Community Health Assessment

Oklahoma City and County

2011

Community Health Status Assessment / Wellness Score
Community Themes and Strengths Assessment
Local Public Health System Assessment
Force of Change Assessment
The Oklahoma City-County Health Department (OCCHD), in conjunction with the Oklahoma City-County Board of Health, was the convening body for this project. Many other individuals including community residents, focus group participants, and community-based organizations also contributed to the formation of the Oklahoma County Community Health Assessment.

Each of the individuals and community partners that participated in this process are vital to improving the health of Oklahoma County. The health department is very appreciative of their ongoing commitment and dedication in this initiative.

A special thank you goes to the Oklahoma City-County Health Department’s Epidemiology Services Program Data Analysis Section and the Oklahoma Turning Point Coalition Data Section for their work on the development and preparation of the Oklahoma County Wellness Score, as well as work analyzing data from the other sections of this report.

The information contained in this Oklahoma City and County 2011 Community Health Assessment is being used to advance the work of the OCCHD and Wellness Now Initiative with the goal of improving the health of Oklahoma County.

Sincerely,

Gary Cox, JD
Director
Oklahoma City County Health Department
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INTRODUCTION

Community health assessments are a critical part of public health practice utilized to describe the health of the community by presenting information on health status, community health needs, resources, and epidemiologic analysis of current local health problems. The Community Health Assessment is the basis for all local public health planning, giving the local public health system the opportunity to identify and interact with key community leaders, organizations, and interested residents about health priorities and concerns. It seeks to identify populations that may be at increased risk of poor health outcomes and to gain a better understanding of the fundamental issues affecting the health of its citizens and the community. Ultimately it serves as the guide to intervention strategies that are aligned with the community of interest and its health issues and as an indicator of necessary change in policy.

BACKGROUND

Research indicates achieving long term sustained improvements in health occur when multilevel strategies are initiated to include a combination of medical delivery and built environment interventions. The Oklahoma City-County Health Department utilized the model Mobilizing for Action through Planning and Partnership (MAPP) as a tool to collect data for developing health improving strategies. MAPP consists of four assessment methods in a structured process for gathering and utilizing data for decision making while facilitating the identification and development of community partnerships.
The Four MAPP Assessments

Three of the assessment methods provide a distinct view of factors that influence positively or negatively the health of county residents by gathering data. Input was gathered from community members through focus groups and questionnaires, by engaging the local public health system partners in a self-evaluation process, and finally by statistical analysis of the combined effect of medical and social determinants within each county zip code. Utilizing insight gained from the initial three assessments, workgroups comprised of community members met for several months to develop health promoting policy recommendations. These workgroups are continuing to meet in order to collect baseline data and to set long term goals and objectives. Assessments are described below.

1. COMMUNITY HEALTH STATUS ASSESSMENT was the first method completed. The Oklahoma County Wellness Score, an innovative approach developed by OCCHD, provided an understanding of what, where, and who as related to the health status of Oklahoma County.

2. COMMUNITY THEMES & STRENGTHS ASSESSMENT utilized two methods: Community Forums open to the public as a time for reflecting upon positive and negative issues at the neighborhood level; and Community Survey which was a 10 question look at what affects the quality of life for Oklahoma County residents.

3. LOCAL PUBLIC HEALTH SYSTEM ASSESSMENT was an opportunity for members of the Public Health System of Oklahoma County to evaluate how it delivers services and to identify gaps in that delivery system.

4. FORCES OF CHANGE ASSESSMENT utilized community workgroups to identify strategies for pursuing nongovernmental and legislative policy that will promote health and wellness. This process used methods to identify important factors related to economic and political realities, as well as strengths and weaknesses of importance when selecting options for the best response.
The traditional view of health has focused on measurable increases or decreases in chronic and infectious disease burdens and, of late, access to necessary primary and specialty medical services. However, recent studies have found a growing connection between the health of individuals and the “health” of their community, confirming that community infrastructure plays a significant role in affecting the decisions individuals can or cannot make and its effect on levels of chronic and infectious disease. Additionally, clear linkages are forming between health outcomes and developmental opportunities at the individual and neighborhood level. This interaction has played a significant role in the national health ranking of Oklahoma. Current findings suggest that achieving long term sustained improvements in health occur best when multilevel interventions are initiated, beginning with environmental changes and ending with decision-making and changes at the individual level, not the other way around. The Oklahoma City-County Health Department has developed a method for identifying the overall wellness of residents at the zip code level by integrating traditional medical issues with social determinants. Resulting wellness scores suggest the effect of poor infrastructure on individual health. The OCCHD Wellness Score serves as a tool for guiding potential interventions in the built environment and provides a recommended location to place interventions. Additionally, this tool suggests partners who should collaborate on the development of intervention strategies in multiple community and health related sectors.

The Concept of the Wellness Score is based on the premise that health, particularly when examined at a community level, is influenced by a wide range of factors. To that end, demographic factors (social determinants) were obtained by zip code and through a statistical process were combined with traditional measures of disease. All data elements were either obtained from local partners with access to data representing the categories contained within Wellness Score or from the census. When data was utilized from census data sets, all partners contributing to the development of Wellness Score were consulted to gain agreement as to the appropriate use of that data source. The following are a list of partners who served on the Wellness Score development team.

- Oklahoma State Bureau Investigations
- Oklahoma State Department of Health
- Oklahoma Department of Mental Health & Substance Abuse Services
- Oklahoma Department of Transportation
- Oklahoma Department of Human Services
- Association of Central Oklahoma Governments
- AT&T
- United Way
- Oklahoma City County Health Department
- Oklahoma County Medical Society
- Association of Central Oklahoma Governments
- Oklahoma County Hospitals
  - (Saint Anthony Hospital, OU Medical Center, Integris Baptist & Southwest Medical Centers, Edmond Medical Center, Deaconess Hospital, Mercy Hospital and Midwest City Hospital)
Wellness Score (cont.)

The resulting analysis was stratified into a Wellness Score for each zip code in Oklahoma County. Wellness Scores (negative or positive) provide an understanding of how individual and community factors impact the health of communities and allow intervention strategies to be targeted where the greatest influence will be realized. Targeting intervention strategies through coordinated purposeful efforts is known to result in measureable improvements in individual, community, and geographic health measures.

Health has long been recognized as the result of a combination of the complex interactions between heredity, environment, and behavior, but the degree to which social and medical issues influence wellness has only recently become clear. The potential exists to affect 70% or more of the underlying causes of early death of Oklahoma County residents through the combination of strategies that include individual changes in behavior and lifestyle, changes in community planning and design, and development of policies that promote individual and community health.

The Wellness Score map (above) indicates clusters of dark blue zip codes with the bottom or worst Aggregate Wellness Scores, while yellow is used to indicate the top or best Aggregate Wellness Score. The worst scores are clustered in the zip codes in and around the downtown area and the nearby suburbs that represent the oldest areas of the county in terms of residential and commercial development and age of structures. The best scores are seen in the outlying suburban and rural areas where residential and commercial development is still ongoing and very active.
The above graph displays each category score (listed in the key) as a percentage of the aggregate score, allowing a clearer visualization of the relative contribution that each component makes on the aggregate score for each zip code. Category scores left of zero are considered negative contributions to the zip code aggregate score. Category scores appearing right of zero would be considered positive contributors. The width of each category score either negative or positive indicates its contribution toward the zip code’s aggregate score. When looking for issues in greatest need of intervention, the categories with the longest bars to the left of zero should be targeted, along with the shortest bars to the right. Analysis of the data provided in the graph results in a rapid understanding of the complex interaction between social determinants and traditional medical measures and the systemic outcome of that interaction.
Wellness Score Findings

The Wellness Score combines scores on a variety of demographic, socioeconomic and health influences and outcomes, assigning an aggregate Wellness Score to each of the fifty major zip codes and stratifying them into five quantiles of ten zip codes each. This report analyzes the differences in the average values of the variables in each of the eleven major categories between the top and bottom ranking quantiles.

THE ZIP CODES
The ten zip codes in the top ranking quantile include: 73003, 73013, 73131, 73142, 73150, 73151, 73162, 73169, 73179 & 74857. These are displayed in yellow on the map (Page 7).

The ten zip codes in the bottom ranking zip codes include: 73102, 73104, 73105, 73106, 73108, 73109, 73111, 73117, 73119 & 73129. These are displayed in dark blue on the map (Page 7).

LOCATION
As can be seen on the map (Page 7), the higher scoring zip codes are more widely scattered across the county, but tend to be closer to the borders of the county, in areas that are more suburban and rural. By contrast, the bottom scoring zip codes are tightly grouped in an area that is predominantly urban.

ECONOMIC FACTORS
Median Household Income, 1999 (Census 2000): The zip codes in the top quantile have an average MHI of $55,900, 2.74 times the average MHI of the bottom quantile ($20,370).

Per Capita Income, 1999 (Census 2000): The zip codes in the top quantile have an average PCI of $25,997, 2.28 times the average PCI of the bottom quantile ($11,386).

Percent of Population Living Below Federal Poverty Threshold (Census 2000): In the zip codes of the top quantile, an average of 6.9% of the population lives below the federal poverty threshold, a prevalence only one fifth of that seen in the bottom quantile (33.0%).

HOUSING FACTORS
Percent of Renter-Occupied Units (Census 2000): The zip codes in the top ranking quantile reported that an average of 17.9% of occupied units housed renters (as opposed to home owners), one-third the rental prevalence of the bottom ranking quantile (55.2%).

Percent of Rental Units Where Rent Exceeds 35% of Household Income: Excessive housing costs are one of the factors that can keep a household mired in poverty. In the zip codes of the top ranking quantile, 20.6% of renters paid 35% or more of their income for rent. The proportion was 1.5 times higher in the zip codes of the bottom quantile (31.8%).

Median Home Value: The zip codes in the top ranking quantile have an average median home value of $126,520. This is 2.61 times higher than the median home value of the bottom quantile ($48,530).
EDUCATION FACTORS
Percent of Population 25+ years without High School Diploma or GED: The zip codes in the top quantile reported that an average of 10.7% of individuals 25 or older did not have their high school diploma or GED. The proportion is 3.24 times higher in the zip codes of the bottom quantile (34.5%).

Percent Population 25+ years with College Degree (Associate Degree or Higher): The zip codes in the top quantile reported that an average of 40.9% of individuals 25 or older have a college degree. The proportion is 2.79 times less in the zip codes of the bottom quantile (14.7%).

TRANSPORTATION FACTOR
Percent Households with No Personal Vehicle Available (Census 2000): The zip codes in the top quantile reported that 2.6% of the households had no personal vehicle available. The proportion is 8.35 times more in the zip codes of the bottom quantile (21.7%). There is a 19.1% difference between the top and bottom quantile.

CHRONIC DISEASE FACTORS
Diabetes Mortality: The zip codes in the top quantile (15.99) have a diabetes mortality that is 2.26 times less than the diabetes mortality in the zip codes in the bottom quantile (36.18).

CVD Mortality: The zip codes in the top quantile (128.63) have a CVD mortality that is 2.10 times less than the CVD mortality in the zip codes in the bottom quantile (269.62).

Stroke Mortality: The zip codes in the top quantile (38.46) have a CVD mortality that is 1.93 times less than the CVD mortality in the zip codes in the bottom quantile (74.40).

Hypertension Mortality: The zip codes in the top quantile (4.76) have a hypertension mortality that is 2.78 times less than the hypertension mortality in the zip codes in the bottom quantile (13.22).

Chronic Lower Respiratory Disease Mortality: The zip codes in the top quantile (28.42) have a chronic lower respiratory disease mortality that is 1.92 times less than the chronic lower respiratory disease mortality in the zip codes in the bottom quantile (54.54).

CANCER FACTORS
Percent Diagnosed in Late Stage Colon Cancer 1997-2005: The zip codes in the top quantile reported that an average of 58.6% had been diagnosed in late stage colon cancer. The proportion is 1.09 times more in the zip codes of the bottom quantile (64.1%). There is a 5.5% difference between the top and bottom quantile.

Percent Diagnosed in Late Stage Breast Cancer 1997-2005: The zip codes in the top quantile reported that an average of 32.3% had been diagnosed in late stage colon cancer. The proportion is 1.23 times more in the zip codes of the bottom quantile (39.9%). There is a 7.6% difference between the top and bottom quantile.

All Cancer Incidence per 100,000 Population 1997-2005: The zip codes in the top quantile reported an average incidence of 408.55 for all cancers. The zip codes in the bottom quantile reported an average incidence of 467.50 for all cancers. The zip codes in the bottom quantile are 1.14 times higher in all cancer incidence than the zip codes in the top quantile.
All Cancer Mortality per 100,000 Population 1997-2006: The zip codes in the top quantile reported an average mortality rate of 128.13 for all cancers. The zip codes in the bottom quantile reported an average mortality rate of 209.46 for all cancers. The zip codes in the bottom quantile are 1.63 times higher in all cancer mortality than the zip codes in the top quantile.

Lung Cancer Mortality per 100,000 Population 1997-2006: The zip codes in the top quantile reported an average lung cancer mortality rate of 40.35. The zip codes in the bottom quantile reported an average mortality rate of 65.47 for lung cancer. The zip codes in the bottom quantile are 1.62 times higher in lung cancer mortality than the zip codes in the top quantile.

Breast Cancer Mortality per 100,000 Population 1997-2006: The zip codes in the top quantile reported an average breast cancer mortality rate of 19.92. The zip codes in the bottom quantile reported an average mortality rate of 31.79 for breast cancer. The zip codes in the bottom quantile are 1.60 times higher in breast cancer mortality than the zip codes in the top quantile.

Prostate Cancer Mortality per 100,000 Population 1997-2006: The zip codes in the top quantile reported an average prostate cancer mortality rate of 12.98. The zip codes in the bottom quantile reported an average mortality rate of 25.55 for prostate cancer. The zip codes in the bottom quantile are 1.97 times higher in prostate cancer mortality than the zip codes in the top quantile.

INFECTIOUS DISEASE FACTORS
STD Average Incidence per 100,000 Population 1997-2006: The zip codes in the top quantile reported an average incidence of 181.03 for STDs. The zip codes in the bottom quantile reported an average incidence of 1835.74 for STDs. The zip codes in the bottom quantile are 10.14 times higher in STD incidence than the zip codes in the top quantile.

Enterics Average Incidence per 100,000 Population 1997-2006: The zip codes in the top quantile reported an average incidence of 36.83 for enterics. The zip codes in the bottom quantile reported an average incidence of 48.00 for enterics. The zip codes in the bottom quantile are 1.30 times higher in enterics incidence than the zip codes in the top quantile.

HBV Average Annual Incidence per 100,000 Population 1998-2007: The zip codes in the top quantile reported an average incidence of 12.69 for HBV. The zip codes in the bottom quantile reported an average incidence of 35.06 for HBV. The zip codes in the bottom quantile are 2.76 times higher in HBV incidence than the zip codes in the top quantile.

HCV Average Annual Incidence per 100,000 Population 1998-2007: The zip codes in the top quantile reported an average incidence of 8.18 for HCV. The zip codes in the bottom quantile reported an average incidence of 59.90 for HCV. The zip codes in the bottom quantile are 7.32 times higher in HCV incidence than the zip codes in the top quantile.

Influenza/Pneumonia Mortality per 100,000 Population 1997-2006: The zip codes in the top quantile reported an average influenza/pneumonia mortality rate of 13.94. The zip codes in the bottom quantile reported an average mortality rate of 26.42 for influenza/pneumonia. The zip codes in the bottom quantile are 1.90 times higher in influenza/pneumonia mortality than the zip codes in the top quantile.
EMERGENCY DEPARTMENT UTILIZATION FACTORS
Self-Pay Low-Acuity ED Encounters per 100,000 Population 2005-2007: The zip codes in the top quantile reported the average number of encounters to be 5310.84. The zip codes in the bottom quantile reported the average number of encounters to be 36942.35 for self-pay low acuity ED visits. The zip codes in the bottom quantile are 6.96 times higher in self-pay low acuity ED visits than the zip codes in the top quantile.

Insured Low-Acuity ED Encounters per 100,000 Population 2005-2007: The zip codes in the top quantile reported the average number of encounters for insured low-acuity encounters to be 19978.31. The zip codes in the bottom quantile reported the average number of encounters to be 75030.30 for insured low-acuity ED visits. The zip codes in the bottom quantile are 3.76 times higher in insured low-acuity ED visits than the zip codes in the top quantile.

MATERNAL CHILD HEALTH FACTORS
Percent of Family Households with Single Mothers: In the zip codes of the top ranking quantile, 5.3% of the households had single mothers. The proportion was 2.32 times higher in the zip codes of the bottom quantile (12.3%).

Percent of Live Births with Low Birth Weight Infants: In the zip codes of the top ranking quantile, 8.4% of the live births had low birth weight. The proportion was 1.32 times higher in the zip codes of the bottom quantile (11.1%).

Wellness Score (cont.)
Confirmed Child Abuse cases per 100,000 Population 2008: The zip codes in the top quantile reported the average number of confirmed child abuse cases to be 63.14 per 100,000 population. The zip codes in the bottom quantile reported the average number of confirmed child abuse cases to be 303.90. The zip codes in the bottom quantile are 4.81 times higher in confirmed child abuse cases than the zip codes in the top quantile.

CONSUMER PROTECTION FACTORS
Private Residence Complaints per 100,000 Population: The zip codes in the top quantile reported the average number of private residence complaints to be 11.92 per 100,000 population. The zip codes in the bottom quantile reported the average number of private residence complaints to be 83.10 per 100,000 population. The zip codes in the bottom quantile are 6.97 times higher to have private residence complaints than the zip codes in the top quantile.

Pest or Animal Related Complaints per 100,000 Population: The zip codes in the top quantile reported the average number of pest or animal related complaints to be 24.96 per 100,000 population. The zip codes in the bottom quantile reported the average number of pest or animal related complaints to be 126.82 per 100,000 population. The zip codes in the bottom quantile are 5.08 times higher to have pest or animal related complaint than the zip codes in the top quantile.

Food Sanitation Complaints per 100,000 Population: The zip codes in the top quantile reported the average number of food sanitation complaints to be 28.10 per 100,000 population. The zip codes in the bottom quantile reported the average number of food sanitation complaints to be 182.59 per 100,000 population. The zip codes in the bottom quantile are 6.50 times higher to have a food sanitation complaint than the zip codes in the top quantile.

CRIME FACTOR
Homicide Rate 1997-2006: The zip codes in the top quantile reported an average homicide rate of 1.65. The zip codes in the bottom quantile reported an average homicide rate of 19.35. The zip codes in the bottom quantile are 11.71 times higher in homicide than the zip codes in the top quantile.
## Wellness Score Variable Comparison

### Top versus Bottom Quintiles

<table>
<thead>
<tr>
<th>Variable</th>
<th>Top quintile</th>
<th>Bottom Quintile</th>
<th>Percent Difference</th>
<th>Variable</th>
<th>Top quintile</th>
<th>Bottom Quintile</th>
<th>Percent Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Household Income</td>
<td>$55,900</td>
<td>$20,370</td>
<td>-64%</td>
<td>Chronic Lower Respiratory Disease Mortality</td>
<td>28.42</td>
<td>54.54</td>
<td>92%</td>
</tr>
<tr>
<td>Median Per Capita Income</td>
<td>$25,997</td>
<td>$11,386</td>
<td>-56%</td>
<td>Colon Cancer % Late Stage Diagnosis 1997-2005</td>
<td>58.8%</td>
<td>64.1%</td>
<td>9%</td>
</tr>
<tr>
<td>% Living in Poverty</td>
<td>6.9%</td>
<td>33.0%</td>
<td>377%</td>
<td>Breast Cancer % Late Stage Diagnosis 1997-2005</td>
<td>32.3%</td>
<td>39.9%</td>
<td>23%</td>
</tr>
<tr>
<td>Renter-Occupied Housing Units - % of Occupied Units</td>
<td>17.9%</td>
<td>55.2%</td>
<td>209%</td>
<td>All Cancer Incidence per 100,000 Population 1997-2005</td>
<td>408.55</td>
<td>467.50</td>
<td>14%</td>
</tr>
<tr>
<td>Household rent &gt; 30% of Household Income - % of Occupied Units</td>
<td>20.6%</td>
<td>31.8%</td>
<td>54%</td>
<td>All Cancer Mortality per 100,000 Population 1997-2006</td>
<td>126.13</td>
<td>209.46</td>
<td>63%</td>
</tr>
<tr>
<td>Median Home Value</td>
<td>$126,520</td>
<td>$48,530</td>
<td>-62%</td>
<td>Lung Cancer Mortality per 100,000 Population 1997-2006</td>
<td>40.35</td>
<td>65.47</td>
<td>62%</td>
</tr>
<tr>
<td>Population 25+ Years w/o HS Diploma or GED</td>
<td>10.7%</td>
<td>34.5%</td>
<td>224%</td>
<td>Breast Cancer Mortality per 100,000 Population 1997-2006</td>
<td>19.92</td>
<td>31.79</td>
<td>60%</td>
</tr>
<tr>
<td>Population 25+ Years with College Degree (Associate Degree or Higher)</td>
<td>40.9%</td>
<td>14.7%</td>
<td>-64%</td>
<td>Prostate Cancer Mortality per 100,000 Population 1997-2006</td>
<td>12.98</td>
<td>25.55</td>
<td>97%</td>
</tr>
<tr>
<td>Households With No Personal Vehicle Available (Census 2000)</td>
<td>2.6%</td>
<td>21.7%</td>
<td>735%</td>
<td>STD Avg Incidence per 100,000 Population 1997-2006</td>
<td>181.03</td>
<td>1835.74</td>
<td>914%</td>
</tr>
<tr>
<td>Diabetes Mortality</td>
<td>15.99</td>
<td>36.18</td>
<td>126%</td>
<td>Enterics Avg Incidence per 100,000 Population 1997-2006</td>
<td>36.83</td>
<td>48.00</td>
<td>30%</td>
</tr>
<tr>
<td>CVD Mortality</td>
<td>128.63</td>
<td>269.62</td>
<td>110%</td>
<td>HBV Avg Annual Incidence per 100,000 Population 1998-2007</td>
<td>12.69</td>
<td>35.06</td>
<td>176%</td>
</tr>
<tr>
<td>Stroke Mortality</td>
<td>38.46</td>
<td>74.40</td>
<td>93%</td>
<td>HCV Avg Annual Incidence per 100,000 Population 1998-2007</td>
<td>8.18</td>
<td>59.90</td>
<td>632%</td>
</tr>
<tr>
<td>Hypertension Mortality</td>
<td>4.76</td>
<td>13.22</td>
<td>178%</td>
<td>Influenza Pneumonia Mortality per 100,000 Population 1997-2006</td>
<td>13.94</td>
<td>26.42</td>
<td>90%</td>
</tr>
</tbody>
</table>
1 Reduction of Poverty by Attaining a Marketable Skill

- 16/50 (32%) of zip codes have higher high school dropout rates than the state average of 19.4% adults aged 25 & older (Census 2000)
- 27/50 (54%) of zip codes have fewer college graduates in adults aged 25 and older than the state average of 25.7%
- Of the 27 zip codes with a negative education score, 19 (70%) also have negative economic scores 17 (63%) have a negative Aggregate Wellness Score
- Of the 20 zip codes with 5% or greater of live births occurring in teen mothers, 18 (90%) have negative education scores

POSSIBLE SOLUTIONS
- Develop visible links between gaining a high school diploma and employment.
- Leverage trade school training for encouraging small business development.
- Develop methods to retain trained/skilled workforce.

2 Connecting Communities to Primary and Preventive Medical Services

- 19/50 (38%) of zip codes have >7% of households without a private vehicle
- 16/19 (84%) zip codes with negative transportation scores also have negative ED utilization scores
- 13/19 (68%) of zip codes with negative transportation scores have negative chronic disease scores 16/19 (84%) have negative acute disease scores
- 18/21 (86%) zip codes with negative ED utilization scores also have negative Aggregate Wellness Scores

POSSIBLE SOLUTIONS
- Develop “health focus zones” utilizing co-located primary and preventive medical services using case management model.
- Promote adoption of faith based/community medical clinics by hospital systems to facilitate delivery of medical services at the neighborhood level.
- Pursue provision of public health services through a network of locations across Oklahoma County.
- Encourage all employers to offer paid sick leave that could be utilized for preventive visits to the doctor and dentist.
3 Physical Activity Through Community Design

- 10/10 (100%) of zip codes with a negative Wellness Score are isolated by manmade barriers such as highways, railroads, water diversions systems.
- Mass transit systems are concentrated in zip codes with the fewest number of people.
- 10/19 (53%) of zip codes with negative transportation scores do not have adequate sidewalk infrastructure to allow walking to accomplish daily living task of short duration.

POSSIBLE SOLUTIONS
- Adopt the recommendations of the Complete Streets Coalition for developing land use plans that promote physical activity.
- Encourage legislative changes at the municipal and state level that will facilitate using “physically active” community development mass transportation designs.
- Establish the use of health impact assessments in all land development plans.

4 Healthy Choices and Economically Sound Communities

- 16/50 (32%) zip codes have a median household income of less than $30,000/year
- 18/50 (36%) have greater than 15% of the population living below 100% of the Federal Poverty Level

POVERTY LEVEL
Of the 21 zip codes with negative economic scores:
- 19 (90%) have negative housing scores
- 17 (80%) have negative transportation scores
- 18 (86%) have negative ED utilization scores
- 16 (76%) have negative violent death scores
- 16 (76%) have negative infectious disease scores
- 20 (95%) have negative Maternal/Child health scores
- 19 (90%) have negative Aggregate Wellness Scores

POSSIBLE SOLUTIONS
- Pursue tax reduction model for business that provide health promoting options.
- Focus reduced tax zones in areas with bottom Wellness Score to encourage development of businesses selling healthy foods.
In order to identify the community’s most pressing issues, the Oklahoma City-County Health Department (OCCHD) assessed community needs by distributing a short, 10-question survey focused on quality of life issues. An anonymous web-based survey and a standard pencil and paper survey were available for completion. These methods were used to encourage the top level of participation possible. The survey was available in English, Spanish, and Vietnamese and was completed by 3,173 residents of Oklahoma County. Some of the survey questions allowed respondents to select multiple answers to ascertain several concerns. The survey was accessible from July 6, 2010 through October 31, 2010. All Oklahoma County residents were eligible to complete the survey within the specified time period.
**Question 1:**
What are the 3 things that would most improve your life? Check only 3

Top responses: health care (39.8%), low crime/safe neighborhoods (37.6%), more jobs (37.3%), neighborhood sidewalks and/or street lights (30.8%).

**Question 2:**
Which 3 things contribute the most to poor health in your neighborhood? Check only 3

Top responses: alcohol and/or drug abuse (48.9%), too many fast food restaurants (43.7%), no place to exercise outside/no sidewalks (40.5%), tobacco use (37.2%).

**Question 3:**
What are the top 3 safety concerns in your neighborhood? Check only 3

Top responses: crime/violence (45.0%), no sidewalks and/or street lights (36.0%), unsafe driving (35.2%).

**Question 4:**
What are the top 3 concerns for CHILDREN in your neighborhood? Check only 3

Top responses: no adult supervision (47.9%), overweight or obese (45.3%), no place to play outside (40.3%).

**Question 5:**
Where do you get health related information? Check all that apply

![Percentage of responses to the question "Where do you get health related information? (check all that apply)"

- doctor’s office
- internet
- family
- TV/radio
- friends/neighbors
- pharmacy
- newspaper
- work
- health department
- free health clinic
- church
- library
- school
Question 6:
What prevents you and/or your family from exercising? Check all that apply

![Bar chart showing percentage of responses to question 6]

Question 7:
Where do you MOST often shop for food/groceries? Check all that apply

![Bar chart showing percentage of responses to question 7]
**Question 8:**
Where do you go when you and/or your family get sick? Check all that apply

**Question 9:**
Are you able to get basic health care when you need it?

- No (21.7%)
- Yes (79.1%)

Why are you not able to get basic health care?

Top responses: cost (70.5%), no health insurance (63.9%).

**Question 10:**
Do you use public transportation? Have other transportation

- No (63.8%)
- Yes (39.4%)

*Survey allowed participants to select the response “No” and the response “Have other transportation”.

Why don’t you use public transportation? Check all that apply

Top responses: takes too long (32.2%), doesn’t go where I need it to go (28.4%), doesn’t work with my schedule (26.4%), not available in my area (21.7%).
Concerns of survey respondents related to personal lives included access to health care services, neighborhood safety, and more employment opportunities. When surveyed about what contributes most to poor health in their neighborhood, participants responded with concerns about alcohol/drug abuse, large number of fast food restaurants, and no place to exercise outside/no sidewalks. When surveyed about neighborhood safety, participants responded that crime/violence, no sidewalks or street lights, and unsafe driving were major concerns. When surveyed about the safety of children, participants reported no adult supervision, being overweight or obese, and no safe places to play outside as issues concerning them the most. When physical activity did not occur, the most frequent answers given were not having enough time and the weather being too cold or too hot.

When surveyed about personal health, respondents reported most often that they obtain health information from the doctor’s office, the internet, and family members. Medical services are most often obtained at the doctor’s office, after hour medical clinics, or hospital emergency departments. Most respondents reported being able to access medical services when needed. However when medical services are not obtainable, cost and no health insurance were the most frequent responses.

The most often cited reasons for not using public transportation were: it takes too long; it doesn’t go where I need to go, and it does not work with personal schedules. Finally participants utilize supermarkets to purchase groceries most often. Wholesale clubs and neighborhood dollar stores were reported as being utilized for this purpose also.
In addition to distributing a community survey, OCCHD conducted 13 community forums throughout the county during July and August of 2010. The purpose of the forums was to assess community members’ perceived strengths and needs in their immediate area. A total of 142 community members attended the forums which were conducted by volunteer facilitators. During each forum, community members were asked seven (7) questions. Upon completing the forums, several issues were raised by community members which they feel have a major impact on the health of those residing in Oklahoma County. To illustrate the issues raised, comments expressed during the forums were divided into three categories: “Changes they propose be made in their communities,” “community obstacles preventing health,” and “lifestyle obstacles preventing health.”
Working with community partners, OCCHD will utilize survey and forum results in conjunction with other zip code level data to identify the most pressing issues which can be addressed through community action. Once identified, the local public health system will begin the process of developing population based programs, policies, and initiatives designed to improve the wellness of Oklahoma County residents.

**SELECTION OF FORUM THEMES**
Themes were extrapolated and chosen based upon the number of forums in which participants mentioned a particular topic. For example, a common answer to one of the seven questions was labeled a theme if it was mentioned in at least 4 or more forums.

**POSITIVE ASPECTS OF THE COMMUNITY/STRENGTHS**
- Abundance of community organizations providing assistance for a variety of needs
- Oklahoma County residents come together to help each other when in need
- Colleges and universities
- Many stated they feel safe in their communities
- Churches
- Availability of parks and walking trails in some areas of the community

**IDENTIFIED ISSUES**
To effectively illustrate themes identified through the forums which identify specific targets of potential change, this section outlines themes gathered from the community grouped into three (3) categories: ¹“If you could change one thing…”, ²Community Obstacles Preventing Health, and ³Lifestyle Obstacles Preventing Health.

“**If you could change one thing…”**
- Improve public transportation
  - Participants voiced strong opinions regarding this subject. If given the opportunity, many would make vital improvements to the public transportation system.
  - Quote: “Our neighborhood is just very dependent on the bus to go to work, to go to the grocery store, there is just nothing in walking distance here.”
  - Quote: “…I realize if you don’t have a car here then it’s really hard to get around. Like, one day I needed to get a bus from my house to downtown and I know there was a bus, but it was late…half an hour.”

- Build more sidewalks
  - Participants expressed concern about the lack of a safe place to walk and felt healthier lifestyles can be attained if the environment were more conducive to walking.
  - Quote: “It boggles my mind as busy as this area is and there is no safe place to walk.”
  - Quote: “Here, they don’t have sidewalks, we don’t walk and they don’t require any physical activity. It’s like, how are we not going to be obese?”
Community Forum Themes and Issues

- Improve/change the K-12 public education system (by reinstating physical education, and adding nutrition and financial education)
- In addition to concerns of children not performing well and dropping out of school, participants stated a desire to bring back physical education and add nutrition and financial education classes in schools. It was also echoed in several forums that many young people do not know how to cook a healthy meal from scratch; participants felt this could be remedied by bringing home economics back into the schools.
- Quote: “I think the ability to cook from scratch is getting to be a lost art.”
- Quote: “I would put some sort of, even the most basic financial education in high schools. These kids are growing up with no clue of interest…”
- Quote: “…that in schools they would promote more physical activity. In Mexico, they have physical activity for everyone. Here it’s maybe one class and there, it’s for all children and I think it would be good that they required it.”

“COMMUNITY OBSTACLES PREVENTING HEALTH”

- Too many fast food restaurants
  - The lack of healthy, affordable food options was mentioned at several forums. Participants expressed the overwhelming abundance of unhealthy, fast food options is a great obstacle preventing a healthy lifestyle.
  - Quote: “…there are not [many] healthy fast food options.
  - Quote: “…Oklahoma, I think is one of the states with more fast food restaurants, and I think that’s bad. I mean every block or two blocks we find a McDonald’s or a Burger King.”

- No sidewalks or places to walk
  - When participants were asked to name obstacles in the community they felt prevented them from living a healthy lifestyle, many indicated a lack of sidewalks and places to walk as a major factor.
  - Quote: “[The] city isn’t pedestrian friendly.”
  - Quote: “[There] are no places to walk in our area.”

- Limited availability of grocery stores and lack of fresh produce
  - Participants expressed concern over the lack of quality grocery stores near their neighborhood. Participants also mentioned a lack of quality, fresh fruits and vegetables in some grocery stores.
  - Quote: “But it is also good access to good grocery stores in the neighborhood. Because if I go someplace and I see this red delicious apple, you know I see the array of colors, but over on my side of town it’s dingy.”

- Lack of affordable exercise facilities
  - Participants were concerned about a lack of affordable or free exercise facilities in the community.
  - Quote: “The lack of affordable exercise facilities. I mean, they’ve got, you know [for little kids] things at the park you can climb on but for older kids there’s nothing. Unless you belong to the Y but that costs money…”
  - Quote: “Everybody can’t get a [gym] membership.”
“LIFESTYLE OBSTACLES PREVENTING HEALTH”

- Busy lifestyles
  - Several participants in various forums mentioned their busy lifestyles were not conducive to practicing a healthy lifestyle.
  - Quote: “We’re workaholics…”
  - Quote: “[I’m] always on the go…”

- Healthy food is more expensive
  - Participants in several forums stated it is more expensive to lead a healthy lifestyle.
  - Quote: “…leading a healthy lifestyle costs money…nutritional supplements are not cheap, organic food is not cheap and just healthy eating in general costs more.”
Community Forum Findings

Forum participants proposed several changes they would make to improve the health of their community. Community members have a strong desire for public transportation to be improved. This is such an important issue because some neighborhoods are dependent upon the bus system and it is difficult to travel around Oklahoma City and Oklahoma County without a car. Community members also expressed a need for more sidewalks to be built. Many expressed a concern about the lack of a safe place to walk and felt healthier lifestyles could be attained if our environment were more conducive to walking. The last change community members expressed was a desire to improve the K-12 public education system by reinstating physical education in schools, and by adding nutrition and financial education courses. Participants felt schools should do more to promote physical activity among students. There is desire to bring home economics courses back into schools to teach children how to cook healthy meals from scratch and to handle personal finances.

Forum participants also identified several community obstacles they feel prevent one’s ability to maintain or achieve a healthy lifestyle. Community members expressed a concern about the lack of healthy, affordable food options while being inundated with an excessive number of fast food restaurants. This is seen as a major obstacle preventing healthy lifestyles. Participants also identified a lack of sidewalks or places to walk as an obstacle to health. It was also stated that Oklahoma City is not pedestrian friendly. They feel that people are much less inclined to walk without the accessibility of a safe place. Additionally, participants expressed a concern about a lack of affordable or free exercise facilities in the community. Some community members cannot afford an expensive gym membership and would like a cost effective alternative.

When asked to identify lifestyle obstacles which prevent health, community members expressed the main lifestyle obstacle which prevents healthy living is that they lead very busy lives and, therefore, do not have time to take care of their health. Community members stated they work too much and are always on the go. Additionally, it was expressed that living a healthy lifestyle is too expensive.
The concepts of health prevention, protection and promotion require the participation of multiple partners working as a system and is not the responsibility of a single organization or agency. Members met in the Fall 2010 to assess and score the ability to perform the 10 Essential Public Health System Services. On August 11, 2011 system partners reconvened to review and discuss findings from the Local Public Health System Performance Assessment and to vote on priorities for developing performance improving strategies.

**Essential Service 1 (ES 1): Monitor Health Status to Identify Community Health Problems**

Essential Service 1 (ES 1) highlights the importance of assessing the health status of the community and monitoring health status utilizing modern technology to collect, analyze, and community health related data. There are 3 standards in ES 1: 1) Population-based community health profile (CHP); 2) Current technology to manage and communicate population health data; and 3) Maintenance of population health registries.

The overall score for these 3 standards for ES 1 was 73%, which is considered an optimal level of activity. However, as shown below, the LPHS received a 100 for registries of population health information and a score of 64% and 54% for Community Profile and Current Technology respectively, reflecting the need for additional activity in the development of a CHP at the time of this assessment and increased use of current technology to report and communicate health data.

Essential Service 1 includes the accurate and periodic assessment of the community’s health status related to identification of health risks, the determinants of health, and health needs; inclusion of vital statistics and health status indicators, especially of high risk populations; and identification of community assets that support the local public health system (LPHS). The importance of utilizing appropriate methods and technology such as geographic information systems and collaboration among all sectors of the LPHS are critical components to be considered in ES 1. The results that follow for ES 1 require thoughtful review and consistent application of resources to assure ongoing effort to improve in this area. A set of possible discussion items related to these results is offered at the end of this section.
ES 1 - STANDARD 1.1 relates to the development and dissemination of a population-based community health profile (CHP) that promotes community-wide use of data and is easily accessible by the community. Community health assessments are expected to be conducted and updated on a regular and periodic basis, allowing the LPHS to monitor progress toward health-related objectives. The importance of processes to assure data based on current science and evidence-based public health practice is accurately, reliably, and consistently interpreted is stressed. Benchmarking between peers, state, and national data is encouraged and allows for evaluation of programs and services based on defined outcomes and standards.

SCORES FOR ES 1 – STANDARD 1.1 WERE AS FOLLOWS:

<table>
<thead>
<tr>
<th>1.1 Population - Based Community Health Profile (CHP) - Overall</th>
<th>64%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1.1 LPHS has conducted a community health assessment (CHA) which is updated at least every 3 years; is compared with data from peer communities, region, state, and/or nation; tracks trends over time; and monitors progress toward health-related objectives.</td>
<td>53%</td>
</tr>
<tr>
<td>1.1.2 LPHS compiles data from CHA into a community health profile (CHP) covering a wide spectrum of data elements from a variety of sources.</td>
<td>71%</td>
</tr>
<tr>
<td>1.1.3 The use of the CHA and the CHP is promoted community-wide; is part of a media strategy; is useful to the LPHS for decision-making; and is easily accessible to the public.</td>
<td>67%</td>
</tr>
</tbody>
</table>

ES 1 – STANDARD 1.2 assures that population health data are presented in formats that allow for clear communication and interpretation by end users. In order to meet this standard the LPHS should have access to and use state-of-the-art technology to collect, manage, integrate, and display health profile databases; access to geocoded data for geographic analysis; and effectively use computer-generated graphics to identify trends and/or compare data by relevant categories. Information should be available in a variety of formats, including web-based versions that are readily accessible in a timely manner. Links to other relevant data sources should also be provided.

SCORES FOR ES 1 STANDARD 1.2 WERE AS FOLLOWS:

<table>
<thead>
<tr>
<th>1.2 Current technology to manage and communicate population health data - Overall</th>
<th>54%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.2.1 LPHS uses state-of-the-art technology to collect, manage, integrate, and display health profile databases. Data is also available on a website, linked to other websites, and in other accessible formats as indicated.</td>
<td>63%</td>
</tr>
<tr>
<td>1.2.2 LPHS has access to geocoded data at the county, zip code, and census tract level and uses GIS to analyze and display (map) information.</td>
<td>50%</td>
</tr>
<tr>
<td>1.2.3 LPHS uses computer-generated graphics to identify trends or compare data in relevant categories as indicated.</td>
<td>50%</td>
</tr>
</tbody>
</table>
ES 1 – STANDARD 1.3 highlights the use of population health registries to track health related events for the community. Examples of registries that might included are cancer and chronic disease incidence, immunization status of specific populations; and injury and trauma mortality by specific category. Standards that assure comparability of data from all public and private sources at a variety of levels should be applied and evidence of on-going collaboration among multiple partners facilitates the aggregation of data useful to the LPHS to inform policy decisions, program implementation, and population research.

SCORES FOR ES 1-STANDARD 1.3 WERE AS FOLLOWS:

<table>
<thead>
<tr>
<th>1.3 Maintenance of Population Health Registries—Overall 100%</th>
<th>100%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.3.1 LPHS either maintains or contributes to a wide variety of population health registries for multiple disease-specific and health-related events. Registries meet standards for data collection and have an established process for timely and accurate reporting.</td>
<td>100%</td>
</tr>
<tr>
<td>1.3. LPHS has used information from one or more of the population health registries within the past year to inform policy decisions; design or implement programs; and/or conduct population research.</td>
<td>100%</td>
</tr>
</tbody>
</table>

Areas for discussion by LPHS Partners related to ES 1:

1. Maintain or enhance disease-specific and/or health-related registries that provide accurate information through a timely process to governmental public health and community partners.

2. Maintain relationships with community partners that assure access to data sets from a variety of health and health-related sectors within the community.

3. Establish a sustainable process for the provision of community health information to the general public, policymakers, and public & private stakeholders that includes community health status and community health needs with emphasis on prevention and risk, as well as trends identified in the results.

4. Plan to meet the ongoing requirements for governmental public health and community partner/stakeholder needs assessments to fulfill accreditation requirements and federal mandates.

Essential Service 2 (ES 2): Diagnose and Investigate Health Problems and Health Hazards

Essential Service 2 defines the epidemiology functions for investigations of disease outbreaks, patterns of infectious disease and injury, environmental hazards, and other health threats. Further, ES 2 has a focus on active disease epidemiology programs and the requirement to assure access to a public health laboratory capable of conducting rapid screening and high volume testing. There are 3 standards in ES 2: 1) Identification and surveillance of health threats; 2) Investigation and response to public health threats and emergencies; and 3) Laboratory support for investigation of health threats.

The overall score for these 3 standards for ES 2 was 92%, which is considered an optimal level of activity and was the top score achieved of all the essential services. Scores for the 3 standards were between 86% and 98% demonstrating an overall high level of capability for Essential Service 2.
The importance of integrated and technologically supported surveillance systems between local, state, and national levels with the ability to identify health problems and health threats is emphasized with ES 2. Additionally, the importance of LPHS capacity to respond rapidly and effectively to public health threats and emergencies, including through laboratory support, is defined in detail in this section. The results that follow for ES 2 require thoughtful review and consistent application of resources to assure ongoing effort to improve in this area. A set of possible discussion items related to these results is offered at the end of this section.

**ES 2 – STANDARD 2.1** focuses on the identification and surveillance of health threats in the local community through local systems that are integrated with state and national systems. These processes are monitored to determine patterns and changes in health that trigger processes for investigation of underlying causes and factors or appropriate emergency response when indicated.

**SCORES FOR ES 1 – STANDARD 1.1 WERE AS FOLLOWS:**

<table>
<thead>
<tr>
<th>2.1 Identification and Surveillance of Health Threats - Overall</th>
<th>86%</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1.1 LPHS operates or participates in surveillance systems that monitor health problems and identify health threats for infectious and chronic disease; injuries, environmental hazards, MCH, social and mental health, and/or bioterror threats. Local system is integrated with state and national systems and compliant with PHIN guidelines and HIPAA requirements.</td>
<td>96%</td>
</tr>
<tr>
<td>2.1.2 Community health professionals submit reportable disease information in a timely manner to the state and LPHS.</td>
<td>75%</td>
</tr>
<tr>
<td>2.1.3 LPHS has adequate resources to support health problem and health hazard surveillance and investigation activities which includes technological and human resources. LPHS has Master or Doctoral prepared epidemiologists and/or statisticians to assess, investigate, and analyze information collected.</td>
<td>88%</td>
</tr>
</tbody>
</table>
ES 2 – STANDARD 2.2 defines the requirement for LPHS to maintain capacity to respond rapidly and effectively investigate public health threats and emergencies which involve communicable disease outbreaks, or chemical, biological, radiological, nuclear, explosive, or environmental incidents. Additionally, this standard emphasizes the importance of coordination for the response to public health emergencies through the system of LPHS partners.

**SCORES FOR ES 2 STANDARD 2.2 WERE AS FOLLOWS:**

<table>
<thead>
<tr>
<th>2.2 Investigation and Response to Public Health Threats and Emergencies - Overall</th>
<th>90%</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.2.1 LPHS maintains written protocols for case finding, contact tracing, source identification, and containment for communicable disease and toxic exposures.</td>
<td>97%</td>
</tr>
<tr>
<td>2.2.2 LPHS has current case investigation protocols to guide immediate investigations of public health emergencies for the full complement of events.</td>
<td>75%</td>
</tr>
<tr>
<td>2.2.3 LPHS has a designated Emergency Response Coordinator for the jurisdiction responsible for coordinating the OCCHD response and coordinating with community partners.</td>
<td>100%</td>
</tr>
<tr>
<td>2.2.4 LPHS can rapidly respond to natural and intentional disasters assuring the ability to mobilize sufficient numbers of multidisciplinary staff and/or volunteers to meet a broad set of needs within 1 hour of event.</td>
<td>78%</td>
</tr>
<tr>
<td>2.2.5 LPHS evaluates the public health emergency response through After Action Reports and uses the findings to improve emergency operational plans.</td>
<td>100%</td>
</tr>
</tbody>
</table>

**ES 2 – STANDARD 2.3** frames requirements for the LPHS to assure access to laboratory support capable of producing timely and accurate laboratory results for diagnostic and investigative public health concerns.

**SCORES FOR ES 2-STANDARD 2.3 WERE AS FOLLOWS:**

<table>
<thead>
<tr>
<th>2.3 Laboratory Support for Investigation of Health Threats — Overall</th>
<th>98%</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.3.1 LPHS maintains ready access to labs capable of meeting routine diagnostic and surveillance needs that include the ability to analyze both clinical and environmental specimens as indicated.</td>
<td>100%</td>
</tr>
<tr>
<td>2.3.2 LPHS has ready access to lab services to support investigations of public health threats, hazards, and emergencies for biological, chemical agents, and radiological agents, as well as infectious and environmental agents that are rarely encountered. At least one microbiology lab is accessible within 4 hours.</td>
<td>94%</td>
</tr>
<tr>
<td>2.3.3 LPHS only use properly licensed or credentialed laboratories.</td>
<td>100%</td>
</tr>
<tr>
<td>2.3.4 LPHS maintains current guidelines or protocols for handling of lab specimens including collection, labeling, storing, and transporting specimens. Also follows the proper chain of custody and requirements for reporting findings.</td>
<td>100%</td>
</tr>
</tbody>
</table>
**Areas for discussion by LPHS Partners related to ES 2:**

1. Maintain competent, appropriately trained staff in OCCHD programs to meet the requirements for conducting surveillance and disease investigations, both routinely and in emergency situations.

2. Assure that requirements for access to required laboratory functions are maintained as part of the LPHS.

3. Maintain and build relationships with community partners to assure collaboration for disease investigation and containment.

4. Continue to support an Emergency Response Coordinator as part of the LPHS that builds relationships with community partners for timely and appropriate response to public health emergencies.

**Essential Service 3 (ES 3): Inform, Educate, and Empower Individuals and Communities about Health Issues**

Essential Service 3 targets communication and health promotion to improve health. There are 3 standards related to Essential Service 3: 1) Health education and promotion; 2) Health communication; and 3) Risk communication.

The overall score for these 3 standards for ES 3 was 77%, which is considered an optimal level of activity. However, as shown below, the LPHS received a 100 for Risk Communication and a score of 69% and 63% for Health Education/Promotion and Health Communication respectively, reflecting the need for additional activity in the Health Education/Promotion and Health Communication areas.

Health information, health promotion, and health education are foundational to the questions in ES 3 pertaining to the day-to-day functioning of the local public health system and support health improvement objectives defined by the community. Open channels for communication within the community to achieve these goals are supported by partnerships between public agencies, schools, faith communities, work sites, personal care providers, policymakers, and others as indicated by ES 3. While scores in this section are among the top in this assessment, it is critical that activities reflected by ES 3 be maintained and enhanced. Additionally, risk communication, another aspect of ES 3, is critical to appropriate community response at a time of crisis and is a strength of the local public health system in Oklahoma County. The results that follow for ES 3 require thoughtful review and consistent application of resources to assure ongoing effort to improve in this area. A set of possible discussion items related to these results is offered at the end of this section.
ES 3 – Standard 3.1 focuses on the provision of information on community health status and community health needs in the community to the public, policymakers, and stakeholders. Information to support evidence-informed decision making responsive to identified needs will provide communities greater control over conditions affecting their health. Strategies included in this section relate to health education, health promotion, and policy development through targeted activities that lower risk and change negative behaviors.

Collaboration and partnership are identified as key components for success.

Scores for ES 3 – Standard 3.1 were as follows:

<table>
<thead>
<tr>
<th>3.1 Health Education and Promotion - Overall</th>
<th>69%</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1.1 Provision of community health information to the general public, policymakers, and public &amp; private stakeholders that includes community health status and community health needs with emphasis on prevention and risk.</td>
<td>56%</td>
</tr>
<tr>
<td>3.1.2 LPHS conducts health education and/or health promotion campaigns designed to support healthy behaviors of individuals and communities that are based on sound theory, evidence of effectiveness, and best practice. (Emphasis is on tailoring campaigns to specific settings and high risk populations and ongoing evaluation that is used to revise and strengthen the programs.)</td>
<td>69%</td>
</tr>
<tr>
<td>3.1.3 LPHS partners collaborate on health communication plans and the implementation of health promotion activities and media campaigns to meet identified goals.</td>
<td>81%</td>
</tr>
</tbody>
</table>

ES 3 – Standard 3.2 defines the use of multiple communication strategies to inform and influence individual and community decisions that enhance health. Activities related to media campaigns, social marketing, entertainment education, and interactive health communication serve to raise awareness of health risks and solutions, support adoption of healthy behavior, and create advocacy for health policies and programs that empower people to adopt healthy lifestyles. The development of relationships with media channels and availability of trained spokespersons for public health issues, along with appropriate health communication plans and guidelines, assures delivery of consistent messages to accomplish local public health system goals.

Scores for ES 3 Standard 3.2 were as follows:

<table>
<thead>
<tr>
<th>3.2 Health Communication - Overall</th>
<th>63%</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.2.1 LPHS works collaboratively to develop health communication plans that address dissemination of information to partners and key stakeholders; public health messages tailored to population sectors; and tailoring of messages for identified communication channels.</td>
<td>25%</td>
</tr>
<tr>
<td>3.2.2 LPHS establishes and utilizes relationships with the media and has defined policies and procedures for appropriately routing and documenting media inquiries. Also, includes proactive strategies for health related topics.</td>
<td>63%</td>
</tr>
<tr>
<td>3.2.3 LPHS designates public information officers (PIOs) to serve as spokespersons to assure accurate, timely, and appropriate information on public health issues is provided to different audiences and is coordinated with LPHS partners.</td>
<td>100%</td>
</tr>
</tbody>
</table>
ES 3 – STANDARD 3.3 focuses on the provision of information by public health professionals to allow individual, stakeholders, or an entire community to make the best possible decisions about their well-being in times of crisis or emergency. Risk communication includes pre-event, event, and post-event communication planning. The LPHS is charged with the development of an effective emergency communication plan for creation and dissemination of materials; ensuring crisis and emergency communications training and adequate resources for a rapid response; and maintaining current, accurate 24 hours-per-day, 7 days per-week contact information and collaborative relationships with news media, public information officers, and system partners.

SCORES FOR ES 3-STANDARD 3.3 WERE AS FOLLOWS:

<table>
<thead>
<tr>
<th>3.3 Risk Communication — Overall</th>
<th>100%</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.3.1 LPHS has developed a unified emergency communications plan that addresses lines of authority, reporting, and responsibilities in accordance with NIMS; has procedures for alerting communities of health threats or disease outbreaks; and has guidelines for sharing information from emergency operation center situation reports and health alerts with stakeholders, partners, and the community.</td>
<td>100%</td>
</tr>
<tr>
<td>3.3.2 LPHS has the resources for rapid communications response that includes technological capacity through a variety of systems and staff adequate to provide communication for all stakeholders and partners in an event.</td>
<td>100%</td>
</tr>
<tr>
<td>3.3.3 LPHS provides crisis and emergency communications training for new and current staff.</td>
<td>100%</td>
</tr>
<tr>
<td>3.3.4 LPHS has policies and procedures for public information officer rapid and mobile response that includes maintenance of a directory of media liaisons, partners, and stakeholders, as well as equipment and resources in “go kits”.</td>
<td>100%</td>
</tr>
</tbody>
</table>

Areas for discussion by LPHS Partners related to ES 3:

1. Initiate or increase dialogue related to the roles and relationships of local public health system partners for the development of effective health communication plans to achieve identified LPHS goals.

2. Establish a sustainable process for the provision of community health information to the general public, policymakers, and public & private stakeholders that includes community health status and community health needs with emphasis on prevention and risk.

3. Plan to meet the ongoing requirements for governmental public health and community partner/stakeholder needs assessments to fulfill accreditation requirements and federal mandates.

4. Assure appropriate access to health-related information to meet grant and funder requirements to enhance local public health system resources.

5. Assure adequate resources are maintained to support the current level of risk communication as part of the public health emergency response system.
Essential Service 4 (ES 4): Mobilize Community Partnerships to Identify and Solve Health Problems

There are 2 standards related to Essential Service 4: 1) Constituency development; and 2) Community partnerships. This model standard is comprised of the following:

The overall score for the 2 standards in ES 4 was 58%. The scores for the 2 standards ranged from 49% to 67% as noted in the chart below.

The questions in ES 4 are aimed at identifying potential stakeholders involved in public health; building and working with coalitions to maximize available resources to improve health; and facilitating strategic alliances and partnerships to enhance health improvement activities that assure the presence of the social and economic conditions necessary for long-term health. The results that follow for ES 4 require thoughtful review and consistent application of resources to assure ongoing effort to improve in this area. A set of possible discussion items related to these results is offered at the end of this section.
ES 4 – Standard 4.1 focuses on the development of the constituents of the LPHS, which all persons and organizations that directly contribute to or benefit from public health, which may include members of the public served by the local public health system (LPHS), the governmental bodies it represents, and other health, environmental, and non-healthrelated organizations in the community. Establishing collaborative relationships among the LPHS and all current and potential stakeholders allows for the development and operation of a communications strategy designed to educate the community about the benefits of public health and the role of the LPHS in improving community health. Community networks of businesses, schools, healthcare organizations, the faith community, community associations, and governmental public health are critical to the process.

**SCORES FOR ES 4-STANDARD 4.1 WERE AS FOLLOWS:**

<table>
<thead>
<tr>
<th>4.1 Constituency Development - Overall</th>
<th>49%</th>
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<tbody>
<tr>
<td>4.1.1 LPHS has a process for identifying key constituents or stakeholders for both general health issues and specific health concerns or risk categories.</td>
<td>72%</td>
</tr>
<tr>
<td>4.1.2 Encourages participation of constituents in improving community health by maintaining a current contact list of constituents and stakeholders and a variety of processes for identifying new constituents and groups, volunteers; and members of the community at-large for participation.</td>
<td>31%</td>
</tr>
<tr>
<td>4.1.3 LPHS maintains a directory of organizations that comprise the LPHS (Broad representation is desirable)</td>
<td>50%</td>
</tr>
<tr>
<td>4.1.4 LPHS has communications strategies to build awareness of public health with the community at-large, as well as between organizations and agencies.</td>
<td>44%</td>
</tr>
</tbody>
</table>

**ES 4 – STANDARD 4.2** assures the presence of community partnerships and strategic alliances to foster the sharing of resources and accountability for community health improvement. Facilitation collaborative processes that include public, private, or non-profit institutions to network, coordinate, cooperate, and collaborate toward accomplishing a common purpose is identified as the responsibility of public health departments within this standard. Assessment of the effectiveness of community partnerships and strategic alliances is an important component of the standard.

**SCORES FOR ES 4-STANDARD 4.2 WERE AS FOLLOWS:**

<table>
<thead>
<tr>
<th>4.2 Community Partnerships - Overall</th>
<th>67%</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.2.1 Partnerships with a broad range of representation exist in the community to maximize public health improvement activities</td>
<td>50%</td>
</tr>
<tr>
<td>4.2.2 LPHS has a broad-based community health improvement committee that meets on a regular base; participates in the community health assessment process and in the implementation of plans for health improvement; and monitors and evaluates progress toward prioritized goals.</td>
<td>75%</td>
</tr>
<tr>
<td>4.2.3 LPHS reviews the effectiveness of community partnerships and strategic alliances; evaluates constituent satisfaction with partnership efforts; assesses system capacity; and implements actions to improve the partnership process and capacity.</td>
<td>75%</td>
</tr>
</tbody>
</table>
Areas for discussion by LPHS Partners related to ES 4:

1. Expand the process for identification of new community partners or stakeholders and strengthen the communication which supports the maintenance of relationships.

2. Enhance the availability of a directory of community partners.

3. Identify methods and initiate processes to reach out more effectively to the community at-large for involvement in planning and activities to improve health.

4. Adequately resource Wellness Now and other community coalitions/collaborations that support community health improvement.

5. Collaborate with other agencies and organizations with similar objectives and requirements to reduce duplication and enhance resource utilization.
   (Example: Hospital Community Benefit Programs, etc.)

Essential Service 5 (ES 5): Develop Policies and Plans that Support Individual and Community Health Efforts

There are 4 standards related to Essential Service 5: 1) Governmental presence at the local level; 2) Public health policy development; 3) Community health improvement process and strategic planning; and 4) Plan for public health emergencies.

The overall score for these 4 standards for ES 5 was 55%. The scores for overall standards 1-3 ranged between 31 and 56%, while the overall score for standard 4 (public health emergencies) was 94% demonstrating a wide degree of variance between sections within ES 5.

A majority of the questions scored within ES 5 relate to governmental public health functions and activities and therefore a significant portion of the review and response will require action by the local and state level governmental public health entities. While some scores related to community health planning actions and policy development initiatives were scored low on this assessment, activities are currently being implemented that meet these standards. This assessment is an example of current community health assessment and improvement plan implementation. The results that follow for ES 5 require thoughtful review and consistent application of resources to assure ongoing effort to improve in this area. A set of possible discussion items related to these results is offered at the end of this section.
ES 5—STANDARD 5.1 focuses on governmental public health entities and their responsibility to assure the delivery of the 10 essential services within the defined jurisdiction. To this end this standard requires the local governmental public health entity (OCCHD) to work in partnership with the community to assure the development and maintenance of a flexible and dynamic public health system. This standard requires appropriate relationships with the local board of health, city and county governmental agencies and officials, state health department, and state governmental agencies and policy makers.

SCORES FOR ES 5-STANDARD 5.1 WERE AS FOLLOWS:

<table>
<thead>
<tr>
<th>5.1 Evaluation of population-based health services - Overall</th>
<th>56%</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Includes assessment and documentation of clear definitions of roles and responsibilities of the LPHS and relationships with governing bodies and OSDH.)</td>
<td></td>
</tr>
<tr>
<td>5.1.1 Governmental local public health presence including clear mission statement; description of statutory authority and legal responsibilities; and assessment of functions as identified by the NACCHO Operational Definition of a functional local health department</td>
<td>71%</td>
</tr>
<tr>
<td>5.1.2 LPHS assures availability of resources for the local health department. (Resources specifically cited include support for mandated programs and public health programs identified by the community; adequate personnel including legal counsel (see ES 8); and the required facilities, equipment, and supplies.)</td>
<td>60%</td>
</tr>
<tr>
<td>5.1.3 Oversight by a local board of health for the local health department</td>
<td>Not Scored</td>
</tr>
<tr>
<td>5.1.4 Local health department works with state public health agency and other state partners to assure provision of public health services (includes completion of the state NPHPSP instrument with input from the local level).</td>
<td>38%</td>
</tr>
</tbody>
</table>

ES 5—STANDARD 5.2 defines the role of the LPHS in “policy development” which is based on the 1988 Institute of Medicine, The Future of Public Health, definition. Policy development means the process of problem identification, application of technical knowledge for possible solutions, and knowledge of societal values used to set a course of action. This should be clearly separated from the development of laws, rules, and regulations which is the focus of ES 6. This standard includes LPHS responsibility to assure effective public health policy by facilitating community involvement and engaging in activities that inform the policy development process; communicating health impact assessment findings to policy makers and key stakeholders; and conducting a review of existing policies on a periodic basis.
### SCORES FOR ES 5-STANDARD 5.2 WERE AS FOLLOWS:

<table>
<thead>
<tr>
<th>5.2 Public Health Policy Development—Overall</th>
<th>40%</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Includes assurance of participation by the community affected in the policy development process, advocacy at the local, state, and national levels, and communication of health impact assessment findings to policy makers and stakeholders.)</td>
<td></td>
</tr>
</tbody>
</table>

| 5.2.1 Contribution to development of public health policies. Includes engaging constituents; advocating for those with disproportionate risk; and participation at the local, state and national level on advisory boards related to public health policy. | 71% |

| 5.2.2 Alert policymakers and the public of public health impacts from policies | 25% |

| 5.2.3 Review of public health policies at least every 3-5 years. Includes community health impact assessment and the inclusion of community constituents and those affected by the policy. | 25% |

### ES 5—STANDARD 5.3 includes the concepts inherent in results-based accountability of alignment, contributory relationships, and appropriate responsibilities. Critical to this standard is the development and implementation of a community health improvement plan/process (CHIP) that involves ongoing collaborative community-wide effort by the LPHS to identify, analyze, and address health problems; inventory community assets and resources; and identify community perceptions. To complete the loop the CHIP must document the development and implementation of coordinated strategies; develop measurable health objectives and indicators; identify accountable entities; and cultivate community “ownership” of the entire process. In addition, alignment of the OCCHD strategic plan, as well as the strategic plans of community partners, is vital to optimize outcomes and community resources to improve the health of the community.

### SCORES FOR ES 5-STANDARD 5.3 WERE AS FOLLOWS:

<table>
<thead>
<tr>
<th>5.3 Community Health Improvement Process and Strategic Planning - Overall</th>
<th>31%</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.3.1 Community health improvement process established by LPHS. (e.g. MAPP, PACE EH, etc.) Requires broad participation in CHIP that uses community health assessments to identify issues and themes, community assets to prioritize community health issues and develop measurable outcomes and indicators.</td>
<td>67%</td>
</tr>
</tbody>
</table>

| 5.3.2 Strategies address community health objectives (outcomes). Includes the identification and participation of accountable individuals and organizations with defined strategic plans toward the broader community goals. | 25% |

| 5.3.3 Local Health Department (OCCHD) conducts a periodic strategic planning process that includes trends and other factors that impact health or the LPHS and an assessment of the organizations strengths and weaknesses. | 0% |
ES 5—STANDARD 5.4 relates to the roles, functions, and responsibilities of the LPHS related to development and implementation of an “All-Hazards” emergency preparedness and response plans. A broad base of community partners is required with attention to all possible public health emergencies including natural and intentional incidents and disasters. The plans describe community interventions necessary to prevent, monitor, and control the incident. Simulations and drills, as well as after-action reports are important aspects of emergency preparedness planning that assures the capacity and capability for LPHS implementation.

SCORES FOR ES 5-STANDARD 5.4 WERE AS FOLLOWS:

<table>
<thead>
<tr>
<th>5.4 Plan for Public Health Emergencies— Overall</th>
<th>94%</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.4.1 Community task force or coalition for development and maintenance of emergency preparedness and response plans. Broad representation is required.</td>
<td>100%</td>
</tr>
<tr>
<td>5.4.2 LPHS has an all-hazards emergency preparedness and response plan. The plan should identify public health disaster and emergency triggers and be aligned with existing plans, protocols, and procedures within the community. Defined protocols and procedures should clearly describe organizational responsibilities and roles and include all components.</td>
<td>96%</td>
</tr>
<tr>
<td>5.4.3 Review and revision of the all-hazards plan within the past 2 years. Includes testing of the plan through simulations or drills, with After Action Reports, and plan modification based on these findings.</td>
<td>88%</td>
</tr>
</tbody>
</table>

Areas for discussion by LPHS Partners related to ES 5:

1. OCCHD to complete the organizational strategic plan and establish the process as a part of ongoing agency processes. (Completed as of June 1, 2011).

2. Define strategic themes that support the alignment of LPHS activities to accomplish community-based goals and outcomes.

3. Define community-based goals and outcomes leading to the alignment of evidence based approaches by LPHS partners to improve health status.

4. Assure an infrastructure for continued community assessment and community health improvement planning.

5. Build a sustainable system for health policy review and impact assessment to inform the LPHS and key stakeholders for policy action to improve the health of the community.

6. Increase collaborative relationships with community partners across sectors in the community to meet strategic community-based goals and outcomes.

While not a scored item, standard 5.1.3 suggests that the local board of health complete the National Public Health Performance Standards Program Local Public Health Governance Performance Assessment instrument. This tool provides insight into the roles and responsibilities of the local board of health and serves as another aspect of the LPHS.
Essential Service 6 (ES 6): Enforce Laws and Regulations that Protect Health and Ensure Safety

There are 3 standards related to Essential Service 6: 1) Review and evaluation of laws, regulations, and ordinances; 2) Involvement in the improvement of laws, regulations, and ordinances; and 3) Enforcement of laws, regulations, and ordinances.

The overall score for ES 6 was 75%. Essential Service 6 scored the best of all areas scored in this assessment. Scores across the 3 standards were between 75-100% for the majority of indicators with only standard 6.2 consistently scoring below that level.

ES 6 focuses on the review, evaluation, and revision of laws, regulations, and ordinances designed to protect health and safety to assure that they reflect current scientific knowledge and best practices for achieving compliance. Education of persons and entities obligated to obey or to enforce laws, regulations, and ordinances is an important strategy to achieve the goals of ES 6. Enforcement activities include a wide variety of areas and require collaboration with numerous segments of the LPHS, State Public Health System, as well as federal agencies. Examples of areas considered to be within the jurisdiction of the public health sector include drinking water, clean air standards, emergency response, health care facility and system regulation, worksite safety, new medical device applications, seat belt/child safety restraint usage, food establishment inspections, and swimming pool inspections. The results that follow for ES 6 indicate a need for support to maintain the effort, but minimal new resource will be required. A set of possible discussion items related to these results is offered at the end of this section.
ES 6—STANDARD 6.1 defines the importance of reviewing existing federal, state, and local laws, regulations, and ordinances relevant to public health on a regular basis (every 5 years). This review should focus on the authority established by these laws, regulations, and rules, as well as their impact on the health of the community. Public health issues that can be addressed through laws, ordinances, regulations, and rules should be identified and addressed. Further this section identifies the importance of have access to legal counsel to assist with this review.

SCORES FOR ES 6-STANDARD 6.1 WERE AS FOLLOWS:

<table>
<thead>
<tr>
<th></th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1 Review and Evaluation of Laws, Regulations, and Ordinances - Overall</td>
<td>89%</td>
</tr>
<tr>
<td>6.1.1 LPHS identifies issues to be addressed through laws, regulations, and ordinances</td>
<td>75%</td>
</tr>
<tr>
<td>6.1.2 LPHS is knowledgeable about federal, state, and local laws, regulations, and ordinances that protect the public’s health. Addresses a broad spectrum of topics.</td>
<td>100%</td>
</tr>
<tr>
<td>6.1.3 LPHS review of laws, regulations, and ordinances is conducted at least every 5 years; determines if they provide authority to carry out the essential services; assesses compliance and determines the impact on the community; and determines the need for updating.</td>
<td>81%</td>
</tr>
<tr>
<td></td>
<td>100%</td>
</tr>
</tbody>
</table>

ES 6—STANDARD 6.2 builds on the review process described to identify areas not adequately addressed in order to actively participate in the modification of existing laws. Drafting of proposed legislation and regulations, involvement in hearings, and periodic communication with legislators and regulatory officials are integral to providing technical assistance and assuring protection of the public.

SCORES FOR ES 6-STANDARD 6.2 WERE AS FOLLOWS:

<table>
<thead>
<tr>
<th></th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.2 Involvement in the Improvement of Laws, Regulations, and Ordinances—Overall</td>
<td>58%</td>
</tr>
<tr>
<td>6.2.1 LPHS identifies public health issues not adequately addressed in existing laws, regulations, and ordinances.</td>
<td>50%</td>
</tr>
<tr>
<td>6.2.2 LPHS organizations have participated within the past 5 years in the development or modification of laws, regulations, or ordinances identified to not adequately address public health issues. This may involve communication with legislators, regulatory officials, or other policy-makers, as well as participation in public hearings.</td>
<td>75%</td>
</tr>
<tr>
<td>6.2.3 LPHS provide technical assistance to legislative, regulatory, or advocacy groups for drafting proposed legislative, regulations, or ordinances.</td>
<td>50%</td>
</tr>
</tbody>
</table>
**ES 6—STANDARD 6.3** recognizes the unique role within the LPHS of the governmental public health agencies to enforce public health laws, regulations, and ordinances. This area of public health varies significantly from one jurisdiction to another requiring interpretation of appropriate actions of this standard with some activities retained by the state or federal levels. Enforcement activities included identification of the appropriate enforcement authority of the LPHS partners; assures system partners are appropriately empowered to act in public health emergencies and implement necessary community interventions; assures that all enforcement actions are conducted in accordance with laws, regulations, and ordinances; informs and educates individuals and organizations on the meaning and purpose of regulatory activities with which they are required to comply; and evaluates the compliance of regulated organizations and entities.

**SCORES FOR ES 6—STANDARD 6.3 WERE AS FOLLOWS:**

<table>
<thead>
<tr>
<th>6.3 Life-Long Learning Through Continuing Education, Training, and Mentoring - Overall</th>
<th>78%</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.3.1 Governmental public health entities within the LPHS have the authority to enforce laws, regulations, and ordinances related to the public’s health. Requires written documentation identifying roles and responsibilities for each entity with enforcement authority and formal training for staff on compliance and enforcement.</td>
<td>81%</td>
</tr>
<tr>
<td>6.3.2 OCCHD or other governmental entity is empowered through laws and regulations to implement necessary community interventions in the event of a public health emergency. Includes the power to implement quarantine and isolation, as well as mass immunizations and dispensing clinics.</td>
<td>100%</td>
</tr>
<tr>
<td>6.3.3 Incentives are provided to the workforce to participate in educational and training exercises. Examples include career advancement, time off and/or paid attendance for conferences, tuition reimbursement or time-off for course work, and recognition by supervisors. Includes indication of dedicated resources such as a budget and staff for training.</td>
<td>79%</td>
</tr>
<tr>
<td>6.3.4 LPHS provides information about public health laws, regulations, and ordinances to individuals and organizations required to comply with them. Includes information on what laws, regulations, and ordinances; why they exist; and how to comply. Should be integrated into other public health activities such as health education, communicable disease control, and planning.</td>
<td>75%</td>
</tr>
<tr>
<td>6.3.5 LPHS has assessed the compliance with laws, regulations, and ordinances of institutions and businesses in the community within the last 5 years. Input from the regulated entities and other key stakeholders related to difficulty with compliance and resistance to or support for enforcement activities.</td>
<td>54%</td>
</tr>
</tbody>
</table>
Areas for discussion by LPHS Partners related to ES 6:

1. Maintain activities within OCCHD Consumer Protection and Emergency Response Programs to assure maintenance of effort at the current level.

2. Continue engagement of community partners in relation to regulatory and enforcement functions of governmental public health. Reach out to partners not fully engaged, such as the Department of Environmental Quality.

3. Establish a mechanism to conduct a formal review of current laws, regulations, and ordinances at least every 5 years to identify areas needing change.

4. Expand LPHS capacity and capability to provide technical assistance in the identification and development of appropriate and necessary laws, regulations, and ordinances to provide for the health and safety of the community.

Essential Service #7: Link People to Needed Personal Health Services and Assure the Provision of Health Care when Otherwise Unavailable

There are 2 standards related to Essential Service 7: 1) Identification of populations with barriers to personal health services; and 2) Assuring the linkage of people to personal health services.

The overall score for these 2 standards for ES 7 was 70%. A significant difference is noted in the scores between the 2 standards for ES 7, with the identification of barriers to personal health services being rated at 83% and the assuring linkages standard being rated at 56%.

ES 7 emphasizes the role of the LPHS to identify populations who may encounter barriers to personal health services related to a wide range of factors that include age, educational level, poverty, race, language, religion, national origin, physical or mental disability, or lack of health insurance. Additionally, ES 7 addresses the identification of personal health service needs of the general population, limitations on access to coordinated systems of clinical care, and assuring linkages to appropriate personal health services that are culturally and linguistically appropriate are in place to address these barriers and needs. The results that follow for ES 7 require thoughtful review and consistent application of resources to assure on-going effort to improve in this area. A set of possible discussion items related to these results is offered at the end of this section.
ES 7 – STANDARD 7.1 focuses on populations who may encounter barriers to personal health services and provides for the definition of roles and responsibilities for local governmental public health agencies, hospitals, managed care plans, and other community care providers in the provision of these services. The identification of personal health service needs for the general population and for those experiencing barriers to personal health services are specified for preventive, curative, and rehabilitative services for the jurisdiction is specifically defined as a role of the LPHS.

**SCORES FOR ES 7 – STANDARD 7.1 WERE AS FOLLOWS:**

| 7.1 Identification of Populations with Barriers to Personal Health Services - Overall | 83% |
| 7.1.1 LPHS identifies populations who experience barriers to personal health services with an emphasis on population sub-groups considered to be most at risk. | 100% |
| 7.1.2 LPHS identifies personal health service needs of populations for the full spectrum of levels of care ranging from outreach to link people to care through tertiary and restorative services. Also includes mental health, substance abuse, and dental services. | 75% |
| 7.1.3 LPHS assesses the personal health services available to populations who experience barriers to care and the utilization of available services for these populations. | 75% |

**ES 7 – Standard 7.2** denotes the LPHS functions related to supporting and coordinating partnerships and referral mechanisms among the spectrum of providers that include public health, primary care, oral health, social service, and mental health systems. The creation of innovative partnerships within the community is encouraged to help improve access to care.

**SCORES FOR ES 7 – STANDARD 7.2 WERE AS FOLLOWS:**

| 7.2 Assuring the Linkage of People to Personal Health Services - Overall | 56% |
| 7.2.1 LPHS links populations to needed personal health services with an emphasis on assuring appropriateness of services for a wide range of population sub-groups. | 50% |
| 7.2.2 LPHS provides assistance to vulnerable populations in accessing needed health services, assuring services are culturally and linguistically appropriate and that transportation issues are addressed. | 50% |
| 7.2.3 LPHS has initiatives for enrolling eligible individuals in public benefit programs. | 100% |
| 7.2.4 LPHS coordinates personal health and social services to optimize access for populations that may encounter barriers. | 25% |

**Areas for discussion by LPHS Partners related to ES 7:**

1. Initiate or increase dialogue related to the coordination and collaboration of personal health services between multidisciplinary providers and organizations to address identified issues.

2. Clearly define populations experiencing barriers to personal health care.

3. Establish or enhance a sustainable process for the provision of assistance to populations encountering barriers to personal health services.

4. Support for personal health and social services that optimize access to personal health care in the appropriate settings.
Essential Service 8 (ES 8): Assure a Competent Public and Personal Health Care Workforce

There are 4 standards related to Essential Service 5: 1) Workforce assessment, planning and development; 2) Public health workforce standards; 3) Lifelong learning through continuing education, training, and mentoring; and 4) Public health leadership development.

The overall score for ES 8 was 57%. Scores across the 4 standards were fairly consistent indicating an overall need to focus resources on workforce planning and development at all levels of the LPHS.

Critical areas covered by the standards within ES 8 include assessment of the workforce of all sectors of the LPHS such as governmental public health agencies, public and private partner organizations, not-for-profit agencies, and volunteers. The incorporation of the national public health core competencies is included to assure appropriate standards are in place to assure the ability to provide essential public health services. Further, actions related to the adoption of continuous quality improvement and lifelong learning programs for all members of the public health workforce are highlighted, along with the need for attention to public health leadership development. The results that follow for ES 5 require thoughtful review and consistent application of resources to assure ongoing effort to improve in this area. A set of possible discussion items related to these results is offered at the end of this section.
ES 8—Standard 8.1 looks at workforce assessment as a process of determining competencies, skills, and knowledge; categories and number of personnel; and training needed to achieve public health and personal health goals within the community. While a major portion of this assessment will focus on the governmental public health agency, this assessment should establish a baseline for the overall system identifying strengths and assets of each partner. Results from this assessment should be used to build sustainable systems and be included in organizational strategic and operational plans.

**SCORES FOR ES 8-STANDARD 8.1 WERE AS FOLLOWS:**

<table>
<thead>
<tr>
<th>8.1 Workforce Assessment, Planning, and Development - Overall</th>
<th>50%</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.1.1 Assessment of the LPHS workforce within the past 3 years. Includes all of LPHS, analyzing demographics and occupational categories, numbers of workers by category, and skills and experience of the current workforce. Determines areas for improvement.</td>
<td>25%</td>
</tr>
<tr>
<td>8.1.2 Identification of shortfalls and/or gaps in the LPHS workforce. Specific issues to be addressed include gaps in composition, size, skills, and recruitment and retention processes. Also requires attention to the development of plans to address the gaps and formal processes to evaluate the effectiveness of the implementation.</td>
<td>50%</td>
</tr>
<tr>
<td>8.1.3 Dissemination of workforce assessment/gap analysis for use in the development of LPHS organizational strategic and operational planning.</td>
<td>75%</td>
</tr>
</tbody>
</table>

**ES 8—STANDARD 8.2 relates to the LPHS as a whole, but there is particular interest in the local health department since it is the agency with the top concentration of public health professionals responsible to carry out essential public health services. The standard specifically addresses the importance of clearly written position descriptions that are linked to core competencies and annual performance evaluations of personnel. Additionally, the importance of assuring that licensure and certification requirements are met is emphasized.**

**SCORES FOR ES 8-STANDARD 8.2 WERE AS FOLLOWS:**

<table>
<thead>
<tr>
<th>8.3 LifeLong Learning Through Continuing Education, Training, and Mentoring - Overall</th>
<th>58%</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.3.1 LPHS identifies education and training needs to encourage opportunities for workforce development. Includes encouragement for workforce development through distance learning; national, state, local, &amp; regional conferences, staff cross-training; and coaching, mentoring, and modeling. Provides refresher courses for key public health issues (e.g. HIPAA, non-discrimination, &amp; emergency preparedness.</td>
<td>100%</td>
</tr>
<tr>
<td>8.3.2 LPHS provides opportunities for all personnel to develop core public health competencies. Addresses the 8 domains defined by the Council on Linkages as well as the 10 Essential Services and cultural competency.</td>
<td>33%</td>
</tr>
<tr>
<td>8.3.3 Incentives are provided to the workforce to participate in educational and training exercises. Examples include career advancement, time off and/or paid attendance for conferences, tuition reimbursement or time-off for course work, and recognition by supervisors. Includes indication of dedicated resources such as a budget and staff for training.</td>
<td>50%</td>
</tr>
</tbody>
</table>
ES 8—STANDARD 8.4 defines leadership to assure the creation of a public health system committed to improving the health of the community. Development of a shared vision and implementation of the 10 Essential Services are critical components. LPHS leadership may be provided by the local governmental public health agency or it may emerge from the private sectors or the community, or may be shared by multiple stakeholders. The LPHS encourages the development of leadership capacity that is inclusive, representative of community diversity, and respectful of the community's perspective. This is accomplished through the provision of formal opportunities for leadership development at all organizational levels; the promotion of collaborative leadership through a shared vision for the LPHS and participatory decision-making; assuring opportunities for organizations and individuals to provide leadership in their areas of expertise, and the development of diverse community leadership to assure sustainability of public health initiatives.

SCORES FOR ES 8-STANDARD 8.4 WERE AS FOLLOWS:

<table>
<thead>
<tr>
<th>8.4 Public Health Leadership Development - Overall</th>
<th>55%</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.4.1 Organizations in the LPHS promote development of leadership skills. Includes participation in the National Public Health Leadership Institute, regional/state public health leadership institutes, executive management seminars or programs, mentoring middle management &amp; supervisors, or graduate programs in leadership/management. Promoting leadership at all organizational levels; the promotion of collaborative leadership through a shared vision for the LPHS and financial resources to support leadership development are identified.</td>
<td>69%</td>
</tr>
<tr>
<td>8.4.2 Organizations in the LPHS promote collaborative leadership through creation of a shared vision and participatory decision making. Includes established mechanisms that encourage informed participation such as forums and list serves.</td>
<td>50%</td>
</tr>
<tr>
<td>8.4.3 LPHS provides leadership opportunities for individuals and/or organizations in areas where their expertise or experience can provide insight, direction, or resources.</td>
<td>50%</td>
</tr>
<tr>
<td>8.4.4 LPHS recruits and retains new leaders that are representative of the population diversity in the community through coaching and mentoring.</td>
<td>50%</td>
</tr>
</tbody>
</table>

Areas for discussion by LPHS Partners related to ES 8:

1. Conduct an assessment of the LPHS workforce that will lead to a LPHS workforce development plan. Collaboration with the College of Public Health is critical to the success of this activity.

2. Establish a LPHS Workforce Development Plan for Oklahoma County.

3. Identify appropriate training needs and develop training/educational opportunities for the local governmental public health agency (OCCHD) and other LPHS partners based on the needs assessment.

4. Assure the inclusion of public health core competencies in job descriptions for all OCCHD employees and encourage the inclusion of same with all LPHS partners.

5. OCCHD to establish and implement an agency-wide employee performance appraisal process based on national standards.—(Established and implemented as of 6-1-2011).

6. Provide training for LPHS on public health core competencies and the 10 essential services as a foundation.

7. LPHS to participate in the national, state, and regional leadership development opportunities.
Essential Service 9 (ES 9): Evaluate Effectiveness, Accessibility, and Quality of Personal and Population-Based Health Services

The NPHPSP breaks this Essential Service into 3 standards: 1) The evaluation of population-based health services; 2) The evaluation of personal health services; and 3) The evaluation of the local public health system overall.

The overall score for these 3 standards for ES 9 was 45% and was the bottom for the 10 Essential Services scored. Scores for 4 other Essential Service areas were below 60% and are important to consider when evaluating the ES 9 results.

- ES 10-Research/Innovations (47%)
- ES 5-Develop Policies/Plans (55%)
- ES 8-Assure Competent Workforce (57%)
- ES 4-Mobilize Partnerships (58%)

The importance of effective planning and training is well documented as a foundation for assuring quality service provision in both personal and population health. As will be seen, the need for building relationships and constituencies and conducting stakeholder assessments are critical areas to be evaluated. Further, it is impossible to develop an evidence base of practice without the implementation of effective evaluation strategies for programs and services followed by communication of results to key stakeholders and partners. The results that follow for ES 9 require careful collaborative review and consideration to establish effective plans and sustainable processes for improvement. A set of possible discussion items related to these results is offered at the end of this section.
ES 9—STANDARD 9.1 focuses on evaluation of population-based health services and requires the Local Public Health System (LPHS) to regularly evaluate the accessibility, quality, and effectiveness of services such as injury prevention initiatives, physical activity strategies, and immunization programs based on program goals and established performance criteria. This standard further requires an assessment of community satisfaction that includes residents who are representative of the community and groups at increased risk of negative health outcomes. Additionally, gaps in population-based services and use of the evaluation findings is required to provide a basis to modify the strategic and operational plans of LPHS organizations to meet the defined needs.

SCORES FOR ES 9-STANDARD 9.1 WERE AS FOLLOWS:

<table>
<thead>
<tr>
<th>9.1 Evaluation of population-based health services - Overall</th>
<th>72%</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.1.1 LPHS has evaluated population-based health services in the last 3 years which include a wide range of preventive services such as injury, tobacco use, and obesity prevention, as well as immunization programs and environmental health. Additionally, requirements for defined criteria for evaluation with goals and established targets based on quality standards are integral to this measure.</td>
<td>63%</td>
</tr>
<tr>
<td>9.1.2 LPHS assesses community satisfaction with population-based health services meeting specific criteria for obtaining input from a cross-section of the community and identification of areas for improvement.</td>
<td>75%</td>
</tr>
<tr>
<td>9.1.3 LPHS identifies gaps in the provision of population-based health services.</td>
<td>75%</td>
</tr>
<tr>
<td>9.1.4 LPHS uses the results of population-based health services evaluation in the development of strategic and operational plans.</td>
<td>75%</td>
</tr>
</tbody>
</table>

ES 9—STANDARD 9.2 shifts the focus to the evaluation of the personal health care system including the accessibility, quality, and effectiveness across all spectrum of personal healthcare from preventive services to acute care and hospice care. Special attention is given to the ability of community providers to deliver services across life stages and to varying population groups. Client satisfaction is an important component, again with representation from actual and potential user groups and identification of barriers and usability of services.

SCORES FOR ES 9-STANDARD 9.2 WERE AS FOLLOWS:

<table>
<thead>
<tr>
<th>9.2 Evaluation of personal health services - Overall</th>
<th>44%</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.2.1 LPHS has evaluated personal health services for the community within the last 3 years addressing access, quality, and effectiveness of personal health services.</td>
<td>25%</td>
</tr>
<tr>
<td>9.2.2 Personal health services are evaluated against established standards relevant to the level of care and provider (such as JCAHO, HEDIS, PHAB, etc.).</td>
<td>50%</td>
</tr>
<tr>
<td>9.2.3 LPHS assesses client satisfaction with personal health services that addresses the scope of personal health services, how well needs are met, responsiveness to complaints or concerns, and systems related to payment. Areas for improvement should be identified.</td>
<td>25%</td>
</tr>
<tr>
<td>9.2.4 LPHS uses information technology to assure quality of personal health services with attention to use of electronic health records and technology used to facilitate communication among providers.</td>
<td>44%</td>
</tr>
<tr>
<td>9.2.5 LPHS uses evaluation results of the evaluation in the development of strategic and operational plans.</td>
<td>75%</td>
</tr>
</tbody>
</table>
**Local Public Health System Assessment (cont.)**

**ES 9—STANDARD 9.3** reviews the performance of the local public health system as a whole. A local public health system includes all public, private, and voluntary entities, as well as individuals and informal associations that contribute to the delivery of the Essential Public Health Services within a jurisdiction. The lead role for convening the collaborative evaluation process in Oklahoma County falls to the Oklahoma City-County Health Department. National standards consistent with this assessment form the basis for this evaluation and the findings should be used to inform the community health improvement process and to improve services and programs. Key components of this standard are the identification of community organizations that contribute to the delivery of all Essential Services; use of established criteria to evaluate the comprehensiveness of LPHS at least every 5 years; assessment of effectiveness of communication, coordination, and linkage among entities; and use of the information for quality improvement of the LPHS.

**SCORES FOR ES 9-STANDARD 9.3 WERE AS FOLLOWS:**

<table>
<thead>
<tr>
<th>9.3 Evaluation of the Local Public Health System - Overall</th>
<th>20%</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Includes identification of partners, inclusiveness of evaluation process, an evaluation of organizational relationships through a formal process, and use of the information to guide actions for community improvement.)</td>
<td></td>
</tr>
</tbody>
</table>

| 9.3.1 LPHS identifies community organizations or entities that contribute to the delivery of the Essential Public Health Services. | 50% |
| 9.3.2 LOPHS conducts periodic comprehensive evaluation of LPHS based on national standards (every 3-5 years and includes participation of a wide range of LPHS entities.) | 29% |

| 9.3.3 LPHS conducts a partnership assessment that evaluates the relationships among organizations including formal and informal processes & communication; coordination; and effective use of resources. | 0% |
| 9.3.4 LPHS uses evaluation results to guide community health improvements including refining current programs, establishing new programs, redirecting resources, and to inform the community health improvement process. | 0% |

**Areas for discussion by LPHS Partners related to ES 9:**

1. Initiate or increase dialogue related to the roles and relationships of local public health system (LPHS) partners.

2. Identify and institutionalize a sustainable process for the periodic evaluation of the LPHS utilizing a standard format that assures a broad representation of community partners.

3. Convene community partners to review data from current Community Health Improvement Plan to establish effective collaborative groups to assure the community health improvement.

4. Continue planning to maintain and extend the development and implementation of information technology (e.g. Health Information Exchange or Regional Health Information Organization) for the LPHS.
Essential Service 10 (ES 10): Research for New Insights and Innovative Solutions to Health Problems

The NPHPSP breaks this Essential Service into 3 standards: 1) Fostering innovation; 2) Linkage with institutions of higher learning and/or research; and 3) Capacity to initiate or participate in research.

The overall score for these 3 standards for ES 10 was 47% and was the one of the bottom for the 10 Essential Services scored.

The research function for local public health systems is often overlooked in favor of the provision of services. This ES denotes the importance of innovation and the translation of evidence into practice, as well as the need to disseminate results of evaluations and practice-based research to the public health community at-large. Innovations ranging from practice-based efforts to more academic efforts that encourage new directions in public health research are encouraged. Additionally, the importance of linkages with institutions of higher learning is noted. Building and maintaining capacity to conduct research relevant to health policy and health systems is also a critical component.

ES 10—STANDARD 10.1 discusses both practice-based innovation that foster change and academic efforts that encourage scientific-based research. The focus of this standard is to identify health issues for investigation by LPHS agencies and partners. Encouragement to support staff in the ability to conduct pilot tests and ongoing evaluation of new ideas in the field is included. The need to routinely monitor “best practice” information from local, state, and national perspectives is important to the advancement of public health for the future.

### SCORES FOR ES 10-STANDARD 10.1 WERE AS FOLLOWS:

<table>
<thead>
<tr>
<th>10.1 Fostering Innovation - Overall</th>
<th>31%</th>
</tr>
</thead>
<tbody>
<tr>
<td>10.1.1 LPHS supports the development of new solutions through the provision of time and resources to pilot test or conduct more formal studies that address broad health issues, as well as barriers and facilitators for implementation.</td>
<td>25%</td>
</tr>
<tr>
<td>10.1.2. LPHS during the past 2 years, proposed one or more public health issue for inclusion in research agenda of appropriate research partners.</td>
<td>50%</td>
</tr>
<tr>
<td>10.1.3. LPHS identify and stay current with “best practices” through appropriate review of scientific publications, participation in professional associations, and attendance at national and state conferences.</td>
<td>25%</td>
</tr>
<tr>
<td>10.1.4 LPHS encourages community participation in the development or implementation of research.</td>
<td>25%</td>
</tr>
</tbody>
</table>
ES 10—STANDARD 10.2 defines the LPHS linkages and relationships important to support innovation and research leading to an effective evidence-base for informed decision making and planning. It is indicated that LPHS partners should have formal and informal relationships with a wide range of organizations and institutions in both the public, private, and academic sectors. More formal partnerships with institutions of higher learning or research are strongly encouraged in order to facilitate public health research, including community-based participatory research, and to support collaboration that fosters the availability of training experiences and continuing education opportunities.

SCORES FOR ES 10 STANDARD 10.2 WERE AS FOLLOWS:

| 10.2 Linkage with Institutions of higher learning and/or research organizations - Overall | 65% |
| 10.2.1 LPHS has formal and informal relationships with institutions of higher learning and/or research organizations including availability of consultation and technical assistance. | 50% |
| 10.2.2 LPHS partners with at least one institution of higher learning or research organization to conduct public health systems and services research. | 75% |
| 10.2.3 LPHS encourages collaboration between the academic and practice sectors that provides for the exchange of faculty and PH workforce members; field training and work-study experiences for students; and continuing education for the public health workforce. | 75% |

ES 10—STANDARD 10.3 frames the importance of the LPHS capacity to initiate and/or participate in research that contributes to epidemiological and health policy analyses and improved health system performance. This research should include the examination of factors related to the efficient and effective implementation of the essential public health services, as well as variables related to health care quality and delivery. Further, this standard addresses the need to assure capacity within the LPHS to design and carry out studies in epidemiology, policy, and health systems areas. All aspects of research and evaluation should be addressed from identification of topics through dissemination of findings, as well as the impact of the research on public health practice.

SCORES FOR ES 10-STANDARD 10.3 WERE AS FOLLOWS:

| 10.3 Capacity to Initiate or Participate in Research - Overall | 44% |
| 10.3.1 LPHS has access to researches with experience in epidemiology, health policy, health economics, health services, public health systems, and community-participatory research. | 50% |
| 10.3.2 LPHS has access to resources such as databases, technical libraries, distance learning, and on-line to facilitate research. | 25% |
| 10.3.3. LPHS disseminates findings from research. | 25% |
| 10.3.4. LPHS evaluates the development, implementation and impact of research on public health practice. Also the LPHS demonstrates involvement of community representatives in collaborative research efforts. | 25% |
Areas for discussion by LPHS Partners related to ES 10:

1. Potential to increase opportunities for public health systems and services research that support innovation in practice with the potential of improving the health of the community.

2. Support on-going evaluation processes that provide evidence for informed decision-making by the LPHS for use in planning and implementation of programs and services.

3. Utilize the best available evidence to inform policy decisions to improve health of the community.

4. Assess the need to expand and strengthen relationships with a broader range of academic settings (beyond traditional public health and community health programs) to increase the inter-disciplinary preparation of public health practitioners and assure a competent and capable workforce.

5. Support effective data collection and analysis systems that assure availability of qualified professionals with the knowledge and skill to design and conduct studies related to policy, health systems, and disease specific responses to improve health.

6. Support the development and dissemination of LPHS best practices to the broader public health community at the local, state, and national levels through publication and presentations targeted to appropriate public health system partners.

7. Seek opportunities to partner at the local, state, and national levels to initiate or participate in the development and evaluation of innovative practices.
• Identify methods and initiate processes to reach out more effectively to the community at large for involvement in planning and activities to improve health.

• Focus on communication to link with groups such as education, faith based community, Central Oklahoma Turning Point (COTP), and the media.

• Collaborate with other agencies and organizations with similar objectives to reduce duplication and enhance resource utilization.

• Establish or enhance a sustainable process that addresses barriers to personal health services to include:
  a. Dedicated funding to transportation to get people access to services,
  b. “Ways to adequately fund Wellness Now and other community coalitions. OCCHD is on the right track but needs to execute and deliver.”
  c. Elimination of stigma that the problem affects “those people” (be more inclusive of all populations, greater participation in wellness programs).

• Establish criteria for tracking progress and connect that process to Quality Improvement principles for each focus area of Wellness Now.

• Establish method for reporting progress, which is useful to system partners as an evaluation and planning tool.

• Develop data gathering systems that will adjust with changing local and national priorities and will align with accreditation needs of local partners.

• Create a Data Workgroup as Wellness Now focus area.

• Support effective data collection and analysis systems that assure the knowledge and skill to design and conduct studies related to policy, health systems, and disease specific responses to improve health for use in planning and implementation of effective and efficient public health services across the LPHS. Includes:
  a. LPHS workforce assessment, planning, and development to assure availability of qualified professionals.
  b. Evaluation of efficiency and effectiveness of programs and services across the LPHS.
  c. Use of methods that foster innovation and interpretation of data to for the development and implementation of LPHS programs and services.
As data and information was collected and analyzed from the three assessments of the MAPP process, it became clear that the Wellness Now Initiative was the appropriate community-based structure to complete this important task. The availability of critical community partners providing expertise across all sectors of the community into the Forces of Change Assessment as the final phase was a resource just waiting to be tapped.

The Wellness Now Initiative then became the foundation for the development of the Oklahoma County Community Health Improvement Plan and will serve to facilitate the implementation of action based on this plan.

Wellness Now represents a major, coordinated push to bring community resources together to provide a framework for improving our health and helping people change their behaviors. Instead of concentrating primarily on treating illness, the focus is shifting toward promoting wellness and preventing health problems before they occur.

The Forces of Change Assessment was carried out under this umbrella with each of the original five workgroups reviewing the information from the Community Health Assessment (CHA) to identify strategic initiatives to be addressed. Each workgroup utilized a process that included a review of the data from the first three assessments, identification of economic and political realities, and opportunities and challenges to the development and implementation of activities as they formulated this plan to address the defined issues. An in-depth look at “best practices” related to these issues (evidenced in the Resources Section of the Community Health Improvement Plan) provided a basis for the development of proposed policy recommendations and action plans.

Wellness Now, linked with the data collection and analysis expertise of OCCHD, provides an ongoing structure that allows for the identification of emerging trends and issues and the ability to respond locally in a timely fashion. This can be seen with the addition of the Mental Health Workgroup in September 2011 addressing the need for access to care.

The current Wellness Now structure also provides a mechanism to assure accountability for accomplishing the strategic initiatives and actions identified in the Community Health Improvement Plan and to provide feedback into future Community Health Assessment activities.
In Conclusion

Oklahoma County is a vibrant and rapidly changing community with many distinct neighborhoods, cultures, and traditions. However, Oklahoma County’s size and diversity pose challenges to providing services to all areas of the county, as some parts of the county are urban and some parts are rural. That diversity provides enormous potential for significant positive health changes. Developing strategies to meet and improve the challenges posed by health disparities within Oklahoma County is critical to the future success of county residents and to the state as a whole, whether from differences in race and/or ethnicity, income levels, geography, or physical and social environmental factors.

Findings from the MAPP assessments summarized in this document indicate solutions are within reach of our current resources, but will require a change in mindset of everyone living in Oklahoma County. Changes may involve personal decisions made about education, diet, and exercise, as well as a broader perspective about changes needed in the development of the communities in which we live. While the findings may appear overwhelming and raise concerns about success, all who have read this report should find energy in the knowledge that health is universal. “Health is the one discussion that binds us all together toward a common, unifying goal.”

Three essential concepts were identified from the Oklahoma County Community Health Assessment and form a foundation from which improvement can occur. These are the concepts that provided a structure for development of the Oklahoma City and County 2011 Community Health Improvement Plan. They are:

1. Issues that reduce the combined negative effect of social and medical determinants of health must be addressed. Ongoing data analysis to monitor and identify emerging trends and new concerns will support this response.

2. Sustainable and relevant programs and services require reaching out to the people of the communities we serve. We must work with people where they live, learn, work, and play to gain acceptance for change.

3. A shared vision between community partners and members of the community requires a broad understanding of health and provides the support and resources for lasting improvement. Through collaborative efforts across all sectors of the community the inclusion of health in all policies and system changes can occur.

The Oklahoma City-County Health Department encourages everyone to find a venue to participate in the process of changing the collective mindset from accepting the current state of health toward one of a desired state of health. Wellness Now provides an avenue to participate and an organized approach to use the information identified in this report to move us forward in the implementation of the Oklahoma City and County Community Health Improvement Plan.
Our Mission
To improve the health and wellness of Oklahoma City and County residents through community partnerships

Our Vision
Working together to improve the health of individuals, families and our community by shifting our focus from treatment to prevention and wellness