RWJF Culture of Health
Sentinel Community Snapshot:

Oklahoma
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ABOUT THIS REPORT
The Sentinel Communities project, conducted by RTI International in collaboration with the RAND Corporation, is sponsored by the Robert Wood Johnson Foundation. The project, which began in 2015, will monitor activities in each of 30 diverse communities around the country for at least five years. For the purpose of this report, the state of Oklahoma is considered one community. This Snapshot is the first in a series of planned reports about this Sentinel Community through which we will provide insights into drivers of a Culture of Health in the state. This report is not intended to comprehensively describe every action underway in the state of Oklahoma, but rather to provide an initial overview of the community’s history, challenges, and approaches to building a Culture of Health.

The information in this report was obtained by using several data collection methods, including an environmental scan of online and published community-specific materials, review of existing population surveillance and monitoring data, and initial interviews with representatives from the state department of health. For this report, the data collection team examined state-level data, as well as data specific to selected regions and cities within the state. This allowed us to build an understanding of the state’s Culture of Health, as well as possible regional differences that may exist.

We will continue our surveillance activities in Oklahoma over the coming years, and report updated information on progress, challenges, and lessons learned in improving health and well-being for all residents. Visit cultureofhealth.org to see the full list of communities and links to other reports and information about the project.
Introduction

Oklahoma is primarily a rural state with a population distinguished by multiple ethnicities, numerous tribal affiliations, and rich cultural traditions. Although American Indians comprise just 7 percent of Oklahoma’s 3.8 million residents, the state includes 38 federally recognized tribal nations and has the second highest percentage of American Indians/Alaska Natives following California. In addition to its diverse tribal nations, Oklahoma’s population comprises residents who are white (68%), Hispanic (9%), black (7%), Asian (2%), and other races/ethnicities (7%).

Nearly two million of the state’s residents live in rural areas. Oklahoma’s geographic features and population density are similarly divergent. The Ozark and Ouachita mountains line the eastern portion, the warm and humid Red River Valley lies to the south, and flat and open terrain covers the western Panhandle. Fewer than three residents per square mile live in the western Panhandle, compared with 1,000 residents per square mile in the state’s major population centers of Oklahoma City and Tulsa. The Panhandle region, however, has seen sharp increases among Hispanic residents in recent years, with five cities and towns in this region now with Hispanic populations that range between 40 percent and 50 percent.

FROM INDIAN TERRITORY TO TODAY’S OKLAHOMA

Oklahoma’s tribal nations share a proud and painful history that to this day exerts an influence on their relationship with the state and federal government. The Indian Removal Act of 1830, signed into law
by President Andrew Jackson, forced American Indians to depart their lands in existing states to unsettled land west of the Mississippi River, known as the Indian Territory.7 Approximately 4,000 Cherokee Indians died on this forced westward march, which became known as the “Trail of Tears.”

Subsequent federal laws enacted in the mid- and late-1800s shrunk portions of the expansive Indian Territory and carved out the Oklahoma Territory from its western region. White settlers began to flood the newly created Oklahoma Territory, putting pressure on the federal government to form a new state out of the Indian and Oklahoma Territories.8 A series of federal laws enacted around the beginning of the 20th century laid the groundwork for Oklahoma statehood and the takeover of the affairs of the tribal nations by the U.S. Congress. Notably, the Curtis Act of 1898 dissolved the Indian Territory tribal governments by abolishing tribal courts and subjecting all persons in the Territory to federal law. The act not only stipulated that any tribal legislation passed after 1898 had to be approved by the U.S. President, but also allowed a congressional commission to determine enrollment of tribal members.8 The act also undermined the autonomy of the “Five Civilized Tribes”—the Choctaw, Cherokee, Creek, Chickasaw, and Seminole tribes—so named because of their adoption of some Anglo-American norms. Prior to the act, the tribes had previously exercised sole autonomy over citizenship requirements.

Although the tribes in Indian Territory opposed local and national efforts toward statehood, the Curtis Act called for the end to tribal governments as of 1906. Aspirations for Indian Territory to be adopted as a single state took shape at the Sequoyah Convention in 1905, but Congress refused to consider the proposal. By 1907, the separate Indian and Oklahoma Territories were joined to form the state of Oklahoma. Tribes retained autonomy for internal affairs, except for a period in the mid-20th century (1940s through 1960s) when a federal Indian Termination Policy9 promoted assimilation and dissolved many tribal lands and legal protections. President Richard Nixon redirected federal policy in 1970 to stop forced assimilation.10 A series of laws were enacted in the following 30 years that affirmed the independent rights of American Indians and other indigenous peoples.11

Today, Oklahoma's American Indian residents are dual citizens of the United States and of their tribal nation.12 About 80 percent (372,100 people) of Oklahoma's American Indian population are members of the original Five Civilized Tribes. (A separate snapshot report on one of these tribes, the Chickasaw Nation, examines how tribes interact with U.S. government entities today.) All recognized tribes have the right of self-determination and a government-to-government relationship with the United States. In Oklahoma, tribal areas comprise a significant portion of the state (see map), yet these areas are not reservations but integrated communities where tribal and nontribal members live. Possessing the right to self-determination, some tribes handle their own health care and other service needs, while others receive direct service from the federal government's Indian Health Service (IHS). Although tribes set their own laws, they have worked with federal and state governments on initiatives to improve community health.14

A BOOM AND BUST ECONOMY

Today, Oklahoma is home to nearly 3.8 million people, with more than 26 percent of residents concentrated in the state’s two metropolitan areas: Oklahoma City, located in the state’s center; and Tulsa, 100 miles to the northeast.5 As the state’s largest and second-largest cities, Oklahoma City and Tulsa are important economic, cultural, and educational centers. The cities grew in the 1930s, largely as a result of migration by Oklahomans who left farms seeking better opportunities following the Depression and Dust Bowl.16

Oil production has figured prominently in Oklahoma’s economic fortunes—and distress—for much of the state’s history. Starting in 1897 when oil was first discovered in the state’s northeast corner, Oklahoma became one of the nation’s leading oil-producing states, a boom that continued through the mid-1940s.17 Drilling slumped in the 1950s as federal controls were imposed on natural gas, but rebounded with the Arab oil embargo of 1973, which increased the demand for domestic oil.18 In the early 1980s, the number of active oil-drilling rigs in Oklahoma hit a record high, along with the price of oil. Prices plunged drastically in the mid-1980s because of global oversupply, then resumed their climb into the mid-1990s, along with a rise in the state’s drilling and production-related jobs.19 Growth continued between 2002 and 2012, pushing migration of new residents to the state to the highest levels in three decades.20 But historic boom-and-bust cycles began anew in 2014, when the bottom dropped from oil prices because of growth in overall U.S. production and price-cutting from foreign suppliers.21

Oil industry revenue plays an integral role in Oklahoma’s state budget, producing about 10 percent (or $65 billion) of state gross domestic product and 14 percent of total statewide earnings. Given oil’s prominence in the economy, the most recent downturn in oil prices has wreaked havoc on state employment and finances.22 Since June 2014,
plummeting oil prices have cost the state more than 12,500 jobs and forced lawmakers to close a $1.3 billion budget hole in fiscal year 2017 and an estimated $870 million shortfall in fiscal 2018. A proposal to raise taxes on cigarettes by $1.50 per pack was struck down by the Oklahoma Supreme Court in August 2017, removing an estimated $215 million that was intended to support state health agencies that operate under the Oklahoma State Department of Health (OSDH). Governor Mary Fallin called a special session of the legislature to address the budget shortfall.

Fiscal constraints on OSDH have far-reaching implications for the health and well-being of all Oklahoma residents. Through its 20-year history of planning and outreach to state and community partners, private foundations, and the federal government—OSDH has laid the groundwork to address barriers to health care access and services and promote health and well-being across urban centers, rural communities, and tribal nations. Early signs of progress from specific collaborative efforts are encouraging, such as transforming the public health infrastructure and reducing high rates of tobacco use and teen pregnancy. But the state's significant fiscal distress has thrown OSDH's multifaceted efforts into question. In light of the chronic disease burden affecting the state's American Indian and other minority populations, how the state will be able to adequately fund OSDH's outreach and educational efforts remains an important, but unanswered, question.

Diverse Populations Face Common Health Challenges

Despite their ethnic and geographic diversity, residents of Oklahoma share several significant health challenges. Overall, the state ranks near the bottom at 43rd of 50 for overall health of residents. Poor health outcomes are driven by high rates of smoking, physical inactivity, obesity, diabetes, and limited access to primary care physicians. As in the rest of the nation, cardiovascular disease attributable to modifiable risk factors is a leading cause of death among all racial and ethnic groups in Oklahoma.

Health behaviors and conditions that contribute to poor outcomes vary among racial and ethnic groups. For example, the prevalence of adult smokers ages 18 years and older is significantly higher among residents who are American Indian (34%) and black (31%) than those who are Hispanic (18%) and white (27%). The percentage of adults who ever had a heart attack or had been told they have coronary heart disease is highest among American Indian (10%), white (8%), and black (6%) populations as compared with Hispanic (3%). American Indians also experience higher rates of diabetes (16%), compared with black (13%), white (10%), and Hispanic (11%) residents. American Indians have significantly higher death rates from unintentional injury (75 deaths per 100,000 population) compared to the populations of white (62 per 100,000), black (44 per
The prevalence of obesity in Oklahoma (32%) is higher than the nation (28%) and is significantly higher among black (46%) and American Indian (38%) residents (Figure 1). Death rates from diabetes (Figure 2) are higher in Oklahoma (27%) compared to the nation (21%), and are highest among the American Indian (37%) and black (32%) populations.

Health issues confronting Oklahoma’s youth are also cause for concern. The state’s teen birth rate (54 per 1,000 residents) is almost double that of the nation (29.4 per 1,000 residents) and infant mortality (78 per 1,000 live births) is also higher than the national average (6 per 1,000 live births). Teen birth rates are highest among Hispanic residents, followed by those who are American Indian, black, white, and Asian.24 Two counties, Oklahoma (including Oklahoma City) and Tulsa (including the city of Tulsa), represented 40 percent of all teen births in the state in 2012, with Oklahoma County, at 60 teen births per 1,000 births, higher than the state’s average, and Tulsa County slightly lower at 50 teen births per 1,000.26

High rates of youth suicide cast a pall on Oklahoma’s future. Suicide rates among adolescents between ages 15 and 19 are 15 deaths per 100,000 adolescents, ranking 42nd in the nation.28 Overall, suicide is the second-leading cause of death among Oklahoma’s American Indian/Alaska Native population ages 10 to 34.29

GAPS IN HEALTH CARE FUELED BY LACK OF INSURANCE

Residents’ profound need for health care services notwithstanding, 18 percent of Oklahoma’s population lacks insurance compared with the national rate of 14 percent.3 Black and Hispanic residents are more likely to be uninsured than their white counterparts,31 with higher rates of uninsured in Oklahoma City (20%) and Tulsa (21%), despite the presence of more hospitals, medical centers, and primary care practices.3

Health services for the state’s American Indian population reflect the diverse nature and preferences of the 38 tribal nations. Large self-governed tribes, such as the Cherokee, Chickasaw, and Choctaw Nations, operate their own health clinics and hospitals. In contrast, smaller tribes receive the majority of their health care through direct service arrangements with the Indian Health Service (IHS), which operates about 50 hospitals and clinics in Oklahoma.39 Because the state’s tribal residents move throughout the state, IHS also operates clinics in urban areas, including Oklahoma City and Tulsa.

Access to health care is also compromised by a shortage of primary health care providers. Nationally, the state ranks 48 of 50 in primary care access.39 Of Oklahoma’s 77 counties, 64 are primary care shortage areas, which means that 59 percent of Oklahoma residents24 may have a hard time accessing a primary care doctor. Although urban areas have better access to care, some rural counties have only one provider for every 14,807 residents.38 The rural nature of the state, an aging physician workforce, and limited in-state residency programs for medical students34 suggest that the shortage of primary health care providers is unlikely to improve in the near-term future.

Compounding Oklahoma’s gaps in health care access, the state in 2012 opted against expanding Medicaid coverage under the Patient Protection and Affordable Care Act (ACA), a policy decision that could have expanded
coverage to approximately 175,000 uninsured adults. At the time, state officials estimated that Medicaid expansion could have cost Oklahoma as much as $475 million between 2014 and 2020. Medicaid expansion was on the table as part of Oklahoma’s fiscal 2017 budget agreement, but the state legislature refused expansion and constructed an alternative budget plan to maintain current service levels in the face of proposed cuts.

POVERTY AND EDUCATIONAL DISPARITIES

Health challenges coexist with, and are worsened by poverty rates that exceed the national average and low educational attainment. Oklahoma’s overall poverty rate is 17 percent, slightly higher than the national average of 16 percent. However, poverty is more concentrated among Hispanic (33%), black (29%), and American Indian (22%) residents than among those who are white (11%). One notable exception is the Chickasaw region of South-Central Oklahoma, a 13-county area that is home to members of the Chickasaw Nation and other racial and ethnic groups. Residents of this region experience lower poverty levels compared to the rest of the state, including its main urban centers (Figure 3).

Educational attainment in Oklahoma also lags behind other states. The state’s high school graduation rate, at 78 percent, is slightly lower than the national rate of 81 percent. Adults in Oklahoma have bachelor’s degrees (24%) and graduate or professional degrees (8%) at lower rates than adults nationally (29% and 11%, respectively). Significant racial disparities in education persist (Figure 4). For example, racial and ethnic minority youth are less likely to finish high school than are white youth (10% for whites versus 50% for other races and 42% for Hispanic youth). Most American Indian residents finish school with a high school diploma or attend some college (35% and 34%, respectively), but have lower college graduation rates than white residents (26% for whites versus 16% American Indians). Asian residents are almost twice as likely as white residents to obtain a college degree (42% Asian versus 26% white). Active recruitment of Chinese students among Oklahoma’s largest universities, a practice started nearly a decade ago as part of partnerships established with Chinese institutions, may be responsible for this difference.

Discrepancies in educational attainment among whites and Hispanics may be related, in part, to the recent increase in jobs that do not require higher education, such as those in manufacturing and agriculture. Hispanics have moved in large numbers to the sparsely populated Panhandle region, where most of these jobs are located, to work in these industries.

Empowering Local Areas

Through the 1990s, Oklahoma’s significant population health challenges were compounded by a centralized, top-down approach to public health improvement. Despite the presence of public health departments in 69 of its 77 counties, decisions about initiatives were made by the Oklahoma State Department of Health (OSDH) and did not reflect input from metropolitan or rural communities or from tribal nations. As a result, evidence of progress remained scant.

Starting in 1997, OSDH and other state agencies and organizations received funding from the Robert Wood Johnson Foundation and W.K. Kellogg Foundation to implement Turning Point, a national program designed to “transform and strengthen the public health system in the United States to make the system more effective, more community-based and more collaborative.” Turning Point helped initiate a new mindset within the Oklahoma public health community by fostering collaboration between state public health systems and local partners, such as businesses, faith, and community organizations. First piloted in three Oklahoma counties (Texas, Cherokee, and Tulsa), Turning Point staff worked with an advisory board of organizations, providing guidance and technical assistance to local programs.

By 2001, Turning Point was supporting OSDH and partners to expand their technical assistance to communities across Oklahoma, hiring field consultants to help establish partnerships, analyze data, and set priorities. At this time, Oklahoma Turning Point hired a local epidemiologist who created local health profiles that helped inform community decision-making about top health issues in each county and their cost implications. In 2003, Turning Point was a founding partner of Certified Healthy Oklahoma, a program that showcases businesses, communities, congregations, restaurants, and schools that promote healthy choices through environmental and policy change. In 2004, it served as catalyst for the founding of the Public Health Institute of Oklahoma, which links government, academia, and communities to promote health improvement.

Turning Point’s influence has sustained beyond its initial foundation funding, and the resulting partnerships have influenced how state and local relationships are formed and sustained. Sixty-six partnerships forged under Oklahoma Turning Point continued to operate in 2014, representing 62 of Oklahoma’s 77 counties. Statewide partnerships demonstrate how these policies and programs have worked to advance the health and well-being of Oklahoma residents. In 2015, for example, the state enacted a law that requires schools be tobacco-free 24 hours per day, 7 days per week; policies backed by coalitions at the local level paved the way for state support.

Partnerships between federal and state agencies, universities, and local health care providers aim to improve and even preserve access to health care in Oklahoma’s sparsely populated rural regions. Nearly two million Oklahomans live in rural areas and are served by 97 rural hospitals, including 34 critical-access hospitals.

Starting in 1998 and funded by the Federal Office of Rural Health, the National Center for Rural Health Works was created to measure and expand public awareness of the economic importance of health services. The Center provides training, tools, and technical assistance to support rural communities in assessing the economic impact of the local health industry, performing community health needs assessments, analyzing rural health needs, and developing emergency medical services systems.

At the state level, the Center for Rural Health, established within Oklahoma State University’s (OSU) Center for Health Sciences and its
College of Osteopathic Medicine, seeks improvements in rural health care access through student education, residency training, research, and advocacy.46 OSU’s Center for Health Sciences’ TeleHealth program has one of the state’s largest telemedicine networks, connecting health providers to patients in communities that lack accessible hospital and physician care.47 All OSU medical students receive training in telemedicine, and OSU’s College of Osteopathic Medicine was the first medical school in the nation to require telemedicine training of all its graduates.

In addition to collaborations that originate with OSDH and those serving rural areas of the state, the urban centers of Tulsa and Oklahoma City promote their own collaborations to improve health and well-being. Residents of these urban areas experience significant chronic health problems related to obesity, tobacco use, and maternal-child health, some of which are exacerbated by limited access to health services. National, state, and local entities are working to develop and implement initiatives to address these issues through evidence-based interventions.

The Pathways to Health initiative in Tulsa is bringing together residents and stakeholders from across the city to engage in efforts to “make the healthy choice the easy choice,” and thereby improve the health and well-being of residents.48 More than 65 stakeholders were brought together to develop a Community Health Improvement Plan for Tulsa County, which was completed in early 2017. The plan focuses on two main priority areas: access, including transportation, housing, health care, and healthy food; and education, which takes into account nutrition, educational attainment, and health literacy. Pathways to Health also awarded six seed grants to community health partners to build a community garden; offer an online, evidence-based health and fitness program at workplaces; and expand a children’s garden to include a library and a miniature farm. Goals will be monitored over the coming three years, with progress and activities documented on the Pathways to Health website and through progress reports from the Tulsa Health Department.

In Oklahoma County, the Wellness Now coalition,49 founded in 2010, was formed to improve the health of Oklahoma County through community partnerships that “create policies, systems, and environments that make living well easier.” Seven workgroups focus on adolescent health; care coordination; faith-based efforts; health at work; mental health; nutrition and physical activity; and tobacco use prevention. The group’s current legislative agenda includes educating and advocating for the proposed $1.50 increase in the cigarette tax and for policies that support paid parental leave.

HEALTH IN OKLAHOMA’S TRIBAL NATIONS

Efforts to address the challenges to health and well-being in Oklahoma’s tribal nations increasingly rely on strategies that reflect the unique needs, resources, and cultural preferences of the American Indian population.

Tribal nations are self-governing, sovereign entities that have the power to create laws, levy taxes, and provide services within their boundaries.50 As a result, approaches to health services and collaborations with other partners vary by tribe. Oklahoma’s five largest tribes—Choctaw, Cherokee, Creek, Chickasaw, and Seminole—coordinate their activities through an Inter-Tribal Council of the Five Civilized Tribes. The variety of services provided for their citizens and community members includes health care, which reduces the burden on state funding for similar services. Smaller tribes, especially those in Inter-Tribal Council of Northeastern Oklahoma, coordinate resources while others work with federal government entities to provide services.

Both the federal and Oklahoma state government have entities that focus on the concerns of tribal nations. At the federal level, the IHS operates some health facilities. The U.S. Bureau of Indian Affairs and Oklahoma Secretary of State’s Secretary of Native American Affairs coordinate government-to-government relations and determine needed services. In 2012, OSDH opened an Office of Tribal Liaison to promote and coordinate government-to-government consultations and strengthen collaborations among tribal nations and federal, state, and community stakeholders.51 Health coordination of federal and state activities is promoted through the Southern Plains Tribal Health Board, which provides health-related advocacy, education, partnerships, and training to 43 federally recognized tribes in Oklahoma, Kansas, and Texas.52

Collaboration between OSDH and the state’s tribal nations shows evidence of success and the need for more timely communication. As part of its mission, OSDH’s Office of Tribal Liaison encourages cultural competence and diversity among the OSDH workforce and supports the translation of public health findings specific to American Indian populations into practice. Its impact was demonstrated through a recent collaboration between tribal health leaders and OSDH regional health directors to address low childhood and adult vaccination rates in the state’s Southeast region. Tribes volunteered to pay for the vaccines, which OSDH administered across tribal districts. Improvements are still needed, as tribal nations expressed in six OSDH-convened listening sessions. At issue was a lack of collaboration before the state began ACA implementation in 2013. Attendees pointed out that the needs of tribes that receive care through IHS hospitals and clinics (called “direct service” tribes) differ widely from those that operate their own clinics and hospitals (called “self-governance” tribes).53 Tribes also advocated for Medicaid expansion to better serve the needs of American Indians and for targeted messages to communicate the benefits of the ACA to tribal members.

In 2013, nearly 8 percent of American Indian/Alaska Native homes did not have safe drinking water or basic sanitation, causing or contributing to illnesses associated with water and soil contamination. Improperly sealed uranium mines on tribal lands have also contributed to illnesses associated with poor sanitation and radiation-related diseases from uranium and arsenic exposure.54 Efforts to increase children’s consumption of safe drinking water are being funded through a grant from the Notah Begay III Foundation. Future reports will continue to explore such efforts to improve health in tribal areas and how this is coordinated through their government-to-government relationship with the United States.

OSDH pursues a collaborative approach to tackle the state’s most pressing health challenges. Following the 2014 State of the
State's Health call for a thorough cross-sectoral approach to health planning, the OSDH and the Oklahoma Health Improvement Coalition produced the 2020 Oklahoma Health Improvement Plan.\(^7\) The 2020 plan committed to work on improving the health system and social determinants throughout the state and address four “flagship issues”: improving behavioral health, reducing obesity, reducing tobacco use, and improving children’s health. Oklahoma’s commitment to collaboration is perhaps best illustrated by the many active local Turning Point partnerships, which are supported by the Oklahoma Turning Point Council. Partners are working to implement the Oklahoma Health Improvement Plan through locally developed Community Health Improvement Plans and align efforts with those of state-level partners.\(^8\)

OSDH is working with the federal government to create a new model for health care delivery and promote value-based payments. In December 2014, the Centers for Medicare & Medicaid Services (CMS) awarded OSDH a $2 million State Innovation Model grant, which is funding the development of Oklahoma’s State Health System Innovation Plan. The plan aims to integrate systemwide data from public and private insurers to create a new model of health care delivery that rewards health care providers for meeting certain performance measures, such as lowering blood pressure, and counseling patients to stop smoking.\(^9,10\) OSDH aims to coordinate the flagship issues identified in the 2020 health improvement plan with the health delivery reforms outlined in the CMS-funded innovation plan.

### Improving Access and Combatting Obesity

The shortage of primary care physicians, accessible health clinics, and widely available insurance coverage all contribute to gaps in access to health services for Oklahoma residents. Oklahoma ranks 48th nationally in the ratio of primary care physicians to the area’s population.\(^11\) Previous proposals to close OSDH’s budget gap would have ended payments for uncompensated care to federally qualified health clinics and closed clinics in areas with more than one county health department, but the repeal of the cigarette tax has scrapped these plans for the short-term future.

Foundations have supported strategies that seek to improve access to health care services in underserved areas. An evaluation conducted in Oklahoma and Arkansas by the Robert Wood Johnson Foundation in 2012 on the impact of primary care delivery innovations on access to care found that specific strategies, such as provider education, practice improvement opportunities (e.g., working extended hours, increasing community engagement, and implementing physician-level quality improvement measures), financial incentives, and payment reform can improve access to services for low-income populations. The Foundation recommended that primary care practices partner with state Medicaid programs through grant opportunities under the Center for Medicare and Medicaid Innovation to deploy providers to high-need areas.\(^12\) Other proposed strategies to attract providers to urban and rural underserved areas included scholarships, loan forgiveness programs, and an increase in the number of primary care residencies.\(^13\)

Despite Oklahoma’s rejection of the Medicaid expansion under the ACA, the Tulsa Health Department conducted ongoing outreach in 2014 and 2015 with residents to provide assistance enrolling in the online health insurance marketplace. The department hosted public events where residents could meet one-on-one with health insurance navigators and certified application counselors to learn more about the ACA, determine their eligibility for subsidies or discounts, and complete the online enrollment process.

One self-governing tribal nation, whose members live in 13 counties in South-Central Oklahoma, developed a local approach to the state-wide shortage of health care facilities and providers. To improve access, the Chickasaw Nation tribal government funded construction of a 370,000-square foot medical center, which opened in August 2010. Operated with IHS funds, the Center includes a 72-bed hospital, an emergency department, a diabetes center, a dental clinic, a diagnostic imaging center, a women’s health center, and offices for the tribe’s health programs. It serves all American Indians (not only Chickasaws) who provide a certificate of Indian ancestry.

With nearly 34 percent of adults considered obese, Oklahoma has the nation’s eighth highest rate of obesity.\(^4\) Partners in Oklahoma’s Turning Point Council have worked with communities to improve the local built environment, including community health centers, extensive walking trails, and community gardens. The Oklahoma Turning Point Council launched a program to award “certified” designation to entities—such as local businesses, communities, restaurants, and congregations—that implement policies and programs to create healthy environments. These include offering healthy menu options, worksite wellness programs, health fairs, and tobacco-free zones.

In spring 2016, the Tulsa Health Department was recognized as an innovator city in the Healthiest Cities & Counties Challenge. The effort is backed by the Aetna Foundation, the American Public Health Association, and the National Association of Counties to support cities, counties, and federally recognized tribes in showing improvements in health indicators and social determinants of health. The health department collaborated with local community partners to submit an early adopter proposal that will focus on food insecurity issues, including access to grocery stores and fresh fruits and vegetables. Community partners include the Tulsa Regional Chamber, the University of Oklahoma-Tulsa, R&G Mobile Grocers, and Civic Ninjas.\(^4\)

In Oklahoma City, the OKC Million program, also referred to as the “this city is going on a diet” initiative, uses media to promote health and reduce obesity. After being ranked among America’s most obese places to live in the 2007 issue of Men’s Fitness, Oklahoma City created a website for citizens to track their weight and levied a one-cent sales tax hike to improve walkability in the car-friendly city. Improvements to the built environment followed, including new, wider sidewalks; biking routes; and an expanded park.

American Indian–led strategies and solutions are also being used to reduce obesity levels among children in the state.\(^4\) The Chickasaw Nation is one of eight Oklahoma grantees of Native Strong: Healthy Kids, Healthy Futures, a national program led by the Notah Begay III Foundation to
address obesity and diabetes among American Indian children through a national childhood obesity prevention framework. It partners with American Indian communities to better understand how root causes and the social determinants of health are linked to obesity and diabetes among American Indian children. Activities include community health assessments, nutrition education, and physical activity programming to strengthen existing programs.65 In June 2016, the program received a $2.4 million award to support American Indian communities in their efforts to eliminate the use of sugar-sweetened beverages among children from birth through age 8 and increase their consumption of water.66

**TACKLING TOBACCO USE**

Although tobacco use in the state has declined, it remains higher than national averages and contributes to Oklahoma's high prevalence of stroke, heart disease, and cancer. Between 2011 and 2014, Oklahoma's adult smoking rate decreased from 26 to 21 percent, compared to a national decline of 21 to 18 percent over that same period.67,68 This progress is in part the result of several large-scale policies and programs implemented over the past several years. In 2000, Oklahoma established the Tobacco Settlement Endowment Trust, which manages funds received through settlements and lawsuits to implement grants and programs aimed to reduce cancer and heart disease.69 The Trust disseminates anti-tobacco message campaigns, funds local community and health department healthy living initiatives, and established the statewide Oklahoma Tobacco Helpline, which has received more than 250,000 calls from smokers seeking cessation support in its 10-year history.70

The statewide Tobacco Stops With Me campaign is one of the Trust's success stories. Targeted to youth, young adults, and families, the campaign provides direct, emotional messages about the negative effects of tobacco use.71 Evaluation data indicate that the messaging campaign was effective in increasing awareness and improving the likelihood of successful cessation attempts. In addition to the activities funded by the settlement trust, Governor Mary Fallin signed an order that barred tobacco use at all state-owned and state-leased properties.72 Turning Point–led partnerships that built support for local ordinances banning tobacco use created momentum for the 2015 enactment of the 24/7 Tobacco-Free Schools Oklahoma state law. It requires that public schools adopt a tobacco-free campus policy, in force 24 hours per day, 7 days per week.

In Tulsa, the Communities of Excellence in Tobacco Control (CX Tobacco), run by the Tobacco Free Coalition for Tulsa County, works with businesses, communities, and schools to adopt and implement tobacco-free policies.73 Throughout the course of its work, CX Tobacco and its partners have helped 14 school districts and 40 companies to adopt tobacco-free campus policies. Other policy-level initiatives include work by the Oklahoma County Tobacco Use Prevention Coalition, which focuses on tobacco-related policy changes in Oklahoma City. With grant funding from CX Tobacco, the coalition is working to enact policy change to increase cessation, reduce initiation, and reduce secondhand smoke exposure among local residents. It works with school districts, youth, parks and recreation, local businesses, and health care agencies to work to create community-wide change.

**TEEN PREGNANCY, INFANT HEALTH, AND SUICIDE**

Educating teens about pregnancy prevention is another important area of collaborative effort in Oklahoma, which has the second highest teen pregnancy rates in the nation. Healthy Teens OK, established by the Oklahoma Institute for Child Advocacy, employs data and research to promote effective teen pregnancy prevention approaches.74 Local efforts include the Tulsa Campaign to Prevent Teen Pregnancy, a program that focuses on improving sex education, collaborating with government and nonprofit organizations to improve education and health services, and make local policy changes that reduce teen pregnancy.75 Both the Tulsa and Oklahoma City Health Departments, through OSDH, have participated in the Personal Responsibility Education Program (PREP), a pregnancy prevention program funded by the federal government's Family & Youth Services Bureau. PREP is an evidence-based program to reduce teen pregnancy through collaboration across public and private agencies.76

To improve maternal and infant health, OSDH operates the Fetal and Infant Mortality Review, a community-based process that reviews the factors influencing fetal and infant mortality to enact systemic change. The program aims to inspire community-driven changes that result in more women being healthy when they become pregnant, therefore increasing their chance of having a positive pregnancy outcome.77 In Tulsa, the health department runs the Healthy Start program, a community-based case management service that links women and families to services and obtaining input and direction from a community consortium.78 Its goal is to reduce infant mortality through communication and support to families and improve continuity of care for women and children.

OSDH is pursuing several collaborations to improve child health. The state's “Every Week Counts” is a collaborative effort to reduce the number of nonmedically necessary induced births or Cesarean sections, which reached more than 6 percent of total deliveries by early 2011. In addition to OSDH, partners include the Oklahoma Hospital Association, Oklahoma University Office of Perinatal Quality, Oklahoma Chapter of March of Dimes, and the state's 52 birthing hospitals. Oklahoma's Medicaid added impetus to the initiative by reducing payments for nonmedically indicated Cesarean sections.79 By late 2014, rates dropped to 0.02 percent of total deliveries.80

Oklahoma ranks among the nation's highest for suicide, with more than 19 deaths per 100,000 population.81 This is especially important for Native American populations, as suicide is the second leading cause of death among Oklahoma's American Indian/Alaska Native population ages 10 to 34.82 Research has shown that the most significant protective factors against suicide in this population include community control, such as the presence of cultural facilities and sovereignty; cultural identification, or a respect for or continuation of cultural practices; spirituality, a commitment to specific tribal cultural and spiritual practices; and family connectedness. The Kiowa Tribe of
Oklahoma blends evidence-based suicide prevention methods and early intervention programs with American Indian cultural identification in its teen suicide prevention outreach. Life skills adapted with the American Indian life skills development curriculum are taught in five area schools. The tribe also hosts community awareness events to promote help-seeking behaviors and create community “gatekeepers” who advance healing to families affected by suicide.79

Conclusion: Challenges and Opportunities

Despite funding challenges and its largely rural environment, Oklahoma has made strides to prioritize key health goals and convene and develop strategic partnerships and collaborations to achieve them. Turning Point provided an infrastructure for collaboration that continues to this day and facilitates initiatives implemented locally throughout the state. Through its Office of Tribal Liaison, OSDH has developed an infrastructure to promote outreach and collaboration on public health initiatives with the state’s 38 tribal nations. Additional surveillance, data and information gathering, and analysis is needed to determine whether Oklahoma’s recent initiatives are reducing chronic disease and improving overall health—especially among minority residents in low-income metropolitan areas and tribal communities. Finally, given the recent funding cuts to key public health programs, questions remain about the sustainability of efforts in turbulent economic times and whether the infrastructure developed to improve health and well-being is at risk. The following questions will be addressed in future reports:

• How are cross-sectoral partners, including those initiated under the Turning Point program, working together to plan and implement statewide infrastructure and vision? To what extent are statewide planners examining data to drive their decision-making?

• How are statewide cross-sectoral partnerships working within Oklahoma’s tribal nations? Have they been effective in promoting collaboration and addressing health challenges facing the American Indian population?

• To what extent can the impact of American Indian–led initiatives to address teen suicide and childhood obesity be measured?

• To what extent will Oklahoma’s extensive planning efforts address socioeconomic disparities, such as poverty and lack of insurance, among Hispanics and blacks?

• To what extent have Oklahoma statewide and regional initiatives been effective in addressing teen pregnancy and maternal-child health?

• How will Oklahoma develop and execute initiatives to improve state health outcomes once planning and priority-setting are finalized?

• To what extent have efforts to address the state’s high rates of childhood obesity been successful? Are new strategies available to help Oklahoma’s fight against childhood obesity?

• What effect has the remote nature of Oklahoma’s vast rural setting had on access to care for low-income, uninsured residents, especially those who live in sparsely populated areas?

• What impact has funding instability had on the health infrastructure in Oklahoma and how has that impacted key factors such as partnerships, collaboration, and service delivery?

• How are collaborative relationships and initiatives, such as the Oklahoma Turning Point Council and Certified Healthy Oklahoma, sustained in the face of unpredictable funding?


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