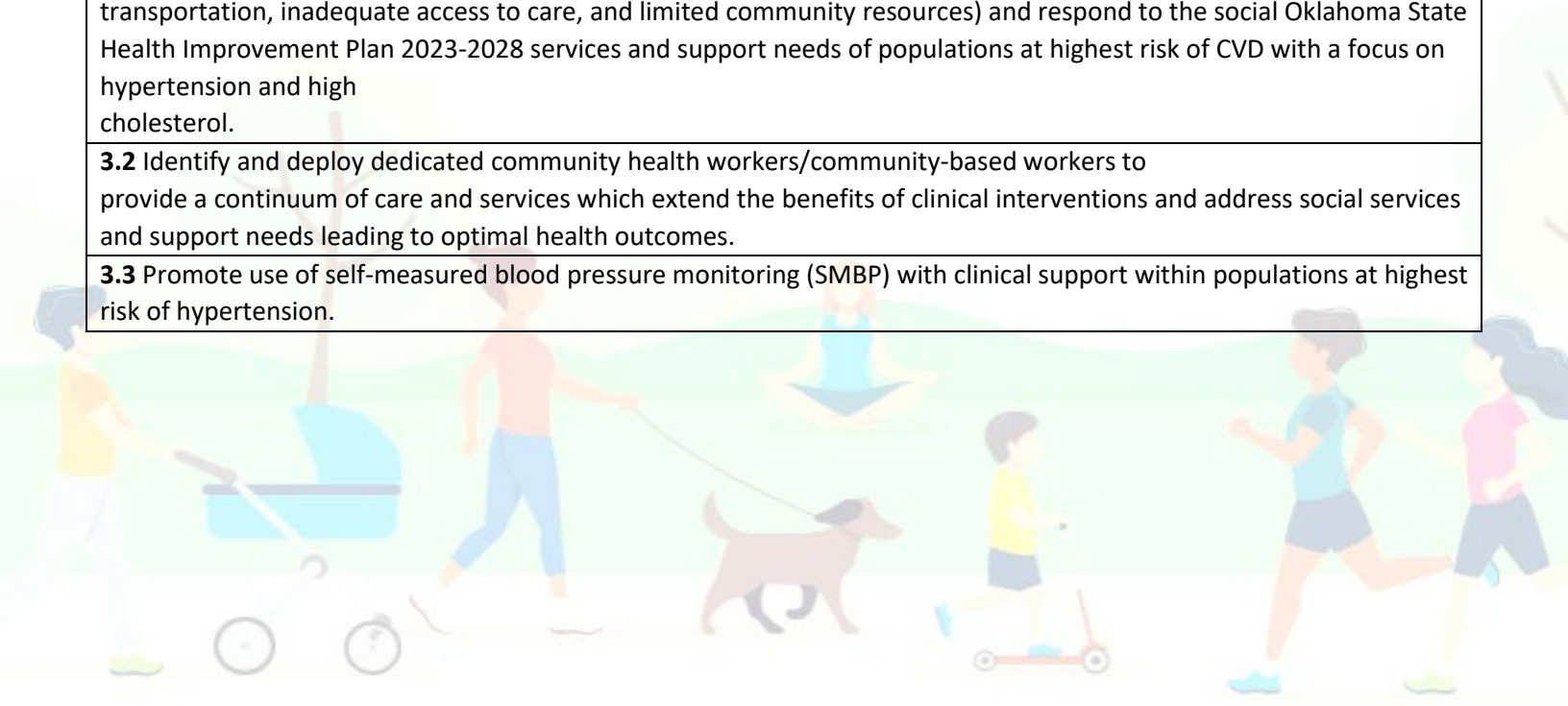
OKLAHOMA State Department of Health

CARDIOVASCULAR DISEASE
Cardiovascular disease partners (as of 5/1/2024): Oklahoma Health Care Authority; Oklahoma Hospital Association; Oklahoma State Department of Health (OSDH), Chronic Disease Prevention Service (CDPS); OSDH, Community Health District 5; Regional Food Bank of Oklahoma; Telligen; University of Oklahoma, Health Sciences Center
Goal 1: Track and monitor clinical and social services and support needs measures shown to improve health and wellness, health care quality, and identify patients at high risk of cardiovascular disease (CVD) with a focus on hypertension and high cholesterol to improve the rate of CVD in Oklahoma
1.1 Promote the use of standardized processes or tools to identify the social services and support needs of patient populations at highest risk of CVD, with a focus on hypertension and high cholesterol, and monitor and assess the referral and utilization of those services, such as food assistance, transportation, housing, childcare, etc.
Goal 2: Implement Team-Based Care to prevent and reduce CVD risk with a focus on hypertension and high cholesterol prevention, detection, control, and management through the mitigation of social support barriers to improve outcomes and the rate of CVD in Oklahoma
2.1 Advance the use of health information systems that support team-based care to monitor population health with a focus on health disparities, hypertension, and high cholesterol.
2.2 Assemble or create multi-disciplinary teams (e.g., nurses, nurse practitioners, pharmacists, nutritionists, physical therapists, social workers, and community-based workers) to identify patients' social services and support needs and to improve the management and treatment of hypertension and high cholesterol.
2.3 Build and manage a coordinated network of multi-disciplinary partnerships that address identified barriers to social services and support needs (childcare, transportation, language translation, food assistance, and housing) within populations at highest risk of CVD.
Goal 3: Link community resources and clinical services that support bidirectional referrals, self-management, and lifestyle change to address drivers of health that put priority populations at increased risk of CVD with a focus on hypertension and high cholesterol to improve the rate of CVD in Oklahoma from 11.5% to 10.8%
3.1 Create and enhance community-clinical links to identify DOH (e.g., inferior housing, lack of transportation, inadequate access to care, and limited community resources) and respond to the social Oklahoma State Health Improvement Plan 2023-2028 services and support needs of populations at highest risk of CVD with a focus on hypertension and high cholesterol.
3.2 Identify and deploy dedicated community health workers/community-based workers to provide a continuum of care and services which extend the benefits of clinical interventions and address social services and support needs leading to optimal health outcomes.
3.3 Promote use of self-measured blood pressure monitoring (SMBP) with clinical support within populations at highest risk of hypertension.



OKLAHOMA State Department of Health

DIABETES
Diabetes partners (as of 5/1/2024): Abbott Diabetes Care; Oklahoma Foundation for Medical Quality; Oklahoma Hospital Association; Oklahoma Primary Care Association; Oklahoma State Department of Health, CDPS; Oklahoma State University, County Extension; Regional Food Bank of Oklahoma; Southwestern Oklahoma State University, Rural Health Clinic; University of Oklahoma, Health Sciences Center
Goal 1: Strengthen self-care practices by improving access, appropriateness and feasibility of DSMES services for priority populations to improve the state rate of diabetes prevalence from 13.3% to 12% by 2028
1.1: Identify and train in the DSMES program and protocols. Training will be provided to those that serve rural and urban populations in becoming Association of Diabetes Care and Education Specialists (ADCES) accredited/American Diabetes Association (ADA) recognized.
1.2: Develop complementary diabetes support programs and services by partnering with community partners in areas of the state where priority populations have a high burden of diabetes
Goal 2: Prevent diabetes complications through early detection
2.1: Increase the number of priority populations (defined in strategy 1.2) who receive regular diabetes screenings by 5% in areas with high burden of diabetes
2.2: Increase the number of priority populations (defined in strategy 1.2) with diabetes who receive diabetic retinopathy screening by 5% in areas with high burden of diabetes
2.3: Increase the number of individuals in priority populations (defined in strategy 1.2) with diabetes who receive an annual chronic kidney disease (CKD) screening by 5% in areas with a high burden of diabetes
Goal 3: Improve acceptability and quality of care for priority populations with diabetes
3.1: Increase the number of individuals in priority populations (defined in strategy 1.2) with diabetes receiving team-based care supported by sustainable payment models by 5%, in areas with high burden of diabetes
3.2: Identify partners to increase adoption and use of clinical systems and care practices in priority populations with diabetes
Goal 4: Increase enrollment and retention of priority populations in the National Diabetes Prevention Program (National DPP) lifestyle intervention and the MDPP by improving access, appropriateness, and feasibility of the programs
4.1: Increase enrollment and retention in the National DPP Lifestyle intervention and MDPP, of priority populations with diabetes by 10%.
4.2: Increase enrollment and retention in the National DPP lifestyle intervention and MDPP, utilizing the Oklahoma county extension offices
Goal 5: Improve the sustainability of Community Health Workers (CHW)/community-based workers (CBWs) by building or strengthening a supportive infrastructure to expand their involvement in evidence-based diabetes prevention and management programs and services
5.1: Increase the number of CHWs/CBWs who are actively involved in evidence-based diabetes prevention and management programs and services by 10%
5.2: Increase the awareness of CHWs within the community by 10% through marketing campaigns and surveys, and increase the availability of CHWs to provide services to the community by 10%, as measured by trainings attended by CHWs
Goal 6: Improve the capacity of the diabetes workforce to address factors related to drivers of health that impact health outcomes for priority populations with and at risk for diabetes
6.1: Increase the number of diabetes healthcare providers who are trained in drivers of health topics by 5%
6.2: Increase the capacity of the diabetes workforce to assess and address factors related to drivers of health impacting health outcomes for priority populations with and at risk for diabetes by 10%

OKLAHOMA State Department of Health

DRIVERS OF HEALTH
Drivers of Health partners (as of 5/1/2024): Counseling and Recovery Services of Oklahoma; Creating Resilience, LLC; Legal Aid Services of OK; LIFT Tri-County Second Chance Re-Entry Program; Muscogee Nation Department of Health; MyHealth Access Network; Oklahoma Health Care Authority; Oklahoma Mobility Management; Oklahoma Public Health Association; Oklahoma State Department of Health (OSDH), Chronic Disease Prevention Service, OK Comprehensive Cancer Network (OCCN); OSDH, Community Health District 4; OSDH, Community Health District 5; OSDH, Emergency Preparedness; OSDH, FSPS, Oklahoma Family Support Network; OSDH, Heart Disease & Diabetes Prevention and Management; OSU, Center for Health Sciences; OKTEP: Oklahoma Tribal Engagement Partners; Oklahoma Turning Point Council; Panhandle Cares Association; Parent Promise; Prevent Child Abuse Oklahoma; PHIO; School Based Services at Checotah Schools in McIntosh County; Supporters of Families with Sickle Cell Disease, Inc.; Red Rock BHS, Medication Assisted Treatment; South Western Oklahoma Development Authority; Telligen; University of Oklahoma, Health Sciences Center, Hudson College of Public Health
Goal 1: *Improve health outcomes and reduce health disparities in Oklahoma as measured by America's Health Rankings social and economic factors from 44th to 41st by 2028*
1.1: Identify and engage advisory committees to include youth advisory committees and parent advisory committees
1.2: Promote peer support groups to strengthen Oklahomans' well-being and protective factors.
1.3: Strengthen and grow collaborations with state and local health departments, tribal nations, non-governmental organizations, policymakers, and private businesses to implement evidence-based practices for reducing health disparities and improving Oklahoma's population health
1.4: Collaborate with community partners and networks to grow the body of evidence designed to improve health outcomes
1.5: Increase the number of grants that directly involve community partners that address health disparities and improved health outcomes
1.6: Partner with business, governmental public health, social service agencies, and non-governmental, charitable, and community volunteer agencies to provide education, health, and social services to communities that have been marginalized.
Goal 2: Develop and grow partnerships to enhance the impact of education, research and service
2.1: Assemble experts and facilitate workgroup action planning from 5 main sectors (education, business, community engagement, health care, and tribal) to develop solutions for protecting the public health and preventing premature death, disability, and excessive demands on health systems
2.2: Facilitate the production of a comprehensive action plan to enhance the readiness and sustainability of Oklahoma's healthcare, business, education, community, and tribal sectors in a public health crisis
2.3: Partner with school districts and teacher training programs to strengthen population health strategies within Oklahoma schools
2.4: Be a resource to policy makers for recommendations on how to improve the health of Oklahoma
2.5: Grow statewide preparedness initiatives with support of private, community based and philanthropic organizations, businesses, tribes, and health departments for best long-term impact across populations
2.6: Provide data driven programming concepts and collaborative training for business, education, health care, tribes, and community engagement organizations across the State

MENTAL HEALTH
Mental health partners (as of 5/1/2024): Chickasaw Nation Department of Health, Division of Research and Public Health; Developing Caring Communities Committed to Action (DCCCA); Duncan Regional Hospital Health, Pathways to a Healthier You; EB Consulting OKC; Handle With Care OK; Lawton Community Health Center; Mental Health First Aid Oklahoma; Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS); Oklahoma Hospital Association; Oklahoma State Department of Health (OSDH), Emergency Preparedness & Response, Oklahoma Medical Reserve Corps (OKMRC); OSDH, Injury Prevention Service; OSU, Center for Family Resilience (CFR); Potts Family Foundation; Public Health Institute of Oklahoma; Red Rock BHS, Medication Assisted Treatment; South Western Oklahoma Development Authority; Tobacco Settlement Endowment Trust (TSET)
Goal 1: Improve Oklahoma's overall rate of death by suicide from 22.4% to 21% by 2028. Source: America's Health Rankings, Explore Suicide in Oklahoma | AHR (americashealthrankings.org)
1.1: Improve Oklahoma's overall rate of death by suicide by promoting and educating on 988
1.2: Improve Oklahoma's overall rate of death by suicide by increasing participation in trauma trainings such as NEAR and Mental Health First Aid (MHFA) training to teach people on how to identify, understand and respond to signs and symptoms of mental health and substance use challenges.
1.3: Improve Oklahoma's overall rate of death by suicide by distributing gun locks to prevent firearm deaths.

SUBSTANCE USE
Substance use prevention partners (as of 5/1/2024): Chickasaw Nation Department of Health, Division of Research and Public Health; Developing Caring Communities Committed to Action (DCCCA); Duncan Regional Hospital Health, Pathways to a Healthier You; EB Consulting OKC; Handle With Care OK; Lawton Community Health Center; Mental Health First Aid Oklahoma; Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS); Oklahoma Hospital Association; Oklahoma State Department of Health (OSDH), Emergency Preparedness & Response, Oklahoma Medical Reserve Corps (OKMRC); OSDH, Injury Prevention Service; OSU, Center for Family Resilience (CFR); Potts Family Foundation; Public Health Institute of Oklahoma; Red Rock BHS, Medication Assisted Treatment; South Western Oklahoma Development Authority; Tobacco Settlement Endowment Trust (TSET)
Goal 1: Improve Oklahoma's overall rate for substance use disorder among individuals aged 18 or older from 19.66% to 18.6% by 2028. Source: Substance Abuse and Mental Health Services Administration (SAMHSA), National Survey on Drug Use and Health
1.1: Improve Oklahoma's substance use rate by increasing primary substance use prevention education
Goal 2: Decrease Oklahoma's annual rate of unintentional drug overdose deaths from 1200 to a rate below 800 by 2028. Source: Oklahoma State Department of Health, Oklahoma Drug Overdose Dashboard, Drug Overdose Data Dashboard (oklahoma.gov)
2.1: Improve Oklahoma's overall rate of death by overdose by distributing medication lockboxes
2.2: Improve Oklahoma's overall rate of death by overdose by distributing fentanyl test strips
2.3: Improve Oklahoma's overall rate of death by overdose by distributing overdose reversal medication (Naloxone/Narcan)

OKLAHOMA State Department of Health

OBESITY

Obesity prevention partners (as of 5/1/2024): America Walks; American Association of Retired Persons; American Heart Association; American Society for Civil Engineers; Association of Central Oklahoma Governments; Avedis Foundation; Bicycle Corporation; Bike Oklahoma; Blue Zones POTT; Chamber of Commerce; City Planners Association; Community coalitions; Community Food Bank of Eastern Oklahoma; Congregations; Congress of Mayors; Department of Commerce; Department of Insurance; Employers; Faith based organizations; Healthcare Providers; Indian Nations Council of Governments; Institute for Quality Communities; Insurance Providers; Local businesses; National Association of City Transportation Officials (Technical training partner); Norman Regional Health System; Oklahoma Child Food Security Coalition; Oklahoma Cross Country Racing Association; Oklahoma Department of Human Services; Oklahoma Department of Transportation; Oklahoma Head Start Collaborative Office; Oklahoma Municipal League; Oklahoma Partnership for Expanded Learning; Oklahoma Partnership for School Readiness; Oklahoma School Nutrition Association; Oklahoma State Department of Education; Partnership for Active Transportation; Rails to Trails; Regional Food Bank of Oklahoma; Regional Transportation Plan Organization; Third Party Payers; Tobacco Settlement Endowment Trust (TSET); Tobacco Settlement Endowment Trust (TSET), Health Promotion Research Center; Town of Jones; YMCA of Greater OKC; YMCA/Salvation Army

Goal 1:

1.1: By 2024, have 100% of counties with an implemented summer feeding program

Goal 2:

2.1: By 2024, have 1 adopted planning and/or design guidance document adopted by a statewide planning organization or Oklahoma Municipal League or Oklahoma Chapter of the American Planning Association

Goal 3:

3.1: By 2026, 40 licensed childcare and education programs in high-risk areas will have participated in the GO Nutrition and Physical Activity Health Assessment for Childcare (GoNAPSACC) program

Goal 4:

4.1: By 2026, businesses will be trained in the CDC's Work@Health program