

FY 2017-FY 2019

St. John Health System

Implementation Strategy

Prepared by:



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Tulsa County Community Health Needs Assessment Survey Respondents

Tulsa County Community Health Needs Assessment Focus Group Participants

Washington County Health Department

Washington County Wellness Initiative Community Assessment Survey Respondents

ST. JOHN HEALTH SYSTEM IMPLEMENTATION STRATEGY

STRATEGY NARRATIVE

Overview

Meeting the healthcare needs of the community lies at the heart of the St. John mission. St. John Health System is dedicated to improving the health of the communities we serve, especially those deemed most vulnerable among us. In order to ensure our efforts will impact the health of our communities, St. John Health System recognizes the importance of following a systematic approach to understanding community needs and to develop strategic plans for addressing identified needs. Accordingly, St. John Health System conducts community health needs assessments of the communities we serve every three years. This assessment of community health needs and assets identifies the significant health needs and provides reference for the organization's response to those needs. This response is otherwise known as an implementation strategy or community health improvement plan. Together, community health assessments and implementation strategy work to align organizational initiatives, programs, and activities to improve the health of the communities we serve.

The importance of assessing community health needs and developing an implementation strategy to address prioritized needs was reinforced by the passage of the Patient Protection and Affordable Care Act (Affordable Care Act, ACA) in 2010. The ACA requires not-for-profit 501(c) (3) healthcare organizations to satisfy certain requirements in order to remain tax-exempt. To comply with federal tax-exemption requirements, a tax-exempt hospital facility must conduct a community health needs assessment every three years and adopt an implementation strategy to meet the community health needs identified through the assessment.

The community health needs assessment process is a powerful tool possessing the potential to be catalyst for immense community change. The assessment process helps to identify the most pressing needs and assets of our communities, build relationships with community partners, and direct resources where they are most needed. Through collaboration with community stakeholders and partner organizations, this community-driven process has the potential to enhance program effectiveness, leverage limited resources, and strengthen communities.

St. John Health's System's six northeastern Oklahoma member hospitals (St. John Medical Center, St. John Broken Arrow, St. John Owasso, St. John Sapulpa, Jane Phillips Medical Center, and Jane Phillips Nowata Health Center) conducted the first set of community health needs assessments in 2013. Over the past three years the health system and its member hospitals have worked to address a set of prioritized health needs based on actions outlined in the implementation strategy plans.

The recurring process of updating assessments and the implementation strategy reflects changes in the health of the communities we serve over time and helps to ensure ongoing improvement efforts are based on the needs of our communities. An updated set of community health needs assessments were conducted by St. John Health System's six northeastern Oklahoma hospitals in 2016. A St. John Health System implementation strategy was developed in response to priority health needs identified in the community health needs assessments to be addressed during the 2017-2019 fiscal years. The first set of community health needs assessments and implementation strategy provided a baseline and historical perspective related to some of the same elements assessed in 2016.

The findings of each hospital's 2016 community health needs assessment have been compiled in written summary reports and posted online on the [St. John Health System website](#). This FY 2017- FY 2019 Implementation Strategy provides a comprehensive overview of how each hospital and St. John Health System will work to address the priority health needs identified by our hospitals' community health needs assessments. Some measures in this publication are applicable to the entire health system while other measures are specific to each of the facilities.

OUR HEALTH SYSTEM

Ascension

Ascension is a faith-based healthcare organization dedicated to transformation through innovation across the continuum of care. As the largest non-profit health system in the U.S. and the world's largest Catholic health system, Ascension is committed to delivering compassionate, personalized care to all, with special attention to persons living in poverty and those most vulnerable. In fiscal year 2015, Ascension provided nearly \$2 billion in care of persons living in poverty and other community benefit programs. Approximately 160,000 associates and 36,000 aligned providers serve in 2,000 sites of care – including 137 hospitals and more than 30 senior living facilities – in 24 states and the District of Columbia.

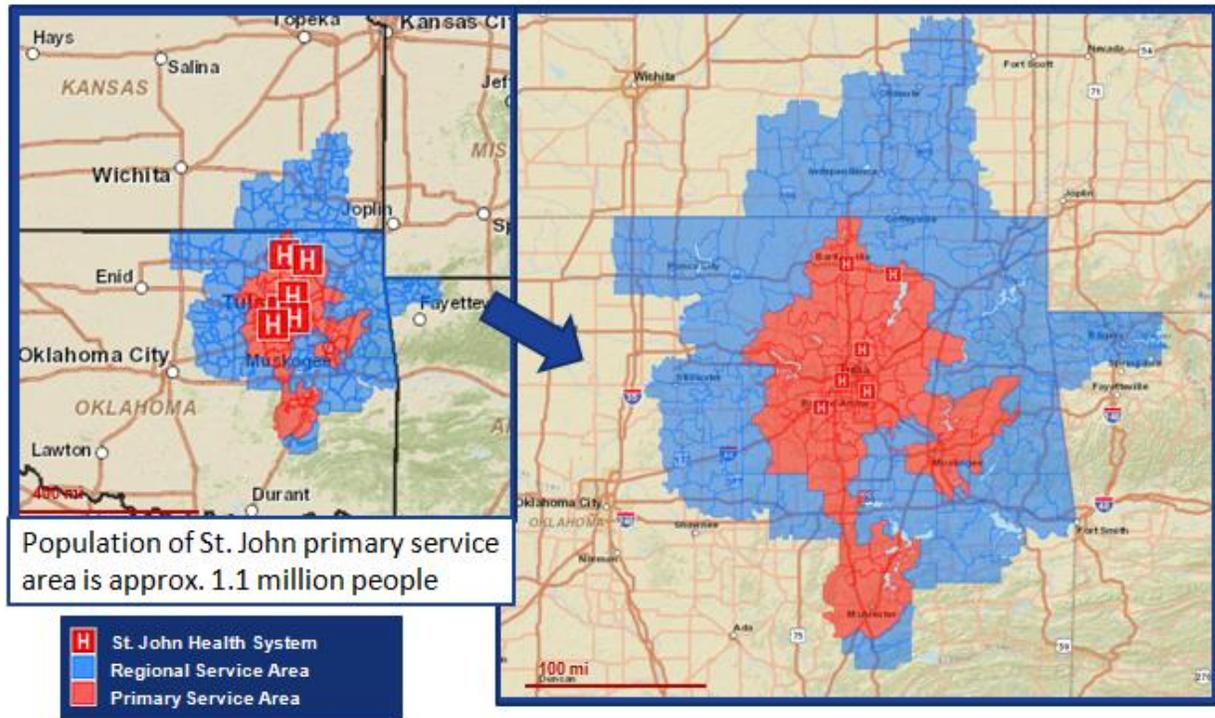
St. John Health System

Established in 1926 with the opening of St. John's Hospital (now St. John Medical Center) in Tulsa, Oklahoma, St. John Health System is a fully-integrated healthcare delivery system encompassing seven hospitals in northeastern Oklahoma and southern Kansas. 2016 marks the 90th anniversary of the founding of St. John in Tulsa by our legacy sponsors, the Sisters of the Sorrowful Mother. Now as part of Ascension Health, St. John Health System has access to additional resources to help us continue to transform the quality of care we provide to our patients.

St. John Health System is organized as a tax-exempt integrated healthcare delivery system. Our mission is to continue the healing ministry of Jesus Christ by providing medical excellence and compassionate care to all those we serve, especially persons living in poverty or who are otherwise deemed vulnerable. Ascension and St. John Health System together are focused on delivering health care that is safe, health care that works and health care that leaves no one behind. We are working to transform health care delivery in the nation to provide high-quality, cost-effective care that is safe and which emphasizes wellness and prevention as well as episodic care.

St. John Health System serves as an important safety net provider of a broad continuum of healthcare services to the citizens of northeastern Oklahoma and the surrounding region. The health system’s service area contains 260 ZIP codes in 32 counties in Oklahoma, Kansas, and Arkansas. The health system’s primary service area is approximately 1.1 million people (Figure 1). The six main hospitals owned by St. John Health System are located in northeastern Oklahoma and together possess approximately 800 beds in service. Each of these six hospitals operates a full-service, 24-hour, 365-day emergency room providing both urgent and emergency care to all individuals, regardless of their ability to pay.

Figure 1: St. John Health System Service Area



St. John Health System also has an array of partner and subsidiary healthcare facilities. In all, the health system serves more than 3,500 patients every day.

St. John Hospitals:

- St. John Medical Center
- St. John Owasso
- St. John Broken Arrow
- St. John Sapulpa
- Jane Phillips Medical Center
- Jane Phillips Nowata Health Center
- Sedan City Hospital

Other St. John Facilities:

- St. John Clinic
- St. John Villas senior living centers
- St. John Urgent Care centers
- Regional Medical Laboratory (RML)

- A variety of outpatient treatment centers

St. John Health System owns and operates St. John Clinic which operates as a multi-specialty physician clinic. A team of more than more than 500 physicians and mid-level providers are employed by St. John Clinic. Additionally, St. John Clinic serves patients in over 95 clinic locations, including urgent care clinics, throughout northeastern Oklahoma and southeastern Kansas.

St. John Health System touches the lives of thousands of patients every day:

- More than 60,000 annual hospital admissions, including 19,000 “observation” patients
- More than 35,000 annual surgeries performed in St. John hospitals. St. John also is a minority owner in two ambulatory surgery centers that perform more than 28,000 annual outpatient surgeries
- More than 3,600 annual births at St. John hospitals
- More than 160,000 annual patient visits to St. John hospital emergency departments
- More than 60,000 annual urgent care visits to St. John urgent care clinics
- Nearly 500,000 annual patient visits to St. John Clinic physician offices
- RML performs more than 9 million annual laboratory tests

ORGANIZATION MISSION

Our mission guides everything we do at St. John and Ascension. It is foundational to our work to transform healthcare and express our priorities when providing care and services, particularly to those most in need. As the health system develops initiatives to address needs within the communities we serve, we strive to ensure that our mission is maintained and promoted.

Mission

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

St. John Medical Center

Established in 1926, St. John Medical Center is St. John Health System’s flagship hospital. Located in Tulsa, Oklahoma, the full-service tertiary hospital provides a broad range of inpatient and outpatient services and is nationally and regionally recognized for its services. St. John Medical Center is an important referral center for many forms of advanced medical for the entire northeast Oklahoma region. The medical center offers advanced services in trauma, neurological and neurosurgical (including stroke) care, cardiology and cardiothoracic surgery, kidney transplant, adult, pediatric and neonatal intensive care, cancer treatment, joint replacement, and many other areas. St. John Medical Center has 543 beds in service, including 20 normal newborn bassinets.

St. John Medical Center is northeastern Oklahoma's only accredited level II trauma center and the area's only joint commission-accredited comprehensive stroke center. Additionally, it is northeastern Oklahoma's only "magnet" accredited hospital, signifying excellence in nursing care.

St. John Medical Center touches the lives of thousands of patients every day:

- More than 40,000 annual hospital admissions, including "observation" patients.
- More than 20,000 annual surgeries performed at St. John Medical Center.
- More than 2,200 annual births at St. John Medical Center.
- More than 64,000 annual patient visits to St. John Medical Center emergency department.
- More than 155,000 "other" patient visits each year for diagnostic testing and treatment.

St. John Medical Center Accomplishments and Awards:

- Fourth consecutive year (2013-2016), American Heart Association/American Stroke Association Get with The Guidelines Gold Plus Award for St. John Heyman Stroke Center
- Magnet® re-designation from the American Nurses Credentialing Center for excellence in nursing services (2015; original designation in 2010)
- Named a certified member of MD Anderson Cancer Network® (2014)
- Only eastern Oklahoma hospital named in *U.S. News & World Report's* "Oklahoma' Best Hospital" list (2014)
- Recently named one of the top 50 U. S. hospitals for cardiovascular surgical excellence

Jane Phillips Medical Center

Jane Phillips Medical Center in Bartlesville, Oklahoma, is a nonprofit healthcare organization and acute care hospital offering a full range of services to northeastern Oklahoma and southern Kansas. After becoming affiliated with St. John Health System in 1996, Jane Phillips Medical Center became fully sponsored by St. John System in 2002. A board of directors governs the hospital and ensures that medical services are available to the residents of Bartlesville and surrounding areas.

Offering both inpatient and outpatient services, Jane Phillips' innovative treatments and preventive healthcare measures range from cardiac rehabilitation, cancer treatments, and heart and vascular services to labor and delivery, pulmonary, surgical and wellness care. As part of Jane Phillips Medical Center, the hospital is licensed for 137 beds and operates a 24-hour Emergency Department. People of all ages and races, men and women receive precision care at Jane Phillips every day, regardless of the way they are able to pay.

Jane Phillips Medical Center touches the lives of thousands of patients every day:

- More than 6,600 annual hospital admissions, including "observation" patients.
- More than 5,000 annual surgeries performed.
- More than 650 annual births.
- More than 34,000 annual patient visits to Jane Phillips Medical Center emergency department.
- More than 67,000 annual "other" patient visits for diagnostic testing and treatment.

Jane Phillips Medical Center Accomplishments and Awards:

- ACTION Registry-Get with The Guidelines Platinum Performance Achievement Award from the National Cardiovascular Data Registry (2015)
- Jane Phillips Medical Center/St. John Clinic BlueStem Cardiology earn Gold Quality Achievement Award from the American Heart Association (2014)
- Mission: Lifeline® Receiving Center-Silver Recognition Award from the American Heart Association (2014)
- Named a certified member of MD Anderson Cancer Network® (2014)

St. John Owasso

St. John Owasso is a 36-bed facility located in one of Oklahoma’s fastest-growing cities. Opened in 2006, it was Owasso’s first hospital. The facility features a 24-hour Emergency Department, medical-surgical and women’s units, and offers patient appointments for urgent care in its emergency center.

St. John Owasso's Center for Women's Health includes a full-service labor and delivery unit, postpartum rooms and a newborn nursery. A medical office building connected to the hospital offers easy access to services for patients and physicians.

St. John Owasso touches the lives of patients every day:

- More than 3,000 annual hospital admissions, including “observation” patients.
- More than 1,400 annual surgeries performed.
- More than 400 annual births.
- More than 22,000 annual patient visits to SJO emergency department.
- More than 37,000 “other” annual patient visits for diagnostic testing and treatment.

St. John Broken Arrow

St. John Broken Arrow is a six-story, 68 bed facility located in the city of Broken Arrow, Oklahoma’s fourth-largest city. The hospital, which opened September 15, 2010, offers a wide range of healthcare services, including a 24-hour Emergency Department, orthopedic services, general surgery and all-digital diagnostic imaging services. In addition, the facility is home to two medical-surgical floors and an emergency center with air ambulance capabilities. A medical office building connected to the hospital offers easy access to services for patients and physicians.

The facility additionally features the Center for Joint Replacement, specializing in knee and hip replacement. For the third consecutive year, St. John Broken Arrow has been recognized by Healthgrades as one of America’s 100 best hospitals for joint replacement. St. John Broken Arrow also received the Healthgrades Joint Replacement Excellence Award™, was named among the top 5 percent in the nation for joint replacement and received five-star ratings for total knee and total hip replacements.

St. John Broken Arrow touches the lives of thousands of patients every day:

- More than 4,500 annual hospital admissions, including “observation” patients.
- More than 3,200 annual surgeries performed.

- More than 24,000 annual patient visits to St. John Broken Arrow emergency department.
- More than 63,000 “other” annual patient visits for diagnostic testing and treatment.

St. John Broken Arrow Accomplishments and Awards:

- Healthgrades 100 Best Hospitals for Joint Replacement™ (2014-2016)
- Recipient of the Healthgrades Joint Replacement Excellence Award™ (2014-2016)
- No. 1 ranking, 100 SafeCare Hospitals® Under 100 Beds (2015)
- Named a certified member of MD Anderson Cancer Network® (2014)

St. John Sapulpa

St. John Sapulpa is a 25-bed facility located in Sapulpa, Oklahoma. St. John Sapulpa joined the St. John Health System in 1997 with the acquisition of Bartlett Memorial Hospital. The facility was renamed St. John Sapulpa in 2000. Designated as a Critical Access Hospital, the St. John Sapulpa offers Creek County residents to much needed quality medical care, including a fully equipped (24 hours, 365 days per year) emergency center and the capability to accept acute patients.

St. John Sapulpa offers full-service primary care as well as gastroenterology, general surgery, ophthalmology and podiatry. In addition, it provides swing-bed care - skilled nursing care plus the benefit of “rehabilitation” therapies to help patients transition to home or a long term care facility. Swing beds can also be utilized to help rehabilitate from surgery, illness or accident.

St. John Sapulpa touches the lives of patients every day:

- More than 1,400 annual hospital admissions, including “observation” patients.
- More than 200 annual surgeries performed.
- More than 19,000 annual patient visits to St. John Sapulpa emergency department.
- More than 18,000 annual other patient visits for diagnostic testing and treatment

Jane Phillips Nowata Health Center

Jane Phillips Nowata Health Center, part of the St. John Health System, is located in Nowata, Oklahoma. Founded in 1946, it was the first hospital financed through the Hill-Burton Act. The 25-bed facility has been part of the regional system of care that includes Jane Phillips Medical Center (also part of the St. John Health System) in Bartlesville since 1989.

Jane Phillips Nowata Health Center serves as an important provider of healthcare services to northeastern Oklahoma, particularly in the Nowata County area, as it is the only hospital located within the county geographical boundaries. Designated as a Critical Access Hospital, Jane Phillips Nowata Health Center provides much needed health services to the community. The facility provides emergency services 24 hours a day, seven days a week. Other services provided include acute inpatient care and on-site laboratory and radiology services (X-ray, ultrasound, and CT). In addition, it provides swing-bed care - skilled nursing care plus the benefit of “rehabilitation” therapies to help patients transition to home or a long term care facility. Swing beds can also be utilized to help rehabilitate from surgery, illness or accident.

Jane Phillips Nowata serves as an important safety net role for northeastern Oklahoma:

- Approximately 100 annual hospital admissions.
- More than 2,300 annual patient visits to Jane Phillips Nowata emergency department
- Approximately 2,000 annual other patient visits each year for diagnostic testing and treatment

Jane Phillips Nowata Health Center Accomplishments:

- First CT scanner installed (2015)

COMMUNITIES SERVED

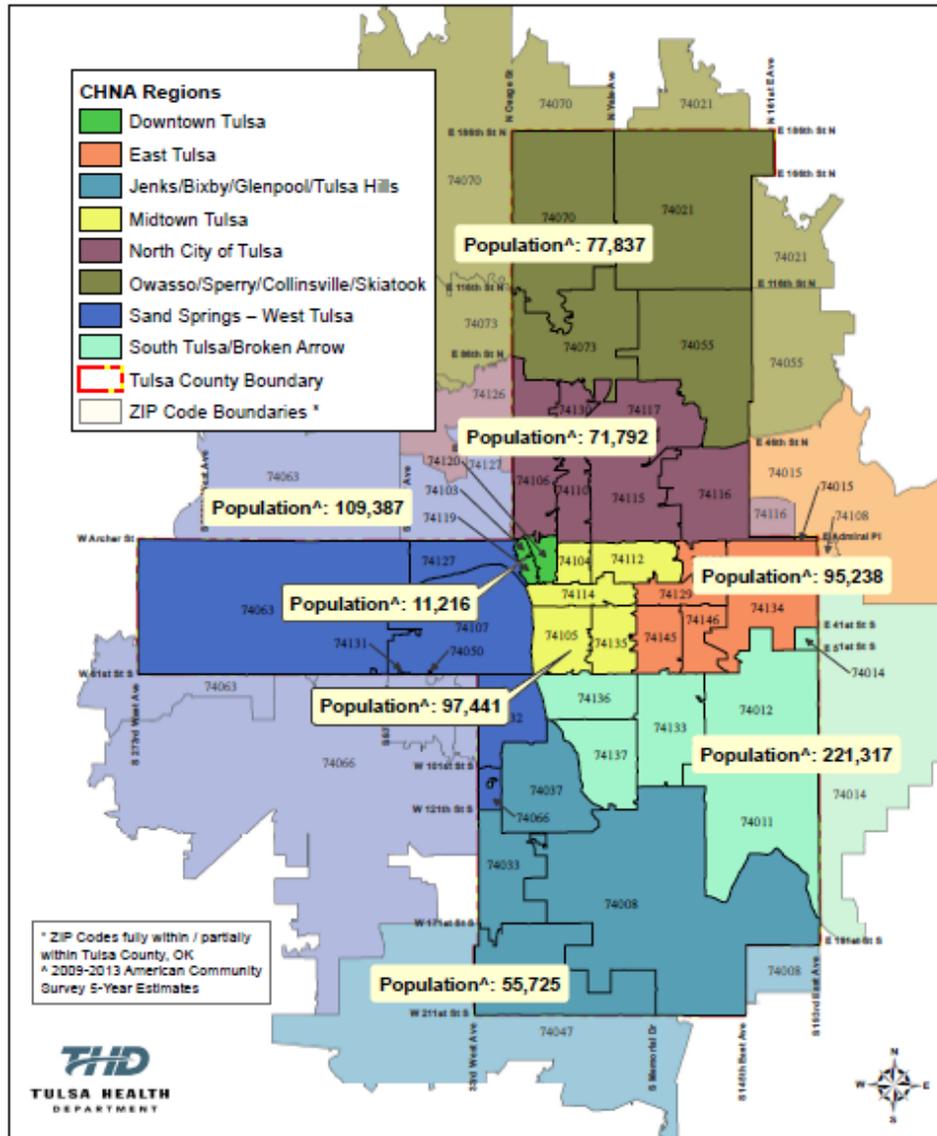
The definition of the communities served by the health system’s six hospitals provided the foundation on which our assessment and subsequent implementation strategy decisions were made. In defining the communities served, the following was taken into consideration:

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

Tulsa County

St. John Medical Center, St. John Owasso, and St. John Broken Arrow serve the entire northeastern Oklahoma region, as well as parts Kansas, and Arkansas. The primary service area is Tulsa County and the surrounding counties. For the purposes of the community health needs assessment process, however, the community served by St. John Medical Center, St. John Owasso, and St. John Broken Arrow includes all of Tulsa County, Oklahoma. The decision to focus on the geopolitical definition of Tulsa County was largely influenced by the fact that a significant number of patients utilizing the hospitals’ services reside in Tulsa County. For our assessment process, Tulsa County was divided into eight geographical regions based on ZIP codes and associated communities: downtown Tulsa, east Tulsa, Jenks/Bixby/Glenpool/Tulsa Hills, midtown Tulsa, north City of Tulsa (Tulsa North), Owasso/Sperry/ Collinsville/Skiatook, Sand Springs/west Tulsa, and south Tulsa/Broken Arrow (Figure 2).

Figure 2: 2016 Tulsa County Community Health Needs Assessment Regions Map



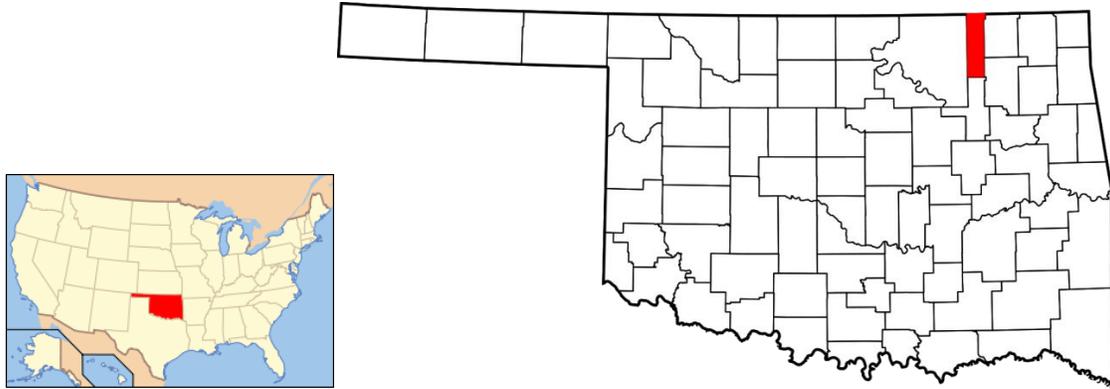
Source: Courtesy of the Tulsa Health Department. (2016). *Tulsa County Community Health Needs Assessment: May 2016*. Retrieved from: http://www.tulsahealth.org/sites/default/files/page_attachments/CHNA%20report_4_15_16-compressed.pdf

Washington County

Jane Phillips Medical Center serves the entire northeastern Oklahoma region, as well as parts Kansas and Arkansas. The primary service area is Washington County and the surrounding counties. Although, Jane Phillips Medical Center serves patients who live throughout the northeastern Oklahoma region and beyond, the community served for purposes of the community health needs assessment process is defined as Washington County, Oklahoma (Figure 3). The decision to focus on the geopolitical definition

of Washington County was largely influenced by the fact that a significant number of patients utilizing Jane Phillips Medical Center’s services reside in Washington County.

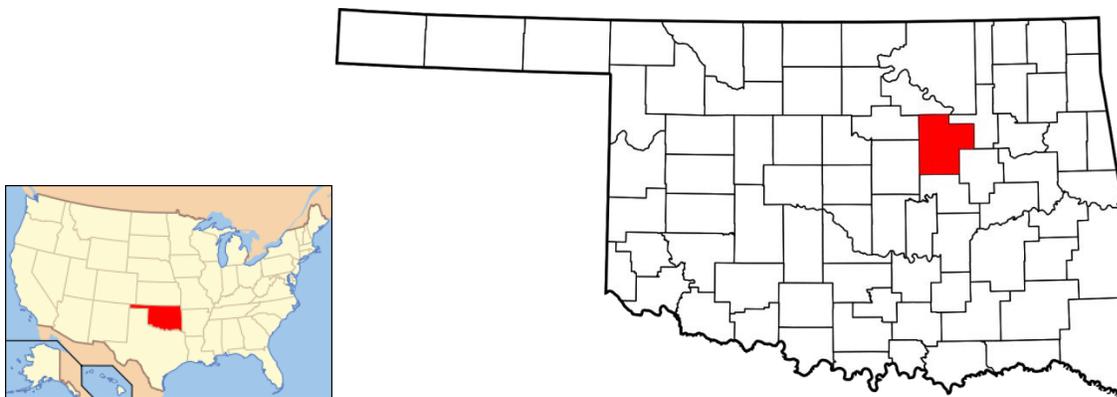
Figure 3: Washington County, Oklahoma Map



Creek County

St. John Sapulpa is a growing community hospital serving northeastern Oklahoma. The primary service area is Creek County and the surrounding counties. Although, St. John Sapulpa serves patients who live throughout the northeastern Oklahoma region and beyond, the community served for purposes of the community health needs assessment process is defined as Creek, County, Oklahoma (Figure 4). The decision to focus on the geopolitical definition of Creek County was largely influenced by the fact that a significant number of patients utilizing St. John Sapulpa’s services reside in Creek County.

Figure 4: Creek County, Oklahoma Map

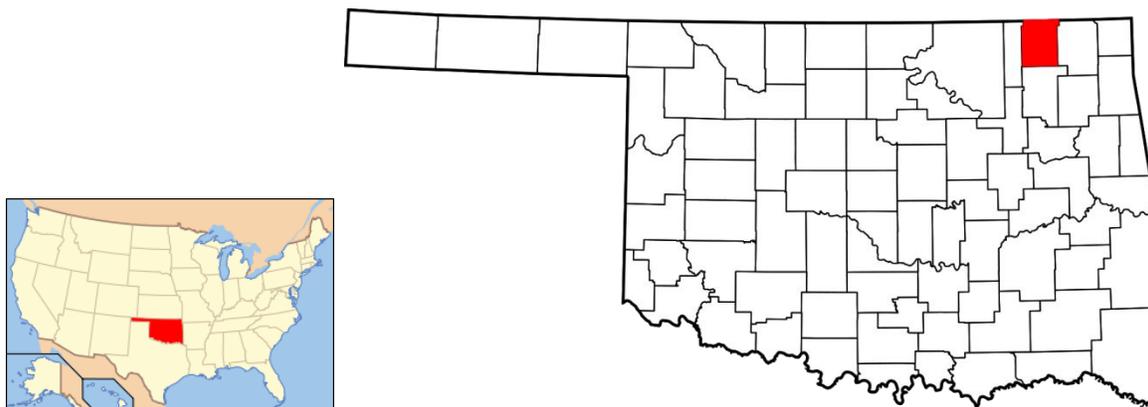


Nowata County

Jane Phillips Nowata Health Center serves the northeastern Oklahoma region, as well as parts Kansas and Arkansas. The primary service area is the city of Nowata, Nowata County, and the surrounding

counties. Although, Jane Phillips Nowata Health Center serves patients who live throughout the northeastern Oklahoma region and beyond, the community served for purposes of the community health needs assessment process is defined as Nowata County, Oklahoma (Figure 5). The decision to focus on the geopolitical definition of Nowata County was largely influenced by the fact that a significant number of patients utilizing Jane Phillips Nowata Health Center’s services reside in Nowata County.

Figure 5: Nowata County, Oklahoma Map



COMMUNITY ENGAGEMENT & COLLABORATION

Tulsa County Partners

St. John Health System and its three hospitals located within Tulsa County, St. John Broken Arrow, St. John Medical Center, and St. John Owasso, engaged the Tulsa City-County Health Department, a community-wide coalition known as Pathways to Health (P2H), the Community Service Council, and a multitude of other community partner organizations throughout the community health needs assessment process. The health system and three Tulsa County hospitals worked closely with Tulsa City-County Health Department and these partners to conduct the community health needs assessment.

Central to the Tulsa County community assessments were a survey and focus groups conducted by the Tulsa City-County Health Department, the Oklahoma State University- College of Public Health, and Saxum to obtain direct input from community members. The survey and focus groups are collectively referred to by the Tulsa City-County Health Department and community stakeholders as the *2015-2016 Tulsa County Community Health Needs Assessment (CHNA)*. A number of community stakeholders and local organizations were also engaged in our health system’s three Tulsa County hospital community input meetings at St. John Medical Center, St. John Broken Arrow, and St. John Owasso in April 2016.

Washington County Partners

St. John Health System and Jane Phillips Medical Center, engaged the Washington County Health Department, the Washington County Wellness Initiative (WCWI), and a multitude of other community organizations throughout the community health needs assessment process. The health system and Jane

Phillips Medical Center worked closely with Washington County Health Department, the Washington County Wellness Initiative (WCWI), and these partners to conduct this assessment.

Central to the community assessment was a survey by the Washington County Wellness Initiative (WCWI) to obtain direct input from community members. The survey is referred to by the Washington County Wellness Initiative (WCWI) and community stakeholders as the *2015 Washington County Community Assessment*. A number of community stakeholders and local organizations also engaged in our hospital community input meetings at Jane Phillips Medical Center on April 19, 2016. Workgroup members from the Washington County Wellness Initiative were also engaged to complete a community input survey in May 2016.

Creek County Partners

St. John Health System and St. John Sapulpa engaged the Creek County Health Department, the Oklahoma State Department of Health's Regional Turning Point consultant for Creek County, the Creek County Community Partnership, the Creek County Healthy Living Program and Coalition, and a multitude of other community partner organizations throughout the community health needs assessment process. The health system hospital worked closely with Creek County Health Department and these partners to conduct the community health needs assessment.

Central to the community assessment was the community input received from community members, community representatives and leaders, the public health workforce, and community-based organizations. A number of community stakeholders and local organizations engaged in our hospital community input meeting at St. John Sapulpa on May 5, 2016.

Nowata County Partners

St. John Health System and Jane Phillips Nowata Health Center, engaged the Washington County Health Department (oversees Nowata County), the Nowata Community Advancement Network (CAN), and a multitude of other community organizations throughout the community health needs assessment process. The health system and Jane Phillips Nowata Health Center worked closely with Washington County Health Department and these partners to conduct the community health needs assessment.

Central to the community assessment was the community input received from community members, community representatives and leaders, the public health workforce, and community-based organizations. A number of community stakeholders and local organizations engaged in our health a community input meeting at Jane Phillips Nowata Health Center on May 2, 2016.

OUR APPROACH

Central to our health system's efforts to improve the health of individuals and communities is our focus on promoting health and well-being all persons, and a commitment to health equity and eliminating barriers to good health. Our community health needs assessment process took into account the following:

- A multitude of factors or health determinants influence the health of our community;

- A commitment to assess and address the four determinants of health: clinical care, health behaviors, physical environment, and socioeconomic factors;
- Addressing health disparities, health equity, and social determinants of health through community building and improvement initiatives is an important component of improving the health of the community;
- Our health and well-being are products of not only the health care we receive, but also the places where we live, learn, work, and play;
- Zip codes can mean more to health than genetic codes;
- A focus on identifying geographic areas of greatest need helps to better understand at-risk and vulnerable populations;
- The importance of incorporating information on the health and well-being of priority populations, or those most in need;
- Working together has a greater impact than working alone; and
- Engaging the community and joining forces with community stakeholders allows all involved to share in the experience of understanding community health needs and to work collaboratively with the communities we serve.

Priority Populations

Priority populations focused upon in this assessment process included those deemed most vulnerable among us. This includes, but was not limited to: persons living in poverty, children, pregnant women, older adults, uninsured and underinsured individuals, members of ethnic or minority groups, members of medically underserved populations, and persons otherwise deemed vulnerable or at-risk.

IDENTIFYING COMMUNITY HEALTH NEEDS: METHODOLOGY

Our hospitals' community health needs assessments utilized a systematic, data-driven approach to determine the health status, behaviors, and needs of residents of the communities we serve. Community health needs and assets were determined using a combination of secondary and primary data (community input). Data contained in the assessments were obtained through multiple sources and methods designed to gather both qualitative and quantitative information. Data collection methods and sources used in the assessments include the following:

- Comprehensive review of secondary data sources
- Surveys of Tulsa County and Washington County residents
- Focus groups with Tulsa County residents
- Community input survey of Washington County Wellness Initiative workgroup members
- Input from community leaders and representatives
- Input from the public health workforce and local coalitions/partnerships
- Hospital and health system input from our Community Health Needs Assessment (CHNA) Advisory Group and leadership

SIGNIFICANT COMMUNITY HEALTH NEEDS

Primary and secondary data were evaluated and synthesized to identify significant community health needs for the communities served by St. John Health System and its six hospitals. These needs span the following topic areas and are often inter-related:

- Diet, nutrition, and physical activity
- Weight and obesity
- Mental health and mental health disorders
- Chronic disease and management
- Health education, health literacy, and navigation of services
- Access to health services, care coordination, and affordability
- Tobacco use
- Substance abuse
- Suicide
- Economic and social environment
- Education
- Prevention and safety
- Aging problems and care
- Available public transportation
- Children's health
- Child neglect/abuse
- Physical environment
- Health behaviors
- Resource development and awareness
- Mammograms
- Prenatal care and infant mortality
- Teen births
- Veteran's care

The data from our assessments demonstrated that Oklahoma continues to rank near the bottom in multiple key health status indicators. Many of these outcomes are related to conditions that Oklahomans must live with every day. Poverty, lack of insurance, limited access to primary care, and inadequate prenatal care, along with risky health behaviors associated with these determinants, such as low fruit/vegetable consumption, low physical activity, and a high prevalence of smoking contributes to the poor health status of our citizens. Diabetes, hypertension, obesity, physical activity and nutrition, and tobacco use are risk factors associated with heart disease and cancer, the leading causes of death in Oklahoma. Greater socioeconomic need and health impacts are found among certain populations and geographic areas. These areas and populations with high socioeconomic need are also the most affected by health problems, as evidenced by significantly worse health outcome measures, higher hospitalization rates, and myriad health challenges.

IMPLEMENTATION STRATEGY PROCESS

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

1. Describes how the hospitals' and health system will plan to meet each identified health need; or
2. Identifies certain health needs as ones the hospitals' and health system does not intend to address and explains why the hospital does not intend to address the health need.

St. John Health System's implementation strategy *process* included the following steps:

- Planning and preparation for the implementation strategy;
- Development of goals and objectives and identification of indicators for addressing community health needs;
- Consideration of approaches to address prioritized needs;
- Selection of approaches;
- Integration of implementation strategy with community and hospital plans;
- Development of a written implementation strategy;
- Adoption of the implementation strategy by hospital and health system boards; and
- Ongoing updates and modifications to sustain the implementation strategy.

The *product* is this written summary of the implementation strategy which includes plans for how St. John Health System and its hospitals will address identified community health needs. This FY 2017- FY 2019 Implementation Strategy provides a comprehensive overview of how each hospital and St. John Health System will work both jointly and independently to address the priority health needs identified by our hospitals' community health needs assessments. Some measures in this publication are applicable to the entire health system while other measures are specific to each of the facilities.

Implementation Strategy Team

The input of hospital leadership and associates, community members and groups, and public health experts is vital to the design and completion of an effective implementation strategy. Accordingly, a team consisting of hospital staff, clinic staff, administrators, and community partners was formed to oversee the development of our implementation strategy under the direction of the Community Health Special Projects Manager, Chief Strategy Officer, and other health system leadership. An existing Community Health Needs Assessment (CHNA) Advisory Group and Community Engagement Committee consisting of key associates and health system leadership also provided input on the process and final product developed.

Strategy Development

The Implementation Strategy team worked together to develop goals, objectives, and indicators to address selected significant community health needs. The team also selected strategies to address

priority needs. In order to select strategies most likely to succeed, the team followed an approach which encompassed the following guidelines:

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

Adoption and Reporting

Upon completion, this implementation strategy was formally adopted by each of our six hospital facility boards and our health system board in September and October of 2016. In order to fulfill public reporting requirements, the strategy is posted and housed on our [health system website](#).

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

PRIORITIZED NEEDS

St. John Health System and its hospitals called together key hospital and health system associates and leadership, community leaders and representatives, and public health experts to prioritize the significant community health needs of the communities we serve considering several criteria:

- Magnitude and severity of health need;
- Opportunity to intervene at a prevention level;
- Circle of influence and ability to impact change;
- Existence of evidence-based approaches for addressing needs;
- Alignment with hospital and health system strategies and programming;
- Alignment and support from the communities served;
- Existing resources and assets both in the hospitals in the community; and
- Capacity to address underserved populations well as populations deemed vulnerable.

A comprehensive review and analysis of secondary data sources was performed to determine the magnitude and severity of health needs for each community served. An analysis of primary data from the following sources was also utilized to further determine priority health needs for each of the communities served:

- Community surveys and focus groups with residents (Tulsa County and Washington County);
- Prioritization survey of Washington County Wellness Initiative workgroup members;

- Prioritization survey of hospital leadership and Community Health Needs Assessment Advisory Group members; and
- Community input meeting feedback exercises including a nominal group exercise performed with community leaders and representatives, local coalitions and partnerships, and public health experts to prioritize significant health needs as identified.

Each of the communities we serve have unique health needs and assets. However, unmet behavioral health, chronic disease management needs, health education and literacy needs, economic development, and healthy behavior supports are recurring themes for our communities as supported by our secondary data review and community input. Accordingly, there are four overarching health needs that were identified as priority health needs to address.

Priority Health Needs:

1. Access to Care
2. Behavioral Health
3. Wellness and Chronic Disease Prevention
4. Health Literacy

NEEDS THAT WILL NOT BE ADDRESSED

The community health needs assessment inevitably identified more significant health needs than the hospitals, health system, and community partners can or should address as priority health needs. It would not be prudent to spread hospital and community resources across too many initiatives. Accordingly, the hospitals, health system, and community partners instead decided to focus attention on priority areas to help ensure sufficient resources are available. Some reasons for not addressing certain needs include:

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

The following significant health need was identified, but will not be addressed directly by the health system as a priority health need:

- **Tobacco use and cessation:** The community identified this need as one that was already being sufficiently addressed at the time and did not feel issue was as pressing other needs identified (this was a change in perspective from our previous community health needs assessment process in 2013 when the need was identified as a priority need). It is important that note that, although not a priority health need for the purposes of this process, the hospitals and health system will continue existing activities regarding tobacco use and cessation.

While not necessarily noted as one of our four priority health needs, the remainder of significant community health needs were considered to be closely inter-related with the priority needs. So while, they may not be explicitly listed as a priority health need, the hospitals and health system do feel confident that the needs are being addressed by virtue of addressing the four selected priority health needs.

Summary of Implementation Strategy

An action plan follows for each prioritized need, including the resources, proposed actions, planned collaboration, and anticipated impact of each strategy.

Prioritized Need #1: Access to Care

GOAL 1: Improve access as needed for healthcare services in solidarity with those living in poverty and/or deemed otherwise vulnerable.

Action Plan

STRATEGY 1: Increase the number of uninsured, low-income, and underserved persons who have access to primary care.

BACKGROUND INFORMATION:

- The strategy's target population is the uninsured, underinsured, and persons living in poverty accessing services through the Tulsa Day Center for the Homeless Clinic in Tulsa, Oklahoma.
- Increasing access to care among uninsured, low-income persons promotes health equity, addresses social determinants of health and reduces health disparities and barriers to care that are often experienced by the target population.
- The strategy is a system change and is informed by evidence found on What Works for Health and The Guide to Community Preventive Services.

RESOURCES:

- St. John Health System (SJHS)
- St. John Health System (SJHS) Medical Access Program (MAP)
- MAP Program Budget – labor consisting of clinical coordinator, data analyst, claims processor, director, support staff
- MAP Program Budget – includes occupancy, general & administrative
- Tulsa Day Center for the Homeless Clinic (TDCHC)

COLLABORATION:

- Tulsa Day Center for the Homeless (TDCH)

ACTIONS:

1. Identify opportunities for increasing available hours to improve patient access to primary care providers at the Tulsa Day Center for the Homeless Clinic.
2. Evaluate current staff availability for the increased need among patients to access primary care services.
3. Determine funding for any additional staffing needs.
4. Prepare budget request to be presented for review and approval.

STRATEGY 1: Increase the number of uninsured, low-income, and underserved persons who have access to primary care.

5. Develop new Tulsa Day Center for the Homeless Clinic schedule demonstrating increased access hours to primary care providers.
6. Funding is dispensed from St. John Health System and Medical Access Program (MAP) to manage the increased access and acuity (e.g. hiring of primary care physician, staff training, and supplies).
7. Educate staff on healthcare resources for patient care available through Medical Access Program (MAP).

ANTICIPATED IMPACT:

- I. **Short-Term:** By June 30, 2017, improve Tulsa Day Center for the Homeless Clinic staff awareness of resources available for patient care by 90% as measured by a staff survey conducted by the Medical Access Program (MAP).
- II. **Medium-Term:** By June 30, 2017, decrease the number of Tulsa Day Center for Homeless Clinic staff referrals for EMSA ambulance assistance by 10% as measured by the Tulsa Day Center for the Homeless Clinic activity report comparing FY 2016 with FY 2017.
- III. **Medium-Term:** By June 30, 2017, increase by 25% (threshold=10%) the number of hours available for primary care access at the Tulsa Day Center for the Homeless Clinic as measured by the quarterly Tulsa Day Center for the Homeless Clinic activity reports comparing FY 2017 with FY 2016 available hours.
- IV. **Long-Term:** By 2020, contribute to efforts to reduce the percentage of persons who are unable to obtain or delay in obtaining necessary medical care from 4.7% in 2007 to 4.2% in 2020 as measured by MEPS and AHRQ (national) data.
- V. **Long-Term:** By 2020, contribute to efforts to increase the percentage of U.S. persons with a usual source of primary care from 76.3% in 2007 to 83.9% in 2020 as measured by MEPS and AHRQ (national) data.
- VI. **Long-Term:** By 2020, contribute to efforts to increase the percentage of U.S. adults aged 18-64 years who have a specific source of ongoing care from 81.3% in 2008 to 89.4% in 2020 as measured by NHIS and CDC/NCHS (national) data.

Alignment with Local, State & National Priorities (Long-Term Outcomes for Prioritized Need #1, Goal #1, Strategy #1)

OBJECTIVE:	LOCAL / COMMUNITY PLAN:	STATE PLAN:	“HEALTHY PEOPLE 2020” (or OTHER NATIONAL PLAN):
IV-VI	<p>The 2016 Community Health Needs Assessment conducted by St. John Health System and community partners identified Access to Care as one of the priority health needs. This was based on community surveys (Tulsa County Health Department and Washington County Wellness Initiative) and focus groups of residents (Tulsa County Health Department) as well as community input meetings at each hospital with community leaders and representatives.</p>	<p>The Oklahoma Health Improvement Plan (OHIP): Healthy Oklahoma 2020 highlighted Access to Health Care as a key strategic area to improve. The plan reported that one in four Oklahoma adults (ranked 35th state in the nation) reported they did not have a usual source of care in 2014. Additionally, the plan reported the state only had 84.8 primary care physicians per 100,000 population (48th in the nation) in 2014.</p>	<p>HealthyPeople 2020 identified Access to Health Services as one of the primary objectives for targeted improvement. One indicator includes the reduction of the proportion of persons who are unable to obtain or delay in obtaining necessary medical care from 4.7% in 2007 to 4.2% in 2020. Indicators also include increasing the proportion of adults with a specific source of ongoing care and with a usual primary care provider.</p>

Action Plan

STRATEGY 2: Increase access to an ongoing source of primary care and preventive services for persons who are uninsured, underinsured, and/or living in poverty through services offered at the St. John Medical Access Clinic (MAC).

BACKGROUND INFORMATION:

- The strategy's target population are persons who are uninsured, underinsured, and/or living in poverty accessing services through the St. John Medical Access Clinic (MAC).
- Increasing access to primary care and preventive care among persons who are uninsured, underinsured, and/or living in poverty promotes health equity, addresses social determinants of health, and reduces health disparities and barriers to care that are often experienced by the target population.
- The strategy is a system change and is informed by evidence found on What Works for Health and The Guide to Community Preventive Services.

RESOURCES:

- St. John Health System (SJHS)
- St. John Clinic
- St. John Medical Access Clinic (MAC)
- Medical Access Program (MAP) Administration
- Labor consisting of a director of operations, an office manager, a physician, an advanced nurse practitioner, a social worker, and medical support staff
- MAC program budget
- MAC facility space and occupancy
- Data sources
- St. John Clinic Community Relations
- MAC Mission and Vision statement
- Mammograms
- Referral sources and free community clinics
- MedWeb (St. John Health System interweb)

COLLABORATION:

- Free community clinics

ACTIONS:

1. Complete on-boarding and orientation of newly hired social worker to support clinic.
2. Recruit and hire, and complete on-boarding and orientation of an office manager to support clinic.
3. Complete on-boarding and orientation of newly hired Nurse Practitioner to support clinic growth and improved access.
4. Re-evaluate target population, logistics, rules of engagement, and goals of MAC through meetings with health system, St. John Clinic, MAC leadership, and MAC medical staff.

STRATEGY 2: Increase access to an ongoing source of primary care and preventive services for persons who are uninsured, underinsured, and/or living in poverty through services offered at the St. John Medical Access Clinic (MAC).

5. Establish a revised MAC Mission and Vision statement and work to familiarize and orient MAC leadership and medical staff to statement.
6. Educate MAC providers and staff on logistics, rules of engagement, and goals of MAC.
7. Educate identified referral sources and free community clinics on eligibility criteria and services offered by MAC.
8. Promote an increased understanding of MAC and services offered among St. John health system and St. John Clinic leadership, providers, and associates on MAC and services offered through MAC information to be housed on the St. John Health System interweb (MedWeb).
9. Re-establish process to provide preventive screenings such as mammograms through MAC.
10. Educate MAC medical staff on promotion of preventive screenings such as mammograms within MAC.
11. Develop processes to track patient wait times and patient attendance at MAC appointments.

ANTICIPATED IMPACT:

- I. **Short-Term:** By July 2017, increase the proportion of Medical Access Clinic (MAC) staff and leadership understanding of the MAC Mission and Vision by 100% upon the creation and dissemination of a new MAC Mission and Vision Statement as measured as St. John Clinic Administration records.
- II. **Medium-Term:** By July 2017, reduce the average wait time experienced by Medical Access Clinic (MAC) patients by 5% as measured by MAC records.
- III. **Medium-Term:** By July 2017, increase the proportion of mammograms among uninsured persons accessing the Medical Access Clinic (MAC) by 3% as measured by St. John Clinic Administration and MAC mammogram records.
- IV. **Long-Term:** By 2020, contribute to efforts to reduce the percentage of persons who are unable to obtain or delay in obtaining necessary medical care from 4.7% in 2007 to 4.2% in 2020 as measured by MEPS and AHRQ (national) data.
- V. **Long-Term:** By 2020, contribute to efforts to increase the percentage of persons with a usual source of primary care from 76.3% in 2007 to 83.9% in 2020 as measured by MEPS and AHRQ (national) data.
- VI. **Long-Term:** By 2020, contribute to efforts to increase the percentage of adults aged 18-64 years who have a specific source of ongoing care from 81.3% in 2008 to 89.4% in 2020 as measured by NHIS and CDC/NCHS (national) data.

Alignment with Local, State & National Priorities (Long-Term Outcomes for Prioritized Need #1, Goal #1, Strategy #2)

OBJECTIVE:	LOCAL / COMMUNITY PLAN:	STATE PLAN:	“HEALTHY PEOPLE 2020” (or OTHER NATIONAL PLAN):
IV-VI	<p>The 2016 Community Health Needs Assessment conducted by St. John Health System and community partners identified Access to Care as one of the priority health needs based on community surveys (Tulsa County Health Department and Washington County Wellness Initiative) and focus groups of residents (Tulsa County Health Department) as well as community input meetings at each hospital with community leaders and representatives.</p>	<p>The Oklahoma Health Improvement Plan (OHIP): Healthy Oklahoma 2020 highlighted Access to Health Care as a key strategic area to improve. The plan reported that one in four Oklahoma adults (ranked 35th state in the nation) reported they did not have a usual source of care in 2014. Additionally, the plan reported the state only had 84.8 primary care physicians per 100,000 population (48th in the nation) in 2014.</p>	<p>HealthyPeople 2020 identified Access to Health Services as one of the primary objectives for targeted improvement. One indicator includes the reduction of the proportion of persons who are unable to obtain or delay in obtaining necessary medical care from 4.7% in 2007 to 4.2% in 2020. Indicators also include increasing the proportion of adults with a specific source of ongoing care and with a usual primary care provider..</p>
II-VI	<p>Several safety net clinics in the northeastern Oklahoma region have also come together to share information and improve access to care for those living in poverty and who are uninsured or underinsured. This group has worked to create a consolidated clinic list for referrals.</p>		

Action Plan

STRATEGY 3: Improve follow-up care and ensure a safe transition home for patients discharging from St. John Medical Center and Jane Phillips Medical Center who do not have a primary care provider or who cannot get an appointment with their provider through services provided by the facilities' Transitional Care clinics.

BACKGROUND INFORMATION:

- The strategy's target population is patients discharging from St. John Medical Center and Jane Phillips Medical Center who do not have a primary care provider or who cannot get an appointment with their provider and accordingly are in need of additional follow-up services.
- Increasing access to care promotes health equity and addresses social determinants of health, health disparities and barriers to care.
- The strategy is a system change informed by evidence found on What Works for Health.

RESOURCES:

- St. John Health System (SJHS)
- St. John Medical Center (SJMC)
- Jane Phillips Medical Center (JPMC)
- SJMC Transitional Care Clinic
- JPMC Transitional Care Services
- Staff and training
- Labor
- Program budget
- Facility space and occupancy
- Connect calls
- Cerner (Electronic Health Record)
- Motivational Interviewing Training

COLLABORATION:

- University of Oklahoma, Anne and Henry Zarrow School of Social Work (Motivational Interviewing Training expertise)

ACTIONS:

1. Hire and train St. John Medical Center Transitional Care Clinic staff.
2. Open St. John Medical Center Transitional Care Clinic and start seeing patients.
3. Open Jane Phillips Medical Center Transitional Care Services and start seeing patients.
4. Perform connect calls with St. John Medical Center patients to f/u with patients following discharge from the hospital (within one business day of discharge).
5. Bring in external trainer to train staff on Motivational Interviewing techniques.
6. Ensure patients who are without primary care provider or who are unable to get an appointment with their provider have a follow-up visit in the SJMC Transitional Care Clinic 3-5 days after discharge

STRATEGY 3: Improve follow-up care and ensure a safe transition home for patients discharging from St. John Medical Center and Jane Phillips Medical Center who do not have a primary care provider or who cannot get an appointment with their provider through services provided by the facilities' Transitional Care clinics.

7. Ensure patients who are without primary care provider or who are unable to get an appointment with their provider have a follow-up visit in the JPMC Transitional Care Services 7-10 days after discharge.
8. Contact patients discharging from the Skilled Nursing Facilities (SNF) to ensure they have follow-up appointments with their primary care provider, or if they do not have a primary care provider, St. John Medical Center Transitional Care Clinic will see them for a follow- up appointment and get them established with a primary care provider.

ANTICIPATED IMPACT:

- I. **Short-Term:** By July 1, 2018, increase the proportion of Transitional Care Clinic associates who are trained in Motivational Interviewing techniques by 90% as measured by SJMC Transitional Care Clinic and JPMC Transitional Care Services records.
- II. **Medium-Term:** By July 1, 2018 reduce the readmission rate among patients served by the SJMC Transitional Care Clinic and JPMC Transitional Care Services by .5% as measured by the Cerner readmissions report.
- III. **Long-Term:** By July 1, 2019, reduce the readmission rate among patients served by the SJMC Transitional Care Clinic and JPMC Transitional Care Services by an additional 1% as measured by the Cerner readmissions report.
- IV. **Long-Term:** By 2020, contribute to the effort to reduce the Oklahoma rate of preventable hospitalizations by 20% from 2013 (based on 2019 data) as measured by the Oklahoma State Department of Health data.
- V. **Long-Term:** By 2020, contribute to the effort to increase the percentage of adults aged 18-64 years who have a specific source of ongoing care from 81.3% in 2008 to 89.4% in 2020 as measured by NHIS and CDC/NCHS (national) data.

Alignment with Local, State & National Priorities (Long-Term Outcomes for Prioritized Need #1, Goal #1, Strategy #2)

OBJECTIVE:	LOCAL / COMMUNITY PLAN:	STATE PLAN:	"HEALTHY PEOPLE 2020" (or OTHER NATIONAL PLAN):
III-V	The 2016 Community Health Needs Assessment conducted by the St. John Health System identified Access to Care as one of the priority health needs among the communities served by our six hospital facilities. This information was based on community surveys (Tulsa County	The Oklahoma Health Improvement Plan 2020 identified the reduction of preventable hospitalizations as a core Health Transformation measure: Reduce by 20% the rate, per 100,000 Oklahomans, of potentially preventable	HealthyPeople 2020 identified Access to Care as one of the primary objectives for improvement by 2020. Indicators included reduce the proportion of persons who are unable to obtain or delay in obtaining necessary medical care from 4.7% in 2007 to 4.2% in 2020 and increasing the proportion of adults with a

<p>Health Department and Washington County Wellness Initiative) and focus groups with Tulsa County residents (Tulsa County Health Department), as well as community input meetings at each hospital with community leaders and representatives.</p>	<p>hospitalizations from 1656 in 2013 to 1324.8 by 2020 (2019 data).</p>	<p>specific source of ongoing care and with a usual primary care provider by 10%.</p>
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Action Plan

<p>STRATEGY 4: Promote access to affordable health insurance coverage through state legislative advocacy.</p>
<p>BACKGROUND INFORMATION:</p> <ul style="list-style-type: none"> • The strategy’s target population is the uninsured and underinsured in Oklahoma. • These activities address health disparities and barriers to care as well promote health equity by increasing access to affordable health insurance coverage and access to care among persons living in poverty and/or who are otherwise underserved. • The strategy is a policy change informed by evidence found on the Henry J. Kaiser Family Foundation, What Works for Health, and the Guide to Community Preventive Services.
<p>RESOURCES:</p> <ul style="list-style-type: none"> • St. John Health System (SJHS) • SJHS Contract Lobbyist • SJHS Vice President of Government Affairs • Legislative roll calls • Legislative votes
<p>COLLABORATION:</p> <ul style="list-style-type: none"> • Tulsa Regional Chamber • Tulsa Regional Chamber Healthcare Committee Trask Force • Oklahoma Hospital Association • Tulsa Hospital Council • Tulsa Hospital Advocacy Committee • Oklahoma Healthcare Authority • Oklahoma State Constitution
<p>ACTIONS:</p> <ol style="list-style-type: none"> 1. Advocacy by St. John Health System to promote support of legislation and tracking of legislative roll calls as an indicator of increased support.

STRATEGY 4: Promote access to affordable health insurance coverage through state legislative advocacy.

2. Advocacy by St. John Health System to promote support of legislation and tracking of legislative votes as an indicator of increased support to pass legislation.
3. Expand Insure Oklahoma through legislative advocacy efforts in collaboration with the Oklahoma Hospital Association.
4. Pass the Medicaid Rebalancing Act through legislative advocacy efforts in collaboration with the Oklahoma Hospital Association
5. Support the tobacco tax through legislative advocacy efforts in collaboration with the Oklahoma Hospital Association.
6. Support the tobacco tax through legislative advocacy efforts in collaboration with the Oklahoma Hospital Association.

ANTICIPATED IMPACT:

- I. **Short-Term:** By May 26, 2017, increase the percentage of Oklahoma legislators in support of all health insurance legislation by 10% as indicated by a difference in the number of 1st roll calls as compared to the final votes in the House and Senate and as measured by House and Senate roll calls and Oklahoma State Constitution recorded votes.
- II. **Medium-Term:** By July 1, 2017, contribute to efforts to increase the proportion of all Oklahoman's with health insurance coverage by 3% from July 1, 2016 as measured by Tulsa Regional Healthcare Committee Task Force data.
- III. **Medium-Term:** By July 1, 2019, contribute to efforts to increase the proportion of all Oklahoman's with health insurance coverage by an additional 10% from July 1, 2017 as measured by Tulsa Regional Healthcare Committee Task Force data.
- IV. **Long-Term:** By 2020, contribute to efforts to increase the percentage of all Oklahoman's with health insurance coverage by 23% from July 1, 2016 to achieve 100% coverage as measured by Tulsa Regional Healthcare Committee Task Force data and Oklahoma Healthcare Authority.
- V. **Long-Term:** By 2020, contribute to efforts to increase the percentage of all U.S. persons with medical insurance by 7% from 2008 to achieve 100% coverage as measured by National Health Interview Survey (NHIS), CDC/NCHS data.

Alignment with Local, State & National Priorities (Long-Term Outcomes for Prioritized Need #1, Goal #1, Strategy #4)

OBJECTIVE:	LOCAL / COMMUNITY PLAN:	STATE PLAN:	“HEALTHY PEOPLE 2020” (or OTHER NATIONAL PLAN):
IV-V	<p>The 2016 Community Health Needs Assessment conducted by St. John Health System and community partners identified Access to Care as one of the priority health needs of the communities served by our hospitals. This information was based on community surveys (Tulsa County Health Department and Washington County Wellness Initiative) and focus groups of Tulsa County residents (Tulsa County Health Departments), as well as community input meetings at each hospital with community leaders and representatives.</p>	<p>The Oklahoma Health Improvement Plan (OHIP) 2020 identified Access to Care as core measure. OHIP established a goal of decreasing the percentage of uninsured in Oklahoma from 17% in 2013 to 9.5% by 2020. The goal for 2020 is not consistent with the national Healthy People 2020 goal, but it may be more realistic since Oklahoma has not expanded Medicaid and as of January 2015, only 18,756 Oklahomans have gained Medicaid or CHIP coverage since the beginning of the Health Insurance Marketplace first open enrollment period.</p> <p>If Oklahoma expanded Medicaid, an additional 123,000 uninsured people would gain coverage. The expansion would be paid 100 percent by federal funds for the first three years and federal funds would never fall below 90 percent of costs thereafter.</p>	<p>HealthyPeople 2020 identified Access to Care as one of the primary objectives for improvement by 2020. The indicators noted below are some of the key indicators for determining success:</p> <p>The HealthyPeople 2020 goal is to increase the proportion of individuals with medical insurance to 100% by 2020. The baseline was 83.2% in 2008.</p>
IV-V	<p>The 2013 Tulsa County Community Health Improvement Plan (CHIP) set a specific goal of a 5% improvement in people with health insurance by 2016 and a</p>	<p>Across the nation, approximately 11.2 million more Americans are now enrolled in Medicaid and CHIP. In Oklahoma, 126,115</p>	<p>The 2020 goals also include increasing the proportion of individuals with preventive services coverage from 76.3% to 83.9%.</p>

	<p>10% improvement in people with health insurance by 2020. Baseline: 77.2% in adults; intermediate goal of 81.06%; 2020 goal of 84.9%. The 2016 Tulsa County Community Health Improvement Steering Committee voted to address Access to Healthcare Resources as one of two priority needs areas selected for the plan</p>	<p>consumers selected or were automatically re-enrolled in quality, affordable health insurance coverage through the Marketplace as of Feb. 22 and the uninsured rate in Oklahoma in 2014 was 18.5 percent, down from 21.4 percent in 2013.</p> <p>Source: http://www.hhs.gov/healthcare/facts-and-features/state-by-state/how-aca-is-working-for-oklahoma/index.html</p>
<p>IV-V</p>	<p>The Tulsa Regional Healthcare Committee has established plans to support expansion of Insure Oklahoma and pass the Medicaid Rebalancing Act to reduce the number of uninsured Oklahomans by accepting federal funds. This will improve the health of Oklahoma’s workforce, strengthen behavioral health services and create sustainable jobs in rural and urban areas — all of which are paramount to an economically viable Oklahoma.</p>	<p>St. John Health System and the Oklahoma Hospital Association support long-term Insure Oklahoma waiver reauthorization. This effort, flexibility in negotiations to grant a long-term reauthorization of Oklahoma’s Section 1115 waiver for Insure Oklahoma will be encouraged. Uncertainty in the long-term future of Insure Oklahoma has hurt enrollment and resulted in the exclusion of thousands of Oklahomans who would be eligible for coverage even under current requirements.</p>

Action Plan

STRATEGY 5: Increase the proportion of persons who are able to obtain or not delay in obtaining necessary prescription medicines.

BACKGROUND INFORMATION:

- The strategy's target population is community dwelling persons in northeastern Oklahoma who lack resources to obtain necessary prescription medicines.
- Improving access to necessary prescription medicines among persons who lack resources to obtain them will address health disparities and barriers to care as well promote health equity among vulnerable and underserved persons.
- The strategy is a system change informed by evidence found on What Works for Health.

RESOURCES:

- St. John Health System
- St. John Medical Center
- Heart Failure (HF) Clinic
- St. John Clinic-Family Medical Care (FMC)
- Medical Access Clinic (MAC)
- Medical Access Program (MAP)
- SJMC Diabetes Education Center
- St. John Medical Center Case Management team
- Pharmacy Staff
- Funding
- Labor
- Supplies
- Facility space and occupancy

COLLABORATION:

- Dispensary of Hope (DOH)
- Tulsa Day Center for the Homeless Clinic
- Good Samaritan Mobile Clinics

ACTIONS:

1. Educate and orient newly added departments and clinics to Dispensary of Hope program, eligibility criteria, and process.
2. Track and disseminate program outcomes via a monthly Dispensary of Hope report.
3. Provide regular updates on program to St. John Health System leadership to increase awareness and understanding of program.
4. Continue to grow Dispensary of Hope program at St. John Health System and at partnering clinics in the community.
5. Expand program to Tulsa Day Center for Homeless clinic that is supported by the Medical Access Program (MAP).

STRATEGY 5: Increase the proportion of persons who are able to obtain or not delay in obtaining necessary prescription medicines.

6. Expand program to Creek County through partnership with newly planned Good Samaritan Mobile Clinic location (SJS).
7. Refine tracking process for hospital readmissions data for patients diagnosed with congestive heart failure (CHF) who are accessing the HF Clinic at St. John Medical Center and who are participating in Dispensary of Hope (DOH) program.

ANTICIPATED IMPACT:

- I. **Short-Term:** By July 2019, increase knowledge and skill level among newly participating departments and clinics by obtaining 100% staff participation in education and orientation as measured by John Medical Center Pharmacy and Dispensary of Hope records.
- II. **Medium-Term:** By July 1, 2017, increase the number of Dispensary of Hope prescriptions filled by at least 5% as measured by St. John Medical Center Pharmacy and Dispensary of Hope monthly records.
- III. **Medium-Term:** By July 1, 2017, increase the number of departments and clinics participating in Dispensary of Hope by 50% as measured by St. John Medical Center Pharmacy and Dispensary of Hope monthly records.
- IV. **Long-Term:** By July 1, 2019, contribute to efforts to reduce hospital readmissions within 30 days among patients diagnosed with congestive heart failure who are accessing Heart Failure Clinic and the Dispensary of Hope program by 5% as measured by HF Clinic readmissions data.
- V. **Long-Term:** By 2020, contribute to efforts to reduce the proportion of persons in the U.S. who are unable to obtain or delay in obtaining necessary prescription medicines by 10% from 2007 as measured by Medical Expenditure Panel Survey (MEPS), AHRQ data.

Alignment with Local, State & National Priorities (Long-Term Outcomes for Prioritized Need #1, Goal #1, Strategy #5)

OBJECTIVE:	LOCAL / COMMUNITY PLAN:	STATE PLAN:	“HEALTHY PEOPLE 2020” (or OTHER NATIONAL PLAN):
IV-V	<p>The 2016 Community Health Needs Assessment conducted by St. John Health System identified Access to Care as one of the priority health needs. This was based on a community surveys conducted (Tulsa County Health Department and Washington County Wellness Initiative) and focus groups with residents (Tulsa County Health Department), and community input meetings at each hospital with community leaders and representatives. Access to affordable prescriptions has been identified as an issue among persons living in poverty in the communities served by the health system.</p>	<p>Access to care in the Oklahoma Health Improvement Plan2020 (OHIP 2020) is addressed as a workforce issue.</p>	<p>HealthyPeople 2020 identified Access to Health Services as one of the primary objectives for targeted improvement. Among objectives identified for improvement is an objective to reduce the proportion of persons in the U.S. who are unable to obtain or delay in obtaining necessary prescription medicines by 10% by 2020.</p>

Action Plan

STRATEGY 6: Improve access to healthcare services by providing transportation assistance to community-dwelling persons served by St. John Health System who are living in poverty and/or are otherwise deemed vulnerable.

BACKGROUND INFORMATION:

- The strategy's target population is northeastern Oklahoma community-dwelling persons served by the health system who are living in poverty and/or are who are otherwise deemed vulnerable.
- Lack of affordable transportation is a major contributor to health disparities and presents as a barrier to accessing healthcare services. Offering transportation assistance addresses health disparities and barriers to care as well promote health equity among persons deemed vulnerable and/or underserved.
- The strategy is a system change informed by evidence found on What Works for Health.

RESOURCES:

- St. John Health System (SJHS)
- SJHS Hospital Facilities:
 - St. John Medical Center (SJMC)
 - Jane Phillips Medical Center (JPMC)
 - St. John Owasso (SJO)
 - St. John Broken Arrow (SJBA)
 - St. John Sapulpa (SJS)
 - Jane Phillips Nowata Health Center (JPNHC)
- SJMC departments currently participating in Morton Transportation Program:
 - Heart Failure Clinic
 - Cardiopulmonary Rehab
 - Wound Centers
 - Transplant Center
 - Life Access Center
 - Infusion Center
 - Case Management
- Okmulgee Women's Clinic
- SJMC Diabetes Education Center
- SJMC Transitional Care Clinic
- Morton Transportation Assistance program tracking spreadsheet
- Training materials for Morton Transportation program (PowerPoint presentation and guide)
- Morton Transportation Program Eligibility criteria document and checklist
- St. John Health System Quality Improvement Department
- Program budget
- Monthly invoices and ride summary tracking sheet

COLLABORATION:

- Morton Comprehensive Health Services Transportation Department
- Morton Transportation Vehicle Fleet and scheduling/mapping software
- Potential pilot with Uber and Lyft (*note only applicable if selected for national pilot, currently awaiting decision from Ascension)

STRATEGY 6: Improve access to healthcare services by providing transportation assistance to community-dwelling persons served by St. John Health System who are living in poverty and/or are otherwise deemed vulnerable.

ACTIONS:

1. Expansion of Morton Transportation Assistance Program to additional St. John Medical Center departments providing recurring services.
2. Expansion of Morton Transportation Assistance Program to Okmulgee Women’s Clinic to offer transportation to and from St. John Medical Center for prenatal orientation.
3. Continuation of process to track daily rides on an internal shared tracking spreadsheet and to review monthly invoices in comparison with tracking sheet.
4. Training of departments who are new participants in Morton Transportation Assistance program.
5. Work with Quality Improvement department to develop process to analyze health outcomes such as admissions and re-admissions data for Morton Transportation Assistance program.
6. Explore expansion of transportation assistance to other St. John Health System facilities through other available transportation assistance vendors (e.g. potential Ascension pilot with Uber and Lyft; *Note will only move forward with Ascension pilot if selected),

ANTICIPATED IMPACT:

- I. **Short-Term:** By July 2017, increase knowledge of departments that are new participants in the Morton Transportation Assistance program on eligibility criteria, scheduling, and tracking processes by 100% as measured by Morton Transportation Assistance Program records.
- II. **Medium-Term:** By July 2017, increase funding for Morton Transportation Assistance Program by 2% as measured by Morton Transportation Assistance Program summary of rides tracking sheet.
- III. **Medium-Term:** By July 2017, increase the proportion of rides provided Morton Transportation Assistance Program by 2% as measured by Morton Transportation Assistance Program tracking summary of rides tracking sheet.
- IV. **Long-Term:** By July 2018, contribute to efforts to reduce 30 day readmissions by TBD% as measured by Quality Improvement and Morton tracking spreadsheet data.
- V. **Long-Term:** By 2020, contribute to efforts to reduce the Oklahoma rate of preventable hospitalizations by 20% from 2013 (based on 2019 data) as measured by the Oklahoma State Department of Health data.

Alignment with Local, State & National Priorities (Long-Term Outcomes for Prioritized Need #1, Goal #1, Strategy #6)

OBJECTIVE:	LOCAL / COMMUNITY PLAN:	STATE PLAN:	“HEALTHY PEOPLE 2020” (or OTHER NATIONAL PLAN):
IV-V	<p>The 2016 Community Health Needs Assessment conducted by St. John Health System and community partners identified Access to Care as one of the priority health needs. This was based on community surveys (Tulsa County Health Department and Washington County Wellness Initiative) and focus groups of residents (Tulsa County Health Department) as well as community input meetings at each hospital with community leaders and representatives. Lack of affordable transportation was often mentioned as a barrier to accessing healthcare services.</p>	<p>The Oklahoma Health Improvement Plan 2020 identified the reduction of preventable hospitalizations as a core Health Transformation measure: Reduce by 20% the rate, per 100,000 Oklahomans, of potentially preventable hospitalizations from 1656 in 2013 to 1324.8 by 2020 (2019 data).</p>	<p>HealthyPeople 2020 identified Access to Care as one of the primary objectives for improvement by 2020. Indicators included reduce the proportion of persons who are unable to obtain or delay in obtaining necessary medical care from 4.7% in 2007 to 4.2% in 2020 and increasing the proportion of adults with a specific source of ongoing care and with a usual primary care provider by 10%.</p>

GOAL 2: Improve access as needed to healthcare providers and an ongoing source care in northeastern Oklahoma and southern Kansas.

Action Plan

<p>STRATEGY 1: Increase recruitment and hiring of providers to improve access to primary care and specialty services in the communities served by St. John Health System.</p>
<p>BACKGROUND INFORMATION:</p> <ul style="list-style-type: none">• The strategy’s target population is all community-dwelling persons served by St. John Health System in northeastern Oklahoma and southern Kansas.• The majority of communities served by St. John Health System include partial or total identified healthcare shortage areas. Improving access to care through provider recruitment addresses these shortage areas, reduces health disparities, and promotes health equity among persons deemed vulnerable.• The strategy is a system change informed by evidence found on What Works for Health and HealthyPeople 2020.
<p>RESOURCES:</p> <ul style="list-style-type: none">• St. John Health System• St. John Clinic• All St. John Health System hospital facilities:<ul style="list-style-type: none">○ St. John Medical Center (SJMC)○ Jane Phillips Medical Center (JPMC)○ St. John Owasso (SJO)○ St. John Broken Arrow (SJBA)○ St. John Sapulpa (SJS)○ Jane Phillips Nowata Health Center (JPNHC)• Physician recruitment team• Director of physician recruitment• Labor• Budget• Facility space and occupancy• Physician on-boarding process• Hospital Administrators• Mid-levels and physicians
<p>COLLABORATION:</p> <ul style="list-style-type: none">• University of Oklahoma (OU) Residency Program
<p>ACTIONS:</p> <ol style="list-style-type: none">1. Continuous primary care provider (mid-level and physician) recruitment and hiring (St. John Clinic).2. Continuous specialist provider recruitment (mid-level and physician) and hiring (St. John Clinic and all hospital facilities).

STRATEGY 1: Increase recruitment and hiring of providers to improve access to primary care and specialty services in the communities served by St. John Health System.

3. Completion of on-boarding process by newly hired providers (St. John Clinic and all hospital facilities).
4. Recruit and hire 1 new pediatrician to join St. John Clinic in Sapulpa who will accept Medicaid.
5. Recruit and hire 1 new pediatrician to join St. John Clinic in Oologah.
6. Establish University of Oklahoma Residency Program with 1 physician and 6 residents at Jane Phillips Medical Center campus to provide outpatient primary care and inpatient coverage (St. John Clinic and Jane Phillips Medical Center).
7. Open new St. John Urgent Care Clinic in Bartlesville with 3 physicians and 1 mid-level.
8. Recruit and hire 2 new cardiologists to join clinic in Bartlesville.
9. Recruit and hire 1 new primary care physician (family medicine/OB) for St. John Clinic in Bartlesville.
10. Recruit and hire 1 neuro-hospitalist at Jane Phillips Medical Center.
11. Develop plan to extend Emergency Room coverage in Jane Phillips Nowata Health Center through use mid-levels and St. John Clinic rotation.
12. Establish standard among St. John Clinic primary care mid-level providers to practice 16 appointments per day.
13. Explore methods to extend hours among St. John Clinic primary care providers and adopt plan to utilize various methods (e.g. opening early, staying open late, On Demand e-visits, etc.) to extend hours in primary care clinics.

ANTICIPATED IMPACT:

- I. **Short-Term:** By July 2017, increase knowledge of newly hired providers regarding medical orientation through on-boarding process by 100% as measured by St. John Health System recruitment records.
- II. **Short-Term:** By September 2016, increase commitment among primary care mid-levels by 100% to practice 16 appointments per day standard as established by St. John Clinic as measured by St. John Clinic Administration records.
- III. **Medium-Term:** By July 2017, increase primary care providers (mid-level and physicians) employed by St. John Clinic and health system by TBD% as measured by Service line director forecast reports.
- IV. **Medium-Term:** By July 2017, increase specialty providers (mid-level and physicians) employed by St. John Clinic and health system by TBD% as measured by Service line director forecast reports.
- V. **Medium-Term:** By July 2018, increase growth of primary care patients by 2% as measured by St. John Clinic Admin. records.
- VI. **Medium-Term:** By July 2018, increase proportion of St. John primary care clinics offering extended hours by 25% as evidenced by St. John Clinic Admin. records.
- VII. **Long-Term:** By 2020, contribute to efforts to reduce the percentage of persons in the U.S. who are unable to obtain or delay in obtaining necessary medical care from 4.7% in 2007 to 4.2% in 2020 as measured by MEPS and AHRQ (national) data.

STRATEGY 1: Increase recruitment and hiring of providers to improve access to primary care and specialty services in the communities served by St. John Health System.

- VIII. **Long-Term:** By 2020, contribute to efforts to increase the percentage of persons in the U.S. with a usual source of primary care from 76.3% in 2007 to 83.9% in 2020 as measured by MEPS and AHRQ (national) data.
- IX. **Long-Term:** By 2020, contribute to efforts to increase the percentage of U.S. adults aged 18-64 years who have a specific source of ongoing care from 81.3% in 2008 to 89.4% in 2020 as measured by NHIS and CDC/NCHS (national) data.

Alignment with Local, State & National Priorities (Long-Term Outcomes for Prioritized Need #1)

OBJECTIVE:	LOCAL / COMMUNITY PLAN:	STATE PLAN:	“HEALTHY PEOPLE 2020” (or OTHER NATIONAL PLAN):
VII-IX	<p>The 2016 Community Health Needs Assessment conducted by community partners and St. John Health System identified Access to Care as one of the priority health needs of the communities we serve. This was based on community surveys (Tulsa County Health Department and Washington Wellness Initiative) and focus groups of Tulsa County residents (Tulsa County Health Department), and community input meetings at each hospital with community leaders and representatives. The Tulsa County Community Health Improvement Plan (CHIP) Steering Committee recently identified Access to Health Resources as one of the two priority health needs to address for 2016-2019.</p>	<p>The Oklahoma Health Improvement Plan (OHIP): Healthy Oklahoma 2020 highlighted Access to Health Care as a key strategic area to improve. The plan reported that one in four Oklahoma adults (ranked 35th state in the nation) reported they did not have a usual source of care in 2014. Additionally, the plan reported the state only had 84.8 primary care physicians per 100,000 population (48th in the nation) in 2014.</p>	<p>HealthyPeople 2020 identified Access to Health Services as one of the primary objectives for targeted improvement. One objective is to reduce the proportion of persons who are unable to obtain or delay in obtaining necessary medical care from 4.7% in 2007 to 4.2% in 2020. Indicators also include increasing the proportion of adults with a specific source of ongoing care and with a usual primary care provider (see outcomes above).</p>

Prioritized Need #2: Behavioral Health

GOAL 1: Improve access to behavioral health services.

Action Plan

<p>STRATEGY 1: Increase access to behavioral health services for at-risk populations through early identification and intervention via an integrated model of behavioral health in primary care.</p>
<p>BACKGROUND INFORMATION:</p> <ul style="list-style-type: none">• The strategy’s target population is all community dwelling persons in northeastern Oklahoma accessing primary care services through St. John Clinic, many of which live in areas that are considered medically underserved or health professional shortage areas.• Increased access to behavioral health services addresses health disparities and barriers to care which will be especially beneficial for subsets of the population deemed vulnerable and/or underserved.• This strategy is a system change informed by evidence found on What Works for Health, Substance Abuse and Mental Health Service Administration – NREPP (National Registry of Evidence Based Practices and Programs), and The Guide to Community Preventive Services.
<p>RESOURCES:</p> <ul style="list-style-type: none">• St. John Health System (SJHS)• St. John Clinic• Labor• Program budget• Facility space and occupancy• Time for conducting assessments and training of staff• Physicians and medical support staff• Behavioral health therapists (LCSW, LPC, LADC, LMFT)• Clinical Informatics team• National Health Forum PHQ2 and PHQ9 Screening tools• Suicide Risk Assessment used by embedded behavioral health therapists• Cerner Electronic health record, SJHS data warehouse, and MyHealth Health Information Exchange (HIE)• SJHS Human Resources
<p>COLLABORATION:</p> <ul style="list-style-type: none">• n/a
<p>ACTIONS:</p> <ol style="list-style-type: none">1. Educate primary care providers on PHQ9 screening process through a mandatory presentation.2. Build PHQ9 screening into Annual Health Maintenance.3. Promotion of annual PHQ9 screenings in all clinics.4. Recruit and hire additional behavioral health therapists to embed in clinics.

STRATEGY 1: Increase access to behavioral health services for at-risk populations through early identification and intervention via an integrated model of behavioral health in primary care.

5. Behavioral health therapists perform full suicide risk assessment on ambulatory patients with a high score on PHQ9 or on answering the question #9 regarding suicide ideation on PHQ9 in the affirmative in CPC and CPC+ clinics.
6. Add new Ad-Hoc form to P4 side in Cerner Electronic Health Record.

ANTICIPATED IMPACT:

- I. **Short-Term:** By July 2017, increase provider knowledge of the PHQ9 screening process through a 100% increase in clinics receiving mandatory education on PHQ9 screening as measured by data on a tracking spreadsheet kept by Behavioral Health Administration.
- II. **Medium-Term:** By July 2018, increase annual PHQ9 depression screenings for all primary care clinic-based patients by 100% as measured by Cerner electronic health record data.
- III. **Medium-Term:** By Dec. 31, 2017, increase the proportion of behavioral health therapists embedded in the primary care clinics by 40% as measured by Behavioral Health Admin. records.
- IV. **Medium-Term:** By July 2018, increase the number of referrals to behavioral health therapists embedded in primary care practices by 5% as measured by report from behavioral health administration.
- V. **Medium-Term:** By July 2017, increase the proportion of full suicide risk assessments performed by embedded behavioral therapists on patients scoring high or answering in the affirmative on question #9 on the PHQ9 by 100% as measured by report from Cerner electronic health record.
- VI. **Long-Term:** By 2020, contribute to efforts to increase the proportion of U.S. adults aged 18 years and older with major depressive episodes (MDEs) or a severe mental illness (SMI) who receive treatment by 10% from 2008 as measured by National Survey on Drug Use and Health data.
- VII. **Long-Term:** By 2020, contribute to efforts to increase the proportion of U.S. primary care physician office visits where adults 19 years and older are screened for depression by 10% from 2008 as measured by National Ambulatory Medical Care Survey (NAMCS), CDC/NCHS data.
- VIII. **Long-Term:** By 2020, contribute to efforts to increase the proportion of U.S. primary care facilities that provide mental health treatment onsite or by paid referral by 10% from 2006 as measured by Uniform Reporting System (URS), SAMHSA/CMHS data.
- IX. **Long-Term:** By 2020, contribute to efforts to increase the proportion of U.S. persons' age 12 years and older who need alcohol and/or illicit drug treatment and received specialty treatment for abuse or dependence in the past year by 10% from 2008 as measured by National Survey on Drug Use and Health data.
- X. **Long-Term:** By 2020, decrease the national age-adjusted rate of suicides per 100,000 by 10% from 2007 to 2020 as measured by National Vital Statistics System-Mortality (NVSS-M), CDC/NCHS; Bridged-Race Population Estimates, CDC/NCHS and Census data.

Alignment with Local, State & National Priorities (Long-Term Outcomes for Prioritized Need #2, Goal #1, Strategy #1)

OBJECTIVE:	LOCAL / COMMUNITY PLAN:	STATE PLAN:	“HEALTHY PEOPLE 2020” (or OTHER NATIONAL PLAN):
VI-X	<p>The 2016 Community Health Needs Assessment conducted by St. John Health System and community partners identified Behavioral Health as one of the priority health needs of the communities we serve. This was based on community surveys (Tulsa County Health Department and Washington Wellness Initiative) and focus groups of Tulsa County residents (Tulsa County Health Department), and community input meetings at each hospital with community leaders and representatives. This need was most pronounced by input from those identified as being among lower socio-economic status. In Tulsa County, expressed behavioral health concerns were greatest for east and west Tulsa and Sand Springs/NW).</p>	<p>The Oklahoma Health Improvement Plan2020 (OHIP2020) identified behavioral health services as one of four “flagship issues” for the state. Oklahoma is 44th in the nation for poor mental health days in the past 30 days reported by adults. Oklahoma ranks 13th in the country in suicides with a rate of 17.2 per 100,000. The state ranks 43rd in adult drug and alcohol abuse and ranks 50th in nation in adults who suffer from some type of mental illness. The OHIP objectives related to this priority need are:</p> <ul style="list-style-type: none"> •Reduce suicide deaths from 22.8 per 100,000 in 2013 to 19.4 per 100,000 by 2020 (2017 data). •Reduce the prevalence of untreated mental illness from an 86% treatment gap to 75% in 2020 (2018 data). •Reduce the prevalence of addiction disorders from 8.8% to 7.8% by 2020 (2018 data). 	<p>Per Healthcare.gov, the new protections for behavioral health coverage build on the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) provisions to expand mental health and substance use disorder benefits and federal parity protections to an estimated 62 million Americans</p> <p>Source: http://www.hhs.gov/healthcare/facts-and-features/fact-sheets/health-insurance-and-mental-health-services/index.html.</p>
VI-X	<p>The Comprehensive Primary Care initiative and Accountable Care Organization (ACO) Medicare Shared Savings Program targets drive the community goals for completion of the PHQ9 and PHQ2s in physician offices since most PCPs in the community</p>		<p>HealthyPeople 2020 identified mental health and mental disorders and substance abuse of some of the primary objectives for improvement by 2020. The indicators noted above are key indicators for determining success.</p>

participate in these programs. In addition, as part of the CPC program, behavioral health therapists have been placed in the clinic setting and there is a goal to expand this coverage to non-CPC practices as well due to the success within the CPC program.

VI-X

Tulsa's suicide rate of 16.8 per 100,000 ranks it 15th among U.S. cities, according to the Centers for Disease Control and Prevention. Tulsa ranks as the fourth-highest city in the U.S. for alcohol-related traffic deaths per capita, according to a report from the University of Tulsa's Institute for Health Care Delivery Sciences.

Funded by the Anne and Henry Zarrow Foundation and coordinated by the University of Tulsa, the Tulsa Regional Mental Health Plan is a 10-year communitywide effort to focus on regional mental health improvements and includes a leadership council with philanthropy, business, university, state and nonprofit representation.

Zero Suicide Initiative: Zero Suicide is a key concept of the 2012 National Strategy for Suicide Prevention, a priority of the National Action Alliance for Suicide Prevention (Action Alliance), a project of Education Development Center's Suicide Prevention Resource Center (SPRC), and supported by the Substance Abuse and Mental Health Services Administration (SAMHSA). The foundational belief of Zero Suicide is that suicide deaths for individuals under care within health and behavioral health systems are preventable. It presents both a bold goal and an aspirational challenge.

For health care systems, this approach represents a commitment:

- To patient safety, the most fundamental responsibility of health care
- To the safety and support of clinical staff, who do the demanding work of treating and supporting suicidal patients

The programmatic approach of Zero Suicide is based on the realization that suicidal individuals often fall through cracks in a fragmented, and sometimes distracted, health care system. A systematic approach to quality improvement in these settings is both available and necessary.

Action Plan

STRATEGY 2: Promote access to behavioral health services through state legislative advocacy.

BACKGROUND INFORMATION:

- The strategy's target population is community-dwelling persons in Oklahoma who lack or have limited access to behavioral health services.
- Improving access to behavioral health services addresses health disparities and barriers to care as well promotes health equity among persons deemed vulnerable and/or underserved.
- This strategy is a policy change informed by evidence found on the Guide to Community Preventive Services.

RESOURCES:

- St. John Health System (SJHS)
- SJHS Contract Lobbyist
- SJHS Vice President of Government Affairs

COLLABORATION:

- Tulsa Regional Chamber
- Tulsa Regional Healthcare Committee Taskforce
- Oklahoma Hospital Association
- Mental Health Association of Oklahoma
- Oklahoma Department of Mental Health and Substance Abuse (ODMHSAS)

ACTIONS:

1. Advocacy by St. John Health System to promote support of legislation and tracking of legislative roll calls as an indicator of increased support.
2. Advocacy by St. John Health System to promote support of legislation and tracking of legislative votes as an indicator of increased support to pass legislation.
3. Expand behavioral health services through legislative advocacy in collaboration with ODMHSAS.
4. Expand mental health and drug courts to decrease unnecessary incarcerations through legislative advocacy in collaboration with ODMHSAS.
5. Enact the Labor Commissioner Mark Costello Act through legislative advocacy in collaboration with ODMHSAS.
6. Attend meetings at Tulsa Regional Chamber to support local behavioral health advocacy.
7. Participate as a community partner in the Tulsa Regional Mental Health plan.

STRATEGY 2: Promote access to behavioral health services through state legislative advocacy.

ANTICIPATED IMPACT:

- I. **Short-Term:** By May 26, 2017, increase the proportion of Oklahoma legislators in support of the passage of the Mark Costello Act by 10% as indicated by a difference in the number of 1st roll calls as compared to the final votes in the House and Senate and as measured by House and Senate roll calls and Oklahoma State Constitution recorded votes.
- II. **Medium-Term:** By May 26, 2017, achieve 100% Oklahoma legislators voting in support of an increase in funding for the Oklahoma State Health Department of Mental Health and Substance Abuse Services (ODMHSAS) as measured by the Oklahoma State Constitution and recorded votes as tracked by VP of Gov't Affairs
- III. **Medium-Term:** By May 26, 2017, achieve 100% of Oklahoma legislators voting needed to reach a simple majority vote in support of passing the Mark Costello Act for the Oklahoma State Health as measured by the Oklahoma State Constitution and recorded votes as tracked by VP of Gov't Affairs.
- IV. **Medium-Term:** By May 26, 2017, achieve 100% of Oklahoma legislators voting needed to reach a simple majority vote in support of expanding behavioral health services as measured by the Oklahoma State Constitution and recorded votes as tracked by VP of Gov't Affairs
- V. **Medium-Term:** By May 26, 2017, achieve 100% of Oklahoma legislators voting needed to reach a simple majority vote in support of expanding mental health and drug court services as measured by the Oklahoma State Constitution and recorded votes as tracked by VP of Gov't Affairs
- VI. **Long-Term:** By 2020, contribute to efforts to increase the proportion of U.S. adults aged 18 years and older with major depressive episodes (MDEs) or a severe mental illness (SMI) who receive treatment by 10% from 2008 as measured by National Survey on Drug Use and Health data.
- VII. **Long-Term:** By 2020, contribute to efforts to increase the proportion of U.S. persons' age 12 years and older who need alcohol and/or illicit drug treatment and received specialty treatment for abuse or dependence in the past year by 10% from 2008 as measured by National Survey on Drug Use and Health data by Behavioral Health Administration.

Alignment with Local, State & National Priorities (Long-Term Outcomes for Prioritized Need #2, Goal #1, Strategy #2)

OBJECTIVE:	LOCAL / COMMUNITY PLAN:	STATE PLAN:	"HEALTHY PEOPLE 2020" (or OTHER NATIONAL PLAN):
VI-VII	The 2016 Community Health Needs Assessment conducted by St. John Health System and community partners identified Behavioral Health as one of the priority health needs of the communities we serve. This was	The Oklahoma Health Improvement Plan2020 (OHIP2020) identified behavioral health services as one of four "flagship issues" for the state. Oklahoma is 44th in the nation for poor	Per Healthcare.gov, the new protections for behavioral health coverage build on the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) provisions to expand mental health and substance use disorder benefits and federal parity

	<p>based on community surveys (Tulsa County Health Department and Washington Wellness Initiative) and focus groups of Tulsa County residents (Tulsa County Health Department), and community input meetings at each hospital with community leaders and representatives. This need was most pronounced by input from those identified as being among lower socio-economic status. In Tulsa County, expressed behavioral health concerns were greatest for east and west Tulsa and Sand Springs/NW).</p>	<p>mental health days in the past 30 days reported by adults. Oklahoma ranks 13th in the country in suicides with a rate of 17.2 per 100,000. The state ranks 43rd in adult drug and alcohol abuse and ranks 50th in nation in adults who suffer from some type of mental illness. The OHIP objectives related to this priority need are:</p> <ul style="list-style-type: none"> •Reduce suicide deaths from 22.8 per 100,000 in 2013 to 19.4 per 100,000 by 2020 (2017 data). •Reduce the prevalence of untreated mental illness from an 86% treatment gap to 75% in 2020 (2018 data). •Reduce the prevalence of addiction disorders from 8.8% to 7.8% by 2020 (2018 data). 	<p>protections to an estimated 62 million Americans</p> <p>Source: http://www.hhs.gov/healthcare/facts-and-features/fact-sheets/health-insurance-and-mental-health-services/index.html.</p>
<p>VI-VII</p>	<p>Tulsa’s suicide rate of 16.8 per 100,000 ranks it 15th among U.S. cities, according to the Centers for Disease Control and Prevention. Tulsa ranks as the fourth-highest city in the U.S. for alcohol-related traffic deaths per capita, according to a report from the University of Tulsa’s Institute for Health Care Delivery Sciences.</p> <p>Funded by the Anne and Henry Zarrow Foundation and coordinated by the University of Tulsa, the Tulsa Regional Mental Health Plan is a 10-year communitywide effort to focus on regional mental health improvements and includes a leadership council with philanthropy, business,</p>		<p>Ascension and St. John Heath System have adopted the objective to support large-scale reform of the national mental health system that elevates the national priority for mental health issues. This includes increasing funding for evidence-based strategies and services; incentivizing assisted outpatient treatment; permitting integration of mental health and substance treatment records with medical records; ensuring complete enactment of the mental health parity law in Medicaid and Medicare; and enhancing behavioral health workforce training.</p>

university, state and nonprofit representation.

VI-VII

The Tulsa Regional Healthcare Committee has adopted objectives to expand behavioral health that improve workforce efficiency, boost public safety, create efficiencies in state spending and help additional Oklahomans suffering from behavioral health issues. This should include increasing funding for the Oklahoma Department of Mental Health and Substance Abuse Services; expanding mental health and drug courts to decrease unnecessary incarcerations; preparing judicial districts to enact the Labor Commissioner Mark Costello Act, with adequate funding for new assisted outpatient treatment; and expanding the use of assisted outpatient treatment by broadening the definition of who can petition courts to seek an order for outpatient treatment.

Action Plan

STRATEGY 3: Increase access to behavioral health services for community-dwelling persons in need of outpatient psychiatry services in Washington County.

BACKGROUND INFORMATION:

- The strategy's target population is community-dwelling persons in need of outpatient psychiatry services in Washington County, many of which live in areas that are considered medically underserved or health professional shortage areas.
- Increased access to behavioral health services addresses health disparities and barriers to care which will be especially beneficial for subsets of the population deemed vulnerable and/or underserved.
- This strategy is a system change informed by evidence found on What Works for Health, Substance Abuse and Mental Health Service Administration – NREPP (National Registry of Evidence Based Practices and Programs), and The Guide to Community Preventive Services.

RESOURCES:

- St. John Health System (SJHS)
- Jane Phillips Medical Center (JPMC)
- Jane Phillips Medical Center Administration
- JPMC Outpatient Psychiatry Clinic
- Labor
- Program budget
- Facility space and occupancy
- Physician Recruitment Team
- Director of Physician Recruitment
- Time for conducting assessments and training of staff
- Psychiatrist
- Advance practice provider
- On-boarding process for providers

COLLABORATION:

- n/a

ACTIONS:

1. Psychiatric provider (advance practice provider and psychiatrist) recruitment search for Jane Phillips Medical Center Outpatient Psychiatry Clinic.
2. Recruit and hire advance practice provider for Jane Phillips Medical Center Outpatient Psychiatry Clinic.
3. Recruit and hire additional psychiatrist for Jane Phillips Medical Center Outpatient Psychiatry Clinic.
4. Completion of on-boarding process by newly hired providers (St. John Clinic and all hospital facilities).

STRATEGY 3: Increase access to behavioral health services for community-dwelling persons in need of outpatient psychiatry services in Washington County.

ANTICIPATED IMPACT:

- I. **Short-Term:** By July 2017, increase knowledge of newly hired providers regarding medical orientation through on-boarding process by 100% as measured by Jane Phillips Medical Center recruitment records.
- II. **Medium-Term:** By November 2016, increase the proportion of psychiatric providers at Jane Phillips Medical Center Outpatient Psychiatry Clinic by 25% as measured by Jane Phillips Medical Center recruitment records.
- III. **Long-Term:** By 2020, contribute to efforts to reduce suicide deaths in Oklahoma from 22.8 per 100,000 population in 2013 to 19.4 per 100,000 population as measured by Oklahoma State Department of Mental Health and Substance Abuse Services (2017) data.
- IV. **Long-Term:** By 2020, contribute to efforts to decrease the national age-adjusted rate of suicides per 100,000 by 10% from 2007 to 2020 as measured by National Vital Statistics System-Mortality (NVSS-M), CDC/NCHS; Bridged-Race Population Estimates, CDC/NCHS and Census data.
- V. **Long-Term:** By 2020, contribute to efforts to increase the proportion of U.S. adults aged 18 years and older with major depressive episodes (MDEs) or a severe mental illness (SMI) who receive treatment by 10% from 2008 as measured by National Survey on Drug Use and Health data.
- VI. **Long-Term:** By 2020, contribute to efforts to increase the proportion of U.S. persons’ age 12 years and older who need alcohol and/or illicit drug treatment and received specialty treatment for abuse or dependence in the past year by 10% from 2008 as measured by National Survey on Drug Use and Health data.

Alignment with Local, State & National Priorities (Long-Term Outcomes for Prioritized Need #2, Goal #1, Strategy #3)

OBJECTIVE:	LOCAL / COMMUNITY PLAN:	STATE PLAN:	“HEALTHY PEOPLE 2020” (or OTHER NATIONAL PLAN):
III-VI	The 2016 Community Health Needs Assessment conducted by St. John Health System and community partners identified Behavioral Health as one of the priority health needs of the communities we serve. This was based on community surveys (Tulsa County Health Department and Washington Wellness Initiative) and focus groups of Tulsa County residents (Tulsa	The Oklahoma Health Improvement Plan2020 (OHIP2020) identified behavioral health services as one of four “flagship issues” for the state. Oklahoma is 44th in the nation for poor mental health days in the past 30 days reported by adults. Oklahoma ranks 13th in the country in suicides with a rate of 17.2	Per Healthcare.gov, the new protections for behavioral health coverage build on the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) provisions to expand mental health and substance use disorder benefits and federal parity protections to an estimated 62 million Americans Source: http://www.hhs.gov/healthcare/facts-and-features/fact-

<p>County Health Department), and community input meetings at each hospital with community leaders and representatives. This need was most pronounced by input from those identified as being among lower socio-economic status. In Tulsa County, expressed behavioral health concerns were greatest for east and west Tulsa and Sand Springs/NW).</p>	<p>per 100,000. The state ranks 43rd in adult drug and alcohol abuse and ranks 50th in nation in adults who suffer from some type of mental illness. The OHIP objectives related to this priority need are:</p> <ul style="list-style-type: none"> •Reduce suicide deaths from 22.8 per 100,000 in 2013 to 19.4 per 100,000 by 2020 (2017 data). •Reduce the prevalence of untreated mental illness from an 86% treatment gap to 75% in 2020 (2018 data). •Reduce the prevalence of addiction disorders from 8.8% to 7.8% by 2020 (2018 data). 	<p>sheets/health-insurance-and-mental-health-services/index.html.</p>
<p>III-VI</p>		<p>HealthyPeople 2020 identified mental health and mental disorders and substance abuse of some of the primary objectives for improvement by 2020. The indicators noted above are key indicators for determining success.</p>
<p>III-VI</p>		<p>Zero Suicide Initiative: Zero Suicide is a key concept of the 2012 National Strategy for Suicide Prevention, a priority of the National Action Alliance for Suicide Prevention (Action Alliance), a project of Education Development Center's Suicide Prevention Resource Center (SPRC), and supported by the Substance Abuse and Mental Health Services Administration (SAMHSA). The foundational belief of Zero Suicide is that suicide deaths for individuals under care within health and behavioral health systems are preventable. It presents both a bold goal and an aspirational challenge.</p>

For health care systems, this approach represents a commitment:

- To patient safety, the most fundamental responsibility of health care
- To the safety and support of clinical staff, who do the demanding work of treating and supporting suicidal patients

The programmatic approach of Zero Suicide is based on the realization that suicidal individuals often fall through cracks in a fragmented, and sometimes distracted, health care system. A systematic approach to quality improvement in these settings is both available and necessary.

The challenge and implementation of a Zero Suicide approach cannot be borne solely by the practitioners providing clinical care. Zero Suicide requires a system-wide approach to improve outcomes and close gaps. The initiative has an objective of saving 20,000 lives in 5 years

GOAL 2: Improve access to behavioral health services and have an impact on the reduction of suicide rates in Tulsa County and surrounding areas.

Action Plan

STRATEGY 1: Improve capacity for humanized behavioral health crisis and acute care through increased access to behavioral health professionals and services as well as increased assessment and recognition of suicide risks at the community level.

BACKGROUND INFORMATION:

- The strategy's target population is all at-risk community dwelling persons in Tulsa County and surrounding areas many of which live in areas that are considered medically underserved or health professional shortage areas.
- Increased access to behavioral health services addresses health disparities and barriers to care which will be especially beneficial for subsets of the population that are deemed vulnerable and/or underserved.
- This strategy is a system change informed by evidence found on What Works for Health, Substance Abuse and Mental Health Service Administration – NREPP (National Registry of Evidence Based Practices and Programs), and The Guide to Community Preventive Services.

RESOURCES:

- St. John Health System (SJHS)
- St. John Health System hospital facilities:
 - St. John Medical Center (SJMC)
 - St. John Owasso (SJO)
 - St. John Sapulpa (SJS)
 - St. John Broken Arrow
- Hospital Emergency Departments
- Labor
- Program budget
- Facility space and occupancy
- Time for conducting assessments and training of staff
- Physicians, nurses, and medical support staff
- Behavioral Health Assessment Team (BAT)
- Voluntary QPR (Question, Persuade, and Refer) training
- Electronic health records, Health Information Exchange (HIE), SJHS data warehouse and MyHealth HIE
- Case Management
- Behavioral Health and Psychiatry
- QSEC (Quality and Safety Executive Committee)

COLLABORATION:

- Mental Health Association of Oklahoma and other community partners
- Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS)

STRATEGY 1: Improve capacity for humanized behavioral health crisis and acute care through increased access to behavioral health professionals and services as well as increased assessment and recognition of suicide risks at the community level.

ACTIONS:

1. Fill open positions on Behavioral Health Assessment Team (BAT).
2. Explore options to develop community level response program with Mental Health Association of Oklahoma based on Colorado Springs Models.
3. Explore options to implement systematic approach in health system to support efforts to humanize crisis and acute care and to increase assessment and recognition for potential of suicide.
4. Meet with Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) to identify QPR (Question, Persuade, and Refer) training resources and develop logistics for offering voluntary training to interested departments and community organizations.
5. Identify and train behavioral health associates as QPR (Question, Persuade, and Refer) training facilitators and/or explore bringing in Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) QPR (trainers to facilitate training).
6. Provide voluntary education and awareness of suicide prevention (QPR) (Question, Persuade, and Refer) training among departments identified as having an interest in receiving education and training.
7. Provide voluntary education and awareness of suicide prevention (QPR) (Question, Persuade, and Refer) training among community organizations identified as having an interest in receiving education and training.
8. Promotion of National Suicide Awareness Month.

ANTICIPATED IMPACT:

- I. **Short-Term:** By July 2018, increase the number of by associates and community-dwelling individuals who are voluntarily trained in QPR by 50 as measured by Behavioral Health Admin. records.
- II. **Medium-Term:** By July 2018, reduce the proportion of patients who are medically stable who are transported to St. John Medical Center for behavioral health crisis and acute care by 25% through increased behavioral health access at the community level as measured by community hospital and Behavioral Health Admin. reports.
- III. **Medium-Term:** By July 2018, increase the proportion of Emergency Department and hospital patients referred to crisis intervention behavioral health services by 10 % as measured by Behavioral Health Admin. reports.
- IV. **Long-Term:** By 2020, contribute to efforts to reduce suicide deaths in Oklahoma from 22.8 per 100,000 population in 2013 to 19.4 per 100,000 population as measured by Oklahoma State Department of Mental Health and Substance Abuse Services (2017) data
- V. **Long-Term:** By 2020, contribute to efforts to reduce the age-adjusted rate of deaths by suicide by 10% in 2020 as measured by Healthy People 2020/ Healthy People 2020 / National Vital Statistics System-Mortality (NVSS-M), CDC/NCHS; Bridged-Race Population Estimates, CDC/NCHS and Census data.

STRATEGY 1: Improve capacity for humanized behavioral health crisis and acute care through increased access to behavioral health professionals and services as well as increased assessment and recognition of suicide risks at the community level.

- VI. **Long-Term:** By 2020, contribute to efforts reduce the U.S. age-adjusted rate of deaths by suicide by 10% in 2020 as measured by National Vital Statistics System-Mortality (NVSS-M), CDC/NCHS; Bridged-Race Population Estimates, CDC/NCHS and Census data.
- VII. **Long-Term:** By 2020, contribute to efforts to increase the proportion of U.S. adults aged 18 years and older with major depressive episodes (MDEs) or a severe mental illness (SMI) who receive treatment by 10% from 2008 as measured by National Survey on Drug Use and Health data.
- VIII. **Long-Term:** By 2020, contribute to efforts to increase the proportion of persons’ age 12 years and older in the U.S. who need alcohol and/or illicit drug treatment and received specialty treatment for abuse or dependence in the past year by 10% from 2008 as measured National Survey on Drug Use and Health data.

Alignment with Local, State & National Priorities (Long-Term Outcomes for Prioritized Need #2, Goal #1, Strategy #2)

OBJECTIVE:	LOCAL / COMMUNITY PLAN:	STATE PLAN:	“HEALTHY PEOPLE 2020” (or OTHER NATIONAL PLAN):
IV-VIII	<p>The 2016 Community Health Needs Assessment conducted by St. John Health System and community partners identified Behavioral Health as one of the priority health needs of the communities we serve. This was based on community surveys (Tulsa County Health Department and Washington Wellness Initiative) and focus groups of Tulsa County residents (Tulsa County Health Department), and community input meetings at each hospital with community leaders and representatives. This need was most pronounced by input from those identified as being among lower socio-economic status. In Tulsa County, expressed behavioral health concerns were greatest for east and west Tulsa and Sand Springs/NW).</p>	<p>The Oklahoma Health Improvement Plan2020 (OHIP2020) identified behavioral health services as one of four “flagship issues” for the state. Oklahoma is 44th in the nation for poor mental health days in the past 30 days reported by adults. Oklahoma ranks 13th in the country in suicides with a rate of 17.2 per 100,000. The state ranks 43rd in adult drug and alcohol abuse and ranks 50th in nation in adults who suffer from some type of mental illness. The OHIP objectives related to this priority need are:</p> <ul style="list-style-type: none"> •Reduce suicide deaths from 22.8 per 100,000 in 2013 to 19.4 per 100,000 by 2020 (2017 data). 	<p>Per Healthcare.gov, the new protections for behavioral health coverage build on the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) provisions to expand mental health and substance use disorder benefits and federal parity protections to an estimated 62 million Americans</p> <p>Source: http://www.hhs.gov/healthcare/facts-and-features/fact-sheets/health-insurance-and-mental-health-services/index.html.</p>

	<ul style="list-style-type: none"> •Reduce the prevalence of untreated mental illness from an 86% treatment gap to 75% in 2020 (2018 data). •Reduce the prevalence of addiction disorders from 8.8% to 7.8% by 2020 (2018 data). 	
IV-VIII	<p>Tulsa’s suicide rate of 16.8 per 100,000 ranks it 15th among U.S. cities, according to the Centers for Disease Control and Prevention. Tulsa ranks as the fourth-highest city in the U.S. for alcohol-related traffic deaths per capita, according to a report from the University of Tulsa’s Institute for Health Care Delivery Sciences.</p> <p>Funded by the Anne and Henry Zarrow Foundation and coordinated by the University of Tulsa, the Tulsa Regional Mental Health Plan is a 10-year communitywide effort to focus on regional mental health improvements and includes a leadership council with philanthropy, business, university, state and nonprofit representation.</p>	<p>HealthyPeople 2020 identified mental health and mental disorders and substance abuse of some of the primary objectives for improvement by 2020. The indicators noted above are key indicators for determining success.</p>
		<p>Zero Suicide Initiative: Zero Suicide is a key concept of the 2012 National Strategy for Suicide Prevention, a priority of the National Action Alliance for Suicide Prevention (Action Alliance), a project of Education Development Center's Suicide Prevention Resource Center (SPRC), and supported by the Substance Abuse and Mental Health Services Administration (SAMHSA). The foundational belief of Zero Suicide is that suicide deaths for individuals under care within health and behavioral health systems are</p>

preventable. It presents both a bold goal and an aspirational challenge.

For health care systems, this approach represents a commitment:

- To patient safety, the most fundamental responsibility of health care
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The programmatic approach of Zero Suicide is based on the realization that suicidal individuals often fall through cracks in a fragmented, and sometimes distracted, health care system. A systematic approach to quality improvement in these settings is both available and necessary.

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Prioritized Need #3: Wellness and Chronic Disease Prevention

GOAL 1: Improve health outcomes and reduce preventable congestive heart failure (CHF) readmissions among diverse populations diagnosed with CHF.

Action Plan

STRATEGY 1: Manage all patients diagnosed with congestive heart failure (CHF) across the continuum of care through structured transition and an expanded follow-up approach as facilitated by the St. John Medical Center Heart Failure Initiative.

BACKGROUND INFORMATION:

- The strategy's target population is all patients admitted to and/or discharged from the hospital with a diagnosis of congestive heart failure (CHF) at St. John Medical Center.
- Congestive heart failure (CHF) patients from diverse populations including racial and ethnic minorities and those living in socioeconomically disadvantaged conditions often face a myriad of barriers to care. Accordingly, this initiative aims to reduce health disparities and to promote health equity among this patient population through structured transition and support provided across a continuum of care regardless of ability to pay.
- The strategy is a system change and is informed by evidence found on What Works for Health and The Guide to Community Preventive Services.

RESOURCES:

- St. John Health System (SJHS)
- St. John Medical Center (SJMC)
- St. John Clinic Administration
- Heart Failure (HF) Initiative
- Heart Failure (HF) Clinic
- Cardiac Rehab Clinic
- Heart Failure Rehab Program
- Transitional Care Clinic
- St. John Health System (SJHS) Emergency Rooms (ERs)
- St. John Medical Center (SJMC) Observation Unit and hospitalists
- Labor
- Program budget
- Ascension funding
- Facility space and occupancy
- Heart Failure (HF) training for associates
- Heart Failure (HF) certification
- Daily Root Cause Analyses (RCAs) (includes patient interviews and RCA meeting)
- RN Case Manager
- Heart Failure (HF) education for patients

- Heart Failure (HF) support group for patients
- Social Worker
- Cardiologists
- Cardiovascular Disease Manager and Coordinator
- Advanced Practice Registered Nurse-Clinical Nurse Specialist
- Medical support staff
- Blood pressure cuffs loaned to patients
- Weight scales loaned to patients
- Heart Failure (HF) magnets for patients
- Informational handouts, brochures, and folders
- AHA low salt intake cookbooks
- Pill boxes and pill cutters

COLLABORATION:

- Economy Pharmacy
- Dispensary of Hope
- Morton Transportation Assistance Program

ACTIONS:

1. Provide educational training on Heart Failure to SJMC nursing associates on 5 East and 5 West in hospital and Transitional Care Clinic staff.
2. Offer Heart Failure certification to nursing associates on 5 East and 5 West.
3. Perform daily Root Cause Analyses (RCAs) for any patients being readmitted with a diagnosis of Congestive Heart Failure (CHF).
4. Provide opportunity for patients to attend one daily Heart Failure education class in a classroom setting prior to hospital discharge.
5. Facilitate patient referrals to Heart Failure clinic.
6. Facilitate patient referrals and enrollment in the Heart Failure Rehab Program, which is a program aimed at increasing affordable access to Heart Failure Rehab services and resources.
7. Facilitate a Heart Failure support group two times per week for patients diagnosed with Congestive Heart Failure (CHF).
8. Heart Failure Clinic labels each blood pressure cuff for SJMC and loans these items to patients in need with the understanding that once the patient is stable over some time frame, the patient returns the items back to the clinic.
9. Heart Failure Clinic labels each weight scale for SJMC and loans these items to patients in need with the understanding that once the patient is stable over some time frame, the patient returns the items back to the clinic.
10. Every Heart Failure patient will leave the hospital with at least a one week supply of medications (at discounted price or for free if patients qualify for assistance)

11. Offer transportation assistance through Morton Transportation program to Heart Failure patients who lack transportation resources to get to Heart Failure Clinic, Heart Failure Rehab program, and/or the Cardiac Rehab Clinic
12. St. John Health System ERs to contact Heart Failure Clinic cardiologist and RN Case Manager prior to admitting a congestive heart failure (CHF) patient and when medically appropriate, patients will be scheduled at the Heart Failure clinic for same day or following day appointment.
13. Implementation of a St. John Medical Center Observation Unit run by hospitalists (have been instructed to notify Heart Failure Clinic Cardiologist and RN Case Manager to coordinate discharge and close follow-up.

ANTICIPATED IMPACT:

- I. **Short-Term:** By FY 2017, increase the proportion of 5 East and 5 West nursing associates who have received Heart Failure certification by 15-20% and by FY 2019, increase the proportion of associates who have received Heart Failure certification by 30% as measured by manual certification tracking performed by the 5th floor RN Nursing Manager.
- II. **Medium-Term:** By the end of December 2017, increase the proportion of new patients receiving services at the Heart Failure Clinic by 100% as measured by Heart Failure Clinic new patient tracking data.
- III. **Medium-Term:** By July 1, 2017, reduce the rate of congestive heart failure (CHF) readmissions by 5% from FY 2016 as measured by Heart Failure readmissions data.
- IV. **Medium-Term:** By July 1, 2018, reduce the rate of congestive heart failure (CHF) readmissions by an additional 5% from FY 2017 as measured by Heart Failure readmissions data.
- V. **Long-Term:** By July 1, 2019, reduce the rate of congestive heart failure (CHF) readmissions by an additional 5% from FY 2018 as measured by Heart Failure readmissions data.
- VI. **Long-Term:** By 2020, contribute to efforts to reduce the national coronary heart disease death rate by 20% from 2007 as measured by National Vital Statistics System-Mortality (NVSS-M), CDC/NCHS; Bridged-Race Population Estimates, CDC/NCHS and Census data.
- VII. **Long-Term:** By 2020, contribute to efforts reduce the Oklahoma rate of preventable hospitalizations by 20% from 2013 (based on 2019 data) as measured by the Oklahoma State Department of Health data.

Alignment with Local, State & National Priorities (Long-Term Outcomes for Prioritized Need #3, Goal #1, Strategy #1)

OBJECTIVE:	LOCAL / COMMUNITY PLAN:	STATE PLAN:	“HEALTHY PEOPLE 2020” (or OTHER NATIONAL PLAN):
V-VII	The 2016 Community Health Needs Assessment conducted by St. John Health System identified Wellness and Chronic Disease Prevention as priority health	Heart disease is the leading cause of death in Oklahoma according to the Oklahoma State Department of Health (OSDH), Center for Health	Ascension has established a goal to prevent avoidable congestive heart failure (CHF) admissions and readmissions among diverse populations in an effort to reduce

<p>need for the communities served by our six hospital facilities in northeastern Oklahoma. This was based on community surveys (Tulsa County Health Department and Washington Wellness Initiative) and focus groups of Tulsa County residents (Tulsa County Health Department), and community input meetings at each hospital with community leaders and representatives.</p> <p>St. John Health System has recognized the need to build a structured transition and expanded follow-up approach for heart failure patients. There is an identified lack of communication across the hospital, heart failure clinic and cardiac rehabilitation program within our system of hospitals. The goal is to increase the number of patients seen and managed in the clinic, prevent readmissions, treat some patients as observation patients with diuresis, and improve cardiac status through participation in the cardiac rehabilitation program.</p>	<p>Statistics, Health Care Information (2016). Congestive Heart Failure (CHF) is a common reason for hospitalization and disability.</p> <p>The Oklahoma Health Improvement Plan 2020 identified the reduction of heart disease deaths and the reduction of preventable hospitalizations as core Health Transformation measures:</p> <ul style="list-style-type: none"> •Improve Population Health – Reduce heart disease deaths by 11% by 2020 (2018 data). •Reduce by 20% the rate, per 100,000 Oklahomans, of potentially preventable hospitalizations from 1656 in 2013 to 1324.8 by 2020 (2019 data). 	<p>health disparities and promote health equity.</p>
<p>V-VII</p>	<p>Healthy Hearts for Oklahoma is a comprehensive project aimed at creating an effective, sustainable system to help primary care practices across Oklahoma improve cardiovascular disease management and prevention. It provides a critical infrastructure to help ensure better health for all Oklahomans, especially those in remote and rural areas. The University of Oklahoma received a 3-year, 15-million-dollar grant as part of the Agency for Healthcare Research and</p>	<p>Healthy People 2020 established specific objectives for reducing hospitalizations among older adults age 65+ by 10% by 2020 and for reducing the rate of coronary heart disease deaths by 20% in 2020.</p>

Quality initiative, Evidence NOW – Advancing Heart Health in Primary Care, which supports the broad U.S. Department of Health and Human Services effort for Better Care, Smarter Spending, and Healthier People, and is aligned with the Department’s Million Hearts® national initiative to prevent heart attacks and strokes.

GOAL 2: Promote equitable and patient-centered pre-diabetic and diabetic care in solidarity with those living in poverty and/or who may be otherwise deemed vulnerable.

Action Plan

STRATEGY 1: Implement an initiative to support diabetic and pre-diabetic patients discharging from the hospital who lack primary care follow-up through patient centered transition of care, education, and disease management support services.

BACKGROUND INFORMATION:

- The strategy's target population is pre-diabetic and diabetic patients discharging from St. John Medical Center and Jane Phillips Medical Center who lack a primary care provider or are unable to follow-up with a primary care provider following discharge. Many within this target population are living in poverty and/or are otherwise deemed vulnerable.
- Diabetes is more prevalent among persons living in poverty and minority populations, and/or populations who are otherwise deemed vulnerable; through equitable prevention and care management programs, health disparities can be reduced.
- The strategy is a system change and is informed by evidence found on What Works for Health and The Guide to Community Preventive Services.

RESOURCES:

- St. John Health System (SJHS)
- St. John Medical Center (SJMC)
- Jane Phillips Medical Center (JPMC)
- SJMC Transitional Care Clinics
- JPMC Transitional Care Services
- Diabetes Education at SJMC and JPMC
- Outpatient Diabetes Education Centers
- Transitional Care Clinics staffing
- Diabetes Education staffing
- Labor
- Program budget
- Facility space and occupancy
- Condensed diabetes education programming developed for the Transitional Care Clinics in partnership with the Diabetes Education Centers
- Diabetes prevention education programming developed for the Transitional Care Clinics in partnership with the Diabetes Education Centers
- Educational videos on diabetes and diabetes prevention (externally produced)
- Educational handouts developed based on healthy literacy and plain language recommendations
- Transportation assistance (taxi cab passes and Morton Transportation Assistance Program)

COLLABORATION:

- Morton Comprehensive Health Services, Transportation Dept.

STRATEGY 1: Implement an initiative to support diabetic and pre-diabetic patients discharging from the hospital who lack primary care follow-up through patient centered transition of care, education, and disease management support services.

ACTIONS:

1. Complete initiative logistics planning and establish plans for workflow and implementation.
2. Develop condensed diabetes educational programming to be used by the SJMC Transitional Care Clinics and JPMC Transitional Care Services staff in partnership with the Diabetes Education Centers.
3. Develop educational handouts based on plain language and health literacy recommendations.
4. Select educational videos to be used by the SJMC Transitional Care Clinic and JPMC Transitional Care Services.
5. Provide SJMC Transitional Care Clinic and JPMC Transitional Care Services staff with diabetes management and diabetes prevention training.
6. Diabetes Education staff to perform medication reviews on patients referred to Transitional Care Clinics upon discharge.
7. Offer diabetes and diabetes prevention education in classroom setting and use of teach back method to ensure comprehension in Transitional Care Clinics.
8. Social work staff within Transitional Care Clinics to assist patients with prescription assistance applications.
9. Link eligible patients to available transportation assistance to get to Transitional Care Clinic appointments and to follow-up with Diabetes Education care.
10. Refer Transitional Care Clinic patients for follow-up care at the outpatient Diabetes Education Centers at SJMC and JPMC as appropriate.

ANTICIPATED IMPACT:

- I. **Short-Term:** By July 1, 2017, increase the knowledge of Transitional Care Clinic staff on diabetes management and diabetes prevention education by 90% as measured by training records kept by the SJMC Transitional Care Clinic and the JPMC Transitional Care Clinic.
- II. **Medium-Term:** By July 1, 2018, increase the proportion of diabetic and pre-diabetic patients accessing the SJMC Transitional Care Clinic and the JPMC Transitional Care Services who are offered diabetic management or diabetes prevention education by 100% as measured by SJMC Transitional Care Clinic and the JPMC Transitional Care Services records.
- III. **Medium-Term:** By July 1, 2018, increase the proportion of diabetic and pre-diabetic patients accessing the SJMC Transitional Care Clinic and the JPMC Transitional Care Services who are referred to follow-up care through the Outpatient Diabetes Education Center by 20% as measured by manual tracking data.
- IV. **Long-Term:** By July 1, 2019, contribute to efforts to reduce the rate of diabetes-related readmissions among diabetic patients by 10% as measured by Optum reports.
- V. **Long-Term:** By 2020, contribute to efforts to reduce the annual number of new cases of diagnosed diabetes among the U.S. population by 10% as measured by National Health Interview Survey (NHIS), CDC/NCHS data.

STRATEGY 1: Implement an initiative to support diabetic and pre-diabetic patients discharging from the hospital who lack primary care follow-up through patient centered transition of care, education, and disease management support services.

VI. **Long-Term:** By 2020, contribute to efforts reduce diabetes rate among the U.S. population by 10% as measured by National Vital Statistics System-Mortality (NVSS-M), CDC/NCHS; Bridged-Race Population Estimates, CDC/NCHS, and Census data.

Alignment with Local, State & National Priorities (Long-Term Outcomes for Prioritized Need #2, Goal #2, Strategy #1)

OBJECTIVE:	LOCAL / COMMUNITY PLAN:	STATE PLAN:	“HEALTHY PEOPLE 2020” (or OTHER NATIONAL PLAN):
IV-VI	<p>The 2016 Community Health Needs Assessment conducted by St. John Health System and community partners identified Wellness and Chronic Disease as one of the priority health needs based on community surveys (Tulsa County Health Department and Washington County Wellness Initiative) and focus groups of residents (Tulsa County Health Department) as well as community input meetings at each hospital with community leaders and representatives.</p> <p>From 2011-2013, diabetes was among the top 10 causes of death in Tulsa County and Washington County (7th leading cause of death). Diabetes was cited in the 2016 Community Health Needs Assessment as a factor in lower life expectancy as a factor in lower life expectancy up to 15 years, increased risk of heart disease by 2 to 4 times, and the leading cause of kidney failure, lower limb amputations, and adult onset blindness.</p>	<p>The Oklahoma Health Improvement Plan (OHIP) 2020 identified the importance of public-private partnerships in addressing systemic and environmental changes to the health of the Oklahoma population. The plan noted that Oklahoma ranks 47th in the nation for physical activity among adults, 49th in the nation for consumption of fruit, 39th for vegetable consumption, 44th for obesity among adults.</p> <p>OHIP set a goal for reduction of adult obesity prevalence in Oklahoma from 32.5% in 2013 to 29.5% in 2020.</p>	<p>HealthyPeople 2020 established sixteen specific objectives to address diabetes and the prevention of diabetes including the reduction of new age-adjusted diabetes cases per 100,000 population by 10% and the reduction of the diabetes death rate per 100,000 population by 10%. In addition, the plan set objectives cross-cutting categories of health improvement goals</p>
	<p>In 2013, the Tulsa County Community Health Improvement</p>		

Plan (CHIP) set the goal of reducing the number of newly diagnosed cases of diabetes by 10% in 2020 (same as HealthyPeople 2020).

GOAL 3: Improve health outcomes for individuals who are in a pre-condition state or who have been diagnosed with a chronic disease.

Action Plan

STRATEGY 1: Promote healthy diet, physical activity, and prevention oriented wellness through health system support of community-based initiatives in partnership with local health departments, coalitions, community-based organizations, and schools; participation in local activities, education classes, events, and health fairs; and chronic disease management support.

BACKGROUND INFORMATION:

- The strategy’s target population is all community dwelling persons in northeastern Oklahoma.
- Obesity and chronic disease are more prevalent among those with health disparities and among poor and vulnerable populations; through equitable prevention and care management programs, health disparities can be reduced.
- The strategy is a system change and is informed by evidence found on What Works for Health and The Guide to Community Preventive Services.

RESOURCES:

- St. John Health System (SJHS)
- St. John Health System hospital facilities
 - St. John Medical Center (SJMC)
 - Jane Phillips Medical Center (JPMC)
 - St. John Owasso (SJO)
 - St. John Broken Arrow (SJBA)
 - St. John Sapulpa (SJS)
 - Jane Phillips Nowata Health Center (JPNHC)
- St. John Clinic
- Special Projects Manager, Community Health
- Community Health/Community Engagement division
- Community Engagement Committee
- Wellness Connection at JPMC
- “Tai Chi – Moving for Better Balance” class (SJS)
- Quarterly CPR class (SJS)
- Labor
- Program budget
- Community Benefit
- Facility space and occupancy

COLLABORATION:

- Pathways to Health (P2H)
- Creek County Community Partnership (CCCP)
- Washington County Wellness Initiative (WCWI)
- Preventative Health Partnership (PHP)
- Nowata Community Advancement Network (Nowata CAN)

STRATEGY 1: Promote healthy diet, physical activity, and prevention oriented wellness through health system support of community-based initiatives in partnership with local health departments, coalitions, community-based organizations, and schools; participation in local activities, education classes, events, and health fairs; and chronic disease management support.

- Broken Arrow Public Schools
- Broken Arrow Police Department
- Local health departments (Tulsa County, Creek County, and Washington County)
- Owasso Public Schools

ACTIONS:

1. Participate in Pathways to Health (P2H, non-profit fundraiser arm of Tulsa City-County Health Department) Board as a member (SJMC, SJO, SJBA).
2. Through Pathways to Health Board representation, participate in alliance group and board sponsored wellness activities and events promoting healthy diet, physical activity, and wellness (SJMC, SJO, and SJBA).
3. Participate as a partner in Creek County Community Partnership (CCCP) (SJS).
4. Participate as a partner in Washington County Wellness Initiative (JPMC).
5. Participate in the Preventative Health Partnership (PHP) in Washington County (JPMC).
6. Participate as a partner in Nowata Community Advancement Network (Nowata CAN) (JPNHC).
7. Continue to sponsor Nowata CAN's "Double Bucks" and "Veggie Vouchers" programs in conjunction with the Nowata Area Farmers Market each spring (JPNHC).
8. Facilitate wellness education classes at Bartlesville Public Library (Flu, Blood Pressure Control, Stress, Diabetes Prevention, Breast Cancer, and Cancer Prevention) (JPMC).
9. Continue to offer Diabetes Prevention program that includes dietary coaching, lifestyle intervention, and moderate physical activity with the goal of preventing onset of diabetes in individuals who are pre-diabetic in Washington County. The program follows the National Diabetes Prevention Program led by the Centers for Disease Control and Prevention (CDC) (JPMC).
10. Continue to sponsor and participate in local runs, walks, and the annual Tour de Tulsa cycling fundraiser for Pathways to Health to promote participation in group exercise (all St. John Health System hospital facilities).
11. Continue to support the Washington County organization named FLOWCo – Fitness Lovers of Washington County, which encourages residents to get healthier together with a free fitness program (JPMC).
12. Continue to support Project Fit America through the sponsorship of the installation of Project Fit America equipment area schools. Project Fit America is a national nonprofit organization that creates and administers fitness education programming in elementary and middle schools. The charity works with sponsors to bring in donations to build fitness equipment at schools and emphasizes techniques to participate in and appreciate fitness-related skills that are necessary to maintain lifelong fitness (JPMC).

STRATEGY 1: Promote healthy diet, physical activity, and prevention oriented wellness through health system support of community-based initiatives in partnership with local health departments, coalitions, community-based organizations, and schools; participation in local activities, education classes, events, and health fairs; and chronic disease management support.

13. Continue to partner with Broken Arrow Public Schools and Broken Arrow Police Department (BAPD) to offer a free health fair for Broken Arrow students as part of the BAPD’s Back to School Bash. Attendees receive free health services and screenings, including blood pressure and heart rate checks, oxygen saturation readings, and physician and nurse consultations (SJBA).
14. Continue to partner with Owasso Public Schools offer a free health fair for Owasso and surrounding communities. Attendees receive free health services and screenings, including blood pressure and heart rate checks, oxygen saturation readings, and physician and nurse consultations (SJO).
15. Continue to offer St. John Sapulpa classroom space for local community partners to health and wellness focused education classes, events, and trainings (Tai Chi, CPR, Group Connections, etc.) (SJS)
16. Continue to partner with the Creek County Health Department to offer “Tai Chi – Moving for Better Balance” to improve community wellness through group exercise and to promote fall risk and injury prevention (SJS).
17. Continue to engage in associate wellness activities and programs and explore options for expanding programs and activities (all St. John Health System hospital facilities).

ANTICIPATED IMPACT:

- I. **Short-Term:** By July 1, 2017, increase positive fitness motivation and skill among Washington County FLOWCo participants by 5-10% from FY 2016 as evidenced by the proportion of participants who complete 70% of training program and as measured by FLOWCo data.
- II. **Medium-Term:** By July 1, 2017, increase the proportion of participants attending weekly Tai Chi classes at St. John Sapulpa by 10% from FY 2016 as measured by Creek County Health Department class attendance records.
- III. **Medium-Term:** By July 1, 2017, achieve average weight loss of 5% among participants of Jane Phillips Medical Center’s Diabetes Prevention Program as measured by Jane Phillips Medical Center Wellness Services records.
- IV. **Medium-Term:** By July 1, 2019, increase participation in local wellness coalitions and partnerships by at least 10% as measured by Community Health/Community Engagement and SJHS hospital facility meeting records data.
- V. **Medium-Term:** By 2020, contribute to efforts to reduce the proportion of adults in Tulsa County who self-report they have been told they have high blood pressure by 10% from 2013 as measured by Tulsa County Health Department Community Health Needs Assessment data (2019 data).
- VI. **Medium-Term:** By 2020, contribute to efforts to ncrease the percentage of the population in Oklahoma that have participated in any physical activity in the last 30 days from 71.7% in 2012 to 79.2% as measured by

STRATEGY 1: Promote healthy diet, physical activity, and prevention oriented wellness through health system support of community-based initiatives in partnership with local health departments, coalitions, community-based organizations, and schools; participation in local activities, education classes, events, and health fairs; and chronic disease management support.

- Behavioral Risk Factor Surveillance System (BRFSS) and Oklahoma State Department of Health data (2019 data).
- VII. **Medium-Term:** By 2020, contribute to efforts increase the median intake of vegetables from 1.6 times per day in 2012 to 2.1 times per day by 2020 as measured by Behavioral Risk Factor Surveillance System (BRFSS) and Oklahoma State Department of Health data (2019 data).
 - VIII. **Long-Term:** By 2020, contribute to efforts to reduce the prevalence of adult obesity in Oklahoma from 32.5% in 2013 to 29.5% as measured by Behavioral Risk Factor Surveillance System (BRFSS) and Oklahoma State Department of Health data (2019 data).
 - IX. **Long-Term:** By 2020, contribute to efforts reduce the proportion of adults with hypertension from 29.9% in 2005-2008 to 26.9% in 2020 as measured by NHANES (national) data.
 - X. **Long-Term:** By 2020, contribute to efforts to increase the proportion of adults with prehypertension who meet the recommended guidelines for the body mass index (BMI) from 28.7% in 2005-2008 to 33% in 2020 as measured by NHANES (national) data.
 - XI. **Long-Term:** By 2020, contribute to efforts to reduce the rate of coronary heart disease deaths in the U.S. by 10% as measured by National Vital Statistics System-Mortality (NVSS-M), CDC/NCHS; Bridged-Race Population Estimates, CDC/NCHS and Census.
 - XII. **Long-Term:** By 2020, contribute to efforts to reduce the annual number of new cases of diagnosed diabetes among the U.S. population by 10% as measured by National Health Interview Survey (NHIS), CDC/NCHS data.

Alignment with Local, State & National Priorities (Long-Term Outcomes for Prioritized Need #2, Goal #1, Strategy #2)

OBJECTIVE:	LOCAL / COMMUNITY PLAN:	STATE PLAN:	"HEALTHY PEOPLE 2020" (or OTHER NATIONAL PLAN):
VI-XII	The 2016 Community Health Needs Assessment conducted by St. John Health System and community partners identified Wellness and Chronic Disease Prevention as one of the priority health needs of the communities we serve. This was based on community surveys (Tulsa County Health Department and Washington Wellness Initiative) and focus groups of Tulsa County	The Oklahoma Health Improvement Plan 2020 (OHIP 2020) identified the importance of public-private partnerships in addressing systemic and environmental changes to the health of the Oklahoma population. The plan noted that Oklahoma ranks 47th in the nation for physical activity among adults, 49th in the nation for	HealthyPeople 2020 established specific objectives for improvement in BP and BMI for specific chronic conditions as well as in cross-cutting categories of health improvement goals. The plan also included objectives for improvement in chronic disease death rates including diabetes coronary heart disease (see above).

residents (Tulsa County Health Department), and community input meetings at each hospital with community leaders and representatives.

Poor diet and activity was identified as a top health concern by the 2016 Community Health Needs Assessment conducted by St. John Health System in all communities served by our six hospital facilities. Obesity is recognized as a high risk factor for health complications. Nearly 2/3 of Oklahoma adults self-reported as being overweight or obese in 2016. Chronic disease was cited in the Community Health Needs Assessment (2016) as a factor in lower life expectancy up to 15 years, increased risk of heart disease by 2 to 4 times, and the leading cause of kidney failure, lower limb amputations, and adult onset blindness. The Tulsa County Health department cited a 10% improvement in these indicators by 2020 as its goals for various related health indicators, consistent with HealthyPeople 2020.

consumption of fruit, 39th for vegetable consumption, 44th for obesity among adults. OHIP set a goal for reduction of adult obesity prevalence in Oklahoma from 32.5% in 2013 to 29.5% in 2020. The plan also identified improvements in physical activity and vegetable intake indicators by 2020 (see above).

Multiple local coalitions and community-based partnerships have formed to address wellness and chronic disease prevention including Pathways to Health (Tulsa County), Washington County Wellness Initiative (Washington County), Preventative Health Partnership (Washington County), Nowata Community Advancement Network (Nowata County), and the Creek County Community Partnership and Healthy Living Coalition (Creek County).

HealthyPeople 2020 established sixteen specific objectives to address diabetes and the prevention of diabetes including the reduction of new age-adjusted diabetes cases per 100,000 population by 10% and the reduction of the diabetes death rate per 100,000 population by 10%. In addition, the plan set objectives cross-cutting categories of health improvement goals.

Prioritized Need #4: Health Literacy

GOAL 1: Help persons of diverse backgrounds navigate health services and gain empowerment in taking charge of their own health improvement.

Action Plan

STRATEGY 1: Assess health literacy needs among patients of diverse backgrounds to work towards assisting patients in understanding how to navigate health services and gain empowerment in taking charge of their own health improvement with the St. John Medical Center Transitional Care Clinic as the pilot site for this effort.

BACKGROUND INFORMATION:

- The strategy's target population is patients discharging from inpatient status at St. John Medical Center and who are accessing follow-up care services through the Transitional Care Clinic at St. John Medical Center (special focus on persons with diverse backgrounds, living in poverty, and at-risk populations).
- Increasing health literacy promotes health equity and addresses social determinants of health, health disparities and barriers to care.
- The strategy is a system change informed by evidence found on the Centers for Disease Control website (<http://health.gov/communication/literacy/quickguide/about.htm>); AHRQ's report: Communication and Dissemination Strategies To Facilitate the Use of Health-Related Evidence; and Institute of Medicine's report from the Committee on Health Literacy: Health Literacy: A Prescription to End Confusion (<http://nap.edu/10883>); and Preventive Community Services Task Force.

RESOURCES:

- St. John Health System (SJHS)
- St. John Medical Center (SJMC)
- Pfizer, vital sign toolkit (health literacy screening tool)
- REALM-SF tool (health literacy screening tool)
- Transitional Care Clinic at SJMC
- Nursing and social work staff
- Information Technology
- Electronic health record; DTA tracked
- Training
- Labor
- Program budget
- Facility space and occupancy
- St. John Clinic
- Medical Access Clinic
- Heart Failure Clinic

COLLABORATION:

- Morningcrest Health Library, University of Oklahoma (health literacy library)

STRATEGY 1: Assess health literacy needs among patients of diverse backgrounds to work towards assisting patients in understanding how to navigate health services and gain empowerment in taking charge of their own health improvement with the St. John Medical Center Transitional Care Clinic as the pilot site for this effort.

ACTIONS:

1. Select health literacy screening tools.
2. Train staff to use screening tools.
3. Meet with Morningcrest librarian at the University of Oklahoma with expertise on health literacy to help further develop process.
4. Obtain staff commitment to screen for health literacy.
5. Implement screening tools into clinic workflow.
6. Work with IT to embed scoring/assessment results into Electronic Health Record (EHR).
7. Notify providers of screening level of patients to ensure appropriate follow-up care is provided through scoring/assessment results in Electronic Health Record (EHR).
8. Explore health literacy improvement program implementation based on needs as assessed in Transitional Care Clinic based on DTA tracking information.
9. Implement health literacy tool into two additional clinics following initiation in Transitional Care (e.g. Heart Failure Clinic and Medical Access Clinic).

ANTICIPATED IMPACT:

- I. **Short-Term:** By July 2017, increase proportion of staff commitment to screen patients for health literacy by 90% as measured by commitment form records managed by the Transitional Care Clinic.
- II. **Medium-Term:** By July 1, 2018 and quarterly thereafter, increase proportion of patients in the Transitional Care Clinic who are screened for health literacy by 90% as measured by tracking form and Cerner electronic health record (EHR) data.
- III. **Long-Term:** By July 1, 2019, increase the number of programs developed to address health literacy improvement by 100% based on health literacy needs as assessed by SJMC Transitional Care Clinic reporting data.
- IV. **Long-Term:** By 2020, contribute to the effort to increase the proportion of U.S. adults who report their healthcare provider always gave them easy-to-understand instructions about what to do to take care of their illness or health condition from 64.1% in 2011 to 70.5% in 2020 as measured by MEPS and AHRQ (national) data.

Alignment with Local, State & National Priorities (Long-Term Outcomes for Prioritized Need #4, Goal #1, Strategy #1)

OBJECTIVE:	LOCAL / COMMUNITY PLAN:	STATE PLAN:	“HEALTHY PEOPLE 2020” (or OTHER NATIONAL PLAN):
III-IV	<p>The 2016 Community Health Needs Assessment conducted by St. John Health System identified Health Literacy as one of the priority health needs of the communities served by our six hospital facilities. This need is based on information from community surveys (Tulsa County Health Department and Washington County Wellness Initiative) and focus groups of Tulsa County residents (Tulsa County Health Department) as well as community input meetings at each hospital with community leaders and representatives.</p>	<p>The Oklahoma Health Improvement Plan identified health literacy (“health education”) as an essential activity for public and private partnerships that will create an environment for healthy choices: “efforts are focused on empowering people to take action by increasing knowledge and skills, while also focusing on systems, environments, and policies that affect health.”</p>	<p>HealthyPeople 2020 identified Health Literacy as one of the primary objectives for improvement by 2020. The indicator noted above is one of three key indicators for determining success.</p> <p>Improving health literacy—that is, the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions—is critical to achieving the objectives set forth in Healthy People 2020. For this reason, the U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, developed a National Action Plan to Improve Health Literacy. The plan seeks to engage organizations, professionals, policymakers, communities, individuals, and families in a linked, multisector effort to improve health literacy. A 2010 report on the plan contains seven goals that will improve health literacy and suggests strategies for achieving them.</p>
III-IV	<p>The 2016 Tulsa County Community Health Improvement Steering Committee recently voted on Health Education, as one of its two priority health needs areas to address. Health literacy is a component of this priority area. There are also initial efforts occurring in Washington County (Washington County Wellness Initiative) and in Creek County (Creek County Community Partnership and Creek County Health Literacy</p>		

Program) that are working to address health literacy.