2023-2028 Oklahoma State Health Improvement Plan Annual Meeting

Thursday, October 2, 2025

OKLAHOMA STATE DEPARTMENT OF HEALTH

VISION

Leading Oklahoma to prosperity through health.

MISSION

To protect and promote health, to prevent disease and injury and to cultivate conditions by which Oklahomans can thrive.

VALUES

Service
Collaboration
Respect
Accountability

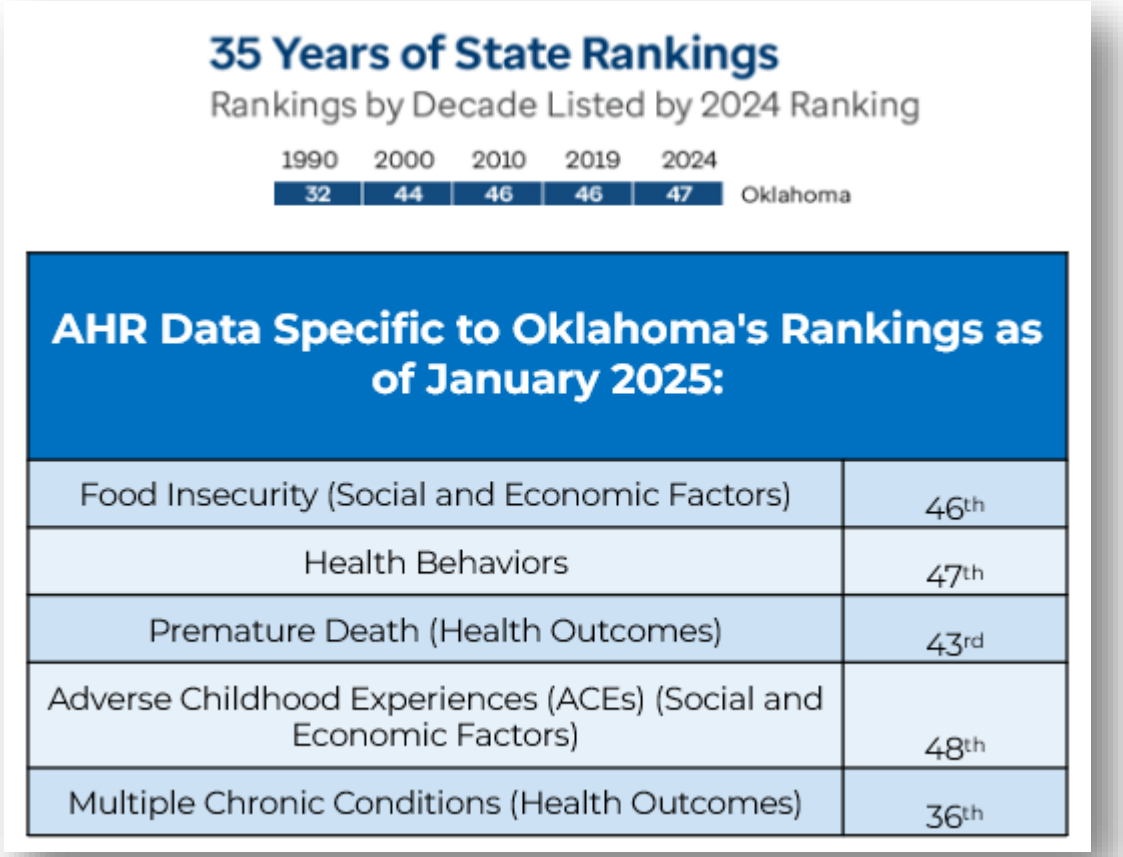
Agenda

1. Welcome & Introductions
2. Oklahoma State Health Improvement Plan (OK SHIP) Year 2 Overview
3. Diabetes Workgroup Updates
4. Mental Health & Substance Misuse Workgroup Updates
5. Tulsa County: Community Health Improvement Plan
6. Stretch Break
7. Drivers of Health (DoH) Workgroup Updates
8. Let's Write A Grant!
9. Cardiovascular Disease (CVD) Workgroup Updates
10. State Obesity Plan Updates
11. Survey & Closing

Oklahoma's Health Rankings and the OK SHIP

Oklahoma's Current Health Rankings

Measure	2024 Value	2024 Rank	
Social and Economic Factors *	-0.740	45	+
Physical Environment *	-0.390	49	+
Clinical Care *	-0.965	46	+
Behaviors *	-1.104	47	+
Health Outcomes *	-0.382	39	+
Overall *	-0.722	47	



Oklahoma's Health Rankings and the OK SHIP

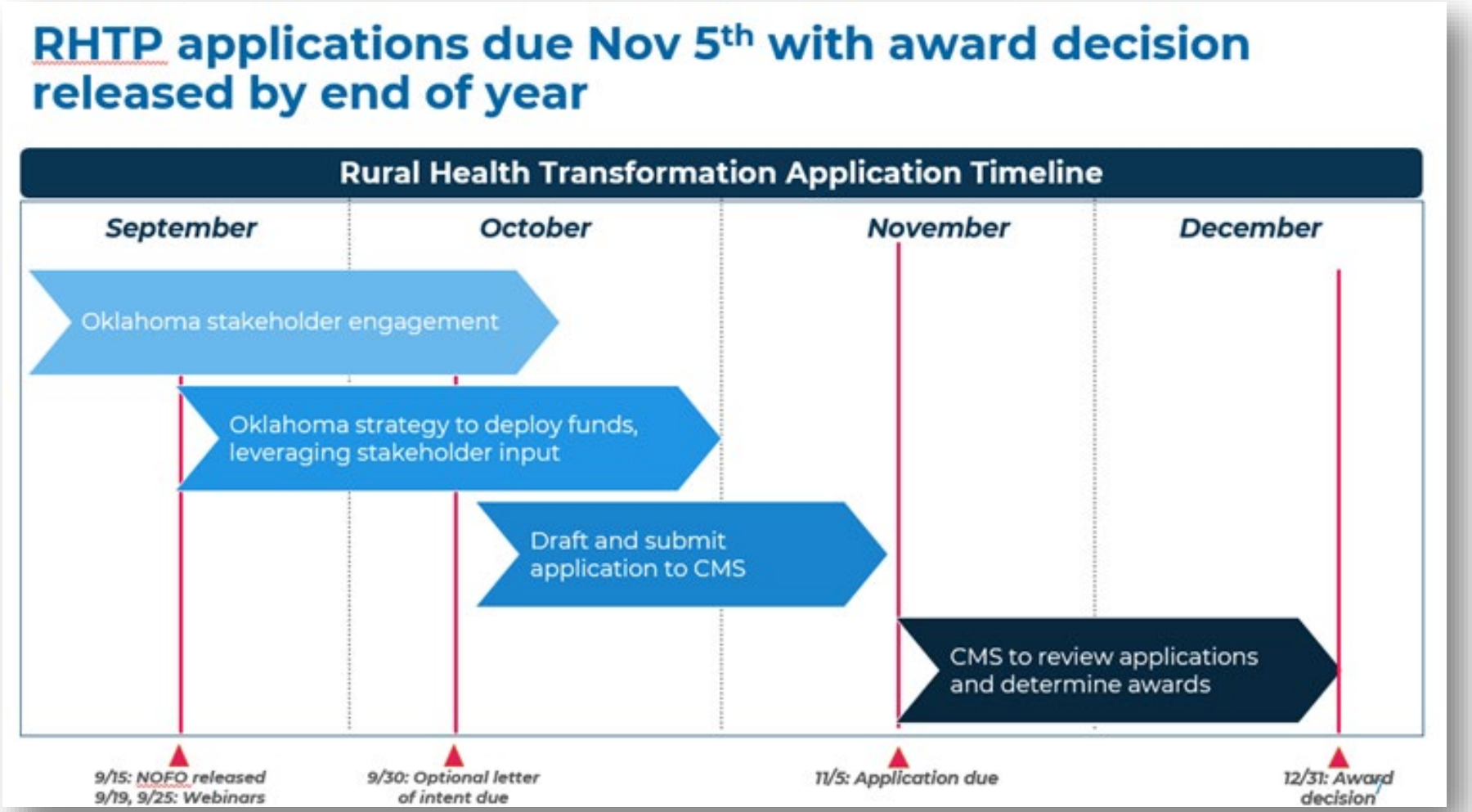
How OK SHIP Supports Improved Health Rankings.

- **Interconnected Impact:** Progress in one priority (e.g., obesity) benefits others (diabetes, cardiovascular disease, mental health).
- **Addressing Root Causes:** Tackling drivers of health strengthens overall outcomes across all priorities.
- **Prevention & Early Intervention:** Reduces preventable hospitalizations and premature death (key ranking measures).
- **Sustainable, Measurable Gains:** Community-focused initiatives drive long-term improvements in health behaviors and outcomes.
- **Call to Action:** By contributing data, engaging in SHIP efforts, and staying active in local initiatives, we can work together to build healthier communities and move Oklahoma forward in the health rankings.

Rural Health Transformation Program

- Created through H.R. 1 (The One Big, Beautiful Bill).
- Applications must address 5 strategic goals.
- Collected information through a Request for Information (RFI) and Listening Sessions.

Rural Health Transformation Program



https://oklahoma.gov/health/rhtp.html

Oklahoma SHIP: Development & Foundation

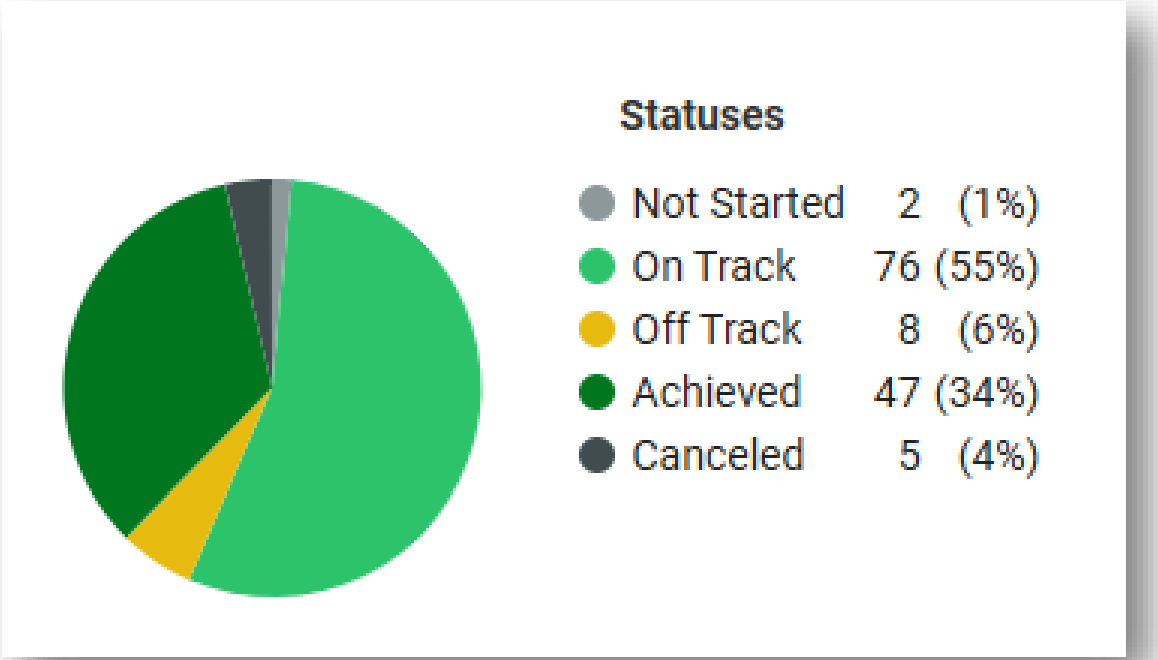
- Built from the 2022/2023 State Health Assessment (SHA) with broad stakeholder input.
- Identifies six statewide health priorities to guide collective action.
- Serves as a framework for aligning efforts across partners and communities.

Oklahoma SHIP: Year 2 Progress & Updates

- Rotating meeting schedule adopted to increase flexibility and engagement.
- SHIP Newsletter launched to keep partners informed and connected.
- Continued focus on communication, partner engagement, and tracking progress.

Oklahoma SHIP: Year 2 Progress & Updates

All Items (138 items)



2023-2028 OK SHIP: Diabetes

6 goals & 11 strategies

Facilitator: Jennifer Like, OSDH Chronic Disease Coordinator

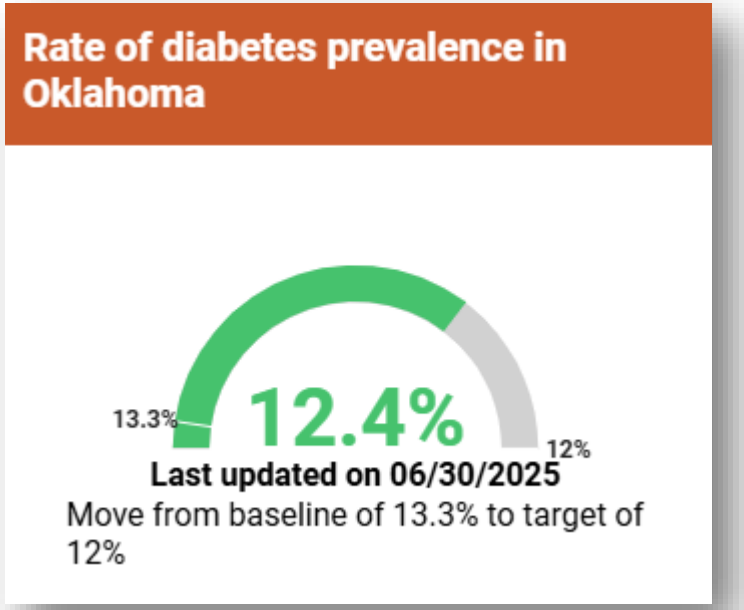
OKLAHOMA
State Department
of Health

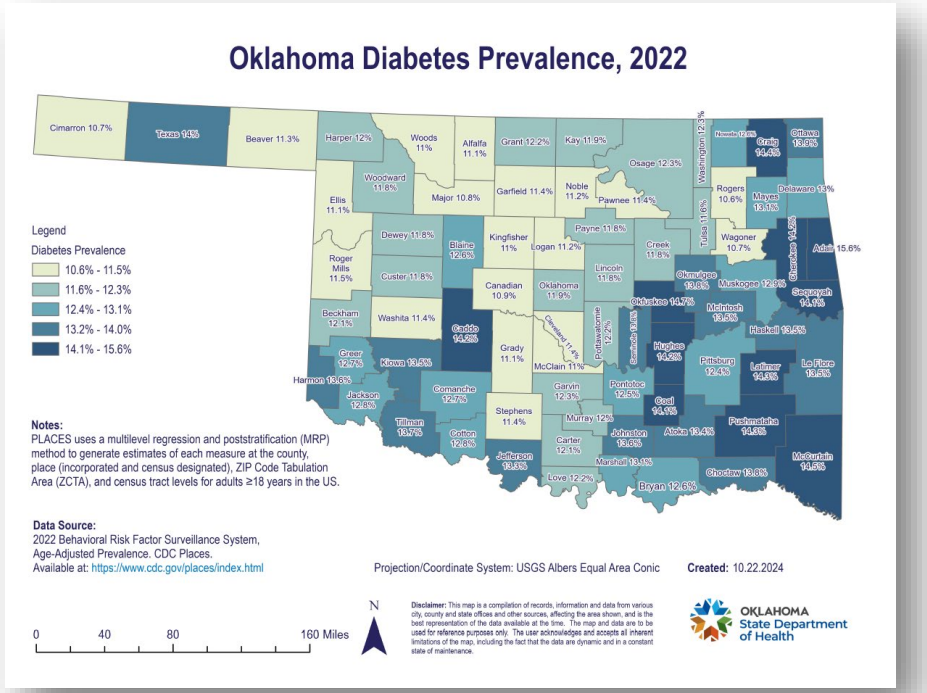
Diabetes: Year 2 Recap

- Two taskforce meetings so far this year
- Attendance more than doubled since transitioning to quarterly calls
- Great presentations:
  - Food is Medicine Pay for Success: A Collaborative Effort Pilot with Oklahoma Impact Investing Collaborative
  - Improving Access to Endocrine Care with eddii-Care from eddii
  - How Continuous Glucose Monitors (CGMs) are Reshaping Care with Blanchard Valley Diabetes Center and Dexcom

Diabetes SHIP Overview

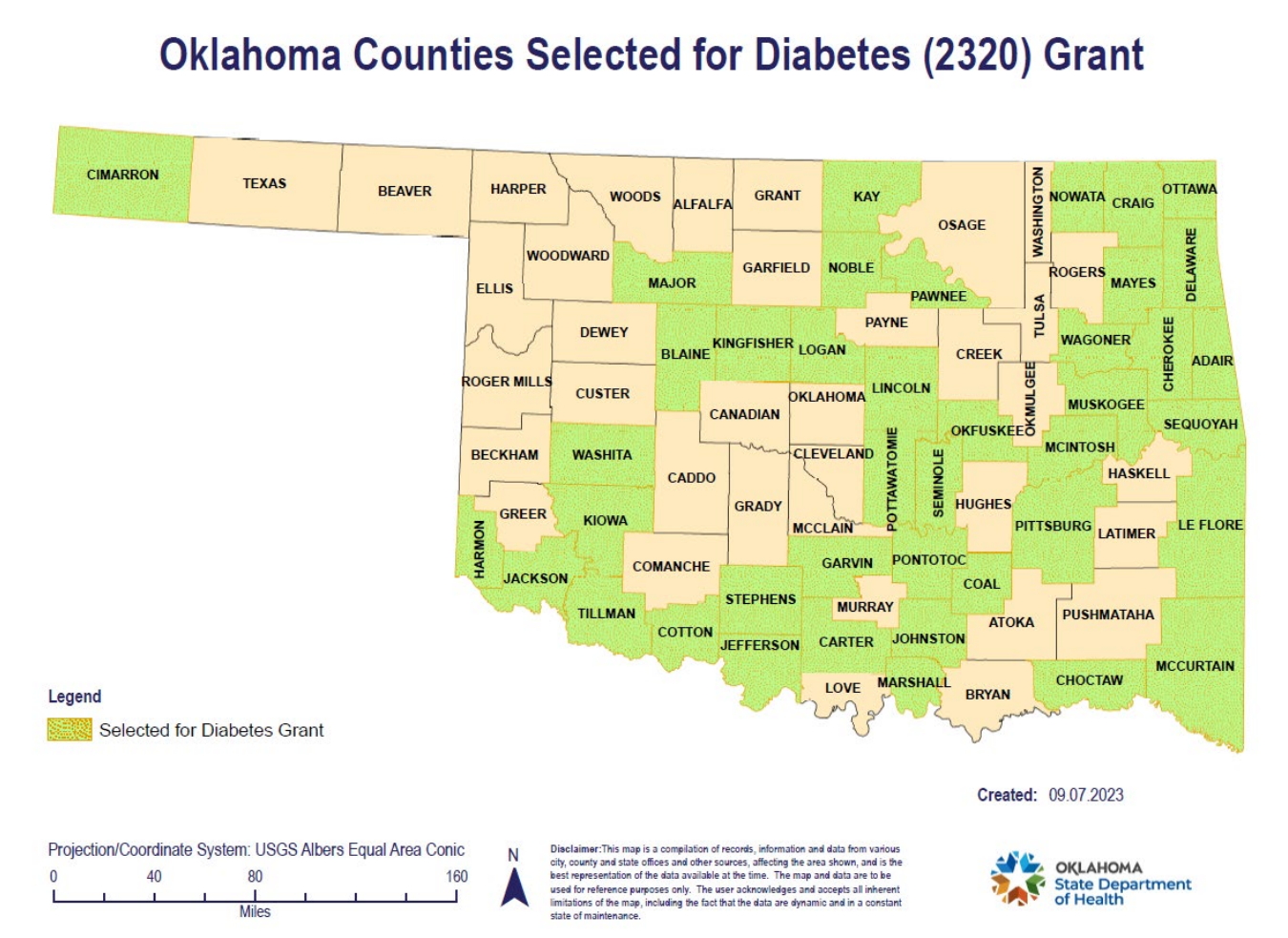
- Oklahoma has one of highest rates of diabetes in the US.
- Diabetes is leading cause of death and disability.
- Cost more than $1.6 billion in annual healthcare costs.





Diabetes SHIP Priority Population

Adults, age 18 and older, in rural and urban areas located within 41 identified counties with a high burden of diabetes, based on data. Forty-one counties in Oklahoma have been identified as target areas for programmatic work. The criteria for selecting counties were guided by GIS maps overlapping 2021 diabetes prevalence data with social vulnerability scores from Inequity Hot Spot census tract data. Identified counties have high rankings in both areas.



Diabetes Workplan

GOAL 1

Strengthen self-care practices by improving access, appropriateness and feasibility of DSMES services for priority populations to improve the state rate of diabetes prevalence from 13.3% to 12% by 2028.

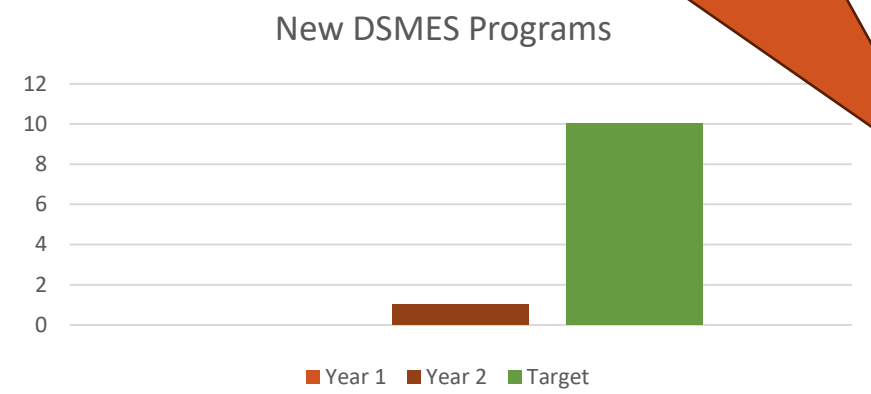
STRATEGY 1.1

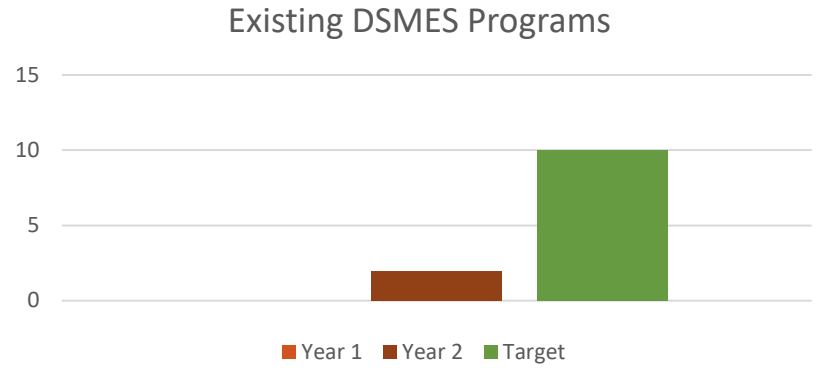
Identify and train in the DSMES program and protocols. Training will be provided to those that serve rural and urban popu abetes Care and Education Specialists (ADCES) accredited/Ame gnized.

Measure: # ted DSMES programs (year one = 0, year two = 1)

Measure: # edited DSMES programs (year one = 1, year two = 2)

Off Track from Targets – we need your help!





Diabetes Workplan

STRATEGY 1.2

Develop complementary diabetes support programs and services by partnering with community partners in areas of the state where priority populations have a high burden of diabetes.

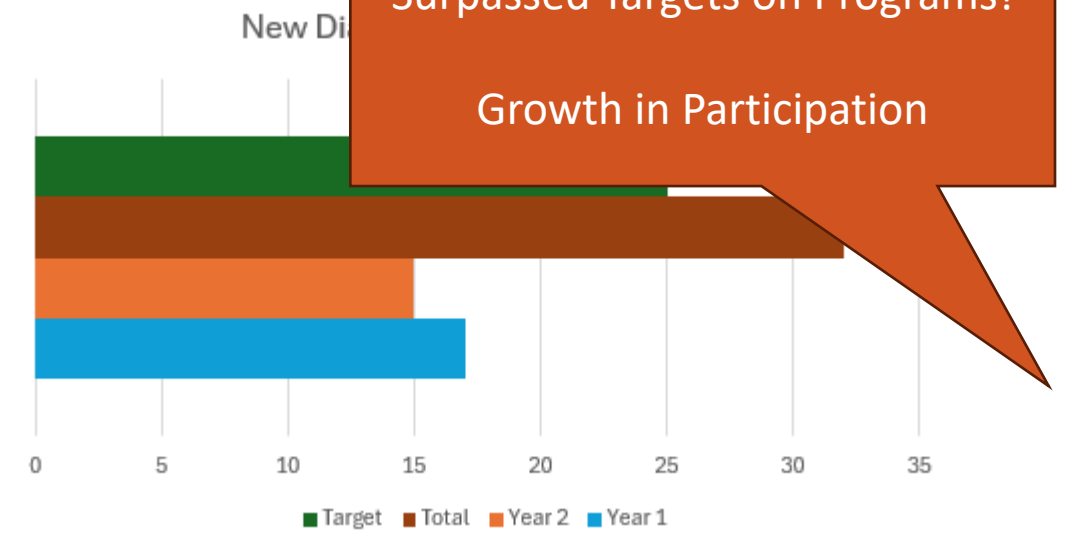
Measure: # new diabetes support programs (year one = 17, year 2 = 15, total = 32, target =25)

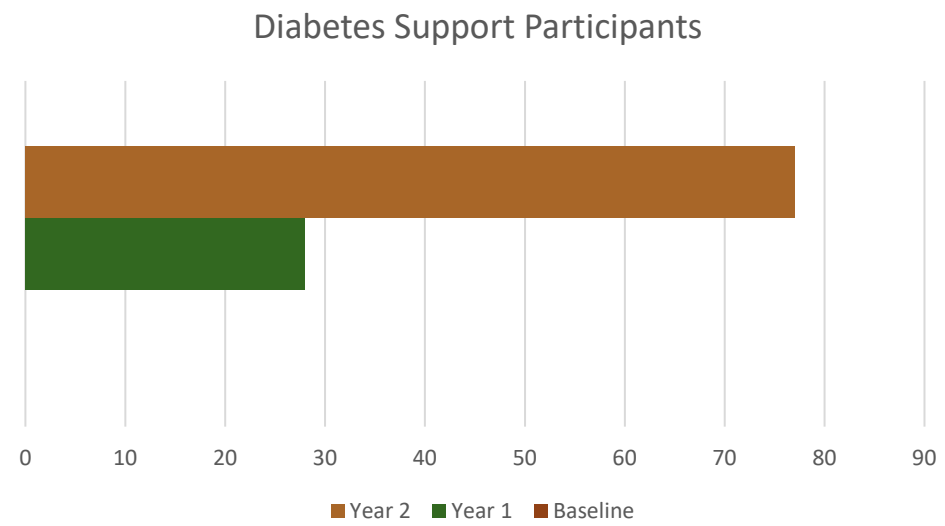
Measure: # existing diabetes support programs (year one = 28, year two = 36, target = 25)

Measure: # p upport programs (year one = 36, year two = 77)

Surpassed Targets on Programs!

Growth in Participation





Diabetes Workplan

GOAL 1

Strengthen self-care practices by improving access, appropriateness and feasibility of DSMES services for priority populations to improve the state rate of diabetes prevalence from 13.3% to 12% by 2028.

YEAR 3 CHANGES

Will increase targets for diabetes support programs – achieved targets!

Will identify target for # participants in diabetes support program.

Management Programs Map

Visit: oklahoma.gov/health/diabetes

TAKE THE RISK TEST >

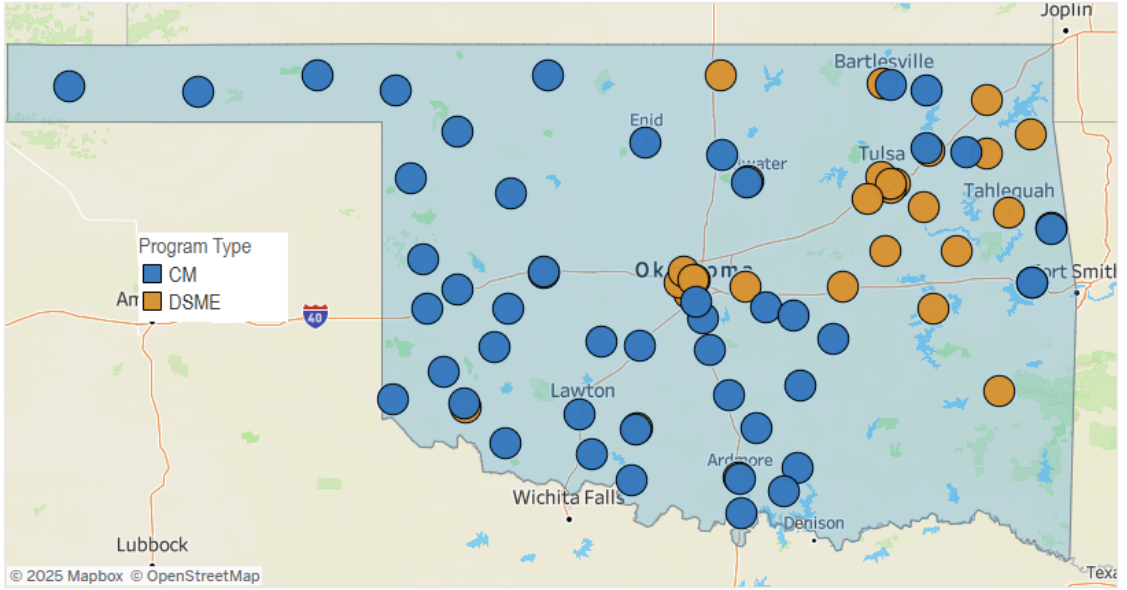
PREVENTION PROGRAMS MAP >

MANAGEMENT PROGRAMS MAP >

Diabetes Self-Management Education and Support and Conversation Map Sites in Oklahoma

Map Instructions

Use the interactive map on the right to learn more about Diabetes Self-Management Education and Support (DSMES) and Conversation Maps (CM) programs across the state. Hover over the dots for more information regarding each program such as city and phone number.



Diabetes Workplan

GOAL 2

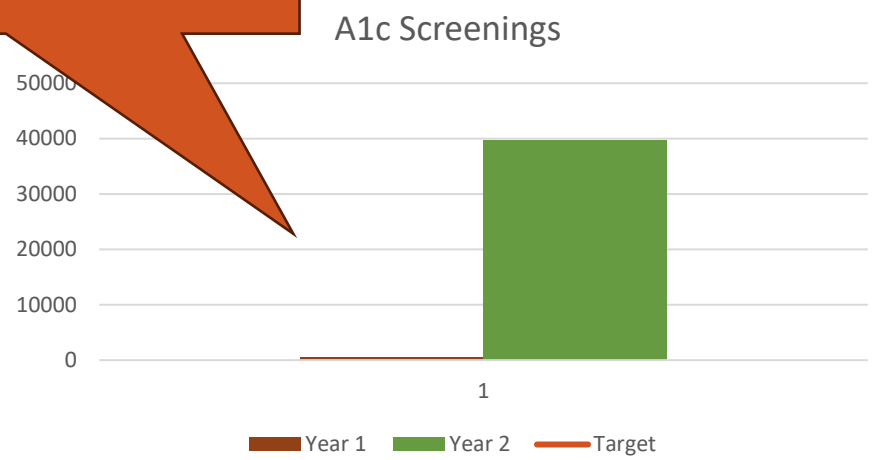
Prevent diabetes complications through early detection.

STRATEGY 2.1

Increase[d] [the number of visits per population] who receive regular diabetes screenings by 5% in areas with high bu[rden]

Me[asure] [Number of visits per population]ations who receive regular diabetes screenings (year one = 45[7]

Surpassed Targets!



Diabetes Workplan

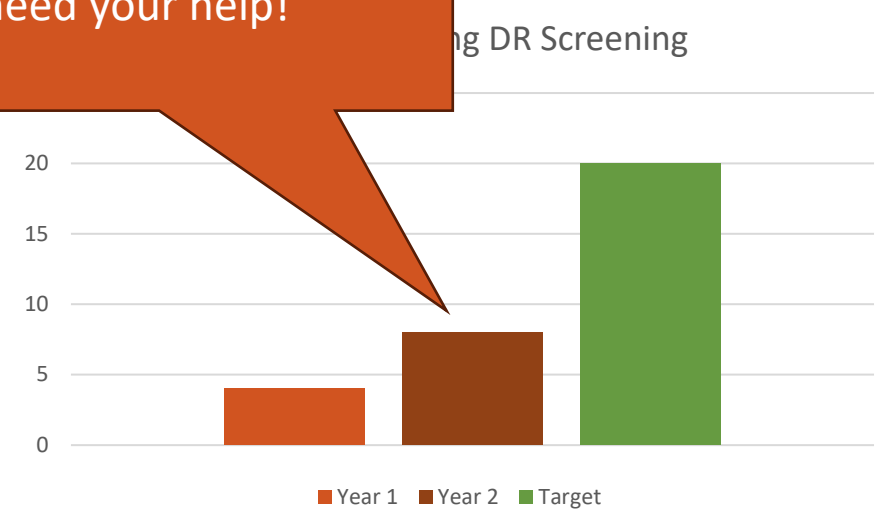
STRATEGY 2.2

Increase the number of priority populations with diabetes who receive diabetic retinopathy screening by 5% in areas with high burden of diabetes.

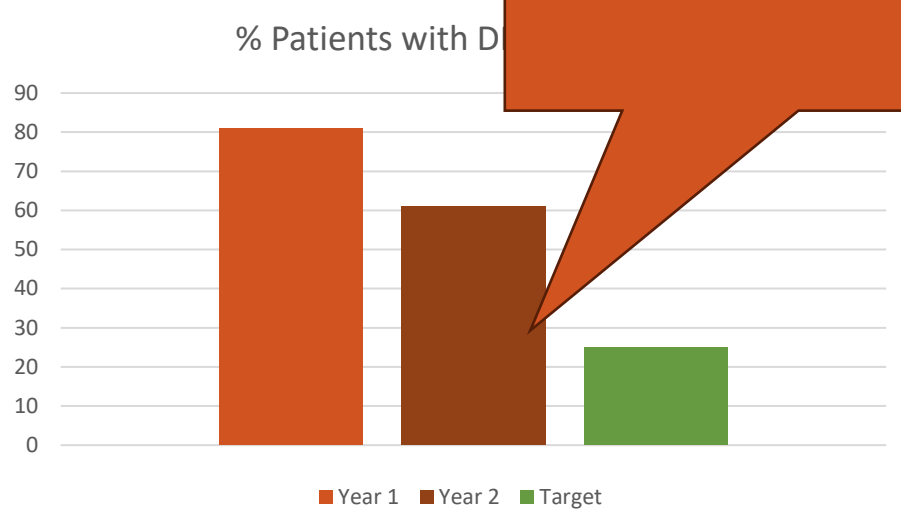
Measure: # clinics working to increase diabetic retinopathy screenings (year one = 4, year two = 8, target = 20)

Measure: % patients with diabetes screened for diabetic retinopathy (ye

Slightly Off Track from Targets – we need your help!



Surpassed Targets!



Diabetes Workplan

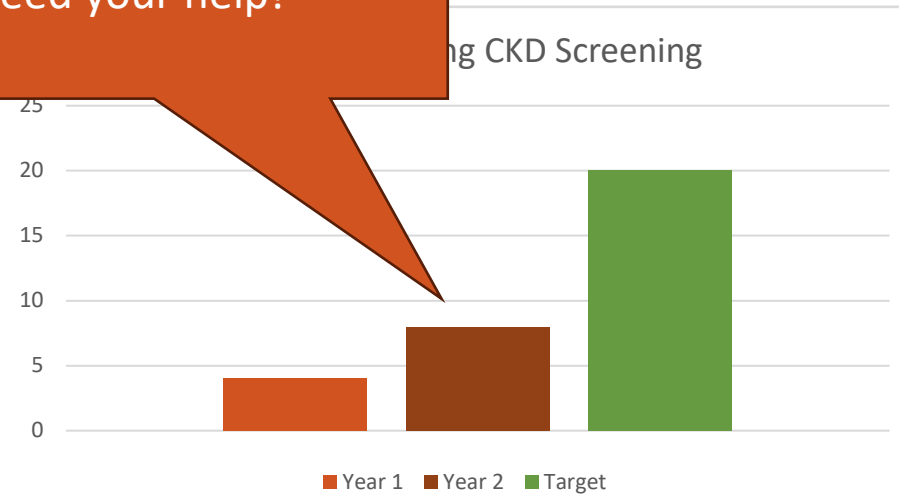
STRATEGY 2.3

Increase the number of individuals in priority populations with diabetes who receive an annual chronic kidney disease (CKD) screening by 5% in areas with a high burden of diabetes.

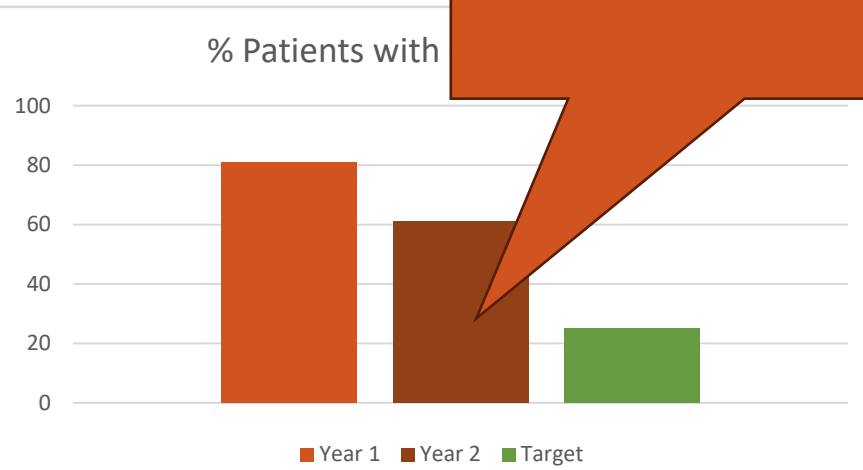
Measure: # clinics working to increase early detections of chronic kidney disease (year one = 4, year

ents with diabetes screened for chronic kidney disease
%)

Slightly Off Track from Targets – we need your help!



Surpassed Targets!



Diabetes Workplan

GOAL 2

Prevent diabetes complications through early detection.

YEAR 3 CHANGES

Change targets for # patients screened for A1c, and % patients screened for DR, and CKD – achieved targets!

Diabetes Workplan

GOAL 3

Improve acceptability and quality of care for priority populations with diabetes.

STRATEGY 3.1

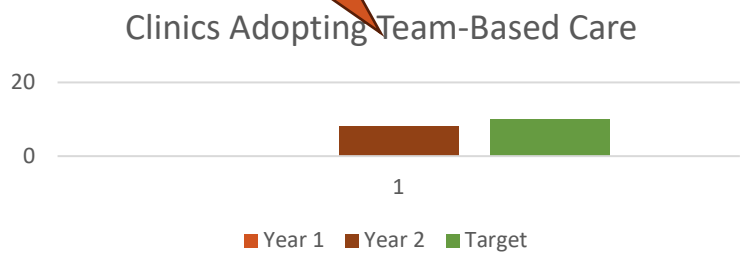
ndividuals in priority populations with diabetes receiving
payment models by 5%, in areas with high burden of d

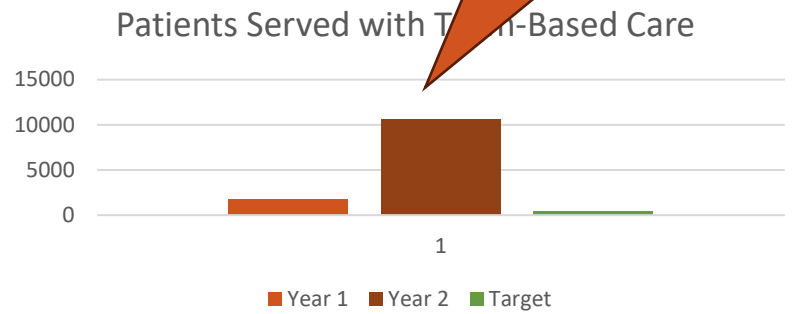
dopted or enhanced team-based care supported by sus
= 8, target 10)

Measu eople with diabetes served by health care organizations that have d or enhanced -based care supported by sustainable payment models. (year on 33, year two = 10,613, target = 0)

On Track

Surpassed Targets!





Diabetes Workplan

STRATEGY 3.2

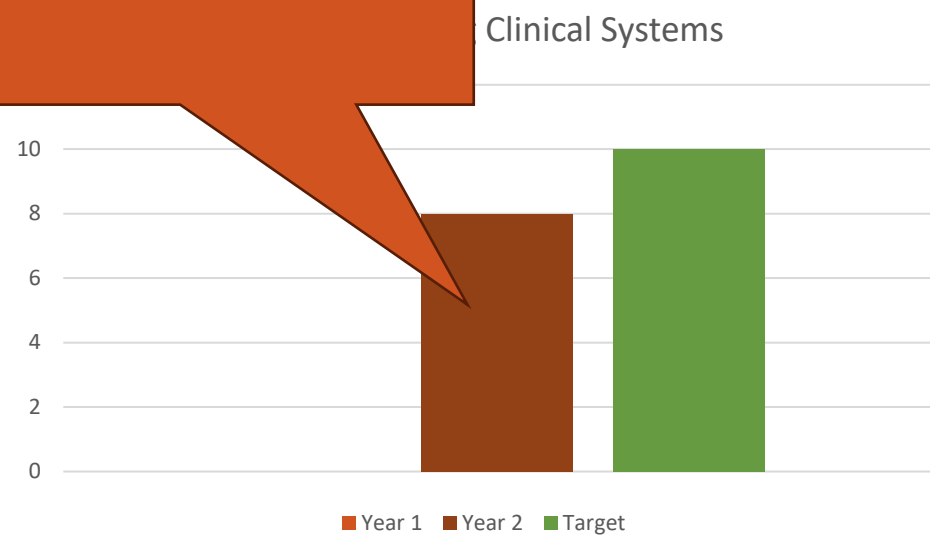
Identify partners to increase adoption and use of clinical systems and care practices in priority populations with diabetes.

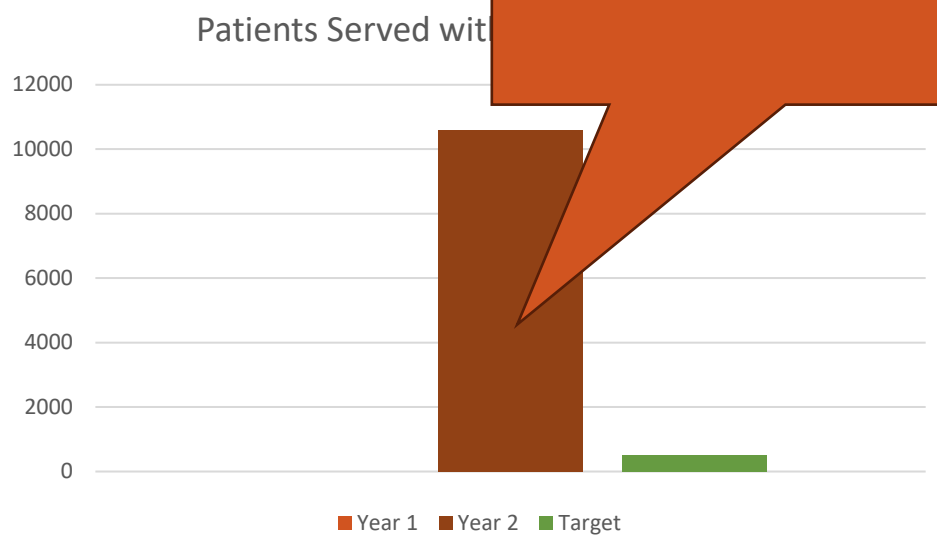
Measure: # healthcare organizations adopted or enhanced clinical systems and care practices to improve health outcomes for people with diabetes (year one = 0, year two = 8, target = 10)

with diabetes served by healthcare organizations that h
tems and care practices (year one = 0, year two = 10,613,

On Track

Surpassed Targets!





Diabetes Workplan

GOAL 3

Improve acceptability and quality of care for priority populations with diabetes.

YEAR 3 CHANGES

Change target for # patients served by Team-Based Care and Clinical Systems and Care Practices – achieved targets!

Diabetes Workplan

GOAL 4

Increase enrollment and retention of priority populations in the National Diabetes Prevention Program (National DPP) lifestyle intervention and the MDPP by improving access, appropriateness, and feasibility of the programs.

STRATEGY 4.1

Increase enrollment and retention in the National DPP Lifestyle intervention and MDPP of priority populations with diabetes by 10%.

Measure: # participants enrolled in DPP/MDPP through a CDC recognized delivery organization.

Measure: # of participants from priority populations enrolled in DPP/MDPP through a CDC recognized delivery organization.

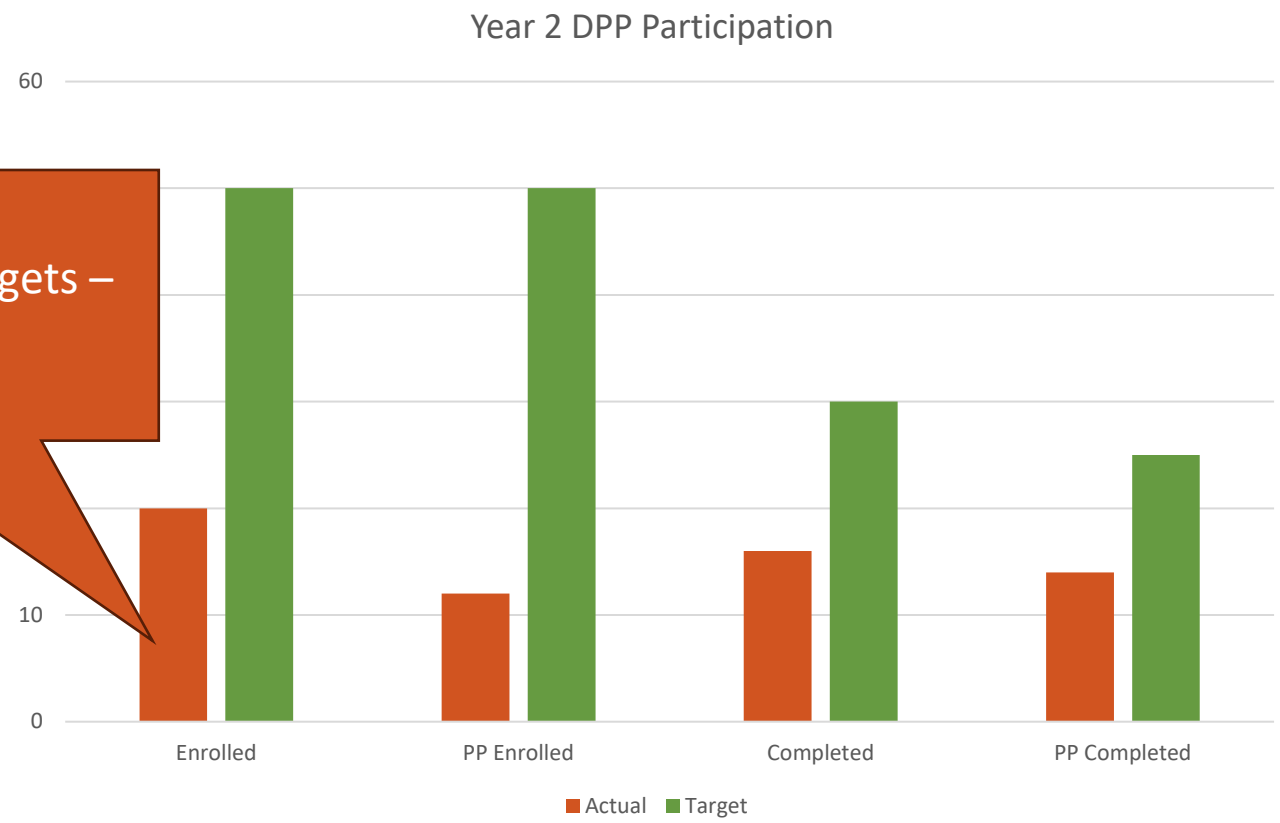
Measure: # of participants that completed DPP/MDPP through a CDC recognized delivery organization.

Measure: # of participants from priority populations that completed DPP/MDPP through a CDC recognized delivery organization.

Diabetes Workplan

STRATEGY 4.1

Slightly Off Track from Targets – we need your help!



Diabetes Workplan

GOAL 4
Increase enrollment and retention of priority populations in the National Diabetes Prevention Program (National DPP) lifestyle intervention and the MDPP by improving access, appropriateness, and feasibility of the programs.
STRATEGY 4.2
Increase enrollment and retention in the National DPP lifestyle change program through organizations utilizing online delivery modes. Measure: # DPP participants enrolled through online delivery mode. Measure: # of people from priority populations enrolled through online delivery mode.

Diabetes Workplan

GOAL 4
Increase enrollment and retention of priority populations in the National Diabetes Prevention Program (National DPP) lifestyle intervention and the MDPP by improving access, appropriateness, and feasibility of the programs.
YEAR 3 CHANGES
Remove strategy 4.2 – increase enrollment through organizations utilizing online delivery modes. Duplication of efforts in strategy 4.1. No partners offering online delivery mode.

Prevention Programs Map

Visit: oklahoma.gov/health/diabetes

TAKE THE RISK TEST >

PREVENTION PROGRAMS MAP >

MANAGEMENT PROGRAMS MAP >

National Diabetes Prevention Programs in Oklahoma

Map Instructions

Use the interactive map on the right to learn more about National Diabetes Prevention Programs across the state. Hover over the dots for more information regarding each program such as address, delivery mode and class type.

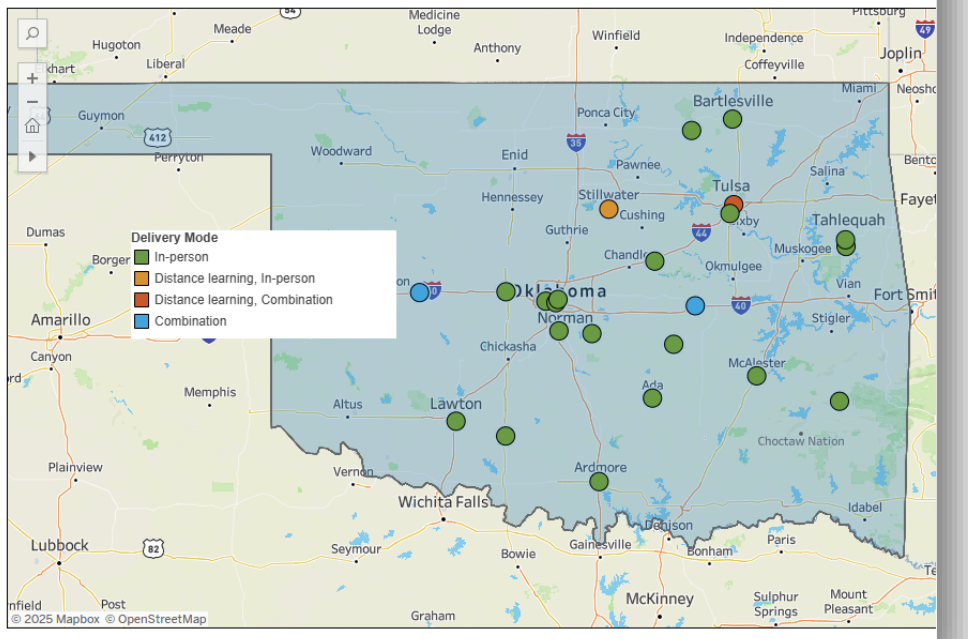
Delivery Mode Definitions

In person: Participants are physically present in a classroom or classroom-like setting

Online: Participants experience classes through the internet on their own time without a live coach

Distance Learning: Lifestyle Coach provides live delivery of session content in one location and participants call-in or video-conference from another location

Combination: Combination of any previously defined delivery mode



Diabetes Workplan

GOAL 5

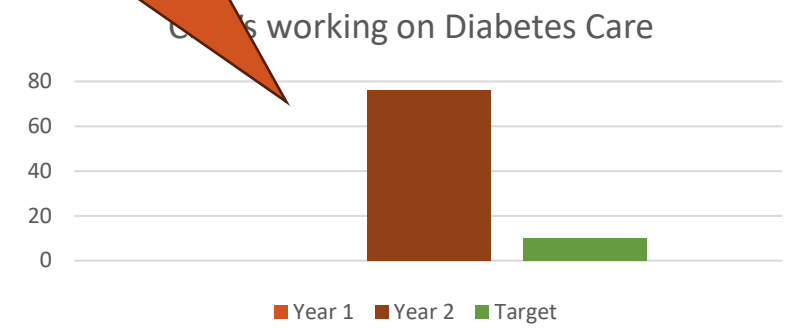
Improve the sustainability of Community Health Workers (CHW)/community-based workers (CBWs) by building or strengthening a supportive infrastructure to expand their involvement in evidence-based diabetes prevention and management programs and services.

TRATEGY 5.1

Increase actively involved in evidence-based diabetes prevention and mar 0%.

Surpassed Targets!

Measure: # CHWs/CBWs actively involved in evidence-based diabetes prevention and management programs and s (year one = 0, year two = 76, target = 10)



Diabetes Workplan

GOAL 5
Improve the sustainability of Community Health Workers (CHW)/community-based workers (CBWs) by building or strengthening a supportive infrastructure to expand their involvement in evidence-based diabetes prevention and management programs and services.
YEAR 3 CHANGES
Change target for # CHWs/CBWs involved in diabetes prevention/management – achieved target!

Diabetes Workplan

GOAL 6

Improve the capacity of the diabetes workforce to address factors related to drivers of health that impact health outcomes for priority populations with and at risk for diabetes.

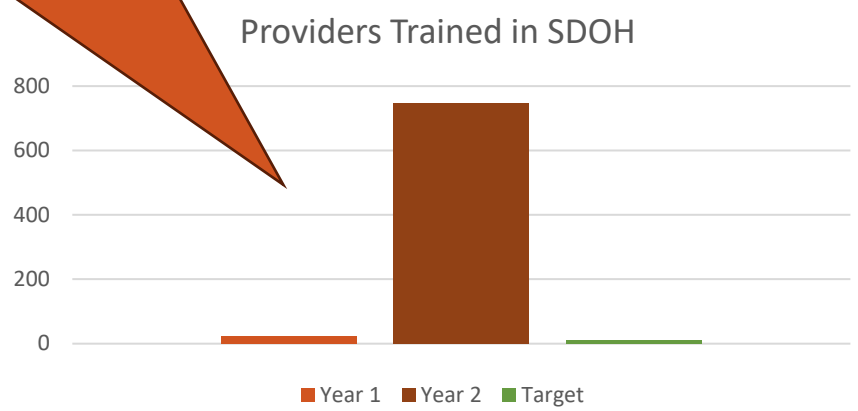
STRATEGY

6.1: Incre e providers who are trained in drivers of health topics by 5%.

Me gies (year one = 24, year two = 747, target = 10)

Me trategies

Surpassed Targets!



Diabetes Workplan

GOAL 6
Improve the capacity of the diabetes workforce to address factors related to drivers of health that impact health outcomes for priority populations with and at risk for diabetes.

YEAR 3 CHANGES
Change target for # providers trained in SDOH – achieved target!

healthy plate OKLAHOMA

Dairy

Fruit

Non-Starchy Vegetables

Water

Grain | Bread | Starch

Protein

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State Department
of Health

STEPS TO BUILDING A healthy plate:

1. Start with a 9" plate.

2. Divide plate in half. Fill one half with non-starchy vegetables.

3. Divide the other half in half again. Fill one part with protein.

4. Fill last part with breads, starches or grains.

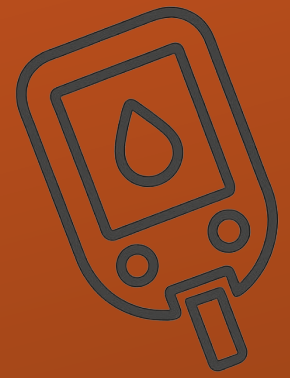
5. Have small servings of fruit and dairy with meals, or save to use as snacks between meals.

6. Be sure to drink water throughout the day.

Call(s) to Action

Contact me!
Jennifer.Like@health.ok.gov

- Join in on Diabetes SHIP taskforce meetings. Next meeting is Wednesday December 10th at 9am.
- Start up DSMES, diabetes support and/or DPP programs within your organizations.
- Share data on the programs you are offering.



DIABETES

Mental Health

1 goal & 4 strategies

Facilitators: Melissa Simms, OSDH D5 Community Engagement & Health Planning Manager and Erica Frazier, OSDH Behavioral Health Specialist

OKLAHOMA
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of Health

Mental Health: Year 2 Recap

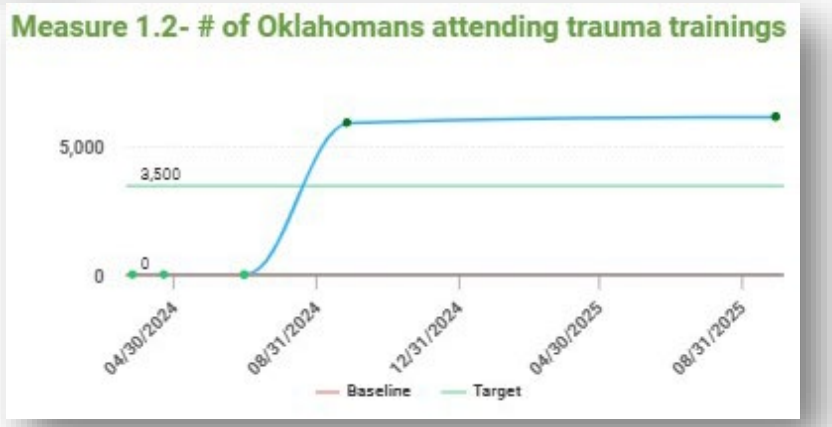
Goal 1	Improve Oklahoma's overall rate of death by suicide from 22.2% to 21%.

Mental Health: Year 2 Recap

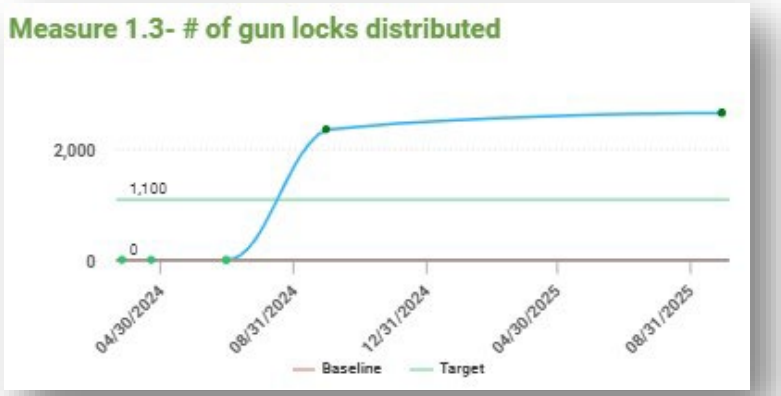
GOAL 1
Improve Oklahoma's overall rate of death by suicide from 22.2% to 21%.
STRATEGIES
1.1: Improve Oklahoma's overall rate of death by suicide by promoting and educating on 988.
1.2: Improve overall rate of death by suicide by increasing participation in trauma trainings.
1.3: Improve Oklahoma's overall rate of death by suicide by distributing gun locks to prevent firearm deaths.
1.4: Increase psychoeducation for common MH conditions to decrease stigma and increase awareness.

Mental Health: Year 2 Recap

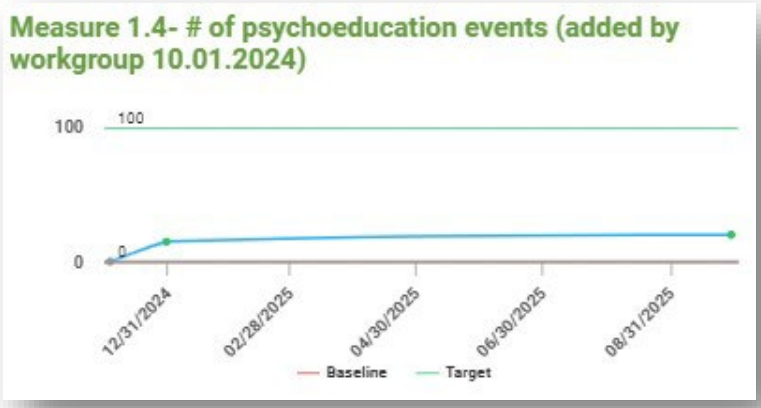
Measure 1.1



Measure 1.2



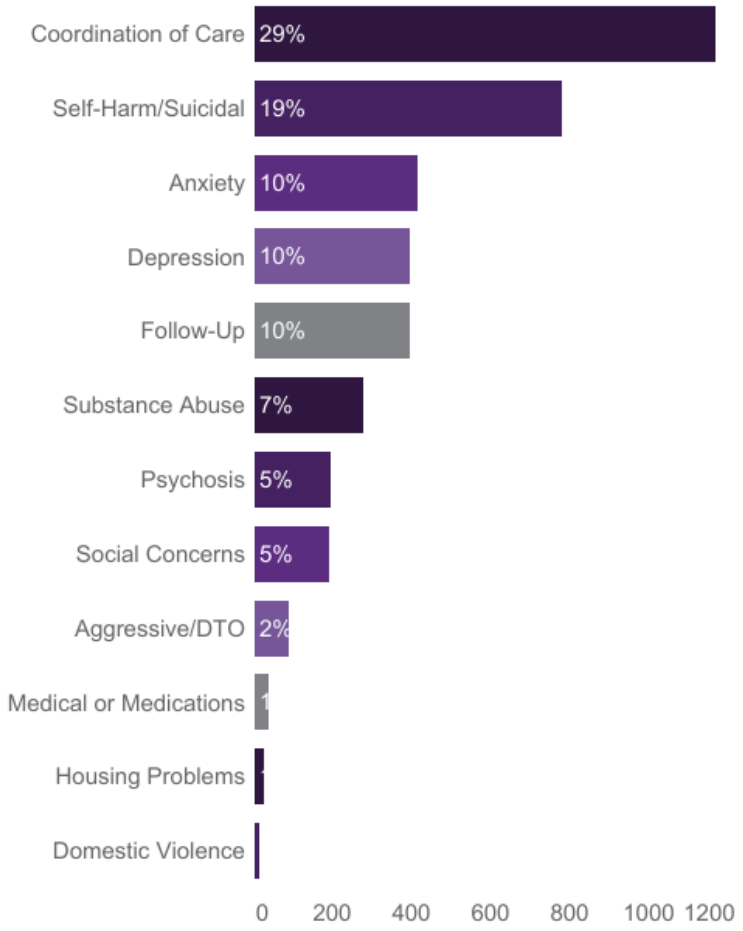
Measure 1.3



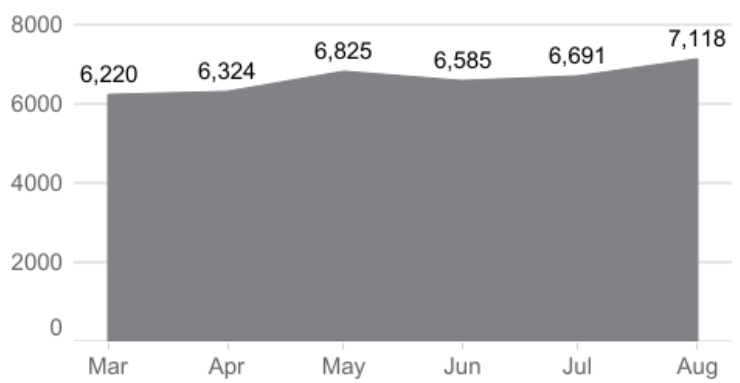
Measure 1.4

7,364	98.0%	11 seconds	90%
30-Day Crisis Call Volume	Answer Rate	Average Speed of Answer	Stabilization Rate

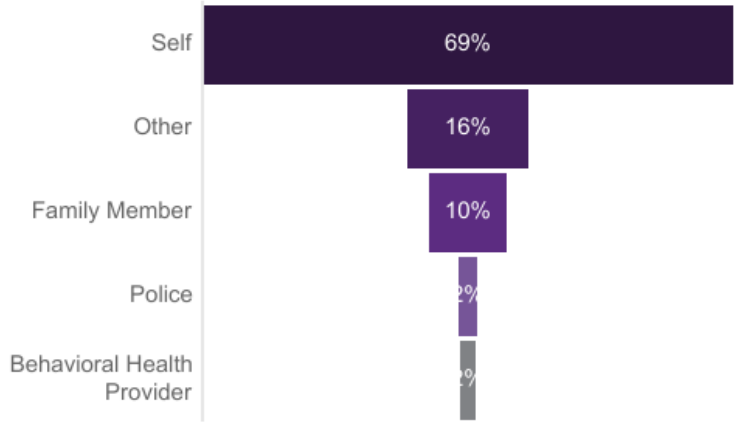
Reasons for Calling



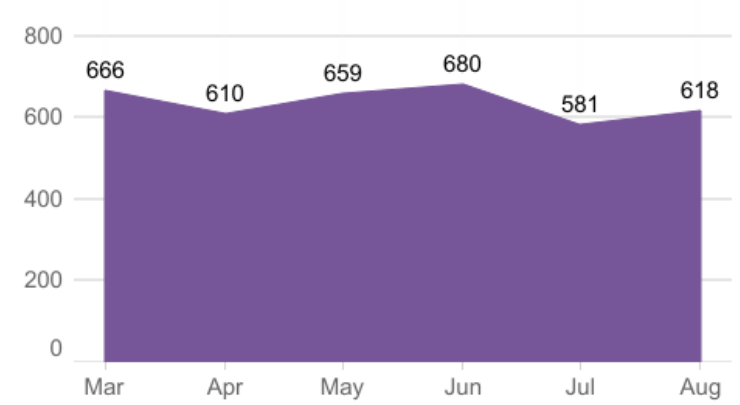
Crisis Call Volume by Month



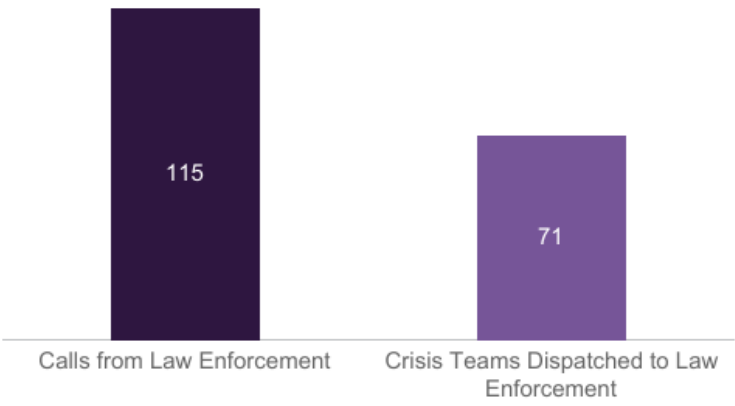
Top 5 Referral Sources



Dispatch Volume by Month



911 Diversion



Mental Health: Year 2 Recap

- Define psychoeducation: Psychoeducation is a therapeutic intervention that involves providing individuals with information about their mental health condition, symptoms, and treatment options. It aims to help clients understand their diagnosis, improve their coping skills, and enhance their ability to manage their symptoms effectively. Psychoeducation can be delivered by mental health professionals and can take various forms, including individual sessions, family education, and group discussions. This approach is beneficial for both clients and their families, as it empowers them to take an active role in their recovery and treatment.

Mental Health: Year 2 Recap

GOAL 1

Improve Oklahoma's overall rate of death by suicide from 22.2% to 21%.

YEAR 3 CHANGES

- With Year 2 goals achieved, we're increasing metrics for 988 promotion, trauma trainings, and gun lock distribution!
- Strategy 1.2 will include Science of Hope and Handle With Care trainings.
- Strategy 1.3 will review data with injury prevention and formulate targeted interventions for geographic areas.
- Strategy 1.4 will add definition of psychoeducation.

Call(s) to Action

- Join the Mental Health SHIP Workgroup! The next meeting Nov. 12 @ 0900am.
- Invite partners to join and share your work with us!
- Continue to engage your team/ community.

MENTAL HEALTH

Substance Misuse

2 goals & 4 strategies

Facilitators: Melissa Simms, OSDH D5 Community Engagement & Health Planning Manager and Erica Frazier, OSDH Behavioral Health Specialist

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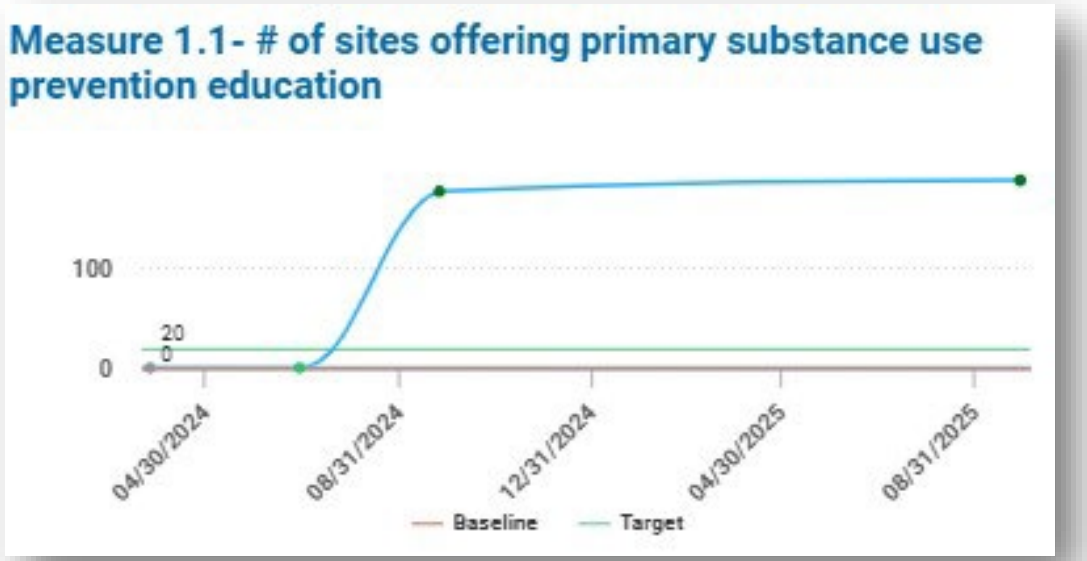
Substance Misuse: Year 2 Recap

Goal 1	Improve Oklahoma's overall rate for substance use disorder among individuals 18 or older from 19.66% to 18.6% by 2028.
Goal 2	Decrease Oklahoma's annual rate of unintentional drug overdose deaths from 1200 to a rate below 800 by 2028.

Substance Misuse: Year 2 Recap

GOAL 1
Improve Oklahoma's overall rate for substance use disorder among individuals 18 or older from 19.66% to 18.6% by 2028.
STRATEGY
1.1: Improve Oklahoma's substance use disorder rate by increasing primary substance use prevention education.

Substance Misuse: Year 2 Recap



Measure 1.1

Substance Misuse: Year 2 Recap

GOAL 1

Improve Oklahoma's overall rate for substance use disorder among individuals 18 or older from 19.66% to 18.6% by 2028.

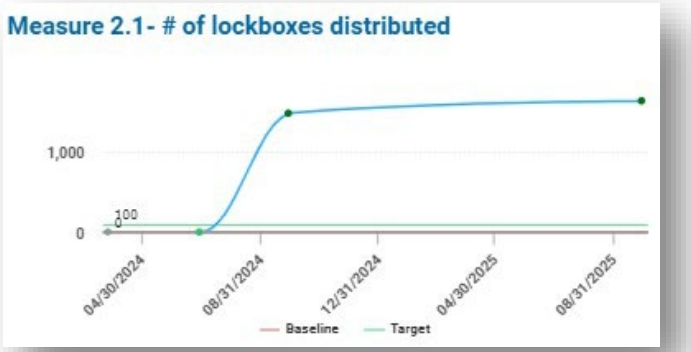
YEAR 3 CHANGES

- Strategy 1.1: Increase partnerships between MH and SUD education to increase capacity and reach .
- The target measure will be increase since the Year 2 goal was met!

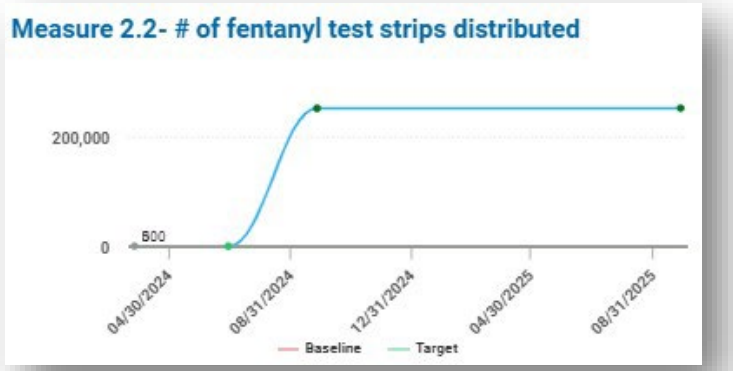
Substance Misuse: Year 2 Recap

GOAL 2
Decrease Oklahoma's annual rate of unintentional drug overdose deaths from 1200 to a rate below 800 by 2028.
STRATEGIES
2.1: Improve Oklahoma's overall rate of death by overdose by distributing medication lockboxes.
2.2: Improve Oklahoma's overall rate of death by overdose by distributing fentanyl test strips.
2.3: Improve Oklahoma's overall rate of death by overdose by distributing overdose reversal medication (Naloxone/Narcan).

Substance Misuse: Year 2 Recap



Measure 2.1



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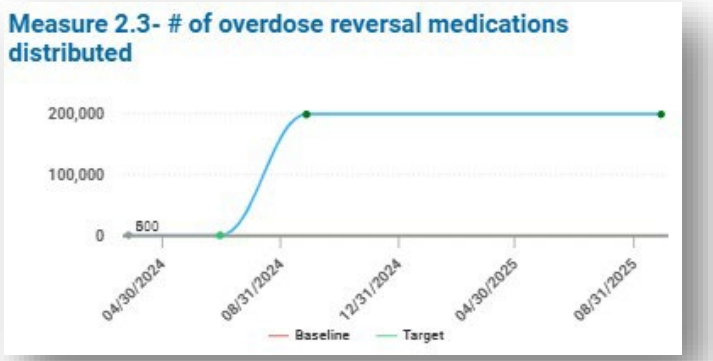


Measure 2.3

Oklahoma Drug Overdose Dashboard
Unintentional All Drug Overdose Deaths, Oklahoma, 2019-2023

OKLAHOMA State Department of Health

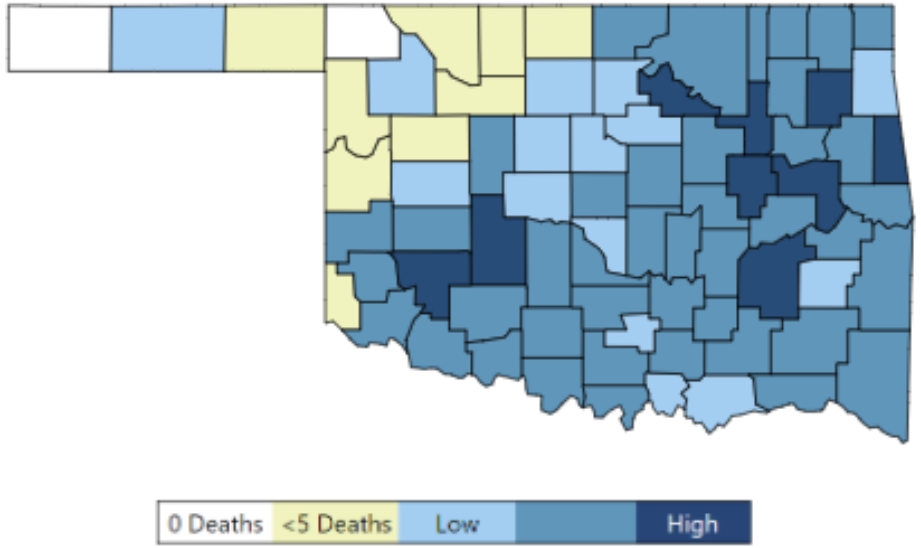
Substance[1]: All Drugs | **County:** All | **Year:** All | **Sex:** All | **Age Group:** All | **Race/Ethnicity:** All | **Reset Filters**

Deaths | **Inpatient Discharges** | **ED Discharges**

Number of Deaths	Death Rate per 100,000	History of Substance Use	History of Mental Illness
4,812	24.1	73%	23%

All Drug Overdose Death Rate by County of Residence
Oklahoma, 2019-2023

View Table



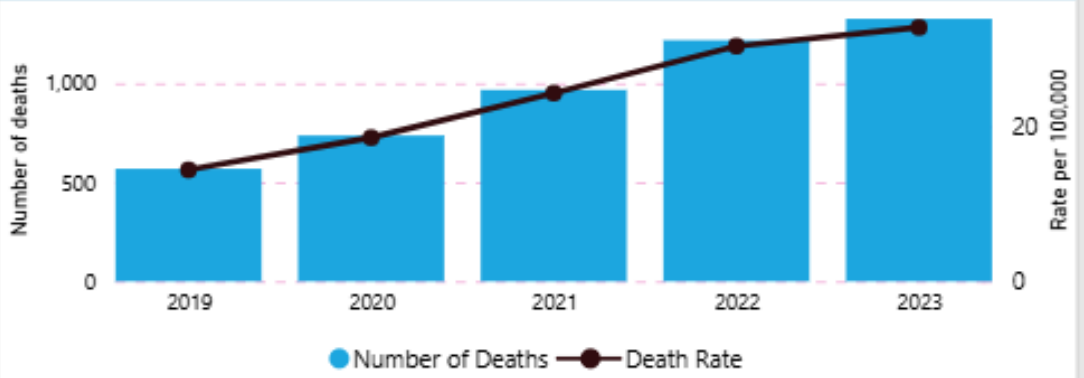
Display Options

- By Year
- By Age Group
- By Race/Ethnicity
- By Sex

All Drugs

Unintentional drug overdose deaths with ICD-10 underlying cause of death codes of X40-X44, as well as deaths identified by reviewing literal text in the cause of death field in the medical examiner reports and death certificates.

All Drug Overdose Deaths by Year
Oklahoma, 2019-2023



All Drug Overdose Deaths by Year
Oklahoma, 2019-2023

Year	Number of Deaths	Death Rate per 100,000
2019	568	14.3
2020	736	18.5
2021	966	24.2
2022	1,217	30.3
2023	1,325	32.7

[1]Substances are not mutually exclusive. More than one substance may be involved in each overdose death. *Rate suppressed due to small number of deaths (<5) or secondary suppression (≥5). NH=Non-Hispanic; AI/AN=American Indian/Alaska Native.

This dashboard was supported by the Centers for Disease Control and Prevention (CDC) of the U.S. Department of Health and Human Services (HHS) as part of the Overdose Data to Action in States cooperative agreement CDC-RFA-CE-23-0002. The contents do not necessarily represent the official views of, nor an endorsement by, CDC/HHS or the U.S. Government.

Naloxone Vending Machines

Keathley Korner
OK-152 &, OK-30
Sweetwater, OK 73666
580-534-2279

Lucky Star Casino
20413 OK-33
Hammon, OK 73650
580-473-2010

Cordell Memorial Hospital
1220 N Glenn English St,
Cordell, OK 73632
(580) 832-3339
&
Kwik Run
218 Highway 44
Burns Flat, OK 73624
580-562-4044

Clinton Regional Hospital
100 N 30th St
Clinton, OK 73601
580-547-5128

Neptune 66
1402 Neptune Dr
Clinton, OK 73601
580-547-4083

BG's Convenience Store
401 W Davis Ave
Weatherford, OK 73096
580-772-7973

Red Rock Behavioral Health
3080 W 3rd St
Elk City, OK 73644
580-225-5136

Great Plains Regional Medical Center
1801 W. 3rd St
Elk City, OK 73644
580-225-2511

Smith's C &K
306 W Roger Miller Blvd
Erick, OK 73645
580-526-3566

Clean Scene Laundromat
406 NE Hwy 66
Sayre, OK 73662
580-928-2944

CareFirst Wellness Associates
1104 East Central Boulevard
Anadarko, OK 73005
405-247-6685

Morgan's Laundromat
118 E Main St
Hinton, OK 73047
405-517-7316

Shortgrass Community Health Center
400 East Sycamore Street
Hollis, OK 73550
580-688-2800

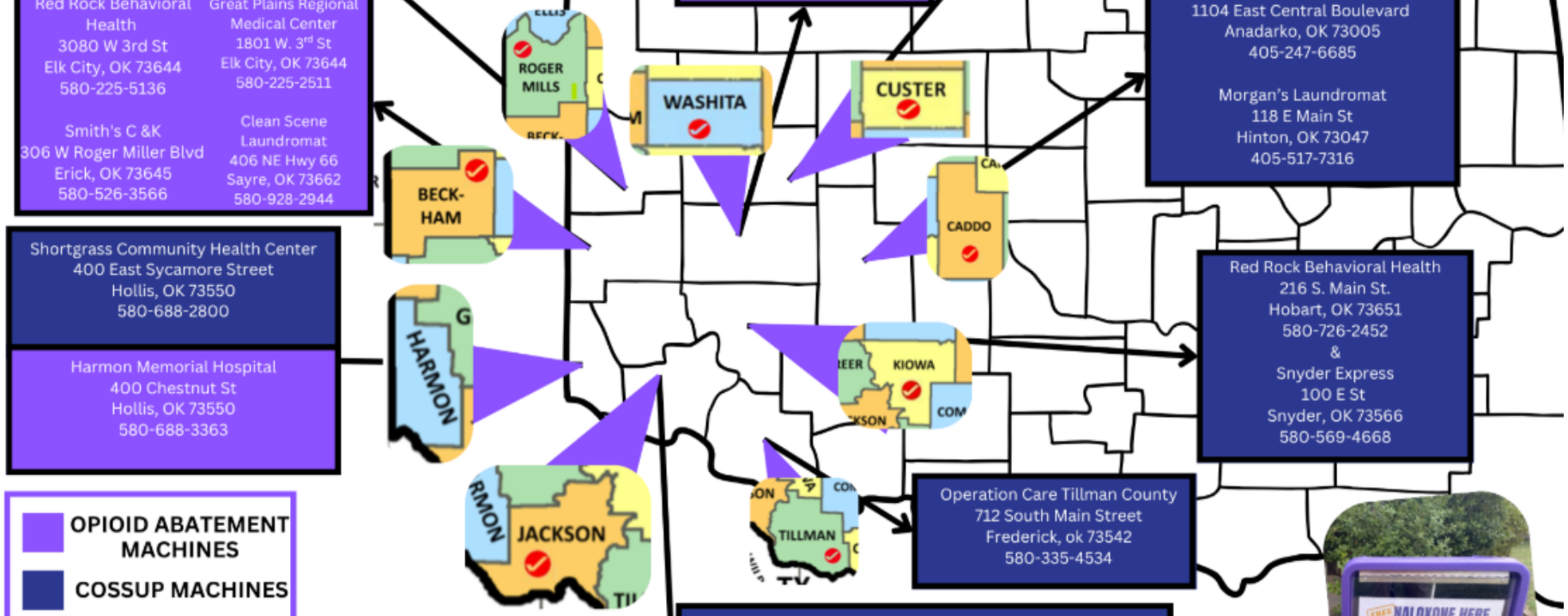
Harmon Memorial Hospital
400 Chestnut St
Hollis, OK 73550
580-688-3363

Red Rock Behavioral Health
216 S. Main St.
Hobart, OK 73651
580-726-2452
&
Snyder Express
100 E St
Snyder, OK 73566
580-569-4668

Operation Care Tillman County
712 South Main Street
Frederick, ok 73542
580-335-4534

Jackson County Memorial Hospital
1200 E Pecan Street
Altus, OK 73521
580-379-5000
&
Shortgrass Community Health Center
111 S. Hudson
Altus, OK 73521
580-379-9215

Hopeful Grounds Association
615 N Main Street
Altus, OK 73521
(580) 471-1855



OPIOID ABATEMENT MACHINES

COSSUP MACHINES

For more information, please scan QR code.

Purchased by:

SWODA

COSSUP

LOOK FOR THESE

Substance Misuse: Year 2 Recap

Adrienne Elder	EB Consulting OKC
Jill Hazeldine	Public Health Institute of Oklahoma
Kim Whaley	Pathways to a Healthier You and DRH Health
Kendra Gift	South Western Oklahoma Development Authority
Lisa Harper	DCCCA with programming including SUPA (Substance Use Prevention Alliance), and Mental Health First Aid Oklahoma
Hayley Warren	Oklahoma Hospital Association
Lezlie Borak	OSDH, Emergency Preparedness & Response, Oklahoma Medical Reserve Corps (OKMRC) volunteer organization
Brittani Brice	Red Rock BHS, Medication Assisted Treatment
Jonathan Crouse	Lawton Community Health Center
Katelyn Wilson	Oklahoma Department of Mental Health and Substance Abuse Services (School-based Prevention)
Don Ramos	Wichita and Affiliated Tribes - 988 RISE Program
Brooke Tuttle	Center for Family Resilience, Oklahoma State University
Melissa Simms	OSDH- D5
Melissa Simms	Oklahoma Turning Point Council
Rebecca Hubbard, PhD	City of Tulsa
Kriston Ahlefeld	Southern Plains Tribal Health Board SHRED the Stigma
Emily Coppock	Oklahoma Hospital Association- Imbedding CHWs in Emergency Departments to reduce morbidities and mortalities associated with opioid or stimulant misuse. Hospitals include Duncan Regional Hospital-Duncan; Hillcrest Hospital-Henryetta; INTEGRIS Health Southwest Medical Center-OKC; Saint Francis Hospital, Muskogee.
Caila Garcia	Oklahoma State Department of Health
Taylor Shelton	Substance Use Prevention Alliance of Oklahoma County, Mental Health First Aid Oklahoma
La'Chanda Stephens-Totimeh	Section on Developmental & Behavioral Pediatrics, OUHSC (Center on Child Abuse & Neglect; Child Study Center)
Sanaria Okongor	Oklahoma Complete Health/Centene
Meg Cannon	ODMHSAS

Substance Misuse: Year 2 Recap

GOAL 2

Decrease Oklahoma's annual rate of unintentional drug overdose deaths from 1200 to a rate below 800 by 2028.

YEAR 3 CHANGES

- **Strategy 2.3:** Naloxone training along with distribution of reversal medication will be included.
- **Stimulant Use & Overamp:** Need to strengthen support for stimulant use disorder; no stimulant detox centers currently in Oklahoma (stimulants are primary drug after marijuana). Explore provider partnerships to expand outpatient support services.
- **Community Education:** Increase awareness on SUD, with emphasis on stimulants (e.g., meth, cocaine), the most prevalent substances in Oklahoma.

Call(s) to Action

- Go beyond prevention education and prioritize interventional approaches. Build partnerships between mental health and primary care providers to expand outpatient SUD treatment capacity and reduce overdose deaths.
- Reduce stigma and raise awareness on mental health (e.g., ACEs) to strengthen support for recovery; launch a bold campaign emphasizing that recovery is possible!
- Join Substance Misuse SHIP workgroup, next meeting is Nov. 12 @ 0900.
- Invite Partners and share the narrative to lessen the stigma!

SUBSTANCE MISUSE

2023-2028 OK SHIP: Drivers of Health (DoH)

2 goals & 13 strategies

Facilitators: Adrienne Elder, Director of Interagency Special Projects, EB Consulting, and Policy Co-Chair, OK Turning Point Council
Dr. Aley Cristelli, Manager, Population Health Strategy at Oklahoma Complete Health

OKLAHOMA
State Department
of Health

Drivers of Health: Year 2 Recap

- We believe in quality over quantity
- Increased collaboration
- Emphasis on enhancing infrastructure that supports community-driven strategies

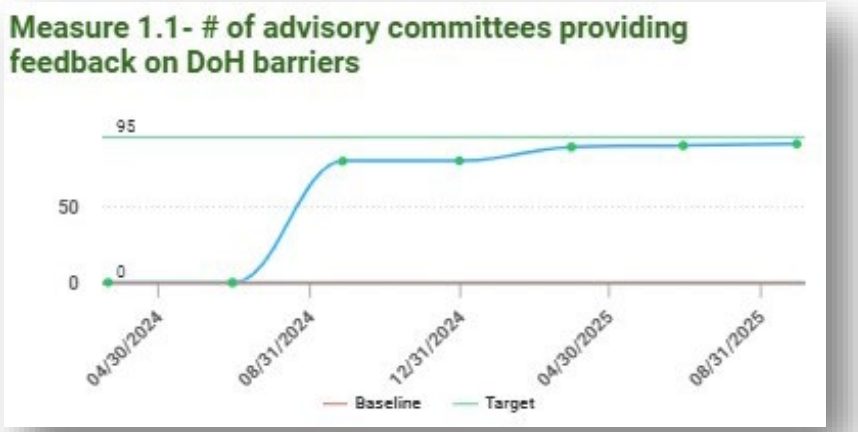
Drivers of Health: Year 2 Data

Goal 1	Improve health outcomes in Oklahoma as measured by America's Health Rankings social and economic factors from 44th to 41st by 2028.
Goal 2	Develop and grow partnerships to enhance the impact of education, research and service related to DoH.

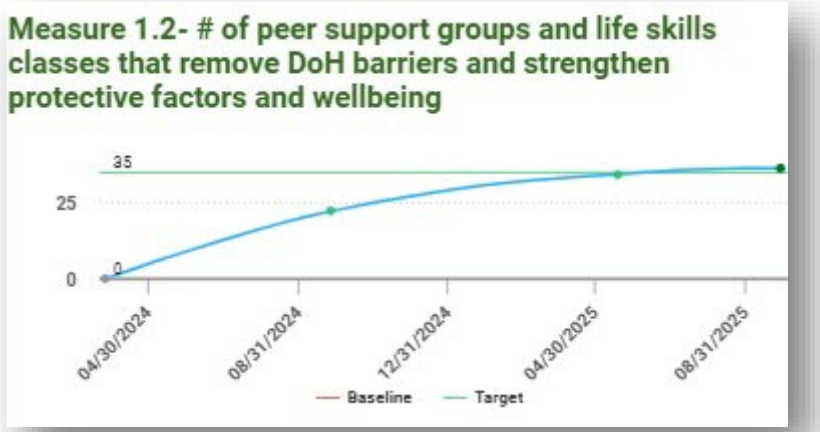
Drivers of Health Work Plan

GOAL 1
Improve health outcomes in Oklahoma as measured by America's Health Rankings social and economic factors from 44th to 41st by 2028.
STRATEGIES
1.1: Identify and engage advisory committees to include community, youth, parent and patient committees that provide feedback on DoH barriers and help remove barriers for those participating in health improvement opportunities.
1.2: Promotion of peer support groups to strengthen Oklahomans' well-being and protective factors.
1.3: Strengthen and grow collaborations with state and local health departments, tribal nations, non-governmental organizations, policymakers, and private businesses to implement evidence-based and promising practices for reducing health disparities and improving Oklahoma's population health.
1.4: Collaborate with community partners and networks to grow the body of evidence designed to improve health outcomes.
1.5: Increase the number of grants that directly involve community partners to improve health outcomes.
1.6: Partner with business, governmental public health, social service agencies, and non-governmental, charitable, and community volunteer agencies to provide education, health, and social services to communities based upon needs identified.

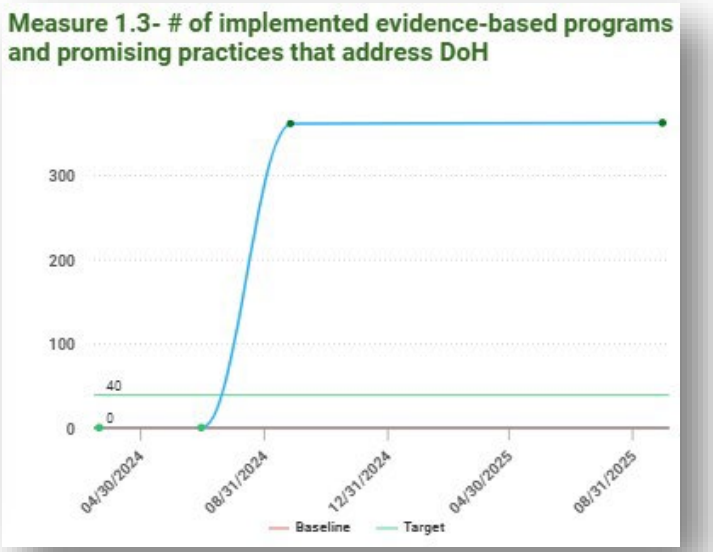
Drivers of Health: Year 2 Data



Measure 1.1

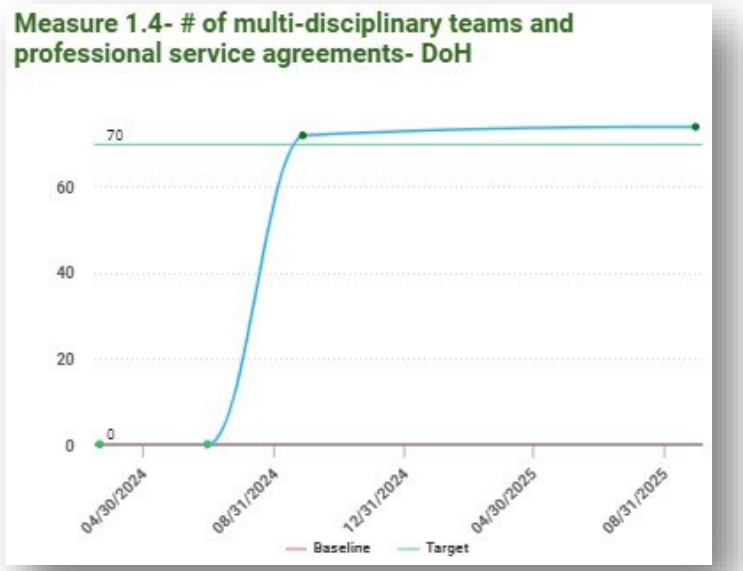


Measure 1.2



Measure 1.3

Drivers of Health: Year 2 Data



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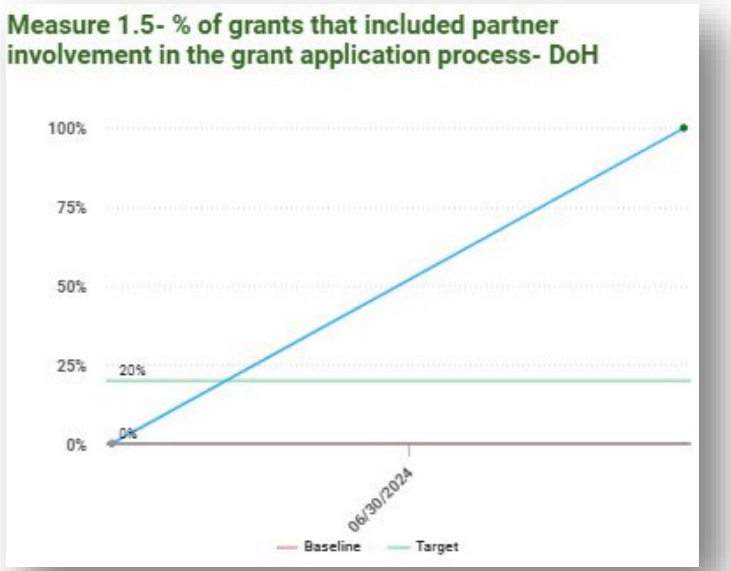
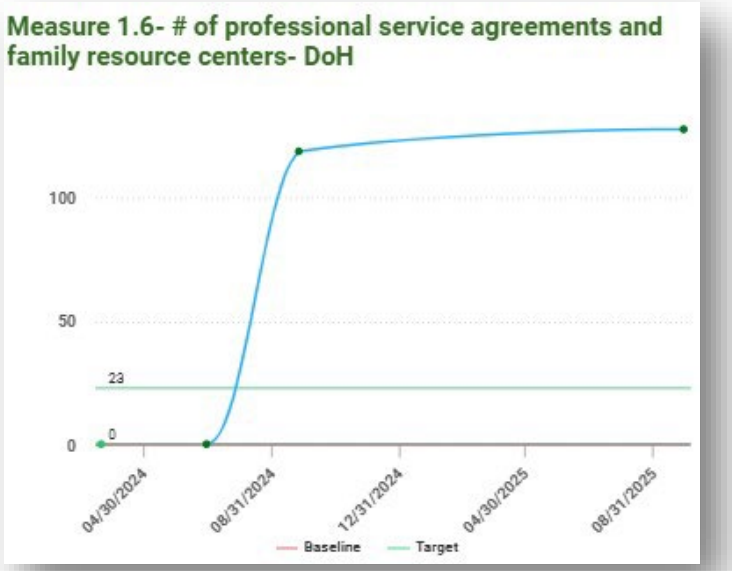


Measure 1.5



Measure 1.6

Drivers of Health Work Plan

GOAL 1

Improve health outcomes in Oklahoma as measured by America's Health Rankings social and economic factors from 44th to 41st by 2028.

YEAR 3 CHANGES

- Include family resource centers identified by Oklahoma Family Support Network, OSU Center for Family Resilience, Potts Family Foundation, and more.
- Include TSET Youth Action for Health Leadership (YAHL) chapters from across the state.
- Include tribal advisory committees.
- Include health education classes that remove barriers for participation in health improvement activities.

Drivers of Health Work Plan

GOAL 1

Improve health outcomes in Oklahoma as measured by America's Health Rankings social and economic factors from 44th to 41st by 2028.

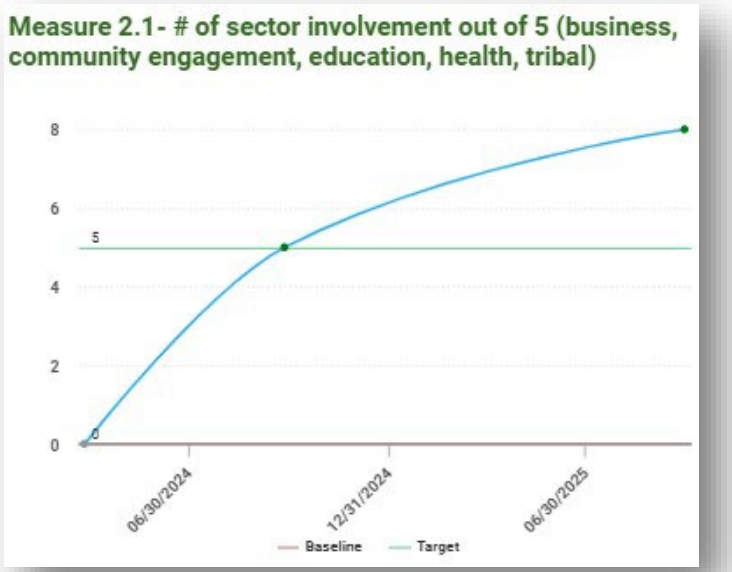
YEAR 3 CHANGES (continued)

- Promote technical assistance opportunities for multi-disciplinary teams that increase interagency collaboration at the local levels.
- Promote sub-contracts with current and future funding streams to help braid efforts and collaboration.
- Promote micro-grants to incentivize collaboration.

Drivers of Health Work Plan

GOAL 2
Develop and grow partnerships to enhance the impact of education, research and service related to DoH.
STRATEGIES
2.1: Assemble experts and facilitate workgroup action planning from 5 main sectors (education, business, community engagement, health care, and tribal) to develop solutions for protecting the public health and preventing premature death, disability, and excessive demands on health systems.
2.2: Facilitate the production of a comprehensive action plan to enhance the readiness and sustainability of Oklahoma's healthcare, business, education, community, and tribal sectors in a public health crisis that include addressing DoH.
2.3: Partner with school districts and teacher training programs to strengthen population health strategies within Oklahoma schools.
2.4: Be a resource to policy makers for recommendations on how to improve the health of Oklahoma.
2.5: Grow statewide preparedness initiatives that include DoH with support of private, community based and philanthropic organizations, businesses, tribes, and health departments for best long-term impact across populations.
2.6: Provide data driven programming concepts and collaborative training for business, education, health care, tribes, and community engagement organizations across the State.
2.7: Create through the passage of legislation an integrated application system and accompanying policy for SNAP, TANF, Child Care Assistance, Low Income Home Energy Assistance, Medicaid, and WIC.

Drivers of Health: Year 2 Data



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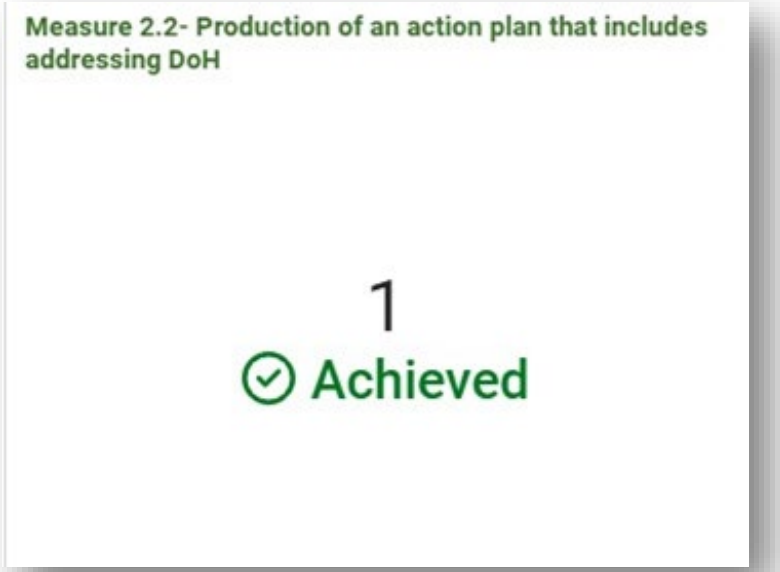
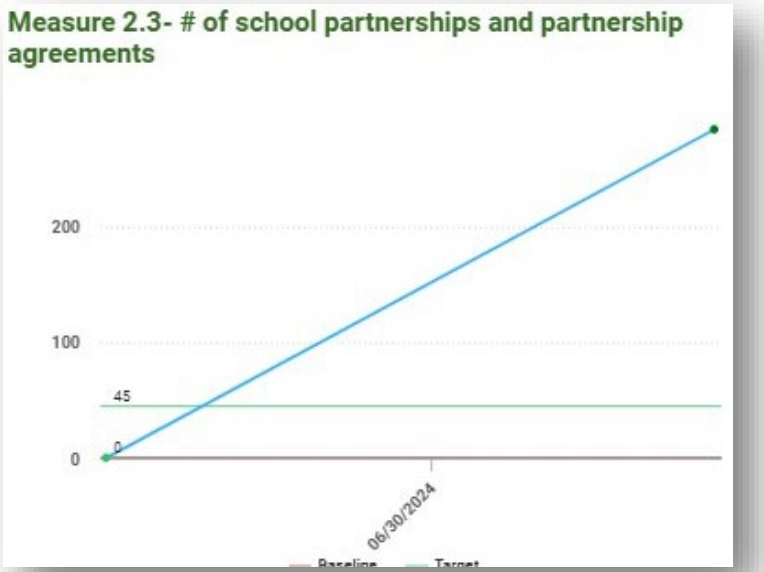
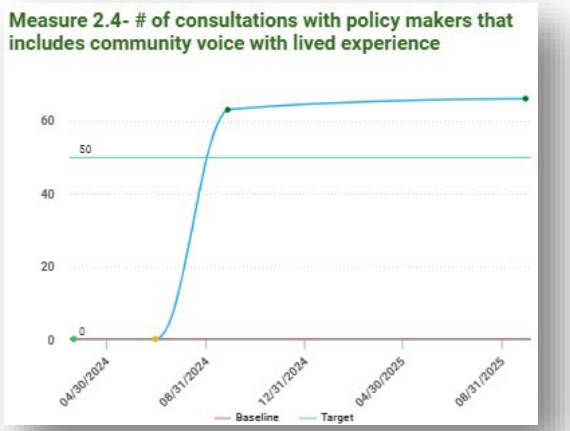


Measure 2.2



Measure 2.3

Drivers of Health: Year 2 Data



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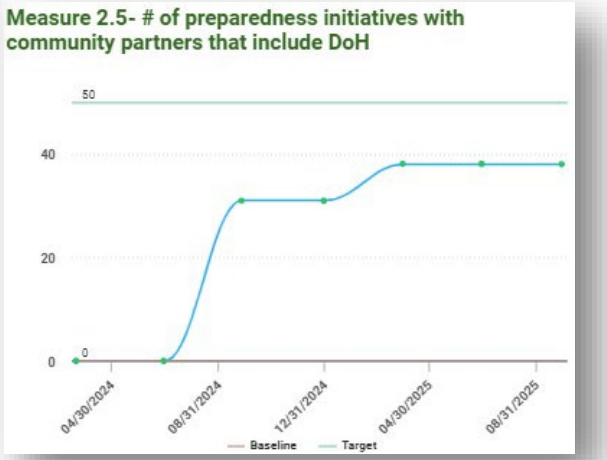

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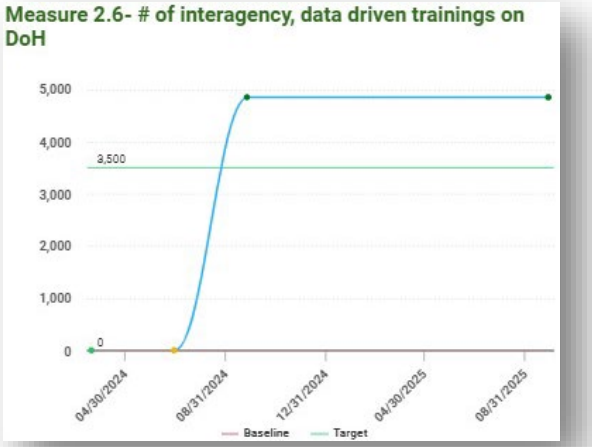
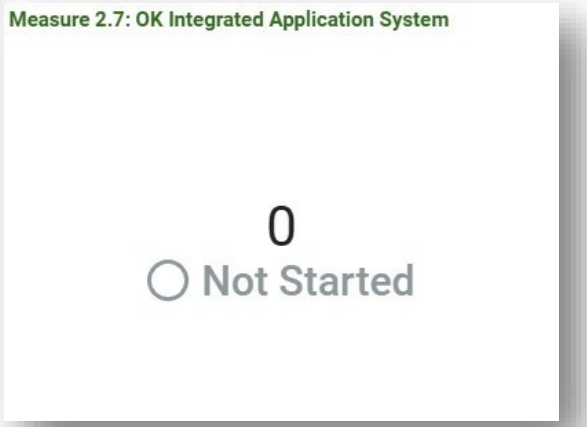


Measure 2.6



Measure 2.7

Drivers of Health Work Plan

GOAL 2

Develop and grow partnerships to enhance the impact of education, research and service related to DoH.

YEAR 3 CHANGES

- Continue to invite more sectors to be involved.
- Promote school-based specialists with OKDHS that partner with schools and remove drivers of health barriers for children to access needed services.
- Increase involvement with Emergency Preparedness and Response Services and FRCs.
- Continue to promote interagency trainings with community coalitions

Drivers of Health Work Plan

GOAL 2

Develop and grow partnerships to enhance the impact of education, research and service related to DoH.

YEAR 3 CHANGES (continued)

- Update Strategy 2.7: “Promote and monitor status of feasibility study that uses an integrated application system and accompanying policy that includes but not limited to SNAP, TANF, Child Care assistance, Low Income Home Energy Assistance, Medicaid, and WIC.” https://legiscan.com/OK/text/HB1575/2025

Call(s) to Action

- Request to incorporate DoH strategies and measures into current state plans and agency budgets to increase alignment, collaboration, and sustainability
- Interim Study on Sustainability of Urban and Rural Family Resource Centers on Oct. 15th at the Capitol
- Include DOH strategies in Oklahoma's Rural Health Transformation Program Application

DRIVERS OF HEALTH

2023-2028 OK SHIP: Cardiovascular Disease

3 goals & 8 strategies

Facilitator: Leslie DeHart, OSDH Lead Tobacco Control Coordinator, Heart Disease Prevention Coordinator

OKLAHOMA
State Department
of Health

Cardiovascular Disease: Year 2 Recap

- Four meetings were held throughout the year due to the change in scheduling.
- With the staggered meeting schedules, more partners were able to attend.
- In July 2025, oversight of the workgroup shifted with staff turnover.

Cardiovascular Disease (CVD) Workplan

GOAL 1
Track and monitor clinical and social services and support needs measures shown to improve health and wellness, health care quality, and identify patients at high risk of CVD with a focus on hypertension and high cholesterol to improve the rate of CVD in Oklahoma.
STRATEGY
1.1: Track and monitor clinical and social services and support needs measures shown to improve health and wellness, health care quality, and identify patients at high risk of cardiovascular disease (CVD) with a focus on hypertension and high cholesterol.

Cardiovascular Disease: Year 2 Data

Measure 1.1

Cardiovascular Disease (CVD) Workplan

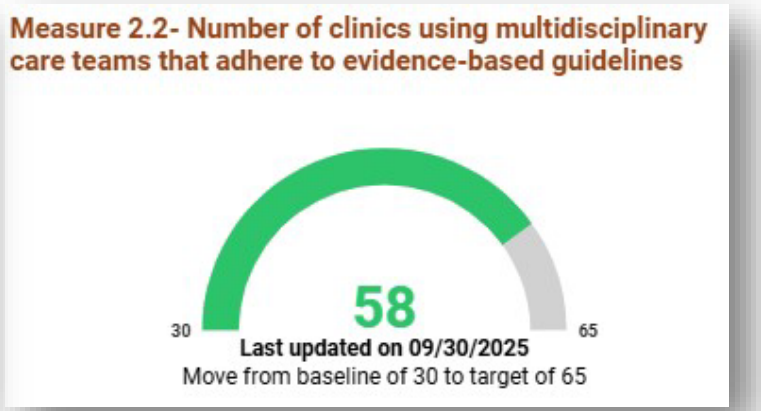
GOAL 1
Track and monitor clinical and social services and support needs measures shown to improve health and wellness, health care quality, and identify patients at high risk of CVD with a focus on hypertension and high cholesterol to improve the rate of CVD in Oklahoma.
YEAR 3 CHANGES
Overwhelmingly, feedback indicates a strong desire to continue working towards this goal. **Measure 1.1:** The existing goal of 50 clinics was set in response to having ACHIEVED the initial goal of 35 in year 1! The workgroup will maintain the goal of 50 and work to exceed that.

Cardiovascular Disease (CVD) Workplan

GOAL 2
Implement Team-Based Care to prevent and reduce CVD risk with a focus on hypertension and high cholesterol prevention, detection, control, and management through the mitigation of social support barriers to improve outcomes.
STRATEGIES
2.1: Advance the use of health information systems that support team-based care to monitor population health with a focus on health disparities, hypertension, and high cholesterol.
2.2: Assemble or create multi-disciplinary teams to identify patients' social services and support needs and to improve the management and treatment of hypertension and high cholesterol.
2.3: Build and manage a coordinated network of multi-disciplinary partnerships that address identified barriers to social services and support needs within populations at highest risk of CVD.

Cardiovascular Disease: Year 2 Data

Measure 2.1



Measure 2.2

Measure 2.3

Cardiovascular Disease (CVD) Workplan

GOAL 2

Implement Team-Based Care to prevent and reduce CVD risk with a focus on hypertension and high cholesterol prevention, detection, control, and management through the mitigation of social support barriers to improve outcomes.

YEAR 3 CHANGES

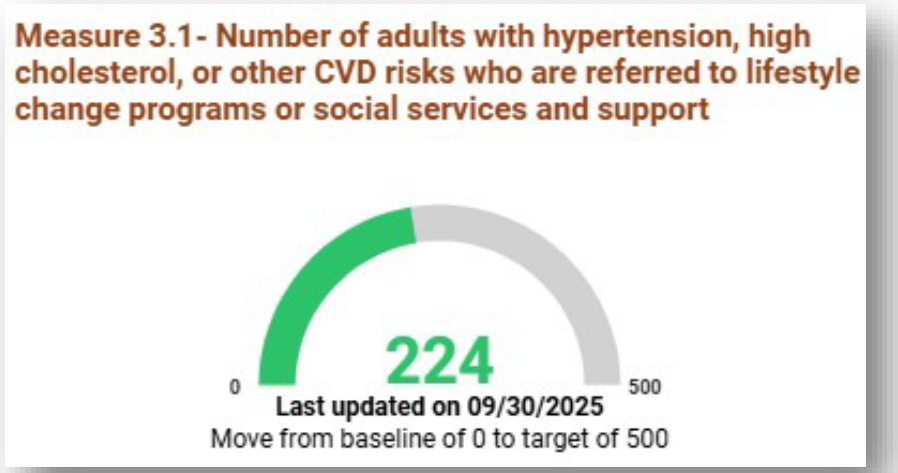
There seems to be wide support for continued focus on these measures.

- **Measure 2.1:** Achieved in Year 2!
- **Measure 2.2:** Keep goal at 65 (not yet met) but aim to surpass; defining “multidisciplinary” suggested, though leaving open may allow flexibility (e.g., includes community pharmacy teams with expanding pharmacy tech training).
- **Measure 2.3:** Achieved in Year 2!

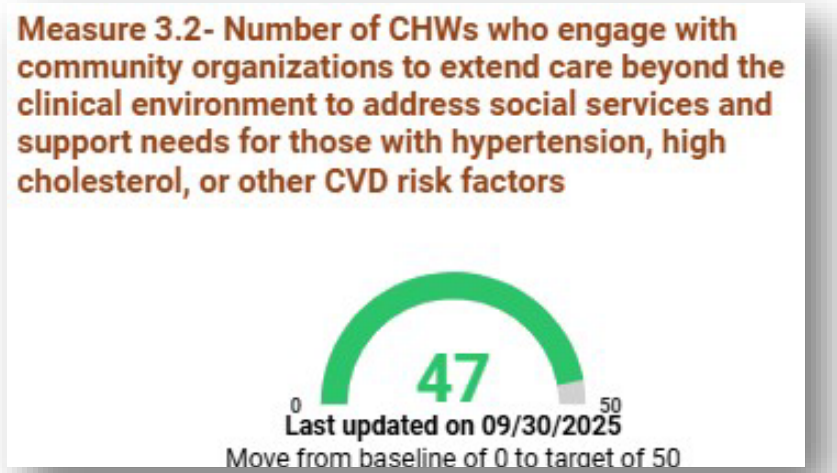
Cardiovascular Disease (CVD) Workplan

GOAL 3
Link community resources and clinical services that support bidirectional referrals, self-management, and lifestyle change to address social drivers that put the priority populations at increased risk of cardiovascular disease with a focus on hypertension and high cholesterol.
STRATEGIES
3.1: Create and enhance community-clinical linkages to identify DoH and respond to the social services and support needs of populations at highest risk of CVD with a focus on hypertension and high cholesterol
3.2: Identify and deploy dedicated community health workers to provide a continuum of care and services which extend the benefits of clinical interventions and address social services and support needs leading to optimal health outcomes.
3.3: Promote use of self-measured blood pressure (SMBP) monitoring with clinical support within populations at highest risk of hypertension.
3.4: Build capacity for the Healthy Heart Ambassador Blood Pressure Self-Monitoring (HHA-BPSM) program statewide and promote available programs within populations at highest risk of hypertension.

Cardiovascular Disease: Year 2 Data

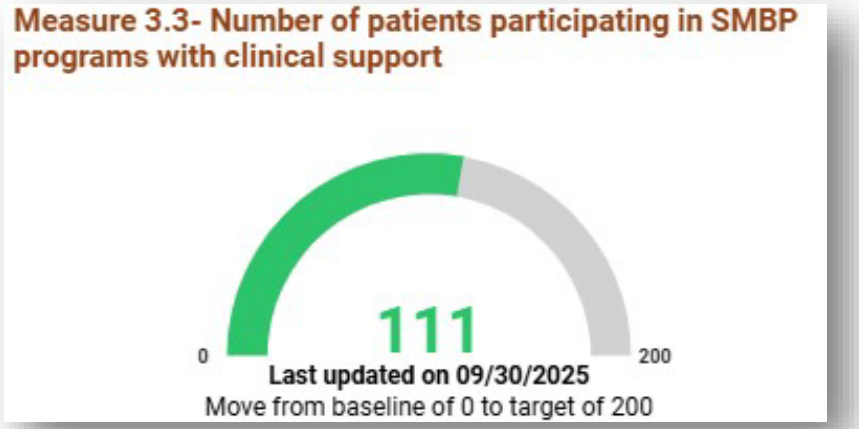


Measure 3.1

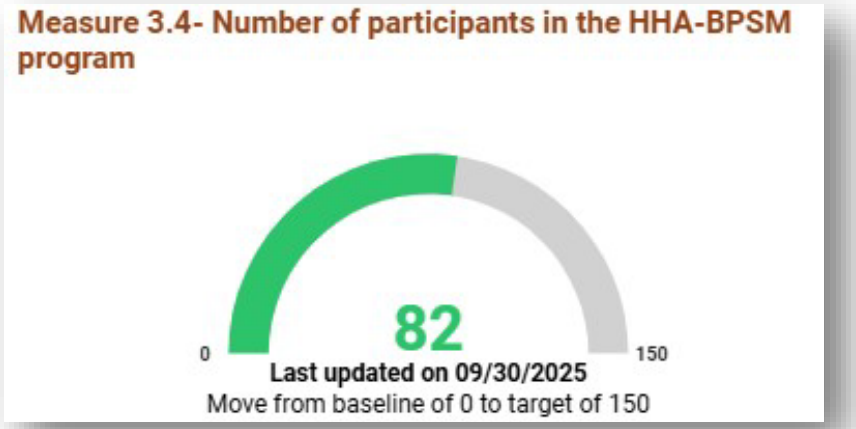


Measure 3.2

Cardiovascular Disease: Year 2 Data



Measure 3.3



Measure 3.4

Cardiovascular Disease (CVD) Workplan

GOAL 3

Link community resources and clinical services that support bidirectional referrals, self-management, and lifestyle change to address social drivers that put the priority populations at increased risk of cardiovascular disease with a focus on hypertension and high cholesterol.

YEAR 3 CHANGES

- **Measure 3.1:** Broad support to continue; OSDH team will identify example lifestyle change programs (e.g., A Way to Wellness, Healthy Heart Ambassador Blood Pressure Self-Monitoring), with potential to expand and present to workgroup.
- **Measure 3.2:** Broad support to continue; suggested revision: *"Train and deploy CHWs to extend benefits of clinical treatments and address social drivers of health to improve outcomes."*
- **Measure 3.3:** Supported to continue; workgroup will proceed with established goal of 200.
- **Measure 3.4:** Supported to continue; maintain goal of 150 and update language to clarify "participant" = "patient."

Call(s) to Action

- Next CVD SHIP meeting will be in January!
- Reach out to Leslie DeHart or Jennifer Like for information about being trained to facilitate Healthy Heart Ambassador BPSM at your location.

CARDIOVASCULAR DISEASE

Obesity State Plan

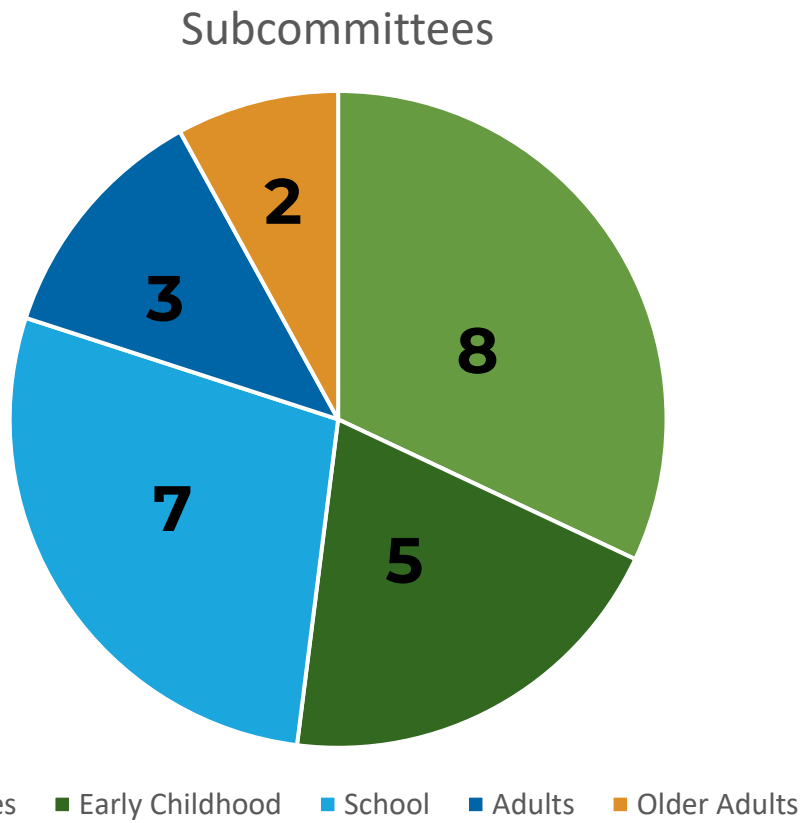
Facilitators: Karin Leimbach, OSDH State Programs Coordinator

Leslie DeHart, OSDH Lead Tobacco Control Coordinator , Heart Disease Prevention Coordinator

OKLAHOMA
State Department
of Health

Obesity: Yearly Recap

- Accomplished 25 goals
- Combined Adults & Older Adults Subcommittees
- Key Informant Interviews



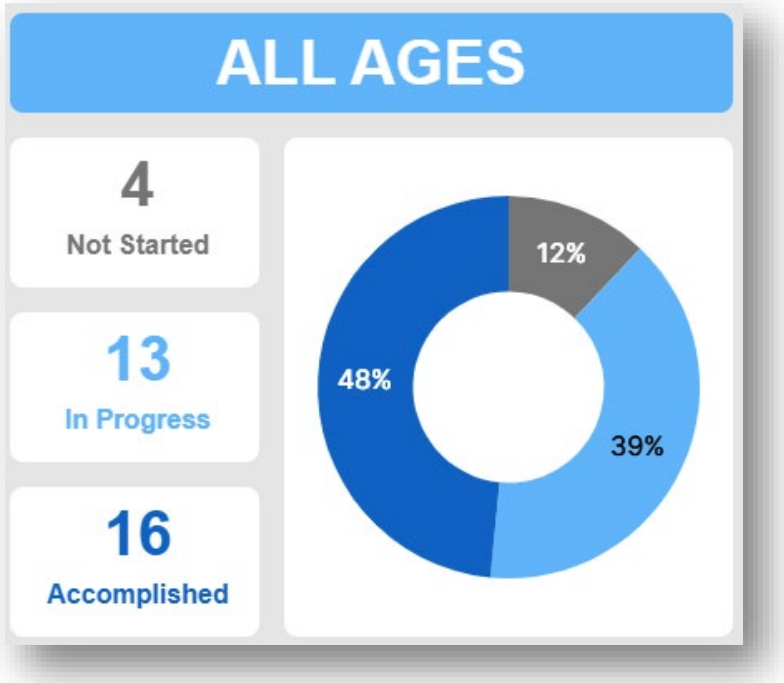
Obesity: High Level Goals

Children	Decrease childhood obesity rates by 3% by 2026.
Adults	Decrease adult obesity rates by 1% by 2026.

	BASELINE	CURRENT	GOAL
Children (ages 2 - 4)	**13.8%** (2018)	**12.9%** (2020)	**13.4%** (2026)
Adolescents (ages 10 - 17)	**18.7%** (2019/20)	**21.4%** (2021/22)	**18.1%** (2026)
High School (Grades 9-12)	**17.6%** (2019)	**17.9%** (2023)	**17.1%** (2026)
Adults (18+)	**36.4%** (2020)	**38.7%** (2023)	**36.0%** (2026)

Obesity: Progress By Goals

GOALS
Increase access to care for all Oklahomans
Increase the utilization of available data
Increase built environment infrastructure which promotes safe biking and walking
Improve the nutrition environment in communities across Oklahoma
Increase the likelihood that persons living in low-income households will make healthy food and physical activity choices
Increase screenings and referrals for all ages
Increase free social support programming to improve nutrition and increase physical activity

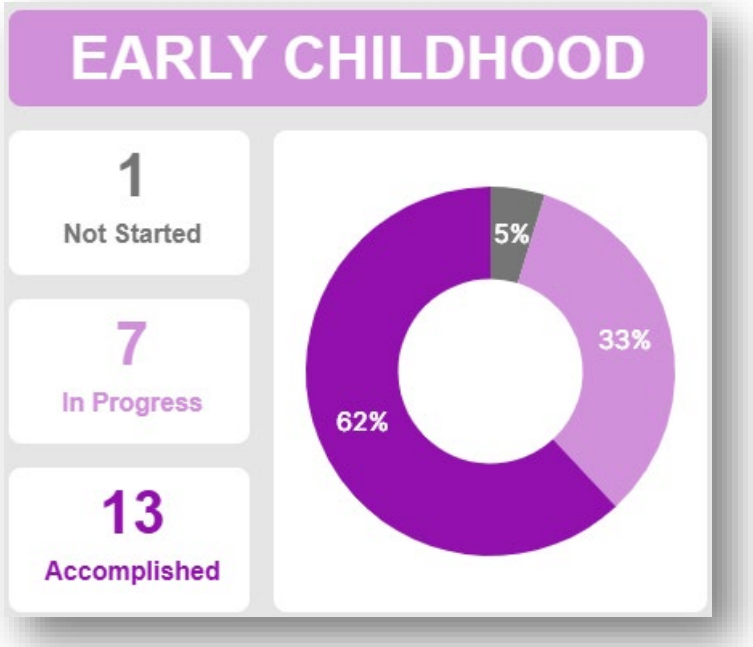


Yearly Updates:

- Increase in community parks across Oklahoma implement environmental structures to promote physical activity
- Regional Food Bank of Oklahoma and the Community Food Bank of Eastern Oklahoma have begun incorporating Healthy Eating Research nutrition guidelines
- Increase in the number of organizations/sites that screen for food insecurity and increase utilization of the OK SNAP Application Assistance Hotline for Grocery Assistance

Obesity: Progress By Goals

GOALS
Improve the quality of care to prevent and/or treat obesity in clinics caring for children
Improve the early care environment supports for appropriate physical activity & nutrition
Increase breastfeeding rates
Increase nutrition education provided to women of childbearing age, during the prenatal period, and to the parents of children aged 0-5
Increase messaging tailored to caregivers of pre-school age children promoting a healthy weight and health promoting behaviors

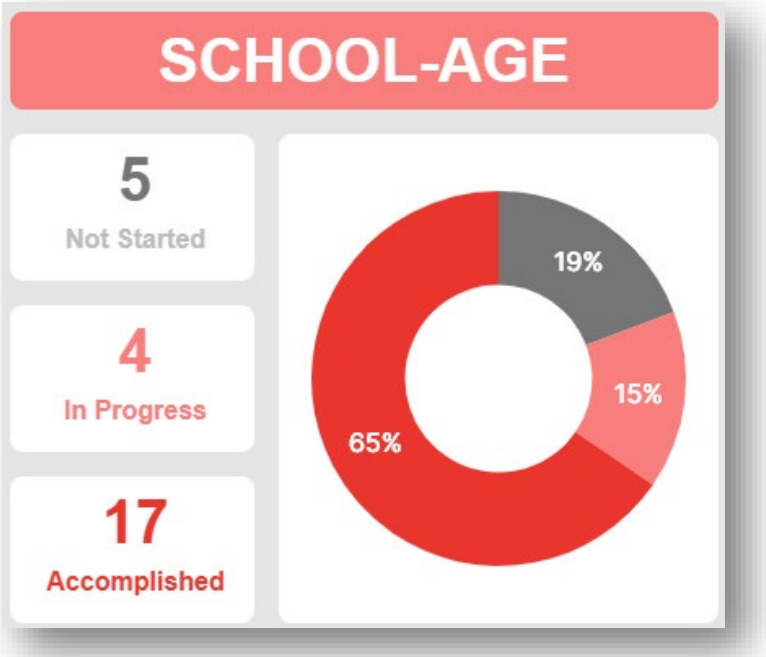


Yearly Updates:

- Increased the number of hospitals with International Board Certified Lactation Consultants
- Increased contacts to the breastfeeding hotline
- Decrease childhood obesity rates in children 2-4 years of age enrolled in the WIC program

Obesity: Progress By Goals

GOALS
Improve the quality of care to prevent and/or treat obesity in clinics caring for children
Increase the utilization of available data
Improve the nutritional environment in Oklahoma schools
Increase the percent of children in areas with 50% or greater Free and Reduced-Price Meal Eligibility (high-need areas) with access to nutrition programs year-round
Increase the amount of moderate to vigorous physical activity time in Oklahoma schools
Increase the number of schools implementing Social Emotional Learning strategies

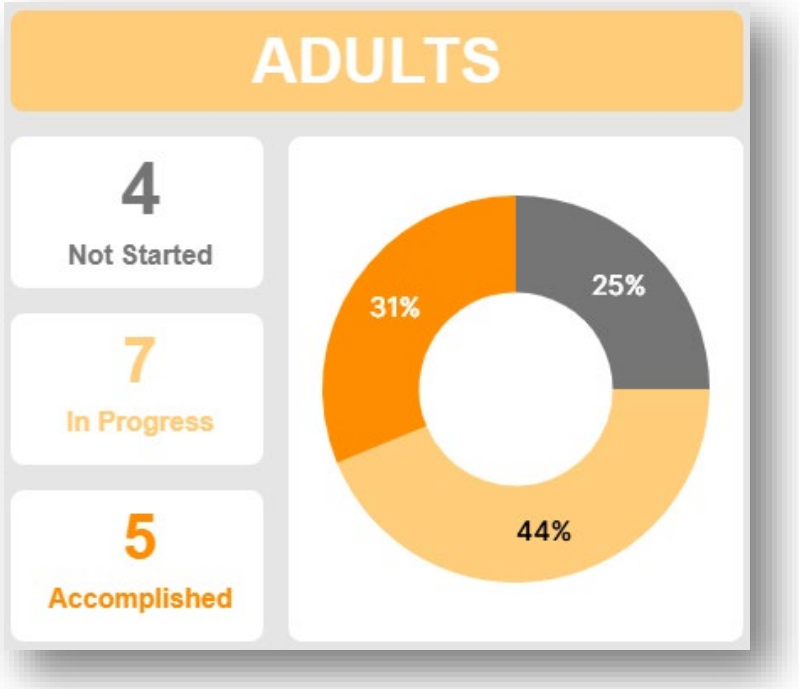


Yearly Updates:

- Increase the number of public school districts utilizing the Smarter Lunch Room Checklist
- Increase percentage of youth accessing summer food through either Seamless Summer, Summer Food Service Program, and or/Tribal Summer EBT
- Increase afterschool meals and/or number of organizations offering afterschool meals in high-needs areas

Obesity: Progress By Goals

GOALS
Increase the health promoting environment of employers across Oklahoma
Increase health promoting partnerships and components within the food system
Increase capacity within the health care system to prevent and treat obesity
Reduce weight stigma and discrimination

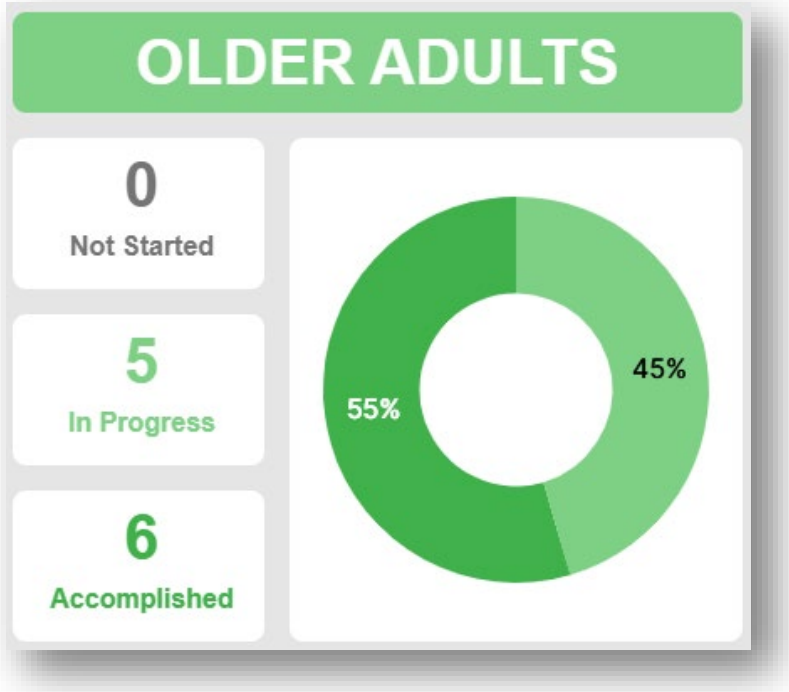


Yearly Updates:

- Dedicated recurring funding for Double of Oklahoma
- Innovative private/public partnership to increase access to health foods in areas of low-income and low-access

Obesity: Progress By Goals

GOALS
Improve the quality and availability of health care for older adults
Increase screenings and referrals for older adults
Improve the nutrition environment in communities across Oklahoma
Increase physical activity opportunities for older adults

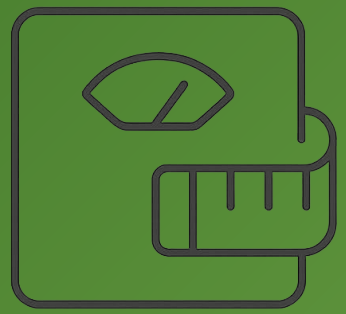


Yearly Updates:

- Implementation of new community gardens in high need areas
- Increase the number of "Age Friendly Communities"

Call(s) to Action

- Continue work on objectives and collecting data
- Noting successes and challenges



OBESITY

Oklahoma SHIP: Year 2 Lessons Learned

- Rotating meetings improved access but created some scheduling challenges.
- Recognized the need for more structured planning as the SHIP matures.
- Importance of sustained partner participation, especially among data partners.

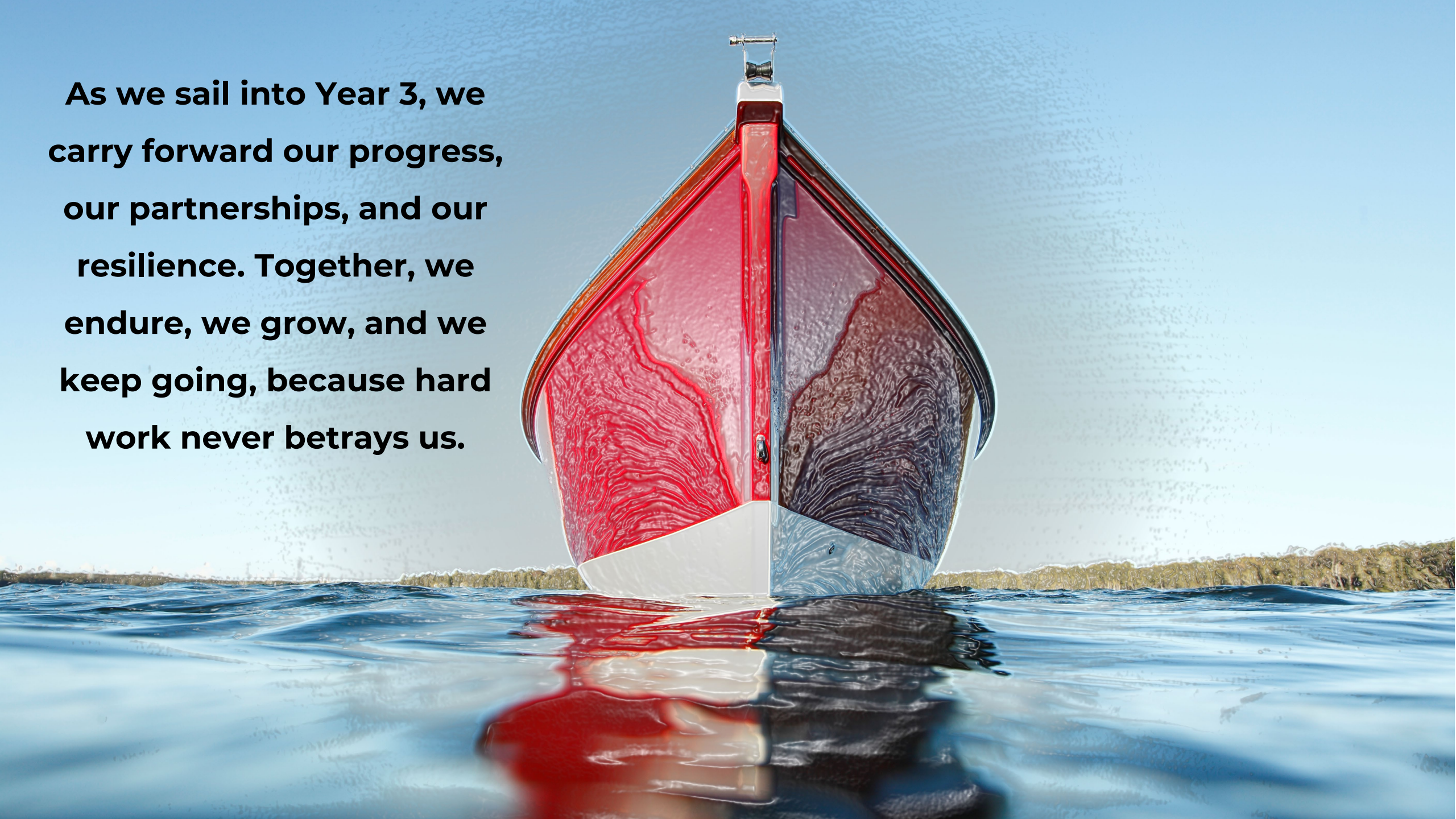
Oklahoma SHIP: Looking Ahead for Year 3

2026 SHIP Schedule:

- Meetings will continue on a rotating schedule, held the second Wednesday of each month, 9–10 a.m.
- Same group rotation as 2025 for consistency.
- Calendar will be shared via email, website update, and remaining workgroup meetings.

Call to Action: Stay engaged as partners, strengthen data collaboration, and help ensure Oklahoma continues making measurable progress on SHIP priorities.

Oklahoma SHIP: Closing Survey


As we sail into Year 3, we carry forward our progress, our partnerships, and our resilience. Together, we endure, we grow, and we keep going, because hard work never betrays us.

Thank you for your time, your insights, and your partnership to make a lasting impact on the health of Oklahomans!

Josh Bouye
Accreditation & Strategic Planning Coordinator

Joshua.Bouye@health.ok.gov

https://oklahoma.gov/health/ship.html