SaintFrancis Health System

FISCAL YEAR 2025

Community Health Needs Assessment

CRAIG COUNTY

LIGHTING THE WAY TO A HEALTHIER TOMORROW.

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CHNA PURPOSE STATEMENT

The purpose of this community health needs assessment (CHNA) is to identify and prioritize significant health needs of the community served by Saint Francis Health System. The priorities identified in this report help to guide the health system's community health improvement programs and community benefit activities, as well as its collaborative efforts with other organizations that share a mission to improve health. This CHNA report meets requirements of the Patient Protection and Affordable Care Act that not-for-profit hospitals conduct a community health needs assessment at least once every three years.

SAINT FRANCIS HEALTH SYSTEM OVERVIEW

Saint Francis Health System (SFHS) is a Catholic, not-for-profit healthcare network based in Tulsa, Oklahoma. Since its founding in 1960, SFHS has grown and adapted to meet the evolving healthcare needs of Eastern Oklahoma. In 2024, the system was honored as one of the 15 Top Health Systems by Premier's PINC AI and Fortune magazine. Today, SFHS stands as Oklahoma's largest private healthcare provider, employing more than 12,000 employees, including over 600 providers through Warren Clinic, serving the region through 110 locations. SFHS is guided by the mission, vision and values noted below.

- Mission: To extend the presence and healing ministry of Christ in all we do.
- Vision: Lighting the way to a healthier tomorrow.
- Values: Excellence, Dignity, Justice, Integrity, Stewardship.

Saint Francis Health System - Craig County Hospital

In Craig County, SFHS has one distinct hospital that serves the community. A brief description of the hospital is provided below.

- Saint Francis Hospital Vinita (SFHV) is a 27-bed community hospital, in northeastern Oklahoma that is recognized as a Top 100 Rural & Community Hospital in 2023 by Chartis. In partnership with Warren Clinic the hospital operates Saint Francis Health Centers in Langley and Monkey Island. The hospital offers a variety of services and programming including Senior Behavioral Health Care, Emergency Services (24/7), Skilled Nursing (Swing Beds), Physical Medicine and Rehabilitation, Lab Locations, Sleep Medicine and more.

Approach & Methodology: Collaborators, Community Definition, Process of Identification & Prioritization

CHNA COLLABORATORS

The following organizations collaborated with SFHS on this CHNA. Additional information on these collaborators can be found in appendix A.

- Oklahoma University Hudson College of Public Health (OU COPH)
- Oklahoma State Department of Health District 4 Team

COMMUNITY DEFINITION

For this CHNA, the defined community is Craig County, encompassing 9 specific zip codes. This definition was validated in collaboration with the local public health department. The CHNA aims to gather data and work with community partners to understand local health challenges and develop strategies to address them effectively through the future Implementation Strategy Plan (ISP).

PROCESS OF IDENTIFICATION AND PRIORITIZATION

In spring 2024, SFHS partnered with the Oklahoma State Department of Health District 4 team to collaboratively conduct a CHNA. To meet the requirements of 501(r)(3) hospitals and the Public Health Accreditation Board (PHAB), SFHS engaged the OU COPH for data collection and analysis.

The CHNA used a mixed methods approach based on the Social Determinants of Health (SDoH) framework to understand factors affecting health outcomes in Craig County. This included a community survey, community engagement meetings, and secondary data analysis.

The collected data was analyzed by SFHS and the Oklahoma State Department of Health District 4 team to identify the most significant health needs in the community. These needs, which are critical to improving overall well-being, include:

1. **Access to Healthcare Services:** Challenges include a shortage of providers, high medical bills, appointment difficulties, and lack of insurance. Solutions involve regional partnerships, expanding telehealth, and funding Federally Qualified Health Centers (FQHCs).

2. **Housing Stability:** Housing instability affects mental health and socioeconomic disparities, with 92% of residents concerned about housing insecurity. Addressing this requires public-private partnerships and utilizing federal programs like HUD for funding and expanding housing resources.

3. **Transportation:** High transportation costs and limited options hinder access to healthcare, employment, and services. Solutions include partnerships with transit authorities and ride-share services to provide affordable and reliable transport.

4. **Mental Health and Substance Use Services:** Limited access to mental health and substance use providers contributes to significant social and health issues. Expanding mental health services in healthcare settings and increasing telehealth options can improve access and support.

5. **Nutrition and Food Security:** Challenges in accessing nutritious food and awareness of available resources contribute to chronic conditions like diabetes. Solutions involve leveraging local food banks and state nutrition programs to improve food access and education.

6. **Employment Opportunities:** Barriers like childcare, lack of skills, and health issues hinder employment, contributing to poverty. Solutions include workforce development and job training programs to enhance employment opportunities and equip residents with necessary skills.

The needs were then prioritized by utilizing criteria that measured the size, severity, and social and economic impact of the problem. The community prioritized addressing the most severe health issues first, followed by consideration of resources and sustainability for long-term solutions.

Prioritized Health Needs, Rationale, Resources to Address

PRIORITIZED HEALTH NEEDS AND RATIONALE

After identifying significant health needs outlined above, SFHS gathered input from about 50 leaders and prioritized three key issues for this CHNA ISP. The selected needs for Craig County are:

1. **Access to Healthcare:** The primary barrier identified in the survey is access to healthcare, driven by concerns over medical costs, inconvenient appointment times, and uncertainty about insurance coverage. This aligns with SFHS's strategic focus on 'Access' and provides an opportunity for integration with the broader SFHS plan.

2. **Food:** Food insecurity is the second most significant issue based on internal data. Barriers include the high cost of nutritious food and limited time to prepare meals. Opportunities exist to further develop partnerships with community stakeholders to address this issue.

3. **Employment:** Employment is the third highest barrier to health in Craig County. Community members face challenges such as limited job opportunities, work experience, education, and necessary skills. With collaborative partnerships already established, SFHS is well positioned to address this issue.

SFHS is committed to improving community health by focusing on these prioritized needs, although other significant needs were not selected for this cycle as they did not meet the same level of urgency or SFHS is not best positioned to address them directly.

POTENTIAL RESOURCES TO ADDRESS

Craig County has an abundance of community assets and resources that are potentially available to address significant health needs beyond the health system's resources. A wide range of community organizations support the health and well-being of the community including health, social services, and nonprofit institutions. Additional information on resources to address the health needs of the community can be found in appendix B.

Report Adoption, Availability and Input

This CHNA report was adopted by the SFHS Board of Directors in April 2025. The report is widely available to the public on the health system's website, and a paper copy is available for inspection upon request. Written comments on this report can be submitted to Saint Francis Hospital (6161 S Yale Ave Tulsa, OK 74136, Attn: G.T. Bynum) or by calling G.T. Bynum, Vice President of Community and Government Affairs, at 918-494-8459.

About Saint Francis

Saint Francis Health System (SFHS) is a Catholic, not-for-profit healthcare network based in Tulsa, Oklahoma. Since its founding in 1960, SFHS has grown and adapted to meet the evolving healthcare needs of Eastern Oklahoma. In 2024, the system was honored as one of the 15 Top Health Systems by Premier's PINC AI and Fortune magazine. Today, SFHS stands as Oklahoma's largest private healthcare provider, employing more than 12,000 employees, including over 600 providers through Warren Clinic, serving the region through 110 locations.

Mission, Vision & Values

Mission: To extend the presence and healing ministry of Christ in all we do
Vision: Lighting the way to a healthier tomorrow
Values: Excellence, Dignity, Justice, Integrity and Stewardship

Commitment to Community

Recognition as a tax-exempt organization carries with it a responsibility to serve the interests of the community. To this end, SFHS publishes a Community Health Needs Assessment every three years and an annual report to the community outlining its community contributions for the prior year.

Justice is one of the core values of Saint Francis Health System. It calls for the organization to advocate for systems and structures that are attuned to the needs of the vulnerable and disadvantaged and that promote a sense of community among all persons.

To effectively do this requires that the SFHS:

- Gather and obtain information identifying those needs; and
- Develop programs and services that address and provide access to those in greatest need.

SAINT FRANCIS HOSPITAL VINITA

As part of the SFHS, Saint Francis Hospital Vinita (SFHV) is a 27-bed community hospital, in northeastern Oklahoma that is recognized as a Top 100 Rural & Community Hospital in 2023 by Chartis. In partnership with Warren Clinic the hospital operates Saint Francis Health Centers in Langley and Monkey Island. The hospital offers a variety of services and programming including Senior Behavioral Health Care, Emergency Services (24/7), Skilled Nursing (Swing Beds), Physical Medicine and Rehabilitation, Lab Locations, Sleep Medicine and more.

CHNA Project Overview

Purpose & Goals

This Community Health Needs Assessment (CHNA) is a systematic, data-driven approach to determining the health status, behaviors, needs and assets in the community. Subsequently, this information may be used to inform decisions and guide efforts to improve community health and wellness. Broadly, the CHNA process aims to:

- Understand the factors that the community feels are impacting their health and quality of life, especially those most vulnerable.
- Aid in identifying areas where assets can align, and the hospital system can collaborate to address health needs.
- Ensure compliance with section 501(r) of the Internal Revenue Code for non-profit hospitals.

JOINT ASSESSMENT

A joint effort was conducted by two primary partners to complete a CHNA for Craig County. In partnership with the Oklahoma State Department of Health District 4 team, SFHS leadership conducted this CHNA on behalf of Saint Francis Hospital Vinita. The partners enlisted the services of The Oklahoma University Hudson College of Public Health (OU COPH) to ensure best practice data collection and integrity of reporting to satisfy regulatory compliance. A description of the collaborators can be found in appendix A.

In partnership with the Oklahoma State Department of Health District 4 team, SFHS reviewed the previous CHNA and determined key health disease outcomes continued to be challenges in today's landscape. Therefore, the partners determined that it would be most helpful to focus the assessment on those factors that are driving continued poor health outcomes.

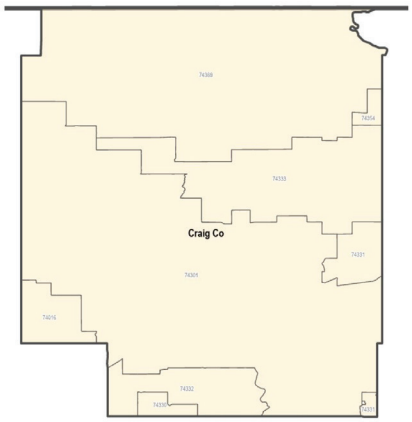
Community Definition

For the purposes of this CHNA, the community has been defined as Craig County. This includes the following 9 zip codes: 74016, 74301, 74330, 74331, 74332, 74333, 74349, 74354 and 74369. In partnering with the local public health department, this definition was validated as appropriate. Given the aims of this CHNA, and the need to make impact in our future Implementation Strategy Plan (ISP), it is important that we start with data and stakeholders at a level that allows us to:

- Clearly understand the problems faced by the community, and
- Work closely with community partners to define strategies and align resources to make an impact.

Community Description

Tulsa County, located in northeastern Oklahoma, is the second-most populous county in the state with a population of around 680,000. The county seat and largest city is Tulsa, which has a population exceeding 410,000, making it the 47th most populous city in the United States. SFHS entities located within the county include Saint Francis Hospital, Saint Francis Children's Hospital, Saint Francis Heart Hospital, Saint Francis Hospital South and Laureate Psychiatric Clinic and Hospital.



POPULATION

Figures 1-3 describe the population of Craig County. Figure 1 below illustrates the racial composition of a population. The majority of the population is White. American Indian individuals make up a significant 20.2%, while those identifying with two or more races constitute 14.7%. Other racial groups represent smaller portions of the population. Pacific Islanders are not represented in this figure.

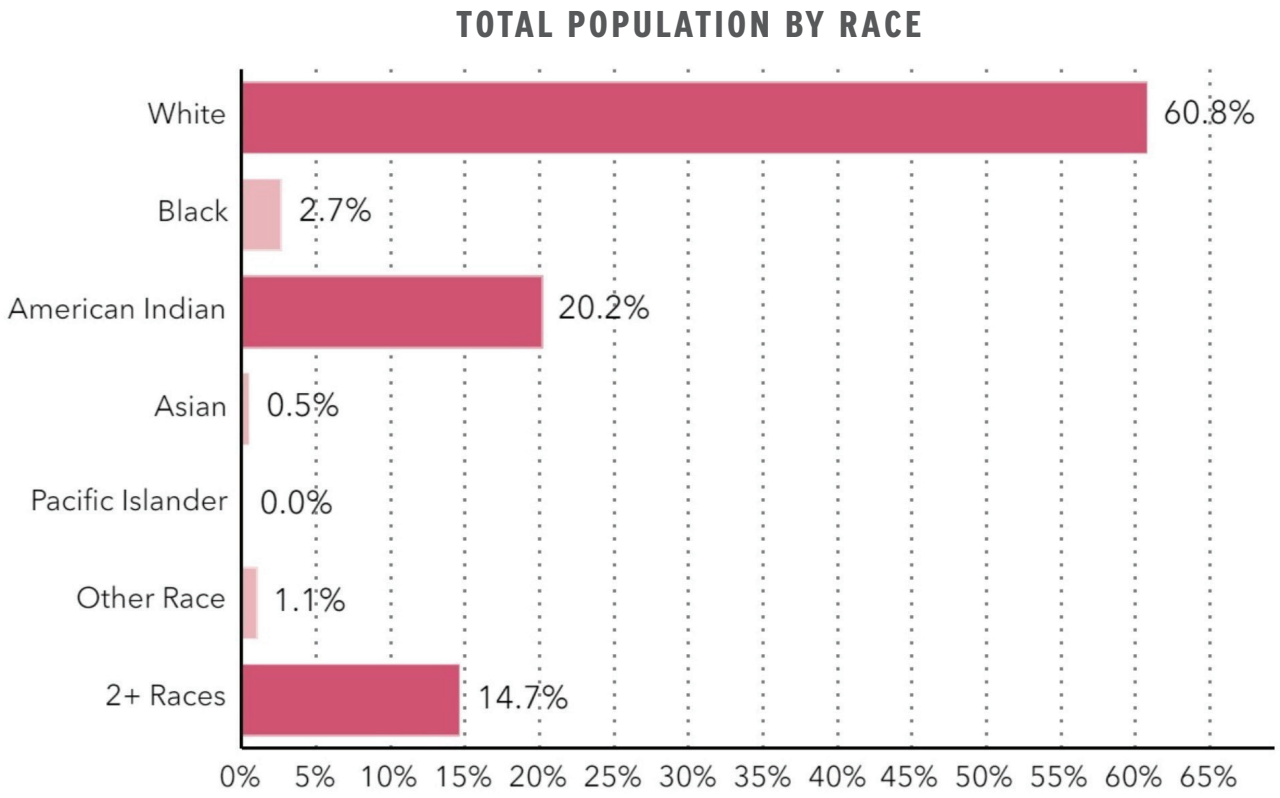


Figure 1: Total Population by Race

Figure 2 below illustrates the distribution of the population by age and gender. It reveals that younger age groups have relatively balanced populations between genders, while there is a noticeable bulge in the 25-34 age group. As age increases, the population decreases, with a higher proportion of one gender in the older age groups (75+).

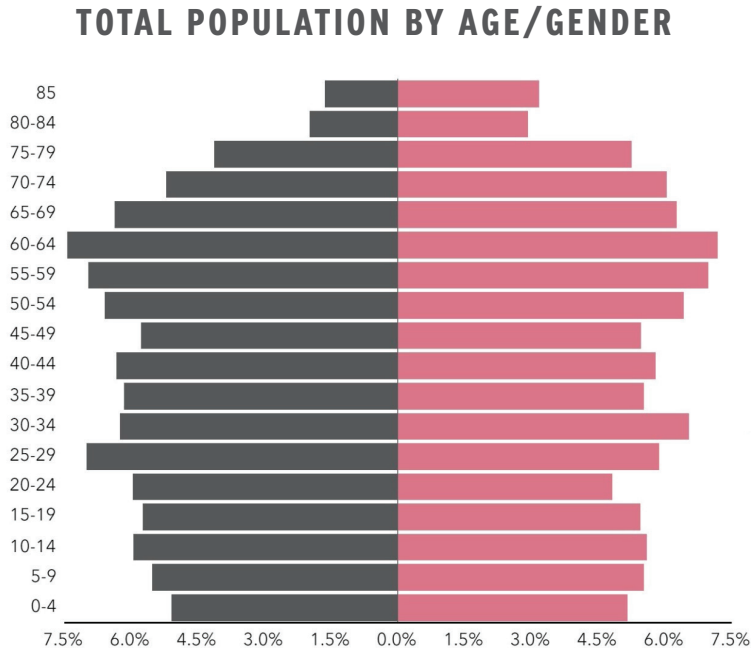


Figure 2: Population by Age/Gender

Figure 3 highlights the challenges faced by at-risk populations, including seniors, individuals with disabilities, and households without access to transportation. It also emphasizes economic hardships, showing a notable portion of the community living below the poverty line and relying on food assistance, underscoring the need for targeted support and resources.

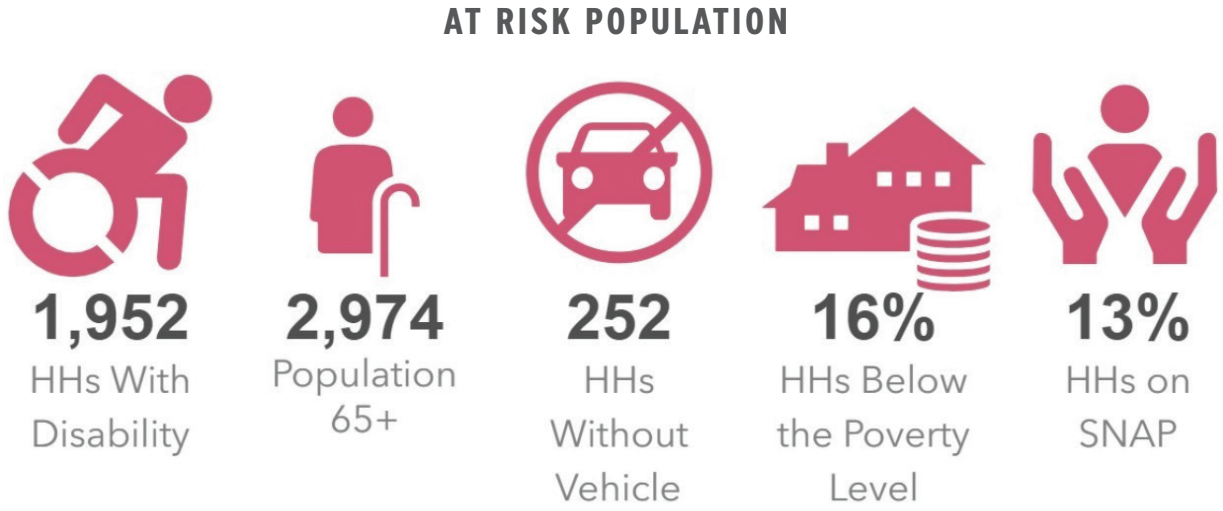


Figure 3: At Risk Population

SOCIAL & ECONOMIC FACTORS

Figures 4-6 describe the social and economic factors of Craig County. Figure 4 provides an overview of employment trends, showing that the majority of jobs are white-collar jobs, accounting for more than half of the workforce, followed by blue-collar and service industries, while the unemployment rate remains relatively low, indicating a stable job market.

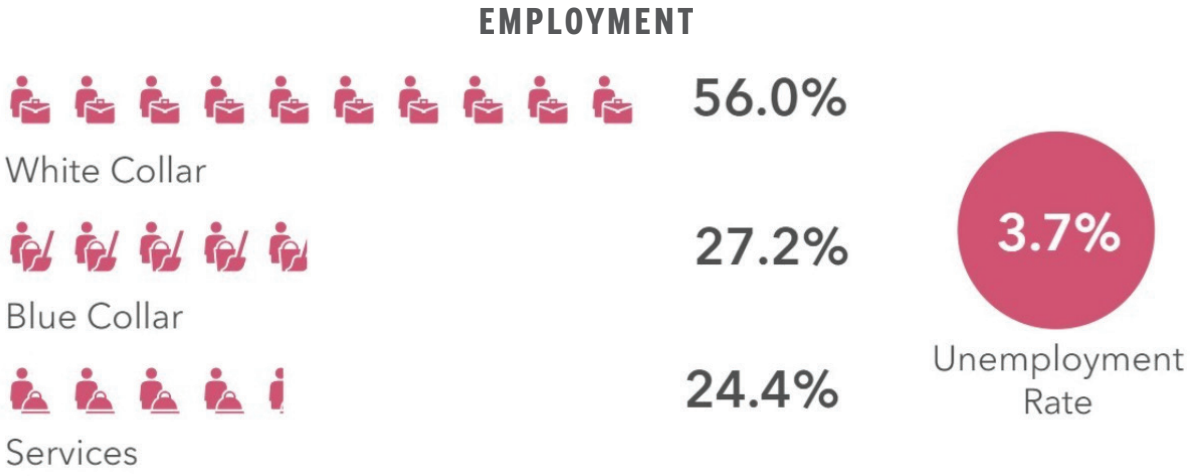


Figure 4: Employment

Figure 5 illustrates the educational attainment of the population, showing that most individuals have pursued higher education beyond high school, with a significant portion earning college degrees, a smaller percentage completing advanced degrees, and a smaller percentage that did not complete high school.

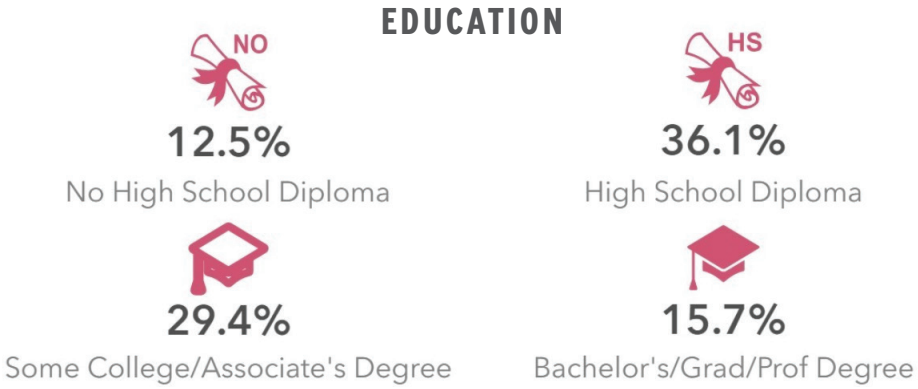


Figure 5: Education

Lastly, Figure 6 highlights a steady decrease in the total number of housing units over time, suggesting potential declines in new housing construction, possibly due to economic factors, changes in population growth, or shifts in housing demand.

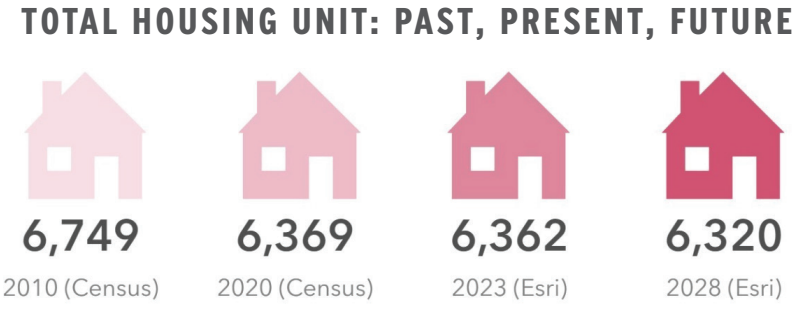


Figure 6: Housing

UNIQUE COMMUNITY CHARACTERISTICS

Craig County is anticipating significant growth and preparing for infrastructure impacts due to the construction of American Heartland, a $2 billion theme park and resort development in northeast Oklahoma. This 1,000-acre resort destination, located in the city of Vinita where Saint Francis Hospital Vinita resides, is expected to attract more than 4.9 million guests per year. The first phase of the theme park is currently under construction, and its development is poised to significantly alter the land use mix, market conditions, housing demand, and capital improvement projects in the area over the next decade.

OTHER HEALTH SERVICES

Health systems and hospitals in the area are listed below and a full list of resources in the community can be found in appendix B.

- Indian Health Services

Process, Approach & Methodology

PROCESS AND APPROACH

In the spring of 2024, SFHS leadership began working with the Oklahoma State Department of Health District 4 team to develop a collaborative approach to conducting a CHNA. To meet the requirements for 501(r)(3) hospitals, the group collectively retained the services of The University of Oklahoma, Hudson College of Public Health (OU COPH) to support data collection, synthesis and analysis of this CHNA.

At the guidance of OU COPH, the 2025 Craig County CHNA collaboration team employed a mixed methods approach to identify and address community needs. Grounded in a Social Determinants of Health (SDoH) framework, the assessment aimed to understand the underlying factors influencing health outcomes in Craig County and begin to identify areas to intervene. Key components included a community survey with a broad range of questions designed to capture residents' experiences, concerns and priorities, as well as direction provided by a community advisory board throughout the process.

Additionally, SFHS and OU COPH facilitated community engagement meetings to gather qualitative insights directly from stakeholders, including community leaders, and local organizations. Secondary data analysis was conducted to complement these findings, providing a more comprehensive view of existing resources and gaps in Craig County. This integrated approach ensured a thorough understanding of both the needs and assets within the community. Figure 7 on the following page depicts the process and approach that the group utilized.

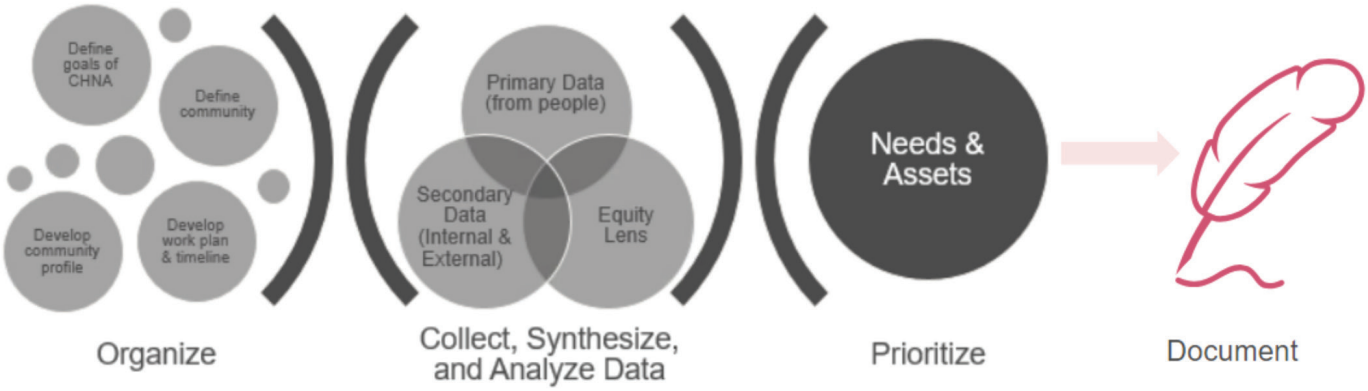


Figure 7: CHNA Process and Approach

The timeline for the CHNA process can be found in Figure 8 below.

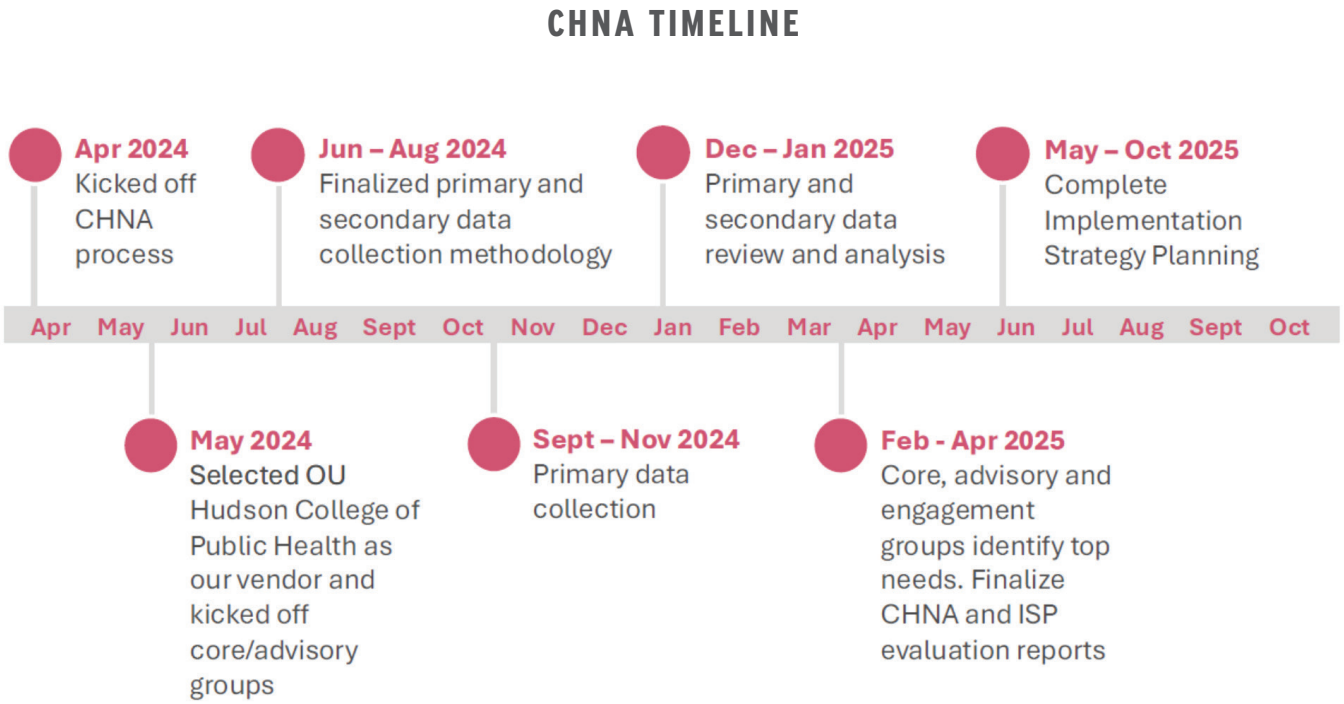


Figure 8: CHNA Timeline

As outlined above, a collaborative approach was deployed to develop, conduct and complete this CHNA. To maximize key stakeholder time, OU COPH, SFHS and the Oklahoma State Department of Health District 4 team developed three key groups to leverage throughout the process. As depicted in Figure 9, the core group oversaw the entire CHNA process which included defining advisory and engagement groups, developing and disseminating the CHNA survey, conducting primary and secondary data analysis and identifying top health needs in the community. Advisory groups, which included the core group and local county health departments, helped inform and support this process, while the engagement groups, consisting of local community subject matter experts, helped provide insight and

context into the survey findings. Throughout this process, the core group met weekly beginning in April 2024, and the advisory committee met monthly beginning in May 2024. The engagement groups met twice throughout this process, once at the beginning of primary data collection and once at the end of primary data collection. Additional information about the community engagement meetings, including date of the meetings and who attended can be found in appendix C.

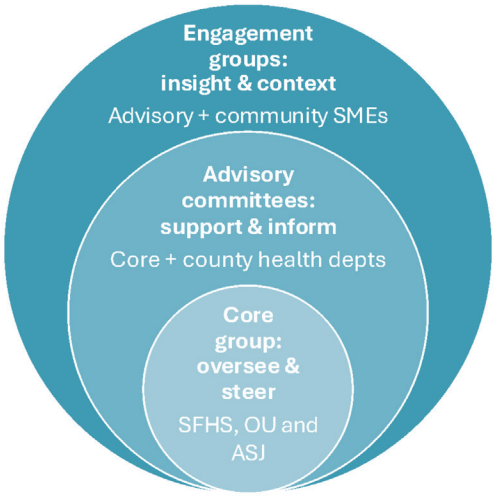


Figure 9: Core, Advisory and Engagement Group Structure

SECONDARY RESEARCH METHODOLOGY

The SHFS team utilized County Health Rankings and Roadmaps (CHRR), to guide the secondary data review, which is a framework for analyzing and improving community health (see figure 10 below). CHRR analyzes health outcomes and influencing factors such as health behaviors, clinical care, socioeconomic conditions, and the physical environment, providing insight into community well-being. Widely used in public health and healthcare systems, it supports valid assessments through benchmarking, trend analysis, and severity measurement. This data supplemented primary insights gathered from community members and stakeholders to identify top health needs.

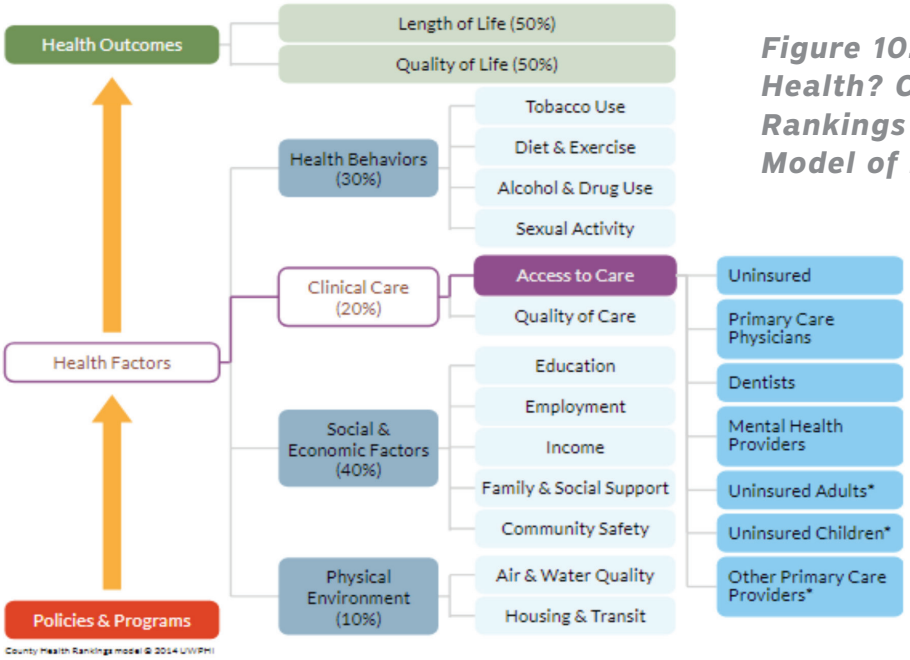


Figure 10: What Impacts Health? County Health Rankings & Roadmaps Model of Health

PRIMARY RESEARCH METHODOLOGY

A community-wide survey consisting of 40 questions was developed to better understand the access barriers experienced by residents of Craig County. The questions were derived from sources such as the U.S. Census and structured using the Social Determinants of Health (SDoH) framework. The survey also incorporated elements from the PRAPARE (Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences) screening tool, a nationally recognized instrument designed to assess social risk factors impacting health outcomes. By integrating these validated measures, the survey aimed to capture a comprehensive picture of the community's needs and inform targeted interventions. A copy of the survey questions is included in appendix D for reference.

To ensure accessibility, the survey was made available in English, Spanish, and Burmese. As a result, the questions were primarily multiple-choice rather than open-ended, enabling consistent responses across languages.

The survey was piloted with community members to ensure clarity, relevance, and ease of understanding before distribution. It was disseminated over a period of 9 weeks through digital QR codes and hyperlinks on flyers and randomized mailings to various zip codes within Craig County. To incentivize responses, interested individuals could submit their names into a raffle for a $100 Visa gift card once they completed the survey.

Upon collection, the data was analyzed and visualized in graphics to clearly reflect the findings and highlight key insights. A dedicated page for each of these findings can be found further along in the document.

In collaboration with OU COPH and the Oklahoma State Department of Health District 4 Team, SFHS synthesized and analyzed the data to determine which of the identified needs were most significant. SFHS has defined significant needs as the identified needs deemed most significant to respond to based on established criteria and/or prioritization methods. A list of criteria was developed in collaboration with OU COPH to serve as a framework for evaluating and narrowing the needs identified in the larger assessment. The criteria include:

- **Size of the Problem:** The number or percentage of people affected by a health condition in Tulsa County.
- **Severity of the Problem:** The risk of disease or death associated with the issue.
- **Impact of the Problem on Certain Groups:** Identifying groups within Tulsa County that are more significantly impacted than others.
- **Known Effective Interventions:** The availability and ease of implementing proven solutions.
- **Resources, Feasibility, and Sustainability:** The availability of resources for addressing the issue in a sustainable manner.
- **Social and Economic Impact:**
    - Social: The potential for solutions to create ripple effects in improving other social determinants of health.
    - Economic: The costs associated with not addressing the issue, such as healthcare expenses and lost productivity.

After developing this criteria list, the community engagement group was asked to vote on the criteria to help prioritize the community's most pressing needs. As shown in Figure 11, the exercise revealed that, for Craig County, prioritizing needs based on the availability of resources as the top concern, indicating that the feasibility and sustainability of addressing the problem in a sustainable manner was the most critical factor. The severity of the problem and availability and ease of solutions followed closely in importance, ranking second and third, respectively. These results reflect the community's focus on addressing the most urgent issues first while ensuring that solutions are both viable and sustainable over time.

Criteria	Weight	Rank
Resources, Feasibility and Sustainability: Availability of resources for addressing the problem in sustainable manner	1.7	1
Severity of the problem: Risk of disease/death among population associated with the problem	3.3	2
Known Effective Interventions: Availability and ease of proven solutions	3.4	3
Size of the problem: Number or percentage of people affected by a health condition	3.5	4
Social and Economic Impact: Social: Ability of solution to create ripple effects in improving other social determinants of health / Economic: Costs associated with not addressing this issue (e.g. healthcare costs, lost productivity)	4	5
Impact of the problem on certain groups (or populations): Groups in the county that are more significantly impacted than others	5.1	6

Figure 11: Portraying the result of the criteria prioritization activity

Gaps in Information

REPRESENTATION OF VULNERABLE POPULATIONS

Certain groups, including transient individuals, non-English speakers, Indigenous populations, and LGBTQ+ individuals, may not have been fully represented in the data collection process. This lack of representation can create gaps in understanding their specific needs, particularly in rural areas like Craig County. Initial survey data reflected an overrepresentation of individuals with higher education and income levels, requiring adjustments to better reflect Craig County's population.

LIMITATIONS OF SECONDARY DATA

Secondary data sources pose challenges due to outdated information, limited geographic detail, and an inability to capture the full scope of rural community needs. County-level data may mask disparities between urban centers and outlying areas, and reliance on older surveys, such as Behavioral Risk Factor Surveillance System and US Census' American Community Survey, may not accurately reflect the current socio-economic and healthcare landscape.

IMPACT OF ACUTE COMMUNITY CONCERNS

Several pressing community concerns have influenced data collection and findings:

- The ongoing impact of COVID-19, especially in rural areas with limited healthcare access.
- Economic instability and inflation disproportionately affecting lower-income households.
- Confusion and barriers to Medicaid access following expansion efforts in Oklahoma.
- Persistent racial and socio-political tensions that contribute to mistrust in public health systems.

Despite these limitations, a combination of qualitative and quantitative research, including stakeholder stories and community surveys, has provided valuable insights. While the assessment aligns with best practices in public health, gaps remain in representing highly vulnerable populations, such as individuals experiencing homelessness or those institutionalized. Additionally, stratifying data by race, language, and other social factors remains a challenge.

As priorities are set to address community health needs, the health system will collaborate with public health and community partners to ensure that underserved populations are better represented in future strategies.

Assessment Data and Findings

SECONDARY DATA FINDINGS

Secondary data were collected primarily from the County Health Rankings & Roadmaps public website and analyzed as outlined below.

Overall, the Quality-of-Life identifiers in Craig County are performing worse than the state benchmarks outside of low birthweight. Craig County has a higher percentage of residents reporting poor or fair health and poorer physical and mental health days compared to Oklahoma and the United States overall. Additionally, the percentage of low birthweight births in Craig County is slightly lower than the state average but matches the national average.

Quality of Life	Craig County	Oklahoma	United States
Poor or Fair Health	23%	19%	14%
Poor Physical Health Days	4.6	3.8	3.3
Poor Mental Health Days	5.9	5.5	4.8
Low Birthweight	7%	8%	8%

Craig County fairs worse overall than the state and national benchmarks. Health behaviors and social and economic factors are the driving forces for negative health factors in Craig County. Craig County is faring poorly in all categories with exception to alcohol-impaired driving deaths which is well below the state and national benchmarks. Access to exercise opportunities, adult smoking, adult obesity, and sexually transmitted infections are key negative metrics that stand out that are well below benchmarks. Sexually Transmitted Infections has been increasing in Craig County over the last decade but has shown a dramatic decrease since 2019.

Health Behaviors	Craig County	Oklahoma	United States
Adult Smoking	25%	18%	15%
Adult Obesity	44%	40%	34%
Food Environment Index	6.1	5.6	7.7
Physical Inactivity	32%	27%	23%
Access to Exercise Opportunities	42%	71%	84%
Excessive Drinking	14%	14&	18%
Alcohol-Impaired Driving Deaths	18%	27%	26%
Sexually Transmitted Infections	375.5	519.5	495.5
Teen Births	34	27	17

Craig County is performing well in clinical care with the exception to primary care Physicians and uninsured which is performing worse than benchmarks.

Clinical Care	Craig County	Oklahoma	United States
Uninsured	19%	14%	10%
Primary Care Physicians	2,350:1	1,690:1	1,330:1
Dentists	1,570:1	1,560:1	1,360:1
Mental Health Providers	170:1	230:1	320:1
Preventable Hospital Stays	3,060	2,979	2,666
Mammography Screening	39%	41%	44%
Flu Vaccinations	43%	44%	48%

Craig County is performing worse than benchmarks for social and economic factors. Some college, children in poverty, and injury deaths are the large detractors. Unemployment is slightly worse than the state benchmark and children in poverty is substantially worse performing than benchmarks.

Social & Economic Factors	Craig County	Oklahoma	United States
High School Completion	85%	89%	89%
Some College	41%	60%	68%
Unemployment	3.1%	3.0%	3.7%
Children in Poverty	27%	20%	16%
Income Inequality	3.8	4.6	4.9
Children in Single-Parent Households	31%	26%	25%
Social Associations	13.5	11.3	9.1
Injury Deaths	128	98	80

When looking at the physical environment in Craig County, air pollution is at a 20-year low although still higher than national benchmarks. Long commute – driving alone is higher than the state and severe housing problems is performing worse than the state benchmark, as shown below.

Physical Environment	Craig County	Oklahoma	United States
Air Pollution - Particulate Matter	8.7	8.7	7.4
Drinking Water Violations	Yes		
Severe Housing Problems	16%	13%	17%
Driving Alone to Work	74%	80%	72%
Long Commute - Driving Alone	30%	28%	36%

PRIMARY DATA FINDINGS

In total, there were 181 surveys completed. A completed survey was defined as half of the survey questions were answered. There were 36 surveys that were completed through the mail survey to random addresses, and 145 were completed through stakeholder engagement.

Upon collection, the data was analyzed and visualized in graphics to clearly reflect the findings and highlight key insights. The table below summarizes the demographics represented by this survey and a high-level summary of the significant barriers identified in the survey.

Representation

Because the survey was completed by 181 respondents, the data was not able to be normalized to the US Census population estimates. Despite that analytic capacity, SFHS attempted to collect a representative sample. Where data was available, SFHS compared demographics of the survey respondents to the US Census[1] demographics for Craig County below.

Sex When asked what sex they were assigned at birth, 73% of the survey respondents replied that they were female, and the other 27% noted that they were male. The county breakdown is 48.5% female and 51.5% male[2].

Ethnicity When asked if the respondents were Hispanic, Latino, or of Spanish origin, 88% noted that they were not Hispanic/Latino/Spanish, while 5.3% said they were Mexican/Mexican American/Chicano, 1.2% were Puerto Rican, 4.1% were Cuban, and 1.2% were Hispanic/Latino.

Race The survey captured a far greater volume of races compared to the US Census. However, a comparison of the racial makeup of the survey respondents compared to the US Census is found below:

	Survey	US Census County Estimates[3]
White (e.g., German, Irish, English, Italian, Lebanese, Egyptian, etc.)	73%	62.5%
Black or African American (e.g., African American, Jamaican, Haitian, Nigerian, Ethiopian, Somali, etc.)	3.3%	3.5%
American Indian or Alaska Native (e.g., Navajo Nation, Blackfeet Tribe, Mayan, Aztec, etc.)	30%	20.0%
Asian Indian	1.1%	0%
Chinese	0%	0.2%
Filipino	0%	0%
Other Asian (e.g., Pakistani, Cambodian, Hmong, Burmese, etc.)	0%	0.5%
Japanese	0%	0%
Korean	0%	0.1%
Vietnamese	0%	0.3%
Native Hawaiian	0%	0.1%
Samoan	0%	0%
Chamorro	0%	0%
Other Pacific Islander (e.g., Tongan, Fijian, Marshallese, etc.)	0%	0%
Some other race	1.7%	1.0%

Age In general, the survey sampled a middle-aged and moderately young population while under-sampling an older population. Below is a breakdown of the percentage of the respondents' ages represented in the survey compared to the US Census for Craig County.

Age Group	Survey	US Census County Estimates[4]
18-24 years	7%	5.6%
25-34 years	24%	12.5%
35-44 years	22%	11.5%
45-64 years	31%	26.8%
65+	16%	19.0%

Using the insights gathered from the community engagement meetings, the community-wide survey, and qualitative feedback from engaged residents, a list of significant needs in Craig County was identified. These needs reflect the challenges that were most frequently highlighted by participants as critical to improving overall well-being in the community. The identified needs selected include:

- **Access to Healthcare Services:** Access to healthcare was identified as a critical need in Craig County, utilizing top-ranking criteria such as severity, which highlights the consequences of delayed care and lack of routine check-ups, including preventable conditions and higher rates of chronic disease. Engagement meeting attendee input revealed significant challenges, such as a shortage of healthcare providers, high medical bills, difficulty accessing appointments, and lack of insurance coverage. To address these barriers, feasible and sustainable solutions include forming regional partnerships, expanding telehealth services to improve access, and leveraging local and state funding to support the growth of Federally Qualified Health Centers (FQHCs).

- **Housing Stability:** Housing was identified as a critical need in Craig County due to its significant impact on mental health, physical well-being, and socioeconomic disparities, driven by housing instability. Stakeholder feedback underscored the issue, with 92% of survey respondents expressing concerns about housing insecurity and highlighting the lack of affordable and safe housing options. To address these challenges, solutions include working with local organizations to leverage public-private partnerships and federal housing programs, such as those offered by HUD, to secure funding and expand housing resources.

- **Transportation:** Transportation was identified as a critical need in Craig County due to its direct impact on residents' ability to access healthcare, employment, and essential services, which exacerbates health and economic disparities. Stakeholder feedback revealed significant challenges, with 59% of respondents citing high transportation costs and 33% reporting a lack of available transport options. To address these barriers, potential solutions include developing partnerships with local transit authorities and ride-share services to create affordable and reliable transportation programs.

- **Mental Health and Substance Use Services:** Mental health and substance use services were prioritized as a critical need in Craig County based on stakeholder feedback during engagement meetings, where participants highlighted limited access to providers and concerns about the impact of substance use on poverty and crime in the community. Stakeholders emphasized the severity of untreated mental health conditions and high rates of substance use, which contribute to significant social and health challenges. Addressing this need presents an opportunity to integrate mental health services into existing healthcare facilities and expand telehealth options, offering a feasible and lower cost approach to improving access and support for residents.

- **Nutrition and Food Security:** Nutrition and food security were identified as key needs in Craig County based on stakeholder feedback during engagement meetings, where residents highlighted challenges in accessing nutritious food and a lack of awareness about available resources. Poor nutrition has severe implications, contributing to chronic conditions such as diabetes and hypertension, which disproportionately impact low-income households. Addressing this need could be feasible by leveraging existing local food banks and state-funded nutrition programs to explore more sustainable solutions. Enhancing access and education around nutritious food can improve long-term health outcomes for the community.

- **Employment Opportunities:** Employment was identified as a critical need in Craig County based on stakeholder feedback shared during engagement meetings, highlighting barriers such as childcare responsibilities, lack of education or skills, and health-related challenges. Unemployment and underemployment significantly contribute to poverty and limit access to essential health services, exacerbating social and economic disparities. Addressing this need is feasible by leveraging local workforce development boards and job training programs, which offer sustainable solutions to enhance employment rates and equip residents with the skills needed for stable and fulfilling job opportunities.

This list above represents the community's most pressing needs based on the survey and the community engagement meetings held, which will be used to guide future health improvement efforts in the county.

ACCESS TO HEALTHCARE

WHY IS IT IMPORTANT?

Access to healthcare is fundamental for preventing disease, managing chronic conditions, and improving overall health outcomes[15]. Without adequate insurance, individuals may delay or avoid necessary care, leading to worse health outcomes, higher healthcare costs, and increased health disparities[16].

LOCAL ASSETS & RESOURCES

- https://oklahoma.gov/health/locations/county-health-departments/craig-county-health-department/county-services.html
- https://chcneo.com/

COMMUNITY CHALLENGES & PERCEPTIONS

High uninsured rates in a community lead to reduced access to healthcare services, resulting in poorer health outcomes and increased financial strain on both individuals and local health systems[17].

Geographic disparities in rural areas pose additional barriers to accessing care[18].

Gaps in Coverage in Craig County, the US Census Bureau estimates a high percentage of the population is living without insurance which is higher than both Oklahoma and the US as a whole[19].

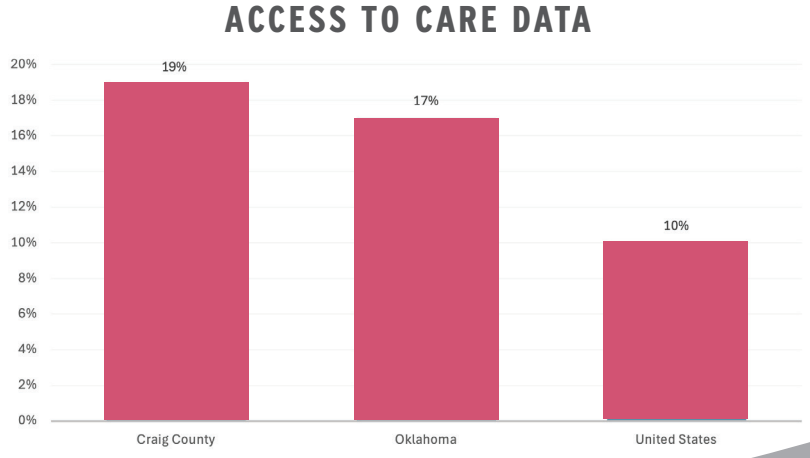
VULNERABLE POPULATIONS

Uninsured adults: 19% of adults under 65 and lack healthcare insurance in Craig County[20].
Rural Residents: Limited provider availability and transportation challenges disproportionately affect rural areas[21] .
Low-income families: Financial barriers exacerbate challenges in accessing affordable insurance or care[22].
Minority communities: Often face compounded disparities in insurance coverage and access to culturally competent care[23].

PRIMARY AND SECONDARY DATA HIGHLIGHTS

SECONDARY DATA

Craig County has a higher percentage of uninsured adults and children as compared to the state and the across the United States[24].

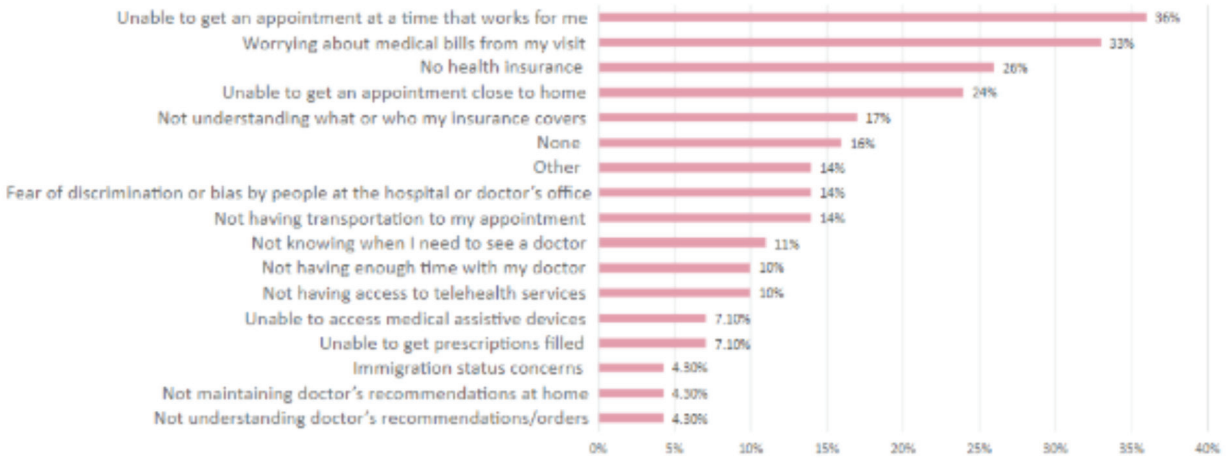


PRIMARY AND SECONDARY DATA HIGHLIGHTS

PRIMARY DATA

The most common challenge reported by Tulsa County respondents in accessing healthcare services was concern about medical bills (33%). Other significant issues included difficulty securing appointments during a time that works for them and a lack of clarity regarding their health insurance coverage and benefits.

In the past 12 months, have you had problems getting healthcare services due to:



The top barrier to accessing healthcare services among Craig County respondents was the inability to secure an appointment time that fit their schedule, reported by 36%. This was followed by concerns about medical bills (33%) and lack of health insurance (26%).

What is your main reason for not having insurance?

Coverage is too expensive	48%
Lost job or changed employers	19%
Lost Medicaid or became ineligible (e.g., due to age, or increase in income)	10%
Other	10%
I do not know how to get it	5%
Employer doesn't offer insurance	5%
Don't need insurance	5%

Among Craig County respondents without health insurance, 48% cited the high cost of coverage as the primary reason, while 19% attributed it to job loss or a change in employers.

WHAT CAN HEALTH SYSTEMS AND POLICYMAKERS DO?

- Increase funding for community health centers and mobile clinics in rural areas.
- Support patients and community members with the enrollment processes for Medicaid and CHIP to ensure eligible individuals can access coverage[25].
- Offer subsidies or incentives to employees in underserved areas to provide health insurance benefits[26].
- Partner with schools and community organizations to enroll uninsured children in CHIP or Medicaid.
- Develop sliding scale payment options and enhance charity care programs to support uninsured adults[27].
- Implement outreach initiatives to educate uninsured individuals about available resources and services.

EMPLOYMENT

WHY IS IT IMPORTANT?

Employment data can provide insight into the economic stability and health of a community[28]. Higher unemployment rates can affect access to healthcare and lead to higher medical expenditures which can exacerbate the financial pressures of a household[29]. Tracking unemployment could allow policymakers to target economic development efforts effectively.

COMMUNITY CHALLENGES & PERCEPTIONS

Underemployment can lead to economic hardships and reduced access to healthcare and social services[30].

Limited advancement opportunities in existing or new jobs and opportunities for accessing professional development education or training can be barriers to meaningful employment[31].

LOCAL ASSETS & RESOURCES

- https://mhaok.org/services/employment-support/
- https://vinitapl.okpls.org/jobs-business/
- https://www.vinitachamber.com/who-s-hiring
- https://oklahoma.gov/careertech/skills-centers/trade-areas/career-readiness-vinita.html

VULNERABLE POPULATIONS

Unemployed individuals, particularly in rural counties like Craig, face greater challenges in accessing employment opportunities[32].

Individuals with limited access to transportation, making commuting to jobs difficult[33].

PRIMARY AND SECONDARY DATA HIGHLIGHTS

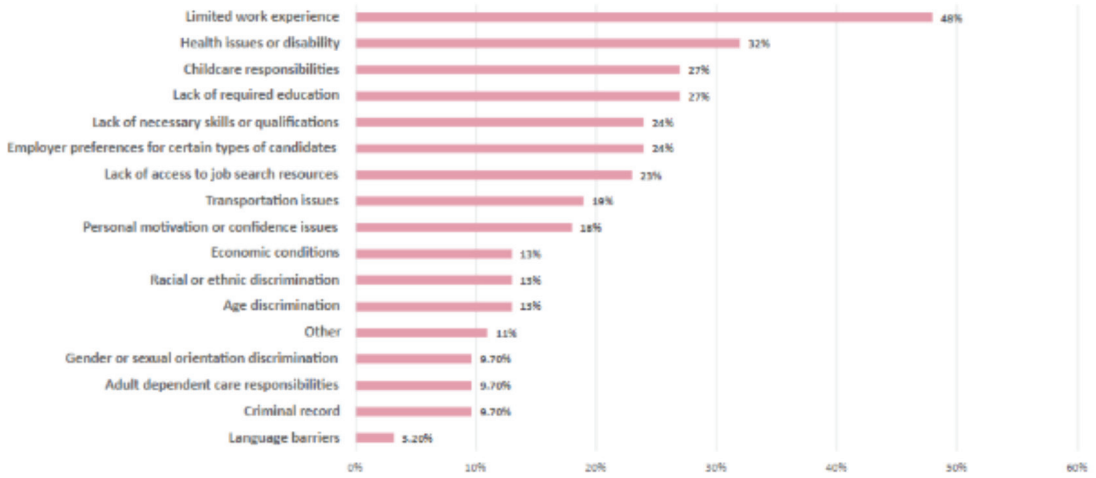
SECONDARY DATA

	Craig County	Oklahoma	United States
Unemployment Rate[34]	3.1%	3.0%	3.7%
Children in Poverty[35]	27%	20%	16%

PRIMARY DATA

The most common challenge reported by Tulsa County respondents in accessing healthcare services was concern about medical bills (33%). Other significant issues included difficulty securing appointments during a time that works for them and a lack of clarity regarding their health insurance coverage and benefits.

What barriers you have personally experienced when trying to get employment?



Craig County respondents identified limited work experience as the top barrier to employment, with 48% ranking it as the primary challenge. Health issues or disabilities followed at 32%, while childcare responsibilities and lack of required education were also found as significant barriers.

WHAT CAN HEALTH SYSTEMS AND POLICYMAKERS DO?

- Invest in and support local job creation programs aligned with market demand and service providers that support the healthcare industry[38].
- Enhance funding for vocational training and education.
- Partner with local businesses to create job-training initiatives; Provide support for mental health and financial stress associated with unemployment[39].
- Improve access through advocacy and specific programs to affordable childcare and transportation to reduce barriers for employment.
- Support community or local businesses through locally sourcing goods and services used by health system regularly[40].
- Consider exploring income disparities within the health system's own workforce by examining the lowest paid workers and the highest paid workers[41].
- Invest in job creation programs tailored to local industries and healthcare-related sectors.

NUTRITION

WHY IS IT IMPORTANT?

Access to healthy foods is a cornerstone of public health[42]. Limited access can lead to poor nutrition, increasing the risk of chronic diseases like diabetes, obesity, and cardiovascular issues[43]. Addressing this issue is essential for improving community health outcomes and reducing healthcare costs.

COMMUNITY CHALLENGES & PERCEPTIONS

Food insecurity affects 18.7% of Craig County residents[44].
Limited food access can contribute to perceptions of neglect and underinvestment in essential infrastructure[45].
Diminished Trust: Persistent food access challenges can undermine trust in public health systems.

LOCAL ASSETS & RESOURCES

- https://ampleharvest.org/food-pantries/white-oak-baptist-church-food-pantry-11053/
- https://www.facebook.com/ccnhn/
- https://oklahomablessingboxes.org/map-list/

VULNERABLE POPULATIONS

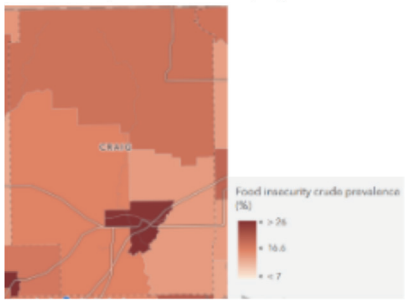
Rural residents may face geographic isolation limiting their food access[46].
Elderly individuals and those with disabilities who may struggle to travel to food sources[47].
Low-income families may face financial barriers to purchasing healthy foods, even when available[48].
Children in households with limited access often experience impacts on their long-term health and academic performance[49].

PRIMARY AND SECONDARY DATA HIGHLIGHTS

SECONDARY DATA

	Craig County	Oklahoma	United States
Limited Access to Healthy Foods[50]	14%	9%	6%

While only 14% of the population is affected by limited access to healthy foods[51].



The heat map visualizes the crude prevalence of food insecurity in Craig County, with darker areas indicating higher percentages of affected residents.

PRIMARY DATA

What are the main reasons you have difficulty getting or eating nutritious food?

Cost: Nutritious foods are too expensive	82%
Availability: Nutritious foods are not available in my local stores	29%
Time: I do not have enough time to prepare or shop for nutritious foods	26%
Knowledge: I do not know how to prepare nutritious meals	18%
Transportation: I do not have reliable transportation to get to a store that sell nutritious foods	12%
Physical Ability: I have physical limitations that make it difficult to shop for or prepare nutritious foods	10%
Other	6%

In Craig County, 82% of respondents identified the high cost of nutritious foods as the primary barrier to accessing or consuming them. Additionally, 29% reported that nutritious foods were not readily available, and 26% cited a lack of time to shop for and prepare healthy meals.

WHAT CAN HEALTH SYSTEMS AND POLICYMAKERS DO?

- Support the development of transportation infrastructure to connect rural areas with urban food resources.
- Support the development of grocery stores to operate in underserved rural areas[52].
- Support programs like mobile markets and food co-ops to address food deserts[53].
- Offer nutrition education programs targeting high-risk communities[54].
- Collaborate with local organizations to distribute healthy foods through clinics or outreach programs.
- Advocate for policies that integrate food access into broader health and economic development strategies.
- Develop a “Food is Health” program and send patients home with healthy groceries[55].

TRANSPORTATION

WHY IS IT IMPORTANT?

Transportation is essential for accessing employment, education, healthcare, and community resources[56]. Reliable transportation ensures that individuals can participate fully in economic and social life. However, challenges such as dependence on driving alone, lack of public transit, and disparities among racial and ethnic groups can limit opportunities and exacerbate inequities[57].

LOCAL ASSETS & RESOURCES

- https://pelivantransit.org/
- https://www.navigateresources.net/tulh/Agency.aspx?c;;0;;N;0;927460;1083128;0867;Transportation;Automobile%20Repair;1060;Transportation%20Expense%20Assistance

COMMUNITY CHALLENGES & PERCEPTIONS

Dependence on Driving Alone: High percentages of workers driving alone to work suggest a lack of alternative transportation options and is linked to increased road congestion and higher traffic fatality rates when compared to public transportation or carpooling[58].

Limited Public Transit: Counties with smaller populations, such as Craig, often lack sufficient public transportation, isolating residents without personal vehicles.

Low Levels of Physical Activity: Utilitarian active transportation is linked to higher levels of physical activity[59]; a heavy dependence on the automobile reduces the likelihood for population-wide physical activity improvements[60].

Environmental Impact: Heavy reliance on single-occupancy vehicles contributes to environmental concerns such as local air quality[61].

VULNERABLE POPULATIONS

Low-Income Residents: Limited access to vehicles or funds for fuel and maintenance can hinder mobility.

Rural Residents: rural areas face greater challenges due to sparse transit options and longer travel distances[62].

Seniors and Disabled Individuals: Dependence on public transit or specialized transportation services can limit their access to essential services for senior adults[63] and disabled individuals[64].

PRIMARY AND SECONDARY DATA HIGHLIGHTS

SECONDARY DATA

	Craig County	Oklahoma	United States
Motor Vehicle Crash Deaths[65]	24 per 100,000 population	18 per 100,000 population	12 per 100,000 population
Percentage of the workforce that drives alone to work[66]	74%	80%	72%
Percent of population not meeting physical activity guidelines[67]	32%	27%	23%

Craig County has a moderate percentage (74%) of its workforce driving alone, reflecting less public transit availability compared to urban areas in the state[68]. However, the motor vehicle deaths at 24 per 100,00069 may indicate a problem around road infrastructure or road safety.

PRIMARY DATA

In the past 12 months, have you experienced any of the following problems with your transport?

High cost of transportation (e.g., car payment, gas, insurance)	59%
Unavailable transportation	33%
Safety concerns	20%
Physical limitations	12%

Among Craig County respondents, 59% identified the high cost of transportation, including car payments, gas, and insurance, as a significant issue. Additionally, 33% reported a lack of available transportation, and 29% noted that transportation options were unreliable.

When asked what unreliable transportation prevented them from accessing, 17% of respondents indicated medical appointments, 15% cited work, and 13% mentioned daily living activities such as grocery shopping.

WHAT CAN HEALTH SYSTEMS AND POLICYMAKERS DO?

- **Support Public Transit:** Advocate to expand bus routes and schedules, particularly in underserved rural areas[70].
- **Support Infrastructure Improvements:** Advocate to enhance roads, bike paths, and pedestrian walkways to encourage diverse transportation modes71; Expand access to physical activity options on the healthcare campus.
- **Provide Patient Transportation:** Offer or partner with rideshare services to ensure patients can access healthcare appointments[72].
- **Advocate for Mobility Solutions:** Work with community leaders to highlight transportation challenges and advocate for funding and policy changes[73].
- **Focus on Outreach:** Collaborate with clinics and nonprofits to address transportation needs in remote areas.

HOUSING

WHY IS IT IMPORTANT?

Housing significantly influences health outcomes[74]. Severe housing cost burdens, and inadequate facilities directly affect residents' well-being. Addressing housing issues is crucial for reducing financial strain, improving mental and physical health, and creating stable environments that foster healthier communities.

COMMUNITY CHALLENGES & PERCEPTIONS

Severe Housing Cost Burden: 12% households in Craig County spent half or more of their income on housing[75]. This has been shown to leave limited resources for other essentials like food and healthcare[76].

Inadequate Facilities: Limited access to safe and functional utilities, especially in underserved areas, contributes to health risks[77].

Inadequate housing: Unsafe and inadequate facilities are more pronounced in counties where housing resources are sparse[78].

LOCAL ASSETS & RESOURCES

- https://www.usgrants.org/oklahoma/93062-vinita-oklahoma-housing-grants
- https://www.ohfa.org/rentalassistance/
- https://homeofhope.com/home-page-copy/residential/

VULNERABLE POPULATIONS

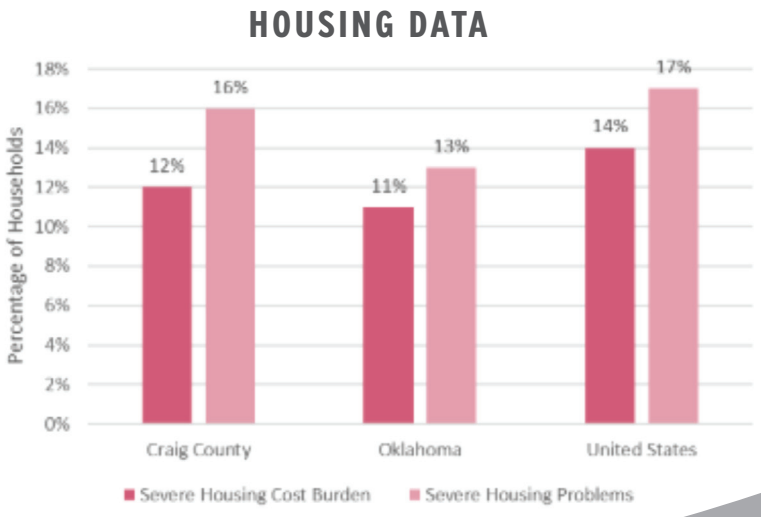
Low-income Families: These groups are disproportionately affected by severe housing cost burdens, limiting access to healthcare and education[79].

Racial and Ethnic Minorities: Historical and systemic inequities make housing challenges more severe for minority communities in urban and rural settings[80].

PRIMARY AND SECONDARY DATA HIGHLIGHTS

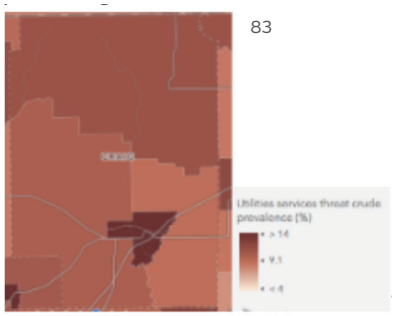
SECONDARY DATA

In Craig County, 12% of households spent more than half of their income on housing and 16% experienced severe housing problems[81]. The County Health Rankings site defines severe housing problems as those households who experience one of the following housing problems: "overcrowding, high housing costs, lack of kitchen facilities or lack of plumbing facilities"[82].



SECONDARY DATA *Continued*

Despite the housing not being as unaffordability as other locations, the heat map indicates that much of the housing and utilities insecurity likely occurs in the more densely populated areas of the county.



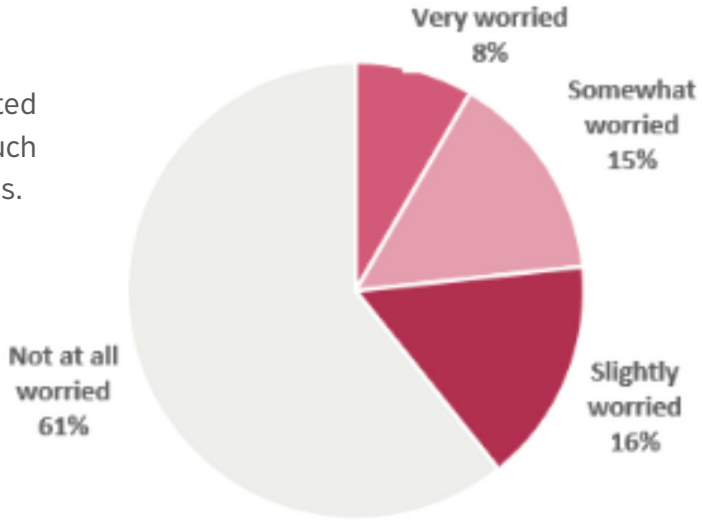
PRIMARY DATA

In the past 12 months, have you experienced any of the following problems with your transport?

PRIMARY DATA

Are you worried about losing your housing?

The CHNA survey indicates that 64% of Craig County residents own their homes, while 21% rent. Approximately 15% reported staying in temporary housing situations, such as with friends, in hotels, or in group homes. Despite the high rate of homeownership, 39% of respondents expressed varying levels of concern about the possibility of losing their housing.



WHAT CAN HEALTH SYSTEMS AND POLICYMAKERS DO?

- I**ncrease affordable housing:** Advocate to expand subsidies and incentives for developing low-cost housing[84].
- **Improve infrastructure:** Prioritize funding for repairs and upgrades to inadequate housing facilities for weatherization, safe respiratory environments and aging in place, especially in rural areas[85].
- **Enhance support services:** Strengthen programs for housing assistance and financial literacy to empower families to access better living conditions.
- **Support families with utilities:** Work with utility service provides to lessen the utilities burden on low-income households.
- **Discharge planning:** Ensure when patients are discharged from the hospital, that they are going home to a safe environment where they can heal.
- **Community Health Workers:** Support and/or hire community health workers to do home visits for discharged patients.

MENTAL AND BEHAVIORAL HEALTH

WHY IS IT IMPORTANT?

Mental and behavioral health are essential for overall well-being and productivity. Poor mental health can affect physical health, workplace performance, family stability, and community safety. Addressing mental health challenges is crucial to reducing healthcare costs, improving quality of life, and ensuring equitable access to care[86].

COMMUNITY CHALLENGES & PERCEPTIONS

High number of mentally unhealthy days: Craig County residents experience higher poor mental health days (5.9) compared to the national average (4.8)[87].
Rural barriers can further intensify challenges in accessing mental health care[88].
Stigma may keep residents from seeking appropriate care and this may lead to a community sense of neglect or hopelessness if left unaddressed[89].

LOCAL ASSETS & RESOURCES

- https://mhaok.org/
- https://www.grandmh.com/
- https://oklahoma.gov/odmhsas.html
- https://mentalhealth.networkofcare.org/oklahoma servicesagency?pid=grandlakecraigcounty urgentrecoverycenter_1746_2_0

VULNERABLE POPULATIONS

Rural Residents: face higher barriers to accessing care due to fewer local providers and resources[90].
Low-Income Families: Cost and transportation challenges may prevent these groups from seeking timely mental health care[91].
Youth and Adolescents: A critical group facing increasing mental health challenges, particularly in underserved schools[92].
Elderly Individuals: Mental health issues in seniors often go unaddressed, especially in rural areas[93].
Individuals with Co-occurring Disorders: Those facing substance use and mental health challenges may require integrated services[94].

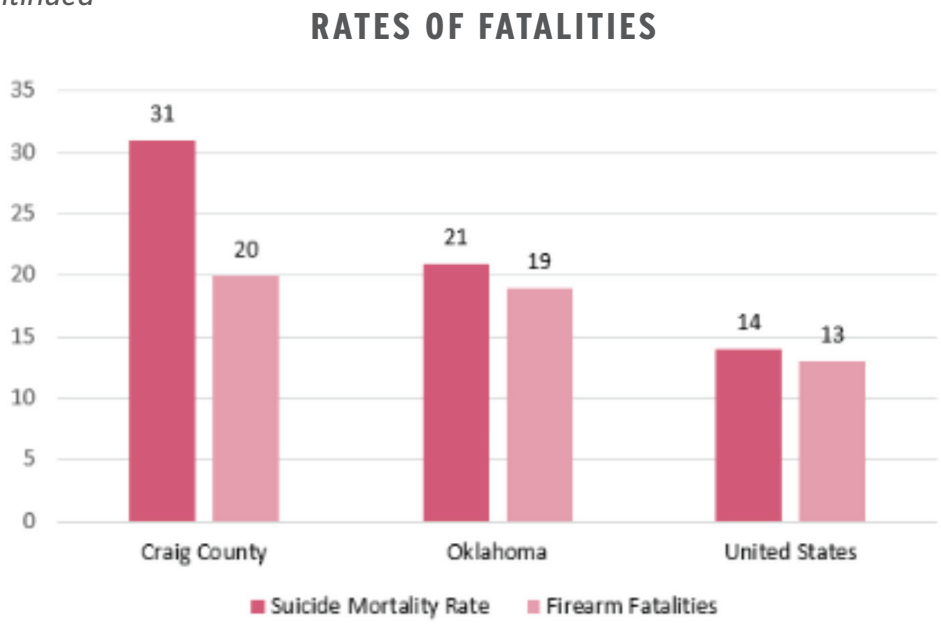
PRIMARY AND SECONDARY DATA HIGHLIGHTS

SECONDARY DATA

	Craig County	Oklahoma	United States
Poor mental health days[95]	5.9 in the last 30 days	5.5 in the last 30 days	4.8 in the last 30 days

SECONDARY DATA *Continued*

Compared to the national average, Craig County experiences substantially higher rates of fatalities from suicide and firearms, both at 31 and 20 per 100,000, respectively[96].



PRIMARY DATA

What would most improve your access to mental/behavioral Healthcare Services?

Affordable services	56%
Providers in my area	40%
Flexible appointment times (e.g., evenings/weekends)	32%
Shorter wait times for appointments	31%
Expanded insurance coverage	28%
Increased awareness of available services	28%
Availability of telehealth options	18%
Transportation options to reach services	16%
Culturally sensitive care	10%
Other	8%

56% of Craig County respondents indicated that affordable services would improve their access to mental and behavioral health services. Forty percent highlighted the need for providers available in their area, while 32% emphasized the importance of flexible appointment times and 31% prioritized shorter wait times for appointments.

WHAT CAN HEALTH SYSTEMS AND POLICYMAKERS DO?

- Expand access to telehealth and mobile mental health clinics to reach underserved areas[97].
- Develop public awareness campaigns to reduce stigma around mental health care and encourage early intervention[98].
- Provide incentives for mental health professionals to practice in rural and underserved areas[99].
- Integrate mental health into primary care settings to improve access and reduce stigma[100].
- Expand crisis intervention programs and ensure 24/7 availability of services like suicide prevention hotlines; support programs like 988
- Collaborate with schools to implement youth mental health programs and early screening initiatives[101].
- Offer culturally competent care to address diverse needs, particularly in rural and minority populations[102].
- Support local healthy democracy initiatives to improve citizen engagement in systems that impact their lives.
- Develop non-profit board development pipelines for underserved population.
- Consider developing a gun-safety strategy such as lock boxes to be given away[103].

Following the identification of the significant health needs described above, SFHS selected a subset of the significant needs as the health system's prioritized needs. Prioritization was a multi-step process that began with review of the significant health needs identified throughout the primary and secondary data collection process. About 50 SFHS leaders participated in the review of this data and then leaders were asked to identify existing initiatives underway and brainstorm dream initiatives related to each of the significant health needs identified. After this exercise, Craig County SFHS leaders met to review the results and select the prioritized needs.

Although SFHS may address many needs, the prioritized needs will be at the center of the formal CHNA implementation strategy and corresponding tracking and reporting. The prioritized needs for Craig County and the reason for their selection are outlined below:

- **Access to Healthcare:** This need was selected because the number one barrier identified through the survey was access to healthcare, driven by the concern over cost of medical bills, inconvenient appointment times, and lack of or uncertainty about health insurance coverage. This issue aligns with the SFHS Strategic Focus Area of 'Access', creating the opportunity to align with the broader SFHS strategic plan.

- **Food:** This need was selected because in the SFHS internal SDoH screening data, food insecurity is the second most significant factor. Of those who identified food as a barrier in the CHNA survey, the cost of nutritious foods and time to prep and prepare the biggest barriers. There is momentum building within SFHS to address food insecurity, and there are a number of stakeholders within the community that SFHS collaborates with on this work.

- **Employment:** Employment is the third highest barrier to health in Craig County. Community members face challenges such as limited job opportunities, work experience, education, and necessary skills. With collaborative partnerships already established, SFHS is well positioned to address this issue

SFHS recognizes the importance of addressing the full range of health needs within the community and is dedicated to actively improving the health of the populations it serves. For this CHNA, SFHS has chosen to focus on the priorities outlined above. Other significant needs identified were not included in this cycle of the CHNA. A comprehensive data analysis was conducted, and while many of these needs are important, they did not reach the same level of priority as the three needs highlighted. Additionally, SFHS is not best positioned to address some of these needs, as other community stakeholders are already working on solutions for them.

Activities Since Last CHNA

Evaluation Plan

The previous Community Health Needs Assessment (CHNA) for Saint Francis Health System (SFHS) was conducted in 2022, and the Implementation Strategy Plan (ISP) represents strategies and activities spanning fiscal years 2023 – 2025. Note: SFHS fiscal years run from July to June.

For each priority area, the health system conducted an evaluation to demonstrate the impact of the related strategies and activities. This plan includes specific data sources such as program records, hospital patient data, and/or community-level data such as the community health needs assessment (CHNA). Measures may include but are not limited to: community indicators, partners, funding and programmatic outcomes. Data was reviewed by internal interdisciplinary teams at appropriate intervals (e.g., quarterly, bi-annually) and will be reported on the annual Schedule H tax reporting as required by the Patient Protection and Affordable Care Act regulations.

This ISP evaluation is a joint evaluation plan for Saint Francis Hospital, Inc., Saint Francis Hospital South, LLC, Saint Francis Hospital Muskogee, Inc., Saint Francis Hospital Vinita, Inc., and Laureate Psychiatric Clinic and Hospital, Inc.

Note: As work began on the 2022 - 2025 Implementation Strategy Plan and these priority health needs, it was acknowledged that the originally outlined measures to evaluate were indirectly impactful to community health, so the work pivoted to track more directly impactful measures. While the initial intent was to track quantitative metrics, qualitative measures will be used to evaluate this implementation strategy plan and its outcomes.

Hospital Role and Required Recources

Internal staff time was leveraged to complete plan deliverables. Key staff was identified at the system level and at the specific hospital entities, as appropriate as well as key community stakeholders including but not limited to: Roman Catholic Dioceses, Catholic Charities, Oklahoma State Department of Health, Grand Nation, Inc., Green County Behavioral Health, Grand Mental Health, and more.

Significant Health Needs to be Addressed

PRIORITY HEALTH NEED #1: ACCESS TO HEALTHCARE SERVICES

Goal: Improve primary care and specialty care provider access through network development, expansion of telehealth, and growing the healthcare workforce.

Background and rationale: 2022 CHNA areas of opportunity considered criteria including standing to benchmark, magnitude, prevalence, and overall impact of issue. Key community indicators related to health care access as a health issue:

- 29.1%, 21.8% and 27.0% of respondents in Tulsa, Craig, and Muskogee Counties respectively cited trouble getting an appointment compared to 14.5% across the U.S.
- Respondents in all three areas cited costs of doctor visits and prescriptions, inconvenient office hours, finding a doctor, and transportation as barriers at levels higher than US averages across all barriers.

STRATEGY #1: Community Partnerships and Network Development

Anticipated impact: Increased health education and preventative care resources provided in the community. Address social determinants of health through a partnership with community organizations, faith-based organizations, and academic institutions.

Key collaborators: Catholic Charities of Eastern Oklahoma, Roman Catholic Diocese of Eastern Oklahoma, Oklahoma State Departments of Health, and local community organizations

Planned actions:

- Expand/develop relationships w/ Roman Catholic Diocese of Tulsa and Eastern Oklahoma.
- Collaborate with county health depts and local leaders, community orgs, academic institutions
- Evaluate opportunities to provide lower costs services while maintaining high-quality of care

Measures to evaluate impact:

- Number of community events co-hosted with other Catholic orgs.
- Number of community events co-hosted with community orgs and academic partners promoting access to care for vulnerable populations.
- Programmatic initiatives to assist underserved communities and reduce the overall cost burden of accessing care.

Strategy #1: Actions taken, results and location of action

SFHS - ALL HOSPITALS

SFHS supports the operations of the Xavier Medical Clinic in East Tulsa, offering volunteer physicians, pharmacists, nurses and other healthcare professionals at no charge to women, children, and men who are uninsured or underserved in the Tulsa community. SFHS provides health education, outpatient primary care services, medication assistance, pregnancy services, referrals to specialists and interpretation services.

Below are the yearly subsidy amounts provided for the Xavier Medical Clinic:

- FY23: $3,594,841
- FY24: $4,094,705
- FY25 (YTD through February): $2,979,513

Below are the yearly volumes for the Xavier Medical Clinic:

- FY23: 10,255 visits
- FY24: 8,966 visits
- FY25: results pending

In December 2022 (FY23), SFHS engaged in a partnership with DispatchHealth, the nation's first comprehensive in-home medical care provider. DispatchHealth delivers and coordinates high-acuity medical care in the home for a wide range of injuries and illnesses, enabling SFHS to reach vulnerable, home-bound and underserved community members. **Below are the yearly volumes for this service:**

- FY23: 1,656 completed visits
- FY24: 4,286 completed visits
- FY25 (YTD through February): 2,933 completed visits

In August 2023 (FY24), SFHS opened a new primary care clinic in North Tulsa to enhance access and address the healthcare needs of a predominantly minority and underserved community.

- FY24 – 1,252 visits
- FY25 (YTD through February) – 1,585 visits
- So far in FY25, 56% of the patients seen are Medicaid recipients

Annually on the first Saturday in December, SFHS hosts 'Saint Francis Serves Day' where SFHS employees volunteer at local charities throughout Eastern Oklahoma. SFHS had a total of 591 volunteers participating in FY24 and FY25. Additionally, we provided 500 meals for community members in Tulsa, McAlester and Muskogee annually. Note: unable to provide FY23 number due to change in tracking system.

Strategy #1: Actions taken, results and location of action

SFHS - ALL HOSPITALS	Annually, SFHS hosts the 'White Mass' where approximately 170 participants across all Eastern Oklahoma hospitals and Roman Catholic Diocese of Tulsa come together to honor healthcare providers with a mass and reception.
	To increase access to specialty services in underserved parts of Oklahoma, SFHS began doing outreach to rural communities. SFHS physicians from Tulsa will spend anywhere from two days a week to one day a month at rural locations, creating new access to specialty services including gastroenterology, cardiology, orthopedics, allergy, OB/GYN, and endocrinology services. This access program also includes virtual services to increase the continuity of care provided.
SAINT FRANCIS HOSPITAL MUSKOGEE	In FY24, Saint Francis Hopsital Muskogee (SFH-M) applied for a Health Resources and Services Administration (HRSA) $100,000 grant that would enable SFHS to hire a rural health care coordinator for underserved members of the Muskogee community. While SFH-M did not receive the grant the first time around, an application was resubmitted in FY25. Results of the grant application are still pending.
	Beginning in FY24, key stakeholders from SFH-M, Muskogee County Health Department (MCHD), Oklahoma State Department of Health District 7 (OSDH), Green Country Behavioral Health (GCBH), Muskogee County Transit, and The Kelly B Todd Center formed the Muskogee County Rural Health Network, a collaborative aimed at improving health outcomes for persons in Muskogee County. Key opportunities the Rural Health Network is working on include: • Women's services: newly established pregnancy resource navigator and SFH-Muskogee obstetrics providers are collaborating and providing support to MCHD for prenatal care • SFH-Muskogee is partnering with the Community Health Workers and Mobile Wellness Unit to increase referrals • Assisting with SoonerCare application process • Improved collaboration with the MCHD and diabetes education services and referrals • Partnering with GCBH on maternal depression, children mental health, and suicide and depression referrals

Strategy #1: Actions taken, results and location of action

SAINT FRANCIS HOSPITAL MUSKOGEE	In FY25, SFHS began planning to expand post-acute care and close care gaps in our rural communities, ensuring patients can stay close to home for their care. These services include expansion of hospice and durable medical equipment into the Muskogee County service area and are anticipated to launch in FY26.
SAINT FRANCIS HOSPITAL VINITA	In FY24, Saint Francis Hospital Vinita (SFH-V) Administrator began serving as a key stakeholder on the TSET Healthy Living Program collaborative, a grant program facilitated by Grand Nation, Inc., that seeks to lessen the burden of unhealthy behaviors before they take root. In partnership with the TSET Healthy Living Grant Program, SFH-Vinita has been supporting work to ensure tobacco-free properties and promotion of the Oklahoma Tobacco Helpline for those who want to quit, establishing community gardens and more.

STRATEGY #2: Telemedicine Outreach

Anticipated impact: Improved access and connectivity to healthcare providers using telemedicine (e-visits, video visits) as an outreach method.

Key collaborators: Warren Clinic

Planned actions:

- Optimize Epic e-visits to improve service line outreach and program development in key regions.
- Expand current central monitoring services to include additional access points.
- Expand e-visits at Warren Clinic, Inc. locations to increase access to primary and specialty care resources with the goal of increasing access for patients in rural and underserved portions of the market.

Measures to evaluate impact:

- Number of specialty care telemedicine visits completed
- Number of primary care telemedicine visits completed
- Geographic dispersion of patient populations

Strategy #2: Actions taken, results and location of action

SFHS - ALL HOSPITALS

In September 2023 (FY24), SFHS launched a virtual nursing pilot of 81 beds at SFH-Yale and SFH-Muskogee. Virtual nurses complete admissions and discharges for each unit, including medication history, patient and family education and regulatory audits. This program enables caregivers to work at the top of their licenses, improving access for SFHS patients. In FY25, SFHS expanded this service to an additional 200 beds with plans to scale to 672 beds in FY26 at all hospitals. As the virtual nursing program continues to expand, SFHS will be expanding virtual sitting to every bed, which is a program that allows caregivers to monitor and support our patients virtually.

The health system underwent a variety of efforts to enhance our digital front door including:

- Direct and open scheduling (FY23)
- Epic care companion to provide access to an interactive, mobile solution to manage health (FY23)
- Apple and Google Pay implementation (FY23)
- eCheck-in redesign and implementation of Epic's 'Hello World' and 'Hello Patient' which allows for auto electronic check-in when patients enter the relevant geography for care (FY24)
- Implementation of Epic's 'On My Way' which allows community members to virtually let SFHS know one is in route to urgent care so a place in line can be held (FY25)

To increase utilization of e-visits, SFHS added additional specialties to the service. Due to the increase of services and specialties offered, SFHS has been able to increase total e-visits over the past three fiscal years as shown below.

- FY23: 9,187 total visits
- FY24: 10,551 total visits
- FY25 (YTD through February): 7,870 total visits
- FY23 to FY24 Growth Rate: +14.8%

To increase access and provide ample coverage for the demand, SFHS expanded the virtual urgent care operation to ensure access 24/7 in FY25. Below are the volumes:

- FY23: 3,399 total visits
- FY24: 4,413 total visits
- FY25 (YTD through February): 1,399 total visits

Strategy #2: Actions taken, results and location of action

SYSTEM (ALL HOSPITALS)	To expand telehealth usage and provide end to end capabilities across the continuum of care, SFHS selected Teladoc as the preferred telehealth technology in FY24. Not only did this enable SFHS to be able to provide individual inpatient room tele-capabilities, but also to expand tele-services to provide additional access to rural, underserved communities.
	To increase access to specialty services in underserved parts of Oklahoma, SFHS began doing outreach to rural communities. SFHS physicians from Tulsa will spend anywhere from two days a week to one day a month at rural locations, creating new access to specialty services including gastroenterology, cardiology, orthopedics, allergy, OB/GYN, and endocrinology services. This access program also includes virtual services to increase the continuity of care provided.
	To expand access to virtual behavioral health services, SFHS has been placing a special focus on growing the virtual behavioral health provider network. Throughout FY25, SFHS has added two virtual medicine providers and four virtual therapy providers, with an additional provider starting by the end of FY25. FY25 results are pending.
	In addition to implementing virtual nursing, in FY25 SFH-Y expanded tele-neurology coverage at night to ensure 24/7 access to Neurology services. Since implementation, SFH-Y has completed 593 virtual tele-neurology consults.
SAINT FRANCIS HOSPITAL SOUTH	In FY24, Saint Francis Hospital South (SFH-S) leveraged Teladoc to improve access to tele-neurology services at SFH-South. In FY25, implementing virtual nursing and virtual sitting to be up and running in May 2025. Since implementation, SFH-S has completed 379 virtual tele-neurology consults.
SAINT FRANCIS HOSPITAL VINITA	Throughout FY24 and FY25, Saint Francis Hospital Vinita (SFH-V) leveraged Teladoc to expand access to Nephrology, Infectious Disease, Neurology, Cardiology, Virtual Nursing and Virtual Sitting services at SFH-Vinita. This allows SFHS to extend specialty services to a geography that severely lacks access to high-quality, specialty care. Since implementation, we have had 22 infectious disease virtual consults. All other results are pending.
	In FY25, SFHS expanded access to psychiatric services in Vinita by offering an outpatient behavioral health clinic with virtual capabilities. • FY25 (YTD through February): 81 visits

Strategy #2: Actions taken, results and location of action

SAINT FRANCIS HOSPITAL MUSKOGEE	In FY24, Saint Francis Hospital Muskogee (SFH-M) leveraged Teladoc to improve access to tele-neurology services at SFH-M and implemented virtual nursing. Since implementation, SFH-M has completed 369 virtual tele-neurology consults.

STRATEGY #3: Grow and Engage Workforce

Anticipated impact: Improved access across the region through alignment with academics to train and develop healthcare professionals.

Key collaborators: Local nursing and medical schools and local community organizations

Planned actions:

- Conduct workforce needs assessment for outreach programs in Pittsburg, Washington, Rogers, and Mayes Counties. (Note: rather than conducting an assessment, SFHS prioritized taking action by developing partnerships in these counties to grow and develop the workforce)
- Nurses and providers recruitment – emphasis on Primary in Owasso, Sand Springs, North Tulsa, and McAlester.
- Expand urgent/emergent care in new, vulnerable markets.
- Recruitment for key specialties.
- Relationships w/ nursing and med schools to recruit.
- Implement an SFHS-housed school of nursing program with local academic partners.

Measures to evaluate impact:

- Simulation space at SFH-Yale for nursing education and development
- Develop recruitment & outreach strategies for underserved communities
- Number of nurses/physicians recruited
- Number of specialists in key svc lines focusing on outreach
- Number of clinical staff educated in telehealth protocols
- Number of nursing school rotations and programs offered at SFHS
- Number of med school residency rotations offered at SFHS
- Number of new partnerships w/ academic institutions to support WF development

Strategy #3: Actions taken, results and location of action

SFHS - ALL HOSPITALS

In June 2024, SFHS opened the William K. Warren, Jr. Simulation Center, a 7,000 sq foot state of the art medical simulation facility that will be used to educate and train nurses and ancillary clinical staff for decades to come. The center has hosted over 1,000 students to date and has hosted 10 events with local schools, EMS and other community partners.

To support and improve workforce development in Eastern Oklahoma, SFHS forged numerous partnerships with local academic institutions. As of March 2025, SFHS has student cohorts with ten universities and is hosting 266 students in the Spring 2025 semester. These universities include:

1. University of Tulsa (Traditional and ABSN)
2. University of Oklahoma (Traditional and ABSN)
3. Rogers State University (traditional cohort and extended campus)
4. Oral Roberts University
5. Langston University
6. Oklahoma State University – Stillwater
7. Oklahoma State University – Institute of Technology
8. Northern Oklahoma College
9. Connors State College
10. Eastern Oklahoma State College

Additionally, in 2024, SFHS began hosting a Rogers State University School of Nursing Extended Campus. There are currently 48 students enrolled in the program with nine students graduating in May 2025. SFHS employs three FTEs to support this program.

To improve provider recruitment, SFHS redesigned the internal process and implemented a method to prioritize. These efforts have enabled the system to be more efficient and successful in recruiting and retaining nurses and providers as seen by the following numbers:

- FY23: 438 new nurses and 81 new providers (physicians, physician assistant and APRN) hired
- FY24: 537 new nurses and 118 new providers (physicians, physician assistant and APRN) hired
- FY25 (YTD through February): 379 new nurses and 85 new providers (physicians, physician assistant and APRN) hired for a current total of 2,871 nurses and 730 providers employed

Strategy #3: Actions taken, results and location of action

SFHS - ALL HOSPITALS

In FY23, SFHS launched Project MASH (Medical Academy for Students in Healthcare), a two-week program for high school students interested in the healthcare field. Students are exposed to a variety of hospital departments and interact with our caregivers to learn more about a future career in healthcare. To date, SFHS has had 42 students from the community participate in the program.

Throughout FY23 – FY25, SFHS collaborated with Project SEARCH, OU Department of Rehab Services and Tulsa Technology Center (TTC) on a program serving individuals aged 18 – 24 with developmental disabilities. The program rotates participants through three different departments during the school year (36 weeks) with the goal of developing competitive job skills and employment in the community by the end of the program. Since inception in 2022, the program has graduated 23 students and three were hired internally for continued employment with SFHS.

In FY23, SFHS launched "Walk-in Wednesdays" for targeted recruitment in areas of the community where people are limited by the application process due to low literacy or some other barrier. Vacancy rates for housekeeping and transporter dropped with the initiation of this program and on-going evaluation is pending.

The STRETCHED program is open to all high school students, with a focus on underrepresented groups in the healthcare profession, as well as would-be first-generation college students. In FY23, SFHS partnered with TU to host a field trip, also known as a field excursion, as part of the STRETCHED camp. SFHS hosted 40 11th-grade STRETCHED students. The students had lunch and listened to several speakers talk about their career paths, successes, and challenges. After lunch, students were able to see select areas of the hospital. Additionally, in FY25, the SFHS Simulation Center hosted the STRETCHED program for 50 11th-grade students, featuring presentations on weather-related injuries, simulations on childbirth, and community-based education, including the use of intranasal NARCAN and use of epinephrine auto-injectors.

Per the Oklahoma Commerce 2023 Report, SFHS is the 5th largest employer in the state of Oklahoma. Meeting the needs of the SFHS workforce and creating a flourishing work environment has a ripple effect on the health of the community. Significant improvements and investments in the SFHS have been made throughout this CHNA cycle as outlined below on the next page:

Strategy #3: Actions taken, results and location of action

SFHS - ALL HOSPITALS

2023 Initiatives:

- SFHS expanded the partnership with Spring Health Employee Assistance Program to provide comprehensive mental health and life services beyond traditional counseling. The program also offers a digital platform with accessible resources to support employee well-being. Spring Health provides crisis response resources as they recently provided resources for the victims who were impacted by the wildfires.
- Established a pet therapy program that offers emotional support to patients, guests and employees by bringing trained therapy animals into the hospital environment. By reducing stress and promoting well-being, Pink Paws enhances the overall care experience for both patients and staff.
- Designed to improve employee access and experience, the HR Service Center ensures quick and consistent responses to inquiries. By utilizing specialized HR representatives, this initiative streamlines support, increases efficiency, and allows HR business partners to focus on strategic priorities rather than daily transactional tasks.
- To address workforce shortages and increase diversity, SFHS has partnered with an international staffing firm to bring 51 foreign-trained nurses to our organization. This program strengthens our talent pipeline and is now expanding to include physical therapy positions as well.

2024 Initiatives:

- A Veterans & Military Task Force employee resource group (ERG) was created to recognize and support employees who have served or are currently serving in the military. It provides valuable resources, fosters a sense of community, and enhances recruitment and retention of military-affiliated employees.
- SFHS leveraged MedImpact Pharmacy Benefit Manager to carve out pharmacy benefits from the medical plan, which led to greater transparency and better cost management of prescription drug benefits for employees.
- SFHS developed a specialized training program for frontline leaders to equip them to proactively address employee relations concerns. This initiative ensures leaders can effectively respond to workplace issues, mitigate risks, and enhance overall workforce engagement.therapy positions as well.

2025 Initiatives:

- In May 2025, SFHS launched an employee benefit and wellness fair, which will provide employees with a holistic range of resources to support their overall well-being. This fair will feature financial, spiritual, healthcare resources, mental health support, wellness programs, and other essential benefits, helping employees make informed decisions about their personal and professional well-being.

Strategy #3: Actions taken, results and location of action

SFHS - ALL HOSPITALS	**Additional noteworthy and ongoing activities include:** • As a nonprofit organization, SFHS qualifies many of our employees for Public Service Loan Forgiveness (PSLF) if they have made student loan payments for at least 10 years. SFHS actively supports staff by providing guidance and resources to help them navigate the application process, ensuring they can take full advantage of this financial relief. • SFHS hosts annual events for current employees, high school students and college students to connect the community with healthcare jobs and resources. • SFHS provides on-site health clinics and screenings, providing employees with convenient access to preventative care, vaccinations, and health assessments. • SFHS has a Workplace Wellness Program (LiveLifeWell) that offers employees on-site fitness facility, fitness challenges, mental health workshops, nutrition counseling, and smoking cessation programs. • Through Fidelity, SFHS offers employees access to a comprehensive financial wellness platform, including digital tools, personalized guidance and workshops on personal finance topics such as budgeting, retirement planning, and investment strategies. These resources empower employees to make informed financial decisions and plan for their future with confidence.
SAINT FRANCIS HOSPITAL YALE	In FY24, SFH-Y developed an internal medicine residency and vascular surgery fellowship to provide additional opportunities to student learners. Currently, the internal medicine residency program has 34 active residents, and the vascular surgery fellowship has three active fellows and five active attendings. SFH-Y has also expanded existing programs to add additional residents in the following programs: Orthopedics (one additional resident per year for a total of five over the next five years), Otolaryngology (one additional resident per year for a total of five over the next five years), General Surgery (two additional residents per year for a total of ten over the next five years). Additionally, SFHS developed an additional residency program for scrub technicians. The scrub technician program launched in FY25, and SFH-Y has hired two participants into the program thus far.
SAINT FRANCIS HOSPITAL SOUTH	In FY25, SFH-S began working with OSU and a local family practice program to develop a residency program focused on increasing access to primary care Obstetrics. SFHS is actively working with these partners to determine the number of residents and timing for launch.

Strategy #3: Actions taken, results and location of action

SAINT FRANCIS HOSPITAL MUSKOGEE	In FY25, SFH-M began developing a rural track residency program that would create specific residencies for rural medicine that include General Surgery, Obstetrics and Behavioral Health. SFHS is actively working with OSU, Cherokee Nation and a graduate medical education consultant to determine number of residents and timing for launch.
SAINT FRANCIS HOSPITAL VINITA	In FY24, SFH-V onboarded a full-time physician to practice in the Langley Rural Health Clinic to expand access to primary care services. • FY24 volumes: 3,129 clinic visits • FY25 volumes: 2, 375 clinic visits

PRIORITY HEALTH NEED #2: BEHAVIORAL HEALTH (SUBSTANCE ABUSE AND MENTAL HEALTH)

Goal: Improve community's access to behavioral health services and treatments through increased education and improved services and develop integrated behavioral services to alleviate emergency and inpatient care need for behavioral care.

Background and rationale: 2022 CHNA areas of opportunity considered criteria including: standing to benchmark, magnitude, prevalence, and overall impact of issue. Key community indicators related to mental health as a health issue:

- 27.4%, 24.5% and 24.3% of respondents in Tulsa, Craig and Muskogee counties, respectively cited "fair or poor" mental health compared to 13.4% nationally.
- Nearly 72% of key informants (community stakeholders) cited Mental Health as a major health problem within the community with another 19% citing is as a moderate problem. Finding a doctor, and transportation as barriers at levels higher than US averages across all barriers.

STRATEGY #1: Behavioral Health Community Education

Anticipated impact: Integrated with the health system's strategic plan for improved community access to behavioral health resources, services, and education.

Key collaborators: Mental Health Association Oklahoma, local foundations such as the Anne and Henry Zarrow Foundation and the George Kaiser Family Foundation, local community organizations, local health departments, higher education institutions such as OU – Tulsa and OSU, other community behavioral health providers such as CREOKS Health Services, Parkside and Certified Community Behavioral Health Clinics

Planned actions:

- Coordinate functions associated with raising community awareness on accessing behavioral health services.

Measures to evaluate impact:

- # BH community events coordinated or attended
- # Collaborations with community orgs and institutions promoting access to BH services and education

Strategy #1: Actions taken, results and location of action

SFHS - ALL HOSPITALS	In FY23, SFHS co-led a pediatric behavioral health collaboration to address the need for resources in Tulsa. Hosted meetings and psychiatric expertise to external providers and community-based organizations to increase capacity of the pediatric behavioral health system of care in the Tulsa area.
	In FY23, SFHS established a psychiatric emergency services provider cohort that includes local community stakeholders and behavioral health providers in our community. This cohort meets quarterly to identify barriers and collectively solve problems around issues related to psychiatric emergency care.
	In FY24, SFHS developed formal relationships with the Certified Community Behavioral Health Centers (CCBHCs) to address and support the need for persistent and on-going behavioral health treatment for patients in post-discharge from inpatient psychiatric care.
	Throughout FY24, SFHS conducted and participated in a variety of eating disorders community outreach education events including: • Oklahoma Christian University Marriage and Family Therapy Program: Eating Disorders 101 • HARUV institute: Using Polyvagal theory within therapy • Alliance of Eating Disorders luncheon

Strategy #1: Actions taken, results and location of action

SFHS - ALL HOSPITALS	To support the City of Tulsa's plan to reduce suicide deaths by 50% by 2027, Laureate Psychiatric Clinic and Hospital (LPCH) has embarked on a journey to incorporate best practices into our organization and processes to improve care and safety for individuals at risk of suicide. In FY25, SFHS began training staff on the Zero Suicide framework, with over 64 caregivers across the system having received training at the Zero Suicide Academy.

STRATEGY #2: Behavioral Health Continuum of Care

Anticipated impact: Improved access to effective treatments and services for mental health and substance abuse disorders.

Key collaborators: Community behavioral health providers serving underserved populations, such as Green County Behavioral Health Services, Inc., Grand Lake Mental Health Center, Inc., Parkside Psychiatric Hospital and Clinic, CREOKS Health Services, Tulsa school districts, Family and Children Services, and The Tulsa Center for Behavioral Health.

Planned actions:

- Collaborate with regional physicians and behavioral providers on building a continuum of care for substance abuse and mental health.

Measures to evaluate impact:

- Number of collaborations with community orgs for pediatric behavioral health needs
- Identify opportunities to address gaps in access (e.g. BH urgent care resources).
- Expand outpatient behavioral health programs and provide resources to underserved communities
- Identify methods and resources to assist patients to prevent crisis events from occurring

Strategy #2: Actions taken, results and location of action

SFHS - ALL HOSPITALS	As part of the pediatric behavioral health collaboration (see above), developed formal meeting process and defined agreements for appropriate placement of pediatric and adult community members needing inpatient psychiatric care. This ensures resources throughout our communities are being leveraged in the most efficient way and ensures organizations can appropriately leverage their expertise.
	In FY24, SFHS developed an Urgent Medication Clinic that sees patients who have been discharged from an inpatient psychiatric stay or community members who need to be seen by a provider more urgently than our wait times will allow. This expands access to vulnerable populations by allowing patients to be started on behavioral health medications more quickly than before. Below are volumes for the Urgent Medication Clinic: • FY24: 194 visits • FY25 (YTD through March 18th): 316 visits

Strategy #2: Actions taken, results and location of action

SYSTEM (ALL HOSPITALS)	To expand access to depression and suicidality treatment, LPCH has launched several programs throughout FY24 and FY25. These include:
	• Developed a Spravato Clinic which provides treatment for community members suffering treatment resistant depression
	  • FY24: 55 Spravato Clinic treatments
	  • FY25 (YTD through February): 164 Spravato Clinic treatments
	• Launched the Zero Suicide Initiative, equipping leaders with a specific set of strategies and tools to treat those suffering suicidality. To date, LPCH has trained 64 caregivers across the system on the Zero Suicide Framework.
	• Launched a pilot for JASPR, an electronic system for the management of suicidality, in LPCH's Clinical Assessment Department and SFH-Yale's Emergency Department. Will be rolled out system-wide in FY26.
	• Training all LPCH clinical staff in the Collaborative Assessment for Managing Suicidality (CAMS) model, an evidence-based approach for assessing and treating individuals suffering from serious thoughts of self-harm.
	• Launching the Jean Marie Warren Center of Excellence for the Treatment of Depression and Suicidality in June 2025. Throughout this cycle, conducted all the analysis, planning and development for the COE.

	In FY25, completed the analysis, planning and began development of a behavioral health urgent care. To launch in FY26, this urgent care will provide treatment and care specialized to treat community members with behavioral health needs.
	To reduce readmissions of inpatient psychiatric patients and better understand why patients are readmitted, LPCH kicked off an initiative to better understand why patients are readmitted. Initial findings suggest a need to enhance discharge planning, ensure compliance with medication and help remove social barriers that exist today. FY25 results pending.
	To expand access to virtual behavioral health services, LPCH has been placing a special focus on growing our virtual behavioral health provider network. Throughout FY25, LPCH has added two virtual medicine providers and four virtual therapy providers, with an additional provider starting by the end of FY25. FY25 results are pending.
SAINT FRANCIS HOSPITAL VINITA	In FY25, SFH-V expanded access to psychiatric services in Vinita by offering an outpatient behavioral health clinic with virtual capabilities. • FY25 (YTD through February): 81 visits
	In Craig County, strengthened collaboration with GRAND Mental Health to ensure adequate pathways for follow up care for patients that have had an inpatient psychiatric stay at SFH-Vinita.

Strategy #2: Actions taken, results and location of action

SAINT FRANCIS HOSPITAL MUSKOGEE	In Muskogee County, strengthened collaboration with Green Country Behavioral health to ensure adequate pathways for follow up care for patients that have had an inpatient psychiatric stay at SFH-M.

STRATEGY #3: Integration of Behavioral Health with Primary Care and Emergency Services

Anticipated impact: Expand behavioral health resources to improve outcomes, reduce emergency and inpatient care use, and increase access to care.

Key collaborators: Warren Clinic, Oklahoma State Department of Mental Health

Planned actions:

- Consolidated clinical direction of SFHS behavioral health resources under Laureate Psychiatric Clinic and Hospital.
- Develop behavioral health service line with a programmatic approach to care delivery and access.
- Explore the feasibility of monitoring or refining the existing social worker model and consider expansion of the “embedded” model in other primary care practices.
- Explore Laureate on-site behavioral health coverage at SFHS emergency room/trauma centers and urgent care facilities.
- Explore the possibility of a pain rehabilitation program at Laureate. (Note: after further exploration, we decided not to move forward with this action. Instead we focused our efforts on creating greater impact on treating depression and suicidality.)

Measures to evaluate impact:

- Continued participation in the peds behavioral health coalition task force for care coordination.
- Continue evaluating clinical and quality metrics, such as readmission rates, to improve patient outcomes.
- Updated or validated SW model to expand behavioral health resources into new primary care practices.
- Expand primary care integration by measuring the # behavioral health patients managed within WC primary care practices.

Strategy #3: Actions taken, results and location of action

SYSTEM (ALL HOSPITALS)	To drive consistency, standardization and collaboration in behavioral health activities, SFHS developed the Laureate Behavioral Health Service Line, which acts as a forum to inform and oversee the strategic direction of behavioral health services across SFHS.
	SFHS created a senior behavioral health consortium that brings together behavioral health leaders across the system to identify barriers, problem solve and standardize protocols, policies and procedures across all senior behavioral health units.
	In FY23, SFHS embedded a Social Worker into one of our primary care practices to expand access to behavioral health resources. By providing integrated social work therapy visits, we have been able to expand quick access to behavioral health resources for some of our most vulnerable community members. • FY23: 1,182 therapy visits • FY24: 1,232 therapy visits • FY25 (YTD through March 18th): 729 therapy visits
	In FY24, SFHS launched inpatient and emergency department psychiatric consult capabilities across the health system. This enables SFHS to provide LPCH expert-level care to all patients regardless of where they are in the system. • FY24: 3,615 consults • FY25 (YTD through February): 2,811 consults
	In FY24, SFHS submitted a letter of support to Oklahoma State Department of Mental Health committing to an integrated, collaborative care model. The state received grant funding to support the larger effort and awarded SFHS a portion of these funds to cover the collaborative care start-up costs, with the initial phase starting in high-need communities in FY26.
	In FY25, SFHS was awarded a $4.5M, five-year grant to support the development and launch of a collaborative care model. SFHS completed the comprehensive analyses and has planned to launch this collaborative care model in FY26. This process connects primary care providers, behavioral health care managers and psychiatric consultants and provides a system and process to support the management of mild to moderate depression in the primary care physicians' offices. SFHS will begin launch of this care model at three of the highest need community primary care locations.
	In FY25, SFHS developed a care pathways program to provide primary care physicians with access to LPCH psychiatrists to receive assistance with psychiatric consults. By creating these connection points, Warren Clinic primary care physicians can quickly get access to treatment recommendations for their patients. FY25 results pending.
	As stated above, in FY25 SFHS completed the analysis, planning and began development of a behavioral health specific urgent care. Set to launch in FY26, this urgent care will provide treatment and care specialized to community members with behavioral health needs.

PRIORITY HEALTH NEED #3: CHRONIC DISEASE MANAGEMENT (HEART DISEASE, CANCER AND STROKE)

Goal: Develop services and expand access to improve chronic disease management, including an evidence-based oncology care model to improve cancer outcomes.

Background and rationale: 2022 CHNA areas of opportunity considered criteria including: standing to benchmark, magnitude, prevalence, and overall impact of issue. Key community indicators related to chronic disease as a health issue:

- Cancer incidence rates in Tulsa, Craig, and Muskogee Counties are 472.7, 462.4 and 473.5, respectively compared to 448.6 nationally.
- 6.2%, 14.3% and 11.7% of the population in Tulsa, Craig, and Muskogee Counties respectively have heart disease compared to 6.1% nationally.
- 44.3%, 51% and 56.5% of the population in Tulsa, Craig and Muskogee Counties respectively have high blood pressure compared to 36.9% nationally.
- Additionally, key informants (community stakeholders) were asked about their beliefs on the relative position of various health topics as problems in the community. Below are the percent of respondents that said the health topic was either a major or moderate problem in our communities:
    - Diabetes: 87.7%
    - Heart Disease and Stroke: 85.5%
    - Cancer: 85%

Note: Upon implementation we recognized that strategies one and two had many similar actions. As such, we condensed these workstreams to achieve synergies and have a greater impact.

STRATEGY #1: Service Development for Chronic Disease Management

Anticipated impact: Increase access to high-quality disease prevention and management for heart disease, cancer, and stroke.

Key collaborators: Warren Clinic, Inc.; community health providers; community-based and faith-based organizations; schools; health fairs such as the City of Tulsa Health Fair; national nonprofit organizations targeting chronic diseases, such as the American Diabetes Association and American Heart Association

Planned actions:

- Develop outreach programs for service lines that contribute significantly to chronic disease management, such as cardiology, neurology, and oncology.

Measures to evaluate impact:

- Number of new outreach programs and new sites of care developed
- Number of partnerships and collaborations addressing non-clinical SDOHs affecting chronic disease
- Strengthened provider network and alignment with community primary care providers

Strategy #1: Actions taken, results and location of action

SFHS - ALL HOSPITALS

To increase access to Cardiology services, SFHS began doing Cardiology outreach clinics in underserved communities in areas surrounding the Tulsa Metro and across Eastern Oklahoma.

To improve the experience for community members being treated for cancer, SFHS has made a number of enhancements to the nurse navigator program to increase capacity. As a result, SFHS has been able to increase the number of patients navigated through the program. Below highlights the average number of patients under oncology nurse navigation per month:

- FY23: 570 patients navigated per month
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- 32.8% increase in average number of patients navigated per month from FY23 to FY24 and 35.3% increase from FY24 to FY25 YTD.

In FY25, SFHS utilized process improvement methodologies to improve the timeliness from lung cancer diagnosis to first treatment for community members. Through this improvement project, SFHS was able to improve time from diagnosis to first treatment by 26.8%.

Over the past few years, SFHS has placed a special focus on increasing the number of lung cancer screenings as a method to improve community health. Since FY22, SFHS has seen a 55.6% increase in the number of lung cancer screenings.

In FY25, SFHS implemented Optellum AI, an AI software that aids in the identification of incidental pulmonary nodules in CT chest scans being performed. Leveraging this software, SFHS has been able to shift the stage at which lung cancer is diagnosed:

	Stage I	Stage II	Stage III	Stage IV
2022	28%	17%	22%	33%
2023	56%	16%	8%	20%
2024	58%	8%	17%	17%

Additionally, in the first half of FY25, SFHS has:

- Identified 1,308 incidental lung nodules
- 748 of the 1,308 have been “dismissed” as not needing additional follow-up at this time
- 27 have had additional imaging recommended
- 21 have been presented at the multidisciplinary chest conference with 17 of these being risk stratified utilizing the Optellum AI software and all recommended for biopsy. Thus far, 12 out of 17 have been biopsied with 9 out of 12 (75%) proving to be lung cancer.

Strategy #1: Actions taken, results and location of action

SFHS - ALL HOSPITALS	In FY23 and FY24 SFHS increased investment in resources and community education and awareness of local services such as outpatient infusion, chemotherapy, radiation oncology, cancer screening and navigation to improve rural/local access to specialized imaging and diagnostics.
	In FY23, SFHS began piloting a Lifestyle Medicine program, which is a program that addresses root causes of chronic diseases through evidence-based lifestyle interventions, including nutrition, physical activity, stress management, substance use and social connection. By empowering patients, the program enhances quality of life, promotes long-term wellness and lowers healthcare costs. Initially, SFHS successfully completed three employee only cohorts and then expanded the program to the public in FY24. Since then, SFHS has successfully graduated four additional cohorts and are actively hosting sessions for two additional cohorts. Each cohort size is approximately 10-12 patients and the program lasts eight weeks.
	In FY25, to improve access to health data, SFHS will be implementing a variety of improvements including: • Conducted planning and analysis work to implement Compass Rose, Healthy Planet and HEDIS modules, which will support SFHS Population Health programs by improving functionality to better support community members with chronic diseases. These modules will improve support during transitions of care and track care gaps and quality scores to improve health outcomes for those with chronic diseases. • Implementing an enterprise data warehouse and analytics capabilities starting with development of a data governance function and structure. • To be able to aggregate internal and external health data and leverage for insights for improved care management, we will be bringing MSSP and Community Care data into our data warehouse.
SAINT FRANCIS HOSPITAL MUSKOGEE	To increase access to specialty services in underserved parts of Oklahoma, SFHS began doing outreach to rural communities. SFHS physicians from Tulsa will spend anywhere from two days a week to one day a month at rural locations, creating new access to specialty services including gastroenterology, cardiology, orthopedics, allergy, OB/GYN, and endocrinology services. This access program also includes virtual services to increase the continuity of care provided.
	In FY23, SFH-M achieved primary stroke center designation. This designation indicates that SFH-M provides the critical elements to achieve long-term success in improving outcomes for stroke patients.

Strategy #1: Actions taken, results and location of action

SAINT FRANCIS HOSPITAL MUSKOGEE	In FY24, SFH-M implemented Teladoc to expand and enhance access to neurology services in Muskogee. Since implementation, SFH-M has completed 369 virtual tele-neurology consults.
	In FY25, SFH-M to further develop heart and vascular services in Muskogee County, a new head of cardiology was hired at SFH-M. In collaboration with the team at SFH-Y, policies, procedures and protocols have been standardized. Additionally, SFH-M has expanded venous thromboembolism (VTE) and interventional cardiology services to improve the quality of care provided and allow patients to receive these treatments closer to home. FY25 results pending.
	In FY25, SFH-M launched a Transitional Care Clinic, which is a clinic that aims to provide transitional care management visits for patients within seven to 14 days post-discharge from the hospital. Particularly focused on uninsured and Medicare/Medicaid patients, this clinic's primary focus is on reducing readmissions among these high-risk patients by providing them with access to timely primary care appointments. FY25 results pending.
	Consolidated breast imaging services under one leadership team which has resulted in improved access to breast imaging services in Muskogee due to enhanced and optimized scheduling practices. Since FY23, SFH-M has seen a 15.4% increase in breast cancer screenings.
	Annually, SFH-M participates in the "Pink Party" in Muskogee which celebrates breast cancer survivors and promotes and educates community members on the importance of early detection.
SAINT FRANCIS HOSPITAL SOUTH	In FY24, SFH-S achieved primary stroke center designation. This designation indicates that SFH-S provides the critical elements to achieve long-term success in improving outcomes for stroke patients. Additionally, in FY25, Saint Francis Glenpool, a subsidiary of SFH-S, received the DNV Acute Stroke Ready certification which allows smaller and rural hospitals to demonstrate excellence by complying with standards of care for the initial treatment of stroke patients, when rapid action and proper medications can save lives and limit the long-term disabling effects of strokes.
	In FY24, SFH-S leveraged Teladoc to expand and enhance access to neurology services in South Tulsa. Since implementation, SFH-S has completed 379 virtual tele-neurology consults.

Strategy #1: Actions taken, results and location of action

SAINT FRANCIS HOSPITAL VINITA	In FY25, SFH-V received the DNV Acute Stroke Ready certification which allows smaller and rural hospitals to demonstrate excellence by complying with standards of care for the initial treatment of stroke patients, when rapid action and proper medications can save lives and limit the long-term disabling effects of strokes.
	Throughout FY25, SFH-V leveraged Teladoc to expand access to Neurology and Cardiology services in Vinita. This allows SFHS to extend specialty services to a geography that severely lacks access to high-quality, specialty care. FY25 results are pending.
SAINT FRANCIS HOSPITAL YALE	In FY25, SFH-Y expanded onsite Neurology/Vascular Neurology to standardize stroke alerts consults, improving intervention times and enhancing the experience for the community.
	To enhance access to heart and vascular services in our communities, throughout FY24 and FY25, SFH-Y launched a variety of programs including: • Left Ventricular Assistance Device (LVAD; “mechanical heart”) program and completed first two surgeries. • Expanded ECMO program and have completed 60 cannulations to date. • Venous Thromboembolism (VTE) program to improve retrieval of blood clots. FY25 results pending. • Advanced Heart Failure Clinic and implemented a variety of technologies to improve the quality and access to care for heart failure patients. These technologies include exercise right heart cath , metabolic cart , CardioMeMs , Barostim , Remede and Cardiac Contractility modulation. SFH-Y also invested in advanced cardiac imaging technology to provide access to noninvasive cardiac imaging through a cardiac MRI and CT testing. FY25 results pending.

Strategy #1: Actions taken, results and location of action

SAINT FRANCIS HOSPITAL YALE

Throughout FY24 and FY25, SFH-Y have focused on increasing access to neurology care, including stroke. By onboarding seven new providers, SFH-Y has been able to grow the physician panel and improve access to care across the community. This has enabled SFHS to increase inpatient consult services by 200% and acute stroke treatment with thrombolytic by 56%. SFHS has been able to significantly grow volumes across the system as outlined below:

- **Outpatient Neurology:**
  - FY24: 522 new patient visits
  - FY25 (YTD through January): 1,184 new patient visits
- **Neuro Interventional:**
  - FY24: 308 new patient visits
  - FY25 (YTD through January): 265 new patient visits
- **Neurosurgery:**
  - FY24: 2,652 new patient visits
  - FY25 (YTD through January): 1,783 new patient visits

STRATEGY #2: Access to Chronic Disease Management Resources

Anticipated impact: Improve access to key specialists in underserved communities to improve the treatment of chronic diseases.

Key collaborators: Warren Clinic, Inc.

Planned actions:

- Expand access and meet the growing demand in underserved communities for service line coverage that contribute significantly to chronic disease management.

Measures to evaluate impact:

- Gap analysis completed to identify underserved communities for service line coverage (related to chronic disease)
- Expanded provider coverage and access in underserved communities
- Number of new screenings and ed classes offered

Strategy #2: Actions taken, results and location of action

SFHS - ALL HOSPITALS

To increase access to Cardiology services, SFHS began doing Cardiology outreach clinics in underserved communities in areas surrounding the Tulsa Metro and across Eastern Oklahoma.

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Strategy #2: Actions taken, results and location of action

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STRATEGY #3: Enhanced Oncology Care Model (EOCM)

Anticipated impact: Improved access to high-quality, coordinated cancer care.

Key collaborators: Warren Clinic, Inc., Aligned academic institutions

Planned actions:

- Identify opportunities to expand access to the oncology care service line.
- Develop new access points for cancer screening and patient education.
- Link Muskogee and Tulsa oncologists through service line rollout and develop comprehensive strategic plan.

Measures to evaluate impact:

- Appropriate performance metrics established for reporting by CMS
- Identify areas with limited access to cancer care.
- # cancer screenings
- # clinical trials offered

Strategy #3: Actions taken, results and location of action

SFHS - ALL HOSPITALS	In FY24, SFHS submitted the application to join CMS's Enhanced Oncology Care Model. While SFHS was accepted into the program, due to changes in strategic direction of the organization it was decided not to pursue the program for this cycle. In FY25, SFHS resubmitted an application to join the second iteration of the CMS Enhanced Oncology Model program. SFHS has been accepted into the program and is considering joining this program in FY26.
	To improve the experience for community members being treated for cancer, SFHS has made a number of enhancements to the nurse navigator program to increase capacity. As a result, SFHS has been able to increase the number of patients navigated through the program. Below highlights the average number of patients under oncology nurse navigation per month: • FY23: 570 patients navigated per month • FY24: 757 patients navigated per month • FY25 (YTD through December): 1,024 patients navigated per month • 32.8% increase in average number of patients navigated per month from FY23 to FY24 and 35.3% increase from FY24 to FY25 YTD.
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SFHS - ALL HOSPITALS

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In FY25, launched the Oncology Service Line Council, which is a multi-disciplinary group of physician and business leaders that oversee and inform the direction of oncology services across the health system. The group will be focused on standardizing oncology care across the system and developing strategies that ultimately improve access, experience and quality of oncology services in our communities.

In FY25, SFHS hosted a Medical Town Hall where a Warren Clinic Pulmonologist educated community members on pulmonary health, lung cancer, the importance of screenings, and more. 155 community members attended this free educational event.

Annually, SFHS hosts a table at the Senior Lifestyle and Wellness Expo in Tulsa, providing free community education and awareness on the various types of cancer and the importance of cancer screenings.

In FY23, SFHS began doing free skin cancer screenings for the community at the Health Zone fitness center. To date we have completed 410 free skin cancer screenings for the community.

SAINT FRANCIS HOSPITAL MUSKOGEE	
	Consolidated breast imaging services under one leadership team which has resulted in improved access to breast imaging services in Muskogee due to enhanced and optimized scheduling practices. Since FY23, SFH-M has seen a 15.4% increase in breast cancer screenings.
	Annually, SFH-M participates in the “Women Who Care” which supports and promotes breast cancer awareness and services for Muskogee area women.

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Appendices

APPENDIX A JOINT ASSESSMENT COLLABORATORS

Collaborators
The 2025 Community Health Needs Assessment for Craig County was conducted in partnership with the University of Oklahoma's Hudson College of Public Health, located in Oklahoma City.

Saint Francis Health System
Saint Francis Health System is a Catholic, not-for-profit organization headquartered in Tulsa, Oklahoma. Its mission is to extend the presence and healing ministry of Christ to all who seek its services. The health system includes Saint Francis Hospital, a 1,112-bed tertiary care center that features the region's only children's hospital, a Level IV neonatal intensive care unit, a dedicated heart hospital, and Tulsa's leading trauma and emergency center. With more than 11,000 employees, 1,000 physicians, and 700 volunteers, St. Francis is the largest private employer in Tulsa County. Through its network of over 110 Warren Clinic locations, St. Francis employs more than 600 providers, offering comprehensive healthcare services to communities throughout eastern Oklahoma.

Oklahoma State Department of Health District 4 Team
The Oklahoma State Department of Health District 4 Team is responsible for overseeing public health initiatives and services in several counties within Oklahoma. This team focuses on various health programs, including immunizations, family planning, maternity education, adolescent health clinics, and environmental health. They work to ensure the well-being of residents through preventive care, health education, and community outreach efforts. They serve the counties of Craig, Delaware, Mayes, Nowata, Ottawa, Rogers, Wagoner and Washington, and their mission is to protect and promote health, to prevent disease and injury and to cultivate conditions by which Oklahomans can thrive. Their vision is "leading Oklahoma to prosperity through health", and their core values are service, collaboration, respect and accountability.

OU Hudson College of Public Health (Brief Description of Consultant)
The Hudson College of Public Health works collaboratively with community organizations, tribal communities, nonprofits, and health departments to advance public health outcomes across Oklahoma. These efforts encompass a wide range of initiatives, including conducting Community Health Needs Assessments for health systems and organizations statewide, fostering community partnerships, and driving innovative research to address critical health challenges.

APPENDIX B CRAIG COUNTY RESOURCES

Craig County Chamber of Commerce
128 S Wilson, Vinita, OK 74301
918-256-7133

Craig County Community Action
918-253-4683 ext. 110
Programs include emergency rent & utility assistance, home weatherization, home rehabilitation, home and utility deposits. Call Jay Community Action in Jay for more information (918-253-4683 ext. 110)

OKDHS
Child Welfare, Food Stamps, Energy Assistance, Adult Protective Services, Medicare
OKDHS Live Customer Service Center
1-877-751-2972
Abuse Hotline
800-522-3511 or online at OKHotline.org

Neighbors Helping Neighbors/Salvation Army
224 W Sequoyah, Vinita OK 74301
918-713-8088 or 918-256-2037
Open Monday, Wednesday, Friday lOam-2pm
Free “closet” for clothes and household items. Will sometimes help with utility bills.

Grand Lake Community Ministry AKA “The Blue House”
268 W Broadway, Langley, OK
918-782-2861
Free “closet” for clothes and household items

Salvation Army
222 W Sequoyah
Vinita, OK - 74301
Phone: (918) 256-2037
Must bring ID
Pantry hours: Monday, Wednesday, and Friday 10 am- 2 pm

First United Methodist Church of Vinita
314 West Canadian
Vinita, OK - 74301
Phone: (918) 256-5727
918-256-5727
Appointment is not needed, walk in. Requirements: Identify yourself and your household members and receive free food with a smile. Food Pantry Distribution Hours: Thursdays 10:00 am - 12:00 pm and 6:00 pm - 7:00 pm

Blue House - Grand Lake Community Ministry
268 West Broadway
Langley, OK - 74350
Phone: (918) 782-6603

Domestic Violence- Community Crisis Center
Women's Advocate and Resource Center- OFFICE ONLY, NO SHELTER— SHELTER IN MIAMI
418 E Illinois Ave Unit C, Vinita OK 74301
918-256-1945 or 24- hr Crisis Line 800-400-0883
Also SafeNet in Pryor and Claremore (see tab)

DOCSenior Services
205 "B" NE, Miami, OK 74354 (serves Ottawa, Craig, Delaware)
918-257-4825
Housekeeping, chore services, congregate meals, home delivered meals, transportation, health promotion and medication management. Provides emotional support and Information & Assistance for needed services.

SoonerRide
877-404-4500 to make reservation

Grand Mental Health
405 E Excelsior Vinita, OK 74301
918-256-6476
After Hours Crisis Line 800-722-3611

Vinita Day Center
131 S Wilson Vinita, OK 74301
918-256-6846
Provides socialization. Open Friday and Saturday from 9am-3pm. Open any day Grand Mental Health is closed. Also provides warm/cool place to sit during day and provides meals.

APPENDIX C COMMUNITY ENGAGEMENT MEETINGS

In collaboration with the OU Hudson College of Public Health, The Grand Nation inc, a local community coalition, Saint Francis hosted three community engagement meetings in Craig County to further understand local needs. These meetings invited leaders from various community organizations, residents, and representatives from vulnerable populations to participate in a dialogue about the challenges they observe within the county.

The engagement meetings provided an opportunity for the community to come together and offer input on the pressing needs and issues faced in Craig County. Participants were guided through a SDoH root cause activity. Once completed as a larger group, individual attendees were asked to select the priority area they deemed most important for Craig County, describe how this area represents a critical need, and provide examples from their own communities.

The qualitative feedback gathered from these meetings were transcribed, and key themes and priorities were identified using the Framework method[5]. This systematic approach for managing and analyzing qualitative data consists of five key stages: familiarization, identifying a thematic framework, indexing, charting, mapping and interpretation. Relevant quotes were also summarized to capture attendees' perspectives on each priority area. The findings are presented and further detailed in the table below.

Key Summary Points

Concerns about affordable and safe housing dominate discussions in Craig County, with issues ranging from poorly maintained neighborhoods to exorbitant housing costs for safer areas. Violence and crime, often tied to substance abuse, present significant challenges for community safety. Transportation remains a persistent issue, as residents struggle with limited and unaffordable options that impede access to healthcare and daily needs. The county also faces healthcare access issues, particularly for Medicare patients and urgent care services, alongside recurring food insecurity and limited availability of nutritious food options.

POPULATIONS/ORGANIZATIONS REPRESENTED	COMMON THEMES
• Saint Francis Health System • OK State Dept. Of Health • Healthcare Service Consultant • Grand Nation Community Coalition Leader	1. Housing: Lack of affordable and safe housing options. 2. Transportation: Limited and unreliable public transportation services. 3. Healthcare Access: Shortage of providers and accessibility issues. 4. Nutrition/Food Access: Need for better food resources and education. 5. Violence/Crime: Issues tied to drugs and poverty.

MEANINGFUL QUOTES

- *"Neighborhoods with affordable homes are run down with a history of crime and drugs."*
- *"There are certain crimes of violence that can be directly tied to drugs/alcohol in communities."*
- *"Transportation services do not cross county lines, making it difficult for people to access care."*
- *"We lost a large primary care office after COVID many of their patients had Medicare."*

APPENDIX D 2025 COMMUNITY HEALTH NEEDS ASSESSMENT SURVEY

2025 Community Health Needs Assessment Survey

Thank you for participating in your community's health needs assessment (CHNA).

This is an anonymous, comprehensive survey done every three years to better understand the health assets, needs, and priorities in your community. Your response will serve as a critical tool in shaping future services, projects, and programs and understanding what resources should be sought to improve health outcomes for everyone across the community.

A digital version of this survey is available in Spanish, Burmese, or English and can be accessed using the QR code. This survey should take about 10 minutes to complete and will close November 3rd. After you complete the survey, you will also have the opportunity to enter a raffle to win a $100 gift card.

Link: **https://ousurvey.qualtrics.com/jfe/form/SV_0lF0D7Q7nZLVs90.≤**

Date: _____

1. Please enter your survey ID number (Skip if not applicable): _____
2. **What County do you live in?**
    a. Craig
    b. Creek
    c. Muskogee
    d. Nowata
    e. Tulsa
    f. Washington
    g. Don’t know / Not sure
3. **What is the ZIP code of where you live?:** _____

4. **In the past year, have you or any family members you live with been unable to get any of the following when it was really needed? Select all that apply.**

Yes	No	Employment
Yes	No	Food
Yes	No	Housing (e.g., rent, utilities, mortgage)
Yes	No	Transportation
Yes	No	Any Health Care (e.g., medical, vision, prescription medications)
Yes	No	Mental Health Services
Yes	No	Phone
Yes	No	Internet
Yes	No	Childcare or Early Childhood Education Services

5. **What is the highest level of school or degree you have completed?**
    a. No schooling completed
    b. Some primary school (1st – 8th grade)
    c. Some high school, no diploma
    d. High school graduate or equivalent (e.g., GED)
    e. Some college, no degree
    f. Associate's degree (this includes vocational or trade school)
    g. Bachelor's degree
    h. Master's degree
    i. Professional school degree (e.g., law or medical degree)
    j. Doctorate degree

6. **What is your current work situation? (Bureau of Labor Statistics)**
    a. Not working for pay but actively looking for paid work
    b. Not working for pay and not looking for paid work
    c. Working for pay: Part-time or seasonal work (less than 35 hours a week)
    d. Working for pay: Full-time work (35 or more hours a week)
    a. Other

7. **How hard is it for you to pay for the very basics like food, housing, clothing, medical care, and utilities?**
    a. Very hard
    b. Somewhat hard
    c. Not hard at all

8. **In the past year, which of the following barriers have you personally experienced when trying to get employment? Select all that apply.**
    - ❑ Lack of necessary skills or qualifications
    - ❑ Limited work experience
    - ❑ Lack of required education
    - ❑ Transportation issues
    - ❑ Childcare responsibilities
    - ❑ Adult dependent care responsibilities
    - ❑ Health issues or disability
    - ❑ Age discrimination
    - ❑ Gender or sexual orientation discrimination
    - ❑ Racial or ethnic discrimination
    - ❑ Language barriers
    - ❑ Criminal record
    - ❑ Lack of job opportunities in your area
    - ❑ Lack of access to job search resources
    - ❑ Economic conditions
    - ❑ Employer preferences for certain types of candidates
    - ❑ Personal motivation or confidence issues
    - ❑ Other

9. **Within the past 12 months the food I/we bought just didn't last and I/we didn't have the money to get more.**
    a. Often True
    b. Sometimes True
    c. Never True

10. **Within the past 12 months I/we were worried whether our food would run out before I/we got money to buy more.**
    a. Yes
    b. No
    c. Don't know/Not Sure

11. What are the main reasons you have difficulty getting or eating nutritious foods? Select all that apply.

- ❑ Cost: Nutritious foods are too expensive
- ❑ Availability: Nutritious foods are not available in my local stores
- ❑ Transportation: I do not have reliable transportation to get to stores that sell nutritious foods
- ❑ Time: I do not have enough time to prepare or shop for nutritious foods
- ❑ Knowledge: I do not know how to prepare nutritious meals
- ❑ Physical Ability: I have physical limitations that make it difficult to shop for or prepare nutritious foods
- ❑ Other

12. Which of the following improvements would most encourage you to increase your physical activity? Select all that apply.

- ❑ Improved access to exercise facilities (e.g., gyms, parks)
- ❑ Better transportation options to reach exercise locations
- ❑ Increased availability of exercise programs or fitness classes
- ❑ More flexible scheduling options for workouts
- ❑ Financial incentives or subsidies for exercise-related expenses
- ❑ Increased social support (e.g., workout groups, community activities)
- ❑ Enhanced safety and security in exercise environments
- ❑ Better information and resources on effective exercise
- ❑ Personalized exercise plans or coaching
- ❑ Other

13. What is your housing situation today?

a. Own
b. Rent
c. Staying with friends or family
d. Hotel / motel
e. Long-term care / skilled nursing
f. Group home
g. Halfway house
h. I do not have shelter right now (unhoused)
i. Other

14. Are you worried about losing your housing?

a. Very worried
b. Somewhat worried
c. Slightly worried
d. Not at all worried

15. Do you feel physically and emotionally safe where you currently live?

a. Yes
b. No
c. Unsure

16. In the past 12 months, have you experienced any of the following problems with your housing? Select all that apply or skip if none.

- ❑ Structural maintenance issues (e.g., plumbing or flooring problems)
- ❑ Neighborhood safety issues
- ❑ Rent or mortgage too expensive
- ❑ Utility bills are too expensive (e.g., water, electricity, or heating/cooling)
- ❑ Unhealthy housing (e.g., pest problems, lead, asbestos, mold or poor air quality)
- ❑ Unsafe relationships in the home
- ❑ Too many people in the household (overcrowding)

17. What are the main barriers you face in getting childcare or early childhood education services? Select all that apply.

- ❑ Cost
- ❑ Location
- ❑ No openings for my child
- ❑ Hours of operation
- ❑ Quality of care
- ❑ Special needs care
- ❑ None
- ❑ Finding somewhere that accepts childcare subsidy
- ❑ Other

18. What is your primary mode of transportation?

a. Private car
b. Public transit (e.g., bus)
c. Walking
d. Biking
e. Carpooling
f. Ride-sharing (e.g., friends, family, Uber, or Lyft)
g. Other

19. In the past 12 months, has unreliable transportation or lack of transportation kept you from any of the following? Select all that apply.

- ❑ Medical appointments
- ❑ Non-medical appointments
- ❑ Work
- ❑ Accessing things needed for daily living (e.g., grocery, shopping)
- ❑ Other
- ❑ No

20. In the past 12 months, have you experienced any of the following problems with your transportation? Select all that apply.

- ❑ High cost of transportation (e.g., car payment, gas, insurance)
- ❑ Unavailable transportation
- ❑ Unreliable transportation
- ❑ Safety concerns
- ❑ Physical limitations

21. Where do you get trusted information about health for yourself and/or your family? Select all that apply.

- ❑ Doctor or other healthcare provider
- ❑ Health care system (either in person or calling the nurse line)
- ❑ Handouts/ Pamphlets
- ❑ Internet
- ❑ Books/ Magazine
- ❑ Friends
- ❑ Family
- ❑ Church
- ❑ Social Media
- ❑ News
- ❑ Other

22. What is your main source of health insurance or healthcare coverage?

a. Employer based insurance
b. Medicare
c. Medicaid or other state program (e.g., CHIP or SoonerCare, SoonerSelect, and Oklahoma Insure)
d. Tricare or other military health care (e.g., VA)
e. None/ Uninsured – Using a Tribal Clinic or Hospital
f. None/ Uninsured – Using Other Tribal Health Services, including IHS
g. Private insurance purchased directly from an insurance company
h. No health insurance
i. Other

23. What is your main reason for NOT having insurance?

a. Coverage is too expensive
b. Lost job or changed employers
c. Lost Medicaid or became ineligible (e.g., due to age, increase in income)
d. Employer doesn't offer insurance
e. Don't need insurance
f. Insurance company refused coverage
g. I do not know how to get it
h. Other

24. In the past 12 months, have you had problems getting healthcare services due to any of the following? Select all that apply.

❑ Not knowing when I need to see a doctor
❑ Unable to get an appointment at a time that works for me
❑ No health insurance
❑ Not having transportation to my appointment
❑ Unable to get an appointment close to home
❑ Not having access to telehealth services (e.g., no internet)
❑ Not having enough time with my doctor
❑ Not understanding what or who my insurance covers
❑ Worrying about medical bills from my visit
❑ Not having a healthcare team that speaks my primary language
❑ Fear of discrimination or bias by people at the hospital or doctor’s office
❑ Not understanding doctor's recommendations/orders
❑ Unable to get prescriptions filled
❑ Unable to access medical assistive devices (e.g., hearing aids)
❑ Not maintaining doctor's recommendations at home
❑ Immigration status concerns
❑ None
❑ Other

25. Do you have at least one person you think of as your personal doctor or health care provider?

a. Yes
b. No
c. Not sure

26. Where do you most frequently go to receive healthcare services? Select all that apply.

- ❑ University Clinic
- ❑ Federally Qualified Health Center (e.g., Morton or Community Health Connection)
- ❑ VA Clinic
- ❑ American Indian/ Tribal Health Clinic
- ❑ Health Department
- ❑ Emergency Room
- ❑ Urgent Care Center
- ❑ Doctor's Office
- ❑ Free Clinic
- ❑ I don't have a place
- ❑ Other

27. Have you ever used drugs (narcotic or illegal) other than tobacco or alcohol?

a. Never
a. Once a month or less
b. 2-4 times a month
c. 2-3 times a week
d. 4 or more times a week

28. Which of the following would improve your access to mental/ behavioral healthcare services? Select all that apply.

- ❑ Affordable services
- ❑ Providers in my area
- ❑ Shorter wait times for appointments
- ❑ Expanded insurance coverage
- ❑ Transportation options to reach services
- ❑ Culturally sensitive care
- ❑ Availability of telehealth options
- ❑ Flexible appointment times (e.g., evenings or weekends)
- ❑ Increased awareness of available services
- ❑ Other

29. How would you describe your health in general?

a. Excellent (Extremely Healthy)
b. Very Good (Very Healthy)
c. Good (Healthy)
d. Fair (Somewhat Unhealthy)
e. Poor (Very Unhealthy)

30. How often do you see or talk to people that you care about and feel close to? (For example: talking to friends on the phone, visiting friends or family, going to church or club meetings)

a. I do not have anyone that I feel close to
b. Less than once a week
c. 1 or 2 times a week
d. 3 to 5 times a week
e. 6 or more times a week

31. If for any reason you need help with activities of daily living such as bathing, preparing meals, shopping, managing finances, etc., do you get the help that you need?

a. I don't need any help
b. I get all the help I need
c. I could use a little more help
d. I need a lot more help

32. I feel I am accepted in my community.

a. Strongly Agree
b. Agree
c. Neutral
d. Disagree
e. Strongly disagree

33. What is your age?

a. 18-24 years
b. 25 to 34 years
c. 35 to 44 years
d. 45 to 64 years
e. 65+

34. What was your total household income before taxes in the past 12 months?

a. Less than $10,000
b. $10,000 to $14,999
c. $15,000 to $24,999
d. $25,000 to $34,999
e. $35,000 to $49,999
f. $50,000 to $74,999
g. $75,000 to $99,999
h. $100,000 to $149,999
i. $150,000 to $199,999
j. $200,000 or more

35. How many people does this income support (free response):

a. Adults (18+)_____
b. Children (Under 18):_____

36. What sex were you assigned at birth on your original birth certificate?

a. Male
b. Female

37. Do you currently describe yourself as male, female or transgender? (U.S. Census)

a. Male
b. Female
c. Transgender
d. None of these

38. Are you of Hispanic, Latino, or Spanish origin? (U.S. Census)

a. No, not of Hispanic, Latino or Spanish origin
b. Yes, Mexican, Mexican Am., Chicano
c. Yes, Puerto Rican
d. Yes, Cuban
e. Yes, another Hispanic, Latino or Spanish origin

39. What is your race? Select all that apply.

- ❑ White (e.g., German, Irish, English, Italian, Lebanese, Egyptian, etc.)
- ❑ Black or African American (e.g., African American, Jamaican, Haitian, Nigerian, Ethiopian, Somali, etc.)
- ❑ American Indian or Alaska Native (e.g., Navajo Nation, Blackfeet Tribe, Mayan, Aztec)
- ❑ Asian Indian
- ❑ Chinese
- ❑ Filipino
- ❑ Other Asian (e.g., Pakistani, Cambodian, Hmong, Burmese, etc.)
- ❑ Japanese
- ❑ Korean
- ❑ Vietnamese
- ❑ Native Hawaiian
- ❑ Samoan
- ❑ Chamorro
- ❑ Other Pacific Islander (e.g., Tongan, Fijian, Marshallese, etc.)
- ❑ Some other race

40. How did you hear about this survey?

a. Ascension St. John
b. Saint Francis Health System
c. County Health Department
d. Mail
e. Church
f. Community-based organization or community Meeting
g. Grocery Store / Shopping Mall
h. Newspaper
i. Newsletter
j. Word of Mouth
k. Facebook or Social Media
l. Other

Thank you for completing the 2025 County Health Needs Assessment! You have reached the end of the survey. If you would like to be entered into a drawing to win a $100 Visa gift card, please complete the fields on the next page!

APPENDIX D 2025 COMMUNITY HEALTH NEEDS ASSESSMENT SURVEY

This page is intentionally left blank so that the raffle entry will be separated from the completed survey.

Flip the page to enter the raflle!

APPENDIX D 2025 COMMUNITY HEALTH NEEDS ASSESSMENT SURVEY

Would you like to be entered into a drawing to win a $100 Visa gift card? If you are interested, please enter your phone number or full mailing address so we can contact you if you win. Skip if you do not wish to be entered to win.

- ❑ Yes (County, phone number): _____
- ❑ Yes (mailing address): _____

Thank you for completing the 2025 County Health Needs Assessment! We are grateful for your participation and look forward to using your feedback to guide health improvement efforts in our community.