TULSA HEALTH
Department

Tulsa County Community Health Improvement Plan

2024-2025 Annual Report Review

Tulsa County Community Health Improvement Plan (CHIP)

2024–2025 Annual Report Review

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Executive Summary

The 2024–2025 Tulsa County Community Health Improvement Plan (CHIP) Annual Report Review documents the second year of implementation progress under the 2023–2028 CHIP cycle. Covering April 2024 through April 2025, the report highlights strategic advancements that reinforce the Tulsa Health Department's (THD) commitment to cross-sector collaboration, data-informed action, and continuous quality improvement—driving expanded health access for all Tulsa County residents.

The CHIP is housed within THD's Office of Community Health and Quality Improvement and guided by the Public Health Accreditation Board (PHAB) 2.0 and adapted National Association of County and City Health Officials' Mobilizing for Action through Planning and Partnerships (MAPP) 2.0 framework. Year 2 implementation activities centered on three priority areas identified in the 2022 Tulsa County Community Health Needs Assessment (CHNA):

- Stress and Mental Health,
- Chronic Disease Risk Factors and Management, and
- Healthy and Affordable Housing.

Throughout Year 2, CHIP partners deepened collective accountability through collaboration among workgroups, co-led implementation, and feedback-informed refinement. Workgroups met regularly to assess progress, share innovations, and update action plans with revised objectives, indicators, and engagement strategies. These efforts align directly with THD's 2025–2029 Strategic Plan, which was shaped by the CHIP.

Key accomplishments this year include:

- Completion of the CHIP Year 2 Midpoint Progress Review (April 2025), showing that 31.3% of strategies were completed or on track, while 68.7% were in progress, under revision, or delayed.
- Expansion of community engagement infrastructure, including hybrid workgroup meetings, site-based gatherings hosted by CHIP Partners to Know, THD Program Highlights, and stronger integration of grassroots perspectives.
- Formal tracking of Continuous Quality Improvement (CQI) revisions to action plans, enabling responsive, measurable adjustments to objectives, timelines, and evaluation methods.
- A strengthened partnership structure with clearer expectations for shared implementation and co-leadership, exemplified by the CHIP Advisory Team and CHIP Leadership Team.

This report also provides:

- A detailed summary of each priority area's implementation progress, including objectives, revisions, and rationale for changes.

- Identification of improvement areas such as data-sharing, accountability mechanisms, interagency alignment, and strategic communication.
- Forward-looking recommendations for Year 3 and beyond, focused on intentionality, partner access, and measurable community impact.

The CHIP remains a vital framework for mobilizing collective action, fostering trust across sectors, and pursuing structural changes that remove barriers to health. This Annual Report Review serves as both a snapshot of progress achieved and a tool for reflection, accountability, and shared learning—guiding our continued journey toward greater health access and thriving communities across Tulsa County.

Tulsa Health Department and CHIP:

Who We Are

Mission

To protect and support Tulsa County communities in pursuit of their health goals.

Vision

Tulsa County Communities will meet their health goals.

Values

We're committed to the constant pursuit of a healthier Tulsa, and we do so by carrying out our core values:

- We believe in the value of every person.
- We believe every person must be treated equally with dignity and respect.
- We believe in giving people resources and opportunities to make informed and healthy choices.
- We believe people deserve honesty and trustworthiness in all we do.
- We believe every person will experience our services in a safe, caring, trauma-informed and confidential manner.

CHIP Partners

9bcorp
Away Home for Tulsa
Ability Resources, Inc.
Activate Oklahoma Incorporated
Aetna
Alzheimer's Diversity Outreach Services
American Heart Association
Ascension St. John Clinical Research Institute
Ascension St. John Health System
Autoimmune Association
Blue Cross and Blue Shield of Oklahoma
CAP Tulsa
Catholic Charities of Eastern Oklahoma
City of Tulsa
Community Health Connection
Counseling + Recovery Services
CREOKS
Echota Behavioral Health
Family and Children's Services
Family Children's Services
Girl Scouts of Eastern Oklahoma
GRAND Mental Health
H.O.P.E. Testing
Healthy Minds Policy
Hillcrest Medical Center
Housing Solution Tulsa
Humana Healthy Horizons
Humble Sons Bike Company
Indian Nations Council of Governments
Integris Health
Legal Aid Services of Oklahoma, Inc.
Lesley University
Mental Health Association Oklahoma
Morton Comprehensive Health Services
My Signal Tree
MyHealth Access Network
OKDHS
Oklahoma Association for Infant & Early Childhood Mental Health
Oklahoma Career Tech
Oklahoma Community Health
Oklahoma Department of Human Services
Oklahoma Family Network
Oklahoma Medical Reserve Corps
Oklahoma Project Woman
Oklahoma State Department of Health
Oklahoma State Department of Human Services
Oklahoma State Health Department
Oklahoma State University Center for Health Sciences
OU Sooner Health Access Network
Our Project Experience
Parent Child Center Tulsa
Parkside Psychiatric Hospital & Clinic
Partner Tulsa
Restore Hope Ministries
Saint Francis Health System
Salvation Army
The Humble Sons (Bike Club Tulsa)
Tulsa Area United Way
Tulsa CARES
Community Members
Tulsa Day Center
Tulsa Health Department
Tulsa Housing Authority
Tulsa Public Schools
Uma Tulsa
University of Oklahoma Health Sciences Center
YWCA Tulsa

About This Report

Purpose

This report documents progress during Year 2 (April 2024–April 2025) of the CHIP. It describes how the community and partners are working together to achieve shared health goals, tracks accomplishments, and highlights where adjustments were made to guide future actions.

Specifically, this report aims to:

- Showcase progress and accomplishments achieved so far.
- Inform partners, stakeholders, and the community about ongoing efforts.
- Support accountability and transparency in implementation.
- Align with national public health accreditation standards.

Background on CHIP

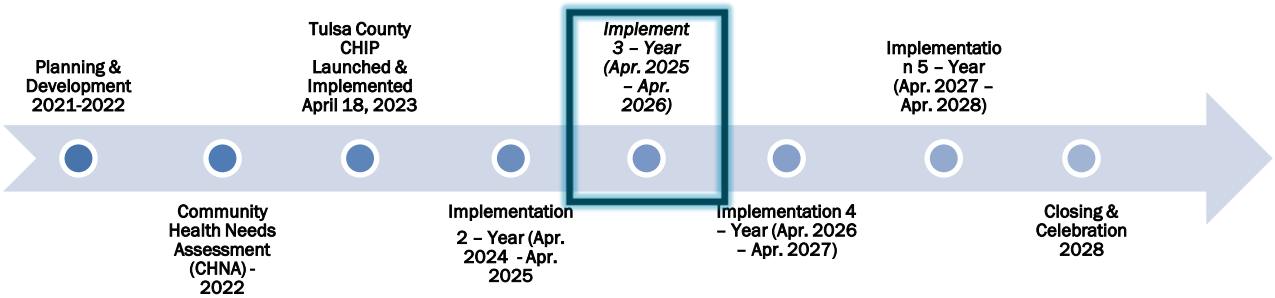
The CHIP is a five-year roadmap for improving health and well-being across the county. It is led by the Tulsa Health Department's Office of Community Health and Quality Improvement and developed with input from more than 65 cross-sector partners including: healthcare, education, housing, and community-based organizations and community members.

The current CHIP covers April 2023 through April 2028 and is informed by the findings of the 2022 Community Health Needs Assessment (CHNA) data baseline. It focuses on three priority areas:

1. Stress and Mental Health
2. Chronic Disease Risk Factors and Management
3. Healthy and Affordable Housing

These priorities reflect the most pressing health challenges facing Tulsa County residents, selected through extensive community engagement, data analysis, and collaborative decision-making. CHIP provides a shared framework for collective action, enabling diverse partners to align efforts, measure progress, and build healthier, more resilient communities.

Timeline:



How the Report Was Developed

Timeline

The development of the April 2024 – April 2025 Annual Report Review followed a structured timeline to ensure timely analysis, partner input, and alignment with the overall CHIP evaluation cycle. Key phases included:

- **April–May 2025:** Internal CHIP Action Plan progress reviews by workgroups and Office of Community Health & Quality Improvement.
- **April 2025:** Dissemination of the 2025 CHIP Partner Feedback Survey.
- **June-August 2025:** Analysis of partner feedback, progress data, and action plan updates.
- **August 2025:** Drafting and finalization of the annual report for dissemination to partners and stakeholders.

This timeline was synchronized with key milestones across the CHIP Workgroups to allow for integrated reporting of implementation progress, feedback, and strategic recommendations.

Community Partners Engagement

CHIP partners are foundational to the success of this report. Their engagement occurred through:

- **CHIP Quarterly Meetings:** Partners engaged in data-informed presentations and panel discussions aligned with the action plans for each health priority.
- **CHIP Workgroup Meetings:** Partners participated in real-time progress discussions, action plan revisions, and feedback sharing.
- **2025 CHIP Partner Feedback Survey:** Distributed to all engaged organizations to gather perspectives on successes, challenges, and opportunities for improvement.
- **1:1 Discussions and Site Visits:** Targeted outreach to high-impact organizations provided qualitative context for implementation stories and data interpretation.
- **Presentation and Data Contributions:** Several partner agencies contributed directly to progress updates by hosting and presenting during the “CHIP Partners to Know” series.
- **Internal Partnership Contributions:** Multiple THD programs supported progress by participating in the “THD Program Highlight” series through presentations.

The feedback, insights, and experiences of partners directly informed report content, narrative framing, and final recommendations.

Data Sources

This report draws upon a comprehensive mix of quantitative and qualitative data sources to evaluate progress and inform continuous improvement. Key sources include:

- *Action Plan Tracking Tools (AchieveIt):* Used to systematically monitor progress toward SMART objectives across all three CHIP priority areas.
- *2024–2025 CHIP Partner Feedback Survey:* Quantitative data and open-ended responses from partners provided valuable insights into levels of engagement, perceived impact, and the quality of strategy implementation.
- *CHIP Workgroup Meeting Records and Reports:* Detailed documentation from each workgroup meeting was reviewed to assess real-time strategy execution, emerging needs, and collaboration dynamics.
- *Tulsa Health Status Report:* Public health indicators and local community health trends were analyzed to contextualize progress toward long-term population health outcomes.
- *2022 Tulsa County CHNA:* The foundational data source for establishing CHIP baseline indicators. These baseline measures were critical in setting initial performance targets and identifying community priorities.
- *2025 CHNA:* THD recently collaborated with Saint Francis Health System and Ascension St. John Health System to support the development of the 2025 Tulsa County CHNA. Early results from this updated assessment are directly aligned with and reflective of trends first identified in the 2022 CHNA, reaffirming the importance of data-driven planning and reinforcing the relevance of ongoing CHIP efforts in addressing evolving community health needs.

What Changed Since Last Year

Key Action Plan Revisions

During Year 2 of implementation (April 2024 – April 2025), the CHIP Workgroups reviewed and updated their Action Plans based on lessons learned, data trends, and feedback from community partners. The updates reflect a commitment to continuous quality improvement and keeping efforts responsive to community needs.

Key changes across Action Plans included:

Refining Objectives for Greater Impact

- Several objectives were revised to improve clarity, feasibility, or alignment with measurable outcomes.
- Some objectives were combined or retired to reduce redundancy and better focus efforts.

Adjusting Measures and Timelines

- New or revised performance measures were introduced to better track implementation.
- Some timelines were extended based on realistic pacing of community partner capacity and external barriers (e.g., funding, staffing).

Adding New Strategies and Partners

- Based on Year 1 engagement and new partnerships, several workgroups added fresh strategies that reflect expanding community involvement.
- Cross-sector contributions, especially from behavioral health, housing, and education partners increased, adding depth and innovation to action plans.

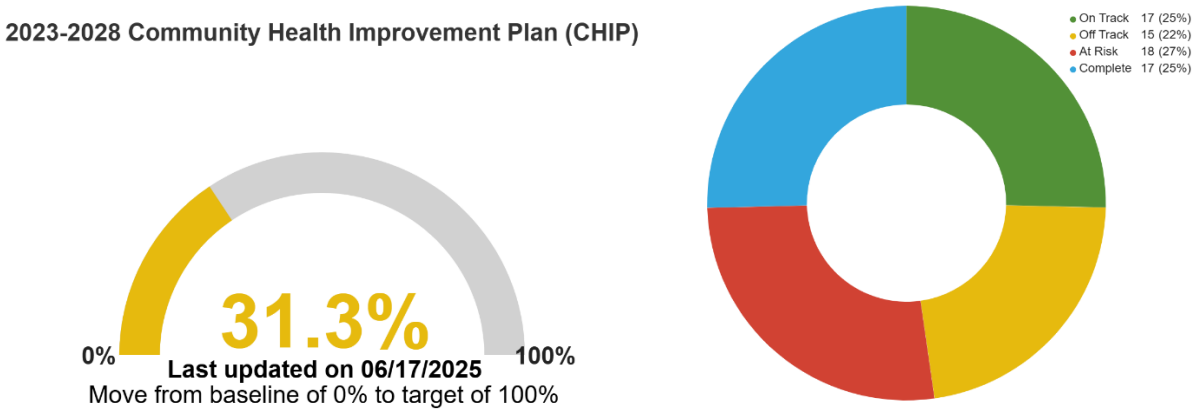
Elevating Community Engagement

- A renewed focus on community voice resulted in the integration of more community-informed activities across all three CHIP priorities.
- Partner-hosted meetings, listening sessions, and new storytelling components were introduced to ensure the work remains people-centered and grounded in lived experience.

These changes demonstrate an adaptive approach to implementation, rooted in collaboration, reflection, and responsiveness to what's working and what's not. Each update was reviewed and approved by CHIP Workgroups to maintain shared ownership and accountability.

Overall Progress

As of April 2025, the CHIP stands at 31.3% completion. This progress reflects early achievements in partnership development and implementation of select initiatives across priority areas. However, the plan remains off track relative to its overall goals, indicating that significant work is still required to meet the targeted outcomes by 2028. The current status calls for renewed focus on strategy execution, enhanced collaboration among partners, and addressing existing barriers to accelerate progress over the remaining timeline.



Criteria for Developing CHIP Objectives

CHIP objectives are created using data, partner input, and evidence-based practices to ensure they are focused, measurable, and community-driven.

- *Aligned with Priorities & Data:* Supports one of the three CHIP priority areas, uses CHNA findings, and addresses root causes.
- *SMART Framework:* Specific, Measurable, Achievable, Relevant, and Time-bound.
- *Evidence-Based:* Draws from national best practices and promising local strategies.
- *Measurable & Feasible:* Includes baseline, target, data source, responsible partners, and realistic scope.
- *Collaborative:* Encourages cross-sector partnerships and community engagement.
- *CQI-Ready:* Reviewed quarterly and annually using PDSA for continuous improvement.

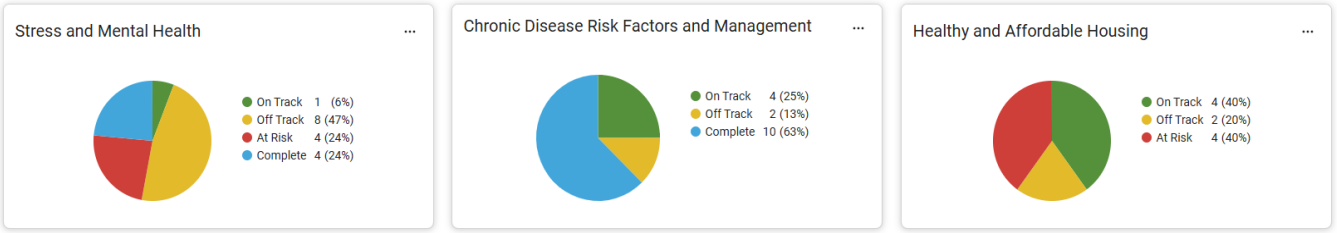
At-a-Glance Status Reporting

The CHIP At-a-Glance Status Reporting system uses a color-coded framework to quickly convey implementation progress. As of the current reporting period, objectives fall across all four indicators:

At-a-Glance Status Reporting	
Status Indicator (Percentage Objective Completion)	Objective Action
Red (0%)	Objective is not progressing as planned. Action I: Review and revise.
Yellow (1% - 49%)	Objective is progressing with some challenges. Action (A): Address specific challenges.
Green (50% - 99%)	Objective is progressing as planned. Action (G): Maintain current strategies.
Blue (100%)	Objective is complete. Action (B): Report findings.

This system ensures timely action planning, performance transparency, and continuous quality improvement across all CHIP priorities.

Progress by Priority

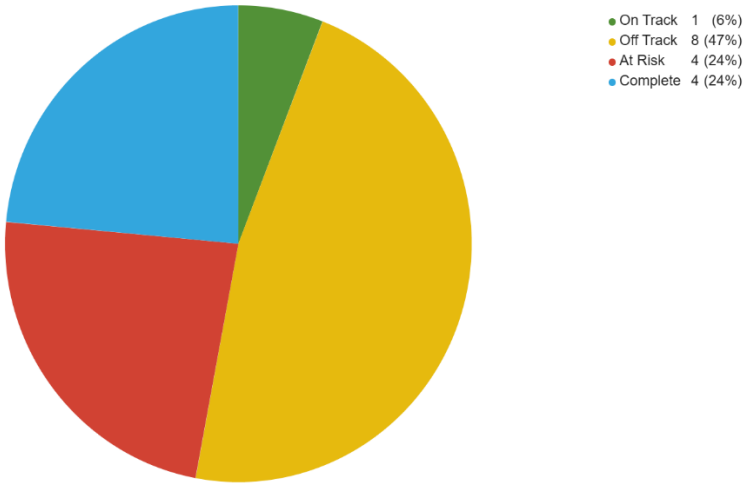


Stress and Mental Health (SMH)

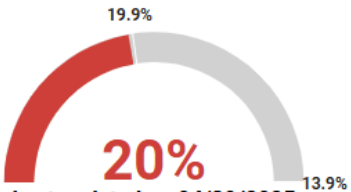
Tulsa County faces significant mental health disparities exacerbated by local socioeconomic challenges and systemic inequities. The county's suicide rate is approximately 20 per 100,000, notably higher than the 2021 U.S. rate of 13.9 per 100,000 (CDC WONDER, 2023). Nearly 47% of residents needing mental health services report barriers to access, worsening outcomes (Oklahoma State Department of Health, 2024).

High incarceration rates among individuals with untreated behavioral health disorders further compound these issues (James & Glaze, 2006; APA, 2020). Socioeconomic factors such as poverty, housing instability, and unemployment disproportionately affect diverse communities in Tulsa County, limiting access to care (U.S. Census Bureau, 2020; Tulsa Health Department, 2023).

Stigma, cultural mistrust, and limited provider capacity hinder early intervention. SAMHSA (2022) highlights trauma-informed, culturally responsive care as essential for improving service use and outcomes. This priority targets reducing suicide, expanding service access, lowering substance misuse impact, and fostering cross-sector collaboration aligned with Healthy People 2030 (ODPHP, 2020).



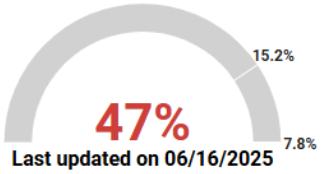
SMH - Goal 1: Reduce the Age-Adjusted Suicide Mortality Rate from 19.9% to 13.9% (US rate) per 100,000 by 2028.



Last updated on 04/30/2025

Move from baseline of 19.9% to target of 13.9%

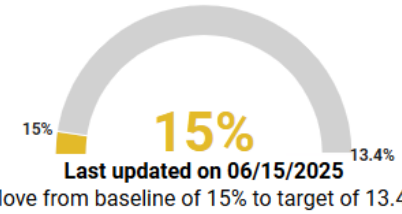
SMH - Goal 2: Decrease the Rate of Those Unable to Get Mental Health Services from 15.2% to 7.8% (US rate) by 2028.



Last updated on 06/16/2025

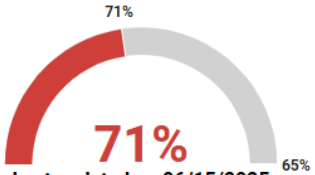
Move from baseline of 15.2% to target of 7.8%

SMH - Goal 3: Decrease the Rate of Those Living Below the Poverty Level from 15.0% to 13.4% (US rate) by 2028.



Last updated on 06/15/2025
Move from baseline of 15% to target of 13.4%

SMH - Goal 4: Decrease the Rate of Perceptions of Substance Misuse as a Problem in the Community from 71% to 65% by 2028.



Last updated on 06/15/2025
Move from baseline of 71% to target of 65%

SMH - Goal 5 (Internal to the CHIP Workgroup) Foster a culture where collaboration is encouraged and valued. Within the CHIP Workgroup invite members to your agency to facilitate networking, knowledge sharing, and resource sharing.

Last updated on 07/18/2025
Move from baseline of 0 to target of 5

SMH - Goal 6 (External interacting with the community) Increase your agency's visibility in the community by participating in joint events to expand your agency's reach.

Last updated on 06/16/2025
Move from baseline of 0 to target of 2

Goal/Objective/Measure

Type	Description	Status	Timeframe	Baseline → Target	Current Progress
Goal 1	Reduce Suicide Mortality Rate from 19.9 to 13.9 per 100,000	**At Risk**	4/18/2023 – 4/30/2028	19.9 → 13.9	20.0
Objective 1.1	Promote use of MH screening tools in clinics/schools	**At Risk**	4/18/2023 – 4/30/2028	TBD → TBD	TBD
Measure 1.1	# of hospitals, FQHCs, clinics screening for MH	**At Risk**	4/18/2023 – 4/30/2028	TBD → TBD	TBD
Objective 1.2	Add 5 partners working to reduce incarceration	**Complete**	4/18/2023 – 4/30/2028	0 → 5	5.0

Measure 1.2	# of MH-focused orgs reducing youth/adult incarceration	**Complete**	4/18/2023 – 4/30/2028	0 → 5	5.0
Objective 1.3	Add 10 orgs offering evidence-based MH & trauma trainings	**Complete**	4/18/2023 – 4/30/2028	0 → 10	10.0
Measure 1.3	# of orgs with evidence-based MH/trauma interventions	**Complete**	4/18/2023 – 4/30/2028	0 → 10	10.0
Goal 2	Decrease % Unable to Access MH Services from 15.2% to 7.8%	**At Risk**	4/18/2023 – 4/30/2028	15.2% → 7.8%	47.0%
Objective 2.1	Hire 3 social workers/navigators/CHWs	**Off Track**	4/18/2023 – 4/30/2028	0 → 3	1.0
Measure 2.1	# of MH support staff hired/deployed	**Off Track**	4/18/2023 – 4/30/2028	0 → 3	1.0
Goal 3	Reduce Poverty Rate from 15.0% to 13.4%	**Off Track**	4/18/2023 – 4/30/2028	15.0% → 13.4%	15.0%
Objective 3.1	Add 10 orgs enhancing MH support for low-income populations	**At Risk**	4/18/2023 – 4/30/2028	0 → 10	0.0
Measure 3.1	# of orgs delivering MH services to underserved	**At Risk**	4/18/2023 – 4/30/2028	0 → 10	0.0
Goal 4	Decrease Substance Misuse Perception Rate from 71% to 65%	**At Risk**	4/18/2023 – 4/30/2028	71% → 65%	71.0%
Objective 4.1	Add 10 orgs offering substance misuse education & messaging	**Off Track**	4/18/2023 – 4/30/2028	0 → 10	2.0
Measure 4.2	# of orgs focused on reducing personal substance misuse impact	**Off Track**	4/18/2023 – 4/30/2028	0 → 10	2.0
Objective 4.3	CHIP members partner with 10 orgs addressing substance misuse	**Off Track**	4/1/2024 – 4/30/2028	0 → 10	3.0
Measure 4.3	# of orgs working with CHIP on substance misuse	**Off Track**	4/1/2024 – 4/30/2028	0 → 10	3.0
Goal 5	Foster collaboration within CHIP Workgroup	**On Track**	4/18/2023 – 4/30/2028	0 → 5	3.0

Objective 5.1	Annually increase internal collaboration by 5	**On Track**	4/1/2024 – 4/30/2028	0 → 5	3.0
Measure 5.1	# of CHIP members hosting collaborative initiatives	**On Track**	4/1/2024 – 4/30/2028	0 → 5	3.0
Goal 6	Increase CHIP agency visibility via joint community events	**On Track**	4/1/2024 – 4/30/2028	0 → 2	1.0
Objective 6.1	Annually engage CHIP agencies in 2 joint community events	**Off Track**	4/1/2024 – 4/30/2028	0 → 2	1.0
Measure 6.2	# of CHIP agencies participating in outreach events	**Off Track**	4/1/2024 – 4/30/2028	0 → 2	1.0

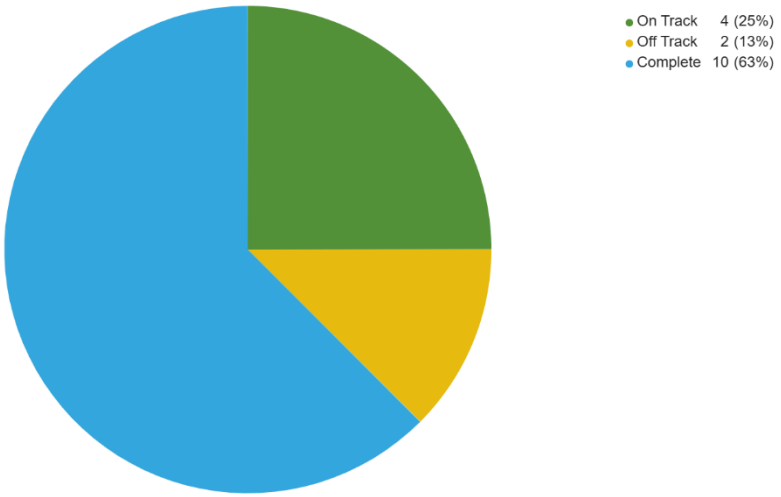
Chronic Disease Risk Factors and Management (CDRFM)

Chronic diseases are leading causes of death in Tulsa County, with heart disease and stroke mortality rates surpassing both state and national levels. According to the Oklahoma State Department of Health (2023), Tulsa County's age-adjusted heart disease mortality rate is 244.6 per 100,000, compared to 234.7 statewide and 161 nationally (CDC WONDER, 2023). Stroke mortality also trends higher at 43.2 per 100,000, above the state rate of 39.8.

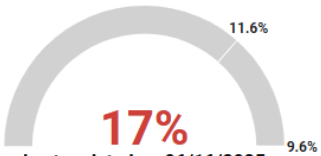
Adult tobacco uses in Tulsa County stand at 18.3%, significantly above the Healthy People 2030 goal of 5% (Oklahoma BRFSS, 2023), contributing to the burden of cardiovascular, cancer, and respiratory diseases. Access to care remains a barrier, with 17% of Tulsa County residents uninsured well above the national average of 11.6% (U.S. Census Bureau, 2022).

Social determinants further compound disparities: 15.2% of households face food insecurity (Feeding America, 2023), and many neighborhoods lack access to affordable healthy foods and safe physical activity spaces (Tulsa Health Department, 2023).

This priority focuses on reducing risk through evidence-based prevention (e.g., American Heart Association's *Know Your Numbers*), increasing Medicaid enrollment, and targeting social determinants via partnerships, aligning with CDC national strategies for chronic disease prevention (CDC, 2023).



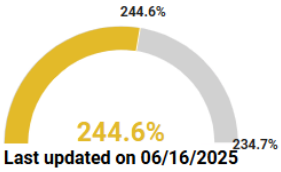
CDRFM - Goal 1: Decrease Lack of Health Care Insurance Coverage between 2023 and 2028 from 11.6% to 9.6% (8.7.% US rate) by 2028.



Last updated on 06/16/2025

Move from baseline of 11.6% to target of 9.6%

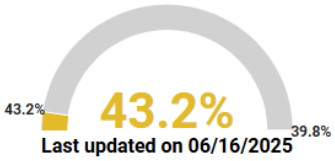
CDRFM - Goal 2: Mortality Rates - Reduce Heart Disease Age-Adjusted Mortality Rate from 244.6% (Tulsa County rate) to 234.7% (Oklahoma rate overall) per 100,000 by 2028.



Last updated on 06/16/2025

Move from baseline of 244.6% to target of 234.7%

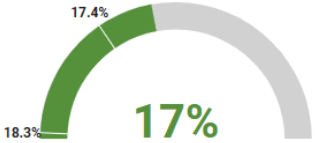
CDRFM - Goal 3: Reduce the Stroke Age-Adjusted Mortality Rate from 43.2% (Tulsa County rate) to 39.8% (Oklahoma rate overall) per 100,000 by 2028.



Last updated on 06/16/2025

Move from baseline of 43.2% to target of 39.8%

CDRFM - Goal 4 Modifiable Health Risks: Decrease the proportion of smokers from 18.3% (Tulsa County rate) to 17.4% (US rate) by 2028.



Last updated on 06/16/2025

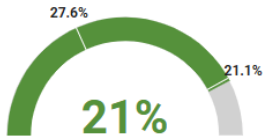
Move from baseline of 18.3% to target of 17.4%

CDRFM - Goal 5: Increase no leisure-time physical activity in the past month in Tulsa County from 21.2% to 29.9% (Healthy People 2030 goal).

Last updated on 06/16/2025

Move from baseline of 0% to target of 29.9%

CDRFM - Goal 6: Decrease those who Find It “Very” or “Somewhat” Difficult to Buy Affordable Fresh Produce in Tulsa County from 27.6% to 21.1% (US percent).



Last updated on 06/16/2025

Move from baseline of 27.6% to target of 21.1%

CDFRM - Goal 7 (Internal to the CHIP Workgroup): Foster a culture where collaboration is encouraged and valued. Within the CHIP Workgroup invite members to your agency to facilitate networking, knowledge sharing, and resource sharing.

Last updated on 07/18/2025

Move from baseline of 0 to target of 5

CDRFM - Goal 8 (External interacting with the community): Increase your agency’s visibility in the community by participating in joint events to expand your agency’s reach.

Last updated on 06/16/2025

Move from baseline of 0 to target of 2

Goal/Objective/Measure

Type	Description	Status	Timeframe	Baseline → Target	Current Progress
Goal 1	Decrease uninsured rate from 11.6% to 9.6%	At Risk	4/18/2023 – 4/30/2028	11.6% → 9.6%	17.0%
Objective 1.1	Partner with 10 orgs on Medicaid enrollment	On Track	4/18/2023 – 4/30/2028	0 → 10	8.0
Measure 1.1	# of orgs involved in Medicaid enrollment	On Track	4/18/2023 – 4/30/2028	0 → 10	8.0
Objective 1.2	Partner with 6 orgs on education linking chronic disease & insurance literacy	**Complete**	4/18/2023 – 4/30/2028	0 → 6	6.0
Measure 1.2	# of orgs doing education on disease + insurance	**Complete**	4/18/2023 – 4/30/2028	0 → 6	6.0
Goal 2	Reduce heart disease mortality from 244.6 to 234.7 per 100,000	Off Track	4/18/2023 – 4/30/2028	244.6 → 234.7	244.6
Objective 2.1	Promote AHA Know Your Numbers Program in 10 orgs	On Track	4/18/2023 – 4/30/2028	0 → 10	6.0
Measure 2.1	# of orgs using AHA program	On Track	4/18/2023 – 4/30/2028	0 → 10	6.0
Goal 3	Reduce stroke mortality from 43.2 to 39.8 per 100,000	Off Track	4/18/2023 – 4/30/2028	43.2 → 39.8	43.2
Objective 3.1	Engage community in stroke research conversations	**Complete**	4/18/2023 – 4/30/2028	0% → 70%	70.0%
Measure 3.1	% feedback received on stroke trials	**Complete**	4/18/2023 – 4/30/2028	0% → 70%	70.0%
Objective 3.2	Improve community stroke awareness (10 outreach events)	Off Track	4/24/2024 – 4/30/2028	0 → 10	1.0
Measure 3.2	# of community stroke education events	Off Track	4/24/2024 – 4/30/2028	0 → 10	1.0
Goal 4	Decrease smoking rate from 18.3% to 17.4%	On Track	4/18/2023 – 4/30/2028	18.3% → 17.4%	17.0%
Objective 4.1	Increase 5 partners using TSET quit services	**Complete**	4/18/2023 – 4/30/2028	0 → 5	5.0
Measure 4.1	# of orgs using TSET quit services	**Complete**	4/18/2023 – 4/30/2028	0 → 5	5.0
Goal 5	Increase physical activity from 21.2% to 29.9%	At Risk	4/18/2023 – 4/30/2028	0% → 29.9%	27.0%
Objective 5.1	Launch 5 inclusive, no/low-cost physical activity initiatives	**Complete**	4/18/2023 – 4/30/2028	0 → 5	5.0

Measure 5.1	# of initiatives launched	**Complete**	4/18/2023 – 4/30/2028	0 → 5	5.0
Goal 6	Reduce produce affordability concern from 27.6% to 21.1%	On Track	4/18/2023 – 4/30/2028	27.6% → 21.1%	21.0%
Objective 6.1	Increase 5 CHIP partners distributing produce	**Complete**	4/18/2023 – 4/30/2028	0 → 5	5.0
Measure 6.1	# of fresh produce distribution partners	**Complete**	4/18/2023 – 4/30/2028	0 → 5	5.0
Goal 7	Foster collaboration within CHIP Workgroup	**Complete**	4/1/2024 – 4/30/2028	0 → 5	5.0
Objective 7.1	Annually increase collaboration by 5 within CHIP	**Complete**	4/1/2024 – 4/30/2028	0 → 5	5.0
Measure 7.1	# of internal member collaborations	**Complete**	4/1/2024 – 4/30/2028	0 → 5	5.0
Goal 8	Increase agency visibility through community joint events	At Risk	4/1/2024 – 4/30/2028	0 → 2	0.0
Objective 8.1	Participate in 2 annual community events	At Risk	4/1/2024 – 4/30/2028	0 → 2	0.0
Measure 8.1	# of volunteer/joint events	At Risk	4/1/2024 – 4/30/2028	0 → 2	0.0

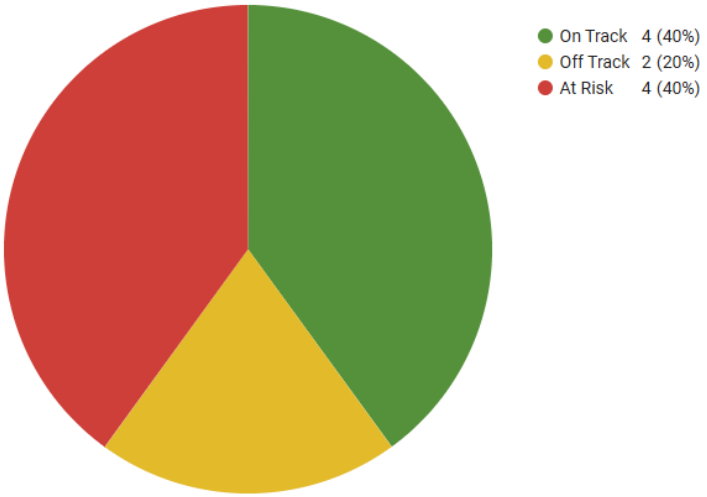
Healthy and Affordable Housing (HAH)

Housing is a key social determinant of health, and Tulsa County continues to face serious challenges in housing quality, affordability, and stability. As of 2023, more than 1,200 individuals in Tulsa County experience homelessness on any given night, highlighting racial and economic disparities in housing access (HUD, 2023).

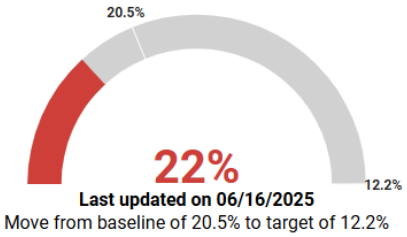
About 22% of Tulsa County residents live in homes with conditions that negatively affect health, including mold, lead, poor ventilation, and overcrowding factors linked to asthma, injury, and stress-related illnesses (U.S. Census Bureau, 2020; WHO, 2018). Additionally, the county faces a deficit of over 10,000 affordable rental units for extremely low-income households (NLIHC, 2023).

Secondhand smoke exposure in multi-unit housing remains a serious health threat, particularly for children and seniors. Evidence shows smoke-free housing policies can reduce preventable illness and health disparities (U.S. Surgeon General, 2020).

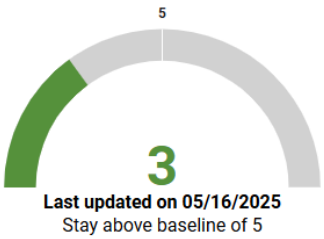
In response, CHIP partners are advancing smoke-free housing efforts (TSET, ALA), expanding access to affordable and supportive housing, delivering fair housing education, and aligning public health, housing, and social services to address structural barriers and promote housing equity (Tulsa Health Department, 2023).



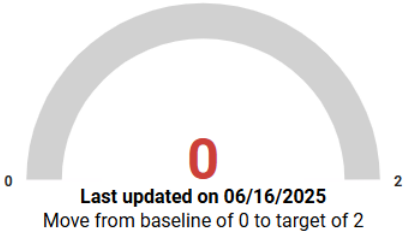
HAH - Goal 1: Reduce the percentage of residents who report Unhealthy or Unsafe Housing Conditions between 2023 and 2028 from 20.5% to 12.2% (US rate).



HAH - Goal 2: (Internal to the CHIP Workgroup): Foster a culture where collaboration is encouraged and valued. Within the CHIP Workgroup invite members to your agency to facilitate networking, knowledge sharing, and resource sharing.



HAH - Goal 3: (External interacting with the community): Increase your agency's visibility in the community by participating in joint events to expand your agency's reach.



Goal/Objective/Measure

Level	Description	Status	Baseline	Target	Current Progress
Goal 1	Reduce % residents reporting unhealthy/unsafe housing (20.5% → 12.2%)	At Risk	20.5%	12.2%	22.0%
Objective 1.1	Increase organizations promoting affordable/supportive housing by 10	On Track	0	10	5
Measure 1.1	Number of organizations promoting/supporting affordable/supportive housing	On Track	0	10	5
Objective 1.2	Increase fair housing education/training sessions by 5	At Risk	0	5	0
Measure 1.2	Number of fair housing education sessions completed	At Risk	0	5	0
Objective 1.3	Increase organizations promoting homeownership education initiatives by 5	Off Track	0	5	1

Measure 1.3	Number of organizations promoting homeownership education initiatives	**Off Track**	0	5	1
Objective 1.4	Increase partners adopting/updating smoke-free policies in multi-unit housing by 4	**On Track**	0	4	2
Measure 1.4	Number of organizations using TSET/AHA resources for smoke-free policies	**On Track**	0	4	2
Goal 2	Foster collaboration within CHIP Workgroup	**On Track**	≥5	≥5	3
Objective 2.1	Annually increase collaboration by 5 (hosting initiatives, events, meetings, volunteers)	**On Track**	0	5	4
Measure 2.1	Number of member agencies hosting initiatives	**On Track**	0	5	4
Goal 3	Increase agency visibility via participation in joint community events	**At Risk**	0	2	0
Objective 3.1	Increase CHIP Workgroup member visibility by participating in 2 joint events annually	**At Risk**	0	2	0
Measure 3.1	Number of joint events participated in	**At Risk**	0	2	0

Looking Ahead

Phase 1: Laying the Foundation (April 2023 – April 2025)

Over the first two years, the CHIP prioritized engagement, mobilization, and strategic alignment. We established a collaborative framework by onboarding new partners, launching priority Workgroups, and increasing awareness across sectors. These efforts created conditions for trust, shared purpose, and inclusive participation. We also began to align partner programs with CHIP goals and launched key tools such as the CHIP Partner Survey to collect valuable insights for improvement.

Phase 2: Scaling Impact through Strategy and Partnership (April 2025 – April 2027)

Phase 2 represents a critical pivot toward data-driven improvement strategies and scaled community impact. Building on the momentum of Phase 1, we are enhancing CHIP action plans through a structured midpoint evaluation, refining performance measures to better reflect health access and innovative strategies that lead to community-led and driven outcomes in real time.

Looking ahead, our improvement strategies will center on adaptive planning, transparent reporting, and smarter use of data to guide implementation. Simultaneously, we will focus on strengthening partnerships deepening collaboration with existing partners, expanding cross-sector engagement, and reinforcing shared accountability through the CHIP Partner Commitment Agreement (2025–2028). These efforts aim to foster a stronger, more sustainable network of community leadership and collective action to accelerate progress toward Tulsa County's health goals.

Appendices

Appendix A: Strategic Planning Reference Materials

The THD is responsible for protecting and promoting the health of more than 675,000 residents in Tulsa County. Strategic planning requires critical thinking, adaptability and a long-range vision. The THD strategic plan will serve as a guide for the department's goals. The strategic planning process is guided by the Public Health Accreditation Board Standard and Measures and the National Association of County and City Health Officials guide.

Our 2025-2029 Strategic Plan not only focuses on the public health department's core activities but also on offering enhanced services to improve the health of Tulsa County residents. The plan is informed first by 2022 Tulsa County CHNA and then the 2023-2028 Tulsa County CHIP. The CHIP gathered stakeholder input to identify the top three health priority areas: Stress and Mental Health, Chronic Disease Risk Factors and Management and Healthy and Affordable Housing.

For plan development, THD offered an opportunity for employees and community members to contribute their expertise and perspectives to the THD strategic planning process. In 2024, THD held a series of nine external listening sessions hosted around Tulsa County to engage in community input toward the strategic plan. Reference Documents and Data Sources:

- 2022 Tulsa County Community Health Needs Assessment (CHNA)
  The CHNA offered foundational data on health indicators, disparities, and social determinants of health across Tulsa County.
  https://www.tulsa-health.org/community-health/community-health-needs-assessment
- Community Health Improvement Plan (CHIP) 2023–2028
  The CHIP identifies community-selected priorities and outlines shared action plans to improve population health through collective impact.
  https://www.tulsa-health.org/community-health/community-health-improvement-plan
- Public Health Accreditation Board (PHAB) Standards & Measures (Version 2022)
  These standards provided a framework for performance improvement and strategic alignment with national public health best practices.
  https://phaboard.org

For full access to the THD 2025–2029 Strategic Plan, visit:
https://www.tulsa-health.org/strategic-plan

Appendix B: CHNA Development Partners and Resources

Saint Francis Health System and Ascension St. John Health System – 2025 Tulsa County CHNA Collaboration

The Tulsa Health Department collaborated with Saint Francis Health System and Ascension St. John Health System to support the development of the 2025 Tulsa County Community Health Needs Assessment (CHNA). This multi-institutional partnership reflects a shared commitment to assessing and addressing community health needs through transparent, data-informed strategies.

These health systems contributed resources, expertise, and leadership to guide the assessment process, which builds upon the 2022 CHNA baseline and aligns with ongoing implementation of the Tulsa County Community Health Improvement Plan (CHIP) 2023–2028.

The updated 2025 CHNA helps reaffirm key community health priorities, identify emerging trends, and enhance the cross-sector alignment necessary to drive population health improvements.

For more information, visit:

- Saint Francis Health System CHNA Reports: https://www.saintfrancis.com/community-health
- Ascension St. John Health System CHNA Reports: https://healthcare.ascension.org/community-impact/oklahoma

These publicly available reports outline each system's approach to community health assessment, priority-setting, and strategic investment in health equity and access.

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