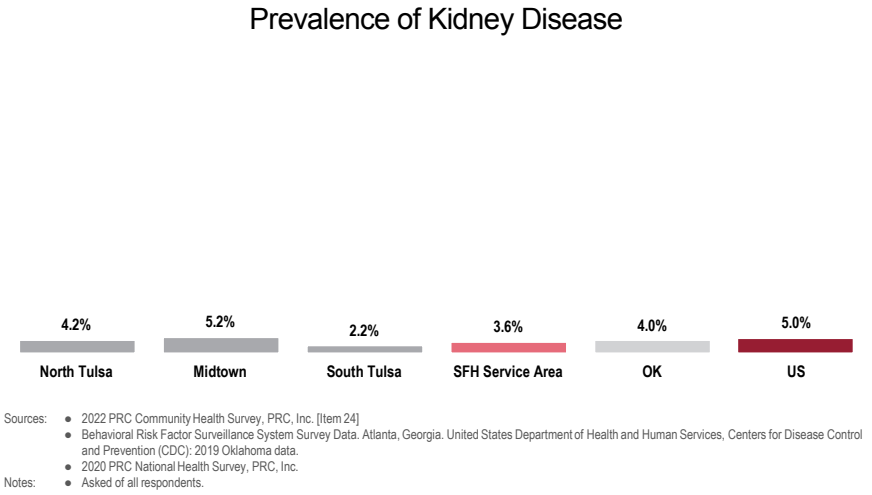
Age-adjusted kidney disease mortality is described in the following chart.



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted March 2022.

Prevalence of Kidney Disease

"Would you please tell me if you have ever suffered from or been diagnosed with kidney disease?"

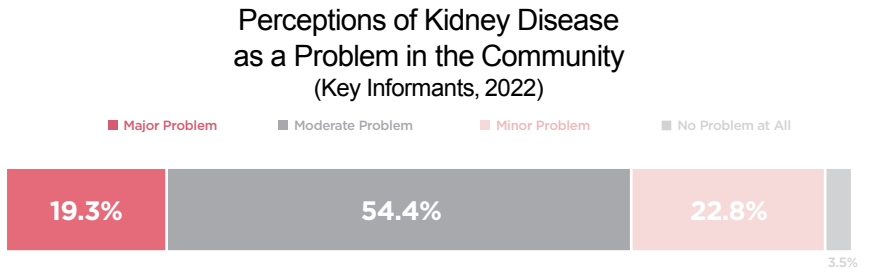


Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 24]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Oklahoma data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Key Informant Input: Kidney Disease

The following chart outlines key informants' perceptions of the severity of Kidney Disease as a problem in the community:



Sources:
- PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Alcohol/Drug Use

> Alcohol abuse. – Community Leader
>
> Addictions to alcohol and other drug issues. – Social Service Agency

Access to Care for Uninsured/Underinsured

> Community is not aware of access to health care for the uninsured. – Social Service Agency

Health Education

> Many tend to think of kidney disease only as an adult issue, however, there are young people who live with CKD and the resources and support are limited and non-existent. – Public Health Representative

Prevention/Screenings

> Not any services hardly for preventative care and education. – Community Leader

Contributing Factors

> Lifestyle and substance abuse. Lack of consistent medical care. – Community Leader

Vulnerable Populations

Potentially Disabling Conditions

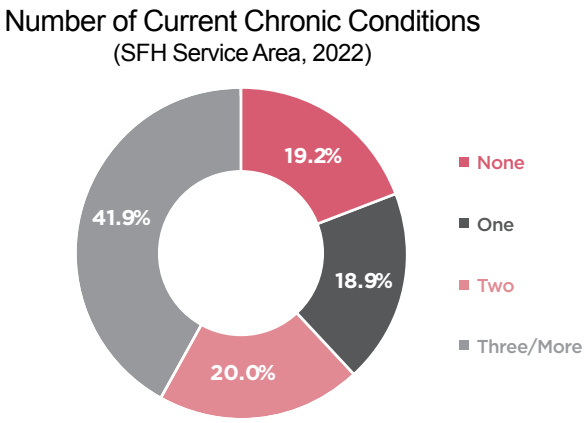
Multiple Chronic Conditions

The following charts outline the prevalence of multiple chronic conditions among surveyed adults, taking into account all of the various conditions measured in the survey.

For the purposes of this assessment, chronic conditions include:

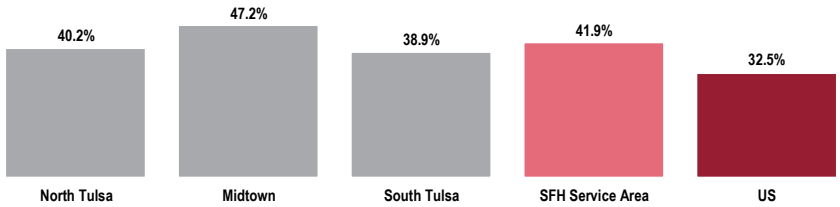
- *Asthma*
- *Cancer*
- *Chronic pain*
- *Diabetes*
- *Diagnosed depression*
- *Heart attack/ angina*
- *High blood cholesterol*
- *High blood pressure*
- *Kidney disease*
- *Lung disease*
- *Obesity*
- *Stroke*

Multiple chronic conditions are concurrent conditions.



Sources: 2022 PRC Community Health Survey, PRC, Inc. [Item 123]
Notes: Asked of all respondents.
In this case, chronic conditions include lung disease, cancer, kidney disease, heart attack/angina, stroke, asthma, high blood pressure, high blood cholesterol, diabetes, high-impact chronic pain, obesity, and/or diagnosed depression.

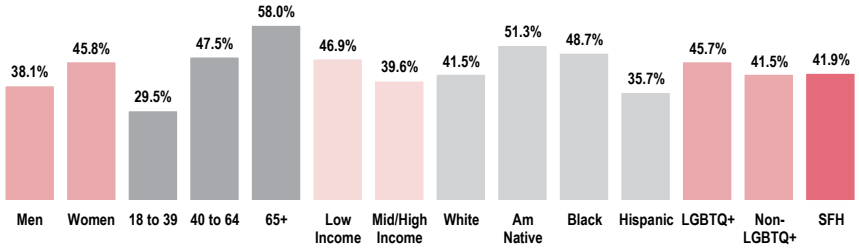
Currently Have Three or More Chronic Conditions



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 123]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- In this case, chronic conditions include lung disease, cancer, kidney disease, heart attack/angina, stroke, asthma, high blood pressure, high blood cholesterol, diabetes, high-impact chronic pain, obesity, and/or diagnosed depression.

Currently Have Three or More Chronic Conditions
(SFH Service Area, 2022)



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 123]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- In this case, chronic conditions include lung disease, cancer, kidney disease, heart attack/angina, stroke, asthma, high blood pressure, high blood cholesterol, diabetes, high-impact chronic pain, obesity, and/or diagnosed depression.

ABOUT DISABILITY & HEALTH

Studies have found that people with disabilities are less likely to get preventive health care services they need to stay healthy. Strategies to make health care more affordable for people with disabilities are key to improving their health.

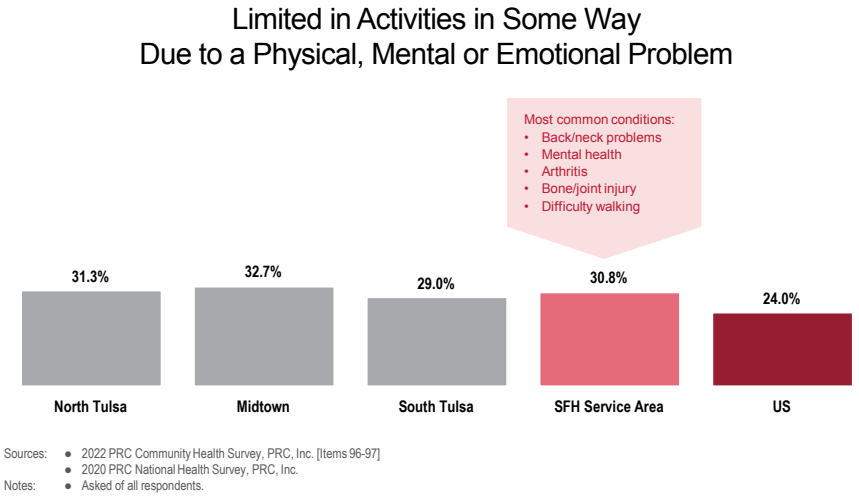
In addition, people with disabilities may have trouble finding a job, going to school, or getting around outside their homes. And they may experience daily stress related to these challenges. Efforts to make homes, schools, workplaces, and public places easier to access can help improve quality of life and overall well-being for people with disabilities.

– Healthy People 2030 (https://health.gov/healthypeople)

Activity Limitations

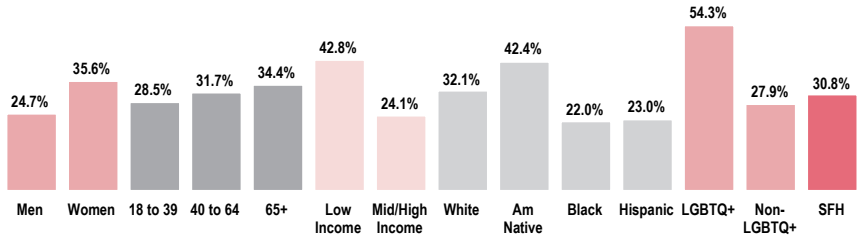
"Are you limited in any way in any activities because of physical, mental, or emotional problems?"

[Adults with activity limitations] "What is the major impairment or health problem that limits you?"



Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Items 96-97]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Limited in Activities in Some Way
Due to a Physical, Mental or Emotional Problem
(SFH Service Area, 2022)

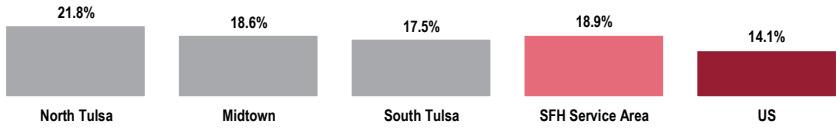


Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 96]
Notes: • Asked of all respondents.

High-Impact Chronic Pain

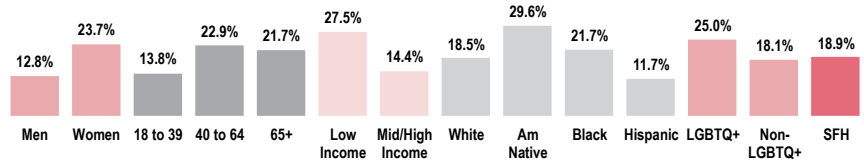
"Over the past six months, how often did physical pain limit your life or work activities? Would you say: never, some days, most days, or every day?" (Reported here among those responding "most days" or "every day.")

Experience High-Impact Chronic Pain
Healthy People 2030 = 7.0% or Lower



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 37]
• 2020 PRC National Health Survey, PRC, Inc.
• US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov [Objective MICH-8.1]
Notes: • Asked of all respondents.
• High-impact chronic pain includes physical pain that limits life or work activities on "most days" or "every day" of the past six months.

Experience High-Impact Chronic Pain
(SFH Service Area, 2022)
Healthy People 2030 = 7.0% or Lower



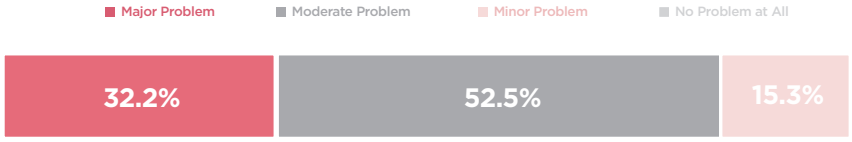
Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 37]
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov [Objective MICH-8.1]

Notes:
- Asked of all respondents.
- High-impact chronic pain includes physical pain that limits life or work activities on "most days" or "every day" of the past six months.

Key Informant Input: Disability & Chronic Pain

The following chart outlines key informants' perceptions of the severity of Disability & Chronic Pain as a problem in the community:

Perceptions of Disability & Chronic Pain
as a Problem in the Community
(Key Informants, 2022)



Sources:
- PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Access to Care/Services

> Our clients have difficulty getting adequate resources for assessments for pain management. – Social Service Agency
>
> There are few places available to assist. – Community Leader
>
> Significant wait list for services with a disability. – Community Leader
>
> We believe that this is a major problem due to lack of community resources, physician and provider services. There is a lack of understanding as to how this impact patients and their families. There should be appropriated wrap around services, that incorporate community care coordination and other empowering services that place the family at the center of care. – Public Health Representative

Prevalence/Incidence

> Unsure of etiology, but good percentage of individuals on chronic pain medicine. – Physician
>
> High percentage of folks on Social Security Disability and dually eligible for Medicare and Medicaid. – Public Health Representative
>
> I feel like I've seen Tulsa Health Department data on high incidence of chronic pain. I'm not sure there are good solutions for people suffering from chronic pain. – Other Health Provider
>
> Chronic pain is recognized by the VA as a disability now. Sometimes it is mental illness too. – Community Leader

Access to Providers

> There are not very many pain management physicians in the area and many of the ones who are only wish to do procedures. – Physician
>
> There are more patients with chronic pain than there are pain management provider openings. – Physician
>
> Not enough pain doctors to address the issue and people turn to street drugs. – Physician

Alcohol/Drug Use

> The high correlation of SUDs as a coping strategy. – Public Health Representative
>
> Because of our issue with addiction to pain medications in our community. – Public Health Representative

Diagnosis/Treatment

> Not seeking medical treatment until crisis. – Community Leader

Contributing Factors

> No healthcare. Low income. Elderly. No transportation. – Community Leader

Vulnerable Populations

> Latinos work in occupations that have high levels of work-related accidents. Often, they are not aware that they qualify for worker's comp or disability insurance. – Community Leader

Alzheimer's Disease

ABOUT DEMENTIA

Alzheimer's disease is the most common cause of dementia and the sixth leading cause of death in U.S. adults.1 Nearly 6 million people in the United States have Alzheimer's, and that number will increase as the population ages.

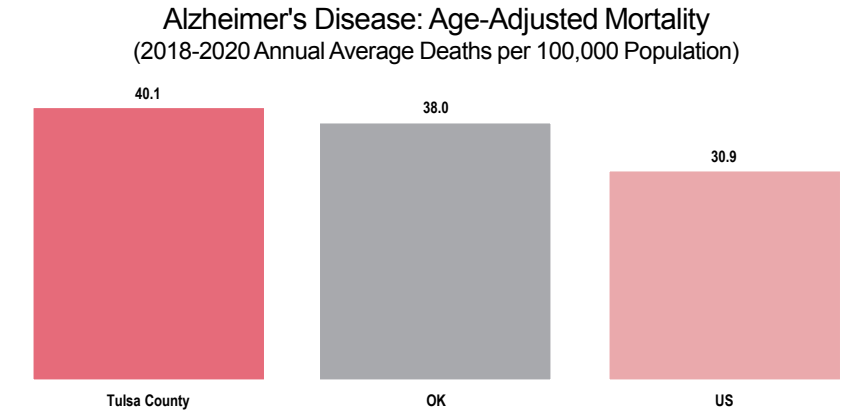
Dementia refers to a group of symptoms that cause problems with memory, thinking, and behavior. People with dementia are more likely to be hospitalized, and dementia is linked to high health care costs.

While there's no cure for Alzheimer's disease, early diagnosis and supportive care can improve quality of life. And efforts to make sure adults with symptoms of cognitive decline — including memory loss — are diagnosed early can help improve health outcomes in people with dementia. Interventions to address caregiving needs can also help improve health and
well-being in people with dementia.

– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Alzheimer's Disease Deaths

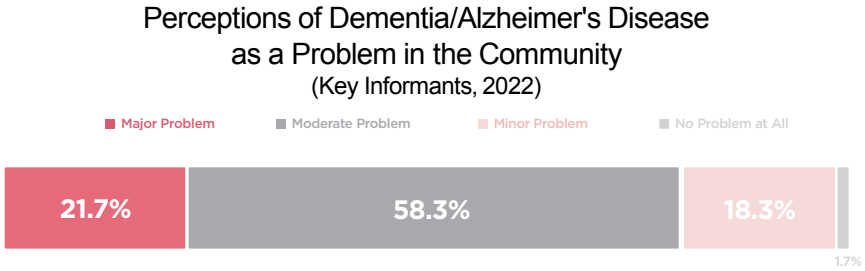
Age-adjusted Alzheimer's disease mortality is outlined in the following chart.



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted March 2022.

Key Informant Input: Dementia/Alzheimer's Disease

The following chart outlines key informants' perceptions of the severity of Dementia, Including Alzheimer's Disease as a problem in the community:



Sources: • PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Access to Care/Services

> Access to resources. These individuals are for the most part 65 or older and accordingly there are not good benefits from Medicare to assist with the disease process such as adult daycare, home health, medication assistance, etc. Essentially to carry this diagnosis you have to have means (money) if you want any quality of life whatsoever. – Physician
>
> Lack of care. – Community Leader
>
> There are long waitlists for services at every Neurology and Psychiatric in the area, and many psychiatrists will not see patients over the age of 65. Both OU Psychiatry and OSU Psychiatry would like to start geriatric psychiatry fellowships, but we do not have the needed number of board-certified geriatric psychiatrists in the area to meet the required faculty needs. – Physician

Prevalence/Incidence

> It has always been a major problem. Now it is getting attention. – Community Leader

> Numerous friends and family members have parents with dementia/Alzheimer's. I have personally witnessed the struggle they face in both trying to care for them at home and/or trying to find the appropriate care for them. – Social Service Agency

Affordable Care/Services

> There are nursing homes for persons below the poverty line. For others, costs of care become financially devastating, and/or personal daily care requires family members to sacrifice work and time with other family members to attend needs. Healthcare costs are particularly burdensome and insurance is inadequate – Public Health Representative

> There needs to be affordable facilities designated for caring for individuals with dementia/Alzheimer's disease so care takers can continue their lives. The communities at large are not sure how to care for individuals experiencing dementia/Alzheimer's disease. – Social Service Agency

Contributing Factors

> Aging population. Financial strain on caregivers. – Physician

> Tulsa's aging population. Lack of understanding of neurologically based disorders. Fragmented infrastructure to obtain services. Cost of in-home care. – Other Health Provider

Aging Population

> Aging population. – Community Leader

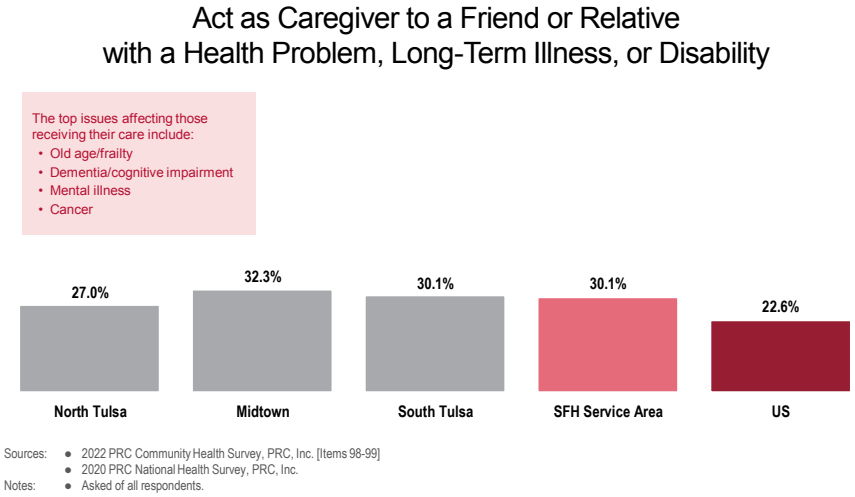
Prevention/Screenings

> There are no preventative measures in place. – Community Leader

Caregiving

"People may provide regular care or assistance to a friend or family member who has a health problem, long-term illness, or disability. During the past 30 days, did you provide any such care or assistance to a friend or family member?"

[Among those providing care] "What is the main health problem, long-term illness, or disability that the person you care for has?"



BIRTHS

ABOUT INFANT HEALTH

Keeping infants healthy starts with making sure women get high-quality care during pregnancy and improving women's health in general. After birth, strategies that focus on increasing breastfeeding rates and promoting vaccinations and developmental screenings are key to improving infants' health. Interventions that encourage safe sleep practices and correct use of car seats can also help keep infants safe.

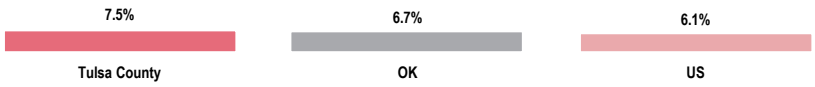
The infant mortality rate in the United States is higher than in other high-income countries, and there are major disparities by race/ethnicity. Addressing social determinants of health is critical for reducing these disparities.

– Healthy People 2030 (https://health.gov/healthypeople)

Prenatal Care

Early and continuous prenatal care is the best assurance of infant health. Lack of (or late) prenatal care (care initiated during the seventh month of pregnancy, if at all) is outlined in the following chart.

Late or No Prenatal Care: 7th Month or Later, If At All
(Percentage of Live Births, 2017–2019)



Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC Wonder, 2019.

Note:
- This indicator reports the percentage of women who did not obtain prenatal care until the seventh month (or later) of pregnancy or who didn't have any prenatal care, as of all who gave birth during the three-year period from 2017 to 2019. This indicator is relevant because engaging in prenatal care decreases the likelihood of maternal and infant health risks. This indicator can also highlight a lack of access to preventive care, a lack of health knowledge, insufficient provider outreach, and/or social barriers preventing utilization of services.

Birth Outcomes & Risks

Low-Weight Births

Low birthweight babies, those who weigh less than 2,500 grams (5 pounds, 8 ounces) at birth, are much more prone to illness and neonatal death than are babies of normal birthweight.

Largely a result of receiving poor or inadequate prenatal care, many low-weight births and the consequent health problems are preventable.

Low-Weight Births
(Percent of Live Births, 2013-2019)

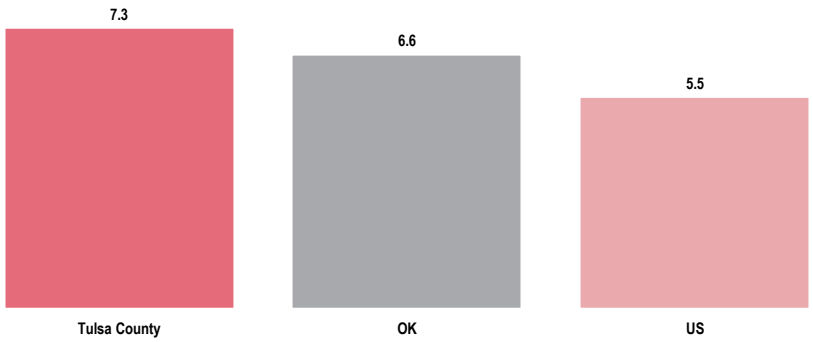
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted March 2022.

Note:
- This indicator reports the percentage of total births that are low birth weight (Under 2500g). This indicator is relevant because low birth weight infants are at high risk for health problems. This indicator can also highlight the existence of health disparities.

Infant Mortality

Infant mortality rates reflect deaths of children less than one year old per 1,000 live births. These rates are outlined in the following chart.

Infant Mortality Rate
(Annual Average Infant Deaths per 1,000 Live Births, 2018-2020)
Healthy People 2030 = 5.0 or Lower



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted March 2022.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Notes:
- Infant deaths include deaths of children under 1 year old.
- This indicator is relevant because high rates of infant mortality indicate the existence of broader issues pertaining to access to care and maternal and child health.

Family Planning

ABOUT FAMILY PLANNING

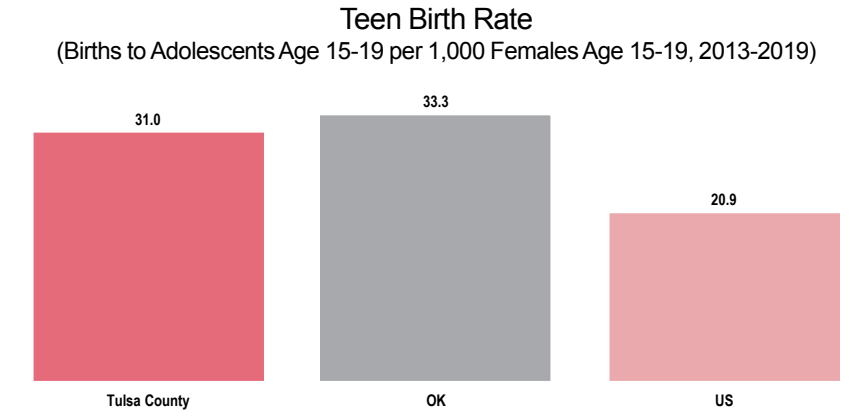
Nearly half of pregnancies in the United States are unintended, and unintended pregnancy is linked to many negative outcomes for both women and infants. ...Unintended pregnancy is linked to outcomes like preterm birth and postpartum depression. Interventions to increase use of birth control are critical for preventing unintended pregnancies. Birth control and family planning services can also help increase the length of time between pregnancies, which can improve health for women and their infants.

Adolescents are at especially high risk for unintended pregnancy. Although teen pregnancy and birth rates have gone down in recent years, close to 200,000 babies are born to teen mothers every year in the United States. Linking adolescents to youth-friendly health care services can help prevent pregnancy and sexually transmitted infections in this age group.

– Healthy People 2030 (https://health.gov/healthypeople)

Births to Adolescent Mothers

The following chart describes births to adolescent mothers under the age of 20 years.

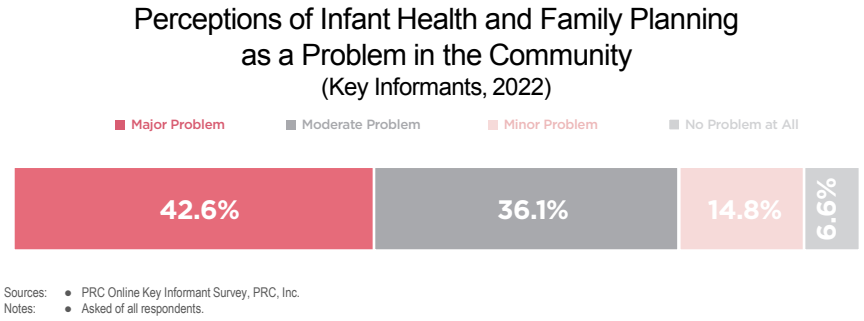


Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved December 2021 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the rate of total births to women under the age of 15–19 per 1,000 female population age 15–19. This indicator is relevant because in many cases, teen parents have unique social, economic, and health support services. Additionally, high rates of teen pregnancy may indicate the prevalence of unsafe sex practices.

Key Informant Input: Infant Health & Family Planning

The following chart outlines key informants' perceptions of the severity of Infant Health and Family Planning as a problem in the community:



Among those rating this issue as a "major problem," reasons related to the following:

Contributing Factors

> Due to the stigma associated with Planned Parenthood, there are limited options for people without finances/insurance. Long-term birth control is frowned upon by many within Oklahoma secondary to religious beliefs or the political climate. Accordingly, we are high on the list of teenage pregnancies. Lots of individuals in these demographic groups may not know they are pregnant and accordingly may miss out on nutritional recommendations or prenatal vitamins etc. – Physician
>
> I work in an NICU. we care for many babies whose mothers have not had prenatal care. That leads to significant risk to the infant. Also, if birth control were more available, there would be fewer unintended pregnancies. we also care for many babies born to narcotic addicted mothers. These mothers sometimes have multiple children, all at risk for long term developmental abnormalities and most go to foster care. These mothers need access to withdrawal care and birth control. – Physician
>
> High smoking and drug use. Poverty. Poor adherence to prenatal care. – Physician
>
> Not a lot of services and education. – Community Leader
>
> No services. No transportation. – Community Leader
>
> Lack of access to prenatal care, lack of knowledge of resources, uninsured. – Community Leader

Health Disparities

> This is a north and east Tulsa issue. – Community Leader
>
> One only has to review the high mortality rates among minority women, especially, to know this is a problem. Teen age pregnancies and lack of family planning and contraception use are recipes for children who are born into difficult or unwelcomed circumstances. Access to contraception, reproductive education, and the impacts of poor pre-natal health are essential. – Other Health Provider
>
> Infant mortality has one of the higher measures of disparities in the Tulsa Equity Indicators report. – Other Health Provider

Access to Care/Services

> Transportation. Need home healthcare. – Community Leader
>
> Lack of resources, services, and programs. Not enough agencies addressing these issues. – Community Leader
>
> Overall, I think we could have better infant mortality rates. I believe that is an outcome of inadequate services in those two areas. – Public Health Representative

Access to Care for Uninsured/Underinsured

> Lack of insurance or ability to pay for health care affects the entire family. Sometimes the only option is the Emergency Room or Urgent Care, which does not give consistent care. – Community Leader
>
> Lack of health insurance leaves many Latinos with few options to pay for family planning services. – Community Leader

Prevalence/Incidence

Have seen stats related to the infant mortality. Tulsa has also historically had a high rate of teen births, although this has gone down. – Community Leader

Our organization has a specific focus on reducing infant mortality and maternal morbidity. Oklahoma has one of the highest infant mortality rates in the nation. – Social Service Agency

Government/Policy

Movements to restrict abortion access and high poverty rates that contribute to food insecurity among families with children. – Other Health Provider

Oklahoma policymakers continuously propose legislation that interferes with women's ability to make sound decisions around their reproductive health in consultation with their physicians and that impacts accessibility to reproductive health services. – Public Health Representative

Cultural/Personal Beliefs

Conservative ideals. – Public Health Representative

Health Education

While access is possibly less the issue, many parents, who were not well cared for themselves as children, often do not grasp importance of infant health and mental health and fail to access care on behalf of their infants. – Public Health Representative

Impact on Quality of Life

Infant health is important as they are our future. – Public Health Representative

MODIFIABLE HEALTH RISKS

Nutrition

ABOUT NUTRITION & HEALTHY EATING

Many people in the United States don't eat a healthy diet. ...People who eat too many unhealthy foods — like foods high in saturated fat and added sugars — are at increased risk for obesity, heart disease, type 2 diabetes, and other health problems. Strategies and interventions to help people choose healthy foods can help reduce their risk of chronic diseases and improve their overall health.

Some people don't have the information they need to choose healthy foods. Other people don't have access to healthy foods or can't afford to buy enough food. Public health interventions that focus on helping everyone get healthy foods are key to reducing food insecurity and hunger and improving health.

– Healthy People 2030 (https://health.gov/healthypeople)

Daily Recommendation of Fruits/Vegetables

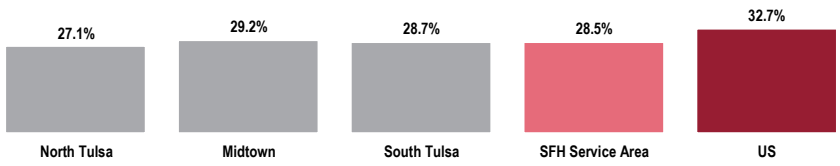
To measure fruit and vegetable consumption, survey respondents were asked multiple questions, specifically about the foods and drinks they consumed on the day prior to the interview.

"Now I would like you to think about the foods you ate or drank yesterday. Include all the foods you ate, both at home and away from home. How many servings of fruit or fruit juices did you have yesterday?"

"How many servings of vegetables did you have yesterday?"

The questions above are used to calculate daily fruit/vegetable consumption for respondents. The proportion reporting having 5 or more servings per day is shown here.

Consume Five or More Servings of Fruits/Vegetables Per Day



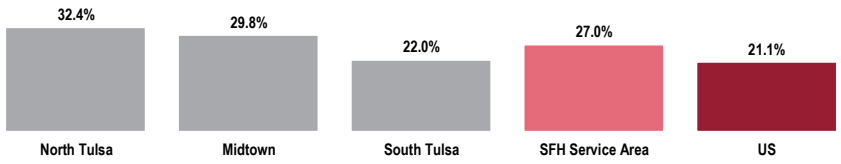
Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 125]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- For this issue, respondents were asked to recall their food eaten on the prior day.

Access to Fresh Produce

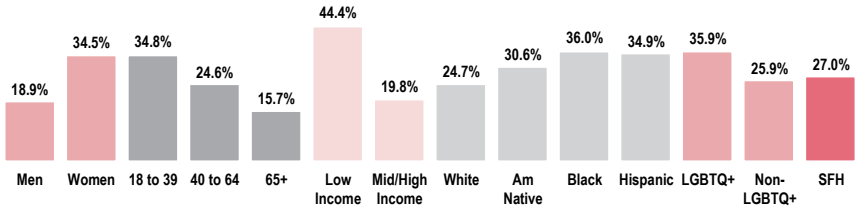
"How difficult is it for you to buy fresh produce like fruits and vegetables at a price you can afford — would you say: very difficult, somewhat difficult, not too difficult, or not at all difficult?"

Find It "Very" or "Somewhat"
Difficult to Buy Affordable Fresh Produce



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 79]
• 2020 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.

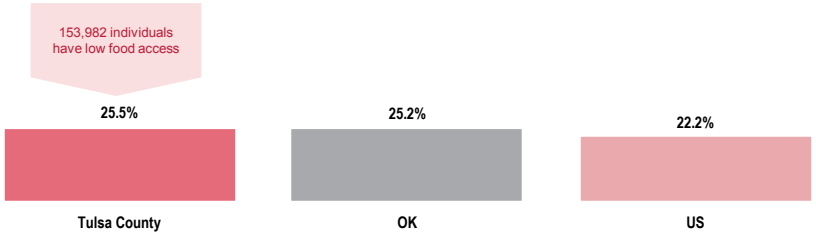
Find It "Very" or "Somewhat"
Difficult to Buy Affordable Fresh Produce
(SFH Service Area, 2022)



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 79]
• 2020 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.

Low food access is defined as living more than ½ mile from the nearest supermarket, supercenter, or large grocery store. This related chart is based on US Department of Agriculture data.

Population With Low Food Access
(Percent of Population That Is Far From a Supermarket or Large Grocery Store, 2019)



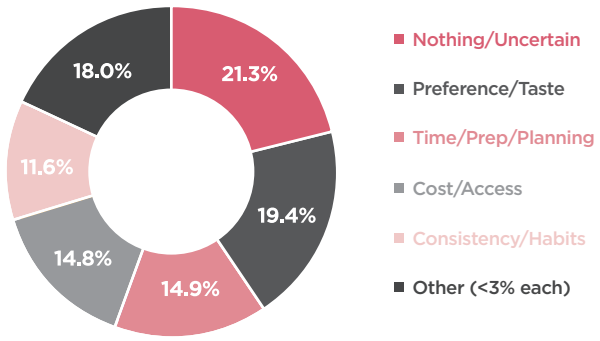
Sources:
- US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas (FARA).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved March 2022 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the percentage of the population with low food access. Low food access is defined as living more than ½ mile from the nearest supermarket, supercenter, or large grocery store. This indicator is relevant because it highlights populations and geographies facing food insecurity.

Barriers to Healthy Eating

"For you, what is the biggest barrier to healthy eating?"

Biggest Barrier to Healthy Eating
(SFH Service Area, 2022)



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 302]

Notes:
- Asked of all respondents.

Physical Activity

ABOUT PHYSICAL ACTIVITY

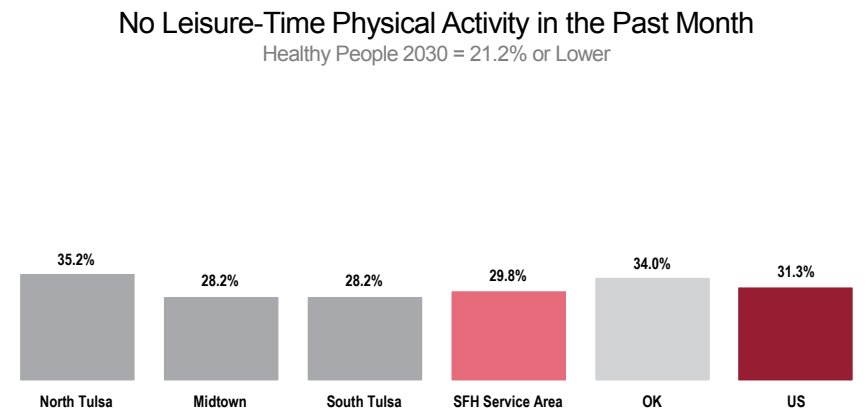
Physical activity can help prevent disease, disability, injury, and premature death. The Physical Activity Guidelines for Americans lays out how much physical activity children, adolescents, and adults need to get health benefits. Although most people don't get the recommended amount of physical activity, it can be especially hard for older adults and people with chronic diseases or disabilities.

Strategies that make it safer and easier to get active — like providing access to community facilities and programs — can help people get more physical activity. Strategies to promote physical activity at home, at school, and at childcare centers can also increase activity in children and adolescents.

– Healthy People 2030 (https://health.gov/healthypeople)

Leisure-Time Physical Activity

"During the past month, other than your regular job, did you participate in any physical activities or exercises, such as running, calisthenics, golf, gardening, or walking for exercise?"



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 82]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Oklahoma data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Notes:
- Asked of all respondents.

Meeting Physical Activity Recommendations

ADULTS: RECOMMENDED LEVELS OF PHYSICAL ACTIVITY

Adults should do 2 hours and 30 minutes a week of moderate-intensity (such as walking), or 1 hour and 15 minutes (75 minutes) a week of vigorous-intensity aerobic physical activity (such as jogging), or an equivalent combination of moderate- and vigorous-intensity **aerobic** physical activity. The guidelines also recommend that adults do **muscle-strengthening** activities, such as push-ups, sit-ups, or activities using resistance bands or weights. These activities should involve all major muscle groups and be done on two or more days per week.

The report finds that nationwide nearly 50 percent of adults are getting the recommended amounts of aerobic activity and about 30 percent are engaging in the recommended muscle-strengthening activity.

– 2013 Physical Activity Guidelines for Americans, US Department of Health and Human Services. www.cdc.gov/physicalactivity

To measure physical activity frequency, duration and intensity, respondents were asked:

"During the past month, what type of physical activity or exercise did you spend the most time doing?"

"And during the past month, how many times per week or per month did you take part in this activity?"

"And when you took part in this activity, for how many minutes or hours did you usually keep at it?"

Respondents could answer the above series for up to two types of physical activity. The specific activities identified (e.g., jogging, basketball, treadmill, etc.) determined the intensity values assigned to that respondent when calculating total aerobic physical activity hours/minutes.

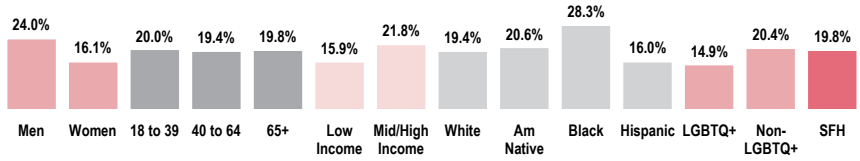
Respondents were also asked about strengthening exercises:

"During the past month, how many times per week or per month did you do physical activities or exercises to strengthen your muscles? Do not count aerobic activities like walking, running, or bicycling. Please include activities using your own body weight, such as yoga, sit-ups, or push-ups, and those using weight machines, free weights, or elastic bands."

"Meeting physical activity recommendations" includes adequate levels of both aerobic and strengthening activity:

- Aerobic activity is at least 150 minutes per week of light to moderate activity, 75 minutes per week of vigorous physical activity, or an equivalent combination of both;

Meets Physical Activity Recommendations
(SFH Service Area, 2022)
Healthy People 2030 = 28.4% or Higher



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 126]
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

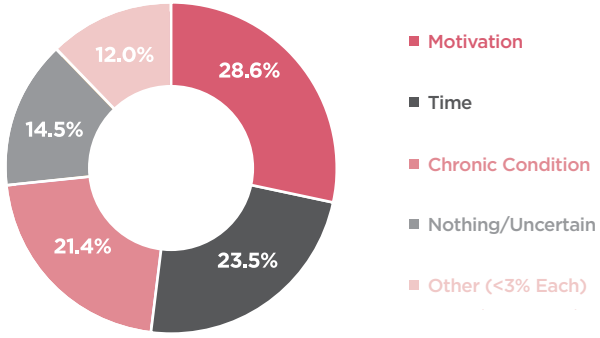
Notes:
- Asked of all respondents.
- Meeting both guidelines is defined as the number of persons age 18+ who report light or moderate aerobic activity for at least 150 minutes per week or who report vigorous physical activity 75 minutes per week or an equivalent combination of moderate and vigorous-intensity activity *and* report doing physical activities specifically designed to strengthen muscles at least twice per week.

- Strengthening activity is at least 2 sessions per week of exercise designed to strengthen muscles.

Barriers to Physical Activity

"For you, what is the biggest barrier to physical activity?"

Biggest Barrier to Physical Activity/Exercise
(SFH Service Area, 2022)



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 303]

Notes:
- Asked of all respondents.

Children's Physical Activity

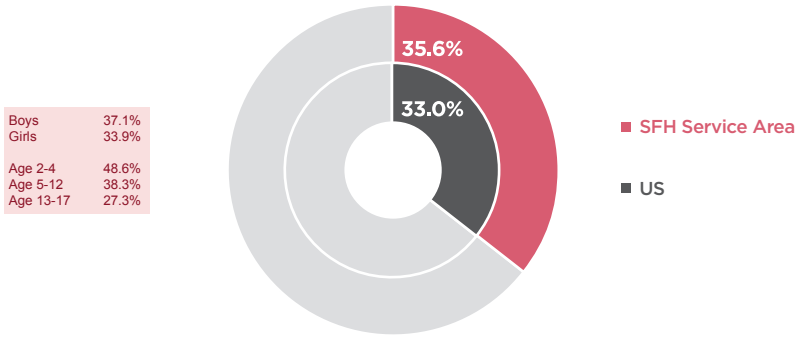
"During the past 7 days, on how many days was this child physically active for a total of at least 60 minutes per day?"

CHILDREN: RECOMMENDED LEVELS OF PHYSICAL ACTIVITY

Children and adolescents should do 60 minutes (1 hour) or more of physical activity each day.

– 2013 Physical Activity Guidelines for Americans, US Department of Health and Human Services. www.cdc.gov/physicalactivity

Child Is Physically Active for One or More Hours per Day
(Parents of Children Age 2-17)



Boys	37.1%
Girls	33.9%
Age 2-4	48.6%
Age 5-12	38.3%
Age 13-17	27.3%

Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 109]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents with children age 2-17 at home.
- Includes children reported to have one or more hours of physical activity on

Weight Status

ABOUT OVERWEIGHT & OBESITY

Obesity is linked to many serious health problems, including type 2 diabetes, heart disease, stroke, and some types of cancer. Some racial/ethnic groups are more likely to have obesity, which increases their risk of chronic diseases.

Culturally appropriate programs and policies that help people eat nutritious foods within their calorie needs can reduce overweight and obesity. Public health interventions that make it easier for people to be more physically active can also help them maintain a healthy weight.

- Healthy People 2030 (https://health.gov/healthypeople)

Body Mass Index (BMI), which describes relative weight for height, is significantly correlated with total body fat content. The BMI should be used to assess overweight and obesity and to monitor changes in body weight. In addition, measurements of body weight alone can be used to determine efficacy of weight loss therapy. BMI is calculated as weight (kg)/height squared (m2). To estimate BMI using pounds and inches, use: [weight (pounds)/height squared (inches2)] x 703.

In this report, overweight is defined as a BMI of 25.0 to 29.9 kg/m2 and obesity as a BMI ≥30 kg/m2. The rationale behind these definitions is based on epidemiological data that show increases in mortality with BMIs above 25 kg/m2. The increase in mortality, however, tends to be modest until a BMI of 30 kg/m2 is reached. For persons with a BMI ≥30 kg/m2, mortality rates from all causes, and especially from cardiovascular disease, are generally increased by 50 to 100 percent above that of persons with BMIs in the range of 20 to 25 kg/m2.

– Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September 1998.

Adult Weight Status

CLASSIFICATION OF OVERWEIGHT AND OBESITY BY BMI	BMI (kg/m^2)
Underweight	<18.5
Normal	18.5 – 24.9
Overweight	25.0 – 29.9
Obese	≥30.0

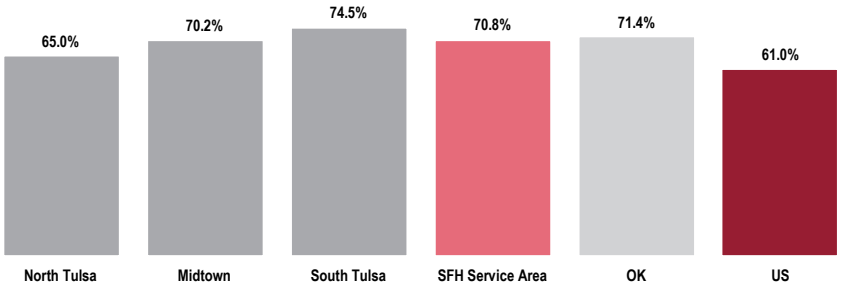
Source: Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September 1998.

"About how much do you weigh without shoes?"

"About how tall are you without shoes?"

Reported height and weight were used to calculate a Body Mass Index or BMI value (described above) for each respondent. This calculation allows us to examine the proportion of the population who is at a healthy weight, or who is overweight or obese (see table above).

Prevalence of Total Overweight (Overweight and Obese)

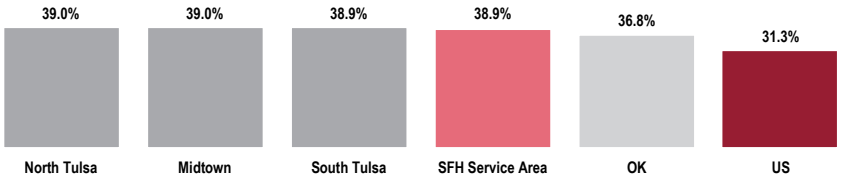


Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 128]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Oklahoma data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Based on reported heights and weights, asked of all respondents.
- The definition of overweight is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 25.0, regardless of gender. The definition for obesity is a BMI greater than or equal to 30.0.

Prevalence of Obesity

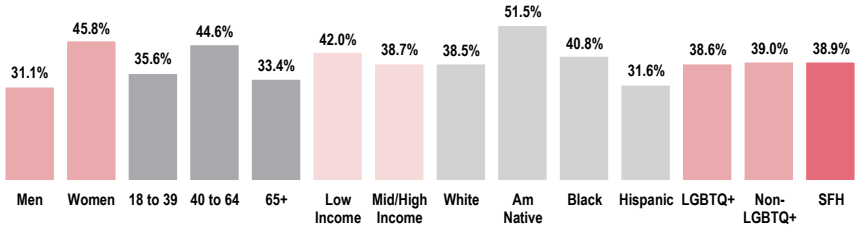
Healthy People 2030 = 36.0% or Lower



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 128]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Oklahoma data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Notes:
- Based on reported heights and weights, asked of all respondents.
- The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.

Prevalence of Obesity
(SFH Service Area, 2022)
Healthy People 2030 = 36.0% or Lower



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 128]
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Notes:
- Based on reported heights and weights, asked of all respondents.
- The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.

Children's Weight Status

ABOUT WEIGHT STATUS IN CHILDREN & TEENS

In children and teens, body mass index (BMI) is used to assess weight status – underweight, healthy weight, overweight, or obese. After BMI is calculated for children and teens, the BMI number is plotted on the CDC BMI-for-age growth charts (for either girls or boys) to obtain a percentile ranking. Percentiles are the most commonly used indicator to assess the size and growth patterns of individual children in the United States. The percentile indicates the relative position of the child's BMI number among children of the same sex and age.

BMI-for-age weight status categories and the corresponding percentiles are shown below:

Underweight	<5th percentile
Healthy Weight	≥5th and <85th percentile
Overweight	≥85th and <95th percentile
Obese	≥95th percentile

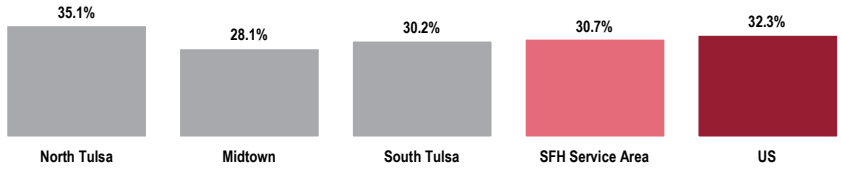
– *Centers for Disease Control and Prevention*

The following questions were used to calculate a BMI value (and weight classification as noted above) for each child represented in the survey:

"How much does this child weigh without shoes?"

"About how tall is this child?"

Prevalence of Overweight in Children
(Parents of Children Age 5-17)



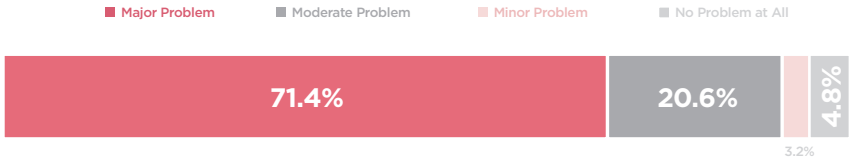
Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 131]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents with children age 5-17 at home.
- Overweight among children is determined by children's Body Mass Index status at or above the 85th percentile of US growth charts by gender and age.

Key Informant Input: Nutrition, Physical Activity & Weight

The following chart outlines key informants' perceptions of the severity of Nutrition, Physical Activity & Weight as a problem in the community:

Perceptions of Nutrition, Physical Activity, and Weight as a Problem in the Community
(Key Informants, 2022)



Sources:
- PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Contributing Factors

Many Oklahomans do not have access to fresh fruits and vegetables. They either can't afford it, live in a food desert, or do not have transportation to get it. Some do not have stable or adequate housing to cook it. – Community Leader

High rates of poverty and food deserts contribute to obesity and poor nutrition, although obesity crosses economic lines. Lack of understanding of nutrition and low walkability score also factor into the issues. – Social Service Agency

Especially in north and east Tulsa where getting good food is hard and parks up there are not that good. – Community Leader

Uneducated and poor population. Car dependency, lack of a walkable community. Weather. Numerous fast food restaurant offerings. – Community Leader

Lack of knowledge, motivation, time, money to address these issues of good nutrition, exercise, and how to maintain or lose weight properly. Other things in life take priority over healthy lifestyles. Of course, so many health problems occur in tandem with poor nutrition, lack of physical activity and obesity. – Community Leader

Uneducated and poor population. Car dependency, lack of a walkable community. Weather. Numerous fast food restaurant offerings. – Community Leader

Lack of knowledge, motivation, time, money to address these issues of good nutrition, exercise, and how to maintain or lose weight properly. Other things in life take priority over healthy lifestyles. Of course, so many health problems occur in tandem with poor nutrition, lack of physical activity and obesity. – Community Leader

Lack of education. Lack of resources. Lack of health clinics. Lack transportation. Poverty. – Community Leader

There are few places to walk and exercise without paying for a gym membership. Latinos become overweight as they acculturate to the U.S. They abandon their traditional diets and start eating fast foods. – Community Leader

Lack of infrastructure to support healthy lifestyles (sidewalks, trails, bike lanes), particularly in lower-income communities; stress stemming from living in poverty and the impact of this stress; lack of access to healthy food and the economic development challenges related to solving food desert gaps. – Community Leader

Food deserts throughout Tulsa, lack of access to recreational facilities, parks, and trails, in underserved communities. High rates of trauma, ACEs, and toxic stress, which impact health behaviors, inflammation, and other biomarkers associated with obesity. – Public Health Representative

Nutrition & Physical Activity Factors

Lack of equitable access to nutritious, affordable food. Too many unsafe neighborhoods where people cannot go for a walk or ride a bike. Lack of amenities in parks that make recreation attractive. – Other Health Provider

We have significant food deserts and a much lower than average adult activity level. Need better, safer access to trails and parks, including sidewalks, adequate lighting, a police force that prioritizes the issue. – Public Health Representative

We don't eat well, don't get enough activity, and are fat. These all lead to serious health issues. – Community Leader

Poor diet, poor education about nutrition, and lack of access to fresh fruits and vegetables in parts of Tulsa. – Public Health Representative

Food deserts and poor access to safe parks. – Physician

Poor diet and exercise habits culturally accepted. Money for healthy foods. – Physician

We need more innovation in what a physical place could look like. More access to nutrition, physical activity, and weight information for the family. Innovative ways to engage all people and especially those within the BIPOC community. – Public Health Representative

A lack of access to physical fitness facilities and programs, healthy food choices, medical support. – Community Leader

Lack of places to exercise, cost of joining a gym, lack of time to spend preparing meals. – Public Health Representative

Access to Healthy Food

Food deserts. – Public Health Representative

Access to fresh and healthy foods via a walkable, bike-able or comfortable and convenient transit journey. The lack of small-scale, convenient food services and grocery stores located within communities of need creates a sense of strain, increased affordability concerns and lack of provision of fresh and healthy food choices. This creates multi-dimensional food insecurities from poor diet to food cost burden to lack of adequate sustenance particularly for the most immobile members of vulnerable communities – seniors and children. – Public Health Representative

High calorie but nutritionally deficient foods and drinks. Fast food, processed food, lack of appropriate grocery store access for certain geographic areas. – Physician

Food desert and lack of access. – Community Leader

Insufficient Physical Activity

Need to be active. – Community Leader

We need to encourage more activity for the SEDENTARY – everything available in the community thus far such as bike races are for those who are already active. We have some good parks that can be cleaned up and we ought to make neighborhoods more walkable. – Public Health Representative

Lifestyle

Healthy lifestyle. – Community Leader

People make poor lifestyle choices. There is not a strong culture of health in Oklahoma. – Community Leader

Nutrition

> Low fruit/vegetable consumption. High food insecurity rates. – Other Health Provider
>
> Continued poor eating habits. – Social Service Agency

Health Education

> Failure of AMA and the health industry, including pharma, to fully stress the importance of achieving good health, through active lifestyles, conscientious diets, and healthy relationships rather than promotion of treatments to maintain the status quo. – Public Health Representative

Homelessness

> Most people experiencing homelessness do not have access to nutritional food, mostly high carbs, etc. – Social Service Agency

Prevention/Screenings

> Not enough preventative services and education. – Community Leader

Eating Disorders

> Eating disorders. Greatly increased prevalence during the pandemic, disordered eating as well as DSM identified ED. – Physician

Substance Abuse

ABOUT DRUG & ALCOHOL USE

More than 20 million adults and adolescents in the United States have had a substance use disorder in the past year. ...Substance use disorders can involve illicit drugs, prescription drugs, or alcohol. Opioid use disorders have become especially problematic in recent years. Substance use disorders are linked to many health problems, and overdoses can lead to emergency department visits and deaths.

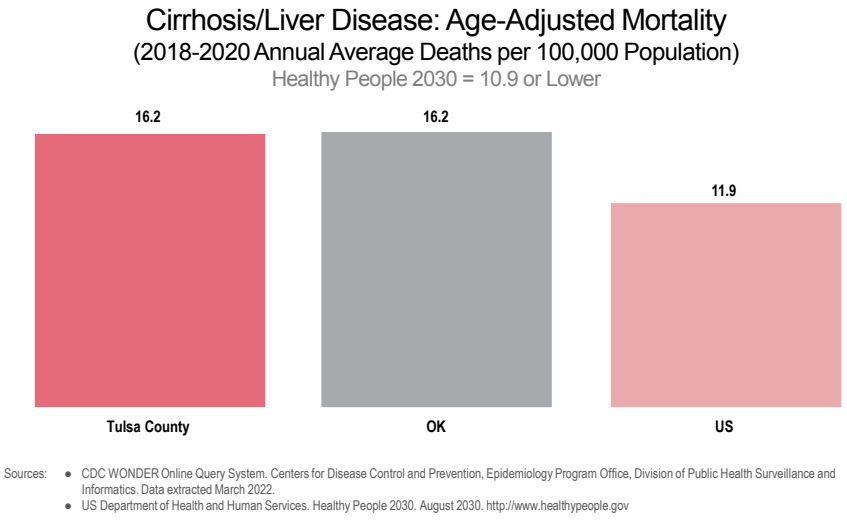
Effective treatments for substance use disorders are available, but very few people get the treatment they need. Strategies to prevent substance use — especially in adolescents — and help people get treatment can reduce drug and alcohol misuse, related health problems, and deaths.

– *Healthy People 2030 (https://health.gov/healthypeople)*

Alcohol

Age-Adjusted Cirrhosis/Liver Disease Deaths

Heavy alcohol use contributes to a significant share of liver disease, including cirrhosis. The following chart outlines age-adjusted mortality for cirrhosis/liver disease in the area.



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted March 2022.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Excessive drinking includes heavy and/or binge drinkers:

- HEAVY DRINKERS ▶ men reporting 2+ alcoholic drinks per day or women reporting 1+ alcoholic drink per day in the month preceding the interview.
- BINGE DRINKERS ▶ men reporting 5+ alcoholic drinks or women reporting 4+ alcoholic drinks on any single occasion during the past month.

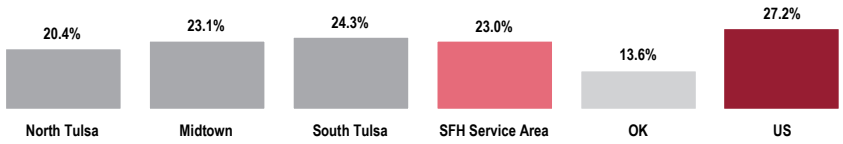
Excessive Drinking

"During the past 30 days, on how many days did you have at least one drink of any alcoholic beverage such as beer, wine, a malt beverage, or liquor?"

"On the day(s) when you drank, about how many drinks did you have on the average?"

"Considering all types of alcoholic beverages, how many times during the past 30 days did you have 5 (if male)/4 (if female) or more drinks on an occasion?"

Excessive Drinkers



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 136]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Oklahoma data.
- 2020 PRC National Health Survey, PRC, Inc.

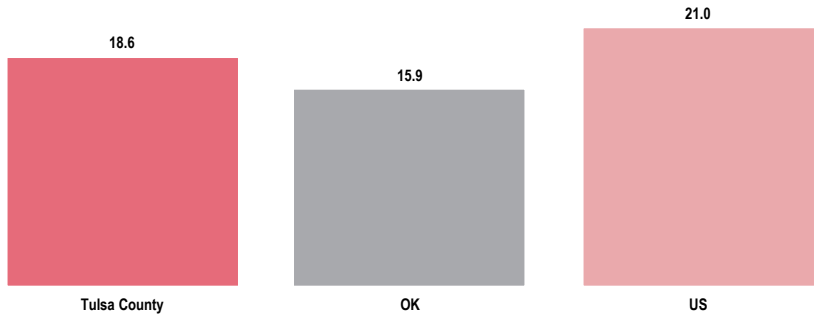
Notes:
- Asked of all respondents.
- Excessive drinking reflects the number of persons aged 18 years and over who drank more than two drinks per day on average (for men) or more than one drink per day on average (for women) OR who drank 5 or more drinks during a single occasion (for men) or 4 or more drinks during a single occasion (for women) during the past 30 days.

Drugs

Age-Adjusted Unintentional Drug-Related Deaths

Unintentional drug-related deaths include all deaths, other than suicide, for which drugs are the underlying cause. A "drug" includes illicit or street drugs (e.g., heroin and cocaine), as well as legal prescription and over-the-counter drugs; alcohol is not included. The following chart outlines local age-adjusted mortality for unintentional drug-related deaths.

Unintentional Drug-Related Deaths: Age-Adjusted Mortality
(2018-2020 Annual Average Deaths per 100,000 Population)



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted March 2022.

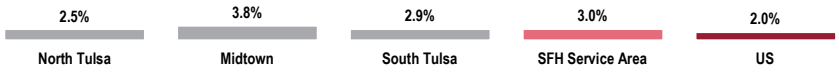
Illicit Drug Use

"During the past 30 days, have you used an illegal drug or taken a prescription drug that was not prescribed to you?"

Note: As a self-reported measure – and because this indicator reflects potentially illegal behavior – it is reasonable to expect that it might be underreported, and that actual illicit drug use in the community is likely higher.

Illicit Drug Use in the Past Month

Healthy People 2030 = 12.0% or Lower



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 49]
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

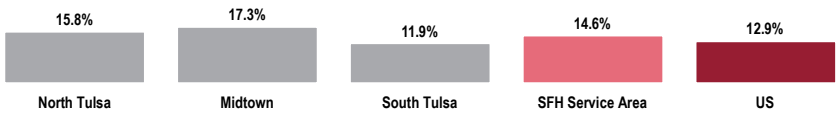
Notes:
- Asked of all respondents.

Use of Prescription Opioids

"Opiates or opioids are drugs that doctors prescribe to treat pain. Examples of prescription opiates include morphine, codeine, hydrocodone, oxycodone, methadone, and fentanyl. In the past year, have you used any of these prescription opiates?"

Opioids are a class of drugs used to treat pain. Examples presented to respondents include morphine, codeine, hydrocodone, oxycodone, methadone, and fentanyl. Common brand name opioids include Vicodin, Dilaudid, Percocet, OxyContin, and Demerol.

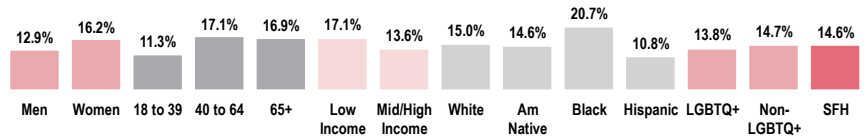
Used a Prescription Opioid in the Past Year



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 50]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Used a Prescription Opioid in the Past Year
(SFH Service Area, 2022)



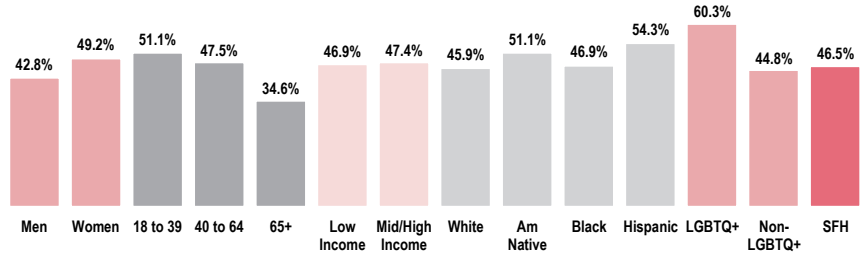
Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 50]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Personal Impact From Substance Abuse

"To what degree has your life been negatively affected by your own or someone else's substance abuse issues, including alcohol, prescription, and other drugs? Would you say: a great deal, somewhat, a little, or not at all?"

Life Has Been Negatively Affected
by Substance Abuse (by Self or Someone Else)
(SFH Service Area, 2022)

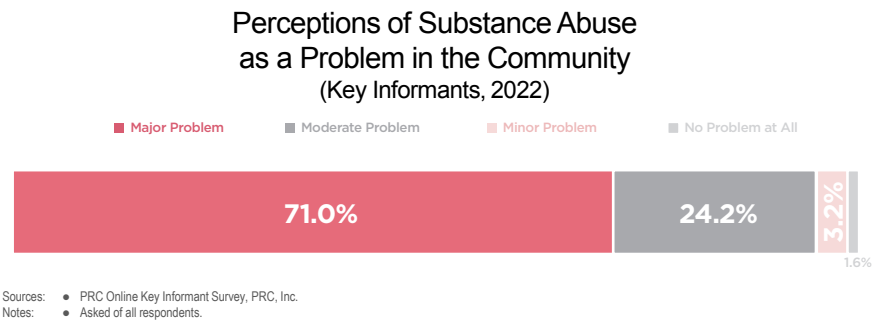


Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 52]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes response of "a great deal," "somewhat," and "a little."

Key Informant Input: Substance Abuse

The following chart outlines key informants' perceptions of the severity of Substance Abuse as a problem in the community:



Among those rating this issue as a "major problem," reasons related to the following:

Access to Care/Services

> No resources. Lack of transportation. High crime area. Lack of education. Impoverished area. – Community Leader
>
> Limited coverage of intensive outpatient programs and/or residential programs by insurance/government payers. – Physician
>
> Limitation on availability of free resources for uninsured or underinsured. – Physician
>
> Usually a waiting time for detox bed and inpatient beds. The transitory nature of our clients for consistent outpatient treatment. – Social Service Agency
>
> Counseling. – Community Leader
>
> Very few providers and places to go for help. – Public Health Representative
>
> Adequately trained professionals to manage substance abuse treatment. – Physician
>
> Lack of resources. – Public Health Representative
>
> Lack of clinics and inpatient and outpatient rehab treatment. Especially lack of pediatric psychiatric care. Lack of MAT clinics. – Physician
>
> There are not a lot of services and education. – Community Leader
>
> There is little in the community that addresses substance abuse, especially in a proactive way. Treating it as a disease. – Physician

Contributing Factors

> Stigma – SAMSHA NSDUH data indicate that stigma is the No. 1 reason why people don't seek treatment for substance abuse when they otherwise had access to it. Children's SUD treatment – very little capacity exists in Tulsa to treat children with substance use issues. Lack of private provider capacity for intensive outpatient and inpatient SUD treatment. The largest capacity is in the public system at 12&12, which is often not a great resource for those with private insurance. Widespread adoption of evidence-based practices for treating meth addiction, which is one of Tulsa's greatest SUD needs according to the data. In primary care settings: Lack of awareness of evidence-based practices appropriate for primary care, lack of consistent screening, and limited use of integrated care practices. – Public Health Representative
>
> Availability and affordability of treatments and services. Stigma preventing people from seeking help. – Public Health Representative
>
> Transportation, living problems, support, encouragement, and education. – Community Leader
>
> Access to providers and cost barriers, prevalence of substance abuse issues (especially given COVID), and how this strains an already limited system. Culture that doesn't acknowledge substance abuse, particularly alcohol abuse. – Community Leader

Addiction is difficult to fix. More emphasis needs to be placed on 'Why you should say 'no' to drugs.' There are no/few treatments centers providing peer-reviewed and proven treatment programs for many types of addiction. The treatment programs that exist are often too short in duration. Cost can be an issue. There is no way to tell the success rates between various treatment centers. The front-end problems are growing. In addition, widespread cannabis access is unhelpful. Culturally, using illicit drugs is considered to be a "reasonable" solution to personal problems. – Community Leader

Drug addiction and lack of accessibility of drug and alcohol services for lower socioeconomic groups. – Physician

Denial/Stigma

The biggest issue for substance abuse is for the person to be able to say they need help. There are many services in the area for this, but people that are currently in this category either don't want help or don't want to admit that they have a problem. – Other Health Provider

Stigma. – Other Health Provider

Afraid to admit they have a problem, not wanting to correct it or motivated to do it, continue due to friends taking drugs, selling drugs makes money, not knowing where to get help. – Community Leader

The stigma still keeps persons away from seeking interventions to intentionally change the course of their lives. There are often no beds available when a person is in crisis, finally motivated to change and seeks inpatient treatment. Other than NA, AA, and Celebrate Recovery in churches, there is little available and essentially no investment in ongoing supports for persons with SUDs. – Public Health Representative

Health Education

Lack of awareness, social normalization of substance abuse. – Physician

Funding and knowledge of potential programs. – Physician

How to provide these services in the community. – Social Service Agency

Prevalence/Incidence

Oklahoma has a very high incidence of drug abuse. There are many reasons for this. OSU Center for health Sciences received about $200 million and invested in the National Center for Wellness and Recovery which will research addiction and hope to find treatments – Community Leader

The opioid epidemic is bad here, as well as the recreational use of medical grade marijuana. – Community Leader

Affordable Care/Services

Cost of treatment, lack of outpatient treatment. – Social Service Agency

Excellent programs are too expensive. The short detox with no further support is inadequate for overcoming addiction. – Physician

Addiction

Addiction. – Physician

Cultural/Personal Beliefs

Programs that incorporate the intersectionality of culture and the role that it plays in substance abuse. Historical trauma and how it can affect treatment with families. – Public Health Representative

Diagnosis/Treatment

Practitioners and strategies that promote treatment on a long term basis. The insidious nature of addiction is obvious in poor outcomes. – Other Health Provider

Easy Access

Affordability and the ridiculous medical marijuana law that causes substance abuse to begin for many. – Community Leader

Vulnerable Populations

That definitely seems to be a significant factor, particularly with the homeless. – Public Health Representative

TOBACCO USE

ABOUT TOBACCO USE

More than 16 million adults in the United States have a disease caused by smoking cigarettes, and smoking-related illnesses lead to half a million deaths each year.

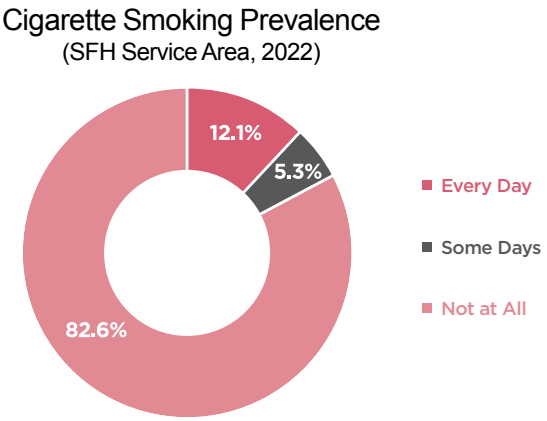
Most deaths and diseases from tobacco use in the United States are caused by cigarettes. Smoking harms nearly every organ in the body and increases the risk of heart disease, stroke, lung diseases, and many types of cancer. Although smoking is widespread, it's more common in certain groups, including men, American Indians/Alaska Natives, people with behavioral health conditions, LGBT people, and people with lower incomes and education levels.

Several evidence-based strategies can help prevent and reduce tobacco use and exposure to secondhand smoke. These include smoke-free policies, price increases, and health education campaigns that target large audiences. Methods like counseling and medication can also help people stop using tobacco.

– *Healthy People 2030 (https://health.gov/healthypeople)*

Cigarette Smoking

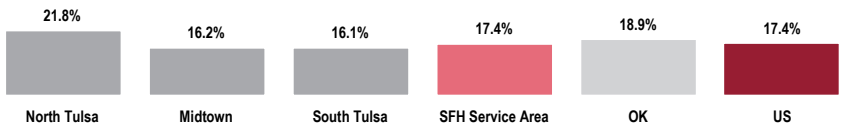
"Do you now smoke cigarettes every day, some days, or not at all?" ("Current smokers" include those smoking "every day" or on "some days.")



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 40]
Notes: • Asked of all respondents.

Current Smokers

Healthy People 2030 = 5.0% or Lower



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 40]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Oklahoma data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Notes:
- Asked of all respondents.
- Includes regular and occasional smokers (those who smoke cigarettes every day or on some days).

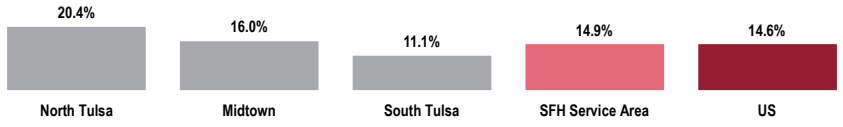
Environmental Tobacco Smoke

"In the past 30 days, has anyone, including yourself, smoked cigarettes, cigars or pipes anywhere in your home on an average of four or more days per week?"

The following chart details these responses among the total sample of respondents, as well as among only households with children (age 0-17).

Member of Household Smokes at Home

16.7% among households with children



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Items 43, 134]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- "Smokes at home" refers to someone smoking cigarettes, cigars, or a pipe in the home an average of four or more times in a week.

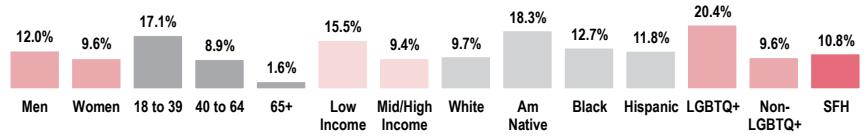
Use of Vaping Products

"The next questions are about electronic vaping products, such as electronic cigarettes, also known as e-cigarettes. These are battery-operated devices that simulate traditional cigarette smoking, but do not involve the burning of tobacco. The cartridge or liquid "e-juice" used in these devices produces vapor and comes in a variety of flavors. Have you ever used an electronic vaping product, such as an e-cigarette, even just one time in your entire life?"

"Do you now use electronic vaping products, such as e-cigarettes, "every day," "some days," or "not at all"?"

"Current use" includes use "every day" or on "some days."

Currently Use Vaping Products
(SFH Service Area, 2022)



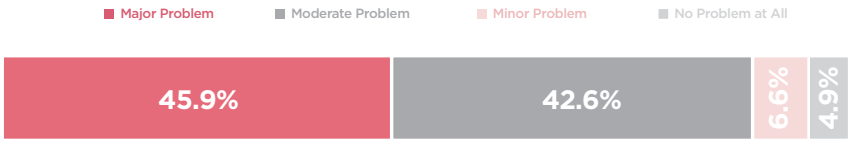
Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 135]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes regular and occasional users (those who smoke e-cigarettes every day or on some days).

Key Informant Input: Tobacco Use

The following chart outlines key informants' perceptions of the severity of Tobacco Use as a problem in the community:

Perceptions of Tobacco Use
as a Problem in the Community
(Key Informants, 2022)



Sources:
- PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Prevalence/Incidence

> It is very prevalent, family history and accessibility. – Community Leader
>
> High percentage of smokers and Indian tobacco shops. – Public Health Representative
>
> Still seeing more than expected patients with heart disease, PAD, and COPD that smoke. – Physician
>
> Roughly one in five Tulsa County adults regularly smoke tobacco products, according to Health Department data. – Public Health Representative
>
> You still see many people on the sidewalks smoking. In the casinos it is sometimes too much to be in there. – Community Leader
>
> The state has an incredibly high percentage of use in comparison to other states. People are elected to quit. Multiple medical problems and mortality associated with this long-term. – Physician
>
> Many people continue to use tobacco, including the smokeless tobacco, flavored tobacco, and other forms of smoking, including adolescents. It is hard to stop smoking especially when they start at a younger age. Tobacco causes all kinds of health issues-cancer, high blood pressure, heart disease, stroke, emphysema, chronic bronchitis. – Community Leader

Comorbidities

> Its contribution to cancer, heart disease, respiratory problems, asthma, etc. Tobacco use correlates to nearly every major health problem. – Other Health Provider
>
> Morbidities. – Physician

Easy Access

> The number of vape shops and cigarette smokers among my employees. – Social Service Agency

Addiction

> It is highly addictive; many have had long history of smoking. – Social Service Agency

Health Education

> Not enough incentive to provide education. Lack of knowledge about programs. – Physician

Environmental Exposure

> There is no smoking in most eating places, but when you leave the eatery all you smell is smoke. People are always smoking around the smoke-free campuses, which still affects people's health. – Community Leader

Contributing Factors

> Because of poverty, poor education, medical marijuana and casinos. – Community Leader

Lifestyle

> Lifestyle. – Community Leader

Social Norms

> Because we have a society that promotes it. – Public Health Representative

Sexual Health

ABOUT HIV & SEXUALLY TRANSMITTED INFECTIONS

Although many sexually transmitted infections (STIs) are preventable, there are more than 20 million estimated new cases in the United States each year — and rates are increasing. In addition, more than 1.2 million people in the United States are living with HIV (human immunodeficiency virus).

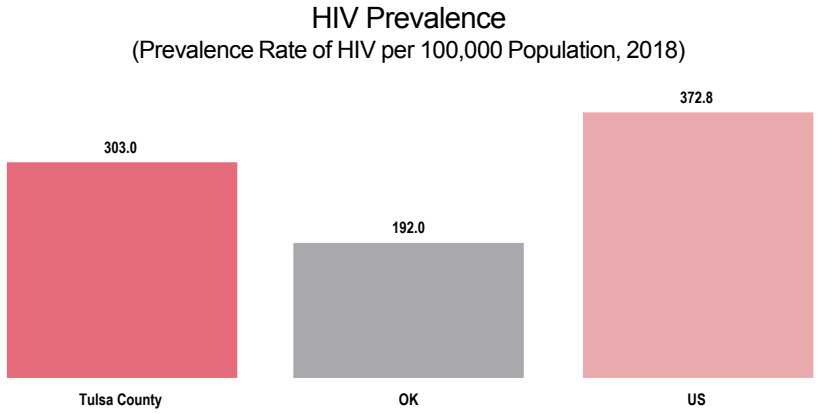
Adolescents, young adults, and men who have sex with men are at higher risk of getting STIs. And people who have an STI may be at higher risk of getting HIV. Promoting behaviors like condom use can help prevent STIs.

Strategies to increase screening and testing for STIs can assess people's risk of getting an STI and help people with STIs get treatment, improving their health and making it less likely that STIs will spread to others. Getting treated for an STI other than HIV can help prevent complications from the STI but doesn't prevent HIV from spreading.

– *Healthy People 2030 (https://health.gov/healthypeople)*

HIV

The following chart outlines prevalence (current cases, regardless of when they were diagnosed) of HIV per 100,000 population in the area.



Sources:
- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved March 2022 via SparkMap (sparkmap.org).

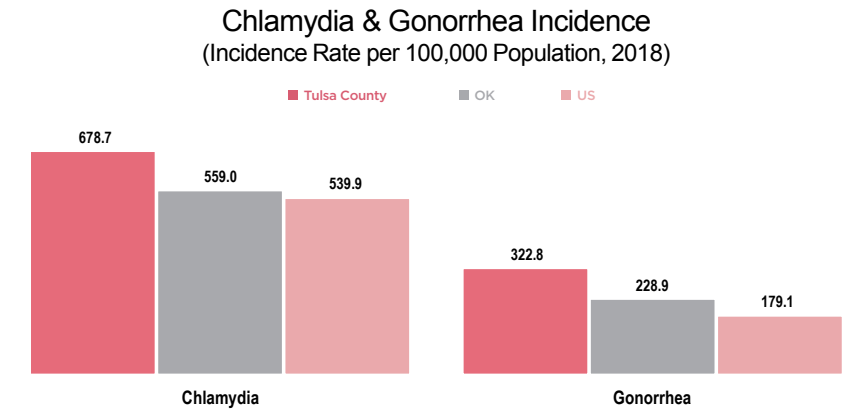
Notes:
- This indicator is relevant because HIV is a life-threatening communicable disease that disproportionately affects minority populations and may also indicate the prevalence of unsafe sex practices.

Sexually Transmitted Infections (STIs)

CHLAMYDIA ▶ Chlamydia is the most commonly reported STI in the United States; most people who have chlamydia are unaware, since the disease often has no symptoms.

GONORRHEA ▶ Anyone who is sexually active can get gonorrhea. Gonorrhea can be cured with the right medication; left untreated, however, gonorrhea can cause serious health problems in both women and men.

The following chart outlines local incidence for these STIs.

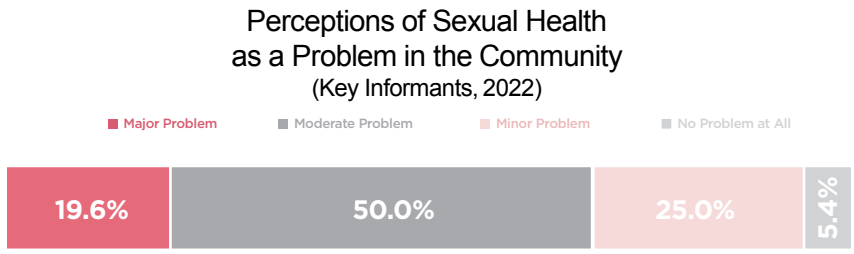


Sources:
- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved March 2022 via SparkMap (sparkmap.org).

Notes:
- This indicator is relevant because it is a measure of poor health status and indicates the prevalence of unsafe sex practices.

Key Informant Input: Sexual Health

The following chart outlines key informants' perceptions of the severity of Sexual Health as a problem in the community:



Sources:
- PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Prevalence/Incidence

> Syphilis cases exponentially increasing with new cases of congenital syphilis occurring much more commonly where it was previously extremely rare. – Physician
>
> There are a few services but still a major issue. – Community Leader
>
> Tulsa has among the highest rate of several STIs in the state and rates have been increasing in recent years. – Public Health Representative
>
> High rates of STI's and HIV. – Other Health Provider
>
> Statistics regarding the number of HIV/AIDs cases among women in our community. – Social Service Agency

Health Education

> Lack of education regarding disease protection. – Social Service Agency
>
> Education surrounding sexual health is needed for youth and in general. Helping individuals understand their bodies and empowering them to take control is always needed. There is a great need within the BIPOC communities that may have certain ideas surrounding the education of this, however; young people should be empowered to know the risk factors of decision they may make. – Public Health Representative
>
> Lack of education in north Tulsa. – Public Health Representative

Access to Care/Services

> Lack of access, limitations for care at some facilities due to religious limitations. – Physician

Affordable Care/Services

> The cost to access treatment for both parties. – Social Service Agency

ACCESS TO HEALTH CARE

ABOUT HEALTH CARE ACCESS

Many people in the United States don't get the health care services they need. ...About 1 in 10 people in the United States don't have health insurance. People without insurance are less likely to have a primary care provider, and they may not be able to afford the health care services and medications they need. Strategies to increase insurance coverage rates are critical for making sure more people get important health care services, like preventive care and treatment for chronic illnesses.

Sometimes people don't get recommended health care services, like cancer screenings, because they don't have a primary care provider. Other times, it's because they live too far away from health care providers who offer them. Interventions to increase access to health care professionals and improve communication — in person or remotely — can help more people get the care they need.

– *Healthy People 2030 (https://health.gov/healthypeople)*

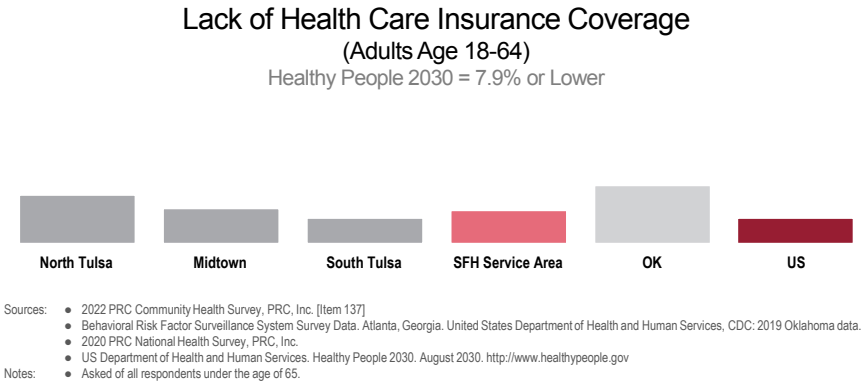
Lack of Health Insurance Coverage

Survey respondents were asked a series of questions to determine their healthcare insurance coverage, if any, from either private or government-sponsored sources.

"Do you have any government-assisted healthcare coverage, such as Medicare, Medicaid (or another state-sponsored program), or VA/military benefits?"

"Do you currently have: health insurance you get through your own or someone else's employer or union; health insurance you purchase yourself; or, you do not have health insurance and pay for health care entirely on your own?"

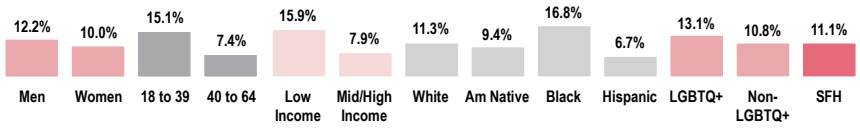
Here, lack of health insurance coverage reflects respondents age 18 to 64 (thus excluding the Medicare population), who have no type of insurance coverage for healthcare services – neither private insurance nor government-sponsored plans (e.g., Medicaid).



Lack of Health Care Insurance Coverage

(Adults Age 18-64; SFH Service Area, 2022)

Healthy People 2030 = 7.9% or Lower



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 137]
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov [Objective AHS-1]

Notes:
- Asked of all respondents under the age of 65.

Difficulties Accessing Health Care

Barriers to Health Care Access

To better understand healthcare access barriers, survey participants were asked whether any of the following barriers to access prevented them from seeing a physician or obtaining a needed prescription in the past year.

"Was there a time in the past 12 months when you needed medical care, but had difficulty finding a doctor?"

"Was there a time in the past 12 months when you had difficulty getting an appointment to see a doctor?"

"Was there a time in the past 12 months when you needed to see a doctor, but could not because of the cost?"

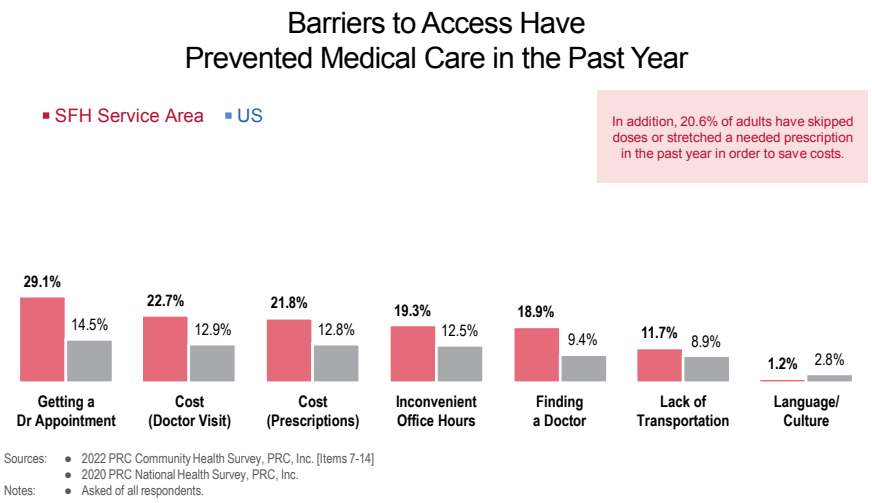
"Was there a time in the past 12 months when a lack of transportation made it difficult or prevented you from seeing a doctor or making a medical appointment?"

"Was there a time in the past 12 months when you were not able to see a doctor because the office hours were not convenient?"

"Was there a time in the past 12 months when you needed a prescription medicine, but did not get it because you could not afford it?"

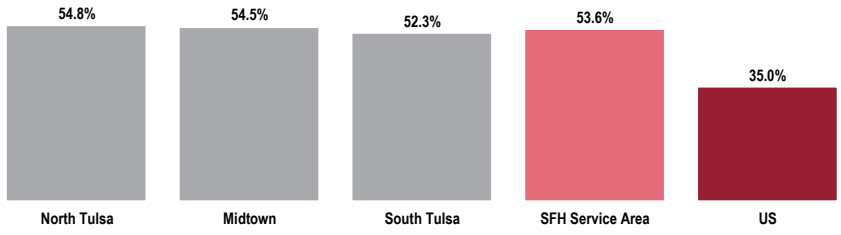
"Was there a time in the past 12 months when you were not able to see a doctor due to language or cultural differences?"

The percentages shown in the following chart reflect the total population, regardless of whether medical care was needed or sought.



The following charts reflect the composite percentage of the total population experiencing problems accessing healthcare in the past year (indicating one or more of the aforementioned barriers or any other problem not specifically asked), again regardless of whether they needed or sought care.

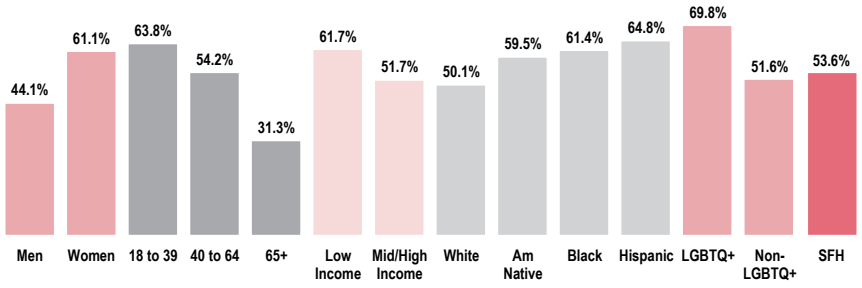
Experienced Difficulties or Delays of Some Kind in Receiving Needed Health Care in the Past Year



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 140]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Percentage represents the proportion of respondents experiencing one or more barriers to accessing health care in the past 12 months.

Experienced Difficulties or Delays of Some Kind in Receiving Needed Health Care in the Past Year
(SFH Service Area, 2022)



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 140]

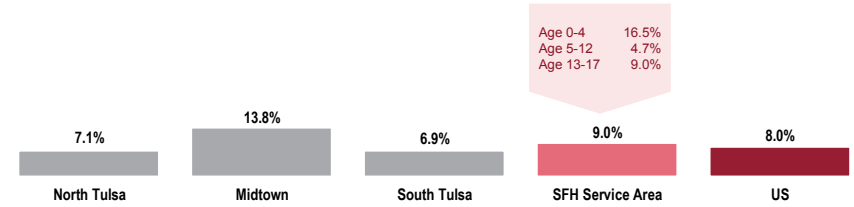
Notes:
- Asked of all respondents.
- Percentage represents the proportion of respondents experiencing one or more barriers to accessing health care in the past 12 months.

Accessing Health Care for Children

Surveyed parents were also asked if, within the past year, they experienced any trouble receiving medical care for a randomly selected child in their household.

"Was there a time in the past 12 months when you needed medical care for this child, but could not get it?"

Had Trouble Obtaining Medical Care for Child in the Past Year
(Parents of Children 0-17)

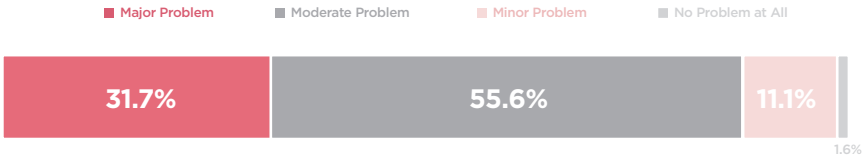


Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 104]
• 2020 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents with children 0 to 17 in the household.

Key Informant Input: Access to Health Care Services

The following chart outlines key informants' perceptions of the severity of Access to Health Care Services as a problem in the community:

Perceptions of Access to Health Care Services
as a Problem in the Community
(Key Informants, 2022)



Sources: • PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Access to Care/Services

Mental health access. Lack of local health resource in certain areas. – Physician

So many residents do not have access to consistent care and wait too long before seeking assistance with medical issues. They skip taking needed medications and do not understand what their options are in the charitable community. – Social Service Agency

I see basically three tiers of healthcare in Tulsa. Those that are VIPs in the community can use their social status and other privileges to see any healthcare provider in the area and receive treatments not available to the rest of the population. The second tier is people who have health care insurance; however, it can still take months to be seen, and deductibles and copays are so high that these patients decide not to obtain needed care. The third tier is the uninsured or underinsured who have little to no access to routine health care and tend to use expensive emergency room services, often after their condition has become severe. – Physician

The nursing shortage on inpatient hospital units is the most critical issue for access to healthcare. Nursing shortages close hospital beds for months. Critically ill patients go to the ER, wait in the waiting room or hallway for 24+ hours to be placed in a proper room. This makes Tulsa feel like a third world country. Another situation, a patient presents to a smaller community or rural ER with a life-threatening critical condition. Normally the patient would be transferred immediately to a large hospital in Tulsa for a specialist. Now because of the nurse shortage, the same patient sits in the community or rural ER for 3-4 days waiting to be transferred. Another major problem with access to healthcare is specialty physicians refuse to take call at a hospital. These Tulsa physicians refuse to take hospital call for the community ophthalmology, ENT, gastroenterology, urology, oral surgery/dentistry. Patients present to the ER needing these specialists and none are available. – Physician

No health clinics in the area within miles. – Community Leader

Lack of health care professionals, namely nurses. – Public Health Representative

Lack of medical services such as urgent care facilities, hospital with emergency room and inpatient care (beds), doctor/patient ratio in the immediate community. – Community Leader

Lack of resources at 61st and Peoria Tulsa. Lack of transportation. Lack of community outreach. Very little mental health services, almost nonexistent. – Community Leader

There are simply not enough health agencies in our community and transportation to health agencies outside of North Tulsa can be a challenge. – Community Leader

Access to Care for Uninsured/Underinsured

Verification of insurance. Even if you have private insurance, it takes too long to get verified and approved for surgery and sometimes your medical claims are not paid even if you have insurance. – Community Leader

There is no health care system for a majority of Tulsans. Only those fortunate enough to have health care insurance. – Physician

Poor access to routine outpatient services, mostly due to lack of insurance coverage. As such, use of ED and hospital for these issues with poor outcomes. – Physician

A great percentage of Latinos lack access to health insurance, so they use emergency services often. Many treat family members at home before they seek medical care. Latinos also face language and cultural barriers when attempting to access health care services. – Community Leader

The biggest challenge is access to full coverage health care benefits. – Community Leader

Contributing Factors

Lack of affordability and insurance, limited locations for care in north and west Tulsa. Very little follow up on patients and lack of ongoing support to patients once they are home. Need for ' hospital at home' services and nursing or social worker continued contact to link patients to needed services, prescriptions, food services and transportation. Many patients do not have the finances, knowledge, or ability to access services such as Meals on Wheels, various food pantries or transportation. Tulsa's 211 Helpline is a good resource for help with finding health services. – Community Leader

Lack of transportation. Lack of knowledge. Lack of motivation to access healthcare until it becomes a crisis. – Community Leader

The biggest challenge is community partners making patients/clients aware of the services that Federally Quality Health Care Centers (FQHC) provide. As by definition no one is turned away regardless of their insurance status and a Sliding Fee Scale is in place for uninsured patients. Transportation is huge barrier for the underserved population to and from medical care visits and Morton provides these services as well as other FQHC. – Social Service Agency

Health Education

> Our community is largely health illiterate. This is at the root of the front-end of poor health outcomes. For example, people don't know that as little as 15 minutes of exercise per day can improve their mood. K-12 was part of the solution in a bygone era. Now, I do not believe that it is much of a solution even though schools actually decide the foods kids are eating (which should be a huge advantage). The kids often throw the healthy food in the trash, so the schools stop serving healthy food. Again, the kids are largely illiterate and need to be educated. – Community Leader

> Lack of patient education. – Physician

Transportation

> The biggest challenge is multi-modal transportation access to health care services and the placement of service locations in relation to neighborhoods of highest need. For the neighborhoods I work with, health care services are primarily not able to be accessed via a safe walking, biking or convenient and comfortable transit journey. There also appears to be a lack of small-scale health care services like urgent cares which can support avoiding the hospital/emergency room for small complaints. – Public Health Representative

Affordable Care/Services

> Affordability and low wage workforce. – Community Leader

Systemic Racism

> Systemic racism is a pervasive health issue in the city, both in the ways it presents itself within a medical office setting, and in the deeply rooted policies around housing, food access, transportation, education, air/water quality and the legal system – all of which contribute to health outcomes. – Public Health Representative

Specialty Care

> Traumatic brain injury. The region has no specific neuro-rehabilitative programs. – Physician

Employment

> There are few resources and occupations for gainful employment for individuals in North Tulsa. – Community Leader

Primary Care Services

ABOUT PREVENTIVE CARE

Getting preventive care reduces the risk for diseases, disabilities, and death — yet millions of people in the United States don't get recommended preventive health care services.

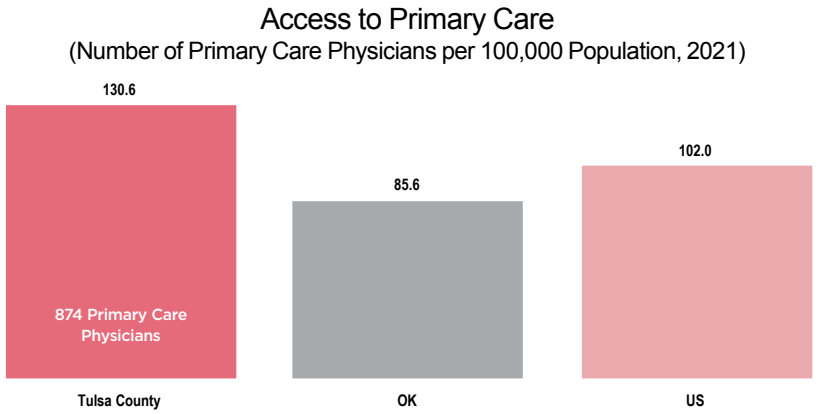
Children need regular well-child and dental visits to track their development and find health problems early, when they're usually easier to treat. Services like screenings, dental check-ups, and vaccinations are key to keeping people of all ages healthy. But for a variety of reasons, many people don't get the preventive care they need. Barriers include cost, not having a primary care provider, living too far from providers, and lack of awareness about recommended preventive services.

Teaching people about the importance of preventive care is key to making sure more people get recommended services. Law and policy changes can also help more people access these critical services.

– *Healthy People 2030 (https://health.gov/healthypeople)*

Access to Primary Care

This indicator is relevant because a shortage of health professionals contributes to access and health status issues.



Sources:
- US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved March 2022 via SparkMap (sparkmap.org).

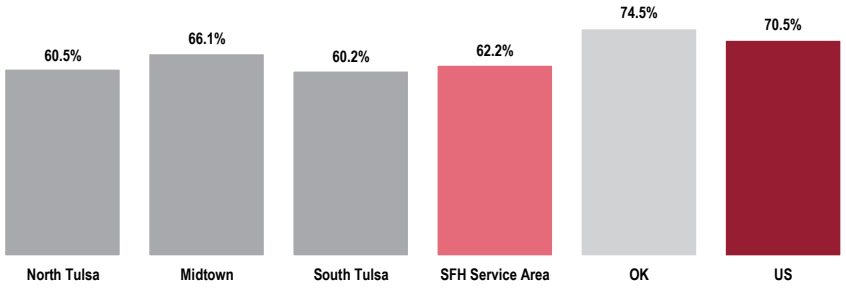
Notes:
- Doctors classified as "primary care physicians" by the AMA include: General Family Medicine MDs and DOs, General Practice MDs and DOs, General Internal Medicine MDs, and General Pediatrics MDs. Physicians age 75 and over and physicians practicing sub-specialties within the listed specialties are excluded. This indicator is relevant because a shortage of health professionals contributes to access and health status issues.

Utilization of Primary Care Services

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

CHILDREN ▶ "About how long has it been since this child visited a doctor for a routine checkup or general physical exam, not counting visits for a specific injury, illness, or condition?"

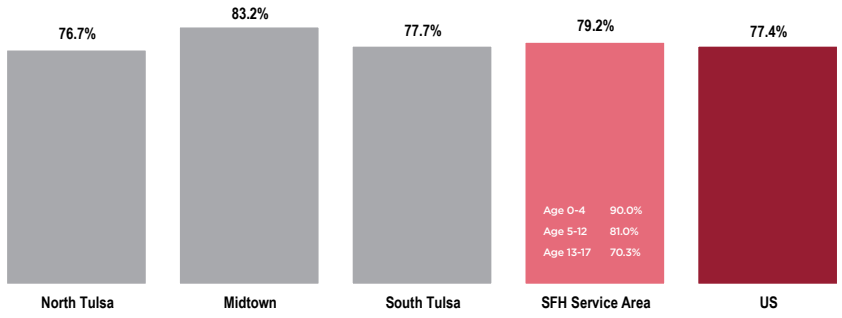
Have Visited a Physician for a Checkup in the Past Year



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 18]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Oklahoma data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Child Has Visited a Physician for a Routine Checkup in the Past Year (Parents of Children 0-17)



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 105]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents with children 0 to 17 in the household.

Oral Health

ABOUT ORAL HEALTH

Tooth decay is the most common chronic disease in children and adults in the United States. ...Regular preventive dental care can catch problems early, when they're usually easier to treat. But many people don't get the care they need, often because they can't afford it. Untreated oral health problems can cause pain and disability and are linked to other diseases.

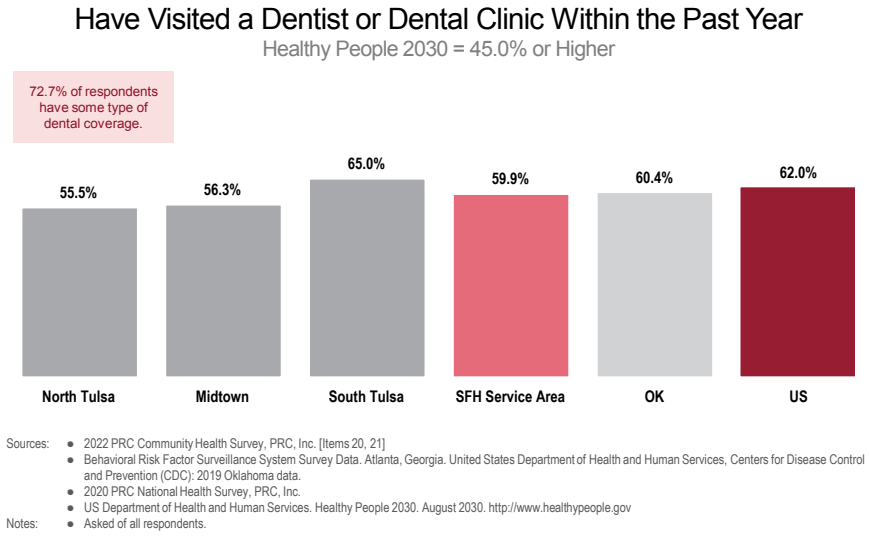
Strategies to help people access dental services can help prevent problems like tooth decay, gum disease, and tooth loss. Individual-level interventions like topical fluorides and community-level interventions like community water fluoridation can also help improve oral health. In addition, teaching people how to take care of their teeth and gums can help prevent oral health problems.

– *Healthy People 2030 (https://health.gov/healthypeople)*

Dental Care

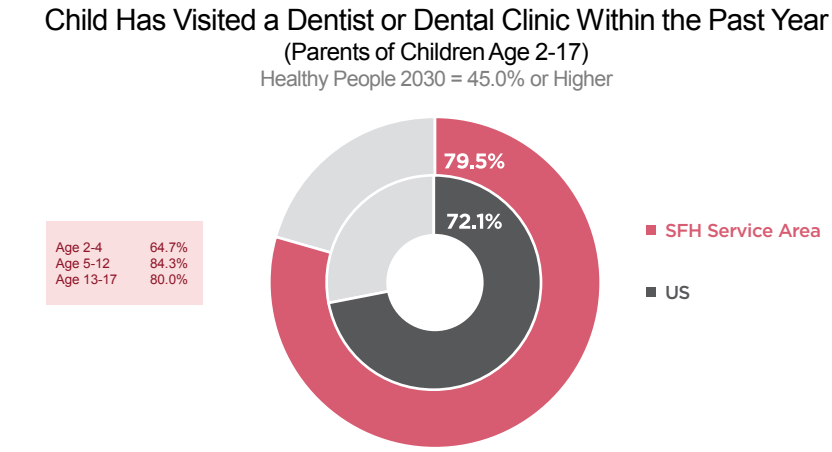
ADULTS ▶ "About how long has it been since you last visited a dentist or a dental clinic for any reason?"

CHILDREN AGE 2-17 ▶ "About how long has it been since this child visited a dentist or dental clinic?"



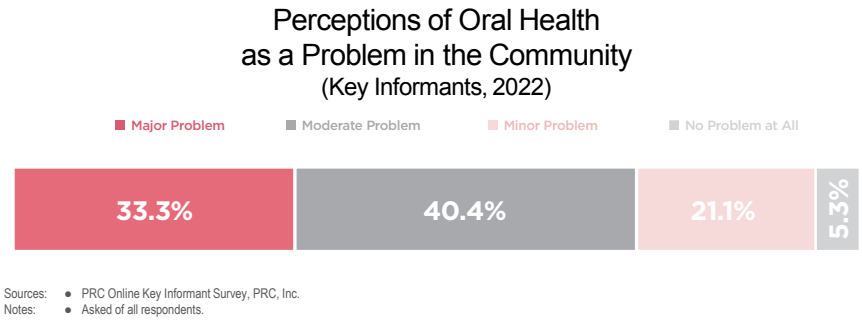
Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Items 20, 21]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Oklahoma data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Notes:
- Asked of all respondents.



Key Informant Input: Oral Health

The following chart outlines key informants' perceptions of the severity of Oral Health as a problem in the community:



Among those rating this issue as a "major problem," reasons related to the following:

Access to Care for Uninsured/Underinsured

> Even some people with health insurance do not have dental insurance and cannot afford dental care. Bad dental health can lead to a variety of general and mental health problems. It can also be a barrier to getting a job. – Community Leader
>
> Lack of free or very low-cost dental care for uninsured individuals, especially for preventive care. Too many people have to wait until they have major, expensive and painful issues to solve. – Other Health Provider
>
> Lack of access to dental services, especially those that assist people with no insurance or difficulty meeting their copay. – Community Leader
>
> Many people do not go and see their dentists regularly, probably because they don't have dental insurance or resources to pay for services or transportation to the dentist. May not consider dental health as important as other health issues. – Community Leader

Cost of Care

> Dental care is extremely expensive without insurance and even with it. – Community Leader
>
> The cost is prohibitive, even sometimes with insurance. – Physician
>
> Poor access to free dental services from routine oral care to extractions, root canals, and oral surgery. – Physician
>
> The cost to access oral health. – Social Service Agency
>
> Lack of affordable dental care. Essentially, every dentist is for profit and has a surplus of patients, meaning they can charge exorbitant costs and accordingly, patients forego care secondary to expense. – Physician

Access to Care/Services

> Accessible dentistry. Transportation. – Community Leader
>
> Lack of access and costs. – Community Leader
>
> Children need better access to dental care. – Community Leader
>
> Not enough dental services in the North Tulsa community. – Community Leader

Homelessness

> One only has to spend time in a dental clinic serving the uninsured or newly insured with Medicaid to see the impact of poor oral health. Tulsa's homeless population is in constant need of extractions and infection treatments. Deferred oral health for children and adults has resulted in poor oral health which impacts every other health outcome. – Other Health Provider
>
> Once again, people experiencing homelessness do not have access to dental care. – Social Service Agency

Contributing Factors

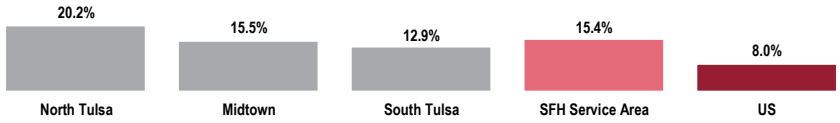
> No dentist in the area. Poverty area. Black transportation to dental services. – Community Leader

LOCAL RESOURCES

Perceptions of Local Health Care Services

"How would you rate the overall health care services available to you? Would you say: excellent, very good, good, fair, or poor?"

Perceive Local Health Care Services as "Fair/Poor"



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 6]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Resources Available to Address the Significant Health Needs

The following represent potential measures and resources (such as programs, organizations, and facilities in the community) identified by key informants as available to address the significant health needs identified in this report. This list only reflects input from participants in the Online Key Informant Survey and should not be considered to be exhaustive nor an all-inclusive list of available resources.

Access to Health Care Services

- Catholic Charities
- Community Health Connection
- Crossover Health
- Doctor's Offices
- Economic Development Initiatives
- Federal Grant Money
- Federally Qualified Health Centers
- Good Samaritan Clinic
- Greenwood Cultural Center
- Hospitals
- Infastructure to Support Safe/Comfortable Transit
- Life Senior Services
- Medicaid Reimbursements
- Medical Marijuana Cards
- Modus
- Morton Comprehensive Health Services
- Morton Health Care
- Morton Health Clinic
- MyHealth
- Neighbor for Neighbor
- Nonprofit Health Agencies
- Nursing Care
- Nursing Programs
- OSU Medical Center
- OSU-Tulsa Hospital
- OU Bedlam and Crossover Clinic
- OU Healthcare
- OU Wayman Tisdale Center
- PA Program
- Partner With Managed Care Organizations
- Pediatric Psychiatry
- Project Woman
- Rudisell Library
- Saint Francis Hospital
- School Systems
- Social Services
- South Peoria Neighborhood House
- Tulsa County Pharmacy
- Tulsa Dream Center
- Tulsa Health Department
- Tulsa Transit
- Westview Medical Center
- Xavier Clinic

Cancer

- 1-800-Quit-Now
- American Cancer Society
- Doctor's Offices
- Hospitals
- Morton Comprehensive Health Services
- Morton Health Care
- OU Healthcare
- Project Woman
- Westview Health Services

Chronic Kidney Disease

- 12 and 12
- Catholic Hospitals
- Family and Children's Services
- John 3:16 Program
- Morton Comprehensive Health Services
- Morton Health Care
- OU Healthcare
- OU Wayman Tisdale Center
- Tulsa County
- Tulsa Health Department

Coronavirus/COVID-19

- Care ATC
- City of Tulsa
- Community Care Insurance
- Community Health Connection
- Crossover Health
- Doctor's Offices
- Federally Qualified Health Centers
- Health Care Facilities
- Health Department
- Hillcrest Hospital System
- Hillcrest Longitudinal Clinic

- Hospitals
- Indian Health Care
- Life Senior Services
- Morton Comprehensive Health Services
- Morton Health Care
- Oklahoma Health Department
- OSU
- OU Healthcare
- OU Wayman Tisdale Center
- Pharmacies
- Saint Francis Health System
- Saint Francis Hospital
- School Systems
- Social Services
- St. John
- Synergy Tulsa Employee Assistance Program
- The Caring Van
- The Uma Center Inc
- Tribal Nations
- Tulsa Health Department
- VA
- Westview Health Services

Dementia/Alzheimer's Disease

- Adult Senior Services
- Alzheimer's Association
- Doctor's Offices
- Home Health Agencies
- Laureate
- Life Senior Services
- Mayor's Dementia Friendly Task Force
- Meals on Wheels
- Morton Comprehensive Health Services
- Morton Health Care
- Nursing Homes/Assisted Living Facilities
- OU Healthcare
- Psychiatric Clinics
- Tulsa Health Department

Diabetes

- ADA
- Care ATC
- Catholic Charities
- Catholic Hospitals
- Community Food Bank
- Community Health Connection
- Community Health Workers
- Crossover Health
- Diabetes Foundation
- Dieticians
- Doctor's Offices
- Farmer's Market
- GoodRx
- Hillcrest Longitudinal Clinic
- Morton Comprehensive Health Services
- Morton Health Care
- Morton Health Clinic
- Nurse Educators
- OU Bedlam and Crossover Clinic
- OU Health Harold Ham Diabetes Center
- OU Healthcare
- OU Wayman Tisdale Center
- Parks and Recreation
- Prescription Assistance Program
- Saint Francis Health System
- Saint Francis Hospital
- St. John's Dispensary of Hope
- Tulsa Community Food Bank
- Tulsa County Pharmacy
- Tulsa Food and Security Council
- Tulsa Health Department
- Tulsa Transit
- Walmart
- YMCA

Disabilities

- Caregiver Support
- Chiropractic Care
- Doctor's Offices
- Mental Health Association
- Morton Comprehensive Health Services
- Morton Health Care
- Oklahoma Parent Center
- OU Healthcare
- PACE Program
- Pain Management Clinic
- Physical Therapy Clinics
- Senior Centers
- Sooner Success
- Supporters of Families With Sickle Cell Disease, Inc.
- Tulsa Health Department
- YMCA

Infant Health and Family Planning

- 211
- Access to Contraception
- Affordable Care Act
- Catholic Charities

- Child and Infant Services
- Community Food Bank
- Community Health Connection
- Emergency Infant Services
- Family and Children's Services
- Health Department
- Healthy Women, Health Futures
- Morton Comprehensive Health Services
- Morton Health Care
- Planned Parenthood
- Saint Francis Hospital
- SNAP
- South Tulsa Community House
- Take Control
- Tulsa Birth Equity Initiative
- Tulsa County
- Tulsa Health Department
- WIC
- Xavier Clinic

Heart Disease

- American Heart Association
- Cardiac Screening CT Exams Available
- Catholic Hospitals
- Community Food Bank
- Diabetes Education
- Doctor's Offices
- Federal Grant Money
- Good Samaritan Clinic
- Heart Association of Oklahoma
- Hospitals
- Morton Comprehensive Health Services
- Morton Health Care
- Morton Health Clinic
- Nursing Care
- Oklahoma Heart Institute
- Online Resources
- OU Healthcare
- OU Wayman Tisdale Center
- Rehab Facilities
- Saint Francis Health System
- Saint Francis Heart Hospital
- Saint Francis Hospital
- St. John
- TSET
- Tulsa Health Department

Injury and Violence

- Child Abuse Network
- DVIS
- Family and Children's Services
- Family Violence Center
- Global Gardens
- Hospitals
- Housing Stabilization
- Indian Health Care
- Morton Health Care
- Oklahoma Coalition Against Domestic Violence
- OSHA Laws
- Parent Child Center
- Police Department
- Rapid Rehousing
- Shelters
- Terrence Crutcher Foundation
- Tribal Agencies
- Tulsa Battered Women's Shelter
- Tulsa Health Department
- Tulsa Police Department

Mental Health

- 12 and 12
- 211
- CALM Center
- Catholic Charities
- Catholic Hospitals
- Center Point Behavioral Health
- Children's Behavioral Health Partnership
- Community Health Connection
- COPES
- Counseling and Recovery Services
- CREOKS
- Doctor's Offices
- Drug/Alcohol Rehab Programs
- Family and Children's Services
- Federally Qualified Health Centers
- Healthy Minds Policy Initiative
- Hospitals
- John 3:16 Program
- Laureate
- Mason Counseling
- McClure Elementary and Marshall Elementary
- Medication Assisted Treatment Program
- Mental Health Association
- Mental Health Services

- Morton Comprehensive Health Services
- Morton Health Care
- Morton Health Clinic
- Oklahoma Policy Institute
- OU Healthcare
- Parkside
- Saint Francis Health System
- School Systems
- Shadow Mountain
- South Tulsa Community House
- Suicide Hotline
- Synergy Tulsa Employee Assistance Program
- TCBH
- The Uma Center Inc
- Tulsa Center of Behavioral Health
- Tulsa County
- Tulsa County Behavioral Health Services
- Tulsa Health Department
- Universities

Nutrition, Physical Activity, and Weight

- Community Food Bank
- Farmer's Market
- Fitness Centers/Gyms
- Food Bank
- Food Security Programs
- Global Gardens
- HealthZone
- Hospitals
- Hunger Free Oklahoma
- Iron Gate
- Laureate
- Morton Health Care
- Muscle Squad Gym
- Neighbor for Neighbor
- Oklahoma State Department of Education
- OSU - Cowboy Kids
- OSU Family Health and Nutrition Clinic
- OU Culinary Medicine
- Parks and Recreation
- R&G Grocers
- Saint Francis Health Zone
- Saint Francis Tulsa Tough
- School Systems
- Shape Down Exercise Program
- South Tulsa Community House
- Sports Leagues
- TSET
- Tulsa Community Food Bank
- Tulsa Food and Security Council
- Tulsa Health Department
- Union Public Schools
- Vibrant Neighborhoods Partnership at INCOG
- WIC
- YMCA
- YWCA

Oral Health

- Catholic Charities
- Community Health Connection
- D Dent
- Dentist's Offices
- Eastern Oklahoma Dental Services
- Morton Comprehensive Health Services
- Morton Health Care
- Morton Health Clinic
- Neighbor for Neighbor
- TCC Oral Hygiene Program

Respiratory Diseases

- 1-800-Quit-Now
- Doctor's Offices
- Lung Association
- Morton Comprehensive Health Services
- Morton Health Care
- Oklahoma State Tobacco Programs
- OU Healthcare
- St. John
- TSET
- Tulsa Health Department

Sexual Health

- Doctor's Offices
- DVIS
- Guiding Right
- Health Department
- HOPE
- Morton Comprehensive Health Services
- Morton Health Care
- Planned Parenthood
- Take Charge Program
- Take Control
- Tulsa Cares
- Tulsa Health Department
- Xavier Clinic

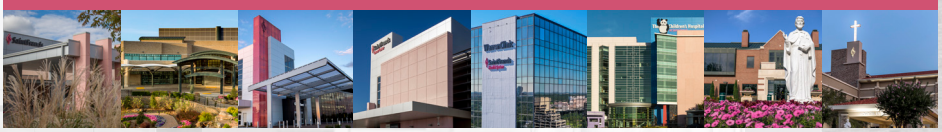
Substance Abuse

- 12 and 12
- AA/NA
- Adult and Teen Challenge
- CALM Center
- Celebrate Recovery
- COPES
- Family and Children's Services
- Health Systems
- Healthy Minds Policy Initiative
- Laureate
- LIBR
- Medication Assisted Treatment Program
- Morton Comprehensive Health Services
- Morton Health Care
- National Center for Wellness Recovery
- ODMHSAS
- OSU
- OSU Addiction Medicine Clinic
- OSU Center for Wellness and Recovery
- Parkside
- Rightway Methadone Clinic
- Sangha
- Substance Use Programs
- Synergy Tulsa Employee Assistance Program
- TBHC
- Tulsa Health Department
- Valley Hope
- Women in Recovery
- Youth Services of Tulsa

Tobacco Use

- 1-800-Quit-Now
- Morton Comprehensive Health Services
- Morton Health Care
- Oklahoma State Tobacco Programs
- Oklahoma Tobacco Text Program
- TSET
- Tulsa Health Department

APPENDIX



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.