RWJF Culture of Health Community Portrait

Oklahoma
ABOUT THIS REPORT

The Sentinel Communities Surveillance project, conducted by RTI International in collaboration with the RAND Corporation, is sponsored by the Robert Wood Johnson Foundation (RWJF). The project, which began in 2016, will monitor activities related to how a Culture of Health is developing in each of 30 diverse communities around the country for at least five years. This community portrait follows from the initial Snapshot report for Oklahoma and provides insights into drivers of a Culture of Health in the community. The report is not intended to comprehensively describe every action underway in Oklahoma, but rather focuses on key insights, opportunities, and challenges as a community advances on its journey toward health and well-being for all residents.

The information in this report was obtained using several data collection methods, including key informant telephone interviews, an environmental scan of online and published community-specific materials, review of existing population surveillance and monitoring data, and collection of local data or resources provided by community contacts or interview respondents. Interviews were conducted with individuals representing organizations working in a variety of sectors (for example, health, business, education, human services, youth development, and environment) in the community. Sector mapping was used to systematically identify respondents in a range of sectors that would have insights about community health and well-being to ensure organizational diversity across the community. We also asked original interviewees to recommend individuals to speak with in an effort to supplement important organizations or perspectives not included in the original sample.

A total of 35 unique respondents were interviewed during winter and spring 2018. All interviews (lasting 30–75 minutes each) were conducted using semistructured interview guides tailored to the unique context and activities taking place in each community and to the role of the respondent in the community. Interviewers used probes to ensure that they obtained input on specific items of interest (for example, facilitators and barriers to improved population health, well-being, and equity) and open-ended questions to ensure that they fully addressed and captured participants’ responses and perceptions about influences on health and well-being in their communities. Individuals who participated in a key informant interview are not identified by name or organization to protect confidentiality, but they are identified as a “respondent.” Information collected through environmental scans includes program and organizational information available on internet websites, publicly available documents, and media reports. Population surveillance and monitoring data were compiled from publicly available datasets, including the American Community Survey; Behavioral Risk Factor Surveillance System; and other similar federal, state, and local data sources.

We will conduct ongoing surveillance and monitoring activities in these communities through 2020 and report updated information on their progress, challenges, and lessons learned in improving health and well-being for all residents.

Data collection and monitoring thus far has revealed common themes among otherwise distinct communities. The next phase of this project will be cross-community reports that will examine common themes across subgroups of the 30 communities (for example, rural communities, communities experiencing large demographic shifts, and communities leveraging local data for decision-making). These reports will also be posted on rwjf.org/cultureofhealth.
# Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>1</td>
</tr>
<tr>
<td>CONTEXTUAL CONDITIONS</td>
<td></td>
</tr>
<tr>
<td>COMMUNITY CAPACITY TO PROMOTE HEALTH, EQUITY, AND WELL-BEING</td>
<td></td>
</tr>
<tr>
<td>Developing a Culture of Health</td>
<td>5</td>
</tr>
<tr>
<td>STATE GOALS ALIGN WITH LOCAL ACTION TO REDUCE PREVENTABLE DEATHS</td>
<td></td>
</tr>
<tr>
<td>MULTISECTOR PARTNERS COLLABORATE TO AUGMENT RURAL HEALTH CARE ACCESS</td>
<td></td>
</tr>
<tr>
<td>TRIBAL NATIONS USE COLLABORATION TO PROMOTE WELL-BEING AND EQUITY</td>
<td></td>
</tr>
<tr>
<td>SUMMARY OF OKLAHOMA'S EFFORTS TO BUILD A CULTURE OF HEALTH</td>
<td></td>
</tr>
<tr>
<td>Emerging Community Themes</td>
<td>9</td>
</tr>
<tr>
<td>FACILITATORS TO A CULTURE OF HEALTH</td>
<td></td>
</tr>
<tr>
<td>BARRIERS TO A CULTURE OF HEALTH</td>
<td></td>
</tr>
<tr>
<td>What’s Next</td>
<td>10</td>
</tr>
<tr>
<td>References</td>
<td>11</td>
</tr>
</tbody>
</table>
Introduction

In our Snapshot report of Oklahoma, we described a diverse community, rich in American Indian cultural tradition that also struggles with high rates of chronic disease, primary care shortages, and significant racial and economic health disparities. We also described a community that is using cross-sector collaboration to transform public health infrastructure and reduce high rates of tobacco use and teen pregnancy. While we recognize there is important work occurring at the local level, for this report, we mainly focus on statewide initiatives and locally originated initiatives that have received attention and success at the state level.

In this report, we examine Oklahoma’s efforts to improve population health and build a healthier and more equitable community using the Culture of Health Action Framework to interpret and organize key findings. The Framework prioritizes four broad Action Areas: 1) Making Health a Shared Value; 2) Fostering Cross-Sector Collaboration to Improve Well-being; 3) Creating Healthier, More Equitable Communities; and 4) Strengthening Integration of Health Services and Systems. Within these areas, activities and investments can advance population health, well-being, and equity in diverse community contexts. Using the Framework, we describe how stakeholders in Oklahoma are taking multisector approaches to address access to primary care and decrease preventable deaths. We also share ways that tribal communities are building internal capacity and engaging in external collaborations to enhance well-being and promote health equity.
CONTEXTUAL CONDITIONS

Oklahoma, also known as the Sooner state, is located in the South-Central region of the United States. The state can be described as having three regions with different cultures and contexts—two anchored by urban areas and a third that covers the largely rural areas of the state: Tulsa, noted for its history of oil production; Oklahoma City, which is home to the seat of government; and an expanse of rural areas that covers one-third of the state’s population and is bisected by two major highways. Within these rural areas, the eastern region has a strong American Indian influence, while the panhandle region of the state (in a northwest quadrant) is the epicenter of Oklahoma’s growth in the Hispanic population.

Overall, Oklahoma has 3,896,251 residents. As of 2017, Tulsa had 410,800 residents (the larger Tulsa metropolitan area was 991,561 residents) and Oklahoma City had 643,648 residents (the larger Oklahoma City metropolitan area was closer to 1.4 million). Taken together, the two metropolitan areas comprise two-thirds of the state’s population. For Oklahoma’s total population, 66 percent is white (not Hispanic/Latino), about 10 percent is Hispanic, 10 percent is black, and about 10 percent is American Indian. The state has observed a sharp increase in the Hispanic population; for instance in Texas County in the Oklahoma panhandle, there was a 29 percent growth in population between 1990 and 2013 mainly due to increasing birth rates.

Oklahoma has the second largest American Indian population of any state in the United States. There are 38 federally recognized tribes in Oklahoma. Tribes interact on a government-to-government basis with the U.S. Government, and act as partners in the state’s efforts to promote health in their territories. Due to early 20th century U.S. government policies that encouraged assimilation and removed land rights from Oklahoma tribes, there are no remaining American Indian reservations in Oklahoma. Tribal governments have jurisdiction over delineated geographies, but the land itself is not owned by the tribes. It is instead owned privately by landowners, (the only exception, an “Underground” Osage reservation, which is owned by the Osage Nation for oil rights.).

More people live in poverty in Oklahoma relative to the U.S. average (16% compared to 12%), and more children live in poverty in the state (22% versus 18% nationally). The poverty rate in rural Oklahoma is 19 percent, compared with 15 percent in urban areas of the state. Overall, the state’s median household income of $50,051 was lower than the national median of $60,336. However, unemployment rates in the state are comparable to U.S. averages, hovering close to 4 percent as of 2018. In terms of educational attainment, 24 percent of Oklahomans have a bachelor’s degree or higher compared to 30 percent of the U.S. population. Fifteen percent of Oklahoma’s rural population has not completed high school, whereas 12 percent of the urban population lacks a high school diploma.

Economically, Oklahoma relies on oil, natural gas, and agriculture. The state’s fiscal health is challenged by a boom and bust cycle related to their primary export, oil. The state’s budget volatility is linked to this reliance on extraction industries, but the state has been reluctant to use oil and gas tax to help and the tax remains the lowest rate in the nation. Other key industries in Oklahoma include agriculture, where the state is a leading producer of wheat, as well as agriculture-related bioscience companies. Aerospace and defense also have a role. Tinker Air Force Base is based in Oklahoma City, and employs 26,000 military and civilian personnel.

Oklahoma is a politically conservative state. The Republican Party holds super-majorities in both chambers of state legislature, though until the mid-1960s, the state was actually considered a swing state. This modern conservative orientation has translated to anti-tax and anti-large government policies, such as the unwillingness to raise oil or other taxes like property and sales taxes. There also has been general political resistance to bills to promote health, address health equity, or increase revenue to support health services. Oklahoma is one of the only states without 100 percent smoke-free laws in restaurants and bars, and pre-emption laws prevent municipalities from officially enacting their own smoke-free policies. Medicaid expansion through the Affordable Care Act was rejected. Unfortunately, the prevailing economic volatility has led to significant state budget shortfalls, translating to major cuts to social programs like schools and health services.

TOBACCO IS THE LEADING PREVENTABLE CAUSE OF ABOUT 6,000 DEATHS IN OKLAHOMA PER YEAR, RESULTING IN [A] 29 PERCENT HIGHER LUNG CANCER MORTALITY RATE THAN THE NATIONAL AVERAGE.

From the public health perspective, the state budget challenges have been acute. Health leaders overspent the allocated budget at the Oklahoma State Department of Health (OSDH) and several officials had to step down after an audit revealed the financial mismanagement. Significant reductions in state health funding and changes in leadership, especially since fall 2017, led to the resignation of high-level officials and a lack of confidence in the department leadership, with rotating interim leaders since and severe budget cuts.

This challenge in public health funding comes during a period of significant health issues for the state’s residents. Tobacco use, poor diet, and sedentary lifestyle are attributed to 60 percent of Oklahoma’s preventable deaths. Tobacco is the leading preventable cause of death in Oklahoma, causing about 6,000 deaths in the state per year, and resulting in a lung cancer mortality rate that is 29 percent higher than the national average. In 2014, Oklahoma’s adult obesity rate was about 33 percent, putting Oklahoma at the seventh highest adult obesity rate in the nation. Oklahoma also struggles with the prevalence of mental illness and substance use disorders. Based on 2012 data, 22 percent of Oklahoma residents have any diagnosed mental illness, compared to 18 percent nationally. Outcomes related to substance use are concerning, but are improving relative to national rates: In 2017, the rate of opioid-related overdose deaths in Oklahoma was 10 deaths per 100,000 persons, less than the national rate of about 15 deaths per 100,000. This rate mostly captures a decline in prescription-related deaths stemming
from the strategies implemented as a result of the 2013 state plan, Reducing Prescription Drug Abuse in Oklahoma. Moreover, racial/ethnic disparities in most health outcomes persist. For example, American Indians experience higher cancer rates than white Oklahomans. Black and American Indian residents experience poorer mental health (average five days mentally unhealthy in last 30 days) than white Oklahomans (four days).14

Oklahoma ranks 47th in Internet Access (i.e., the fourth least-connected state) with 31 percent underserved without internet access.

Health outcomes like these also sit in the context of challenges in access to health care. Federally designated underserved areas and populations cover nearly the entirety of Oklahoma. As noted earlier, the state has a large rural population, and many rural areas are health care provider shortage areas (64 of 77 total counties in the state are primary care shortage areas), particularly for specialties like mental health.15 Addressing the medical and mental health shortage areas and increasing access to medical and community care are important needs in Oklahoma.16 Transportation to health services is a significant issue. The state is working to expand its rural transportation services and incorporate technology when possible to get services to rural areas.17 Due to the distance problems and scarcity of rural providers, the state depends on telemedicine to fill gaps. However, Oklahoma ranks 47th in internet access (i.e., the fourth least-connected state) with 31 percent underserved without internet access.15

Provider capacity is limited by regulations that restrict the practice of nurse practitioners. Oklahoma is listed as a “Restricted Practice” state, meaning that licensure laws require career-long supervision, delegation, or team management by another health provider in order for nurse practitioners to provide patient care. However, the state did enact an enhanced nurse licensing compact, which allows multistate licensure and gives approval for telehealth nurses to practice in multiple states.16

Community Capacity to Promote Health, Equity, and Well-Being
Oklahoma is working to address health and well-being issues in the state through a vision provided by OSDH paired with a network of collaborations with universities, some philanthropies, and nonprofit organizations. However, concerns about state budget shortfalls have led to instability around health programming and resources. Access to health care, while improving through workforce and incentive programs, is not yet at the level to fully address unmet health need. Networks of activities outside of government are essential in a state that has a limited tax base to invest in health.

Public health department provides health vision for state. The OSDH creates the Health Improvement Plan (OHIP), which requires counties to address flagship issues pre-selected by the state, such as tobacco use, obesity, children’s health, and behavioral health. Staff of county health departments are employees of the OSDH, except for the two large metro areas, which have independent city-county health departments. State policies apply to county offices. For example, while counties must address the flagship issues of OHIP 2020 set by the state, they also conduct local community health improvement plans that can include additional priority areas to address. A signature activity of OSDH comes through the Tobacco Settlement Endowment Trust (TSET). This gives Oklahoma a portion of the billions of dollars awarded to 46 states as part of the 1998 Master Settlement Agreement between the Attorneys General of those states and the five largest cigarette companies. (In Fiscal Year 2018, Oklahoma received $71.7 million in Master Settlement Agreement funds.) Oklahoma has dedicated these entitlement funds to prevention activities, with a focus on tobacco use and obesity. TSET and the health department provide technical assistance, and local communities can apply for grants.

The Office of Rural Health Works With Rural Communities to Help Ensure Their Health Care Infrastructure Is Economically Viable and to Broaden and Improve the Access and Quality of Health Care Services.

Certified Healthy OK is an initiative run through OSDH that distributes responsibility for healthy eating, physical activity, and tobacco-free living among community groups to build a shared vision of health. The program funds certification in eight different sectors. Groups must have this certification to apply for TSET incentive grants. This reciprocal relationship builds commitment to following through on Certified Healthy goals of the community, which then provides them access to funds to implement a locally desired wellness project. There is a business component to the program, Certified Healthy Business—created in 2003 to recognize Oklahoma businesses that promote health and wellness for their employees.

Health care systems dedicated to improving access in rural communities. As noted earlier, access and availability of health care for rural and remote populations in the state remains a priority issue. The Rural Health Network is a series of organizations that work together to enhance the connections and services available to rural health providers. The Oklahoma State University (OSU) Center for Health Sciences28 includes the Center for Rural Health and State Office of Rural Health. Responsible for the rural education portion of the OSU College of Osteopathic Medicine, the Center for Rural Health oversees the rural rotations of medical students, and provides rural practitioners, hospitals, and clinics that support access to health care for rural residents. It also serves as a statewide clearinghouse for rural health information. The Office of Rural Health works with rural communities to help ensure their health care infrastructure is economically viable and to broaden and improve the access and quality of health care services. The University of Oklahoma at Tulsa School of Community Medicine provides rural and urban rural residents access to specialized health care.
Tribal Epidemiologic Center, which provides epidemiological help to the tribes, including developing Community Health Profiles (CHPs) for each of the 42 tribes in Kansas, Oklahoma, and Texas.

The OSDH established the American Indian Data Community of Practice (AID CoP).27 The AID CoP engages data experts and stakeholders in learning networks, collaboration, and utilization of American Indian data in innovative ways. Through these activities, the forum uses data to change decision-making around health and well-being. OSDH also relies on their Office of the Tribal Liaison to advocate for tribal nations while using evidence-based practices and maintaining inclusive partnerships.

BY ADMINISTERING RESIDENCY, INTERNSHIP AND SCHOLARSHIP INCENTIVE PROGRAMS, PMTC ENCOURAGES MEDICAL AND NURSING PERSONNEL TO PRACTICE IN RURAL AND UNDERSERVED AREAS.

In addition to encouraging health care personnel to serve in rural areas, another aim of rural health infrastructure development is to provide opportunities for direct communication and collaboration between rural health care providers. The Rural Health Association of OK Inc. is a community-based network of providers. The Rural Oklahoma Network (ROK-Net), run by a collaboration of OSU centers, provides an infrastructure for the development of peer-learning networks comprised of rural clinicians and providers. The Rural Health Network (RHN) of Oklahoma was established through a grant awarded in 2008 through the Office of Rural Health Policy,28 Health Resources and Services Administration of the U.S. Department of Health and Human Services. It connects specific rural health care providers and provides supportive technical services in electronic health records (EHRs) and health information exchange (HIE).

Tribal health capacity strengthened through collaboratives. There are several efforts to bolster the activities of the 38 recognized tribes in the state. The Southern Plains Tribal Health Board (SPTHB)29 was founded in the 1970s as a collaboration between the tribes to advocate for proper support from the Indian Health Service (IHS). The region is one of 12 IHS units in the United States. One goal of the organization is to provide a tribal perspective toward the development of health policy and health program operations impacting tribes. SPTHB does not directly operate health care facilities, it serves the Indian Health Service, Tribal and Urban programs (I/TUs) as an advocate by representing the interests of the area at state and national levels. The SPTHB houses the Tribal Epidemiologic Center, which provides epidemiological help to the tribes, including developing Community Health Profiles (CHPs) for each of the 42 tribes in Kansas, Oklahoma, and Texas.

One goal of the Southern Plains Tribal Health Board is to provide a tribal perspective toward the development of health policy and health program operations impacting tribes.

Philanthropy is limited but focuses on major metro centers. Although limited and located mainly in the two urban areas, local foundations tend to focus on a target issue and collaborate as necessary to improve this issue throughout the state. For instance, the George Kaiser Family Foundation28 has many initiatives in Tulsa for early childhood development and has expanded to a broader focus on health care for low-income residents. The foundation also is working in Tulsa to improve the built environment and cooperating with universities and businesses to institute cross-sector programs. The Potts Family Foundation29 (Potts) is working on the Ok25by25 campaign,30 a statewide collaboration of businesses, nonprofits, state agencies, legislators and foundations. The collaboration is working to improve the well-being of Oklahoma’s children and raise the state ranking to within the top 25 states for children by 2025. Potts works on resilience and trauma issues through Resilient Oklahoma. The Oklahoma Caring Foundation provides preventative health services, including operating the Caring Van (free child immunizations across the state).31

Faith-based and nonprofit networks bolster community services. The faith community, particularly churches, provide on-the-ground services to their communities. There are networks of churches, which provide information about available social and health programs and services and coordinate statewide advocacy. Churches are also a point of access in rural communities. The Oklahoma Conference of Churches32 provides ministry and works with government agencies to educate people on specific needs. The Oklahoma Department of Human Services Office of
Faith-Based and Community Initiatives builds partnerships between government offices and faith and community groups to address social service needs. Priority areas are facilitation, prison re-entry, foster care, health and wellness, and emergency preparedness.

**NETWORKS OF CHURCHES PROVIDE INFORMATION ABOUT AVAILABLE SOCIAL AND HEALTH PROGRAMS AND SERVICES AND COORDINATE STATEWIDE ADVOCACY.**

In addition to the faith community, there are other efforts to engage nonprofit networks to address health and social needs. My Access Health Network was created as a collaboration of universities, health systems, and social service organizations (e.g., the Community Service Council) to create a health information exchange that is now spreading across the state. My Access also established The Route 66 Coalition to create an accountable health community where social issues and needs are addressed. The Coalition includes the Oklahoma City-County and Tulsa Health Departments and more than 200 other health care and social service organizations in Oklahoma. The Tulsa Zip Code Study started in 2005, represents a collaboration between major Tulsa organizations and the community (including black churches) to reduce health disparities between zip codes.

**Developing a Culture of Health**

Oklahoma has pursued many efforts to address key risk factors linked to preventable death and has endeavored to improve access to health care among the state’s rural and remote population. The state has significant financial challenges in its ability to leverage state funds for health and well-being promotion but benefits from collaborations and networks that are creatively investing in key health initiatives, in both urban and rural areas. Access to health care is a key issue for rural areas, which is being addressed through various provider training and incentive programs. Bright spots are noticeable in the health leadership within tribal nations as well, which in many cases are paving the way for a more holistic approach to improving health.

**STATE GOALS ALIGN WITH LOCAL ACTION TO REDUCE PREVENTABLE DEATHS**

Oklahoma has made progress in reducing preventable diseases by aligning state and local public health efforts to support collaboration, with a concerted focus on local implementation. This shared vision for health begins with the legislatively required Oklahoma Health Improvement Plan (OHIP), which calls for communities, businesses, schools, and congregations to address at least one of four issues: 1) tobacco use; 2) obesity; 3) children’s well-being; and 4) behavioral health. Synergy in efforts like the Certified Healthy Oklahoma program link the Oklahoma State Chamber with the OSDH and influence indicators of Oklahoma’s health.

**OKLAHOMA HAS MADE PROGRESS IN REDUCING PREVENTABLE DISEASES BY ALIGNING STATE AND LOCAL PUBLIC HEALTH EFFORTS TO SUPPORT COLLABORATION, WITH A CONCERTED FOCUS ON LOCAL IMPLEMENTATION.**

Until recently, communities throughout the state relied on their Turning Point Council coalition or other community partnerships to plan and implement local health improvement efforts. Historically, OSDH activities were bolstered by the Turning Point Initiative, a national effort funded by RWJF and the Kellogg Foundation, aimed at transforming local public health infrastructures through cross-sector partnerships, community action, and local engagement. Turning Point established 73 cross-sector partnerships in Oklahoma communities that included business, health, nonprofit, and public health entities. Participation in the Turning Point Initiative helped to build much of the local public health infrastructure. That provided a critical resource for localized public health initiatives through TSET and Healthy Oklahoma. This initiative began in the 1990s and continued to link state and local public health efforts until 2017/early 2018 when almost all of OSDH’s community liaisons to Turning Point were laid off because of the state financial crisis.

**A [TOBACCO] HELPLINE AND “TOBACCO STOPS WITH ME” STATEWIDE CAMPAIGN PROVIDE AN EFFICIENT, EMOTIONAL, AND HIGHLY RECOGNIZABLE TOBACCO-FREE MESSAGE FOR OKLAHOMANS TO RALLY AROUND.**

While Turning Point is now facing challenges, TSET is more stable. The structure is embedded in the state constitution, providing more sustainable wellness funding. Through research and grant funding, TSET inspires and supports local efforts in both urban and rural areas. Increased advocacy from local coalitions around these successes put pressure on the state to adopt policies that decrease tobacco use and exposure. TSET’s tobacco efforts include a Helpline and a “Tobacco Stops With Me” statewide campaign. These provide an efficient, emotional, and highly recognizable tobacco-free message for Oklahomans to rally around. By educating the public about the negative effects and impact of tobacco, the goal is to prevent and reduce tobacco use, and improve the health and quality of life of every Oklahoman. Local partners passed 24/7 smoke-free school policies, making about 70 percent of schools smoke-free. The state legislature was then able to pass a bill making all schools smoke-free in 2015. In 2017, the governor signed an executive order codifying smoke-free policies on state properties, a policy that was initiated and spread at the local level.

In addition to these legislative acts, TSET’s Healthy Living Program (HLP) combines tobacco and obesity work. Only Certified Healthy
Oklahoma groups can apply for HLP incentive grants. For example, the McAllister community passed a complete streets policy, and then was able to obtain a TSET grant to implement the engineering component for the community’s first complete street. In another instance, TSET funds were used to support the Rethink Your Drink effort to offer the public information about the harms of consuming sugar-sweetened beverages and the benefits of drinking water. A restricted online portal at OK in the Know helps TSET grantees communicate, share successes/challenges, and includes periodic technical assistance sessions. Public access for more general information is also provided.

"WE'RE NOT GOING TO SPEND MORE, WE'RE GOING TO SPEND LESS…[THE] TAKE CARE OF YOURSELF, INDEPENDENT-MINDED SPIRIT IS REALLY STRONG HERE."  
HEALTH SECTOR RESPONDENT (RELAYING PREVAILING RESIDENT ATTITUDE)

The network of nonprofits and philanthropies supports local action as well. For instance, the OK25by25 is taking on the child well-being priority from OHIP and addressing the issue of early childhood development through Oklahoma Champions for Early Opportunities. This includes identifying investments in social-emotional and cognitive activities and advocating for the needs of children at birth to age 5. Also in the area of child well-being, the Oklahoma Department of Human Services Office of Faith-Based and Community Initiatives is working with churches to identify congregations that can support children in foster care. Some church activities include providing a foster care ministry or donating items (e.g., luggage) for foster children in transition.

The broader issue of state goal alignment with local implementation is influenced by several factors, which span urban and rural communities. The state has a proud heritage of independence in which challenges and solutions are addressed at the most local level. One health leader noted the prevailing attitude of “we’re not going to spend more, we’re going to spend less” … [the] take care of yourself, independent-minded spirit is really strong here.”

The volatile nature of the oil industry has contributed to fortifying the mindset of local control. Adjusting to oil’s boom and bust cycles, local entities have grown accustomed to finding alternative sources of funding outside of this unstable revenue stream. The state’s current fiscal crisis has forced communities to build their own governmental infrastructure to compensate for the absence of state resources and services. While some of these drivers help to motivate local engagement, this push of responsibility to the local level is mixed. There are policy restrictions on a local jurisdiction’s ability to regulate unhealthy behaviors. While local culture may value local decisions, jurisdictions are not allowed to enact many local laws due to state-level pre-emption.

MULTISECTOR PARTNERS COLLABORATE TO AUGMENT RURAL HEALTH CARE ACCESS

With one-third of the state residing in rural and sparsely populated areas, access to even basic health care is difficult. In urban/metro regions like Tulsa and Oklahoma City, efforts like the Route 66 Coalition are working to improve access and address health issues by linking community services with better-integrated clinical service delivery, using the increasingly popular accountable health communities’ model, with the goal of spreading this model across the state.

However, outside of Tulsa and Oklahoma City in rural areas, the rest of the state still struggles with a severe shortage of medical providers, especially in primary, behavioral health, and dental care. A poorly developed infrastructure further exacerbates the problem; Oklahoma ranks 40th in the nation in the quality of rural roads. With the national news spotlighting Oklahoma’s underfunded educational system and the state’s low ranking in many health indicators, attracting physicians to Oklahoma’s rural communities is tough. However, organizations from diverse sectors are collaborating to improve health care access using various approaches, including: strategic planning and policy review; workforce development; telehealth; and networking.

"PMTC HARDLY WORK(S) HARD TO MATCH THE STUDENTS. IT’S NOT JUST ABOUT DOING YOUR SERVICE TO GET YOUR LOANS REPAID, IT’S ABOUT GETTING YOU IN A PLACE THAT YOU WANT TO STAY … SO THEY HAVE A MOTHER (HIGH) RETENTION RATE."

COMMUNITY LEADER RESPONDENT

At the urging of the governor, the Healthcare Workforce Subcommittee of Oklahoma Works was created to bring together high-level stakeholders to coordinate and engage in long-term workforce planning, with an emphasis on the rural health care labor force. The committee’s charge was to quantify the workforce gaps, increase the supply of critical health care occupations, and recommend policies and programs that support and retain a high-quality and well-distributed health workforce.

Given the findings of the committee, workforce development has been a central approach. With OSU Center for Health Science leading the way, partners such as PMTC, 3Rnet, National Health Service Corps, and Oklahoma Rural Health Works are collaborating to recruit, train, and retain rural health providers. One community leader noted that PMTC “really work(s) hard to match the students. It’s not just about doing your service to get your loans repaid, it’s about getting you in a place that you want to stay … so they have a retention rate, a very high retention rate.”

Other example programs include OSU’s Blue Coats to White Coats program, which targets high school students in the Future Farmers of America club interested in veterinary care and encourages them to consider medical school. Operation Orange and Native American Outreach offers immersion programs and camps to students interested in careers in health care. Recruitment also focuses on students in medical school, who are offered loan repayment, loan forgiveness, and scholarships to those willing to practice medicine in rural Oklahoma. OSU has created a special rural residency track aimed at students who come from rural environments and thus are more likely to start rural practices.
The Oklahoma Nursing Association has advocated for full practice authority, and the state recently adopted the aforementioned, expanded nursing compact, which provides more flexibility for nurses practicing between states.

The gaps in rural health care persist despite considerable improvement and effort. As such, provider capacity has to be bolstered by innovations like telehealth and strong health networks. Oklahoma’s telehealth initiative encompasses the largest network in the country and replicates the successful Extension for Community Health Outreach (ECHO) program developed in New Mexico. The heart of the ECHO model is its hub-and-spoke knowledge-sharing networks, led by expert teams who use multipoint videoconferencing to conduct virtual clinics with community providers. OSU facilitates ECHO and extends urban-based health care systems to sparsely populated areas through an extensive telehealth infrastructure staffed by medical experts within and outside of the state universities. Key contributors to the telehealth mission include the Oklahoma Telehealth Network; the Telehealth Alliance of Oklahoma; the OSDH Center for Health Innovation; and the Effectiveness Office of Telehealth. Additionally, the Oklahoma Universal Service Fund offers resources to improve broadband access. The telehealth technology also has enabled the Oklahoma Department of Mental Health and Substance Use Services (ODMHSAS) to provide previously underserved areas of Oklahoma with a significant increase in access to mental health and substance abuse information and services.

“THE TRIBES ARE GREAT ABOUT HAVING COMMUNITY INITIATIVES QUITE OFTEN ON EVERYTHING FROM DIABETES TO HEART ISSUES, TO DENTAL AND VISION, SUICIDE PREVENTION, ADDICTION, OPIOID PREVENTION.”

TRIBAL HEALTH RESPONDENT

Rural health networks further leverage slim resources through collaboratives (e.g., ROK-Net, the Rural Health Association of Oklahoma, and the Rural Health Network described previously) that integrate training opportunities; provide social support and incentives for retaining rural providers; and save resources through collective buying. Foundations and the federal government have stepped in to compensate for the state’s refusal to accept the Affordable Care Act which would have expanded health care access to fully support rural health. TSSET is providing a $3.8 million grant to fund 118 osteopathic physician residents in six hospitals across the state in OSU’s rural medical track program. The George Kaiser Family Foundation provided a $50 million gift to University of Oklahoma at Tulsa’s School of Community Medicine to prioritize the social determinants of health for underserved subpopulations in urban and rural areas. Grants from the Health Resources and Services Administration, the Agency for Health Care Research and Quality, and other federal agencies support rural health recruitment and retention efforts. In addition, these grants fund opioid treatment and mental health and substance abuse telehealth treatment services.

TRIBAL NATIONS USE COLLABORATION TO PROMOTE WELL-BEING AND EQUITY

While state agencies struggle for survival, tribal nations are moving ahead with a progressive vision for health and well-being. However, tribal nations still face significant health issues—including obesity; diabetes; cancer; mental health and substance use concerns, as well as in some cases, remote access to health care services. As such, the nations have a need to find new pathways to sustainable health solutions. Tribal nations are focused on building equitable communities using an expansive definition of health that ties together the physical, emotional, economic, environmental, and cultural well-being of their communities.

Tribes are less affected by the state’s budget crisis, leadership vacuum, and conservative governance philosophies. As sovereign nations with the power to determine their own laws and regulations and administer their own educational, health, and social systems, tribes have more control over local health care delivery and different resource streams to draw upon. Tribal governments have used their sovereignty to create accessible, integrated, and culturally relevant health care systems and collaborate with other tribal nations and state and local government to leverage resources and share their benefits of their success. One health leader noted, “We have tribes here that run their own health systems, their hospitals, clinics, that have public health programs. The tribal nations here are, I would say, sophisticated in the health programs they run, which necessitated more resources being devoted [by the state] to working with tribes in the government-to-government capacity that we do.”

Running their own clinics also allows tribal providers to incorporate cultural and traditional healing practices. A tribal provider noted, “The tribes are great about having community initiatives quite often on everything from diabetes to heart issues, to dental and vision, suicide prevention, addiction, opioid prevention ... a lot of tribes and the youth have been using tradition over addiction campaigns, getting people involved in their cultural values and their cultural traditions to keep teens and youth occupied …”

Tribal leaders are acutely aware of the connection between a thriving economy and good health and are looking for avenues of economic autonomy and diversification. The gaming industry has been a prominent source of additional funding benefiting both tribes and the state. In 2016, the state of Oklahoma collected more than $132 million in tribal gaming exclusivity fees based on over $2 billion in gaming revenue. This source of money has grown steadily since the 2005 vote-approved state-tribal gaming compact.

The tribes have taken this revenue and invested in various health and economic efforts. The Cherokee Nation invested $100 million of casino revenue into health care capital improvement projects. In 2016, they opened the 42,000 square foot, state-of-the-art Sam Hilden Health Care Center—offering integrated care, including physical therapy; primary care; dental; optometry; radiology; behavioral health; public health nursing; pharmacy; laboratory; nutrition; WIC; and diabetes care services. Tribal nations have diversified beyond gaming, creating their own business enterprises, and the Chickasaw Nation is a prime
example. The tribe owns more than 20 gaming facilities, 18 smoke shops, seven motor fuel outlets, and two truck stops. They also own and operate a fine chocolate shop, a family fun center, multiple hotels, a health care center, and radio stations. These entities are located throughout the state and in Texas. Their estimated annual tribal economic impact is near $14 billion, and they have contributed more than 10,000 jobs to the surrounding area.

"Tribal resources are more prevalent today than state resources, specifically in mental health and behavioral health issues. So we are trying to work closely with the state in making sure that we can help provide services to really help the greater good—for tribal and non-tribal patients."

TRIBAL LEADER RESPONDENT

In addition to building capacity at the individual tribal nation level, leaders are building inter-tribal linkages to leverage their collective voice. Since the 1970s, Oklahoma’s 38 tribes (along with those in Texas and Kansas) have banded together to form the SPTHB, a nonprofit organization that advocates for American Indian health. This group also hosts the federally supported Oklahoma Tribal Epidemiology Center, noted earlier. The center produces the community profiles for each of Oklahoma’s tribes to set health care priorities, inform health care decisions, and identify issues where policy change is needed.

With a culture that emphasizes the collective rather than the individual, tribes also are reaching out to build both state and county-level intergovernmental collaboratives. A tribal leader noted, “For the first time in Oklahoma’s history, tribal resources are more prevalent right now today than state resources, specifically in mental health and behavioral health issues. So we are trying to work closely with the state in making sure that we can help provide services to really help the greater good—for tribal and non-tribal patients.”

Oklahoma uses tribal liaisons and consultation practices to get tribal buy-in and ensure its policies and programs do not negatively impact tribes. Key to this collaboration within OSDH is the Tribal Public Health Advisory Committee, created to give tribal presidents an equal voice at the table. Tribal and state health department leaders, health care CEOs, and other agency heads meet quarterly to share information and build consensus about health-related policies and programmatic decisions. The American Indian Data Community of Practice brings together individuals from multiple sectors and jurisdictions to improve the statewide capacity to collect and link data needed to drive health policy for all citizens. Leaders across jurisdictions recognize the benefits of collaboration.

In addition to this collaboration, there are significant instances of tribal resource sharing. Although tribes set their own laws, there is a history of cooperation with state authorities for public health measures. Oklahoma’s tribes have implemented a special tax compact with the state to tax cigarettes sold in their territory at an equivalent rate as elsewhere in the state. This prevents residents from circumventing the tax by buying cigarettes from the tribes, thus protecting the revenue and effectiveness of the cigarette tax. In health care, a tribal leader noted, “We really deliver care beyond just what people would think of as American Indians. We opened that up to all citizens. We’re in the process of considering opening up two of our clinics for gauging the demand, as well as the supply that we have of time to open up outpatient clinic services to the non-Indian population who are asking us to be providers to them.” The Choctaw Nation worked with OSDH to purchase $500,000 worth of flu shots. A health leader explained, “the Health Department handled all the logistics of storing it and administering it and going out and doing flu clinics and that sort of thing, things like that. That’s an ongoing project that we have every year with them, and Chickasaw Nation has jumped on board as well.” There is also a grant with the Choctaw Nation to train pharmacists to help manage hypertension to reduce the need to see primary care doctors.

SUMMARY OF OKLAHOMA’S EFFORTS TO BUILD A CULTURE OF HEALTH

Based on the Culture of Health Action Framework used to guide Sentinel Community data collection and monitoring in Oklahoma, we observe evidence that the state is working to address many of the challenges related to chronic disease prevention and health care access. The state principally relies on a model that prioritizes health needs at the state level but assumes action at the local level. While this self-reliance and local control model has many advantages in terms of ensuring that approaches are culturally aligned to local values, there are concerns regarding the level of available resources to support these efforts. Another concern is state pre-emption that can make true local control and decision-making to advance health-promoting policies quite difficult.

Efforts in Making Health a Shared Value are observed through the setting of flagship health priorities in the OHIP. This plan offers the benefit of clear vision to help state and local leaders coalesce around key health needs. Further, investments in programs like Certified Healthy OK suggest a deep commitment to embedding health in the missions of organizations, including businesses. Foster ing Cross-Sector Collaboration to Improve Well-being is an essential lever for Oklahoma to pool resources, particularly given state budget challenges and refusal to accept Medicaid expansion. The networks of university health centers, faith-based organizations, nonprofits, and philanthropies are essential to keep focus on pressing health issues in the state, including early childhood, mental health, and chronic disease prevention.

In the area of Creating Healthier and More Equitable Communities, there are some signs of progress, though this work appears somewhat limited and varies by urban, rural, and tribal area. For instance, TSET grants have been used to support healthy design (e.g., complete streets) in the metropolitan areas, but there is rather limited focus on this issue in rural communities outside of the tribal nations. The state has spent considerable effort in the area of Strengthening Integration of Health Services and Systems—with particular focus on workforce incentives; innovations in health care delivery such as telehealth; and other rural network capacity development. The Route 66 Coalition may offer
promise in implementing an accountable health communities’ model to better link clinical services with community services to reduce costs and improve access. Tribal nations are particularly advanced in the area of providing integrated services. While significant advancements have been made, there is much more to do given the level of unmet health care need in Oklahoma.

Emerging Community Themes

Oklahoma is a state of contrasts with respect to health and well-being. On one hand, Oklahoma has clearly outlined health priorities in the state-level health improvement plan, which align well to resident needs. However, the instability in the state budget, as well as in the OSDH, does not offer much optimism about the state’s ability to consistently invest in health to address many health problems, including a significant number of preventable deaths due to tobacco and obesity. Much of the state’s health success in recent years can be tied to TSET and Turning Point. However, the collapse of the latter places the state on shaky ground with respect to whether or not it can build back its regional health network that was the backbone of health promotion, education, and preventive services.

At the local level, the story is more promising. In urban or metro areas such as Tulsa and Oklahoma City, the activities suggest there is more action around health promotion, such as the Tulsa Zip Code study and the My Access Network to facilitate greater focus on social determinants of health and the development of healthier communities. Further, these efforts appear to put a spotlight on disparities and health equity issues in ways that are not as clearly outlined in state level efforts. There are growing investments by philanthropy to help local organizations address the state’s health priorities, including OK25by25, among other campaigns. Further, the tribal nation efforts are quite innovative, setting a high bar for how health investments can be made and how collaboration between tribal nations and the rest of the state can fill gaps in health services.

While Oklahoma has much more to accomplish in expanding access to rural health care, the efforts underway represent tremendous investment in rural network capacity. The provider incentive programs, as well as expansions in the use of telehealth position Oklahoma as a state exemplar on how to leverage academic health center capacity. However, policies linked to nurse practitioner expansion or refusal of programs like Medicaid expansion has hampered the progress in health care. It will be important to monitor how these apparent conflicts between health care capacity investments and concurrent acceptance of policies that pose health care barriers will affect future health outcomes.

F ACILITATORS TO A CULTURE OF HEALTH

Sustainable funding through TSET. TSET offers an essential level of protected and sustained funding for prevention activities, with a focus on tobacco use and obesity. In addition to funding (including local grants), TSET provides leadership and technical assistance to support prevention activities across the state.

Academic health networks supporting rural health care access. The state’s large university centers (University of Oklahoma at Tulsa and OSU Center for Health Sciences) have been able to fund and implement programs that address some of the state’s more dire needs (e.g., rural access to health care) and have successfully acquired foundation funding for this work.

Tribal nation self-reliance and innovation. The network of tribal nations throughout the state provide state-local links that facilitate economic development, delivery of public health interventions, and access to health care. The nations also provide a model in many cases of ways to invest revenue into health and well-being activities.

Philanthropic investment to close gaps in health promotion. While the number and level of foundation support is limited relative to other states, the philanthropies that have engaged in Oklahoma have been essential supporting health and well-being.

BARRIERS TO A CULTURE OF HEALTH

State tax policy limiting ability to invest in health. The state’s fiscal problems continue to degrade the capacity of the state to deliver basic services, including the collapse of the Turning Point regional health infrastructure. Given that corporate, sales, and property taxes are some of the lowest in the nation, it is unclear that there will be enough of a tax base to address these state budget shortfalls.

Rejection of the federal Medicaid expansion under the Affordable Care Act. The refusal of the state to opt into Medicaid expansion has severely hampered efforts to ensure access to health care in rural and remote areas of the state.

Poor infrastructure in rural areas. Development and access to services for many residents, especially in rural areas, are negatively impacted by transportation issues. The success of the state’s telehealth initiative, while a bright spot, is still hindered by a lack of broadband access in rural areas.

State health care provider practice and licensure laws. These laws limit the extent to which nurses can increase access and availability of health care. These laws place restrictions on what patient care nurses can provide, despite the well-recognized number of health provider shortage areas in the state.
What’s Next

Oklahoma is at a crossroads with respect to how it will support its health infrastructure. While critical programs like TSET are essential to maintain focus on chronic disease prevention, the loss of the Turning Point capacity will have a significant impact on the ability of communities in the state to pursue the local and regional health activities that led to successful health efforts in the past, such as anti-smoking legislation and marketing. It will be essential to assess how much of an impact the Turning Point losses will have in both orientation to health statewide, but also in terms of what programming remains available and the impact on health outcomes. Relatedly, this larger budget shortfall is not promising for health investments generally. As such, assessment of other effects on essential public health activities such as health services; data capacity and surveillance; prevention programs; health education; and other supports will need to be included as part of ongoing monitoring.

Digging deeper into the role of philanthropies and businesses (the latter was not an explicit focus of interviews conducted for this report) will also be crucial. State funding challenges have given rise to foundations filling those gaps, but it is uncertain if this can be sustained and in what capacity. Further exploration is needed on the tangible benefits of foundation investments regarding measurable health and well-being outcomes. We see the role of business in initiatives like Certified Healthy OK, but we need more information on large employers adopting healthy practices for employees and surrounding communities. For instance, what role does or could business have in shaping mindsets about the value of health?

A next step will also include further analysis on the role of tribal nations, both in terms of the nations’ influence on the health of members, but also how these state-tribal relationships are filling gaps for the state in times of compromised health capacity. There are questions about the mutual benefit of the arrangements summarized earlier, but also great potential that this model of reciprocity could be replicated in other states with strong tribal presence.

Opioid-related issues were not a significant focus in interviews but there are some notable trends to watch in synthetic and prescription opioid use. Given national focus on this topic, understanding what is working in Oklahoma is worthy of further investigation. Finally, Oklahoma has clear disparities in health risk behaviors and outcomes by both geography and race/ethnicity. While the latter was not a heavy focus among interviewees, the issues of access and equity remain questions for the state going forward, particularly with a growing Hispanic population. Whether the state is able to address these demands is an important area of further investigation.
References


