Retreat Objectives:

1. *Strategic changes based on environment*
2. *Deeper understanding of other influences on health*

**Friday, August 12th**

<table>
<thead>
<tr>
<th>Time</th>
<th>Event Description</th>
<th>Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>12:00 PM</td>
<td>Board Tutorial (Board of Health Members)</td>
<td>VaLauna Grissom</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Break</td>
</tr>
<tr>
<td>1:00 PM</td>
<td>Meet and Greet</td>
<td>Martha Burger</td>
</tr>
<tr>
<td>2:00 PM</td>
<td>Call to Order</td>
<td>Welcome Governor</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Anoatubby</td>
</tr>
</tbody>
</table>

Retreat Mission and Objectives

1. *Strategic changes based on environment*
2. *Deeper understanding of other influences on health*

Panel Discussion

*Moderator: Terry Cline*

*Panelists: Julie Cox-Kain, Nico Gomez, Ted Haynes*

*(3) 15 minute presentations: Oklahoma Plan; Background on Medicaid Rebalancing Act; Payment Reform- Value Based*

Break

Panel Discussion

*Moderator: Terry Cline*

*Panelists: Julie Cox-Kain, Nico Gomez, Ted Haynes*

*Open discussion with the Board*

Proposed Executive Session

Pursuant to 25 O.S. Section 307(B)(4) for confidential communications to discuss pending department litigation, investigation, claim, or action; pursuant to 25 O.S. Section 307(B)(1) to discuss the employment, hiring, appointment, promotion, demotion, disciplining or resignation of any individual salaried public officer or employee and pursuant to 25 O.S. Section 307 (B)(7) for discussing any matter where disclosure of information would violate confidentiality requirements of state or federal law.

- OAS 2016-029

Possible action taken as a result of Executive Session
Saturday, August 13th

Learning Objectives:
1. Review how we report progress on the strategic plan.
2. Identify top priorities based on budget constraints.
3. Discuss budget neutral innovative public practices to achieve priorities.

8:00 AM   Continental Breakfast

8:30 AM   Call to Order & Welcome

Approval of June 14, 2016 Meeting Minutes
Discussion and possible action

Retreat Objectives

State Innovation Model (SIM) Presentation

Break

High Level Strategic Plan Metrics
Discussion and possible action

Budget Cuts / Impact of Budget on Strategic Plan Breakout
Board discussion and possible readjustments

12:00 PM   Working Lunch

Innovation Breakout
Discussion and possible action

Health Impact Assessments (HIA) + Health in All Policies (HiAP)
Deeper dive into the HiAP (Choctaw Nation)

Break

3:00 PM   Summary, Wrap up, Closing, Adjournment
The Oklahoma Plan
A Health Plan Created by Oklahomans for Oklahoma

- Invest in Smart Coverage
  - Rebalance Medicaid
  - Expand Private Coverage
  - Restore Provider Rates
  - Promote Personal Responsibility

- Pay for Performance
  - Medicaid & EGID Outcome Based Healthcare
  - Measure Outcomes & Pay for Performance
  - Invest in Healthcare Transitions

- Insure Oklahoma HealthStead Account
  - Prevent 31,800 Kids from Smoking
  - Reduce Healthcare Costs
  - Save Lives
  - Oklahoma Voters Support (62% Favor)

- Improve Community Health
  - Support Rural Healthcare Access
  - Enable Rural Economic Development
  - Improve Quality in Healthcare

- Support Rural Healthcare Access
  - Develop Private/Public Partnerships
  - Protect Private Health Information Exchanges
  - Promote Data Interoperability
  - Empower Patients thru Information

- Preserve and Expand Health Workforce
  - Create More Funding for Teaching Health Centers
  - Expand Access and Utilization of Telemedicine
  - Ease Regulatory Barriers to Care
  - Support Rural Providers by Paying at the Upper Payment Limit (UPL)

- Empower Patients & Providers
  - Promote Private and Public Partnerships
  - Protect Private Health Information Exchanges
  - Promote Data Interoperability
  - Empower Patients and Providers through Health Information Exchange
  - Increase Transparency of Cost and Quality Data

The Oklahoma Plan: High Level Goals

- Improve Access to Efficient Coverage Options
- Provide Coverage that Achieves the Triple Aim
- Address Cost Drivers
- Ensure Robust Access to Behavioral and Mental Health Services
- Promote Patient Responsibility

- Move 80% of Payments to Value-Based Purchasing (VBP) by 2020
- Authorize Innovation Waivers (1115 and 1332 Waivers)
- Move All State Purchased to VBP Models
- Invest in HealthCare Transitions

- Increase the Price Point of Cigarettes to Improve Health
- Improve Investments in Primary Prevention
- Integrate Community Supports into the Delivery of Care
- Create Regional and Community Accountability for Health Outcomes
- Broaden Pay for Performance/Social Impact Bonds

- Create More Funding for Teaching Health Centers
- Expand Access and Utilization of Telemedicine
- Ease Regulatory Barriers to Care
- Support Rural Providers by Paying at the Upper Payment Limit (UPL)
- Promote Private and Public Partnerships
- Protect Private Health Information Exchanges
- Promote Data Interoperability
- Empower Patients and Providers through Health Information Exchange
- Increase Transparency of Cost and Quality Data
STATE BOARD OF HEALTH
OKLAHOMA STATE DEPARTMENT OF HEALTH
Choctaw Nation Community Center
2750 Big Lots Parkway
Durant, OK 74701

Tuesday, June 14, 2016 9:30 a.m.

Ronald Woodson, President of the Oklahoma State Board of Health, called the 410th regular meeting of the Oklahoma State Board of Health to order on Tuesday, June 14, 2016 at 9:37 a.m. The final agenda was posted at 9:30 a.m. on the OSDH website on June 13, 2016, and at 9:30 a.m. at the Choctaw Nation Community Center Entrance on June 13, 2016.

ROLL CALL

Members in Attendance: Ronald Woodson, M.D., President; Cris Hart-Wolfe, Secretary-Treasurer; Murali Krishna, M.D.; Jenny Alexopulos, D.O.; Terry Gerard, D.O.; Timothy E. Starkey, M.B.A.; Robert S. Stewart, M.D.

Absent: Martha Burger, M.B.A., Vice-President; Charles W. Grim, D.D.S.

Central Staff Present: Terry Cline, Commissioner; Henry Hartsell, Jr., Deputy Commissioner, Protective Health Services; Tina Johnson, Deputy Commissioner, Community and Family Health Services; Carter Kimble, Director of Office of State and Federal Policy; Deborah Nichols, Chief Operating Officer; Don Maisch, Office of General Counsel; Jay Holland, Director of Internal Audit and Office of Accountability Systems; Tony Sellars, Director of Office of Communications; Valauona Grissom, Secretary to the State Board of Health.

Visitors in attendance: (see sign in sheet)

Call to Order and Opening Remarks

Dr. Woodson called the meeting to order and thanked guests in attendance. He explained that following the Executive Session, the Board will convene the open Board meeting and guests/attendees are welcome to attend at that time.

PROPOSED EXECUTIVE SESSION

Ms. Wolfe moved Board approval to go in to Executive Session at 9:40 AM Proposed Executive Session pursuant to 25 O.S. Section 307(B)(4) for confidential communications to discuss pending department litigation, investigation, claim, or action; pursuant to 25 O.S. Section 307(B)(1) to discuss the employment, hiring, appointment, promotion, demotion, disciplining or resignation of any individual salaried public officer or employee and pursuant to 25 O.S. Section 307(B)(7) for discussing any matter where disclosure of information would violate confidentiality requirements of state or federal law.

• OAS 2015-042
• Administrative Procedure 1-30A and Board Policy CP-54

Second Dr. Gerard. Motion carried.

AYE: Alexopulos, Gerard, Krishna, Stewart, Starkey, Wolfe, Woodson
ABSENT: Burger, Grim

Dr. Krishna moved Board approval to move out of Executive Session. Second Dr. Woodson. Motion carried.

AYE: Alexopulos, Gerard, Krishna, Stewart, Starkey, Wolfe, Woodson
ABSENT: Burger, Grim

Dr. Alexopulos moved Board approval of recommended changes to Administrative Procedure 1-30A and Board Policy CP-54 as presented. Second Dr. Krishna. Motion carried. See policy form for list of revisions.
AYE: Alexopulos, Gerard, Krishna, Stewart, Starkey, Wolfe, Woodson
ABSENT: Burger, Grim

WELCOME & OPENING REMARKS
Dr. Woodson welcomed all guests and thanked Teresa Jackson, Senior Executive Officer of Health Services for the Choctaw Nation, for her coordination of this meeting. Dr. Woodson presented Teresa Jackson, with a plaque of appreciation for her partnership efforts. Mrs. Jackson also received plaques of appreciation on behalf of Chief Gary Batton and Tribal Councilmen.

REVIEW OF MINUTES
Dr. Woodson directed attention to review of the minutes of the May 12, 2016, regular meeting. Ms. Wolfe moved Board approval of the minutes of the May 12, 2016, regular meeting, as presented. Second Dr. Gerard. Motion carried.
AYE: Alexopulos, Gerard, Krishna, Starkey, Wolfe, Woodson
ABSENT: Burger, Grim
ABSTAIN: Stewart

CHOCTAW NATION PRESENTATION
Teresa Jackson, Senior Executive Officer of Health Services See Attachment A

CONSIDERATION OF STANDING COMMITTEES’ REPORTS AND ACTION
Executive Committee
Dr. Woodson directed attention to the proposed organizational changes as presented in Board member packets. Dr. Cline briefly described the changes found on the proposed organizational chart. See Attachment B
Ms. Wolfe moved Board approval of the new Oklahoma State Department of Health organizational chart as presented. Second Dr. Alexopulos. Motion carried.
AYE: Alexopulos, Gerard, Krishna, Stewart, Starkey, Wolfe, Woodson
ABSENT: Burger, Grim

Finance Committee
Mr. Starkey directed attention to the Financial Brief provided to each Board member and presented the following SFY 2016 Finance Report and Board Brief as of May 24, 2016:
- The Agency is in “Green Light” status overall
- One Division is in yellow light status due to the federal grant and rebates for the Ryan White program which began April 1, 2016. This funding will be available throughout the period of the grant that ends March 31, 2017.

Finance Brief
The Brief focused on the OSDH Informatics Service which was created in October 2013 to address critical information and data integration needs and respond to an emerging practice in public health. Below are some of the successes that have been accomplished to date.
- Developed agency IT portfolio management process
- Launched Oklahoma State Immunization Information System (OSIIS) capable of bidirectional exchange using Health-e Oklahoma
- Launched Laboratory Information Management System (LIMS) capable of electronic laboratory reporting
- Assisted in the implementation of eWic system pilot
OKLAHOMA STATE BOARD OF HEALTH MINUTES

June 14, 2016

- Implemented Meaningful Use (MU) Registration and Onboarding website for healthcare providers needing to achieve MU with public health
- Deployment of the first multi-agency Master Person Index (MPI) and interoperability system in calendar year 2016 (Health-e Oklahoma)

Accountability, Ethics, & Audit Committee
The Accountability, Ethics, & Audit Committee met with Jay Holland. Ms. Wolfe indicated there were no known significant audit issues to report at this time.

Public Health Policy Committee
Dr. Gerard indicated the Policy Committee reviewed the status of OSDH legislative issues. Board members with policy questions should contact Carter Kimble at any time.

PRESIDENT’S REPORT
Dr. Woodson presented Michael Echelle with a retirement plaque on behalf of the Oklahoma State Board of Health and thanked him for 33 years of service. Michael has been a tremendous asset to this agency and to public health. He has had impressive career, serving as the Administrative Director for the Pittsburg, Pontotoc, Coal and Atoka County Health Departments. He briefly listed commendations and awards of achievement received by Michael during his tenure with the OSDH. Lastly, he noted his involvement in the Choctaw Nation Flu Project as referenced in Teresa Jackson’s presentation as he has played a key role.

Dr. Woodson reminded Board members that immediately following the Board meeting, the Choctaw Nation will host a meet and greet where they will have opportunity to meet the Tribal Councilmen. The Choctaw nation honored the meeting with a blessing, prayer, and dance by Tribal Elder and the Indian Princesses.

ELECTION OF OFFICERS 2016-2017
Dr. Krishna, Dr. Alexopulos and Dr. Grim served on the Nominating Committee. The Committee recommended the 2015-2016 Officers as follows: President, Martha Burger; Vice-President, Cris Hart-Wolfe; and Secretary/Treasurer, Dr. Robert Scott Stewart.

Dr. Krishna moved Board approval to approve the Committee recommendations for President, Vice President, and Secretary-Treasurer as presented. Second Dr. Gerard. Motion carried.

AYE: Alexopulos, Gerard, Krishna, Stewart, Starkey, Wolfe, Woodson
ABSENT: Burger, Grim

COMMISSIONER’S REPORT
Dr. Cline briefly commented on the recent Governor’s Walk for Wellness held on May 4th at the State Capitol. We will share some photos from during the August retreat. Dr. Cline thanked Dr. Krishna for his attendance and leadership. Dr. Cline thanked Michael Echelle for his service to the Health Department and his community. He recognized Delbie Walker, Mendy Spohn and Juli Montgomery. Dr. Cline also thanked Sally Carter for the incredible job she does as the Tribal Liaison for the State Department of Health. Lastly, he thanked Teresa Jackson for efforts and then continued partnership between the Oklahoma State Department of Health and the Choctaw Nation.

NO NEW BUSINESS

ADJOURNMENT
Dr. Gerard moved Board approval to Adjourn. Second Ms. Wolfe. Motion carried.

AYE: Alexopulos, Gerard, Krishna, Stewart, Starkey, Wolfe, Woodson
ABSENT: Burger, Grim
The meeting adjourned at 11:48 a.m.

Approved

____________________
Martha A. Burger, M.B.A.
President, Oklahoma State Board of Health
August 13, 2016
Welcome on behalf of the Choctaw Nation of OK and the Choctaw Nation Health Care

Overview

- Organizational Chart
- Chief & Assistant Chief
- Tribal Council
- Senior Executive Officers

Chief Gary Batton began his career with the Choctaw Nation in 1987 as a clerk in the Purchasing Department. In 1989, he accepted the position of Deputy Director of the Choctaw Nation Housing Authority.

In 1997, he accepted the position of Executive Director of Health. His first undertaking was to construct the new state-of-the-art Choctaw Nation Health Care Center. This was the first tribally funded health facility in the United States, and a considerable improvement over the Choctaw Nation Hospital which was constructed in the 1930s.

He was selected for the position of Assistant Chief in May 2007. As the Assistant Chief, his focus changed from improving the health centers for tribal members to growing and improving the entire Choctaw Nation for the benefit of tribal members.

Under Chief Batton’s administration, the Choctaw Nation opened a large expansion to its health clinic in Poteau, three new wellness centers, two Chili’s franchises, Antlers Travel Plaza, resort expansion in Durant, McAlester Community Center, two food distribution centers and a new independent living community for Choctaw Elders.

Assistant Chief Jack Austin, Jr.

Assistant Chief Austin has had a long career with the Choctaw Nation, beginning employment at the Choctaw Nation Health Care system in 1991 after being honorably discharged from the U.S. Army. He holds a Master of Education degree. He began his journey with the healthcare system in the Material Management department – and just prior to being selected as Assistant Chief, Austin was the program director for the Choctaw Nation Recovery Center.

He and his wife, Philisha, have been married 24 years. They have three children, Clark, Malacha, and Sam.

Assistant Chief Austin has attended the Lighthouse Cathedral Church for the past 30 years. As a youth pastor, his service included teaching weekly youth classes.

Tribal Council

- District 1: Thomas Williston
- District 2: Tony Ward
- District 3: Kenny Bryant
- District 4: Delton Cox
- District 5: Ron Perry
- District 6: Joe Coley
Tribal Council

Jack Austin, Sr.
Jerry Perry Thompson
Bill Dean
Anthony Gallow
Bob Pate
James Fraizer

Tribal Judges

Constitutional Court
Chief Judge Mitch Muhl, Judge Frederick Davis
Appellate Division
Chief Judge J.R. Pat Phelps
Judge Alan Parks
Judge Warren Gutcher
Tribal District Courts
Chief Judge Bob Epperson
Judge Steven Fakler
Judge Rebecca Cuddy

Senior Executive Officers

MEMBER SERVICES: Stacy Shepherd
- Cultural Services, Summer Camps, Tivka homes, Historic Preservation, Weavers, Cultural Affairs, Arts Education, Archiving and Documentation
- Education, Jones Academy, Public School programs, Early Childhood, Child Care Assistance, School of Choctaw Language, Adult Education, Higher Education, WIGA, College and Career Retention, Career Development, SMS program
- Housing, Rental Assistance, Homeownership Services, Rental Services
- Outreach, Youth Outreach, Injury Prevention, Connecting Choctaw Kids to Coverage, BIOWEB, Project HOPE, Victim Assistance, Elder advocacy, Community Relations, Youth, Women, Children, Rehabilitation, Pregnant and Parent Support
- Special Services, Job of the Day, Veterans Advocacy, Child and Family Services, Tribal Services, Membership, CDIB, Genealogy, Emergency Services, Next Step

HEALTH SERVICES – Teresa Jackson
- Talihina campus includes hospital and clinic
- Diabetic Wellness Center, two residential substance abuse centers, Behavioral Health program, Youth Center, Hospitality House, Talihina Community Clinic.
- Eight Clinics-Poteau, Stigler, McAlester, Atoka, Durant, Hugo, Idabel, & Broken Bow
- Employee Health locations in Durant and Poteau
- Pharmacy located in Poteau
- Wellness Centers located in Talihina, Poteau, Wilburton, McAlester, Crowder, Cushing, Atoka, Durant, Hugo, Wilburton, Broken Bow, & Bethel
- Construction has started on two more located in Stigler and Antlers.
- Medical Transportation Program
- WIC program, Farmer’s market, Farmer’s market for Seniors
- Patient Relations Program
- Eye Glasses, Dentures, and Hearing Aid Program

TRIBAL RELATIONS – Judy Allen
- Public Relations, Media, Circulation, Biskinik
- Community Relations
- Marketing, Choctaw Store, Welcome Center
- Online Communication
- Tribal Policy, Public Policy
- Congressional Relations
- Natural Resources
- Recycling Center

ADMINISTRATIVE SERVICES – Jesse Pacheco
- Grants, Program Development
- Support Services
- Human Resources
- Leadership Coaching
- Organizational Development
- Finance
- Risk Management
- Information Systems
- Public Safety
- Facilities Management
Senior Executive Officers

- Commerce – Thomas (TR) Kanuch
- Gaming
- Travel Plazas
- Franchises
- Grocery
- Agriculture
- Leasing
- Business Development
- Tenders
- Project Management
- Construction
- Facilities Management

**Health Organizational Chart**

**Talihina campus includes hospital and clinic:**
- Diabetes Wellness Center, two residential substance abuse centers, Behavioral Health program, Youth Center, Hospitality House, Tribal Community Clinic, Emergency & Urgent Care, Pediatric, Obstetrics & Gynecology, General Surgery, Podiatry, Dermatology, Physical Therapy, Hearing Clinic, OPEDH program, Reflexology, Audiology.
- **SPCC/ATTC:** Orthopedy, Ophthalmology, Cardiology, Pediatric, Dentistry, Diabetic Retinal Eye Surgery, Memory Loss Clinic, Podiatric Endocrinology, Pathology, IDT, Dermatology, Health Aging Clinic, and Remicade Clinic.

**Geographic Structure and Services**

- 10.5 Counties/12 council districts
- Area size comparison-State of Vermont
- Over 250,000 outpatient visits per year. Average 600 newborn deliveries per year (on target for over 250,000 visits for this year)
- **SERVICES:** Endocrinology, Family Practice, Internal Medicine, Pediatrics, Emergency & Urgent Care, Pediatric, Obstetrics & Gynecology, Behavioral Health, Physical Therapy, Hearing Clinic, OPEDH program, Reflexology, Audiology.
- **SPCC/ATTC:** Orthopedics, Ophthalmology, Cardiology, Pediatric, Dermatology, Diabetic Retinal Eye Surgery, Memory Loss Clinic, Podiatric Endocrinology, Pathology, IDT, Dermatology, Health Aging Clinic, and Remicade Clinic.
- Choctaw Referred Care- Services we cannot provide.

**Financial Structure**

- Federal Funding from Indian Health Service
- Third Party billing/collections from Medicare, Medicaid, and Private Insurance (Public Law 93-638)
- Grants
- Tribal Support

**Choctaw Nation Health Care**

- Talihina campus includes hospital and clinic:
  - Diabetes Wellness Center, two residential substance abuse centers, Behavioral Health program, Youth Center, Hospitality House, Tribal Community Clinic, Emergency & Urgent Care, Pediatric, Obstetrics & Gynecology, General Surgery, Podiatry, Dermatology, Physical Therapy, Hearing Clinic, OPEDH program, Reflexology, Audiology.
  - **SPCC/ATTC:** Orthopedics, Ophthalmology, Cardiology, Pediatric, Dentistry, Diabetic Retinal Eye Surgery, Memory Loss Clinic, Podiatric Endocrinology, Pathology, IDT, Dermatology, Health Aging Clinic, and Remicade Clinic.
- Choctaw Referred Care- Services we cannot provide.
Certifications, Partnerships and Successes

- Joint Commission Accredited
- Medicaid contracts with Oklahoma, Alabama, and Texas
- Contact with private insurance carriers
- Subcontractor in service contracts
- Staff certified to enroll members for insurance through the Affordable Care Act
- One of only three in the country to have a fully accredited Family Practice Residency Program
- First tribe in Oklahoma to sign a contract with Logisticare for billing for medical transportation
- Medically staffed, the first in the country to have an on-site hospital, which was completed and open when we moved.
- With the opening of the new facility in Durant, we will be the first tribe to have an outpatient surgery center in a clinical setting (working with CMS on regulatory requirements)
- Choctaw Nation and Chickasaw Nation were the first tribes to sign an MOU for transferring ownership of a clinic with the approval of Indian Health Service
- First tribe to partner with VA for seeing and billing VA patients
- First tribe to receive Promise Zone designation

Certifications, Partnerships, & Successes

- Oklahoma Department of Health-Immunization Project
- First tribe to partner with the state health department on the immunization project.

Certifications, Partnerships & Successes

- The OSDH and the Choctaw Nation of Oklahoma signed a Memorandum of Understanding (MOU) in August 2015, combining efforts to protect the public's health. Adopting from the concept of 'herd immunity', the primary purpose of this inter-jurisdictional collaboration is to increase the number of tribal and non-tribal community residents (children, adults, and seniors) within the 11 tribal jurisdiction counties of Choctaw Nation who received a flu vaccination between September 2015 and May 2016.
- Choctaw Nation purchased 30,000 doses of flu vaccine & distributed vaccines to the local county health departments in the 11 counties.
- OSDH provided nursing & office staff and supplies to administer the vaccines.
- Both agencies recorded information in OSIS and advertised outreach in the community.

Certifications, Partnerships & Successes

- Oklahoma Department of Health-Medical Emergency Response Program
- Choctaw Nation is designated as a Push Partner Site with Region 3 Medical Emergency Response program.
- Through this regional agreement, the Dept. of Health is to provide medications and our health staff is to administer the medication to all CNO associates, their families and/or current in-house clients during mass immunization or prophylaxis events.
- Choctaw Nation participates in all trainings and exercises associated with the program.
Oklahoma Department of Health - Boswell tornado relief efforts

May 9, 2016 the communities of Hugo and Boswell were affected by a tornado that hit the area.

Oklahoma Department of Health and the Choctaw Nation public health nursing department collaborated and provided staffing in both areas to administer tetanus shots to residents and volunteer workers in the area.
Oklahoma State Department of Health

Oklahoma State Innovation Model

Julie Cox-Kain
Deputy Secretary of Health and Human Services
Sr. Deputy Commissioner

Oklahoma State Innovation Model Design Grant - What is it?

- A state plan initiative
- Multi-payer payment and service delivery reform
- Improve health outcomes
- Must improve health system performance, increase quality of care and decrease costs for the following:
  - Medicare
  - Medicaid
  - Children’s Health Insurance Program (CHIP) beneficiaries
  - And all residents of participating states

OSIM State Health System Innovation Plan

Components of a Successful Model Design Plan

Goals of OSIM

- Smooth transitions to multi-payer value based payment models and align quality metrics
  - Leverage what is already working
  - Reduce variation & administrative burden
  - Leverage existing technology & systems

- Focus on primary cost drivers:
  - Tobacco
  - Obesity
  - Hypertension
  - Diabetes
  - Behavioral Health

- Improve Population Health by focusing on the total health system and addressing social determinants of health:
  - Poverty
  - Poor education/literacy
  - Poor housing
  - Employment/working conditions

- Achieve the Triple Aim
  - Cost
  - Quality
  - Population Health

- Creating a scalable, flexible model that can be implemented in rural settings

- Multiple models of care coordination
- Provider directed teams
- Community support structure

SIM Model Proposal

Report on Stakeholder Engagement

This section details stakeholder engagement activities and analysis and interpretation of key findings on collected data.
Quality Metric & Value Based Payment Alignment

### Proposed Model: Three Components
The three components of the proposed model are: Regional Care Organizations (RCOs), Multi-Payer Quality Metrics, and Multi-Payer Episodes of Care.

### Quality Metric Alignment

**State of Oklahoma High-Cost Condition Relative Cost**

<table>
<thead>
<tr>
<th>Condition</th>
<th>% Increase</th>
<th>Average Annual Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Entire Population</td>
<td>100%</td>
<td>$4,993</td>
</tr>
<tr>
<td>Diabetes</td>
<td>349%</td>
<td>$17,426</td>
</tr>
<tr>
<td>Obesity</td>
<td>345%</td>
<td>$17,226</td>
</tr>
<tr>
<td>Tobacco Usage</td>
<td>343%</td>
<td>$17,126</td>
</tr>
<tr>
<td>Hypertension</td>
<td>283%</td>
<td>$14,130</td>
</tr>
</tbody>
</table>

### Quality Measure Alignment

A key finding from the SIM grant was the disjointed, burdensome, or ineffective use and reporting of quality metrics.

Two key things came from this finding:

1. Recommendations to establish a Quality Metrics Committee to compile a list of recommended measures for state purchased healthcare and private payers.
2. A key finding from the SIM grant was the disjointed, burdensome, or ineffective use and reporting of quality metrics.

### Multi-Payer Episodes of Care – Payment Model Design

**Example Episode I**
- Delivery
- OB-GYN
- Pre-Natal Care
- Medications
- In-Patient Stay
- Appointments
- Follow Up
- Nutrition
- Post-Discharge Care

**Example Episode II**
- Medications
- In-Patient Stay
- Appointments
- Follow Up

### Episodes of Care – Payment Model Design (continued)

Each episode for a particular condition has an overall performance year in which all patient episodes for that condition are aggregated and evaluated against benchmarks for cost and/or quality of care. PAPs that exceed the acceptable level of costs may have to pay a portion of the overrun as a penalty. PAPs that exceed the acceptable level of costs may also meet quality benchmarks. PAPs that exceed the acceptable level of costs may have to pay a portion of the overrun as a penalty. PAPs that exceed the acceptable level of costs may also meet quality benchmarks. PAPs that exceed the acceptable level of costs may also meet quality benchmarks.
Regional Care Organizations: Overview

What are Regional Care Organizations?

RCOs are local, risk-bearing care delivery entities that are accountable for the total cost of care for patients within a particular region of the state. They are governed by a partnership of health care providers, community members, and other stakeholders in the health system to create shared responsibility for health.

RCOs will meet a high bar of patient-centered care through a focus on primary care and prevention strategies, using care coordination and the integration of social services and community resources into care delivery.

RCOs will utilize global, capitated payments with strict quality measure accountability to ensure cost and quality targets are being met statewide.

RCOs will create local delivery strategies that best utilize current healthcare resources and non-traditional health care workers and services, such as community health workers, local community partners, housing, etc.

Initially, this model is proposed for all state-purchased health care, which comprises a quarter of the state's population.

State Governing Body – Example Advisory Boards and Committees

OSIM Health Information Technology Plan

Next Steps & Timeline
OSIM Operational Roadmap: Healthcare System Initiatives

Milestones

Quality

Milestone

Regional Care Organizations

Program Milestones

Deliberate on Core RCO Metrics

Form Metrics Committee

Payer Metrics Alignment

Meeting Initial Multi Payer Metrics Report

Form EOC Task Force

Determine Episodes Scope & Definition

Initial Episodes Tracking & Assessment

Episodes Reporting & Evaluation

Model Development Stakeholder Engagement

RCO Enabling Legislation

RCO RFI & RFP Evaluation Process

CMS Waiver Development

CMS Waiver Approval

CMS Waiver Submission

RCO Development & Transition Process

RCO Go-Live

Initial RCO Metrics Report

Annual RCO Metrics Report

Episodes of Care for Payment CMS Waiver Development

CMS Waiver Submission

CMS Waiver Approval

DSRIP Implementation and payments Impacts to Market/Health Services

Federally Facilitated Marketplace (FFM) Enrollment: Year over Year Enrollment

<table>
<thead>
<tr>
<th></th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>Compound Annual Growth Rate (Effectuated)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrollment Pre-effectuated</td>
<td>69,221</td>
<td>106,392</td>
<td>130,178</td>
<td>32.94%</td>
</tr>
<tr>
<td>Effectuated</td>
<td>55,407</td>
<td>106,392</td>
<td>130,178</td>
<td>32.94%</td>
</tr>
<tr>
<td>APTC Enrollment Pre-effectuated</td>
<td>46,460</td>
<td>87,136</td>
<td>113,209</td>
<td>34.57%</td>
</tr>
<tr>
<td>Effectuated</td>
<td>46,460</td>
<td>87,136</td>
<td>113,209</td>
<td>34.57%</td>
</tr>
<tr>
<td>CSR Enrollment Pre-effectuated</td>
<td>34,906</td>
<td>64,543</td>
<td>81,053</td>
<td>32.42%</td>
</tr>
<tr>
<td>Effectuated</td>
<td>34,906</td>
<td>64,543</td>
<td>81,053</td>
<td>32.42%</td>
</tr>
</tbody>
</table>

Federally Facilitated Marketplace (FFM) Enrollment: Projected Enrollment

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrollment</td>
<td>55,407</td>
<td>106,392</td>
<td>130,178</td>
<td>173,059</td>
<td>230,064</td>
<td>305,847</td>
</tr>
<tr>
<td>APTC Enrollment</td>
<td>46,460</td>
<td>87,136</td>
<td>113,209</td>
<td>152,345</td>
<td>205,011</td>
<td>275,883</td>
</tr>
<tr>
<td>CSR Enrollment</td>
<td>34,906</td>
<td>64,543</td>
<td>81,053</td>
<td>107,330</td>
<td>142,127</td>
<td>188,204</td>
</tr>
</tbody>
</table>

FFM Average Advanced Premium Tax Credits (APTC) and Premium Cost

<table>
<thead>
<tr>
<th></th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>Compound Annual Growth Rate (Effectuated)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrollment</td>
<td>$5,407</td>
<td>$106,392</td>
<td>$130,178</td>
<td>32.94%</td>
</tr>
<tr>
<td>Average Monthly Premium (Total)</td>
<td>$277</td>
<td>$294</td>
<td>$370</td>
<td>10.72%</td>
</tr>
<tr>
<td>Average Monthly APTC</td>
<td>$212</td>
<td>$206</td>
<td>$298</td>
<td>12.02%</td>
</tr>
<tr>
<td>Average Monthly Premium After APTC</td>
<td>$65</td>
<td>$89</td>
<td>$80</td>
<td>7.17%</td>
</tr>
<tr>
<td>Estimated Annual Total of APTC</td>
<td>$140,955,408</td>
<td>$263,001,024</td>
<td>$465,516,528</td>
<td>48.92%</td>
</tr>
<tr>
<td>Estimated Annual Amount Spent on Premium</td>
<td>$184,172,868</td>
<td>$376,627,680</td>
<td>$590,487,408</td>
<td>47.46%</td>
</tr>
</tbody>
</table>

FMM: Projected Annual Premium and APTC
134,266 4% 38% 23% 16% 9% 8% 2%

80%
50%
30%
0%

2011 2012 2013 2014 2015

0% 10% 20% 30% 40% 50% 60% 70% 80% 90%

0% 10% 20% 30% 40% 50% 60% 70% 80% 90%

Oklahoma Hospitals, Total Bad Debt / Charity Care

Oklahoma Hospitals, Total Bad Debt by Type
Questions
Oklahoma State Department of Health
Strategic Map: 2016-2020

Improve Population Health

A

Improve Targeted Health Outcomes for Oklahomans
1. Operationalize OHIP Flagship Priorities
2. Focus on Core Public Health Priorities
3. Identify and Reduce Health Disparities
4. Use a Life Course Approach to Health and Wellness

B

Expand and Deepen Partner Engagement
1. Identify and Develop Public Health Champions
2. Develop Strategic Partnerships to Achieve Prioritized Health Outcomes
3. Engage Communities in Policy and Health Improvement Initiatives
4. Leverage Shared Resources to Achieve Population Health Improvements
5. Promote Health in All Policies (HiAP) Across Sectors

C

Strengthen Oklahoma’s Health System Infrastructure
1. Reduce Barriers to Accessible Care
2. Champion Health Workforce Transformation
3. Align Health System Goals and Incentives Across the Spectrum
4. Achieve Compatible HIE Across Public and Private Sectors
5. Evaluate and Reduce Regulatory Barriers to Health Outcome Improvement

D

Strengthen the Department’s Effectiveness and Adaptability
1. Cultivate a Competent, Adaptive, Customer-Oriented OSDH Workforce
2. Foster Excellence Through Continuous Quality Improvement and Accreditation
3. Evaluate and Improve Agency Processes and Communication
4. Leverage Technology Solutions
5. Encourage a Culture of Innovation
6. Optimize Resources by Targeting High-Value Outcomes

E

Address the Social Determinants of Health and Improve Health Equity

F

Promote Health Improvement Through Policy, Education and Healthy Behavior

G

Foster Data-Driven Decision Making and Evidence-Based Practices
The following OSDH Performance Scorecard includes selected performance measures established in the 2015 - 2020 OSDH Strategic Plan. The scorecard offers a snapshot of data and information across the Department and is one tool used to monitor and improve performance as we complete the first year of a five year strategic plan.

It should be noted that data for each measure is drawn from the best, most current available data source and measures the degree of change for that time period.

Routine review by the agency is conducted whereby data is compared against a baseline, a one year target and a five year target. This may result in modified, removed, or newly adopted measures throughout the implementation period (2015 - 2020). This process is necessary to ensure realistic, relevant and achievable targets are established.

Color was assigned based on the rate of improvement as follows:

- **Green**: Target Met or Exceeded
- **Yellow**: Within 5% or Less of Target
- **Red**: Greater Than 5% From Target

The scorecard is concluded with a brief explanation of why particular performance measures did not meet the target as evidenced by assignment of yellow or red to the measure.
<table>
<thead>
<tr>
<th>Strategic Map Reference</th>
<th>Measure</th>
<th>Baseline Data</th>
<th>Year 1 Target</th>
<th>Year 1 Actual</th>
<th>Trend</th>
<th>5 Year Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>A2</td>
<td>Inspection - Percent of state mandated inspection frequency and complaint investigations are achieved annually.</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>➢ 100%</td>
<td></td>
</tr>
<tr>
<td>A2</td>
<td>Infectious Disease - % of immediately notifiable reports received by phone consultation or PHIDDO submission in which investigation is initiated within 15 minutes.</td>
<td>95%</td>
<td>96%</td>
<td>95%</td>
<td>➢ 98%</td>
<td></td>
</tr>
<tr>
<td>A2</td>
<td>Infectious Disease - Average number of reported Tuberculosis, Pertussis and Salmonella cases per 100,000population.</td>
<td>27.2</td>
<td>New Measure</td>
<td>27.2</td>
<td>➢ 20.25</td>
<td></td>
</tr>
<tr>
<td>A2</td>
<td>Preparedness - Improve State Score on National Health Security Preparedness Index by 0.5%</td>
<td>6.5</td>
<td>New Measure</td>
<td>6.5</td>
<td>➢ 9%</td>
<td></td>
</tr>
<tr>
<td>A3</td>
<td>Children - Infant deaths per 1,000 live births</td>
<td>7.5</td>
<td>7.4</td>
<td>7.4*</td>
<td>➢ 7</td>
<td></td>
</tr>
<tr>
<td>A3</td>
<td>Children - Maternal deaths per 100,000</td>
<td>28.4</td>
<td>24.7</td>
<td>25*</td>
<td>➢ 23.1</td>
<td></td>
</tr>
<tr>
<td>A3</td>
<td>Children - Birth rate to adolescents age 15-17</td>
<td>20.5</td>
<td>20.2</td>
<td>16.2*</td>
<td>◼ 19.2</td>
<td></td>
</tr>
<tr>
<td>A3</td>
<td>Injury - Reduction in the age-adjusted motor vehicle crash hospitalization rate per 100,000 population</td>
<td>70.6</td>
<td>69.2</td>
<td>60</td>
<td>◼ 63.5</td>
<td></td>
</tr>
<tr>
<td>A2</td>
<td>Injury - Prevent any increase in the rate per 100,000 of fall-related hospitalizations among persons age 65 and older.</td>
<td>1289.7</td>
<td>1289.7</td>
<td>1275.9</td>
<td>◼ 1289.7</td>
<td></td>
</tr>
<tr>
<td>A3</td>
<td>Prevention - Reduce the rate, per 100,000, of potentially preventable hospitalizations.</td>
<td>1836.2</td>
<td>1762.8</td>
<td>1702.9</td>
<td>◼ 1468.96</td>
<td></td>
</tr>
<tr>
<td>A2</td>
<td>Immunization - 4:3:1:3:3:1:4 Immunization coverage rates of children 19-35 months of age</td>
<td>73.30%</td>
<td>71.96%</td>
<td>73.3%</td>
<td>➢ 80%</td>
<td></td>
</tr>
<tr>
<td>A2</td>
<td>Immunization - Percent of adolescents age 13 - 17 receiving meningococcal vaccine</td>
<td>70.80%</td>
<td>70.94%</td>
<td>70.8%</td>
<td>➢ 71.50%</td>
<td></td>
</tr>
<tr>
<td>A2</td>
<td>Immunization - Percent of adults age 65 and over receiving influenza vaccine</td>
<td>67%</td>
<td>69.60%</td>
<td>68.9%</td>
<td>➢ 80%</td>
<td></td>
</tr>
<tr>
<td>A4</td>
<td>Obesity - Percent of adults who are obese</td>
<td>33.0%</td>
<td>32.30%</td>
<td>34%</td>
<td>◼ 29.5%</td>
<td></td>
</tr>
<tr>
<td>A4</td>
<td>Obesity - Percent of adolescents who are obese</td>
<td>11.8%</td>
<td>11.56%</td>
<td>11.7%</td>
<td>◼ 10.6%</td>
<td></td>
</tr>
<tr>
<td>A5</td>
<td>Obesity - Percentage of the population that has participated in any physical activity in the last 30 days</td>
<td>67.0%</td>
<td>69.44%</td>
<td>66.8%</td>
<td>◼ 79.2%</td>
<td></td>
</tr>
<tr>
<td>A5</td>
<td>Tobacco - Percent of adults who smoke</td>
<td>21.1%</td>
<td>20.48%</td>
<td>22.2%</td>
<td>◼ 18%</td>
<td></td>
</tr>
<tr>
<td>A5</td>
<td>Tobacco - Percent of high-school adolescents who smoke</td>
<td>15.1%</td>
<td>14.08%</td>
<td>14.6%</td>
<td>◼ 10%</td>
<td></td>
</tr>
<tr>
<td>A5</td>
<td>Tobacco - Percent of middle-school adolescents who smoke</td>
<td>4.8%</td>
<td>4.24%</td>
<td>4.1%</td>
<td>◼ 2%</td>
<td></td>
</tr>
<tr>
<td>A2</td>
<td>Cardiovascular - Cardiovascular disease deaths per 100,000</td>
<td>289.8</td>
<td>284.8</td>
<td>288.5</td>
<td>◼ 265</td>
<td></td>
</tr>
<tr>
<td>A3</td>
<td>Behavioral Health - Suicide deaths per 100,000</td>
<td>24.7</td>
<td>23.64</td>
<td>25.3%</td>
<td>◼ 19.4</td>
<td></td>
</tr>
<tr>
<td>A3</td>
<td>Behavioral Health - Unintentional poisoning deaths per 100,000</td>
<td>19.66</td>
<td>19.26</td>
<td>18.88</td>
<td>◼ 17.69</td>
<td></td>
</tr>
<tr>
<td>B1/B2</td>
<td>Policy - # of community organizations supporting OHIP legislation</td>
<td>13</td>
<td>18</td>
<td>60</td>
<td>➢ 40</td>
<td></td>
</tr>
<tr>
<td>B3</td>
<td>Public Health Partnerships - # of certified healthy community</td>
<td>77</td>
<td>80</td>
<td>78</td>
<td>➢ 94</td>
<td></td>
</tr>
<tr>
<td>B3</td>
<td>Public Health Partnerships - # of certified healthy schools</td>
<td>595</td>
<td>640</td>
<td>683</td>
<td>➢ 820</td>
<td></td>
</tr>
<tr>
<td>C2</td>
<td>Immunization Interoperability - # of interoperable immunization systems</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>➢ 1</td>
<td></td>
</tr>
<tr>
<td>D2</td>
<td>Workforce - % of turnover agency wide</td>
<td>12.9%</td>
<td>12.32%</td>
<td>12.18%**</td>
<td>◼ 10%</td>
<td></td>
</tr>
<tr>
<td>D2</td>
<td>Accreditation - # of PHAB accredited OSDH Health Departments in OK</td>
<td>2</td>
<td>4</td>
<td>2</td>
<td>➢ 10</td>
<td></td>
</tr>
</tbody>
</table>

Legend: 
- Target met or exceeded
- Within 5% of target
- Greater than 5% from target

Oklahoma State Department of Health (OSDH)  
2015-2020 Core Measures Scorecard - SFY 2016

The measures in this Scorecard were established in the 2015-2020 OSDH Strategic Plan.
Infectious Disease – Investigation Initiation: This particular measure has a relatively high baseline (95%) and is within 3% of the five year goal of 98%. This measure was unchanged from the baseline which still reflects a very high level of compliance with the 15 minute timeline for investigation initiation following a PHIDDO submission. Efforts will continue to increase the proportion of reports meeting the timeliness objective.

Infectious Disease – Reported Cases: This is a new composite measure that was too late to establish a benchmark for year SFY 2016.

Preparedness: Due to significant recent changes in the National Health Preparedness Security Index a performance benchmark was not established for SFY 2016.

Maternal Deaths: While not achieving the benchmark target, the rate of maternal mortality deaths decreased and is still on track to meet the five year target.

Immunization – Children and Adolescents: The baseline data indicated represents the 2014 National Immunization Survey (NIS) results. The report for 2015 will be released at the end of summer and the scorecard will be updated at that time.

Immunization Adults: The Kaiser Family Foundation survey has not been updated since 2014, and many of the providers across the state do not regularly enter adult immunization information into OSIIS. For these reasons, the BFRSS was utilized for these numbers.

Obesity - Adult: Though the percentage of adults who are obese increased in 2015, this increase is not statistically significant.

Obesity – Adolescent: Adolescent obesity increased on the Youth Risk Behavior Survey from 2013 to 2015 but the increase is not statistically significant. The most recent data point suggests a continuation of the upward trend seen in the last decade.

Adult Tobacco: Though the percentage of adults who smoke increased slightly in 2015, this increase is not statistically significant.

Cardiovascular Disease Deaths: Since 2013 Oklahoma has experienced a slight increase in cardiovascular disease deaths following a 25% reduction in age adjusted heart disease death rates from 2003-2013. The 25% reduction has been influenced by local adoption of evidence based strategies such as clinical support tools designed to increase early diagnosis of hypertension, initiation of team-based medication adherence programs, and referral of patients to lifestyle change services. Steady declines in the age adjusted heart disease death rate from 2010-2014 was reported among populations where such evidence-based approaches have been initiated highlighting the need to continue and enhanced focus on populations living in communities with the greatest challenges toward adopting such strategies and healthcare policies focused on health outcome improvement.
Behavioral Health – Suicide: Nationwide, males complete suicide at a much higher rate than females. In Oklahoma, the adult rate is approximately 3 times higher for males. From 2004 to 2010, the adult female suicide death rate remained at a steady level until a recent small spike from 2013 – 2014. Adult male suicides in Oklahoma have continued to trend upwards from a rate of 23.00 per 100,000 in 2004 to 32.60 per 100,000 in 2015. The OSDH will continue to work with our sister agency, the Oklahoma Department of Mental Health and Substance Abuse Services, and other partners to identify evidence based strategies and interventions that may improve this alarming trend.

Certified Healthy Community: In previous years, TSET Community of Excellence grantees were able to recruit and provide technical assistance to communities interested in applying for the Certified Healthy program. In 2015, TSET launched a new Healthy Living program that was in the assessment phase of funding. This transition placed the focus of the program coordinators on their assessment process with little emphasis available for the Certified Healthy program. This reduced our capacity at the local level to work with communities. For the coming year, there will be increased availability of TSET grantee staff, and additional tools and resources have been developed for use with partners in recruiting communities to make application.

Accreditation: While not achieving the benchmark target, there are multiple county health departments in the process of becoming accredited. Logan County had an accreditation site visit in June. Washington County and Cleveland County Health Departments both have site visits scheduled this year on August 25-26 and September 29-30th, respectively. Other county health departments actively working toward accreditation and preparing documentation include Kingfisher, Canadian, Delaware, and Garfield (who has submitted its Letter of Intent to the Public Health Accreditation Board). We anticipate 3 additional accredited county health departments by the end of 2017.
Purpose: The following pages provide insight into the current progress towards Oklahoma's Core Public Health 2020 targets, identified by the 2015-2020 Oklahoma Health Improvement Plan & OSDH Strategic Plan. The goal of this information is to provide timelier (and therefore actionable) information as to the current progress towards Oklahoma's Core Public Indicator Targets.

Proxy/Provisional Data: Data presented as proxy/provisional will not necessarily match the annual "official" statistics. These data are also subject to change as additional data are collected and processed. Lag times/data timeliness varies based on the particular indicator. Data have been limited to different time frames based on subject matter experts input in an effort to limit the variation between provisional data and the official numbers.

Data Sources: Data were collected from a variety of (internal and external) sources. When possible and appropriate the base data source for the official indicator was used. When more timely data from the official source was not available alternates/proxies were utilized.

Information on the specific data sources and definitions can be obtained from the OSDH, Center for Health Statistics, Office of Health Care Information (405) 271-6225 or email OKSHARE@health.ok.gov.

Data last updated July 21, 2016
# Table of Contents

- Annual Values Adolescent Meningococcal Vaccination ................................................................. 1
- PROXY/PROVISIONAL - A1 OHIP Children's Health Measures ......................................................... 2
- PROXY/PROVISIONAL - A1 OHIP Injury & Behavioral Health Measures ........................................ 3
- PROXY/PROVISIONAL - A1 OHIP Obesity & Physical Activity Measures .................................... 4
- PROXY/PROVISIONAL - A1 OHIP Tobacco Measures ..................................................................... 5
- PROXY/PROVISIONAL - A2 CORE PH Priorities (CVD & Falls) .................................................... 6
- PROXY/PROVISIONAL - A2 CORE PH Priorities (Infectious & Immunizations) ............................ 7
- Annual Stoplight ............................................................................................................................ 8
Percent of adolescents age 13 - 17 receiving meningococcal vaccine

Measure
Adolescent Meningococcal Vaccination

Target Value

Year

Value
75.0
70.0
65.0
60.0
55.0
50.0
45.0
40.0
35.0
30.0
25.0
20.0
15.0
10.0
5.0
0.0

Target
75.0
70.0
65.0
60.0
55.0
50.0
45.0
40.0
35.0
30.0
25.0
20.0
15.0
10.0
5.0
0.0
PROXY/PROVISIONAL - A1 OHIP Injury & Behavioral Health Measures

**MVC Related EMS Calls and Trauma Rate (per 100,000 Population)**

**Unintentional Poisonings Mortality Rate (per 100,000 Population)**

**Suicide (25+ yrs) Rate (per 100,000 Population)**
PROXY/PROVISIONAL - A1 OHIP Obesity & Physical Activity Measures

Percent of Adult Population that is Obese (BMI 30+)

Percent of the Adult Population that Participated in Any Leisure Time Physical Activity (past 30 days)

WIC Cash Value Benefits (CVBs) for fresh/frozen fruits & vegetables redeemed

<table>
<thead>
<tr>
<th>Year</th>
<th>0</th>
<th>10.0</th>
<th>20.0</th>
<th>30.0</th>
<th>40.0</th>
<th>50.0</th>
<th>60.0</th>
<th>70.0</th>
<th>80.0</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>0.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2012</td>
<td>0.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td>0.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2016</td>
<td>0.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2018</td>
<td>0.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2020</td>
<td>0.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Year

<table>
<thead>
<tr>
<th>Year</th>
<th>0.0</th>
<th>10.0</th>
<th>20.0</th>
<th>30.0</th>
<th>40.0</th>
<th>50.0</th>
<th>60.0</th>
<th>70.0</th>
<th>80.0</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>0.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2012</td>
<td>0.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td>0.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2016</td>
<td>0.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2018</td>
<td>0.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2020</td>
<td>0.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Year

<table>
<thead>
<tr>
<th>Year</th>
<th>0.0</th>
<th>10.0</th>
<th>20.0</th>
<th>30.0</th>
<th>40.0</th>
<th>50.0</th>
<th>60.0</th>
<th>70.0</th>
<th>80.0</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>0.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2012</td>
<td>0.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td>0.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2016</td>
<td>0.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2018</td>
<td>0.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2020</td>
<td>0.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

WIC Cash Value Benefits (CVBs) for fresh/frozen fruits & vegetables redeemed

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Amount Redeemed</td>
<td>$400,000</td>
<td>$230,000</td>
<td>$250,000</td>
<td>$220,000</td>
<td>$240,000</td>
<td>$260,000</td>
<td>$280,000</td>
</tr>
<tr>
<td>Number of CVBs Redeemed</td>
<td>40K</td>
<td>30K</td>
<td>35K</td>
<td>45K</td>
<td>50K</td>
<td>45K</td>
<td>50K</td>
</tr>
</tbody>
</table>
PROXY/PROVISIONAL - A1 OHIP Tobacco Measures

Cigarette packs per capita (Total, Regular & Tribal)

Other tobacco product tax collected (Total, Regular, & Tribal)
PROXY/PROVISIONAL - A2 CORE PH Priorities (CVD & Falls)

Cardiovascular Disease Crude Mortality Rate (per 100,000 Population)

Fall (65 and older) related EMS Calls & Trauma Rate (per 100,000 Population)
PROXY/PROVISIONAL - A2 CORE PH Priorities (Infectious & Immunization)

Reported Tuberculosis, Pertussis and Salmonella cases (per 100,000 population)

Percent of Seniors (65+) that Received an Influenza Vaccination (Past 12 Months)

Immunization Coverage (Percent) for children 19-35 months of age (4:3:1:3:1:4)

Percent of adolescents age 13 - 17 receiving meningococcal vaccine
Measure
Adolescent Meningococcal Vaccination

Percent of adolescents age 13 - 17 receiving meningococcal vaccine

Year

Value

0.0

10.0

20.0

30.0

40.0

50.0

60.0

70.0


Target

StepLight

Target

Historic

Greater Than 5% From Target

Within 5% of Target
State Appropriation Reductions
SFY - 16 & SFY - 17
August 2016

Oklahoma State Department of Health

SFY 16 & SFY 17 State Appropriation Reductions

<table>
<thead>
<tr>
<th>Program/Function</th>
<th>SFY-16 Revenue Failure</th>
<th>SFY-17 Revenue Failure</th>
</tr>
</thead>
<tbody>
<tr>
<td>OSDH Infrastructure</td>
<td>$1,242,691</td>
<td>$914,566</td>
</tr>
<tr>
<td>Federally Qualified Health Centers</td>
<td>$319,531</td>
<td>$237,891</td>
</tr>
<tr>
<td>Uncompensated Care</td>
<td>$741,051</td>
<td>$237,891</td>
</tr>
<tr>
<td>Cord Blood Bank</td>
<td>$500,000</td>
<td>$252,933</td>
</tr>
<tr>
<td>Strategic Planning (STEP-UP) Software</td>
<td>$220,000</td>
<td>$252,933</td>
</tr>
<tr>
<td>Dental Health Education Services</td>
<td>$220,000</td>
<td>$252,933</td>
</tr>
<tr>
<td>Colorectal Cancer Screen</td>
<td>$200,000</td>
<td>$252,933</td>
</tr>
<tr>
<td>Ryan White Part B Program</td>
<td>$786,000</td>
<td>$252,933</td>
</tr>
<tr>
<td>Oklahoma Athletic Commission</td>
<td>$14,000</td>
<td>$4,315</td>
</tr>
<tr>
<td>Total</td>
<td>$4,243,273</td>
<td>$2,684,813</td>
</tr>
</tbody>
</table>

The following services were not restored for SFY-17:
- OSDH Infrastructure budgeted at SFY-16 ending balance
- Federally Qualified Health Centers (FQHC) start-up funding
- Dental Health Education Services
- Colorectal Cancer Screening (restored $50,000)
- Ryan White – Utilizing Drug Rebate Funds

OSDH Appropriations History
SFY 2009 - SFY 2017

SB 1616 General Appropriations 8th
State funded state appropriation revolving funds to be used for public health activities as outlined in SFY 2016 in the amount of $1,275,108.

SB 1555 General Appropriations 9th
State funded state appropriation revolving funds to be used for public health activities as outlined in SFY 2017 in the amount of $1,275,108.

Performance Related Impacts:
- County Health Department Services (estimated savings $360,000)
- Suspension of all state funded positions in various years to meet the reduction.
- Financial Management Services has had a significant impact:
  - 12% reduction in staff in FY2016 (8 positions)
  - 29% vacancy rate for two consecutive years
  - Accounting system from 1974 – need to modernize
  - Billing system needs modernization in order to bill insurers and bring in revenue
  - Impacts the ability to complete administrative requirements timely such as federal and state reporting, payment of invoices.
  - Multiple systems that are unable to speak to each other
  - Paper driven
  - Customer service suffers
  - Slow down in completing contracts and purchases
Oklahoma State Department of Health (OSDH)
Innovation

The following definition of Innovation was developed by a team of OSDH employees to identify more specifically what needs to be accomplished in order to achieve the strategic priority “Strengthen the Department’s Effectiveness and Adaptability.”

**Strategic Map Objective:**
Encourage a Culture of Innovation

**OSDH Innovation Team:**
Becky Moore, Mariam McGAugh, Michael Jordan, Carter Kimble, Lee Martin, Deborah Nichols, Christin Eberly

**Proposed Definition of Innovation:**
Doing new things or doing things in new ways, in a manner that creates value for anyone, anywhere through the application of practical tools and techniques that make changes, large or small, to products, processes, and services that result in added value and contributes to knowledge.

**What does innovation mean for public health?**
1. What does innovation mean for the OSDH?
2. What are the top 4 characteristics of an innovative culture for the OSDH?
3. Does this definition capture the meaning of innovation? If not, what changes would you recommend to the definition?
4. What do you think are the top 1 & 2 innovation priorities for OSDH given the current fiscal environment?
Strategic Planning Innovation Team

<table>
<thead>
<tr>
<th>Goal: 1</th>
<th>D5 Objective: 1</th>
<th>D5 Performance Measure: 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>OSDH staff are provided with information to recognize a transformational and innovative culture.</td>
<td>By 12/31/2016, the Innovation team will research and define Innovation for OSDH including any barriers or opportunities that may impact achieving a culture of innovation.</td>
<td>Definition of innovation</td>
</tr>
<tr>
<td>D5 Objective: 2</td>
<td>Number of OSDH staff and public partners provided definition for feedback</td>
<td></td>
</tr>
<tr>
<td>By 12/31/2016, OSDH staff are provided with information to recognize a transformational and innovative culture.</td>
<td>Definition approved by leadership</td>
<td></td>
</tr>
<tr>
<td>D5 Objective: 2</td>
<td>D5 Performance Measure: 1</td>
<td></td>
</tr>
<tr>
<td>By 12/31/2016, OSDH staff will receive transformational and innovative thinking training.</td>
<td>Number of training provided</td>
<td></td>
</tr>
<tr>
<td>D5 Performance Measure: 2</td>
<td>Number of staff trained</td>
<td></td>
</tr>
<tr>
<td>D5 Performance Measure: 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D5 Objective: 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>By 12/31/2017, 80% of OSDH staff will receive transformational and innovative thinking training.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D5 Objective: 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>By 6/30/2018, OSDH staff are recognized for innovative thinking (Innovation Day).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D5 Goal: 2</td>
<td>D5 Objective: 1</td>
<td>D5 Performance Measure: 1</td>
</tr>
<tr>
<td>OSDH staff is encouraged to participate in an innovative culture.</td>
<td>By 12/31/2016, innovation is promoted on the IRENE homepage.</td>
<td>Innovation web part implemented</td>
</tr>
<tr>
<td>D5 Objective: 2</td>
<td>Number of venues</td>
<td></td>
</tr>
<tr>
<td>By 12/31/2016, two venues are created to encourage and promote cross-pollination of innovative thinking around defined problems and/or creation of new ideas.</td>
<td>Number of new ideas</td>
<td></td>
</tr>
<tr>
<td>D5 Objective: 3</td>
<td>Number of participants of venues</td>
<td></td>
</tr>
<tr>
<td>By 6/30/2018, OSDH staff are recognized for innovative thinking (Innovation Day).</td>
<td>Number of staff participating</td>
<td></td>
</tr>
<tr>
<td>D5 Performance Measure: 2</td>
<td>Number of staff recognized for innovative thinking</td>
<td></td>
</tr>
</tbody>
</table>
Exploring the Connection Between Early Literacy and Health: Health Impact Assessment on K-3 Summer Learning Programs

Overview
An inter-agency team has developed a Health Impact Assessment (HIA) that examines the potential impact of early academic success (supported through summer learning programs with an emphasis on literacy skills) on long-term outcomes related to teen pregnancy and high school completion. The HIA focuses on a life course approach to health, with the underlying assumption that when children experience academic success early in life, it reduces the risk of negative health behaviors and results in more positive outcomes in adolescence and adulthood.

POSSE Program
In Oklahoma, a comprehensive summer learning program is currently operating in the southeastern part of the state. An initiative of the Choctaw Nation, the Partnership of Summer School Education (POSSE) program operates in 10 ½ counties for children in kindergarten through 3rd grade who are below or slightly above average for their grade level on their mid-year reading assessment. The program serves a high proportion of American Indian and Hispanic students, as well as students who participate in the free or reduced lunch program. The POSSE program involves 1,700 students at 14 locations, with plans for expansion.

The POSSE program collects a number of educational performance data before and after a child’s participation in the program. Initial data show positive outcomes related to reading. The figure at right shows results for children in grades 1-3 who participated in the 2015 program. It indicates that the children, as a group, showed improvement after the program in their STAR reading scores. The majority of students also exceeded the expected progress standard for both the STAR Reading and STAR Math assessments. Additionally, over 90% of students showed gains in sight word and letter recognition assessments.

Given its early success and foundation in research, as well as reading-focused elements, this HIA utilizes the POSSE program as a model program on which

STAR Reading Results, Grades 1-3, Summer 2015

Source: Partnership of Summer School Education
Findings

Using both evidence in the literature and POSSE program data, the HIA team finds that quality K-3 summer learning programs that include a focus on reading have a significant positive impact on early academic achievement and a potentially long-term positive impact on teen pregnancy and high school completion.

While there are limitations to the data and evidence gathered, the following can be said with confidence:

- Quality summer learning programs have a short-term positive effect on academic achievement for at-risk children.¹
- Children, as a group, who participate in the 2015 POSSE program improved performance in reading and math assessments after completing the program. The majority of students also exceeded the expected progress standard for both the STAR Reading and STAR Math assessments.²
- There is some evidence of a relationship between low literacy and teenage pregnancy.³
- Though inconclusive, several studies indicate favorable effects of summer learning programs on high school completion and participation in post-secondary education.¹

The HIA impact analysis is provided below.

<table>
<thead>
<tr>
<th>Initial Academic Outcome</th>
<th>Direction and Extent of Effect</th>
<th>Likelihood</th>
<th>Distribution</th>
<th>Quality of Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Academic achievement (3rd Grade Reading Performance)</td>
<td>↑↑↑↑↑ Significant impact on a high proportion of participants</td>
<td>Likely</td>
<td>Low-income students and students behind in reading impacted more</td>
<td>▲▲▲</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Many studies that support a direct relationship; supporting local data</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Potential Long-Term Health Outcomes</th>
<th>Direction and Extent of Effect</th>
<th>Likelihood</th>
<th>Distribution</th>
<th>Quality of Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teen pregnancy</td>
<td>↓↓↓ Small impact on a high proportion of participants</td>
<td>Possible</td>
<td>Hispanic and African American adolescent women may be impacted more</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>At least one study that strongly supports an indirect relationship</td>
</tr>
<tr>
<td>High school completion</td>
<td>↑↑↑ Small impact on a high proportion of participants</td>
<td>Possible</td>
<td>Hispanic and African American children, as well as low-income children, are impacted more</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>More than one study that supports a direct relationship but results are inconclusive</td>
</tr>
</tbody>
</table>

Recommendations

**Invest in early education summer learning programs.**
Evidence supports the idea that early interventions, since they put students on a trajectory to experience success and become more engaged in school, are not only effective but contribute to long-term outcomes for school completion. Furthermore, evidence shows that reading-focused programs are effective *only for students in grades K-3* \(^1\) – which could be due to the fact that third grade is the crucial point at which reading must be mastered.

**Make reading instruction the first priority for summer learning programs.**
However a program is implemented, it should include a reading focus as a first priority for early childhood. Reading-focused programs were more effective than general or minimal academic programs at improving reading achievement.\(^1\)

**Focus on children who are at risk for academic failure.**
Summer learning programs are shown to be effective for children who are at-risk,\(^1\) and focusing on at-risk children may decrease the need for more intensive interventions later.

**If you must choose, invest in summer learning programs over after-school programs.**
Summer learning programs have been shown to be more effective at improving reading achievement.\(^1\)
Summer learning programs may also be especially beneficial to students in low-income households, as they may have fewer academic resources available to them.

**Keep class sizes small.**
Supported by the research and implemented in the POSSE program, small class sizes increase programs’ effectiveness.\(^4\)

**Identify other strategies to support literacy at an early age.**
Summer learning programs are one strategy to support literacy, but there are others ways that communities and programs can support these efforts. There may be some strategies that are simple and relatively inexpensive (e.g., providing books in clinics), and may enhance and complement larger efforts.

**Engage parents.**
Summer learning programs, while valuable, are one part of a child’s environment. Engaging parents about ways to promote learning outside of the classroom during the summer can certainly help the child be more successful.

**Build partnerships with entities that can support summer learning programs in your community.**
The POSSE program has expanded rapidly over just a few years. This Choctaw Nation initiative partners with school districts, several colleges and universities, and other public entities to build and maintain the program. Building partnerships can increase community buy-in, make the program more sustainable, and reduce the burden of resources on schools.

---

Implementation Strategies

In consultation with a variety of stakeholders, the HIA team developed the following strategies:

**Public Health Professionals**
- Communicate regularly that literacy and health are connected
- Form partnerships with local schools to learn about and support literacy efforts
- Leverage opportunities the currently exist to engage young children and their parents about literacy (e.g., home visitation programs, clinic visits)
- Educate yourself about local and statewide literacy and learning initiatives

**School Personnel**
- Assess the best investment for helping children get on track for reading by the third grade
- Engage your community to see what existing efforts (e.g., library programs) could be leveraged to support literacy efforts for young children
- Engage higher education, tribes, businesses, and other partners who may support the infrastructure necessary to implement a summer learning program
- Engage parents to better understand what needs young children have to increase literacy skills at school and at home
- Ensure that school administrators are included in the planning and development of programs
- Be aware of possible stigma associated with “summer school” programs

**Parents**
- Ask staff at your child’s school about summer learning and literacy programs
- Advocate for programs that are designed to meet your needs and the needs of other parents (e.g., length and timing of instruction, transportation)
- Talk to your child’s teacher(s) about ways to promote early literacy at home to complement efforts at school

**Community Partners**
- Engage your local school district and health department on ways you can partner to support early literacy and health
- Consider the positive contributions summer learning programs can have for children, parents, employers, and communities

**State Agencies**
- Find ways to support literacy within current programs
- Work together: Positive outcomes for children represent a joint vision across agencies and cabinets.

For more information contact: James Allen, Director, Partnerships for Health Improvement at JamesA@health.ok.gov or Melissa Fenrick, Health Planning Coordinator at MelissaDF@health.ok.gov
What is the best investment to improve health?

Recommendations

HEALTH PRIORITY AREA(S)
TBD

Access
1) MEASURE: Burden, Investment, Performance
2) SYNTHESIZE: Evidence-based Practice
3) ASSESS: Inventory State Assets
4) ANALYZE: Review Program Fidelity

Wellness
1) MEASURE: Burden, Investment, Performance
2) SYNTHESIZE: Evidence-based Practice
3) ASSESS: Inventory State Assets
4) ANALYZE: Review Program Fidelity

Prevention
1) MEASURE: Burden, Investment, Performance
2) SYNTHESIZE: Evidence-based Practice
3) ASSESS: Inventory State Assets
4) ANALYZE: Review Program Fidelity

Social Stability
1) MEASURE: Burden, Investment, Performance
2) SYNTHESIZE: Evidence-based Practice
3) ASSESS: Inventory State Assets
4) ANALYZE: Review Program Fidelity

Refer to Health In All Policies/HIA Team:
HHS Team
Education
Correction
Transportation
Public Safety
OMES
Workforce

Refer to OHIP and/or Other Workgroup

Refer to Quality Improvement

TBD or New Action
What is a Health Impact Assessment?
Health Impact Assessment (HIA) is a practical approach that uses data, research and stakeholder input to determine a policy or project’s impact on the health of a population.

In practice, HIA is a useful way to
• Ensure that health and health disparities are considered in decision-making.
• Engage stakeholders in the process.

How is it Done?
A typical HIA includes six steps:
1. Screening - Determines the need and value of an HIA
2. Scoping - Determines which health impacts to evaluate, the methods for analysis, and the work plan for completing the assessment
3. Assessment - Provides: a) profile of existing health conditions; b) evaluation of health impacts
4. Recommendations - Provides strategies to manage identified adverse health impacts
5. Reporting - Includes development of the HIA report and communication of findings and recommendations
6. Monitoring - Tracks impacts of the HIA on decision-making processes and the decision, as well as impacts of the decision on health determinants

Within this general framework, approaches to HIA vary as they are tailored to work with the specific needs, timeline, and resources of each particular project.

When is it Done?
HIA is a flexible process. Generally an HIA should be carried out before a decision is made or policy is implemented, to allow the HIA to inform the decision or policy.

How Much Does it Cost?
Because HIA can be described as a spectrum of practice, there is no standard cost for conducting one. Health Impact Assessments are highly tailored to work with individual budgets. Scale and approaches of HIA vary based on:
• The depth and breadth of issues analyzed
• The types of research methods employed
• The extent to which stakeholders are involved in developing the HIA
• The way that HIA findings are used
• The relationship to regulatory requirements

Health-focused foundations and public agencies are increasingly interested in funding HIAs as a way to proactively reduce costly negative health outcomes that may be associated with a proposed decision or policy.
Is HIA Time Consuming?
Like cost, the length of an HIA can vary, but even a long and complicated HIA is likely to reduce the time associated with project approval. When recommendations from a well-executed HIA (e.g., one that involves community stakeholders) are implemented, the project is less likely to get held up in the approval process or by litigation.

What Does an HIA Produce?
Generally, a completed HIA results in a report that documents the HIA process and findings. This report can then be used to inform policy-makers and engage communities in advocating for decisions in the best interest of community health.

How Do I Know if an HIA is Appropriate?
In order to assess whether an HIA is appropriate, one should consider the potential for the HIA to influence the proposal, the timing of the proposal, and the capacity of stakeholders and community members to participate. Screening, the first step in conducting an HIA, will help you determine if the HIA is appropriate by addressing these considerations.

Is an HIA Ever Required?
Currently, there are few state and no federal regulations that require HIA. However, because many laws and regulations do require the consideration and analysis of health effects on proposed project and plans, an HIA can be a great way to comply with these types of requirements. HIA can also add value to Environmental Impact Assessment.

What Is the Result of an HIA?
There are two desired outcomes of an HIA. One is to influence policies and projects in a way that improves health and diminishes health disparities. The other is to engage community members and stakeholders so they understand what impacts health and how to advocate for improving health.

The Benefits of HIA
At Human Impact Partners, we are dedicated to helping organizations and public agencies who work with low-income communities and communities of color to understand the effects of projects and policies on community health. And we help them use this information to take action.

Our HIAs have looked at many topics, including land use, transportation and housing plans and projects, as well as employment, incarceration and education policy.

Here’s what our work has led to:

- Changes in proposed developments that improve neighborhood housing and employment conditions.
- The inclusion of comprehensive health analyses in decision-making processes that would have otherwise not included such analyses.
- Changes in how policies are framed and debated to improve public health.
- An increase in coverage of health impacts of decisions in the news.
- New collaborations between community organizations, public agencies, and other stakeholders to make sure health is considered in decisions.
- Increased participation in decision-making processes by community residents and empowerment of community organizations.
- New capacity among our partners to conduct HIA successfully.
**AN INTRODUCTION TO**

**HEALTH IN ALL POLICIES**

A Guide for State and Local Governments

---

Health in All Policies: A Guide for State and Local Governments was created by the Public Health Institute, the California Department of Public Health, and the American Public Health Association in response to growing interest in using collaborative approaches to improve population health by embedding health considerations into decision-making processes across a broad array of sectors. The Guide draws heavily on the experiences of the California Health in All Policies Task Force and incorporates information from the published and gray literature and interviews with people across the country.

**WHY DO WE NEED HEALTH IN ALL POLICIES?**

Health in All Policies is based on the recognition that our greatest health challenges—for example, chronic illness, health inequities, climate change, and spiraling health care costs—are highly complex and often linked. Promoting healthy communities requires that we address the social determinants of health, such as transportation, education, access to healthy food, economic opportunities, and more. This requires innovative solutions, a new policy paradigm, and structures that break down the siloed nature of government to advance collaboration.

---

**A MESSAGE FROM THE AMERICAN PUBLIC HEALTH ASSOCIATION**

The environments in which people live, work, learn, and play have a tremendous impact on their health. Responsibility for the social determinants of health falls to many non-traditional health partners, such as housing, transportation, education, air quality, parks, criminal justice, energy, and employment agencies. Public health agencies and organizations will need to work with those who are best positioned to create policies and practices that promote healthy communities and environments and secure the many co-benefits that can be attained through healthy public policy.

This guide follows in that tradition: We believe it will be of great value as the implementation of Health in All Policies expands and evolves to transform the practice of public health for the benefit of all.

Adewale Troutman, MD, MPH, MA, CPH  
President

Georges C. Benjamin, MD  
Executive Director
WHAT IS HEALTH IN ALL POLICIES?

Health in All Policies is a collaborative approach to improving the health of all people by incorporating health considerations into decision-making across sectors and policy areas. The goal of Health in All Policies is to ensure that decision-makers are informed about the health, equity, and sustainability consequences of various policy options during the policy development process. A Health in All Policies approach identifies the ways in which decisions in multiple sectors affect health, and how better health can support the goals of these multiple sectors. It engages diverse governmental partners and stakeholders to work together to promote health, equity, and sustainability, and simultaneously advance other goals such as promoting job creation and economic stability, transportation access and mobility, a strong agricultural system, and educational attainment. There is no one “right” way to implement a Health in All Policies approach, and there is substantial flexibility in process, structure, scope, and membership.

FIVE KEY ELEMENTS OF HEALTH IN ALL POLICIES

Promote health, equity, and sustainability. Health in All Policies promotes health, equity, and sustainability through two avenues: (1) incorporating health, equity, and sustainability into specific policies, programs, and processes, and (2) embedding health, equity, and sustainability considerations into government decision-making processes so that healthy public policy becomes the normal way of doing business.

Support intersectoral collaboration. Health in All Policies brings together partners from the many sectors that play a major role in shaping the economic, physical, and social environments in which people live, and therefore have an important role to play in promoting health, equity, and sustainability. A Health in All Policies approach focuses on deep and ongoing collaboration.

Benefit multiple partners. Health in All Policies values co-benefits and win-wins. Health in All Policies initiatives endeavor to simultaneously address the policy and programmatic goals of both public health and other agencies by finding and implementing strategies that benefit multiple partners.

Engage stakeholders. Health in All Policies engages many stakeholders, including community members, policy experts, advocates, the private sector, and funders, to ensure that work is responsive to community needs and to identify policy and systems changes necessary to create meaningful and impactful health improvements.

Create structural or process change. Over time, Health in All Policies work leads to institutionalizing a Health in All Policies approach throughout the whole of government. This involves permanent changes in how agencies relate to each other and how government decisions are made, structures for intersectoral collaboration, and mechanisms to ensure a health lens in decision-making processes.
The Healthy Community Framework was developed by the California Health in All Policies Task Force, based upon discussion with community, government, and public health leaders in response to the question, “What is a healthy community?”

A Healthy Community provides for the following through all stages of life:

<table>
<thead>
<tr>
<th>HEALTHY COMMUNITY FRAMEWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Meets basic needs of all</strong></td>
</tr>
<tr>
<td>• Safe, sustainable, accessible, and affordable transportation options</td>
</tr>
<tr>
<td>• Affordable, accessible and nutritious foods, and safe drinkable water</td>
</tr>
<tr>
<td>• Affordable, high quality, socially integrated, and location-efficient housing</td>
</tr>
<tr>
<td>• Affordable, accessible and high quality health care</td>
</tr>
<tr>
<td>• Complete and livable communities including quality schools, parks and recreational facilities, child care, libraries, financial services and other daily needs</td>
</tr>
<tr>
<td>• Access to affordable and safe opportunities for physical activity</td>
</tr>
<tr>
<td>• Able to adapt to changing environments, resilient, and prepared for emergencies</td>
</tr>
<tr>
<td>• Opportunities for engagement with arts, music and culture</td>
</tr>
<tr>
<td><strong>Quality and sustainability of environment</strong></td>
</tr>
<tr>
<td>• Clean air, soil and water, and environments free of excessive noise</td>
</tr>
<tr>
<td>• Tobacco- and smoke-free</td>
</tr>
<tr>
<td>• Green and open spaces, including healthy tree canopy and agricultural lands</td>
</tr>
<tr>
<td>• Minimized toxics, greenhouse gas emissions, and waste</td>
</tr>
<tr>
<td>• Affordable and sustainable energy use</td>
</tr>
<tr>
<td>• Aesthetically pleasing</td>
</tr>
<tr>
<td><strong>Adequate levels of economic and social development</strong></td>
</tr>
<tr>
<td>• Living wage, safe and healthy job opportunities for all, and a thriving economy</td>
</tr>
<tr>
<td>• Support for healthy development of children and adolescents</td>
</tr>
<tr>
<td>• Opportunities for high quality and accessible education</td>
</tr>
<tr>
<td><strong>Health and social equity</strong></td>
</tr>
<tr>
<td><strong>Social relationships that are supportive and respectful</strong></td>
</tr>
<tr>
<td>• Robust social and civic engagement</td>
</tr>
<tr>
<td>• Socially cohesive and supportive relationships, families, homes and neighborhoods</td>
</tr>
<tr>
<td>• Safe communities, free of crime and violence</td>
</tr>
</tbody>
</table>

WHAT’S IN HEALTH IN ALL POLICIES: A GUIDE FOR STATE AND LOCAL GOVERNMENTS?

- A discussion of why Health in All Policies approaches are necessary to meet today’s health and equity challenges
- Five key elements of Health in All Policies, and how to apply them to your work
- Stories of cities, counties, and states that are implementing Health in All Policies
- “Food for Thought”—Lists of questions that leaders of a Health in All Policies initiative might want to consider
- Tips for identifying new partners, building meaningful collaborative relationships across sectors, and maintaining those partnerships over time
- A discussion of different approaches to healthy public policy, including applying a health lens to “non-health” policies
- Reflections on funding, evaluation, and the use of data to support Health in All Policies
- Information about messaging and tips on how to talk about Health in All Policies
- A case study of the California Health in All Policies Task Force
- Over 50 annotated resources for additional information
- A glossary of commonly used terms

To download Health in All Policies: A Guide for State and Local Governments, visit one of these websites:
http://www.apha.org/hiap
http://www.phi.org/resources/?resource=hiapguide

For more information, write to hiap@phi.org.